Master the OASIS-C2 Guidance Changes

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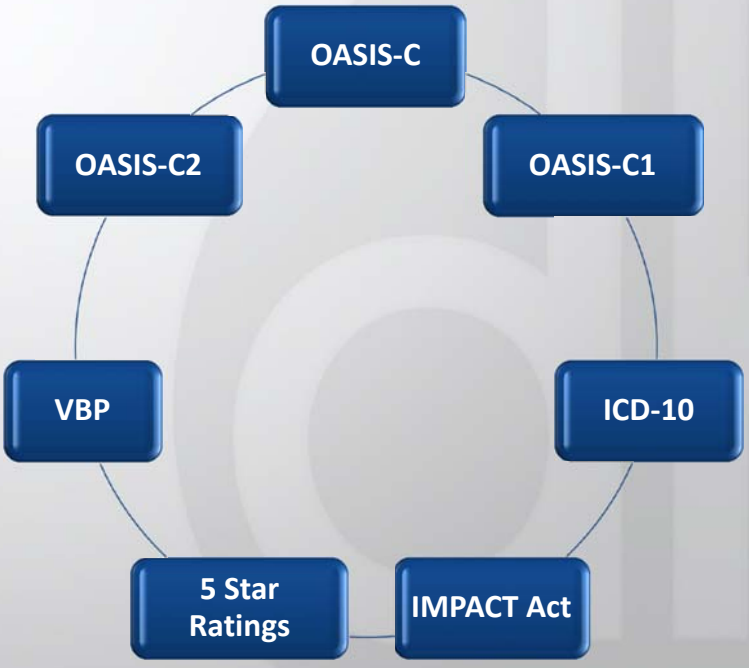
Critical OASIS Changes since 2009



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OASIS-C2 is Effective 1/1/2017

Why now?

OASIS-C2 is a step toward CMS' compliance with the provisions of the IMPACT Act of 2014.

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Improving Medicare Post-Acute Care Transformation Act of 2014 (the Impact Act)

- Requires CMS to develop/implement quality measures using cross-setting standardized patient assessments from post acute care settings (LTACHs, SNFs, IRFs, and HHAs). For example:
  - Skin integrity
  - Functional status and cognitive function
  - Medication reconciliation
  - Incidence of major falls
  - Medical conditions and co-morbidities

IMPACT ACT

- In addition to clinical quality measures, the Act requires CMS to develop, calculate and enable reporting of measures pertaining to:
  - Resource use, including Medicare spending per beneficiary
  - Hospitalization (re-admission)
  - Discharge to community

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Home Health IMPACT Act Measures – CY2016 and CY2017

Domain	Measure
Skin Integrity	**% of patients with new or worsening pressure ulcers (OASIS-based)**
Medication Reconciliation	**Drug regimen review with follow-up for identified issues (OASIS-based)**
Resource Use	Total Medicare estimated spending per beneficiary (Claims-based)
Resource Use	Discharge to community (Claims-based)
Resource Use	Potentially preventable 30 day post-discharge readmission (Claims-based)

Revisions in OASIS-C2 due to IMPACT Act Requirements

- Revisions include:
  - Formatting changes to convert to response entry boxes rather than a line or multiple lines.
  - Conversion of pressure ulcers stages to Arabic numbers (1, 2, 3, 4).
  - Change in lookback period in 6 items: M1500, M1510, M2004, M2015, M2300, M2400 (including renumbering).
  - Addition of 3 new standardized items: M1028, M1060, GG0170c.
  - Modification/Renumbering of medication and integumentary items to standardize with other post acute settings: M1308, M1309, M2000, M2002, M2004.

Items with Revised Numbering

- **M1308 > M1311,** Current # Unhealed Pressure Ulcers
- **M1309 > M1313,** Worsening in PU status since SOC/ROCC
- **M1500 > M1501,** Symptoms of Heart Failure
- **M1510 > M1511,** Heart Failure Follow-up
- **M2000 > M2001,** Drug Regimen Review
- **M2002 > M2003,** Medication Follow-up
- **M2004 > M2005,** Medication Intervention
- **M2015 > M2016,** Patient/Caregiver Drug Education
- **M2300 > M2301,** Emergent Care
- **M2400 > M2401,** Intervention Synopsis

Item Formatting

- Formatting changes were made to many M-items allowing entry of one coded value rather than relying on check boxes (☐) or lines.

(M0080) Discipline of Person Completing Assessment	
Enter Code ☐	1 RN 2 PT 3 SLP/ST 4 OT

Note: Formatting changes do not appear in items where the clinician may select more than one response.

For example: M1030 (Therapy in the Home)

Changes to Conventions

- Number of general conventions decreased from 15 to 14:
  - Revised timing of the "look back" period.
  - Clarified meaning of terms "specifically" and "for example".
  - Added guidance for use of a dash (-) in responses.
  - Deleted definition of "one calendar day". (Item not replaced.)
- Number of ADL/IADL specific conventions increased from 5 to 6:
  - Added guidance related to the presence of a caregiver.

Change in Lookback Period

- 6 items reflect change in "lookback period":
  - New numbers: M1501, M1511, M2005, M2016, M2301, M2401.
- "Look back" convention revised to reflect a change in timing of the period under consideration:
  - **Old wording:** "Several process items require documentation of prior care, at the time of or since the time of the most recent SOC, ROC, or FU OASIS assessment."
  - **New wording:** ". . . documentation of prior care, ***at the time of or since the time of the most recent SOC or ROC OASIS assessment***.

New lookback period: ". . . at the time of or at any time since the most recent SOC/ROC OASIS assessment."

(M1501) **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 the time of or at any time since the most recent SOC/ROC assessment?	
Enter Code ☐	0 No [*Go to M2005 at TRN; Go to M1600 at DC*] 1 Yes 2 Not assessed [*Go to M2005 at TRN; Go to M1600 at DC*] NA Patient does not have diagnosis of heart failure [*Go to M2005 at TRN; Go to M1600 at DC*]

- Only one sign/symptom at any time since SOC/ROC. Time period could be over several episodes of care for maintenance-type patients (i.e. monthly catheter change).

