CHAPTER 1 – INTRODUCTION

The Outcome and ASsessment Information Set (OASIS) is a group of standard data elements developed, tested, and refined over the past two decades through a research and demonstration program funded primarily by the Centers for Medicare & Medicaid Services (CMS), with additional funding from the Robert Wood Johnson Foundation and the New York State Department of Health. OASIS data elements are designed to enable systematic comparative measurement of home health care patient outcomes at two points in time. Outcome measures are the basis for outcome-based quality improvement (OBQI) efforts that home health agencies (HHAs) can employ to assess and improve the quality of care they provide to patients. Under OBQI, CMS provides HHAs with agency-patient related characteristic (case mix), risk-adjusted outcome, potential avoidable event (adverse event outcome), and patient tally reports for their patients for a 12-month period. The agency also is provided with comparison data from the HHA's prior 12-month period and national reference data.

Comparisons are risk adjusted for patient differences (both over time for the agency and between the agency and the reference group). OBQI requires uniform measures that are calculated from standardized data elements. Further details on OASIS and OBQI are included in Appendix F of this manual, and a full description of OBQI is available in the Outcome-Based Quality Improvement Manual, which can be found at OASIS OBQI Home Health Quality Initiatives.[1] OASIS-C allows for the computation and reporting of measures of clinical processes to supplement currently reported outcome measures. In addition to quality measurement, a subset of OASIS items is used to calculate payment algorithms under the Medicare Prospective Payment System (PPS).

In 1999, Medicare-certified HHAs began collecting and submitting OASIS data related to all adult (18 years or older) nonmaternity patients receiving skilled services with Medicare or Medicaid as a payer source. The OASIS items have been revised several times since 1999 to address the burden of data collection, refine items for payment algorithms, and enhance outcome reporting. In 2008, CMS began a large-scale effort to revise OASIS for three reasons:

a) To address issues raised by the HHA provider community for specific OASIS items;

b) To incorporate the measurement of selected processes of care to supplement the measurement of outcomes, and

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

A draft version of OASIS-C was developed and tested for inter-rater reliability and burden estimates in 11 HHAs in three states: Ohio, Massachusetts, and Colorado. The instrument was extensively revised based on both quantitative findings and provider feedback, then posted by the Office of Management and Budget (OMB) for public comment. During that time, a set of 55 new or refined outcome and process measures that could be calculated from OASIS-C items

[1] http://www.cms.hhs.gov/HomeHealthQualityInits/16_HHQIOASISOBQI.asp#TopOfPage

was submitted to the National Quality Forum (NQF) for endorsement. OASIS-C items were further revised based on the public comments to the OMB notice and feedback obtained during the NQF endorsement process. More information about OASIS-C can be found on the CMS web page (OASIS-C Home Health Quality Initiatives).[2]

A. Manual Overview

The OASIS Implementation Manual, originally developed in 1999, was intended to serve as a resource for HHAs implementing the new OASIS data collection requirements. Many of the chapters of the OASIS Implementation Manual primarily were relevant to new HHAs seeking Medicare certification. While the manual has been revised several times over the past decade to reflect changes to the OASIS, the basic structure of the manual has not changed.

This revised manual, the OASIS-C Guidance Manual, is a streamlined version of the original manual that contains content most relevant for HHAs experienced with OASIS requirements, with an emphasis on OASIS item guidance. Selected content from the OASIS Implementation Manual has been incorporated into the appendix to provide additional context for OASIS data collection requirements. Sections relevant to first-time implementation of OASIS data have been deleted. HHAs new to OASIS collection, or those interested in reviewing sections of the retired OASIS Implementation Manual, may access it at the following link: Archives Home Health Quality Initiatives.[3] However, please note that the OASIS Implementation Manual has **not** been updated to reflect the most recent revisions to OASIS.

In addition to streamlining the manual contents, the format of the manual has changed to facilitate future updates and to decrease burden for those who access OASIS guidance electronically. Item-specific guidance is no longer contained in a single document, but has been divided into sections that can be accessed through individual links. Thus, when accessing guidance for a specific OASIS item, the user can more easily locate the OASIS question, rather than scrolling through a large document. All manual sections can be viewed online or printed. This manual is divided into five chapters:

Chapter 1 – The Introduction, which provides contextual information and other general information relevant to OASIS data collection.

