CHAPTER 4

THE COMPREHENSIVE ASSESSMENT AND OASIS

A. 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 which 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 provision.

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 its own assessment policies and procedures.

B. 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 which 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?, etc.), 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.[1]

All these methods and techniques should be used in conducting the comprehensive assessment and in 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. As an opportunity, the clinician is

[1] Instructional material on conducting patient interviews and physical assessment is beyond the purview of this manual. A list of references for such information is found in Attachment A at the end of the chapter.

able to collect data on environmental characteristics (such as safety features) through first-hand observation rather than needing to rely exclusively on report. The accuracy of the patient status information thus 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 pertinent for care planning.

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. Additional information on integrating the OASIS items into the performance of the comprehensive patient assessment can be found in Chapter 8 of this manual.

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.

C. WHICH HOME CARE PATIENTS SHOULD RECEIVE THE COMPREHENSIVE ASSESSMENT AND OASIS DATA COLLECTION?

In a Medicare-certified home care agency, all patients are to receive equivalent care. Therefore, effective July 19, 1999, all adult (18 years of age and older), nonmaternity patients receiving skilled care from the Medicare-certified agency are to receive the comprehensive assessment at the specified time points. All Medicare and Medicaid patients will have OASIS data collection as part of the comprehensive assessment. Clients receiving only personal care, homemaker, or chore services exclusively are excluded since these are not skilled services.

D. WHEN IS THE COMPREHENSIVE ASSESSMENT CONDUCTED?

Patient status data require updating if they are to be current and useful in planning care. To that end, specific time points have been identified for completing the comprehensive assessment, including OASIS data. These time points include: start of care (SOC), within the last five days of each 60-day period after SOC (i.e., in the last five days of the certification period), and at discharge from home care. Data collection at these time points is required to report patient status and to compute patient outcomes. (The comprehensive

assessment [and OASIS data] should also be updated and revised when there is a significant change in the patient's condition). All of these assessments must be conducted at a home visit, because all require the clinician to be in the physical presence of the patient.

Admission to an inpatient facility during the home care episode is a significant event that must be considered in computing home care outcomes. Therefore, the transfer of a patient to an inpatient facility for a period of 24 hours (or more) for any reason other than diagnostic testing and the resumption of care after this inpatient facility stay also require the reporting of assessment data. The transfer to an inpatient facility requires collection of limited OASIS data (which may be obtained through a telephone call), while the resumption of home care necessitates a comprehensive assessment at a home visit.

The home care episode may not proceed smoothly from SOC to discharge. Agency staff must know and monitor when the comprehensive assessment and OASIS data collection are required. The following examples demonstrate appropriate assessment procedures.

Example 1:

Ms. A, a newly diagnosed diabetic, is admitted to home care for instruction and supervision in medication administration. She is 17 years old and requires close supervision due to her moderate mental retardation. She is admitted October 2 and discharged November 17. When will Ms. A receive the comprehensive assessment and OASIS data collection?

Response: Ms. A will receive the agency's normal comprehensive assessment used for a 17-year-old at SOC and discharge. This assessment will not have OASIS data incorporated due to her age (17). (See Section C of this chapter).

Example 2:

Mr. B, age 78, is admitted to home care (for skilled care) on October 7 after hip replacement surgery. After the SOC assessment, when will his next comprehensive assessment be required?

Response: If Mr. B is still receiving home care between December 1 and December 5, the comprehensive assessment and OASIS data collection will be due. If Mr. B is discharged from home care before this time, a comprehensive discharge assessment is required at the time of discharge. (See Section D of this chapter.)

Example 3:

Ms. C, age 83, is admitted November 2 with advanced cardiac disease. On November 13, she is admitted to the hospital after a fall at home. She returns home on November 22 and resumes home care. Her daughter (from a neighboring state) visits in early December and decides to move her mother to a residential facility near the daughter's home. The agency discharges her on December 16. When are comprehensive assessments (and OASIS data collection) required?

Response: A comprehensive assessment is required at SOC. Collection of limited OASIS data is required on November 13. A comprehensive assessment is necessary when Ms. C resumes home care (November 22) and again when she is discharged (December 16). (See Section D.)

Not all OASIS items are completed at every assessment time point. Some items are completed only at SOC, some only at discharge, and still others only when a patient is admitted to a specific type of inpatient facility (e.g., M0900 - Reason for Nursing Home Admission). The "skip logic" identified in M0100 - Reason Assessment is Being Completed allows the clinician conducting the assessment to complete the necessary OASIS items.

In implementing the comprehensive assessment and OASIS data collection, HHAs must develop policies and procedures that address these time points. Further discussion of these policies and procedures is found in Chapter 9 of this manual.

Additional home care patient situations can be found in Attachment B to this chapter. These situations can be used in training agency staff and to test understanding of time points for completion of the comprehensive assessment and OASIS data collection for patients receiving skilled care.