Other Conventions – New/Revised in C2

- **Revised in C2:** The use of the term "specifically," means scoring of the item should be limited to only the circumstances listed. The use of "for example," means the clinician may consider other relevant circumstances or attributes when scoring the item.
  - OASIS-C1 guidance had been that the use of "that is," meant scoring of the item should be limited to only the circumstances listed.
- **New in C2:** Some items allow a dash response. A dash (–) value indicates that no information is available, and/or an item could not be assessed. Most often occurs when patient is unexpectedly transferred, discharged or dies before assessment of the item could be completed. *CMS expects dash use to be a rare occurrence.* ***See:*** *M1028, M1060, M1311, M1313, GG0170C, M2001.*

New ADL/IADL Convention

New in C2: Presence of a Caregiver

While the presence or absence of a caregiver may impact the way a patient carries out an activity, it does not impact the assessing clinician's ability to assess the patient in order to determine and report the level of assistance that the patient requires to safely complete the task.

For example:

If a patient is able to safely get to and from the toilet and perform the transfer with assistance of another person, but they live alone and have no caregiver so they are using a bedside commode, what should be the response to M1840?

The OASIS item response should reflect the patient's ability to safely perform a task, regardless of the presence or absence of a caregiver. If the patient is able to safely get to and from the toilet and transfer with assistance, then Response 1 should be selected, as this reflects their ability, regardless of the availability of a consistent caregiver in the home. *(CMS Q&A #146, 4/15)*

(M1028) *New in C-2*

Impact

(M1028) Active Diagnoses- Comorbidities and Co-existing Conditions—Check all that apply

See OASIS Guidance Manual for a complete list of relevant ICD-10 codes.

☐ 1 – Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)

☐ 2 – Diabetes Mellitus (DM)

- Identifies whether two specific diagnoses are present and **active**. These diagnoses influence a patient's functional outcomes or increase a patient's risk for development or worsening of pressure ulcer(s).
- The diseases and conditions in this item require a physician documented diagnosis at the time of assessment.
- If patient does not have an active diagnosis of PVD, PAD, or diabetes within the assessment timeframe, leave boxes in M1028 unchecked. *(CMS Qtrly Q&A #6-7, 10/16)*
- Use a dash (-) if information not available or could not be assessed. *(CMS Qtrly Q&A #5, 10/16)*

M1028: Active Diagnoses

- **Select Response 1** if the patient has an active diagnosis of:
  - Peripheral Vascular Disease (PVD)
    - Codes that start with the first 3 characters of I73
  - Peripheral Arterial Disease (PAD)
    - Codes that start with the first 4 characters of: I70.2 –, Atherosclerosis of native arteries of the extremities
- **Select Response 2** if the patient has an active diagnosis of Diabetes Mellitus (DM) indicated by any one of the following diagnosis codes that start with:
  - E08. – DM d/t underlying conditions
  - E09. – Drug or chemical induced DM
  - E10. – Type 1 DM
  - E11. – Type 2 DM
  - E13. – Other specified DM

(M1028) Guidance

New Definitions!

- **Active diagnoses:** include only diagnoses that have a **direct relationship** to the patient's current functional, cognitive, mood or behavior status; medical treatments; nurse monitoring; or risk of death at the time of assessment.
  - **DO NOT** include diseases or conditions that have been resolved.
  - **Nurse monitoring:** includes clinical monitoring by a licensed nurse (e.g., serial blood pressure evaluations, medication management).
  - A diagnosis may not be inferred by association with other conditions (i.e., weight loss inferred to mean "malnutrition").
- Leave M1028 blank if no active diagnoses of PVD, PAD, or DM. Do not use a dash (-).

(M1028) Guidance

- Diagnostic information, including past medical and surgical history obtained from family members and close contacts, must also be documented in the medical record by the physician . . . to ensure validity, follow-up and coordination of care.
- Only diagnoses confirmed and documented by the physician . . . should be considered when coding this item.
- It is also essential that diagnoses communicated verbally be documented in the medical record by the physician . . . to ensure follow-up and coordination of care.

(M1028) Tips

- There must be specific documentation in the medical record by a physician . . . of the disease or condition being an active diagnosis.
- The physician . . . may specifically indicate that a diagnosis is active. Specific documentation areas in the medical record may include, but are not limited to, progress notes, admission history and physical, transfer notes, and the hospital discharge summary.
- The physician . . . for example, may document at the time of assessment that the patient has inadequately controlled diabetes and requires adjustment of the medication regimen. This would be sufficient documentation of an active diagnosis.

(M1028) Examples of Active Diagnoses

Mr. A is prescribed insulin for diabetes mellitus. He requires regular blood glucose monitoring to determine whether blood glucose goals are achieved by the current medication regimen. The physician progress note documents diabetes mellitus.

- **Response 2:** Diabetes Mellitus would be checked.
- **Rationale: D**iabetes mellitus is considered an active diagnosis because the physician progress note documents the diagnosis and because there is ongoing medication management and glucose monitoring.

(M1028) Examples of Active Diagnoses

- Mrs. B is admitted to home health for physical therapy s/p total hip. The patient also has type 2 diabetes controlled by diet & independently monitors her blood sugars. She is knowledgeable about diabetic foot care & checks her feet daily using a mirror. Because her change in activity could affect her blood sugar levels and because diabetes could affect her ability to heal from her surgery, DM meets the selection criteria for a secondary diagnosis and would be reported in M1023. The PT will be monitoring the patient holistically to identify problems/modify the POC as appropriate with physician collaboration. Orders do not list any active interventions related to her DM.
  - **Response 2:** Diabetes Mellitus would be checked.
  - **Rationale:** The home health provider's monitoring of the patient/wound healing with specific knowledge that the patient is a diabetic, would make diabetes an active diagnosis for this patient. *(CMS Qtrly Q&A #8, 10/16)*

(M1028) Examples of Active Diagnoses

Your patient underwent a below the knee amputation due to gangrene associated with peripheral vascular disease. She requires dressing changes to the stump and monitoring for wound healing. In addition, peripheral pulse monitoring is ordered. The physician's progress note documents peripheral vascular disease and a left below the knee amputation.

- **Response 1:** Peripheral Vascular Disease (PVD) would be checked.
- **Rationale:** Consider PVD an active diagnosis because the physician's note documents with peripheral pulse monitoring and recent below the knee amputation and with dressing changes and wound status monitoring.

(M1060): *New in OASIS-C2*

Impact

(M1060) Height and Weight—While measuring, if the number is X.1 – X.4 round down; X.5 or greater round up

☐☐ inches — a. Height (in inches). Record most recent height measure since the most recent SOC/ROC

☐☐☐ pounds — b. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard agency practice (for example, in a.m. after voiding, before meal, with shoes off, etc.).

