Highlights of OASIS-C
Changes by Section

Train the Trainer - Part 2 of 3

Slide #2

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

Slide #3

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/hhadownload.html

www.oasiscertificate.org

Slide #4

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

Slide #5

Clinical Record Items Domain: Timely Care$_1$

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

Slide #6

Clinical Record Items Domain: Timely Care$_2$

(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

Slide #7

Clinical Record Items Domain: Timely Care$_3$

(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

Slide #8

Patient History & Diagnosis Domain: Immunizations$_1$

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

Slide #9

Patient History & Diagnosis Domain: Immunizations$_2$

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

Slide #10

Patient History & Diagnosis Domain: Immunizations$_3$

(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]

Slide #11

Patient History & Diagnosis Domain: Immunizations$_4$

(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

Slide #12

Patient History & Diagnosis Domain: Immunizations$_5$

(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]**

Slide #13

Patient History & Diagnosis Domain: Immunizations$_6$

(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

Slide #14

Living Arrangements Domain: Patient Living Situation$_1$

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

Slide #15

Living Arrangements Domain: Patient Living Situation$_2$

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	_ 01	_ 02	_ 03	_ 04	_ 05
b. Patient lives with other person(s) in the home	_ 06	_ 07	_ 08	_ 09	_ 10
c. Patient lives in congregate situation (e.g. assisted living)	_ 11	_ 12	_ 13	_ 14	_ 15

Slide #16

Living Arrangements Domain: Patient Living Situation$_3$

(M1100) Patient Living Situation

To select the appropriate response:

First, determine living arrangement – whether the patient lives alone, in a home with others, or in a congregate setting;

Second, determine availability of assistance

how frequently caregiver(s) are in the home and available to provide assistance

Review guidance in the manual to become familiar with the definitions

Slide #17

Sensory Status Domain: Pain Assessment$_1$

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

Slide #18

Sensory Status Domain: Pain Assessment$_2$

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

Slide #19

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

Slide #20

Integumentary Status Domain: Pressure Ulcer Risk Assessment$_1$

(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

Slide #21

Integumentary Status Domain: Pressure Ulcer Risk Assessment$_2$

(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

Slide #22

Integumentary Status Domain: Pressure Ulcers – Stage II or Higher$_1$

(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

Slide #23

Integumentary Status Domain: Pressure Ulcers – Stage II or Higher$_2$

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

Slide #24

Integumentary Status Domain: Unhealed Pressure Ulcers$_1$

(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

Slide #25

Integumentary Status Domain: Unhealed Pressure Ulcers$_2$

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

Slide #26

Integumentary Status Domain: Pressure Ulcer Count$_1$

(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	Number Currently Present	Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)
a. **Stage II:** 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. **Stage III:** 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	____	____

Slide #27

Integumentary Status Domain: Pressure Ulcer Count$_2$

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

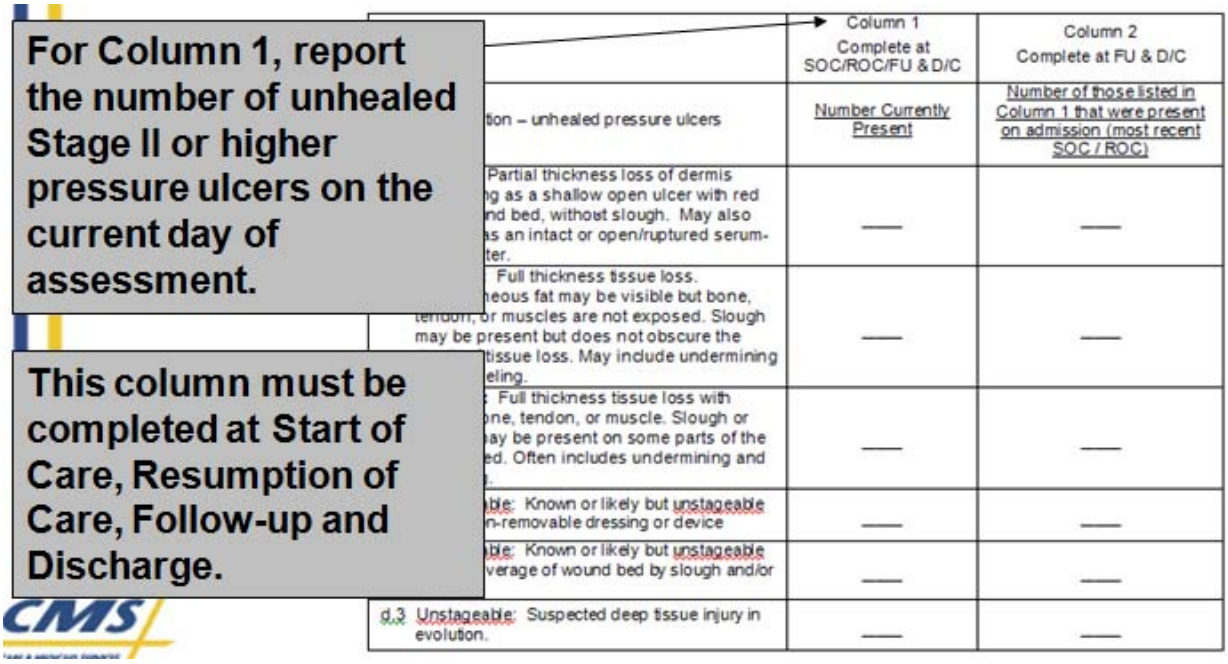
2nd column at FU and DC identifies ulcers that were present on admission

