

# Highlights of OASIS-C Changes by Section

## Train the Trainer - Part 2 of 3

# 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)

# 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

# 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

# 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

# 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

# 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

# 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**

# 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** ]

# 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

# 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** ]

# 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

# 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**

# 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

# 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

# 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

# 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**

# 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

# 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*

## 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*

# 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**

# 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

# 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

# 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	—	—

# 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

# 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
tion – 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>
Partial thickness loss of dermis appearing as a shallow open ulcer with red wound bed, without slough. May also include an intact or open/ruptured serum-crust.	—	—
Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the wound bed.	—	—
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 in-removable dressing or device	—	—
Unstageable: Known or likely but unstageable because of slough and/or eschar covering the wound bed	—	—
d.3 Unstageable: Suspected deep tissue injury in evolution.	—	—

# 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	<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>
Stage II: Partial thickness loss of dermis with a shallow open ulcer with red, non-sloughing wound bed, without slough. May also include intact or open/ruptured serum-filled vesicles.	—	—
Stage III: Full thickness tissue loss. Slough, eschar, or fat may be visible but bone, tendon, or muscle are not exposed. Slough or eschar may be present but does not obscure the wound bed. May include undermining and tunneling.	—	—
c. Stage IV: Full thickness tissue loss with exposed tendon, bone, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.	—	—
Known or likely but <u>unstageable</u> due to coverage of wound bed by slough and/or eschar.	—	—
d.3 <u>Unstageable</u> : Suspected deep tissue injury in evolution.	—	—

# 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

# 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

# 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

# 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

# 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**]

# 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.)

# 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

# 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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# 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**

# 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

## 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.

## 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.

# 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.

# 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.

# 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

# 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

## 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

# 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

# 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*

# 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

# 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 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**]

# 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

# 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

# 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

# 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

# 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

# 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.

# 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

# 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**

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

# 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

# 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

# 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"/>

# 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) <u>not likely</u> to provide assistance	Unclear if Caregiver(s) will provide assistance	Assistance needed, but no Caregiver(s) available
a. <b>ADL assistance</b> (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

# 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

# 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

# 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

# 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

# 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

# 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

# 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

# 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

# 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\\_HHQIOASISUserManual.asp](http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.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:**

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