Centers for Medicare & Medicaid Services
Outcome and Assessment Information Set OASIS-C Conference Call
Moderator: Robin Sutton
November 12, 2009
1:30 pm ET

Operator: Welcome to the Outcome and Assessment Information Set OASIS-C conference 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 1. If there are between two and eight of you listening in, enter the corresponding number between 2, and 8. And if there are nine of you or more enter 9.

Thank you for participating in today's call. I will now turn the conference call over to Ms. Robin Sutton. Ma'am, you may begin.

Robin Sutton: Thank you, Sean. Hello everyone and welcome to the Outcome and Assessment Information Set National Provider Conference Call. My name is Robin Sutton, and I will be your moderator.

This call will review the OASIS-C, section by section providing attendees with information on data collection guidance for selected OASIS-C items. The presenters will be Ms. Linda Krulish, who has been a member of the clinical team assisting CMS with the refinement of OASIS-C guidance.

Following the formal presentation the lines will be open to allow participants to ask questions of CMS OASIS-C subject matter experts.

A PowerPoint presentation on the OASIS-C website at www.cms.hhs.gov/homehealthqualityinits/02_cmssponsoredcalls.asp on the CMS website under the downloads. If you haven't done so already, please take the time to download it now so that you can follow along with the presenters.

I will now turn the call over to Ms. Pat Sevast, for a few introductory remarks.

Pat Sevast: Thank you, Robin. Welcome everyone to the Centers for Medicare and Medicaid Services Provider Communications Group Second National Provider Conference Call on the Outcome and Assessment Information Set otherwise known as OASIS-C.

My name is Pat Sevast, and I work in the Survey and Certification group here at CMS. We are the ones responsible for the enforcement of the OASIS regulations as well as the Conditions of Participation.

The Outcome and Assessment Information Set, OASIS, is used to collect information on home health patients' status and selected services. The Medicare Conditions of Participation for home health agencies require agencies to collect and transmit OASIS data sets as part of their comprehensive assessment for all adult non-maternity Medicare/Medicaid patients receiving skilled services.

OASIS-C is the first major update of the OASIS data set since it was introduced in 1999. Changes include deletions, revisions and additions to the OASIS items including the addition of items that measure agency implementation of best practices.

Transmission to OASIS-C is scheduled to occur January 1, 2010. This call is second in a three part series of National “Train the Trainer” conference calls on topics related to OASIS-C that have been planned for October, November, and December, of 2009.

The first call provided an overview of the OASIS-C changes and impact on agency operations.

The third call scheduled for December will cover the topics of the impact of OASIS-C on outcome measures and process measures.

This second call will review the OASIS-C section by section providing attendees with information on new data collection guidance for selected OASIS-C items. We want to make it very clear that providers will not learn everything they need to know for accurate data collection from this one call. But it will provide a good overview of the new items, guidance and resources which should be the focus of further study and review.

In order to obtain maximum benefit from the presentation today, it is most helpful to have certain items in front of you for review during the presentation.

As Robin indicated, a PowerPoint slide presentation is posted under the download section on the CMS Quality Initiative site. If you have not downloaded this yet, it would be a good idea to do so to follow along.

The registration page site also recommended that you download for review during the presentation several other documents including the OASIS-C Items and Guidance Manual.

In order to maximize learning opportunities, you should have downloaded and familiarized yourself with the new OASIS instrument and other pertinent materials prior to the call including the ”All Time Points” version of OASIS-C, the OASIS-C Guidance Manual and the OASIS Qs & As.

We are aware of the hundreds of questions submitted by providers prior to the first call and many more prior to this call. Most of these questions have been reviewed and incorporated into the presentation and will be covered today.

If providers have additional questions, they can submit them to the OASIS mailbox, which we have listed on the final slide.

Today's presenter will be Linda Krulish. Linda is a physical therapist and has been involved with the clinical team here at CMS in assisting CMS with the refinement of the OASIS-C guidance.

Following the presentation, time permitting, the lines will be opened to allow participants to ask questions of us here at CMS.

Linda, I'm going to turn it over to you.

Linda Krulish: Thanks, Pat. Again, we're calling this a review of highlights by section because 90 minutes is not enough time to go through every item that is new or revised or every item that has new or revised guidance. Providers will need to compliment this training with other education strategies to gain a working knowledge of the OASIS-C and the related data collection guidance.

One strategy that should be considered is a careful review of the OASIS-C Guidance Manual and frequent referencing of the manual while OASIS-C is still new to you.

Much of the information in this presentation, and many important pieces of information that are not in this presentation, can be found in greater depth in the OASIS-C Guidance Manual.

In this call we will also be incorporating some but not all of the additional data collection guidance that was released on October 21, in the form of the third quarter CMS OCCB Q&As. A link for access to these Q&As was provided with the call registration instructions or the Q&As can be accessed by visiting the OCCB website at www.oasiscertificate.org .

To be effective, data collectors must be familiar with the new OASIS-C items, the data collection instructions and item guidance that's found in Chapter 3 of the OASIS-C Guidance Manual and the Q&As found at the QTSO and OCCB web links that are referenced in the handout on slide 3.

When completing OASIS items it will be risky, if you simply read the M item and think that you know what it means. You will understand and follow the data collection rules that are outlined in the critical CMS resources and then if you think know how to answer the question based on your knowledge of OASIS-B1 guidelines, you may also get the item wrong under OASIS-C.

Inaccurate data has a potential to impact your quality measures, your reimbursement and your compliance.

You're encouraged to be familiar with the new OASIS-C Guidance Manual. There are three sections of that manual that will closely relate to the information we will cover today.

Chapter 1, of the OASIS-C Guidance Manual includes a discussion of the data collection conventions. A listing of the OASIS conventions is available in Chapter 1, in Table 4. In this session we'll be discussing how the conventions apply to collection of some of the new OASIS-C items and use of these conventions is critical in ensuring standardized data collection across the country and the achievement of inter-rater reliability in the data collected.

Chapter 2, of the OASIS-C Guidance Manual includes versions of OASIS-C data set for each of the required time points. A special version called the Highlighted OASIS-C “All Time Points” version is a good version to use for education purposes. It includes all items collected at any time point and highlights those that are new or significantly changed for OASIS-C.

In today's session we'll be reviewing some of the new items that are highlighted in this version. But please note that there other changes to the instrument that are not highlighted in this file and will not be covered in the session today and you will need to review the manual and the Q&As for additional details.

Chapter 3, of the OASIS-C Guidance Manual includes the item-by-item guidance. This is where you'll find the additional essential information that you will need to accurately complete the OASIS.

You may want to reference the data set, or Chapter 3, as we go through the presentation today so that you can become more familiar with the items, the wording and the response options.

So let's start by looking at some of the highlighted new or changed items in the various OASIS domains. We'll start in the clinical record items domain by highlighting the items, M0102, Date of Physician-ordered Start of Care and M0104, Date of Referral.

While the Conditions of Participation require a 48 hour timeframe from referral or hospital discharge to the initial assessment visit, evidence shows that this timely assessment is not always achieved. Collection of these new OASIS items will allow tracking of timeliness of initiation of home health services and may allow evaluation of whether shorter timeframes such as 24 hours could make a significant difference in patient outcomes.

M0102, the Date of Physician-ordered Start of Care specifies the date that home care services are ordered to begin, if a date was specified by the physician. If a referral for home health services is received with no specific start of care date, then select the N/A response for M0102, indicating that no specific start of care date was ordered by the physician.