- Height and weight support calculation of body mass index (BMI). – a risk co-variant for Worsening of Pressure Ulcer IMPACT measure.
- Data collection by self-report or from paperwork from another provider setting is not acceptable. *(CMS Qtrly Q&A #10, 10/16)*
- If a patient cannot be weighed/measured, enter the dash value (-) and document the rationale on the patient's medical record.

(M1306)

(M1306) Does this patient have at least one **Unhealed Pressure Ulcer at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure ulcers and healed Stage 2 pressure ulcers)	
Enter Code ☐	0 No [*Go to M1322*] 1 Yes

- Agencies may adopt the NPUAP guidelines in their clinical practice and documentation.
- Since CMS has adapted the NPUAP guidelines for OASIS purposes, the definitions do not perfectly align with each stage as described by NPUAP.
- When discrepancies exist between the NPUAP definitions and the OASIS scoring instructions provided in the OASIS Guidance Manual and CMS Q&As, providers should rely on the CMS OASIS instructions.

(OASIS-C2 Guidance Manual, Ch. 3, M1306, 6/2016)

(M1306) Response-Specific Guidance

- Pressure ulcers are defined as localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.
- If pressure is not the primary cause of the lesion, do not report the wound as a pressure ulcer. *(OASIS-C2, M1306)*
  - For example: Blister of the heel due to rubbing of a new shoe on the heel.
- Terminology referring to "healed" vs. "unhealed" ulcers can refer to whether the ulcer is "closed" vs. "open". *(OASIS-C2, M1306)*

(M1306) Response-Specific Guidance

- Stage 2 (partial thickness) pressure ulcers heal through the process of regeneration of epidermis across the wound surface, known as "re-epithelialization".
  - Stage 2 ulcers do not granulate and are reported as unhealed until they have epithelialized.
  - Newly epithelialized Stage 2 ulcers are not reported or counted.

(OASIS-C2 Guidance Manual, Ch. 3, M1306, 6/2016)

(M1306) Response-Specific Guidance

- Unstageable pressure ulcers are not considered healed, including:
  - Suspected Deep Tissue Injuries (DTIs)
  - "Known" (documented in record) pressure ulcers covered with a nonremovable dressing.
  - Known pressure ulcers where eschar or slough is obscuring visualization of Stage 4 structure.
- Stage 3 and 4 (full thickness) pressure ulcers heal through a process of granulation (filling of the wound with connective/scar tissue), contraction (wound margins contract and pull together), and re-epithelialization (covers with epithelial tissue from within wound bed and/or from wound margins). *(OASIS-C2 Guidance Manual, Ch. 3, M1306, 6/2016)*

(M1306) Response-Specific Guidance

- Once (a stage 3 or 4) pressure ulcer has fully granulated and the wound surface is completely covered with new epithelial tissue, the wound is considered closed, and will continue to remodel and increase in tensile strength. *(OASIS-C2, M1306)*
- For the purposes of scoring the OASIS, the wound is considered healed at this point, and should no longer be reported as an unhealed pressure ulcer. *(OASIS-C2, M1306)*
- Tensile strength of the skin overlying a closed full thickness pressure ulcer is only 80% of normal skin tensile strength. Agencies should pay careful attention that preventative measures are put into place that will mitigate the re-opening of a closed ulcer. *(OASIS-C2, M1306)*

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(M1307)

(M1307) The **Oldest Stage 2 Pressure Ulcer** that is present at discharge: (Excludes healed Stage 2 Pressure Ulcers)	
Enter Code ☐	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 Stage 2 pressure ulcers are present at discharge

- Stage 2 (partial thickness) pressure ulcers heal through the process of regeneration of the epidermis across a wound surface called, "re-epithelialization." *(OASIS-C2, M1306)*
- Do not reverse stage pressure ulcers as a way to document healing as it does not accurately characterize what is physiologically occurring as the ulcer heals. *(OASIS-C2, M1306)*
  - For example, over time, even though a Stage 4 pressure ulcer has been healing and contracting such that it is less deep, wide, and long, the tissues that were lost (muscle, fat, dermis) will never be replaced with the same type of tissue. Clinical standards require that this ulcer continue to be documented as a Stage 4 pressure ulcer until it has healed.

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(M1307) Guidance

- If no pressure ulcer existed at the SOC, then a Stage 1 pressure ulcer developed, which progressed to a Stage 2 by discharge, enter Response 2, and specify the date that the pressure ulcer was first identified as a Stage 2 ulcer. *(See also: CMS Qtrly Q&A #16, 10/16)*
- The determination of whether a lesion is a pressure ulcer, or what stage a pressure ulcer should be reported as should not be determined solely by the presence of a serum-filled blister. If the tissue under/around the serum-filled blister is reddened or pink, and the wound etiology is unrelieved pressure, the wound would be reported as a Stage 2 Pressure Ulcer. *(CMS Qtrly Q&A #11, 10/16)*
- An ulcer that is suspected of being a Stage 2, but is Unstageable due to non-removable dressing/device at the time of discharge, should not be identified as the "oldest Stage 2 pressure ulcer".
- Enter "NA" if the patient has no Stage 2 pressure ulcers at the time of discharge, or all previous Stage 2 pressure ulcers have healed.

M1311 Replaces M1308 in OASIS-C2

- M1311 contains new/revised terminology and guidance that differs from M1308 in OASIS-C1.
- Continues to count number of Stage 2 or higher pressure ulcers at all time points.
- New terminology specifies that "healed" vs. "unhealed" ulcers refers to whether the ulcer is "closed" vs. "open". *(OASIS-C2, Chapter 3)*

M1311: New Two-Line Format

- Line 1 (completed at all time points)

  Number of current pressure ulcers at each stage

  A1 (Stage 2); B1 (Stage 3); C1 (Stage 4); D1 (Unstageable d/t non-removable dressing; E1 (Unstageable d/t eschar/slough); F1 (Unstageable w/suspected DTI)

- Line 2 (completed at F/U and D/C only)

  Number of <u>these</u> ulcers that were present at most recent SOC/ROC

  A2 (Stage 2); B2 (Stage 3); C2 (Stage 4); D2 (Unstageable d/t non-removable dressing; E2 (Unstageable d/t eschar/slough); F2 (Unstageable w/suspected DTI)

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(M1311)

Impact

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage	Enter Number
A1. **Stage 2:** 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 blister. **Number of Stage 2 pressure ulcers** [If 0 at FU/DC Go to M1311B1]	☐
A2. **Number of <u>these</u> Stage 2 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐
B1. **Stage 3:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers** [If 0 at FU/DC Go to M1311C1]	☐
B2. **Number of <u>these</u> Stage 3 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐
C1. **Stage 4:** 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. **Number of Stage 4 pressure ulcers** [If 0 at FU/DC Go to M1311D1]	☐
C2. **Number of <u>these</u> Stage 4 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐

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(M1311) continued . . .

