Introduction to OASIS-D

Kathryn D. Roby and Charlotte Steniger
Qualidigm

August 28, 2018
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Today’s Presenters

**Kathryn D. Roby**, M.Ed., M.S., R.N., CHCE, CHAP/ACHC
Senior Consultant, Home Health Services
Qualidigm

**Charlotte Steniger**, R.N., M.S.N., COS-C, COQ-S, CHAP/ACHC
Consultant, Home Health Services
Qualidigm
Acronyms in This Presentation

- Activities of Daily Living (ADL)
- Certification and Survey Provider Enhancement Reports (CASPER)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Diabetes Mellitus (DM)
- Drug Regimen Review (DRR)
- Home and Community-Based Services Continuity Assessment Record and Evaluation (HCBS CARE)
- Home Health (HH)
- Home Health Agency (HHA)
Acronyms in This Presentation (cont. 1)

- Home Health Quality Reporting Program (HH QRP)
- Home Health Value-Based Purchasing (HH VBP)
- Instrumental Activities of Daily Living (IADL)
- Improving Medicare Post-Acute Care Transformation (IMPACT) Act
- Inpatient Rehabilitation Facility (IRF)
- Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI)
- Long-Term Care Hospital (LTCH)
Acronyms in This Presentation (cont. 2)

- Long-Term Care Hospital Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS)
- Medicare Learning Network (MLN)
- Minimum Data Set (MDS)
- National Pressure Ulcer Advisory Panel (NPUAP)
- Outcome and Assessment Information Set (OASIS)
- Peripheral Arterial Disease (PAD)
- Peripheral Vascular Disease (PVD)
- Post-Acute Care (PAC)
Acronyms in This Presentation (cont. 3)

- Potentially Avoidable Event (PAE)
- Pressure Ulcer (PU)
- Prospective Payment System (PPS)
- Quality Improvement and Evaluation System (QIES)
- QIES Technical Support Office (QTSO)
- Quality Reporting Program (QRP)
- Registered Nurse (RN)
- Resumption of Care (ROC)
- Start of Care (SOC)
- Standardized Patient Assessment Data Elements (SPADEs)
Learning Objectives

1. Describe the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 and resulting changes to Outcome and Assessment Information Set (OASIS)

2. Identify the major changes from OASIS-C2 to OASIS-D

3. Identify available resources for implementing OASIS-D
OASIS-D Training Opportunities

- Introduction to OASIS-D Webinar
  August 28, 2018
- Introduction to OASIS-D Section GG Webinar
  September 5, 2018
- Q&A Teleconference
  Anticipated October/November 2018
- In-Person Home Health Provider Training, Baltimore, MD
  Anticipated October/November 2018

Webcast available!

Presentation and recording will be posted on the CMS website
Training Information and Updates

Spotlight and Announcements


Home Health Quality Reporting Training

Overview of OASIS-D and IMPACT Act of 2014
Overview

• IMPACT Act of 2014
• Changes from OASIS-C2 to OASIS-D
  – New, revised, and removed assessment items
  – Rationale for OASIS changes
IMpact Act of 2014

- Bipartisan bill signed into law by President Obama on October 6, 2014
- Requires post-acute care (PAC) providers to report standardized patient assessment data and quality measure data
PAC Matters

LTCH, IRF, HHA, Nursing Homes

POST-ACUTE CARE (PAC)

Section 3004 of the Affordable Care Act mandates the establishment of PAC quality reporting programs (QRP) for long-term care hospitals (LTCH), inpatient rehabilitation facilities (IRF), and hospices. The Improving Medicare Post-Acute Care Transformation Act of 2014 mandates the establishment of QRP for skilled nursing facilities (SNF).

Section 1955 of the Social Security Act mandates the establishment of home health agencies (HHA) QRP.

PAC Settings

<table>
<thead>
<tr>
<th>Setting</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHA</td>
<td>Skilled nursing or therapy services available to beneficiaries who are homebound.</td>
</tr>
<tr>
<td>IRF</td>
<td>Intensive rehabilitation services such as physical, occupational, and recreational therapy, post-acute care management, and pain management.</td>
</tr>
<tr>
<td>HOSPICE</td>
<td>Palliative care services, including pain management and spiritual counseling.</td>
</tr>
<tr>
<td>LTCH</td>
<td>Hospital-level care such as prolonged ventilator support and cardiac care management.</td>
</tr>
<tr>
<td>SNF</td>
<td>Short-term skilled nursing and rehabilitation services to individuals whose health problems are not acute or comprehensive for home care or assisted living.</td>
</tr>
</tbody>
</table>

Quality reporting in PAC settings aligns with the CMS National Quality Strategy Goals:

- Making Care Safer
- Patient and Family Engagement
- Effective Prevention & Treatment of Chronic Diseases
- Communication & Care Coordination
- Best Practice of Healthy Living
- Making Care Affordable

HOW CAN YOU LEARN MORE? VISIT WWW.CMS.GOV

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Facilities</th>
<th>Providers</th>
<th>Medicare Beneficiaries</th>
<th>PAC Medicare Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTCH</td>
<td>441</td>
<td>408 k</td>
<td>118 k</td>
<td>$5.4</td>
</tr>
<tr>
<td>SNF</td>
<td>15,031</td>
<td>20.2 million</td>
<td>1.7 million</td>
<td>$28.6</td>
</tr>
<tr>
<td>IRF</td>
<td>1,177</td>
<td>469 k</td>
<td>339 k</td>
<td>$7</td>
</tr>
<tr>
<td>HHA</td>
<td>12,461</td>
<td>17.3 million</td>
<td>3.4 million</td>
<td>$17.7</td>
</tr>
<tr>
<td>Hospices</td>
<td>4,092</td>
<td>441 k</td>
<td>1.3 million</td>
<td>$15.1</td>
</tr>
<tr>
<td>All PAC Facilities</td>
<td>33,172</td>
<td>38.5 million</td>
<td>6.9 million</td>
<td>$73.8</td>
</tr>
</tbody>
</table>

Data Source:
1. CMS: "Medicare.gov/Medicare/Provider-Participation/Quality-Improvement-Requirements/Participating-LTC-IRF-Hospice-CMS-Data/.pdf");
2. CMS: "Quality Measures for Nursing Homes and Bullets (QMB)"
Driving Forces of the IMPACT Act

Purpose:
- Improve Medicare beneficiary outcomes
- Provide access to longitudinal data to facilitate coordinated care
- Enable comparable data and quality across PAC settings
- Improve hospital discharge planning
- Research

Why the attention on Post-Acute Care?
- Escalating costs associated with PAC
- Lack of data standards/interoperability across PAC
- Goal of establishing payment rates according to the individual characteristics of the patient, not the care setting
What Is Standardization?
Standardizing Function at the Item Level

- Inpatient Rehabilitation Facilities – Patient Assessment Instrument (IRF-PAI)
- Skilled Nursing Facilities – Minimum Data Set (MDS)
- Home Health Agencies – Outcome & Assessment Information Set (OASIS)
- Long-Term Care Hospitals – Continuity Assessment Record & Evaluation (CARE) Data Set (LCDS)

- IRF-PAI: Eating
- MDS: Eating
- OASIS: Eating
- LCDS: Eating
What Is Standardization?
Standardizing Function at the Item Level (cont.)

