



# Highlights of OASIS-C Changes by Section

## Train the Trainer - Part 2 of 3



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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



## Session 2 Learning Objectives

- **IMPORTANT:** This review will NOT take the place of a careful review of the OASIS-C Guidance Manual and frequent referencing of the manual while OASIS-C is still new to you
  - **Review Chapter 3** for detailed guidance
  - **Refer to Q&As** for clarifications/refinements
    - <https://www.qtso.com/hhdownload.html>
    - [www.oasiscertificate.org](http://www.oasiscertificate.org)



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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 3<sup>rd</sup> 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

## Session 2 - Reference Materials

- OASIS-C Guidance Manual
  - Chapter 1 - OASIS Conventions (Table 4)
  - Chapter 2 - Highlighted OASIS-C “All Time Points” version
  - Chapter 3 – Item by Item Guidance



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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.

## Clinical Record Items Domain

### Timely Care<sub>1</sub>

- Two new items:
  - (M0102) Date of Physician-ordered Start of Care (Resumption of Care)
  - (M0104) Date of Referral
- Added to support process measure on Timely Care
- Collected only at SOC/ROC



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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.

## Clinical Record Items Domain

### Timely Care<sub>2</sub>

- **(M0102) Date of Physician-ordered Start of Care (Resumption of Care)**
  - If the physician indicated a specific date for SOC/ROC, enter the date and **SKIP M0104**
  - Otherwise, select NA – No specific SOC date ordered - and GO TO M0104 to enter date of referral
  - If original physician-ordered SOC/ROC date gets delayed, the updated/revised date would be entered



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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.

## Clinical Record Items Domain

### Timely Care<sub>3</sub>

- **(M0104) Date of Referral**
  - Most recent date that verbal, written, or electronic authorization to begin home care was received by the HHA
  - If SOC/ROC gets delayed, enter the date the agency received the updated/revised referral information
  - Communications from assisted living facility staff or family do not constitute a referral



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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.

## Patient History & Diagnosis Domain Immunizations<sub>1</sub>

- **4 New Items report immunization status**
  - (M1040) Influenza Vaccine
  - (M1045) Reason Influenza Vaccine not received
  - (M1050) Pneumococcal Vaccine
  - (M1055) Reason PPV not received
- **Collected at Transfer & Discharge**
  - Used for publicly-reported measures of immunization rates
  - Harmonized with other care settings



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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.



## Patient History & Diagnosis Domain Immunizations<sub>2</sub>

- **Focus:** is patient **up to date on flu vaccine** and have they **ever had a PPV?**
- **Initial question:** did you give the vaccine during the episode?
  - Asked **at Transfer/Discharge** – episode defined as from SOC/ROC to transfer or DC
  - If the answer is yes, you are done
- **Follow-up question: if the answer is no, then explain why**



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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

## Patient History & Diagnosis Domain Immunizations<sub>3</sub>

- **(M1040) Influenza Vaccine:** Did the patient receive the influenza vaccine **from your agency** for this year's influenza season (October 1 through March 31) **during this episode of care?**
  - 0 - No
  - 1 - Yes [ **Go to M1050** ]
  - NA - Does not apply because **entire episode** of care (SOC/ROC to Transfer/ Discharge) is outside this influenza season [ **Go to M1050** ]



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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

## Patient History & Diagnosis Domain Immunizations<sub>4</sub>

- **(M1045) Reason Influenza Vaccine not received:**  
If the patient did not receive the influenza vaccine from your agency during this episode of care, **state reason:**
  - 1 - Received from another health care provider (e.g., physician)
  - 2 - Received from your agency previously during this year's flu season
  - 3 - Offered and declined
  - 4 - Assessed and determined to have medical contraindication(s)
  - 5 - Not indicated; patient does not meet age/ condition guidelines for influenza vaccine
  - 6 - Inability to obtain vaccine due to declared shortage
  - 7 - None of the above



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- 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

## Patient History & Diagnosis Domain

### Immunizations<sub>5</sub>

- (M1050) **Pneumococcal Vaccine**: Did the patient receive pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC Transfer/Discharge)?
  - 0 - No
  - 1 - Yes [ *Go to M1500 at TRN; Go to M1230 at DC* ]



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**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

## Patient History & Diagnosis Domain Immunizations<sub>6</sub>

- **(M1055) Reason PPV not received:** If patient did not receive the pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge), **state reason:**
  - 1 - Patient **has received PPV in the past**
  - 2 - Offered and declined
  - 3 - Assessed and determined to have medical contraindication(s)
  - 4 - Not indicated; patient does not meet age/condition guidelines for PPV
  - 5 - None of the above



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The follow-up PPV question, like the flu vaccine, allows the agency to report whether there was a legitimate reason for the fact that the patient 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.