E. WHO COMPLETES THE COMPREHENSIVE ASSESSMENT AND RECORDS OASIS DATA?

As identified in M0080 - Discipline of Person Completing Assessment, the comprehensive assessment and OASIS data collection should be conducted by an RN or any of the therapies (PT, SLP/ST, OT). For a therapy-only case, the primary therapist conducts the comprehensive assessment. In cases with multiple disciplines, the registered nurse completes the comprehensive assessment at SOC. (Any of the appropriate disciplines may complete subsequent

assessments.) Note that multidisciplinary cases may have multiple points of discipline-specific discharge, though only one is the agency discharge. It is the agency discharge that requires the comprehensive assessment and OASIS data collection. Consider the following as an example:

Example 4:

Mr. D, age 51, is admitted to home care on May 19 after a severe automobile accident. He underwent extensive shoulder and leg orthopedic surgery and now has multiple surgical wounds requiring dressing changes and assessment. Nursing, physical therapy, and occupational therapy services are ordered. According to requirements in the Conditions of Participation, an RN conducts the comprehensive assessment at SOC. His wounds heal without incident, and nursing is not needed after June 6. Physical and occupational therapy continue. Physical therapy exits the case on July 19. (Occupational therapy continues.) Mr. D is discharged from the agency on August 3. When are the comprehensive assessments and OASIS data collection completed?

Response: The RN completed the SOC comprehensive assessment. In the last five days of the 60-day certification period (July 13-17), whichever therapy discipline is considered to be the primary case manager performs the comprehensive assessment. (Agency policy should address this issue.) At agency discharge (August 3), the occupational therapist, as the remaining discipline, completes the comprehensive assessment.

A thorough and holistic assessment of the patient is in the scope of responsibility of each professional clinician identified in the January 25, 1999 *Federal Register*. State professional practice acts may limit some disciplines' involvement in these activities, however. Agencies must be familiar with and observe all applicable State regulations. It also is the responsibility of the agency to evaluate the competence of its clinical staff to perform comprehensive patient assessments. Some clinicians may require more extensive orientation and instruction in assessment skills and strategies before being considered competent to perform comprehensive assessments.

F. IS A SINGLE COMPREHENSIVE ASSESSMENT EXPECTED TO MEET THE NEEDS OF ALL DISCIPLINES PROVIDING CARE?

The comprehensive assessment is expected to meet the *patient's* medical, nursing, rehabilitative, social, and discharge planning needs. As such, it is an assessment of needs that might be met by a variety of disciplines. It is not

expected that a single clinician conducting the assessment will perform a nursing, physical therapy, speech-language pathology, occupational therapy, and social work assessment. The assessing clinician must, however, conduct a sufficiently broad assessment of environmental, social support, functional, and health domains that effective identification of patient needs is possible.

Each agency can determine how to best operationalize the "content" of the comprehensive assessment. Some agencies may choose to develop a single "discipline-neutral" assessment tool that can be utilized effectively by all disciplines providing skilled care. Formulating such a uniform assessment tool is likely to require considerable input from and communication among the various disciplines that will be conducting the comprehensive assessments.

In other agencies, individual disciplines will desire some discipline-specific assessment items be included in an assessment tool. These discipline-specific items are presumed to require the unique understanding and skill of specific clinician types. In this situation, the agency might take the following approach:

- Begin with the required OASIS items.

- Add core assessment items deemed necessary to meet clinical, regulatory, or accreditation requirements. Examples of such items might include patient nutritional status, vital signs at rest and following activity, and cultural or educational barriers that might impact progress toward goals.

At this point, the agency has a discipline-neutral core assessment that all qualifying disciplines are (or can become) competent in performing. All skilled care patients would be expected to receive this assessment, regardless of diagnosis or services ordered. Needs for referral to additional services also would be identified through this assessment. To this core comprehensive assessment with OASIS items, the agency would then:

- Add discipline-specific assessment items that supplement, not duplicate, the core assessment items. For example, the discipline-specific items for physical therapy might include assessment items necessary to develop the physical therapy treatment plan, such as the Tinetti Gait Assessment.

The discipline-specific portion of the assessment can be as detailed as the agency (or clinician) deems appropriate. Additional standardized assessment approaches, measurement tools, or evaluative methods can be incorporated into the discipline-specific portion of the assessment. Following this procedure results in an approach depicted as:

Comprehensive Patient Assessment =

OASIS items	**+**	Core comprehensive assessment items	**+**	Discipline-specific assessment items

The comprehensive assessment describes the patient's current health status and identifies needs that subsequently are addressed in the plan of care. Updates of this assessment identify progress toward goals. Incorporating OASIS collection into this assessment process provides the data needed for computation of outcomes useful in performance improvement activities. The comprehensive assessment thus addresses multiple patient-level and agency-level purposes.

