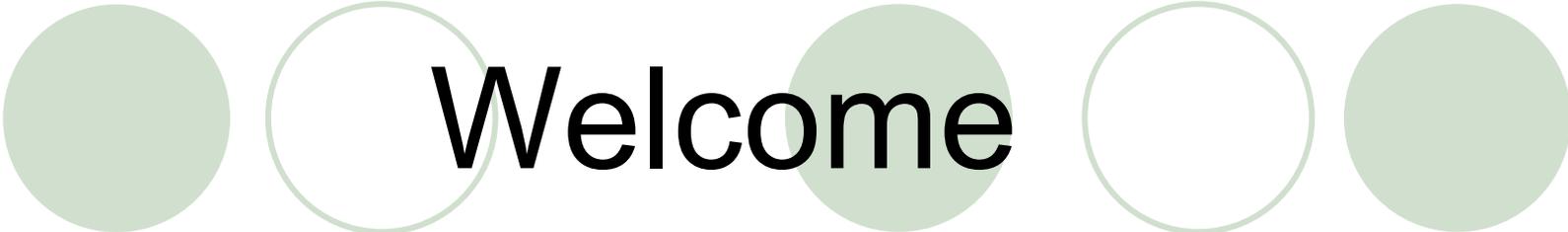# OASIS C

Welcome to Tennessee's 2009 OASIS-Education Coordinators' Conference

Welcome

- Who is here? (OASIS Coordinator's, RNs, PTs, supervisors, AO, others)

Your Questions?

- Your questions are important

- Although **OASIS C** is here, there are still a number of questions that you may have that are **not clear in the guidance**, CMS has requested that we not answer at this time but request that we forward your questions to them so that the panel may be able to respond appropriately to your question.

- Comment/Index cards are on the tables.

OASIS-C

- ## Background & History of OASIS-C
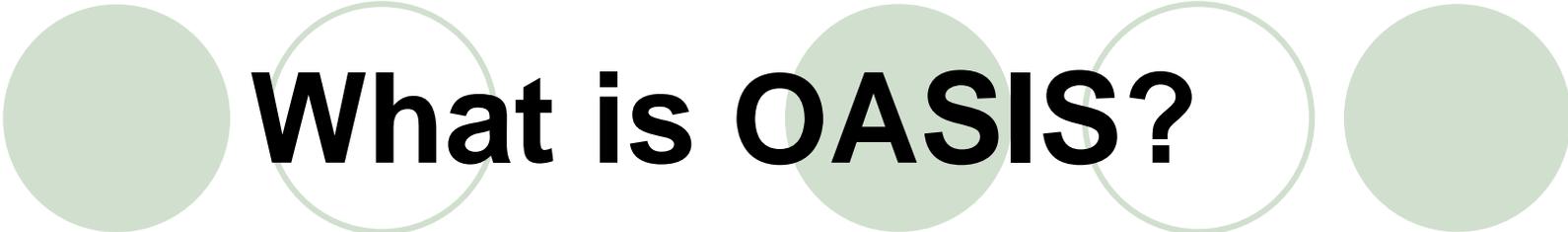
What is OASIS?

- **O**utcome and **AS**sessment **I**nformation **S**et

- Data Collection Tool-A set of data items designed to enable systematic comparative measurement of home health care patient outcomes at two points in time

- Medicare/Medicaid data are submitted to the State

- 114 items/questions used to collect patient-specific information which includes items used for:

  - Risk-adjusted comparisons over time and

  - National benchmarking data

Initiation of OASIS Data Collection

In 1999, Medicare-certified HHAs began collecting and submitting OASIS data related to all adult (18 years or older) non maternity patients receiving skilled services with Medicare or Medicaid as a payer source

Purpose of OASIS

- OASIS data are used for multiple purposes
  - ○ Guidance to surveyors
  - ○ Payment algorithms
  - ○ Publicly Reported Quality Measures (HH Compare)

Purpose of OASIS

- CMS has provided these reports to HHAs to help guide quality/performance improvement efforts
  - Risk-adjusted outcome reports (OBQI)
  - Potentially avoidable event (adverse event outcomes) reports (OBQM)
  - Agency/patient related characteristics (agency case mix) reports
  - Patient tally reports

Purpose of OASIS (cont.)

- Data are used by CMS & other payers for payment
- Prospective Payment System or PPS
- Other payers payment models

OASIS Evolution

- The OASIS items have been revised several times since 1999 to address the burden of data collection, refine items for payment algorithms, and enhance outcome reporting

- Hundreds of comments have been submitted from the industry, providers, professional organizations and researchers in the 10 years since OASIS was initiated

OASIS Evolution (cont.)

- Since 1999, health care quality experts have made recommendations for framing and expanding national quality measurement efforts.

- These recommendations, along with work occurring in two CMS-funded demonstration projects, set the stage for OASIS revisions

- **The next 3 slides provide a timeline of important events that have led up to the OASIS-C revisions**

Timeline of Events Leading to OASIS Revisions

- 2001 – Institute of Medicine (IOM) identified 6 aims for health care quality improvement (safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity)

- 2003 – Home Health Compare launched

- 2005 – National Quality Forum (NQF) endorsed the initial set of home health quality measures for public reporting and recommended future changes to the measures

Timeline of Events Leading to OASIS Revisions (cont.)

- 2006 – Medicare Payment Advisory Commission (MedPAC) Report to Congress included recommendations for expanding home health quality measures to:

  A. Broaden the patient population covered by the OASIS

  B. Capture safety as an aspect of quality

  C. Capture an aspect of care directly under providers' influence

  D. Reduce variation in practice

Timeline of Events Leading to OASIS Revisions

- 2006 - CMS funded the development of the CARE instrument as part of the Medicare Post-Acute Care Payment Reform Initiative

- 2007 – CMS funded the Home Health Pay for Performance Demonstration

- 2008 – NQF developed a new set of guidelines/frameworks for measures and priorities
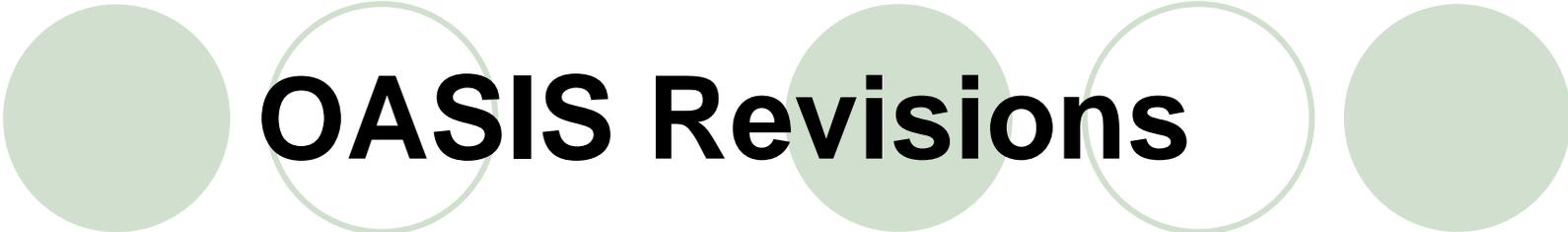
OASIS Revisions

- Based on these events, CMS began a large-scale effort to revise OASIS for three reasons:

    A. To address issues raised by the HHA provider community for specific OASIS items

    B. To address suggestions made by MedPAC and NQF, including the measurement of selected processes of care to supplement the measurement of outcomes, and

    C. To align OASIS measures and items with other instruments being developed to measure care across post-acute care settings (i.e., the nursing home Minimum Data Set [MDS] and the Continuity Assessment Record Evaluation [CARE])

Examples of Harmonization

- Coordination of care across settings
- Post-acute CARE demo (PAC-PRD)
- The National Quality Forum (NQF) developed harmonization of influenza and pneumonia immunization assessment items
- NQF also working to develop a framework for measuring pressure ulcers across provider settings
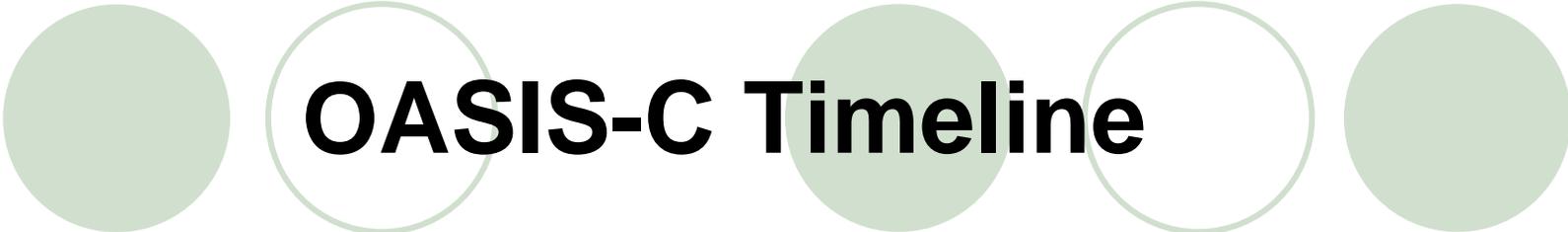
OASIS-C Timeline

- Where we are now:
  - Fall 2009:
    - Training of OASIS Coordinators and Home Health Providers
    - Special Open Door Forum and/or National Provider Call
  - Jan 2010: Anticipated implementation date for OASIS-C
  - Dec 2010: Anticipated Process Measures for HH Compare/OBQI
  - June 2011: Anticipated Outcome Measures for HH Compare/OBQI

Special Open Door Forum and/or National Provider Call

- 3 series of "Train the Trainer" teleconferences lasting approx. 2 hours

- October 22, 2009 at 2:30 pm
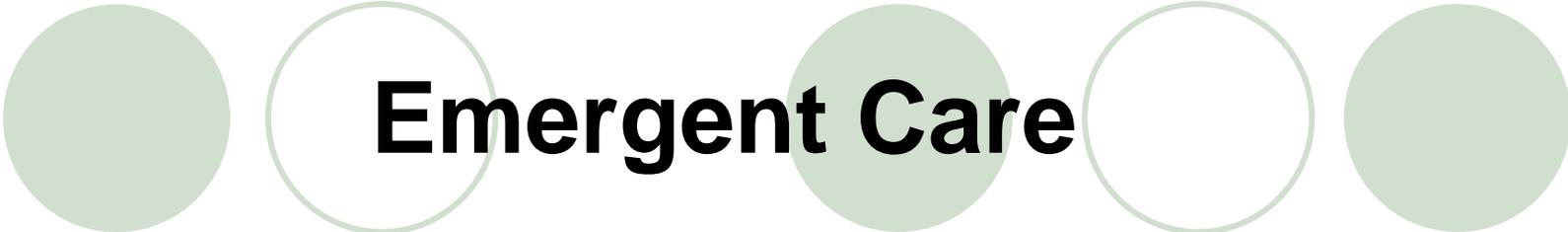- November 12, 2009 at 1:30 pm
- December 8, 2009 at 1:30 pm
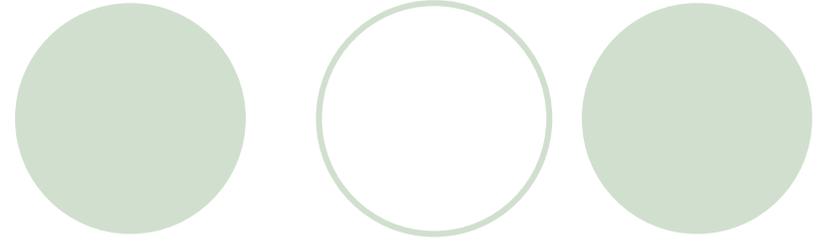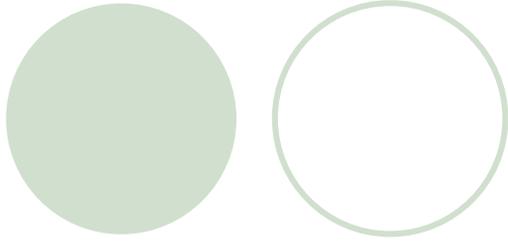
OASIS-C Changes
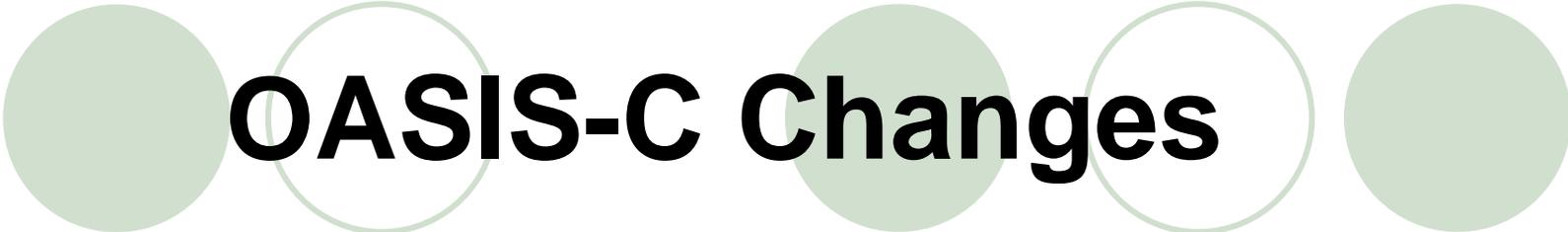
OASIS-C Changes

Major areas:

- Elimination of existing items not used for payment, quality or risk adjustment

- Addition of new items to support process measures (e.g., screening for depression)

- Revisions to existing items (e.g., changes to scales, re-wording for clarity or harmonization)

Emergent Care

- Re-definition of emergent care as a visit to the ER only. The decision to exclude all but emergency room visits in the Emergent Care item will provide more realistic data on the true incidence of emergent care. This is a more helpful and reflective of health care cost than the current OASIS-B interpretation*
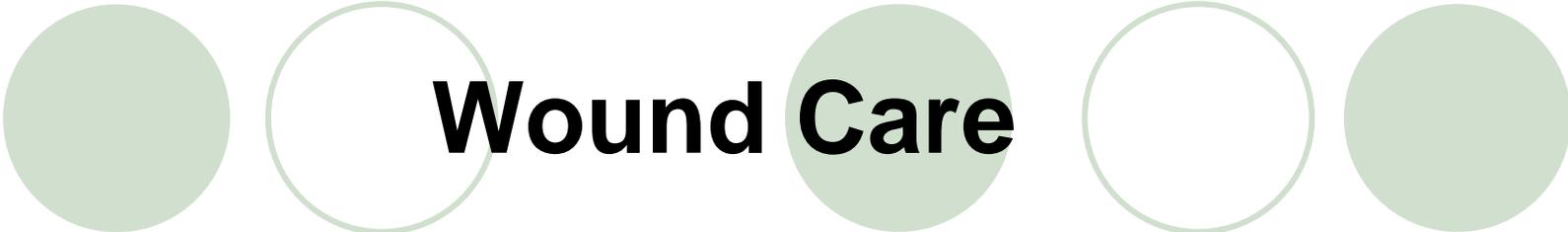
Wound Care

- In general, the wound care questions are better phrased and the integumentary assessment has been greatly expanded and improved to include risk factors and measurements*

- The language has been brought up to date allow for a more descriptive portrayal of pressure ulcers*

- The question regarding the presence of a wound has been edited to specify wound that are receiving assessment and/or intervention

23
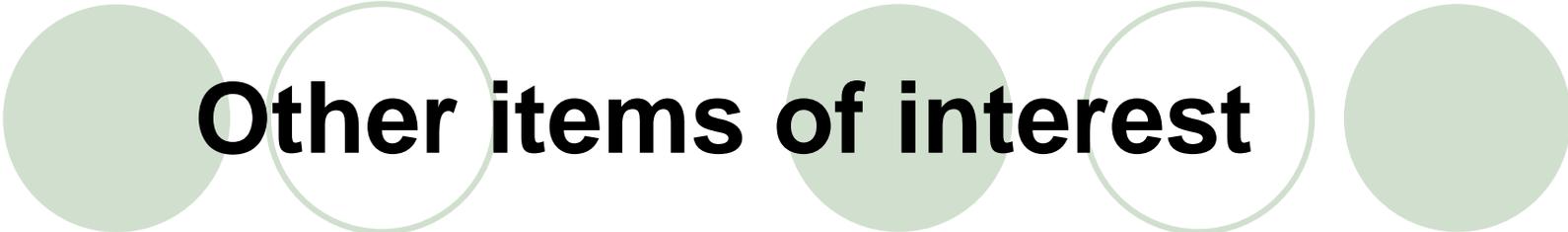
Other items of interest

- An increased specificity in the functional limitations assessments is welcome*

- The word "**safely**" added to many of the functional domain questions will go a long way to improve data … so everyone understands it is the ability to perform safely, including getting in and out of the tub*

Other items of interest (cont.)

- Several items have modified wording or response categories to clarify and show progress.

- Change in response options for Ambulation/Locomotion should better reflect the more subtle changes that can occur during an episode of care. The new item better reflects the progress someone would make from a walker to a cane during an episode*

Other items of interest (cont.)

- Urinary incontinence: the new answers are more appropriate (stress incont. Added)

- Toileting: New answers make a lot more sense and the separation of toileting ability from hygiene ability is greatly supported*

Other items of interest (cont.)

- Frailty Indicators and Stability Prognosis (now Risk for Hospitalization and Overall Status): these are clearer and more comprehensive than previous questions.

- An improvement in the separation of hearing and understanding .
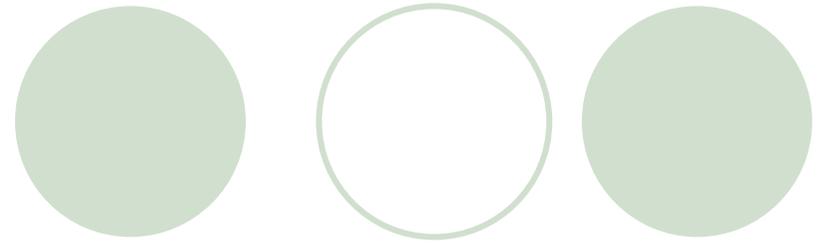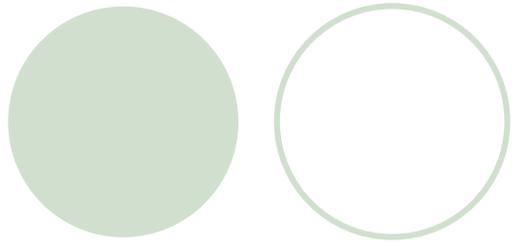
Time Required for OASIS-C

Time Required for OASIS-C

- SOC/ROC ranged from 20 to 125 minutes, with a mean of 49.61 minutes.

- Recertification ranged from 10 to 75 minutes, with a mean of 33.45 minutes.

- Transfer ranged from 2 to 40 minutes, with a mean of 17.44 minutes.

- Discharge ranged from 8 to 80 minutes, with a mean of 26.31 minutes.

Time Required for OASIS-C

- OASIS-C times similar to previous estimates for OASIS-B1

- Exception is Transfer when items have been added for calculation of process measures(takes more time in order to respond to the transfer questions)

OASIS-C

Guidance Manual

OASIS Guidance Manual

- The OASIS Implementation Manual, originally developed in 1999, was intended to serve as a resource for HHAs implementing the new OASIS data collection requirements

OASIS Guidance Manual
(cont.)

- Many of the chapters of the OASIS Implementation Manual primarily were relevant only to new HHAs seeking Medicare certification

OASIS Guidance Manual
(cont.)

- While the manual has been revised several times over the past decade to reflect changes to the OASIS, the basic structure of the manual has not changed

OASIS Guidance Manual
(cont.)

- This revised manual, the OASIS Guidance Manual, is a consolidated version of the original manual

- Now contains content more relevant for HHAs experienced with OASIS requirements, with an emphasis on OASIS item guidance

OASIS Guidance Manual
(cont.)

- Selected content from the OASIS Implementation Manual has been incorporated into the appendices to provide additional context for OASIS data collection requirements

OASIS Guidance Manual
(cont.)

- Sections relevant to first-time implementation of OASIS data have been deleted

OASIS Guidance Manual
(cont.)

In addition to streamlining the manual contents, the format of the manual has changed to:

- Facilitate future updates
- To decrease burden for those who access OASIS guidance electronically

OASIS Guidance Manual
(cont.)

- Item specific guidance is no longer contained in a single document, but has been divided into sections that can be accessed through individual links

OASIS Guidance Manual
(cont.)

Thus, when accessing guidance for a specific OASIS item, the user can more easily locate the OASIS question, rather than scrolling through a large document

OASIS Guidance Manual
(cont.)

- OASIS-C Guidance Manual
  - Chapter 1 - OASIS Conventions (Table 4)
  - Chapter 2 - Highlighted OASIS-C "All Time Points" version
  - Chapter 3 – Item by Item Guidance

41

OASIS Guidance Manual Reference

All manual sections can be viewed online or printed

Data Sets: http://www.cms.hhs.gov/HomeHealthQualityInits/12_HHQIOASISDataSet.asp#TopOfPage

Manual: by 9-21-09 http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp#TopOfPageby

All B1 to be archived in late December: http://www.cms.hhs.gov/HomeHealthQualityInits/20_HHQIArchives.asp#TopOfPage
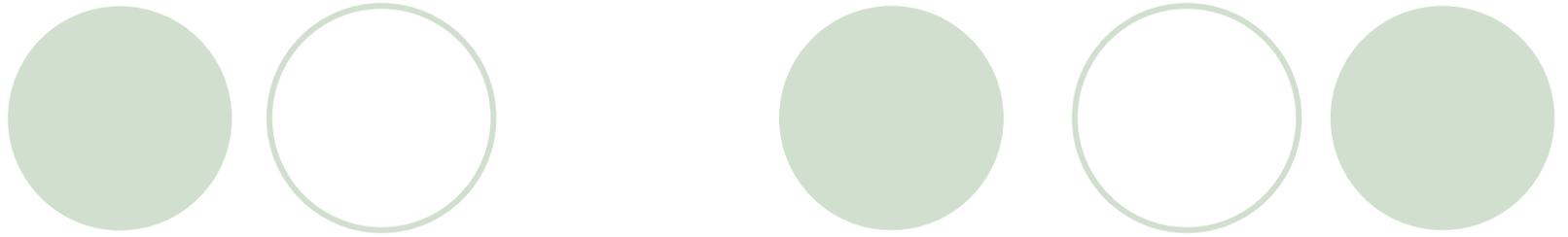
OASIS BASICS
Foundational Concepts for Data Collection
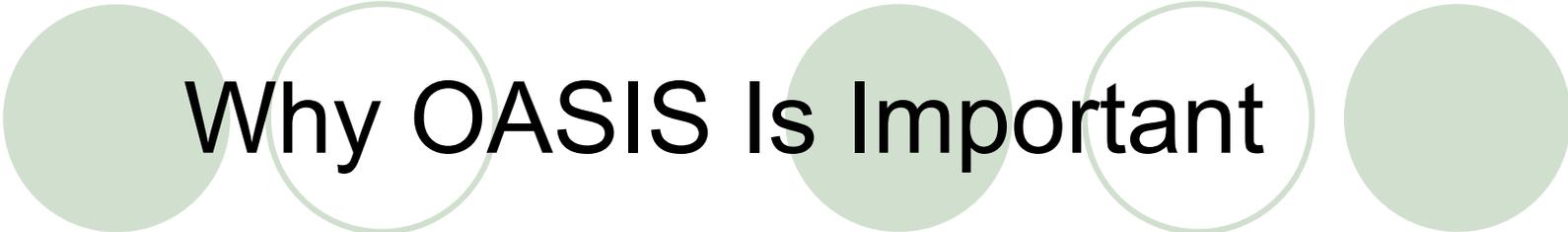
Why OASIS Is Important

- Data are used by CMS & agency to measure quality
  - Outcome Based Quality Improvement or OBQI
  - Outcome Based Quality Monitoring or OBQM/Adverse Events
  - Process Measure Reporting

Why OASIS Is Important (cont.)

- Data are used by CMS & other payers for payment
  - Prospective Payment System or PPS
  - Other payers payment models

Why OASIS Is Important (cont.)

- **Data are used for survey & audits**
  - State surveyors focus survey action based on agency level reports
  - Office of Inspector General & other auditors use data for potential error or fraud detection

Why OASIS Is Important (cont.)

- **Data are used by consumers**
  - Home Health Compare data helps patients decide which agency to select as their home care provider

Why OASIS Is Important (cont.)

- **Data are used by the agency**
  - ○ Case Mix Report directs agency decisions about program development and quality improvement focus.
  - ○ Patient outcomes direct quality initiatives; improve patient care
  - ○ Agency's good outcomes can attract business and potential employees

Why OASIS Is Important (cont.)

- Data describes current health status and measures change over time

- Change over time = patient outcome
  - Example: End Result Outcome – Improvement in Bathing
  - The patient's ability to bathe at start of care compared to their ability to bathe at discharge.

- As an agency, how are our patients doing with bathing?

- What % of our patients improve in their ability to bathe?

OASIS Required Populations

- CMS requires OASIS data collection on skilled Medicare and Medicaid patients
  - Not pediatric, maternity, known one-visit or personal care patients UNLESS the payer needs the Home Health Resource Group (HHRG) for payment

OASIS Required Populations (cont.)

- OASIS data collection on private pay patients is optional
  - Agency policy may require OASIS on private pay
- If private pay and Medicare/Medicaid
  - OASIS required

Comprehensive Assessment of Patients Regulation

- **484.55 Conditions of Participation: Comprehensive Assessment of Patients**
- Published January 1999
- 5 Standards
- (a) Initial assessment visit
- (b) Completion of the comprehensive assessment
- (c) Drug regimen review
- (d) Update of the comprehensive assessment
- (e) Incorporation of OASIS data items

Comprehensive Assessment

- Patient-specific assessment
- Reflects current health status & information that can be used to demonstrate progress toward goals
- Identify continuing need for home care
- Meet patient's medical, nursing, rehabilitative, social and DC planning needs
- For Medicare, verify eligibility & homebound
- Must incorporate current version of OASIS

OASIS and the Comprehensive Assessment

- The Comprehensive Assessment includes:
  - OASIS Assessment Items
    - For the OASIS required patient population
  - The agency's core comprehensive assessment items
    - Varies from agency to agency
    - Examples: Immunization record, vital signs, medication profile, falls risk assessment
  - The agency's discipline specific assessment items
    - Varies from agency to agency and from discipline to discipline
    - Examples: In-depth assessments of gait/balance, swallowing, perceptual awareness and motor integration

Comprehensive Assessment

- **Condition of Participation 484.55 Comprehensive Assessment of Patients**

Must be completed in timely manner

- Consistent with patient's immediate needs
- No later than 5 days after SOC
- SOC = "day 0"
- SOC = date of the first billable service
- May **not** be completed **before** the SOC date
- Does not have to be started or completed on the SOC date, but usually is

Comprehensive Assessment Patient Population Requirements

- Provide ALL patients with a **Comprehensive Assessment <u>except</u>**:
  - Clients receiving services entirely limited to housekeeping or chore services
  - OASIS will be a required part of the Comprehensive Assessment for *some* patients and not for others
    - Example: OASIS required for Medicare/Medicaid skilled patient but not for maternity patient (unless payer requires it for payment purposes)

Who Completes the Comprehensive Assessment?

- At SOC, if nursing is ordered, the RN must complete the comprehensive assessment
- If no nursing orders exist, PT or SLP may complete the assessment on Medicare patients

Who Completes the Comprehensive Assessment? (cont.)

- OT may complete it on non-Medicare patients at SOC, if payer allows.

- After SOC, any discipline may complete the subsequent assessments

Who Completes the Comprehensive Assessment? (cont.)

- Agency policy may be more restrictive than the federal regulations
  - Example: Agency may require all comprehensive assessments be completed by RNs

Completing the Assessment

Must be completed by one clinician

- If two clinicians are seeing the patient at the same time,
  - Reasonable to confer about the interpretation of assessment data
  - May confer about plan of care interventions in order to answer Process Measure items
    - To be counted, assessment/screening must have been completed by clinician completing the assessment
  - Reasonable for the clinician performing the assessment to follow-up on any observations of patient status reported by other agency staff

Completing the Assessment (cont.)

○ Clerical staff may enter demographic and agency ID items – assessing clinician must verify accuracy

○ Assessment, however, is the responsibility of **one clinician – RN, PT, OT, or SLP**
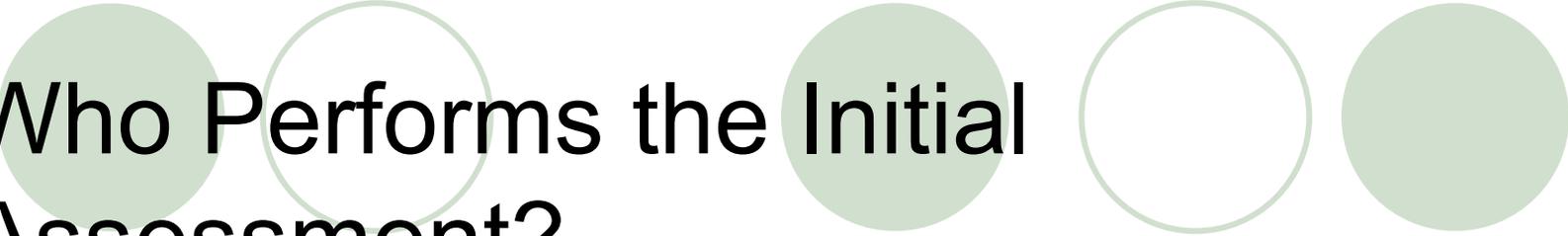
What's an Initial Assessment?

Condition of Participation 484.55 Comprehensive Assessment of Patients

- First *(initial)* time patient is seen by agency staff
- Purpose is to determine immediate care and support needs of patient
  - What does this patient need?
  - Can our agency meet the patient's identified needs?
  - Should we admit this patient?

What's an Initial Assessment? (cont.)

- If Medicare patient, determines eligibility for benefit and homebound status

- Must be conducted within 48 hours of referral or return home from inpatient facility or on physician ordered SOC date.

# Who Performs the Initial Assessment?

- If orders are present for skilled nursing at SOC, RN must conduct the initial assessment visit

Who Performs the Initial Assessment? (cont.)

- **If therapy only**
  - ○ Appropriate therapy may perform initial assessment
  - ○ OT may only complete assessment if need for OT establishes program eligibility
    - Not for Medicare
    - Possible for other payers
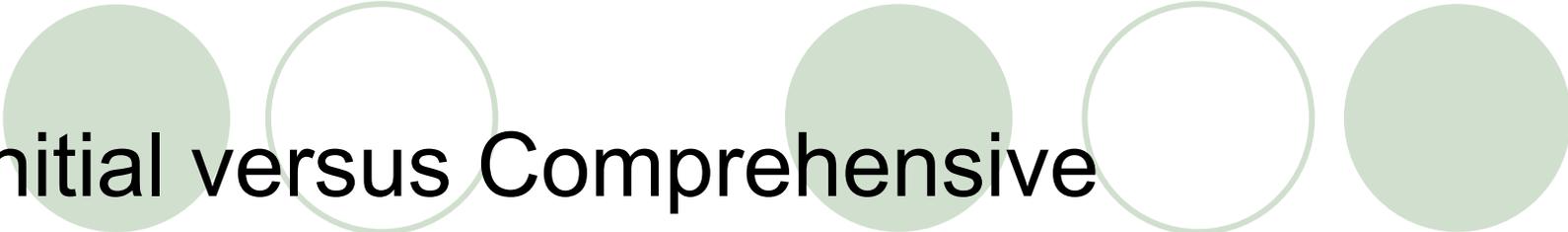
Initial versus Comprehensive Assessment

- Initial assessment begins to occur when the patient opens their door
  - Determines the patient's immediate care & support needs, if the patient meets both the agency's admission criteria and the payer's benefit requirements

Initial versus Comprehensive Assessment (cont.)

- If time allows, the comprehensive assessment is completed during the same visit

- If unable to complete comprehensive assessment on the first visit,

  ○ e.g. very late at night & patient is exhausted,

- It must be completed within 5 days after the SOC, as long as the patient's immediate needs are met in a timely manner

When Does OASIS Get Collected?

- Time points regulated by the Conditions of Participation & OASIS data collection requirements

OASIS Reasons for Assessment or RFAs
- Start of Care (RFA 1)
- Resumption of Care (RFA 3)
- **Follow-up**
  - Recertification (RFA 4)
  - Other Follow-up (RFA 5)
- **Transfer to Inpatient Facility**
  - Not Discharged (RFA 6)
  - Discharged (RFA 7)
- **Discharge from Agency: Not to an Inpatient Facility**
  - Death at Home (RFA 8)
  - Discharge from Agency (RFA 9)

RFA 1 - Start of Care
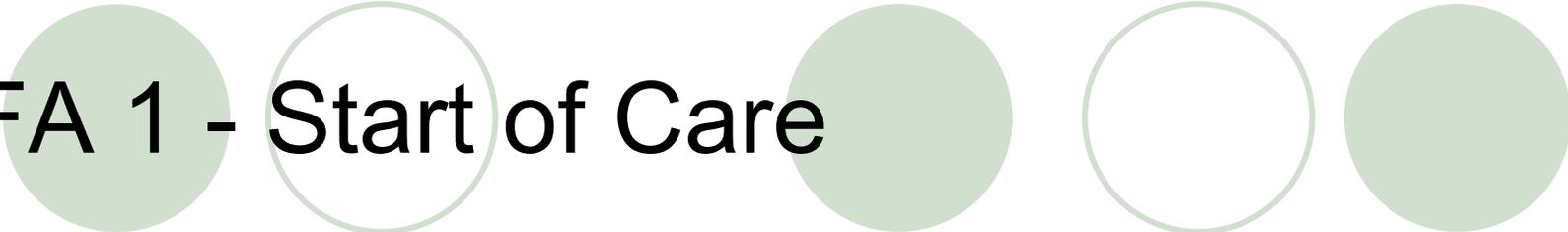
- OASIS data items are part of the Start of Care comprehensive assessment
- Must be conducted during a home visit
- Completed within 5 days after SOC date
  - SOC date = Day 0

RFA 3 - Resumption of Care

- Following an inpatient stay of 24 hours or longer
- For reasons other than diagnostic tests
- Requires home visit
- Must be completed within 2 calendar days of patient's return home (or knowledge of the patient's return home)

RFA 4 - Recertification (Follow-up)

- Comprehensive assessment during the last five days of the 60-day certification period
- Requires a home visit
- If agency misses recert window, but still provides care
  - Do not discharge & readmit
  - **Make a visit** and complete Recertification assessment as soon as oversight identified
  - M0090 = the date the assessment
  - A warning message will result
  - Explain circumstances in clinical documentation

RFA 5 - Other Follow-up

- Comprehensive assessment due to a major decline or improvement in patient condition
  - At time other than during last 5 days of the episode or when another OASIS assessment is due
  - Requires a home visit
  - Updates the patient's plan of care
  - Policies regarding trigger for RFA 5 must be determined by individual agencies

- Must be completed within 2 calendar days of identification of major change in patient's condition
- Agency may call this a "SCIC" assessment
  - Significant Change in Condition
 - SCIC dropped from PPS in 2008

RFA 6 - Transfer to Inpatient Facility, *(Not Discharged)*

- All 3 criteria must be met:
  - Transferred and admitted to inpatient facility
  - Stay of 24 hours or longer (in the inpatient bed, not ER)
  - Reasons other than diagnostic tests
- Must be completed within 2 calendar days of Transfer date (M0906) or knowledge of transfer that meets criteria
- Agency's choice to place "on hold" (vs. D/C)
- Does not require a home visit
- If patient does not return to HHA after inpatient admission, no further assessment required
- This data collection triggers the Acute Care Hospitalization utilization outcome measure
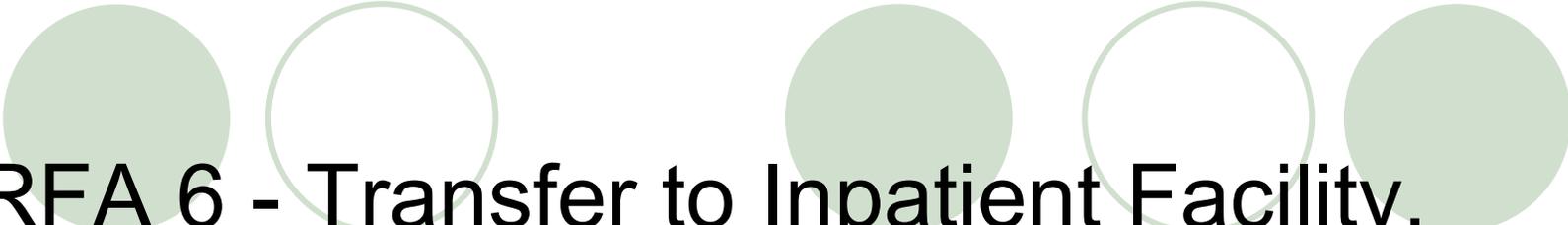
RFA 6 - Transfer to Inpatient Facility, *(Not Discharged)*

- You make a routine visit and discover the patient had a qualifying stay in an inpatient facility and did not inform you
  - Within 2 calendar days of knowledge of transfer
    - Complete the RFA 6 – Transfer to Inpatient Facility
    - Then, complete the RFA 3 – Resumption of Care
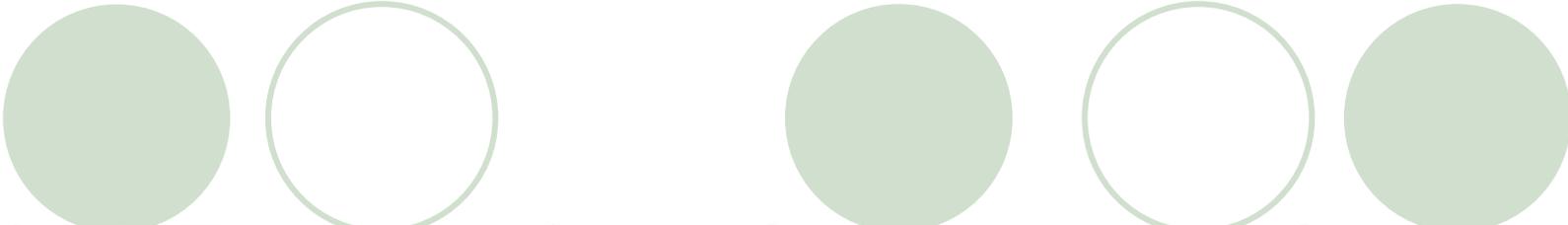
RFA 7 - Transfer to Inpatient Facility, *(Discharged from Agency)*

- Same as RFA 6, but agency decides to discharge patient
  - May be close to end of 60-day episode and patient condition is such that return home during episode is highly unlikely

RFA 8 - Death at Home

- RFA 8 Death at Home = Death anywhere except:
    - Inpatient facility, or
    - The emergency department   (OASIS Assessment Reference Sheet)

- If patient dies in ER or in inpatient facility (before or after 24 hours)
    - NOT an RFA 8 Death at Home
        - Complete RFA 7 Transfer to Inpatient Facility
            - Usual requirements for RFA 7 waived
                - Admission to an inpatient facility
                - 24 hours or greater   (CMS Q&As Cat. 2 Q22)
   - for reasons other than diagnostic testing

RFA 8 – Death at Home (cont.)

