CHAPTER 1 – INTRODUCTION

The Outcome and ASsessment Information Set (OASIS) is a group of standard data elements developed, tested, and refined over 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 were 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. CMS provides HHAs with a) process quality, b) risk-adjusted outcome, and c) potentially avoidable event reports. In addition, HHAs can access patient-related characteristic reports and patient tally reports. Reports are provided for up to two time intervals selected by the HHA requesting the reports. Process quality measures include indicators of how often the HHA follows best practices in assessment, care planning, education, prevention and clinical intervention to improve patient outcomes. Outcome measures include end-result functional and physical health improvement/stabilization, health care utilization measures (hospitalization and emergency department use), and potentially avoidable events. Potentially avoidable events are negative outcomes that clinical evidence indicates can be influenced (although not necessarily totally avoided) by following best practices in providing care. In addition to quality measurement, OASIS data are used to adjust per-episode payment rates for patient conditions that affect care needs.

A. Manual Overview

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

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

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

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

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

Appendices – Include additional contextual information, including sections on OBQI, home health care regulations related to OASIS data collection, and recommendations for ensuring accuracy of OASIS data.

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 15 years, numerous changes have occurred within the health care system, including specific recommendations for changes in the area of home health care quality measurement. Currently the main reasons for revising OASIS include:

- In 2010, Congress passed the Health Insurance Portability and Affordability Act, which required CMS to adopt the ICD-10-CM code set for reporting patient diagnoses for payment and other purposes. The implementation date for conversion from diagnosis reporting using the current ICD-9-CM coding system to reporting using the ICD-10-CM

coding system was October 1, 2014. Subsequently, Congress passed the "Protecting Access to Medicare Act," signed into law April 1, 2014, which specified that "The Secretary of Health and Human Services may not, prior to October 1, 2015, adopt ICD–10 code sets as the standard for code sets under section 1173(c) of the Social Security Act (42 U.S.C. 1320d–2(c)) and section 162.1002 of title 45, Code of Federal Regulations. Therefore, the diagnosis items that were revised to accommodate ICD-10-CM coding, must revert to the items using ICD-9-CM from OASIS-C.

- Between the adoption of OASIS-C in 2009 and the present, numerous clarifications have been proposed to specific OASIS data items through the OASIS Q&A mailbox, public forums, an expert panel, and other channels. In addition, there has been a concerted effort within CMS to harmonize measures and assessment items across care settings, within the constraints imposed by the varying patient characteristics and care needs of patients served under different modalities of health care.

- The CMS team responsible for the maintenance of the OASIS data set has subjected the data set to a thorough review to eliminate unnecessary or redundant data collection efforts, in order to minimize data collection burden on patients and HHA clinicians.

- Although the ICD-9 to ICD-10 transition has been delayed, the revisions to other items, including dropping selected items at specific time points, have been retained for the purposes of improving accuracy and reducing burden. The current item set has been designated OASIS-C1/ICD-9 Version, to distinguish it from a potential future ICD-10 version.

C. What's New About OASIS-C1?

Several OASIS items were revised to reflect comments from the provider community, clinician groups, or the National Quality Forum in its capacity as an external reviewer of quality measures. Other OASIS items were revised to harmonize them with data items collected in other settings, such as nursing homes and rehabilitation facilities. Selected OASIS items have been eliminated from the data set or omitted from selected data collection time points if they were not being used for quality measurement, risk adjustment, or payment adjustment.

D. Collecting OASIS Data

Techniques for collecting OASIS-C1 data are the same used for OASIS-C. This section will provide a basic overview for collecting OASIS-C1 data. For more detail on clinical strategies for collecting OASIS data as part of a comprehensive assessment, refer to Chapter 3 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 are excluded since these are not considered skilled services.

Time Points

OASIS 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 during the home health episode of care
- 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, require the clinician to have an in-person encounter with the patient during a home visit. 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. The table of "Items to be Used at Specific Time Points" included at the beginning of the OASIS data set allows the home health agency to integrate the necessary OASIS items at each time point into clinical documentation forms or an electronic health record.

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 return home after 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?