## Living Arrangements Domain Patient Living Situation<sub>1</sub>

- **Replaced 6 Oasis-B1 items collected at SOC/ROC:**
  - (M0300) Current Residence:
  - (M0340) Patient Lives With:
  - (M0350) Assisting Person(s) Other than Home Care Agency Staff
  - (M0360) Primary Caregiver
  - (M0370) How Often does the patient receive assistance from the primary caregiver?
  - (M0380) Type of Primary Caregiver Assistance
- **With 3 New Items collected at SOC/ROC**



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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

## Living Arrangements Domain Patient Living Situation<sub>2</sub>

### First item: (M1100) Patient Living Situation:

Which of the following best describes the patient's residential circumstance and availability of assistance? (Check one box only.)

Living Arrangement	Availability of Assistance				
	Around the clock	Regular Daytime	Regular Nighttime	Occasional/short-term assistance	No assistance available
a. Patient lives alone	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 03	<input type="checkbox"/> 04	<input type="checkbox"/> 05
b. Patient lives with other person(s) in the home	<input type="checkbox"/> 06	<input type="checkbox"/> 07	<input type="checkbox"/> 08	<input type="checkbox"/> 09	<input type="checkbox"/> 10
c. Patient lives in congregate situation (e.g. assisted living)	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 13	<input type="checkbox"/> 14	<input type="checkbox"/> 15

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<sub>3</sub>



- **(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**





**Sensory Status Domain**  
**Pain Assessment<sub>1</sub>**

- Deleted - (M0430) Intractable Pain
- Added **(M1240) Has this patient had a formal Pain Assessment** using a standardized pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?
  - 0 - No standardized assessment conducted
  - 1 - Yes, and it does not indicate severe pain
  - 2 - Yes, and it indicates severe pain

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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.

## Sensory Status Domain Pain Assessment<sub>2</sub>

### M1240 – Pain Assessment

- **CMS does not mandate pain assessment or endorse a specific tool**, but tool selected must:
  - Be conducted according to instructions
  - Be appropriate for the patient
- “Standardized tool” is one that includes a standard response scale (e.g., 0-10 pain scale)
- “Severe pain” is defined according to the scoring system for the standardized tool being used
- See links to resources in Chapter 5 of Guidance Manual



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

## Integumentary Status Domain Pressure Ulcers

### Many changes to Pressure Ulcer items:

- (M1300) Pressure Ulcer Risk Assessment - **NEW**
- (M1302) Pressure Ulcer Risk - **NEW**
- (M1307) Oldest Non-epithelialized Stage II Pressure Ulcer that is present at discharge - **NEW**
- (M1308) Current Number of Pressure Ulcers Table – **Revised**
- (M1310/M1312/M1314) Pressure Ulcer Length, Width & Depth - **NEW**



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

## Integumentary Status Domain Pressure Ulcer Risk Assessment<sub>1</sub>

- **(M1300) Pressure Ulcer Assessment: Was this patient assessed for Risk of Developing Pressure Ulcers?**
  - 0 - No assessment conducted  
**[ Go to M1306 ]**
  - 1 - Yes, based on an **evaluation of clinical factors**, e.g., mobility, incontinence, nutrition, etc., without use of standardized tool
  - 2 - Yes, using a **standardized tool**, e.g., Braden, Norton, other



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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.

