OAI Quarterly OASIS Update – January 17, 2018

- review of CMS OASIS-related guidance & resources from 4th quarter 2017

OASISanswers

AGENDA:

Session Handouts:
Significant Changes 2018 OASIS Guidance Manual (OAI)
Expansion of the One Clinician Convention (CMS)
Removal of Influenza Measure from QoPC Star Rating (OAI)
2018 Home Health Quality Report Reference (OAI)
Home Health QRP Provider Training (May 2017) Q&As (CMS)
Application Scenarios (OAI)

Updates - NEW Resources from CMS

- Highlight of changes in the 2018 OASIS Guidance Manual
- Expanded One Clinician Guidance_Implemented January 1, 2018
- Changes to the Quality of Patient Care Star Rating Methodology
- Changes to the 2018 Home Health Quality Reports
- OASIS Q&As- review of expanded document released October 2017

Highlights

- *Application Scenarios*

Audience Questions/Answers

This ongoing series of teleconferences is designed to serve as a means of allowing agencies to stay updated on the latest guidelines and expectations from the Centers for Medicare & Medicaid Services (CMS) related to OASIS data collection and related quality measures. Please allow us to meet this goal for the participating audience by focusing your questions on the material presented in today's learning event.

OASIS Questions that relate to existing OASIS guidance or issues otherwise not presented on today's call may be forwarded to your state's OASIS Education Coordinator: OASIS Education Coordinators (by state) posted at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/downloads/OASISeducationalcoordinators.pdf.
Questions related to quality measures and the expansion of the One Clinician Convention may be forwarded to homehealthqualityquestions@cms.hhs.gov (for OASIS and claims-based measures) and hhcahps@rti.org (for HH CAHPS measures).

Presenters:

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UPCOMING TELECONFERENCE SCHEDULE

Wednesday – April 18, 2018

1:00-2:30 Eastern
12:00-1:30 Central
11:00-12:30 Mountain
10:00-11:30 Pacific

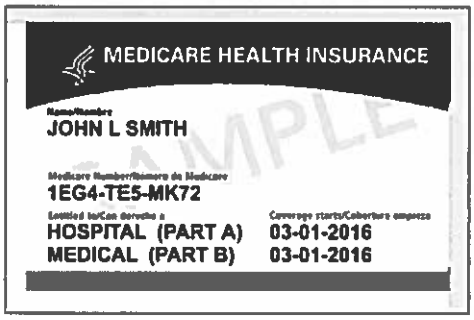
2018 OASIS Guidance Manual Significant Changes

The 2018 version of the OASIS Guidance Manual, effective January 1, 2018, replaces the 2017 OASIS Guidance Manual entirely. There are 5 chapter and 7 Appendices. This chart represents the most significant changes in content. Edits for formatting, correction of typos, punctuation, page numbers, footers etc. are not included in the following table.

2018 OASIS Guidance Manual - Significant Changes	
Chapter 1	
Page 1-5 **Convention #13**	Expands One Clinician Convention: **Only one clinician may take responsibility for accurately completing a comprehensive assessment. However, for all OASIS data items integrated within the comprehensive assessment, collaboration with the patient, caregivers, and other health care personnel, including the physician, pharmacist, and/or other agency staff is appropriate and would not violate the one clinician convention. When collaboration is utilized, the assessing clinician is responsible for considering available input from these other sources and selecting the appropriate OASIS item response(s) within the appropriate timeframe and consistent with data collection guidance.**
Chapter 3	
M0063 Medicare Number	Added guidance for how to handle the replacement of the patient's current Social Security based Health Insurance Claim number (HICN) with his/her new Medicare Beneficiary Identifier (MBI). Transition and mailing of new cards to begin April 1, 2018 with completion by April 2019. *(See Sample below)*
M0102 Date of Physician Ordered SOC/ROC	Deleted Response Specific Instruction (RSI) to "...mark NA if the Physician ordered ROC date extended beyond 2 calendar days of the facility discharge date."
M1028 Active DX	Added RSI: **If the assessment is completed and it is determined that the patient does not have a diagnosis of diabetes, PVD, or PAD, both boxes should be left unchecked.**
M1060 Height and Weight	Added guidance to 4th step for assessment for height and weight: **The assessing clinician should measure the patient's height and weight in accordance with the agency's policies and procedures, which should reflect current standards of practice (shoes off, etc.).** **Data collection for M1060 by self-report or from paperwork from another provider setting is not acceptable.**

M1240 Pain Assessment **M1300 Pressure Ulcer Assessment** **M1501 Symptoms in HF Patients** **M1511 HF Follow-up** **M2010 Pt/CG High Risk Drug Education**	Item intent: Deleted sentence indicating the item is used to calculate process measure.
M1311 Current Number of Unhealed Pressure Ulcers	RSI 2nd bullet: Added "at the same stage". For each pressure ulcer, determine whether the pressure ulcer was present **at the same stage** at the time of the most recent SOC/ROC, and did not form during this home health quality episode.
M1313 Worsening Pressure Ulcer Algorithm	Edited placement of arrows used in 4th column of the table
M1340 Surgical Wound	RSI 7th bullet: thoracotomy corrected to **thoracostomy**
M1350 Skin Lesion/Open Wound	RSI sub bullet: thoracotomies corrected to **thoracostomies**
M1810 Dress Upper Body	RSI, 1st bullet: added "**tasks**" to the end of the sentence. Prosthetic, orthotic, or other support devices applied to the upper body (for example, upper extremity prosthesis, cervical collar, or arm sling) should be considered as upper body dressing items/**tasks.**
GG0170C Mobility	Corrected instruction in chart and changed "response" to "code" **↓Enter Code in Boxes↓**
M2001 Drug Regimen Review	Added RSI: **If elements of the drug regimen review were skipped, (for example drug-to-drug interactions were not completed), a dash (–) should be reported, indicating the drug regimen review was not completed.**
M2102 Types and Sources of Assistance	RSI, Row f: Reworded **Supervision and safety includes needs related to the ability of the**