If a specific start of care date is indicated, and later delayed due to the patient's condition extending the hospitalization, then the date reported in M0102 would be the updated or revised physician's ordered start of care date.

M0104 specifies the referral date which is the most recent that verbal, written or electronic authorization to begin home care was received by the home health agency.

If the physician specified a start of care date, it would have been reported in the previous item, M0102, and then this item, M0104, would be skipped. This date of referral refers to the date the referral was received from the physician or from facility discharge planners or others who would be considered as acting on behalf of the physician and it would generate a verbal order from the physician.

Referral date does not refer to the date the agency receives calls or documentation from assisted living facility staff or family members who contact the agency to notify the agency of a potential home care admission. If the start of care is delayed due to the patient's condition, extending the hospitalization, or delayed at the physician's request then the date the agency received updated revised referral information for home care services to begin would be considered the date of the referral.

Next, let's move to the patient history and diagnosis domain. CMS is interested in tracking immunizations across post acute care settings with hopes of increasing immunization rates nationally.

To support this effort, the immunization items and resulting measures were developed as a cooperative effort between CMS, the CDC, or Centers for Disease Control and Prevention and the NQF, or the National Quality Forum. The language and logic of the OASIS-C immunization items follow CDC recommendations and have been adopted to harmonize across all healthcare delivery settings through the NQF process.

For OASIS-C information on influenza and pneumococcal vaccinations is collected at transfer and discharge using four OASIS items. The objective of the immunization items is to determine if the patient is up to date on their flu

vaccine at the end of an outcome episode of care with your agency and if they ever had a pneumonia vaccine at any time in the past.

For both flu and pneumonia there is an initial question that is answered at the time of transfer or discharge, "Did you give the vaccination during this past outcome episode, where outcome episode is defined as the period of time from a start of care or resumption of care to a transfer or discharge?" If the answer is, yes then you are done. If the answer is, no, then you will need to explain why the vaccination was not given. There could be many legitimate reasons why you did not give the vaccination during the past outcome episode.

M1040 is the initial flu vaccine question. Again, this is a harmonized measure meaning that all care settings will collect information the same way. All settings include home health through this OASIS item are just going to look at whether the patient is up to date between the six month time period of October 1, through March 31. So if the entire current outcome episode of home care falls outside the flu season then N/A should be reported and the question of whether or not the vaccine was actually received would not apply.

Any time you are conducting an OASIS on an episode of care that included any time between October 1, and March 31, you need to respond either 0, no or 1, yes. And any time you are conducting an OASIS on an episode of care that did not include any time between October 1, and March 31, you need to respond N/A, does not apply because the entire episode of care is outside this influenza season.

We received questions about what you should do if the flu vaccine is released early, say in August. Early vaccine arrival does not change the item instructions. If you're conducting this OASIS and the patient was not in your

care at any time between October 1, and March 31, just check N/A. Even if you got the vaccine early and gave it on September 29, and discharged the patient on September 30, you still would skip the question.

However, if you got the vaccine early and gave it on September 29, and discharged the patient October 15, you would say 1, yes, because the episode of care contained days between October 1, and March 31 and you gave the flu vaccine for this year's flu season during the episode of care.

Here's another example, if you were answering this question for the same patient that you gave the flu vaccine to in September but now the patient is readmitted to home care with a start of care in December and was discharged in January, from M1040 you would respond 0, or no. Even though your agency provided the flu vaccine it was not provided during this episode of care, so no, would be marked.

When you mark no you would move to the next item, M1045, reason the flu vaccine was not received and here is where you will have the opportunity to identify why you did not give the flu vaccine during this episode.

There are a number of reasons why the flu vaccine would not be received. M1045 is the flu follow up item where you get to record why the patient did not receive the flu vaccine from your agency during this home health episode.

Note that you would skip this item if you reported 1, yes, in M1040 indicating that you in fact did give the flu vaccine during the episode. Or you would skip this item if M1040 you had reported N/A meaning that no part of the episode fell within the specific flu season date range of October 1, to March 31.

Again, there could be many legitimate reasons for a “No” response. For instance, the patient received the flu vaccine at the doctor's office or at a health fair, or if your agency gave it to them in a previous episode this year. Or if the patient or their healthcare proxy refused the vaccine or if the patient has an allergy to a component of the vaccine or some other medical contraindication, like a recent bone marrow transplant explaining why the vaccine was not provided now. Or the patient may not meet the guidelines, they may be 42 years old with no high-risk conditions and they do not live or reside in a congregate setting.

Another reason that the vaccine may not have been provided is that there was a declared shortage. The response options in M1045 specifically allow the reporting of all of these reasons that have just been described. And a careful review of Chapter 3, provides more important detail on when to select each response. Response 1, “Received from another healthcare provider”, would be selected if there's documentation in the medical record that the patient received the flu vaccine for the current flu season from another provider, which could be the patient's physician, a clinic or health fair.

Response 2, “Received from your agency previously during this year's flu season”, is the response that you'd select if your agency gave the flu vaccine during a prior episode in October, or even in August, or September, because you got the flu vaccine for that year early.

Response 3, “Offered and declined”, means the agency offered the vaccine to the patient but the patient or a proxy, meaning someone with power of attorney declined the vaccination.

Response 4, “Assessed and determined to have medical contraindication(s)”, refers specifically to the few genuine medical contraindications that are listed

in Chapter 3. When selecting response 4, “Assessed and determined to have medical contraindication(s)”, refer specifically and only to the listed contraindications that are listed in Chapter 3 of the OASIS-C Guidance Manual as these are the contraindications that are being used across all care settings for this harmonized item and resulting measure.

Response 5, “Not indicated; patient does meet age/condition guidelines for influenza vaccine”. Again, refer specifically to the age and condition guidelines that are outlined in Chapter 3.

Select response 6, “Inability to obtain vaccine due to declared shortage” only when and if there is a true national CDC declared shortage.

The initial pneumonia vaccine item is just like the initial flu vaccine item without the complication of a flu season calculation. M1050 asks, did the patient receive the pneumococcal polysaccharide vaccine, or PPV, from your agency during this episode of care.

Select response 1,”Yes”, only if the patient received the vaccine from your agency during this episode. And again, episode means the most recent start of care or resumption of care to transfer or discharge.

If the answer is “Yes”, then you're done, but if the answer is, “No”, then move to the next item, M1055 where you will have an opportunity to explain why the vaccine was not provided.

M1055 is the follow up PPV question. Like the flu vaccine it allows the agency to explain why the pneumonia vaccine was not given by the agency during this episode.

The developers of the harmonized measure decided to only measure if the PPV was ever received. So response 1, can be selected if the patient received the PPV from your agency or from another provider including a patient's physician or clinical health fair ever, at any time past, prior to this outcome episode.

The patient's PPV does need to be up to date to select response 1, that the patient has received the PPV in the past. However, if the patient has never gotten the PPV, the clinician will need to determine the appropriate response from the remaining options.

Response 2, should be selected if the PPV was offered by your agency and was declined by the patient or a health care proxy acting under power of attorney on behalf of the patient.

Response 3, should be selected if the PPV was not provided due to a medical contraindication. When selecting response 3, “Assessed and determined to have medical contraindication(s)”, this refers specifically and only to the listed contraindications from Chapter 3 of the OASIS-C Guidance Manual as these are the contraindications that are being used across all care settings for this harmonized item and its resulting measure.

The same consideration should be given when selecting response 4, “Not indicated, patient does not meet age/condition guidelines for PPV”. This response should only be selected when the CDC age/condition guidelines as outlined in Chapter 3 indicate that the PPV is not indicated for this particular patient.

