Centers for Medicare & Medicaid Services
Outcome and Assessment Information Set (OASIS-C) National Provider Call
Moderator: Geanelle Griffith
October 22, 2009
2:30 pm ET

Operator: Welcome to the Outcome and Assessment Information Set (OASIS-C) National Provider Call.

All lines will remain in a listen-only mode until the question and answer session. Today's conference call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

CMS greatly appreciates that many of you minimize the government's teleconference expense by listening to these calls together in your office using only one line.

Today we would like to obtain an estimate of the number of participants in attendance to better document how many members of the provider community are receiving this valuable information. At this time, please use your telephone keypad and enter the number of participants that are currently listening in.

If you are the only person in the room enter one. If there are between two and eight at the listening in, enter the corresponding number between 2, and 8. If there are nine or more of you in the room, please enter 9. Thank you for participating in today's call. I will now turn the conference call over to our moderator, Ms. Griffith.

Geanelle Griffith: Hello, everyone, and welcome to the Outcome and Assessment Information Set OASIS-C National Provider Conference Call. My name is Geanelle Griffith and I will be your moderator.

This call will provide you, the attendees, with background information on why OASIS is changing and tips on preparing for the transition. I am pleased to introduce you to the CMS Home Health team for OASIS-C. They are Robin Dowell, from the Office of Clinical Standards and Quality, Pat Sevast, and Debbie Terkay, from CMS's Office of Survey and Certification.

Presenting today is Deborah Deitz, RN, BSN, of Abt Associates, Incorporated, and Elizabeth Madigan, RN, PHD, FAAN of Case Western Reserve University.

Following the formal presentation, the lines will be opened to allow participants to ask questions of CMS OASIS-C subject matter experts. A PowerPoint slide presentation is posted to the OASIS-C web page at http://www.cms.hhs.gov/HomeHealthQualityInits/02cmssponsoredcalls.asp. That's cms.hhs.gov/HomeHealthQualityInits/02cmssponsoredcalls.asp on the CMS website.
Post call clarification: The complete web address is:
http://www.cms.hhs.gov/HomeHealthQualityInits/02_cmssponsoredcalls.asp

If you have not done so already, please take the time now to download the PowerPoint presentation so you can follow along with the presenters.

I will now turn the call over to Ms. Terkay for a few introductory remarks.

Debbie Terkay: Good afternoon.

registration packet and it is our intent that most of these questions will be answered in either the OASIS-C Guidance Manual or the actual planned presentations and/or our review at the end of each session.

In the event we are unable to answer all of your questions, we will post a document at the end of our series of calls in order to address questions that are related to the OASIS-C implementation. We do believe that some questions have been identified as beyond the scope of the OASIS-C implementation plan and we will identify them as such when our document is posted.

Now I'm turning this call over to our contractor, Deb Deitz, from Abt Associates.

Deb Deitz: Good afternoon.

We will be presenting to you this afternoon – that will be Dr. Liz Madigan and myself. And also since 2006, Angela Richard, of University of Colorado, plus other members of the Clinical Project Development team, including Henry Goldberg from Abt Associates, and Dr. David Hittle, and Dr. Gene Nuccio. have all been working together on OASIS-C and we're excited to be speaking to you today and providing you with information to help you successfully make the transition to OASIS-C on January 1.

We're also excited about the opportunity for quality improvements that OASIS-C is going to bring to home health and about all of the positive feedback that we have been getting as we go around the country and talk to clinicians and others in the home health industry. It's very gratifying to see that all of that positive energy. It's going to be very helpful in moving us through the big changes that are coming ahead.

Today's call, as has been said, will focus on the big picture of OASIS-C, providing you with background and an overview of OASIS changes and how they're going to affect your agency. Hopefully you all have the PDF version of the slides that you can use to follow along today. A PowerPoint version will be posted in about a week that agencies can use to train staff as part of your own educational efforts.

Although you won't need to refer to it for today's session, I'm just going to mention that we hope that everyone has also downloaded the revised version of the OASIS-C Guidance Manual that was posted on the CMS website October 9. If you haven't gotten it yet, the link to the site where the manual is posted is provided on the last slide of this presentation.

If you have a version of the manual that you downloaded before October 9, you should get rid of it and get the new one. Also as Deb Terkay mentioned, there were quite a few questions submitted for today's call. We have tried to incorporate those answers into this presentation where we could, and we'll have some time at the end for question and answers.

So the goals for today's session as listed on slide 4 include that you'll have a basic understanding of the rational for why OASIS is changing and of the OASIS-C development and testing process. You will be able to identify what the major changes are in OASIS-C, how those changes are going to impact you and what you can do to get ready. Information about future educational opportunities that are planned will be posted on the CMS Sponsored Call website in the coming weeks. These will include highlights of item-specific guidance and impact on quality measurement - quality measures and quality measurement reporting. In the meantime, we encourage everyone to review the OASIS-C Guidance Manual carefully so you can see if questions that you have are answered there.

So we're going to start today's session with a very brief overview of OASIS's history. The Outcome and Assessment Information Set, OASIS, is a group of standardized data elements that have been developed and refined over the past 20 years through research and demonstration programs funded primarily by CMS.

OASIS collection has been required by the Conditions of Participation since 1999, for all Medicare-certified agencies.

When we say standardized data elements, what we mean is that every OASIS response that you provide represents a piece of information that's collected by every agency on every adult non-maternity Medicare/Medicaid patient who is receiving skilled services. Because it's standardized, CMS can use that data to feed information back to you about the kinds of patients you care for, and how much those patients improve under your care. CMS also uses that information to adjust your PPS payments, to provide guidance to surveyors and publish quality health information on Home Health Compare.

Now before 1999, before OASIS, there was no consistent measurement of home health outcomes or reporting of quality measures and home - Medicare home health payments were based on services provided without taking into account patient status or need. So the past ten years has seen some very dramatic changes in home care quality measurement. And we're getting ready to take the next big step now.

So OASIS quality reports - Right now the OASIS that you provide to CMS comes back to you in the form of the OBQI, OBQM, and other reports listed here in slide 7, that you're familiar with. You may have noticed that the Adverse Event Report is now going to have a new name, the Potentially

Avoidable Event Report. And the Case Mix Report is being renamed the Agency/Patient Specific Characteristics Report. These will better reflect the content of those reports and avoid confusion with the case mix that's related to prospective payments.

So, OASIS evolution - Since 1999, OASIS has undergone a few minor revisions, usually either to minimize burden or to refine the items that are used for the payment algorithm like the January 2008, changes that it seems like we just went through.

During that same ten-year period since 1999, though, CMS has also received hundreds of comments and requests for changes from providers, professional organizations, home care associations, consumer representatives, and other stakeholders.

In 2001, just two years after OASIS was implemented, Institute of Medicine published their “Crossing the Quality Chasm” report. IOM identified six focus areas for improving health care quality, sometimes abbreviated as STEEEP for safety, timeliness, effectiveness, efficiency, equity, and patient-centeredness. So they were saying outcomes are important, but don't forget about patient safety or measuring whether the care provider was efficient or the most effective care available for that specific patient.

In addition, health care quality experts and organizations like MedPAC, that's the Medicare Payment Advisory Commission, and NQF, which is the National Qualify Forum, have also published reports about how OASIS could be improved.

So, OASIS revisions, this is slide 9. CMS has three major goals for the OASIS-C revisions.

Number one is to address the issues raised by home health providers, like requests to eliminate any non-essential items, update language like using NPUAP and WOCN guidance on wound measures and improve the ability to accurately measure patient status and show progress.
The second goal was to address suggestions for home health quality measurement to include care processes, especially those that have been shown to prevent exacerbation of various conditions and that capture aspects of care under the provider's influence.