	patient to safely remain in the home. This category of assistance needs should focus on supervision and safety necessary due to cognitive or mental health issues. Such assistance may range from calls to remind the forgetful patient to take medications, to in-person visits to ensure that a patient with impaired decision making is safe, to the need for the physical presence of another person in the home to ensure that the patient doesn't wander, harm themselves or others or to monitor other safety risks related to cognitive/mental health concerns.
Appendices A-G	Topics include: Data accuracy, OASIS items, Time points and uses table, Data reporting regulations, OASIS and Quality Improvement with sample Casper reports. Appendix F: Contains sample review and correct reports Some of the sample reports edited. Appendix A: OASIS and the comprehensive assessment. Much of the information deleted from this appendix.



Removal of Influenza Measure
from Quality of Patient Care (QoPC) Star Rating

Background

The following activities led to Centers for Medicare & Medicaid Services (CMS) decision to remove the Influenza Immunization Measure from the QoPC Star Rating:

- *January 19, 2017* - CMS proposed two changes to the QoPC methodology: removal of the Influenza Immunization Measure from the QoPC star rating calculation and the addition of the claims-based measure of Emergency Department Use without Hospitalization.
- Stakeholder feedback strongly supported the removal of the Influenza Immunization Measure, but did not support the addition of the Emergency Department Measure.
- *October 10, 2017* - CMS proposed to only remove the Influenza Immunization Measure from the QoPC star rating calculation. Public comment supported the removal of this measure.
- *December 14, 2017* - CMS hosted a webinar that announced the removal of the Influenza Immunization Measure from the QoPC Star Rating calculation.

New Updates Related to the Immunization Measure

- The Influenza Immunization Measure will be removed from the QoPC Star Rating, *but will continue to be reported on Home Health Compare and in other home health quality measure reports*. CMS will monitor measure results in the coming quarters to ensure rates do not decrease.
- There will now be eight measures that comprise the QoPC Star Rating:

  Process Measures
  1. Timely Initiation of Care
  2. Drug Education on all Medications Provided to Patient/Caregiver

  Outcome Measures
  3. Improvement in Ambulation
  4. Improvement in Bed Transferring
  5. Improvement in Bathing
  6. Improvement in Pain Interfering with Activity
  7. Improvement in Dyspnea
  8. Acute Care Hospitalization (claims-based)

- Agencies must have reported data for 5 of the 8 measures to have a rating computed.

Data Collection Dates

2018 QoPC Star Rating Data Reporting Periods	January 2018 Refresh (*with* Influenza measure)	April 2018 Refresh (*without* Influenza measure)
Source	**Begin/End Dates**	**Begin/End Dates**
OASIS data	April 2016 - March 2017	July 2016 – June 2017
Claims data (ACH)	April 2016 - March 2017	July 2016 – June 2017

Report Dates

Type of Report	Influenza Measure	Location
December 2017 ***QoPC Star Rating Provider Preview Report*** • 1st report without Influenza Immunization Measure	NO	CASPER folders
December 2017 **Home Health Compare Provider Preview Report** • Influenza Immunization Measure will remain on the Home Health Compare Provider Preview Reports and on Home Health Compare	YES	CASPER folders
April 2018 • 1st refresh of the ***Quality of Patient Care Star Rating*** on Home Health Compare without the Influenza Immunization measure	NO	QoPC Star Rating on Home Health Compare
NOTE: Immunization Measure will remain on the CASPER REPORTS and on HOME HEALTH COMPARE (and the Home Health Compare Preview Reports)		

References:

1. "Removal of Influenza Vaccination Measure from Quality of Patient Care Star Rating Webinar" transcript and handouts are available on the CMS Home Health Quality Reporting Training page: https://downloads.cms.gov/files/Home-Health-Removal-Influenza-Vaccination-Quality-Rating-Webinar-Transcript.zip and https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/QoPC-Star-Ratings-Call_12_14_17.pdf.
2. Information on the Quality of Patient Care Star Rating is available on the "Home Health Star Ratings" page on the CMS Home Health Quality Initiatives website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIHomeHealthStarRatings.html.

CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS OASIS Q&A - August 2017

Expansion of the One Clinician Convention

Based on feedback from home health stakeholders, and to better align with assessment practices in other Post-Acute Care settings, we have modified the current home care guidance related to the one clinician convention. As required by the Conditions of Participation, the Comprehensive Assessment will continue to be the responsibility of one clinician. However, effective January 1, 2018, the assessing clinician will be allowed to elicit feedback from other agency staff, in order to complete any or all OASIS items integrated within the Comprehensive Assessment.