- **Inpatient Rehabilitation Facilities – Patient Assessment Instrument (IRF-PAI)**
- **Skilled Nursing Facilities – Minimum Data Set (MDS)**
- **Home Health Agencies – Outcome & Assessment Information Set (OASIS)**
- **Long-Term Care Hospitals – Continuity Assessment Record & Evaluation (CARE) Data Set (LCDS)**

- **IRF-PAI** • Eating
- **MDS** • Eating
- **OASIS** • Eating
- **LCDS** • Eating
Standardized Patient Assessment Data Elements (SPADEs)

- **SPADEs:**
  - Question and response options that are identical in all four PAC assessment instruments
  - Identical standards and definitions apply
- The move toward standardized assessment data elements facilitates cross-setting data collection, quality measurement, outcome comparison, and interoperable data exchange
• Overview of the IMPACT Act
  − This video from the November 2016 HH Quality Reporting Program (QRP) Provider Training held November 16 and 17, 2016, presents an overview of the IMPACT Act of 2014

https://www.youtube.com/watch?v=xyoC-ZnrZMw
Overview of OASIS Changes, Effective January 1, 2019

6 New Items
- GG0100
- GG0110
- GG0130
- GG0170
- J1800
- J1900

7 Revised Items
- M1028
- M1306
- M1311
- M1322
- M1324
- M2102
- M2310

28 Removed Items
- M0903, M1011, M1017, M1018, M1025, M1034, M1036, M1210, M1220, M1230, M1240, M1300, M1302, M1313, M1320, M1350, M1410, M1501, M1511, M1615, M1750, M1880, M1890, M1900, M2040, M2110, M2250, M2430
Overview of Guidance Manual Changes

Guidance Manual Changes for 33 Items

Why Is OASIS Being Changed?

**IMPACT Act/Standardization**
- New Standardized Items
  - Section J: J1800 & J1900
  - Section GG: GG0100, GG0110, GG0130 & GG0170

**Cross-Setting Alignment**
- Alignment in content of items that support cross-setting measures
  - Drug Regimen Review (DRR)
  - Pressure Ulcers
  - Active Diagnoses
  - Height & Weight

**Comprehensive Item Use Evaluation**
- Reduction of burden
  - Quality measure changes
  - Survey and certification

**Updates/Corrections**
- General updates/corrections made as necessary
Section J: Health Conditions (Falls)

- J1800. Any Falls Since SOC/ROC
- J1900. Number of Falls Since SOC/ROC

Section GG: Functional Abilities and Goals

- GG0100. Prior Functioning: Everyday Activities
- GG0110. Prior Device Use
- GG0130. Self-Care
- GG0170. Mobility
### OASIS-D: New Items and Time Points

<table>
<thead>
<tr>
<th>Section</th>
<th>Item</th>
<th>Time Points Completed</th>
</tr>
</thead>
</table>
| **Section J:** Health Conditions (Falls) | • J1800. Any Falls Since SOC/ROC  
• J1900. Number of Falls Since SOC/ROC | • Transfer  
• Discharge from Agency – Not to an Inpatient Facility  
• Death at home |
| **Section GG:** Functional Abilities and Goals | • GG0100. Prior Functioning: Everyday Activities  
• GG0110. Prior Device Use | • Start of care (SOC)  
• Resumption of care (ROC) |
|                              | • GG0130. Self-Care  
• GG0170. Mobility                          | • SOC  
• ROC  
• Follow-Up  
• Discharge from Agency – Not to an Inpatient Facility |
## OASIS-D: Revised Items

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>M1028</td>
<td>Active Diagnoses</td>
</tr>
<tr>
<td>M1306</td>
<td>Unhealed Pressure Ulcer/Injury at Stage 2 or Higher?</td>
</tr>
<tr>
<td>M1311</td>
<td>Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage</td>
</tr>
<tr>
<td>M1322</td>
<td>Current Number of Stage 1 Pressure Injuries</td>
</tr>
<tr>
<td>M1324</td>
<td>Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable</td>
</tr>
<tr>
<td>M2102</td>
<td>Types and Sources of Assistance</td>
</tr>
<tr>
<td>M2310</td>
<td>Reason for Emergent Care</td>
</tr>
</tbody>
</table>
Data Items Removed From OASIS

• In 2017, CMS undertook a comprehensive review of the OASIS

• 28 OASIS items identified for removal to reduce data collection burden
Why Were These Items Removed?

- OASIS items were removed if they were not used to support:
  - HH QRP measures
  - HH Prospective Payment System (PPS)
  - Survey process for Medicare certification
  - HH Value-Based Purchasing (VBP) demonstration measures
  - Critical risk-adjustment factors
  - Conditions of Participation
# OASIS-D: Removed Items

<table>
<thead>
<tr>
<th>Item</th>
<th>Item Description</th>
<th>SOC</th>
<th>ROC</th>
<th>Follow-Up</th>
<th>Transfer to an Inpatient Facility</th>
<th>Death at Home</th>
<th>Discharge from Agency</th>
</tr>
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<tbody>
<tr>
<td>M0903</td>
<td>Date of Last Home Visit</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>M1011</td>
<td>Inpatient Diagnosis</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M1017</td>
<td>Diagnoses, Treatment Regimen Change</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M1018</td>
<td>Conditions Prior</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M1025</td>
<td>Optional Diagnoses</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>M1034</td>
<td>Overall Status</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>M1036</td>
<td>Risk Factors</td>
<td>X</td>
<td>X</td>
<td></td>
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# OASIS-D: Removed Items (cont. 1)

<table>
<thead>
<tr>
<th>Item</th>
<th>Item Description</th>
<th>SOC</th>
<th>ROC</th>
<th>Follow-Up</th>
<th>Transfer to an Inpatient Facility</th>
<th>Death at Home</th>
<th>Discharge from Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1210</td>
<td>Ability to Hear</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>M1220</td>
<td>Understanding Verbal Content</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>M1230</td>
<td>Speech and Oral Expression</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M1240</td>
<td>Pain Assessment</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M1300</td>
<td>Pressure Ulcer (PU) Assessment</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M1302</td>
<td>Risk of Developing PUs</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M1313</td>
<td>Worsening in PU Status</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>M1320</td>
<td>Status of Most Problematic PU</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>M1350</td>
<td>Skin Lesion or Open Wound</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
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# OASIS-D: Removed Items (cont. 2)