The third goal was to align OASIS measures and harmonize items with instruments being developed in other post-acute care settings.

I'm not sure if everyone is familiar with the concept of harmonization. It's what it sounds like. The idea is to try to assess, measure, and report information on patients in the same way across settings of care using similar wording and scales where possible.

This will allow tracking of outcomes across care settings and enhance coordination of care. This is in line with the new national emphasis on a more patient-centered approach to care delivery across the health care continuum versus the traditional setting-specific approaches.

A good example of the need for harmonization is, if you think about how many times you've had problems tracking down a patient history of pressure ulcers that developed in another setting or how many times you have been interviewing a patient or a family to try to get information like that and had them say, you know, “I'm so sick of telling this story. Don't you people ever talk to each other?”

Well, that's what harmonization is aimed at helping. If all of the settings from hospitals to SNFs to rehabs and home health collect and report information using the same scales, and we can make that information available to each other, it'll go a long way to improving communication and continuity between settings.

So when OASIS was - items were being refined, this goal of harmonization was always in the back of our minds and implemented when we - when it was possible.

I'm also just going to say a word here about the CARE, the continuity assessment record and evaluation tool, which you may have heard of. It's being developed as part of the Medicare post-acute payment reform demonstration. It's intended to be collected when the patient is discharged from the hospital and then at admission and discharge to each post-acute care setting, including home health care. It's another example of national efforts at harmonization.

So because improvement to quality measurement is such a big driver of OASIS-C revisions, we're going to focus on that topic for a few more minutes.

On slide 10, you'll see the IOM definition of quality of care: “The degree to which health care services for individuals and populations increase the likelihood of desired health outcomes, so these are health outcomes, but also are consistent with current professional knowledge.”

So, IOM was saying quality can be measured both by whether you're doing - what you're doing for the patient results in good outcomes and if what you're doing is consistent with what's been identified as best care practices for your profession.

For example, if research shows that doing a multifactor falls risk assessment is beneficial for community-dwelling elders, then high quality care includes providing that risk assessment for those patients because it's consistent with current professional knowledge.

Quality also includes the degree to which a provider competently and safety delivers clinical services that are appropriate for the patient within the optimal time frame.

One way to think about quality measures is the classic Donabedian quality framework structural process and outcome that we have here on slide 11. And this can be expanded to include processes of access and patient experience.

Access measures, the first one listed here, look at whether patients are getting timely and appropriate care and can help identify if there are barriers to that care.

One of the most - one of the new measures supported by OASIS-C is whether home health admission occurs in a timely fashion, so that touches upon patient access.

Structure measures, these look at the capacity of organizations or professionals to provide care. Now in home health, the Conditions of Participation deal with requirements for agency structure such as services provided and personnel. So CMS hasn't added any structure measures to OASIS-C.

And we're all familiar with outcome measures, which is what OASIS traditionally was focused on and that assess changes in patient health status over time and provide information that can suggest areas for improvement.

Measures of patient experience, on the other hand, are agency-level reports that provide the patient's perspective on quality of care. As you're probably aware, CMS is going to start implementing the CAHPS survey.

That's the home health Consumer Assessment of Healthcare Providers and Systems, which will report on the patient's perspective and experiences with home care services. We're giving you the CAHPS website here on slide 12, if you want to learn more about CAHPS.

Process measures on the next slide evaluate whether or not a specific healthcare service is provided to a patient. It can be an assessment or care planning or coordination or intervention.

They are often used to measure adherence to best practices based on either scientific evidence or expert consensus like the falls risk assessment we just talked about. And they can identify specific areas of care that may require improvement.

Adding process measures to OASIS is not a new idea. For many years, clinicians and others have said CMS should recognize the care that's provided to patients instead of basing all quality reporting on patient outcomes that are sometimes not under the control of the agency.

The MedPAC report recommended specifically that there should be quality measures that capture aspects of care directly under the provider's influence.

Adding process measures is really also a logical follow-up to the QIO team's scope of work, which provided guidance and practical tools for agencies to improve their care for patients with the same conditions that are targeted by the new OASIS process items. CMS is essentially saying we gave you the tools, now we want to recognize and give credit to those agencies that have put them into practice.

The OASIS-C process measures will be discussed in depth later in upcoming sessions. In summary, they're aimed at patients that have high risk for negative outcomes such as pressure ulcers and falls.

And they look at interventions for high frequency and high cost conditions, the frequent flyers. These are the areas where it was felt that agencies can have the most impact.

Geanelle Griffith: Deb?

Deb Deitz: Yes?

Geanelle Griffith: Hi, this is Geanelle. I'm sorry to interrupt, but we're having a hard time hearing you, so do you mind speaking a little bit louder, even if you have to yell?

Deb Deitz: Okay. I appreciate that because I was concerned that it might not be loud enough, so I'm glad to hear the feedback.

Deb Deitz: So there are a lot of potential benefits to incorporating process items into OASIS as listed on slide 14.

First, as was said, they are intended to measure elements of care under the agency's control. And from a CMS perspective, their addition to OASIS will hopefully promote the use of evidence-based care practices more consistently across all home health agencies nationally.

Process measures also can identify specific areas of care that can require improvement so they can be used in the agency performance improvement systems.

And some of the measures will be publicly reported so that they will publicly give credit to agencies that have incorporated evidence-based practices.

It's also possible that the process measures might be part of future quality-based purchasing systems for home health care that would link reimbursement to adoption of evidence-based care practices.

We're not saying this is just around the corner, but value-based purchasing is definitely one of the options that health care reform is considering.

Overall CMS's goal in expanding home health quality measurement is to include process and patient experience measures so that the information that will be provided will provide a better-rounded picture of agency performance.

We've had people ask, but why is CMS putting process items into the OASIS? Isn't OASIS a patient assessment tool?”

Well, as we’ve discussed, OASIS was originally designed to collect information on the quality of home health care. It's just that up until now, the only quality measures that were supported were outcome measures.

So in order to incorporate process measures, CMS needed to identify a way for agencies to collect and report the care information that would require as little additional time and effort as possible.

Because the systems supporting OASIS data collection and transmission are already in place in agencies and states and the mechanisms for analyzing the data and producing reports from OASIS are already in place at CMS, the least burdensome option was to revise OASIS to include the process items.

So quite a few questions were submitted asking us to please explain why process measures have been added to OASIS. So hopefully now these have been added. Now we're going to move on to a brief of the development and testing process for OASIS-C.

As it says on slide 17, right from the beginning, CMS assumed that OASIS would need to be updated from time to time to respond to scientific advances, population trends, payment changes, and other industry and system needs.

So starting in 2002, CMS convened a series of technical expert panels or TEPs to review approximately 700 suggestions from providers, government bodies like MedPAC, and others.

Another TEP met in 2005, to consider a list of 97 potential process measures based on the evidenced-based practices that were culled from literature, from AHRQ quality measures, and from NQF-endorsed measures used in other settings.

So the experts rated the measures in terms of priority, so what's most important, what's most relevant to home care, what's most feasible to collect, and on the ability to impact outcomes. So after considering that, those factors,

a smaller set of measures was identified for OASIS-C development and testing.

In 2006, CMS said okay, we've collected all of this information, we have had the expert group, and if we want to have a revised OASIS ready to go in 2010, we need to start the development and testing process.

So they funded a study to be conducted by Abt, University of Colorado, and Case Western, with the goal of developing and testing a revised OASIS that would respond to all of the input from stakeholders and include items that could be used to support a set of new process measures.

During 2006, and 2007, the development team worked on translating those requests and suggestions and directives into actual changes in the OASIS instrument.