## Integumentary Status Domain Pressure Ulcer Risk Assessment<sub>2</sub>

- **(M1302) Does this patient have a Risk of Developing Pressure Ulcers?**

- 0 - No
- 1 - Yes

- *If using standardized tool, use tool's scoring parameters to identify risk*

- *If using clinical factors, clinician or agency must define what constitutes risk*



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

## Integumentary Status Domain Pressure Ulcers – Stage II or Higher<sub>1</sub>

- **(M1306)** Does this patient have at least one **Unhealed Pressure Ulcer at Stage II or Higher** or designated as "unstageable"?
  - 0 - No [ **Go to M1322** ]
  - 1 - Yes

*At SOC/ROC, allows the clinician to skip the next 5 questions if the patient does not have a Stage II or higher pressure ulcer*



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)

## Integumentary Status Domain Pressure Ulcers – Stage II or Higher<sub>2</sub>

- **Clinicians will need to study and refer to Chapter 3** in the guidance manual to know how to respond to M1306 and M1308
- **Guidance about counting fully epithelialized Stage II, III and IV ulcers has not changed**
  - Closed Stage II are **still NOT counted** in this item
  - Closed Stage III and IV ulcers are **still counted**



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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.

**Integumentary Status Domain**  
**Unhealed Pressure Ulcers<sub>1</sub>**

- **(M1307) The Oldest Non-epithelialized Stage II Pressure Ulcer** that is present at discharge
  - 1 - Was present at the most recent SOC/ROC assessment
  - 2 - Developed since the most recent SOC/ROC assessment: record date pressure ulcer first identified:  
 \_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_ \_\_\_  
 month / day / year
  - NA - No non-epithelialized Stage II pressure ulcers are present at discharge

**Collected at Discharge ONLY**

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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.



## Integumentary Status Domain Unhealed Pressure Ulcers<sub>2</sub>

- **Respond 1 or 2 only if discharging with an unhealed Stage II pressure ulcer**
- If more than one unhealed Stage II pressure ulcer, determine which one is the oldest
- If the oldest Stage II Pressure Ulcer was present at the last SOC/ROC select response 1
- If the oldest Stage II Pressure Ulcer present at discharge developed since the last SOC/ROC
  - Select response 2
  - Record the date the ulcer was first identified



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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 1<sup>st</sup> 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

## Integumentary Status Domain Pressure Ulcer Count<sub>1</sub>

- (M1308) Current Number of Unhealed (non epithelialized) Pressure Ulcers at Each Stage: (Enter “0” if none; excludes Stage I pressure ulcers)

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
Stage description – unhealed pressure ulcers	<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>
a. <b>Stage II:</b> Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.	—	—
b. <b>Stage III:</b> Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the	—	—



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**

## Integumentary Status Domain Pressure Ulcer Count<sub>2</sub>

### What's new in M1308:

- Stage I pressure ulcers are not counted
- Number of ulcers at each stage is documented
- Unstageable ulcers are broken out into reason for unstageable
- 2nd column at FU and DC identifies ulcers that were present on admission
  - Tracks whether an ulcer developed during a quality episode



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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 2<sup>nd</sup> column which is answered at FU and DC that identifies ulcers that were present on admission

Why was the 2<sup>nd</sup> 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 2<sup>nd</sup> 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**

## Integumentary Status Domain Pressure Ulcer Count<sub>3</sub>

- (M1308) **Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage:**  
(Enter "0" if none; excludes Stage I pressure ulcers)

**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.**

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
	Number Currently Present	Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)
Number of unhealed pressure ulcers		
Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with a red wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Partial thickness loss may also include ulcers of the heel with removal of callus and biofilm. Slough or eschar is not present. May include undermining and tunneling.	—	—
Stage III: Full thickness tissue loss. Slough, eschar or fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the wound bed. Tissue loss may include undermining and tunneling.	—	—
Stage IV: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.	—	—
Unstageable: Known or likely but unstageable because of slough and/or eschar covering the wound bed.	—	—
Unstageable: Suspected deep tissue injury in evolution.	—	—



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.