Again, this new guidance will go into effect January 1, 2018, and at the time should be considered to supersede all previously published guidance related to application of the one clinician convention. Additional clarification is available in Chapter 1 of the 2018 OASIS Guidance Manual.

If providers have questions after reviewing the guidance manual instruction, questions may be submitted to the home health quality help desk at homehealthqualityquestions@cms.hhs.gov.

Question 1. I am aware that it is my responsibility as the assessing clinician to complete the comprehensive assessment document that includes appropriate OASIS data items and the drug regimen review. Can I get help from my interdisciplinary team when collecting OASIS data and selecting responses?

Answer 1. Yes. Effective January 1, 2018, as the assessing clinician, you may elicit input from the patient, caregivers, and other health care personnel, including the physician, the pharmacist and/or other agency staff to assist you in your completion of any or all OASIS items integrated within the comprehensive assessment document.

Some elements, for instance the Clinical Records Items (Patient Name, Birth Date, Medicare Number, etc.), may be completed initially by clerical staff as part of the intake/referral process; but should be verified by the assessing clinician when completing the assessment. For OASIS items requiring a patient assessment, the collaborating healthcare providers (e.g., other agency clinical staff: LPN/LVN, PTA, COTA, MSW, HHA) should have had direct in-person contact with the patient, or have had some other means of gathering information to contribute to the OASIS data collection (health care monitoring devices, video streaming, review of photograph, phone call, etc.) Of course, in their collaborative efforts, all staff, including professional assistants or non-clinical staff, are expected to function within the scope of their practice and state licensure.

For OASIS items that reflect clinical/patient assessment (e.g., height, weight, functional status, pressure ulcer status), HHA's should base OASIS responses on assessment by agency staff, and not directly on documentation from previous care settings.

When collaboration is utilized, the assessing clinician is responsible for considering available input from these other sources, and selecting the appropriate OASIS item response(s), within the appropriate timeframe and consistent with data collection guidance. M0090 (Date Assessment Completed) will indicate the last day the assessing clinician gathered or received any input used to complete the comprehensive assessment document, which includes the OASIS items. The comprehensive assessment is a legal document and when signed by the assessing clinician, the signature serves as an attestation that to the best of his/her knowledge, the document, including OASIS responses, reflects the patient status as assessed, documented and/or supported in the patient's clinical record.

It is the responsibility of the agency to ensure the completeness and accuracy of the OASIS. Agencies should follow practices in accordance with provider policies and procedures related to staff communication and patient information to track and/or identify those staff members contributing to the patient assessment information.

In the case of an unplanned or unexpected discharge (an end of home care where no in-home visit can be made), the last qualified clinician who saw the patient may complete the discharge comprehensive assessment document based on information from his/her last visit. The assessing clinician may supplement the discharge assessment with information documented from patient visits by other agency staff that occurred in the last 5 days that the patient received visits from the agency prior to the unexpected discharge. The "last 5 days that the patient received visits" are defined as the date of the last patient visit, plus the four preceding days.

If desired, agencies may continue to limit the OASIS to only that data directly assessed and collected by the single assessing clinician.

This guidance becomes effective January 1, 2018, and at that time should be considered to supersede all previously published guidance related to application of the one clinician convention.

HOME HEALTH QUALITY REPORTING PROGRAM
PROVIDER TRAINING

PARTICIPANT QUESTIONS FROM IN-PERSON TRAINING ON MAY 3 AND 4, 2017

Current as of October 2017

#	Question Category	Question	Proposed Response
1	Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened and Associated OASIS-C2 Items: M1311 and M1313	Which item is used in the pressure ulcer measure? M1311 or M1313? What was said today in the Quality Reporting Program (QRP) training was said differently then what has been reported previously.	The item used in the calculation of the quality measure is M1313. We trained on M1311 because understanding how to code M1311 helps to understand how to code new or worsened pressure ulcers at M1313.
2	Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened and Associated OASIS-C2 Items: M1311 and M1313	The guidance that the response to M1311 cannot be updated when the pressure ulcer is unstageable at SOC/ROC has great impact on payment for care of that pressure ulcer. Does that same guidance apply to M1324?	The first clinical skin assessment is the assessment used to complete the Outcome and Assessment Information Set (OASIS). This is to ensure consistency of data collection across all post-acute care (PAC) providers. For example, even though the standard assessment timeframe for the Minimum Data Set (MDS) is 7 days and up to 5 days after SOC to complete OASIS, guidance for both MDS and OASIS includes that providers are required to use the initial clinical skin assessment to code the presence of a pressure ulcer. The guidance to assess and report the pressure ulcer stage and status as close to SOC/ROC as possible applies to all OASIS pressure ulcer items.
3	Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened and Associated OASIS-C2 Items: M1311 and M1313	If a patient with a Stage 4 pressure ulcer has a skin graft that is captured as a surgical wound and then heals and remains epithelized for more than 30 days, the wound is now considered a scar and not captured on OASIS. If this same area reopens due to pressure and clinically "looks like" a Stage 2 pressure ulcer, can we capture it as a Stage 4 since the underlying tissue was not replaced, as would happen with a muscle flap?	Skin grafts are considered surgical wounds because skin grafting is a surgical procedure during which skin is sewn into a defect to close the wound. If a Stage 4 pressure ulcer was closed with a skin graft, the surgical wound healed, and another pressure ulcer formed in the same anatomical location due to pressure, then this pressure ulcer would be staged as a Stage 4 (i.e., the highest stage the pressure ulcer was prior to closure). It is important to remember that regardless of whether the Stage 3 or 4 ulcer is closed using a skin graft or via granulation tissue, the original tissues are never replaced. These ulcers can be closed using a skin graft, yet they are more likely to have recurrent breakdown even after such closure. To prevent a recurrence of skin breakdown, preventative efforts should be adhered to .