Testing of draft OASIS-C began in spring 2008, after we got OMB approval. It involved 11 volunteer agencies that were diverse in terms of location, size, and data collection methods.

We asked agencies to seek to include patients within the conditions that were targeted by the new OASIS-C process measures like diabetes, heart failure, and pressure ulcers.

Field-testing results: the main goals of the field-testing were driven by CMS concerns that the new items should not increase burdens and had to be reliable so that they would be answered consistently.

So here's what we found -- that the time needed collect OASIS-C was very similar to times reported for OASIS-B1 by previous studies for most of the

time periods. The one difference was the transfer at 17 minutes was higher for OASIS-C. And we'll talk about the reasons for that in a few minutes.

Inter-rater reliability evaluated whether two clinicians using the same items on the same patient within two days would get the same answers. Reliability results ranged from slight to almost perfect. Whenever we identified items through our field-testing that didn't demonstrate the reliability, they were then revised to improve clarity.

We also did validity testing as part of our field-testing to examine the degree to which the new process items actually assess the specific concept that CMS was attempting to measure, in other words, if falls risk screening was reported on OASIS, was there documentation in the clinical record that it actually had occurred? And we found that most of those items had good validity.

We also met with the participating clinicians and received very valuable feedback on changes needed to wording and formatting and clarifying time periods.

Once we got that feedback from the field-testing, we revised the OASIS based on what we learned and on additional internal and feedback from NQF. We also got a lot of feedback from all of you during the public comment period November 2008, through January 2009, when CMS received over 140 responses from home care clinicians, agencies, and organizations.

We got a lot of positive comments, even people who had concerns about some items, generally had some good things to say about others. Some of the specific OASIS changes that generated the most positive comments are listed here on slide 22: improved relevance, usability, consistency, and clarity.

People liked the deletions and the improvements to wound items, the ADL questions, emergency room and hospitalization items.

Some, but not all commenters were pleased with the incorporation of best practices. I would say the nicest and most frequent comment we received was thank you for listening to us, because it was important that we were recognized for the fact that we really did try to take their feedback on OASIS-1 into consideration with our revisions.

Many commenters also expressed concerns about, you know, burden or why the process measures were incorporated or how workflow would be affected by the new items.

So each of these comments was reviewed and evaluated and further revisions to the data set were made when appropriate. You can see the entire 74-page document of comments that CMS received and our responses on the CMS OASIS website.

Now we've mention the NQF several times. For those of you not familiar with them, NQF is a nonprofit organization that reviews and endorses national consensus standards for measuring and public reporting of health provider quality and performance. NQF endorsed the initial set of home health quality measures for public reporting in 2005.

And in the fall of 2008, all of the proposed home health measures were, again, submitted to them for review. They offered several suggestions for changes to both data items and associated measures, which we then addressed in the OASIS development process. And they endorsed some of the proposed measures that will appear in public reporting.

Now the final version of OASIS-C, CMS submitted the current version of OMB in March of this year and incorporating the changes that were based on public comments and internal review. During the OMB process, there were a few minor updates that were made to direct problems like the skip logic and those were identified during the manual development.

This version was approved by OMB in the summer of 2009, and it is the version that will be used by home health agencies starting January 1, 2010.

We received a number of questions about whether and where CMS has posted the data sets for the different time points. The OASIS-C Guidance Manual contains versions of each data collection time point, as well as an all time points version.

They're also available in a downloadable zip file on the CMS OASIS data set website and there's a all time points version there as well that's highlighted to show new items.

So it's just a reminder that all of these data sets are just the OASIS-C data elements. Agencies are still required to use a comprehensive assessment that just includes these elements, one that either your agency has created by integrating the OASIS-C items into your assessment or one that a vendor has created.

But the OASIS-C from the CMS website can't be used as- is for a patient assessment because they don't represent a full, comprehensive assessment. They're just the elements that are required to be submitted to CMS.

We're just going to touch on some things agencies can be thinking about when they integrate the OASIS elements into their comprehensive assessment.

Also before we move on, we wanted to address another issue that we received a lot of questions on and that's about when the transition to collecting OASIS-C data should be made.

The answer is very simple. If you're doing an assessment and the M0090 Date Assessment Completed is January 1, or later, then you need to be collecting OASIS-C data, no matter if it's a start of care, resumption of care, follow-up, transfer, or discharge, a new patient on service or a patient continuing on service. Something to think about is if you start a start of care assessment in the five days prior to January 1, you would need to finish it by December 31.

Because otherwise if the date assessment completed, the M0090, is January 1, or later, then you're going to need to start over with an assessment using OASIS-C.

Conversely, if you're training your staff on OASIS-C, they really liked an item or they really liked the guidance associated with an item, you need to be clear that the guidance doesn't go into effect until January 1. You can't start using it in December. So I hope that clarifies those questions.

Now let's get to an overview of the changes that you'll be seeing. By the way, another plug for the manual, if you're looking for a document that shows all of the items in one place and that identifies the ones that have been changed or have been deleted or added, Appendix G in the manual provides two different tables, one brief and one very detailed, that I think people are finding to be very helpful.

So changes to the numbering system, one very obvious change is the new numbering system, while making the OASIS-C revisions, it became clear that

there were so many changes that attempting to align the items with the previous numbering system was going to be impossible for some sections.

CMS decided that providing each section with a range of numbers is a better long-term solution and it mirrored the systems being used in other settings and in the new care instrument.

You'll see that each section now has its own range of numbers such as integumentary status - it's the 1300 and medications is now its own section, so it has its own range of M numbers.

The only items that aren't consistent with this reordering are M0903, Date of Last Most Recent Home Visit, M0906, Discharge/Transfer/Death Date, which are the dates of last home visit and transfer, discharge, death date because those are being used in systems that it would be very difficult and problematic if they were changed.

So other than that, even if an OASIS item, you should remember that even if an OASIS item hasn't changed other than the M0903, and M0906, the M number has changed.

So when you're incorporating OASIS items into your forms, you should be careful to update item numbers even for the OASIS items that haven't changed.

On slide 27, you can see how the sequential numbering works. You might notice some new domains as you look at this slide like cardiac status. And here's the second half on slide 28 showing the new domains for medications and care management there.

We are sorry to see the M0 number go. We have had internal debates about whether they should be M numbers or saying M0 numbers or M numbers, but it's - we, - although we're sorry- we think it might be possible that it might end up being a little easier to actually find and refer to items when they fall inside these ranges such as the 1600s.

Another major change is that many OASIS items that are not used for payment quality reports or risk adjustment were in fact deleted. Some were eliminated altogether.

Some were eliminated from specific time points. For example, four of the IADLs have been eliminated altogether. That would be transportation, shopping, housekeeping, laundry.

The number of surgical wounds and some items that were previously collected at discharge were also deleted, resulting in 11 fewer items collected for OASIS-C at that time point. Inhalant medications were also deleted because they weren't being used for outcomes or risk adjustments.

Of course, just because CMS doesn't require these items to be reported in the OASIS, it doesn't mean your agencies have to or should delete them from your clinical assessment. That's your agency's decision about what is needed for care planning.

In terms of replacement of OASIS-C items, in some cases OASIS items were deleted, but then they were replaced by other items to capture the needed information.

For example, the prior status items for the ADLs and IADLs were deleted. However, information on a patient's prior level of functioning is actually

important for risk adjustment. It can predict to some degree whether a patient can be expected to improve.

So two new OASIS-C items were created to capture the data in a way that's less burdensome and more meaningful than the prior status question, that specifies 14 days.

Updating clinical terminology and concepts: in some cases, item wording was updated to reflect changes and recommendations for clinical practice, especially for wounds, such as changes that reflect the current NPUAP and WOCN guidance on pressure ulcer assessment.

