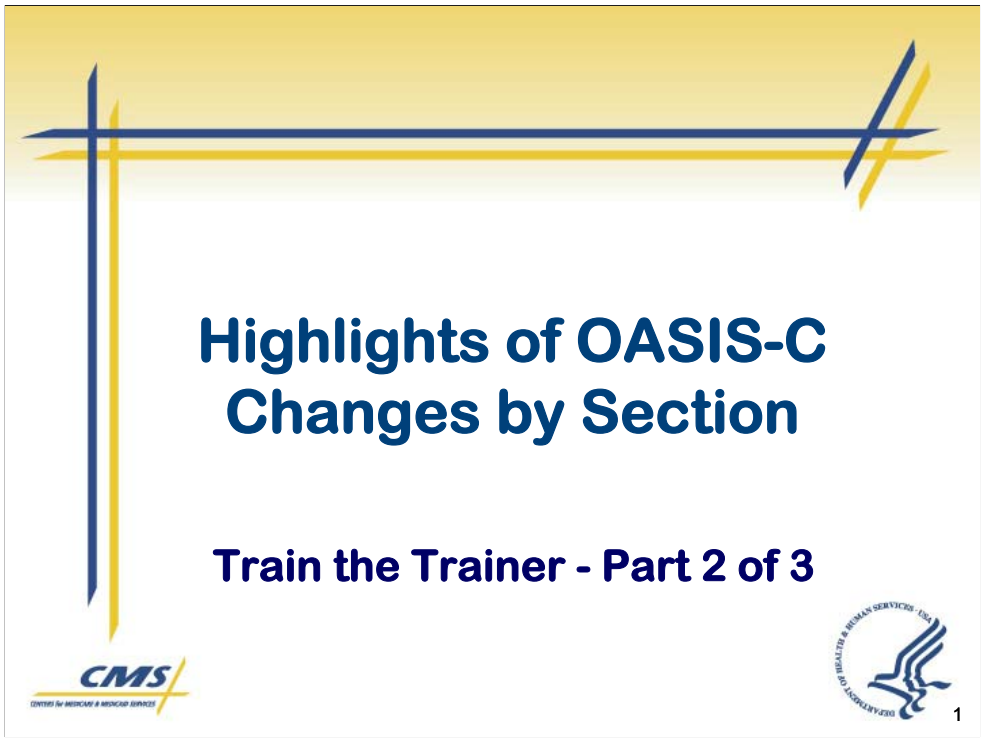
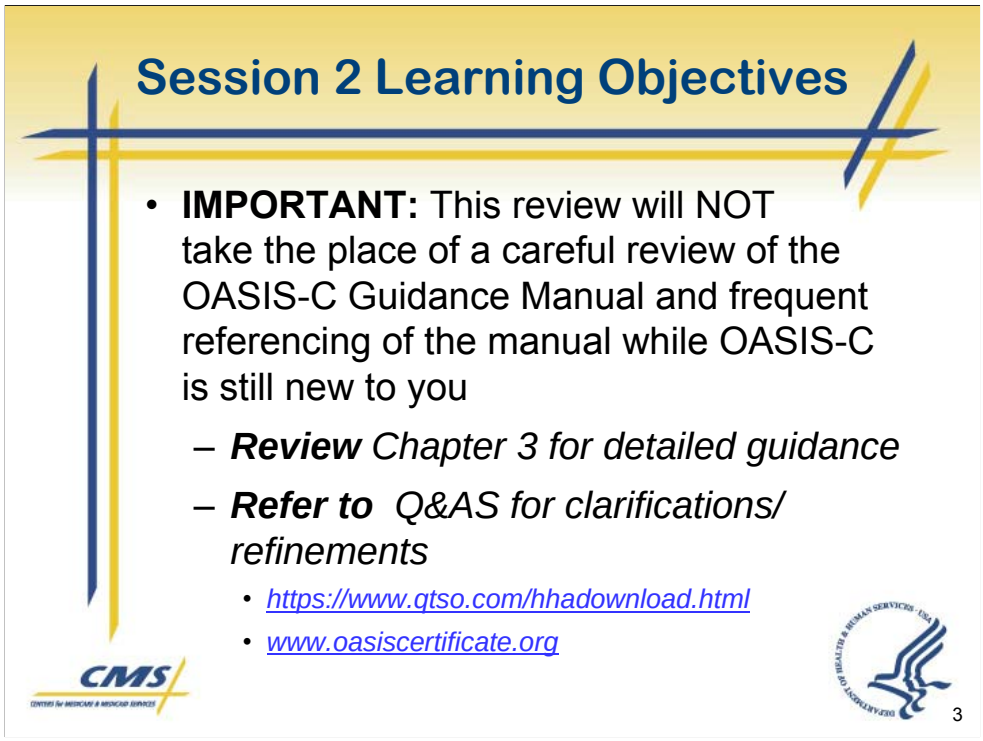


Welcome to the 2nd of 3 OASIS-C Train-the-Trainer sessions provided by CMS
The 1st call in October provided information on background, an overview of OASIS-C changes and

Session 2 Learning Objectives

At the end of this session, you will be able to:

- Identify new data collection guidance for highlighted OASIS-C items
- Identify available resources for learning more about OASIS-C 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 additional data collection guidance that was released on Oct 21 in the form of the 3rd Quarter CMS OCCB Q&As. A link and/or file for access to the Q&As was provided with handout materials for this call.

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

When completing OASIS items

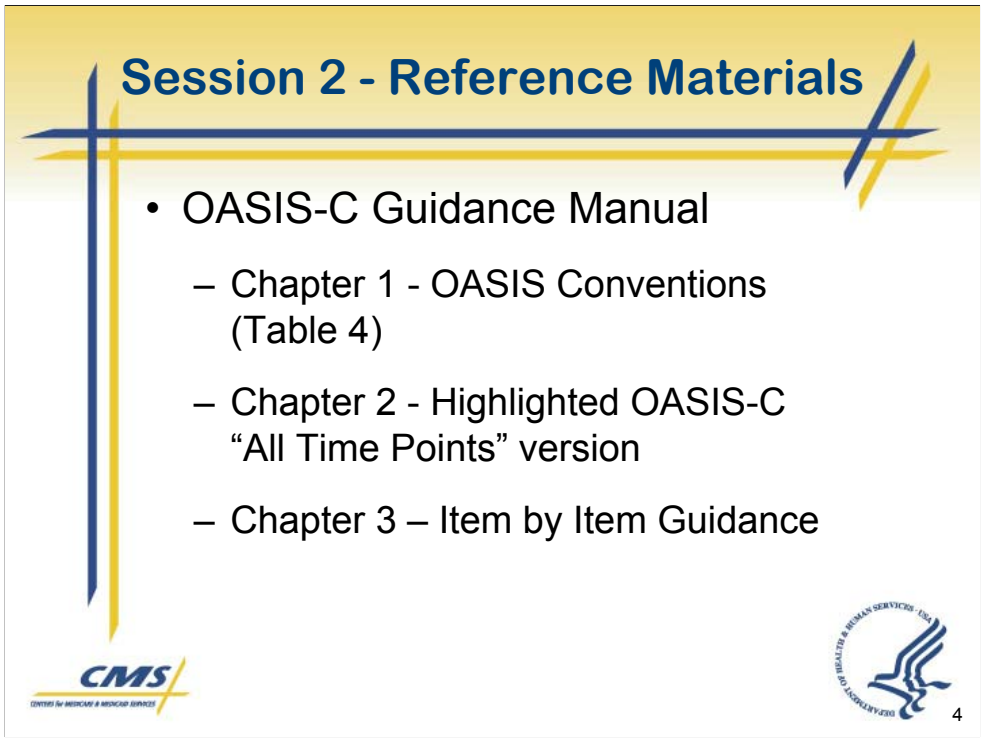
•It will be risky if you simply read the M item and think you know what it means

-You must understand and follow the data collection rules that are outlined in this critical CMS resources

-If you think you know how to answer an item based on your OASIS-B experience ***you may get it wrong and your data will be inaccurate!***

This has potential to impact

-your quality measures in Home Health Compare and CASPER OBQI/OBQM reports



Become familiar with the new OASIS-C Guidance Manual. There are 3 sections of the manual that you closely relate to today's presentation

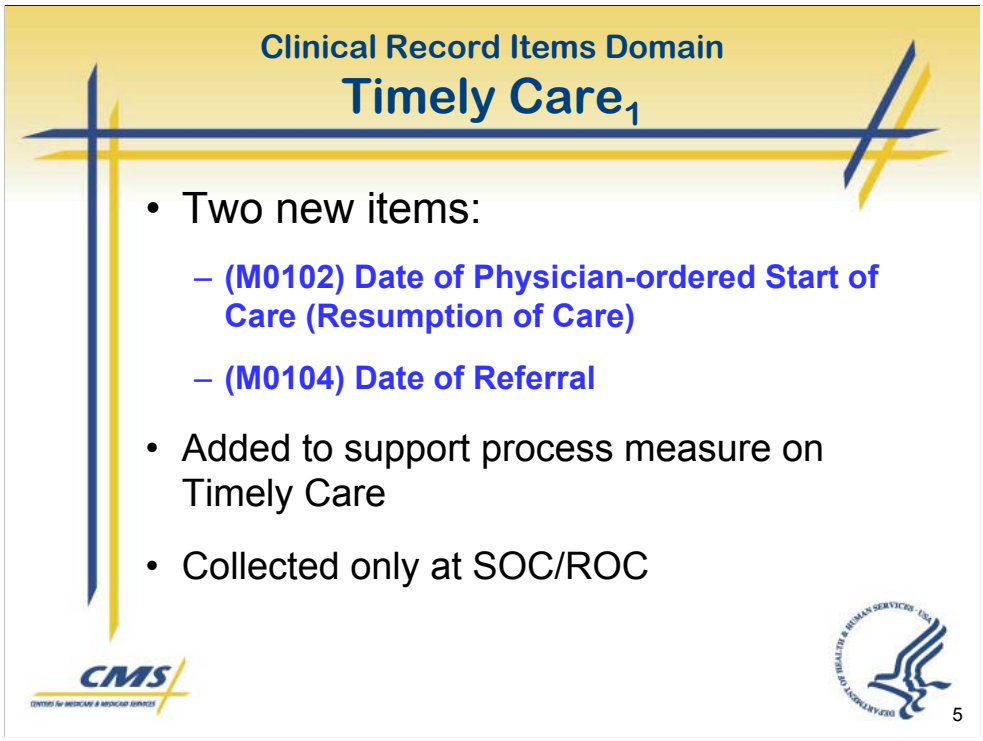
Chapter 1 of the OASIS-C Guidance Manual includes a discussion of the data collection conventions. A listing of the OASIS Conventions is available in Chapter 1 as (Table 4).

- In this session, we will be discussing how the conventions apply to collection of some new OASIS-C items
- 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 a versions of OASIS-C data set for each required time point. A special version, called the Highlighted OASIS-C "All Time Points" version, is a good version to use for educational purposes, as 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 will be reviewing each of the new items that are highlighted in this version
- But please note that there are other changes to the instrument that are not highlighted in this file and will not be covered in this session, and you will need to review the manual and Q&As for additional details

Chapter 3 of the OASIS-C Guidance Manual includes the Item by Item Guidance – this is where you will find the additional essential information you will need to accurately select a response for each OASIS item.



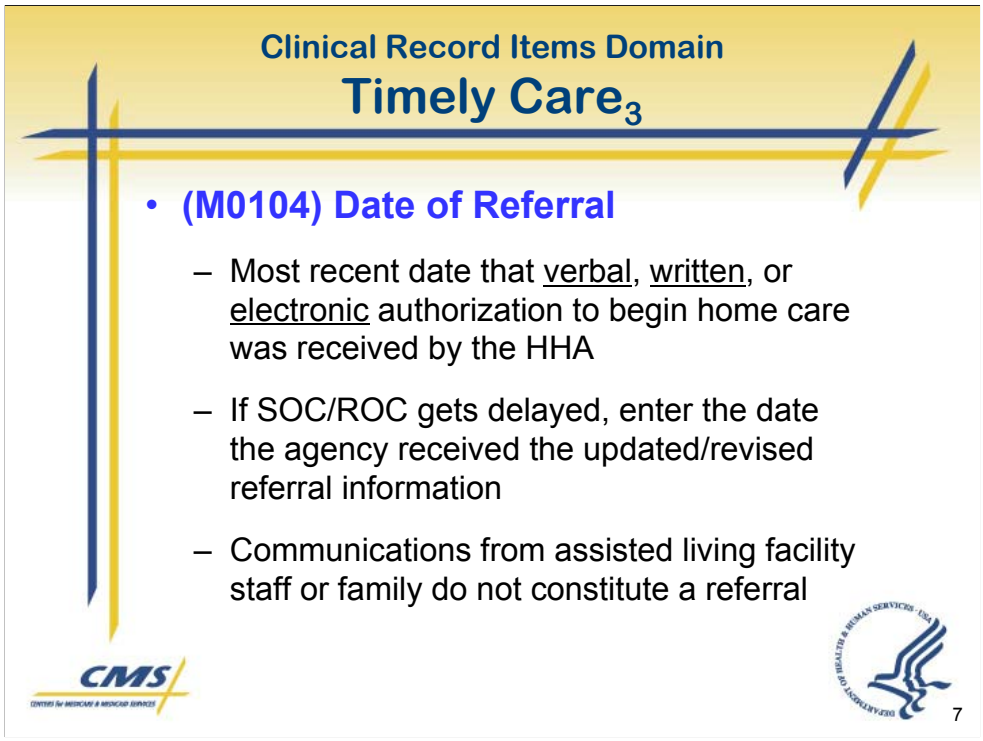
M0102 Date of Physician-ordered Start of Care, and M0104 Date of Referral from the Clinical Record Items domain.

While the CoPs require a 48 hour timeframe from referral/hospital discharge to the initial assessment visit, evidence shows that this timely assessment isn't always achieved. This will allow tracking of timeliness of initiation of HH services; and may allow evaluation of whether shorter timeframes such as 24 hours could make a difference in 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 NA response for M0102, indicating that no specific SOC 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/revised physician's ordered start of care date.



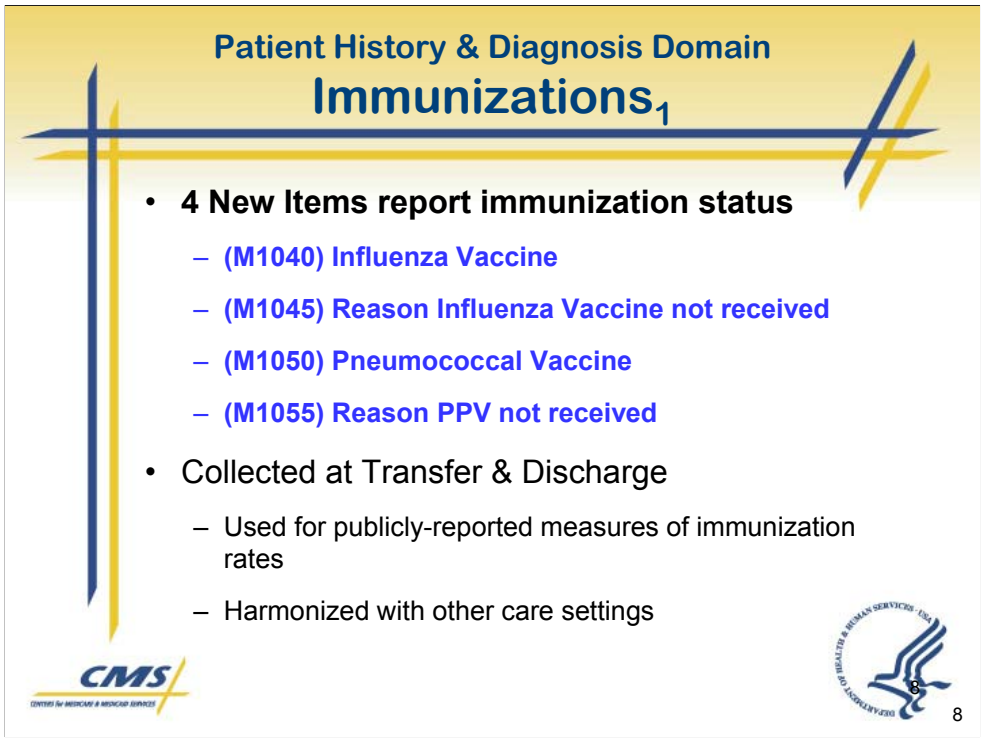
M0104 Specifies the referral date, which is the most recent date that verbal, written, or electronic authorization to begin home care was **received** by the home health agency.

If the physician specified a SOC care, it would have been reported in the previous item M0102, and then this item M0104 would be skipped.

Referral date does not refer to the date the agency receives calls or documentation from others, such as assisted living facility staff or family who contact the agency to prepare the agency for possible admission.

However, the referral date does include referrals from facility discharge planners and others who would be considered as acting on the behalf of the physician AND THAT WOULD GENERATE A VERBAL ORDER FROM THE PHYSICIAN.

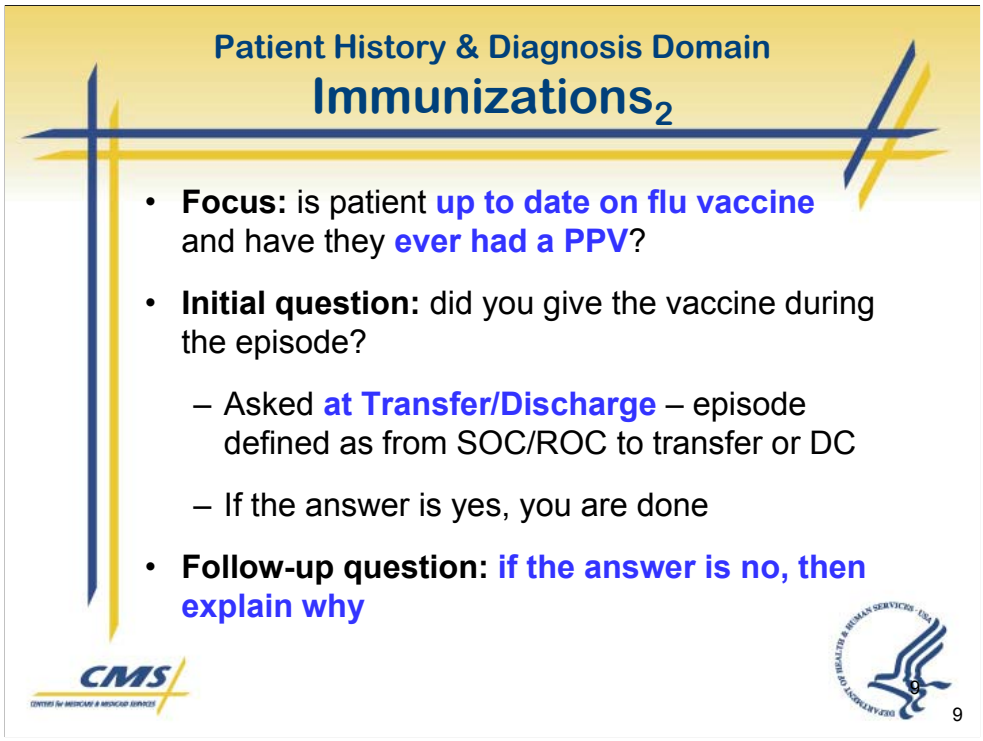
If start of care is delayed due to the patient's condition extending the hospitalization, or delayed at physician request, then the date the agency received **updated/revised** referral information for home care services to begin would be considered the date of referral.



CMS is interested in tracking immunizations across post-acute care settings, with hopes of increasing immunization rates nationally.

Development of the immunization measures was a cooperative effort between CMS, CDC and NQF.

The language and logic of the OASIS C immunization items follow CDC recommendations and have been adopted to “harmonize" across all health care delivery settings through the NQF process.

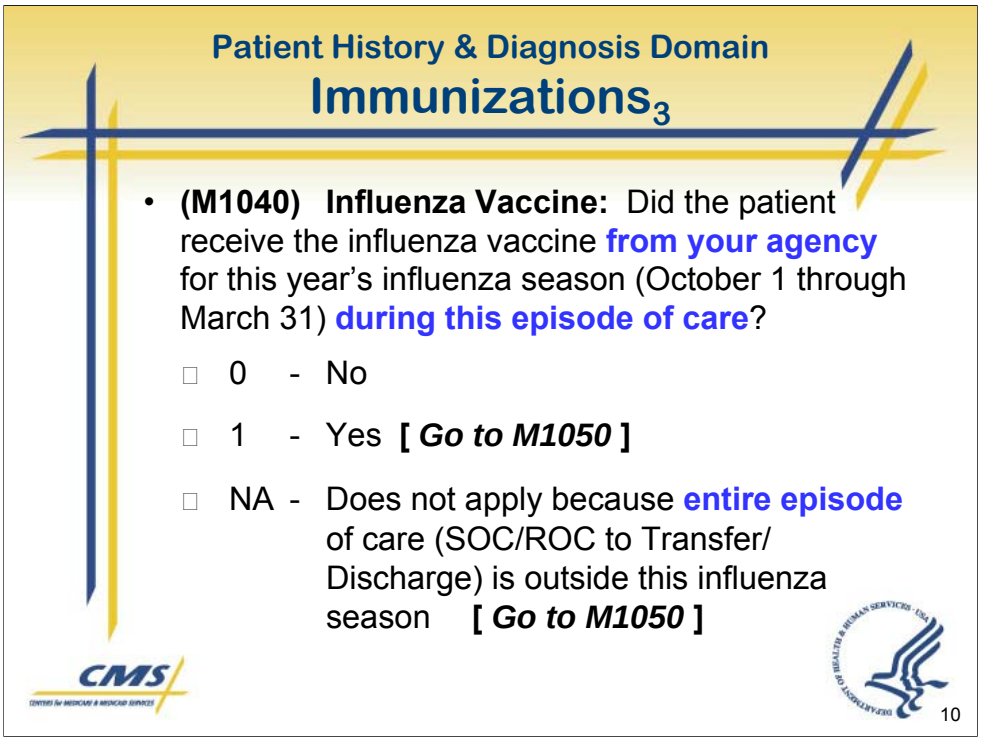


Objective of the items is to determine if the patient is up to date on their flu vaccine when they leave the care of your agency, and if they have had a pneumonia vaccine at any time in the past.

For each, there is an initial question that is answered at the time of transfer or discharge - did you give it during this past episode (defined as from SOC/ROC to transfer or DC)

if the answer is yes, you are done

If the answer is no, then you explain why – there could be many legitimate reasons for a no response



Here's the initial flu vaccine question.

This is a harmonized measure – all the settings are just going to look at whether the patient is up to date between October 1 and March 31 - if the entire episode falls outside the flu season you don't have to respond

•So anytime you are conducting an OASIS on an episode of care that included any time between Oct 1 and March 31 you need to respond either 1 or 2

•And anytime you are conducting an OASIS on an episode of care that DID NOT include any time between Oct 1 and March 31 you need to respond NA

This should be fairly straightforward, but we have gotten questions about what you should do if flu vaccine is released early – say in August.

•Early vaccine arrival doesn't change the item

•if you're conducting this OASIS and the patient was NOT in your care any time between Oct 1 and March 31 – just check NA

•even if you got the vaccine early and gave it on Sept 29 and Discharged the patient September 30, you still skip the question.