#	Question Category	Question	Proposed Response
4	Data Submission and Reporting	Is there a plan to address all of the statistically "topped out" quality measures that are impacting the star measure ranking of home health agencies (HHAs)? Patients are used to seeing five stars as good (five-star restaurants, hotels, etc.). If the statistical data continues to rise rapidly such as influenza vaccination requiring 100% to achieve a five-star rating, how does a HHA truly report 100%? Is the data being submitted in the QRP truly accurate? Are there other ways to rate HHAs? Potential examples: • Include patient satisfaction in just one-star ratings. Is what patients are saying about a HHA more important than data that HHAs submit that could be falsely altered to show better numbers? • Use claim-based information. Is there a way to have a star rating that is more familiar to patients, perhaps something similar to hospitals or skilled nursing facilities? Why is it necessary to use a bell curve? Does it matter that more than 5% of HHAs become five star?	We evaluate all measures for continued public reporting on Home Health Compare as well as for use in the Quality of Patient Care star ratings. As more measures become available for consideration for use in star ratings, we will evaluate whether replacing them with the existing measures results in a better summary of agency performance. Additional information regarding the Home Health Quality of Patient Care star rating can be accessed at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIHomeHealthStarRatings.html.
5	Data Submission and Reporting	Can you explain why we see warnings on our validation report showing there was a Health Insurance Prospective Payment System code change from what was originally submitted on the extract file?	This question should be referred to the payment policy staff at HomeHealthPolicy@cms.hhs.gov.

#	Question Category	Question	Proposed Response
6	Data Submission and Reporting	Current Q&A guidance states that if a patient is unexpectedly discharged, the last clinician to see the patient is allowed to complete OASIS and must complete the Discharge OASIS based on the last visit findings. For OASIS items where a dash is a valid response, should a dash be used on the Discharge OASIS, or should the item be answered based on findings from that last visit? Or do we answer based on findings from the last visit, unless it is something not assessed at that visit, and then use the dash only in these instances? For example, a physical therapist (PT) may not have assessed an ulcer at the most recent visit if it was under a dressing, but may have visualized an ulcer that was not covered by a dressing.	In the case of an unexpected discharge, the last qualified clinician to see the patient should complete the Discharge OASIS based on his or her last visit findings. If the clinician did not assess an issue on that last visit, a dash—indicating that no information is available or the item was not assessed—could be used for those limited OASIS items where a dash is a valid response. In situations where it is discovered that there is no one person at the agency who has all the information needed to complete the assessment, it may not be possible to produce a Discharge assessment. This, of course, means you are noncompliant with the Condition of Participation 484.55, Comprehensive Assessment of Patients. The Centers for Medicare & Medicaid Services (CMS) has announced an expansion to the one clinician convention that could assist the last qualified clinician in completing discharge items that may have been assessed by other agency staff. This new guidance becomes effective January 1, 2018, and additional details are available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html.

#	Question Category	Question	Proposed Response
7	Home Health QRP Requirements, Definitions, and Assessments	Slide 57 references the HHA Q&As. My question is as follows: When are the January 2017 and April 2017 Q&As coming out? This is of great concern that Medicare has not completed them or offered HHAs the ability to ask and receive answers back. Running a company in multiple States, we rely on the opportunity to ask, receive clarification, and learn what we are to do to stay within the regulations. This is especially true right now, as there are new conditions of participation. Agencies need to have the Q&As up-to-date so we can follow regulation, report correct data to CMS, and have a proper QRP.	Due to contractual changes, the OASIS Q&A data collection Help Desk and the related OASIS Quarterly Q&A releases are no longer available. The last published CMS Quarterly Q&As available are from October 2016. Questions related to OASIS data collection may be forwarded to your State OASIS Education Coordinator (OEC). A list of OECs by State is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/EducationCoord.html. For OASIS data collection questions that your OEC is not able to address, please contact Peggye Wilkerson at Peggye.Wilkerson@cms.hhs.gov.
8	Home Health QRP Requirements, Definitions, and Assessments	When will we again have a centralized and standardized resource for OASIS Q&As? Right now, it takes up to 3 weeks to get an answer for an OASIS question. In speaking with an OEC, I learned the process now is for the OEC to try to answer using current resources. If no current guidance is available, then the OEC emails all OECs in other States for their opinions. This communication can go back and forth with discussion over several points, and the OEC finally pulls together the various opinions and responds to the question for the requesting agency. There have been situations of different answers in different States, which threatens standardization of data collection. It is essential for agencies to have a resource for timely and consistent answers to OASIS questions, especially as we get new items for the dataset.	Due to contractual changes, the OASIS Q&A data collection Help Desk and the related OASIS Quarterly Q&A releases are no longer available. The last published CMS Quarterly Q&As available are from October 2016. Questions related to OASIS data collection may be forwarded to your State OEC. A list of OECs by State is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/EducationCoord.html. For OASIS data collection questions that your OEC is not able to address, please contact Peggye Wilkerson at Peggye.Wilkerson@cms.hhs.gov. HHAs will be notified of any changes to this process.
9	Home Health QRP Requirements, Definitions, and Assessments	Is the other follow-up used for risk adjustment?	No, the other follow-up is not used for risk adjustment. Only the SOC and ROC are used for risk adjustment.