Again, refer to the OASIS-C Guidance Manual for the specific CDC guidelines.

Select response 5, if the reason the PPV was not received was a reason other than those listed above.

Now let's move to the living arrangements domain. OASIS-C brings a lot of changes to the living arrangements domain including replacing six previous items with three new OASIS-C items where the reporting of caregiver support is expanded from focusing not just on the primary caregiver and what the primary caregiver does for the patient, but now to allow the reporting of care from multiple sources.

One of the new living arrangement domain items is M1100, Patient Living Situation, which focuses on the patient's arrangement and availability of assistance.

The other two items, M2100, Types and Sources of Assistance and M2110, How Often does the patient receive ADL or IADL Assistance from any caregivers, other than home health agency staff? , are asked later in the OASIS data set, after the cognitive and ADL and IADL assessment items are completed. So the clinician will have a better ability to discover the types and frequency of assistance that caregivers are providing. We'll discuss M2100 and 2110 a little later in this session.

M1100, Patient Living Situation, is collected at start of care and resumption of care and is used for risk adjustment. This item reports whether the patient is living alone, or with others, and the availability of caregivers to provide in person assistance. Availability of assistance can impact a patient's ability to remain safely in the home.

Only one response should be marked in the entire table. Select the appropriate row, A, B, or C that reflects the patient's living situation and then select the response from the column in that row that best describes the availability of in person assistance at the time of the OASIS assessment.

To complete the M1100 table, first look at column 1 and determine if the patient lives alone, lives in a home with others or in a congregate living situation. For M1100, the Chapter 3 resource provides a lot of valuable details and clarifications that will need to be reviewed and frequently referenced to gain a familiarity with the definitions of special situations, like what to do when a patient has a temporary living situation.

Some examples of details from Chapter 3 that will be critical for data collectors to know and apply include understanding that a patient with only live in paid help is considered to be living alone for M1100.

A patient who normally lives alone but temporarily has a caregiver staying in the home to provide assistance is considered to be living alone. A patient who lives alone but can obtain emergency help by phone or lifeline is still living alone.

The item takes multiple caregivers into consideration. For instance the availability of assistance of around the clock could apply for a patient who has multiple family members who coordinate their schedules to make sure that someone is with the patient 24 hours a day.

This item does not gather information about the type or frequency of help that is actually offered. That information will be collected in other OASIS items.

The intent of M1100 is just to report where the patient lives and how often someone is in the home that could offer any help to provide information necessary for risk adjustment of outcomes.

Next, let's move to the Sensory Status Domain. Changes in the Sensory Status Domain include deleting the OASIS-B1 item, M0430, Intractable Pain and adding M1240, Has this patient had a formal pain assessment?
The item on Intractable Pain is one that clinicians have said was difficult to answer and unreliable and is now deleted. M1240 is a new item added to identify if a standardized pain assessment was conducted at the start of care or resumption of care and whether a clinically significant level of pain is present as determined by the assessment tool used.

This item is used to calculate process measures to report the rate at which the agency utilizes the best practice of standardized pain assessment.

Like most of the process measures, utilization of the best practice is not mandated but the addition of this pain assessment and other process measure items provides an opportunity for your agency to get credit for a best practice that you have implemented.

Response 0 should be selected if no pain assessment was conducted, if the pain assessment used was not standardized, if the pain assessment was conducted but not within the assessment timeframe or if the pain assessment was conducted by someone other than the assessing clinician.

Responses 1, or 2, should be selected if a standardized pain assessment was conducted during the assessment timeframe by the person completing the comprehensive assessment. The difference between response 1, and response

2, is if the standardized pain assessment identified the presence of severe pain or not.

In defining the standardized pain assessment that would satisfy the criteria for a “Yes” response on M1240, it should be noted that CMS does not endorse any specific pain assessment tool. But selecting a “Yes” response meaning response 1, or 2, on M1240 does require that a standardized pain assessment tool was used.

A standardized tool is one that includes a standardized response scale and must be administered as indicated in the standardized tool instructions or protocols.

A variety of standardized pain assessment approaches have been tested and are available for provider use in patient assessment. These approaches include but are not limited to the 0 through 10 pain intensity scale, the Wong-Baker FACES pain rating scale or visual analog scales.

Whichever standardized tool is used must be appropriately administered as indicated in the tool's instructions. The assessment selected must be appropriate for the patient. For instance, a patient must be able to adequately understand the tool and be able to effectively communicate his or her pain intensity to the clinician.

For instance, use of a visual analog scale for a very confused patient or use of the FACES scale for a patient with low vision may not result in an effective pain assessment.

The identification of severe pain from your pain assessment is important, as the identification of severe pain was what differentiated responses 1 and 2 in M1240.

The identification of severe pain should be dependent on the scoring system and the nomenclature used in the standardized tool or tools that you decide to use.

For example, if using the Wong-Baker FACES 7 to 10, is considered severe pain. So if using this FACES scale, response 1, “Yes, and it does not indicate severe pain” would be selected for FACES scale results of less than 7. And response 2, “Yes, the assessment was done and it does indicate severe pain” would be selected for FACES scale results of 7 and above.

Chapter 5 of the OASIS-C Guidance Manual contains numerous links to resources that can be used to meet these best practice assessment requirements.

Let's move to the Integumentary Status Domain. Items in the Integument section have undergone significant revision with OASIS-C, primarily in the pressure ulcer section.

The foundation for these revisions to the Integument section is the NQF pressure ulcer framework that has been under development while the OASIS-C was being revised and tested.

The framework is intended to be used in multiple care settings. Language has been updated to be consistent with updated NPUAP staging definitions and items have been added to assess whether a risk assessment was done, whether

a pressure ulcer was present on admission and items that document the length, width, and depth of a pressure ulcer.

WOCN and NPUAP feedback was solicited on all changes in OASIS items and guidance through quarterly calls during the development period, and wound care experts have assisted with the development of the items and the related guidance. Because many of the items in the Integumentary section are used in the home health PPS payment algorithm in some cases the final changes represent a compromise between efforts to update language with more clinically accurate terms like epithelialization, efforts to make the item more sensitive to change and better able to capture improvement in wound status and efforts to maintain consistency in the way the items impact payment in the PPS algorithm.

The first item in the Integumentary Domain is M1300, Pressure Ulcer Risk Assessment. M1300 identifies whether the home health agency care providers assessed the patient's risk of developing pressure ulcers. This item is used to calculate process measures at the start of care or resumption of care, to capture the rate at which the agency utilized the best practice of conducting an assessment of a patient's risk for pressure ulcer development.

Screening each patient for potential for developing pressure ulcers has been shown to reduce the development of new pressure ulcer formation. Like most of the assessment process measure items, the assessment for risk of pressure ulcers is not required by the Conditions of Participation, so there is an option to select the response 0, no assessment was conducted.

To report, yes, that an assessment was done, the agency or clinician has two options. The assessment can be completed by the clinician's clinical assessment of pressure ulcer risk factors such as inactivity, incontinence,

malnutrition - in which case the clinician would select response 1, “Yes an assessment was done based on an evaluation of clinical factors”.

Or the assessment can be completed using a standardized screening tool such as the Braden or Norton scales - in which case the clinician would select response 2, “Yes, an assessment was done using a standardized tool”.

Note that numerous risk assessment tools exist; the Braden and Norton scales have been tested extensively and are specifically listed in the OASIS response as examples of standardized pressure ulcer risk assessment tool. But CMS does not require the completion of a pressure ulcer risk assessment and does not endorse the use of any specific tool.