- Must be completed within 2 calendar days of death date (M0906)
- Does not require a home visit

Discharge from Agency

- Not due to an inpatient facility admission

- Not due to death

- Must be completed within 2 calendar days of discharge date (M0906) or knowledge of discharge

- Visit is required to complete this assessment
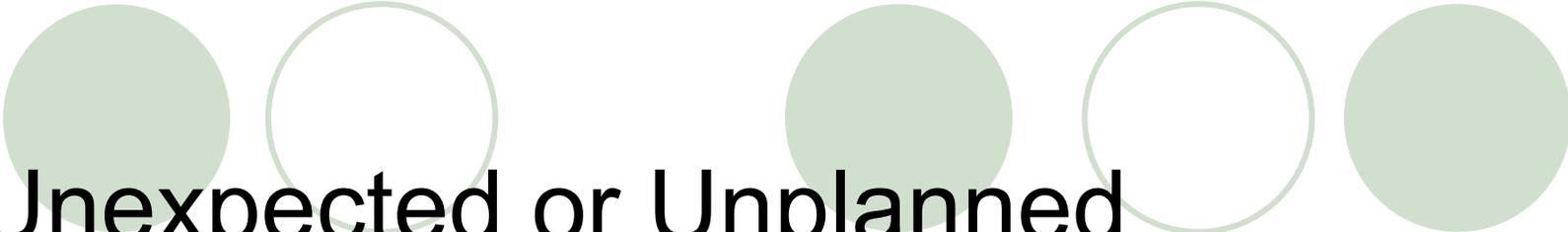
# Unexpected or Unplanned Discharge from Agency

- Examples
  - Patient sees physician and physician orders discharge from agency
  - Patient refuses further home care and won't allow final discharge visit
  - Patient moves unexpectedly

Unexpected or Unplanned Discharge from Agency (cont.)

- Requirements must be met

  - Discharge assessment must report patient status at an actual visit– *not on information gathered during a telephone call*

  - Assessment data should be based on the last visit conducted by a qualified clinician - RN, PT, OT, SLP

    - Don't include events that occurred after the last visit by a qualified clinician, e.g. ER visit, Foley DC

OASIS Data Items
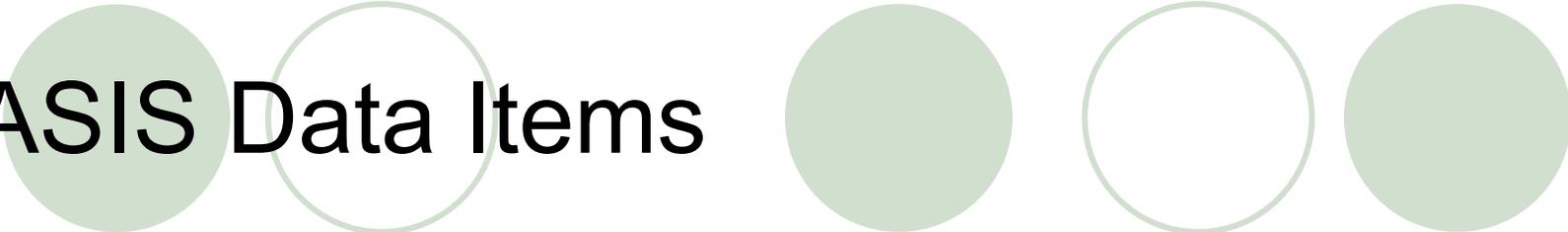
- Standardized items provide ability to measure outcomes and make comparisons across agencies.
- Tested to ensure validity and reliability
- Incorporated into the agency's comprehensive assessment
- Identified by a number beginning with "M"
  - OASIS-B1 called "M0" or "MO"items
  - OASIS-C "M items"
- Organized by domain

OASIS Item Domains

|	
Patient Tracking Items	M0010 – M0069; M0140 – M0150
Clinical Record Items	M0080 – M0110
Patient History and Diagnoses	M1000s
Living Arrangements	M1100
Sensory Status	M1200s
Integumentary Status	M1300s
Respiratory Status	M1400s
Cardiac Status	M1500s
Elimination Status	M1600s
Neuro/Emotional/Behavioral Status	M1700s
ADLs/IADLs	M1800s + M1900s
Medications	M2000s
Care Management	M2100s
Therapy Need and Plan of Care	M2200s
Emergent Care	M2300s
Data Collected at Transfer/Discharge	M2400s, M0903+M0906
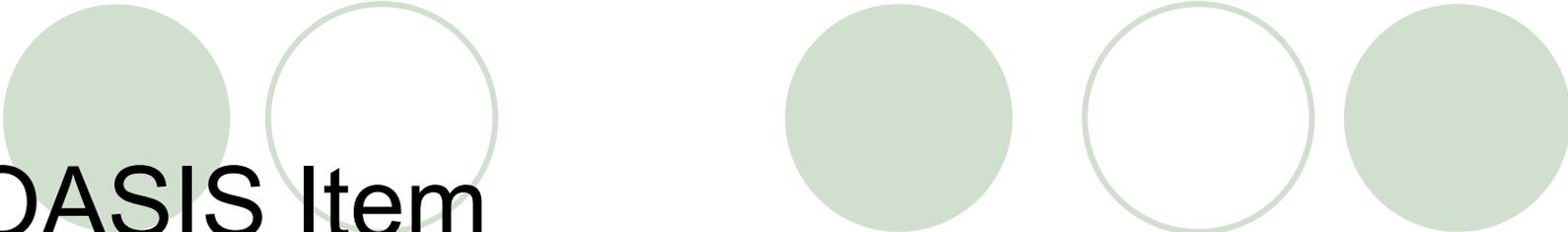
OASIS Item

(M1242) Frequency of Pain interfering with patient's activity or movement:

☐ 0 – Patient has no pain

☐ 1 – Patient has pain that does not interfere with activity or movement

☐ 2 – Less often than daily

☐ 3 – Daily, but not constantly

☐ 4 – All the time

OASIS Item Responses

- "0" Response **usually** represents the least impaired or most independent or optimal status or ability
  - ○ Example: M1850 **Transferring**

    0 = Able to independently transfer
- Response options **usually** progress to most impaired or dependent or least optimal status or ability
  - ○ Example: M1850 **Transferring**

    5 = Bedfast, unable to transfer and is

    unable to turn and position self
- Some items require a simple Yes or No
  - ○ Example: 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?

    0 = No; 1= Yes

OASIS Item Responses
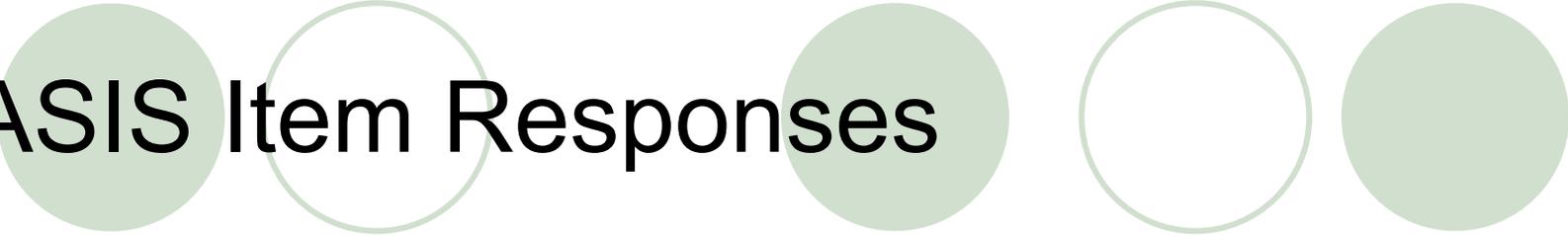
- NA means the item is not applicable to this patient
- M1890 Ability to Use Telephone
  - NA-Patient does not have a telephone
- M1620 Bowel Incontinence Frequency
  - NA-Patient has ostomy for bowel elimination
- M1320 Status of Most Problematic (Observable Pressure Ulcer
  - NA-No observable pressure ulcer
- M1710 When Confused
  - NA-Patient nonresponsive

NA - Nonresponsive
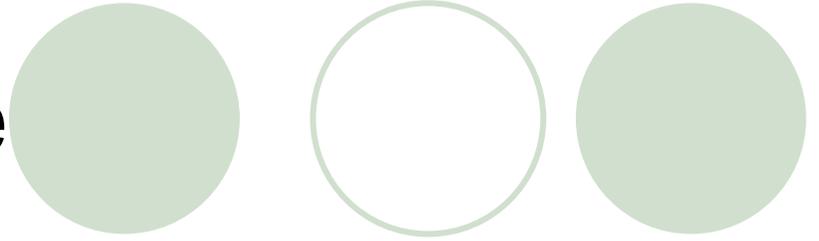
- Non-responsive has an OASIS specific definition

NA - Nonresponsive
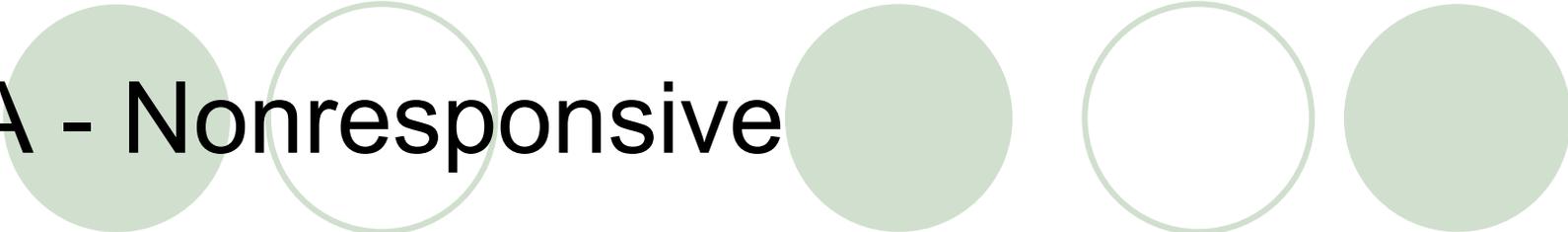
● Unresponsive means unconscious or unable to voluntarily respond or responds in a way that you can't make a clinical judgment about the patient's level of orientation

  ○ A patient with language or cognitive deficits are not automatically considered "unresponsive"

    ● May respond by blinking eyes or raising finger

    ● A refusal to answer questions is not = "unresponsive"

      • Complete comprehensive assessment and select correct responses based on observation and caregiver interview

(CMS OASIS Q&As Cat 4b)

Selection of NA-Non-responsive for Confusion or Anxiety means the patient episode is **not included** in the OBQI report

Getting it Right

- You can't just read the M item and think you know what it means

- You must understand & follow the data collection rules
  - Chapter 3, OASIS-C Guidance Manual
  - Additional guidance provided through Q&As
    - CMS OASIS Q&As at www.qtso.com website
    - CMS OASIS OCCB Q&As at www.oasiscertificate.org website
      - The OASIS OCCB Q&As prior to 09/09 have been integrated into the 09/09 CMS OASIS Q&As

Rules & Guidance

OASIS ITEM

(M1500) Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (such as dyspnea, orthopnea, edema, or weight gain) at any point since the previous OASIS assessment?

☐ 0 - No [*Go to M2004 at TRN; Go to M1600 at DC*]

☐ 1 - Yes

☐ 2 - Not assessed [*Go to M2004 at TRN; Go to M1600 at DC*]

☐ NA - Patient does not have diagnosis of heart failure [*Go to M1752 at TRN; Go to M1600 at DC*]

ITEM INTENT

Identifies whether a patient with a diagnosis of heart failure experienced one or more symptoms of heart failure at the time of the most recent OASIS assessment or since that time.

This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices/assessments stated in the item are not necessarily required in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED

Transfer to inpatient facility

Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Select only response options 0, 1, or 2 if the patient has a diagnosis of heart failure in any one or all of:
    - M1010: Inpatient Diagnoses,
    - M1016: Diagnoses Causing Change in Treatment, or
    - M01020/1022/1024: Primary/Secondary diagnoses for home care.
- Select "NA" if the patient does not have a diagnosis of heart failure.
- Consider any new or ongoing heart failure symptoms that occurred at the time of the previous OASIS assessment or since that time.

DATA SOURCES / RESOURCES

- Review of clinical record including physical assessment data, weight trends, clinical notes using HHA systems put into place to accomplish such a review (e.g., flow sheets, reports from electronic health record data).
- A complete list of symptoms of heart failure can be found in clinical heart failure guidelines in Chapter 5 of this manual.

Chapter 3 OASIS-C Guidance Manual

Chapter 3 – Item-Specific Guidance

OASIS ITEM

(M1500) **Symptoms in Heart Failure Patients:** If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (such as dyspnea, orthopnea, edema, or weight gain) at any point since the previous OASIS assessment?

☐   0 -   No [*Go to M2004 at TRN; Go to M1600 at DC*]

☐   1 -   Yes

☐   2 -   Not assessed [*Go to M2004 at TRN; Go to M1600 at DC*]

☐   NA -   Patient does not have diagnosis of heart failure [*Go to M1732 at TRN; Go to M1600 at DC*]

ITEM INTENT

Identifies whether a patient with a diagnosis of heart failure experienced one or more symptoms of heart failure at the time of the most recent OASIS assessment or since that time.

This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices/assessments stated in the item are not necessarily required in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED

Chapter 3 – Item-Specific Guidance (cont.)

TIME POINTS ITEM(S) COMPLETED
Transfer to inpatient facility
Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Select only response options 0, 1, or 2 if the patient has a diagnosis of heart failure in any one or all of:
  - M1010: Inpatient Diagnoses,
  - M1016: Diagnoses Causing Change in Treatment, or
  - M01020/1022/1024: Primary/Secondary diagnoses for home care.
- Select "NA" if the patient does not have a diagnosis of heart failure.
- Consider any new or ongoing heart failure symptoms that occurred at the time of the previous OASIS assessment or since that time.

DATA SOURCES / RESOURCES

- Review of clinical record including physical assessment data, weight trends, clinical notes using HHA systems put into place to accomplish such a review (e.g., flow sheets, reports from electronic health record data).
- A complete list of symptoms of heart failure can be found in clinical heart failure guidelines in Chapter 5 of this manual.

General OASIS Conventions

- Located in Chapter 1 of the OASIS-C Guidance Manual
  - 15 conventions that apply generally across all items
  - 3 conventions that apply specifically to the ADL and IADL items
- Must be followed to standardize data collection and score accurately

General OASIS Conventions (cont.)

- 1. Understand the time period under consideration for each item.

- Report what is true on the day of assessment unless a different time period has been indicated in the item or related guidance
  - Each M item has a specific assessment time period
  - Most are "Day of Assessment"
  - Multiple other assessment time periods

94

M Item Assessment Time Periods

- **Day of assessment** = 24 hours preceding and including the assessment visit

- OASIS scoring is based on the patient's usual status, circumstance, or condition

- **Example:** M1400, Dyspnea
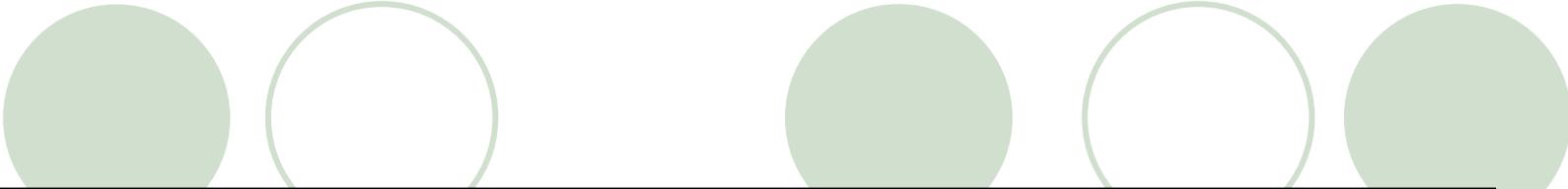
OASIS ITEM:

M1400 When is the patient dyspneic or noticeably **Short of Breath**?
- ☐   0 - Patient is not short of breath
- ☐   1 - When walking more than 20 feet, climbing stairs
- ☐   2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
- ☐   3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
- ☐   4 - At rest (during day or night)

Select response that reflects level of exertion that caused dyspnea during the 24 hours before you walked in the home and include dyspnea you observed while in the home

M Item Assessment Time Periods

- **Day of assessment** - Include a new therapy or service which will occur based on the current assessment
  - Example: Enteral nutrition will be initiated, psych nursing orders will be received, or antibiotics are ordered to treat a UTI, then the new therapy or service should be reported on the applicable OASIS item
  - The new therapy or service does not have to begin on the day of the assessment, as long as an order for the new service/treatment needs was obtained on the day of the assessment (or up to 5 days after the SOC date, if allowed by agency policy), in order for it to be included in the OASIS reporting

M Item Assessment Time Periods (cont.)

- **Day of Assessment & Recent Pertinent Past**

- **Example:** M1242, Frequency of Pain

- Report pain observed during assessment visit

- Report pain reported by patient or caregiver

- You know you have to go into the recent pertinent past because one of the response options is "2-Less often than daily"

M Item Assessment Time Periods (cont.)

- <u>During the Past 14 Days</u> - 14-Day Period Immediately Preceding the date of the Assessment
- OASIS scoring should be based on events or circumstances that occurred within the 14-day period (span of 14 days) immediately preceding the date of assessment.
- **Example:** M1600 – Urinary Tract Infection
- Determine 14 day timeframe by counting back 14 days from the SOC, ROC, or Discharge assessment date
- In addition to the preceding 14 days, events or circumstances occurring on the Day of the Assessment (Day 0) should also be considered in this item
- Anxiety & Confusion, under OASIS-C, include "Last 14 Days"

M Item Assessment Time Periods (cont.)

AT SOC/ROC: "14-Day Period Immediately Preceding the SOC/ROC"

14 days immediately preceding the SOC/ROC

SOC/ROC date

Sun	Mon	Tue	Wed	Thur	Fri	Sat
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28

**Report inpatient D/C's during these 14 days**

Note: Also include DC from inpatient facilities that occur on same day as SOC/ROC

M Item Assessment Time Periods (cont.)

- **Since the Last Time OASIS Data Were Collected**

- OASIS scoring should be based on events or circumstances which occurred since the last OASIS data collection time point

- This time period could include a period of up to 60 days

- **Examples:** M2300 – Emergent Care
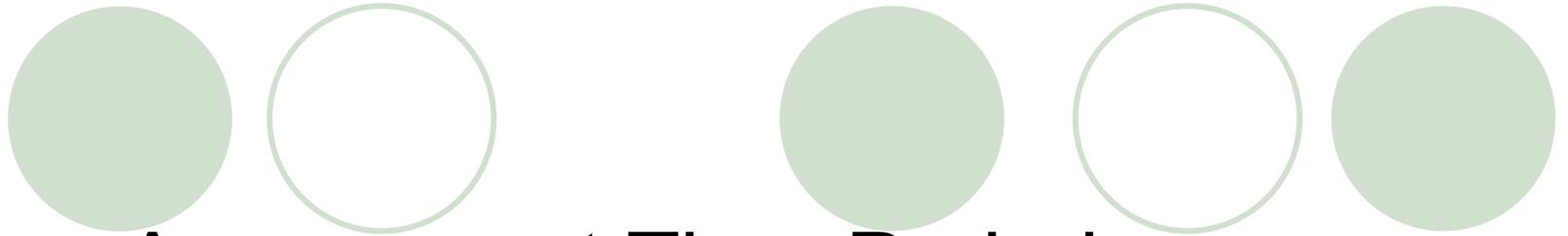
M Item Assessment Time Periods (cont.)

- **Since the Previous OASIS Assessment**

- Defined as at the time of the previous OASIS assessment **or** since that time

- **Example:** M2400 – Intervention Synopsis

M Item Assessment Time Periods (cont.)

- **Prior to the Inpatient Stay or Prior to the Change in Medical or Treatment Regimen**
- OASIS scoring should be based on events, circumstances or status of the patient prior to the specific events identified
- **Example:** M1018 – Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days
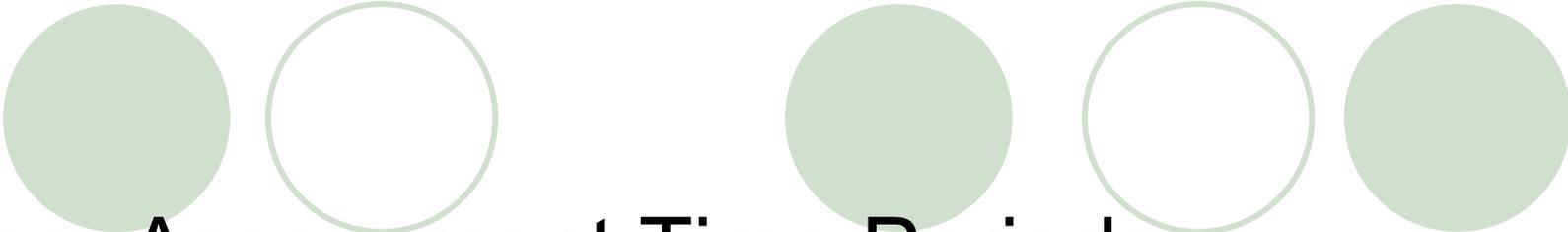
M Item Assessment Time Periods (cont.)

- **Prior**
- OASIS scoring should be based on the patient's status prior to this current illness, exacerbation, or injury
 - **Example**: M1900 – Prior Functioning ADL/IADL
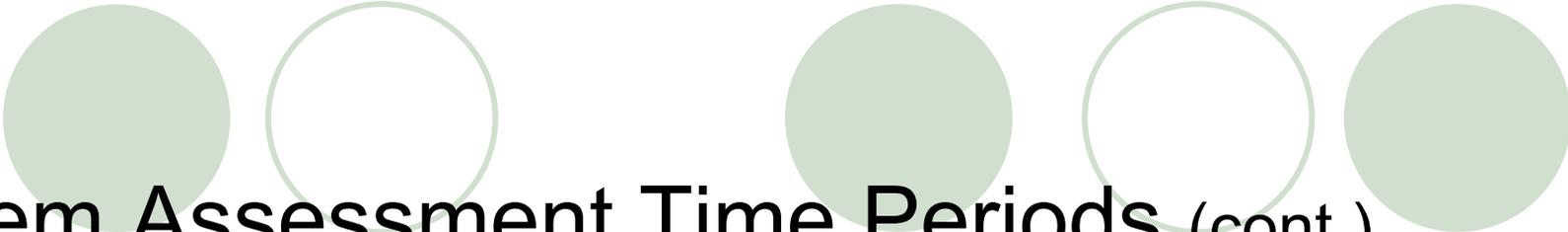
M Item Assessment Time Periods (cont.)

- **Current 60-Day Episode or Subsequent 60-Day Episode**

- OASIS scoring should be based on the prediction of events/utilization during an upcoming time period

- **Example:** M2200, Therapy Need [time period under consideration is either the current 60-day episode, or the subsequent 60-day episode]

General OASIS Conventions

- 2. If the patient's ability or status varies on day of the assessment, report patient's "usual status" or what is true greater than 50% of the assessment timeframe,

  - **Unless** the item specifies differently (e.g., for M2020 Management of Oral Medications, M2030 Management of Injectable Medications and M2100e Management of Equipment, instead of "usual status" or "greater than 50% of the time," consider the medication or equipment for which **the most assistance is needed**)

OASIS Conventions
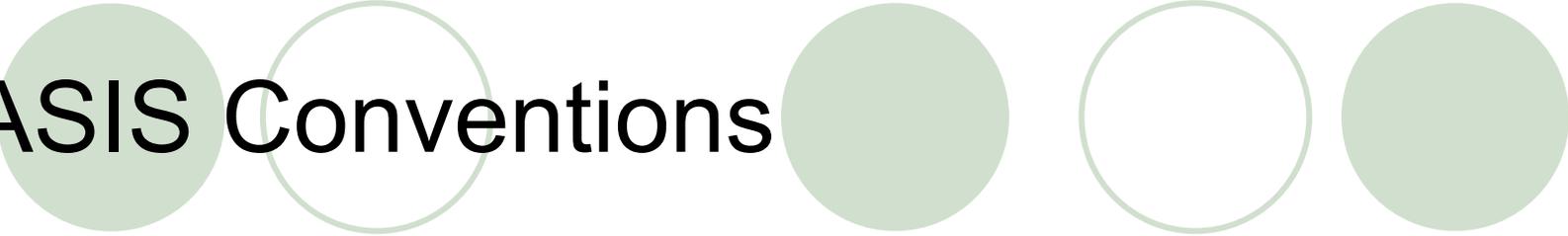
- Usual Status/Most of the Time
  - Report patient's usual status during assessment timeframe
    - The patient's status may change from day to day or during a given day
  - If ability varies, select response reflecting what's true most of the time during the day under consideration
    - Greater than 50% of the time

OASIS Conventions (cont.)

- 3. Minimize the Use of NA/Unknown
  - Only use when no other response is possible or appropriate
  - If patient refuses to answer, don't automatically select NA/Unknown
  - If NA/Unknown response selected, patient outcome can't be computed
  - **Example**: M1620 Bowel Incontinence Frequency – NA appropriate when patient has an ostomy for bowel elimination

General OASIS Conventions

- 4. Responses to items documenting a patient's current status should be based on **independent observation** of the patient's **condition and ability** at the time of the assessment **without referring back to prior assessments**
  - ○ Unless collection of the item includes review of the care episode (e.g., process items)

OASIS Conventions

- No Reference to Prior Assessments
  - To standardize data collection each assessment should be an independent observation at the time point
  - Looking back at prior assessments may bias clinician and influence M response selected
  - **Example:** M1342 Status of Most Problematic (Observable) Surgical Wound

  - **Exception**: Historical data that cannot be obtained through assessment and certain process measure items
  - **Example**: M1510, Heart Failure Follow-up

General OASIS Conventions

- 5. Combine observation, interview, and other relevant strategies to complete OASIS data items as needed

  - ○ (e.g., it is acceptable to review the hospital discharge summary to identify inpatient procedures and diagnoses at Start of Care, or

  - ○ To examine the care notes to determine if a physician-ordered intervention was implemented at Transfer or Discharge)

  - ○ However, when assessing physiologic or functional health status, direct observation is the preferred strategy

OASIS Conventions

- Direct Observation is Preferred
  - The more you observe, the more accurate the assessment
  - When the assessment is accurate, payment and quality outcomes are accurate
  - Problems with relying solely on interview
    - Patients don't truly understand question
    - Patients are not skilled at clinical assessment
    - Patients may consciously or unconsciously mislead clinician
  - Combined observation-interview approach may be needed
    - M1720, When Anxious Patient or in-home caregiver primary source for interview

General OASIS Conventions

- 6. When an OASIS item refers to assistance, this means assistance from another person unless otherwise specified within the item

- Assistance is not limited to physical contact and includes both verbal cues and supervision

  - (Contact guard, stand by assist, reminders, hands-on)

General OASIS Conventions (cont.)

- 7. Complete OASIS items accurately and comprehensively, and adhere to skip patterns
- Skip Patterns
  - Skips items not relevant to patient
  - Quicker completion
- **Example:** M1040 Influenza Vaccine
  - Response 1 – Yes [Go to M1050]
  - Skip M1045 Reason Influenza Vaccine not received

General OASIS Conventions (cont.)

- 8. Understand what tasks are included and excluded in each item

- Score item based only on what is included

  - Some items are more inclusive than what you might expect

    - Surgical wounds

  - Some items are less inclusive than what you might expect

    - Bathing

General OASIS Conventions (cont.)

- 9. Consider medical restrictions when determining ability
  - For example, if the physician has ordered activity restrictions, these should be considered when selecting the best response to functional items related to ambulation, transferring, etc.

General OASIS Conventions (cont.)

- 10. Understand the definitions of words as used in the OASIS
  - ○ Home care and OASIS language distinctive
  - ○ Learning the language decreases frustration & increases accuracy
- Some words in OASIS defined differently than in common English usage
  - ○ **Example:** Bathing
  - ○ Common usage – Gathering supplies, preparing water, getting into a tub/shower, washing body, shampooing hair, stepping out of tub/shower, drying off
  - ○ OASIS – Only transferring into and out of the tub shower and washing the entire body once in a tub/shower is included
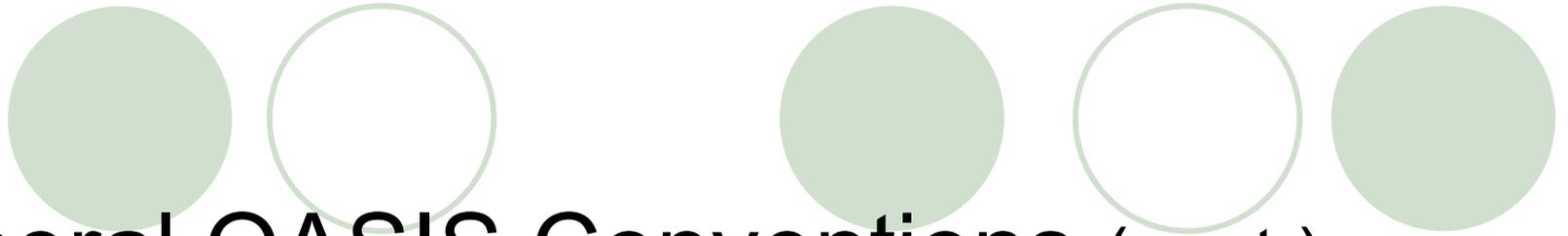
General OASIS Conventions (cont.)

- 11. Follow rules included in the Item-Specific Guidance

  - Clinician must know the rules & follow them to score accurately

- 12. Stay current with evolving CMS OASIS guidance updates

  - Additional clarifications will be needed

  - Q&As released on a quarterly basis

  - Other notices posted at CMS OASIS Websites

General OASIS Conventions (cont.)

- 13. Only one clinician takes responsibility for accurately completing a comprehensive assessment,
  - Although for selected items, collaboration is appropriate (e.g., Medication items M2000 – M2004)
  - These exceptions are noted in the Item-Specific Guidance

General OASIS Conventions (cont.)

- 14. When the OASIS item includes language specifying "one calendar day" this means until the end of the next calendar day

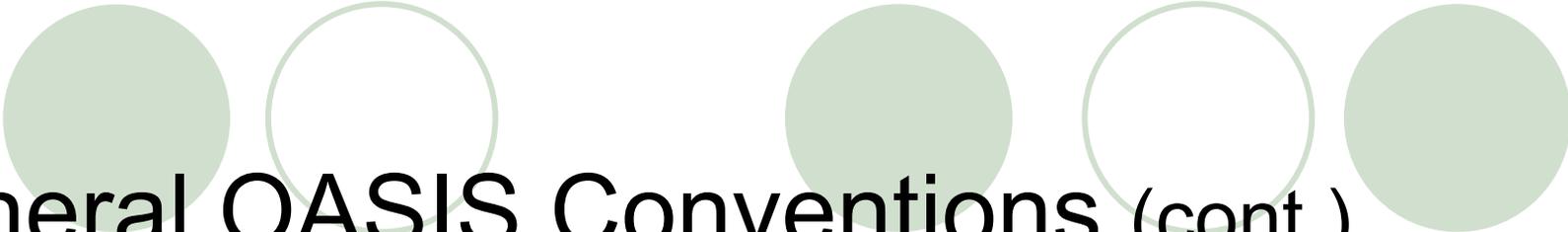- **Example:** M2002 Medication Follow-up

General OASIS Conventions (cont.)

OASIS ITEM:
(M2002) **Medication Follow-up:** Was a physician or the physician-designee contacted within one calendar day to resolve clinically significant medication issues, including reconciliation? ☐ 0 - No ☐ 1 - Yes

General OASIS Conventions (cont.)

- 15.   **The use of i.e.,** means "only in these circumstances" or "that is", scoring of the item should be limited to the examples listed
  - **Example:** M1610, Urinary Incontinence or Urinary Catheter Presence, Response 2-Patient requires a urinary catheter (i.e. external, indwelling, intermittent, suprapubic)
- **The use of e.g.,** means "for example" and the clinician may consider other relevant examples when scoring this item
  - **Example:** M2100, Types and Sources of Assistance, c. Medication administration (e.g., oral, inhaled or injectable)

Additional Conventions Specific to ADLs/IADLs

- 1. Report the patient's ability, not actual performance or willingness, to perform a task

- While the presence or absence of a caregiver may impact actual performance of activities, it does not impact the patient's **ability** to perform a task

Ability, Not Performance

- Patient's ***ability***, not necessarily willingness or actual performance
 Example

  – *(M1880) Plan & Prepare Light Meals: Ability to plan and prepare...*

    • *"0" – (a) Able to independently plan and prepare all light meals for self or reheat delivered meals;*

      OR

      (b) Physically, cognitively and mentally able to prepare light meals on a regular basis but has not routinely performed light meal prep in the past…

Ability, Not Performance (cont.)

- Ability may be **temporarily** or **permanently** limited by:
  - Physical impairments
  - Emotional/cognitive/behavioral impairments
  - Sensory impairments
  - Environmental barriers
  - Medical restriction

(Ch. 3, Each ADL/IADL item)
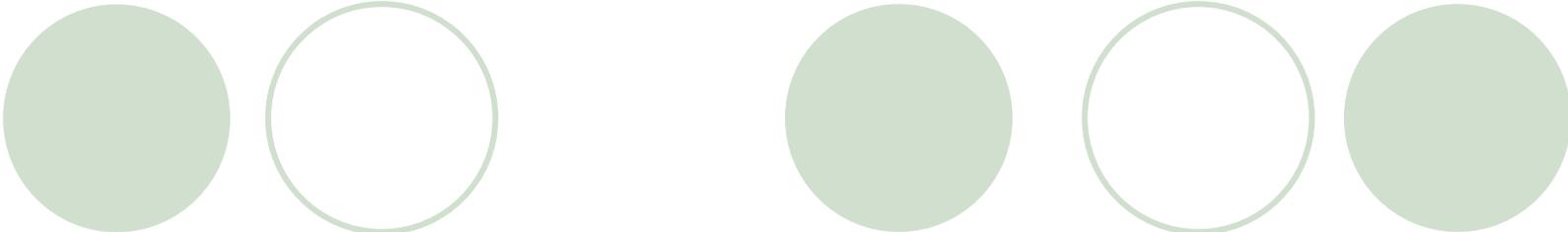
Caregiver Doesn't Impact Ability

- Disregard presence/absence of caregiver when determining ability to complete tasks
  - Score based on the patient's ability
  - Care plan when a patient doesn't have the caregiver present in the home that allows them to perform to the level of their ability

Additional Conventions Specific to ADLs/IADLs

- 2.   The level of ability refers to the patient's ability to **safely** complete specified activities
- Patient's *ability* to ***safely*** perform ADL/IADL tasks
  - Determine safety through skilled observation
    - Evaluate:
      - Technique used, equipment used and
      - Risk for injury

Additional Conventions Specific to ADLs/IADLs (cont.)

- 3. If the patient's ability varies between the different tasks included in a multi-task item,
  - Report what is true in a majority of the included tasks,
  - Giving more weight to tasks that are more frequently performed
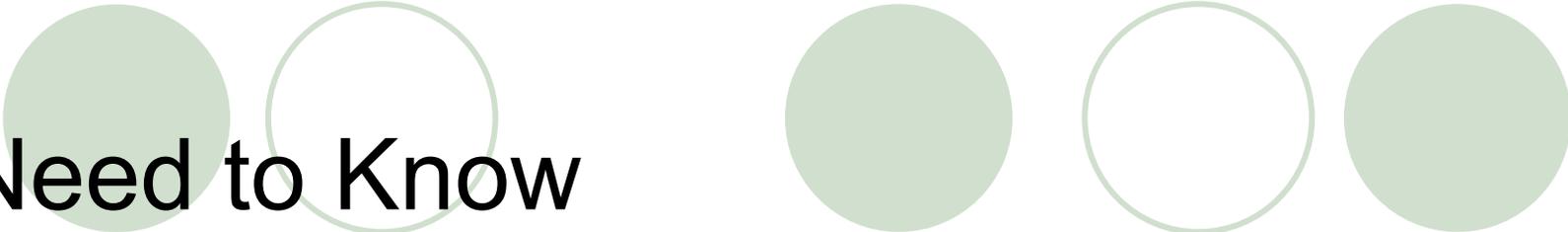
Need to Know
Item Specific Guidance

- Follow rules and conventions generally

- After mastering the basics of OASIS data collection, you'll next learn guidance that is specific to certain items

- Guidance found in Chapter 3 and the Q&As

Where to Find More Information

- OASIS-C Guidance Manual
  - Chapter 1 – Introduction
    - Collecting OASIS-C data
      - Eligible Patients
      - Time Points
      - Who Completes OASIS-C
      - Comprehensive Assessment and Plan of Care
      - Process Data Items
    - OASIS Data Accuracy
    - OASIS Data Encoding & Transmission
  - Chapter 3 – OASIS Item Guidance
  - Appendices A-G

Where to Find More Information (cont.)

- Conditions of Participation – CoPs
  - 484.55 Comprehensive Assessment of Patients
    - Initial Assessment Visit
    - Completion of the Comprehensive Assessment
    - Drug Regimen Review
    - Update of the Comprehensive Assessment
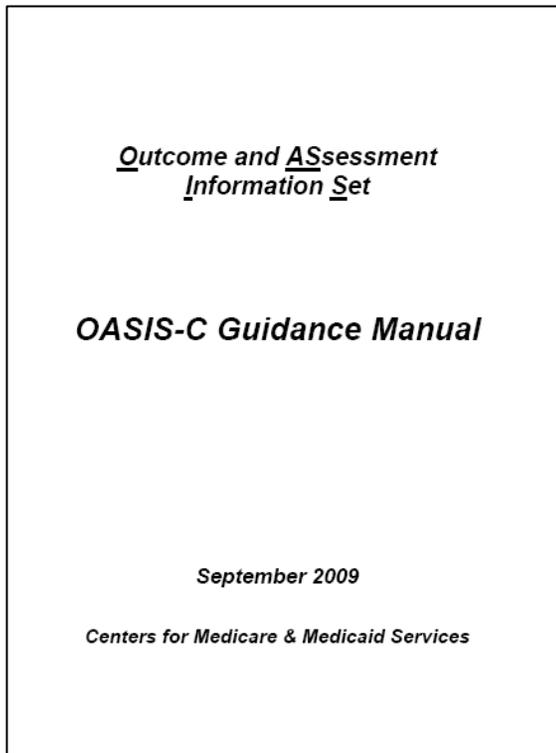   - Incorporation of the OASIS Data Items

Where to Find More Information (cont.)