FREQUENTLY ASKED QUESTIONS

1. Can any of the identified disciplines (RN, PT, SLP/ST, OT) complete the SOC comprehensive assessment?

For patients receiving skilled care, the SOC comprehensive assessment must be conducted by a registered nurse unless therapy services are the only required service(s) for the patient. In the latter case, the therapist can conduct the assessment. Agencies may choose to evaluate the clinical competency of their individual staff members to perform these assessments as they implement the comprehensive assessment rules.

2. Should the comprehensive assessment and OASIS data collection be the collaborative effort of all the disciplines ordered?

One clinician is responsible for completing the comprehensive assessment. The OASIS data set and responses are incorporated into that individual's clinical documentation for the specific visit. When the clinician signs her/his name to the legal documentation, she/he verifies the accuracy of the assessment data. Therefore, standards for clinical documentation indicate that OASIS data are collected by one person.

If two clinicians are seeing the patient at the same time, it is reasonable for them to confer about the interpretation of assessment data. It is also reasonable for the clinician performing the assessment to follow-up on any observations of patient status reported by other agency staff. The actual assessment, however, is the responsibility of one clinician.

3. My skilled care patient does not have a visit scheduled during the five-day period at the end of the 60-day certification period. What should I do?

A comprehensive assessment with OASIS data collection is required to be done during this period. In managing the patient's care, the visit schedule should be monitored to include a visit during this time. If multiple disciplines are providing care, the assessment and data collection can be done by a member of another discipline. A patient assessment could be done during an aide supervisory visit. In nearly all situations, agency staff have been able to schedule visits to occur within this period.

FREQUENTLY ASKED QUESTIONS

4. We occasionally receive requests for one-time visits to perform specific services (e.g., evaluate patients for DME needs, perform a venipuncture, administer an injection, etc.). Do these patients require a comprehensive assessment with OASIS data collection? If so, which data are transmitted to the State?

You are describing visits where patients are eligible for specific services and these services are performed. If Medicare or Medicaid patients meet the criteria for the comprehensive assessment, they also require OASIS data collection. The start of care (SOC) assessment is performed, and Response 1 (SOC) should be marked for M0100 - This Assessment Completed for the Following Reason. The OASIS data should be encoded (data entered) to generate a Health Insurance Prospective Payment System (HIPPS) code and transmitted to the State. No discharge assessment is required, as the patient receives only one visit. (If the patient is not a Medicare or Medicaid patient, the comprehensive assessment will be completed, but OASIS data are not required to be collected.) In all circumstances, agency clinical documentation should indicate that no further visits occurred.

5. What are the indications for an "other follow-up" assessment?

In the preamble to the comprehensive assessment regulation, it is noted that a comprehensive assessment with OASIS data collection is required when there is a significant change in a patient's health status. "Significant change" is further defined as a major decline or improvement in health status. Each agency will need to determine its own policies regarding examples of major decline or improvement in health status and to assure that the clinical staff is adhering to these policies. In the event the agency determines that an assessment at a point in time not already required is necessary based on its own policies, Response 5 - Other Follow-up would be selected for M0100 Reason Assessment is Being Completed.

FREQUENTLY ASKED QUESTIONS

6. If a resumption of care survey is performed, does the clock "reset" with respect to follow-up survey, i.e., is the follow-up due 60 days after resumption of care date or does it remain 60 days from the original start of care date?

As long as the agency has not discharged the patient, the original admission start of care date stands for any subsequent recertification period that follows when a patient resumes care by the agency after having been temporarily transferred to an inpatient facility for care. Therefore, unless the patient has been discharged, the due dates for follow-up assessments are calculated from the original start of care date rather than from the resumption of care date. Currently, whether or not an agency discharges a patient due to transfer to another inpatient setting is a matter of that agency's policy.

FREQUENTLY ASKED QUESTIONS

7. In multidiscipline cases, who can perform the comprehensive assessment in the following situations:

a) When RN and PT are both ordered at SOC?

b) When PT is ordered at SOC, and the RN will enter 7-10 days after SOC?

c) When PT (or ST) is ordered along with an aide?

d) If our agency policy is for the RN to perform an assessment before the therapist's SOC visit (in a therapy-only case)?

e) OT services are the only ones ordered for a non-Medicare patient?

f) Both RN and PT will conduct discharge visits on the same day?