#	Question Category	Question	Proposed Response
10	Home Health QRP Requirements, Definitions, and Assessments	What is the best way to be compliant with transfers to an inpatient acute facility when you are unsure if the patient is being held for observation or will be admitted to the inpatient facility?	When a home health patient goes to an inpatient facility, the HHA should make efforts to communicate with the facility to determine the patient status (e.g., whether the patient is admitted as an inpatient or in observation status). Based on information available to the agency at the time of the transfer, a transfer assessment should be completed when the criteria for a qualifying patient admission has been met.
11	Home Health QRP Requirements, Definitions, and Assessments	Are star ratings calculated from each quality episode (SOC to ROC and ROC to discharge) or from the time of SOC to the final discharge of the episode?	Star ratings are calculated for all quality episodes: from SOC to transfer, from SOC to discharge, from ROC to transfer, and from ROC to discharge.
12	Home Health QRP Requirements, Definitions, and Assessments	Who sets and requires OASIS-C2? Fee for services? Medicaid? What about Medicare Advantage? Or Medicare HMO?	CMS requires OASIS data collection and submission for all skilled Medicare and Medicaid patients, excluding pediatric and maternity. This would also include managed Medicare and Medicaid.
13	Other	Can a nurse practitioner following a patient at home sign a clinician's verbal orders, or must a medical doctor cosign it? Can the nurse practitioner order lab tests for patients?	This is a payment policy question that should be referred to HomeHealthPolicy@cms.hhs.gov.
14	Other	When will Interpretive Guidelines be out for the July regulations that are now delayed until January? Having Interpretive Guidelines can assist in policy decisions.	This question is outside the scope of the purpose of this OASIS-C2 training. Please refer your question to Peggye Wilkerson at Peggye.Wilkerson@cms.hhs.gov.
15	Other	There have been discrepancies among surveyors and regulatory education regarding diagnoses related to a plan of care (POC). Some still insist that if a patient is on a medication, there should be a diagnosis to substantiate the medication. Others educate us to use the diagnosis appropriate for the patient's current medical issue. As an example, hypothyroidism does not need to be on a POC unless it is not under control.	Only current medical diagnoses should be reported as primary or secondary diagnoses in M1021 and M1023. Diagnoses should be excluded if they are resolved or do not have the potential to affect the skilled services provided by the HHA or the patient's responsiveness to treatment and rehabilitative prognosis. Additional questions related to survey implications for diagnoses and POC should be referred to Peggye Wilkerson in the Survey and Certification Group. Her email address is Peggye.Wilkerson@cms.hhs.gov.

#	Question Category	Question	Proposed Response
16	Other	Is it enough for a physician to sign the 485 to confirm diagnoses? Is the interim order absolutely necessary?	These questions are outside the scope of this OASIS-C2 training. However, the question regarding the reporting of a diagnosis is a topic that Peggye Wilkerson (Peggye.Wilkerson@cms.hhs.gov) can best address.
17	Other	For CMS: Patients have rights, including the right to refuse. I would like to know why HHAs either get "dinged" in quality star ratings for patients who get their flu shots in the physician's office or are unable to be weighed (e.g., weight greater than 400 lbs), and financially dinged for face-to-face and lack of medical office records. Agencies spend a lot of time/money trying to get physicians to supply what we need. We have no control over physicians' actions, yet we are the ones who will have financial implications for not getting what we need.	If a patient receives a flu shot in the physician's office, the HHA should respond by entering code 3, Yes; received from another healthcare provider (e.g., physician, pharmacist) in item M1046. Influenza Vaccine Received: Did the patient receive the influenza vaccine for this year's flu season? Questions related to quality measures and the quality of patient care star rating may be directed to HomeHealthQualityQuestions@cms.hhs.gov. Questions related to face-to-face should be directed to payment policy staff at HomeHealthPolicy@cms.hhs.gov.
18	Drug Regimen Review Conducted with Follow-Up for Identified Issues	How should we complete M2003 if the SOC occurs on a Sunday, the registered nurse (RN) finds a medication issue, and the physician is unavailable within the 24-hour period?	In completing M2003, select response "1 – Yes" when the two-way communication with the physician or physician designee AND completion of the prescribed/recommended actions have occurred by midnight of the next calendar day after the potential clinically significant medication issues were identified, regardless of the assessment's day of the week or the physician's availability.
19	Drug Regimen Review Conducted with Follow-Up for Identified Issues	During medication reconciliation, how far do we look back when the patient has multiple longstanding medications? What is the CMS regulation on the timeframe?	The Drug Regimen Review should consider all medications that the patient is currently using.