- Further Clarification of the Rules or Guidance
  - Q&As: CMS OASIS Q&As
    - https://www.qtso.com/hhadownload.html
  - CMS OCCB (OASIS Certificate & Competency Board) OASIS Q&As
    - Posted quarterly
    - www.oasiscertificate.org

OASIS-C Guidance Manual

Outcome and ASsessment
Information Set

OASIS-C Guidance Manual

September 2009

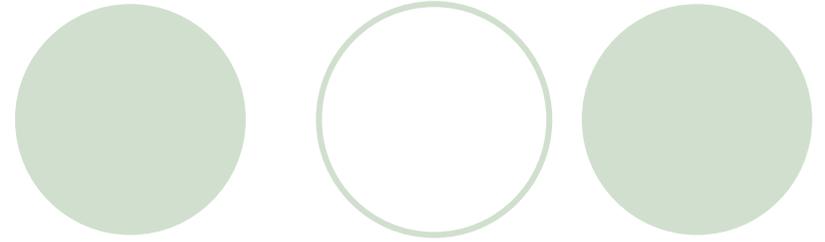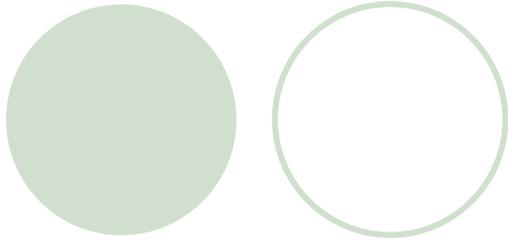Centers for Medicare & Medicaid Services

OASIS-C Guidance Manual
www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp#TopOfPage
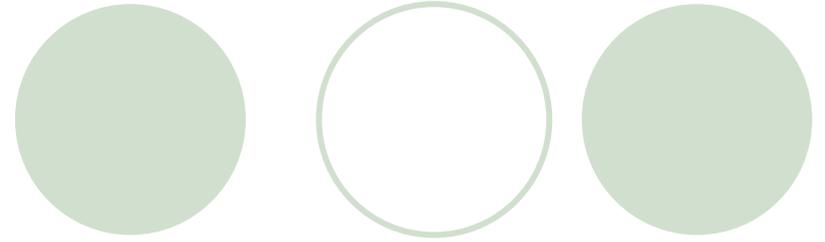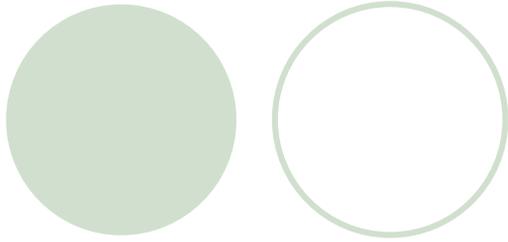

Note: The old OASIS Implementation Manual will be stored on:
http://www.cms.hhs.gov/HomeHealthQualityInits/20_HHQIArchives.asp#TopOfPage

OASIS-C

OASIS-C Overview of Goals,Changes & Crosswalk

OASIS-C

What's New About OASIS-C

OASIC-C Revisions: Goals

- The OASIS-C represents the most comprehensive revision to OASIS since its original release
- Changes meet CMS's goals:
  - Eliminate items not needed for quality measurement, payment or risk adjustment
  - Update terminology and concepts
  - Improve ability to accurately measure patient status and show progress
  - Add items to support measurement of care processes and clinical domains not previously addressed
- Many OASIS items were revised to reflect comments from the provider community

Appendix G
OASIS-B1 to OASIS-C Crosswalks

Appendix G.1: Comparison of OASIS-B1 to OASIS-C

M0290	(M0290) High Risk Factors characterizing this patient: (Mark all that apply.) • 1 - Heavy smoking • 2 - Obesity • 3 - Alcohol dependency • 4 - Drug dependency • 5 - None of the above • UK – Unknown	M1036	Risk Factors, either present or past, likely to affect current health status and/or outcome: (Mark all that apply.) 1 - Smoking 2 - Obesity 3 - Alcohol dependency 4 - Drug dependency 5 - None of the above UK – Unknown Note: No longer collected at Discharge, No change at other collection timepoints.
	New item on OASIS-C	M1040	Influenza Vaccine: Did the patient receive the influenza vaccine from your agency for this year's influenza season (October 1 through March 31) during this episode of care? 0 - No 1 - Yes [Go to M1050] NA - Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season. [Go to M1050]

Elimination of OASIS-B1 Items

- OASIS-B1 items not used for payment, quality measures (including those used in the survey process), case mix, or risk adjustment purposes were **eliminated**

- Examples include items related to:

  - Number of Surgical Wounds
  - Transportation
  - Shopping
  - Housekeeping
  - Laundry

Replacement of OASIS-B1 Items

- In some cases, eliminated items were replaced with items intended to capture the assessment parameter in a more efficient way

  - For example, the "prior status" items for all the ADLs/IADLs have been eliminated

  - Two new OASIS-C items were developed to capture the patient's prior level of dependence with ADLs/IADLs (M1900) and medication management (M2040)

Updating Clinical Terminology & Concepts

Example: pressure ulcers items were revised to:

- Reflect current National Pressure Ulcer Advisory Panel (NPUAP) and Wound, Ostomy, and Continence Nurses Society (WOCN) guidance on pressure ulcer assessment

- Collect additional information considered critical to care planning (wound length, width, depth)

- Harmonize with other measures of pressure ulcers used in other settings

Improved Accuracy in Measurement of Patient Status

- **(M1845) Toileting Hygiene** was created to supplement measurement of toilet transferring (M1840) to more accurately capture toileting ability

- **(M1220) Understanding of Verbal Content** supplements the item for ability to hear (M1210) to provide a more comprehensive understanding of the patient's receptive communication ability

- **(M2020) Management of Oral Medications** now specifies that the item refers to the patient's ability to correctly manage **all** medications safely and reliably

Ability to Show Progress

- Some items have been expanded to include additional scale levels that will allow agencies to document changes in patient status with more accuracy

(M1830) 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.*

(M1860) Ambulation/Locomotion:

- ☐ 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.

- ☐ 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.

Addition of "Process Items"

- Research has identified several evidence-based "best practice processes" (use of screening tools and interventions) relevant for home care patients

- New process data items in OASIS-C allow measurement of agency implementation of selected processes

- Focus is on high-risk, high-volume, problem-prone conditions in home health care that reflect Institute of Medicine (IOM) focus areas and MedPAC recommendations

- The process items are a logical follow-up to the Quality Improvement Organizations (QIOs) 8th Scope of Work on Best Practices (MedQIC - HHQI Campaign)

Addition of "Process Items"

- It is anticipated that processes of care implemented according to evidence-based guidelines will ultimately lead to better clinical outcomes

- Agencies participating in reliability testing of OASIS-C felt process items gave them "credit" for excellent patient care practices already in place

- Will be discussed in more detail in Lesson 4: Measures

Changes to Numbering System

- With the exception of the tracking items and **M0903/M0906**, the OASIS–C items have been renumbered

- Each section has now been assigned to a range of numbers (e.g., Integumentary Status items are numbered M1300-M1350)

- **Medication management** – now a separate domain, outside of the ADL/IADL section

Changes to Numbering System (cont.)

No more M0230/240/246?   No more M0700?

- Necessary because new OASIS items were placed within the existing sequence of items, and other OASIS items were re-sequenced

- Renumbering was determined to be the best long-term solution

- Mirrors systems being used by the data sets in other settings and the CARE instrument

New Numbering System

Tracking Items	M0010 – M0150
Clinical Record Items	M0080 – M0110
Patient History and Diagnoses	M1000s
Living Arrangements	M1100
Sensory Status	M1200s
Integumentary Status	M1300s
Respiratory Status	M1400s
Cardiac Status	M1500s

New Numbering System

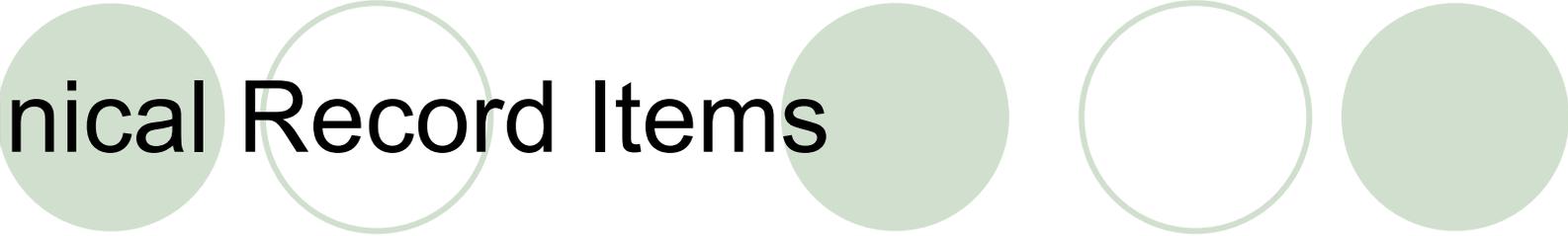|	
Elimination Status	M1600s
Neuro/Emotional/Behavioral Status	M1700s
ADLs/IADLs	M1800s + M1900s
Medications	M2000s
Care Management	M2100s
Therapy Need and Plan of Care	M2200
Emergent Care	M2300
Data Collected at TF/DC	M2400s, M0903+M0906
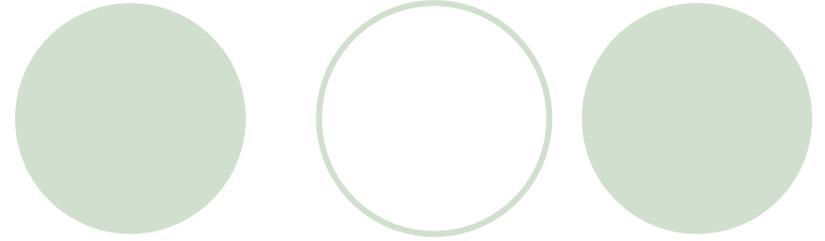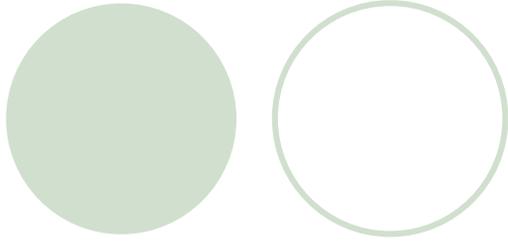
OASIS-C

Highlights of Changes by Section
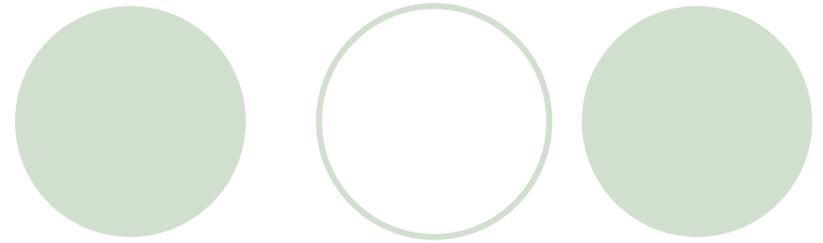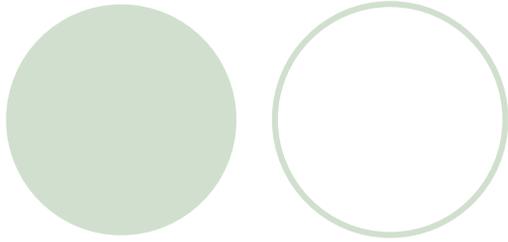
OASIS - C

Clinical Record Items

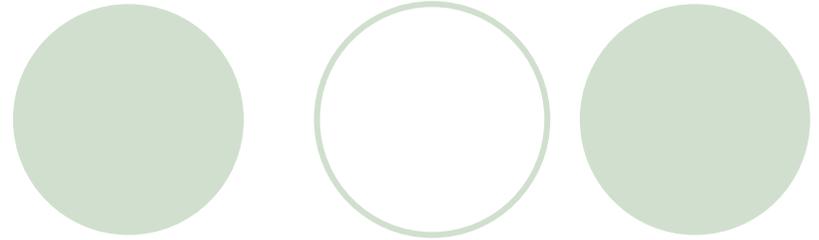# Clinical Record Items

- **Introduction of two(2) new items collected at   SOC/ROC to support measure for timely care**

Clinical Record Items Domain
Timely Care$_1$

- Two new items:
  - **(M0102) Date of Physician-ordered Start of Care (Resumption of Care)**
  - **(M0104) Date of Referral**
- Added to support process measure on Timely Care
- Collected only at SOC/ROC

Clinical Record Items Domain
Timely Care$_2$

- **(M0102) Date of Physician-ordered Start of Care (Resumption of Care)**
  - If the physician indicated a specific date for SOC/ROC, enter the date and **SKIP M0104**
  - Otherwise, select NA – No specific SOC date ordered - and GO TO M0104 to enter date of referral
  - If original physician-ordered SOC/ROC date gets delayed, the updated/revised date would be entered

Timely Care$_3$

- **(M0104) Date of Referral**
  - Most recent date that <u>verbal</u>, <u>written</u>, or <u>electronic</u> authorization to begin home care was received by the HHA
  - If SOC/ROC gets delayed, enter the date the agency received the updated/revised referral information
  - Communications from assisted living facility staff or family do not constitute a referral

Patient History & Diagnoses

Added option for recording inpatient procedures

- **(M1012)** List each **Inpatient Procedure** and the associated ICD-9-C M procedure code relevant to the plan of care

  - Asked at SOC/ROC

  - Useful for risk adjustment

  - Agencies only required to respond to the best of their ability

155

Patient History & Diagnoses

- **Replaced 3 OASIS–B-1 items**
  - **(M0260) Overall Prognosis**
  - **(M0270) Rehabilitative Prognosis**
  - **(M0280) Life Expectancy**
- **With 2 new OASIS–C items collected at SOC/ROC:**
  - **(M1032) Risk for Hospitalization:** Which of the following signs or symptoms characterize this patient as at risk for hospitalization?
  - **(M1034) Overall Status:** Which description best fits the patient's overall status?
  - Used for risk adjustment

Patient History & Diagnoses

Added items to collect immunization status at discharge

- **(M1040) Influenza Vaccine**
  - (Did the patient receive the influenza vaccine from your agency for this year's influenza season?)
- **(M1045) Reason Influenza Vaccine not received**
  - (If not, why not?)
- **(M1050) Pneumococcal Vaccine**
  - (Did the patient receive pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care?)
- **(M1055) Reason PPV not received**
  - (If not, why not?)

Living Arrangements

- **Replaced 6 Oasis-B1 items:**
  - ○ (M0300) Current Residence
  - ○ (M0340) Patient Lives With
  - ○ (M0350) Assisting Person (s) Other than Home Care Agency Staff
  - ○ (M0360) Primary Caregiver
  - ○ (M0370) How often does the patient receive assistance from the primary caregiver?
  - ○ (M0380) Type of Primary Caregiver Assistance
- **With 2 grid items collected at SOC/ROC**
 - ○ Used for risk adjustment

Living Arrangements$_2$

- **First grid (M1100) Patient Living Situation:** Which of the following best describes the patient's residential circumstance and availability of assistance? **(Check one box only.)**

Living Arrangement	Availability of Assistance				
	Around the clock	Regular daytime	Regular nighttime	Occasional / short-term assistance	No assistance available
a. Patient lives alone	☐ 01	☐ 02	☐ 03	☐ 04	☐ 05
b. Patient lives with other person(s) in the home	☐ 06	☐ 07	☐ 08	☐ 09	☐ 10
c. Patient lives in congregate situation (e.g., assisted living)	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15

- **Second grid (M2100) Types and Sources of Assistance** located at the end of the OASIS-C in the Care Management Section

Sensory Status
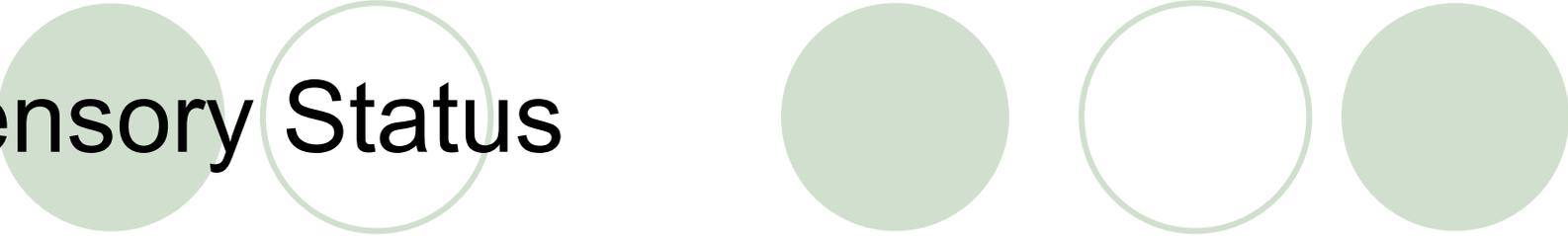
Speech and hearing:

- OASIS–B-1 item **(M0400) Hearing and Ability to Understand Spoken Language** *split out* into:
  - **(M1210) Ability to hear** (with hearing aid or hearing appliance if normally used)
  - **(M1220) Understanding of Verbal Content** in patient's own language (with hearing aid or device if used)

Pain:

- Deleted - **(M0430) Intractable Pain**
- Added - **(M1240)** Has this patient had a formal **Pain Assessment** using a standardized pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?
- Collected at SOC/ROC to support process measure

Integumentary Status

- **Pressure Ulcer Additions include:**
  - (M1300) Pressure Ulcer Assessment
  - (M1307) The Oldest Non-epithelialized Stage II Pressure Ulcer that is present at discharge
  - (M1310) Pressure Ulcer Length
  - (M1312) Pressure Ulcer Width
  - (M1314) Pressure Ulcer Depth
- (M1308) Current Number of Unhealed (non-epithelialized) Pressure Ulcers now includes suspected deep tissue injury in evolution
- Changes in guidance are discussed in the OASIS Guidance Manual and will be reviewed later

Cardiac Status

- **New Domain**
  - **(M1500) Symptoms in Heart Failure Patients:** If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at any point since the previous OASIS assessment?
  - **(M1510) Heart Failure Follow-up:** If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure since the previous OASIS assessment, what action(s) has (have) been taken to respond?
- **Collected at transfer and discharge**
- **Support new process measures**

162
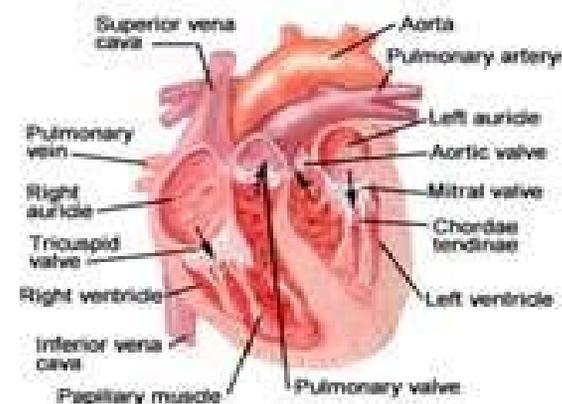
Neuro/ Emotional/ Behavioral Status

- **Dropped:**
  - **(M0590) Depressive Feelings** Reported or Observed in Patient
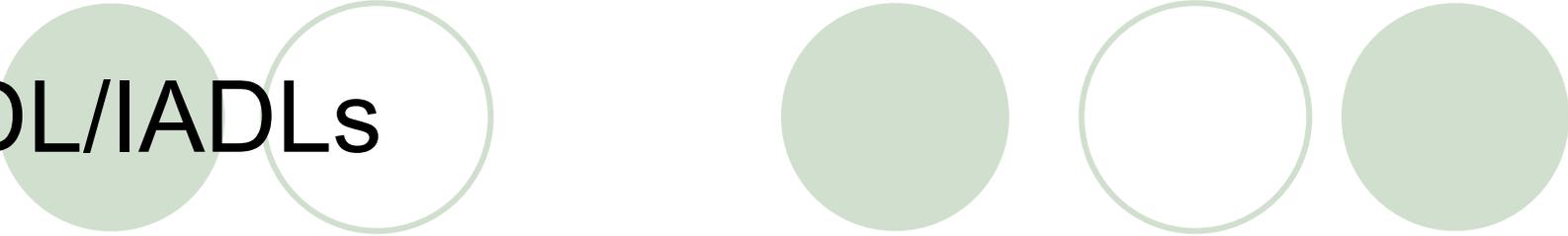- **Added:**
  - **(M1730) Depression Screening:** Has the patient been screened for depression, using a standardized depression screening tool?
- Includes but does not require PHQ2 assessment
- Collected at SOC/ROC
- Supports new process measure

# Depression Screening

PHQ-2© Pfizer		Not at all 0 - 1 day	Several days 2 - 6 days	More than half of the days 7 – 11 days	Nearly every day 12 – 14 days	N/A Unable to respond
a)	Little interest or pleasure in doing things	☐0	☐1	☐2	☐3	☐na
b)	Feeling down, depressed, or hopeless?	☐0	☐1	☐2	☐3	☐na

ADL/IADLs

- Added **(M1845) Toileting Hygiene** collected at SOC/ROC and DC (supports new outcome measure)

- Added **(M1910) Fall Risk Assessment** collected at SOC/ROC (supports new process measure)

- Dropped Transportation, Shopping, Housekeeping, Laundry

- Additional responses (bathing, ambulation) and wording changes (safely) to numerous items

ADL/IADLs (cont.)
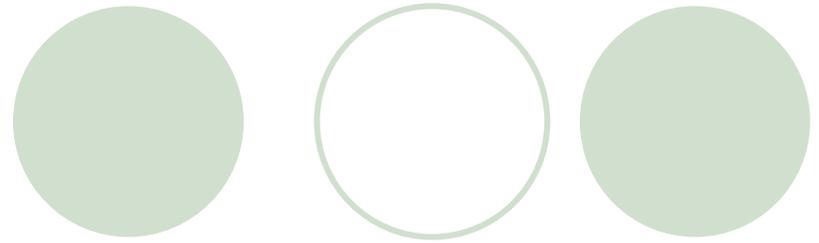
- Dropped prior status and replaced with grid

(M1900) Prior Functioning ADL/IADL: Indicate the

Functional Area	Independent	Needed Some Help	Dependent
a. Self-Care (e.g., grooming, dressing, and bathing)	☐0	☐1	☐2
b. Ambulation	☐0	☐1	☐2
c. Transfer	☐0	☐1	☐2
d. Household tasks (e.g., light meal preparation, laundry, shopping)	☐0	☐1	☐2

Medications

- **Now a separate domain**
- Added items to support process measures:
  - ○ (M2000) Drug Regimen Review
  - ○ (M2002) Medication Follow-up
  - ○ (M2004) Medication Intervention
  - ○ (M2010) Patient/Caregiver High Risk Drug Education
  - ○ (M2015) Patient/Caregiver Drug Education Intervention
- Added new response options to improve ability to show patient progress
  - ○ (M2020) Management of Oral Medications
  - ○ (M2030) Management of Injectable Medications
- Dropped questions about inhaled medications

Medications

- Replaced prior status questions with grid:

(M2040) Prior Medication Management: Indicate the patient's usual ability with managing oral and injectable medications prior to this current illness, exacerbation, or injury. Check only **one** box in each row.

Functional Area	Independent	Needed Some Help	Dependent	Not Applicable
a. Oral medications	☐0	☐1	☐2	☐na
b. Injectable medications	☐0	☐1	☐2	☐na

Care Management
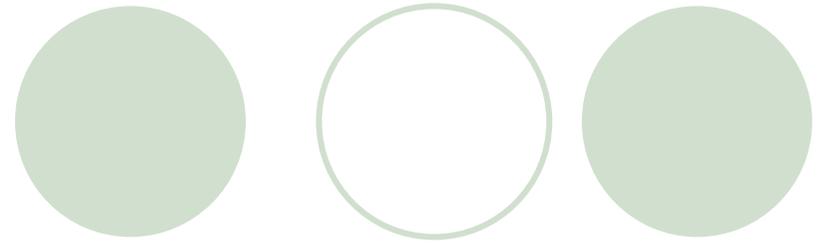
- **New domain**
  - **(M2100) Types and Sources of Assistance:** Determine the level of caregiver ability and willingness to provide assistance for the following activities, if assistance is needed. (Check only **one** box in each row.)

Type of Assistance	No assistance needed in this area	Caregiver(s) currently provide assistance	Caregiver(s) need training/ supportive services to provide assistance	Caregiver(s) not likely to provide assistance	Unclear if Caregiver(s) will provide assistance	Assistance needed, but no Caregiver(s) available
a. **ADL assistance** (e.g., transfer/ ambulation, bathing, dressing, toileting, eating/feeding)	☐0	☐1	☐2	☐3	☐4	☐5
b. **IADL assistance** (e.g., meals, housekeeping, laundry, telephone, shopping, finances)	☐0	☐1	☐2	☐3	☐4	☐5
c. **Medication administration** (e.g.,	☐0	☐1	☐2	☐3	☐4	☐5

Therapy Need and Plan of Care

- New grid item **(M2250) Plan of Care Synopsis:** (Check only **one** box in each row.) Does the physician-ordered plan of care include the following:

	Plan / Intervention	No	Yes	Not Applicable	
a.	Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings	☐0	☐1	☐na	Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference
b.	Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	☐0	☐1	☐na	Patient is not diabetic or is bilateral amputee
c.	Falls prevention interventions	☐0	☐1	☐na	Patient is not assessed to be at risk for falls
d.	Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	☐0	☐1	☐na	Patient has no diagnosis or symptoms of depression
e.	Intervention(s) to monitor and mitigate pain	☐0	☐1	☐na	No pain identified
f.	Intervention(s) to prevent pressure ulcers	☐0	☐1	☐na	Patient is not assessed to be at risk for pressure ulcers
g.	Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician	☐0	☐1	☐na	Patient has no pressure ulcers with need for moist wound healing

Emergent Care
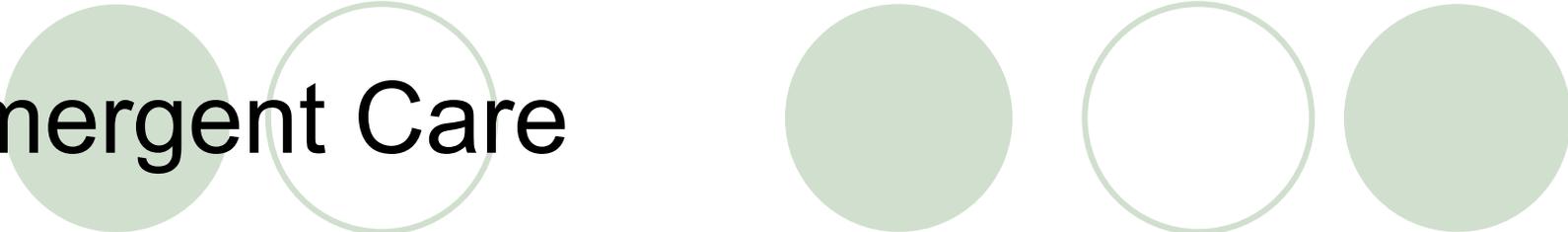
- **(M2310) Reason for Emergent Care**: For what reason(s) did the patient receive emergent care (with or without hospitalization)?

- New and reordered response options are now consistent with response options for **(M2430) Reason for Hospitalization**

- **Emergent care** also now refers exclusively to care provided in a hospital emergency department

Data Items Collected at Inpatient Facility Admission or Agency Discharge Only

- **New grid item collected at Transfer and Discharge supports measures of care process implementation**

  (M2400) Intervention Synopsis: (Check only **one** box in each row.) Since the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

	Plan / Intervention	No	Yes	Not Applicable	
a.	Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	☐0	☐1	☐na	Patient is not diabetic or is bilateral amputee
b.	Falls prevention interventions	☐0	☐1	☐na	Formal multi-factor Fall Risk Assessment indicates the patient was not at risk for falls since the last OASIS assessment
c.	Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	☐0	☐1	☐na	Formal assessment indicates patient did not meet criteria for depression AND patient did not have diagnosis of depression since the last OASIS assessment

OASIS-C

Impact of Changes

Changes in Number of OASIS Items

For those of you keeping score, that is a total of two more items across all time points!

Time Point	B1	C	Net Change (C - B1)
SOC	77	79	2
ROC	77	79	2
Follow-up	31	32	1
Transfer	11	19	8
Discharge	72	61	-11
Death at home	4	5	1
Patient Tracking	18	17	-1

Why the Increase at Transfer?

- CMS interested in what happens at transfer as a way to focus on improvement in acute care hospitalization

- Additional items needed to:

  (a) Calculate additional quality measures related to reasons for hospitalization

  (b) Assess care processes that potentially can reduce the rate of acute care hospitalization.

- Critical to examine the reasons for and reduce the rate of acute care hospitalization

Time for OASIS–C vs. OASIS–B-1

- Testing to date indicates that the time required by OASIS–C will not be significantly different than OASIS–B-1

- Skip patterns reduce the number of items collected on some patients

- Field testing results are still considered to be the most useful estimate of burden associated with collection of the OASIS–C

- Follow-up is the exception - 13 fewer items than the field test version

OASIS-C Impact on HH Payment

- OASIS-C items tested to insure changes did not affect the payment algorithm

- Once OASIS-C data are collected, CMS can assess whether they could be used for refinements to the case mix adjustor

- **If** CMS develops a P4P(paid for performance) component to the home health reimbursement system, an HHA's decision not to incorporate evidence-based practices could impact their payment

Impact on HH Quality Measurement

- The development of new quality measures has been an important force behind OASIS-C

- The National Quality Forum has reviewed proposed measures based on OASIS-C items since fall 2008

- NQF Final Report of endorsement of publicly reported measures is anticipated by August 30, 2009

- Detailed information about new process and outcome measures and the reporting schedule will be addressed in Lesson 4
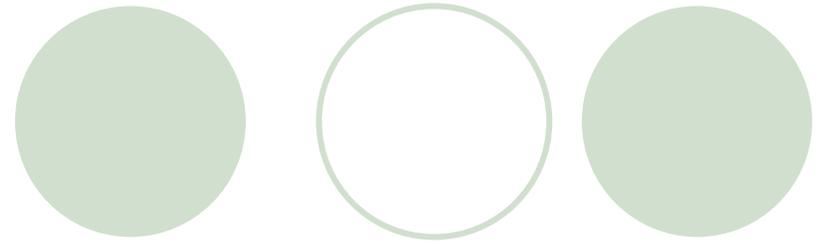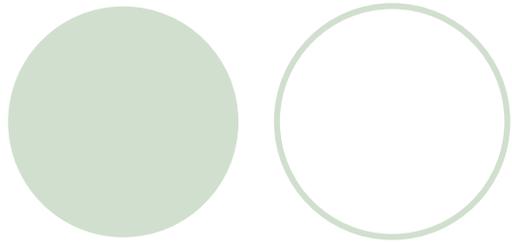
OASIS-C

Potential Impacts on Agency Operations

Collecting Information at Referral

- Agencies may choose to revise what is asked and how information is collected/recorded at the time of referral
  - Referral forms can capture information useful in the OASIS–C such as status of immunizations, previous diagnosis and procedure codes and history of pressure ulcers to reduce agency burden and enable agencies to respond to those items
- How will clinicians access information efficiently?
  - Where do you record Date of Referral and Date of Physician-ordered Start or Resumption of Care?
  - If you are paper-based, is there a location in the record for this information?
  - If you are e-based, will your vendor facilitate accessing that information?

New Information at SOC/ROC

- OASIS-C has opportunities for agencies to document best practices that include screening for:
  - Depression
  - Pain
  - Falls Risk
  - Pressure Ulcer Risk

Screening Assessments

- Agencies need to decide:
  - If they are not doing now, do they want to start?
  - If they are doing now, do the screening tools they are using meet the OASIS-C criteria? (*multi-factor* falls risk assessment, *standardized* depression screening tool?)
  - How are they going to educate their staff?
- Staff may have concerns that they need special training to conduct screening assessments
- Similar concerns about other assessments such as for pressure ulcers or medications

Do Screening Assessments Require Special Skills?

- Concern: "We do not have psych nurses or wound nurses. How can we be expected to do these depression and wound items?"

- Clinicians need to know these are assessments that any health care provider can use

- E.g., the PHQ2 is only two questions that indicate whether the patient needs additional evaluation

- Depression screening done in many sites of health care (e.g. primary care)
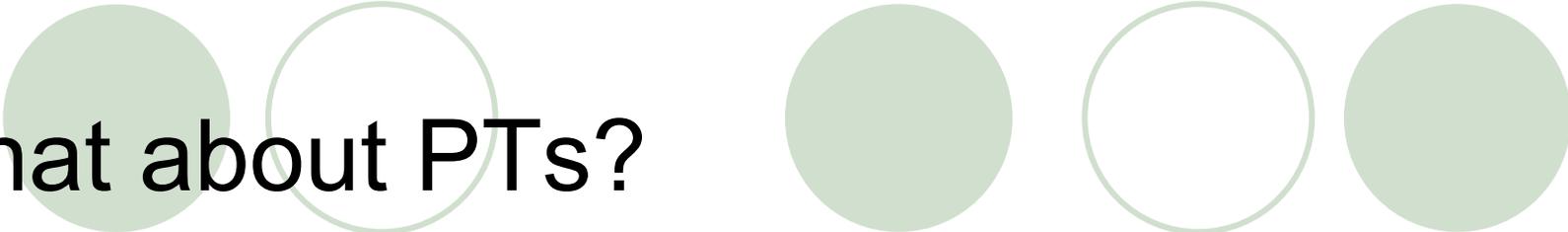
What about PTs?

Comments from the American Physical Therapy Association (APTA) received as part of the public response specifically addressed whether PTs can respond to new items in OASIS–C

- ○ **Depression screening**: recommended the PHQ-9© Depression Scale Form in order to harmonize with data collected in other settings (i.e. MDS)

- ○ **Medication evaluation:** it is within the scope of the PTs to perform a patient screen in which medication issues are assessed, even if the PT does not perform the specific care needed to address the medication issue

- ○ **Heart failure items:** PTs are more than competent to complete the information needed

- ○ **Wound care items:** PTs are permitted to perform all wound care interventions legally mandated by State licensure and defined by the education curriculum of the physical therapist, including dressings, debridement, application of topical agents; physical agents and mechanical modalities

Assessment Strategies

- OASIS-C data, like the rest of the comprehensive assessment, are collected using a variety of strategies:
  - Observation
  - Interview
  - Review of pertinent documentation (e.g., hospital discharge summaries to obtain information on inpatient facility procedures and diagnoses)
  - Discussions with other care team members where relevant (e.g., phone calls to the physician to verify diagnoses)
  - Measurement (e.g., wound length/width, intensity of pain)

Obtaining Information for Care Planning Items at the Time of SOC/ROC

- **Care planning items ask about whether interventions have been ordered:**
  - Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings
  - Diabetic foot care and education
  - Falls prevention interventions
  - Depression intervention(s)
  - Intervention(s) to prevent pressure ulcers
  - Pressure ulcer treatment based on principles of moist wound healing

Plan of Care Items at SOC/ROC

- How can we know about physician orders while we're doing the patient assessment?
  - The care plan should evolve from the findings of the assessment
  - Responding that the "current physician-ordered plan of care" includes a plan/intervention means the patient condition has been discussed and there is agreement as to the plan of care between the home health staff and the physician
  - POC orders must be in place within the 5-day SOC window or 2-day ROC window in order to meet the measure definition
  - CMS recognizes that this may not happen for all patients at all agencies
  - If window is closing and interventions not in POC, then respond "no" to relevant items

Obtaining Information for Implementation Items at TRF/DC$_1$

- **Process items ask about whether care practices and interventions were implemented since the last OASIS assessment:**
  - Diabetic foot care and education
  - Falls prevention interventions
  - Depression intervention(s)
  - Intervention(s) to monitor and mitigate pain
  - Intervention(s) to prevent pressure ulcers
  - Pressure ulcer treatment based on principles of moist wound healing
  - Heart failure symptoms addressed
  - Physician contacted for medication issues
  - Immunizations received

Obtaining Information for Implementation Items at TRF/DC$_2$

- Review documentation since the last OASIS assessment to determine
  - If a condition (e.g., pain, symptoms of heart failure) was present
  - Whether interventions to address the condition were:
    a) Incorporated into the physician-ordered plan of care
    b) Implemented as part of patient care
- Similar process for completion of a discharge summary required by current Conditions of Participation

Obtaining Information for Implementation Items at TRF/DC$_3$

- Process items at TRF/DC will require knowledge of
  - Patient symptoms
  - Initial and subsequent physician's orders clinical interventions performed to address patient symptoms across the episode of care
- Must consider care provided by all disciplines during the episode, not just the discipline of the clinician completing the OASIS assessment
- Clinician completing the OASIS TRF or DC may not be familiar with the patient
- How will clinicians access this information efficiently?

Accessing Information Needed at TRF/DC

- This evaluation of the care episode can be accomplished in several different ways

  ○ Review clinical records, including the plan of care, updated orders, and visit notes

  ○ Agency may elect to create a flowsheet with the appropriate parameters that are checked off on each visit so that a review of the clinical record would be unnecessary

  ○ E.g. if plan to mitigate falls risk is needed, documenting the elements and when they are addressed would simplify OASIS-C data collection

  ○ Agencies using electronic health records can create a report template that could pull the needed information from data fields incorporated into visit notes

A Note About "Look-Back"

- The current OASIS–B-1 look back prohibition forbids the use of a prior OASIS form to complete a present OASIS form

- As with OASIS–B-1, OASIS–C data should be collected at each time point based on a unique patient assessment, not simply carried over from a previous assessment

- For OASIS–C implementation items, clinicians may need to review clinical records: *this is not the same!*
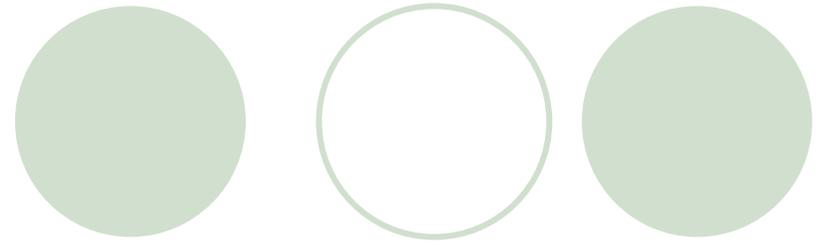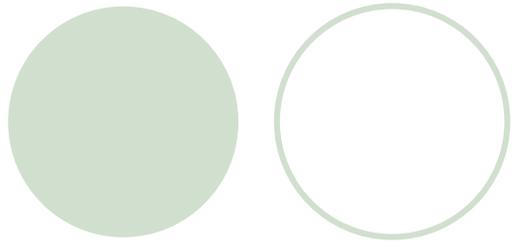
OASIS-C

Preparing for OASIS-C

Preparing for OASIS-C
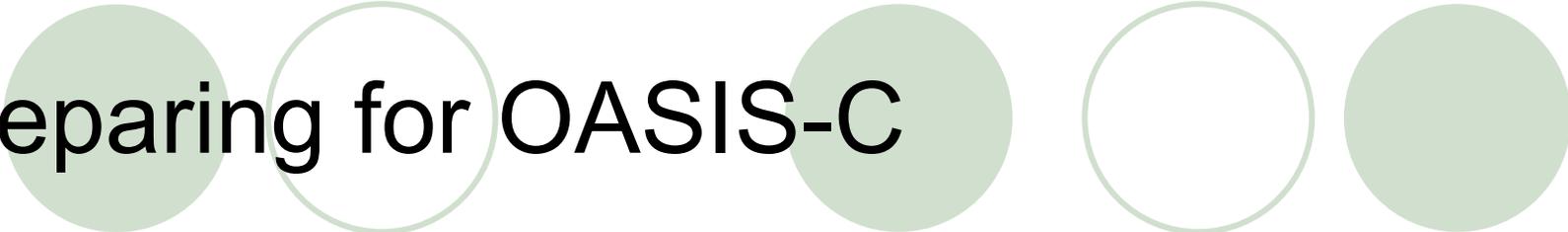
- If you *choose* to do process items, identify which process items you are currently doing, if any, and which are the next most logical process items to take on

- Consider whether you need to change your workflow processes to accommodate OASIS-C requirements

- Download the guidance document and begin to work on preferred training approaches

Educating Staff on OASIS-C

- Identify your agency's preferred approach to training: "Train the trainer" who will then train the rest? Train everyone?