## Integumentary Status Domain Pressure Ulcer Count<sub>4</sub>

- (M1308) Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage:  
(Enter "0" if none; excludes Stage I pressure ulcers)

**For Column 2, report the number of unhealed Stage II or higher pressure 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.**

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
Unhealed pressure ulcers	Number Currently Present	Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)
a. Stage I: A shallow open ulcer with red, intact or open/ruptured serum-	—	—
b. Stage II: Partial thickness tissue loss. Fat may be visible but bone, tendons, ligaments, or cartilage are not exposed. Slough or eschar is not present. May include undermining and tunneling.	—	—
c. Stage III: Full thickness tissue loss with slough or eschar present on some parts of the wound bed. Often includes undermining and tunneling.	—	—
d. Stage IV: Full thickness tissue loss with exposed tendon, ligament, muscle, bone, or cartilage. Slough or eschar is present on some parts of the wound bed. Often includes undermining and tunneling.	—	—
e. Suspected deep tissue injury in evolution. Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.	—	—
f. Unstageable: Suspected deep tissue injury in evolution. Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.	—	—



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.

## Integumentary Status Domain Pressure Ulcer Dimensions<sub>1</sub>

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

- Reports dimensions of pressure ulcer **with the largest surface area** that is:
  - **Stage III or IV** not covered with epithelial tissue
  - **Unstageable** due to eschar or slough
- Skip if no stage III, IV or unstageable
- If multiple open stage III, IV or unstageable ulcers, measure to see which has largest surface area



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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<sub>2</sub>

### 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



## Integumentary Status Domain Pressure Ulcer Healing Status<sub>1</sub>

- **M1320 Status of Most Problematic (Observable) Pressure Ulcer**

- 0 - Newly epithelialized
- 1 - Fully granulating
- 2 - Early/partial granulation
- 3 - Not healing
- NA - No observable pressure ulcer



**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.**



## Integumentary Status Domain Pressure Ulcer Healing Status<sub>2</sub>

- **M1320 Status of Most Problematic (Observable) Pressure Ulcer**
  - Response 0 – **Newly Epithelialized** - epithelial tissue has completely covered wound surface *regardless of how long the pressure ulcer has been re-epithelialized*
  - Response 1 – **Fully Granulating** - epithelial tissue has not completely covered the wound surface
  - Response 2 – **Early/partial Granulation** - necrotic or avascular tissue covers <25% of the wound bed
  - Response 3 - **Not Healing**, for a Stage III or IV pressure ulcer if the wound has  $\geq 25\%$  necrotic or avascular tissue
- Refer to the OASIS-C Guidance Manual and the WOCN OASIS Guidance Document



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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  $\geq 25\%$  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

Cardiac Status Domain  
**Heart Failure Symptoms<sub>1</sub>**

- **Two new items:**
  - (M1500) Symptoms in Heart Failure Patients
  - (M1510) Heart Failure Symptom Follow-up
  - Collected at Transfer and DC
  - Time Period under consideration – at or since the previous OASIS Assessment
  - Only for patients with a diagnosis of heart failure in OASIS
  - Used for quality measurement



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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.

**Cardiac Status Domain**  
**Heart Failure Symptoms<sub>2</sub>**

- **(M1500) Symptoms in Heart Failure**  
**Patients:** If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at any point since the previous OASIS assessment?
  - 0 - No **[Go to M2004 at TRN; Go to M1600 at DC]**
  - 1 - Yes
  - 2 - Not assessed **[Go to M2004 at TRN; Go to M1600 at DC]**
  - NA - Patient does not have diagnosis of heart failure **[Go to M2004 at TRN; Go to M1600 at DC]**



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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 (Response 2) then you are done with the cardiac section.

**BUT** if the patient 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

**Cardiac Status Domain**  
**Response to Heart Failure Symptoms**

**(M1510) Heart Failure Follow-up:**

- Asks clinician to identify ALL actions that have been taken to respond to heart failure symptoms
  - Patient’s physician (or other primary care practitioner) contacted the same day
  - Patient advised to get emergency treatment (e.g., call 911 or go to emergency room)
  - Implemented physician-ordered patient-specific established parameters for treatment
  - Patient education or other clinical interventions
  - Obtained change in care plan orders (e.g., increased monitoring by agency, change in visit frequency, telehealth, etc.)

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**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**

## Neuro/ Emotional/ Behavioral Status Domain Depression Screening<sub>1</sub>

### (M1730) Depression Screening

- Asks if the patient has been screened for depression, using a **standardized depression screening tool**
- Allows clinician to document **if assessed**:
  - not assessed
  - assessed using the PHQ-2<sup>®</sup> scale\*
  - assessed different standardized assessment
- Allows clinician to document **results** of screening if conducted



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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<sup>®</sup> 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.

