

APPENDIX A – OASIS AND THE COMPREHENSIVE ASSESSMENT

1. WHAT IS A COMPREHENSIVE ASSESSMENT?

Patient assessment is an essential component of health care delivery. Assessment requires the collection of pertinent data regarding the patient, supportive assistance, and the patient's environment. Clinicians of all types systematically collect and categorize such data, analyze and evaluate these data, and draw conclusions from the data that guide their subsequent interventions. It is the interventions that then are directed toward improving or maintaining health status (or supporting the patient in a dignified dying process). Assessment involves the active gathering of accurate and well-defined patient status information.

A comprehensive assessment involves collecting data on multiple aspects of the patient and the environment. The patient receiving home care particularly benefits from a comprehensive assessment because the interrelated aspects of patient and environment all influence current and future health status. An assessment with too narrow a focus omits many components relevant to care delivery. Consider the example of a patient with an open surgical wound requiring dressing changes. A narrowly focused assessment would evaluate only the wound status. Such an assessment fails to take into account other factors relevant for wound healing, such as nutrition. The comprehensive assessment will consider the patient's nutritional status, which must address the actual food intake, the ability to prepare food, the ability to shop for food, and the presence of financial factors that may limit the ability to purchase food. The presence (or absence) of sanitation hazards, also important for wound healing, can be identified by the comprehensive assessment. In addition, the patient's ability to perform his/her own dressing change or the availability, willingness, and ability of a family member (or other caregiver) to change the dressing will also be evaluated in the comprehensive assessment. By collecting data on the variety of interrelated aspects of patient and environment that affect health status, such an assessment clearly provides a better base for care planning and delivery.

It should be noted that the data items in OASIS are not, in and of themselves, a complete or comprehensive assessment. Home health agencies will need to supplement the OASIS data items with others necessary for a full assessment. For example, the OASIS items do not include vital signs, assessment of breath sounds, or collection of data on fluid intake, which are part of a more complete assessment. Each agency will be expected to incorporate the OASIS items into its own comprehensive assessment documentation and related policies and procedures.

2. HOW ARE THE COMPREHENSIVE ASSESSMENT DATA COLLECTED AND DOCUMENTED?

Patient assessment data are collected through a combination of methods -- including interaction with patient/family, observation, and measurement. When used in combination, these methods provide a full picture of the patient's health status. Interaction and interview (i.e., report) data can be verified through observation and measurement; observation data can identify factors that require additional interview questions.

Interaction and interview involve purposeful communication with the patient or family. Some interview questions are short and direct (e.g., what is your birth date?, are you taking/receiving any injectable medications?), while others begin with an open-ended question that leads to further inquiries with a more specific focus (e.g., "what kind of assistance do you receive from

family or friends?,” can be followed by more specific questions about types and frequency of assistance if an affirmative response is obtained). In all cases, the patient is the preferred source for interview/interaction data, though the family/caregiver (or other health care provider) can provide information if the patient is unable to do so. Information such as biographical data, pertinent health and social history, and the review of body systems can only be obtained through interview/interaction. Observation often supplements and enriches the interview data. For example, the clinician observing a healed surgical wound scar may supplement the health history when additional questions identify disease conditions not previously mentioned.

Observation techniques obtain data through the senses. Using sight, sound, smell, and touch, the clinician collects and records patient status information. Measurement is a form of observation that uses a calibrated “instrument” to obtain data. For example, blood pressure, joint range of motion, height, and weight are all obtained by measurement. In all observational approaches, consistency and objectivity are particularly important. Standards for clinical observation are important to apply in conducting patient assessment.

All these methods and techniques should be used in conducting the comprehensive assessment and collecting OASIS data. Using only one approach limits both the amount and quality of the information obtained. Direct observation is the preferred method for data collection, but some historical data may only be obtained by interview. This interaction should supplement, not replace, observational techniques.