- Identify training resources: OASIS education coordinators and Medicare Learning Network are two resources

- Open Door Forums will be scheduled

- Training materials prepared for agencies (e.g. Medicare Learning Network)

OASIS–C Guidance Manual

- OASIS Guidance Manual (Item-by-Item, formerly known as Chapter VIII is now Chapter 3)

- Guidance prepared by CMS and OASIS–C clinician teams and with external stakeholder input

- Reviewed by 14 outside home health experts for accuracy

- Posted on the CMS OASIS–C Website

OASIS–C Guidance Manual is an Essential Training and Reference Tool

- Recommended that all clinicians collecting OASIS–C have access to the guidance document, either electronic or paper versions

- Guidance document will identify how to most accurately answer the OASIS items

- Guidance now has a Resource Guide – Chapter 5, that contains links to CMS resources and additional clinical resources (e.g., for screening tools, clinical guidelines, etc.)
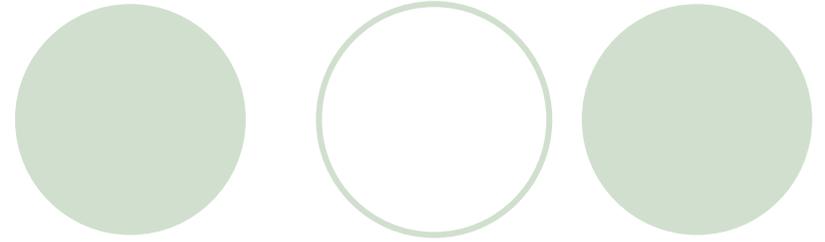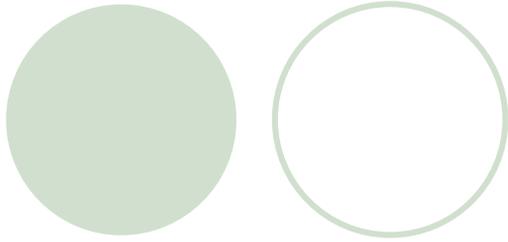
OASIS-C

Quality Measures

Measuring Quality of Care

- Clinical performance measures assess the degree to which a provider **competently** and **safely** delivers clinical services that are appropriate for the patient in the **optimal time period**

- Conceptually, quality of care can be measured in several areas, including:

  ○ Access
  ○ Structure
  ○ Patient Experience

  ○ Process
  ○ Outcome

Measuring Quality of Care (cont.)

- **Access measures:**
  - Assess whether patients can obtain timely and appropriate health care
  - Help to identify if barriers to access exist, such as inability to pay for health care, unavailability of health care services, or cultural or health beliefs that prevent recognition of the need for and benefits of health care
- **Measures of structure**:
  - Assess the capability and the capacity of organizations or professionals to provide care: e.g., ratio of staff to patients
  - Include the physical structure of care settings as well as administrative and other processes and operations that support and direct care delivery

Measuring Quality of Care (cont.)

- Patient experience measures
  - Aggregate reports of patients about their observations of and participation in health care
  - Provide the patient perspective on quality of care
  - CMS is beginning plans for implementation of Home Health Care CAHPS Survey
  - Home Health Care CAHPS Web site: http://www.homehealthCAHPS.org

Measuring Quality of Care (cont.)

- **Outcome measures:**

  - Assess the health state of a patient, including physiologic, functional, cognitive, emotional, and behavioral

  - Reflect the cumulative impact of multiple processes of care or natural progression of disease and disability, or both

  - Can be used to assess quality of care **to the extent that health care services influence the likelihood of desired health outcomes**

  - Can **suggest** specific areas of care that may require quality improvement

- Risk adjustment of outcome measures is used to separate the effect of care provided on outcomes from the effect of the natural progression of disease and disability. This is critical to accurate outcome analysis and for to compensating for differences in case mix or risk factors

Measuring Quality of Care (cont.)

- **Process measures:**
  - Assess the health care service provided including assessment, care planning and coordination, decisions on specific types of therapy and competence of interventions
  - Assess adherence to recommendations for clinical practice based on evidence or consensus
  - Can **identify** specific areas of care that may require improvement

Process Measures

- Development of home health process measures recommended by:
  - Medicare Payment Advisory Committee [MedPAC]
  - National Quality Forum [NQF]
- In line with the Institute of Medicine (IOM) aims for improving the U.S. health care system: care that is safe, timely, effective, efficient, equitable and patient-centered (IOM, 2001)
- Logical follow-on to the Quality Improvement Organizations (QIOs) 8th Scope of Work on Best Practices (MedQIC - HHQI Campaign)

Process Measures Will Be Useful for:

- Measuring elements of care under an HHA's control

- Promoting the use of evidence-based care practices

- Improving patient care across settings

- Performance improvement activities

- Public reporting

- Possible quality-based purchasing systems in the future

Measuring Elements of Care Under an HHA's Control

- Many have noted that outcomes of care are not always under the control of an HHA because of the home environment, patient/caregiver adherence to clinical advice, physician practice patterns, etc.

- The new process data items will allow measurement of selected processes of care that have been identified as particularly relevant for home health care

- Agencies participating in reliability testing of OASIS-C felt process items gave them "credit" for excellent patient care practices already in place

Promoting the Use of Specific Evidence-based Care Practices

- By incorporating process data items into OASIS-C, clinicians are reminded and encouraged to use specific evidence-based care practices

- In addition, process measures can be helpful in assisting HHAs to assess the degree to which clinicians are implementing specific evidence-based practices that can affect clinical outcomes

- HHAs may elect to use the data in performance improvement systems to increase the use of such evidence-based practices used in daily care delivery, thus ultimately improving patient outcomes

Improving Patient Care Across Settings

- From a national policy perspective, CMS anticipates that these process measures will promote the use of best practices across the home health industry

- Several process items constructed to align with similar items used for other data collection initiatives crossing care settings (i.e., NQF Pressure Ulcer framework; the CARE instrument)

- These items will encourage enhanced communication across providers to minimize duplicative services such as repeated immunizations

- Sets the stage for a national, patient-centered approach to measuring clinical care and outcomes, which will eventually subsume traditional setting-specific approaches to quality measurement

For Performance Improvement Activities

- Process measures can be used in HHA performance/quality improvement programs
  - An assessment of clinician adherence to evidence-based practices
  - Provide guidance to agencies on how to improve care received by individual patients, prevent exacerbation of serious conditions and avoid adverse events

Potential Use in Future P4P

- It is also possible that the process measures **may be** incorporated in a future quality-based purchasing (pay for performance) system for home health care

- A Pay-for-Performance system would link home health reimbursement to:
  - Improvements in patient outcomes; and/or
  - Adoption of evidence-based care processes

Incorporating Process Items into OASIS

But why is CMS putting process items into OASIS?

Isn't the OASIS a patient assessment tool?

Not exactly…

○ OASIS is a dataset designed to collect information on the quality of home health care

○ Integrating process items into the OASIS data set is the **least burdensome** method of collecting the data needed to calculate process measures for HHAs
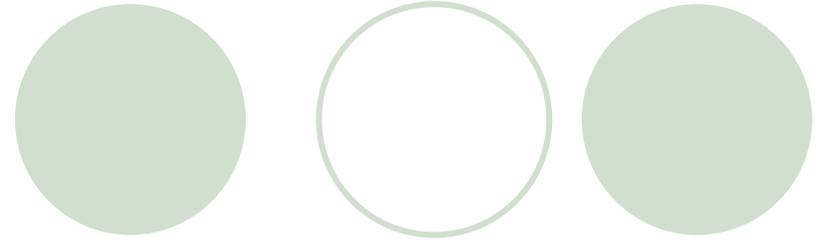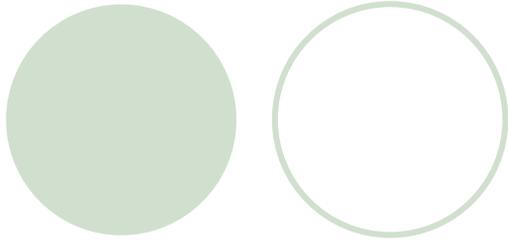
OASIS-C

Process Measure Domains

What Do Home Health Process Measures Measure?

- Measures of the rate of home health agency use of specific **evidence-based** processes of care

- Some measures pertain to all or most home care patients:
  - Timeliness of home care admission
  - Immunizations

- Some measures focus on specific high-risk, high-volume, problem-prone areas for home health care
  - Heart failure
  - Diabetes
  - Pressure ulcers

Process Item Domains
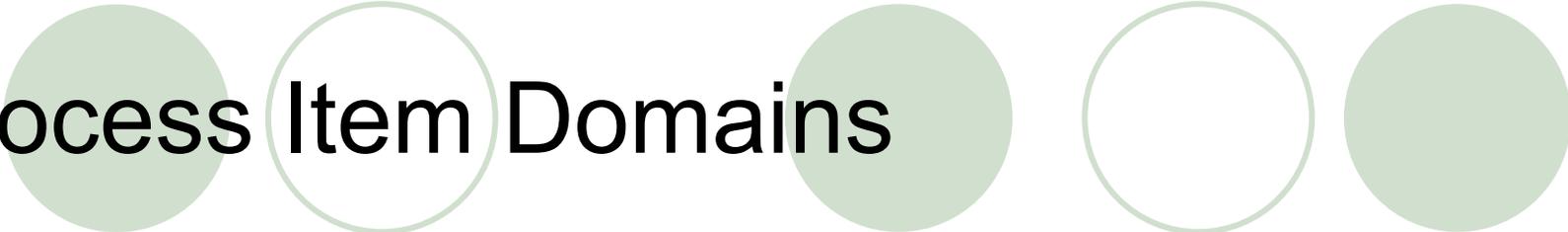
Processes measured in OASIS-C can be classified into one of the following 7 domains:

- Timely care
- Care Coordination

- Patient Assessment
- Care planning

- Care Plan Implementation
- Education
- Prevention

Timely Care

Measure	Based on OASIS-C Item:	Collected at:
Timely Initiation of Care	(M0102) Date of Physician-ordered Start of Care : (M0104) Date of Referral: (M0030) Start of Care Date: (M0032) Resumption of Care Date: (M0100) Reason for Assessment	SOC/ ROC

Care Coordination

Measure	Based on OASIS-C Item:	Collected at:
Physician Notification Guidelines Established	(M2250) a. Patient-specific parameters for notifying physician plan of care	SOC/ ROC

Assessment

Measure	Based on OASIS-C Item:	Collected at:
Depression Assessment Conducted	(M1730) Depression Screening	SOC/ ROC
Multifactor **Fall** Risk Assessment Conducted For Patients 65 And Over	(M1910) Multi-factor Fall Risk Assessment (M0066) Birth Date: (M0030) Start of Care Date: (M0032) Resumption of Care Date	SOC/ ROC
Pain Assessment Conducted	(M1240) Pain Assessment	SOC/ ROC
Pressure Ulcer Risk Assessment Conducted	(M1300) Pressure Ulcer Assessment	SOC/ ROC

Care Planning

Measure	Based on OASIS-C Item:	Collected at:
Depression Interventions In Plan Of Care	(M2250) d. Depression intervention(s) plan of care	SOC/ ROC
Diabetic Foot Care And Patient Education In Plan Of Care	(M2250) b. Diabetic foot care in plan of care	SOC/ ROC
Falls Prevention Steps In Plan Of Care	((M2250) c. Falls prevention plan of care	SOC/ ROC
Pain Interventions In Plan Of Care	(M2250) e. Intervention(s) to monitor and mitigate pain plan of care	SOC/ ROC
Pressure Ulcer Prevention interventions in Plan of Care	(M1300) Pressure Ulcer Assessment: (M2250) f. Intervention(s) to prevent pressure ulcers plan of care	SOC/ ROC
Pressure Ulcer Treatment Based On Principles Of Moist Wound Healing In Plan Of Care	(M2250) g. Pressure ulcer treatment plan of care	SOC/ ROC

Care Plan Implementation

Measure	Based on OASIS-C Item:	Collected at:
Depression Interventions Implemented During Short Term Episodes Of Care	(M2400) c. Depression intervention(s)	TRF/DC
Diabetic Foot Care And Patient/Caregiver Education Implemented During Short Term Episodes Of Care	(M2400) a. Diabetic foot care intervention(s)	TRF/DC
Heart Failure Symptoms Addressed During Short Term Episodes Of Care	(M1510) Heart Failure Follow-up:	TRF/DC
Pain Interventions Implemented During Short Term Episodes Of Care	(M2400) d. Intervention(s) to monitor and mitigate pain	TRF/DC
Treatment Of Pressure Ulcers Based On Principles Of Moist Wound Healing Implemented During Short Term Episodes Of Care	(M2400) f. Pressure ulcer treatment based on principles of moist wound healing	TRF/DC

Education

Measure	Based on OASIS-C Item:	Collected at:
Drug Education On High Risk Medications Provided To Patient/Caregiver At Start Of Episode	(M2010) Patient/Caregiver High Risk Drug Education	SOC/ ROC
Drug Education On All Medications Provided To Patient/Caregiver During Short Term Episodes Of Care	(M2015) Patient/Caregiver Drug Education Intervention	TRF/DC

Prevention

Measure	Based on OASIS-C Item:	Collected at:
Falls Prevention Steps Implemented For Short Term Episodes Of Care	(M2400) b. Falls prevention interventions	TRF/DC
Influenza Immunization Received For Current Flu Season	(M1040) Influenza Vaccine: (M1045) Reason Influenza Vaccine not rec'd	TRF/DC
Pneumococcal Polysaccharide Vaccine Ever Rec'd	(M1050) Pneumococcal Vaccine (M1055) Reason PPV not rec'd	TRF/DC
Potential Med Issues Identified and Timely Physician Contact at Start Of Episode	(M2002) Medication Follow-up	SOC/ROC
Potential Med Issues Identified and Timely Physician Contact During Short Term Episodes Of Care	(M2004) Medication Intervention	TRF/DC
Pressure Ulcer Prevention Implemented During Short Term Episodes Of Care	(M1300) Pressure Ulcer Assessment: (M2400) f. Pressure ulcer treatment based on principles of moist wound healing	TRF/DC
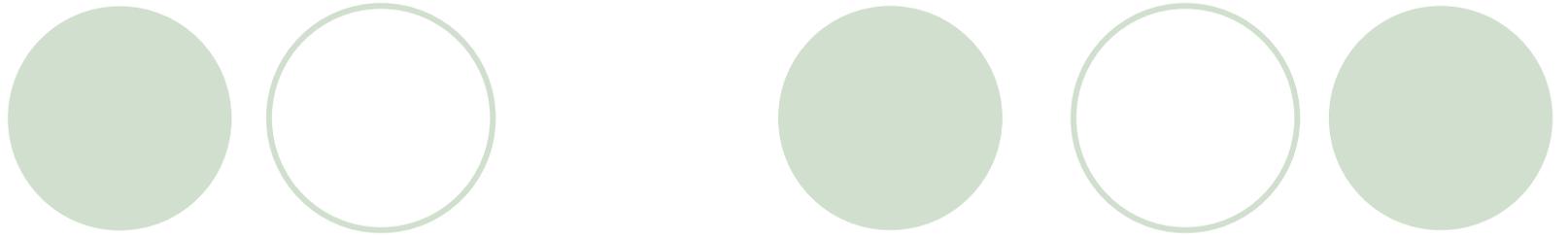
Some Considerations About the Collection of Process Items

Measured Does Not Equal Mandated

- Agencies are encouraged to use evidence-based care practices, but the care processes documented in the OASIS-C **are not mandated** under the current Conditions of Participation

- HHAs may elect to not incorporate the care processes used for OASIS-C process measures

- BUT… some of the OASIS-C process items will support publicly-reported measures and agencies choosing not to adopt those processes of care will see that decision reflected in Home Health Compare scores

Agencies Are Encouraged to Aim High, but…

- CMS understands that the evidence-based practices being measured do not pertain to every patient, and a rate of 100% is not expected for any agency for any measure

- Clinicians may find that these processes of care have no application for a particular patient and therefore no related assessment or intervention is needed

- As always, clinicians may document in the clinical record any appropriate supporting documentation for their clinical decisions and actions explaining why a process was not appropriate or possible

Not All Best Practices Are in OASIS-C

- Process measures included in the process measure report do not represent an all-inclusive set of all evidence-based practices that can or should be used in home health care delivery

- Agencies are encouraged to implement additional evidence-based care practices for patient care that they determine to be appropriate

Process Implementation
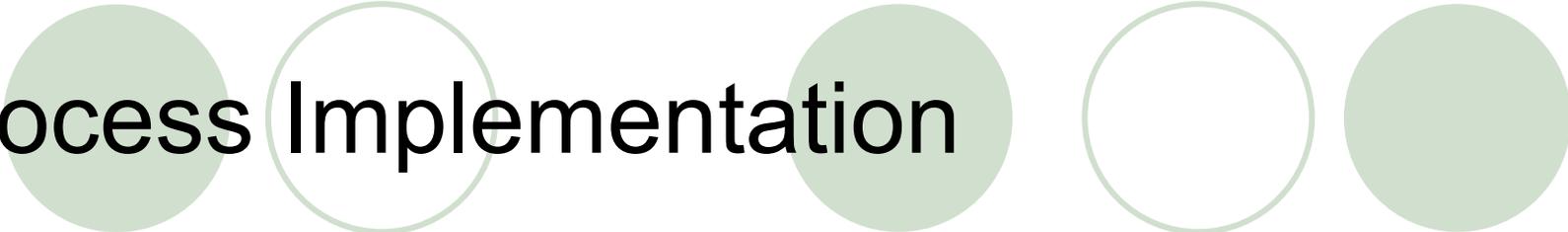
- Agencies electing to use the evidence-based care practices specified in OASIS-C data items will want to:
  - Review their policies and procedures guiding care delivery to ensure that they are congruent with the OASIS-C process items and the patient care practices being implemented
  - Examine and adapt work flow to ensure ability to report process data about interventions that were implemented
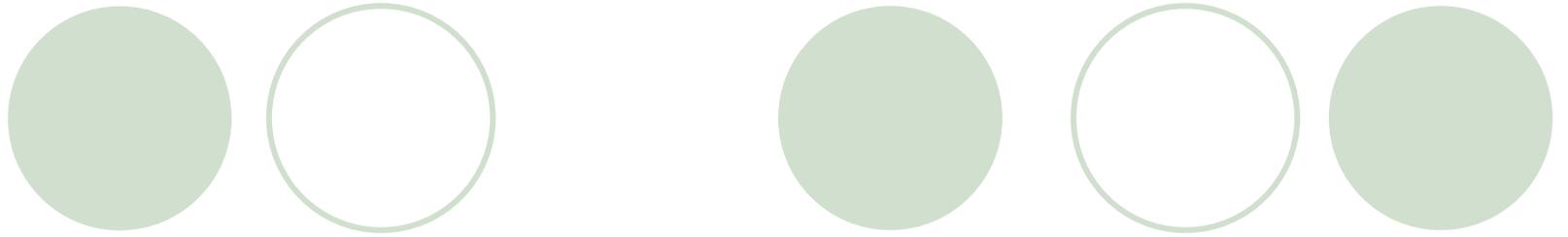
NQF Endorsement Process & Public Reporting

Public Reporting & NQF Endorsement

- CMS's goal is to have all publicly-reported home health measures reviewed and endorsed by an accrediting body prior to posting on Home Health Compare

- NQF-endorsed voluntary consensus standards are now widely viewed as the "gold standard" for measurement of healthcare quality
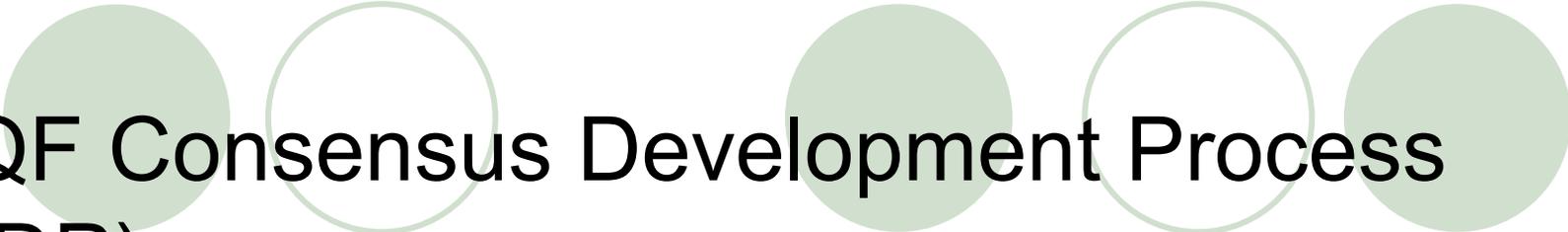
NQF Consensus Development Process (CDP)

- The formal process by which NQF achieves consensus and endorses measures Reflects a careful process designed to produce consensus from disparate groups across the healthcare industry

NQF Consensus Development Process

Formation of a Project Steering Committee → Call for measures

Call for measures → Measure evaluation by Project Steering Committee ← TAP/Advisors

Measure evaluation by Project Steering Committee → Draft recommendations

Draft recommendations ← Member and public comment

Draft recommendations → Draft consensus standards

Draft consensus standards ← Member voting
← CSAC/Board action

Draft consensus standards → NQF-endorsed consensus standards

NQF-endorsed consensus standards ← Appeals

Update as warranted

230

NQF Measure Criteria

1. **Importance to Measure and Report**
   - Is the measure focus important to making significant gains in healthcare quality (safety, timeliness, effectiveness, efficiency, equity, patient-centeredness)?
   - Does the measure focus on a specific high impact aspect of healthcare where there is variation in performance or overall poor performance?

- Candidate measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria

Measure Criteria
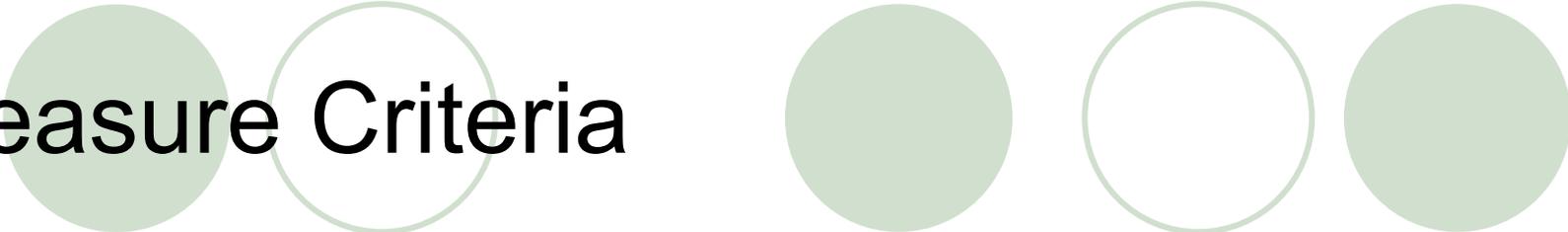
2. **Scientific Acceptability of Measure Properties**

○ Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented

3. **Usability**

○ Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making

Measure Criteria
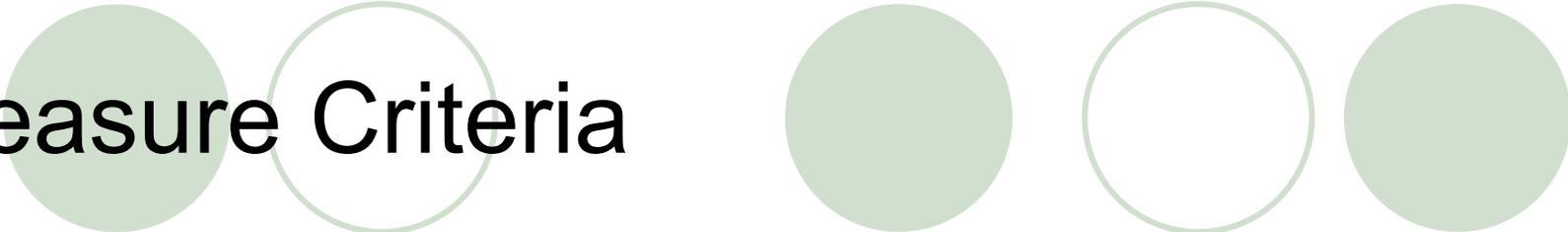
4. Feasibility

- Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement

- Measures that have not been tested, but satisfy all the other criteria may be considered for time-limited endorsement
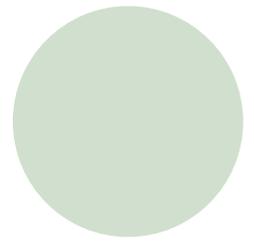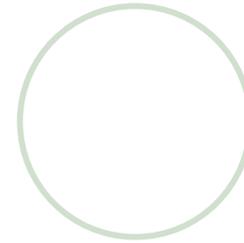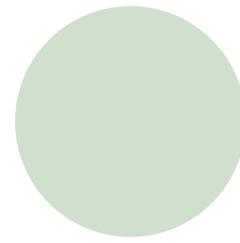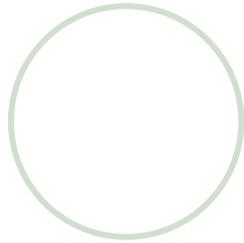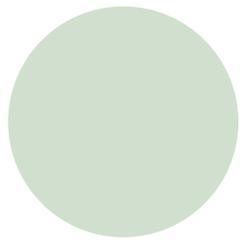
Results of the NQF Review of OASIS-C Based Measures

Publicly Reported Process Measures

Domain	Measure
Timely Care	Timely Initiation of Care
Assessment	Depression Assessment Conducted
	Pain Assessment Conducted
	Multi-factor Falls Risk Assessment for Patients 65 and older
	Pressure Ulcer Risk Assessment Conducted
Education	Drug Education on All Medications Provided to Patient/Caregiver During Short-term Episodes

Publicly Reported Process Measures

Domain	Measure
Care Planning	Pressure Ulcer Prevention included in Plan of Care
Care Plan Implementation	Diabetic Foot Care and Patient Education Implemented during Short-term Episodes of Care
	Heart Failure Symptoms Addressed during Short-term Episodes
	Pain Interventions Implemented during Short-term Episodes
Prevention	Influenza Immunization Rec'd for Current Flu Season
	Pneumococcal Polysaccharide Vaccine Ever Rec'd
	Pressure Ulcer Prevention Plans Implemented

Process Measures Under Consideration for Public Reporting

Domain	Measure
Education	Drug Education on High Risk Medications Provided to Patient/Caregiver at Start Of Episode
Prevention	Potential Medication Issues Identified and Timely Physician Contact at Start Of Episode
	Potential Medication Issues Identified and Timely Physician Contact during Short Term Episodes Of Care

Process Measures Not Publicly Reported

Domain	Measure
Care Coordination	Physician Notification Guidelines Established
Care Planning	Depression Interventions in Plan of Care
	Diabetic Foot Care and Patient Education in Plan of Care
	Falls Prevention Steps In Plan Of Care
	Pain Interventions In Plan Of Care
	Pressure Ulcer Plan Of Care includes Treatment Based On Principles Of Moist Wound Healing
Care Plan Implementation	Depression Interventions Implemented
	Treatment of Pressure Ulcers Based On Principles Of Moist Wound Healing Implemented
Prevention	Falls Prevention Steps Implemented

Short- and Long-Term Implementation Measures

- Implementation measures report whether a care process was "implemented since the last OASIS assessment"

- Calculated separately for short-term episodes and long-term episodes

- Short-term episodes
  - SOC/ROC to TRF/DC less than or equal to 60 days
  - **Do not** contain a 60 day follow-up assessment

- Long-term episodes
  - SOC/ROC to TRF/DC longer than 60 days
  - **Do** contain a 60 day follow-up assessment

239

Reporting Implementation Measures

- Publicly-reported implementation measures will be calculated using only the agency's short-term episodes

- This ensures that care processes implemented in the first 60 days are captured and reported

- OBQI reports will include both short-term episodes, long-term episodes and a combined "all episodes" measure
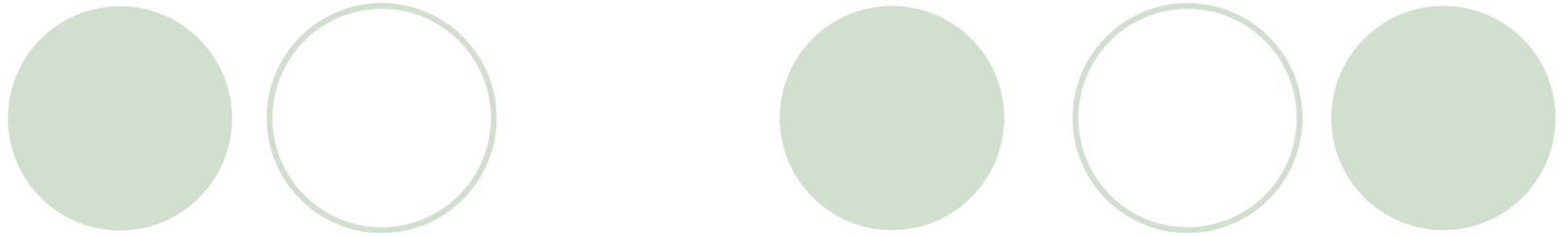
Using Process Measure Reports

Using Process Measure Reports

- All process measures will be reported to agencies on CASPER (OBQI/OBQM reports)
- The Process Measure Report can be a valuable tool for HHAs to use for performance/quality improvement efforts
- The reports call attention to the rate of adherence to the evidence-based practices measured and provide national comparisons
- After the first reporting period, a comparison of the adherence rate to the previous reporting period also will be reported

Using Process Measure Reports (cont.)

May identify needs for staff education or oversight:

- Example: Low rate of adherence for the process measure "Multifactor Fall Risk Assessment Conducted for Patients 65 and Over"

- If the agency's policy specifies use of a fall risk assessment, then the agency should investigate reasons for the low adherence rate as a stand-alone concern

Using Process Measure Reports (cont.)

May shed light on related outcomes:

- Example: low rate of adherence for the process measure "Multifactor Fall Risk Assessment Conducted for Patients 65 and Over"

- If the HHA also had a high rate of emergency care due to falls, the relationship between these two measures should be evaluated as part of an outcome-based quality improvement (OBQI) initiative

- Is one possible reason for the high rate of emergency care use (outcome) related to a low percentage of patients receiving a falls risk assessment (process)?
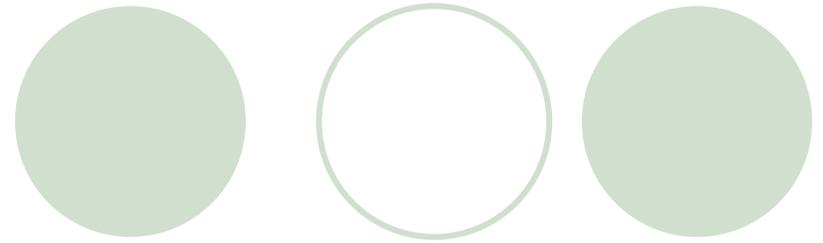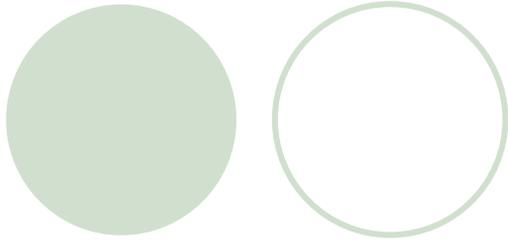
OASIS-C

OBQI Outcome Measures

Publicly Reported Outcome Measures

Domain	Measure
Utilization	Acute Care Hospitalization
	Emergency Department Care **Without Hospitalization**
Functional Status	Improvement in Ambulation/Locomotion
	Improvement in Bathing
	Improvement in Bed Transferring
	Improvement in Management of Oral Medications
Clinical Status	Improvement in Dyspnea
	Increase in Number of Unhealed Pressure Ulcers
	Improvement in Pain Interfering with Activity
	Improvement in Status of Surgical Wounds

Outcome Measures in OBQI Reports

Domain	Measure
Utilization Outcomes	Acute Care Hospitalization
	Discharged to Community
	Emergency Department Use - All
	Emergency Department Use - Without Hospitalization
	Emergency Department Use - With Hospitalization

OBQI Outcome Measures₃

Domain	Measure
Clinical Status Improvement	Improvement in Anxiety Level
	Improvement in Bowel Incontinence
	Improvement in Confusion Frequency
	Improvement in Dyspnea
	Improvement in Pain Interfering with Activity
	Improvement in Speech and Language
	Improvement in Status of Surgical Wounds
	Improvement in Urinary Incontinence
	Improvement in Urinary Tract Infection
Clinical Status Stabilization	Stabilization in Anxiety Level
	Stabilization in Cognitive Functioning
	Stabilization in Speech and Language

OBQI Outcome Measures$_3$

Domain	Measure
Functional Status Improvement	Improvement in Ambulation/Locomotion
	Improvement in Bathing
	Improvement in Bed Transferring
	Improvement in Dressing - Lower Body
	Improvement in Dressing - Upper Body
	Improvement in Eating
	Improvement in Grooming
	Improvement in Management of Oral Medications
	Improvement in Light Meal Preparation
	Improvement in Phone Use
	Improvement in Toileting Hygiene
	Improvement in Toilet Transferring

OBQI Outcome Measures₄

Domain	Measure
Functional Status Stabilization	Stabilization in Bathing
	Stabilization in Bed Transferring
	Stabilization in Grooming
	Stabilization in Light Meal Preparation
	Stabilization in Management of Oral Medications
	Stabilization in Phone Use
	Stabilization in Toileting Hygiene
	Stabilization in Toilet Transferring

OBQM Measures$_1$

Domain	Measure
Potentially Avoidable Events	- Development of Urinary Tract Infection - Discharged to the Community with Behavioral Problems - Discharged to the Community Needing Toileting Assistance - Discharged to the Community Needing Wound Care or Medication Assistance - Emergent Care for Hypo/Hyperglycemia - Emergent Care for Improper Medication Administration, Medication Side Effects

OBQM Measures$_2$

Domain	Measure
Potentially Avoidable Events	- Emergent Care for Injury Caused by Fall - Emergent Care for Wound Infections, Deteriorating Wound Status - Increase in Number of Unhealed Pressure Ulcers - Increase in Number of Unhealed Pressure Ulcers - Discharged to Community with Unhealed Stage II Pressure Ulcer Present for More than 30 days - Substantial Decline in 3 or more Activities of Daily Living - Substantial Decline in Management of Oral Medications

252

11 Outcome/Avoidable Event Measures Dropped

Domain	Measure
Improvement	Improvement in Behavior Problem Frequency Improvement in Cognitive Functioning Improvement in Housekeeping* Improvement in Laundry* Improvement in Number of Surgical Wounds* Improvement in Shopping*
Stabilization	Stabilization in Housekeeping* Stabilization in Laundry* Stabilization in Shopping*
Potentially Avoidable Events	Unexpected Death* Unexpected Nursing Home Admission

* = underlying OASIS item dropped

Other Changes to Outcome Measures

- Emergency Department Use based on NQF feedback
  - Without hospitalization
  - With hospitalization
- Measure on toileting hygiene added (new OASIS-C item)
- Measure on discharge to community with unhealed stage II ulcer added (new OASIS-C item)
- Potentially avoidable event measure for falls/accidents now just measures falls
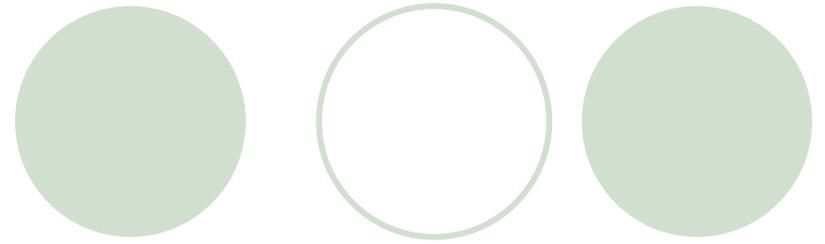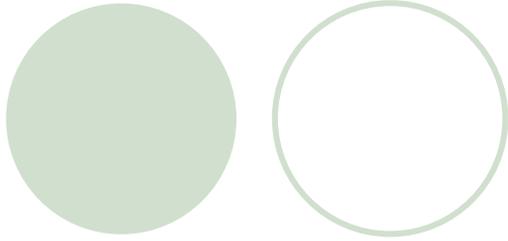
OASIS-C

Blackout Issue Table

Transition from OASIS-B1 to C Will Create a Time Lag for Public Reporting

- Need sufficient numbers of patient episodes before reporting of measures based on new OASIS-C data can begin

- Measures based on patient sample sizes taken over short periods of time can be inaccurate and misleading due to issues like seasonal variation and under-representation of long-stay home health patients

- Current risk adjust models for outcome measures are based on OASIS-B1 data elements

  - Many data items in OASIS-C are different from OASIS-B1 items

  - Risk adjustment models will need to be re-estimated using OASIS-C data

Home Health Compare and CASPER Performance Reporting Schedule
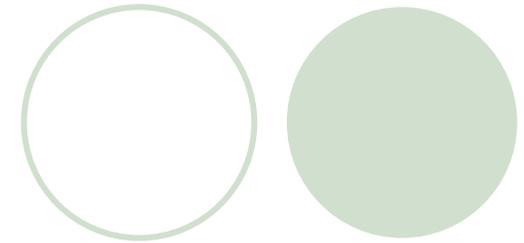
Measure Type	Report Method	Date Available	Data Period of:
OASIS-B1	CASPER	12/2009	10/2008-9/2009
OASIS-B1	HH Compare	3/2010	10/2008-9/2009
OASIS-B1	HH Compare	6/2010	1/2009-12/2009
OASIS-C Process	CASPER	9/2010	1/2010-6/2010
OASIS-C Process	HH Compare	12/2010	1/2010-6/2010
OASIS-C Outcome	CASPER	05/2011	1/2010-12/2010
OASIS-C Outcome	HH Compare	06/2011	1/2010-12/2010