HOWEVER - if you got the vaccine early and gave it on Sept 29 and Discharged the patient October 15, you would say 1 – yes, because

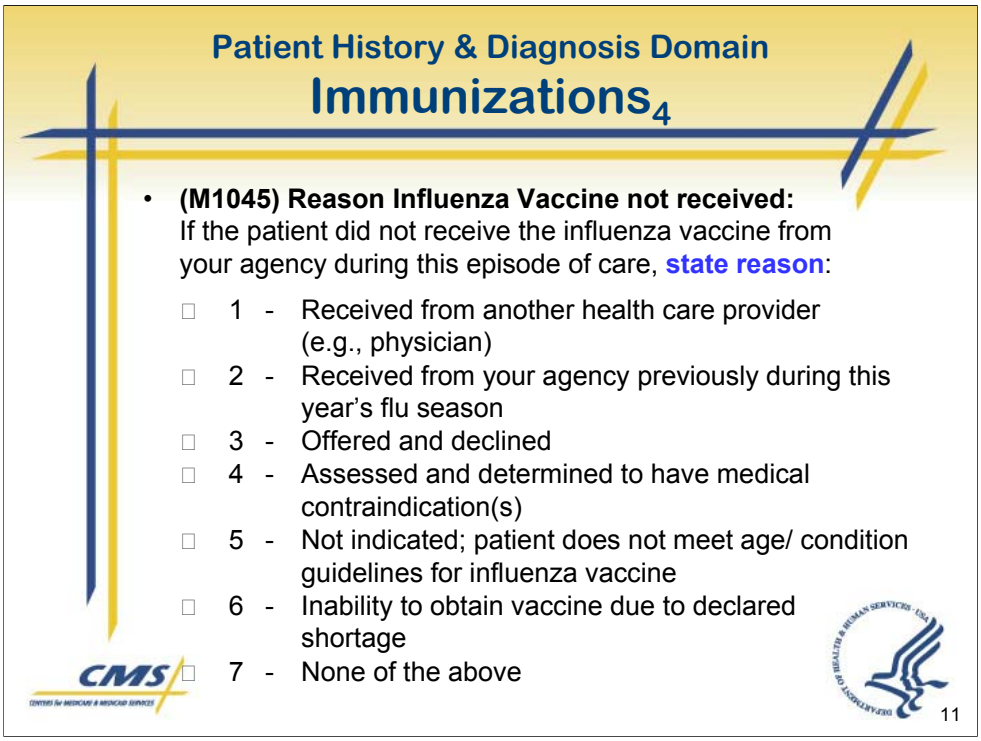
- the episode of care contained days between Oct 1 and March 31

- you gave the influenza vaccine for this year's influenza season

Here's another example –

If you are answering this question for this same patient that you gave the flu vaccine to in September, but now the patient is readmitted to home care with a SOC in December 1 and was discharged January 30. For M1040, you would respond 0 – No. You didn't give it –

When you respond "NO" you are taken to M1045, where there is a opportunity to identify WHY you didn't give the flu vaccine, in this case because the patient already rec'd it from your agency



•Here's the follow-up flu vaccine where you get to record why they didn't receive the flu vaccine from your agency during this home health admission:

•(Item is skipped if M1040 = "1" [you gave it] or "NA" – [no care Oct 1 to March 31])

•Could be many legitimate reasons for a no response

•For flu:

•They got it at the doctor's office or at a clinic or health fair

•You gave it to them in a previous admission that year

•They or their health care proxy refused

•They have an allergy to a component of the vaccine or some other medical contraindication (they recently had a bone marrow transplant).

•They don't meet the guideline –they are 42 years old with no high risk conditions and they don't live in a congregate setting

•You were unable to get the flu vaccine due to a declared shortage

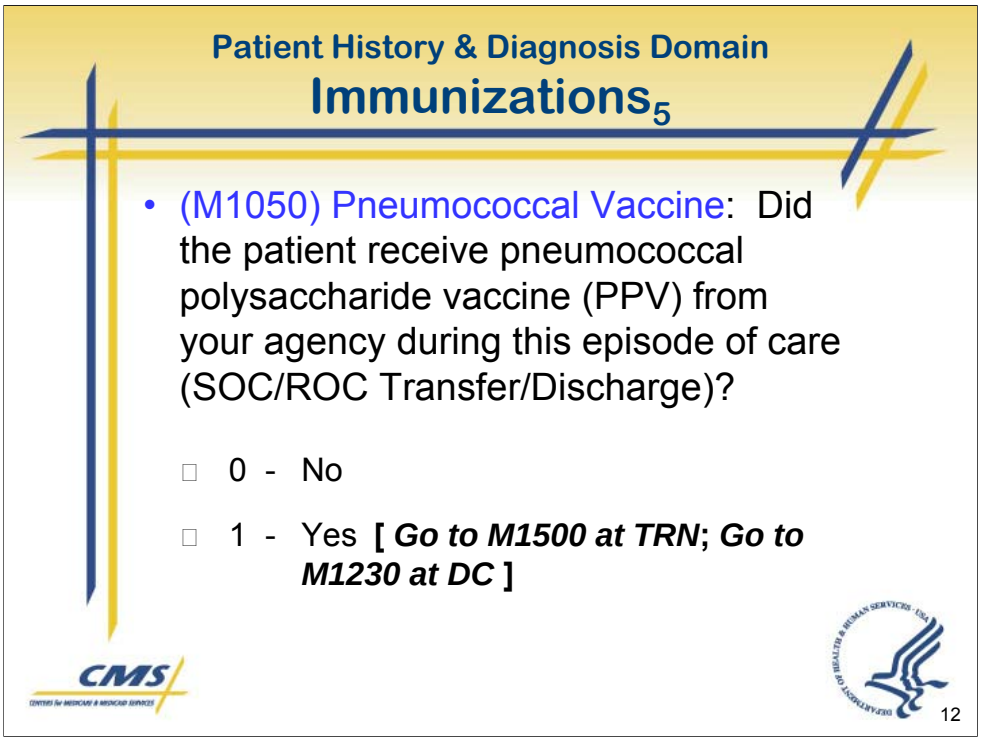
•Notes:

•Response 2 – this is the response you would select if your agency gave it during a prior episode in October or even in August because you got the flu vaccine for that year early

•Response 4 – there are only a few genuine medical contraindications – they are listed in the manual – do not use this response if their medical condition is not one of the listed contraindications that are being used across all care settings for this harmonized item

•Response 5 – the age/condition guidelines are described in the manual

•Select Response 6 – only in the event that the vaccine is unavailable due to a CDC- declared shortage



Initial Pneumonia Vaccine Item is just like the initial flu vaccine item, without the complication of the flu season calculation:

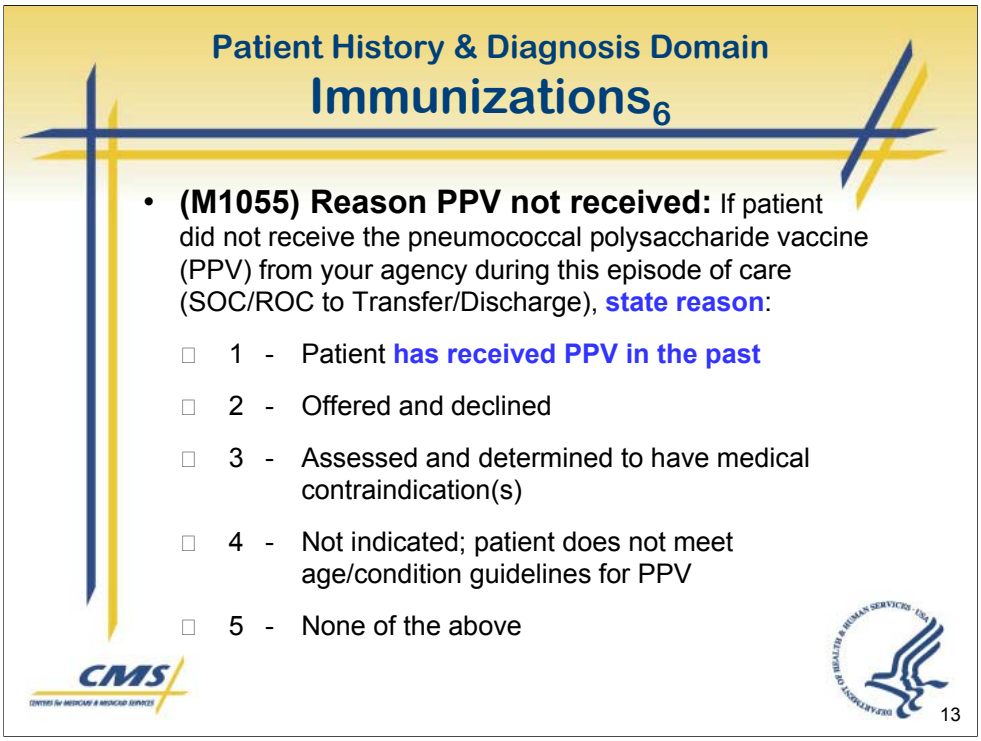
Asks: Did the patient receive a PPV from the HHA during this episode of care?

Select "1" only if the patient received the pneumococcal (PPV) vaccine from your agency during this episode

Episode again means Most recent SOC/ROC to Transfer/Discharge

•if the answer is yes, you are done

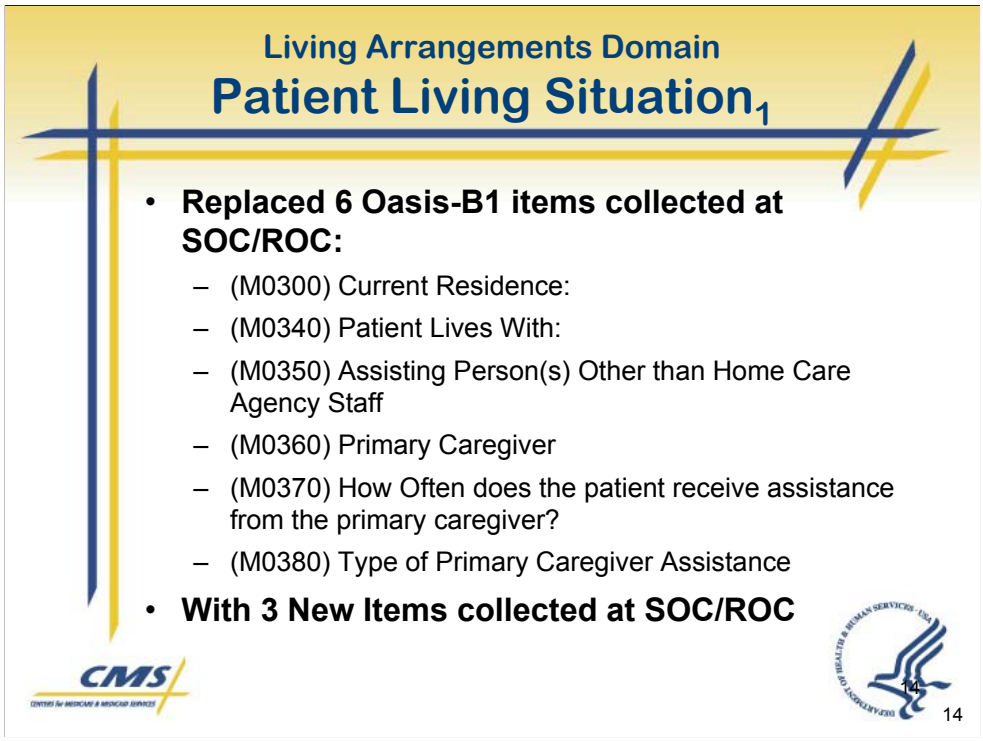
•If the answer is no, then you explain why in the next item



The follow-up PPV question, like the flu vaccine, allows the agency to report whether their was a legitimate reason for the fact that the pt did not receive it

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 the patient's physician, a clinic or health fair, etc.) **at any time in the past.** The patient's PPV does not need to be up-to-date to select this response.

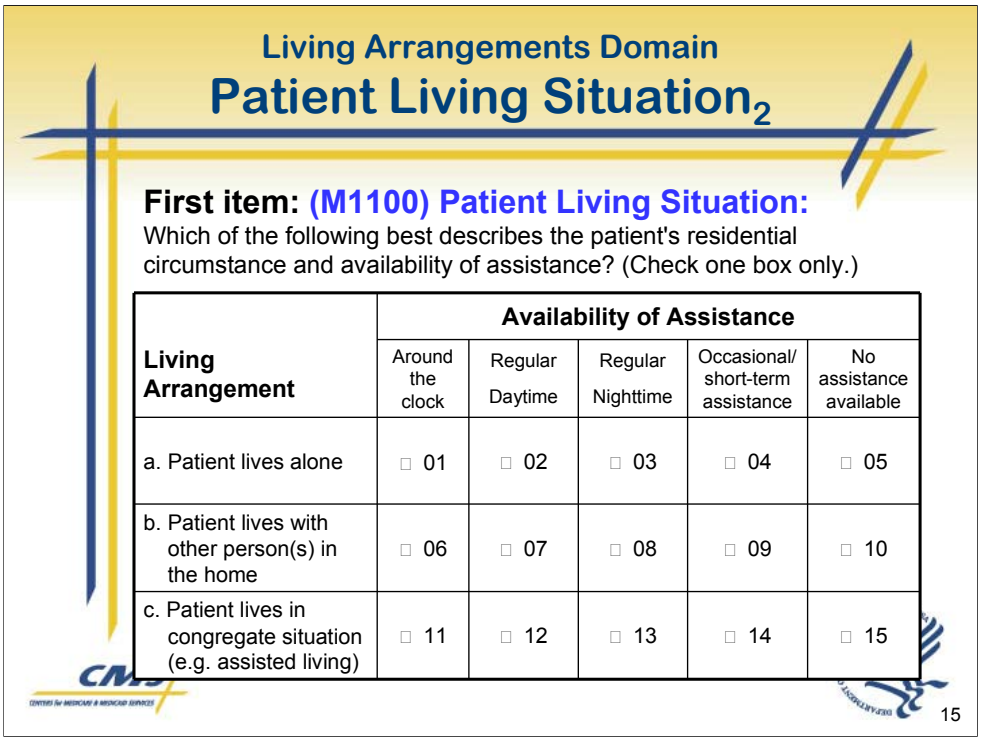
If they've never gotten the PPV, however, the clinician is going to have to determine the appropriate response based on guidance in the manual (which again is harmonized and based on CDC guidelines on whether PPV administration is medically contraindicated for this patient or if the CDC age/condition guidelines indicate that PPV is not indicated for this patient. For example, the patient is less than 64 without a high-risk condition such as diabetes, ESRD, CHF, or COPD – see the manual for the CDC guidelines.



The new items get away from the concept of “primary” care provider, and instead focus on MULTIPLE sources of caregiver assistance and availability of assistance

M1100 focuses on the patient’s living situation

The other 2 items – M2100 and M2110 - are asked later in the OASIS, after the cognitive and ADL/IADL assessment is completed, so the clinician will have a better ability to think about how well caregivers can assist the patient with their needs



Collected at SOC/ROC. Used for Risk Adjustment

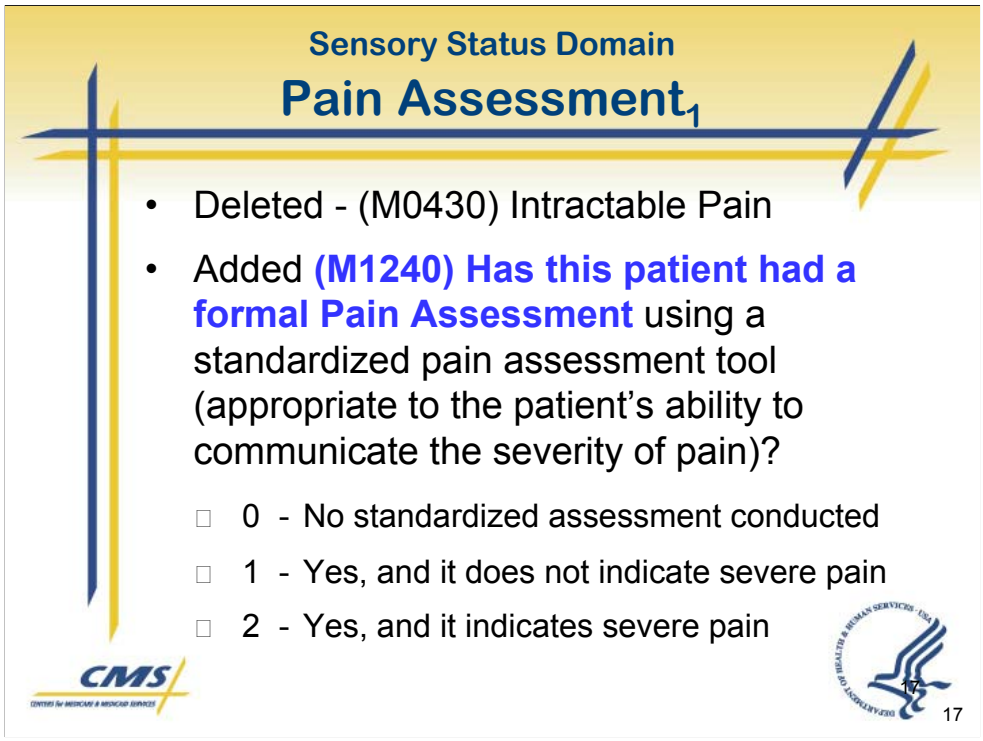
Reports whether the patient is living alone or with other(s) and b) the availability of caregiver(s) to provide in-person assistance. Availability of assistance can impact the patient's ability to remain safely in the home.

Only one response should be marked. Select the appropriate row (a, b, or c) to reflect the patient's living situation, then select the one response in the column that best describes the availability of in-person assistance at the time of the OASIS assessment.

Living Arrangements Domain

Patient Living Situation$_3$

- **(M1100) Patient Living Situation**
- To select the appropriate response:
  - First, determine living arrangement – whether the patient lives alone, in a home with others, or in a congregate setting;
  - Second, determine availability of assistance
  - how frequently caregiver(s) are in the home and available to provide assistance
- **Review guidance in the manual to become familiar with the definitions**



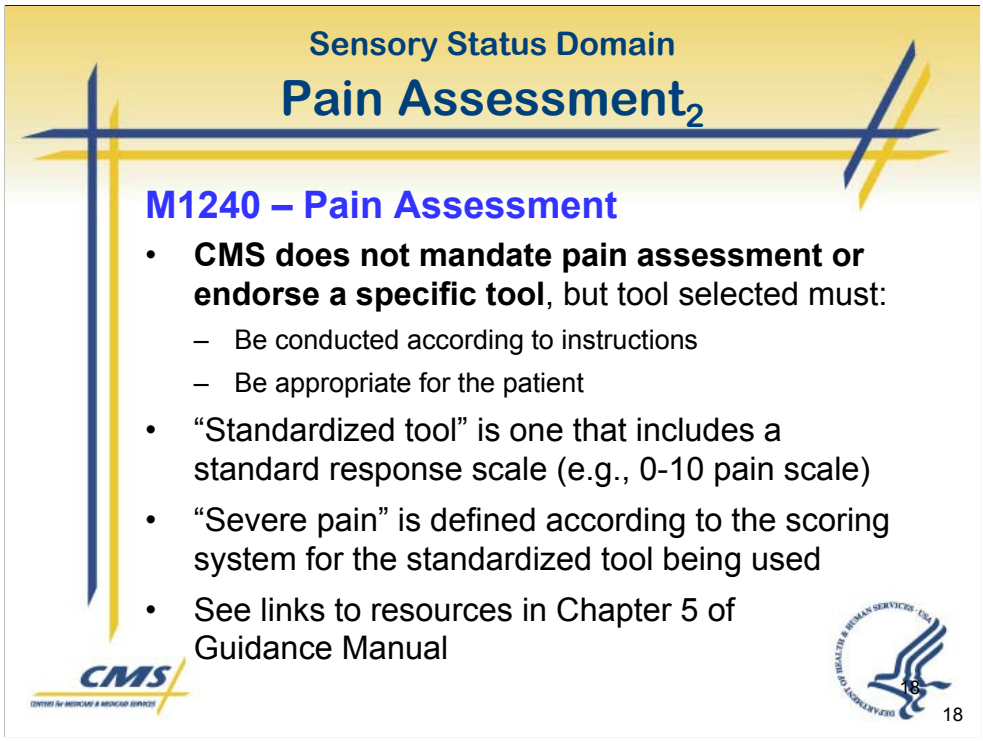
The item on intractable pain is one that clinicians have said was difficult to answer and unreliable and is now deleted.

M1240 is a new item added to identify if a standardized pain assessment was conducted at SOC/ROC 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 capture the agency's use of best practices.

Like the other process measures, it's not mandated, but provides opportunity for agency to get credit for a best practice if they have implemented

Response 0 should be selected if a non-standardized pain assessment was done, if no pain assessment was conducted during the assessment time frame by the person completing the COMPREHENSIVE ASSESSMENT.

Response 1 or 2 should be selected if a standardized pain assessment tool was used if a pain assessment WAS conducted during the assessment time frame by the person completing the COMPREHENSIVE ASSESSMENT.



CMS does not endorse a specific tool, but does require that a response of 1 or 2 indicates that a standardized tool was used – i.e. one that includes a standard response scale (for example, a scale where patients rate pain from 0-10).

A variety of standardized pain assessment approaches have been tested and are available for provider use in patient assessment. These approaches include THE 0 THROUGH 10 SCALE , the Wong-Baker FACES Pain Rating Scale, numerical scales, and the Memorial Pain Assessment Card.

Whichever standardized tool is used must be appropriately administered as indicated in the instructions

Tool used must be appropriate to the patient's ability to respond.

So if someone had low visions, you wouldn't use the faces scale

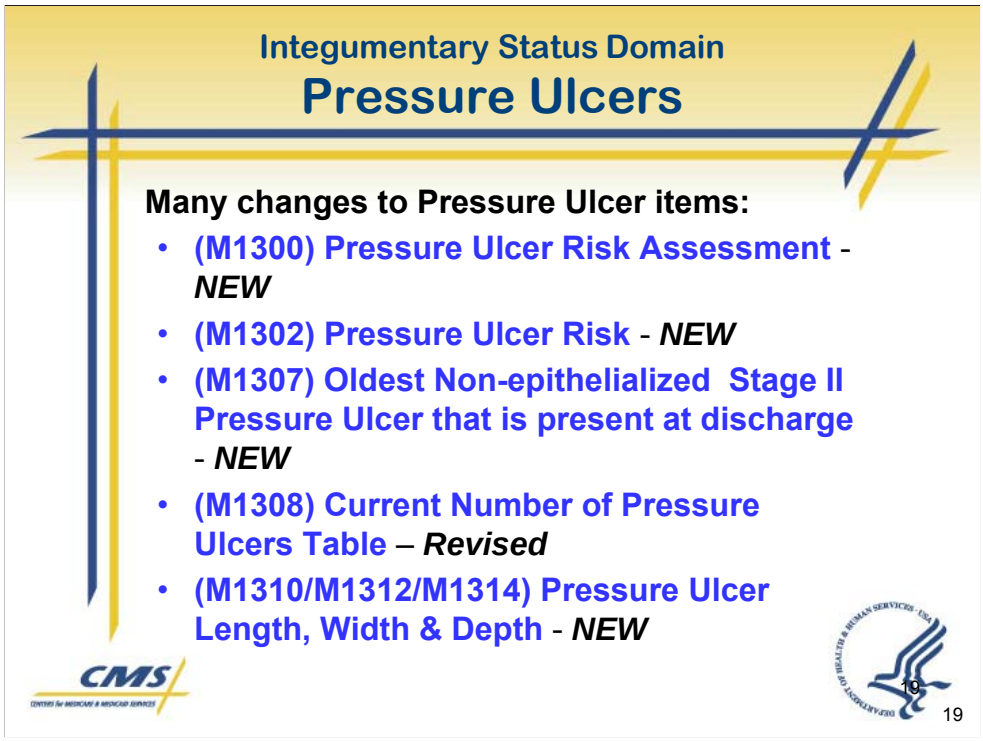
Severe pain is defined according to the scoring system for the standardized tool being used.

Example using the Wong Baker Faces Scale, 7-10 is considered severe pain

See links to resources in Guidance Manual for pain assessment tools that meet criteria for standardization

There may be reasons why a standardized pain assessment is not done – "0" would be the correct choice in that case

Clinicians should review the guidance in chapter 3 for more information about time frames for the assessments



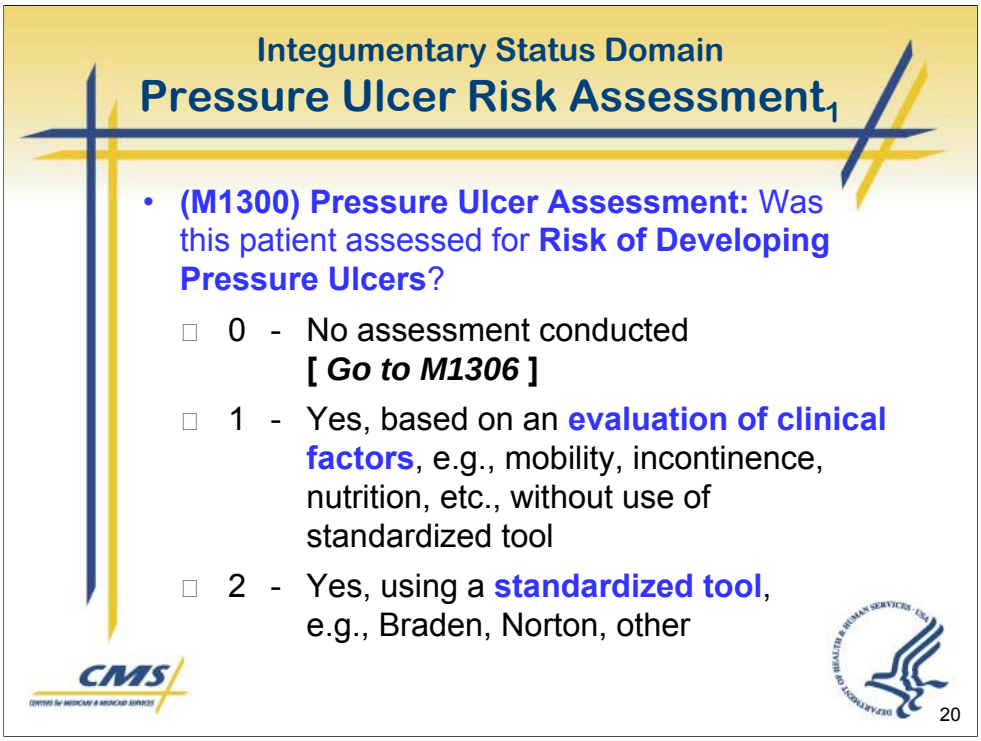
Items in the Integument section have undergone significant revision, primarily in the pressure ulcer section.