The goal was to ensure that OASIS reflects as much as possible the state-of-the-art of clinical knowledge and that the wound items would harmonize as much as possible with similar measures about pressure ulcers and other wound items used in other settings, such as adding the pressure ulcer length, width, and depth measurement.

By the way, WOCN has told us that the guidance on OASIS wound items will be revised and posted on their site prior to the end of the year.

Another goal was to improve the accuracy of items. On slide 32, there's an example of an item that was changed in response to comments and suggestions from clinicians who felt that the OASIS could do a better job capturing patient status.

M2020, Management of Oral Medications, was moved out of the IADL section where the 50% of the time rule applied, and the item now refers to the patient's ability to correctly manage all medications safely and reliably at all times.

In many cases, items were changed in response to comments and suggestions from clinicians who felt that the OASIS could do a better job capturing patient improvement.

For example, some existing OASIS items have new scale levels such as M1860, Ambulation/Locomotion. In this item, an extra response option now allows discrimination between the use of a one-handed and two-handed device so that agencies can document when a patient progresses from a walker to a cane.

You'll see other examples of this with new rating scales for bathing and medication management and measurement of pressure ulcers.

We've talked quite a bit about the reasons for the inclusion of process measures and measures that measure evidence-based practices that are because they're relevant for home care patients.

Their integration into OASIS is probably the change that will impact agencies the most, and understanding the purpose of including them will be important for clinicians to both respond accurately and use the results of the process measures for a quality measurement.

We want to make sure everyone understands three very important concepts for the new process items starting on slide 35.

The first is that agencies are encouraged to use these best practices, but they're not mandated under the current Conditions of Participation. With the exception of requiring that the item be included on the assessment form and

answered, CMS is not prescribing the content of agency clinical assessments or mandating specific processes of care.

There’s no requirement for agencies to change their care processes to match the processes or the practices measured in OASIS-C. It's up to each agency to determine which processes it will implement based on its patients and operations.

When making decisions about which of the best practices to adopt, agencies should remember, however, that some of the process items will support publicly-reported measures and agencies choosing not to adopt those processes of care will see that decision reflected in Home Health Compare scores.

So on slide 36, number 2 here, very important, CMS understands that the evidence-based practices being measured don't pertain to every patient. A rate of 100% is not expected for any measure.

Some processes might not have any application for a particular patient so no related assessment or intervention is needed. For example, a depression screen wouldn't be appropriate for a comatose patient who can't respond, only if the patient will receive a screening or intervention.

So each process item provides an opportunity for clinicians to indicate that a process wasn't conducted for whatever reason. And in some cases, a response has been added that reflects the reason why a practice might not be appropriate for that patient.

Then number three, not all best practices are in OASIS-C. The process measures in OASIS-C don't represent an all-inclusive set of all evidence-based practices that can or should be used in home health.

There may be other measures that JCAHO or NQF considers high priority in cross settings used that your agency may want to look at to determine if some of those would be appropriate for you.

I'm going to sneak in one more answer to a question that was submitted several times asking for CMS to identify the items that contribute to the process measures.

I just want to point people toward the item uses table in OASIS-C of the Guidance Manual and - I'm sorry, in Appendix C of the Guidance Manual that identifies whether each item is used for payment or quality measures.

I want to make sure Liz has enough time for her presentation, so I'm going to skip quickly over the next two slides, which basically say that the time point where there are significantly more items, the only time point where there are significantly more items is at transfer.

And that's so CMS and agencies can have better information to help reduce acute care hospitalization. But 41, however, I want to go to, so you can look at the information on slides 39, and 40. I think everything I would want to say is there.

On slide 41, however, I want to reinforce that about the payment items, did OASIS-C impact them? And the answer is no, OASIS-C has no impact on reimbursement.

Part of the development and testing of the OASIS-C included a careful assessment to make sure that there was minimal or zero impact on payment. Changes to items that contribute to the payment algorithm were examined by the payment group within CMS to ensure the changes were payment neutral.

We're not going to get into impacts on measure reporting today. CMS will provide more detailed information on this topic, including both process and outcome measures and the reporting schedule, at a later training session.

At this point, I want to turn this presentation over to Dr. Liz Madigan to discuss the impact of OASIS changes on your agency operations.

Liz Madigan: Great. Thanks Deb.

So I'm on slide 42, OASIS-C data collection conventions and exceptions. So to go along with these new data items in OASIS-C, there have been some changes to both the general conventions that you want to consider when collecting data and the item-specific guidance.

The OASIS conventions in Table 4 is part of the OASIS Guidance Manual in Chapter 1, has 15 conventions that generally apply across all items. There are three conventions that apply specifically to ADLs and IADLs.

And it's very important that these are followed in a standardized way so that the data that are collected are both collected accurately and that the information that goes into the CMS system to determine measures is actually accurate data.

These are detailed in great detail in the new Guidance Manual, but we're going to touch on a couple of these that have particular relevance and that may

be very different. This will help to illustrate why it's critical for accurate data collection that you want to be familiar with these conventions and the exceptions.

So on the next slide; we talk about the time period, Convention #1. You want to understand the time period under consideration for each item. This is important in OASIS-B1, right now, just like it will be in OASIS-C.

What you want to remember is in most cases, you report what is true on the day of assessment unless a different time period has been indicated in the item or the guidance.

There are some other assessment periods and we're going to give some examples.

On the next slide, 44, we talk about M1900, which is Prior Functioning. For this one, what you're looking for is the time period prior to the illness exacerbation or injury that led to this episode of home care.

This is different than the current OASIS-B1, which refers to 14 days prior to the day of assessment. Now we're looking back to prior to the illness, injury, or exacerbation. It may be two weeks. It may be longer. It may be shorter.

This is where it's important to really understand these time periods that are exceptions. And this is one example that's an exception.

In slide 45, we're talking about symptoms in heart failure patients. This is another example of a time period that's used for many of the new OASIS process items.

This assesses whether patient symptoms occurred or a care process was completed by the agency during the episode of care. This question asks about whether the patient has exhibited heart failure symptoms since the previous OASIS assessment. So you need to make sure to read and understand the period of time under consideration for each data item.

On slide 46, we talk about usual status, Convention # 2. If the patient's ability or status varies on the day of assessment, report what is true greater than 50% of the assessment time unless the item specifies differently.

This is a big change because now, for M2020, Management of Oral Medications, it refers to the patient's ability to manage their medications all the time. So the new mantra is all meds all the time.

This is, the patient is independently able to take their morning and afternoon medications but routinely forgets their evening blood pressure medication, the response would be 2, “able to take medications if given reminder by another person.”

This is in direct response to concerns and comments that medication management really requires people to be able to manage all of their medications, all the time.

And this is one of the examples of how the comments were so helpful during the technical expert panels on the comments.

We're skipping convention 3 and moving to convention 4. Now we're on slide 47. Convention # 4 is responses to items documenting a patient's current status should be based on independent observation of the condition and ability at the time of assessment without referring back to prior assessments.

This is where you don't use an admission OASIS to do the discharge OASIS for functional status. That would be inappropriate.

However, there are some times with OASIS-C where you're going to have to look at other things that happened during the care episode. And the example here is process items.

So what happens with process items is that you may need to look back at the record, at the communication with the physician and other clinicians to determine what happened.

Again, this is one that refers to an exception. There are some exceptions to the look-back when we look back and when it's appropriate to look back. And that's part of what we're trying to clarify in these conventions and exceptions is that time points are very important and you want to make clear to your staff about which time points are appropriate for which kinds of assessment periods.