D1. Unstageable: Non-removable dressing: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers due to non-removable dressing/device** [If 0 at FU/DC Go to M1311E1]	☐
D2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** [If 0 at FU/DC Go to M1311F1]	☐
E2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
F1. Unstageable: Deep tissue injury: Suspected deep tissue injury in evolution **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** [If 0 - Go to M1322 (at Follow up), Go to M1313 (at Discharge)]	☐
F2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
[*Omit "A2, B2, C2, D2, E2 and F2" on SOC/ROC*]	

(M1311) Guidance

- Not reported in M1311:
  - Stage 1 pressure ulcers
  - Pressure ulcers that have healed
- Not considered healed:
  - Stage 1 pressure ulcers, although closed (intact skin)
  - Stage 2 pressure ulcers
  - Suspected Deep Tissue Injury (sDTI), although closed (intact skin)
  - Unstageable pressure ulcers, whether covered with a non-removable dressing or eschar or slough

(M1311) Guidance

- Stage II pressure ulcers (partial thickness wounds):
  - Characterized by partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured blister.
  - Includes blisters due to pressure or shearing but not blisters due to rubbing or friction of shoes on foot.
  - Do not granulate.
  - Heal through regeneration of epidermis (epithelialization)
- **Stage 3 Pressure Ulcers:** Characterized by full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling. Heal through granulation.

(M1311) Guidance

- **Stage 4 Pressure Ulcers:** Characterized by 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. Heal through granulation.
  - If any bone, tendon or muscle or joint capsule (Stage 4 structures) is visible, the pressure ulcer should be reported as a Stage 4 pressure ulcer, regardless of the presence or absence of slough and/or eschar in the wound bed.
  - A previously closed Stage 3 or Stage 4 pressure ulcer that is currently open again should be reported at its worst stage.

(M1311) Guidance

- Surgically debrided pressure ulcers remain pressure ulcers. They are not surgical wounds.
- Pressure ulcers sutured closed are still considered pressure ulcers, not surgical wounds.
  - Report these ulcers in M1311 as: D1 (unstageable d/t a nonremovable dressing or device *(CMS Qtrly Q&A #15, 10/16)*
- Make and document every effort to contact previous providers (including patient's physician) to determine the stage of the wound at its worst and report that stage.

(M1311) Guidance

- A muscle flap, skin advancement flap, or rotational flap graft performed to surgically replace a pressure ulcer is not a pressure ulcer. It is a surgical wound. Do not report the surgical wound in M1311.
  - Muscle flap, advancement flap, or rotational flap is defined as full thickness skin and subcutaneous tissue partially attached to the body by a narrow strip of tissue so that it retains its blood supply)
- A pressure ulcer treated with a skin graft (defined as transplantation of skin to another site) should not be reported as a pressure ulcer and, until the graft edges completely heal, should be reported as a surgical wound on M1340. *(OASIS-C2, Chapter 3)*

Present on Admission = Present at SOC/ROC

- "Present on Admission" means the pressure ulcer was present at the time of the most recent SOC/ROC, and did not form during this home health quality episode.
- If a pressure ulcer was unstageable at SOC/ROC, but becomes numerically stageable later, when completing the Discharge assessment, its "Present on Admission" stage should be considered the stage at which it first becomes numerically stageable.
  - If the ulcer subsequently increases in numerical stage, do not report the higher stage ulcer as being "present at SOC/ROC" when completing the Discharge assessment.

(OASIS-C2, M1311)

Present on Admission = Present at SOC/ROC

- The general standard of practice for patients starting or resuming care is that patient assessments are completed beginning as close to the actual time of the SOC/ROC (5-day/48-hr. window) as possible. *(OASIS-C2)*
  - If a pressure ulcer that is identified on the SOC date increases in numerical stage (worsens) within the assessment time frame , the initial stage of the pressure ulcer would be reported in M1311 at the SOC.
  - **For example:** At SOC on 8/1, patient has a Stage 2 pressure ulcer and no other pressure ulcers. At a routine visit on 8/3, the pressure ulcer has worsened to a Stage 3. Report the Stage 2 on M1311, A1.

(M1311) Scenario

- Patient was admitted with a Stage 3 pressure ulcer on her right hip at the SOC. She has no other pressure ulcers. At follow-up, the patient's ulcer was assessed as unstageable due to eschar and slough. The patient was discharged 3 weeks later because she was moving in with her daughter who lives in another state. At discharge, the ulcer on the right hip is assessed as a Stage 3. There is a new Stage 2 ulcer on her left hip. How should M1311 be answered at SOC, Follow-up, and Discharge?
  - **SOC/M1311:** B1 = 1 (Stage 3), Line 2 does not apply
  - **Follow-up/M1311:** B1 = 0, E1 = 1 (Unstageable d/t slough)
    B2 = 0, E2 = 0 (Unstageable d/t slough)
  - **Discharge/M1311:** A1 = 1 (Stage 2), B1 = 1 (Stage 3)
    A2 = 0, B2 = 1 (Stage 3)

? How many pressure ulcers worsened?

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(M1313)

Impact

(M1313) Worsening in Pressure Ulcer Status since SOC/ROC:	
Instructions for a-c: Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** at the most recent SOC/ROC. If no current pressure ulcer at a given stage, enter 0.	
	Enter Number
a. Stage 2	
b. Stage 3	
c. Stage 4	
Instructions for e: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were at a Stage 1 or 2 at the most recent SOC/ROC.	
	Enter Number
d. Unstageable – Known or likely but Unstageable due to non-removable dressing.	
e. Unstageable – Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar.	
f. Unstageable – Suspected deep tissue injury in evolution.	

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(M1313)

- Expanded Response-Specific Instructions:
  - Compare the current stage at Discharge to past stages to determine whether any pressure ulcer currently present is new or at an increased numerical stage (worsened) when compared to the most recent SOC/ROC.
  - Count the number of current pressure ulcers that are new or have increased in numerical stage since the last SOC/ROC was completed.
- A pressure ulcer increased in numerical stage from SOC (or ROC) to Discharge, is considered worsened.
- *For pressure ulcers that are currently Stage 2, 3, and 4, "worsening" refers to a pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of 1-4 at the time of discharge in comparison to the most recent SOC/ROC assessment.*

(M1313) Guidance

- A dash (–) value is a valid response for this item. A dash (–) value indicates that no information is available, and/or an item could not be assessed.
- Do not reverse stage pressure ulcers as a way to document healing as it does not accurately characterize what is physiologically occurring as the ulcer heals.
- Pressure ulcers that are Unstageable at Discharge due to a dressing/device, such as a cast that cannot be removed to assess the skin underneath cannot be reported as new or worsened unless no pressure ulcer existed at that site at the most recent SOC/ROC.