According to the comprehensive assessment regulation, the following disciplines would perform the assessments in these situations:

a) When both disciplines are ordered at SOC, the RN would perform the SOC comprehensive assessment. Either discipline may perform subsequent assessments.

b) If the RN's entry into the case is known at SOC (i.e., nursing is scheduled, even if only for one visit), then the case is NOT therapy-only, and the RN should conduct the SOC comprehensive assessment. If the order for the RN is not known at SOC and originates from a verbal order after SOC, then the case is therapy-only at SOC, and the therapist can perform the SOC comprehensive assessment. Either discipline may perform subsequent assessments.

c) Because this is considered a therapy-only case (i.e., therapy is the only skilled service), the PT (or ST) would perform the comprehensive assessment and all subsequent assessments.

d) A comprehensive assessment performed BEFORE the SOC date cannot be entered into HAVEN (or HAVEN-like software). The therapist could perform the SOC comprehensive assessment, or the RN could perform an assessment on or after the therapist's SOC date (within five days to be compliant with the regulation).

e) The OT can perform the comprehensive assessment if OT services establish program eligibility.

f) Either discipline may perform the discharge comprehensive assessment. Agency policy may address this issue.

FREQUENTLY ASKED QUESTIONS

8. Can the MSW or an LPN ever perform a comprehensive assessment? What about therapy assistants?

According to the comprehensive assessment regulation, the MSW or an LPN are not able to perform the comprehensive assessment. Only RN, PT, SLP (ST), or OT are able to perform the assessment. Therapy assistants are also not able to perform the comprehensive assessment. This is no different from the previously existing Medicare requirements that set forth the qualification standards of those conducting patient assessments.

9. I understand that the SOC (or resumption of care) initial assessment is to be done within 48 hours of the referral (or hospital discharge). What do we do if the patient puts us off longer than that? For example, the patient says, "I have an appointment today (Friday); please come Monday."

The SOC initial assessment is to be done within 48 hours of the referral OR on the physician-ordered date. In the absence of a physician-ordered SOC date, if the patient refuses a visit within this 48-hour period, the agency should contact the physician to determine whether a delay in visiting would be detrimental to the plan of care. We advise documenting the event in the patient's chart for future reference.

The ROC visit is to be done within 48 hours of the patient's hospital discharge. If the physician's order requests that the home health agency resume care at a point later than 48 hours or if the patient refuses a visit within this 48-hour period, document the event in the patient's chart for future reference.

FREQUENTLY ASKED QUESTIONS

10. We have questions about the discharge comprehensive assessment:

a) Does the clinical documentation need to include anything other than the OASIS discharge items?

b) Under what circumstances is the discharge comprehensive assessment required to be done -- only in case of a discharge when goals are met?

c) If nursing and therapy visit the same day, which is also the date of discharge, who is responsible for the discharge comprehensive assessment?

a) The exact content of the discharge comprehensive assessment documentation (other than the required OASIS items) is left to each agency's discretion. To fulfill the comprehensive assessment requirement, agencies should remember that the OASIS items are not considered a comprehensive assessment by themselves. HHAs should determine any other assessment items needed for a discharge assessment and include these in their clinical documentation.

b) The discharge comprehensive assessment is required for all situations that result in an agency discharge except transfer to an inpatient facility or patient death at home. A patient who moves from the service area, who refuses further services, who is discharged because goals are met, or whose physician requests no further services all are required to have a discharge comprehensive assessment recorded and submitted. (Patients transferred to an inpatient facility who are subsequently discharged by the HHA without receiving additional visits/services do not require a discharge comprehensive assessment -- the patient has not been under the care of the agency since the transfer.)

c) If a nurse and therapist both see the patient on the day of discharge, the last qualified clinician who visits the patient is responsible for the discharge comprehensive assessment.

FREQUENTLY ASKED QUESTIONS

11. Is it ever acceptable for an LPN to complete the OASIS? For example, could an LPN complete the OASIS if she/he were the last to see a patient prior to an unexpected rehospitalization?

The comprehensive assessment and OASIS data collection must be conducted by an RN or, for therapy-only cases, any of the allowable disciplines, i.e., physical therapy, speech therapy, or occupational therapy as described in the regulations. Collection of OASIS data is done by the primary care provider employed directly by the HHA or under contract to the HHA. Once collected by the appropriate health professional, data entry of the OASIS items may be performed by other staff.

12. For patients who are discharged after a hospital stay or a visit to the doctor, is it necessary to complete the discharge assessment? We will not be able to make a home visit after the discharge order is obtained.

The patient who is discharged after a hospital stay will have had OASIS data reported at the point of transfer to the inpatient facility. No additional assessments or OASIS data collection are expected in this situation unless a resumption of care occurs. Therefore, the agency will complete a "paper discharge" in their records, but no OASIS data are reported.

In the second situation, if the physician determines that the patient does not need additional visits and requests discharge, the agency must report the patient status at the last skilled visit prior to this date. When agency staff are aware that the patient's needs for home care are decreasing and that a physician visit is imminent, the possibility of such discharge must be considered and communicated among team members. Close attention to the details of the comprehensive assessment thus can be incorporated into the home visit scheduled prior to the physician visit.