Chapter 2 – Includes versions of the OASIS-C data set for each time point.

Chapter 3 – Contains item-specific guidance, subdivided into sections.

Chapter 4 – Contains sample clinical record forms for OASIS data collection time points.

Chapter 5 – Includes relevant resources for HHAs, with hyperlinks when available.

Appendices – Includes additional contextual information, including sections on OBQI, home health care regulations related to OASIS data collection, and recommendations for ensuring accuracy of OASIS data. Appendix D, formerly Attachment D, addresses the OASIS diagnosis items that pertain to the home health episode (i.e., M1020, M1022, and M1024).

[2] http://www.cms.hhs.gov/HomeHealthQualityInits/06_OASISC.asp#TopOfPage
[3] http://www.cms.hhs.gov/HomeHealthQualityInits/20_HHQIArchives.asp#TopOfPage

B. Why is OASIS Being Revised Now?

HHAs began collecting and transmitting OASIS data for adult skilled Medicare and Medicaid patients (with the exception of maternity patients) in 1999. During the past 10 years, numerous changes have occurred within the health care system, including specific recommendations for changes in the area of home health care quality measurement:

- 2001 – Institute of Medicine (IOM) identified six focus areas for improving health care quality (safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity).

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

- 2006 – Medicare Payment Advisory Commission (MedPAC) Report to Congress included recommendations for expanding home health quality measures to a) broaden the patient population covered by the OASIS, b) capture safety as an aspect of quality, c) capture an aspect of care directly under providers' influence, d) reduce variation in practice, and e) provide incentives to improve information technology.

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

Current efforts are underway to create a system for assessing patients using consistent terminology and measuring quality across post-acute care settings. The instrument being developed for this program is the Continuity Assessment Record Evaluation (CARE), which will harmonize data elements across three well-known CMS clinical assessment instruments: the Minimum Data Set (MDS) for nursing homes, the Uniform Data Set for Medical Rehabilitation (FIM™) for rehabilitation facilities, and the OASIS for home care. In addition, the National Quality Forum has called for harmonization of influenza and pneumonia immunization assessment items and is working to develop a framework for measuring pressure ulcers across provider settings.

At the time OASIS was initially implemented, it was anticipated that the data set would evolve to reflect changes in quality priorities, health research, health care policy, payment, and care practices. To oversee this evolution of OASIS, CMS convened several technical expert panels to consider provider feedback on OASIS — along with the IOM aims and MedPAC recommendations — and recommend potential revisions. These recommendations, along with efforts to align OASIS-C elements with other data collection instruments where possible, were the basis for OASIS revisions being made for 2010. Because revisions to OASIS-B1 were extensive, this current version has been renamed OASIS-C.

C. What's New About OASIS-C

The OASIS-C represents the most comprehensive revision to OASIS since its original release. A summary of the types of revisions made to OASIS is provided below. A crosswalk of OASIS-B1 and OASIS-C items is provided in Appendix G. In the discussion below, examples are given to highlight the types of changes incorporated into OASIS-C.

Please note that, with the exception of the tracking items and M0903/M0906, the OASIS-C items have been renumbered; thus the OASIS-B1 M0 item numbers do not correspond to the

new OASIS-C numbering scheme. This was necessary because new OASIS items were placed within the existing sequence of items and other OASIS items were resequenced. Attempting to align the new items with the previous numbering system proved impossible for some sections. Instead, each section has been assigned to a range of numbers (e.g., Integumentary Status items are numbered M1300-M1350). This was determined to be a better long-term solution and one that mirrors systems being used by the data sets in other settings and the CARE instrument. See Table 1 for a list of OASIS items and their numbering sequence.

TABLE 1: OASIS-C Numbering System.