(M1313) Guidance

- A previously closed Stage 3 or Stage 4 pressure ulcer that breaks down again should be staged at its worst stage.
- Once a pressure ulcer has fully granulated and the wound surface is completely covered with new epithelial tissue, the wound is considered healed, and should no longer be reported as an unhealed pressure ulcer.
- If a pressure ulcer was unstageable for any reason at the most recent SOC/ROC, do not consider it new or worsened if at some point between SOC/ROC and Discharge it became stageable and remained at that same stage at Discharge.

(M1313) Guidance

- If the pressure ulcer was unstageable at SOC/ROC, then was stageable on a routine visit and/or Follow-Up assessment, and by Discharge the pressure ulcer had increased in numerical stage since the routine visit and/or Follow-Up assessment, it should be considered worsened at Discharge.
- If a previously stageable pressure ulcer becomes unstageable, then was debrided sufficiently to be restaged by Discharge, compare its stage before and after it was deemed unstageable. If the pressure ulcer's stage has increased in numerical staging, report this as worsened.

(M1313) Reporting Algorithm

CURRENT STAGE *at Discharge*	*Look back to most recent SOC/ROC*	PRIOR STAGE *at most recent SOC/ROC*		*REPORT AS NEW OR WORSENED?*
a. Stage 2 *at Discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	▪ **Not present** ▪ **Stage 1** ▪ **Covered with a non-removable dressing/device, then documented as a Stage 1 at any home visit or Follow-Up assessment(s)**	⇨	**YES**
		▪ Stage 2	→	NO
		▪ Stage 3 ▪ Stage 4	→	NA (Stage 3 or 4 could not become a Stage 2)
		▪ Covered with a non-removable dressing/device and remains Unstageable until assessed as a Stage 2 at Discharge	→	NO
b. Stage 3 *at Discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	▪ **Not present** ▪ **Stage 1** ▪ **Stage 2** ▪ **Unstageable with documented Stage 1 and/or 2 at any home visit or Follow-Up assessment(s)**	⇨	**YES**
		▪ Stage 3	→	NO
		▪ Stage 4	→	NA (Stage 4 could not become a Stage 3)
		▪ Unstageable until assessed as a Stage 3 at Discharge	→	NO

(M1313) Reporting Algorithm

CURRENT STAGE *at Discharge*	*Look back to most recent SOC/ROC*	PRIOR STAGE *at most recent SOC/ROC*		*REPORT AS NEW OR WORSENED?*
c. Stage 4 *at Discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	▪ **Not present** ▪ **Stage 1** ▪ **Stage 2** ▪ **Stage 3** ▪ **Unstageable with documented Stage 1, 2, and/or 3 at any home visit or Follow-Up assessment(s)**	⇨	**YES**
		▪ Stage 4 ▪ Unstageable until assessed as a Stage 4 at Discharge	→	NO
d. Unstageable due to non-removable dressing *at Discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	▪ **Not present**	⇨	**YES**
		▪ Stage 1 ▪ Stage 2 ▪ Stage 3 ▪ Stage 4 ▪ Unstageable	→	NO

(M1313) Reporting Algorithm

CURRENT STAGE *at Discharge*	*Look back to most recent SOC/ROC*	PRIOR STAGE *at most recent SOC/ROC*		*REPORT AS NEW OR WORSENED?*
e. Unstageable due to slough and/or eschar *at Discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	▪ **Not present** ▪ **Stage 1** ▪ **Stage 2**	⇨	**YES**
		▪ Stage 3 ▪ Stage 4 ▪ Unstageable	⇨	NO
f. Unstageable – suspected deep tissue injury *at Discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	▪ **Not present** ▪ **Stage 1** ▪ **Stage 2**	⇨	**YES**
		▪ Stage 3 ▪ Stage 4 ▪ Unstageable due to slough and/or eschar		NA (Full thickness pressure ulcer could not become a sDTI)
		▪ Unstageable – Suspected DTI or due to a non-removable dressing/device		NO

DECISIONHEALTH

M1311 / M1313 Example (Part 1)

- Patient had a Stage 2 pressure ulcer on her left hip at SOC. How do you complete M1311 at SOC?
  - **M1311:** A1(Stage 2) = 1 (Line 2 does not apply)
- After two weeks in home health, she was transferred to acute care for 3 days due to pneumonia. At the ROC assessment, the pressure ulcer on her left hip had deteriorated to a Stage 3 and she had a new Stage 1 pressure ulcer on her right hip. Complete M1311 for ROC.
  - **M1311:** B1(Stage 3) = 1

    Line 2 completed at F/U and D/C only

    Stage 1 pressure ulcers are excluded from M1311

DECISIONHEALTH

M1311 / M1313 Example (Part 2)

- At Discharge, the Stage 3 pressure ulcer on her left hip was 80% granulated and the Stage 1 pressure on the right hip had evolved to a Stage 2 pressure ulcer. Complete M1311 and M1313.
  - **M1311 Line 1:** A1(Stage 2) = 1, B1(Stage 3) = 1
  - **M1311 Line 2:** A2(Stage 2) = 0, B2(Stage 3) = 1

    Line 2 is always completed at F/U and D/C

  - **M1313:**
    - **M1313a = 1 -** Stage 2 ulcer worsened

      (Stage 1 ulcer at ROC became Stage 2)
    - **M1313b = 0** - Stage 3 ulcer at ROC remained a Stage 3 ulcer

DECISIONHEALTH

(M1320)

(M1320) Status of Most Problematic Pressure Ulcer that is Observable: (Excludes pressure ulcer that cannot be observed due to a non-removable dressing/device)

Enter Code ☐

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

Do not use Response 0. Newly epithelialized (healed) ulcers should not be reported.