So here's an example. This is M2400, Intervention Synopsis. If you look just at row a, this is on slide 48, plan or intervention for diabetic foot care. So the question is, since the previous OASIS assessment, was diabetic foot care included on the plan of care and implemented with the patient?

As you can see, to actually answer this question, you need to know what happened during the episode, to be able to look back and say, was it actually both on the plan of care and implemented.

So slide 49, Convention # 5, you want to combine observation, interviews, and other relevant strategies to complete the OASIS data items as needed.

Again, this is similar to other OASIS questions. You may need to use - you may need to look at things like inpatient procedures for the new OASIS questions. You might want to review the hospital discharge summary to do so.

Again, what you're looking for is getting the correct data to help you answer the items that you're answering. You may need to review the clinical note. Again, remember when you're assessing the physiologic or functional status, observation is the preferred strategy. OASIS-C is not designed to be an interview form for functional status for physiologic measures.

On slide number 50, we talk about the one clinician rule, which is Convention #13. And this is, only one clinician takes responsibility for accurately completing a comprehensive assessment, although remember, for selected items collaboration is appropriate. And these exceptions are noted in the item-specific guidance.

Here is an example. For M2000, Drug Regimen Review, does a complete drug regimen review indicate potentially clinically significant medication issues?

This might require communication with the physician to be completed by the agency staff other than the clinician responsible for completing the start of care or resumption of care.

In this situation, information on the findings from the physician communication is communicated to the clinician who is responsible for the assessment so that that person can then assess the - include the appropriate response for the drug regimen review.

This does not violate the one clinician rule for completion of the assessment. As Debora stated, remember, OASIS-C is only part of the comprehensive assessment. It is not sufficient in and of itself to be the entire comprehensive assessment.

On slide 51, what you want to make sure is, and this is the bottom line, to collect the data accurately, everyone needs to read the items carefully and follow the data collection rules.

The Item-Specific Guidance Manual is very helpful in this regard and we're going to discuss it a little more a little later. However, our big reminder to everyone is that you need to have this manual available.

Use it for training and make sure that your clinicians have it available when they're answering the OASIS-C items. It will help to decrease a lot of the confusion.

All right, so slide number 52, now we're going to talk about the potential impacts on agency operations.

So when you're thinking about what you're going to do, what do you need to consider? What we're doing in this part of the presentation is really focusing on those issues, and we really encourage you to really think about what works best in your agency.

Every agency has its own culture and approach. We have ideas for you, but these are not designed to be exhaustive or prescriptive ideas. You have to figure out, for your agency, what works best.

And we encourage you to consider both what works best in your agency in the past and how this is an opportunity for you to really work with your staff to get the best understanding of what's going on.

So we're going to go sort of time point by time point. The first time point we're starting with is referral. One possible change you might want to consider is what information you collect at referral.

The three most pertinent items we've identified for which this referral time point is most important include pneumonia and influenza immunization, which is M1040 through M1055, the relevant inpatient procedure code, M1012, and the pressure ulcer history items in Section 1300.

Many providers, remember, are requiring information that is collected as part of the harmonization effort on pneumonia and influenza vaccine, so people who historically in the past have not had this information may now have it available. For example, primary care offices and hospitals may have this information available whereas in the past it was hard to find out.

The relevant inpatient procedure codes are items that you might want to start with your hospitals on getting. In addition, pressure ulcer history is something that you might want to put on your referral intake form so you can ask at the time of referral has this patient had a pressure ulcer.

On slide 54, we talk about more information. You might want to choose to revise what is asked and how it's collected at the time of referral. What we've found in part of the field-testing is that the referral forms are - every agency has a different kind of referral form.

The information that's included on the referral form sometimes has multiple places where the same information is collected or it's collected in two different places in the clinical record. This is going to make it hard for the clinicians to actually get efficient use of those records.

So we would recommend that you really look at what information you're collecting on referral, how the information is collected, and really start working with your hospital referral sources right now, to identify how to get some of this information if you're not currently getting it.

If you give yourself sufficient lead time, you can explain to them how things are changing for you and how you may need additional information from them on relevant inpatient procedure codes, for example, or for immunization and pneumonia, for example.

On slide 55, part of what we've identified is on timely delivery of care, you might want to redesign your forms to make sure it's very clear where the date of referral information is located and whether a specific physician-ordered plan of care date is ordered.

The Date of Referral, which is M0104, is required on all patients and according to the Guidance Manual includes the most recent date that verbal, written, or electronic authorizations are received by the agency.

So if your agency tracks initial calls and records those as well, make sure it's clear to the admitting clinician which date meets the requirements.

For the Physician-Ordered start of Care Date, M0102, again, this applies if the physician specifies a care date. This item may also be marked as not

applicable if there's not a specific date. Again, be sure your forms and your processes make this easy for the admitting clinicians to determine.

If you're paper-based, is it clear where this information is collected? If you're electronic-based, will your vendor facilitate you accessing this information? These are the kinds of questions that you want to start working on now so that you're ready for OASIS-C when it starts on January 1.

On slide 56, we're moving to start of care and resumption of care. OASIS-C has opportunities for agencies to document best practices that include screening for depression, pain, falls risk, and pressure ulcer risk.

In our travels around the country when we asked how many agencies are routinely doing any of these, many agencies already routinely do this, so this is not going to be a change for many agencies.

One of the things we learned in the field-testing, however, is that clinicians sometimes had several places in the record where they recorded this information. And that was not necessarily consistent from one clinician to another.

So if I was the discharging clinician and I needed to look back to see if a screening was done, I might have to look in three different places. This is going to be a problem when OASIS-C goes into implementation if you choose to do these measures.

Regardless of whether you're electronic or paper-based, make sure the information is easy to find.

And slide 57, screening assessment, the first question you need to ask yourself is whether you're already doing any of these screening assessments. If you're not, do you want to start? Remember, these are not mandated.

The second question to ask yourself is whether the screening assessments you are doing, do they meet the criteria? For example, it's a multifactor falls risk assessment, it's a standardized depression screening tool that needs to be used. Please note that CMS does not require the use of specific tools, but does require that some screening forms use standardized assessments for specific parameters.

If your agency is using screening assessments, be sure to follow the guidelines for determining risk. There are scores for the standardized assessments that indicate risk, and this is where you need to follow those scoring mechanisms.

Finally, if you're going to be newly implementing one or more of these, be sure to determine how you're going to educate your staff on these items and how they are used.

There are specific kinds of parameters included in the Guidance Manual that give you some indication about that. But, again, it's your choice as an agency as to which of these you implement and which instruments you use to do so.

On slide 58, screening assessments, some of your staff may have concerns that they need special training to conduct these assessments. There have been other concerns expressed about assessments for pressure ulcer evaluation or drug regimen review.

There are many resources available for you to use to educate your staff on these screening assessments. Many of these screening assessments are done in other sites of care.

They do not require specific additional education beyond that done or received by a physical therapist, speech language pathologist, and registered nurses. All are qualified by their education and licensing to do these kinds of screening evaluations. You do not require psychiatric training to do a depression screening.

There are many resources available for assisting your staff if you decide to undertake these. And the Guidance Manual has a whole section on resources to help you with this.

On slide 59, we go into a little bit more detail about this. So especially for depression screening and wound care assessments, one of the things this means is that because PTs, speech language pathologists, and RNs are all qualified to do this, they're concerned that they need to have special training.

Part of why the depression in particular, and the wound care in particular, are process items in OASIS-C as opportunities, is because we know especially depressive symptoms interfere with patient self-care and self-management.

We also know that few agencies routinely screen and refer or intervene. We also know that screening can be easily done by any healthcare provider and is already done in many sites of care.

So as a result, the PHQ-2, which is a depression screening, was built into the OASIS data item only to simplify the data collection. It's not required. You may elect to use other tools. It's your choice as an agency.