If you've responded to M1300 saying you did assess the patient for pressure ulcer risk, then you would go on to M1302 to document the result of the assessment, is the patient at risk for developing pressure ulcers or not.

If pressure ulcer risk was assessed using a validated standardized screening tool, the clinicians should use the scoring parameters specific for that tool to identify if a patient is at risk for developing pressure ulcers.

If the tool does not define levels of risk or if the evaluation was based on clinical factors without a validated standardized screening tool, then the agency or the assessing clinician will need to define what constitutes risk in order to select a response for M1302.

Once you've completed the questions on pressure ulcer risk assessment which are asked for all patients, you would then go to M1306, which functions as the gateway item that determines whether you should skip a series of questions that are just for Stage II and higher ulcers or those that are unstageable.

M1306 reads, “Does the patient have at least one unhealed pressure ulcer at Stage II or Higher or designated as unstageable?” Select response 0, “No”, if the patient has no unhealed pressure ulcers at all or if the only pressure ulcers the patient has are Stage I ulcers.

Select response 1, “Yes”, if the patient has at least one unhealed Stage II pressure ulcer or a Stage III or Stage IV pressure ulcer at any healing status level or if the patient has any unstageable ulcers.

Chapter 3 of the Guidance Manual has a lot of very helpful information that clinicians will need to study and refer to in order to answer M1306 in terms of how you would respond to pressure ulcers that are documented here including unstageable ulcers, unobservable ulcers, full thickness tissue loss in which the true wound depth is obscured by slough, suspected deep tissue injury in evolution which is identified by the NPUAP as a purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shear, Stage II, III, or IV ulcers that have re-epithelialized.

To accurately respond to this item, it's important to understand the guidance that describes how Stage II, Stage III and Stage IV ulcers heal or close.

When a Stage II pressure ulcer becomes completely re-epithelialized it is considered healed and no longer reported as a pressure ulcer. Guidance about Stage II ulcers that have healed through epithelialization has not changed. A former Stage II ulcer that is now healed is still not counted in this OASIS item.

When a Stage III or a Stage IV pressure ulcer becomes completely re-epithelialized it is not considered healed since Stage III and Stage IV pressure ulcers can never be considered healed.

Instead of healed, the term closed better represents a Stage III or IV pressure ulcer that has completely re- epithelialized. Guidance about continuing to include Stage III and IV ulcers that have closed and are re- epithelialized has not changed. They are still included in this item.

At discharge if you responded, “Yes” to M1306 that the patient does have at least one unhealed pressure ulcer at Stage II or higher or designated as unstageable you would then go on to this item that asks about Stage II ulcers that are present at discharge. This item was added to assist CMS tracking whether Stage II pressure ulcers are healing within 30 days as current wound guidelines suggest they should.

To track this it would be helpful if agencies always knew the date that the Stage II ulcer first appeared. But CMS recognizes they can't always know, so there was a response to indicate that it was there when the patient was admitted at the start of care or resumption of care.

So then in that case, the clinician does not have to investigate to obtain further information about that date. Agencies will receive a measure as part of their OBQI reports, identifying if patients are being identified as discharged with Stage II ulcers that have been present for more than 30 days.

First determine if the patient has a current Stage II pressure ulcer at discharge. If at the time of discharge the patient has no open or non-epithelialized Stage II pressure ulcers then select N/A and go on. Remember this item refers only to non-epithelialized Stage II pressure ulcers. You would not consider Stage

III or Stage IV pressure ulcers or Stage II pressure ulcers that have already healed when you're answering this item.

If the patient does have one or more unhealed Stage II ulcers at discharge you need to track down how long the oldest one has been present. If it was there at the start of care or resumption of care, select response 1, that it was present at the most recent start of care resumption of care assessment, and the item is complete.

If it developed since the last start of care or resumption of care then select response 2 and record the date the ulcer was first identified.

Let's look at some examples to demonstrate the available responses. If a patient was admitted on January 1, with a Stage II pressure ulcer which was still partially opened, and it was not completely epithelialized at discharged on February 15; response 1, that the oldest non-epithelialized Stage II pressure ulcer that is present at discharge was present at the most recent start of care or resumption care would be marked.

If the patient was admitted January 1, with no pressure ulcers, then developed one Stage II pressure ulcer on January 5, which was still open when the patient was discharged on February 15, then the clinician would select response 2, that the oldest non-epithelialized Stage II pressure ulcer that is present at discharge developed since the most recent start of care assessment and the date of January 5, should be reported as the date the pressure ulcer was first identified.

The next item we'll look at is a revised version of the pressure ulcer grid that is currently in OASIS-B1. M1308 reports the current number of pressure

ulcers at each stage present at the time of the assessment. Stage I pressure ulcers are excluded from collection on M1308.

If you've been following OASIS-C development or have downloaded earlier versions of the OASIS-C data set or guidance, you might have seen that when this item was tested it did not include Stage III or Stage IV pressure ulcers that were closed.

However, to avoid having an impact on the payment system, the guidance has reverted to stay consistent with how we are reporting pressure ulcers under OASIS-B1 meaning that Stage III or Stage IV pressure ulcers that have completely re-epithelialized or closed should be reported as present at the time of the current assessment.

So to summarize which pressure ulcers should be reported as being present at the time of the current assessment, Stage Is are excluded from this item, M1308, Stage IIs are reported until they become completely epithelialized or healed after which they are no longer considered a pressure ulcer and Stage IIIs and Stage IVs are reported as present whether they are open or closed, epithelialized or covered with slough.

Since IIIs and IVs never heal, they will continue to be counted in M1308 even after they are re-epithelialized. Data collectors will need to be familiar with the language and the instructions in Chapter 3 to be able to report patient status in OASIS accurately.

The pressure ulcer grid contains two columns. The first column reports the number of pressure ulcers that currently exist at each stage and the second column reports how many of the pressure ulcers currently present were present at the most recent start of care or resumption of care.

The main differences between the new item and the grid you're familiar with in OASIS-B1 again, are that Stage I pressure ulcers are not counted in this item for OASIS-C, they are reported in a separate item that we'll discuss shortly.

The data collector will report the actual number of pressure ulcers at each stage including reporting a 0 if there were none at that stage. Unstageable ulcers are broken out into the reason for unstageable and include suspected DTI or deep tissue injury.

An M1308, a second column which is answered at follow up and discharge identifies ulcers that were present on admission, which for M1308 is defined as the beginning, the most recent start of care or resumption of care of this outcome episode.

So why was the second column added? In B1 when you say that a patient has two Stage III ulcers at the start of care and then 60 days later report that the patient has two Stage II ulcers, there is no way to know whether these are the same two ulcers or one healed and one new developed sometime in the last 60 days.

This item will help answer that question. You may be aware that CMS has efforts to track whether ulcers were present on admission in hospitals and SNF settings. The second column has been included in OASIS to harmonize with those settings.

Note that you will need to learn the definitions in the Guidance Manual of unstageable ulcers and the directions for completing column 2 to accurately respond to this item.

For column 1 of M1308, report the number of unhealed Stage II or higher pressure ulcers on the current day of the assessment. This column must be completed at the start of care, resumption of care, follow up and discharge.

For column 2 of M1308, report the number of ulcers that were identified in column 1on that same row and were present on the most recent start of care or resumption of care. Column 2 is completed only at follow up and discharge.

This might look a little complex when you first look at it, but thinking about it and working through some patient examples from your practice will assist you in understanding how it should be filled out.