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 (that is, 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 there is only one HHA discharge, which must include completion of the OASIS discharge comprehensive assessment**.** Other non-OASIS required documentation for recertification and discharge are specified in the Condition of participation: Comprehensive assessment of patients.[1] 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 data are collected as part of the comprehensive assessment required by the Medicare Conditions of Participation (see Appendix A of this manual). OASIS is not intended to represent a comprehensive assessment in and of itself. HHAs are expected to incorporate OASIS items into their comprehensive assessment documentation and follow their own assessment policies and procedures. Agencies are free to rearrange OASIS 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. Like other comprehensive assessment documentation, OASIS data are collected using a variety of strategies, including observation, interview, review of pertinent documentation (for example, hospital discharge summaries) discussions with other care team members where relevant (for example, phone calls to the physician to verify diagnoses), and measurement (for example, intensity of pain). OASIS 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 above and 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 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 that were 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 implemented as part of patient care at the time of or since the most recent start of care, resumption of care or follow-up OASIS assessment (see example in Table 1). 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 documentation of care provided during the home health episode in order to accurately complete the items. **Note that this review must consider care provided by all disciplines, and is not**

[1] http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=1c743ade23ae8533ee0732689c166e31&r=PART&n=42y5.0.1.1.3#42:5.0.1.1.3.3.7.8

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 prior assessment.

TABLE 1: Illustrative Process Items.

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

Plan / Intervention	No	Yes	Not Applicable	
a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	☐0	☐1	☐NA	Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
b. Falls prevention interventions	☐0	☐1	☐NA	Every standardized, validated multi-factor fall risk assessment conducted at or since the last OASIS assessment indicates the patient has no risk for falls.
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	☐0	☐1	☐NA	Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the last OASIS assessment indicates the patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.

Conventions for Completing OASIS

Table 2 lists conventions, or general rules, that should be observed when completing OASIS. Item-specific guidance is provided in Chapter 3. The OASIS Guidance is updated periodically to provide additional clarification based on "Frequently Asked Questions" sent to CMS. (A link to Frequently Asked Questions is provided in Chapter 5). It may not be possible to address all of the situations that arise, due to the rare and unique nature of some of the questions, and 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 2: Conventions for Completing OASIS 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 (that is, an SOC or ROC assessment) and a conclusion (that is, 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 (for example, 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. Several process items require documentation of prior care, at the time of or since the time of the most recent SOC, ROC, or FU OASIS assessment. 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 (for example, 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 the definitions of words as used in the OASIS.
10. Follow rules included in the Item Specific Guidance (Chapter 3 of this manual).
11. Stay current with evolving CMS OASIS guidance updates. CMS may post updates up to twice per year, in June and December.
12. Only one clinician may take responsibility for accurately completing a comprehensive assessment. However, for selected items, collaboration is appropriate (for example, Medication items M2000 – M2004). These exceptions are noted in the Item Specific Guidance.
13. When the OASIS item includes language specifying "one calendar day" (for example, M2002 Medication Follow-up), this means until the end of the next calendar day.
14. The use of "that is," means scoring of the item should be limited to only the circumstances listed. The use of "for example," means the clinician may consider other relevant circumstances or attributes when scoring the item.

TABLE 2: Conventions for Completing OASIS Items. (cont'd)

Conventions Specific to ADL/IADL Items

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. Understand what tasks are included and excluded in each item and select the OASIS response based only on included tasks.
4. 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.
5. Consider medical restrictions when determining ability. For example, if the physician has ordered activity restrictions, consider this when selecting the best response to functional items related to ambulation, transferring, etc.

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, public reports on the Medicare Home Health Compare website, and to determine payment. 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[2] (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 CMS-supplied data entry software and other data entry systems. These may include clinical record audits, data entry audits, reports produced from electronic health record systems or other activities.

HHAs can correct nearly all erroneous assessments themselves following professional standards for correcting documents. Information related to correction of erroneous OASIS data is provided in the April 20, 2001 Survey and Certification memorandum on this topic. A copy of the memorandum is also provided in Appendix B of this manual.

[2] http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=1c743ade23ae8533ee0732689c166e31&r=PART&n=42y5.0.1.1.3#42:5.0.1.1.3.2.7.7

F. OASIS Data Encoding and Transmission

HHAs are required to encode and electronically submit OASIS data to CMS within 30 days of assessment completion (M0090). The requirements are specified in the Medicare Conditions of Participation[3] §484.20(a) Standard: Encoding OASIS Data, §484.20(c) Standard: Transmittal of OASIS Data, and §484.20(d) Standard: Data Format, 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 User Guides and Training[4]).

[3] http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=5aad0315b2e678ef56bbbd491bc8b31b&n=42y5.0.1.1.3&r=PART&ty=HTML#42:5.0.1.1.3.2.7.7

[4] https://www.qtso.com/hhatrain.html