For wound care, one of the things we know is that the research is clear, screening and intervention are effective in preventing the development of, and worsening of, pressure ulcers. Early and effective interventions also reduce the severity of pressure ulcers. Thus OASIS-C includes a pressure ulcer risk assessment as a process item, to help identify patients at particular risk.

On slides number 60, and 61, there was concern especially expressed by physical therapists about discipline neutrality, especially for therapy-only cases.

The American Physical Therapy Association, the APTA, made specific recommendations, and we've highlighted these. This information and the letter that they provided is also available on the CMS website if you need additional information.

What's important to notice here is that they've identified that it is within the scope of PTs to perform a patient screen in which medication issues are assessed even if the PT does not perform the specific care needed to address the medication issue.

They have identified the depression screening is within the scope of PT practice. They actually recommended the PHQ-9, although what we included in the OASIS-C was the PHQ-2.

They really made a strong point that the APTA strongly urges CMS to duly note and recognize the role of physical therapists in OASIS items as they relate to medication management.

On slide 61, we go into more detail about heart failure. For the heart failure items, they noted that PTs are more than competent to complete the information needed.

For wound care, they said the same kind of thing. Physical therapists are permitted to perform all wound care interventions legally mandated by state licensure and defined by the education curriculum of the physical therapist. We are providing the wording here so that you can work with your agency staff on their concerns about these changes.

On slide 62, we're talking about assessment strategies. Again, as OASIS-C is part of the comprehensive assessment, a number of assessment strategies are required. This includes observation. It may include interview.

You may need to review pertinent documentation like hospital discharge summaries. There may need to be discussions with other care team members where relevant. For example, phone calls to physicians to verify diagnoses or to clarify medication regimens.

Also there's a measurement, the integumentary section of OASIS includes pressure ulcer length, width, and depth.

These are all assessment strategies. OASIS was never designed to an interview form only. And so part of what's important is to use the best approach to get the information you need.

On slide 63, what we're talking about here is information you need for start of care and resumption of care. There are specific OASIS items that specifically address care planning and are in a synopsis format.

This is item M2250. The slide here provides the items that show up on the physician-ordered plan of care and would be recorded in the item. Note that some of these are generally applicable to all patients, for example, pain, while others may be specific to certain conditions, diabetic foot care is a good example or pressure ulcer treatment.

Again, you want your processes and your documentation to make it easy for the admitting clinician to identify the relevant possible choices and to include the relevant choices on the physician-ordered plan of care.

On slide 64, one of the questions that have come up is, how can we know about physician orders while we're doing the patient care assessment?

The intent is that the care plan evolves from the findings of the assessment. Answering that the physician-ordered plan of care includes a plan or intervention means that the patient condition has been discussed with the physician, and that there is agreement on the plan of care.

The Guidance Manual for this item, M2250, has extensive detail on what is required and how to complete this item.

On slide 65, the plan of care items at start and resumption of care for documenting the plan of care, the dates of completion remain the same. You have five days at the start of care and two days for resumption of care.

Remember, CMS recognizes that this may not happen for all patients at all agencies. If the time window is closing and the interventions are not in the plan of care, then respond no to the relevant items.

The expectation continues that there should be congruency between the documentation of findings from the assessment and the plan of care. And remember, the usual formats for physician orders are acceptable. Written orders, verbal orders, the same way that you do it now, you can still get orders in the same way.

On slide 66, now we move to transfer and discharge items. Process items specifically ask about whether care practices and interventions were implemented since the last OASIS assessment.

This includes things like diabetic foot care, falls preventions and interventions, depression interventions, and others. And those are listed on the slide.

This means at the time of the most recent OASIS assessment and since that time. You can collect this information in several ways. You may want to review the clinical record.

You may want to create a flow sheet to track these interventions over time. You might want to have a report pulled from your electronic clinical record. The responses to these items, remember, should be congruent with the clinical record. And remember, CMS does not require many of these best practices in the Conditions of Participation. Agencies may elect to implement these processes or not.

For slide 67, when you're obtaining information for transfer or discharge, what you want to do is there are three steps to really answering these items.

First, you want to identify, was the condition present? So, for example, did the patient have pain, did they have symptoms of heart failure? Second, you want

to identify if the condition was present, was the intervention to address the condition included on the physician-ordered plan of care, and finally was the intervention implemented?

Again, you may want to develop a flow sheet or a checklist for your clinicians to use or your electronic vendor may already have this in development. Our experience from the field-testing and the comments indicate that these kinds of work processes will simplify completion of OASIS-C.

Agencies are already working on some of these things. People have talked with us about the things that they're planning and what they're doing, so it looks to us like agencies are already moving forward in many cases on these items.

Slide number 68, there were a number questions regarding the prohibition against using prior documentation against OASIS items. And as we've explained a couple of times, this does not apply to process items.

Process items require different information. Process items like M2400 are similar to a discharge summary. You would not expect your clinicians to complete a discharge summary without referring back to the clinical record.

This is the same kind of approach. The completion of an item like M2400 is the same. The clinical record and the supporting documentation are used to answer the items.

The clinical record, remember, is more than just the actual clinical notes, but also includes physician orders, communication logs and retrievals, and comprehensive clinical assessments. So, remember, when you're looking at

these process items, you might to use additional information to actually answer the items.

On slide number 69, you have to consider the care that's provided by all disciplines, not just the discipline of the clinician completing the assessment. If the clinician completing the OASIS transfer discharge is not familiar with the patient, how are they going to get access to that information?

One of the points that became clear to us during the field-testing is that some agencies allow contract therapists only access to the therapy part of the record. If the contract therapist is the discharging clinician, they're going to need access to the entire record to be able to answer these kinds of questions. So you're going to have to rethink how you're currently doing this process.

On slide70, what we're looking at is how to get the information at transfer and discharge. And, again, you can look at the clinical record. You may want to a flow sheet. Maybe your vendor is creating an electronic template that can be used.

The important point is that the clinicians can get access to the information in an easy way and that the chart supports that this information was available.

On slide 71, we're going to do one more clarification on the issue of prior documentation. These process items are a major difference from the other OASIS items, in that they don't reflect a snapshot of the patient on the day of the assessment, but require knowledge of what happened across the episode.

This change for the review period should not be confused for the clinical assessment item. The no-carry-over rule still applies. In the current OASIS

rules for B1, you can't use a current - an existing OASIS form to answer one for today. You need to use the day of assessment form.

The same thing applies for things like functional status items in OASIS-C. The same rule applies.

On slide number 72, we're going to do a couple reminders first and answer a couple questions. Excuse me.

So in preparing for OASIS-C, a couple of things that you want to think about. Again, as Debora said, starting January 1, these are the only OASIS forms to be used. So if your M0090 dates, your date assessment completed, is January 1, or later, use OASIS-C.

The second thing is that there have been a number of questions regarding OASIS forms and how agencies choose to use the forms. Some agencies combine the start of care and resumption of care into one form.

Some agencies use different discharge forms for transfer and death versus those for patients who remain at home. The key point is that the appropriate items are answered at the appropriate time point. How you choose to organize your forms is your decision. The comprehensive assessment, including OASIS-C, is your decision.

The important point to remember is the OASIS-C items for those particular time points need to be included in a way that is very clear so the clinician using the form knows which items need to be answered at which time point. The organization of the forms is your choice.

So on slide 73, we're talking about preparing for OASIS-C.

Remember, your agency may choose to implement some of these care process measures; a lot of agencies are already doing these. If you're not sure which ones, you might want to consider which ones would be best for your agency.