Two-Year Transition from OASIS-B1 to OASIS-C$_1$

End of Calendar Month	OASIS-B1 Data Reported	OASIS-C Available Data	HOME HEALTH OBQI CASPER Reports					Home Health Compare	
			OBQI Outcomes	Adverse Events	Case Mix	Tally	Process Measures	Outcome Measures	Process Measures
Jan-10	Nov08 - Oct09	None	12 mo "B1" data (Nov08 - Oct09)	12 mo "B1" data (Nov08 - Oct09)	12 mo "B1" data (Nov08 - Oct09)	12 mo "B1" data (Nov08 - Oct09)	N/A		
Feb-10	Dec08 - Nov09	Jan10	12 mo "B1" data (Dec08 - Nov09)	12 mo "B1" data (Dec08 - Nov09)	12 mo "B1" data (Dec08 - Nov09)	12 mo "B1" data (Dec08 - Nov09)	N/A		
Mar-10	Jan09 - Dec09	Jan10 - Feb10	12 mo "B1" data (Jan09 - Dec09)	12 mo "B1" data (Jan09 - Dec09)	12 mo "B1" data (Jan09 - Dec09)	12 mo "B1" data (Jan09 - Dec09)	N/A	12 mo "B1" data (Oct08 - Sep09)	N/A
Apr-10	n/a	Jan10 - Mar10	Blackout[1]	Blackout[1]	Blackout[1]	Blackout[1]	N/A		
May-10	n/a	Jan10 - Apr10	Blackout	Blackout	Blackout	Blackout	N/A		
Jun-10	n/a	Jan10 - May10	Blackout	Blackout	Blackout	Blackout	N/A	12 mo "B1" data (Jan09 - Dec09)	N/A
Jul-10	n/a	Jan10 - Jun10	Blackout	Blackout	Blackout	Blackout	N/A		
Aug-10	n/a	Jan10 - Jul10	Blackout	Blackout	Blackout	Blackout	N/A		
Sep-10	n/a	Jan10 - Aug10	Blackout	6 mo "C" data (Jan10 - Jun10)	Blackout	Blackout	6 mo "C" data (Jan10 - Jun10)	Display data not updated	N/A
Oct-10	n/a	Jan10 - Sep10	Blackout	7 mo "C" data (Jan10 - Jul10)	Blackout	Blackout	7 mo "C" data (Jan10 - Jul10)		
Nov-10	n/a	Jan10 - Oct10	Blackout	8 mo "C" data (Jan10 - Aug10)	Blackout	Blackout	8 mo "C" data (Jan10 - Aug10)		
Dec-10	n/a	Jan10 - Nov10	Blackout	9 mo "C" data (Jan10 - Sep10)	Blackout	Blackout	9 mo "C" data (Jan10 - Sep10)	Display data not updated	6 mo "C" data (Jan10 - Jun10)
Jan-11	n/a	Jan10 - Dec10	Blackout	10 mo "C" data (Jan10 - Oct10)	Blackout	Blackout	10 mo "C" data (Jan10 - Oct10)		
Feb-11	n/a	Feb10 - Jan11	Blackout	11 mo "C" data (Jan10 - Nov10)	Blackout	Blackout	11 mo "C" data (Jan10 - Nov10)		
Mar-11	n/a	Mar10 - Feb11	Blackout	12 mo "C" data (Jan10 - Dec10)	Blackout	Blackout	12 mo "C" data (Jan10 - Dec10)	Display data not updated	9 mo "C" data (Jan10 - Sep10)
Apr-11	n/a	Apr10 - Mar11	Blackout	12 mo "C" data (Feb10 - Jan11)	Blackout	Blackout	12 mo "C" data (Feb10 - Jan11)		

Two-Year Transition from OASIS-B1 to OASIS-C$_2$

End of Calendar Month	OASIS-B1 Data Reported	OASIS-C Available Data	HOME HEALTH OBQI CASPER Reports					Home Health Compare	
			OBQI Outcomes	Adverse Events	Case Mix	Tally	Process Measures	Outcome Measures	Process Measures
May-11	n/a	May10 - Apr11	Preview Report of HHC "12 mo 'C' data" provided[2]	12 mo "C" data (Mar10 - Feb11) or Preview Report[3]	Preview Report of HHC "12 mo 'C' data" provided[2]	Preview Report of HHC "12 mo 'C' data" provided[2]	12 mo "C" data (Mar10 - Feb11)		
Jun-11	n/a	Jun10 - May11	12 mo "C" data (Apr10 - Mar11)	12 mo "C" data (Apr10 - Mar11)	12 mo "C" data (Apr10 - Mar11)	12 mo "C" data (Apr10 - Mar11)	12 mo "C" data (Apr10 - Mar11)	12 mo "C" data (Jan10 - Dec10)	12 mo "C" data (Jan10 - Dec10)
Jul-11	n/a	Jul10 - Jun11	12 mo "C" data (May10 - Apr11)	12 mo "C" data (May10 - Apr11)	12 mo "C" data (May10 - Apr11)	12 mo "C" data (May10 - Apr11)	12 mo "C" data (May10 - Apr11)		
Aug-11	n/a	Aug10 - Jul11	12 mo "C" data (Jun10 - May11)	12 mo "C" data (Jun10 - May11)	12 mo "C" data (Jun10 - May11)	12 mo "C" data (Jun10 - May11)	12 mo "C" data (Jun10 - May11)		
Sep-11	n/a	Sep10 - Aug11	12 mo "C" data (Jul10 - Jun11)	12 mo "C" data (Jul10 - Jun11)	12 mo "C" data (Jul10 - Jun11)	12 mo "C" data (Jul10 - Jun11)	12 mo "C" data (Jul10 - Jun11)	12 mo "C" data (Apr10 - Mar11)	12 mo "C" data (Apr10 - Mar11)
Oct-11	n/a	Oct10 - Sep11	12 mo "C" data (Aug10 - Jul11)	12 mo "C" data (Aug10 - Jul11)	12 mo "C" data (Aug10 - Jul11)	12 mo "C" data (Aug10 - Jul11)	12 mo "C" data (Aug10 - Jul11)		
Nov-11	n/a	Nov10 - Oct11	12 mo "C" data (Sep10 - Aug11)	12 mo "C" data (Sep10 - Aug11)	12 mo "C" data (Sep10 - Aug11)	12 mo "C" data (Sep10 - Aug11)	12 mo "C" data (Sep10 - Aug11)		
Dec-11	n/a	Dec10 - Nov11	12 mo "C" data (Oct10 - Sep11)	12 mo "C" data (Oct10 - Sep11)	12 mo "C" data (Oct10 - Sep11)	12 mo "C" data (Oct10 - Sep11)	12 mo "C" data (Oct10 - Sep11)	12 mo "C" data (Jul10 - Jun11)	12 mo "C" data (Jul10 - Jun11)

[1] The CASPER Reports values could remain either unchanged from April 2010 values or be empty (blacked out).

[2] A Preview OBQI Report would be made available to HHAs during this month using the new "OASIS-C only" measures and prediction models. The HHC Preview OBQI Report would cover the time period Jan10 - Dec10.

[3] If CMS decides to risk adjust the Adverse Event Report, then the recommendation would be to launch these at the same time as the risk adjusted OBQI Report.

OASIS Measure Manual References[1]

All manual sections can be viewed online or printed
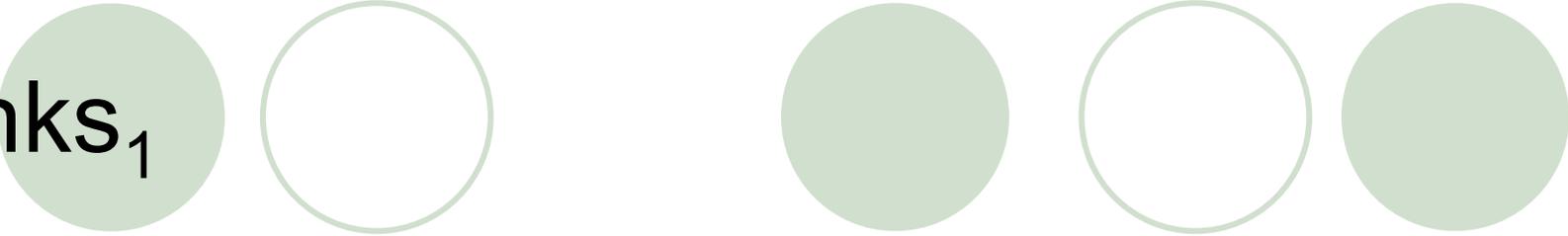
OBQI updates:
http://www.cms.hhs.gov/HomeHealthQualityInits/16_HHQIOASISOBQI.asp#TopOfPage

OBQM updates:
http://www.cms.hhs.gov/HomeHealthQualityInits/18_HHQIOASISOBQM.asp#TopOfPage

Links[1]

- To access information on the NQF home health measure development process, search www.qualityforum.org.
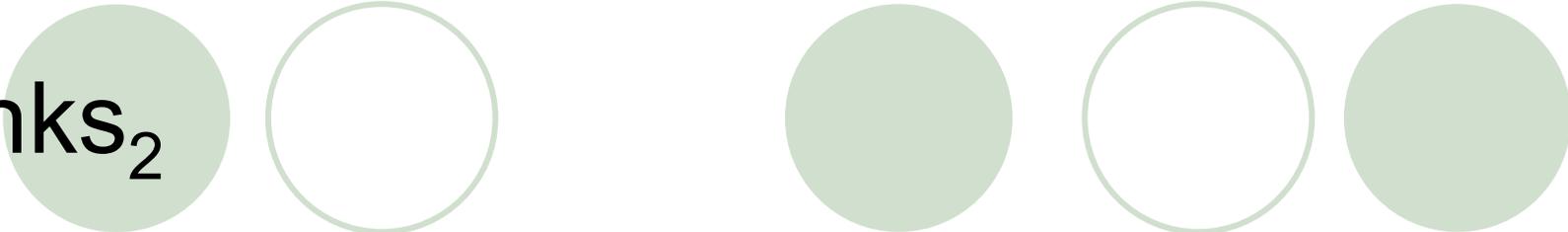
- NQF Final Report/Quality Measure Updates:

http://www.cms.hhs.gov/HomeHealthQualityInits/10_HHQIQualityMeasures.asp#TopOfPage

- Home Health Care CAHPS Survey Home Page

https://homehealthcahps.org/

Links$_2$

- When OASIS-C is released, (by 9/ 21/ 2009)

- OASIS-B1 materials will be available at the following Website:

  http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp#TopOfPage

- The **archived** OASIS Implementation Manual will be available at the following link effective late December 2009:

- Archives Home Health Quality Initiatives.

  http://www.cms.hhs.gov/HomeHealthQualityInits/20_HHQIArchives.asp#TopOfPage
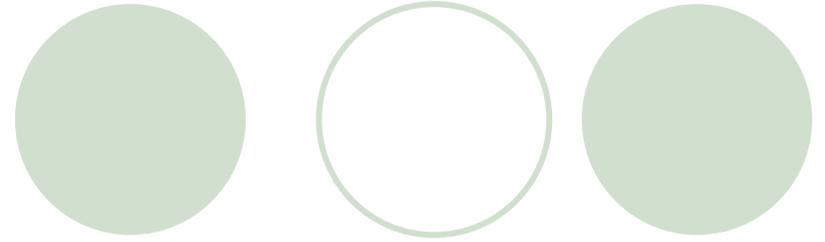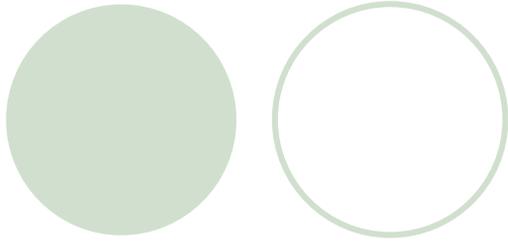
OASIS-C

Patient History & Diagnoses

M1000 Inpatient Facility DC

☐ 1 - Long-term nursing facility (NF)

☐ 2 - Skilled nursing facility (SNF / TCU)

☐ 3 - Short-stay acute hospital (IPP S)

☐ 4 - Long-term care hospital (LTCH)

☐ 5 - Inpatient rehabilitation hospital or unit (IRF)

- **(M1000)** From which of the following **Inpatient Facilities** was the patient discharged **during the past 14 days**? **(Mark all that apply.)**

☐ 6 - Psychiatric hospital or unit

☐ 7 - Other (specify) _____

☐ NA - Patient was not discharged from an inpatient facility
  [*Go to M1016*]

M1000 Inpatient Facility DC

- Identifies whether the patient has been discharged from an inpatient facility within the 14 days immediately preceding SOC/ROC

- Mark all that apply

- An inpatient facility DC that occurs on the day of the assessment **does** fall within the 14-day period

- "Past fourteen days" is the two-week period immediately preceding SOC/ROC

- SOC is Day 0 and the day immediately prior to the date of admission is Day 1

- Facility type is determined by the facility's State license

M1000 Inpatient Facility DC

- **Response 1** - **Long-term Nursing facility** (NF) means:

- Patient was discharged from a MC-certified skilled nursing facility,

- But **did not** receive care under the Medicare Part A benefit in the 14 days prior to home health care

M1000 Inpatient Facility DC

- **Response 4**, **Long-term Care Hospital**, (LTCH) applies to a hospital which has an average inpatient length of stay of greater than 25 days

- **Response 5, Inpatient rehabilitation hospital or unit** (IRF) means a freestanding rehab hospital or a rehabilitation bed in a rehabilitation distinct part unit of a general acute care hospital

- Intermediate care facilities for the mentally retarded (ICF/MR) = **Response 7 – Other**

M1000 Inpatient Facility DC

- If discharged from a **swing-bed hospital**, determine whether the patient was occupying:
  - A designated hospital bed (response 3)
  - A skilled nursing bed under Medicare part A (response 2), or
  - A nursing bed at a lower level of care (response 1)

M1005 Inpatient DC Date

- **(M1005)**   **Inpatient Discharge Date** (most recent):

  __ __ /__ __ /__ __ __ __

  month / day /   year

  ☐ UK   -   Unknown

- Identifies the date of the **most recent** discharge from an inpatient facility (within last 14 days)
- Even though the patient may have been discharged from more than 1 facility in the past 14 days
  - Use the most recent date of discharge from any inpatient facility

M1010 Inpatient Diagnosis[1]

- **(M1010)** List each **Inpatient Diagnosis** and ICD-9-C M code at the level of highest specificity for only those conditions treated during an inpatient stay within the last 14 days (no E-codes, or V-codes):

Inpatient Facility Diagnosis	ICD-9-C M Code
a. _____	__ __ __ . __ __
b. _____	__ __ __ . __ __
c. _____	__ __ __ . __ __
d. _____	__ __ __ . __ __
e. _____	__ __ __ . __ __
f. _____	__ __ __ . __ __

M1010 Inpatient Diagnosis$_2$

- List each **Inpatient Diagnosis** and ICD-9-CM code at the level of highest specificity **for only** those conditions **treated** during an inpatient stay within the last 14 days
- No E-codes, or V-codes
  - List underlying diagnosis
- No surgical codes
  - List underlying dx that was surgically treated. If a joint replacement for osteoarthritis, list the disease, not the procedure

M1010 Inpatient Diagnosis$_3$

- If diagnosis **not treated** during an inpatient admission, **don't list it**

- E.g., Patient has a long-standing diagnosis of "osteoarthritis," but was treated during hospitalization only for "peptic ulcer disease"

- Do **not** list "osteoarthritis" as an inpatient diagnosis

M1012 Inpatient Procedure$_1$

- (**M1012**)   List each **Inpatient Procedure** and the associated ICD-9-C M procedure code relevant to the plan of care

	Inpatient Procedure	Procedure Code
a.	_____	__ __ __ . __ __
b.	_____	__ __ __ . __ __
c.	_____	__ __ __ . __ __
d.	_____	__ __ __ . __ __

☐ NA - Not applicable

☐ UK - Unknown

M1012 Inpatient Procedure$_2$

- **Medical procedures** that the patient received **during an inpatient facility stay within the past 14 days** that are **relevant** to the home health plan of care

- Based on the info available at SOC/ROC
  - Example: a joint replacement surgery that requires home rehabilitation services

M1016 Dx Req. Med. Tx Reg Chg Within Past 14 Days$_1$

- **(M1016) Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days:** List the patient's Medical Diagnoses and ICD-9-C M codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days (no surgical, E-codes, or V-codes):

	Inpatient Facility Diagnosis	ICD-9-C M Code
a.	_____	__ __ __ . __ __
b.	_____	__ __ __ . __ __
c.	_____	__ __ __ . __ __
d.	_____	__ __ __ . __ __
e.	_____	__ __ __ . __ __
f.	_____	__ __ __ . __ __

☐ NA - Not applicable (no medical or treatment regimen changes within the past 14 days)

M1016 Dx Req. Med. Tx Reg Chg Within Past 14 Days$_2$

- Identifies if any change occurred to the patient's tx regimen, health care services, or medications within the past 14 days

- Helps identify patients at higher risk of becoming unstable

- Mark NA if changes due to improvement

M1016 Dx Req. Med. Tx Reg Chg Within Past 14 Days$_3$

- No surgical codes
  - List the underlying diagnosis
- No V-codes or E-codes
  - List the appropriate diagnosis
- May include the same diagnosis as M01010 if the condition was treated during an inpatient stay **and** caused changes in the treatment regimen
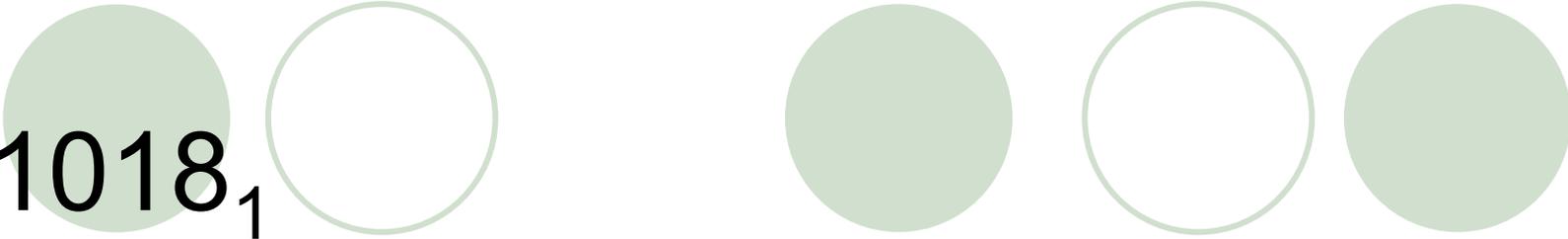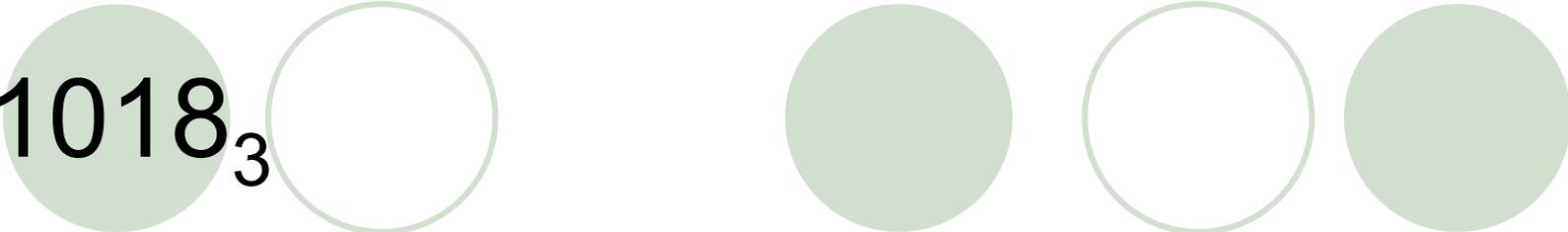
M1018$_1$

- **(M1018)   Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days**: If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions which existed **prior to** the inpatient stay or change in medical or treatment regimen. **(Mark all that apply.)**

  ☐   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 required

  ☐   7   -   None of the above

  ☐   NA   -   No inpatient facility discharge **and** no change in medical or treatment regimen in past 14 days

  ☐   UK   -   Unknown
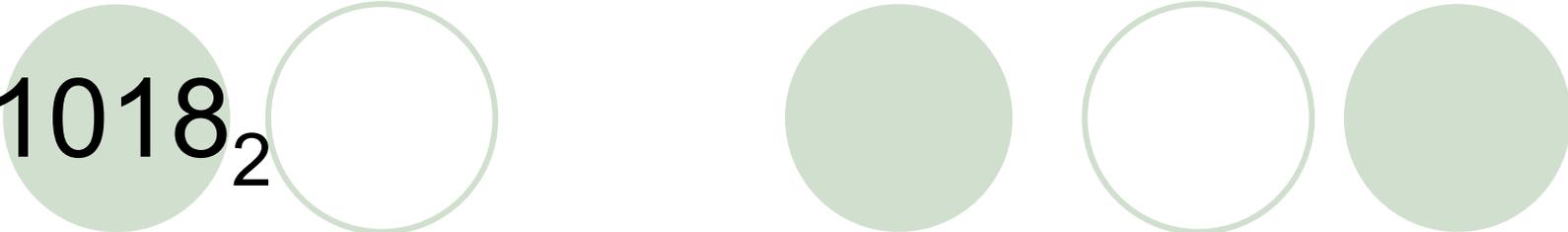
M1018$_2$

- Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days
- Identifies existence of condition(s) **prior to** medical regimen change or inpatient stay within past 14 days
- Mark **"7 – None of the above"**

  - If the patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days,

    and

  - None of the indicated conditions existed **prior to** the inpatient stay or change in medical or treatment regimen

M1018$_3$

- Mark "**NA**"
  - If no inpatient facility discharge

    and

  - No change in medical or treatment regimen in past 14 days
  - **Note** that **both** situations **must be true** for this response to be marked "NA"

M1018$_4$

- Mark **"Unknown"** if:

  ○ The patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days,

  and

  ○ It is unknown whether the indicated conditions existed **prior to** the inpatient stay or change in medical or treatment regimen

M1020/1022/1024₁

(M1020) Primary Diagnosis & (M1022) Other Diagnoses		(M1024) Payment Diagnoses (OPTIONAL)	
Column 1	Column 2	Column 3	Column 4
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-9-C M and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	Complete if a V-code is assigned under certain circumstances to Column 2 in place of a case mix diagnosis.	Complete **only if** the V-code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
Description	ICD-9-C M / Symptom Control Rating	Description/ ICD-9-C M	Description/ ICD-9-C M
(M1020) Primary Diagnosis a. _____	**(V-codes are allowed)** a. (__ __ __.__ __) ☐0 ☐1 ☐2 ☐3 ☐4	**(V- or E-codes NOT allowed)** a._____ (__ __ __ . __ __)	**(V- or E-codes NOT allowed)** a._____ (__ __ __ . __ __)
(M1022) Other Diagnoses b. _____	**(V- or E-codes are allowed)** b. (__ __ __.__ __) ☐0 ☐1 ☐2 ☐3 ☐4	**(V- or E-codes NOT allowed)** b._____ (__ __ __ . __ __)	**(V- or E-codes NOT allowed)** b._____ (__ __ __ . __ __)
c. _____	c. (__ __ __.__ __) ☐0 ☐1 ☐2 ☐3 ☐4	c._____ (__ __ __ . __ __)	c._____ (__ __ __ . __ __)
d. _____	d. (__ __ __.__ __) ☐0 ☐1 ☐2 ☐3 ☐4	d._____ (__ __ __ . __ __)	d._____ (__ __ __ . __ __)
e. _____	e. (__ __ __.__ __) ☐0 ☐1 ☐2 ☐3 ☐4	e._____ (__ __ __ . __ __)	e._____ (__ __ __ . __ __)
f. _____	f. (__ __ __.__ __) ☐0 ☐1 ☐2 ☐3 ☐4	f._____ (__ __ __ . __ __)	f._____ (__ __ __ . __ __)

(M1020) Primary Diagnosis & (M1022) Other Diagnoses		(M1024) Payment Diagnoses (OPTIONAL)	
Column 1	Column 2	Column 3	Column 4
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-9-C M and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	Complete if a V-code is ~~~~~~~~~~~~~	Complete **only if** the V-code in Column 2 is reported in ~~~~~ of a case mix ~~~ that is a multiple ~~~ situation (e.g., a ~~~estation code).
Description	ICD-9-C M / Symptom Control Rating		~~~escription/ ~~~CD-9-C M
(M1020) Primary Diagnosis a. _____	(V-codes are allowed) a. (__ __ __·__ __) ☐0 ☐1 ☐		~~des NOT allowed) _____ __ __ · __ __)
(M1022) Other Diagnoses b. _____	(V- or ~~~		~~des NOT allowed) _____ __ __ · __ __)
c. _____	c. (__ __ __ ☐0 ☐1 ☐2 ☐~		_____ __ __ · __ __)
d. _____	d. (__ __ __·__ __) ☐0 ☐1 ☐2 ☐3 ☐4		_____ __ __ · __ __)
e. _____	e. (__ __ __·__ __) ☐0 ☐1 ☐2 ☐3 ☐4		_____ __ __ · __ __)
f. _____	f. (__ __ __·__ __) ☐0 ☐1 ☐2 ☐3 ☐4	f. _____ (__ __ __ · __ __)	f. _____ (__ __ __ · __ __)

Column 1
List each diagnosis for which the patient is receiving home care

M1020/1022/1024[3]

(M1020) Primary Diagnosis & (M1022) Other Diagnoses		(M1024) Payment Diagnoses (OPTIONAL)
Column 1	Column 2	Column 3
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-9-C M and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	Complete if a V-co assigned under ce circumstances to Co in place of a case diagnosis.
Description	ICD-9-C M / Symptom Control Rating	Description/ ICD-9-C M
(M1020) Primary Diagnosis a. _____	(V-codes are allowed) a. (__ __ __ ▫ __ __) ☐0 ☐1 ☐2 ☐3 ☐4	(V- or E-code OT a. _____
(M1022) Other Diagnoses b. _____	(V- or E-codes are allowed) b. (__ __ __ ▫ __ __) ☐0 ☐1 ☐2 ☐3 ☐4	(V
c. _____	c. (__ __ __ ▫ __ __) ☐0 ☐1 ☐2 ☐3 ☐4	c. _____ (__ __ __ · __
d. _____	d. (__ __ __ ▫ __ __) ☐0 ☐1 ☐2 ☐3 ☐4	d. _____ (__ __ __ · __
e. _____	e. (__ __ __ ▫ __ __) ☐0 ☐1 ☐2 ☐3 ☐4	e. _____ (__ __ __ · __
f. _____	f. (__ __ __ ▫ __ __) ☐0 ☐1 ☐2 ☐3 ☐4	f. _____ (__ __ __ · __

Column 2 Enter its ICD-9-CM code at the level of highest specificity (no surgical, procedure codes)

M1020/1022/1024₄

(M1020) Primary Diagnosis & (M1022) Other Diagnoses		(M1024) Payment D...
Column 1	**Column 2**	**Column 3**
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-9-C M and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	Complete if a V-c... assigned under c... circumstances to C... in place of a cas... diagnosis.
Description	ICD-9-C M / Symptom Control Rating	Description ICD-9-C M
(M1020) Primary Diagnosis a. _____	**(V-codes are allowed)** a. (__ __ __.__ __ __) ☐0 ☐1 ☐2 ☐3 ☐4	**(V- or E-cod**es NOT... a. _____
(M1022) Other Diagnoses b. _____	**(V- or E-codes are allowed)** b. (__ __ __.__ __ __) ☐0 ☐1 ☐2 ☐3 ☐4	......
c. _____	c. (__ __ __.__ __ __) ☐0 ☐1 ☐2 ☐3 ☐4	c. _____ (__ __ __ . __ ...
d. _____	d. (__ __ __.__ __ __)	d. _____ (__ __ __ . __ ...

> **Column 2**
> Rate the degree of symptom control for each condition
> Choose one value that represents the degree of symptom control appropriate for each diagnosis

> Do not assign symptom control ratings for V- or E-codes.

Symptom Control Rating[1]

- Symptom control ratings defined:
  - 0 - Asymptomatic, no treatment needed at this time
  - 1 - Symptoms well controlled with current therapy
  - 2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring
  - 3 - Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring
  - 4 - Symptoms poorly controlled; history of re-hospitalizations

Symptom Control Rating$_2$

- The symptom control rating should not be used to determine the sequencing of the diagnoses

- Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided
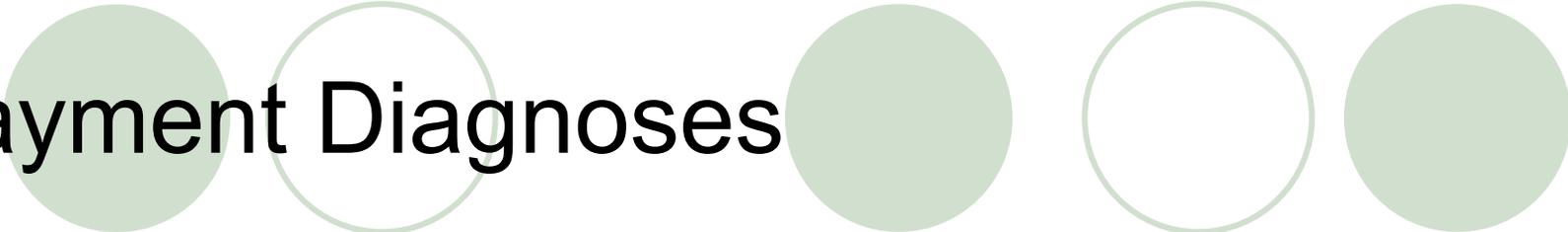
Columns 3 and 4
If a V-code is reported in place of a case mix diagnosis, then optional item M1024 Payment Diagnoses may be completed
Refer to Appendix D for guidance

Other Diagnoses	(M1024) Payment Diagnoses (OPTIONAL)	
Column 2	Column 3	Column 4
-C M and symptom trol rating for each condition. hat the sequencing of atings may not match sequencing of the diagnoses	Complete if a V-code is assigned under certain circumstances to Column 2 in place of a case mix diagnosis.	Complete only if the V-code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
ICD-9- M/ tom Co Rating	Description/ ICD-9-C M	Description/ ICD-9-C M
es are a	(V- or E-codes NOT allowed)	(V- or E-codes NOT allowed)
	a._____ (__ __ __ . __ __)	a._____ (__ __ __ . __ __)
or E-codes NOT allowed)	(V- or E-codes NOT allowed)	
	b._____ (__ __ __ . __ __)	b._____ (__ __ __ . __ __)
_____) □1 □2 □3 □4	c._____ (__ __ __ . __ __)	c._____ (__ __ __ . __ __)
_____) □1 □2 □3 □4	d.	d.
_____) □1 □2 □3 □4	e.	
_____) □0 □1 □2 □3 □4	f.	

A case mix diagnosis gives a score toward the Medicare PPS group assignment.

Payment Diagnoses

- **Column 4:   (OPTIONAL)**

- If a V-code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-C M coding guidelines:

 - Enter the diagnosis descriptions and the ICD-9-C M codes in the same row in Columns 3 and 4

(M1020) Primary Diagnosis & (M1022) Other Diagnoses		(M1024) Payment Diagnoses (OPTIONAL)	
Column 1	Column 2	Column 3	Column 4
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-9-C M and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	Complete if a V-code is assigned under certain circumstances to Column 2 in place of a case mix diagnosis.	Complete only if the V-code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
Description	ICD-9-C M / Symptom Control Rating	Description/ ICD-9-C M	Description/ ICD-9-C M
(M1020) Primary Diagnosis a. _____	(V-codes are allowed) a. (__ __ __.__ __) ☐0 ☐1 ☐2 ☐3 ☐4	(V- or E-codes NOT allowed) a._____ (_____)	(V- or E-codes NOT allowed) a._____ (_____)
(M1022) Other Diagnoses b. _____	(V- or E-codes are allowed) b. (__ __ __.__ __) ☐0 ☐1 ☐2 ☐3 ☐4	(V- or E-codes NOT allowed)	(V- or E-codes allowed)
c. _____	c. (__ __ __.__ __) ☐0 ☐1 ☐2 ☐3 ☐4		
d. _____	d. (__ __ __.__ __) ☐0 ☐1 ☐2 ☐3 ☐4		
e. _____	e. (__ __ __.__ __) ☐0 ☐1 ☐2 ☐3 ☐4	e._____	e._____
f. _____	f. (__ __ __.__ __) ☐0 ☐1 ☐2 ☐3 ☐4		

Column 3 Etiology Underlying Condition

Column 4 Manifestation

Complete Column 4 ONLY If the case mix dx is a manifestation code

Coding Accurately
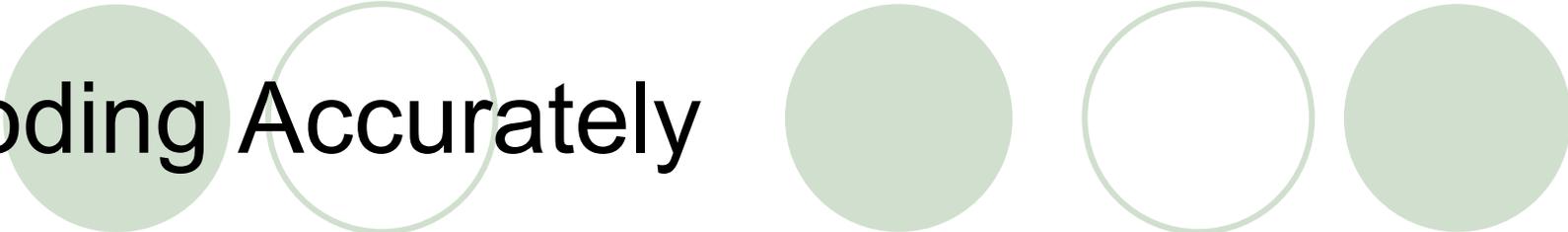
- To code diagnoses accurately and compliantly
  - CMS expects HHAs to understand each patient's specific clinical status before selecting and assigning each diagnosis
- Each patient's overall medical condition and care needs must be comprehensively assessed
- **BEFORE** the HHA identifies and assigns each diagnosis for which the patient is receiving home care

Coding Accurately
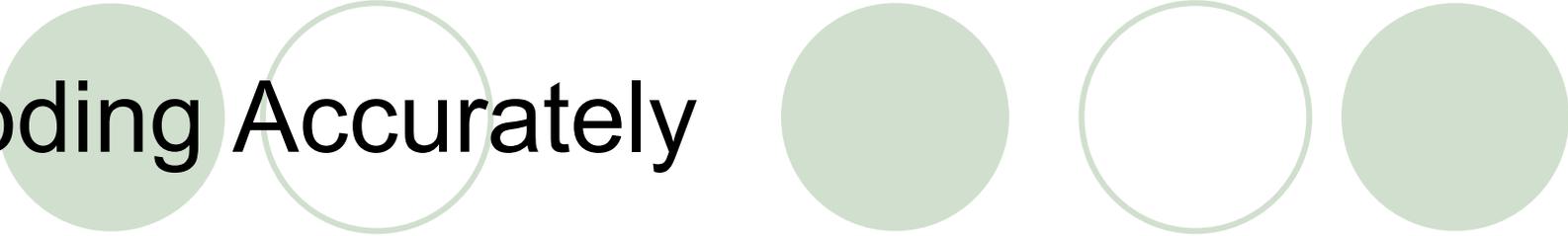
- Each **diagnosis** (other than an E code) **must comply** with the "Criteria for OASIS Diagnosis Reporting"

- See Appendix D - if a patient has a **resolved condition** which has **no impact** on the patient's **current plan of care**, then the **condition does not meet the criteria** for a **home health diagnosis** and **should not be coded**

M1020 Primary Diagnosis

- The **primary diagnosis** should be:
  - The **diagnosis most related** to the patient's **current plan of care**,
  - The **most acute diagnosis** and
  - Therefore the **chief reason** for providing home care

M1022 Secondary Diagnosis

- All conditions that coexisted at the time the plan of care was established, or which developed subsequently, or affect the treatment or care

- Include not only conditions actively addressed in the POC but also any co-morbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis
  - Even if the condition is not the focus of any home health treatment itself

M1022 Secondary Diagnosis

- Avoid listing diagnoses that are of mere historical interest and without impact on patient progress or outcome

- List in the order to best reflect the seriousness of the patient's condition and justify the disciplines and services provided

M1022 Secondary Diagnosis

- List by the degree they impact the patient's health and need for home health care, rather than the degree of symptom control

- Example, if a patient is receiving home health care for Type 2 diabetes which is "controlled with difficulty", this diagnosis would be listed above a diagnosis of a fungal infection of a toenail that is receiving treatment, even if the fungal infection is "poorly controlled"

M1022 Secondary Diagnosis

- The diagnosis may or may not be related to a patient's recent hospital stay but must relate to the services rendered by the HHA

- Skilled services (skilled nursing, physical, occupational and speech language pathology) are used in judging the relevancy of a diagnosis to the plan of care and to the OASIS

Case Mix or Payment Dx
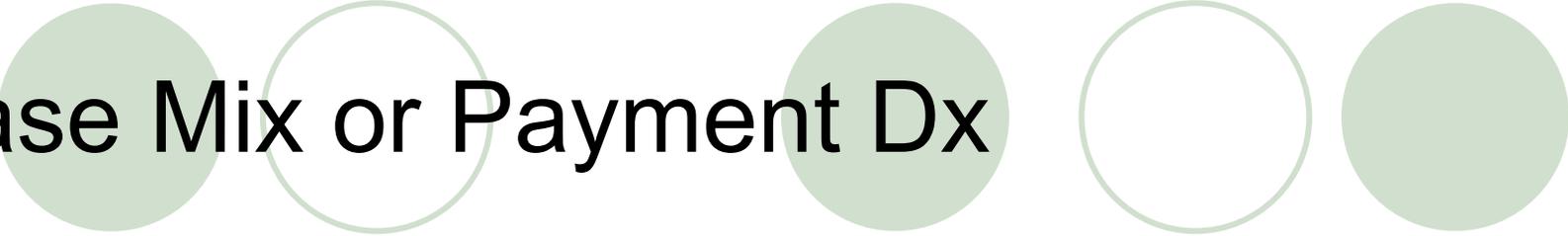
- A case-mix diagnosis is a diagnosis that gives a patient a score for Medicare Home Health PPS case-mix group assignment

- A case mix diagnosis may be the primary diagnosis, "other" diagnosis, or a manifestation associated with a primary or other diagnosis

- Each diagnosis listed in M1020 and M1022 should be supported by the patient's medical record documentation

- The list of case mix diagnosis codes is included in the HH PPS Grouper documentation available on the CMS Web site