The foundation for the 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 and items have been added to assess whether a risk assessment was done, whether an ulcer was present on admission and that document the ulcer's length, width and depth.

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 guidance.

Because many of the items in the integumentary section are used in the payment algorithm, changes have been in many cases a compromise with wanting to update language with terms like epithelialization and yet not wanting to change the items in a way that would impact how agency payments are calculated



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 SOC/ROC to capture the agency's use of best practices.

Screening each patient for potential for developing pressure ulcers has been shown to reduce the development of new pressure ulcers

However, the assessment for risk of pressure ulcers is not required in the Conditions of Participation, so like all the process items, there is an option to say no (0) .

Assessing for this risk can be done:

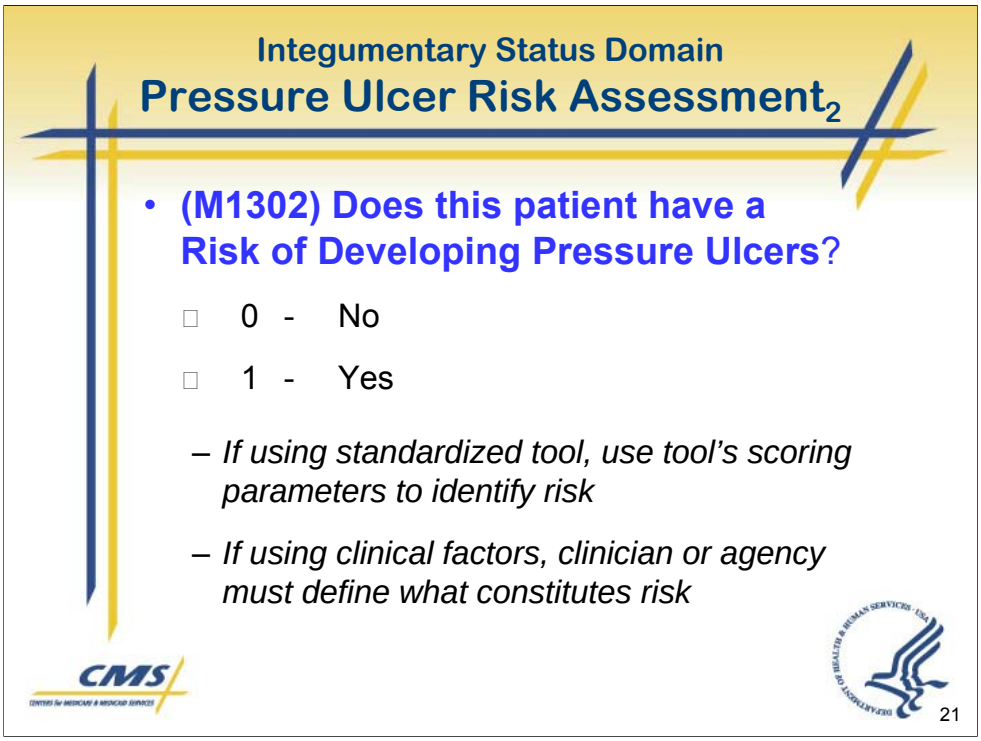
using clinical assessment for factors such as inactivity, incontinence, malnutrition - note the e.g. – in which case the clinician would select response 1

OR

using a standardized screening tool such Braden, Norton – note the e.g. – in which case the clinician would select response 2

Note that numerous risk assessment tools exist; however, only the Braden Scale and the Norton Scale have been tested extensively

CMS does not require the use of standardized tools, nor does it endorse one particular tool.

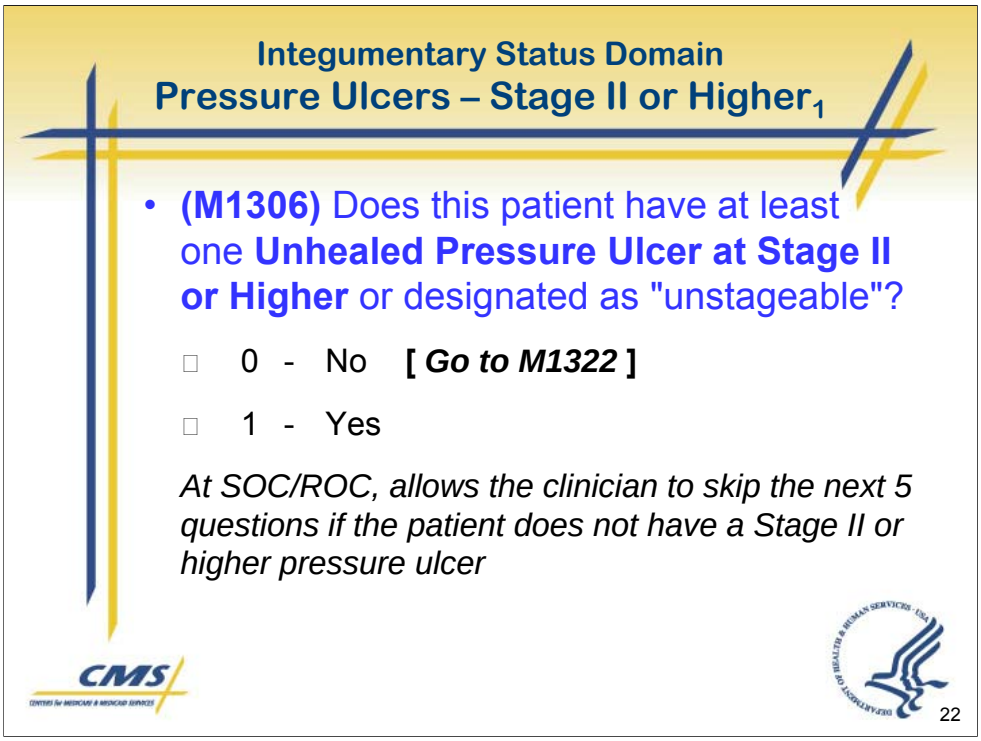


If you've responded to M1300 saying you did assess the pt for pressure ulcer risk, then you would go on to M1302 to document what the result of assessment was

If pressure ulcer risk was assessed using a validated standardized screening tool, use the scoring parameters specified for the 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 care provider may define what constitutes risk

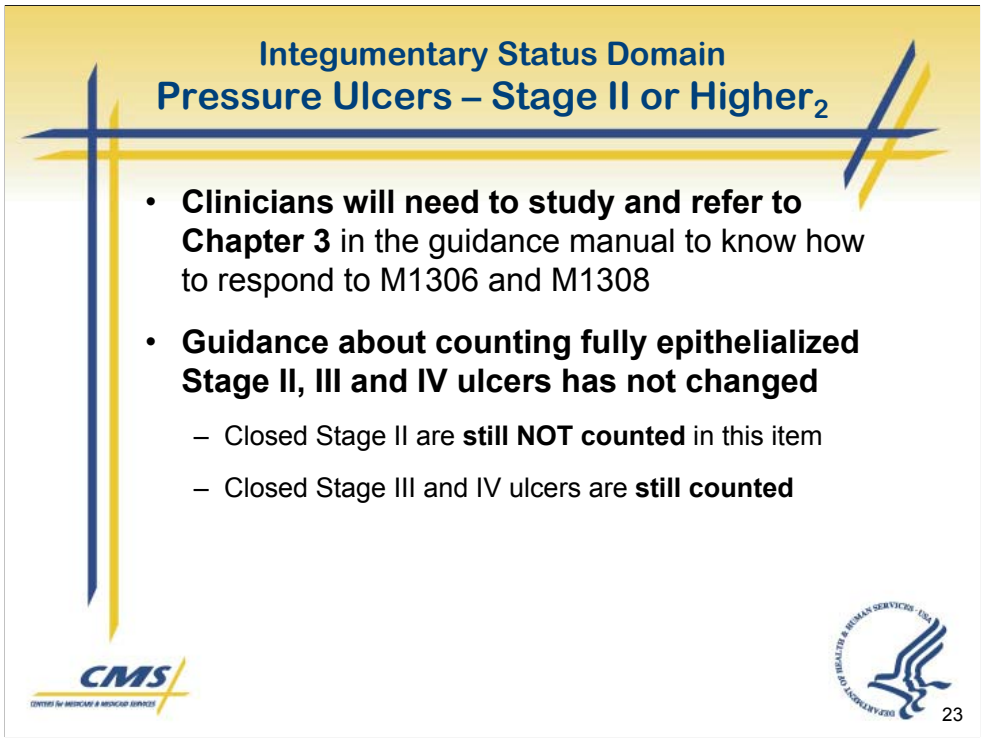
As part of your comprehensive assessment, these items should drive care planning about what interventions should be included in the care plan and implemented to avoid the development of pressure ulcers



Once you have completed the questions on pressure ulcer risk, which is asked for all patients, you then go to M1306 which functions as the gateway item that determines whether you should skip the questions that are just for stage II and higher ulcers.

Select Response 0 – No, if the only pressure ulcer(s) is Stage 1 OR .if a former Stage 2 pressure ulcer has healed AND the patient has no other pressure ulcers .

Select Response 1 – Yes, if the patient has an unhealed Stage II pressure ulcer, OR a Stage III, or Stage IV pressure ulcer at any healing status level OR if the patient has an unstageable ulcer(s



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 this question in terms of how you would respond to the 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

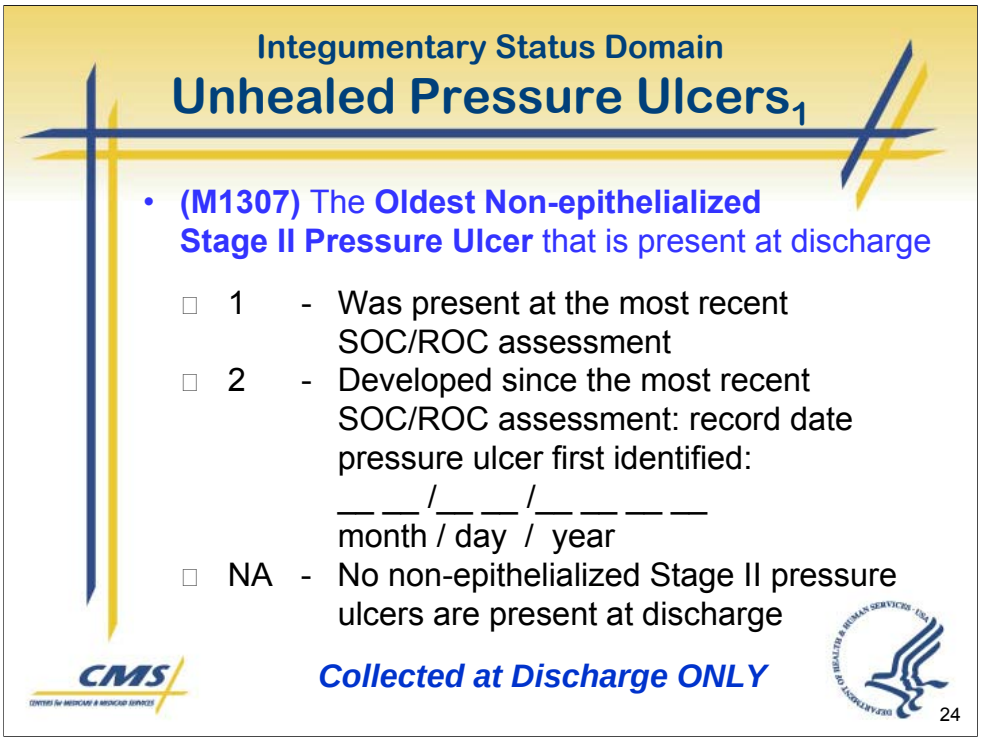
•Suspected deep tissue injury in evolution, which is defined by the NPUAP as a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear.

•Stage II, III or IV ulcers that have re-epithelialized

Guidance that describes how stage II, III and IV ulcers heal or close.

•Guidance about Stage II ulcers that have healed through epithelialization has not changed – they are still NOT counted in this item

•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.

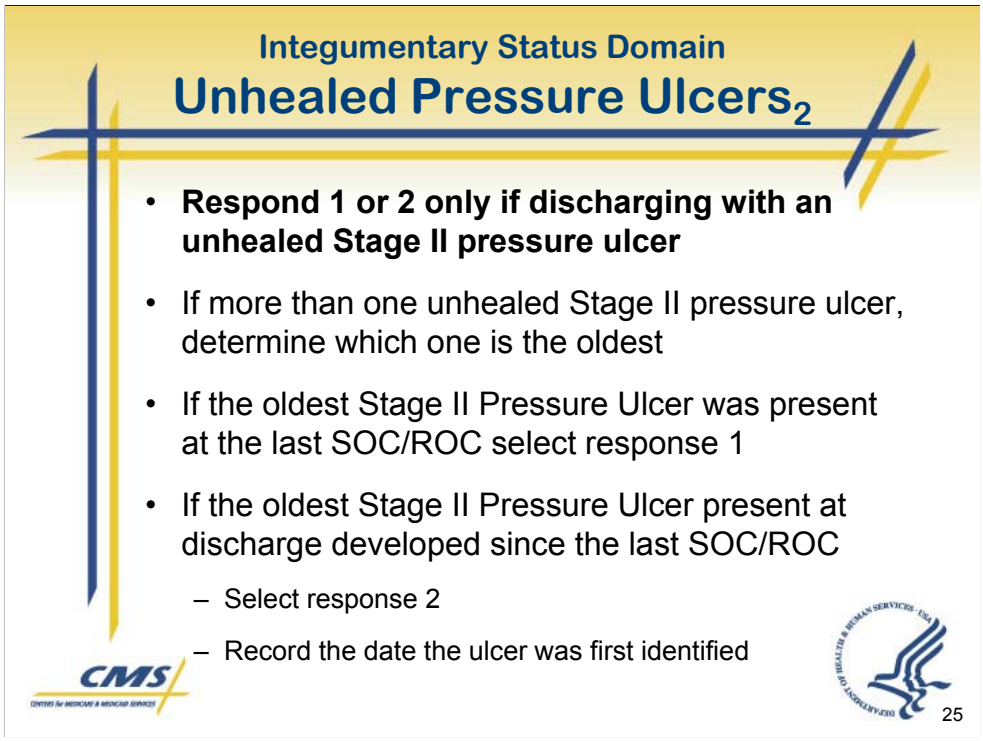


At Discharge, if you responded YES to M1306 – that the patient does have at least one Unhealed Pressure Ulcer at Stage II or Higher or designated as "unstageable“ - you would then go on to this item that asks about stage II ulcers that are present at discharge.

This item was added to assist with CMS tracking whether stage II pressure ulcers are healing within 30 days, as current wound guidance suggests 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 that they can’t always know, so there is a response to indicate that it was there when the patient was admitted (SOC/ROC), so that in that case, the clinician doesn’t 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.

Step 1 – determine if the patient has an open Stage II pressure ulcer at discharge - IF at the time of discharge the patient has no open (non-epithelialized) pressure ulcers then select NA and go on.

Remember: THIS ITEM REFERS ONLY TO NONEPITHELIALIZED STAGE II PRESSURE ULCERS. YOU WOULD NOT CONSIDER STAGE III OR IV ULCERS OR HEALED STAGE II ULCERS WHEN 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.

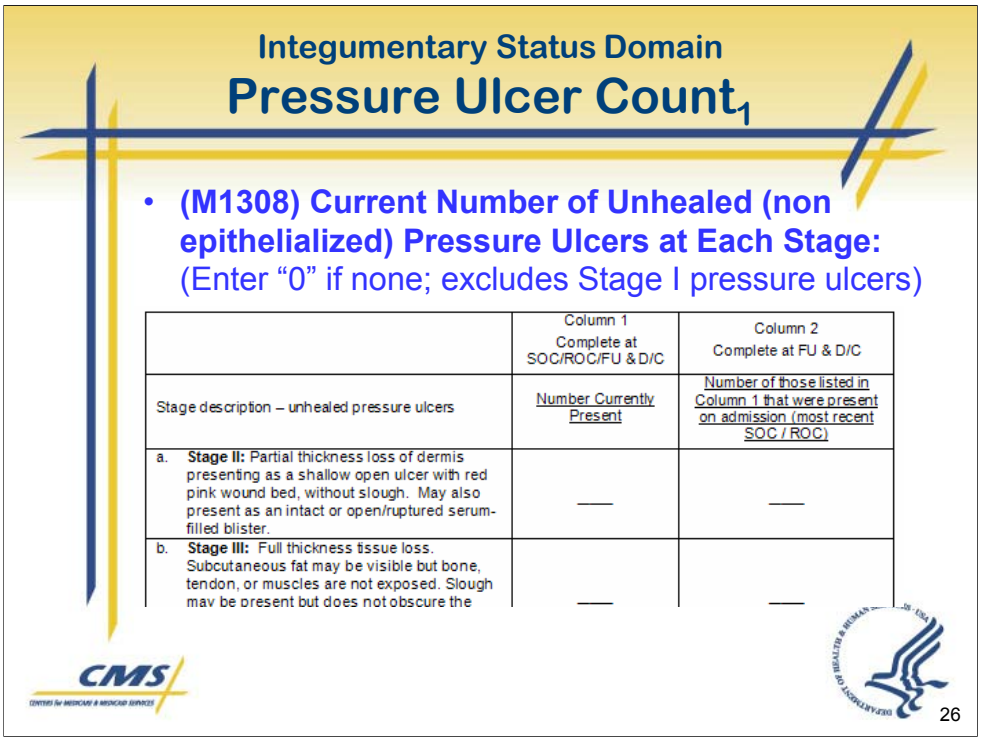
If it was there at SOC/ROC –select #1 – "Was present at the most recent SOC/ROC assessment" and the item is complete.

If it developed since the last SOC/ROC - select response 2 and record the date the ulcer was first identified

Examples:

• If pt was admitted January 1st with a stage II PrU which was still partially open (not completely covered with epithelial tissue) at discharge on February 15 – response would be 1 - Was present at the most recent SOC/ROC assessment

• If Pt was admitted Jan 1 with no pressure ulcers, developed one stage II ulcer on Jan 5 which was still open when the patient was discharged on February 15, then the clinician would select response 2 and enter the date 01-05-2010

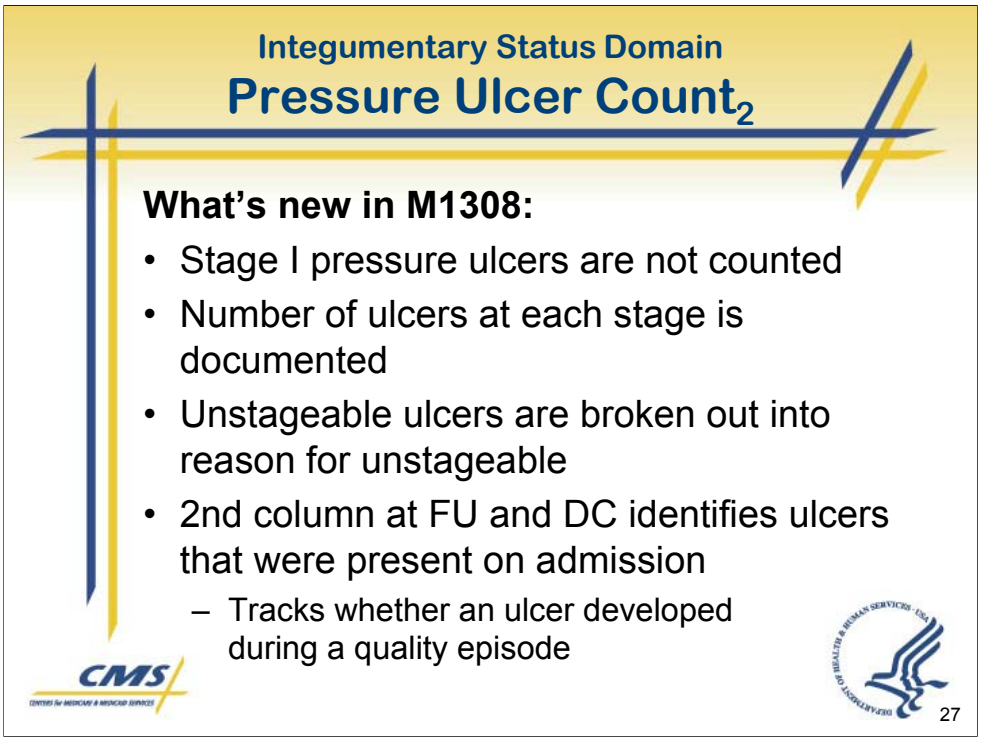


This next item is a revised version of the pressure ulcer grid that is currently in B1. Just like the B1 item, it identifies the number of pressure ulcers at each stage present at the time of assessment.

If you have been following OASIS-C development or have downloaded earlier versions of the OASIS-C dataset or guidance, you might have seen that when this item was tested it did not include stage III and IV ulcers that were closed – however, to avoid having any impact on the payment system, we have gone back to the existing B1 definitions and guidance

Directions on counting epithelialized Stage II, III and IV ulcers has not changed

- Healed Stage II are **still NOT counted** in this item
- Closed Stage III and IV ulcers are **still counted**



The main differences between the new item and the grid you are familiar with in B1 are that:

- Stage I pressure ulcers are not counted in this item – they are reported in a separate item –

- the clinician is asked to write in an actual number – you would enter "0" if there were none at that stage.

- unstageable ulcers are broken out into reason for unstageable and include suspected DTI (deep tissue injury)

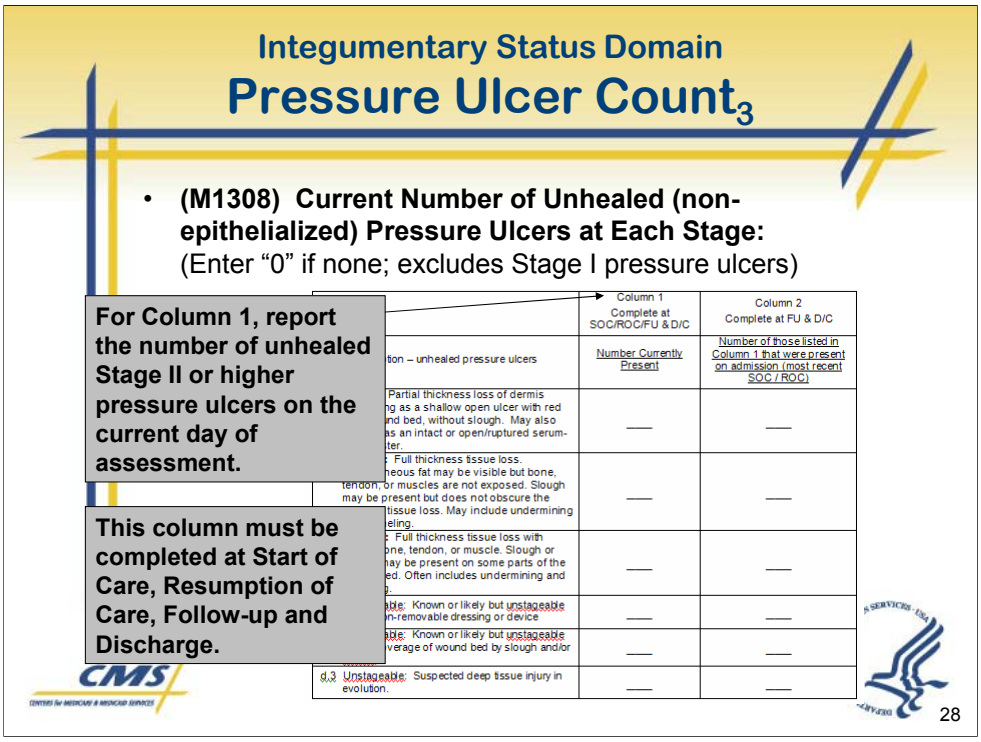
- there is now a 2nd column which is answered at FU and DC that identifies ulcers that were present on admission

Why was the 2nd column added?