FREQUENTLY ASKED QUESTIONS
ABOUT OASIS DATA COLLECTION
SURROUNDING INPATIENT FACILITY ADMISSION

13. My agency places patients on "hold" status during an inpatient facility stay. My patient was transferred to a hospital and then went to a nursing home. At this point, my agency decided to discharge the patient. What do I do about OASIS data collection?

My agency also places patients on a "hold" status when they are transferred to an inpatient facility. My patient died during the inpatient facility stay. What do I do about OASIS data collection?

(The same answer is appropriate for both questions.) If the Transfer to Inpatient Facility data were collected and reported (using Response 6 to M0100), no additional OASIS data are required. Your agency will complete a discharge summary that reports what happened to the patient for the agency clinical record, however.

The important principle that applies to both these situations is that the patient has not been under the care of the agency since the inpatient facility admission. Because the agency has not had responsibility for the patient, no additional OASIS data are necessary.

14. Is OASIS data collection required if the patient is admitted to an inpatient facility for diagnostic tests only?

No.

15. What do I do about OASIS data collection if the patient's inpatient facility admission is less than 24 hours?

The answer to this question depends on your agency's policy. If your agency discharges patients admitted to an inpatient facility regardless of the time interval, Transfer to Inpatient Facility data are reported (using Response 7 for M0100).

However, if your agency's policy (to discharge or not with inpatient facility admission) is dependent on the patient being admitted to the inpatient facility for more than 24 hours, this condition has not been met (i.e., the patient was not in the inpatient facility for 24 hours or more). Therefore, OASIS data collection is not required.

FREQUENTLY ASKED QUESTIONS
ABOUT OASIS DATA COLLECTION
SURROUNDING INPATIENT FACILITY ADMISSION

16. If the patient is admitted to an inpatient facility for diagnostic tests, but the tests lead to further treatment (e.g., surgery, etc.), is OASIS data collection required?

Yes, because the inpatient facility admission is for more than diagnostic testing. Transfer to Inpatient Facility data would be reported.

17. My patient was transferred to an inpatient facility and is still there during the five-day recertification (follow-up) assessment period. My agency places patients on "hold" status during an inpatient stay. What should I do about the required OASIS data collection?

The Transfer to Inpatient Facility data collection with Response 6 selected for M0100 is completed at the time of the transfer.

For Medicare PPS patients only: Because the 60-day certification period is also an episode payment period, the patient who is not receiving care from the agency at the end of the episode must be discharged. The already-completed Transfer to Inpatient Facility for will be the last OASIS data required for the episode. When the patient returns home, a new Start of Care (SOC) comprehensive assessment (including OASIS data collection) is completed because this begins a new payment episode, based on the new SOC date. (A new CMS 485 is required.) ***Example:*** *Patient's SOC date is 10/06/00 and initial certification period is 10/06 - 12/04/00. The transfer to an inpatient facility occurs 11/28/00, and patient returns home on 12/06/00. The new SOC date is 12/07/00 (first visit after return home), and the new certification period is 12/07/00 - 02/04/01.*

For other patients: No data are collected at the recertification time point because the patient is not under the current care of the agency. When the patient returns to home care, complete the Resumption of Care (ROC) comprehensive assessment with OASIS data collection for a second 60-day certification (still based on the original SOC date). ***Example:*** *Non-Medicare patient's SOC date is 10/06/00, therefore, initial certification is 10/06 - 12/04/00. Transfer to inpatient facility occurs 11/28/00, and patient returns home on 12/06/00. ROC date (M0032) is 12/07/00 (first comprehensive assessment after return home), for a second certification period of 12/05/00 - 02/02/01.* ***Alternatively, the HHA may choose to follow the procedure for Medicare PPS patients for all patients.***

FREQUENTLY ASKED QUESTIONS
ABOUT OASIS DATA COLLECTION
SURROUNDING INPATIENT FACILITY ADMISSION

18. What OASIS data are required to be collected when the Resumption of Care (ROC) and the Follow-up (FU) assessment for recertification are within days of each other (i.e., when the patient is discharged from the inpatient facility during the last five days of a 60-day episode)?

For Medicare PPS patients prior to January 1, 2008: If the HHA wishes to request a payment adjustment for a Significant Change in Condition (SCIC) for the remaining days of the current payment episode, the FU assessment is completed as well as the ROC comprehensive assessment. (The ROC assessment data are used to determine the case mix for the SCIC payment adjustment, and the FU data predict the case mix for the subsequent 60-day episode.) If the HHA's decision is NOT to request a SCIC for the remaining days of the current episode, only a ROC assessment is required.

For Medicare patients after January 1, 2008 and other patients: The ROC comprehensive assessment is required within 48 hours of the patient's return from the inpatient facility, and the FU recertification assessment is required during the last five days of the 60-day certification period. It is possible for these two time periods to overlap as they do in this situation. When they do, a ROC is the only assessment required. This data collection will also satisfy the requirement for the FU assessment. Note that only Response 3 should be marked for M0100.