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<th>Item Description</th>
<th>SOC</th>
<th>ROC</th>
<th>Follow-Up</th>
<th>Transfer to an Inpatient Facility</th>
<th>Death at Home</th>
<th>Discharge from Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1410</td>
<td>Respiratory Treatments</td>
<td>X</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>M1501</td>
<td>Symptoms in Heart Failure Patients</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M1511</td>
<td>Heart Failure Follow-up</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M1615</td>
<td>When does Urinary Incontinence occur?</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>M1750</td>
<td>Psychiatric Nursing Services</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M1880</td>
<td>Ability to Plan and Prepare Light Meals</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M1890</td>
<td>Ability to Use Telephone</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
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## OASIS-D: Removed Items (cont. 3)

<table>
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<tr>
<th>Item</th>
<th>Item Description</th>
<th>SOC</th>
<th>ROC</th>
<th>Follow-Up</th>
<th>Transfer to an Inpatient Facility</th>
<th>Death at Home</th>
<th>Discharge from Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1900</td>
<td>Prior Functioning</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M2040</td>
<td>Prior Medication Management</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M2110</td>
<td>How often does the patient receive ADL or IADL assistance?</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M2250</td>
<td>Plan of Care Synopsis</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M2430</td>
<td>Reason for Hospitalization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
# OASIS-D: Removal From Discharge Time Point Only

<table>
<thead>
<tr>
<th>Item</th>
<th>Item Description</th>
<th>SOC</th>
<th>ROC</th>
<th>Follow-Up</th>
<th>Transfer to an Inpatient Facility</th>
<th>Death at Home</th>
<th>Discharge from Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1610</td>
<td>Urinary Incontinence or Urinary Catheter Presence</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>M1322</td>
<td>Current Number of Stage 1 Pressure Ulcers</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>M1332</td>
<td>Current Number of Stasis Ulcers that are Observable</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>M2030</td>
<td>Management of Injectable Medications</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
<td>✔</td>
</tr>
</tbody>
</table>
# OASIS-D: Select Item Response Removals

<table>
<thead>
<tr>
<th>Item</th>
<th>Item Description</th>
<th>SOC</th>
<th>ROC</th>
<th>Follow-Up</th>
<th>Transfer to an Inpatient Facility</th>
<th>Death at Home</th>
<th>Discharge from Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>M2102</td>
<td>Types and Sources of Assistance</td>
<td>6* out of 7 response options removed</td>
<td>6* out of 7 response options removed</td>
<td></td>
<td></td>
<td></td>
<td>3** out of 7 response options removed</td>
</tr>
<tr>
<td>M2310</td>
<td>Reason for Emergent Care</td>
<td></td>
<td></td>
<td>15*** out of 19*** response options removed</td>
<td></td>
<td></td>
<td>15*** out of 19*** response options removed</td>
</tr>
</tbody>
</table>

* M2102 row f to remain collected at SOC, ROC, and Discharge From Agency as part of the HH VBP program
** M2102 rows a, c, and d to remain collected at Discharge From Agency for survey purposes
*** M2310 responses 1, 10, OTH, UK to remain collected at Transfer to an Inpatient Facility and Discharge From Agency for survey purposes
### Revised Skip Patterns

- Skip pattern changes resulting from item removals:

<table>
<thead>
<tr>
<th>Item Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1000</td>
<td>Inpatient Facility Discharge</td>
</tr>
<tr>
<td>M1051</td>
<td>Pneumococcal Vaccine</td>
</tr>
<tr>
<td>M1306</td>
<td>Unhealed Pressure Ulcer/Injury at Stage 2 or Higher</td>
</tr>
<tr>
<td>M1311</td>
<td>Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage</td>
</tr>
<tr>
<td>M1340</td>
<td>Does This Patient Have a Surgical Wound?</td>
</tr>
<tr>
<td>M1610</td>
<td>Urinary Incontinence or Urinary Catheter Presence</td>
</tr>
<tr>
<td>M2001</td>
<td>Drug Regimen Review</td>
</tr>
<tr>
<td>M2410</td>
<td>Which Inpatient Facility Has the Patient Been Admitted?</td>
</tr>
<tr>
<td>M2420</td>
<td>Discharge Disposition</td>
</tr>
</tbody>
</table>
New OASIS-D Assessment Items

Section J: Health Conditions
• Describe the new assessment items in Section J: Health Conditions
  – Time points completed
  – Item intent
  – Definitions
  – Coding instructions
• Apply coding instructions to accurately code practice scenarios
Section J: New Items

**J1800:** Any Falls Since SOC/ROC, whichever is more recent

**Time Points Completed:**
- Transfer
- Discharge – not to an Inpatient Facility
- Death at Home

**J1900:** Number of Falls Since SOC/ROC, whichever is more recent

**Time Points Completed:**
- Transfer
- Discharge – not to an Inpatient Facility
- Death at Home
Section J: New Items (cont.)

<table>
<thead>
<tr>
<th>J1800.</th>
<th>Any Falls Since SOC/ROC, whichever is more recent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
<td>Has the patient had any falls since SOC/ROC, whichever is more recent?</td>
</tr>
<tr>
<td>0. No</td>
<td>Skip J1900</td>
</tr>
<tr>
<td>1. Yes</td>
<td>Continue to J1900, Number of Falls Since SOC/ROC, whichever is more recent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>J1900.</th>
<th>Number of Falls Since SOC/ROC, whichever is more recent</th>
</tr>
</thead>
<tbody>
<tr>
<td>CODING:</td>
<td>↓ Enter Codes in Boxes</td>
</tr>
<tr>
<td>0. None</td>
<td>A. No injury: No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall</td>
</tr>
<tr>
<td>1. One</td>
<td>B. Injury (except major): Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain</td>
</tr>
<tr>
<td>2. Two or more</td>
<td>C. Major injury: Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma</td>
</tr>
</tbody>
</table>
J1800: Any Falls Since SOC/ROC, whichever is more recent
**New OASIS-D Item: J1800**

<table>
<thead>
<tr>
<th>J1800.</th>
<th>Any Falls Since SOC/ROC, whichever is more recent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
<td>Has the patient <strong>had any falls since SOC/ROC</strong>, whichever is more recent?</td>
</tr>
<tr>
<td></td>
<td>0. <strong>No</strong> → Skip J1900</td>
</tr>
<tr>
<td></td>
<td>1. <strong>Yes</strong> → Continue to J1900, Number of Falls Since SOC/ROC, whichever is more recent</td>
</tr>
</tbody>
</table>
J1800 Intent

• Identifies if the patient had any witnessed or unwitnessed falls since the most recent SOC/ROC
Definition of a Fall

• Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface
  – E.g., a bed or chair

• Fall may be witnessed or unwitnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground

• Not a result of an overwhelming external force
  – E.g., a person pushes a patient
Definition of Intercepted Fall

• An **intercepted fall** occurs when the patient would have fallen if he or she:
  
  − Had not caught him/herself
  − Had not been intercepted by another person

• An intercepted fall is considered a fall
Challenging a Patient’s Balance

• CMS understands that challenging a patient’s balance and training him/her to recover from a loss of balance is an intentional therapeutic intervention and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls.
J18000 Response-Specific Instructions