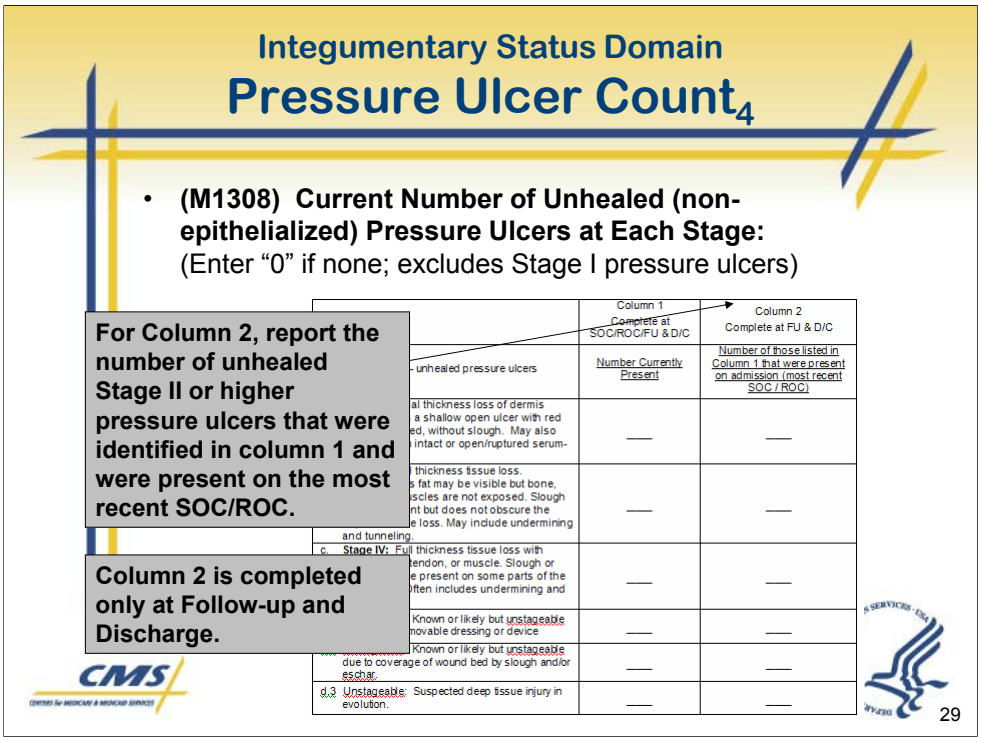
- In B1, when you say that the patient has 2 stage III ulcers at SOC and then 60 days later report that the patient has 2 stage II ulcers, there's no way to know whether these are the same two ulcers, or one healed and a new one developed some time in the last 60 days. This item will help answer that question.

- You may be aware of CMS efforts to track whether ulcers were present on admission in hospital and SNF settings. This 2nd column has been included in OASIS to harmonize with those settings.

NOTE: 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, report the number of unhealed Stage II or higher pressure ulcers on the current day of assessment. This column must be completed at Start of Care, Resumption of Care, Follow-up and Discharge.



For Column 2, report the number of ulcers that were identified in column 1 and were present on the most recent SOC/ROC. Column 2 is completed only at Follow-up and Discharge.

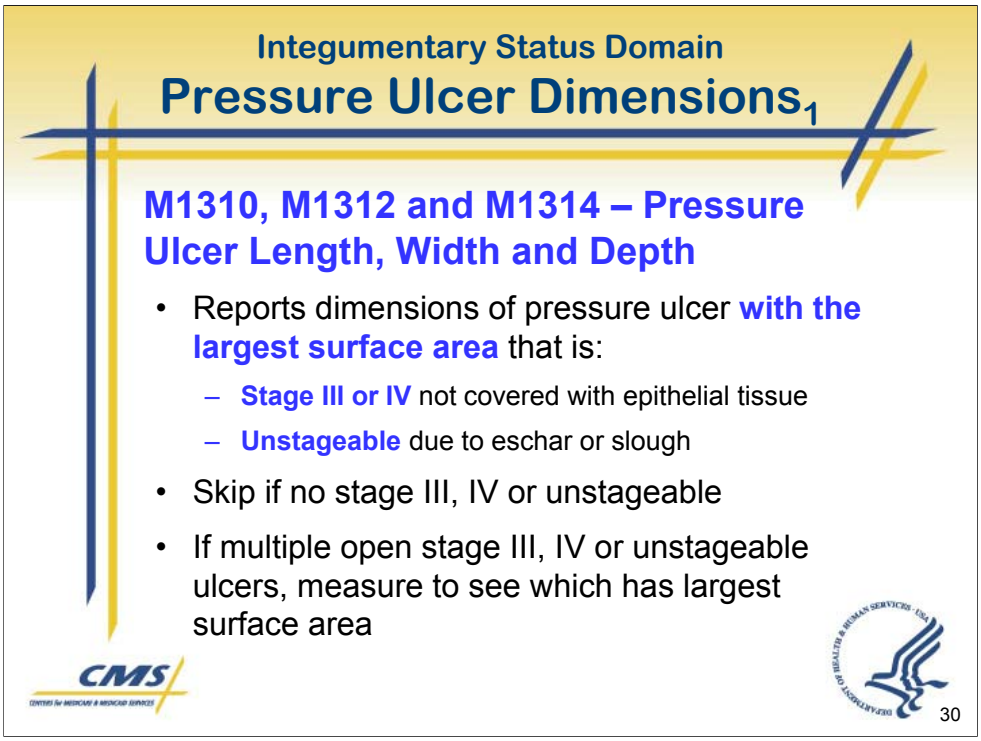
This is an example of an item that seems quite complex when reviewed in this fashion, but thinking about examples from your practice will assist you in understanding how to respond.

Here are some examples:

Example 1: Patient has no unhealed Stage II pressure ulcers on admission, but develops one during the first episode which is present at the time of follow-up. In this case, at SOC row a, column 1 would be "0". At follow-up, row a, column 1 would be "1" and row a column 2 would be "0", indicating the pressure ulcer was not present on admission.

Example 2: Patient has a Stage III pressure ulcer on admission that is assessed to be a Stage IV at follow-up. In this case, row b, column 1 would be "1" at SOC. 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 ulcer was present on admission, **even though it was at a different stage**.

Example 3: Patient has an unhealed Stage II pressure on admission that heals within the first 2 weeks, but then develops another Stage II ulcer prior to discharge at week 4. In this case, row a, column 1 would be "1" at SOC. At follow-up, row a, column 1 would be "1" and row a, column 2 would be "0", indicating the pressure ulcer that is present at follow up or discharge was not present on admission.



Immediately after the pressure ulcer count grid, there are 3 items collected at SOC/ROC and DC that asks the clinician to document the dimension of the largest Stage III or 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 3 items:

•**Step 1** – decide if you should you complete or skip them

- Only answer if the patient has a pressure ulcer that is stage III or IV OR an ulcer that is Unstageable due to eschar or slough, otherwise skip the items

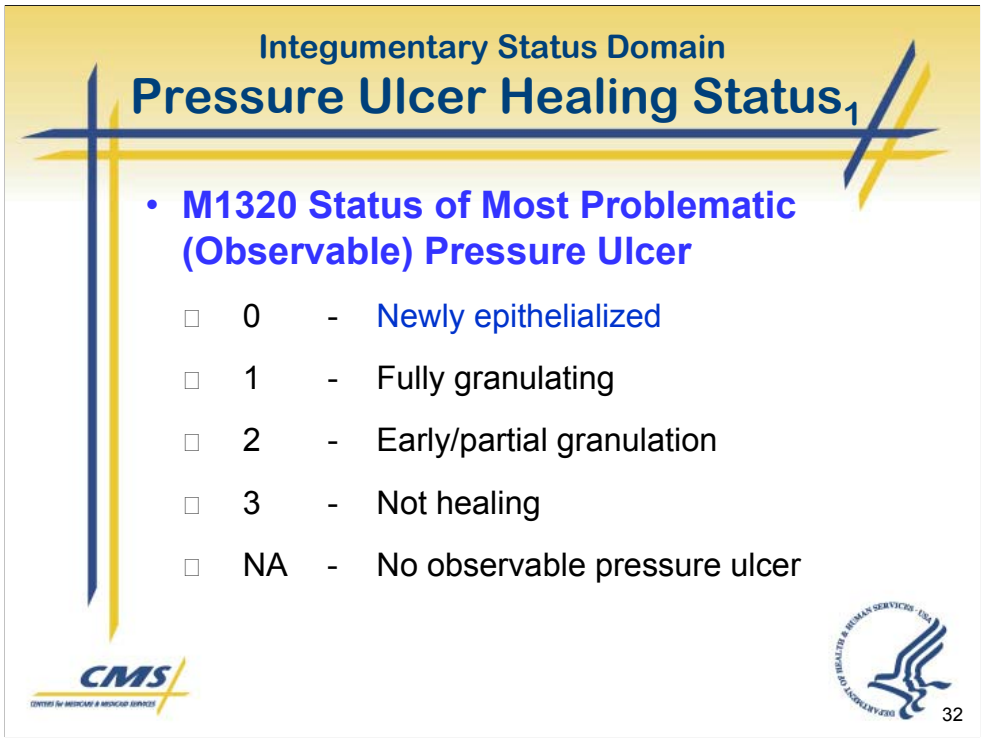
• **Step 2** – decide which ulcer you should measure. If the patient has more than 1 ulcer that is stage III, IV or Unstageable you will need to determine which has the largest surface dimension (length x width). Depth is not considered when determining the largest.

Integumentary Status Domain

Pressure Ulcer Dimensions$_2$

M1310, M1312 and M1314 – Pressure Ulcer Length, Width and Depth

- Record dimensions of the pressure ulcer with the largest surface area in centimeters
  - **Length** = longest head to toe
  - **Width** = greatest width perpendicular to length
  - **Depth** = from visible surface to deepest area
- Chapter 3 of OASIS-C Guidance Manual has
  - Further instructions and pictures
- Clinicians **must become familiar with the manual instructions** to respond accurately

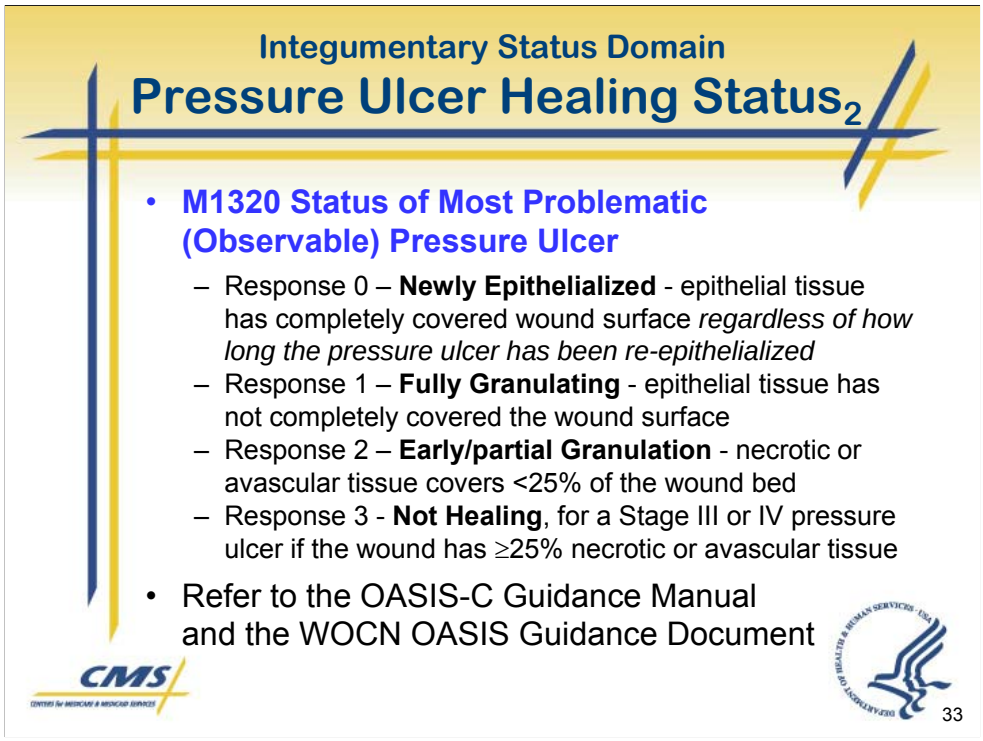


Just like in OASIS-B1, clinicians are asked to document the healing status of the most problematic pressure ulcer. Note that there is a new response – 0 – which allows the clinician to document that the ulcer has re-epithelialized.

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, etc., depending on the specific situation.

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



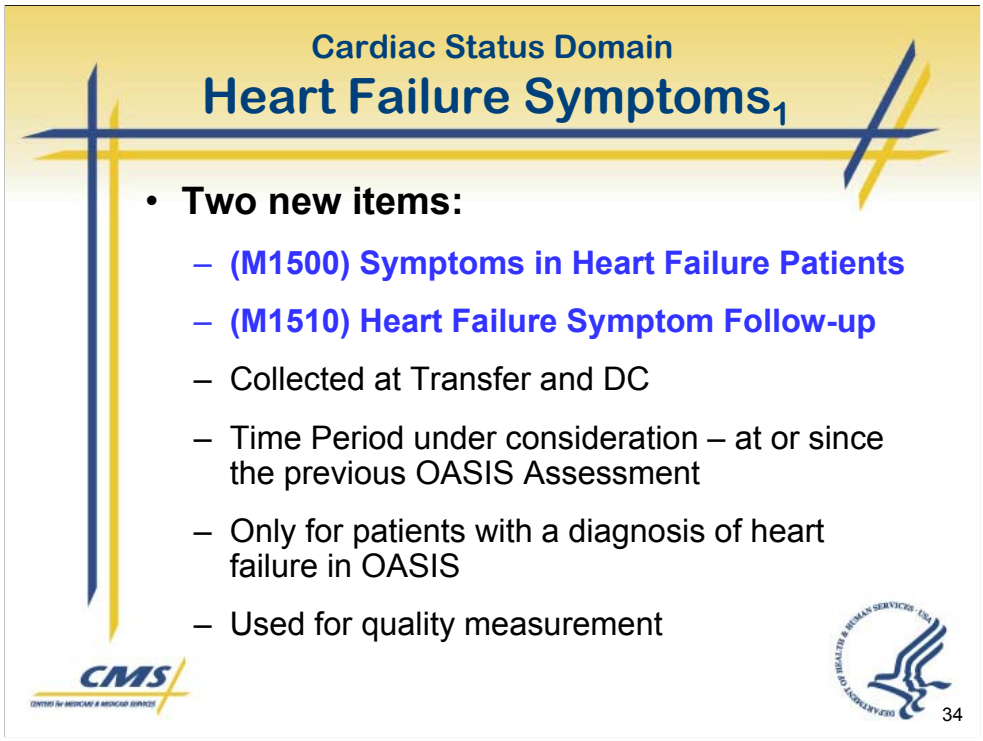
Response 0 - Newly epithelialized – is the appropriate response when epithelial tissue has completely covered the wound surface of the pressure ulcer, regardless of how long the pressure ulcer has been re-epithelialized. Epithelialization is regeneration of the epidermis across the wound surface.

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

Response 2 – Early/partial granulation is the appropriate response for a Stage III or IV pressure ulcer if necrotic or avascular tissue covers <25% of the wound bed

Response 3 - Not healing, is the appropriate response for a Stage III or IV pressure ulcer if the wound has ≥25% necrotic or avascular tissue.

Assessing clinicians should refer to the OASIS-C Guidance Manual and the WOCN OASIS Guidance Document, and use the clinical parameters to identify that a pressure ulcer to determine wound healing status



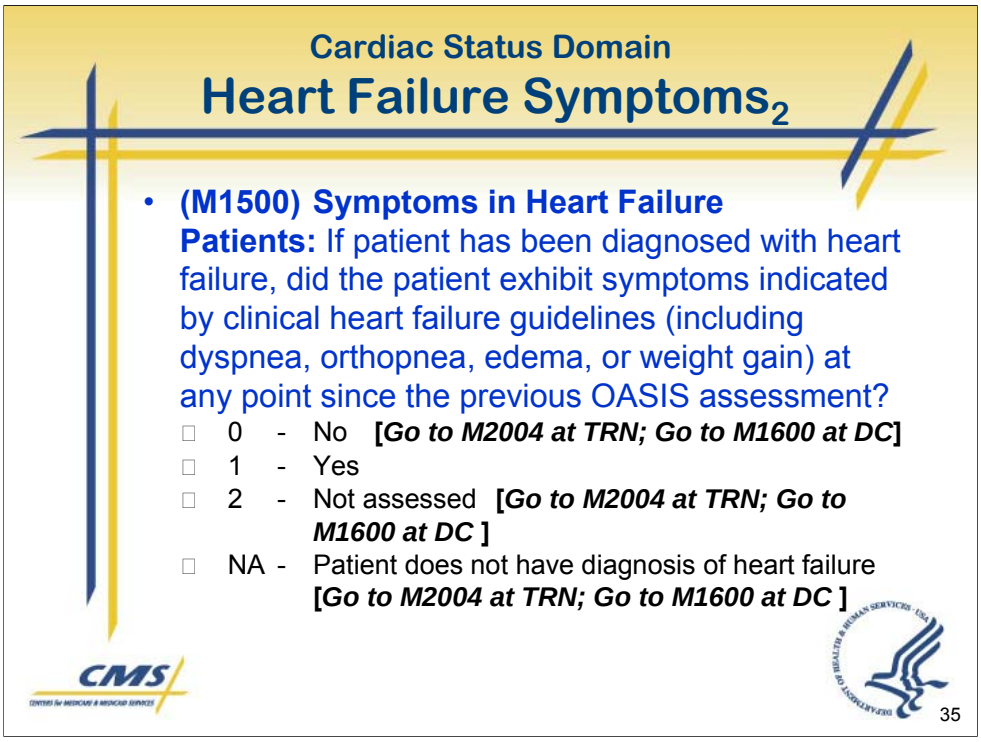
Heart failure is the most frequently seen diagnosis in home care, and these patients are often the “frequent fliers”, so anew domain was added to OASIS with **items that ask the clinician to look back at care since the last OASIS assessment to:**

1) Identify any new or ongoing heart failure symptoms that have occurred

2) Identify the actions the home health care providers took in response to those symptoms

These items are used to calculate a process measures to capture the agency’s use of best practices following the

completion of the 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 need to first determine if the patient has a **diagnosis of heart failure** in OASIS in any one of:

M1010: Inpatient Diagnoses

M1016: Diagnoses Causing Change in Treatment, or

M01020/1022/1024: Primary/Secondary diagnoses for home care

If they don't select NA and you are done with the cardiac section

If they do, then go on to step 2 – review the clinical information since the last OASIS assessment to see if they had 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 – there are links to these guidelines in the guidance manual in Chapter 5, Resources

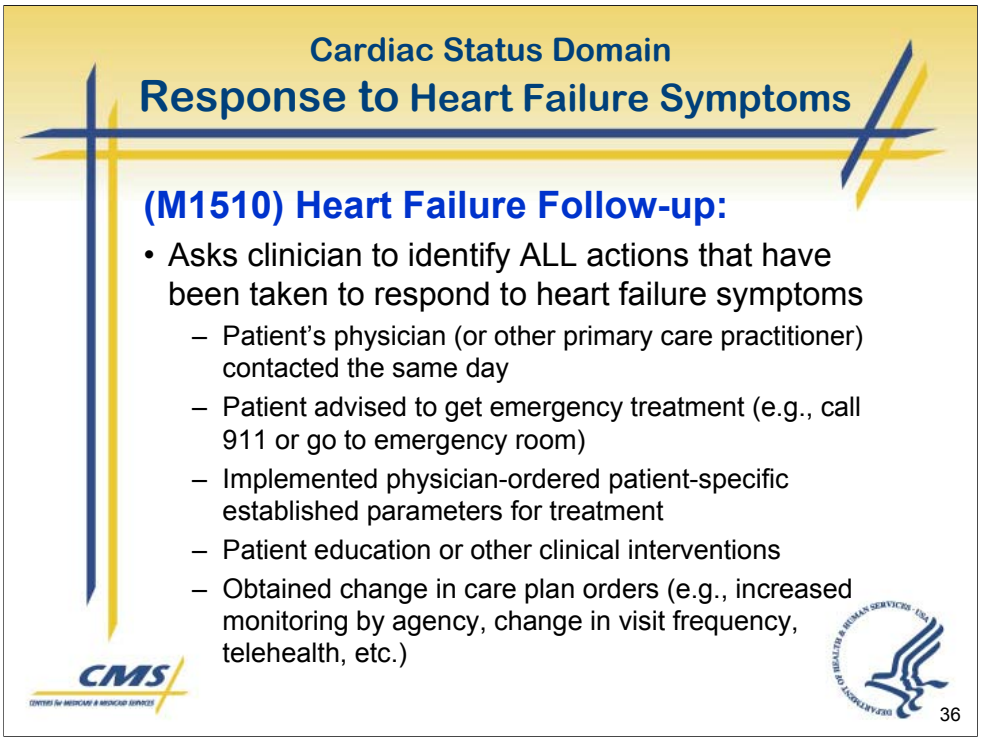
Data collection sources - Review of clinical record including physical assessment data, weight trends, clinical notes using HHA systems designed for this purpose

(e.g., flow sheets, electronic health record data reports, etc.)

Once you've reviewed the clinical documentation, then you are able to choose responses 0, 1, or 2

If the patient didn't have any symptoms (response 0) or you don't know if the patient had any symptoms because they weren't assessed 9Response 2) then you are done with the cardiac section.

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



M1510 Identifies **actions** the HHA providers took **in response to symptoms of HF** that occurred **since the most recent OASIS assessment**

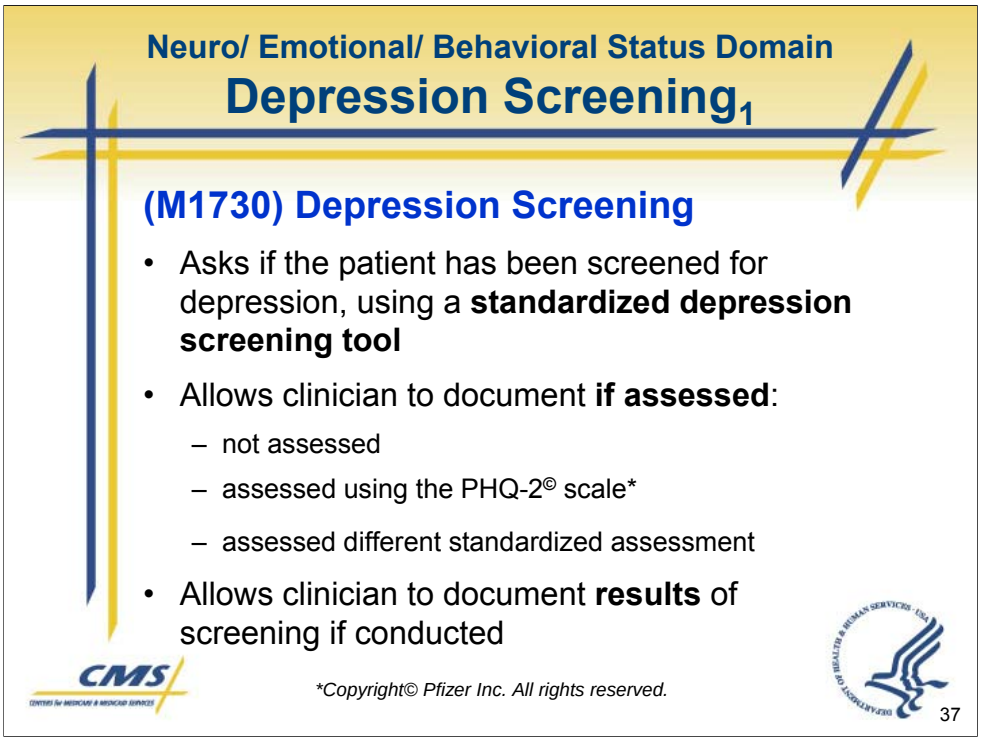
This item is used for calculation of quality measures **Process measure** item – Best Practices - and is collected at Transfer and Discharge. The clinician will be required to "look back" at clinical documentation to determine the appropriate score.

Report **any actions** that were taken **at least once** since completion of **the last OASIS assessment. This is a mark all that apply question.**

Communication to the physician (for response 1) requires physician acknowledgment of the information from the agency and/or further advice or instructions.