- Includes all Stage 2 or higher pressure ulcers that are not covered with a non-removable dressing.
- The presence of necrotic tissue does NOT make the pressure ulcer "NA – No observable pressure ulcer".
- A pressure ulcer with necrotic tissue (eschar/slough) obscuring the wound base cannot be staged, but its healing status is either:
  - Response 2 – Early/Partial Granulation if necrotic or avascular tissue covers <25% of the wound bed, or
  - Response 3 - Not Healing, if the wound has ≥25% necrotic or avascular tissue.
- Enter "NA" for pressure ulcer sutured closed. *(CMS Qtrly Q&A #15, 10/16)*

DECISIONHEALTH

(M1324)

(M1324) Stage of Most Problematic Unhealed Pressure Ulcer that is Stageable: (Excludes pressure ulcer that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or suspected deep tissue injury.)	
Enter Code ☐	1 Stage 1 2 Stage 2 3 Stage 3 4 Stage 4 NA Patient has no pressure ulcers or no stageable pressure ulcers

- Ulcers that have healed are not considered for this item.
- If a pressure ulcer is Stage 4 at SOC and is granulating at the Follow-up Assessment, the ulcer remains a Stage 4 ulcer.
- Enter "NA" if the patient has NO pressure ulcers or only has pressure ulcers that are Unstageable as defined above.

Pressure Ulcer of the Heel

- Your patient had a pressure ulcer on his right heel that is unstageable due to black stable eschar. How should this be reported at SOC on M1308/M1311?

  - **M1308: d2, Unstageable due to eschar/slough**
  - **M1311: E1, Unstageable due to slough and/or eschar**

Pressure Ulcer of the Heel (Part 2)

During the episode the eschar peels off and leaves an area of fully granulated tissue. Assuming there is no documentation in the record that supports the most advanced stage of the ulcer, how should this ulcer be staged at Discharge on M1308/M1311?

- **M1308: b., Stage 3**
- **M1311: Line 1 B1 = 1 (Stage 3)**
  Line 2 B2 = 1 (Stage 3)
  - Stage 1 and 2 ulcers do not form eschar or slough. Due to the presence of this avascular tissue, the assumption is allowed for the less advanced stage of a Stage 3. *(CMS Q&A #89.6, 04/15)*
  - If a pressure ulcer was unstageable at SOC/ROC, but becomes numerically stageable later, when completing the Discharge assessment, its "Present on Admission" stage should be considered the stage at which it first becomes numerically stageable. *(Chapter 3, M1311)*

- Should this ulcer be reported as worsened in M1309/M1313?
  - **No**

(GG0170C Mobility)

- New in OASIS-C2
- **Time Points:** Collected at SOC/ROC only – not at DC
- **Item Intent:** Identify the patient's need for assistance with the mobility task of moving from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
- **Rationale:** Risk adjustment for development of pressure ulcers, impact on wound healing.
- **Key words:** Usual performance, lying on back to sitting on side of bed, feet flat on floor, no back support, safe, need for assistance, discharge goal.

(GG0170C) Mobility

Code the patient's usual performance at the SOC/ROC using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal.

Coding:

Safety and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activity may be completed with or without assistive devices.

06 **Independent** – Patient completes the activity by him/herself with no assistance from a helper.

05 **Setup or clean-up assistance** – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.

04 **Supervision or touching assistance** – Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.

03 **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.

02 **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

01 **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

07 **Patient refused**

09 **Not applicable**

88 Not attempted due to **medical condition or safety concerns**

1. SOC/ROC Performance	2. Discharge Goal	
↓Enter Response in Boxes↓		
☐☐	☐☐	

Lying to Sitting on Side of Bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.

DECISIONHEALTH

(GG0170C) Performance Levels

- **06 - Independent –** No human assistance.
- **05 - Set-up/Clean-up Assist –** CG assists prior to or after activity, but not during activity.
- **04 - Supervision or Touching Assist** – CG must provide VERBAL CUES or TOUCHING/STEADYING assist as patient completes activity.
- **03 – Partial/moderate Assist –** CG provides less than half of effort. (Lifts, holds, supports trunk or limbs)
- **02 – Substantial/maximal Assist -** CG provides more than half of effort. (Lifts, holds, supports trunk or limbs)
- **01 - Dependent –** CG must provide ALL effort or 2 or more CGs are required to complete activity.

DECISIONHEALTH

(GG0170C) Assessment Steps

- The activity in GG0170C: Lying to Sitting on Side of Bed
  - The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
- Use direct observation and/or patient/CG/family report.
- Have patient perform independently if safe to do so or with CG assistance if needed to be safe. Respond according to level of assistance needed.
- May use assistive device to be safe to complete task. Use of device should not impact score adversely.
- If performance varies, report patient's **usual** performance **not most independent** performance.

(GG0170C) Scoring SOC/ROC Performance

- Report patient's usual status at SOC/ROC using 6-point scale (01 – 06) **OR**,
- If the patient does not attempt the activity and a caregiver does not complete the activity for the patient, report the reason the activity was not attempted.
- Use one of three "activity was not attempted" codes:
  - **07**, Patient refused
  - **09**, Not applicable, patient did not perform this activity prior to the current illness, exacerbation, or injury
  - **88**, Not attempted due to medical or safety concerns
- If no information is available or assessment is not possible for reasons other than above, enter a dash ("–") for 1-SOC/ROC Performance.

(GG0170C) Scoring Discharge Goal

- Report the Discharge Goal using the 6-point scale. Do not use 07, 09, or 88 to report D/C Goal.
- Assessing clinician, in conjunction with patient and family input, can establish the discharge goal.
- For example:
  - Patient expected to make progress, D/G would be higher than SOC/ROC response.
  - Patient not expected to make progress but would be expected to maintain SOC functional level, D/C Goal would be same as SOC score.
  - Patient expected to decline rapidly but skilled therapy services may slow decline of function, D/C Goal would be lower than SOC score.