V Codes
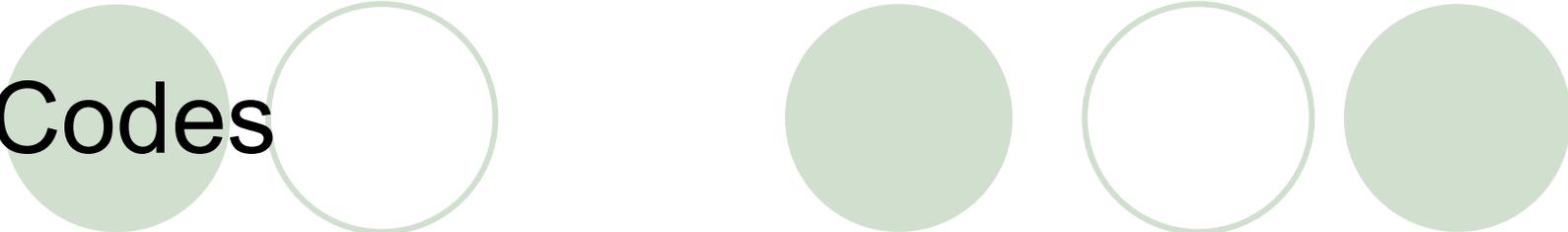
- V-codes may be primary or secondary codes
- CMS expects HHAs to avoid assigning excessive V-codes to the OASIS
- V-codes are less specific to the clinical condition of the patient than are numeric diagnosis codes
- In the home health setting, V-codes are appropriately assigned to M1020 and M1022 when:
  - A patient with a resolving disease or injury requires specific aftercare of that disease or injury
  - Example: surgical aftercare or aftercare for rehabilitation

V Codes
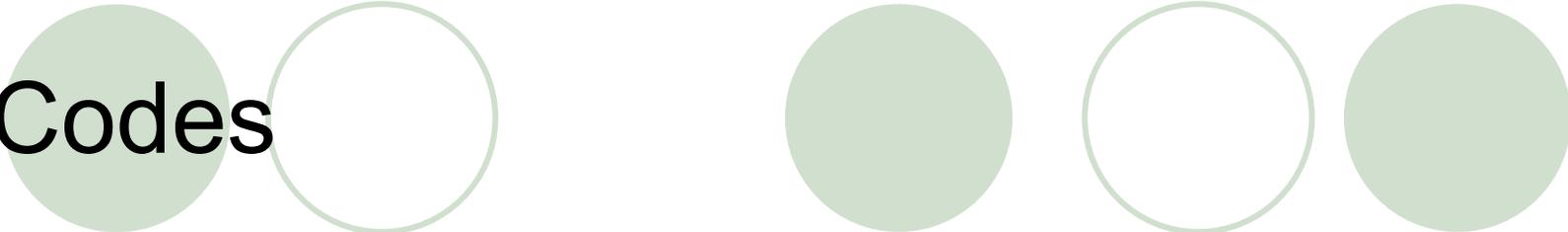
- V-codes and E-codes **may not** be entered in optional Columns 3 or 4 as these columns pertain to the Medicare PPS case mix diagnosis only
  - See Appendix D for further guidance
- No surgical codes – list underlying diagnosis

M1030 Therapies at Home

- **(M1030)** **Therapies** the patient receives **at home**: **(Mark all that apply.)**

  ☐ 1 - Intravenous or infusion therapy (excludes TPN)

  ☐ 2 - Parenteral nutrition (TPN or lipids)

  ☐ 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy or any other artificial entry into the alimentary canal)

  ☐ 4 - None of the above

M1030 Therapies at Home

- Identifies whether the patient is receiving intravenous, parenteral nutrition, or enteral nutrition therapy **at home**

  ○ Whether or not the home health agency is administering the therapy

- This item is not intended to identify therapies administered in outpatient facilities or by any provider outside the home setting

M1030 Therapies at Home

- Mark the applicable therapy
  - If the patient will receive such therapy as a result of this SOC/ROC or follow-up assessment
  - Example: the IV will be started at this visit or a specific subsequent visit; the physician will be contacted for an enteral nutrition order; etc.
- Select "1" if a patient receives intermittent medications or fluids via an IV line (e.g., heparin or saline flush)
- Do **not** mark "1" if IV catheter is present but not active (e.g., site is observed only or dressing changes are provided)

M1030 Therapies at Home

- Select "1" if ongoing infusion therapy is being administered at home via:
  - ○ Central line,
  - ○ Subcutaneous infusion,
  - ○ Epidural infusion,
  - ○ Intrathecal infusion,
  - ○ Insulin pump
  - ○ Hemodialysis or peritoneal dialysis **in the home**

M1030 Therapies at Home

- Do **not** select "1"
  - If there are orders for an IV infusion to be given when specific parameters are present (e.g., weight gain),
  - But those parameters are not met on the day of the assessment
- Select Response 3, if any enteral nutrition is provided
- If a feeding tube is in place, but not currently used for nutrition, Response 3 does **not** apply
- A flush of a feeding tube does **not** provide nutrition

M1032 Risk for Hospitalization

- **(M1032)   Risk for Hospitalization:** Which of the following signs or symptoms characterize this patient as at risk for hospitalization? **(Mark all that apply.)**

    ☐   1   -   Recent decline in mental, emotional, or behavioral status

    ☐   2   -   Multiple hospitalizations (2 or more) in the past 12 months

    ☐   3   -   History of falls (2 or more falls - or any fall with an injury - in the

    past year)

    ☐   4   -   Taking five or more medications

    ☐   5   -   Frailty indicators, e.g., weight loss, self-reported exhaustion

    ☐   6   -   Other

    ☐   7   -   None of the above

M1032 Risk for Hospitalization

- Patient characteristics that may indicate patient is at risk for hospitalization in the **care provider's professional judgment**

- Response 3, History of falls, includes witnessed and unwitnessed falls

- In Response 4, Taking five or more medications, includes OTC meds

# M1032 Risk for Hospitalization

- **Recent decline in mental, emotional, or behavioral status** refers to significant changes occurring over the past year that may impact the patient's ability to remain safely in the home and increase the likelihood of hospitalization

- **Frailty** includes weight loss in the last year, self-reported exhaustion, and slower movements (sit to stand and while walking)

M1034 Overall Status

- **(M1034)Overall Status:** Which description best fits the patient's overall status? **(Check one.)**

  ☐   0   -   The patient is stable with no heightened risk (s) for serious complications and death (beyond those typical of the patient's age)

  ☐   1   -   The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient's age)

  ☐   2   -   The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death

  ☐   3   -   The patient has serious progressive conditions that could lead to death within a year

  ☐   UK -   The patient's situation is unknown or unclear

M1034 Overall Status
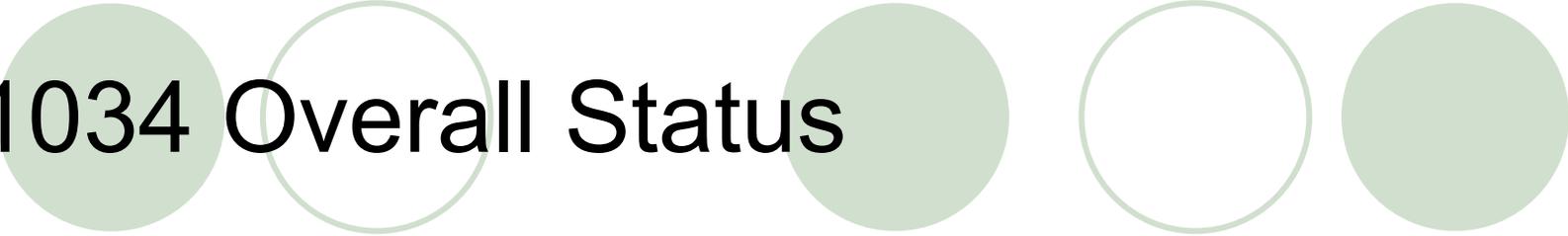
- The general potential for health status stabilization, decline or death

- Use information from other providers and clinical judgment

- Consider current health status, medical dx and information from the physician and patient/family on expectations for recovery or life expectancy

- DNR order not needed for 2 or 3

M1036 Risk Factors

- **(M1036) Risk Factors**, either present or past, likely to affect current health status and/or outcome:
  (Mark all that apply.)

  ☐ 1 - Smoking

  ☐ 2 - Obesity

  ☐ 3 - Alcohol dependency

  ☐ 4 - Drug dependency

  ☐ 5 - None of the above

  ☐ UK - Unknown
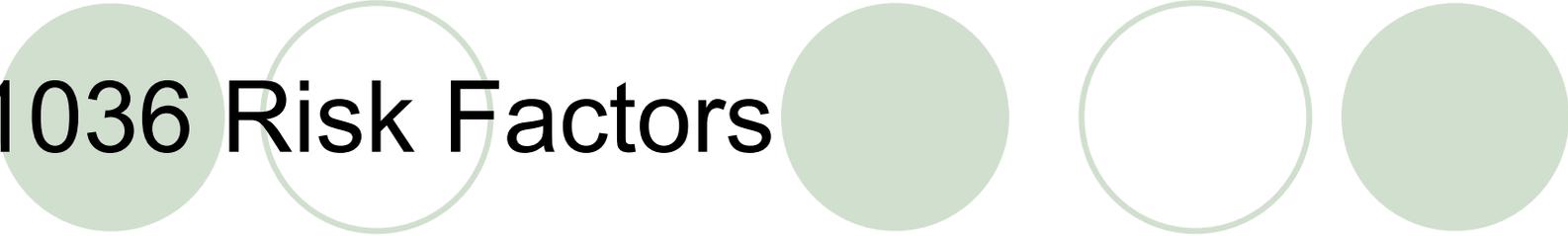
M1036 Risk Factors

- Specific factors that may exert a substantial impact on:
  - The patient's health status,
  - Response to medical treatment, and
  - Ability to recover from current illnesses
- In the **care provider's professional judgment**

M1036 Risk Factors

- CMS does not provide a specific definition for each of these factors

  - Amount and length of exposure (e.g., smoking one cigarette a month may not be considered a risk factor) should be considered when responding

- Use judgment in evaluating risks to current health conditions from behaviors that were stopped in the past

Immunizations[1]

- **4 New Items report immunization status**
  - ○ **(M1040) Influenza Vaccine**
  - ○ **(M1045) Reason Influenza Vaccine not received**
  - ○ **(M1050) Pneumococcal Vaccine**
  - ○ **(M1055) Reason PPV not received**
- Collected at Transfer & Discharge
  - ○ Used for publicly-reported measures of immunization rates
  - ○ Harmonized with other care settings

Immunizations$_2$

- **Focus:** is patient **up to date on flu vaccine**

  and have they **ever had a PPV**?

- **Initial question:** did you give the vaccine during the episode?

  - Asked **at Transfer/Discharge** – episode defined as from SOC/ROC to transfer or DC

  - If the answer is yes, you are done

- **Follow-up question:** **if the answer is no, then explain why**

Patient History & Diagnosis Domain
Immunizations$_3$

- **(M1040) Influenza Vaccine:** Did the patient receive the influenza vaccine **from your agency** for this year's influenza season (October 1 through March 31) **during this episode of care**?

  ☐ 0 - No

  ☐ 1 - Yes **[*Go to M1050*]**

  ☐ NA - Does not apply because **entire episode** of care (SOC/ROC to Transfer/ Discharge) is outside this influenza season **[*Go to M1050*]**

Immunizations$_4$

- **(M1045) Reason Influenza Vaccine not received:**
  If the patient did not receive the influenza vaccine from your agency during this episode of care, **state reason**:

  - ☐ 1 - Received from another health care provider (e.g., physician)
  - ☐ 2 - Received from your agency previously during this year's flu season
  - ☐ 3 - Offered and declined
  - ☐ 4 - Assessed and determined to have medical contraindication(s)
  - ☐ 5 - Not indicated; patient does not meet age/ condition guidelines for influenza vaccine
  - ☐ 6 - Inability to obtain vaccine due to declared shortage
  - ☐ 7 - None of the above

Immunizations$_5$

- (M1050) Pneumococcal Vaccine: Did the patient receive pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC Transfer/Discharge)?

  ☐ 0 - No

  ☐ 1 - Yes **[*Go to M1500 at TRN*; *Go to*]**

  M1230 at DC]

318

Patient History & Diagnosis Domain
Immunizations$_6$

- **(M1055) Reason PPV not received:** If patient did not receive the pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge), **state reason**:

  ☐ 1 - Patient **has received PPV in the past**

  ☐ 2 - Offered and declined

  ☐ 3 - Assessed and determined to have medical contraindication(s)

  ☐ 4 - Not indicated; patient does not meet age/condition guidelines for PPV

  ☐ 5 - None of the above
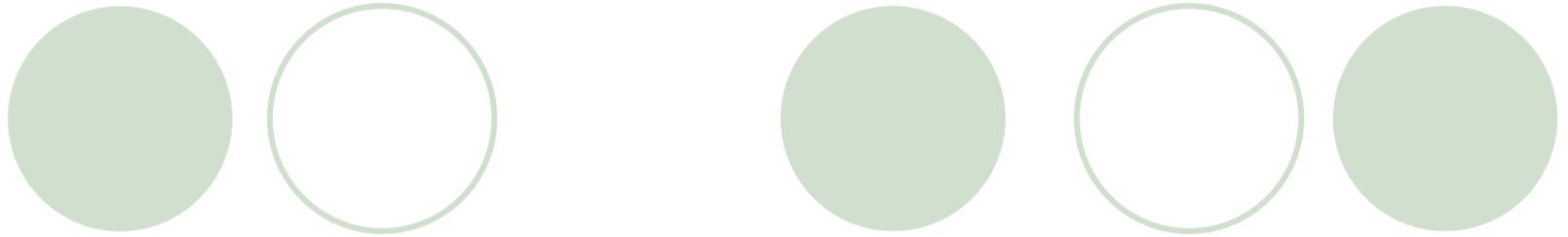
OASIS Payment Overview & Coding Issues

Patient History & Diagnoses Items

Key Elements of BBA '97

- Coverage related issues:

  - Elimination of venipuncture as qualifying service

  - Mandated HCFA report on definition of homebound

  - Defined "part-time or intermittent care" as part of statute

  - Mandated development of normative standard regulations
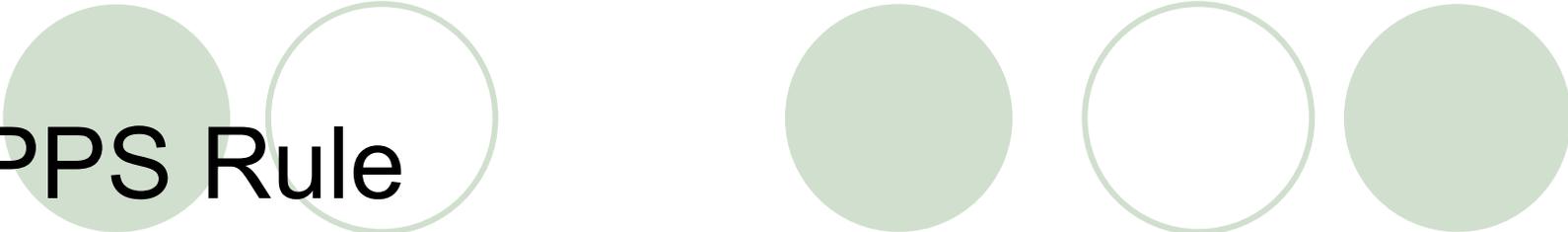
PPS Rule

- Proposed Rule Published 10/28/99
- Final Rule Published 8/29/07
- Based on BBA requirements
  - Unit of service
  - Audited cost reports
  - Case-mix system
  - Market basket update minus 1.1%
  - Payment adjustments
  - Pro-ration and consolidated billing

PPS Refinement
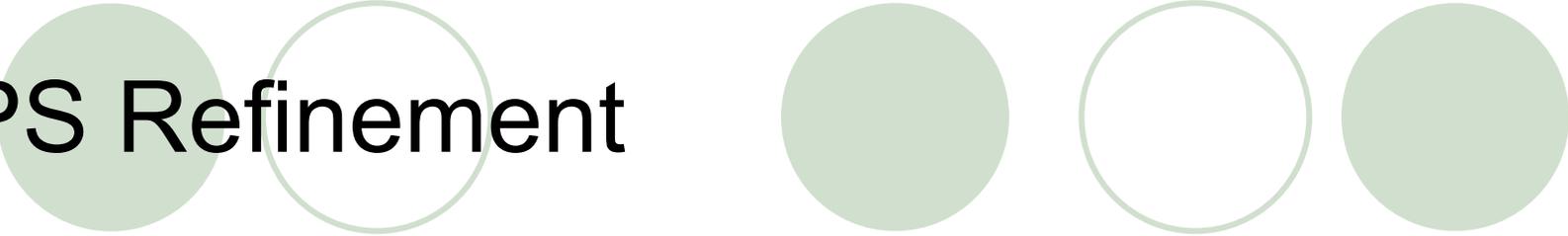
- Proposed Rule Published – May 4, 2007
- Final Rule Published – August 29, 2007
- Payment Rule update almost every year
  - Includes current base payment rate
  - Includes current LUPA rates
  - Other changes in payment policy

Key Elements of PPS

- 60-day episode

- Standardized episode rate

- Split payments
  - Initial episode
    - 60% at request for anticipated payment
    - 40% at end of episode
  - Subsequent episode
    - 50% at initial claim
    - 50% at end of episode

Request for Anticipated Payment (RAP)

- Not considered a claim
- Not subject to payment floor or interest
- Includes basic beneficiary information
- Does not require signed physician orders
- Must have documentation of verbal orders
- Submitted for all beneficiaries receiving services
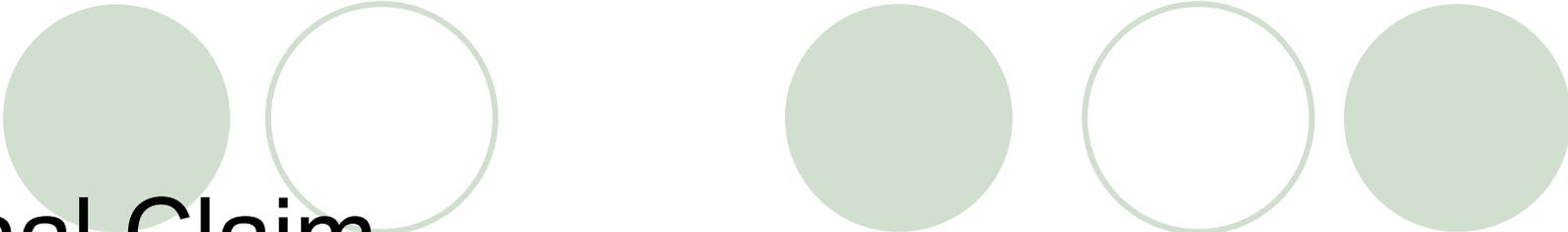
Final Claim

- Submit at end of 60-day episode
- Line item detail of all services provided
- Is subject to payment floor and interest
- Physician signed orders required prior to submission
- Will be a debit/credit action
  - RAP payment will be reversed in full and all payment made on final claim

Key Elements of PPS

- Physician orders
  - Request for Anticipated Payment (RAP)
    - Verbal orders with description of patient's condition and services to be provided, or
    - Signed and dated referral with detailed orders
  - Final claim
    - All orders for services within episode must be signed

Key Elements of PPS (cont.)

- Case-mix adjusted payments
- National visit rates
- LUPAs
- Outliers
- Proration-transfers
- SCICs (were eliminated 1/1/2008)
- Consolidated billing of routine and non-routine supplies and bundled services

Consolidated Billing

- Cannot "Unbundle" services

- Episode rate includes payment for all services within the scope of home health benefit

- Excludes DME (fee schedule items)

- HHA must furnish service either directly or under arrangement

Consolidated Billing Services

- Routine and non-routine medical supplies
- Covered osteoporosis drug
- Intern/resident-in-training in approved programs
- Services of hospitals, SNFs or rehabilitation centers when they provide equipment too cumbersome to bring to the home (e.g., Outpatient Services)

Case-Mix Adjustment

- Different types of patients require different levels of resources

- Tailors payments to expected resource use – allows high cost patients to be served

- Based on objective patient characteristics – **not** provider behavior

Case-Mix Adjustment (cont.)

- Combination of components:
  - Clinical indicators
  - Functional status
  - Service utilization
- Scores based on OASIS items and projected need for therapy (M2200)
- Early versus later episodes (M0110)(effective 1/1/2008)

Home Health Resource Groups (HHRGs)

- OASIS collected

- Scored based on OASIS data

- Scores summed within components

- Assigned to severity categories:
  - Clinical
  - Functional
  - Service utilization

Home Health Resource Groups (HHRGs) (cont.)

- HHRGs
- HIPPS code
- 4-Equation Model (based on therapy need)
- January 2008 – 153 HHRGs
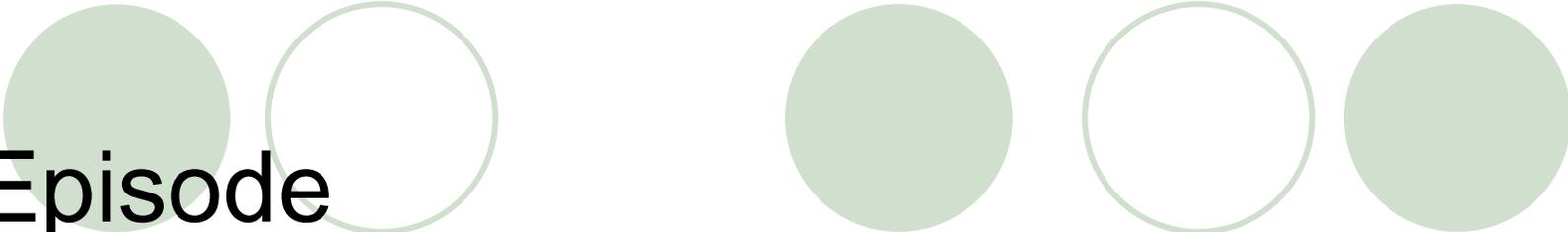
Episode

- 60 calendar days, not 62
- Begins with first billable visit
- Ends on Day 60
- New episode (recertification) begins Day 61
- Unlimited number of episodes as long as the patient "qualifies"
- Exceptions

Partial Episode Payment - PEP

- Voluntary transfer:
  - Patient elects to transfer to another agency
  - 1st agency episode proration
  - 2nd agency starts new episode
  - Common ownership exclusion if same MSA

- Discharge with goals met, readmitted to same agency later:
  - 1st episode prorated
  - New episode with readmission

Significant Change in Condition

- Major change in patient's condition – decline or improvement

- SCIC Payment Adjustment – eliminated 1/1/2008

Low Utilization Payment Adjustment (LUPA)

- LUPA
  - Less than 5 visits provided in 60-day episode
  - Paid per standardized, per visit amount
  - Effective 1/1/2008 – Add-on for first or only LUPA episode ($87.93)

PPS Payment Items: Clinical

- M1020/1022/1024 – Primary Diagnosis/Other Diagnosis/Payment Diagnosis
- M1030 – Therapies the patient receives at home
- M1200 – Vision
- M1242 – Pain interfering with activity or movement
- M1308 – Current Number of Pressure Ulcers
- M1324 – Stage of most problematic pressure ulcer
- M1334 – Status of most problematic stasis ulcer

PPS Payment Items: Clinical (cont.)

- M1342 – Status of most problematic surgical wound
- M1400 – Is the patient dyspneic or short of breath?
- M1615 – Urinary Incontinence
- M1620 – Bowel Incontinence Frequency
- M1630 – Ostomy for Bowel Elimination
- M0800 – Management of Injectable Medications

PPS Payment Items: Functional

- M1810/M1820 – Ability to Dress Upper/Lower Body
- M1830 – Bathing
- M1840 – Toileting
- M1850 – Transferring
- M1860 – Ambulation/Locomotion

PPS Payment Items: Service Utilization

- M0100 – Reason for Assessment (RFA)
- M0110 – Episode Timing

PPS Changes: Non-Routine Medical Supplies

- Non-routine supplies:
  - Not included in national, standardized 60-day episode payment rate
  - Case-mix adjusted based on 6 NRS severity groups (added to episode rate)
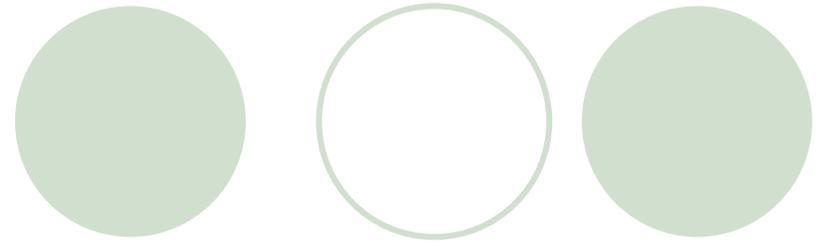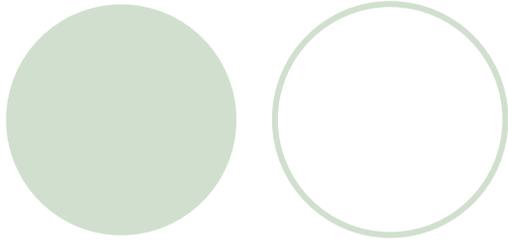
OASIS - C

Patient Tracking

M0010 CMS Certification Number

- **(M0010)   C M S Certification Number**

  __ __ __ __ __ __

M0014 Branch State

- **(M0014)**   **Branch State**

—— ——

M0016 Branch ID Number

- **(M0016)   Branch I D Number**

  __ __ __ __ __ __ __ __ __ __

M0018 National Provider Identifier (NPI)

- **(M0018) National Provider Identifier (N P I)** for the attending physician who has signed the plan of care

  — — — — — — — — — —

  ☐ UK– Unknown or Not Available

M0020 Patient ID Number

- **(M0020)   Patient I D Number**

    __ __ __ __ __ __ __ __ __ __ __ __ __ __ __
    __ __ __ __ __

M0030 Start of Care Date

- **(M0030)**   **Start of Care Date:**

__ __ / __ __ / __ __ __ __
month / day /   year

M0032 Resumption of Care Date

- **(M0032)   Resumption of Care Date:**

  __ __ / __ __ / __ __ __ __
  month / day /   year

  ☐ NA- Not Applicable

M0040 Patient Name

- **(M0040)** **Patient Name:**

__ __ __ __ __ __ __ __ __ __ __ __   __
(First)   (M I)

__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __
__ __   __ __ __
(Last)   (Suffix)

M0050 Patient State of Residence

- **(M0050)   Patient State of Residence**

  __ __

M0060 Patient Zip Code

- **(M0060)   Patient Zip Code**

   __ __ __ __ __   __ __ __ __

M0063 Medicare Number

- **(M0063)   Medicare Number:**

__ __ __ __ __ __ __ __ __ __
(including suffix)

☐ NA–No Medicare

M0064 Social Security Number

(M0064) **Social Security Number**

__ __ __ - __ __ - __ __ __ __

☐ UK– Unknown or Not Available
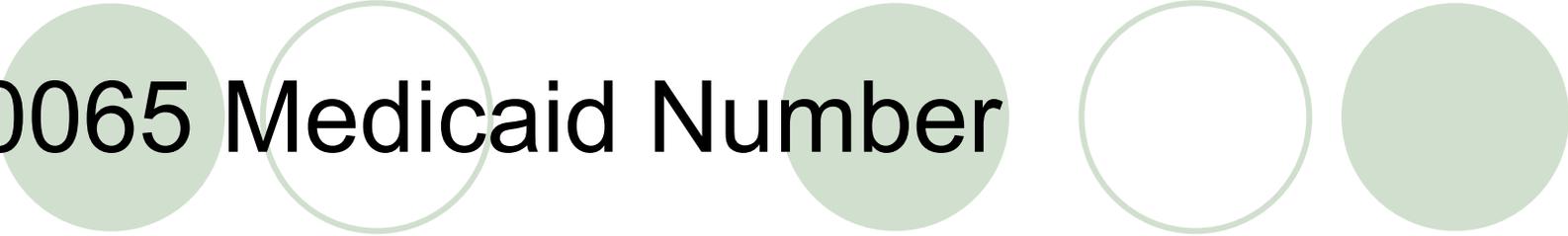
M0065 Medicaid Number

(M0065)
   Medicaid Number

__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

☐ NA– No Medicaid

M0066 Birth Date
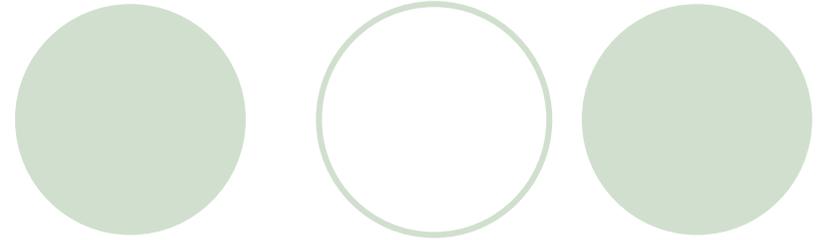
- **(M0066)   Birth Date:**

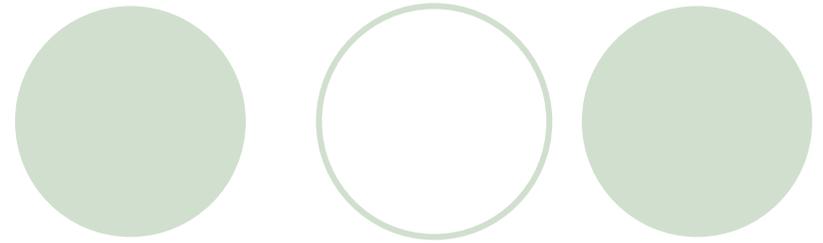 __ __ / __ __ / __ __ __ __
  month / day /   year

M0069 Gender

- **(M0069) Gender:**

  ☐ 1 - Male

  ☐ 2 - Female

M0140 Race/Ethnicity

- **(M0140) Race/Ethnicity: (Mark all that apply.)**

  ☐ 1 - American Indian or Alaska Native

  ☐ 2 - Asian

  ☐ 3 - Black or African-American

  ☐ 4 - Hispanic or Latino

  ☐ 5 - Native Hawaiian or Pacific Islander

  ☐ 6 - White

M0150 Current Payment Sources

- **(M0150)   Current Payment Sources for Home Care: (Mark all that apply.)**

☐   0   -   None; no charge for current services

☐   1   -   Medicare (traditional fee-for-service)

☐   2   -   Medicare (HMO/managed care/Advantage plan)

☐   3   -   Medicaid (traditional fee-for-service)

☐   4   -   Medicaid (HMO/managed care)

☐   5   -   Workers' compensation

☐   6   -   Title programs (e.g., Title III, V, or XX)

☐   7   -   Other government (e.g., TriCare, VA, etc.)

☐   8   -   Private insurance

☐   9   -   Private HMO/managed care

☐   10 -   Self-pay

☐   11 -   Other (specify)   _____

☐   UK -   Unknown

Items to be Used at Specific Time Points[1]

Items to be Used at Specific Time Points

Start of Care --- M0010-M0030, M0040- M0150, M1000-M1036, M1100-M1242, M1300-M1302, M1306, M1308-M1324, M1330-M1350, M1400, M1410, M1600-M1730, M1740-M1910, M2000, M2002, M2010, M2020-M2250

    Start of care—further visits planned

Resumption of Care -- M0032, M0080-M0110, M1000-M1036, M1100-M1242, M1300-M1302, M1306, M1308-M1324, M1330-M1350, M1400, M1410, M1600-M1730, M1740-M1910, M2000, M2002, M2010, M2020-M2250

    Resumption of care (after inpatient stay)

Follow-Up -- M0080-M0100, M0110, M1020-M1030, M1200, M1242, M1306, M1308, M1322-M1324, M1330-M1350, M1400, M1610, M1620, M1630, M1810-M1860, M2030, M2200

    Recertification (follow-up) assessment
    Other follow-up assessment

Transfer to an Inpatient Facility ---------------------------------- M0080-M0100, M1040-M1055, M1500, M1510, M2004, M2015, M2300-M2410, M2430-M2440, M0903, M0906

    Transferred to an inpatient facility—patient not
    discharged from an agency
    Transferred to an inpatient facility—patient
    discharged from agency

Discharge from Agency — Not to an Inpatient Facility

    Death at home-- M0080-M0100, M0903, M0906
    Discharge from agency---------------------------------- M0080-M0100, M1040-M1055, M1230, M1242, M1306-M1350, M1400-M1620, M1700-M1720, M1740, M1745, M1800-M1890, M2004, M2015-M2030, M2100-M2110, M2300-M2420, M0903, M0906

Items to be Used at Specific Time Points$_2$

Start of Care --------------------------------- Start of care—further visits planned	M0010-M0030, M0040- M0150, M1000-M1036, M1100-M1242, M1300-M1302, M1306, M1308-M1324, M1330-M1350, M1400, M1410, M1600-M1730, M1740-M1910, M2000, M2002, M2010, M2020-M2250
Resumption of Care --------------------- Resumption of care (after inpatient stay)	M0032, M0080-M0110, M1000-M1036, M1100-M1242, M1300-M1302, M1306, M1308-M1324, M1330-M1350, M1400, M1410, M1600-M1730, M1740-M1910, M2000, M2002, M2010, M2020-M2250

Follow-Up ------------------------------------
    Recertification (follow-up) assessment
    Other follow-up assessment
	M0080-M0100, M0110, M1020-M1030, M1200, M1242, M1306, M1308, M1322-M1324, M1330-M1350, M1400, M1610, M1620, M1630, M1810-M1860, M2030, M2200

Items to be Used at Specific Time Points₃

Transfer to an Inpatient Facility ---------
Transferred to an inpatient facility –
patient not discharged from an agency

M0080-M0100, M1040-M1055, M1500, M1510, M2004, M2015, M2300-M2410, M2430-M2440, M0903, M0906

Transferred to an inpatient facility –
patient discharged from agency

Discharge from Agency -- Not to an Inpatient Facility

Death at home ------------------------------------
Discharge from agency ------------------------

M0080-M0100, M0903, M0906
M0080-M0100, M1040-M1055, M1230, M1242, M1306-M1350, M1400-M1620, M1700-M1720, M1740, M1745, M1800-M1890, M2004, M2015-M2030, M2100-M2110, M2300-M2420, M0903, M0906

OASIS Regulation Resources

COMPREHENSIVE ASSESSMENT REQUIREMENTS FOR MEDICARE-APPROVED HHAS

PATIENT CLASSIFICATION/PAYOR	Does OASIS Apply?	Comprehensive Assessments Only Excluding OASIS	Timing of Follow-up Comprehensive Assessment
SKILLED Medicare (traditional fee-for-service) Medicare (HMO/Managed Care) Medicaid (traditional fee-for-service) Medicaid (HMO/Managed Care)	Yes	NA	Day 56-60²

SKILLED
Non-Medicare/Non-Medicaid:
  Workers' Compensation
  Title Programs
  Other Government
  Private Insurance
  Private HMO/Managed Care
  Self-pay; other; unknown
	No³	Yes	Anytime after SOC assessment up to day 60; subsequent Followup assessment must be within 60 days 4

PERSONAL CARE ONLY
Medicaid (traditional fee-for-service)
Medicaid (HMO/Managed Care)
Waiver service or HH aide services
  Without skilled services
Non-Medicaid:
  Workers' Compensation
  Title Programs
  Other Government
  Private Insurance
  Private HMO/Managed Care
  Self-pay; other; unknown
	No	Yes	Anytime after SOC assessment up to day 60; subsequent Followup assessment must be within 60 days

OASIS EXCLUDED			

OASIS ASSESSMENT REFERENCE SHEET

RFA * Type	RFA Description	Assessment Completed	Locked Date	Submission Timing
01	SOC - further visits planned	Within 5 calendar days after the SOC Date (SOC = Day 0)	Effective 6/21/2006 No required lock date	Effective 6/21/2006 Transmission required within 30 calendar days of completing the assessment (M0090)
03	ROC - after inpatient stay	Within 2 calendar days of the facility discharge date or knowledge of pt's return home		
04	Recertification - F/U	The last 5 days of every 60 days, i.e., days 56-60 of the current 60-day period.		
05	Other F/U	Complete assessment within 2 calendar days of identification of		

www.cms.hhs.gov/OASIS/Downloads/patientclassificationtable.pdf

www.qtso.com/download/hha/OASIS_Ref_Sheet.07.19.06.pdf

OASIS Regulation Resources (cont.)

3784   Federal Register / Vol. 64, No. 15 / Monday, January 25, 1999 / Rules and Regulations

Conditions of Participation:
The Comprehensive Assessment of Patients

OASIS Collection Regulation – published January 1999

Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary.

(a) Standard: Initial assessment visit.
(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.
(2) When rehabilitation therapy service (speech language pathology, physical therapy, or occupational therapy) is the only service ordered by the physician, and if the need for that service establishes program eligibility, the initial assessment visit may be made by the appropriate rehabilitation skilled professional.
(b) Standard: Completion of the comprehensive assessment.

assessment if the need for occupational therapy established program eligibility.
(c) Standard: Drug regimen review. The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.
(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the a
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date;
(2) W

www.cms.hhs.gov/OASIS/Downloads/collection.pdf

Type of Episode or Adjustment	OASIS Assessment: M0100 & M0825* Response Selection	Comments
	OASIS CONSIDERATIONS FOR MEDICARE PPS PATIENTS revised August, 2004	
1. PPS Start-up for new home health patients	Start of Care: (M0100) RFA 1 and (M0825) select 0-No, 1-Yes, or NA

All new Medicare patients after October 1, 2000: All applicable Medicare patients accepted for care on or after October 1 will be assessed according to the established time points at 42 CFR 484.55, i.e., a patient whose start of care date is October 15 would be re-assessed for the need to continue services for another certification period during the last 5 days of the current 60-day certification period. In this example, the follow-up assessment would be conducted during the period 12/9/04 through 12/13/04. | OASIS data elements are not required for Private Pay individuals effective December 2003.

Requirements for non-Medicare patients are found in S&C Memorandum 04-26. |
| 2. a) First 60-day episode. | Start of Care: | |

www.cms.hhs.gov/OASIS/08_OASISPPS.asp#TopOfPage

CMS Q&As – by Category

CMS OASIS Q&As 8/07 will be archived at:
http://www.cms.hhs.gov/OASIS/09_HHAQA.asp#TopOfPage

CMS OCCB Q&As

Updates planned Quarterly

All existing OCCB Q&As added to CMS Q&As at www.qtso.com Website 09/09

www.oasiscertificate.org
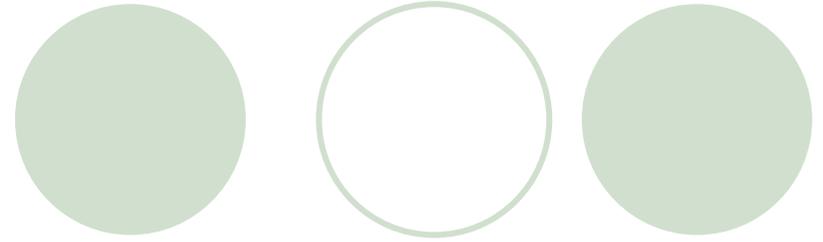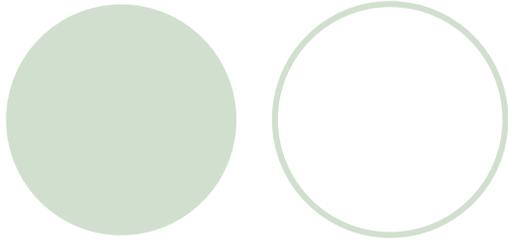
OASIS - C

Living Arrangements

Living Arrangements Domain
Patient Living Situation$_1$

- **Replaced 6 Oasis-B1 items collected at SOC/ROC:**
  - ○ (M0300) Current Residence:
  - ○ (M0340) Patient Lives With:
  - ○ (M0350) Assisting Person(s) Other than Home Care Agency Staff
  - ○ (M0360) Primary Caregiver
  - ○ (M0370) How Often does the patient receive assistance from the primary caregiver?
  - ○ (M0380) Type of Primary Caregiver Assistance
- **With 3 New Items collected at SOC/ROC**370

Patient Living Situation$_2$

First item: (M1100) Patient Living Situation:
Which of the following best describes the patient's residential circumstance and availability of assistance? (Check one box only.)