If the none of the listed **interventions were implemented there is an opportunity to select "0 – No action taken".**

If that were the case, you would probably want to document rationale in the clinical record



Depression is an under-diagnosed condition in elderly patients that can directly affect the patient's ability to learn and perform self-care skills necessary to remain in the home. The items addressing depression call attention to an issue that often not appropriately 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

Allows clinician to document **if assessed**:

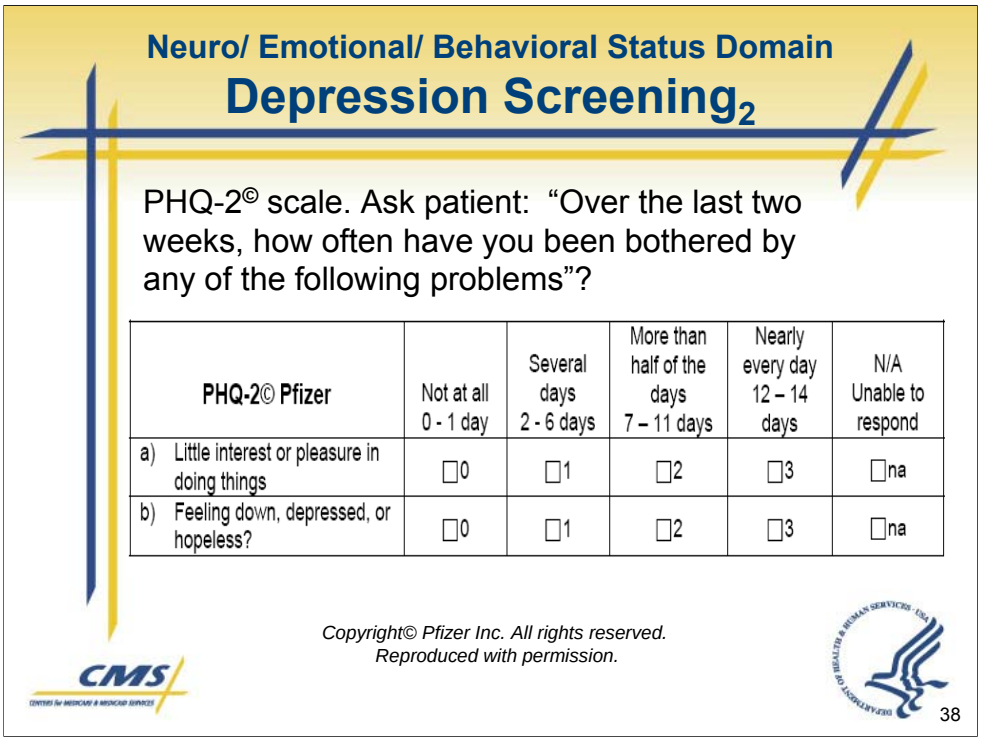
not assessed

assessed using the PHQ-2© scale*

assessed different standardized assessment

Responses allow clinician to document **results** -if patient meets criteria for further evaluation for depression

The item is asked at SOC/ROC and is used to calculate the process measure documenting whether this best practice has been implemented.

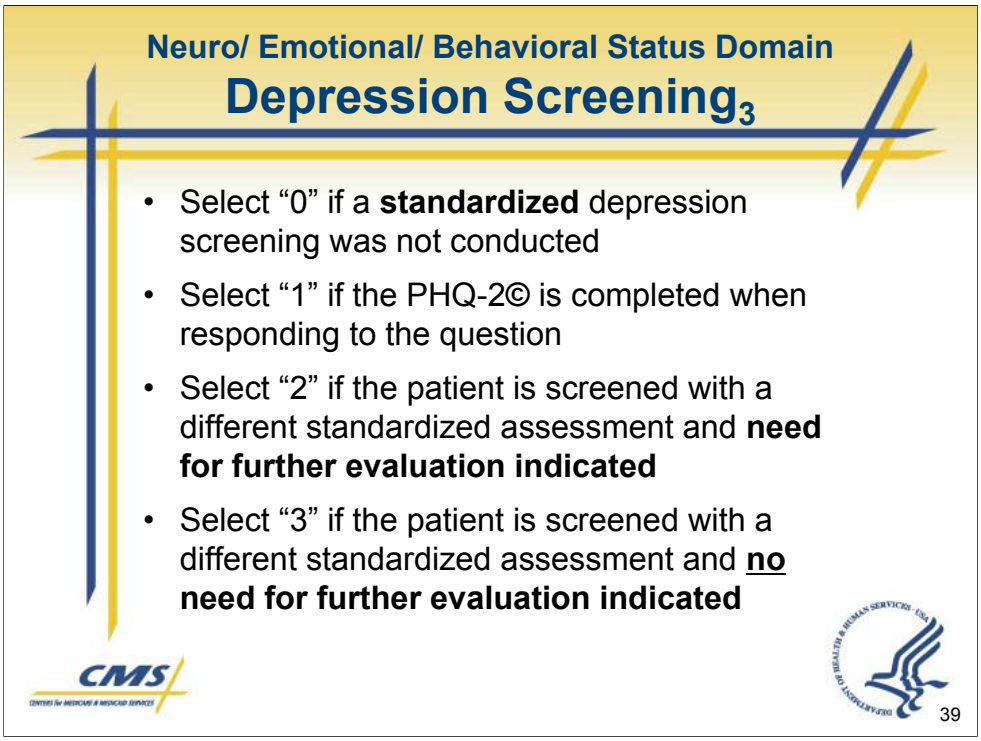


CMS **does not mandate** that clinicians conduct depression screening for all patients, nor the use of the PHQ-2 or any other particular standardized tool.

The PHQ-2 Depression has been included in the OASIS-C in order to harmonize with data collected in other settings by (i.e. MDS) which is collecting the PHQ-9© and because it is a simple 2 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 & b are for agency use only and will not be encoded and transmitted with OASIS data.

If patient scores at "3" or higher on the PHQ-2, further depression screening is indicated.



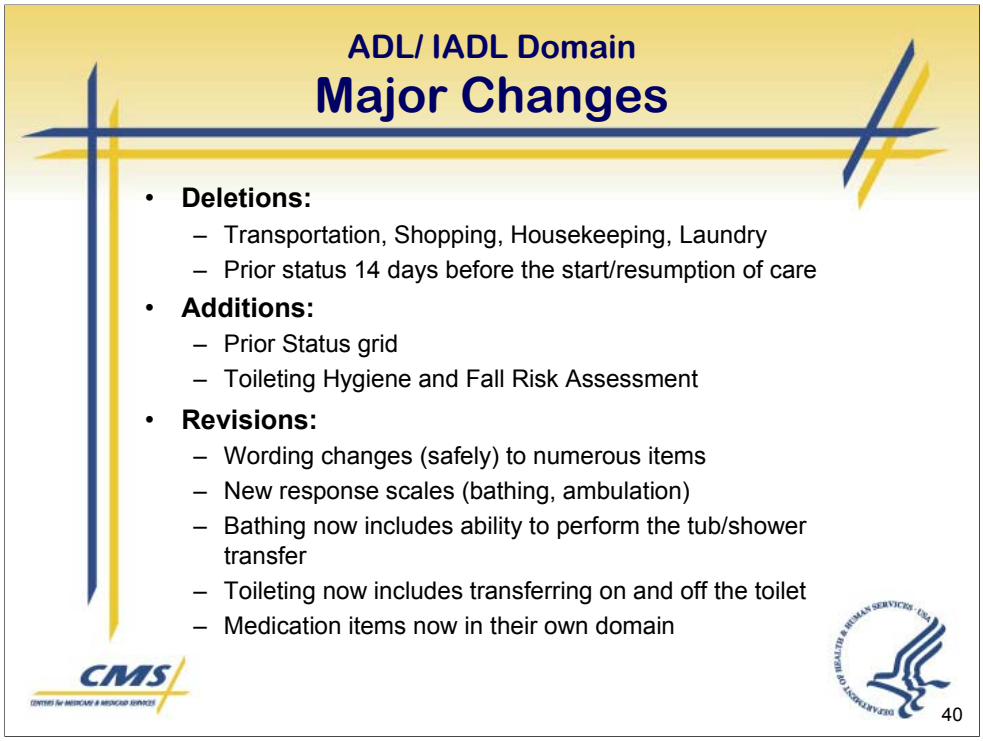
Select "0" if no depression assessment was conducted or if a "**non-standardized"** depression screening was conducted. Standardized means that that the screening tool includes a standard response scale, as opposed to an evaluation in which the clinician would decide based on their own judgment whether the patient had sufficient symptoms of depression to warrant further action.

Select "1" if the PHQ-2© is completed when responding to the question

Select "2" if a standardized depression screening tool other than the PHQ-2©

Select "3" if the patient is screened with a different standardized assessment and **no need for further evaluation indicated**

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

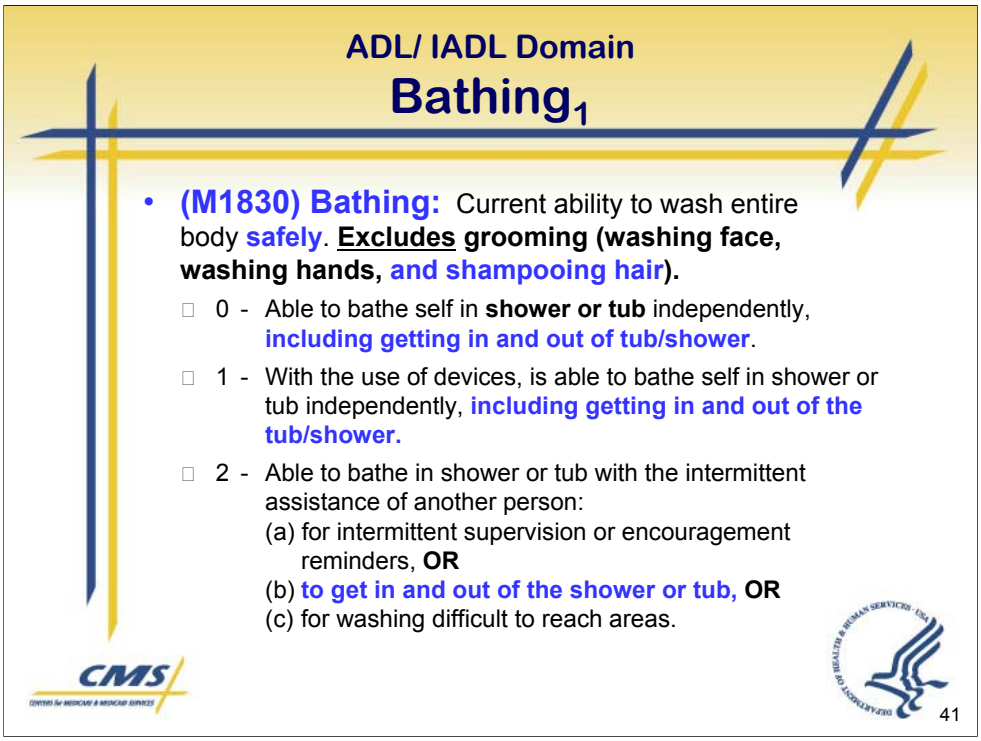


•There have been many changes to the ADL/IADL section.

•You will notice that a number of IADLs are no longer collected – they were deleted because they were rarely used for quality improvement efforts and because CMS knew there were items that needed to be added to the OASIS, so other things needed to be cut

•Clinicians are also no longer asked to report the patient's status 14 days before the start/resumption of care – to replace this, a single grid item asks about prior functioning

•We aren't going to discuss every item that has changes related to the addition of the word "safely" and/or deletion of the prior status column, but we will review the 2 new items, Toileting Hygiene and Fall Risk Assessment and the other major revisions, many of which were instituted because of clinician input on needed changes



Bathing is one of the items that has undergone significant changes – you can see them highlighted in blue here where we are just showing the first 3 responses

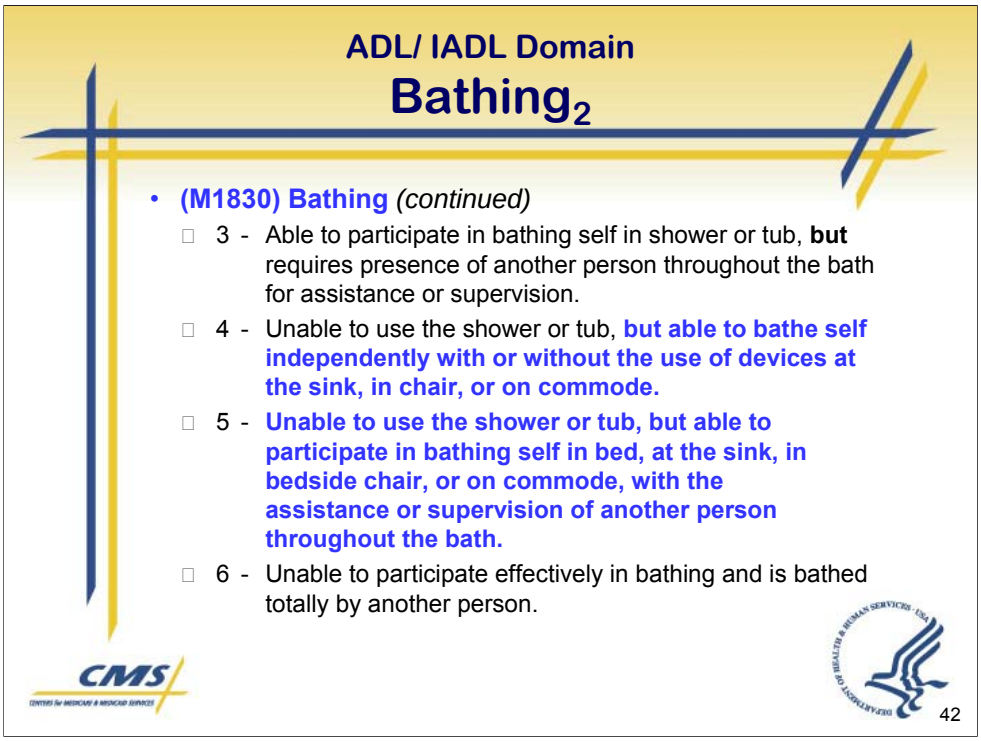
The exclusion of shampooing is not new for this item, but now it's stated right in the item for clarity

Bathing now includes getting in and out of the tub or shower

The 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 bathe safely in the tub or shower or requires verbal cueing/reminders, select Response 2 if the assistance needed is intermittent.



If the patient requires standby assistance or verbal cueing/reminders continuously to bathe safely in the tub or shower, then select Response 3

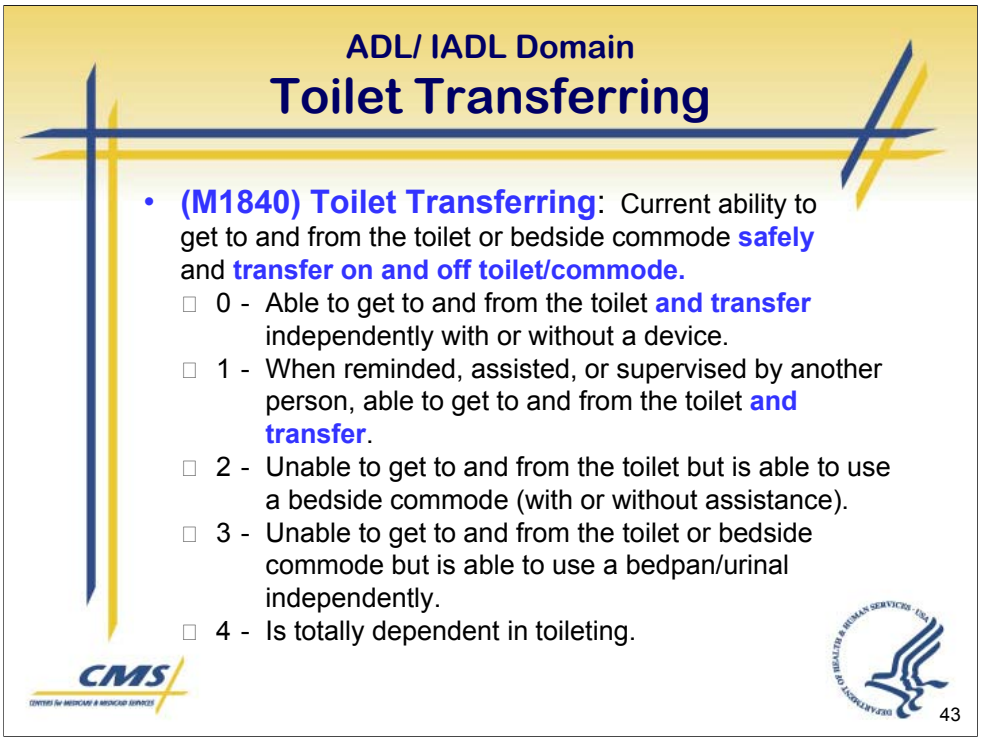
New wording in responses 4 and 5 allow the clinician to show progress in a patient who is able to bathe at the sink

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

For Response 5, patient must be unable to bathe in tub/shower, **can participate** in bathing self but **needs assistance.**

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 2nd floor tub or shower

The bathing item and the next item, toilet transferring, are collected at SOC/ROC FU and DC and used for both payment and quality measurement.

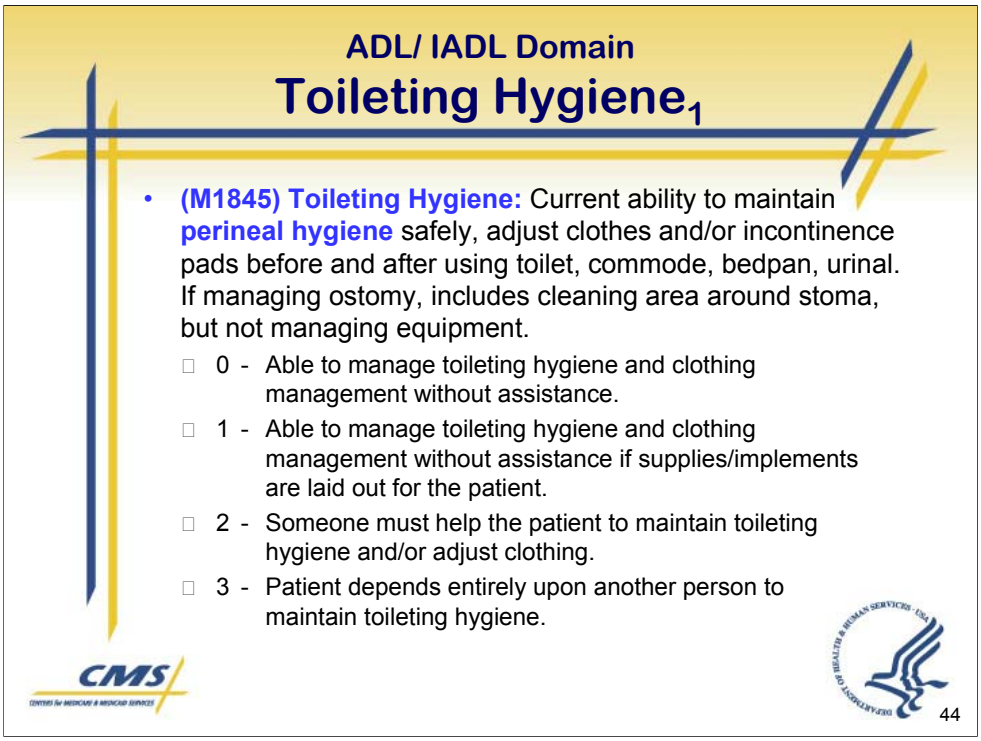


As mentioned previously, the ability to **transfer on and off toilet/commode is** now included in the toileting item

Manual guidance instructs clinicians to select "1" if patient:

> Requires standby assistance to get to and from toilet **safely** or requires verbal cueing/reminders.
>
> Can independently get to the toilet, but requires assistance to get on and off the toilet.
>
> Needs assistance getting to/from toilet **OR** with toileting transfer **OR both.**

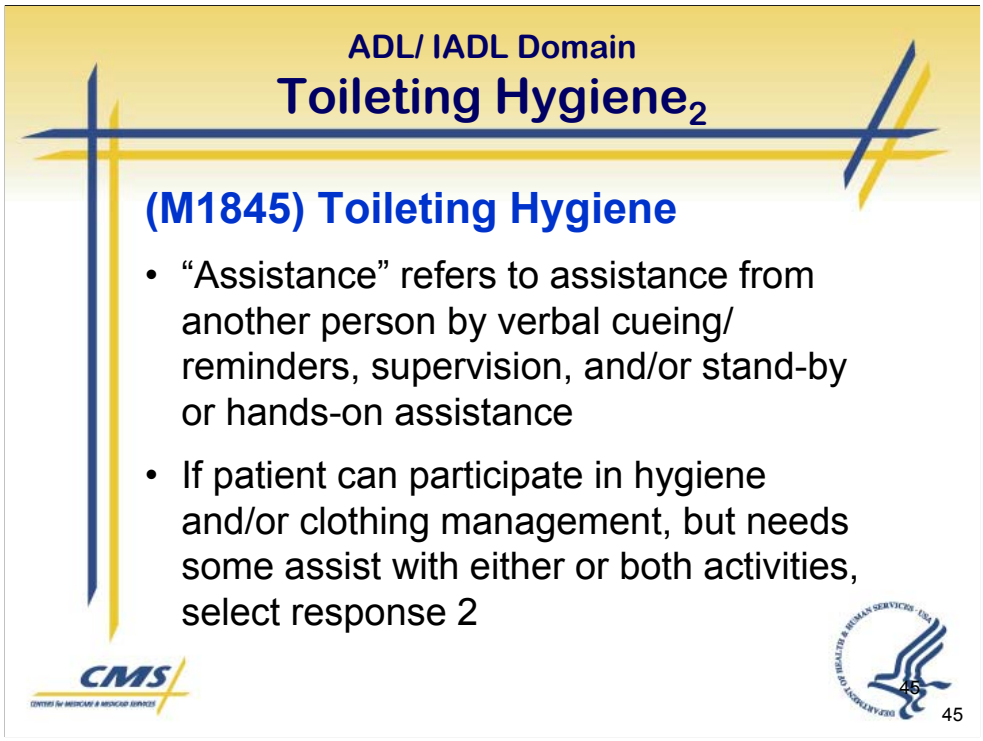
Read the manual to become familiar with how to respond to this item in other circumstances



New item reports the patient's ability to manage personal hygiene and clothing when toileting (with or without assistive devices).

Reported at SOC/ROC and DC. Used for quality measure calculation.

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



OASIS-C Guidance Manual advises:

Toileting hygiene includes several activities, including pulling clothes up or down and adequately cleaning

(wiping) the perineal area.

● 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, and/or stand-by or hands-on assistance.

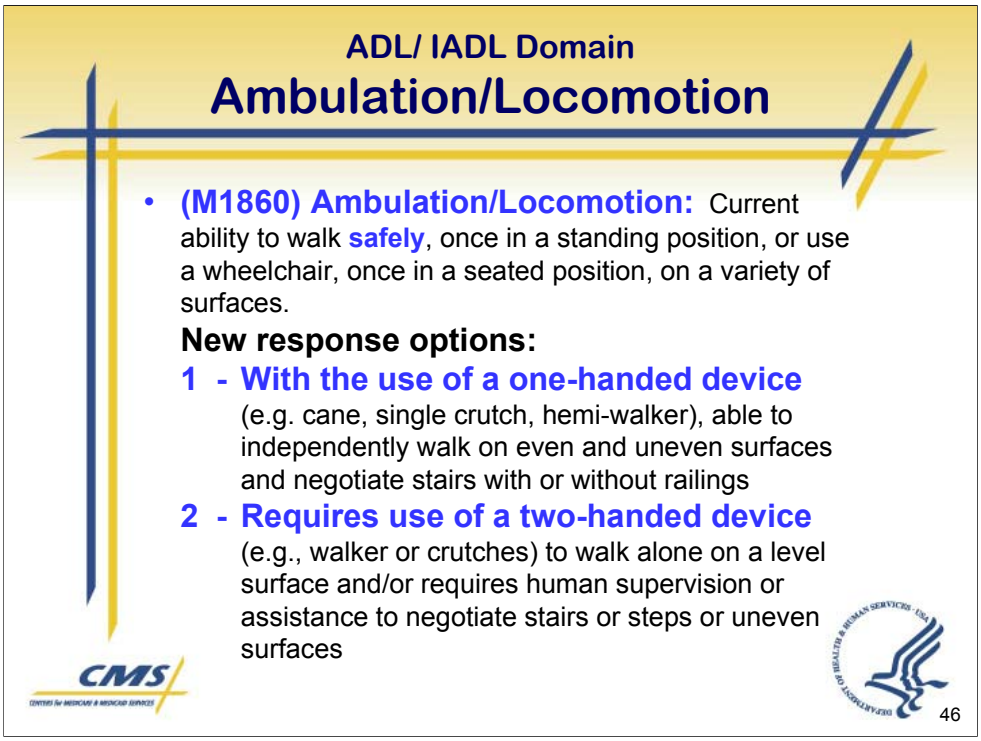
● Select Response 0 if the patient is independent in managing toileting hygiene and managing clothing.

● Select Response 1 if if the patient is able to manage toileting hygiene and manage clothing IF supplies are laid

out for the patient.

•If the patient can participate but needs standby assistance or verbal cueing or direct assistance with either or

both hygiene and/or clothing management activities, select Response 2.



The ambulation and locomotion item is collected at SOC/ROC, FU and DC and used for both payment and quality measurement.