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

✓Revisions to OASIS-B1 Items

Many OASIS items were revised to reflect comments from the provider community. Some items (e.g., bathing, transferring) have been expanded to include additional scale levels, which will allow agencies to document changes in patient status with greater accuracy. Other items reflect wording changes designed to improve item clarity. For example, the Management of Oral Medications (M2020) now specifies that the item refers to the patient's ability to correctly manage all medications safely and reliably, in contrast to OASIS B-1 wording: "all *prescribed* oral medications." Because patient ability to take medications is so important to patient safety, CMS has determined that medication management warrants its own domain, outside of the ADL/IADL section. The OASIS data items for pressure ulcers (M1300 - M1324) were revised to reflect current National Pressure Ulcer Advisory Panel (NPUAP) and Wound, Ostomy, and Continence Nurses Society (WOCN) guidance on pressure ulcer assessment and to harmonize with other measures of pressure ulcers (based on the National Quality Forum framework for pressure ulcer measurement).

✓Elimination of OASIS-B1 Items

OASIS-B1 items not used for payment, quality measures (including those used in the survey process), case mix, or risk adjustment purposes (e.g., Transportation and Shopping), were eliminated. In some cases, eliminated items were replaced with items intended to capture the assessment parameter in a more efficient way. For example, the "prior status" items for all the ADLs/IADLs have been eliminated. Two new OASIS-C items were developed to capture the patient's prior level of dependence with ADLs/IADLs (M1900) and medication management (M2040).

✓New OASIS Items

OASIS-C items were created to a) increase clarity in measurement; b) replace OASIS-B1 items being eliminated; or c) measure processes of care in home health agencies.

a. New items to increase clarity in measurement: An example of such an item is (M1845), Toileting Hygiene, which was created to supplement measurement of toilet transferring (M1840). Together, these items are intended to more accurately capture toileting ability. Similarly, an item for understanding of verbal content (M1220) supplements the item for ability to hear (M1210) to provide a more comprehensive understanding of the patient's receptive communication ability.

b. New items to replace OASIS-B1 items: As noted above, two new OASIS-C items were developed to capture patient prior level of dependence with ADLs/IADLs (M1900) and medication management (M2040). As another example, (M1730) Depression Screening replaces the OASIS-B1 data item that assessed the presence of depressive feelings. M1730 includes a two-item screening tool (the PHQ-2©) for agencies choosing to use this standardized screening instrument.

c. New items to measure processes of care: Care processes refer to the use of assessment tools (included in a comprehensive assessment) or the planning and delivery of specific clinical interventions. Several evidence-based screening tools and interventions that can be considered "best practices" In home health care were identified through literature review and expert panel input. OASIS-C includes data items to measure the use of these "best practice" care processes. To reflect Institute of Medicine (IOM) aims and MedPAC recommendations, and to focus on high-risk, high-volume, problem-prone conditions in home health care, data items were created to measure processes of care in the following domains:

- Date of referral and physician-ordered start of care (timeliness)
- Patient-specific parameters for physician notification (care coordination)
- Influenza and pneumococcal vaccines (population health and prevention)
- Formal pain assessment, pain interventions, and pain management steps (effectiveness of care)
- Pressure ulcer risk assessment, prevention measures, and use of moist healing principles (effective care and prevention)

- Diabetic foot care plan, education and monitoring (disease specific: high risk, high volume, problem prone)
- Heart failure symptoms of volume overload and follow-up (disease specific: high risk, high volume, problem prone)
- Depressive symptom screening and intervention/referral (influences self-management abilities)
- Falls risk assessment, planning and interventions (safety)
- Medication adverse events/reaction, reconciliation and follow up; drug education (high priority for safety – care coordination)

It is anticipated that processes of care implemented according to evidence-based guidelines will ultimately lead to better clinical outcomes. The process items are a logical follow-up to the Quality Improvement Organizations (QIOs) 8th Scope of Work on Best Practices (MedQIC - HHQI Campaign).[4] Agencies participating in reliability testing of OASIS-C felt process items gave them "credit" for excellent patient care practices already in place.