One thing to remember is to check your policies and procedures as well. Here is an example. If your policy is that OASIS is completed at the first visit, you might want to think about this because you have the five-day start-of-care window to get those physician-ordered plan-of-care items into the plan of care.

However, if you try to do the OASIS form on the same day and that's your policy that it has to be done on one visit, then that first visit, you may be limiting yourself unnecessarily on this kind of approach. So you want to look at all of those policies and procedures.

There are also some pieces in workflow that need to be changed. We recommend strongly that you take a patient assessment and you go all the way from referral to admission and into discharge to make sure that you understand where all of your policies are going to have to change, if any.

You might also need to consider if there are other departments within your organization that may be impacted as well. For example, if you have a change in a clinical policy, is that going to have implications for your billing department or for supply or for referral or intake?

If you're working with electronic records, work closely with your vendor on integration of those OASIS-C items. There are a number of items to consider: the timing of the changes, ensuring the items are placed appropriately within

the assessment, ensuring that the wording is correct and the testing has been adequate.

Again, we really encourage you to use the guidance document and when you're working on your training approaches, identify what works best within your agency and follow those work processes through.

On slide number 74, it's really important to figure out what's the best approach within your agency. Are you going to train everyone on this, are you going to train a trainer who then trains everyone.

A lot of agencies have identified OASIS-C resource persons or OASIS-C experts. And these are the people who are working on the processes and training.

We recommend you cross-train people so that if you have someone whose focus is OASIS-C integumentary section and that person is on vacation, there is a resource person available to answer questions if that person is gone.

There are many resources available, including your State OASIS Education Coordinator. There are also training materials on the website.

The important point you want to make sure of is that all of the staff affected by OASIS-C are adequately trained. This includes the clinicians, the clinical managers, the quality improvement folks, the data entry staff, the clerical folks.

Our experience in the field-testing is that the staff accustomed to collecting the OASIS data was able to understand the instructions on the new items fairly easily.

It was the clerical people who needed a little more help sometimes. So this is where we would encourage you to really think about all of the departments that are going to be touched with these changes.

On slide 75, remember, if you elect to use the evidence-based care practices, you want to make sure your policies and procedures are congruent and are being implemented.

If you recommend that a specific instrument is being used and you have that in your policy, make sure that that's the only instrument available to your clinician. That may not be the best approach. You might want to have a selection based on the patient population.

Follow your work processes for the care practices you are using and make sure that all of the departments and steps are clear to everyone and everyone knows what is being done.

Slide 76, we've talked about the OASIS-C Guidance Manual. This was formerly known as Chapter VIII and now it's known as Chapter 3. This is an important resource for OASIS training.

This manual was prepared by the CMS and OASIS-C clinician teams and was reviewed by 14 outside experts who gave very detailed comments and helped us really finesse this.

We think this will be very helpful to you. It has a lot of examples in it, and there are lots of resources available within the entire manual. We really recommend that this is available to folks, that they have it in their hands as they start using OASIS-C.

On slide 77, what we've talked about here is that this is really a consolidated version of the original manual. There's a lot more content relevant for agencies that are experienced with OASIS requirements. There's less about what is OASIS and why it is important and more on item guidance.

Some of the content from the implementation manual has been incorporated into the appendices to give additional context for OASIS data collection requirements. And the implementation manual will be archived, but it will be available on the web through the CMS website for people who are new.

On slide 78, we talk about the OASIS Guidance Manual. Part of what we did here, we really tried to streamline the manual. So what's happened with this is it's really designed to facilitate future updates and to decrease the burden for those who access it electronically.

On slide 79, what do we mean by this? The item-specific guidance is no longer contained in a single document, but it's been divided into sections that can be accessed through individual links by domain, so all of the questions and item-by-item guidance by integumentary section are all in one particular document.

That means when clinicians want to get access to something, rather than scrolling through the entire document, they can actually get to that section very easily.

As we've said, and we'll say it one more time, we strongly recommend that the frontline and admitting clinicians receive electronic or paper versions of this Guidance Manual.

We were surprised when we were doing our field tests and in our interactions with clinicians how many indicated that they did not realize that there was such a document available, even for B1.

There is a resource guide in Chapter 5 that has links to CMS resources and additional clinical resources. One of the questions that have come up is what screening tools are available for certain kinds of process measures? These are contained in Chapter 5. Are there clinical guidelines for particular things? These are also contained in Chapter 5.

So finally, we come to our last slide, which are the references. The OASIS Guidance Manual reference has the information on the website. The other manuals are either being developed or updated.

The data sets are available. And there will be a switch from the old manuals to the new manuals on the CMS website and the B1 manuals will be archived in late December.

Now with that, we go back to our moderator, Geanelle Griffith.

Geanelle Griffith: Thank you, Liz. We will now open the call for questions. But before we begin the question-and-answer session, I would like to remind everyone that this call is being recorded and transcribed.

So please state your name and the organization you are with. In an effort to get as many questions answered from as many participants on the line, we ask that you limit your questions to just one.

Liz, at this time, you may open the line for questions.

Operator: We will now open the lines for a question-and-answer session. To ask a question, please press star followed by the number 1, on your touchtone phone. To remove yourself from the queue, please press the pound key.

Please state your name and organization prior to asking a question and pick up your headset before asking your question to assure clarity.

Please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference.

Your first question comes from the line of Amy Pastor. Your line is open.

Amy Pastor: Hi.

The reason for my question is I just want a little clarity as to when is the latest B1 OASIS that should be used in 2009? What should my cutoff date be?

Robin Dowell: That would be December 31, 2009. OASIS B1 up through midnight December 31, OASIS-C as of January 1.

Amy Pastor: Okay, so if I have a patient that the start of care was in November...

Robin Dowell: Right. Mm-hm.

Robin Dowell: Yeah.

Amy Pastor: No, I'm sorry, the start of care let's say was December 1. And it'll take me to late January. In the case like that, do I have to do a discharge and then do a start of care on January 1, with the OASIS-C?

Robin Dowell: Absolutely not. You just - when that patient is due for a restart or a discharge, whatever date that falls on, you do the OASIS-C if it's January 1, or after. You do the OASIS-B1 if it's up through midnight December 31.

Amy Pastor: Okay, thank you.

Operator: Your next question comes from the line of Donna Schade, from Bally Home Care. Your line is open.

Donna Schade: Hi.

You mentioned that the Guidance Manual would be available in late December. However my question is, is the current guidance in the User Manual released by the OCCB today the most current and the one that we should be using in 2010, particularly the wound guidance?

Debbie Terkay: CMS has posted a user manual as of October 9, 2009 that is the most current. When you refer to the OCCB, are you saying that they have our manual posted there? Or are you referring to their Q&As?

Donna Schade: No, they have the manual posted.

Debbie Terkay: Well, then, that would be the most current manual, which is also on the CMS website.

Donna Schade: Thank you.

Operator: Your next question comes from the line of Marcella Jones, from Health In-Home Care. Your line is open.

Marcella Jones: Hi.

My question is do we need to incorporate the assessment part as we've done with the previous OASIS? We had to incorporate the physical assessment in between the OASIS questions. Do we need to do that with the new OASIS as well?

Pat Sevast: Hi. This is Pat Sevast, from Survey and Certification.

The answer is yes. The regulations and the Conditions of Participation at 484.55 have not changed. And they require the incorporation of the current OASIS version into your assessment form.

So just like back in 1999, you need to take your comprehensive assessment form and look at the pieces that are old OASIS items and replace them with the new OASIS items.

So you take out the B1 and put in the C. So your assessment forms are essentially all going to change and you're going to incorporate the C items into the comprehensive assessment form.

Marcella Jones: Okay, thank you. That was my question.

Pat Sevast: Okay.