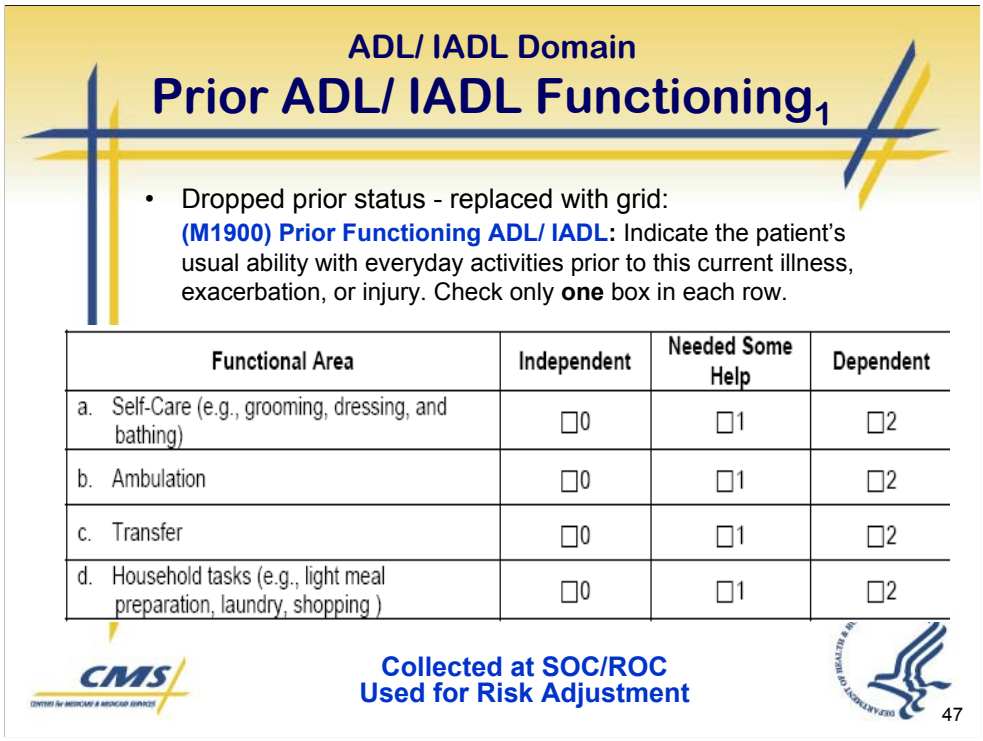
There is a new breakout in the response options that allows the OASIS to show progress of a patient from a two handed device to a one handed device. This was added based on requests from the industry.

Manual advises that the term “variety of surfaces” refers to typical surfaces that the patient would **routinely** encounter **in his/her environment**, and may vary based on the individual residence.

Also:

If a patient does not require human assistance, but safely ambulates with a walker in some areas of the home, and a cane in other areas (due to space limitations, distances, etc.), select the response that reflects the device that best supports safe ambulation on all surfaces the patient routinely encounters (e.g., Response 2 is 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 provides adequate support).

Read the manual for other guidance specific to this item.

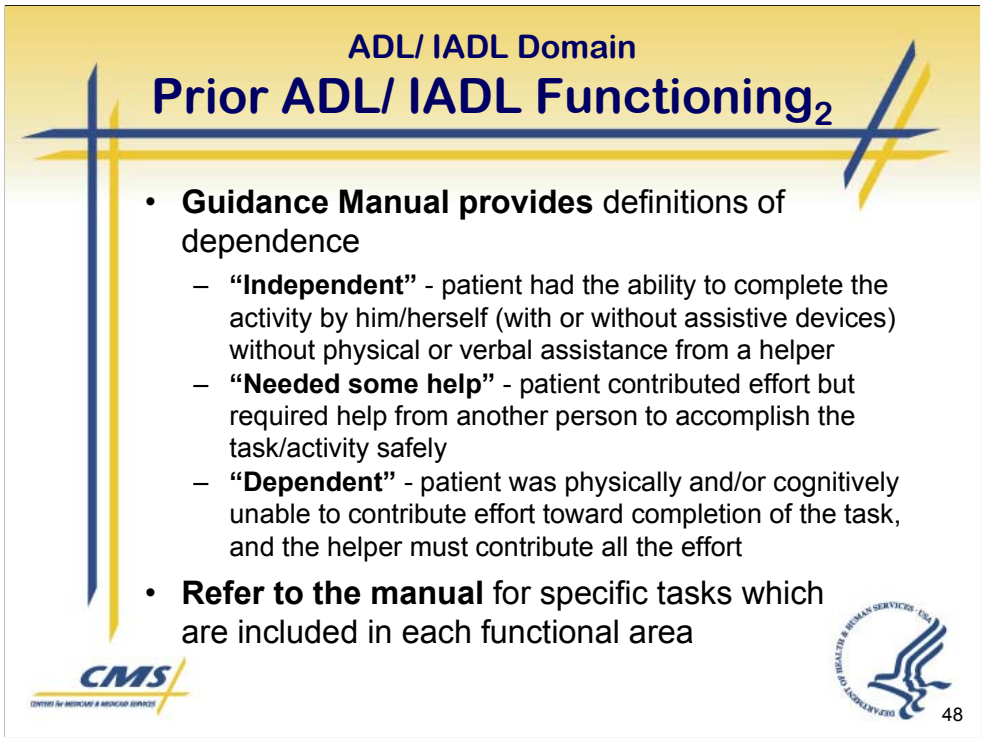


Here is the new M1900 Prior functioning grid that is collected at SOC/ROC only and replaces the prior status column for the ADLs/IADLs

An understanding of prior status can allow for appropriate goal setting and risk adjustment of outcomes. However, the old OASIS-B1 time frame of "past 14 days" was sometimes problematic. This allows for assessment of ability prior to an event leading to the need for home care.

The new item identifies changes that have occurred in the patient's ability to perform ADL and IADL activities **since the onset** of the **current illness**, **exacerbation of a chronic condition**, or **injury** (whichever is most recent) that initiated this episode of care.

(New! No longer limited to 14 days!)
Manual guidance states If patient experienced more than one illness, injury or exacerbation, refer to the most recent

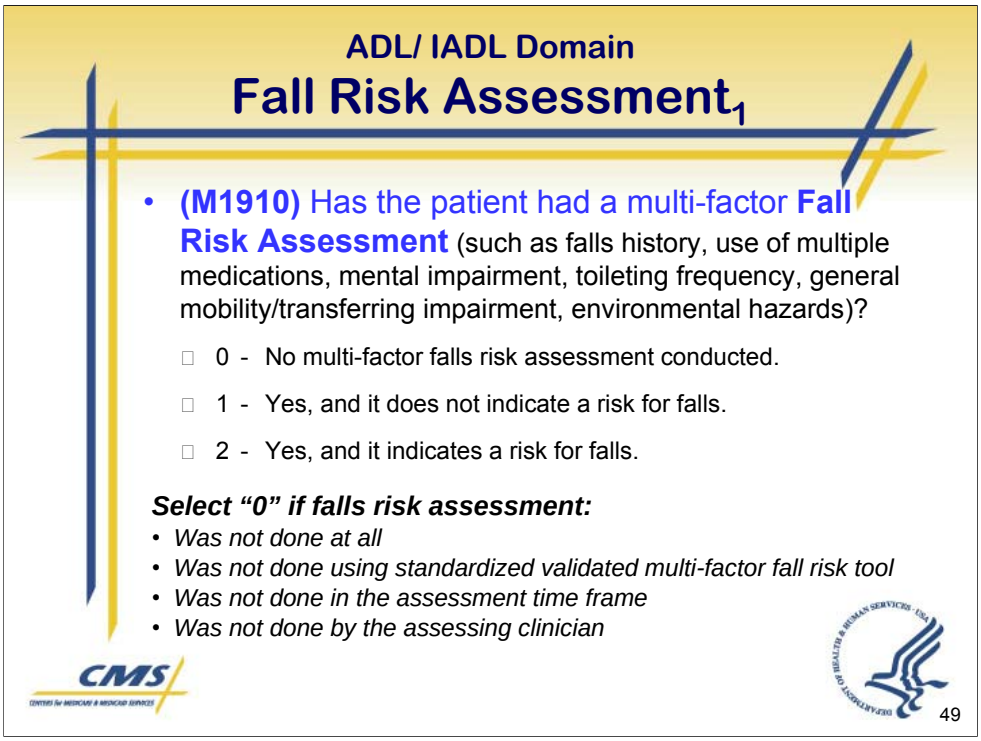


The manual also defines the dependence levels used in this item

"Independent" means that the patient had the ability to complete the activity by him/herself (with or without assistive devices) without physical or verbal assistance from a helper.

"Needed some help" means that the patient contributed effort but required help from another person to accomplish the task/activity safely.

"Dependent" means that the patient was physically and/or cognitively unable to contribute effort toward completion of the task, and the helper must contribute all the effort.
Look to OASIS-C Item Guidance for specific tasks which are included in each functional area



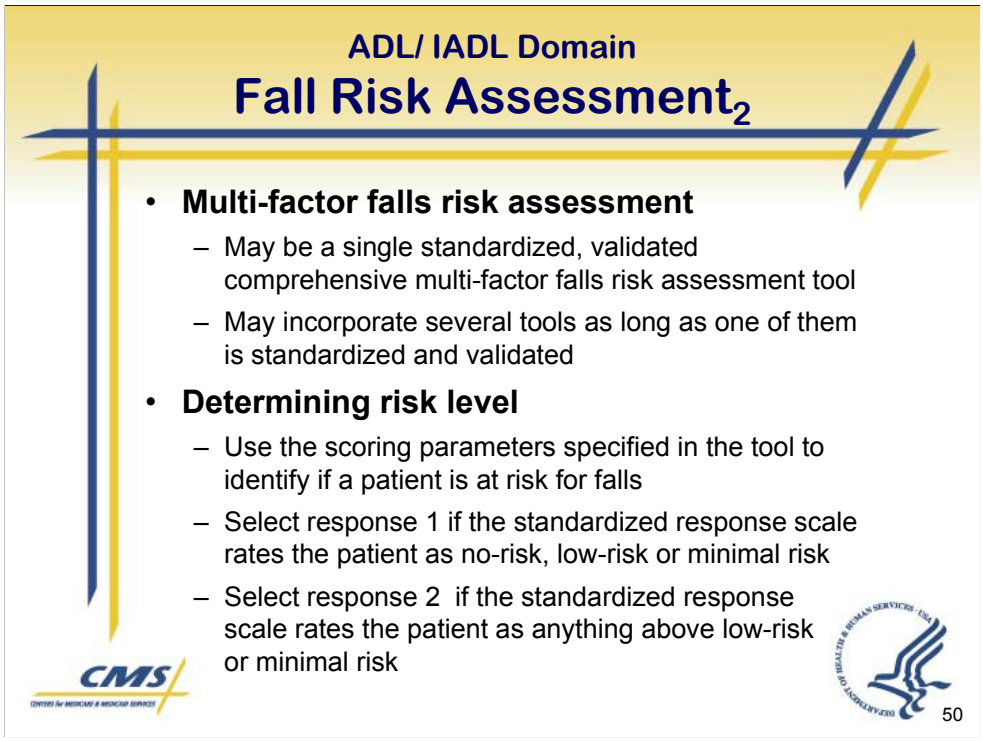
Identifies whether the home health agency has assessed the patient and home environment for characteristics that place the patient at risk for falls.

It is collected at SOC/ROC for quality measurement – because the scientific evidence of benefit for this care process has only been demonstrated for patients 65 and over, patients under the age of 65 will be excluded from the denominator of the publicly reported measure.

CMS does not mandate that clinicians conduct falls risk screening for all patients, nor is there a mandate for the use of a specific tool. However, to respond yes to this item, the falls 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 HHA during** the **CMS-specified time frames** for completion of the comprehensive assessment.

must have been completed by the clinician completing the SOC or ROC Comprehensive Assessment.



For Responses 1 and 2, an agency may use a single comprehensive multi-factor falls risk assessment tool that meets the criteria as described in the item intent.

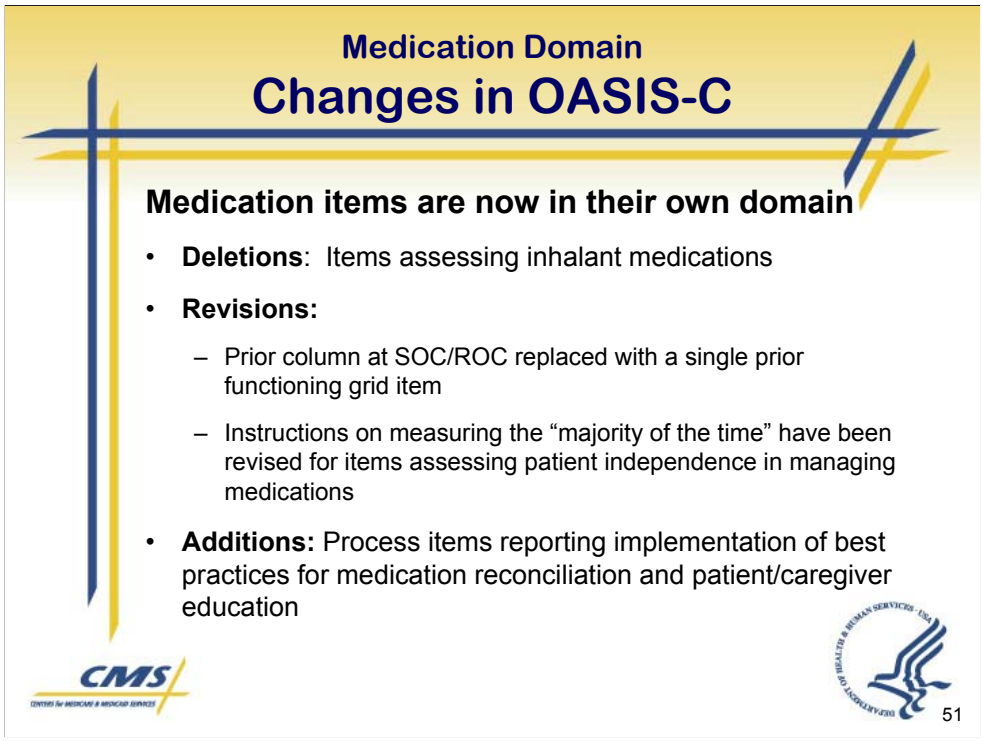
Alternatively, an agency may incorporate several tools as long as one of them meets the criteria as described in the item intent.

For example, a physical performance component (e.g., Timed Up and Go), a medication review, review of patient history of falls, assessment of lower limb function and selected OASIS items (e.g., OASIS items for cognitive status, vision, incontinence, ambulation, transferring).

Use the scoring parameters specified in the standardized tool to identify if a patient is at risk for falls.

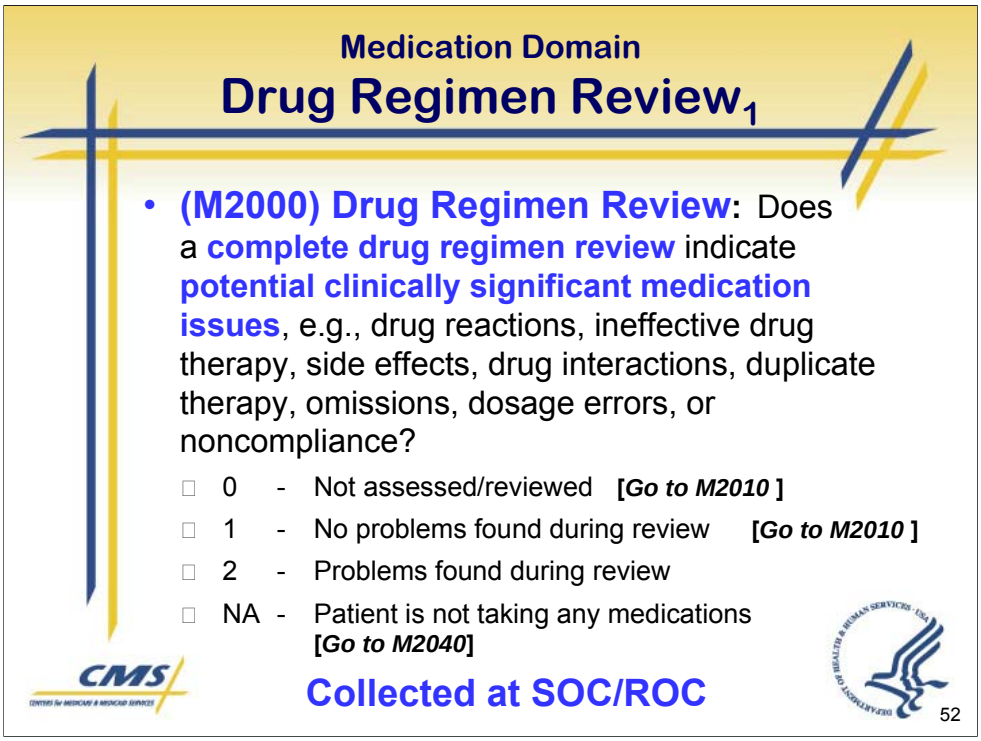
Select response 1 if the standardized response scale rates the patient as no-risk or low-risk. OR MINIMAL RISK

Select response 2 if the standardized response scale rates the patient as anything above low-risk OR MINIMAL RISK .



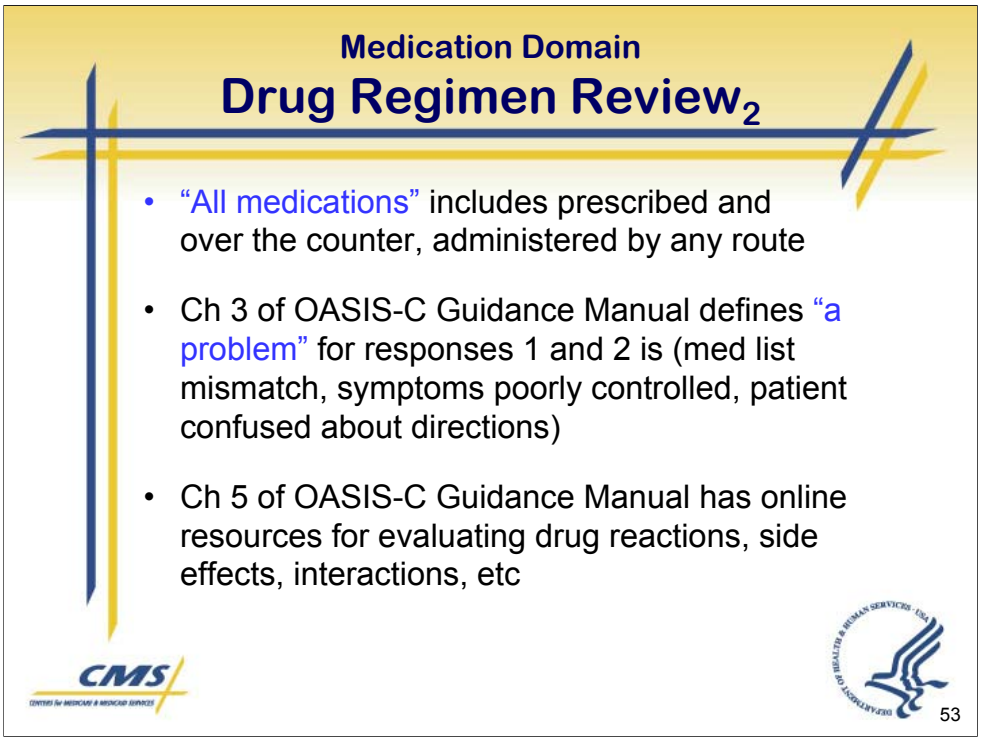
medication safety has become a prominent measure for all health care delivery systems, justifying its own domain

Significant changes have been made in addition.



M2000 is the first of 2 items that are asked at SOC/ROC and evaluate whether medication reconciliation was done and action taken if problems found – similar to the items on heart failure intervention. It is the only process that is actually required by the COPs

As with all process items, there is an option to say that the process was not implemented (response 0). There is also an option to indicate that a review was not necessary.



"All medications" includes prescribed and over the counter, administered by any route

e.g. oral, topical, inhalant, pump, injection

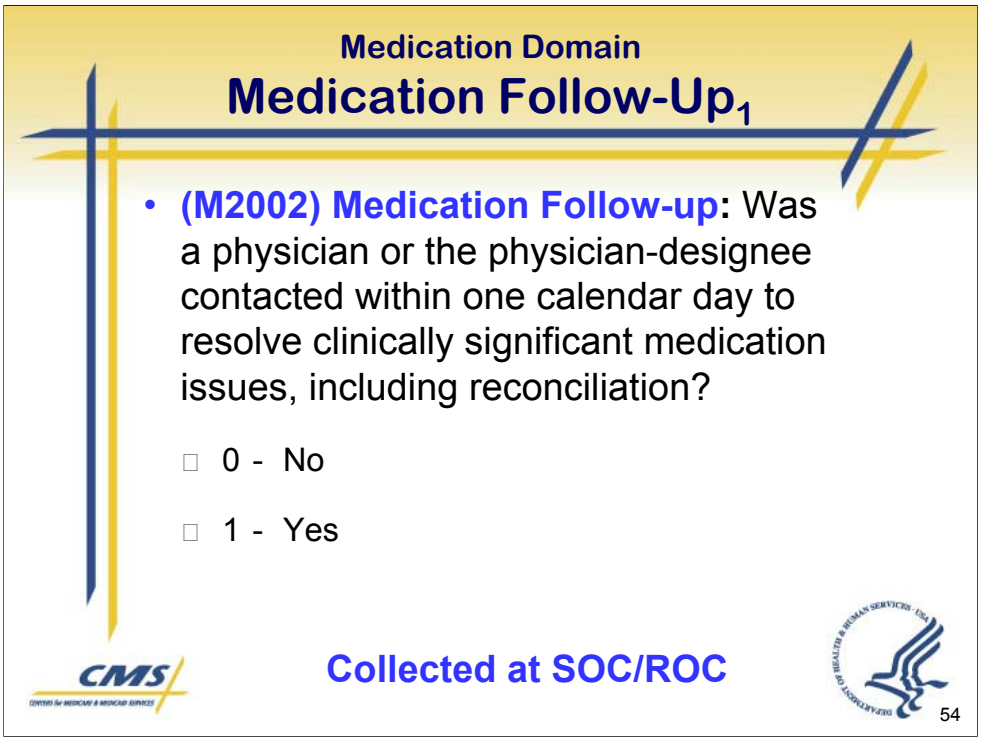
Definition of what is "a problem" for responses 1 and 2 is provided in the OASIS-C guidance manual and include

Patient's list of medications from the inpatient facility discharge instructions DO NOT match the medications the patient shows the clinician at the SOC/ROC assessment visit.

Assessment shows that diagnoses/symptoms for which patient is taking medications are NOT adequately controlled (as able to be assessed within the clinician's scope of practice).

Patient seems confused about when/how to take medications indicating a high risk for medication errors.

Online resources for evaluating drug reactions, side effects, interactions, etc. can be found in ch 5 of the manual



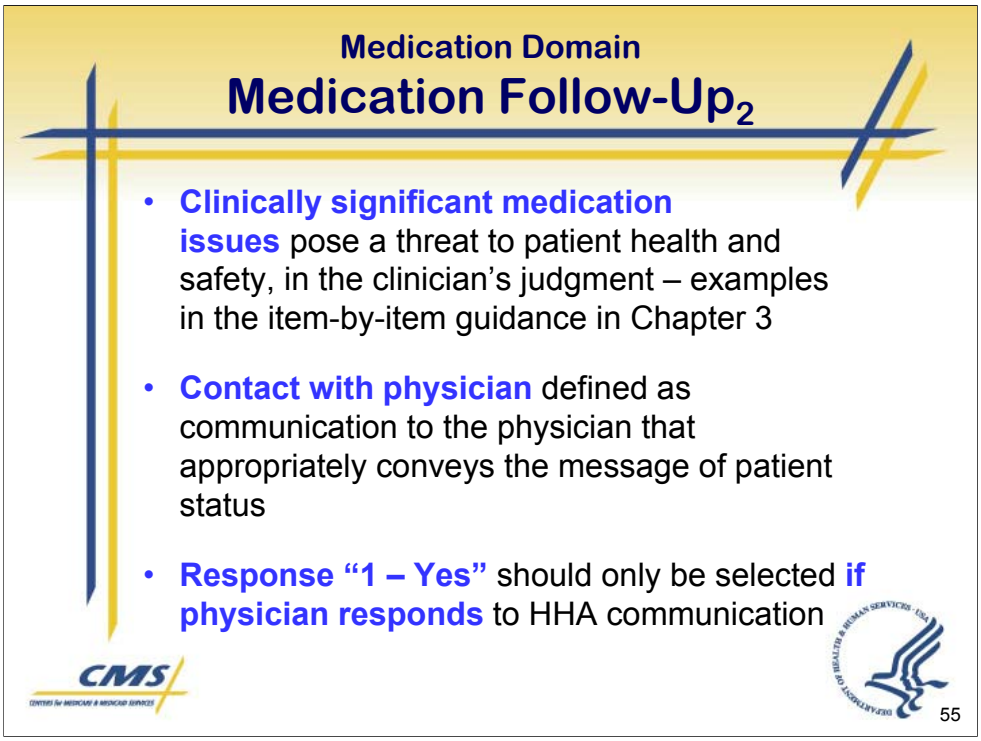
This item is used for the calculation of quality measures.