## Neuro/ Emotional/ Behavioral Status Domain Depression Screening<sub>2</sub>

PHQ-2<sup>®</sup> scale. Ask patient: “Over the last two weeks, how often have you been bothered by any of the following problems”?

PHQ-2 <sup>®</sup> Pfizer	Not at all 0 - 1 day	Several days 2 - 6 days	More than half of the days 7 - 11 days	Nearly every day 12 - 14 days	N/A Unable to respond
a) Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> na
b) Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> na

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**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<sup>®</sup> 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.

## Neuro/ Emotional/ Behavioral Status Domain Depression Screening<sub>3</sub>

- Select “0” if a **standardized** depression screening was not conducted
- Select “1” if the PHQ-2© is completed when responding to the question
- Select “2” if the patient is screened with a different standardized assessment and **need for further evaluation indicated**
- Select “3” if the patient is screened with a different standardized assessment and **no need for further evaluation indicated**



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Select “0” if no depression assessment was conducted or if a “**non-standardized**” depression screening was conducted. Standardized means 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.

## ADL/ IADL Domain Major Changes

- **Deletions:**
  - Transportation, Shopping, Housekeeping, Laundry
  - Prior status 14 days before the start/resumption of care
- **Additions:**
  - Prior Status grid
  - Toileting Hygiene and Fall Risk Assessment
- **Revisions:**
  - Wording changes (safely) to numerous items
  - New response scales (bathing, ambulation)
  - Bathing now includes ability to perform the tub/shower transfer
  - Toileting now includes transferring on and off the toilet
  - Medication items now in their own domain





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- 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



**ADL/ IADL Domain**  
**Bathing<sub>1</sub>**

- **(M1830) Bathing:** Current ability to wash entire body **safely**. **Excludes grooming (washing face, washing hands, and shampooing hair).**
  - 0 - Able to bathe self in **shower or tub** independently, **including getting in and out of tub/shower.**
  - 1 - With the use of devices, is able to bathe self in shower or tub independently, **including getting in and out of the tub/shower.**
  - 2 - Able to bathe in shower or tub with the intermittent assistance of another person:
    - (a) for intermittent supervision or encouragement reminders, **OR**
    - (b) **to get in and out of the shower or tub, OR**
    - (c) for washing difficult to reach areas.

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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.

**ADL/ IADL Domain**  
**Bathing<sub>2</sub>**

- **(M1830) Bathing** *(continued)*
  - 3 - Able to participate in bathing self in shower or tub, **but** requires presence of another person throughout the bath for assistance or supervision.
  - 4 - Unable to use the shower or tub, **but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.**
  - 5 - **Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person throughout the bath.**
  - 6 - Unable to participate effectively in bathing and is bathed totally by another person.

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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 2<sup>nd</sup> 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.

**ADL/ IADL Domain**  
**Toilet Transferring**

- **(M1840) Toilet Transferring:** Current ability to get to and from the toilet or bedside commode **safely** and **transfer on and off toilet/commode**.
  - 0 - Able to get to and from the toilet **and transfer** independently with or without a device.
  - 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet **and transfer**.
  - 2 - Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).
  - 3 - Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
  - 4 - Is totally dependent in toileting.

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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

## ADL/ IADL Domain Toileting Hygiene<sub>1</sub>

- **(M1845) Toileting Hygiene:** Current ability to maintain **perineal hygiene** safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.
  - 0 - Able to manage toileting hygiene and clothing management without assistance.
  - 1 - Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.
  - 2 - Someone must help the patient to maintain toileting hygiene and/or adjust clothing.
  - 3 - Patient depends entirely upon another person to maintain toileting hygiene.



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.

**ADL/ IADL Domain**  
**Toileting Hygiene<sub>2</sub>**

**(M1845) Toileting Hygiene**

- “Assistance” refers to assistance from another person by verbal cueing/ reminders, supervision, and/or stand-by or hands-on assistance
- If patient can participate in hygiene and/or clothing management, but needs some assist with either or both activities, select response 2

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.