- Review:
  - Home health clinical record
  - Incident reports
  - Other relevant clinical documentation
    - Fall logs
- Interview patient and/or caregiver about occurrence of falls
J1800 Coding Instructions

- **Code 0, No**, if the patient has not had any fall since the most recent SOC/ROC
- **Code 1, Yes**, if the patient has fallen since the most recent SOC/ROC
  - Code falls no matter where the fall occurred
- **A dash** is a valid response for this item. CMS expects dash use to be a rare occurrence

<table>
<thead>
<tr>
<th>J1800. Any Falls Since SOC/ROC, whichever is more recent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
</tr>
<tr>
<td>0. No → Skip J1900</td>
</tr>
<tr>
<td>1. Yes → Continue to J1900, Number of Falls Since SOC/ROC, whichever is more recent</td>
</tr>
</tbody>
</table>
J1800 Practice Coding
Scenario 1

- The discharging registered nurse (RN) reviews the clinical record and interviews the patient and caregiver, Mrs. K and her daughter Susan, determining that a single fall occurred since the most recent SOC/ROC

- The fall is documented on a clinical note from an RN home visit in which Susan reported her mother slipped from her wheelchair to the floor the previous day
How would you code J1800. Any Falls Since SOC/ROC?

A. Code 0, No
B. Code 1, Yes
How would you code J1800. Any Falls Since SOC/ROC? (cont.)

A. Code 0, No

B. Code 1, Yes

✓
J1800 Practice Coding
Scenario 1 (cont.)

• **Coding:** J1800. Any Falls Since SOC/ROC, would be coded 1, Yes

• **Rationale:** This item addresses unwitnessed as well as witnessed falls

![Diagram of J1800 coding decision tree]
J1800 Practice Coding Scenario 2

- An incident report describes an event in which Mr. S appeared to slip on a wet spot on the floor during a home health aide bath visit.

- He lost his balance and bumped into the wall, but was able to steady himself and remain standing.
How would you code J1800. Any Falls Since SOC/ROC?

A. Code 0, No
B. Code 1, Yes
How would you code J1800. Any Falls Since SOC/ROC? (cont.)

A. Code 0, No

B. Code 1, Yes

✓
• **Coding:** J1800. Any Falls Since SOC/ROC, would be coded **1, Yes**

• **Rationale:** An intercepted fall is considered a fall
J1800 Practice Coding Scenario 3

• A patient is participating in balance retraining activities during a therapy visit
• The therapist is intentionally challenging patient’s balance, anticipating a loss of balance
• The patient has a loss of balance to the left due to hemiplegia, and the physical therapist provides minimal assistance to allow the patient to maintain standing
How would you code J1800. Any Falls Since SOC/ROC?

A. Code 0, No
B. Code 1, Yes
How would you code J1800. Any Falls Since SOC/ROC? (cont.)

A. Code 0, No
B. Code 1, Yes
J1800 Practice Coding
Scenario 3 (cont.)

- **Coding:** J1800. Any Falls Since SOC/ROC, would be coded 0, **No.**
- **Rationale:**
  - The patient’s balance was intentionally being challenged by the physical therapist, so a loss of balance is anticipated
  - When assistance is provided to a patient to allow him/her to maintain standing during an anticipated loss of balance during a supervised therapeutic intervention, this is not considered a fall or intercepted fall
J1900: Number of Falls Since SOC/ROC, whichever is more recent
## New OASIS-D Item: J1900

<table>
<thead>
<tr>
<th>J1900.</th>
<th>Number of Falls Since SOC/ROC, whichever is more recent</th>
</tr>
</thead>
<tbody>
<tr>
<td>CODING:</td>
<td>↓ Enter Codes in Boxes</td>
</tr>
<tr>
<td>0. None</td>
<td>A. <strong>No injury:</strong> No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient’s behavior is noted after the fall</td>
</tr>
<tr>
<td>1. One</td>
<td>B. <strong>Injury (except major):</strong> Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain</td>
</tr>
<tr>
<td>2. Two or more</td>
<td>C. <strong>Major injury:</strong> Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma</td>
</tr>
</tbody>
</table>
J1900 Intent

• Identifies the number of falls a patient had since the most recent SOC/ROC, and fall-related injury
Definition: Injury Related to a Fall

Any documented injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall.
### J1900 Response-Specific Instructions

<table>
<thead>
<tr>
<th>Review</th>
<th>Interview</th>
<th>Determine</th>
<th>Code</th>
</tr>
</thead>
</table>
| Review the home health clinical record, incident reports, and any other relevant clinical documentation, such as fall logs | Interview the patient and/or caregiver about occurrence of falls | Determine the number of falls that occurred since the most recent SOC/ROC and code the level of fall-related injury for each | Code falls no matter where the fall occurred  
Code each fall only once  
• If the patient has multiple injuries in a single fall, code the fall for the highest level of injury |
Coding Instructions: J1900A. No Injury

- **Code 0, None**, if the patient had no injurious falls since the most recent SOC/ROC
- **Code 1, One**, if the patient had one non-injurious fall since the most recent SOC/ROC
- **Code 2, Two or more**, if the patient had two or more non-injurious falls since the most recent SOC/ROC
- **A dash** is a valid response for this item. CMS expects dash use to be a rare occurrence
Definition: No Injury

- No evidence of any injury noted on assessment
- No complaints of pain or injury by the patient
- No change in the patient’s behavior is noted after the fall
Coding Instructions:
J1900B. Injury, Except Major

- **Code 0, None**, if the patient had no falls with injury, except major, since the most recent SOC/ROC

- **Code 1, One**, if the patient had one fall with injury, except major, since the most recent SOC/ROC

- **Code 2, Two or more**, if the patient had two or more falls with injury, except major, since the most recent SOC/ROC

- A dash is a valid response for this item. CMS expects dash use to be a rare occurrence
Definition: Injury (Except Major)

• Examples include:
  - Skin tears
  - Abrasions
  - Lacerations
  - Superficial bruises
  - Hematomas
  - Sprains
  - Any fall-related injury that causes the patient to complain
Coding Instructions: J1900C. Major Injury

- **Code 0, None**, if the patient had no falls with major injury since the most recent SOC/ROC
- **Code 1, One**, if the patient had one fall with major injury since the most recent SOC/ROC
- **Code 2, Two or more**, if the patient had two or more falls with major injury since the most recent SOC/ROC
- **A dash** is a valid response for this item. CMS expects dash use to be a rare occurrence
Definition: Major Injury

- Examples Include:
  - Bone fractures
  - Joint dislocations
  - Closed head injuries with altered consciousness
  - Subdural hematoma
J1900 Practice Coding Scenario 4

• Review of the clinical record and incident reports and patient and caregiver report identify that a single fall occurred since the most recent SOC/ROC

• The fall is documented on a clinical note from an RN home visit that describes the patient Mr. R’s report of a fall that occurred between visits, in which he tripped on the dog, fell against the wall, and banged his elbow, sustaining a skin tear that he treated himself

• Documentation of the RN assessment during the home visit details the healing skin tear and no other injury or symptom identified related to the fall
How would you code J1800. Any Falls Since SOC/ROC?