(GG0170C) Scoring Example

- The patient states he wishes he could get out of bed himself rather than depending on his wife to help. At the SOC the patient requires his wife to do most of the effort.
- Based on the patient's prior functional status, his current diagnoses, the expected length of stay, and his motivation to improve, the clinician expects that by discharge, the patient would likely only require assistance helping his legs off the bed to complete the supine to sitting task.
  - **SOC/ROC Performance = 02, Substantial/maximal assistance**
  - **Discharge Goal = 03 Partial/moderate assistance**

See additional GG0170C examples in Chapter 3, OASIS-C2 Guidance Manual

(M2001) Drug Regimen Review

IMPACT

(M2001)	**Drug Regimen Review:** Did a complete drug regimen review identify potential clinically significant medication issues?
Enter Code ☐	0 No - No issues found during review *[Go to M2010]* 1 Yes - Issues found during review 9 NA - Patient is not taking any medications *[Go to M2040]*

- A positive response on M2001 is required for calculation of IMPACT Measure: *Drug Regimen Review with Follow-up for Identified Issues.*
- "Problems" are now issues.
- If elements of the drug regimen review were skipped (i.e., drug-to-drug interactions), a dash (–) should be reported, indicating the drug regimen review was not completed. *(CMS Qtrly Q&A #21, 10/16)*

Clinically Significant Medication Issues May Include

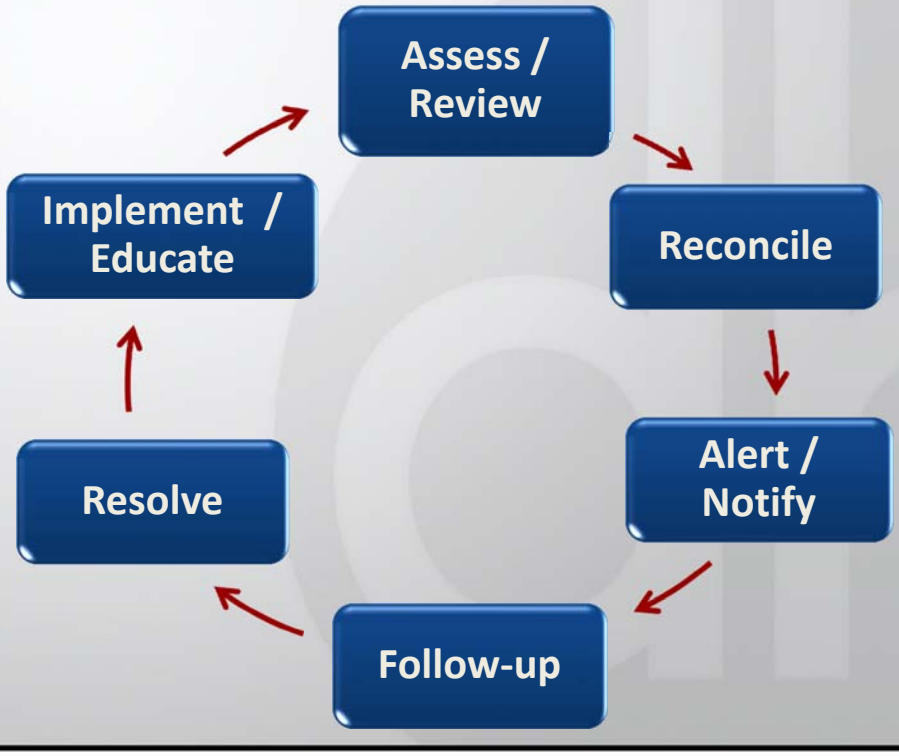
Adverse Drug Reaction	Duplicate Therapy
Ineffective Drug Therapy	Omissions
Side Effects	Dosage Errors (high or low)
Drug-Drug Interactions	Nonadherence
Drug-Food Interactions	

Clinically Significant Issues : Any of the circumstances listed above must reach a level of clinical significance that warrants notification of the physician/physician-designee for orders or recommendations—by midnight of the next calendar day, at the latest. Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue.

(M2001) Drug Regimen Review

- **Includes:** Medication reconciliation, a review of all medications a patient is currently using and review of the drug regimen to identify, and if possible, prevent potential clinically significant medication issues.
- A **potential** clinically significant medication issue is an issue that in the care provider's clinical judgment, requires physician /physician-designee notification by midnight of the next calendar day (at the latest). M2001 includes **existing** clinically significant medication issues as well.
- The comprehensive assessment must be completed by one clinician (the assessing clinician). Collaboration, between the assessing clinician and another clinician is allowed.

Drug Regimen Review Process



(M2003)

(M2003)	**Medication Follow-up:** Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?
Enter Code ☐	0 No 1 Yes

Impact Item

- Revision / Wording change to:
  - Clarify timing (12MN of next calendar day)
  - Emphasize requirement to complete prescribed/recommended actions by 12MN of next calendar day
  - Recommended actions must also occur within the allowed timeframe for the SOC/ROC *(CMS Qtrly Q&A #22, 10/16)*

M2003/M2005: Medication Reconciliation

- Physician notification alone is NOT medication reconciliation.

- In M2003/M2005, Medication follow-up and reconciliation **require**:
  - **2-way communication** with the physician or physician designee regarding the potentially significant medication issue **AND**
  - **Completion of the prescribed / recommended actions** no later than 12 midnight of the next calendar day.

M2003: Response Guidance

- If the physician/physician-designee recommends an action that will take longer than the allowed time to complete, enter **Response 1 – Yes** as long as the agency has taken whatever recommended actions are possible to comply with by midnight of the next calendar day.
  - Includes when a weekend "on-call" physician unfamiliar with the patient directs agency to call the PCP on Monday for further orders. *(CMS Qtrly Q&A #21, 10/16)*
- When multiple potential clinically significant medication issues are identified at the SOC/ROC, all must be communicated to the physician/designee, with completion of ***ALL*** prescribed/recommended actions that are possible to comply with by midnight of the next calendar day in order to enter **Response 1 –Yes**.

M2003: Response Guidance

- If the physician's/designee's **response** to notification of potentially significant issues is that there are no new orders or instructions related to the plan of care, then this completes the requirement for 2-way communication. Enter **Response 1 – Yes.** [Bullet #6 in M2003 should be amended.] *(email clarification from CMSOASISquestions, 8/22/2016)*
  - Document the physician's response in the record.
- If a potential clinically significant medication issue was identified, and the clinician attempted to communicate with the physician, but did not receive communication back from the physician/physician designee until after midnight of the next calendar day, enter **Response 0 – No.**

M2005

Impact

(M2005)	**Medication Intervention:** Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?
Enter Code ☐	0 No 1 Yes 9 NA – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications

- Wording now emphasizes that actions must be taken "**each time** clinically significant medication issues were identified since the SOC/ROC.
- M2005 added to the Death at Home Assessment (RFA 8)
  - "Go to" instruction in M0100, RFA 8 will be corrected to instruct clinician to "Go to M2005", not M0903 *(CMS Qtrly Q&A #1 &3, 10/16)*

(M2401) Intervention Synopsis: (Check only one box in each row.) At the time of or at any time since the most recent SOC/ROC assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

Plan / Intervention	No	Yes	Non-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 missing lower legs due to congenital or acquired condition (bilateral amputee).
b. Falls prevention interventions.	❑0	❑1	❑NA Every standardized, validated multi-factor fall risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no risk for falls.
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment.	❑0	❑1	❑ NA Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the most recent SOC/ROC assessment indicates patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.