For instance, let's say we have a patient with no pressure ulcers on admission but develops a Stage II pressure ulcer during the first episode which is present at the time of the follow up. In this case, at start of care, Row A, Column 1 would be 0. At follow up, Row A, Column 1 would be 1, and Row A and Column 2 would be 0, indicating the Stage II pressure ulcer that's currently present was not present on admission.

Let's look at another example. The patient has a Stage III pressure ulcer on admission that is assessed to be a Stage IV pressure ulcer at follow up. In this case, Row B, Column 1 would be 1, at start of care. At follow up, Row B, Column 1 and 2 would both be 0 as the patient no longer has a Stage III ulcer.

Row C, Column 1 would be 1, and Column 2 would be 1, indicating the patient currently has one Stage IV pressure ulcer and that ulcer was present on admission even though it was at a different stage at that time.

Let's look at one last example. The patient has an unhealed Stage II pressure ulcer on admission that heals within the first two weeks. But then the patient develops another Stage II ulcer prior to being discharged at week four. In this case Row A, Column 1 would be 1, at the start of care. At follow up, Row A, Column 1 would be 1, indicating that at the time of the discharge assessment the patient had 1 unhealed Stage II pressure ulcer and Row A, Column 2 would be 0, indicating that the pressure ulcer that is present at the follow up or discharge was not present on admission.

The next items we'll highlight are M1310, M1312 and M1314 which are three items collected at the start of care and resumption of care and discharge that ask the clinician to document the dimensions of the largest Stage III or Stage IV or unstageable pressure ulcer.

This is another example of information that is already documented by many agencies as part of their comprehensive wound assessment and the OASIS-C items are harmonized with similar items in the MDS and CARE instruments.

There are several steps needed to respond accurately to these three items. First decide if you should complete or skip the items. Only answer if the patient has a pressure ulcer that is a Stage III, a Stage IV or an ulcer that is non-observable or unstageable due to eschar or slough otherwise skip the items meaning leave them blank.

Step 2, is decide which ulcer you should measure. If the patient has more than one ulcer that is a Stage III, IV or unstageable because it is covered with necrotic tissue, you'll need to determine which has the largest surface dimensions, which is defined as the length times the width. Depth is not considered when determining which pressure ulcer is the largest.

Step 3, is record in centimeters the length head to toe and the width perpendicular to the length and depth of the pressure ulcer with the largest surface area.

Chapter 3 of the Guidance Manual has additional instructions with pictures about how to measure these dimensions and how to handle special circumstances. It will be necessary for data collectors to review the additional guidance in Chapter 3 to supplement it with the information we just covered in order to allow accurate data collection of these items.

The next item we'll look at is M1320 Status of the Most Problematic Observable Pressure Ulcer. Just like in OASIS-B1 clinicians are asked to document the healing status of the most problematic pressure ulcer. Two notable changes in this item from OASIS-B1 to OASIS-C is that the OASIS-C version excludes Stage I's from being considered and the OASIS-C version contains a new response option of 0, "Newly epithelialized" which allows the clinician to document that a Stage III or a Stage IV ulcer has re-epithelialized.

Step 1 for responding to this item is to determine the most problematic pressure ulcer. Most problematic may be the largest, the most advanced stage, the most difficult to access for treatment, the most difficult to relieve pressure, depending on the specific situation.

If the patient has more than one pressure ulcer you will use your clinical judgment to determine which is the most problematic.

If the patient has only one observable pressure ulcer then that ulcer is the most problematic.

Response 0, “Newly epithelialized” is the appropriate response when epithelial tissue has completely covered the wound surface of a pressure ulcer regardless of how long the pressure ulcer has been re-epithelialized.

Epithelialization is regeneration of the epidermis across the wound surface. This is the appropriate response for re-epithelialized Stage III and Stage IV pressure ulcers but not for Stage II pressure ulcers since once a Stage II pressure ulcer has epithelialized; it becomes healed and is no longer reported on OASIS.

Response 1, “Fully granulating” is the appropriate response for a Stage III or a Stage IV pressure ulcer that is fully granulated but epithelial tissue has not yet completely covered the wound surface.

Response 2, “Early/partial granulation” would be the appropriate response for a Stage III or a Stage IV pressure ulcer if necrotic or a vascular tissue covers less than 25% of the wound bed but there are no signs or symptoms of infection.

Additional data collection guidance from the WOCN, the Wound Ostomy and Continence Nurses Society, is expected to be made available prior to the January implementation of OASIS-C.

That will provide important details related to the definitions and clinical features of various wound types to help data collectors in accurate and consistent scoring of the OASIS integumentary items.

Data collectors should be looking for the release of this update WOCN guidance document on OASIS skin and wound status items in order to support accurate data collection.

Response 3, “Not healing”, is the appropriate response for a Stage III or a Stage IV pressure ulcer if the wound had more than 25% necrotic or avascular tissue. “Not healing” would also be appropriate response for all Stage II pressure ulcers and all suspected deep tissue injuries.

Remember it is critical to refer to the Chapter 3 guidance and to the WOCN guidance when selecting responses for the wound items.

Now we'll move to the Cardiac Status Domain and discuss two new items, M1500 Heart Failure and M1510, Heart Failure Symptom Follow up.

Heart failure is the most frequently seen diagnosis in home care. And these patients are often challenging resulting in frequent or repeated use of the emergency room or re-hospitalization.

So a new domain was added to OASIS with items that ask the clinician to look back at care since the last OASIS assessment to identify any new or ongoing heart failure symptoms that have occurred and to identify the actions that the home health care providers took in response to those symptoms.

These items are used to calculate a process measure to capture the agency's use of best practices following the completion of a comprehensive assessment.

M1500 identifies whether a patient with a diagnosis of heart failure experienced one or more symptoms of heart failure since the most recent OASIS assessment.

To respond to this item accurately you will need to first determine if the patient has heart failure. And for the purposes of determining how this item

should be marked at transfer or discharge, a patient should be considered as having a diagnosis of heart failure if, at the previous OASIS assessment, the diagnosis of heart failure was listed in OASIS in any one of the following items:M1010, which is the inpatient diagnosis, M1016, which is diagnoses causing a change in treatment or M1020, 1022 or 1024, primary, secondary or payment diagnoses for home care.

If the diagnosis of heart failure was not reported in any of those specific OASIS items on the previous OASIS assessment, select N/A, patient does not have a diagnosis of heart failure on M1500 and you are done with the cardiac section.

If the patient does have a diagnosis of heart failure reported in one of those specific OASIS items, then go on to Step 2, review the clinical information since the last OASIS assessment to see the patient had experienced any symptoms of heart failure.

A few of the most common symptoms are listed in the item; dyspnea, orthopnea, edema and weight gain. If you want to reference a complete list of heart failure symptoms, they can be found in clinical heart failure guidelines and there are links to these guidelines in the Guidance Manual in Chapter 5 which provides resources.

In order to determine if a patient had experienced any symptoms of heart failure, various data collection sources and approaches may be utilized. A review of the clinical record including physical assessment data, weight trends and clinical notes may be accessed. An agency may incorporate or already have systems in place for this purpose, like flow sheets or electronic health record data reports or search features that allow the easy identification of

whether or not heart failure symptoms occurred since the previous OASIS assessment.

Once you've reviewed the clinical documentation then you are able to choose responses, 0, 1 or 2. If a patient didn't have any symptoms, response 0, or you don't know if the patient had any symptoms because they weren't assessed, response 2, then you're done with the cardiac section.

But if the patient does have a diagnosis of heart failure and has had symptoms, you check response 1, and go on to M1510 that asks what you did about the heart failure symptoms.