The patient receiving care at home presents both unique opportunities and challenges for clinicians in assessing patients. One opportunity is that the clinician is able to collect data on environmental characteristics (such as safety features) through first-hand observation rather than needing to rely exclusively on report. Thus, the accuracy of the patient status information is increased, which also increases the likelihood of appropriate pertinent interventions. Within this setting, however, the patient and family exercise control, in contrast to other health care delivery settings where the provider controls the environment. The clinician does not have the immediate and constant support of rules, policies, and colleagues to aid in data verification or compliance. The home care clinician often is required to exercise creativity and flexibility in collecting patient assessment data for care planning. For example, assessment of the home care patient begins even before the clinician enters the home. The initial referral provides an introduction to the client situation. A telephone contact with the patient/family to arrange the visit furnishes additional data. Environmental characteristics of the neighborhood and the patient residence are apparent as the clinician approaches the home. When the comprehensive assessment is documented, the clinician’s actual observations that describe the patient’s current status should be recorded. The conclusions derived from these assessment data will direct the subsequent care planning activities.

3. COMPREHENSIVE ASSESSMENT AND OASIS REGULATION

In 1999, the Centers for Medicare & Medicaid Services (CMS) revised the Conditions of Participation (CoP) that home health agencies (HHAs) must meet to participate in the Medicare program. Specifically, this added rule states that each patient receive from the HHA a patient-specific, comprehensive assessment that identifies the patient’s need for home care and that meets the patient’s medical, nursing, rehabilitative, social, and discharge planning needs. The rule requires that as part of the comprehensive assessment, HHAs use OASIS when evaluating adult, nonmaternity patients. Additionally, the OASIS meets the condition specified in §1891(d) of the Social Security Act, which requires the Secretary of the Department of Health and Human Services to designate an assessment instrument for use by an agency in order to evaluate the

extent to which the quality and scope of services furnished by the HHA attain and maintain the highest practicable functional capacity of the patient as reflected in the plan of care. These components were identified as an integral part of CMS' efforts to achieve broad-based improvements in the quality of care furnished through Federal programs and in the measurement of that care. The following briefly describes the CoP relevant to OASIS data collection. Specific regulatory language can be found within the CoP at http://cms.hhs.gov/manuals/Downloads/som107ap_b_hha.pdf

Condition of Participation: Comprehensive Assessment of Patients

42 CFR 484.55 requires that a patient receive from the HHA a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must (1) identify the patient's continuing need for home care; (2) meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs; and (3) for Medicare patients, identify eligibility for the home health benefit, including the patient's homebound status. The comprehensive assessment must also incorporate the exact use of the current version of the OASIS data set, which is found on the CMS OASIS web site at <http://www.cms.hhs.gov/oasis>; click on "Data Set." A comprehensive assessment identifies patient progress toward desired outcomes or goals of the care plan.

CMS expects that HHAs will collect OASIS data in the context of a comprehensive assessment on adult Medicare or Medicaid patients (age 18 or over) receiving skilled health services from the HHA, except for patients receiving care for pre- and post-partum conditions. Patients receiving skilled health services, whose care is reimbursed by other than Medicare or Medicaid, must receive comprehensive assessments, but the collection of OASIS data is not required. For patients receiving only personal care services, regardless of payer source, a comprehensive assessment is also required, but not the collection of OASIS data. Patients who receive only services such as homemaker, chore, or companion services do not require the comprehensive assessment.

Five standards are contained in the Comprehensive Assessment CoP. Following are the requirements for each standard.

a. §484.55 Standard: Initial Assessment Visit

The initial visit is performed to determine the immediate care and support needs of the patient. This visit is conducted within 48 hours of referral or within 48 hours of a patient's return home from an inpatient stay, or on the physician-ordered start of care date. The initial assessment visit is intended to ensure that the patient's most critical needs for home care services are identified and met in a timely fashion. For Medicare patients, this initial assessment determines eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be conducted by a registered nurse unless rehabilitation therapy services are the only services ordered by the physician. Under the Medicare home health benefit, any one of three services (skilled nursing, physical therapy, or speech-language pathology) can establish program eligibility. If rehabilitation therapy services are the only services ordered by the physician, the initial assessment may be made by the appropriate rehabilitation skilled professional if the need for that service establishes eligibility for the home health benefit. The law governing home health eligibility prevents occupational therapy from

establishing eligibility for the Medicare home health benefit at the initial assessment, though once eligibility is established, then continuing occupational therapy could establish eligibility for a subsequent episode (meaning that the occupational therapist could complete the Recertification assessment). If no skilled service is delivered at this initial assessment, this visit will not be considered the SOC nor is it considered a reimbursable visit for the Medicare home health benefit.