The care processes documented in the OASIS-C **are not mandated** under the current Conditions of Participation. Clinicians may find that these processes of care have no application for a particular patient and therefore no related assessment or intervention is needed. Clinicians may document in the clinical record any appropriate additional information. With the exception of the OASIS-C items, CMS does not prescribe the content of agency clinical assessment forms nor mandate specific processes of care.

However, some of the OASIS-C process items will support publicly-reported measures and agencies choosing not to adopt those processes of care will see their decisions reflected in Home Health Compare scores. It should also be noted that it is possible that the process measures **may be** incorporated in a future quality-based purchasing (pay for performance) system for home health care. While the OASIS-C process items will be used for quality reporting, CMS understands that the evidence-based practices being measured are not appropriate for every patient, and a rate of 100% is not expected for any agency or any measure.

OASIS-C process data items address use of screening assessments (e.g., for falls or depression), inclusion of specific evidence-based care processes in the plan of care (M2250), and whether clinical interventions were provided to the patient during the care episode. For example, M2400 asks if pain management steps to monitor and mitigate pain were implemented during the care episode. Many of the process items are skipped at certain time points if patients do not exhibit these problems. It should be noted that some of the process data items require review of care provided since the most recent OASIS assessment to determine if assessment and interventions for certain conditions occurred during that specified time period. This will require some new data collection strategies as discussed in detail in Section D below.

[4] http://www.qualitynet.org/dcs/ContentServer?c=MQParents&pagename=Medqic%2FContent%2FParentShellTemplate&cid= 1196689997847&parentName=Topic

✓Number of items

Overall, agencies pilot testing OASIS-C noted that the new version of OASIS required little additional time to complete when compared to OASIS-B1 assessment time, regardless of the overall item increase. The net changes are shown in Table 2.

The time point with the largest increase in data items is Transfer. This increase was needed to (a) calculate additional quality measures related to reasons for hospitalization, and (b) assess care processes that potentially can reduce the rate of acute care hospitalization. Many process items, like other OASIS items, are simple yes/no responses or are skipped if the patient does not have the relevant condition. For example, (M1510) Heart Failure Follow-Up is skipped for patients who do not have a diagnosis of heart failure.

TABLE 2: Change in Number of OASIS Items.

Time Point	Total Number of OASIS-C Items	Net Change in Number of Items from OASIS-B1
Patient Tracking	17	-1
SOC	79	+2
ROC	79	+2
Follow-up	32	+1
Transfer	19	+8
Discharge	61	-11
Death at home	5	+1

D. Collecting OASIS-C Data

Techniques for collecting OASIS-C data are the same used for OASIS-B1, with the exception of the process items. This section will provide a basic overview for collecting OASIS-C data. For more detail on clinical strategies for collecting OASIS data as part of a comprehensive assessment, refer to Appendix A of this manual.

Eligible Patients

OASIS data are collected for Medicare and Medicaid patients, 18 years and older, receiving skilled services, with the exception of patients receiving services for pre- or postnatal conditions. Patients receiving only personal care, homemaker, or chore services exclusively are excluded since these are not considered skilled services.

Time Points

OASIS-C data are collected at the following time points:

- Start of Care
- Resumption of Care following inpatient facility stay
- Recertification within the last five days of each 60-day recertification period
- Other Follow-Up
- Transfer to inpatient facility
- Discharge from home care
- Death at Home

All of these assessments, with the exception of transfer to inpatient facility and death at home, must be conducted during a home visit because all require the clinician to have an in-person encounter with the patient. The transfer to an inpatient facility requires collection of limited OASIS data (most of which may be obtained through a telephone call).

Not all OASIS items are completed at every assessment time point. Some items are completed only at start of care, some only at discharge, and still others only when a patient is admitted to a specific type of inpatient facility (e.g., M2400 - Reason for Nursing Home Admission). The table of "Items to be Used at Specific Time Points" included at the beginning of the OASIS data set allows the clinician conducting the assessment to identify the necessary OASIS items at each time point.