M1510 identifies actions that the agency took in response to symptoms of heart failure that occurred since the most recent OASIS assessment. This item is used for calculation of quality measures process measure items to identify the rate at which certain best practices were carried out by your agency. This item is collected at the transfer and discharge and the clinician will be required to look back at the clinical documentation to determine exactly what actions were taken so the appropriate OASIS response or responses, since it's a mark all that apply item, should be reported.

Report any actions that were taken at least once since the completion of the OASIS assessment.

Chapter 3 also contains additional detail about the various response options, for instance communication to the physician for response 1, requires not only the effective communication from the agency to the physician, but also physician acknowledgement of the information from the agency and/or further advice or instructions.

Data collectors are encouraged to review and reference the additional guidance that's provided in Chapter 3. If none of the listed interventions were implemented, there is an opportunity to select 0, no action taken.

Next let's move to the Neuro/Emotional/Behavioral Status Domain and look at M1730, Depression Screening. Depression is an under diagnosed condition in elderly patients that can directly affect the patient's ability to learn and to perform self care skills necessary to remain safely in their home.

The items addressing depression call attention to an issue that has often not appropriately been assessed or addressed in home health. M1730 is a new item that asks the clinician to document if the patient was screened for depression using a standardized depression screening tool. It allows a clinician to document if depression was either not assessed, was assessed using the PHQ-2©[1] scale or was assessed using a different standardized depression assessment.

In some cases the responses allow the clinician to document the results if the patient meets the criteria for further evaluation for depression. The item is asked at the start of care and resumption of care and is used to calculate the process measure documenting the rate at which this best practice of depression screening is occurring within your agency.

CMS does not mandate that clinicians conduct a depression screen for all patients nor must an agency use the PHQ-2© or any other particular standardized tool if they do choose to conduct a depression screen.

The PHQ-2© depression scale has been included in the OASIS-C item itself in order to harmonize with data collected in other settings like the MDS which

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is collecting the PHQ-9, and because it is a simple two question screening tool that is commonly used in outpatient settings and does not require any type of psychiatric or behavioral health training to administer. The results for Row A and B in the PHQ-2© are for agency use only and will not be encoded and transmitted with the OASIS data.

Based on the scoring parameters for the tool, if the patient scores a 3 or higher on the PHQ-2©, further depression screening is indicated. For M1730 Depression Screening, select 0 if no depression assessment was conducted, or if a non-standardized depression screening was conducted, or if a depression screening occurred after the date the assessment was completed, or the depression screen was completed but it was completed by someone other than the assessing clinician.

Standardized means that the screening tool includes a standardized response scale, as opposed to an evaluation in which the clinician would decide based on their own clinical judgment, whether the patient had sufficient symptoms of depression to warrant further action.

Select response 1, if the PHQ-2© is completed when responding to the question. Select 2, if the patient is screened with a standardized depression screening tool other than the PHQ-2© and the other tool indicates a need for further evaluation.

Select 3, if the patient is screened with a standardized depression screening tool other than the PHQ-2© and it indicates no need for further evaluation.

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If a standardized depression screening tool other than the PHQ-2© is used, use the scoring parameters specific for that tool to identify if the patient meets the criteria for further evaluation of depression.

Next, let's move to the ADL and IADL Domain and first look at a quick overview of the changes in this domain.

There have been many changes to the ADL and IADL section. A number of IADLs including transportation, shopping, housekeeping and laundry will no longer be collected in OASIS-C. They were deleted because they were rarely used for quality improvement efforts and because CMS knew there were new items that needed to be added to the OASIS, so other things that needed to be removed.

Some new items have been added to the ADL and IADL section including an item that measures the patient's ability related to toileting hygiene and related clothing management and an item related to fall risk assessment.

Clinicians are no longer asked to report the patient's status 14 days before the start or resumption of care. To replace this, a single grid item asks the clinician to summarize the patient's prior functional status in some ADL and IADL items.

Many of the functional items experience slight revisions with OASIS-C, many of which have the word, "safely" inserted into the item's stem somewhere to remind the assessing clinicians to consider and take into account the patient's safety as the complete the assessment and report for each functional task.

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Other important changes relate to what tasks are included in which items, like changes related to the inclusion of transferring into the toileting and bathing items. This is a big change from OASIS-B1, so data collectors are encouraged to carefully review the CMS resources in Chapter 3.

Other changes refer to the functional items including the expansion of some of the response options like ambulation and bathing, enhancing the OASIS items use in being more sensitive and more able to identify changes in patient's status to make the outcome reporting more sensitive to patient improvement.

So let's look at the bathing item and review how the item will change under OASIS-C. Slide 41 highlights new areas of wording or data collection guidance changes. Please note that the example on slide 41, only provides the first three responses and the rest of M1830, bathing item is presented on the next slide.

The word, “safely” has been added to remind assessing clinicians that the patient's safety should be considered when determining the level at which they are safely able to complete the various tasks, in this case, washing their entire body.

The fact that shampooing is not included in the bathing item is not new but it's now highlighted and specifically listed in the item language as an exclusion.

In OASIS-C, bathing will include the transfer in and out of the tub or shower. Chapter 3 of the OASIS-C Guidance Manual states that if a patient requires one, two or all three of the types of assistance listed in response 2 of M1830 but not the continuous presence of another person then response 2 is the correct response.

If the patient requires standby assistance to bath safely in the tub or shower or requires verbal cueing or reminders, select response 2, if the assistance needed is intermittent.

If the patient requires standby assistance or verbal cueing or reminders continuously to bathe safely in the tub or shower then select response 3. New wording in responses 4, and 5, allow the clinician to show progress in a patient who is able to bathe at the sink independently.

For response 4, the patient must be able to safely and independently bathe outside the tub or shower including independently accessing water at the sink or setting up a basin at the bedside.

For response 5, the patient must be unable to bathe in the tub or shower and can't bathe independently but can participate in some portion of the bathing tasks at some location outside the tub or shower.

Clinicians should read the manual to become familiar with how to respond to this item in other circumstances such as a patient who has a medical restriction against bathing or can't access their second floor tub or shower.

The bathing item and the next item, toileting, transferring are collected at start of care, resumption of care, follow up and discharge and used for both payment and quality measures.

For M1840, toileting transfer, in OASIS-C the toilet transfer item now includes the ability to get to and from the toilet and to transfer on and off the toilet or commode. Manual guidance instructs the clinicians to select response 1 if the patient requires standby assistance to get to and from the toilet safely or requires verbal cueing or reminders, can independently get to the toilet but

requires assistance to get on and off, or needs assistance getting to and from the toilet or with toileting transferring or both.

Refer to Chapter 3 of the OASIS-C Guidance Manual and the Q&As to become familiar with how to respond to this item in other circumstances. M1845 is a new item. It reports the patient's ability to manage personal hygiene and clothing when toileting with or without the use of devices. It's reported at the start of care, resumption of care and discharge and is used for quality measure calculations.

The item stem notes that if a patient has an ostomy, the item also measures the patient's ability to clean around the area of the stoma but not to manage the equipment.

The OASIS-C Guidance Manual also advises that toileting hygiene includes several activities including pulling clothes down or up and adequately cleaning or wiping after toileting. This item refers the patient's ability to manage personal hygiene and clothing with or without assistive devices.

The word “assistance” in this question refers to assistance from another person by verbal cueing, reminders, supervision, standby or hands-on assistance.