Process measure item

Identifies use of best practices.

Best practices not necessarily required by CoP.

Complete M2002 Med Follow-up if M2000 DRR = Response 2 “Problems found during review”.

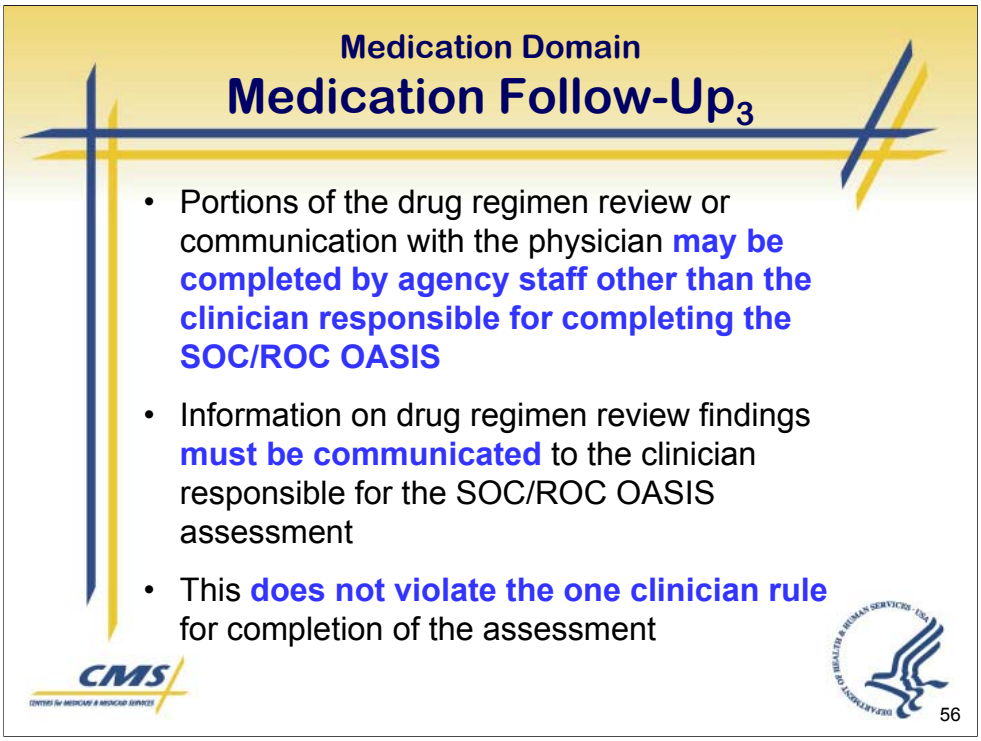


Clinically significant medication issues are those that pose an **actual or potential threat** to **patient health and safety**, in the **clinician's judgment**, such as:

> Drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, medication omissions, dosage errors, or nonadherence to prescribed medication regimen.

Contact with physician is defined as communication to the physician made by telephone, voicemail, electronic means, fax, or any other means that appropriately conveys the message of patient status.

Select "1 – Yes", **only** if a physician **responds** to HHA communication with acknowledgment of receipt of information and/or further advice or instructions



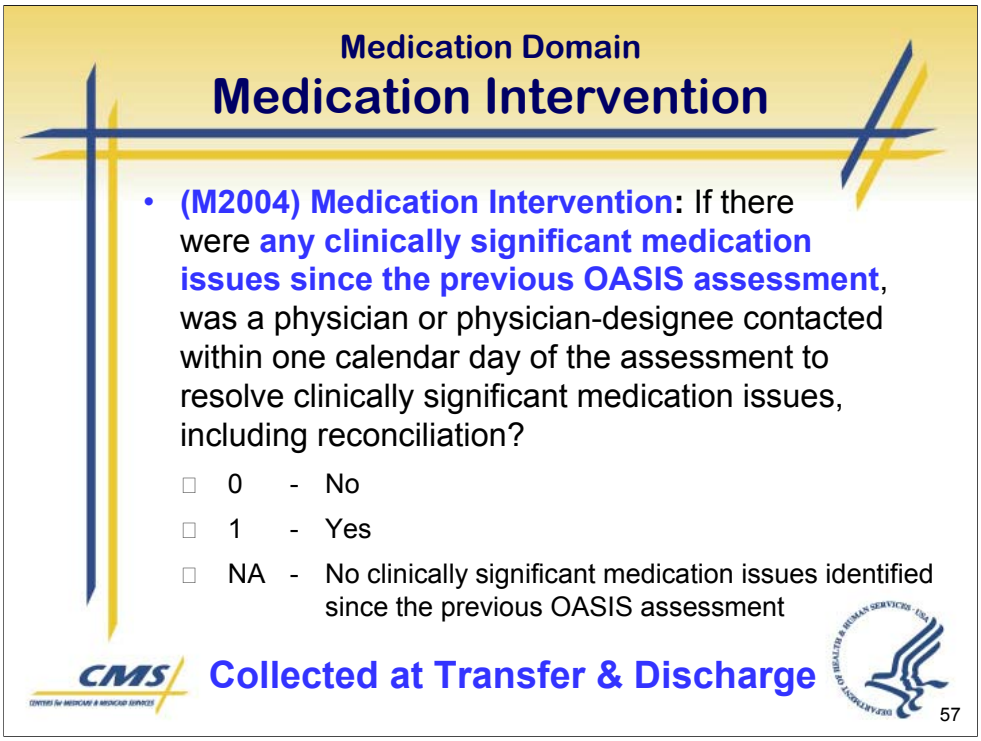
Portions of the drug regimen review or communication with the physician may be completed by agency staff other than the clinician responsible for completing the SOC/ROC OASIS.

However, information on drug regimen review findings and physician response **must** be communicated to the clinician responsible for the SOC/ROC OASIS assessment

Collaboration does not violate the one clinician rule for completion of the assessment.

E.g. the assessing clinician evaluates patient status (e.g., presence of potential ineffective drug therapy or patient noncompliance), and another clinician (in the office) assists with review of the medication list (e.g. for possible duplicate drug therapy or omissions).

Agency policy and practice will determine the collaborative process and how it is documented



The 2 prior items report what was done about medication problems identified at SOC/ROC. M2004 collects the same information at transfer and discharge about what action was taken to respond to medication issues that occurred since the last OASIS assessment. This item is used in the calculation of quality measures.

Process measure item Identifies use of best practices.

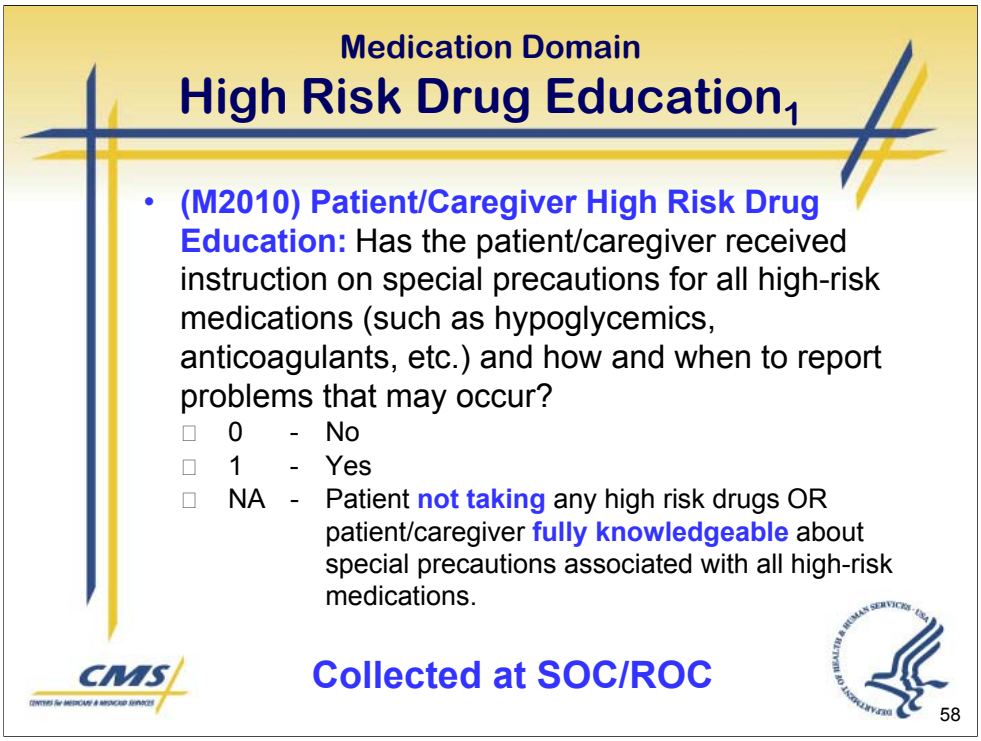
Best practices not necessarily required by CoP.

Identifies **if** potential clinically significant **problems** such as adverse effects or drug reactions **identified** at the time of the most recent OASIS assessment or after that time **were addressed with the physician.**

If the interventions were not completed as outlined in this item, select “0-No” and explain why not.

This item will require the clinician to “look back” at information contained in the medical record.

The guidance at M2002, Medication Follow-up, is repeated here



This item is collected at SOC/ROC and used in the calculation of quality measures.

Identifies if clinicians instructed the patient and/or caregiver about all high-risk medications the patient takes at SOC/ROC.

Targeted to high-risk medications for 2 reasons

Unrealistic to expect that patient education on all medications occur on admission.

Failure to educate on high-risk medications at SOC/ROC could have severe negative impacts on patient safety and health.

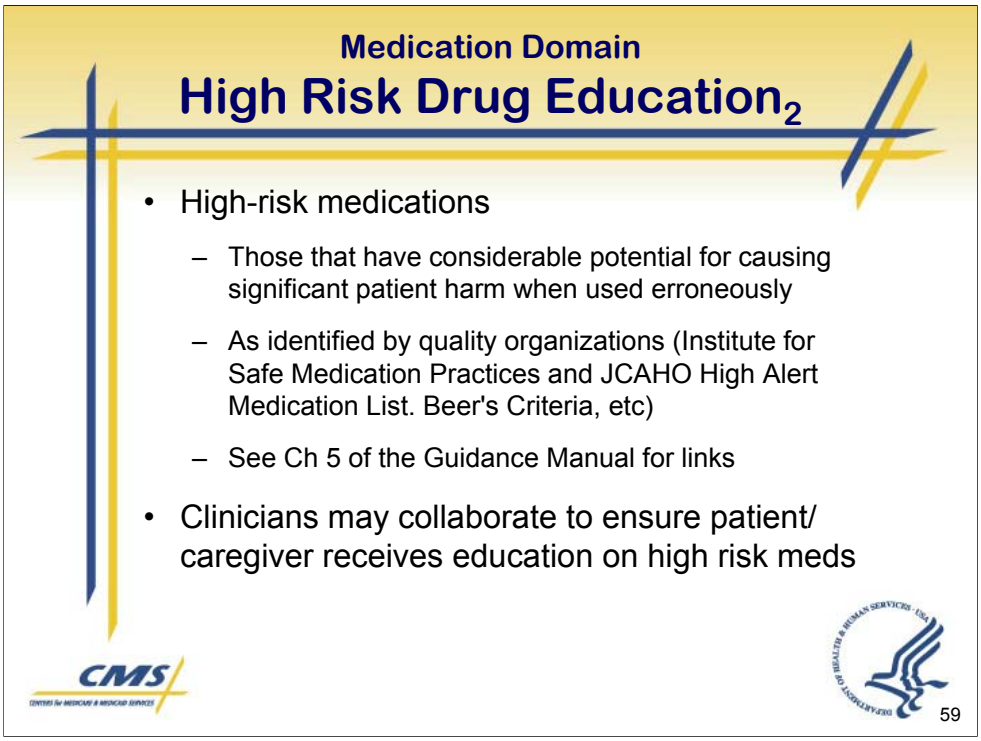
Process measure item

Identifies use of best practices.

Best practices not necessarily required by CoP.

Select “0 – No”, if the interventions are not completed as outlined in this item. Document **why not**, unless patient is not taking any drugs.

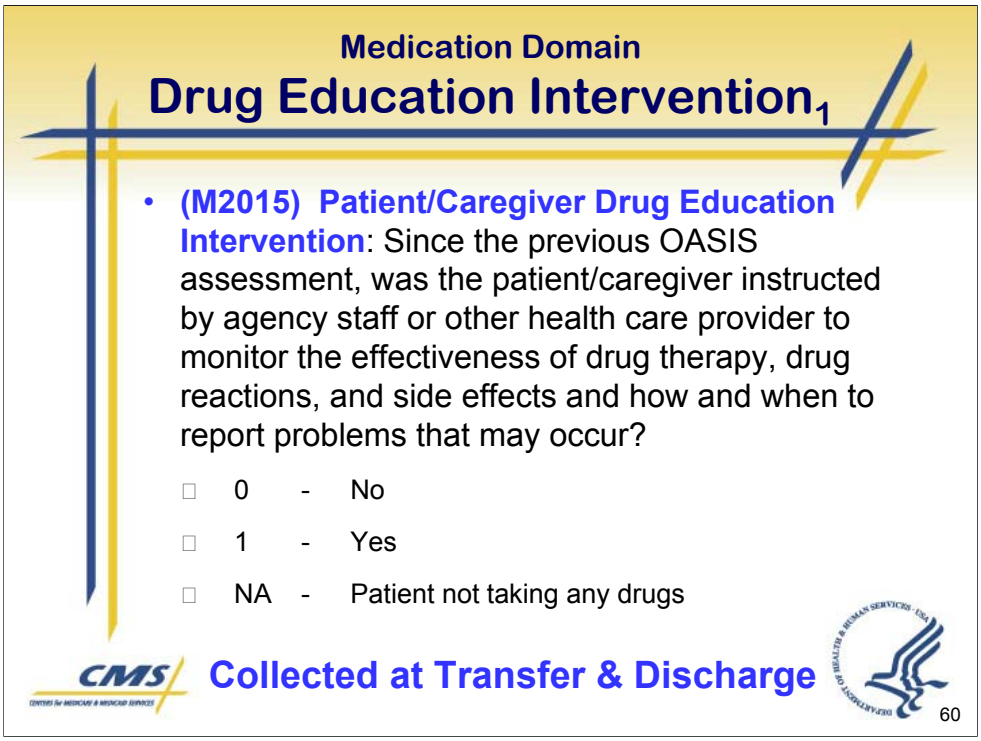
NA option allows documentation that either pt is not on any high risk meds or they have already been instructed by home health staff or others and is fully knowledgeable about special precautions associated with the high-risk medications they are prescribed



High-risk medications are those identified by quality organizations (Institute for Safe Medication Practices, JCAHO, etc.) as having considerable potential for causing significant patient harm when they are used erroneously.

Sources to identify high-risk medications for the purposes of responding to this item can include the ISMP High Alert Medication List, Beer's Criteria, Joint Commission's High Alert Medication lists, or other authoritative resources. Links to resources for identifying high-risk medications can be found in Chapter 5 of the guidance manual.

If agency staff other than the clinician responsible for completing the SOC/ROC OASIS provided education to the patient/caregiver on high-risk medications, this information must be communicated to the clinician responsible for the SOC/ROC OASIS assessment so that the appropriate response for M2010 may be selected. This collaboration does not violate the requirement that the comprehensive patient assessment is the responsibility of, and ultimately must be completed by one clinician.



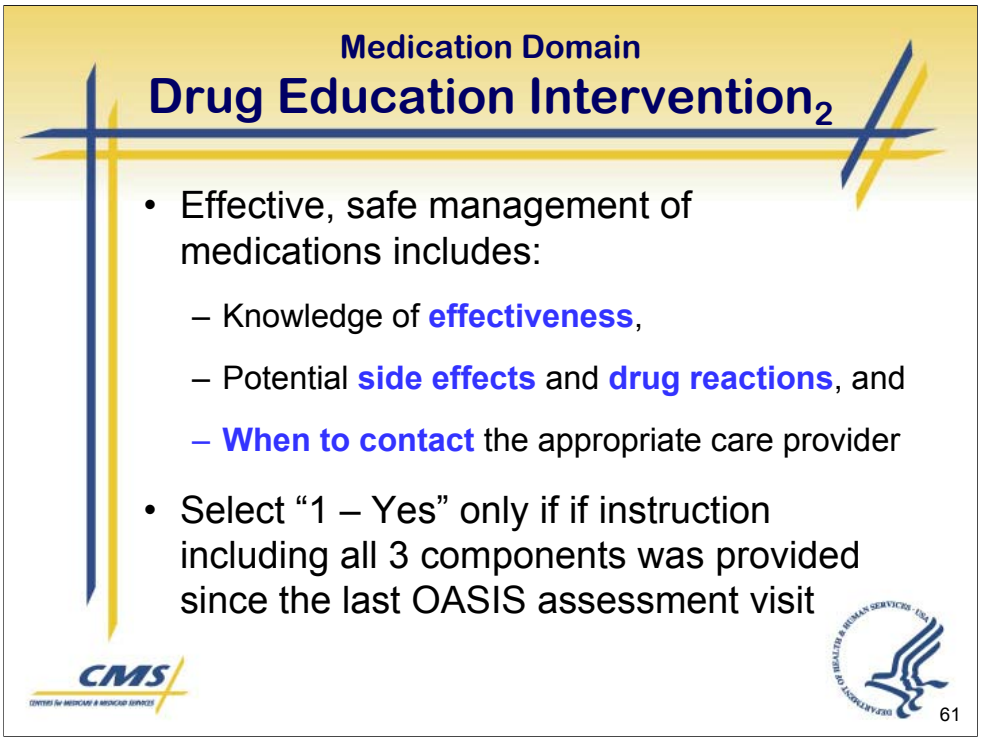
The previous item asked about drug education at admission and was limited to high risk meds – this item reports on the education that occurs during the home health stay since the last OASIS admission. It is used in the calculation of quality measures and will require that the clinician “look back” at clinical documentation to score accurately.

Identifies if clinicians instructed the patient/caregiver about how to manage medications effectively and safely.

Process measure item

Identifies use of best practices.

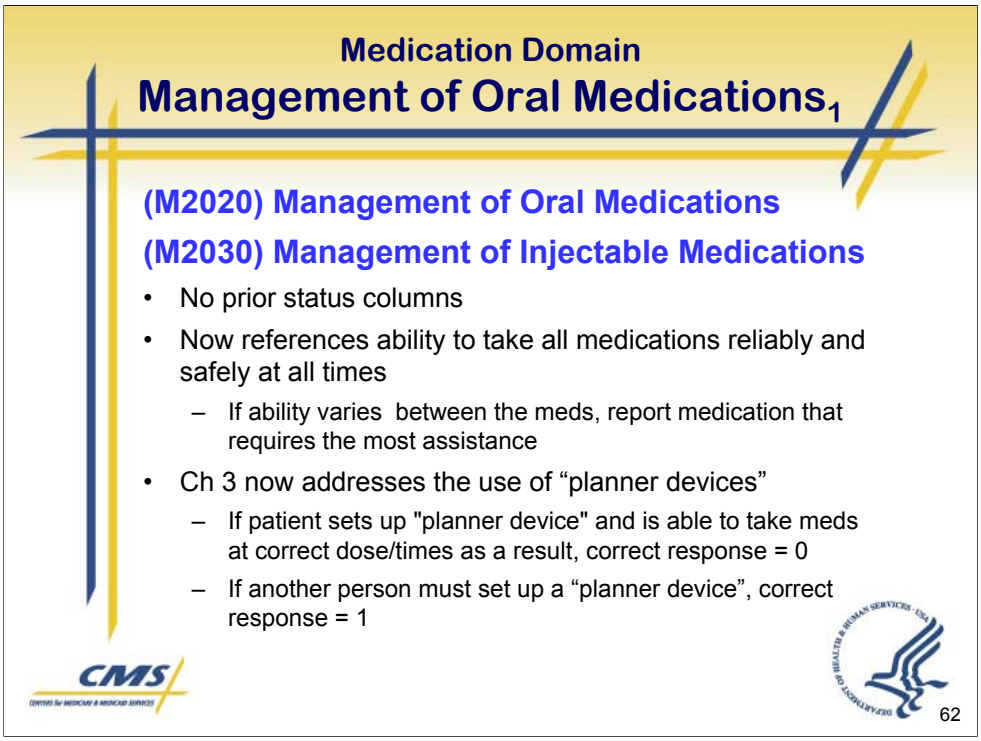
Best practices not necessarily required by CoP.



Effective, safe management of medications includes knowledge of effectiveness, potential side effects and drug

reactions, and when to contact the appropriate care provider.

Clinicians should review ch 3 of the Guidance Manual for more instructions about completing this item.



M2020, the management of oral med item is collected at SOC/ROC and DC. M2030. the management of injectable meds is collected at SOC/ROC, FU and DC. Both are used in the calculation of quality measures and both have undergone similar changes.

Prior status at SOC/ROC have been deleted

Another significant change is that in OASIS-B, med management has been considered as an IADL, and the IADL instructions were to address patient ability “more than 50% of the time.”

Medication management ability now addresses patient ability to manage all meds all of the time. Both M2020 and M2030 report on the ability to take **all** oral or **all** IM medications reliably and safely at **all** times.

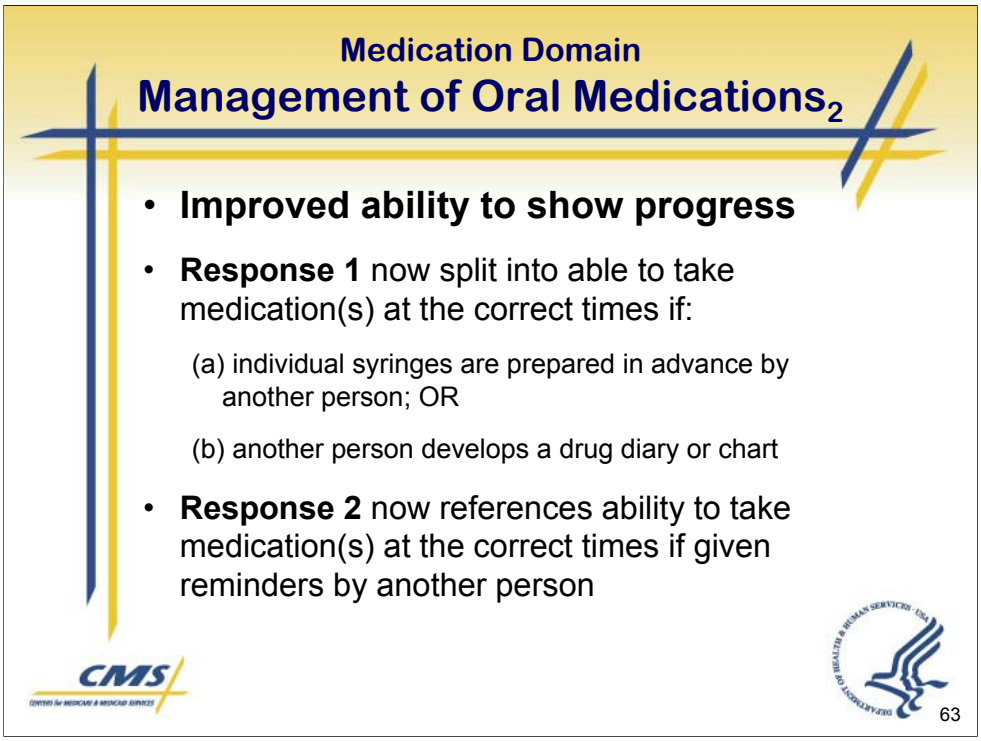
In each item, if the ability varies between the meds, report medication that requires the most assistance.

Guidance manual instructions now address the use of “planner devices”.