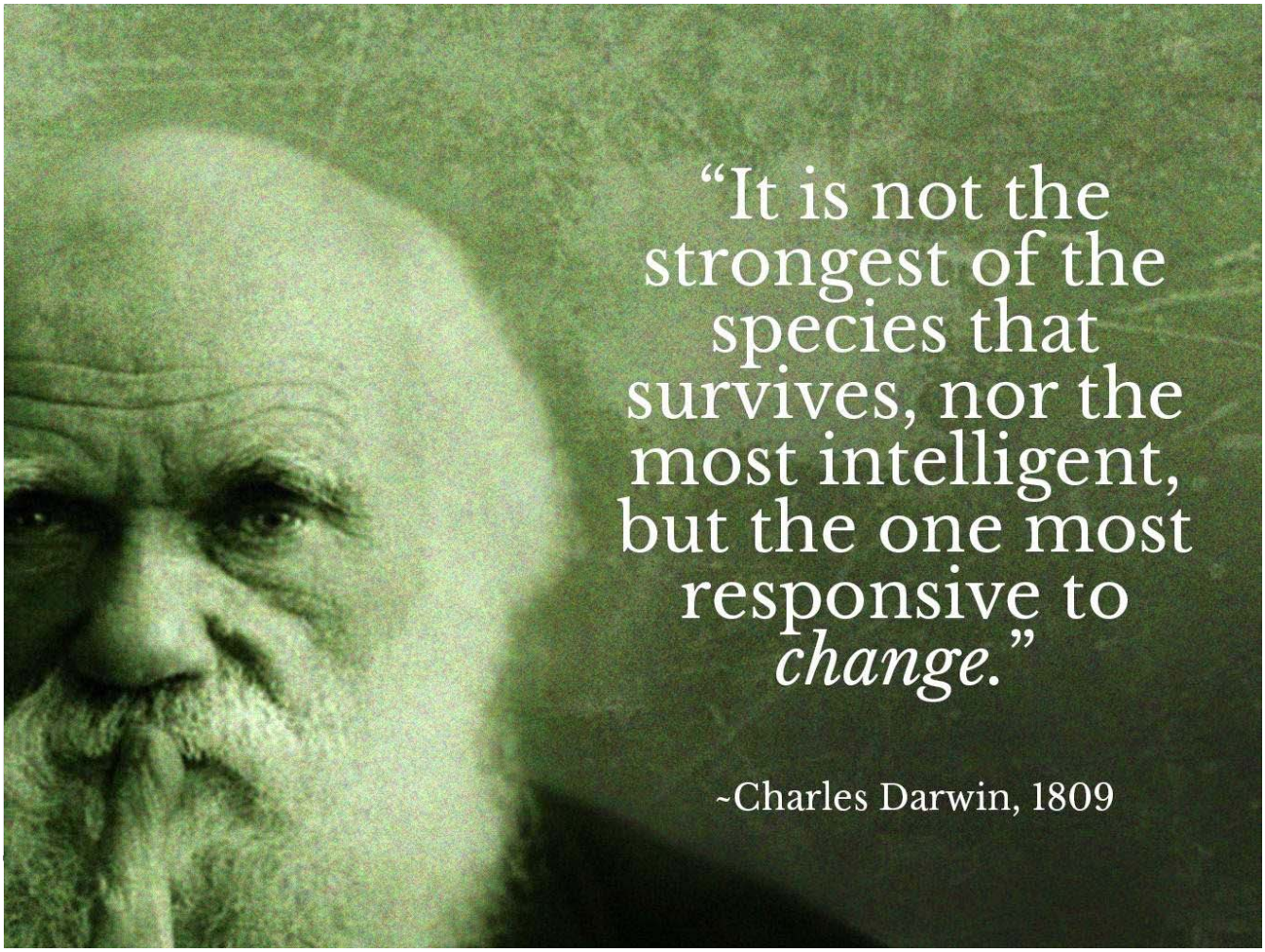
(M2401) Intervention Synopsis: (Check only one box in each row.) At the time of or at any time since the most recent SOC/ROC assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

Plan / Intervention	No	Yes	Non-Applicable
d.. Intervention(s) to monitor and mitigate pain.	❑0	❑1	❑NA Every standardized, validated pain assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no pain.
e. Intervention(s) to prevent pressure ulcers.	❑0	❑1	❑NA Every standardized, validated pressure ulcer risk assessment conducted at or since the most recent SOC/ROC assessment indicates patient is not at risk of developing pressure ulcers.
f. Pressure ulcer treatment based on principles of moist wound healing.	❑0	❑1	❑NA Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

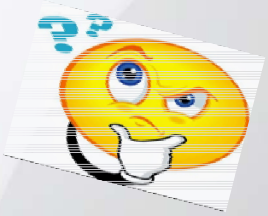
What should we look for in the future?

More Change!

- Release of updated OASIS-C2 wound guidance from WOCN.
- Clarifications from CMS and/or Coding Clinic relative to reporting of pressure ulcers in OASIS and assignment of diagnosis codes.
- Re-configuration and release of the CMS OASIS Q&A master (consolidated) list to conform to OASIS-C2 revisions and numbering.
- Release of new IMPACT mandated items (i.e., falls) in 2017.



What Questions Do You Have?



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Thank you for attending!

Web Site References

- **OASIS-C2 Data Set**
  https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/OASIS-Data-Sets.html
- **OASIS-C2 Guidance Manuals**
  https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html
- **All CMS Q&As for OASIS-C1 and OASIS-C2**
  https://www.qtso.com/hhatrain.html

Web Site References

- **CMS List of State OASIS Education Coordinators (9/21/16)**
  https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/Downloads/OASISeducationalcoordinators.pdf
- **Home Health Quality Reporting Measures**
  https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.html
- **Home Health Star Ratings**
  http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIHomeHealthStarRatings.html

Web Site References

- **WOCN Guidance on OASIS-C1**

  http://c.ymcdn.com/sites/www.wocn.org/resource/resmgr/Publications/WOCN_Guidance_on_OASIS-C1_In.pdf

- **Value Based Purchasing Model – HH VPB**

  https://innovation.cms.gov/initiatives/home-health-value-based-purchasing-model

- **Impact Act of 2014 & Cross Setting Measures**

  https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-of-2014-Data-Standardization-and-Cross-Setting-MeasuresMeasures.html