If these two time periods do not overlap, two comprehensive assessments are required, each within the appropriate time period. One assessment will be done for the ROC, and the other will occur for the FU assessment.

19. One of my agency's patients goes to a nursing home for respite services one weekend each month. What assessments and data collection are required?

If the respite stay is longer than 24 hours, this meets the criteria for inpatient facility admission. Transfer to Inpatient Facility data would be recorded, followed by a resumption of care assessment and data collection within 48 hours of the patient's return home.

ATTACHMENT A TO CHAPTER 4

SUPPLEMENTAL REFERENCES ON PATIENT ASSESSMENT

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ATTACHMENT B TO CHAPTER 4

ADDITIONAL HOME CARE PATIENT SCENARIOS

The following examples describe possible home care patient scenarios. In each case, identify how OASIS item M0100 - Reason Assessment is Being Completed should be correctly marked.

Example B1

Mr. E has private insurance and receives chemotherapy in the hospital every four weeks. For each admission, he is hospitalized for 72 hours. Your agency has a policy of discharging non-Medicare patients who are admitted to the hospital for longer than 24 hours. **What response option for M0100 should be selected when Mr. E returns to home care?**

Response: Mr. E receives a new SOC comprehensive assessment each time he resumes home care. OASIS data collection is not required.

Example B2

Ms. F is a Medicare patient and has the same chemotherapy regimen as Mr. E, but the home care agency providing her care does not discharge patients with each inpatient facility stay of 24 hours or longer. **Which response option for M0100 should be selected when Ms. F returns to home care?**

Response: Ms. F receives a new comprehensive assessment each time she resumes home care. Because she was not discharged, however, M0100 response option 3 (resumption of care after inpatient facility stay) is selected.

Example B3

Ms. G was admitted to your agency after a lengthy hospitalization for CHF and diabetes complications. She is on multiple medications, some of which are new to her. She lacks information about her conditions and their treatment but is interested and willing to learn. You do the SOC comprehensive assessment at the first visit. When you call her two days later to remind her of your next visit, her daughter answers the telephone. The daughter indicates that the family is packing Ms. G's belongings to move her to the daughter's home across the state**. What should be done about OASIS data collection?**

Response: You conducted the SOC assessment and developed the plan of care with the intention of making additional visits, yet no additional visits have been made. The OASIS SOC data should be encoded (data entered) to generate a Health Insurance Prospective Payment System (HIPPS) code and transmitted to the State system. No discharge assessment is required, as the patient received only one visit, and no subsequent OASIS data must be submitted. Agency clinical documentation should note that no further visits occurred. You should be aware that the patient's name will appear on the data management system (DMS) agency roster report for six months, after which time the patient's name is dropped from the DMS report. If the patient is admitted again to the agency and a subsequent SOC assessment submitted, the agency will receive a warning that the new assessment is out of sequence. This will not prevent the agency from transmitting that assessment, however.

Example B4

You visited Ms. I, your 83-year-old patient with multiple long-term cardiac diagnoses, yesterday for evaluation of your teaching plan. When you arrived, she reported radiating chest pain. The physician concurred with your recommendation to have Ms. I sent to the emergency room via ambulance. You learned that the patient was admitted to the coronary care unit. Today you hear from the physician's office that Ms. I died last night in the hospital**. What do you do about OASIS data collection and reporting?**

Response: If your agency routinely discharges patients admitted to the inpatient facility at the point of their admission, you would have completed the appropriate items directed for Response 7 to M0100 - Reason Assessment is Being Completed. Response 7 notes that the patient was admitted to the inpatient facility and was discharged from the agency. If your agency waits to see whether the patient's admission lasts longer than 24 hours, you would not yet have completed the Transfer to Inpatient Facility Form. You can complete it now, also choosing Response 7. (This response is selected regardless of your agency's policy regarding inpatient facility admission, because this patient will not be returning to the agency for care.) If more than 24 hours had elapsed between the patient's admission to the hospital and her death (and your agency places such patients on a "hold" status), then you might have completed the same items with Response 6 (transfer without agency discharge). Once you learn of the patient's death, you would complete the appropriate agency discharge summary, though no additional OASIS data collection would be required. Response 8 (death at home) is not a correct response, because the patient was admitted to an inpatient facility before she died.

Example B5

Mr. J, who lives alone, is admitted to your agency in mid-November. On 12/02, you call prior to your previously scheduled visit, but there is no answer. You try several more times with no success. You call his physician and learn that he was admitted to the hospital on 11/29. You reach the patient in the hospital, who reports that he was found by his neighbor on the floor and sent to the hospital in an ambulance. He states that he may be going home tomorrow. Four days later (12/06), you have not heard any report from the patient or the physician. You call the patient's home; he is there and reports that he came home yesterday with several new medications. You contact the physician's office and the hospital discharge planner, requesting both to fax current orders, including all medications. You see the patient later that day. **What assessments and OASIS data collection have occurred between 11/29 and end of day today?** (Your agency places patients admitted to an inpatient facility on "hold" status.)