Living Arrangement	Availability of Assistance				
	Around the clock	Regular Daytime	Regular Nighttime	Occasional/ short-term assistance	No assistance available
a. Patient lives alone	☐ 01	☐ 02	☐ 03	☐ 04	☐ 05
b. Patient lives with other person(s) in the home	☐ 06	☐ 07	☐ 08	☐ 09	☐ 10
c. Patient lives in congregate situation (e.g. assisted living)	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15

Living Arrangements Domain
Patient Living Situation$_3$

- **(M1100) Patient Living Situation**
- To select the appropriate response:
  - First, determine living arrangement – whether the patient lives alone, in a home with others, or in a congregate setting;
  - Second, determine availability of assistance
  - how frequently caregiver(s) are in the home and available to provide assistance
- **Review guidance in the manual to become familiar with the definitions**

OASIS-C

Sensory Status
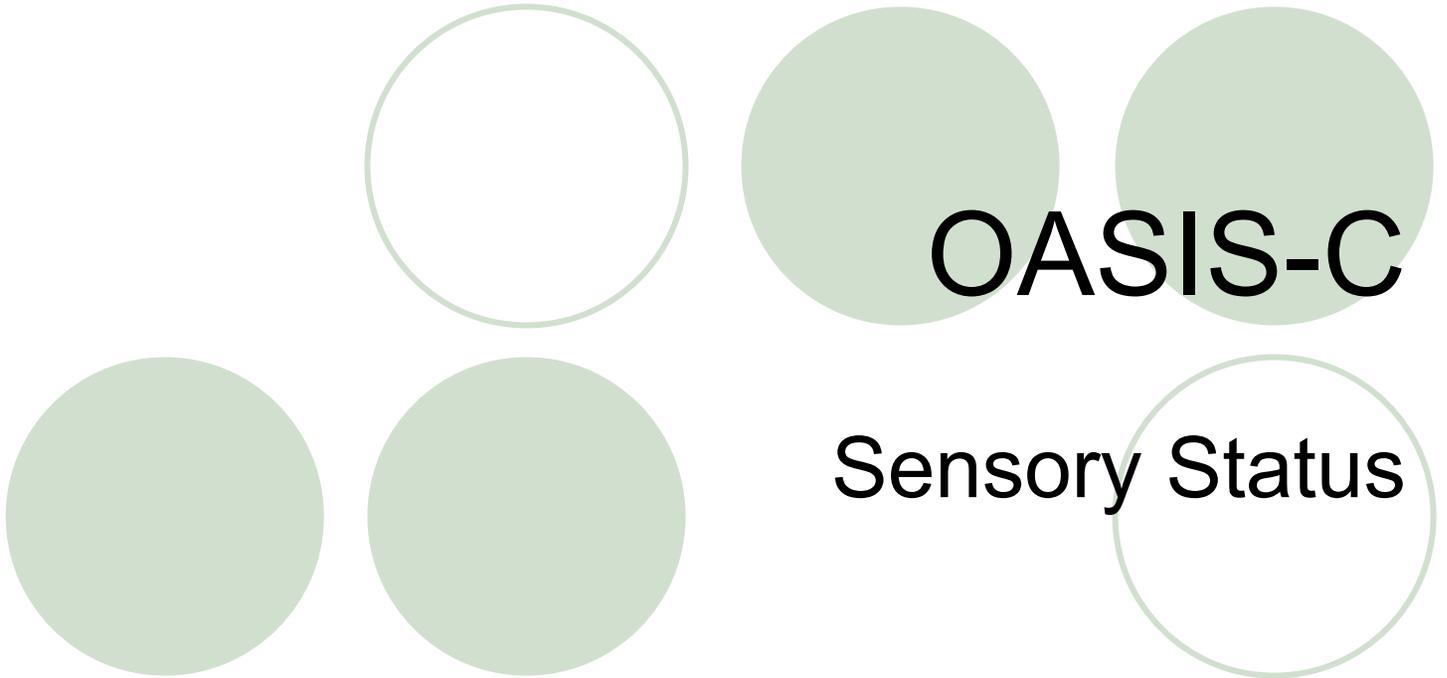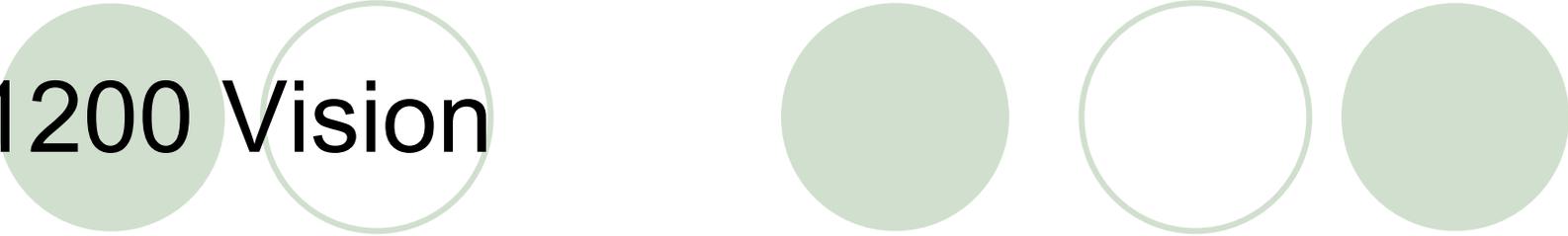
M1200 Vision

- **(M1200) Vision** (with corrective lenses if the patient usually wears them):

  ☐ 0 - Normal vision: sees adequately in most situations; can see medication labels, newsprint.

  ☐ 1 - Partially impaired: cannot see medication labels or newsprint, but <u>can</u> see obstacles in path, and the surrounding layout; can count fingers at arm's length.

  ☐ 2 - Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive.

M1210 Hearing
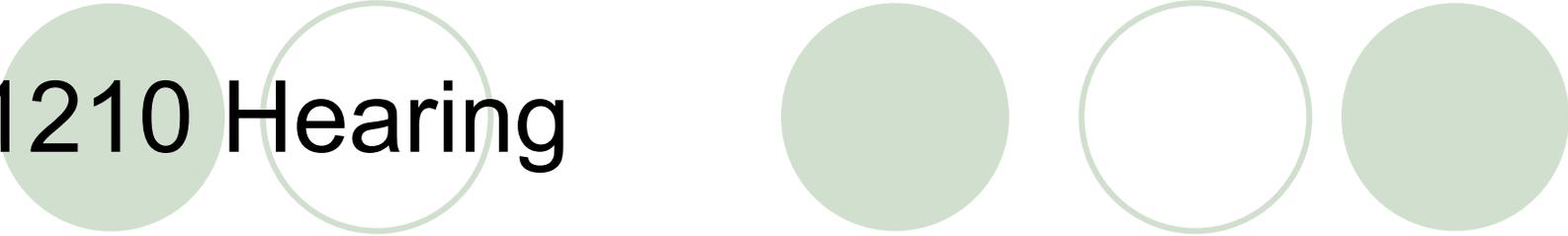
- **(M1210) Ability to Hear** (with hearing aid or hearing appliance if normally used):

  ☐   0   -   Adequate: hears normal conversation without difficulty.

  ☐   1   -   Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly.

  ☐   2   -   Severely Impaired: absence of useful hearing.

  ☐   UK   -   Unable to assess hearing.

M1220 Understanding Verbal Content

- **(M1220) Understanding of Verbal Content** in patient's   own language (with hearing aid or device if used):

  ☐   0   - Understands: clear comprehension without cues or repetitions.

  ☐   1   - Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand.

  ☐   2   - Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.

  ☐   3   - Rarely/Never Understands

  ☐   UK - Unable to assess understanding.

M1230 Speech & Oral (Verbal) Expression of Language$_1$

- **(M1230) Speech and Oral (Verbal) Expression of Language** (in patient's own language):

  - ☐ 0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.

  - ☐ 1 - Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).

  - ☐ 2 - Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.

  - ☐ 3 - Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.

  - ☐ 4 - <u>Unable</u> to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (e.g., speech is nonsensical or unintelligible).

  - ☐ 5 - Patient nonresponsive or unable to speak.

M1230 Speech & Oral (Verbal) Expression of Language$_2$
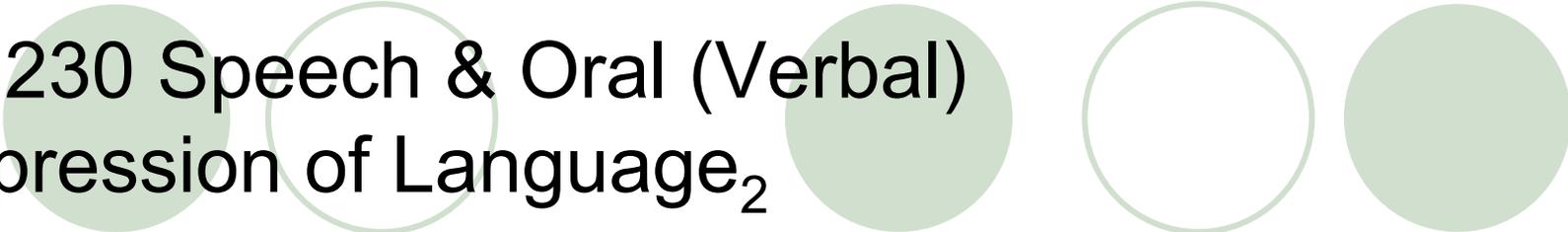
- **(M1230)   Speech and Oral (Verbal) Expression of Language** (in patient's own language):

  ☐ 0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.

  ☐ 1 - Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).

  ☐ 2 - Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.

M1230 Speech & Oral (Verbal) Expression of Language$_3$

- **(M1230)   Speech and Oral (Verbal) Expression of Language** (in patient's own language):

  ☐ 3 - Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.

  ☐ 4 - <u>Unable</u> to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (e.g., speech is nonsensical or unintelligible).

  ☐ 5 - Patient nonresponsive or unable to speak

M1240 Pain Assessment

- **(M1240)** Has this patient had a formal **Pain Assessment** using a standardized pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?

  ☐ 0 - No standardized assessment conducted

  ☐ 1 - Yes, and it does not indicate severe pain

  ☐ 2 - Yes, and it indicates severe pain

Pain Assessment$_1$
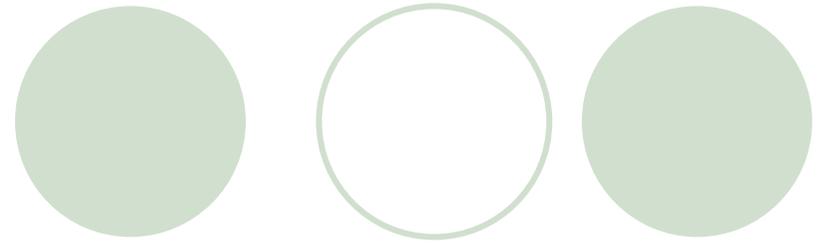
- Deleted - (M0430) Intractable Pain

- Added **(M1240) Has this patient had a formal Pain Assessment** using a standardized pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?

  - ☐ 0 - No standardized assessment conducted

  - ☐ 1 - Yes, and it does not indicate severe pain

  - ☐ 2 - Yes, and it indicates severe pain

Pain Assessment$_2$
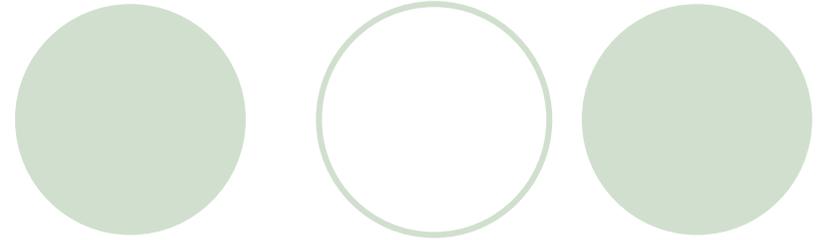
M1240 – Pain Assessment

- **CMS does not mandate pain assessment or endorse a specific tool**, but tool selected must:
  - Be conducted according to instructions
  - Be appropriate for the patient
- "Standardized tool" is one that includes a standard response scale (e.g., 0-10 pain scale)
- "Severe pain" is defined according to the scoring system for the standardized tool being used
- See links to resources in Chapter 5 of Guidance Manual

M1242 Frequency of Pain Interfering

- **(M1242) Frequency of Pain Interfering** with patient's activity or movement:

  ☐ 0 - Patient has no pain

  ☐ 1 - Patient has pain that does not interfere with activity or

  movement

  ☐ 2 - Less often than daily

  ☐ 3 - Daily, but not constantly

  ☐ 4 - All of the time
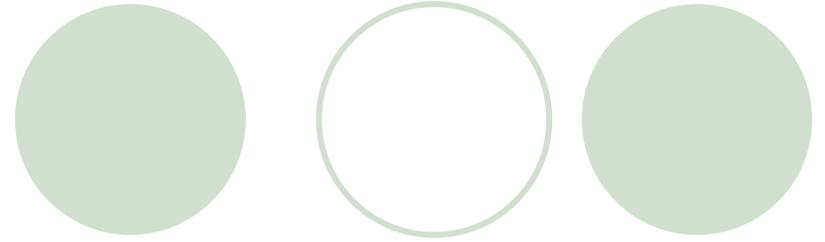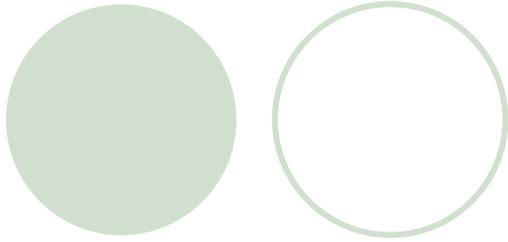
OASIS - C

Integumentary Status
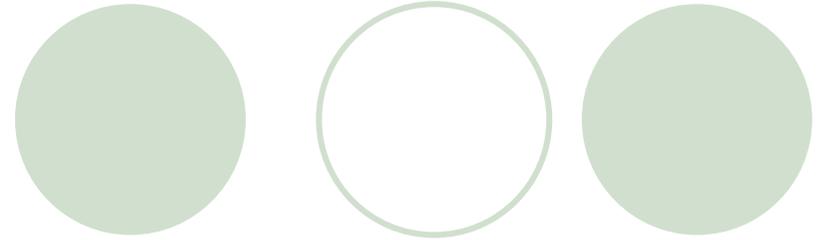
Pressure Ulcers

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*

- **(M1308) Current Number of Pressure Ulcers Table** – *Revised*

- **(M1310/M1312/M1314) Pressure Ulcer Length, Width & Depth** - *NEW*

Pressure Ulcer Risk Assessment[1]

- **(M1300) Pressure Ulcer Assessment:** Was this patient assessed for **Risk of Developing Pressure Ulcers**?

  ☐ 0 - No assessment conducted **[*Go to M1306*]**

  ☐ 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

Pressure Ulcer Risk Assessment$_2$

- **(M1302) Does this patient have a Risk of Developing Pressure Ulcers**?

    ☐   0 -   No

    ☐   1 -   Yes

    – *If using standardized tool, use tool's scoring parameters to identify risk*

    – *If using clinical factors, clinician or agency must define what constitutes risk*

Pressure Ulcers – Stage II or Higher[1]

- **(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

  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

Pressure Ulcers – Stage II or Higher$_2$

- **Clinicians will need to study and refer to Chapter 3** in the guidance manual to know how to respond to M1306 and M1308

- **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**

Unhealed Pressure Ulcers[1]

- **(M1307)** The **Oldest Non-epithelialized Stage II Pressure Ulcer** that is present at discharge

  ☐ 1   -   Was present at the most recent SOC/ROC assessment

  ☐ 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$_2$

- **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

- 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

Pressure Ulcer Count[1]

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

Stage description – unhealed pressure ulcers	Column 1 Complete at SOC/ROC/FU & D/C — Number Currently Present	Column 2 Complete at FU & D/C — 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	___	___

Pressure Ulcer Count$_2$

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

- 2nd column at FU and DC identifies ulcers that were present on admission

  – Tracks whether an ulcer developed during a quality episode

Pressure Ulcer Count$_3$

- **(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-...ter.	——	——
... Full thickness tissue loss. ...heous 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 ...g.	——	——
...ble: Known or likely but unstageable ...n-removable dressing or device	——	——
...ble: Known or likely but unstageable ...verage of wound bed by slough and/or	——	——
d.3 Unstageable: Suspected deep tissue injury in evolution.	——	——

Pressure Ulcer Count$_4$

- **(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. fat may be visible but bone, scles are not exposed. Slough nt but does not obscure the e 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	____	____
Known or likely but unstageable novable dressing or device	____	____
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.	____	____

395

Pressure Ulcer Dimensions[1]

M1310, M1312 and M1314 – Pressure Ulcer Length, Width and Depth

- Reports dimensions of pressure ulcer **with the largest surface area** that is:
  - **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

Pressure Ulcer Dimensions$_2$

M1310, M1312 and M1314 – Pressure Ulcer Length, Width and Depth

- Record dimensions of the pressure ulcer with the largest surface area in centimeters
  - **Length** = longest head to toe
  - **Width** = greatest width perpendicular to length
  - **Depth** = from visible surface to deepest area
- Chapter 3 of OASIS-C Guidance Manual has
  - Further instructions and pictures
- Clinicians **must become familiar with the manual instructions** to respond accurately

Pressure Ulcer Healing Status[1]

- **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

Pressure Ulcer Healing Status$_2$

- **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**
  - ○ **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**
  - ○ **Response 3 - Not Healing, for a Stage III or IV pressure ulcer if the wound has $\geq$25% necrotic or avascular tissue**

- **Refer to the OASIS-C Guidance Manual and the WOCN OASIS Guidance Document**
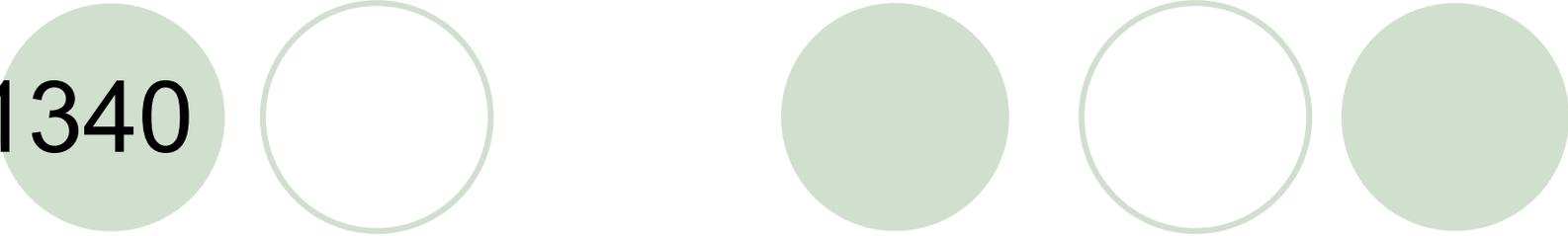
M1340

- **(M1340)** Does this patient have a **Surgical Wound?**

  ☐ 0 - No   **[*Go to M1350*]**

  ☐ 1 - Yes, patient has at least one (observable) surgical wound

  ☐ 2 - Surgical wound known but not observable due to non-removable dressing **[*Go to M1350*]**
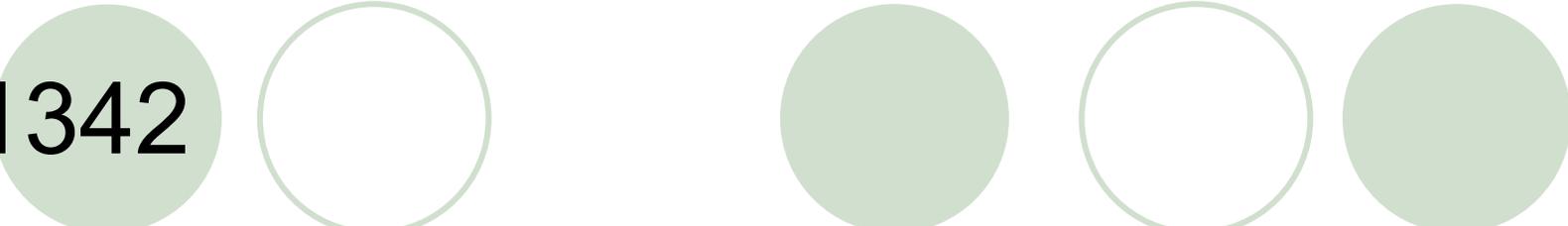
M1342

- **(M1342)   Status of Most Problematic (Observable) Surgical Wound:**

  ☐ 0 - Newly epithelialized

  ☐ 1 - Fully granulating

  ☐ 2 - Early/partial granulation

  ☐ 3 - Not healing
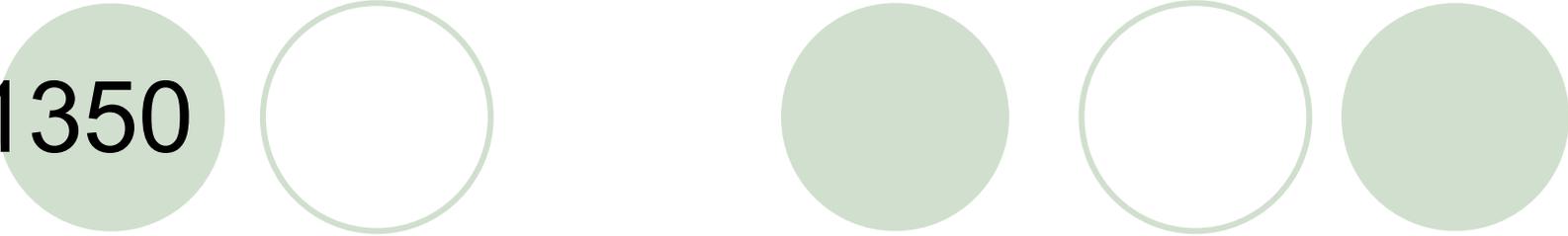
M1350

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

  ☐ 0 - No
  ☐ 1 - Yes
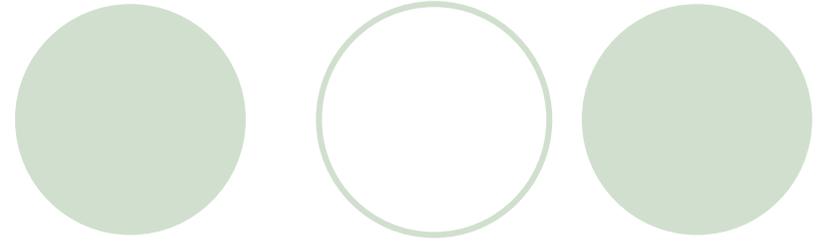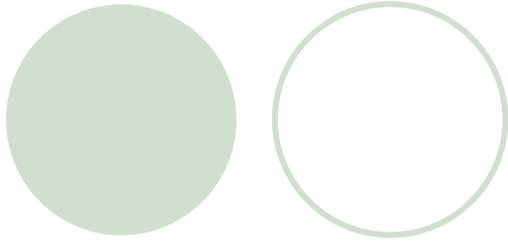
OASIS - C

Respiratory Status

M1400 Dyspnea
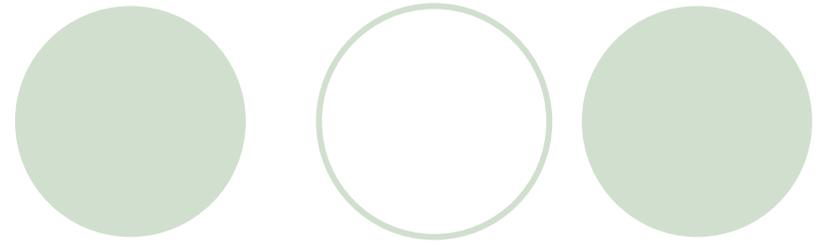
- **(M1400)** When is the patient dyspneic or noticeably **Short of Breath**?

  ☐ 0 - Patient is not short of breath

  ☐ 1 - When walking more than 20 feet, climbing stairs

  ☐ 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)

  ☐ 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation

  ☐ 4 - At rest (during day or night)

M1410 Respiratory Treatments

- **(M1410) Respiratory Treatments** utilized at home: **(Mark all that apply.)**

  ☐ 1 - Oxygen (intermittent or continuous)

  ☐ 2 - Ventilator (continually or at night)

  ☐ 3 - Continuous / Bi-level positive airway pressure

  ☐ 4 - None of the above
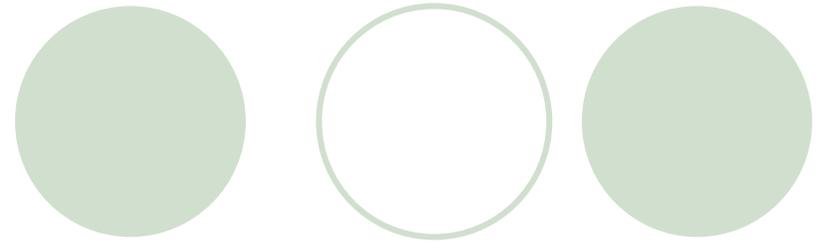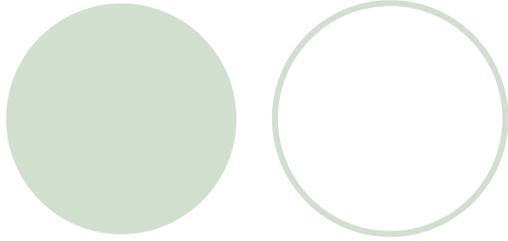
OASIS - C

Cardiac Status

Heart Failure Symptoms[1]

- **Two new items:**
  - (M1500) Symptoms in Heart Failure Patients
  - (M1510) Heart Failure Symptom Follow-up
  - Collected at Transfer and DC
  - Time Period under consideration – at or since the previous OASIS Assessment
  - Only for patients with a diagnosis of heart failure in OASIS
  - Used for quality measurement

Cardiac Status Domain
Heart Failure Symptoms$_2$

- **(M1500) Symptoms in Heart Failure Patients:** If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at any point since the previous OASIS assessment?

  ☐   0   -   No   **[*Go to M2004 at TRN; Go to M1600 at DC*]**

  ☐   1   -   Yes

  ☐   2   -   Not assessed   **[*Go to M2004 at TRN; Go to M1600 at DC*]**

  ☐   NA   -   Patient does not have diagnosis of heart failure **[*Go to M2004 at TRN; Go to M1600 at DC*]**

Cardiac Status Domain
Response to Heart Failure Symptoms

(M1510) Heart Failure Follow-up:

- **Asks clinician to identify ALL actions that have been taken to respond to heart failure symptoms**
  - ○ **Patient's physician (or other primary care practitioner) contacted the same day**
  - ○ **Patient advised to get emergency treatment (e.g., call 911 or go to emergency room)**
  - ○ **Implemented physician-ordered patient-specific established parameters for treatment**
  - ○ **Patient education or other clinical interventions**
  - ○ **Obtained change in care plan orders (e.g., increased monitoring by agency, change in visit frequency, telehealth, etc.)**
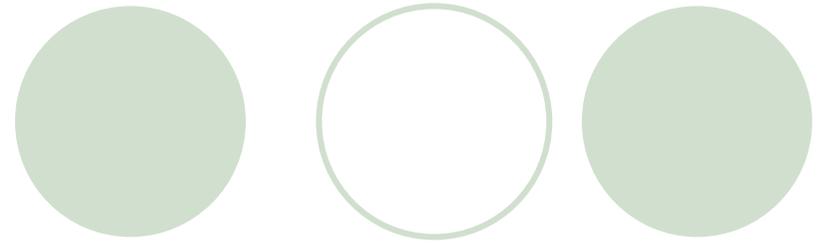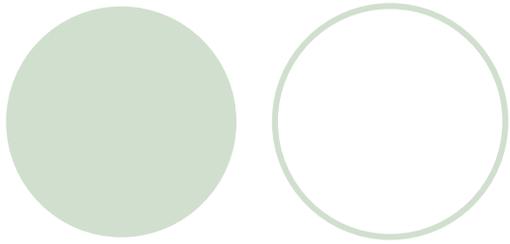
OASIS - C

Elimination Status

M1600 UTI Treatment

- **(M1600)** Has this patient been treated for a **Urinary Tract Infection** in the past 14 days?

  ☐ 0 - No

  ☐ 1 - Yes

  ☐ NA - Patient on prophylactic treatment

  ☐ UK - Unknown **[Omit "UK" option on DC]**

M1610 Urinary Incontinence or Urinary Catheter Presence

- **(M1610)   Urinary Incontinence or Urinary Catheter Presence:**

  ☐ 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) **[*Go to M1620*]**

  ☐ 1 - Patient is incontinent

  ☐ 2 - Patient requires a urinary catheter (i.e., external,indwelling, intermittent, suprapubic) **[*Go to M1620*]**

M1615 When Urinary Incontinence Occurs

- **(M1615)   When** does **Urinary Incontinence** occur?

  ☐ 0 - Timed-voiding defers incontinence

  ☐ 1 - Occasional stress incontinence

  ☐ 2 - During the night only

  ☐ 3 - During the day only

  ☐ 4 - During the day and night

M1620 Bowel Incontinence Frequency

- **(M1620) Bowel Incontinence Frequency:**
  - ☐ 0 - Very rarely or never has bowel incontinence
  - ☐ 1 - Less than once weekly
  - ☐ 2 - One to three times weekly
  - ☐ 3 - Four to six times weekly
  - ☐ 4 - On a daily basis
  - ☐ 5 - More often than once daily
  - ☐ NA - Patient has ostomy for bowel elimination
  - ☐ UK - Unknown **[Omit "UK" option on FU, DC]**

M1630 Ostomy for Bowel Elimination

- **(M1630) Ostomy for Bowel Elimination:** Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay, <u>or</u> b) necessitated a change in medical or treatment regimen?

  ☐ 0 - Patient does <u>not</u> have an ostomy for bowel elimination.

  ☐ 1 - Patient's ostomy was <u>not</u> related to an inpatient stay and did <u>not</u>

  necessitate change in medical or treatment regimen.

  ☐ 2 - The ostomy <u>was</u> related to an inpatient stay or did necessitate

  change in medical or treatment regimen.
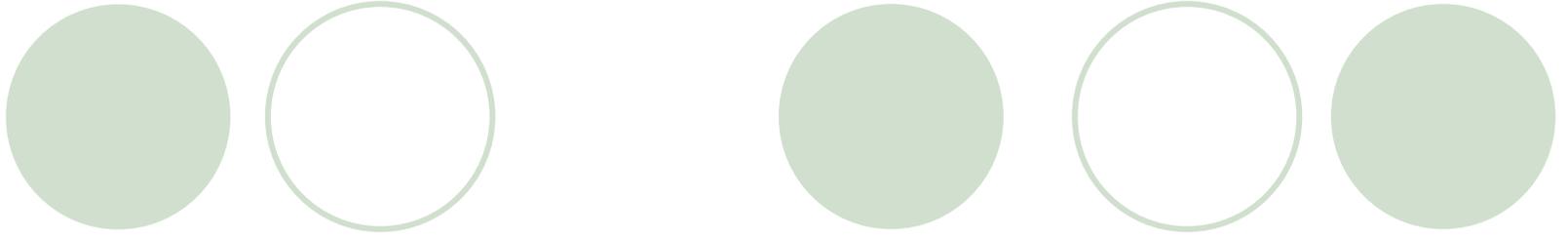
OASIS - C

Neuro/ Emotional/ Behavioral Status

M1700 Cognitive Functioning

- **(M1700) Cognitive Functioning:** Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

  - ☐ 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.

  - ☐ 1 - Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.

  - ☐ 2 - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.

  - ☐ 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.

  - ☐ 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

M1710 When Confused

- **(M1710) When Confused (Reported or Observed Within the Last 14 Days):**

  ☐ 0 - Never

  ☐ 1 - In new or complex situations only

  ☐ 2 - On awakening or at night only

  ☐ 3 - During the day and evening, but not constantly

  ☐ 4 - Constantly

  ☐ NA - Patient nonresponsive

M1720 When Anxious

- **(M1720) When Anxious (Reported or Observed Within the Last 14 Days):**
  - ☐ 0   - None of the time
  - ☐ 1   - Less often than daily
  - ☐ 2   - Daily, but not constantly
  - ☐ 3   - All of the time
  - ☐ NA - Patient nonresponsive

Neuro/ Emotional/ Behavioral Status Domain
Depression Screening$_1$

(M1730) Depression Screening

- Asks if the patient has been screened for depression, using a **standardized depression screening tool**

- Allows clinician to document **if assessed**:

  ○ not assessed

  ○ assessed using the PHQ-2$^©$ scale*

  ○ assessed different standardized assessment

- Allows clinician to document **results** of screening if conducted

420

Neuro/ Emotional/ Behavioral Status Domain
Depression Screening$_2$

PHQ-2© scale. Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems"?

PHQ-2© Pfizer	Not at all 0 - 1 day	Several days 2 - 6 days	More than half of the days 7 – 11 days	Nearly every day 12 – 14 days	N/A Unable to respond
a) Little interest or pleasure in doing things	☐0	☐1	☐2	☐3	☐na
b) Feeling down, depressed, or hopeless?	☐0	☐1	☐2	☐3	☐na

Neuro/ Emotional/ Behavioral Status Domain
Depression Screening$_3$

- Select "0" if a **standardized** depression screening was not conducted

- Select "1" if the PHQ-2© is completed when responding to the question

- Select "2" if the patient is screened with a different standardized assessment and **need for further evaluation indicated**

- Select "3" if the patient is screened with a different standardized assessment and **<u>no</u> need for further evaluation indicated**

M1740 Cognitive, Behavioral, & Psychiatric Symptoms$_1$

- **(M1740) Cognitive, behavioral, and psychiatric symptoms** that are demonstrated <u>at least once a week</u> (Reported or Observed): **(Mark all that apply.)**

  - ☐ 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required

  - ☐ 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, in-ability to appropriately stop activities, jeopardizes safety through actions

  - ☐ 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.

  - ☐ 4 - Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)

  - ☐ 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)

  - ☐ 6 - Delusional, hallucinatory, or paranoid behavior

  - ☐ 7 - None of the above behaviors demonstrated

M1740 Cognitive, Behavioral, & Psychiatric Symptoms$_2$

- **(M1740) Cognitive, behavioral, and psychiatric symptoms** that are demonstrated <u>at least once a week</u> (Reported or Observed): **(Mark all that apply.)**

☐ 1 - Memory deficit: failure to recognize familiar persons/places,   inability to recall events of past 24 hours, significant memory loss
        so that supervision is required

☐ 2 - Impaired decision-making: failure to perform usual ADLs or IADLs,
        in-ability to appropriately stop activities, jeopardizes safety through
        actions

M1740 Cognitive, Behavioral, & Psychiatric Symptoms$_3$

☐ 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.

☐ 4 - Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)

☐ 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)

☐ 6 - Delusional, hallucinatory, or paranoid behavior

☐ 7 - None of the above behaviors demonstrated

M1745 Frequency of Disruptive Behavior Symptoms

- **(M1745) Frequency of Disruptive Behavior Symptoms (Reported or Observed)** Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.

  ☐ 0 - Never

  ☐ 1 - Less than once a month

  ☐ 2 - Once a month

  ☐ 3 - Several times each month

  ☐ 4 - Several times a week

  ☐ 5 - At least daily

M1750 Psychiatric Nursing

- **(M1750)** Is this patient receiving **Psychiatric Nursing Services** at home provided by a qualified psychiatric nurse?

  ☐ 0 - No

  ☐ 1 - Yes
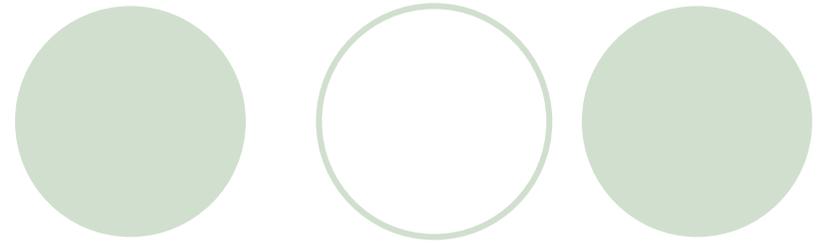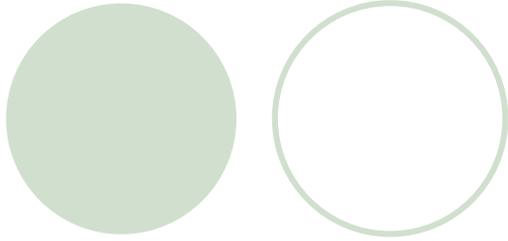
OASIS - C

ADLs/IADLs

ADL/ IADL Domain
Major Changes
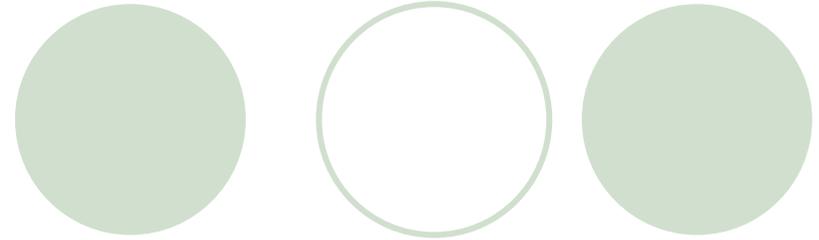
- **Deletions:**
  - Transportation, Shopping, Housekeeping, Laundry
  - Prior status 14 days before the start/resumption of care
- **Additions:**
  - Prior Status grid
  - Toileting Hygiene and Fall Risk Assessment
- **Revisions:**
  - Wording changes (safely) to numerous items
  - New response scales (bathing, ambulation)
  - Bathing now includes ability to perform the tub/shower transfer
  - Toileting now includes transferring on and off the toilet
  - Medication items now in their own domain

M1800 Grooming
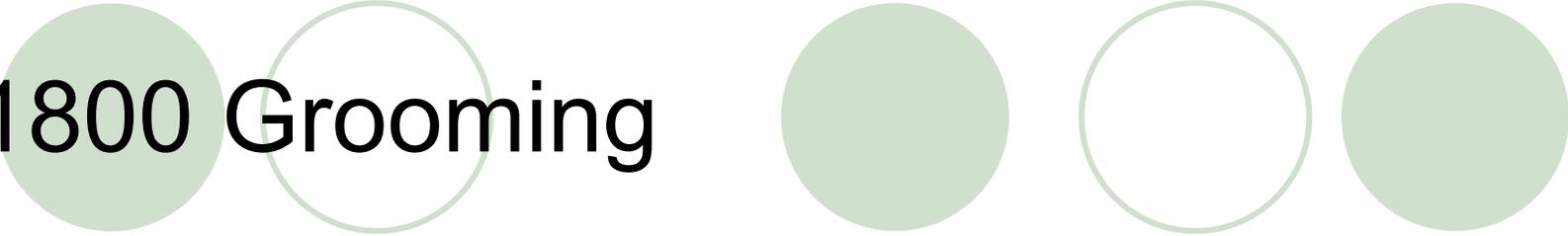
- **(M1800) Grooming:** Current ability to tend safely to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care).