Tracks whether an ulcer developed during a quality episode

Slide #28

Integumentary Status Domain: Pressure Ulcer Count$_3$

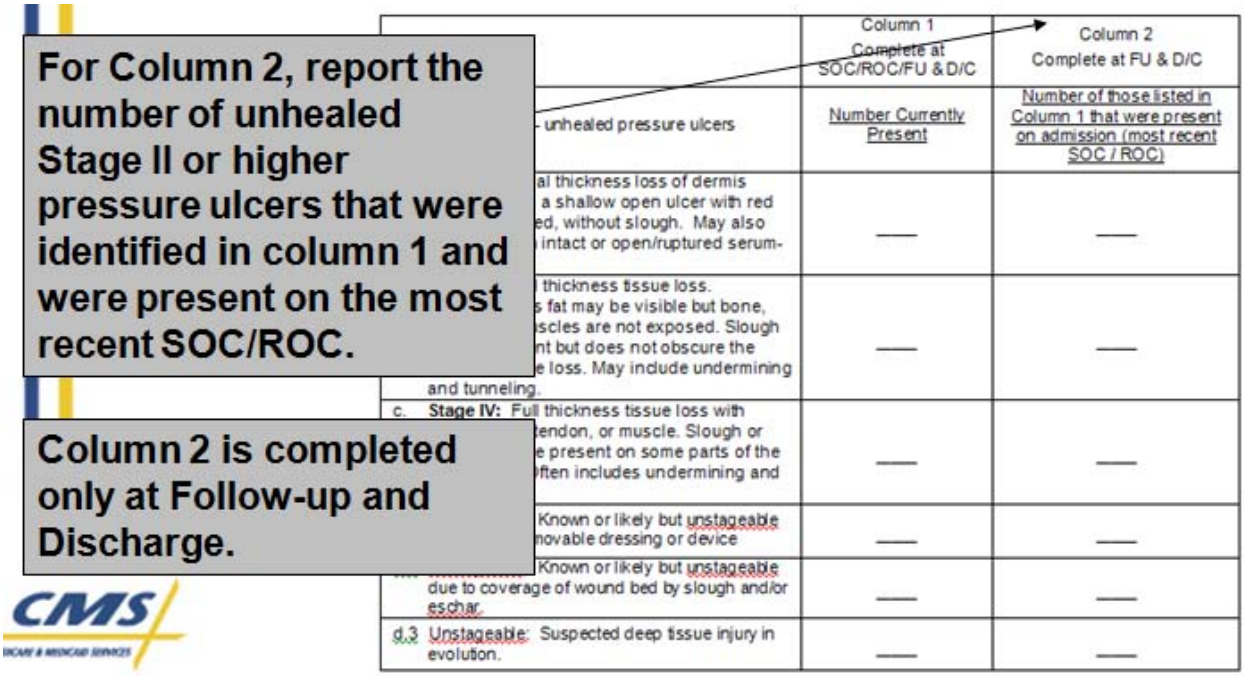
(M1308) Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage: (Enter "0" if none; excludes Stage I pressure ulcers)



Slide #29

Integumentary Status Domain: Pressure Ulcer Count$_4$

(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
- unhealed pressure ulcers	Number Currently Present	Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)
al thickness loss of dermis a shallow open ulcer with red ed, without slough. May also intact or open/ruptured serum-	___	___
thickness tissue loss. s fat may be visible but bone, scles are not exposed. Slough nt but does not obscure the e loss. May include undermining and tunneling.	___	___
c. **Stage IV:** Full thickness tissue loss with endon, or muscle. Slough or e present on some parts of the often includes undermining and	___	___
Known or likely but unstageable novable dressing or device	___	___
Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.	___	___
d.3 Unstageable: Suspected deep tissue injury in evolution.	___	___

Slide #30

Integumentary Status Domain: Pressure Ulcer Dimensions$_1$

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

Slide #31

Integumentary Status Domain: Pressure Ulcer Dimensions$_2$

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

Record dimensions of the pressure ulcer with the largest surface area in centimeters

Length = longest head to toe

Width = greatest width perpendicular to length

Depth = from visible surface to deepest area

Chapter 3 of OASIS-C Guidance Manual has

Further instructions and pictures

Clinicians must become familiar with the manual instructions to respond accurately

Slide #32

Integumentary Status Domain: Pressure Ulcer Healing Status$_1$

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

Slide #33

Integumentary Status Domain: Pressure Ulcer Healing Status$_2$

M1320 Status of Most Problematic (observable) Pressure Ulcer

Response 0 – Newly Epithelialized – epithelial tissue has not completely covered the 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 ≥25% necrotic or avascular tissue

Refer to the OASIS-C Guidance Manual and the WOCN OASIS Guidance Document

Slide #34

Cardiac Status Domain: Heart Failure Symptoms$_1$

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

Slide#35

Cardiac Status Domain: Heart Failure Symptoms$_2$

(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]**

Slide #36

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.)