A. Code 0, No
B. Code 1, Yes
How would you code J1800. Any Falls Since SOC/ROC? (cont.)

A. Code 0, No

✓ B. Code 1, Yes
## How would you code J1900. Number of Falls Since SOC/ROC?

<table>
<thead>
<tr>
<th>J1900.</th>
<th>Number of Falls Since SOC/ROC, whichever is more recent</th>
</tr>
</thead>
<tbody>
<tr>
<td>CODING:</td>
<td>↓ Enter Codes in Boxes</td>
</tr>
<tr>
<td>0. None</td>
<td>A. <strong>No injury</strong>: No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient’s behavior is noted after the fall</td>
</tr>
<tr>
<td>1. One</td>
<td>B. <strong>Injury (except major)</strong>: Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain</td>
</tr>
<tr>
<td>2. Two or more</td>
<td>C. <strong>Major injury</strong>: Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma</td>
</tr>
</tbody>
</table>
How would you code J1900. Number of Falls Since SOC/ROC? (cont. 1)

A. Code J1900A = 1, J1900B = 0, J1900C = 0
B. Code J1900A = 0, J1900B = 0, J1900C = 1
C. Code J1900A = 0, J1900B = 1, J1900C = 0
D. Enter a dash for J1900A, J1900B, and J1900C

<table>
<thead>
<tr>
<th>J1900. Number of Falls Since SOC/ROC, whichever is more recent</th>
<th>Enter Codes in Boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>CODING: 0. None</td>
<td>↓</td>
</tr>
<tr>
<td>1. One</td>
<td>A. No injury: No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall</td>
</tr>
<tr>
<td>2. Two or more</td>
<td>B. Injury (except major): Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain</td>
</tr>
<tr>
<td></td>
<td>C. Major injury: Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma</td>
</tr>
</tbody>
</table>
How would you code J1900. Number of Falls Since SOC/ROC? (cont. 2)

A. Code J1900A = 1, J1900B = 0, J1900C = 0
B. Code J1900A = 0, J1900B = 0, J1900C = 1
C. Code J1900A = 0, J1900B = 1, J1900C = 0
D. Enter a dash for J1900A, J1900B, and J1900C

<table>
<thead>
<tr>
<th>J1900.</th>
<th>Number of Falls Since SOC/ROC, whichever is more recent</th>
</tr>
</thead>
<tbody>
<tr>
<td>CODING:</td>
<td>↓ Enter Codes in Boxes</td>
</tr>
<tr>
<td>0. None</td>
<td></td>
</tr>
<tr>
<td>1. One</td>
<td></td>
</tr>
<tr>
<td>2. Two or more</td>
<td></td>
</tr>
</tbody>
</table>

A. **No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall

B. **Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain

C. **Major injury:** Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma
## J1900 Coding

<table>
<thead>
<tr>
<th>J1900</th>
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<tbody>
<tr>
<td>CODING:</td>
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<td>0. None</td>
<td>0</td>
</tr>
<tr>
<td>1. One</td>
<td>1</td>
</tr>
<tr>
<td>2. Two or more</td>
<td>0</td>
</tr>
</tbody>
</table>

### CODING:

- **No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall.

- **Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain.

- **Major injury:** Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma.
• Coding:
  - J1900A. No injury, would be coded 0, no non-injurious falls since the most recent SOC/ROC
  - J1900B. Injury (except major), would be coded 1, one injurious (except major) fall since the most recent SOC/ROC
  - J1900C. Major injury, would be coded 0, no falls with major injury since the most recent SOC/ROC

• Rationale: Documentation of only one fall since the most recent SOC/ROC is identified. A laceration is considered an injury (except major)
Summarizing J1800 and 1900
Knowledge Check 1: J1800 and J1900 are **not** completed at which of the following time points?

A. Transfer
B. Discharge – not to an Inpatient Facility
C. SOC/ROC
D. Death at Home
Knowledge Check 1: J1800 and J1900 are **not** completed at which of the following time points? (cont.)

A. Transfer

B. Discharge – not to an Inpatient Facility

**C. SOC/ROC**

D. Death at Home
Knowledge Check 1: Rationale

• **J1800.** Any Falls Since SOC/ROC, and **J1900.** Number of Falls Since SOC/ROC, are completed at:
  - Transfer
  - Discharge – not to an Inpatient Facility
  - Death at Home
Knowledge Check 2: Which example below does not meet the definition of a fall?

A. Ms. T reports losing her balance while going down the stairs but catching herself on the railing to remain standing

B. Mrs. B’s daughter reports her mother falling while walking to her mailbox

C. Mr. W reports falling after being pushed by his roommate

D. All of the above meet the fall definition
Knowledge Check 2: Which example below does not meet the definition of a fall? (cont.)

A. Ms. T reports losing her balance while going down the stairs but catching herself on the railing to remain standing

B. Mrs. B’s daughter reports her mother falling while walking to her mailbox

C. Mr. W reports falling after being pushed by his roommate

D. All of the above meet the fall definition
Knowledge Check 2: Rationale

• Although Mr. W sustained a fall, it was a result of an overwhelming external force (his roommate pushing him)

• Ms. T experienced an intercepted fall. If she had not caught herself on the stair railing, she would have fallen
  – An intercepted fall is considered a fall
Section J: Highlights

- **J1800.** Any Falls Since SOC/ROC, and **J1900.** Number of Falls Since SOC/ROC, are completed at:
  - Transfer
  - Discharge – not to an Inpatient Facility
  - Death at Home

- An intercepted fall is considered a fall

- CMS does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls

- There are three levels of fall-related injury:
  - No Injury
  - Injury (Except Major)
  - Major Injury
Revised OASIS-D Assessment Items
Overview: Revised Items

• Identify assessment items that have been revised in OASIS-D

• Summarize the changes to each revised assessment item
Overview of OASIS-D Revisions

Revisions to OASIS-D involve either:

- Changes to assessment items and related guidance
- Revisions to the Guidance Manual only
# OASIS-D: Seven Revised Assessment Items

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1028</td>
<td>Active Diagnoses</td>
</tr>
<tr>
<td>M1306</td>
<td>Unhealed Pressure Ulcer/Injury at Stage 2 or Higher?</td>
</tr>
<tr>
<td>M1311</td>
<td>Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage</td>
</tr>
<tr>
<td>M1322</td>
<td>Current Number of Stage 1 Pressure Injuries</td>
</tr>
<tr>
<td>M1324</td>
<td>Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable</td>
</tr>
<tr>
<td>M2102</td>
<td>Types and Sources of Assistance</td>
</tr>
<tr>
<td>M2310</td>
<td>Reason for Emergent Care</td>
</tr>
</tbody>
</table>
OASIS-D: Seven Revised Assessment Items (cont.)