**ADL/ IADL Domain**

## Ambulation/Locomotion

- **(M1860) Ambulation/Locomotion:** Current ability to walk **safely**, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

**New response options:**

- 1 - With the use of a one-handed device**  
(e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings
- 2 - Requires use of a two-handed device**  
(e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces

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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.

## ADL/ IADL Domain

# Prior ADL/ IADL Functioning<sub>1</sub>

- Dropped prior status - replaced with grid:  
**(M1900) Prior Functioning ADL/ IADL:** Indicate the patient's usual ability with everyday activities prior to this current illness, exacerbation, or injury. Check only **one** box in each row.

Functional Area	Independent	Needed Some Help	Dependent
a. Self-Care (e.g., grooming, dressing, and bathing)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b. Ambulation	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c. Transfer	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
d. Household tasks (e.g., light meal preparation, laundry, shopping )	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2



**Collected at SOC/ROC  
Used for Risk Adjustment**



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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

## ADL/ IADL Domain

### Prior ADL/ IADL Functioning<sub>2</sub>

- **Guidance Manual provides** definitions of dependence
  - “**Independent**” - 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**” - patient contributed effort but required help from another person to accomplish the task/activity safely
  - “**Dependent**” - patient was physically and/or cognitively unable to contribute effort toward completion of the task, and the helper must contribute all the effort
- **Refer to the manual** for specific tasks which are included in each functional area



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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





**ADL/ IADL Domain**  
**Fall Risk Assessment<sub>1</sub>**

- **(M1910) Has the patient had a multi-factor Fall Risk Assessment** (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)?
  - 0 - No multi-factor falls risk assessment conducted.
  - 1 - Yes, and it does not indicate a risk for falls.
  - 2 - Yes, and it indicates a risk for falls.

**Select "0" if falls risk assessment:**

- Was not done at all
- Was not done using standardized validated multi-factor fall risk tool
- Was not done in the assessment time frame
- Was not done by the assessing clinician

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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.

**ADL/ IADL Domain**  
**Fall Risk Assessment<sub>2</sub>**

- **Multi-factor falls risk assessment**
  - May be a single standardized, validated comprehensive multi-factor falls risk assessment tool
  - May incorporate several tools as long as one of them is standardized and validated
- **Determining risk level**
  - Use the scoring parameters specified in the 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, low-risk or minimal risk
  - Select response 2 if the standardized response scale rates the patient as anything above low-risk or minimal risk

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 Domain Changes in OASIS-C

### Medication items are now in their own domain

- **Deletions:** Items assessing inhalant medications
- **Revisions:**
  - Prior column at SOC/ROC replaced with a single prior functioning grid item
  - Instructions on measuring the “majority of the time” have been revised for items assessing patient independence in managing medications
- **Additions:** Process items reporting implementation of best practices for medication reconciliation and patient/caregiver education



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

Significant changes have been made in addition.

## Medication Domain Drug Regimen Review<sub>1</sub>

- **(M2000) Drug Regimen Review:** Does a **complete drug regimen review** indicate **potential clinically significant medication issues**, e.g., drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance?
  - 0 - Not assessed/reviewed [*Go to M2010*]
  - 1 - No problems found during review [*Go to M2010*]
  - 2 - Problems found during review
  - NA - Patient is not taking any medications [*Go to M2040*]



Collected at SOC/ROC



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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.

## Medication Domain Drug Regimen Review<sub>2</sub>

- “All medications” includes prescribed and over the counter, administered by any route
- Ch 3 of OASIS-C Guidance Manual defines “a problem” for responses 1 and 2 is (med list mismatch, symptoms poorly controlled, patient confused about directions)
- Ch 5 of OASIS-C Guidance Manual has online resources for evaluating drug reactions, side effects, interactions, etc



“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

Medication Domain  
**Medication Follow-Up<sub>1</sub>**

- **(M2002) Medication Follow-up:** Was a physician or the physician-designee contacted within one calendar day to resolve clinically significant medication issues, including reconciliation?
  - 0 - No
  - 1 - Yes



Collected at SOC/ROC



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**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”.