Slide #37

Neuro/ Emotional/ Behavioral Status Domain: Depression Screening[1]

(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© scale*

assessed different standardized assessment

Allows clinician to document results of screening if conducted

Slide #38

Neuro/ Emotional/ Behavioral Status Domain: Depression Screening$_2$

PHQ-2© scale. Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems"?

PHQ-2© 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	☐0	☐1	☐2	☐3	☐na
b) Feeling down, depressed, or hopeless?	☐0	☐1	☐2	☐3	☐na

Slide #39

Neuro/ Emotional/ Behavioral Status Domain: Depression Screening$_3$

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

Slide #40

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

Slide #41

ADL/ IADL Domain: Bathing$_1$

(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.

Slide #42

ADL/ IADL Domain: Bathing$_2$

(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.

Slide #43

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.

Slide #44

ADL/ IADL Domain: Toileting Hygiene[1]

(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.

Slide #45

ADL/ IADL Domain: Toileting Hygiene$_2$

(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

Slide #46

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

Slide #47

ADL/ IADL Domain: Prior ADL/ IADL Functioning$_1$

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)	☐0	☐1	☐2
b. Ambulation	☐0	☐1	☐2
c. Transfer	☐0	☐1	☐2
d. Household tasks (e.g., light meal preparation, laundry, shopping)	☐0	☐1	☐2

Slide #48

ADL/ IADL Domain: Prior ADL/ IADL Functioning[2]

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

Slide #49

ADL/ IADL Domain: Fall Risk Assessment[1]

(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

Slide #50

ADL/ IADL Domain: Fall Risk Assessment$_2$

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

Slide #51

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

Slide #52

Medication Domain: Drug Regimen Review$_1$

(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

Slide #53

Medication Domain: Drug Regimen Review$_2$

"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

Slide #54

Medication Domain: Medication Follow-Up$_1$

(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

Slide #55

Medication Domain: Medication Follow-Up$_2$

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

Slide #56

Medication Domain: Medication Follow-Up$_3$

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

Slide #57

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

Slide #58

Medication Domain: High Risk Drug Education$_1$

(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

Slide #59

Medication Domain: High Risk Drug Education$_2$

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

Slide #60

Medication Domain: Drug Education Intervention$_1$

(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

Slide #61

Medication Domain: Drug Education Intervention$_2$

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 if instruction including all 3 components was provided since the last OASIS assessment visit

Slide #62

Medication Domain: Management of Oral Medications$_1$

(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

Slide #63

Medication Domain: Management of Oral Medications$_2$

Improved ability to show progress

Response 1 now split into able to take medication(s) at the correct times if:

individual syringes are prepared in advance by another person; OR

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

Slide #64

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				
b. Injectable medications				

Slide #65

Care Management: Types and Sources of Assistance[1]

(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)	☐0	☐1	☐2	☐3	☐4	☐5

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Care Management: Types and Sources of Assistance$_2$

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

Slide #67

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

Slide #68

Therapy Need and Plan of Care: Plan of Care Synopsis$_1$

(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	☐0	☐1	☐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	☐0	☐1	☐na	Patient is not diabetic or is bilateral amputee
c. Falls prevention interventions	☐0	☐1	☐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	☐0	☐1	☐na	Patient has no diagnosis or symptoms of depression
e. Intervention(s) to monitor and mitigate pain	☐0	☐1	☐na	No pain identified
f. Intervention(s) to prevent pressure ulcers	☐0	☐1	☐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	☐0	☐1	☐na	Patient has no pressure ulcers with need for moist wound healing

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Therapy Need and Plan of Care: Plan of Care Synopsis$_2$

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

Slide #70

Therapy Need and Plan of Care: Plan of Care Synopsis$_3$

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

Slide #71

Data Collected at TRF/ DC: Intervention Synopsis$_1$

(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	☐0	☐1	☐na	Patient is not diabetic or is bilateral amputee
b. Falls prevention interventions	☐0	☐1	☐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	☐0	☐1	☐na	Formal assessment indicates patient did not meet criteria for

Slide #72

Data Collected at TRF/ DC: Intervention Synopsis$_2$

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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Data Collected at TRF/ DC: Intervention Synopsis$_3$

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

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Rely on CMS: Guidance Resources$_1$

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

OASIS-C Guidance Manual

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

Q&As

https://www.qtso.com/hhadownload.html

www.oasiscertificate.org

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Rely on CMS: Guidance Resources$_2$

For DATA COLLECTION questions not already addressed in the OASIS-C Guidance Manual or posted Q&As, contact your state OASIS Education Coordinator (OEC):

www.cms.hhs.gov/OASIS 06_EducationCoord.asp

Or submit to:

CMSOASISquestions@oasisanswers.com