• Revised assessment items may have changes in one or more of the following areas:
OASIS-D: Guidance Manual Changes

Guidance Manual Changes for 33 Items

- M0080
- M0090
- M0102
- M1021
- M1023
- M1046
- M1056
- M1060
- M1307
- M1332
- M1334
- M1342
- M1610
- M1730
- M1800
- M1810
- M1820
- M1830
- M1840
- M1845
- M1850
- M1860
- M1870
- M1910
- M2001
- M2003
- M2005
- M2010
- M2016
- M2020
- M2030
- M2301
- M2401
For these 33 items, the Guidance Manual has been updated in one or more of the following sections:

- Item intent
- Time points collected
- Response-specific instructions
- Examples
- Data sources and resources
OASIS-D: Description of Guidance Manual Changes

- Response-specific instructions revised to reflect one clinician expansion (collaboration allowed)
- Content associated with deleted items removed
- Skip language revised
- Alignment with new Conditions of Participation
- Alignment of language across PAC settings
OASIS-D: Description of Guidance Manual Changes (cont.)

- References to specific Centers for Disease Control and Prevention (CDC) content replaced with a general statement to refer to CDC
- Definitions added
- Removed references to process quality measures no longer reported
- Minor editorial changes
Knowledge Check 3: Revisions to OASIS-D involve which of the following?

A. Changes to assessment items and related guidance
B. Revisions to the Guidance Manual only
C. Both A and B
Knowledge Check 3: Revisions to OASIS-D involve which of the following? (cont.)

A. Changes to assessment items and related guidance

B. Revisions to the Guidance Manual only

C. Both A and B
Knowledge Check 3: Rationale

• Revisions to OASIS-D include both the:
  − Specific changes to seven assessment items and related guidance
  − General revisions to the Guidance Manual in the areas of item intent, time points collected, response-specific instructions, coding examples, data sources, and resources
Item Specific Changes
OASIS-D: Seven Revised Assessment Items

- **M1028**: Active Diagnoses
- **M1306**: Unhealed Pressure Ulcer/Injury at Stage 2 or Higher?
- **M1311**: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage
- **M1322**: Current Number of Stage 1 Pressure Injuries
- **M1324**: Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable
- **M2102**: Types and Sources of Assistance
- **M2310**: Reason for Emergent Care
Changes to M1028. Active Diagnoses

- Standardized assessment item (present on OASIS-C2)
- Response options revised to align with other PAC instruments:
  - Option 3: “None of the above” was added
(M1028) Active Diagnoses – Comorbidities and Co-existing Conditions – Check all that apply

See OASIS Guidance Manual for a complete list of relevant ICD-10 codes.

- [ ] 1 - Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
- [ ] 2 - Diabetes Mellitus (DM)
- [ ] 3 - None of the above
Changes to M1306. Unhealed Pressure Ulcer/Injury at Stage 2 or Higher

• Incorporated National Pressure Ulcer Advisory Panel (NPUAP) terminology updates to align with other PAC instruments

• Item text revised:
  - Replaced “excludes … healed Stage 2 pressure ulcers” with “excludes … all healed pressure ulcers”
  - Added the words “injury/injuries”
### OASIS-D: M1306. Unhealed Pressure Ulcer/Injury at Stage 2 or Higher

Complete at SOC/ROC, Follow-Up, and Discharge

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No</td>
<td>Go to M1322 at SOC/ROC/FU; Go to M1324 at DC</td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

Does this patient have at least one **Unhealed Pressure Ulcer/Injury at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure injuries and all healed pressure ulcers/injuries)
Changes to M1311. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

- Item retained but different versions created for SOC/ROC, Follow-Up, and Discharge
- SOC/ROC and Discharge information used to calculate revised pressure ulcer measure
- Alignment with other PAC instruments
  - Incorporated NPUAP terminology updates
  - Skip pattern language and directions modified
Changes to M1311. Current Number of Unhealed Pressure Ulcer/Injuries at Each Stage (cont. 1)

• Dash “-” is a valid response for the Discharge time point only
• CMS expects dash use to be a rare occurrence
• Used to standardize the IMPACT measure
Changes to M1311. Current Number of Unhealed Pressure Ulcer/Injuries at Each Stage (cont. 2)

Item text revised

- Added ulcers/injuries where applicable
- Added the word “device” to the item title in D1. Unstageable: non-removable dressing/device
- Removed “suspected …in evolution” from F1. Unstageable: Deep tissue injury
### OASIS-D: M1311. Current Number of Unhealed Pressure Ulcer/Injuries at Each Stage

<table>
<thead>
<tr>
<th>(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A1. Stage 2:</strong> Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. Number of Stage 2 pressure ulcers</td>
</tr>
<tr>
<td><strong>B1. Stage 3:</strong> Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Number of Stage 3 pressure ulcers</td>
</tr>
<tr>
<td><strong>C1. Stage 4:</strong> Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. Number of Stage 4 pressure ulcers</td>
</tr>
<tr>
<td><strong>D1. Unstageable: Non-removable dressing/device:</strong> Known but not stageable due to non-removable dressing/device. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device</td>
</tr>
<tr>
<td><strong>E1. Unstageable: Slough and/or eschar:</strong> Known but not stageable due to coverage of wound bed by slough and/or eschar. Number of unstageable pressure ulcers/injuries due to coverage of wound bed by slough and/or eschar</td>
</tr>
<tr>
<td><strong>F1. Unstageable: Deep tissue injury:</strong> Number of unstageable pressure injuries presenting as deep tissue injury</td>
</tr>
</tbody>
</table>
### OASIS-D: M1311. Current Number of Unhealed Pressure Ulcer/Injuries at Each Stage (cont. 1)

<table>
<thead>
<tr>
<th>(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage</th>
<th>Enter Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A1. Stage 2:</strong> Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. <strong>Number of Stage 2 pressure ulcers</strong> (If 0 – Go to M1311B1, Stage 3)</td>
<td>□</td>
</tr>
<tr>
<td><strong>A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC</strong> – enter how many were noted at the time of most recent SOC/ROC</td>
<td>□</td>
</tr>
<tr>
<td><strong>B1. Stage 3:</strong> Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. <strong>Number of Stage 3 pressure ulcers</strong> (If 0 – Go to M1311C1, Stage 4)</td>
<td>□</td>
</tr>
<tr>
<td><strong>B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC</strong> – enter how many were noted at the time of most recent SOC/ROC</td>
<td>□</td>
</tr>
<tr>
<td><strong>C1. Stage 4:</strong> Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. <strong>Number of Stage 4 pressure ulcers</strong> (If 0 – Go to M1311D1, Unstageable; Non-removable dressing/device)</td>
<td>□</td>
</tr>
<tr>
<td><strong>C2. Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC</strong> – enter how many were noted at the time of most recent SOC/ROC</td>
<td>□</td>
</tr>
</tbody>
</table>
OASIS-D: M1311. Current Number of Unhealed Pressure Ulcer/Injuries at Each Stage (cont. 2)