## Medication Domain Medication Follow-Up<sub>2</sub>

- **Clinically significant medication issues** pose a threat to patient health and safety, in the clinician's judgment – examples in the item-by-item guidance in Chapter 3
- **Contact with physician** defined as communication to the physician that appropriately conveys the message of patient status
- **Response "1 – Yes"** should only be selected **if physician responds** to HHA communication



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**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

## Medication Domain Medication Follow-Up<sub>3</sub>

- 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**
- Information on drug regimen review findings **must be communicated** to the clinician responsible for the SOC/ROC OASIS assessment
- This **does not violate the one clinician rule** for completion of the assessment



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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



**Medication Domain**  
**Medication Intervention**

- **(M2004) Medication Intervention:** If there were **any clinically significant medication issues since the previous OASIS assessment**, was a physician or physician-designee contacted within one calendar day of the assessment to resolve clinically significant medication issues, including reconciliation?
  - 0 - No
  - 1 - Yes
  - NA - No clinically significant medication issues identified since the previous OASIS assessment

**Collected at Transfer & Discharge**

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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

**Medication Domain**  
**High Risk Drug Education<sub>1</sub>**

- **(M2010) Patient/Caregiver High Risk Drug Education:** Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?
  - 0 - No
  - 1 - Yes
  - NA - Patient **not taking** any high risk drugs OR patient/caregiver **fully knowledgeable** about special precautions associated with all high-risk medications.

**Collected at SOC/ROC**

58

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

## Medication Domain High Risk Drug Education<sub>2</sub>

- High-risk medications
  - Those that have considerable potential for causing significant patient harm when used erroneously
  - As identified by quality organizations (Institute for Safe Medication Practices and JCAHO High Alert Medication List, Beer's Criteria, etc)
  - See Ch 5 of the Guidance Manual for links
- Clinicians may collaborate to ensure patient/caregiver receives education on high risk meds



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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.

## Medication Domain

### Drug Education Intervention<sub>1</sub>

- **(M2015) Patient/Caregiver Drug Education Intervention:** Since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, drug reactions, and side effects and how and when to report problems that may occur?
  - 0 - No
  - 1 - Yes
  - NA - Patient not taking any drugs



Collected at Transfer & Discharge



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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.

## Medication Domain

# Drug Education Intervention<sub>2</sub>

- Effective, safe management of medications includes:
  - Knowledge of **effectiveness**,
  - Potential **side effects** and **drug reactions**, and
  - **When to contact** the appropriate care provider
- Select “1 – Yes” only if instruction including all 3 components was provided since the last OASIS assessment visit



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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.

**Medication Domain**  
**Management of Oral Medications<sub>1</sub>**

**(M2020) Management of Oral Medications**  
**(M2030) Management of Injectable Medications**

- No prior status columns
- Now references ability to take all medications reliably and safely at all times
  - If ability varies between the meds, report medication that requires the most assistance
- Ch 3 now addresses the use of “planner devices”
  - If patient sets up “planner device” and is able to take meds at correct dose/times as a result, correct response = 0
  - If another person must set up a “planner device”, correct response = 1

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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.

## Medication Domain Management of Oral Medications<sub>2</sub>

- **Improved ability to show progress**
- **Response 1** now split into able to take medication(s) at the correct times if:
  - (a) individual syringes are prepared in advance by another person; OR
  - (b) another person develops a drug diary or chart
- **Response 2** now references ability to take medication(s) at the correct times if given reminders by another person



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.

**Medication Domain**

## Prior Medication Management

- **(M2040) Prior Medication Management:**  
Indicate the patient's usual ability with managing oral and injectable medications prior to this current illness, exacerbation, or injury. Check only **one** box in each row.

Functional Area	Independent	Needed Some Help	Dependent	Not Applicable
a. Oral medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Injectable medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Just 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.



## Care Management Types and Sources of Assistance<sub>1</sub>

### (M2100) Types and Sources of Assistance:

Determine the level of caregiver ability and willingness to provide assistance for the following activities, if assistance is needed. (Check only **one** box in each row.)

Type of Assistance	No assistance needed in this area	Caregiver(s) currently provide assistance	Caregiver(s) need training/ supportive services to provide assistance	Caregiver(s) not likely to provide assistance	Unclear if Caregiver(s) will provide assistance	Assistance needed, but no Caregiver(s) available
a. ADL assistance (e.g., transfer/ ambulation, bathing, dressing, toileting, eating/feeding)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5



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.