Select response 0, if the patient is independent in managing toileting hygiene and managing clothing. Select response 1, if the patient is able to manage toileting hygiene and manage clothing if supplies are laid out for the patient.

Select 2, if the patient can participate but needs standby assistance or verbal cueing or direct assistance with either or both hygiene or clothing management activities.

M1860, ambulation and locomotion item is collected at the start of care, resumption of care, follow up and discharge and is used for payment and quality measurement.

There is a new breakout option in the responses that allows the OASIS to show progress of a patient from a two handed device to a one handed assistive device. This was added based on the request from data collectors, quality managers and the industry leaders requesting a change that could make the item more sensitive to the improvement that a patient achieves when they progress from requiring the use of a two handed device, like a walker, to requiring a less restrictive device, like a cane or a single crutch.

If a patient does not require human assistance but safely ambulates with a walker in some areas of their home and a cane in other areas due to space limitations or distances, select the response that reflects the device that best supports safe ambulation on all surfaces the patient routinely encounters.

For instance, response 2, might be appropriate if a walker is required for safe ambulation in the hallway and living room even if there are some situations in the home where a cane might provide adequate support. Again, clinicians are encouraged to reference and become familiar with the additional specific guidance that's provided in Chapter 3.

The next item we'll look at in the ADL and IADL Domain is the new M1900 prior functioning grid that is collected at the start of care or resumption of care. It's expected that this grid will replace the risk adjustment input that has been available under OASIS-B1 through collection of the 14-day prior status column for the ADLs and IADLs.

An understanding of prior status can allow for appropriate goal setting and risk adjustment of outcomes. However, the old OASIS-B1 timeframe of past 14 days was sometimes problematic.

The new M1900 item has a different timeframe for consideration than the OASIS-B1 14-day timeframe. With OASIS-C when determining a response for M1900 Prior Functioning ADLs and IADLs the time period to consider is the patient's usual ability prior to this current illness, exacerbation or injury, whichever is most recent, that initiated this home health episode of care.

Chapter 3 provides definitions for the dependence levels used in M1900. “Independent” means that the patient had the ability to complete the activity by him or herself with or without assistive devices but without physical or verbal assistance from any helper.

“Needed Some Help” means that the patient contributed effort but required help from another person to accomplish the task or activity safely. And “Dependent” means that the patient was physically or cognitively unable to contribute effort toward completion of the task and the helper must contribute all the effort.

Look to the OASIS-C item guidance for specific tasks, which are included in each of the listed functional areas.

The last item we'll look at in the ADL and IADL Domain is M1910, Has the patient had a multi-factor Fall Risk Assessment? This item identifies whether the home health agency has assessed for characteristics that place the patient at risk for falls.

It's collected at the start of care and resumption of care for quality measurement allowing the reporting of the rate at which your agency carries out the best practice of assessing for fall risk.

Based on the current scientific evidence of benefit that this care process of fall risk prevention has only been demonstrated effective for patients 65 and over, patients under the age of 65 will be excluded from the calculation of this process measure, which is expected to among those process measures that are publicly reported.

CMS does not mandate that clinicians conduct fall risk screens for all patients nor is there a mandate for the use of a specific tool. However, to respond yes to this item the fall assessment tool used must include a standardized tool that has been appropriately validated for home care or community dwelling geriatric patients.

The assessment must also have been completed by the assessing clinician during the CMS specified assessment timeframe for completing the start of care or resumption of care comprehensive assessment.

Response 0, “No multi-factor falls risk assessment conducted”, should be marked if no fall risk assessment was done or if the risk assessment conducted was not validated, not multi-factorial, not completed within the assessment timeframe or not conducted by the assessing clinician.

Responses 1, and 2, both state that a multi-factor fall risk assessment was done with response 1 being selected if the assessment did not indicate the patient had a fall risk, and response 2 being selected if the assessment did indicate a fall risk.

An agency can use a single comprehensive multi-factor Fall Risk Assessment tool that meets the criteria as described in the item intent or the agency can combine two or more tools to achieve the requirements of the fall risk assessment where one tool may meet the criteria of the standardized validated fall risk tool and a second may serve to meet the need that the tool measures at least two factors.

Now let's move to the Medication Domain. In OASIS-B1, medications were included in the IADL Domain. And in OASIS-C the medications are in their own domain and have been expanded to include items that will allow a number of process measures to be calculated including the rate at which the drug review is being completed by your agency, the rate at which the effective and timely communication occurs with a doctor to reconcile identified problems, and the rate at which specific drug education tasks are being completed.

In addition to several new process measure items, we'll continue to report the patient's ability to manage their oral meds and injectable meds but the inhalant mist medication question has been dropped.

So let's look to the medication items. M2000 is the first of two items that are asked at the start of care or resumption of care and they report whether a drug review was conducted and if so, if problems were found, and if so, did collaboration with the physician occur to reconcile the problem.

As with all of the process items there's an option on M2000 to say that the process was not implemented, response 0, which for M2000 means that a drug regimen review was not conducted.

Providers should be aware that completion of a drug regimen review is not only a best practice but it is also a required standard in the Home Health Conditions of Participation.

There is also an option to indicate that a review was not necessary or N/A if the patient was taking or using no medications at all including no prescribed or over the counter meds by any route of administration.

Examples of situations which could be defined as clinically significant medication problems are found in Chapter 3 of the OASIS-C Guidance Manual. They include things like a patient's list of medications from the inpatient facility discharge instructions do not match the medications the patient shows the clinician at the start of care or resumption of care visit. Or the assessment shows that the diagnoses or symptoms for which the patient is taking medications are not adequately controlled.

So we look at all medications to determine if there are clinically significant problems and we'll look for Chapter 3 to help us identify some guidelines for what should be considered clinically significant.

Chapter 5 resource section of the Guidance Manual contains online resources for evaluating adverse effects related to medication like drug interactions and side effects.

M2002 is the medication follow up item and it's used for the calculation of quality measures. If when you complete the previous OAISIS item, M2000, you select response 2, reporting that you had conducted a drug review and problems were identified then the assessing clinician would be directed to complete M2002, was the physician or physician designee contacted within

one calendar day to resolve clinically significant medication issues including reconciliation?

Details available in Chapter 3 can help data collectors better understand CMS's expectations related to this drug review requirement and the OASIS rules for reporting related communication and care planning.

It should be noted that the term “contact with physician” as stated in M2002, response 1, is defined as communication to the physician made by telephone, voice mail, electronic means, FAX or any other means that appropriately conveys the message of a patient's status. But response 1,”Yes”, should only be reported if a physician not only gets the information from the agency but also responds back to the agency with communication of acknowledgement of receipt of the information and further advice or instructions.

Portions of the drug review or communication with the physician may be completed by the agency staff other than the assessing clinician. Chapter 3 gives more information on how collaboration can occur to complete the medication items in a way that does not violate the one clinician rule for OASIS data collection.

The two medication items we just discussed report what was done related to the drug review and identified problems at the start of care or resumption of care.

M2004 collects the same information at the transfer and discharge about what action was taken to respond to the medication issues that occurred since the last OASIS assessment and this item is used in the calculation of quality measures.

Specifically, M2004 identifies if potentially clinically significant problems, such as adverse effects or drug reactions identified at the time of the most recent OASIS assessment or any time since that last assessment, were addressed with the physician.

M2010 is the patient and caregiver high risk drug education. It's collected at the start of care or resumption of care and is used to calculate quality measures. It identifies that the agency instructed the patient or caregiver about all high risk medications that that patient takes at the start of care or resumption of care.