  ☐ 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods.

  ☐ 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.

M1810 Upper Body Dressing

- **(M1810)** Current **Ability to Dress Upper Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

  ☐ 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.

  ☐ 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.

  ☐ 2 - Someone must help the patient put on upper body clothing.

  ☐ 3 - Patient depends entirely upon another person to dress the upper body.

M1820 Lower Body Dressing

- **(M1820)** Current **Ability to Dress <u>Lower</u> Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

  ☐ 0 - Able to obtain, put on, and remove clothing and shoes
  without assistance.

  ☐ 1 - Able to dress lower body without assistance if clothing and
  shoes are laid out or handed to the patient.

  ☐ 2 - Someone must help the patient put on under-garments,
  slacks, socks or nylons, and shoes.

  ☐ 3 - Patient depends entirely upon another person to dress lower
  body.

M1830 Bathing$_1$

- **(M1830) Bathing:** Current ability to wash entire body safely. **Excludes** grooming (washing face, washing hands, and shampooing hair).

    ☐ 0 - Able to bathe self in <u>shower or tub</u> independently, including getting in and out of tub/shower.

    ☐ 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.

    ☐ 2 - Able to bathe in shower or tub with the intermittent assistance of another person:
    (a) for intermittent supervision or encouragement or reminders, <u>OR</u>
    (b) to get in and out of the shower or tub, <u>OR</u>
    (c) for washing difficult to reach areas.

    ☐ 3 - Able to participate in bathing self in shower or tub, <u>but</u> requires presence of another person throughout the bath for assistance or supervision.

    ☐ 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.

    ☐ 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.

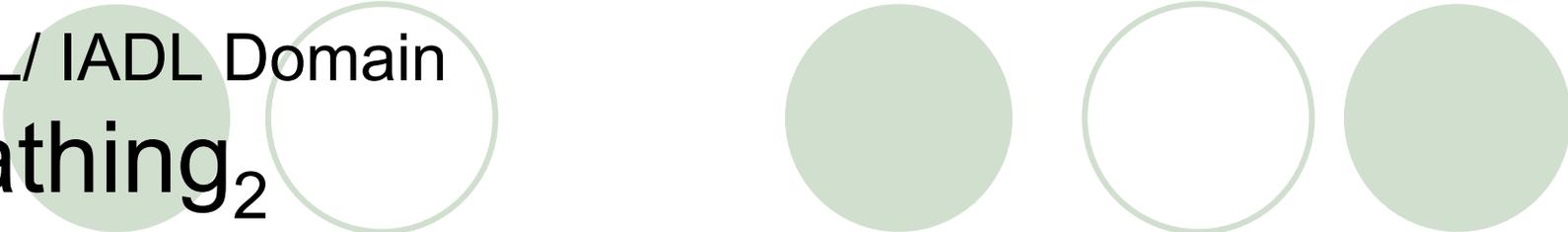   ☐ 6 - Unable to participate effectively in bathing and is bathed totally by another person.

Bathing$_1$

- **(M1830) Bathing: Current ability to wash entire body safely. <u>Excludes</u> grooming (washing face, washing hands, and shampooing hair).**

  - ☐ **0 - Able to bathe self in shower or tub independently, including getting in and out of tub/shower.**

  - ☐ **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.

  - ☐ **2 - Able to bathe in shower or tub with the intermittent assistance of another person:**
    (a) for intermittent supervision or encouragement reminders, OR
    (b) to get in and out of the shower or tub, OR
    (c) for washing difficult to reach areas.

ADL/ IADL Domain
Bathing$_2$

- **(M1830) Bathing** (continued)

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

  - ☐ **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.**

  - ☐ **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.**

M1840 Toilet Transferring

- **(M1840) Toilet Transferring:** Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.

  ☐ 0 - Able to get to and from the toilet and transfer independently with or without a device.

  ☐ 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.

  ☐ 2 - Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).

  ☐ 3 - Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.

  ☐ 4 - Is totally dependent in toileting.

ADL/ IADL Domain
Toilet Transferring

- **(M1840) Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.**
  - ☐ **0 - Able to get to and from the toilet and transfer independently with or without a device.**
  - ☐ **1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.**
  - ☐ **2 - Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).**
  - ☐ **3 - Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.**
 - ☐ **4 - Is totally dependent in toileting.**

ADL/ IADL Domain
Toileting Hygiene$_1$

- **(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.**

  - ☐ **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.**

  - ☐ **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.**

Toileting Hygiene$_2$
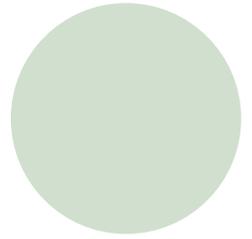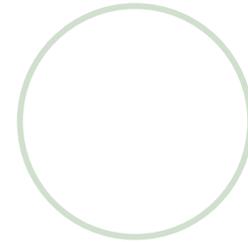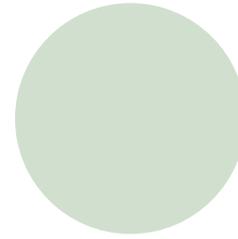
(M1845) Toileting Hygiene

- "Assistance" refers to assistance from another person by verbal cueing/ reminders, supervision, and/or stand-by or hands-on assistance

- If patient can participate in hygiene and/or clothing management, but needs some assist with either or both activities, select response 2

M1850 Transferring

- **(M1850) Transferring:** Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

  ☐ 0 - Able to independently transfer.

  ☐ 1 - Able to transfer with minimal human assistance or with use of an assistive device.

  ☐ 2 - Able to bear weight and pivot during the transfer process but unable to transfer self.

  ☐ 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.

  ☐ 4 - Bedfast, unable to transfer but is able to turn and position self in bed.

  ☐ 5 - Bedfast, unable to transfer and is unable to turn and position self.

ADL/ IADL Domain
Ambulation/Locomotion

- **(M1860)   Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.**
  New response options:
  1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings
  2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces

M1870 Feeding or Eating₁

- **(M1870) Feeding or Eating:** Current ability to feed self meals and snacks safely. Note: This refers only to the process of <u>eating</u>, <u>chewing</u>, and <u>swallowing</u>, <u>not preparing</u> the food to be eaten.

  ☐ 0 - Able to independently feed self.

  ☐ 1 - Able to feed self independently but requires:
      (a) meal set-up; <u>OR</u>
      (b) intermittent assistance or supervision from another person; <u>OR</u>
      (c) a liquid, pureed or ground meat diet.

  ☐ 2 - <u>Unable</u> to feed self and must be assisted or supervised through-out the meal/snack.

  ☐ 3 - Able to take in nutrients orally <u>and</u> receives supplemental nutrients through a nasogastric tube or gastrostomy.

  ☐ 4 - <u>Unable</u> to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.

  ☐ 5 - Unable to take in nutrients orally or by tube feeding.

442

M1870 Feeding or Eating$_2$

- **(M1870) Feeding or Eating:** Current ability to feed self meals and snacks safely. Note: This refers only to the process of <u>eating</u>, <u>chewing</u>, and <u>swallowing</u>, <u>not preparing</u> the food to be eaten.

  ☐ 0 - Able to independently feed self.

  ☐ 1 - Able to feed self independently but requires:
  (a) meal set-up; <u>OR</u>
  (b) intermittent assistance or supervision from another person; <u>OR</u>
  (c) a liquid, pureed or ground meat diet.

M1870 Feeding or Eating$_3$

☐ 2 - <u>Unable</u> to feed self and must be assisted or supervised through-out
   the meal/snack.

☐ 3 - Able to take in nutrients orally <u>and</u> receives supplemental nutrients
   through a nasogastric tube or gastrostomy.

☐ 4 - <u>Unable</u> to take in nutrients orally and is fed nutrients through a
   nasogastric tube or gastrostomy.

☐ 5 - Unable to take in nutrients orally or by tube feeding.

M1880 Plan & Prepare Light Meals

- **(M1880)** Current **Ability to Plan and Prepare Light Meals** (e.g., cereal, sandwich) or reheat delivered meals safely:

  ☐ 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; <u>OR</u>
  (b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission).

  ☐ 1 - <u>Unable</u> to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.

  ☐ 2 - Unable to prepare any light meals or reheat any delivered meals.

M1890 Telephone Use$_1$

- **(M1890) Ability to Use Telephone:** Current ability to answer the phone safely, including dialing numbers, and <u>effectively</u> using the telephone to communicate.

  ☐ 0 - Able to dial numbers and answer calls appropriately and as desired.

  ☐ 1 - Able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers.

  ☐ 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.

  ☐ 3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation.

  ☐ 4 - <u>Unable</u> to answer the telephone at all but can listen if assisted with equipment.

  ☐ 5 - Totally unable to use the telephone.

  ☐ NA - Patient does not have a telephone.

M1890 Telephone Use₂

- **(M1890) Ability to Use Telephone:** Current ability to answer the phone safely, including dialing numbers, and <u>effectively</u> using the telephone to communicate.

  ☐ 0 - Able to dial numbers and answer calls appropriately and as desired.

  ☐ 1 - Able to use a specially adapted telephone (i.e., large numbers on
       the dial, teletype phone for the deaf) and call essential numbers.

  ☐ 2 - Able to answer the telephone and carry on a normal conversation
       but has difficulty with placing calls.

447

M1890 Telephone Use$_3$

☐ 3 - Able to answer the telephone only some of the time or is

able to carry on only a limited conversation.

☐ 4 - <u>Unable</u> to answer the telephone at all but can listen if

assisted with equipment.

☐ 5 - Totally unable to use the telephone.

☐ NA- Patient does not have a telephone.

ADL/ IADL Domain
Prior ADL/ IADL Functioning$_1$

- Dropped prior status - replaced with grid:

  (M1900) Prior Functioning ADL/ IADL: Indicate the patient's usual ability with everyday activities prior to this current illness, exacerbation, or injury. Check only

Functional Area	Independent	Needed Some Help	Dependent
a. Self-Care (e.g., grooming, dressing, and bathing)	☐0	☐1	☐2
b. Ambulation	☐0	☐1	☐2
c. Transfer	☐0	☐1	☐2
d. Household tasks (e.g., light meal preparation, laundry, shopping)	☐0	☐1	☐2

Collected at SOC/ROC
Used for Risk Adjustment

449

ADL/ IADL Domain
Prior ADL/ IADL Functioning$_2$

- **Guidance Manual provides** definitions of dependence

  - **"Independent"** - patient had the ability to complete the activity by him/herself (with or without assistive devices) without physical or verbal assistance from a helper
  - **"Needed some help"** - patient contributed effort but required help from another person to accomplish the task/activity safely
  - **"Dependent"** - patient was physically and/or cognitively unable to contribute effort toward completion of the task, and the helper must contribute all the effort

- **Refer to the manual** for specific tasks which are included in each functional area

Fall Risk Assessment$_1$

- **(M1910)** Has the patient had a multi-factor **Fall Risk Assessment** (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)?

  ☐ 0 - No multi-factor falls risk assessment conducted.

  ☐ 1 - Yes, and it does not indicate a risk for falls.

  ☐ 2 - Yes, and it indicates a risk for falls.

Select "0" if falls risk assessment:
- *Was not done at all*
- *Was not done using standardized validated multi-factor fall risk tool*
- *Was not done in the assessment time frame*
- *Was not done by the assessing clinician*

ADL/ IADL Domain
Fall Risk Assessment$_2$

- **Multi-factor falls risk assessment**
  - ○ **May be a single standardized, validated comprehensive multi-factor falls risk assessment tool**
  - ○ **May incorporate several tools as long as one of them is standardized and validated**
- **Determining risk level**
  - ○ **Use the scoring parameters specified in the tool to identify if a patient is at risk for falls**
  - ○ **Select response 1 if the standardized response scale rates the patient as no-risk, low-risk or minimal risk**
  - ○ **Select response 2 if the standardized response scale rates the patient as anything above low-risk or minimal risk**
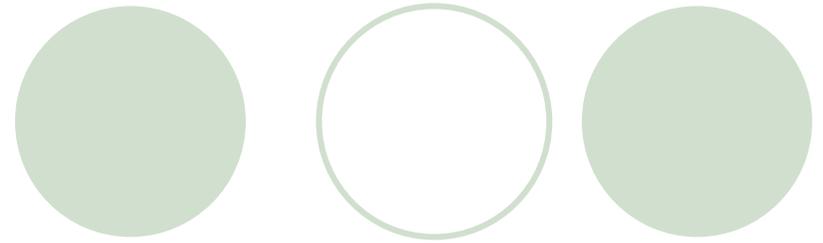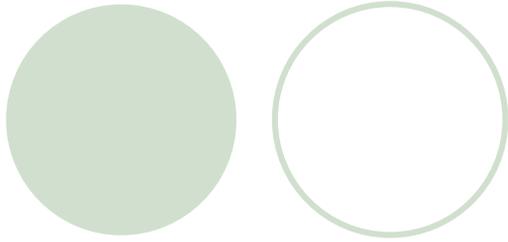
OASIS - C

Medications

Medication Domain
Changes in OASIS-C

Medication items are now in their own domain

- **Deletions**: Items assessing inhalant medications
- **Revisions:**
  - Prior column at SOC/ROC replaced with a single prior functioning grid item
  - Instructions on measuring the "majority of the time" have been revised for items assessing patient independence in managing medications
- **Additions:** Process items reporting implementation of best practices for medication reconciliation and patient/caregiver education

Drug Regimen Review$_1$

- **(M2000) Drug Regimen Review**: Does a **complete drug regimen review** indicate **potential clinically significant medication issues**, e.g., drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance?

  ☐   0   -   Not assessed/reviewed   **[*Go to M2010*]**

  ☐   1   -   No problems found during review   **[*Go to M2010*]**

  ☐   2   -   Problems found during review

  ☐   NA -   Patient is not taking any medications
  [*Go to M2040*]

Collected at SOC/ROC

Medication Domain
Drug Regimen Review$_2$

- "All medications" includes prescribed and over the counter, administered by any route

- Ch 3 of OASIS-C Guidance Manual defines "a problem" for responses 1 and 2 is (med list mismatch, symptoms poorly controlled, patient confused about directions)

- Ch 5 of OASIS-C Guidance Manual has online resources for evaluating drug reactions, side effects, interactions, etc

Medication Follow-Up$_1$

- **(M2002) Medication Follow-up**: Was a physician or the physician-designee contacted within one calendar day to resolve clinically significant medication issues, including reconciliation?

  ☐ 0 - No

  ☐ 1 - Yes

Collected at SOC/ROC

Medication Follow-Up$_2$

- **Clinically significant medication issues** pose a threat to patient health and safety, in the clinician's judgment – examples in the item-by-item guidance in Chapter 3

- **Contact with physician** defined as communication to the physician that appropriately conveys the message of patient status

- **Response "1 – Yes"** should only be selected **if physician responds** to HHA communication

Medication Domain
Medication Follow-Up$_3$

- Portions of the drug regimen review or communication with the physician **may be completed by agency staff other than the clinician responsible for completing the SOC/ROC OASIS**

- Information on drug regimen review findings **must be communicated** to the clinician responsible for the SOC/ROC OASIS assessment

- This **does not violate the one clinician rule** for completion of the assessment

Medication Intervention

- **(M2004) Medication Intervention**: If there were **any clinically significant medication issues since the previous OASIS assessment**, was a physician or physician-designee contacted within one calendar day of the assessment to resolve clinically significant medication issues, including reconciliation?

  ☐   0   -   No

  ☐   1   -   Yes

  ☐   NA   -   No clinically significant medication issues identified since the previous OASIS assessment

Collected at Transfer & Discharge

Medication Domain
High Risk Drug Education$_1$

- **(M2010) Patient/Caregiver High Risk Drug Education:** Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?

  ☐ 0 - No

  ☐ 1 - Yes

  ☐ NA - Patient **not taking** any high risk drugs OR patient/caregiver **fully knowledgeable** about special precautions associated with all high-risk medications.

Collected at SOC/ROC

Medication Domain
High Risk Drug Education$_2$

- High-risk medications
  - Those that have considerable potential for causing significant patient harm when used erroneously
  - As identified by quality organizations (Institute for Safe Medication Practices and JCAHO High Alert Medication List. Beer's Criteria, etc)
  - See Ch 5 of the Guidance Manual for links

- Clinicians may collaborate to ensure patient/ caregiver receives education on high risk meds

Medication Domain
Drug Education Intervention$_1$

- **(M2015) Patient/Caregiver Drug Education Intervention**: Since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, drug reactions, and side effects and how and when to report problems that may occur?

  ☐   0   -   No

  ☐   1   -   Yes

  ☐   NA   -   Patient not taking any drugs

Collected at Transfer & Discharge

Medication Domain
Drug Education Intervention$_2$

- Effective, safe management of medications includes:
  - Knowledge of **effectiveness**,
  - Potential **side effects** and **drug reactions**, and
  - **When to contact** the appropriate care provider
- Select "1 – Yes" only if if instruction including all 3 components was provided since the last OASIS assessment visit

Medication Domain
Management of Oral Medications₁

(M2020) Management of Oral Medications

(M2030) Management of Injectable Medications

- **No prior status columns**

- **Now references ability to take all medications reliably and safely at all times**

    ○ **If ability varies between the meds, report medication that requires the most assistance**

- **Ch 3 now addresses the use of "planner devices"**

    ○ **If patient sets up "planner device" and is able to take meds at correct dose/times as a result, correct response = 0**

    ○ **If another person must set up a "planner device", correct response = 1**

Management of Oral Medications$_2$

- **Improved ability to show progress**

- **Response 1** now split into able to take medication(s) at the correct times if:

    (a) individual syringes are prepared in advance by another person; OR

    (b) another person develops a drug diary or chart

- **Response 2** now references ability to take medication(s) at the correct times if given reminders by another person

Prior Medication Management

- **(M2040) Prior Medication Management:** Indicate the patient's usual ability with managing oral and injectable medications prior to this current illness, exacerbation, or injury. Check only **one** box in each row.

Functional Area	Independent	Needed Some Help	Dependent	Not Applicable
a. Oral medications	☐	☐	☐	☐
b. Injectable medications	☐	☐	☐	☐
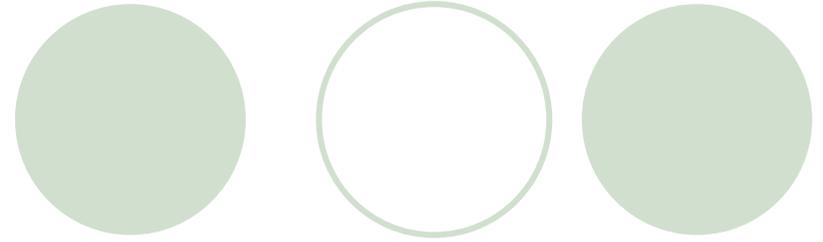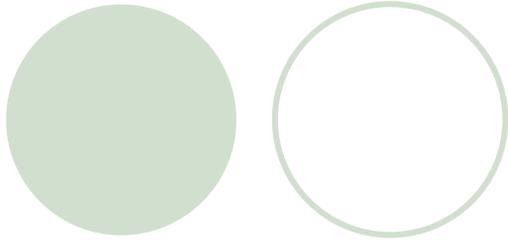
OASIS - C

Care Management

Types and Sources of Assistance$_1$

(M2100) Types and Sources of Assistance:
Determine the level of caregiver ability and willingness to provide assistance for the following activities, if assistance is needed. (Check only **one** box in each row.)

Type of Assistance	No assistance needed in this area	Caregiver(s) currently provide assistance	Caregiver(s) need training/ supportive services to provide assistance	Caregiver(s) not likely to provide assistance	Unclear if Caregiver(s) will provide assistance	Assistance needed, but no Caregiver(s) available
a. **ADL assistance** (e.g., transfer/ ambulation, bathing, dressing, toileting, eating/feeding)	☐0	☐1	☐2	☐3	☐4	☐5

Types and Sources of Assistance$_2$

- For M2100, consider the aspect that represents the **most need** and the availability and ability of caregiver(s) to meet that need

  - When determining patient needs in each row, respond based on the patient's greatest need in that category (e.g., ADL with greatest level of dependence)

  - When determining caregiver's ability and willingness, select the response that represents the greatest need

Care Management
Frequency of Assistance

- **(M2110) How Often** does the patient receive **ADL or IADL assistance** from any caregiver(s) (other than home health agency staff)?

- Collected at SOC/ROC and DC for risk adjustment

- Responses include Daily, 3 or more times per week, 1-2 times per week, Less than weekly, None, or Unknown (Unknown not allowed at DC)

- Select the response that reports how often the patient receives assistance with any ADL or IADL
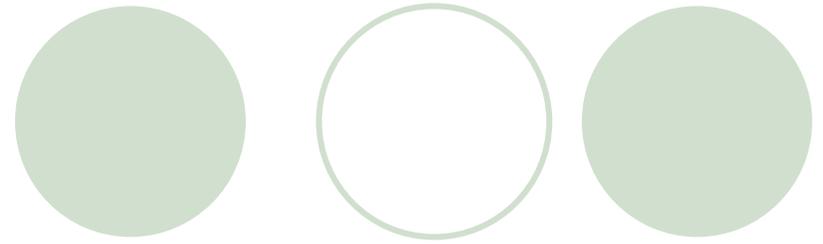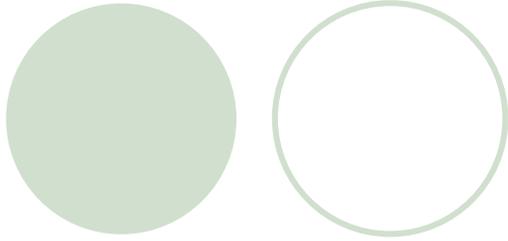
OASIS - C

Therapy Need and Plan of Care

M2200 Therapy Need

- **(M2200) Therapy Need:** In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? **(Enter zero ["000"] if no therapy visits indicated.)**

(__ __ __)   Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).

☐ NA - Not Applicable: No case mix group defined by this assessment.

Therapy Need and Plan of Care
Plan of Care Synopsis$_1$

(M2250) Plan of Care Synopsis: (Check only **one** box in each row.) Does the physician-ordered plan of care include the following:

	Plan / Intervention	No	Yes	Not Applicable	
a.	Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings	☐0	☐1	☐na	Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference
b.	Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	☐0	☐1	☐na	Patient is not diabetic or is bilateral amputee
c.	Falls prevention interventions	☐0	☐1	☐na	Patient is not assessed to be at risk for falls
d.	Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	☐0	☐1	☐na	Patient has no diagnosis or symptoms of depression
e.	Intervention(s) to monitor and mitigate pain	☐0	☐1	☐na	No pain identified
f.	Intervention(s) to prevent pressure ulcers	☐0	☐1	☐na	Patient is not assessed to be at risk for pressure ulcers
g.	Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician	☐0	☐1	☐na	Patient has no pressure ulcers with need for moist wound healing

Plan of Care Synopsis$_2$

- Responding that the "current physician-ordered plan of care" includes a plan/intervention means

  - The patient condition has been **discussed** with the physician

  - There is **agreement** as to the plan of care between the home health staff and the physician

  - If prior to the receipt of signed orders, the clinical record should reflect **evidence of communication with the physician** to include specified best practice interventions in the POC

Therapy Need and Plan of Care
Plan of Care Synopsis₃

Review Chapter 3 guidance carefully for:

- Acceptable POC interventions
  - Example: Row a "specific clinical parameters" may include ranges or limits for temp, pulse, respirations, BP, weight, wound measurements, pain intensity ratings etc
- Guidance on timeframes
  - Plan of Care orders must be in place within the 5-day SOC or 2-day ROC window to respond "Yes"
- Guidance on collaboration
  - Assessing clinician may choose to wait until after other disciplines have completed their assessments and developed their care plans
  - This does not violate the requirement that the comprehensive assessment be completed by one clinician

Intervention Synopsis[1]

(M2400) Intervention Synopsis: (Check only **one** box in each row.) Since the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

Plan / Intervention	No	Yes	Not Applicable	
a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	☐0	☐1	☐na	Patient is not diabetic or is bilateral amputee
b. Falls prevention interventions	☐0	☐1	☐na	Formal multi-factor Fall Risk Assessment indicates the patient was not at risk for falls since the last OASIS assessment
c. Depression intervention(s) such as medication, referral for other treatment, or a	☐0	☐1	☐na	Formal assessment indicates patient did not meet criteria for

Intervention Synopsis$_2$

Example for Row b – Falls Prevention:

- Select "Yes" if:
  - The physician-ordered POC contains specific interventions to reduce the risk of falls **and**
  - Interventions were performed by any home health agency staff since (or at) the time of the previous OASIS assessment

- Select "No" if:
  - The POC does not include interventions for fall prevention, and/or
  - These interventions were not performed at the time of the previous OASIS assessment or since that time

478

Intervention Synopsis$_3$

- Select "NA" if a formal multi-factor Fall Risk Assessment indicates patient was not at risk for falls since the last OASIS assessment

- The formal assessment that is referred to in the last column for rows b – e refers to the assessment defined in M1240, M1300, M1730, and M1910
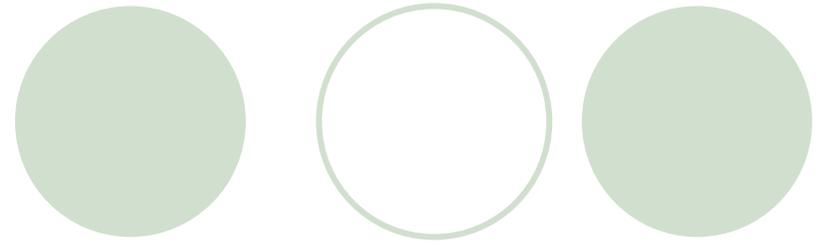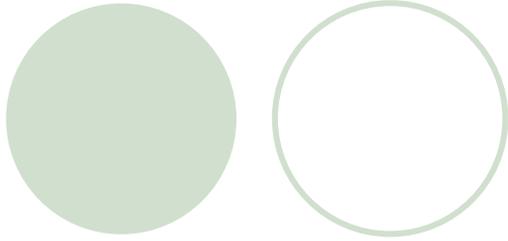
OASIS - C

Emergent Care

M2300 Emergent Care

- **(M2300) Emergent Care:** Since the last time OASIS data were collected, has the patient utilized a hospital emergency department (includes holding/observation)?

    ☐ 0   -   No **[*Go to M2400*]**

    ☐ 1   -   Yes, used hospital emergency department WITHOUT hospital admission

    ☐ 2   -   Yes, used hospital emergency department WITH hospital admission

    ☐ UK -   Unknown **[*Go to M2400*]**

M2310 Emergent Care Reason$_1$

- **(M2310) Reason for Emergent Care:** For what reason(s) did the patient receive emergent care (with or without hospitalization)? (**Mark all that apply.)**

  ☐ 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
  ☐ 2 - Injury caused by fall
  ☐ 3 - Respiratory infection (e.g., pneumonia, bronchitis)
  ☐ 4 - Other respiratory problem
  ☐ 5 - Heart failure (e.g., fluid overload)
  ☐ 6 - Cardiac dysrhythmia (irregular heartbeat)
  ☐ 7 - Myocardial infarction or chest pain
  ☐ 8 - Other heart disease
  ☐ 9 - Stroke (CVA) or TIA
  ☐ 10 - Hypo/Hyperglycemia, diabetes out of control
  ☐ 11 - GI bleeding, obstruction, constipation, impaction
  ☐ 12 - Dehydration, malnutrition
  ☐ 13 - Urinary tract infection
  ☐ 14 - IV catheter-related infection or complication
  ☐ 15 - Wound infection or deterioration
  ☐ 16 - Uncontrolled pain
  ☐ 17 - Acute mental/behavioral health problem
  ☐ 18 - Deep vein thrombosis, pulmonary embolus
  ☐ 19 - Other than above reasons
  ☐ UK - Reason unknown

482

M2310 Emergent Care Reason$_2$

- **(M2310) Reason for Emergent Care**: For what reason(s) did the patient receive emergent care (with or without hospitalization)? **(Mark all that apply.)**

  - ☐ 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis

  - ☐ 2 - Injury caused by fall

  - ☐ 3 - Respiratory infection (e.g., pneumonia, bronchitis)

  - ☐ 4 - Other respiratory problem

  - ☐ 5 - Heart failure (e.g., fluid overload)

  - ☐ 6 - Cardiac dysrhythmia (irregular heartbeat)

  - ☐ 7 - Myocardial infarction or chest pain

  - ☐ 8 - Other heart disease

M2310 Emergent Care Reason₃

☐ 9 - Stroke (CVA) or TIA

☐ 10 - Hypo/Hyperglycemia, diabetes out of control

☐ 11 - GI bleeding, obstruction, constipation, impaction

☐ 12 - Dehydration, malnutrition

☐ 13 - Urinary tract infection

☐ 14 - IV catheter-related infection or complication

☐ 15 - Wound infection or deterioration

☐ 16 - Uncontrolled pain

☐ 17 - Acute mental/behavioral health problem

☐ 18 - Deep vein thrombosis, pulmonary embolus

☐ 19 - Other than above reasons

☐ UK - Reason unknown
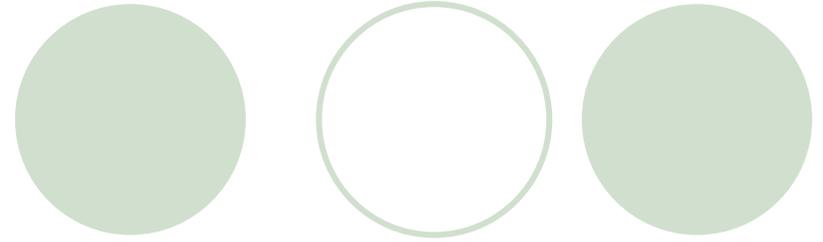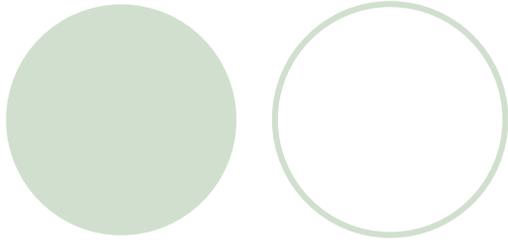
OASIS - C

Data Items Collected at Inpatient Facility Admission or Agency Discharge Only

M2400 Intervention Synopsis[1]

- **(M2400) Intervention Synopsis:** (Check only **one** box in each row.) Since the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

	Plan / Intervention	No	Yes	Not Applicable	
a.	Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	☐0	☐1	☐na	Patient is not diabetic or is bilateral amputee
b.	Falls prevention interventions	☐0	☐1	☐na	Formal multi-factor Fall Risk Assessment indicates the patient was not at risk for falls since the last OASIS assessment
c.	Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	☐0	☐1	☐na	Formal assessment indicates patient did not meet criteria for depression AND patient did not have diagnosis of depression since the last OASIS assessment
d.	Intervention(s) to monitor and mitigate pain	☐0	☐1	☐na	Formal assessment did not indicate pain since the last OASIS assessment
e.	Intervention(s) to prevent pressure ulcers	☐0	☐1	☐na	Formal assessment indicates the patient was not at risk of pressure ulcers since the last OASIS assessment
f.	Pressure ulcer treatment based on principles of moist wound healing	☐0	☐1	☐na	Dressings that support the principles of moist wound healing not indicated for this patient's pressure ulcers OR patient has no pressure ulcers with need for moist wound healing

486

M2400 Intervention Synopsis₂

- **(M2400) Intervention Synopsis:** (Check only **one** box in each row.) Since the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

M2400 Intervention Synopsis$_3$

Plan / Intervention	No	Yes	Not Applicable	
a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	☐ 0	☐ 1	☐ na	Patient is not diabetic or is bilateral amputee
b. Falls prevention interventions	☐ 0	☐ 1	☐ na	Formal multi-factor Fall Risk Assessment indicates the patient was not at risk for falls since the last OASIS assessment

M2400 Intervention Synopsis$_4$

Plan / Intervention	No	Yes	Not Applicable	
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	☐ 0	☐ 1	☐ na	Formal assessment indicates patient did not meet criteria for depression AND patient did not have diagnosis of depression since the last OASIS assessment
d. Intervention(s) to monitor and mitigate pain	☐ 0	☐ 1	☐ na	Formal assessment did not indicate pain since the last OASIS assessment

M2400 Intervention Synopsis$_5$

Plan / Intervention	No	Yes	Not Applicable	
e. Intervention(s) to prevent pressure ulcers	☐ 0	☐ 1	☐ na	Formal assessment indicates the patient was not at risk of pressure ulcers since the last OASIS assessment
f. Pressure ulcer treatment based on principles of moist wound healing	☐ 0	☐ 1	☐ na	Dressings that support the principles of moist wound healing not indicated for this patient's pressure ulcers OR patient has no pressure ulcers with need for moist wound healing

M2410 Inpatient Facility Admission

- **(M2410)** To which **Inpatient Facility** has the patient been admitted?

  ☐ 1 - Hospital   **[*Go to M2430*]**

  ☐ 2 - Rehabilitation facility   **[*Go to M0903*]**

  ☐ 3 - Nursing home   **[*Go to M2440*]**

  ☐ 4 - Hospice   **[*Go to M0903*]**

  ☐ NA - No inpatient facility admission **[Omit "NA" option on TRN]**

M2420 Discharge Disposition

- **(M2420) Discharge Disposition:** Where is the patient after discharge from your agency? **(Choose only one answer.)**

  ☐ 1 - Patient remained in the community (without formal assistive services)

  ☐ 2 - Patient remained in the community (with formal assistive services)

  ☐ 3 - Patient transferred to a non-institutional hospice

  ☐ 4 - Unknown because patient moved to a geographic location not served by this agency

  ☐ UK - Other unknown   **[*Go to M0903*]**

M2430 Reason for Hospitalization$_1$

- **(M2430) Reason for Hospitalization**: For what reason(s) did the patient require hospitalization? **(Mark all that apply.)**

☐	1 -	Improper medication administration, medication side effects, toxicity, anaphylaxis
☐	2 -	Injury caused by fall
☐	3 -	Respiratory infection (e.g., pneumonia, bronchitis)
☐	4 -	Other respiratory problem
☐	5 -	Heart failure (e.g., fluid overload)
☐	6 -	Cardiac dysrhythmia (irregular heartbeat)
☐	7 -	Myocardial infarction or chest pain
☐	8 -	Other heart disease
☐	9 -	Stroke (CVA) or TIA
☐	10 -	Hypo/Hyperglycemia, diabetes out of control
☐	11 -	GI bleeding, obstruction, constipation, impaction
☐	12 -	Dehydration, malnutrition
☐	13 -	Urinary tract infection
☐	14 -	IV catheter-related infection or complication
☐	15 -	Wound infection or deterioration
☐	16 -	Uncontrolled pain
☐	17 -	Acute mental/behavioral health problem
☐	18 -	Deep vein thrombosis, pulmonary embolus
☐	19 -	Scheduled treatment or procedure
☐	20 -	Other than above reasons
☐	UK -	Reason unknown

[*Go to M0903*]

493

M2430 Reason for Hospitalization$_2$

- **(M2430) Reason for Hospitalization**: For what reason(s) did the patient require hospitalization? **(Mark all that apply.)**

  ☐ 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis

  ☐ 2 - Injury caused by fall

  ☐ 3 - Respiratory infection (e.g., pneumonia, bronchitis)

  ☐ 4 - Other respiratory problem

  ☐ 5 - Heart failure (e.g., fluid overload)

  ☐ 6 - Cardiac dysrhythmia (irregular heartbeat)

  ☐ 7 - Myocardial infarction or chest pain

  ☐ 8 - Other heart disease

  ☐ 9 - Stroke (CVA) or TIA

  ☐ 10 - Hypo/Hyperglycemia, diabetes out of control

M2430 Reason for Hospitalization$_3$

☐ 11 - GI bleeding, obstruction, constipation, impaction

☐ 12 - Dehydration, malnutrition

☐ 13 - Urinary tract infection

☐ 14 - IV catheter-related infection or complication

☐ 15 - Wound infection or deterioration

☐ 16 - Uncontrolled pain

☐ 17 - Acute mental/behavioral health problem

☐ 18 - Deep vein thrombosis, pulmonary embolus

☐ 19 - Scheduled treatment or procedure

☐ 20 - Other than above reasons

☐ UK - Reason unknown **[*Go to M0903*]**

M2440 Reason for Nursing Home Admission

- **(M2440)** For what **Reason(s)** was the patient **Admitted** to a **Nursing Home**? **(Mark all that apply.)**

  ☐   0   -   Therapy services

  ☐   1   -   Respite care

  ☐   2   -   Hospice care

  ☐   3   -   Permanent placement

  ☐   4   -   Unsafe for care at home

  ☐   5   -   Other

  ☐   UK   -   Unknown   **[*Go to M0903*]**

M0903 Date of Last (Most Recent) Home Visit

- **(M0903) Date of Last (Most Recent) Home Visit:**

  __ __ / __ __ / __ __ __ __
  month / day /   year

M0906 DC/ TRF/ Death Date

- **(M0906) Discharge/Transfer/Death Date:** Enter the date of the discharge, transfer, or death (at home) of the patient.

  __ __ / __ __ / __ __ __ __

  month / day /   year

OASIS-C

- **IMPORTANT:** This seminar will **NOT** take the place of a careful review of the OASIS-C Guidance Manual and frequent referencing of the manual while OASIS-C is still new to you

OASIS-C Guidance Manual
  - *www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp*

- ***Review** Chapter 3 for detailed guidance*
  - ***Refer to** Q&AS for clarifications/ refinements*
    - *https://www.qtso.com/hhadownload.html*
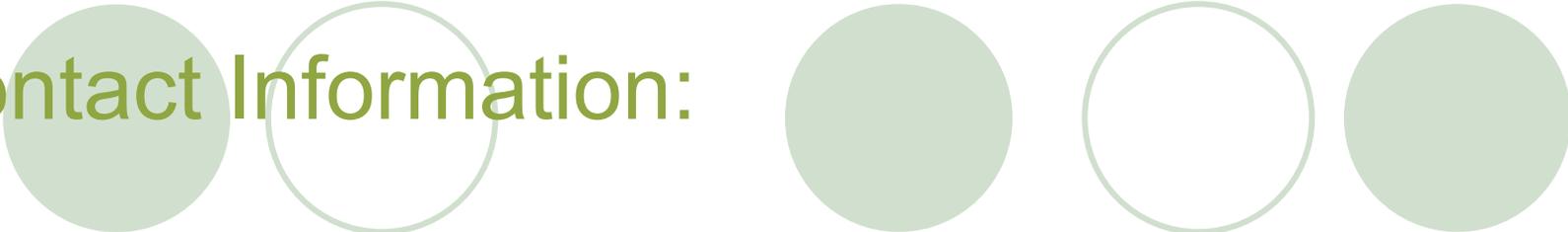   - *www.oasiscertificate.org*

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