## Care Management Types and Sources of Assistance<sub>2</sub>

- For M2100, consider the aspect that represents the **most need** and the availability and ability of caregiver(s) to meet that need
  - When determining patient needs in each row, respond based on the patient's greatest need in that category (e.g., ADL with greatest level of dependence)
  - When determining caregiver's ability and willingness, select the response that represents the greatest need



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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”).

## Care Management

### Frequency of Assistance

- (M2110) How Often does the patient receive ADL or IADL assistance from any caregiver(s) (other than home health agency staff)?
- Collected at SOC/ROC and DC for risk adjustment
- Responses include Daily, 3 or more times per week, 1-2 times per week, Less than weekly, None, or Unknown (Unknown not allowed at DC)
- Select the response that reports how often the patient receives assistance with any ADL or IADL



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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.

## Therapy Need and Plan of Care Plan of Care Synopsis<sub>1</sub>

**(M2250) Plan of Care Synopsis:** (Check only **one** box in each row.) Does the physician-ordered plan of care include the following:

Plan / Intervention	No	Yes	Not Applicable
a. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference
b. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Patient is not diabetic or is bilateral amputee
c. Falls prevention interventions	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Patient is not assessed to be at risk for falls
d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Patient has no diagnosis or symptoms of depression
e. Intervention(s) to monitor and mitigate pain	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na No pain identified
f. Intervention(s) to prevent pressure ulcers	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Patient is not assessed to be at risk for pressure ulcers
g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Patient has no pressure ulcers with need for moist wound healing

**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.

## Therapy Need and Plan of Care Plan of Care Synopsis<sub>2</sub>

- 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
  - If prior to the receipt of signed orders, the clinical record should reflect **evidence of communication with the physician** to include specified best practice interventions in the POC



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

## Therapy Need and Plan of Care Plan of Care Synopsis<sub>3</sub>

Review Chapter 3 guidance carefully for:

- Acceptable POC interventions
  - Example: Row a “specific clinical parameters” may include ranges or limits for temp, pulse, respirations, BP, weight, wound measurements, pain intensity ratings etc
- Guidance on timeframes
  - Plan of Care orders must be in place within the 5-day SOC or 2-day ROC window to respond “Yes”
- Guidance on collaboration
  - Assessing clinician may choose to wait until after other disciplines have completed their assessments and developed their care plans
  - This does not violate the requirement that the comprehensive assessment be completed by one clinician



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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)?

## Data Collected at TRF/ DC Intervention Synopsis<sub>1</sub>

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

Plan / Intervention	No	Yes	Not Applicable
a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Patient is not diabetic or is bilateral amputee
b. Falls prevention interventions	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Formal multi-factor Fall Risk Assessment indicates the patient was not at risk for falls since the last OASIS assessment
c. Depression intervention(s) such as medication referral for other treatment or a	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Formal assessment indicates patient did not meet criteria for



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•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.

## Data Collected at TRF/ DC Intervention Synopsis<sub>2</sub>

### Example for Row b – Falls Prevention:

- Select “Yes” if:
  - The physician-ordered POC contains specific interventions to reduce the risk of falls **and**
  - Interventions were performed by any home health agency staff since (or at) the time of the previous OASIS assessment
- Select “No” if:
  - The POC does not include interventions for fall prevention, and/or
  - These interventions were not performed at the time of the previous OASIS assessment or since that time



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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.



Data Collected at TRF/ DC  
**Intervention Synopsis<sub>3</sub>**

- 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



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<sub>1</sub>

**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\\_HHQIO/ASISUserManual.asp](http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIO/ASISUserManual.asp)

### **Q&As**

- <https://www.qtso.com/hhdownload.html>
- [www.oasiscertificate.org](http://www.oasiscertificate.org)



## Rely on CMS Guidance Resources<sub>2</sub>

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](http://www.cms.hhs.gov/OASIS_06_EducationCoord.asp)

Or submit to:

[CMSOASISquestions@oasisanswers.com](mailto:CMSOASISquestions@oasisanswers.com)