<table>
<thead>
<tr>
<th>(M1311)</th>
<th>Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage</th>
<th>Enter Number</th>
</tr>
</thead>
</table>
| **D1. Unstageable: Non-removable dressing/device:** Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device** 
  [If 0 – Go to M1311E1, Unstageable: Slough and/or eschar] | ☐ | |
| **D2. Number of these unstageable pressure ulcers/injuries that were present at most recent SOC/ROC** 
  – enter how many were noted at the time of most recent SOC/ROC | ☐ | |
| **E1. Unstageable: Slough and/or eschar:** Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** 
  [If 0 – Go to M1311F1, Unstageable: Deep tissue injury] | ☐ | |
| **E2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC** 
  – enter how many were noted at the time of most recent SOC/ROC | ☐ | |
| **F1. Unstageable: Deep tissue injury **Number of unstageable pressure injuries presenting as deep tissue injury** 
  [If 0 – Go to M1324] | ☐ | |
| **F2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC** 
  – enter how many were noted at the time of most recent SOC/ROC | ☐ | |
Changes to M1322. Current Number of Stage 1 Pressure Injuries

• M1322 retained at SOC/ROC and Follow-Up
• Item **removed** from the Discharge time point
  – Not needed for measure calculation (burden reduction)
• Alignment with other PAC settings (IRF, LTCH, and SNF)
  – Replaced the word “ulcers” with “injuries” (NPUAP terminology)
  – Updated Stage 1 definition
• No edits to response options
### OASIS-D: M1322. Current Number of Stage 1 Pressure Injuries

**Complete only at SOC/ROC and Follow-Up**

- Replaced the word “ulcers” with “injuries”
- Updated Stage 1 Definition

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Current Number of Stage 1 Pressure Injuries: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4 or more</td>
<td></td>
</tr>
</tbody>
</table>
Changes to M1324. Stage of Most Problematic Unhealed Pressure Ulcer/Injury That Is Stageable

- Incorporated NPUAP terminology updates to align with the pressure ulcer items in the other PAC instruments
  - Added the word “injury”
**OASIS-D: M1324. Stage of Most Problematic Unhealed Pressure Ulcer/Injury That Is Stageable**

Complete at SOC/ROC, Follow-Up, and Discharge

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable: (Excludes pressure ulcer/injury that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or deep tissue injury.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Stage 1</td>
</tr>
<tr>
<td>2</td>
<td>Stage 2</td>
</tr>
<tr>
<td>3</td>
<td>Stage 3</td>
</tr>
<tr>
<td>4</td>
<td>Stage 4</td>
</tr>
<tr>
<td>NA</td>
<td>Patient has no pressure ulcers/injuries or no stageable pressure ulcers/injuries</td>
</tr>
</tbody>
</table>
Changes to M2102.
Types and Sources of Assistance

Different versions of this item are available for SOC/ROC and Discharge

Some response options were not essential and removed to reduce burden
Changes to M2102.
Types and Sources of Assistance (SOC/ROC)

- **Response options removed:**
  - a. ADL (activities of daily living) assistance
  - b. IADL (instrumental activities of daily living) assistance
  - c. Medication administration
  - d. Medical procedures/treatments
  - e. Management of equipment
  - g. Advocacy or facilitation of patient’s participation in appropriate medical care

- **Response options retained:**
  - f. Supervision and safety (lettering sequence retained)
### Types and Sources of Assistance

(M2102)

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>f. Supervision and safety (for example, due to cognitive impairment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No assistance needed –patient is independent or does not have needs in this area</td>
</tr>
<tr>
<td>1</td>
<td>Non-agency caregiver(s) currently provide assistance</td>
</tr>
<tr>
<td>2</td>
<td>Non-agency caregiver(s) need training/supportive services to provide assistance</td>
</tr>
<tr>
<td>3</td>
<td>Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance</td>
</tr>
<tr>
<td>4</td>
<td>Assistance needed, but no non-agency caregiver(s) available</td>
</tr>
</tbody>
</table>
Changes to M2102. Types and Sources of Assistance (Discharge)

- Response options removed:
  - b. IADL (instrumental activities of daily living) assistance
  - e. Management of equipment
  - g. Advocacy or facilitation of patient’s participation in appropriate medical care

- Response options (and lettering sequence) retained:
  - a. ADL (activities of daily living) assistance
  - c. Medication administration
  - d. Medical procedures/treatments
  - f. Supervision and safety
OASIS-D: M2102. Types and Sources of Assistance

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Types and Sources of Assistance: Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.</th>
</tr>
</thead>
</table>
| a. | **ADL assistance** (for example, transfer/ambulation, bathing, dressing, toileting, eating/feeding)  
0 No assistance needed - patient is independent or does not have needs in this area  
1 Non-agency caregiver(s) currently provide assistance  
2 Non-agency caregiver(s) need training/supportive services to provide assistance  
3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance  
4 Assistance needed, but no non-agency caregiver(s) available |
| b. | **Medication administration** (for example, oral, inhaled or injectable)  
0 No assistance needed - patient is independent or does not have needs in this area  
1 Non-agency caregiver(s) currently provide assistance  
2 Non-agency caregiver(s) need training/supportive services to provide assistance  
3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance  
4 Assistance needed, but no non-agency caregiver(s) available |
| c. | **Medical procedures/treatments** (for example, changing wound dressing, home exercise program)  
0 No assistance needed - patient is independent or does not have needs in this area  
1 Non-agency caregiver(s) currently provide assistance  
2 Non-agency caregiver(s) need training/supportive services to provide assistance  
3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance  
4 Assistance needed, but no non-agency caregiver(s) available |
| d. | **Supervision and safety** (for example, due to cognitive impairment)  
0 No assistance needed - patient is independent or does not have needs in this area  
1 Non-agency caregiver(s) currently provide assistance  
2 Non-agency caregiver(s) need training/supportive services to provide assistance  
3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance  
4 Assistance needed, but no non-agency caregiver(s) available |
Changes to M2310. Reason for Emergent Care

- M2310 is completed on Transfer and Discharge
- The four response options needed for calculation of potentially avoidable event (PAE) measures were retained
- The remaining 15 of 19 response options not needed for measure calculation have been removed
Changes to M2310. Reason for Emergent Care (cont.)

Response Options Retained:

1 = Improper medication administration
10 = Hypo/hyperglycemia, diabetes out of control
19 = Other than above reasons
UK = Reason unknown
OASIS-D: M2310. Reason for Emergent Care

Complete at Transfer and Discharge

(M2310) **Reason for Emergent Care:** For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)? *(Mark all that apply.)*

- [ ] 1 - Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
- [ ] 10 - Hypo/Hyperglycemia, diabetes out of control
- [ ] 19 - Other than above reasons
- [ ] UK - Reason unknown
Knowledge Check 4: Which statement regarding M1028. Active Diagnoses is true?

A. New time point versions have been created

B. Response options have been revised to include “None of the above”

C. Dash is **not** a valid response
Knowledge Check 4: Which statement regarding M1028. Active Diagnoses is true? (cont.)