#	Question Category	Question	Proposed Response
20	Drug Regimen Review Conducted with Follow-Up for Identified Issues: M2001, M2003, and M2005	Please expand on directing clinicians on using clinical judgement to determine if an issue is clinically significant. 1. Our electronic medical record (EMR) has numerous alerts; some are things like "may require dose adjustment." I would not think that is significant. 2. I would hesitate to recommend clinicians entering all meds into a secondary system or application (increase time, may be more confusing). 3. Physicians are complaining when they are informed about medication combinations the patient has been on for years as an issue. 4. Therapists are especially hesitant not to inform the physician about every alert. 5. Could it be that the physician should be aware of an issue, but may not require the 24-hour timeframe, and therefore is not clinically significant?	Determination of whether a situation is considered a potential clinically significant medication issue is completely up to the clinical judgement of the assessing clinician. This includes interpreting EMR drug review alerts. It is possible for a clinician to determine the physician should be notified of an issue that does not require the timing of "by midnight of the next calendar day," and therefore the issue would not meet the definition of a potential clinically significant medication issue as defined for this item.
21	Drug Regimen Review Conducted with Follow-Up for Identified Issues: M2001, M2003, and M2005	The drug regimen review is done at SOC/ROC. With what frequency should medication updates be made during weekly visits?	The drug regimen review is a required part of every mandatory comprehensive assessment. Agencies may complete a drug review more frequently, as needed, which would be considered a best practice. If, at any time during the quality episode, a potential clinically significant medication issue is identified, information related to this issue (or issues, if there are more than one) and subsequent communications and actions taken would determine the response to M2005 at the next Transfer/Discharge/Death time point.

#	Question Category	Question	Proposed Response
22	Drug Regimen Review Conducted with Follow-Up for Identified Issues: M2001, M2003, and M2005	If a patient is missing a medication at SOC and there is a plan for the medication to be picked up, can a clinician use judgment and select "0 – NO"? For example, a patient ran out of a Calcium 600 mg supplement today, but the caregiver is picking up more later in the day. The clinician determines this is not of a level of significance that requires contact with the medical doctor by midnight of the next calendar day. Can "0 – NO" be selected?	Determination of whether a situation is considered a potential clinically significant medication issue is completely up to the clinical judgement of the assessing clinician. In your example, the clinician determined that this was not a potential clinically significant issue, making "0, No – No issues found during review" an appropriate response for M2001.
23	Drug Regimen Review Conducted with Follow-Up for Identified Issues: M2001, M2003, and M2005	What is the rationale for the 24-hour window for physician response time?	Note that the time for action is not "24 hours," but rather "by midnight of the next calendar day" from the time the potential clinically significant medication issue is identified. 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). This approach and timeframe was informed by input from a cross-setting technical expert panel to provide a standardized definition to identify medication-related issues that need timely notification and collaboration with the physician.
24	Percent of Patients with Pressure Ulcers That Are New or Worsened Covariates: M1028, M1060, and M1620	M1060 reads SOC/ROC. However, if a patient is discharged and readmitted within 30 days, can we use the weight from the previous episode? If the patient was discharged from a HHA episode and then readmitted 10 days later to the same agency, can the agency use its own last recorded weight that was obtained within the 30-day period?	The HHA should attempt to obtain a new weight because the condition of the patient and the reason for readmission to the HHA may have changed since the previous home health episode. If weighing the patient at the new SOC is not possible and a previous agency obtained weight from an M1060 reporting within the 30-day window, that weight can be used at the new SOC.
25	Percent of Patients with Pressure Ulcers That Are New or Worsened Covariates: M1028, M1060, and M1620	During a response to a question from the floor, Ms. Roby indicated that you would leave "weight" blank if unable to obtain it. Chapter 3 does not include instruction to leave either measure blank. Rather, we are to use the dash value when unable to obtain. Please clarify.	M1060 cannot be left blank. Providers should use the dash in M1060b if unable to obtain the weight.

#	Question Category	Question	Proposed Response
26	Percent of Patients with Pressure Ulcers That Are New or Worsened Covariates: M1028, M1060, and M1620	I am wondering why CMS did not use urinary incontinence as a risk adjustment covariate for the risk of a pressure ulcer that is new or worsened since this condition is more frequently encountered in home care?	The measure "Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened" will be risk-adjusted based on an evaluation of potential risk factors and their statistically significant impact on the outcome. The anticipated risk factor covariates found in the measure specifications (March 2017) are proposed to standardize risk adjustment across the four PAC settings. However, the risk model for this measure, including the final determination of which items will be used as covariates, has not yet been fully developed. During testing and research related to this quality measure, bowel incontinence was determined to be a more reliable risk adjuster.
27	Percent of Patients with Pressure Ulcers That Are New or Worsened Covariates: M1028, M1060, and M1620	Is there an opportunity now or in the near future to move toward standardization of height and weight assessment across PAC settings? This would be especially helpful for HHAs, the one uncontrolled setting as compared to the other three inpatient settings. Would it be possible to use height and weight collected in another setting, say within the past 30 days? This would help decrease burden and possibly move us toward standardization as a healthcare system in collecting these data.	The height and weight items added to the OASIS already exist on other assessments across PAC settings and are collected using standardized guidance that requires reporting of height and weight measurements taken by the treating facility/agency. CMS appreciates stakeholder feedback and welcomes provider engagement in developing and refining the QRP.
28	Percent of Patients with Pressure Ulcers That Are New or Worsened: OASIS-C2 Covariate GG0170C	Regarding item GG0170C, a patient used her bed prior to a fall. After discharge from the hospital, she sleeps in a recliner. How do we score this?	If the patient uses a recliner, sofa, or mattress on the floor as a "bed" (preferred or necessary sleeping surface), assess the need for assistance using that sleeping surface when determining ability for GG0170C.