Hospitalization rates are a CMS priority across settings and an important quality measure; therefore, admission to an inpatient facility during the home care episode is a significant event that must be considered in the computation of home care outcomes. Thus, 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 (which necessitates a comprehensive assessment during a home visit) also require the reporting of assessment data. Understanding the reasons for these potentially avoidable events will help agencies improve care.

At the start of care time point, the comprehensive assessment should be completed within five days of the start of care date. At the resumption of care, the comprehensive assessment must be completed within 48 hours of inpatient facility discharge. For the transfer to inpatient facility, discharge from home care, death at home, and other follow-up, the assessments must be completed within 48 hours of becoming aware of the transfer, discharge, death, or significant change in condition.

Who Completes OASIS-C

As identified in (M0080) Discipline of Person Completing Assessment, the comprehensive assessment and OASIS data collection should be conducted by a registered nurse (RN) or any of the therapies (PT, SLP/ST, OT). An LPN/LVN, PTA, OTA, MSW, or Aide may not complete OASIS assessments,

In cases involving nursing, the RN completes the comprehensive assessment at SOC. Any discipline qualified to perform assessments – RN, PT, SLP, OT – may complete subsequent assessments. For a therapy-only case, the therapist usually conducts the comprehensive assessment. It is acceptable for a PT or SLP to conduct and complete the comprehensive assessment at SOC. An OT may conduct and complete the assessment when the need for occupational therapy establishes program eligibility. Note: Occupational therapy alone does not establish eligibility for the Medicare home health benefit at the start of care; however, occupational therapy may establish eligibility under other programs, such as Medicaid. The Medicare home health patient who is receiving services from multiple disciplines (i.e., skilled nursing, physical therapy, and occupational therapy) during the episode of care, can retain eligibility if, over time, occupational therapy is the only remaining skilled discipline providing care. At that time, an OT can conduct OASIS assessments.

Multidisciplinary cases may have multiple points of discipline-specific discharge, though only one is the agency discharge, which must include OASIS data collection and completion of the OASIS discharge comprehensive assessment**.** Other non-OASIS required documentation for recertification and discharge are specified in the Home Health Services Conditions for Coverage (CfCs) & Conditions of Participations (CoPs).[5] OASIS items were designed to be discipline-neutral and have been tested and validated with clinicians from various disciplines.

Comprehensive Assessment and Plan of Care

OASIS-C data are collected as part of the comprehensive assessment required by the Medicare Conditions of Participation (see Appendix A of this manual). As with OASIS-B1, OASIS-C is not intended to represent a comprehensive assessment in and of itself. Each agency is expected to incorporate the OASIS items into its own comprehensive assessment documentation and follow its own assessment policies and procedures. Agencies are free to rearrange OASIS-C item sequence in a way that permits logical ordering within their own forms, as long as the actual item content, skip patterns, and OASIS number remain the same. OASIS data, like the rest of the comprehensive assessment, are collected using a variety of strategies, including observation, interview, review of pertinent documentation (e.g., hospital discharge summaries to obtain information on inpatient facility procedures and diagnoses), discussions with other care team members where relevant (e.g., phone calls to the physician to verify diagnoses), and measurement (e.g., wound length/width, intensity of pain). As with OASIS-B1, OASIS-C data should be collected at each time point based on a unique patient assessment, not simply carried over from a previous assessment. Comprehensive assessment data form the basis of the physician-ordered plan of care. Thus, there should be congruency between documentation of findings from the comprehensive assessment and the plan of care. As specified in the Medicare Conditions of Participation for Home Health (see link to the Conditions of Participation in Chapter 5 of this manual), the plan of care should be updated to reflect revised care orders and current diagnoses throughout the period the patient is receiving home health care services.

Process of Care Data Items

Process of care data items (process items) document whether certain evidence-based practices were implemented. Process items collected at SOC/ROC document assessment and care planning interventions such as a) whether the patient was assessed to be at risk for certain

[5] http://www.cms.hhs.gov/CFCsAndCoPs/12_homehealth.asp#TopOfPage

conditions like pain, falls, or pressure ulcers; and b) whether interventions to address the conditions were incorporated into the plan of care. These items refer to assessments completed and orders included in the plan of care within the five day SOC period or the two day ROC period.