Response: On 12/02, you completed the OASIS Transfer to Inpatient Facility items, following the skip logic directed in Response 6 to M0100 - Reason Assessment is Being Completed. At that time, you would enter 12/02 as the response to M0090 - Date Assessment Completed and 11/29 as the response to M0906 - Discharge/Transfer/Death Date. These data were reported on the basis of your telephone contacts. On 12/06, when you visit the patient, you complete a comprehensive assessment. At this time, you select Response 3 (Resumption of Care) for M0100 - Reason Assessment is Being Completed.

Example B6

Ms. K, a Medicare PPS patient, was admitted to your agency for physical therapy services following hip replacement surgery. After eight days of care, the PT learns that the patient was readmitted to the hospital after going to the emergency room with a severe nosebleed and a very high pro-time. The PT completes the appropriate Transfer to Inpatient Facility items. When the patient returns home, a nursing manager requests nursing services in addition to therapy. **Who completes the comprehensive assessment when the patient returns home? Which response is selected for M0100 - Reason Assessment is Being Completed? If nursing discharges before therapy, who completes the discharge comprehensive assessment? If therapy discharges before nursing, who completes the discharge comprehensive assessment?**

Response: Response 3 (Resumption of Care) is answered to M0100 - Reason Assessment is Being Completed because she is Medicare PPS, and it still is the same 60-day episode. The RN or PT should conduct the comprehensive assessment for the ROC following hospitalization. The discharge comprehensive assessment will be completed by whichever discipline remains on the case, whether it is the same discipline that completed the resumption of care or not. If nursing is the last discipline out of the case, the nurse will complete the discharge comprehensive assessment. Alternatively, if therapy is the last discipline out of the case, the therapist will complete the discharge comprehensive assessment.

Example B7

Mr. L, a Medicare patient, was transferred to a hospital on June 14. Your agency collected the appropriate Transfer to Inpatient Facility data at that time, but did not discharge the patient in accord with agency policy. He had an extended hospitalization with several days in a nursing home, and home care is not resumed until July 18. Your agency has a policy that states patients are discharged if services are not resumed within 21 days from the transfer date. **What procedures should be followed, and what data are reported?**

Response: Following agency policy, Mr. L would be discharged from your agency on July 6. No OASIS data would be collected or reported, since your agency had not been responsible for his care since June 14. When he returns to home care on July 18, a comprehensive assessment will be performed with a new start of care date.

Example B8

A nurse visits Ms. M at home today, one day after her discharge from the hospital. She has several comorbidities and problems that require immediate skilled interventions. The nurse is unable to complete the full comprehensive assessment today but plans a visit tomorrow to finish the assessment**. Is this permissible? How are M0030 (Start of Care Date) and M0090 (Date Assessment Completed) answered?**

Response: If agency policy allows more than one visit to complete the comprehensive assessment, the nurse's actions are congruent with agency policy. M0030 has today's date entered, while M0090 will have tomorrow's date entered (assuming that is the date when the comprehensive assessment is completed).

Example B9

The nurse conducts a routine visit (not SOC) for Mr. N on August 4. An aide visits August 5 and August 7. On August 8, the physician calls the agency and unexpectedly discontinues home care. **What OASIS data are reported? What dates are used for M0090, M0903, and M0906? How does the agency note the patient's status at discharge?**

Response: The general principle to follow in these cases is to report the patient's status on the last visit by the clinician qualified to complete the comprehensive assessment with OASIS. We suggest the following approach:

1. All OASIS data required for discharge must be reported. Response 9 for M0100--Reason Assessment is Being Completed will indicate that the patient is being discharged from the agency, but NOT to an inpatient facility.

2. M0090 would be noted as August 8, the date the agency learns of the discharge. (This is the date to be used for compliance with the submission timeframe.) M0903 - Date of Last (Most Recent) Home Visit would be noted as August 7, the date of the last visit by the aide. M0906 - Discharge/Transfer/Death Date would be reported as August 8.

3. To be compliant with the discharge comprehensive assessment requirement, the qualified clinician that last saw the patient should complete the agency's discharge documentation as completely as possible, based on the patient status at that provider's last visit -- in this example, August 4. The clinician should note on this documentation that it is "based on the visit of mm/dd/yyyy." The OASIS data from this assessment will be encoded, locked, and transmitted. The agency will thus have a discharge assessment recorded and a clinical record document that matches the OASIS data transmitted to the State.