A. New time point versions have been created

B. Response options have been revised to include “None of the above”

C. Dash is not a valid response
Knowledge Check 4: Rationale

- M1028 is completed at SOC/ROC (no change from OASIS-C2)
- “None of the above” was added as a new response option
- Dash is a valid response; however, CMS expects dash use to be a rare occurrence
Knowledge Check 5: The same assessment version of M1311 is used for SOC/ROC, Follow-Up, and Discharge

M1311. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

A. True
B. False
Knowledge Check 5: The same assessment version of M1311 is used for SOC/ROC, Follow-Up, and Discharge (cont.)

M1311. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

A. True

✓ B. False
Knowledge Check 5: Rationale

• M1311 is retained, but different versions were created for SOC/ROC, Follow-Up, and Discharge

• SOC/ROC and Discharge Assessments are used to calculate the revised pressure ulcer measure
Knowledge Check 6: Select the best response regarding M2102. Types and Sources of Assistance

A. Response options have been removed to reduce burden
B. New time point versions created for SOC/ROC and Discharge
C. Retained lettering sequence for response option(s)
D. All of the above
Knowledge Check 6: Select the best response regarding M2102. Types and Sources of Assistance (cont.)

A. Response options have been removed to reduce burden
B. New time point versions created for SOC/ROC and Discharge
C. Retained lettering sequence for response option(s)
D. All of the above
Knowledge Check 6: Rationale

- Response options have been removed to reduce burden
- New versions created for SOC/ROC and Discharge time points
  - SOC/ROC version has row “f” only
  - Discharge version has rows “a,” “c,” “d,” and “f”
- M2102 lettering sequence was retained for remaining rows
Additional Guidance
Clarifications
Expansion of the One Clinician Convention

• Guidance related to the one clinician convention was modified as of January 1, 2018
  - While only the assessing clinician is responsible for accurately completing and signing a comprehensive assessment, s/he may collaborate to collect data for all OASIS items, if agency policy allows.
Expansion of the One Clinician Convention (cont. 1)

• Modifications in home care guidance related to the one clinician convention were made:
  – Based on feedback from home health stakeholders
  – To better align with assessment practices in other PAC settings

• Any exception to this general convention concerning collaboration is identified in item-specific guidance
• Additional information:
  – OASIS-D Guidance Manual, Chapter 1
Drug Regimen Review

- There are no DRR item changes in 2019
- The DRR items were first introduced to home health in 2010 and revised January 1, 2017
  - These items are being implemented in IRF, LTCH, and SNF during 2018
- Changes to the DRR items for home health in 2019 are limited to guidance refinement to promote cross-setting alignment
Knowledge Check 7: Select the best response regarding the One Clinician Convention

A. The Comprehensive Assessment, which includes OASIS, remains the responsibility of one clinician

B. The assessing clinician may elicit feedback from other agency staff in order to complete the OASIS

C. Both A and B
Knowledge Check 7: Select the best response regarding the One Clinician Convention (cont.)

A. The Comprehensive Assessment, which includes OASIS, remains the responsibility of one clinician

B. The assessing clinician may elicit feedback from other agency staff in order to complete the OASIS

C. Both A and B

✅ C. Both A and B
Knowledge Check 7: Rationale

• The assessing clinician is responsible for accurately completing and signing a comprehensive assessment.

• However, s/he may collaborate to collect data for all OASIS items, if agency policy allows.
  – Any exception to this general convention concerning collaboration is identified in item-specific guidance.
OASIS-D Revised Assessment Items: Highlights

- Revisions to OASIS-D involve either:
  - Changes to the assessment item and related guidance
  - Revisions to the Guidance Manual only
- Some response options have been removed to reduce provider burden
- Different time point versions created for some items
OASIS-D Revised Assessment Items: Highlights (cont.)

- Incorporated NPUAP terminology updates
- Revised language to align with other PAC settings
- Consult the OASIS-D Guidance Manual for specific direction
Summary and Resources
Overview: Summary and Resources

- Identify resources available to guide utilization of OASIS-D
HH QRP Website

- Home Health Quality Measures
- Home Health Star Ratings
- OASIS Data Sets
- OASIS User Manuals
- Training
- Data Submission Deadlines
- Spotlight and Announcements

HH QRP Website
OASIS Educational Coordinators

• Each State has a designated OASIS Educational Coordinator with the responsibility to ensure that all home care providers have access to:

  Training in the OASIS data set administration for assessing patients

  Training and technical support in integrating the OASIS items in the agency’s record-keeping system

  Technical support in answering questions on the clinical aspects of OASIS

Find your OASIS Education Coordinator:
Technical Help Desk

- Data Submission & Certification and Survey Provider Enhancement Reports (CASPER): Quality Improvement and Evaluation System (QIES)
  Technical Support Office (QTSO) Help Desk

Phone: (800) 339-9313
Email: Help@qtso.com
Website: https://qtso.cms.gov
Help Desk Disclaimer

• Please do not send any identifiable patient information through email, such as:
  – Medical record numbers
  – Dates of birth
  – Service dates (including visit dates, admission dates, or discharge dates)
  – Any other data items considered identifiers or protected health information
Rulemaking

• Proposed Rules and Final Rules are published in the Federal Register and typically released each year in July and November

• Proposed and Final Rules are posted on this web page:
  – https://www.federalregister.gov/agencies/centers-for-medicare-medicaid-services
Stay Connected: Medicare Learning Network (MLN)

- Free educational materials for healthcare professionals on CMS programs, policies, and initiatives:

- Subscribe to MLN Connects weekly email newsletter for healthcare professionals:
Stay Connected: Home Health, Hospice & Durable Medical Equipment Open Door Forum

• The Home Health, Hospice & Durable Medical Equipment Open Door Forum addresses the concerns of three unique health care areas within the Medicare & Medicaid programs

• Issues related to Home Health PPS, the newly proposed competitive bidding for Durable Medical Equipment and the Medicare Hospice benefit are all topics the forum has covered:

• Subscribe to email newsletter:
OASIS-D Training Opportunities

- **Introduction to OASIS-D Webinar**
  - August 28, 2018

- **Introduction to OASIS-D Section GG Webinar**
  - September 5, 2018

- **Q&A Teleconference**
  - Anticipated October/November 2018

- **In-Person Home Health Provider Training, Baltimore, MD**
  - Anticipated October/November 2018

Presentation and recording will be posted on the CMS website.

Webcast available!
Training Information and Updates

Spotlight and Announcements


Home Health Quality Reporting Training

• OASIS-D to be implemented with all assessments with a M0090 Date Assessment Completed date of January 1, 2019, or later

• Changes to OASIS-D include:
  − **New** standardized patient assessment data elements
  − Alignment in content of items that support cross-setting measures (**revised**)
  − Comprehensive Item Use Evaluation, resulting in reduction of burden and quality measure changes (**removal**)
  − Updates and corrections to guidance
Questions?