Process items collected at transfer and discharge time points include documentation of interventions that were implemented as part of patient care "since the previous OASIS assessment" (see example in Table 3). This phrase should be interpreted to mean "at the time of, or since, the most recent SOC, ROC, or FU OASIS assessment." Specific instructions about review periods are included in item guidance for the relevant OASIS questions.

Process items collected at transfer and discharge may require a clinician to review prior care in order to accurately complete the items. **Note that this review must consider care provided by all disciplines, and is not limited to care provided by the discipline of the clinician completing the OASIS assessment.** The review can be accomplished in several different ways. The care provider may find it necessary to review clinical records, including the plan of care, updated orders, and visit notes. Alternatively, the agency may elect to create a flowsheet with the appropriate parameters that are checked off on each visit. Review of the flowsheet may provide the needed information, such that a review of the clinical record would be unnecessary. Another strategy for agencies using electronic health records is to create a report template that could pull the needed information from data fields incorporated into visit notes. Regardless of the technique that an agency chooses, the process data items completed at transfer and discharge will require knowledge of patient symptoms, initial and subsequent physician's orders, and clinical interventions performed to address patient symptoms that were present at the time of, or since, the most recent SOC, ROC, or FU OASIS assessment.

TABLE 3: Illustrative Process Items.

Since the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

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

Conventions for Completing OASIS-C

Table 4 lists conventions, or general rules, that should be observed when completing OASIS-C. Item-specific guidance is provided in Chapter 3. The OASIS-C Guidance provides clarification of item intent based on "Frequently Asked Questions" posted to CMS since OASIS was initially implemented. We do, however, anticipate that we will not clarify all of the situations that are unique and the exceptions that may be encountered in clinical practice.

Each patient scenario, clinical status, social and environmental situation is unique, requiring professional/clinical judgment and care coordination. In the event you cannot resolve your understanding of the OASIS questions, CMS will continue to provide avenues to accept and respond to questions.

TABLE 4: Conventions for Completing OASIS-C Items.

General OASIS item conventions

1. Understand the time period under consideration for each item. Report what is true on the day of assessment unless a different time period has been indicated in the item or related guidance. Day of assessment is defined as the 24 hours immediately preceding the home visit and the time spent by the clinician in the home.
2. For OASIS purposes, a care episode (also referred to as a quality episode) must have a beginning (i.e., an SOC or ROC assessment) and a conclusion (i.e., a Transfer or Discharge assessment) to be considered a complete care episode.
3. If the patient's ability or status varies on the day of the assessment, report the patient's "usual status" or what is true greater than 50% of the assessment time frame, unless the item specifies differently (e.g., for M2020 Management of Oral Medications, M2030 Management of Injectable Medications, and M2100e Management of Equipment, instead of "usual status" or "greater than 50% of the time," consider the medication or equipment for which the most assistance is needed).
4. Minimize the use of NA and Unknown responses.
5. Responses to items documenting a patient's current status should be based on independent observation of the patient's condition and ability at the time of the assessment without referring back to prior assessments. For process items that require documentation of prior care, the phrase "since the previous OASIS assessment" should be interpreted to mean "at the time of, or since, the time of the most recent SOC, ROC or FU OASIS assessment," as noted on page 1-10. These instructions are included in item guidance for the relevant OASIS questions.
6. Combine observation, interview, and other relevant strategies to complete OASIS data items as needed (e.g., it is acceptable to review the hospital discharge summary to identify inpatient procedures and diagnoses at Start of Care, or to examine the care notes to determine if a physician-ordered intervention was implemented at Transfer or Discharge). However, when assessing physiologic or functional health status, direct observation is the preferred strategy.
7. When an OASIS item refers to assistance, this means assistance from another person unless otherwise specified within the item. Assistance is not limited to physical contact and includes both verbal cues and supervision.
8. Complete OASIS items accurately and comprehensively, and adhere to skip patterns.
9. Understand what tasks are included and excluded in each item and score item based only on what is included.