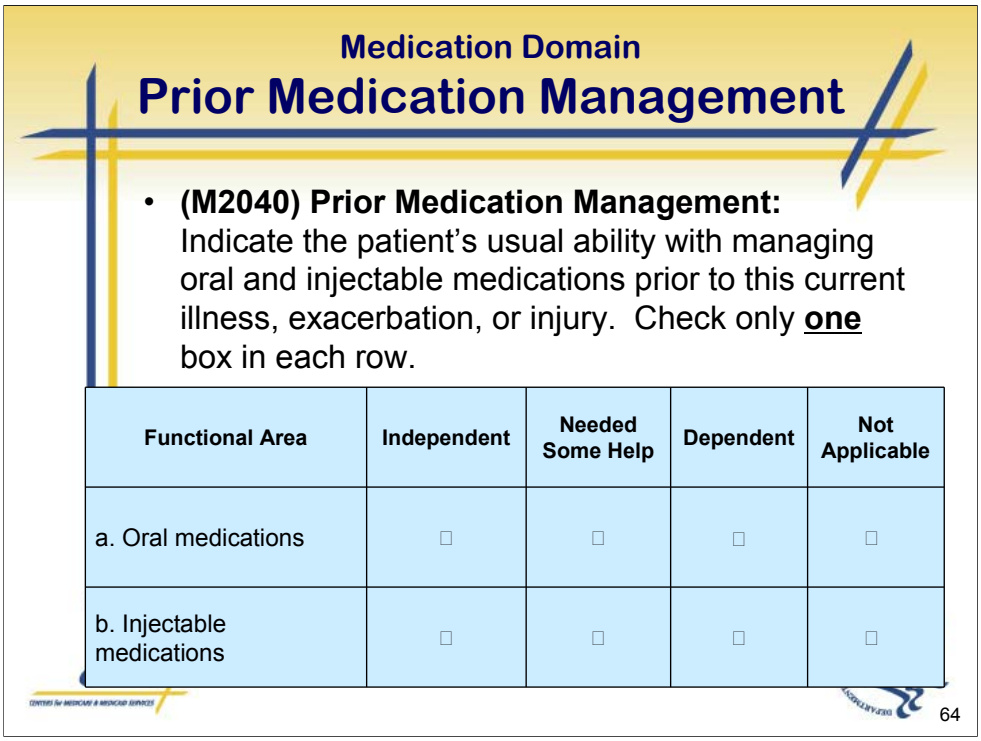
Reminders provided by a device that the patient can independently manage are not considered “assistance” or “reminders.”

CH3 guidance states if patient sets up her/his own "planner device" and is able to take the correct medication in the correct dosage at the correct time as a result. the clinician should choose response “0”

Select “1” if another person must prepare individual doses (e.g., set up a “planner device”) **and/or** if another person must develop a drug diary/chart which the patient relies on to take meds appropriately.



The items also allow increased ability to show improvement, so that if a pt goes from needing daily reminders from another person, to able to take correctly if meds are set up in advance, or a drug chart, diary or planner device is developed by another person, this will be reflected in the OASIS response.



Here is the new Prior functioning grid that is collected at SOC/ROC only and replaces the prior status column for the medications

Juat as with ADLs. an understanding of prior status can allow for appropriate goal setting and risk adjustment of outcomes.

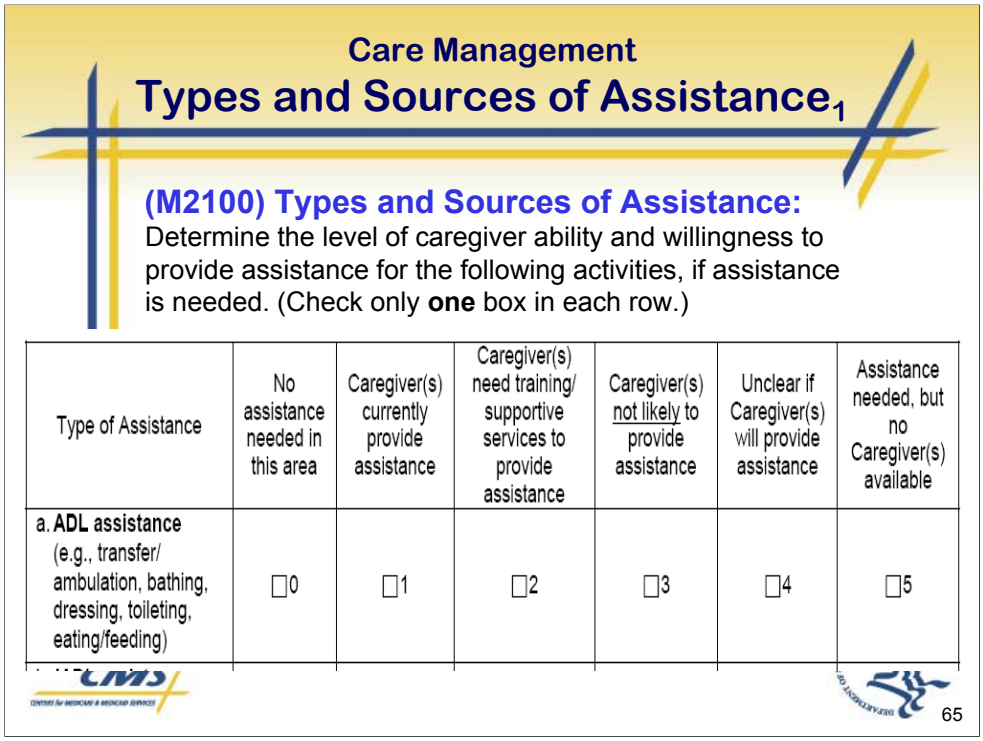
The new item identifies medication management ability **since the onset** of the **current illness**, **exacerbation of a chronic condition**, or **injury** (whichever is most recent) that initiated this episode of care.
Manual guidance states If patient experienced more than one illness, injury or exacerbation, refer to the most recent

If the patient's prior ability to manage oral or injectable medications varied from medication to medication, and

consider the medication for which the most assistance was needed when selecting a response.

Select only one response for each functional area (oral medications and injectable medications

Select Response "NA" if there were no oral medications (row a) or no injectable medications (row b) used.



M1100 reported information about the patient's living situation. There is now a domain called "Care management" that contains 2 additional items that report on caregiver availability and assistance that replace some of the B-1 items about living situation and primary care taker. It is located after the ADL/IADL and medication sections when clinician will have a better idea about patient abilities and need for assistance.

These items are asked at SOC/ROC and DC and used for risk adjustment.

M2100 identifies availability and ability of the caregiver(s) to provide categories of assistance needed by the patient. Concerned broadly with types of assistance, not just the ones specified in other OASIS items.

Refer to your highlighted version of the OASIS to see all the rows in the item.

Types of assistance include ADLs and IADLs, Medications and medical treatments (e.g., dressing changes), equipment management, supervision and safety, and advocacy and facilitation in getting medical care.

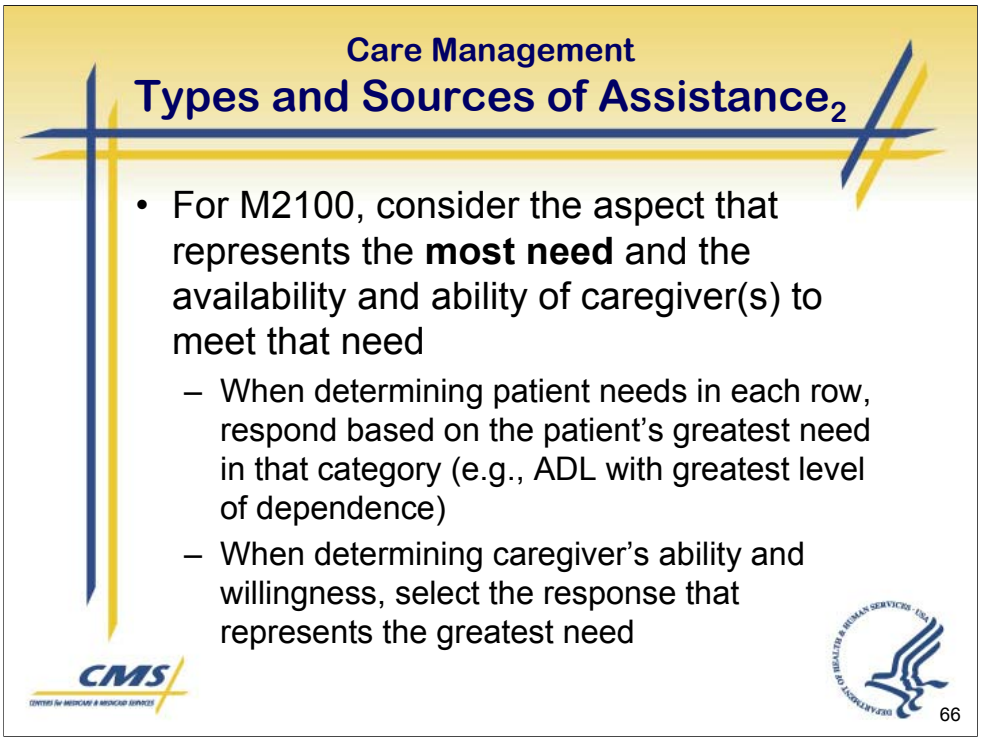
For each row a-g, select one description of caregiver assistance.

Example: patient may have been discharged home with caregiver who is not willing to assist or needs training – this item allows agencies to document those needs and the impact of their teaching

Ch 3 of the manual contains additional explanations of the activities included in each row.

There are also definitions of:

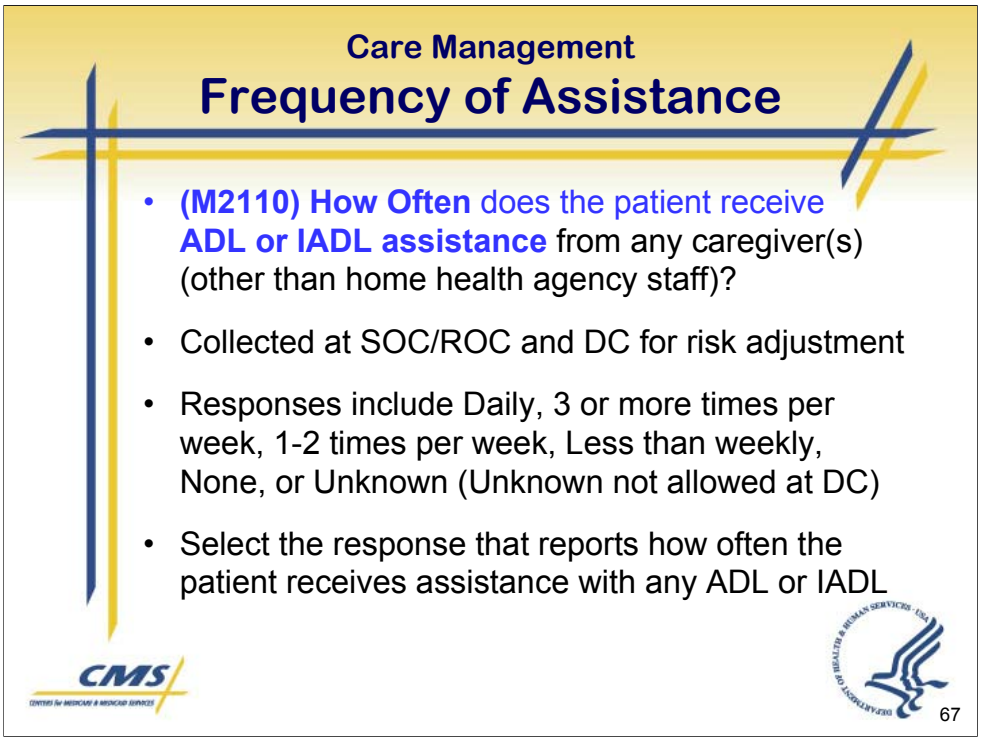
- "Caregiver(s) not likely to provide" - indicates that the caregiver(s) has indicated an unwillingness to provide assistance, or that the caregiver(s) is/are physically and/or cognitively unable to provide needed care.
- "Unclear if caregiver(s) will provide" - indicates that the caregiver(s) may express willingness to provide care, but their ability to do so is in question or there is reluctance on the part of the caregiver(s) that raises questions as to whether the caregiver will provide the needed assistance.



Note this item is asking you to report the task with which the caregiver needs the most help. Where is the greatest need?

If patient needs help with any aspect of a category of assistance (e.g., needs assistance with some IADLs but not others), consider the aspect that represents the most need and the availability and ability of the caregiver(s) to meet that need.

If more than one response in a row applies, (e.g., the caregiver(s) provides the assistance but also needs training or assistance), select the response that represents the greatest need ("caregiver(s)needs training/supporting services to provide assistance").



Identifies the frequency of the assistance with ADLs or IADLs. provided by any non-agency caregivers

Concerned broadly with ADLs and IADLs, not just the ones specified in other OASIS items.

Select the response that reports how often the patient receives assistance with **any** ADL or IADL.

Based on responses to M1100 on living situation, M2100 on ability of caregiver to provide assistance, and M2110 on frequency of assistance, CMS should have sufficient information to risk adjust patient outcomes, and agencies should have information needed to plan care and discharge needs.

This is another item it would be better for you to view looking at the OASIS all-time points version.

M2250 identifies if the physician-ordered home health POC incorporates specific best practices.
This item supports process measures. HHAs are not required by CoPs to put the best practices specified on the plan of care. HHAs may select "no," but may want to support the decisions in the clinical record. CMS recognizes that the best practices may not be appropriate for some patients, thus does not expect to see a rate of 100% for any of the process measures derived from this item.

Select "No" if the best practice interventions specified in this item are **not** included in the POC.

Select NA if the specified best practice is not appropriate for that patient as described in the NA column. For example, diabetic foot care and education is NA if the patient is not diabetic.

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

the patient condition has been **discussed** with the physician

there is **agreement** as to the plan of care between the home health staff and the physician

Verbal orders are fine -, the clinical record should reflect **evidence of communication with the physician** to include specified best practice interventions in the POC

Review Chapter 3 guidance carefully for:

Acceptable POC interventions

> E.g., for **Row a:** Select "Yes" if the physician-ordered POC contains specific clinical parameters relevant to patient's condition that, when exceeded, would indicate that the physician should be contacted. The parameters may be ranges and may include temp, pulse, respirations, BP, weight, wound measurements, pain intensity ratings, intake and output measurements, blood sugar levels, or other relevant clinical assessment findings.

Timeframe: Plan of Care orders must be in place within the 5-day SOC window and the 2-day ROC window in order to meet the measure definition

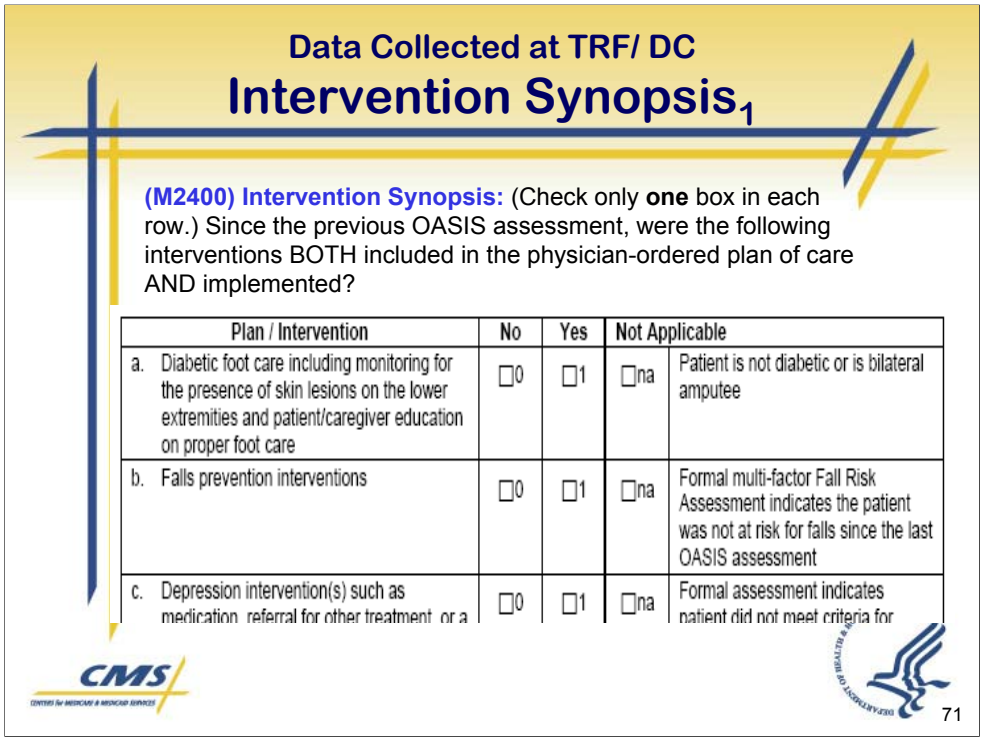
Collaboration: If the assessing clinician chooses to wait to complete M2250 until after discussion with another discipline that has completed their assessment and care plan development, this does not violate the requirement that the comprehensive assessment be completed by one clinician within the required time frame (five days for SOC, two days for ROC).

For example, if the RN identifies fall risk during the SOC comprehensive assessment, the RN can wait until the PT conducts his/her evaluation and develops the PT care plan to determine if the patient's Plan of Care includes interventions to prevent fall risk. The M0090 date should reflect the last date that information was gathered that was necessary for completion of the assessment.Responses to M2300 item will be reported in OBQI reports and can be used by the agency to enhance their understanding of pt outcomes

Example: low rate of adherence for "Multifactor Fall Risk Assessment Conducted for Patients 65 and Over"

If the HHA also had a high rate of emergency care due to falls, the relationship between these two measures should be evaluated as part of an outcome-based quality improvement (OBQI) initiative

Is one possible reason for the high rate of emergency care use (outcome) related to a low percentage of patients receiving a falls risk assessment (process)?



•M2400 is the new intervention synopsis item which is located in the last section of the OASIS. **collected at Transfer and Discharge supports measures of care process implementation**

It Identifies if physician-ordered interventions focused on diabetic foot care, falls prevention, depression, pain, and preventing and treating pressure ulcers. specific problems were **both** included on the physician-ordered home health plan of care.

AND

Implemented as part of care provided during the home health care episode.

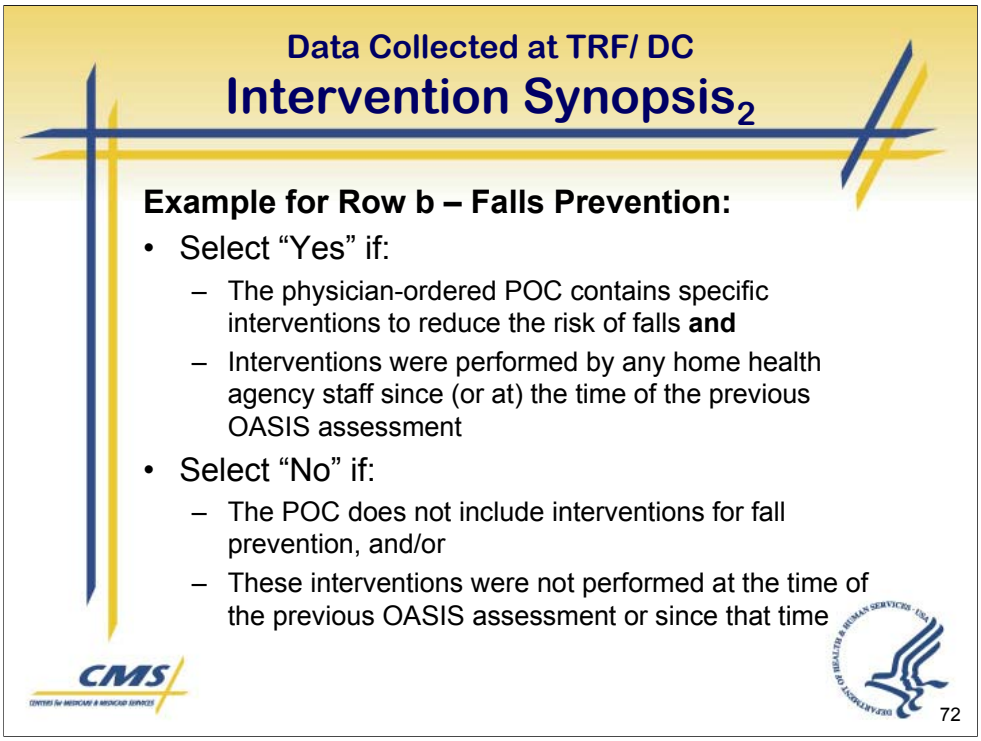
At the time of the previous OASIS assessment **or** since that time.

•"Look back" has been specified to collect data on whether specific interventions that were included in the physician-ordered plan of care were implemented at the time of the previous OASIS assessment or since that time. This requires knowledge both of the plan of care AND for visits across the home health episode of care: agencies may elect to do this in different ways (i.e., E.H.R., flowsheet, etc.)

•This item supports process measures. HHAs are not required by CoPs to put the best practices specified on the plan of care. HHAs may select "no," but likely will want to support the decisions in the clinical record. CMS recognizes that the best practices may not be appropriate for some patients, thus does not expect to see a rate of 100% for any of the process measures derived from this item.

The item includes options for clinicians to indicate if an intervention was not appropriate for the patient.

Responses will be used to support both publicly reported measures and OBQI/OBQM measures on evidence-based practice implementation.



Example:

Row b: Select "Yes" if the physician-ordered POC contains:

Specific interventions to reduce the risk of falls **and** the clinical record contains documentation that these interventions were performed at the time of the previous OASIS assessment or since that time.

Could be Environmental changes, strengthening exercises, and consultation with the physician regarding med concerns are examples of possible falls prevention interventions.

Not e that interventions provided by home health agency staff, including the assessing clinician, may be reported by the

assessing clinician in M2400. For example, if the RN finds a patient to be at risk for falls, and the physical

therapist implements fall prevention interventions included on the plan of care prior to the end of the allowed

assessment time frame, the RN may select "Yes" for row b of M2400. The M0090 Date Assessment

Completed should report the date the last information was gathered to complete the Comprehensive

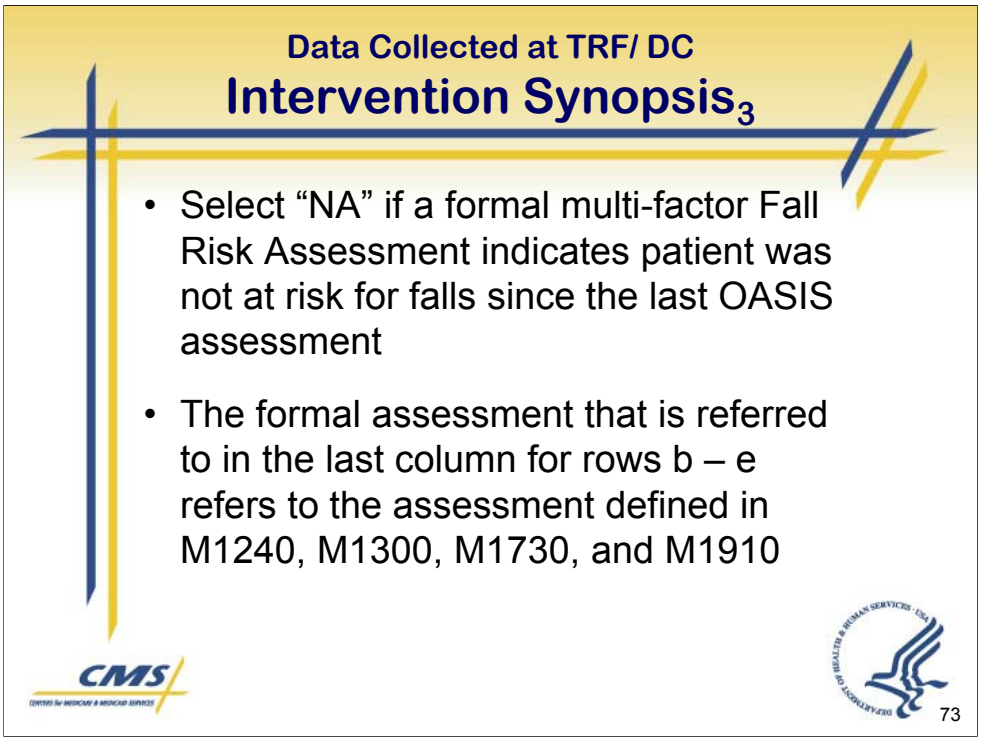
Assessment.

Row b: Select "No" if the POC does not include interventions for fall prevention.

And/or

No documentation in the clinical record that these interventions were performed at the time of the previous OASIS assessment or since that time.

Mark "No" whether or not an assessment for falls risk was conducted.



Select “NA” if a formal multi-factor Fall Risk Assessment indicates patient was not at risk for falls since the last OASIS assessment

The formal assessment that is referred to in the last column for rows b – e refers to the assessment defined in M1240, M1300, M1730, and M1910.

So for falls risk assessment, it must have been a standardized validated risk assessment as specified in M1910.

Rely on CMS Guidance Resources[1]

IMPORTANT: This overview will NOT take the place of a careful review and frequent referencing of the OASIS-C Guidance Manual & Q&As

OASIS-C Guidance Manual

- www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp

Q&As

- https://www.qtso.com/hhadownload.html
- www.oasiscertificate.org

Rely on CMS Guidance Resources$_2$

For DATA COLLECTION questions not already addressed in the OASIS-C Guidance Manual or posted Q&As, contact your state OASIS Education Coordinator (OEC):
www.cms.hhs.gov/OASIS 06_EducationCoord.asp

Or submit to:
CMSOASISquestions@oasisanswers.com