The intent and expectation of this item is to target high risk medications. High risk medications are those that are may be defined by the Institute for Safe Medication Practices or ISMP, JCAHO, Beer's Criteria or others. Agencies may select the quality organization that they choose to access the high risk medications for this item.

If agency staff, other than the clinician responsible for completing the start of care or resumption of care OASIS, provide education to the patient or caregiver on high risk meds, this information may be communicated to the clinician responsible for completing the start of care or resumption of care assessment so that the appropriate response for M2010 may be selected.

M2010 asks about drug education at admission and was limited to high risk meds. M2015 reports on all medications taken by all routes and reports if the patient or caregiver have been instructed by the agency staff to monitor the effectiveness of the drug therapy reactions and side effects and how and when to report problems that may occur since the last OASIS assessment.

It's used in the calculation of quality measures and will require the clinician to look back at the clinical documentation to determine if education was done.

Effective safe management of medications includes knowledge of effectiveness, potential side effects and drug reactions and how and when to contact the appropriate care provider.

In order to select response 1,”Yes”, on M2015, all components of the item must have been achieved. Clinicians should review Chapter 3 of the Guidance Manual for more instructions on how to calculate this and to collect this item.

M2020 is the patient's ability to manage their oral medications and is collected at the start of care, resumption of care and discharge. And M2030 is the patient's ability to manage their injectable medications and is also collected at start of care, resumption of care, discharge and follow up. Both are used in the calculation of quality measures and M2030, injectable medications is also an item that contributes to the PPS payment determination.

For both oral meds and injectable meds, reporting of the prior status at the start of care or resumption of care has been deleted. In OASIS-C the medication items have been moved out of the IADL Domain so that the functional majority of the task convention no longer applies.

Instead, in OASIS-C the medication management ability now reports the patient's ability to manage all meds all of the time.

The item also allows increased ability to show improvement so that if a patient goes from needing daily reminders from one person to the ability to take correctly their medication if their meds are set up in advance using a drug chart or diary by the changing of response options 1 and 2.

Again, clinicians are directed to look at the item through the data set or in Chapter 3 to become more familiar with these changes.

M2040 is a prior medication management grid where the clinician is directed to report the patient's ability to take their medications, oral medications and injectables where the timeframe is looking at prior to this current illness, exacerbation or injury. Select one response for each row to reflect the patient's prior status.

Next, let's move to the domain called Care Management. M2100, Types and Sources of Assistance. This contains two items that report on the caregiver's ability and assistance and replaced some B1 items about living situations.

These items are asked at the start of care, resumption of care and discharge and are important for risk adjustment. They identify the ability and the availability of caregivers to provide different categories of assistance needed by the patient.

All types of assistance that are found in the first column and all levels of assistance provided across the first row are clearly outlined in Chapter 3 of the OASIS-C Guidance Manual.

When you're looking at M2100, note that the item is asking you to report the task with which the caregiver needs the most help, where is there the greatest need. If the patient needs help with any aspect of the category of assistance, like they need assistance with some IADLs but not others, consider the aspect that represents the most need and the availability and ability of caregivers to meet that need.

M2110 identifies the frequency of the assistance with ADLs or IADLs provided by any non-agency caregivers. This item is concerned broadly with ADLs and IADLs and clinicians should not just be limited to those ADL or IADL items that are specified in other OASIS items.

M2250 identifies if a physician-ordered home health plan of care incorporates specific best practices. If you haven't already been referencing each item that we're discussing you will want to look at this item. It will be helpful for you to reference it in your copy of Chapter 3 or your version of the data set since it's a rather large table with lots of text.

This item supports calculation of the process measures. Agencies are not required by the conditions to put these best practices in place, and agencies may select, "No" indicating that you do not have orders to provide specific care discussed. But if your agency does not choose to get orders and address some of these best practice areas, you may want to support or explain your action and decisions in your clinical records.

Select N/A if a specified best practice is not appropriate for that patient as described in the N/A column. For example, diabetic foot care and education is N/A if the patient is not a diabetic or is a bilateral amputee.

The care plan should evolve from the findings of the assessment. Responding that the current physician ordered plan of care includes a plan/intervention means that the patient's condition has been discussed with the physician and that there's agreement as to the plan of care between the home health staff and the physician.

If you've received verbal orders to provide the types of interventions that are outlined in 2250, the plan of care synopsis then you are fine to mark that the physician ordered plan of care contains such orders.

Again, review of Chapter 3 guidance and review it carefully for information related to what each of the terms in the rows and columns mean for the plan of care synopsis.

M2400, Intervention Synopsis, is an item that is collected at transfer and discharge and like the plan of care synopsis it supports measures of care process and implementation. It identifies if the physician ordered plan of care includes interventions that are focused on various aspects of care and it also reports if those ordered services were implemented as part of the care during the home health episode.

Again, look through the item and through Chapter 3 of the OASIS-C Guidance Manual to get specific clarification on what the items include and what the “not applicable” responses reflect.

Become more familiar with the M2400 intervention synopsis by looking through the examples that are in Chapter 3 and seeing if the response options can be selected based on your problem solving skills.

Select N/A for intervention synopsis if a formal multi-factor fall risk assessment or the type of assessment listed by the row was not completed since the last OASIS assessment.

The formal assessment that's referred to in the last column of M2400 for rows B through E refer to the assessments that were completed previously in the

OASIS document for pain, for depression, for falls risk and for pressure ulcers.

In order to mark N/A for M2400 for fall, depression, pain or pressure ulcers, the risk assessment must have been performed at the beginning of this outcome episode.

I hope that this overview of new items and guidance changes for OASIS-C has been helpful and given a foundation for considering what other educational efforts you will need to undertake to prepare for the implementation of OASIS-C in January.

Please remember that this presentation was not intended to be a comprehensive program but rather a high level overview. It's important that each clinician collecting OASIS data be aware of, and familiar with, the OASIS items, the associated data collection rules from CMS in the form of item guidance and Q&As.

All data collectors are encouraged to have ready access to at least the item by item and conventions, details from the OASIS-C Guidance Manual and current and future Q&As that relate to data collection.

The websites where these references can be accessed is located on slide 74, in the handout.

If you have questions related to OASIS-C data collection, please refer to the Chapter 3 guidance and the Q&As to resolve your questions. If after you have referenced the available CMS resources you're still unable to answer your question, please contact your state OASIS Education Coordinator, or OEC. A list of OECs by state, are located at the CMS URL listed on slide 75.

If after accessing your OEC you are still not able to resolve your question, submit it to the CMS OASIS mailbox at CMSOASISquestions@oasisanswers.com . This address is also on slide 75, of your handout. Thank you for participating in today's session.

Pat Sevast: Thank you, Linda. I don't think we're going to have time for any live Q&As here today. But as Linda indicated, please submit your questions to CMSOASISquestions@oasisanswers.com . We would ask that you do not send any questions related to payment or non-OASIS-C questions. We're just not able to answer those through the mailbox. And I think that's probably it for today? Robin?

Robin Sutton: It has come to our attention that participants who registered for the October call assumed they would automatically be registered for the entire three part series. This is not the case. Please be on the lookout for how to register for the December 8th call.

We would like to thank everyone for joining us today and for your participation in the question and answer portion of the call. A transcript of the call will be available at least one week after the call at http://www.cms.hhs.gov/homehealthqualityinits/02_cmssponsoredcalls@asp on the CMS website. I would like to thank our subject matter experts for their participation on this call.

"Post call clarification" – the correct web address is www.cms.hhs.gov/homehealthqualityinits/02_cmssponsoredcalls.asp

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

END