Note that for payers other than Medicare, the occupational therapist may complete the initial assessment if the need for occupational therapy establishes program eligibility.

The comprehensive assessment is not required to be completed at the initial assessment visit, although the HHA may choose to do so. If a skilled service is delivered at the initial assessment visit, thus establishing the SOC, the comprehensive assessment may be initiated at this visit and completed within the time frames discussed below, depending on agency policy.

b. §484.55(b) Standard: Completion of the Comprehensive Assessment

The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than five calendar days after the start of care.

This requirement does not preclude an HHA from completing the comprehensive assessment during the SOC visit, and many HHAs currently operate in such a manner. This time frame provides operational flexibility to the HHA while maintaining patient safety in ensuring that all patient needs will be identified within a standard time period. Some HHAs have policies requiring that a nurse conduct the comprehensive assessment. Home care staff should follow agency policies governing which disciplines can complete the comprehensive assessment.

c. §484.55(c) Standard: Drug Regimen Review

Under this requirement, the comprehensive assessment must include a review of all medications the patient is currently using to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects and drug interactions, duplicate drug therapy, and noncompliance with drug therapy.

While patients receive their drug regimen from the physician, review of this regimen is an integral part of the comprehensive assessment. In addition, this review is an important safeguard for patients who may receive medications from a variety of physicians and pharmacies. Some agencies have policies requiring nurses to do the drug regimen review. In addition, some state practice acts may preclude therapists from completing the drug regimen review. Home care staff should follow state regulations and agency policies governing which disciplines can complete the drug regimen review.

d. §484.55(d) Standard: Update of the Comprehensive Assessment

The comprehensive assessment, which includes OASIS items for Medicare and Medicaid patients, must be updated and revised as frequently as the patient's condition requires, but not less frequently than every 60 days beginning with the start of care date; within 48 hours of the patient's return home from an inpatient facility stay of 24 hours or more for any reason except diagnostic testing; and at discharge. The update of the

comprehensive assessment must include completion of all required OASIS items for that time point, plus any others determined necessary by the HHA for a comprehensive assessment. This assessment provides information for determination of changes in treatment or plan of care. Therefore, a comprehensive assessment also is required when there is a major decline or improvement in a patient's health status as defined by the HHA.

An inpatient facility admission as an event is generally a predictor of a change in the patient's health status and therefore should be captured in the OASIS data. In addition, because patients frequently improve rapidly upon returning home from an inpatient facility, it is important for the HHA to assess the patient's true needs as quickly as possible after discharge from the inpatient facility. Therefore, the comprehensive assessment is required within 48 hours of the patient's return to the home from an inpatient facility admission of 24 hours or more for any reason other than diagnostic tests.

Follow-up assessments must be completed every 60 days that a patient is under care. For Medicare and Medicaid patients, when a follow-up assessment is due, it must be completed no earlier than four calendar days before, and no later than the day marking the end of the 60-day period (i.e., day 56 through day 60 of the period).

e. §484.55(e) Standard: Incorporation of the OASIS Data Set

OASIS must be incorporated into the HHA's own assessment, exactly as written. Both the language and the groupings of the OASIS items must be maintained. Integrating the OASIS items into the agency's own assessment system in the sequence presented in the OASIS form would facilitate data entry of the items into data collection and reporting software. However, HHAs may integrate the items in such a way that best suits the agency's own assessment.

The OASIS data set is not intended to constitute a complete comprehensive assessment instrument. Rather, the data set comprises items that are a necessary part of a complete comprehensive assessment and that are essential to uniformly and consistently measure patient outcomes. An HHA can use the data set as the foundation for valid and reliable information for patient assessment, care planning, service delivery, and improvement efforts.

The OASIS items are already used in one form or another by virtually all HHAs that conduct thorough assessments, and simply adding the OASIS data set to the rest of the HHA's paperwork would be burdensome and duplicative. Therefore, we expect HHAs to replace similar assessment items with OASIS items in their assessment forms to avoid lengthening the assessment unnecessarily. This may be accomplished by modification of existing forms or using commercially available comprehensive assessment forms that include OASIS items. The Mxxxx numbers for each OASIS data item should be retained to allow for easy recognition of the required OASIS item in the HHA comprehensive assessments.