Operator: Your next question comes from the line of Wanda Gailey, from University Hospital. Your line is open.

Wanda Gailey: Hello.

We have a question regarding the OASIS items regarding the physician-ordered start of care date. We typically will range our start of cares. What date should we put in there?

Pat Sevast: This is Pat again.

You should use the specific date ordered by the physician. A range is really not acceptable. The regulations indicate that you need to do the initial visit within 48 hours of referral or on the physician start of care date. So you really can't use a range. If the physician wants the care started tomorrow, you have to do it tomorrow.

Wanda Gailey: If the physician gives us the information, we can start it on Tuesday or Wednesday, so what...

Pat Sevast: Well, then ask - I would ask the physician - if you write that on your referral form, then I would probably, when you get to the OASIS use the later date for safety purposes.

Wanda Gailey: Thank you.

Debbie Terkay: And this is Debbie from CMS, and I just wanted to clarify on this particular set of questions, physician-ordered start of care and date of referral, it will be an either/or situation.

The physician-ordered start of care is intended to capture very specific dates when the doctor says please see my patient on Wednesday to do a home health assessment and draw a lab. The date of referral would better capture the

flexibility when there's no specific procedure ordered attached to the physician-ordered start of care.

Operator: Your next question comes from the line of Pam Ireland, from Mount Carmel Regional. Your line is open.

Pam Ireland: Clarification on the OASIS-B and the OASIS-C .If I have a patient in December on OASIS-B and they're going to be ready for discharge January 15, I would have an OASIS-B start of care and I would have an OASIS-C discharge, correct?

Robin Dowell: That is - this is Robin Dowell, and that is correct.

Pam Ireland: Thank you.

Operator: Your next question comes from the line of Kathy Pecaut, from Perry County Memorial. Your line is open.

Kathy Pecaut: Yes, I would like to know, I know that the data sets are available on the CMS website, but will CMS also make that available in a Word document and when?

Robin Dowell: We are working on posting Word versions of the OASIS-C as we speak. So it should be up within - by the end of next week.

Geanelle Griffith: Next question.

Operator: Your next question comes from the line of Alma Calug, from Goodwill Press. Your line is open.

Alma Calug: Hello? Hi.

The question is if we do an actual evaluation on the December 31, and then we have five days to finish the OASIS, the assessment, and we finish it like January 2, what are we going to use? The OASIS-C or the OASIS-B?

Robin Dowell: This is Robin again.

And you - if you finish - you complete your assessment on January 2, your M0090 date is January 2, you are using the OASIS-C.

Alma Calug: Okay, thanks.

Operator: Your next question comes from the line of Lee Cooper, Your line is open.

Lee Cooper, your line is open.

Geanelle Griffith: Next question, Sarah.

Operator: Your next question comes from the line of Karen Miller. Your line is open.

Karen Miller: Hi.

I have a question. You were referring to those items that required information from a prior assessment such as diabetic foot care. What if the patient was taken care of by another agency and you don't have that information?

Debbie Terkay: The question is based on what your agency has provided.

Karen Miller: Okay.

So if we don't have that information from another agency, we just go on what we - the last time we had taken care of that patient?

Debbie Terkay: Yeah, I think...

Karen Miller: If any?

Debbie Terkay: I mean, I think maybe you just need to be clear that certain elements of these measures are collected at either/or situations and some of those intervention measures are specific only to discharge or transfer

Karen Miller: Okay.

Woman: ...for your agency.

KarenMiller Great. Thank you.

Operator: Your next question comes from the line of Patricia Fiedler, from Visiting Nurse Services. Your line is open.

Patricia Fielder, your line is open.

Patricia Fiedler: We've been reviewing the Chapter 3 guidance very carefully in particular for the wound items.

And we have found a particular problem in the measurement items and 1301, 1312, and 1314, on bullet 3b. We feel there's an inconsistency in the items. So

what we are seeing is that this item only includes a stage 3/4 or a D2, which is a wound that is unstageable due to eschar or slough. But 3b refers to an unstageable wound, which has a non-removable dressing, which is not part of this item.

So we've, you know, we're wondering if there was some problem with the guidance at this point. It seems to contradict what it says initially.

Hello?

Debbie Terkay: Yes, we believe that in that situation that it if it was covered with a dressing, you would not have the capacity to measure it. And there's guidance to list 00.0 in that circumstance.

Patricia Fiedler: The problem, though, is that a D1 is excluded from this item, so we're not quite sure why it's even mentioned as a - you know, that we should be measuring it because it says that this item only refers to a row B, C, and D2.

Robin Dowell: In this situation, it's really difficult to answer this complex a question. Could you email that question to me please at Robin.dowell -- D-O-W-E-L-L -- @cms.hhs.gov.

Patricia Fiedler: Thank you.

Operator: Your next question comes from the line of Patty Mulhern, from Home Care Association. Your line is open.

Patty Mulhern: Hi.

I'm referring - I had a question related to one of the early slides about harmonization. Did I hear correctly that there will be an additional form required at discharge across all post-hospital settings to be consistent?

Debbie Terkay: What was mentioned during the presentation was that CMS has in demonstration a cross-setting post-acute care payment reform demonstration and that the final outcome and desire of CMS as a payer is that they would be able to assess population health in patients across all settings.

And currently we have very discordant measurement scales and wording so that the hospital charts certain things in a certain way, and a home health charts things in another way and a long-term care provider/nursing home charts things in another way.

So there is in demonstration a project where items are harmonized. That's chosen from all of the different instruments across the different settings of care. And they're being tested in each setting of care to see if they could not come up with a better method for all long-term care providers' post-acute settings.

Pat Sevast So that - in other words, that's off in the future? It does not apply to this OASIS-C situation.

Patty Mulhern: Thank you.

Geanelle Griffith: We have time for one more question.

Operator: Your next question comes from the line of Maria Sanagustin, from A-Plus Home Care. Your line is open.

Man: Hi.

I wanted to know the information that you gave today, is it available on the website that - the home health quality website?

Robin Dowell: Yes. This is Robin.

And the slides are available on the website now. And a transcript of the call plus an MP3 file will be posted within two weeks.

Man: Thank you.

Debbie Terkay: Hi. This is Debbie, and I wanted to take this opportunity to end the call with answering several of the questions that were posed with the registration materials, some important items that people were particularly interested in.

The data specs were posted for vendors back in July. There have been several revisions and the most current revisions of data specs have an R3 attached to them with a date of 10/20/09.

Also a question was posed asking specifically for the user guide and error correction guidance that is attached to the actual HAVEN and specifications. And those manuals will be produced in December.

Again, the OASIS-C Guidance Manual for clinicians is currently available and has been available as of October 9.

Another question, again, relating to HAVEN was, when that will be available and the answer is that the HAVEN 10.0 will be available in December.

However, the validation.dll will be available in November for those vendors who need to test their software prior to the OASIS-C release.

When should we start using OASIS-C? I do believe that we've answered that question throughout the presentation today. And, again, that is when the M0090 date is on or after January 1, 2010

Also the other question that was asked frequently was in regards to payment structure and we are not in a position to discuss any future plans, changes, and the OASIS-C grouper has to be adjusted based on the new scale.

But the payment structure is not changing in any way, shape, or form related to OASIS-C. And an OASIS-C grouper revision will be posted around November 3, 2009.

Geanelle Griffith: Thank you, Debbie.

I would like to thank everyone for joining us today and for your participation in the question and answer portion of the call.

As stated earlier, a transcript of the call as well as an audio MP3 file of the call will be posted at least two weeks after today's call.

Thank you, everyone, for joining us today. Have a great day.

Operator: This concludes today’s conference call. You may now disconnect.

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