TABLE 4: Conventions for Completing OASIS-C Items. (cont'd)

10. Consider medical restrictions when determining ability. For example, if the physician has ordered activity restrictions, these should be considered when selecting the best response to functional items related to ambulation, transferring, etc.
11. Understand the definitions of words as used in the OASIS.
12. Follow rules included in the Item Specific Guidance.
13. Stay current with evolving CMS OASIS guidance updates.
14. Only one clinician takes responsibility for accurately completing a comprehensive assessment, although for selected items, collaboration is appropriate (e.g., Medication items M2000 – M2004). These exceptions are noted in the Item Specific Guidance.
15. When the OASIS item includes language specifying "one calendar day" (e.g., M2002 Medication Follow-up), this means until the end of the next calendar day.
16. The use of i.e., means "only in these circumstances" or "that is" and scoring of the item should be limited to the examples listed. The use of e.g., means "for example" and the clinician may consider other relevant examples when scoring this item.

ADL/IADL item-specific conventions

1. Report the patient's ability, not actual performance or willingness, to perform a task. While the presence or absence of a caregiver may impact actual performance of activities, it does not impact the patient's ability to perform a task.
2. The level of ability refers to the patient's ability to safely complete specified activities.
3. If the patient's ability varies between the different tasks included in a multi-task item, report what is true in a majority of the included tasks, giving more weight to tasks that are more frequently performed.

E. OASIS Data Accuracy

In any data-driven system, the quality of the output is only as good as the quality of the data input. OASIS data are used to produce quality reports for agencies and for public reporting on the Medicare Home Health Compare website, as well as to determine payment. At some point in the future, OASIS data may be used to determine incentive payments under a quality-based purchasing program. Thus, it is imperative that the OASIS data that HHAs collect and submit be accurate and complete. Regulatory language specifying accuracy of OASIS data can be found in the Medicare Conditions of Participation §484.20(b) Standard: Accuracy of Encoded OASIS Data (2005 CFR Title 42, Volume 3).[6] (For additional discussion of OASIS Data Accuracy, see Appendix B of this manual.)

CMS recommends that agencies develop internal systems for monitoring data accuracy in addition to data checking features incorporated into HAVEN and other data entry systems. These may include clinical record audits, data entry audits, and other activities that are

[6] http://www.access.gpo.gov/nara/cfr/waisidx_05/42cfr484_05.html

explained in detail in Appendix B of this manual, which incorporates Chapter 12 of the OASIS Implementation Manual (Archives Home Health Quality Initiatives).[7]

HHAs can correct nearly all erroneous assessments themselves following professional standards for correcting documents. Inactivation procedures to correct assessments containing key field errors can be found at https://www.qtso.com/download/hha/HHAcorrectionpolicy.pdf. Additional information related to correction of erroneous OASIS data is provided in the April 20, 2001 Survey and Certification memorandum on this topic (https://www.qtso.com/download/hha/HHAcorrectionpolicy.pdf).[8] A copy of the memorandum is also provided in Appendix B of this manual.

F. OASIS Data Encoding and Transmission

OASIS-C revisions do not change the requirements for OASIS data encoding within 30 days of assessment completion (M0090). The requirements are specified in the Medicare Conditions of Participation §484.20(a) Standard: Encoding OASIS Data, §484.20(c) Standard: Transmittal of OASIS Data, and §484.20(d) Standard: Data Format. (Available at Home Health Services Conditions of Participations (CoPs); and summarized in Appendix E of this manual. Detailed instructions on encoding and transmitting OASIS data are found in the HHA System User's Guide and the OASIS Validation Report Messages and Description Guide (both available at QIES Technical Support Office - OASIS Download)[9] and the HAVEN System Reference Manual (QIES Technical Support Office - HAVEN Download)[10] for those agencies using HAVEN to meet these requirements.

[7] http://www.cms.hhs.gov/HomeHealthQualityInits/20_HHQIArchives.asp#TopOfPage
[8] https://www.qtso.com/download/hha/HHAcorrectionpolicy.pdf
[9] https://www.qtso.com/hhadownload.html
[10] https://www.qtso.com/havendownload.html