Situation Variation 1: What if the same dates apply to the nurse's visit (August 4) and the date the physician calls the agency to discontinue services (August 8), but there have been no aide visits? **What, if anything, is different from the situation described above?**

Response: Only one difference exists between this situation and the one described above. That is the date recorded in M0903 - Date of Last (Most Recent) Home Visit. In this variation, the date would be August 4, the date of the nurse's visit.

Example B9 (Cont'd.)

Situation Variation 2: The situation is the same as Variation 1, but agency policy requires the discharge date to be the date of the last visit. **What, if anything, is different from the situation in Variation 1?**

Response: The date recorded in M0090 - Date Assessment Completed would be August 8, the date that the agency learned of the discharge. M0903 - Date of Last (Most Recent) Home Visit again would be August 4. Agency policy would dictate the date to be recorded in M0906 - Discharge/Transfer/Death Date, which would be recorded as August 4 (the last actual visit). This will produce a warning message in HAVEN or other data entry software, because the assessment was completed more than two days after the discharge. The warning will not hinder transmission of data.

Situation Variation 3: What if the visits on August 5 and August 7 were made by an LPN (or therapy assistant)? **What, if anything, is different from the situation described above?**

Response: There is no difference from the initial situation described earlier. The LPN (or therapy assistant) is not qualified to perform the comprehensive assessment, therefore the recorded assessment must describe the patient's status at the nurse's (or qualified therapist's) visit. If the LPN/therapy assistant made the last visit before the MD discontinued services, the LPN/therapy assistant's last visit date would be recorded for M0903. In this case, that date would be August 7.

Situation Variation 4: What if the nurse's August 4th visit was the SOC assessment, followed by the aide visits on August 5 and August 7? **What, if anything, is different from the initial situation?**

Response: There is no difference from this situation and the initial one described. The HHA must report the patient's status from an actual visit -- in this case, the only possible visit would be the SOC assessment. The qualified clinician must complete the agency's discharge documentation as noted above, with the note that the assessment is "based on the visit of mm/dd/yyyy."

Example B9 (Cont'd.)

Situation Variation 5: What if the nurse makes a visit on August 4, expecting this to be the discharge visit pending a final check with the patient a few days later? A telephone call to the patient on August 8 confirms that the patient is doing well, and the agency discharges the patient. **What, if anything, is different from the situations described above?**

Response: There are some subtle differences from the situations described above. Because the nurse is expecting the discharge to occur, it is recommended that a complete assessment be recorded on August 4. However, the regulations require an assessment congruent with the discharge date of August 8. The agency must assure the presence in the clinical record of a discharge assessment completed on (or within 48 hours of) the date recorded in M0090 (August 8 in this example). The HHA has two options for this precise situation: (1) To conduct a (most likely nonreimbursed) visit on or after August 8 to complete another discharge assessment, or (2) To follow the procedures for recording a discharge assessment dated August 8, based on the patient status of August 4 (and so noted in the clinical documentation). Possibly a better option would be to place the telephone call to the patient within 48 hours of the August 4 visit, thus placing the discharge assessment and the discharge date within 48 hours of each other.

In providing patient care that focuses on achievement of outcomes, the HHA assumes responsibility for monitoring patient progress and for coordinating care among all participating providers. The agency, thus, is responsible for planning, coordinating, and communicating about improvement in patient status that can indicate the need for less frequent visits or even discharge. Agencies that do this well will have relatively few "unexpected" discharges, though such events can occur (for example, when a patient unexpectedly moves out of the service area). To meet the various requirements for the comprehensive assessment, as well as collection and use of OASIS data, the following requirements must be met: (1) the discharge assessment must report patient status at an actual visit (i.e., the clinician must be able to assess the patient, not merely report on patient status from a telephone call); (2) the comprehensive assessment must be conducted by a qualified clinician (RN, PT, SLP, OT); (3) the encoded OASIS data must accurately reflect the patient's status at the time of the assessment; and (4) the HHA's clinical record must contain documentation matching the encoded data sent to the State.

Example B9 (Cont'd.)

HHAs must be aware that retrospective data reporting can negatively impact the agency's outcome report in two ways: (1) the clinician's recall of patient status information is likely to be less accurate than the information recorded immediately upon assessment, and (2) the patient's status at time of discharge may actually be better (i.e., improved) than it was at the time of the visit conducted by the RN, PT, SLP, or OT.

Change Page
January 1, 2008

Page(s)	
4.3, Section C	Language simplified
4.18, FAQ #18	Language updated to reflect changes in SCIC policy effective 1/1/2008
4.21, Example B1	Response updated to indicate that OASIS data collection not required
4.21, Example B2	Clarification added that patient is a Medicare patient
4.25, Example B6	Clarification added that Resumption of care can be completed by RN or PT
4.25, Example B7	Clarification added that patient is a Medicare patient