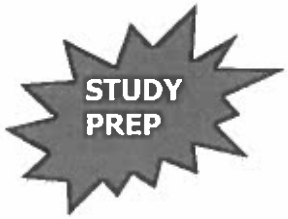
#	Question Category	Question	Proposed Response
29	Percent of Patients with Pressure Ulcers That Are New or Worsened: OASIS-C2 Covariate GG0170C	Within the SOC (5-day window), the RN goes in and the patient refuses to perform the task of lying to sitting that day. The PT goes in for an evaluation visit the next day and the patient agrees. Can both disciplines collaborate upon the PT assessment, and can the RN complete GG, or does it have to be the RN going in again within the 5-day window? In our agency, the PT cannot do SOC OASIS.	Based on current (2017) guidance, the comprehensive assessment must be completed by one clinician. Therefore, the RN may not use the PT assessment findings to complete GG0170C. CMS has announced an expansion to this one clinician convention that would allow the type of collaboration referenced in the posed question. This new guidance becomes effective January 1, 2018, and additional details are available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html.
30	Overview of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014	I have been reviewing the proposed PAC questions by RAND. Will the current OASIS questions on the same topics (e.g., pain) be removed when the new PAC questions are added?	Public comment will inform modifications to the OASIS dataset, with notification provided to stakeholders through formal rulemaking. CMS considered provider burden carefully when proposing new assessment instrument data elements. We will consider removal of items as appropriate. It is important to remember that some items are currently used for different purposes and cannot be changed until new data elements are in place and being used by providers. Therefore, some items may remain even though they are similar to newer data elements, with the eventual goal to reduce redundancy wherever feasible.

OASISanswers

Application Scenarios for Quarterly OASIS Update - January 2018

COS-C Exam Candidates -- Simulate exam conditions by:

- answering the following 7 questions in 10.5 minutes,
- accessing any paper resource you choose for references, &
- recording your response in the corresponding lettered bubble.



Scenario 1: Mr. Renee is discharged from the hospital on Friday with a wound vac in place for treatment of a pressure ulcer, and orders to change the dressing Monday, Wednesday and Friday x 3 wks. The nurse visited Saturday to admit the patient and begin instruction and noted the dressing was in place and equipment functioning appropriately. The RN noted there were no other pressure ulcers present upon skin inspection. The same nurse visited on Monday to change the dressing and visualized the wound as a Stage 3 pressure ulcer.

(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**	☐
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**	☐
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**	☐
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**	☐
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**	☐
F1. Unstageable: Deep tissue injury: Suspected deep tissue injury in evolution **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution**	☐

Q.1: What is the correct response for M1311 at SOC?

A. Row A1 (1); Rows B1, C1, D1, E1, F1 (0)
B. Row B1 (1); Rows A1, C1, D1, E1, F1 (0)
C. Row C1 (1); Rows A1, B1, D1, E1, F1 (0)
D. Row D1 (1); Rows A1, B1, C1, E1, F1 (0)

1. (A) (B) (C) (D)

Scenario 2: Mr. Renee is discharged from the hospital on Friday with a wound vac in place for treatment of a pressure ulcer, and orders to change the dressing Monday, Wednesday and Friday x 3 wks. The nurse visited Saturday to admit the patient and begin instruction and noted the dressing was in place and equipment functioning appropriately. The RN noted there were no other pressure ulcers present upon skin inspection. The same nurse visited on Monday to change the dressing and visualized the wound as a Stage 3 pressure ulcer.

(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

Q.2: What is the correct response for M1324 at SOC?

A. 2 – Stage 2
B. 3 – Stage 3
C. 4 – Stage 4
D. NA Patient has no pressure ulcers or no stageable pressure ulcers

2. (A) (B) (C) (D)

Scenario 3: Mrs. Knott has been receiving services from your agency for several weeks. Prior to her physician's visit on Jan. 15, as the RN case manager, you called the physician's office with a report of her condition and progress and requested visits for 2 more weeks of care and then discharge from the agency. To your surprise, the physician has called with an order the day after the office visit to discharge her from the agency, that she is recovered enough and can manage her own care. You attempt to see Mrs. Knott one more time to conduct the discharge assessment, but she refuses, reporting she is fine. You discharge Mrs. Knott on January 16 unable to conduct a final visit. Agency policy/procedure allows for a collaborative discharge process. Prior to this unexpected discharge, you last made a visit on January 2, LPNs made visits on Jan. 4, 6, 8, 10, 12, and 14.

Q.3: What is a compliant way to complete the discharge OASIS assessment?

A. The RN must complete the discharge assessment based on her visit of Jan. 2 and enter a dash (-) for any OASIS items that were not assessed at the time of that visit.
B. The RN may complete the discharge assessment based only on visits made by agency staff in the last five days of care, the LPN visits on Jan. 12 and 14.
C. The RN may complete the discharge assessment based on the last five visits made, the LPN visits on Jan. 6, 8, 10, 12, and 14.
D. The RN may complete the discharge assessment based on her visit of Jan. 2 supplementing it with information from the LPN visits on Jan. 10, 12, and 14.

3. (A) (B) (C) (D)

Scenario 4: During the drug regimen review at ROC on Saturday, you note Mr. Sleasman is taking both warfarin and aspirin. Your software provides an alert regarding the increased risk for bleeding and your agency policy requires you to notify the physician of this combination upon discovery. Interviewing the patient, you learn he has been on this combination for several years, he makes regular visits to the clinic for PT/INRs and watches his diet for consistent Vitamin K consumption. He denies blood in his stools, bleeding gums or nosebleeds. There is no evidence of excessive bruising during the skin assessment and his blood work during hospitalization was within the physician's parameters. You don't consider this a significant medication issue but follow your agency policy and leave a message for the physician from the home regarding the medication combination. The physician does not call back until Monday and confirms the patient is to continue taking both medications as ordered. There are no other medication issues.

(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

Q.4: What is the best response for M2003 at ROC?

A. This item would be skipped because no potential clinically significant issues were identified in M2001 Drug Regimen Review.

B. 0 - No, because the assessing clinician did not consider the medication combination to be clinically significant.

C. 1 - Yes, because the physician was notified by midnight of the next calendar day.

D. 1 - Yes, because the nurse did everything possible within the assessment time frame.

4. (A) (B) (C) (D)

Scenario 5: Mrs. Casper was admitted on Sept. 10. The admitting clinician, following agency policy, obtained and recorded Mrs. Casper's actual weight of 135 lbs. She was seen for 2 weeks, met her goals and was discharged to the community and the care of her physician on Sept. 24. The agency received a new referral for Mrs. Casper after she stumbled over her sleeping cat and broke her ankle yesterday. She was readmitted to the agency on Sept. 30. The nurse was unable to weigh her due to the cast on her foot. Mrs. Casper reported that when she weighed herself at the grocery store 3 days ago she was 137 lbs. The admitting nurse noted that Mrs. Casper had been weighed by agency staff on Sept. 10 during the SOC assessment in the previous episode.

(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.)

Q.5: What is the best response for M1060 weight?

A. Enter 135 lbs.
B. Enter 137 lbs.
C. Enter "000" for the weight.
D. Skip M1060b weight.

5. (A) (B) (C) (D)

Scenario 6: Mr. Cimillo was admitted to your agency after a fall yesterday resulting in a fractured right shoulder and a physician's order for a sling and swath at all times and to sleep in a recliner. He complains of pain with movement and awkwardly positions himself in the recliner due to the immobilization of his dominant upper extremity. He can manage the chair remote independently to change recliner positions and stop in a sitting position but needs verbal cues for encouragement due to the pain and light touching for guidance to scoot forward in the chair and sit with his feet flat on the floor and his back unsupported. He is frustrated and reports he was able to get in and out of his bed independently without a problem prior to his injury.

Section GG: FUNCTIONAL ABILITIES and GOALS – SOC/ROC

(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:	1. SOC/ROC Performance	2. Discharge Goal	
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.	↓Enter Codes in Boxes↓		
06 **Independent** – Patient completes the activity by him/herself with no assistance from a helper.	☐☐	☐☐	**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.
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**			

Q.6: What is the correct response for GG 0170C SOC Performance?

A. **06 Independent** because he was able to get in and out of his bed independently yesterday.
B. Enter a **Dash (-)** because mobility could not be assessed in a bed.
C. **09 Not applicable** because he does not sleep in a bed.
D. **04 Supervision or touching assistance** because he requires verbal cues and touching assistance for mobility using the recliner.

6. (A) (B) (C) (D)

Scenario 7: The RN is conducting the SOC assessment on Tuesday, January 9. She ambulates Mr. Bieler to the bedroom. While cooperative for most of the assessment, Mr. Bieler refuses to demonstrate lying to sitting on the side of the bed, the bed to chair and back transfer or allow the nurse to assess the skin on his buttocks. The agency policies allow for a collaborative process when completing comprehensive assessments and the nurse calls the therapist scheduled to see Mr. Bieler on Wednesday and asks him to do these assessments. On Wednesday afternoon the nurse and therapist discuss their assessments. The nurse decides the missing assessment information provided by the therapist represents Mr. Bieler's current condition and uses the information to select the pressure ulcer OASIS responses, the SOC performance and goal for GG0170 item and the M1850 transferring item for the SOC comprehensive assessment. The aide reported to the RN that Mr. Bieler was tired and unsteady after the therapy visit and she did not leave him unattended during his shower for his safety. The RN changed her response to M1830 Bathing based on this information from the aide and submitted the comprehensive assessment Wednesday evening.

Q.7: Which statement is false?

A. The assessing clinician may not consider input from a home health aide because aides are not qualified to complete the comprehensive assessment.
B. The clinician responsible for the comprehensive assessment may collaborate with other agency staff who had direct patient contact within the assessment timeframe to complete the SOC comprehensive assessment if agency policy and procedures allow.
C. The M0090 Date assessment completed is January 10.
D. The assessing clinician chooses which input from other agency staff best represents the patient's condition to finish an assessment and/or change her/his OASIS responses.

7. (A) (B) (C) (D)

