Learning Objectives

At the conclusion of this lesson, you will be able to:

• Identify acronyms used in OASIS data collection
• Identify the common uses for OASIS data
• Identify the elements of the comprehensive assessment
  Condition of Participation and compliance with the CoP
• Describe tasks associated with comprehensive assessment
• Explain the value of the comprehensive assessment
• Describe how data collected during the assessment should be analyzed

Content

• What is OASIS?
• The OASIS language
• Why is it important?
• Which patients need OASIS data collection?
• How does it fit into the comprehensive & initial assessments?
• Who can collect the OASIS?
• When does OASIS get collected?
• OASIS items detail
  – What is it?
  – How are the items organized?
  – How are the responses organized?
  – What are the rules that must be followed?
  • Conventions
  • OASIS Item Time Periods
  • Guidance specific to ADLs/IADLs
• Where can I find more information?
What is OASIS?

- Outcome and Assessment Information Set
- Data collection tool
- 70+ items/questions used to collect patient specific information
- Medicare/Medicaid data are submitted to the state

Learning the OASIS Language

- Home care and OASIS language distinctive
- Learning the language decreases frustration
- Some words in OASIS have a different definition than in common English usage.
  - Example: Bathing
    - Common usage – Gathering supplies, preparing water, getting into a tub/shower, washing body, shampooing hair, stepping out of tub/shower, drying off
    - OASIS – Only the act of washing the entire body once in a tub/shower, does not include shampooing hair or any of the other above mentioned activities

A World of Acronyms

- Knowing unique terms and acronyms are essential to your understanding of OASIS. Examples:
  - CMS – Centers for Medicare and Medicaid Services
    - A branch of the Department of Health and Human Services (DHHS) formerly known as the Health Care Financing Administration (HCFA).
  - RFA – Reason for Assessment
    - The reason why assessment data are being collected and reported. These correspond to specific time points. There are eight time points, designated by numbers. For example, RFA 1 relates to data collected at Start of Care - further visits planned & Response 9 relates to RFA 9 - Discharge from agency.
You Need to Know Acronyms

Now It’s Your Turn

• Turn to "Acronyms" tab, look up:
  – ROC
  – IADL
  – OBQI

Why OASIS is important?

• Data are used by CMS & agency to measure quality
  – Outcome Based Quality Improvement or OBQI
  – Outcome Based Quality Monitoring or OBQM/Adverse Events
• Data are used by CMS & other payers for payment
  – Prospective Payment System or PPS
  – Other payers payment models

Why OASIS is important?

• Data are used for survey & audits
  – State surveyors focus survey action based on agency level reports
  – Office of Inspector General & other auditors use data for potential error or fraud detection
• Data are used by consumers
  – Home Health Compare data helps patients decide which agency to select as their home care provider
• Data are used by the agency
  – Case Mix Report directs agency decisions about program development and quality improvement focus.
  – Patient outcomes direct quality initiatives; improve patient care
  – Agency’s good outcomes can attract business and potential employees
Why OASIS is important?

- Data describes current health status and measures change over time
- Change over time = patient outcome
  - Example: End Result Outcome – Improvement in Bathing
  - The patient’s ability to bathe at start of care compared to their ability to bathe at discharge.
- As an agency, how are our patients doing with bathing? What % of our patients improve in their ability to bathe?

OASIS Required Populations

- CMS requires OASIS data collection on skilled Medicare and Medicaid patients
  - Not pediatric, maternity, known one-visit or personal care patients UNLESS the payer needs the Home Health Resource Group (HHRG) for payment
- OASIS data collection on private pay patients is optional
  - Agency policy may require OASIS on private pay
- If private pay and Medicare/Medicaid
  - OASIS required

Comprehensive Assessment of Patients Regulation

- 484.55 Conditions of Participation: Comprehensive Assessment of Patients
  - Published January 1999
  - 5 Standards
    - (a) Initial assessment visit
    - (b) Completion of the comprehensive assessment
    - (c) Drug regimen review
    - (d) Update of the comprehensive assessment
    - (e) Incorporation of OASIS data items

CMS/Gain Cell 3 G4 & Col 1 Q1, Comprehensive Assessment Requirements for HC-approved HHAs.
Comprehensive Assessment

• Patient-specific assessment
• Reflects current health status & information that can be used to demonstrate progress toward goals
• Identify continuing need for home care
• Meet patient’s medical, nursing, rehabilitative, social and DC planning needs
• For Medicare, verify eligibility & homebound
• Must incorporate current version of OASIS

(Conditions of Participation 484.55)

OASIS and The Comprehensive Assessment

• The Comprehensive Assessment includes:
  – OASIS Assessment Items
    • For the OASIS required patient population
    • The agency’s core comprehensive assessment items
      • Varies from agency to agency
      • Examples: Immunization record, vital signs, medication profile, falls risk assessment
    – The agency’s discipline specific assessment items
      • Varies from agency to agency and from discipline to discipline
      • Examples: In-depth assessments of gait/balance, swallowing, perceptual awareness and motor integration

Comprehensive Assessment

• Condition of Participation 484.55
• Must be completed in timely manner
  – Consistent with patient’s immediate needs
  – No later than 5 days after SOC
  – SOC = “day 0”
  – SOC = date of the first billable service
  – May not be completed before the SOC date
  – Does not have to be started or completed on the SOC date, but usually is

(CMS-OASIS OAAv C2 G51 & Cat 6c-G23 1)
Comprehensive Assessment Patient Population Requirements

- Provide ALL patients with a comprehensive assessment except:
  - Clients receiving services entirely limited to housekeeping or chore services
  - OASIS will be a required part of the comprehensive assessment for some patients and not for others
    - Example: OASIS required for Medicare/Medicaid skilled patient but not for maternity patient (unless payer requires it for payment purposes)

(OMS OAA; Cat 2 QA4)

Who Completes the Comprehensive Assessment?

- At SOC, if nursing is ordered, the RN must complete the comprehensive assessment
- If no nursing orders exist, PT or SLP may complete the assessment on Medicare patients
- OT may complete it on non-Medicare patients at SOC, if payer allows.
- After SOC, any discipline may complete the subsequent assessments
- Agency policy may be more restrictive than the federal regulations
  - Example: Agency may require all comprehensive assessments be completed by RNs

(Conditions of Participation 484.31, CMS OASIS OAA; Cat 2 QA5)

Completing the Assessment

Must be completed by one clinician
- If two clinicians are seeing the patient at the same time,
  - Reasonable to confer about the interpretation of assessment data.
  - Reasonable for the clinician performing the assessment to follow-up on any observations of patient status reported by other agency staff.
- Clerical staff may enter demographic and agency ID items – assessing clinician must verify accuracy
- Assessment, however, is the responsibility of one clinician – RN, PT, OT, or SLP.

(OMS OAA; OAA; Cat 2 GS)
What’s an Initial Assessment?

- Condition of Participation 484.55 Comprehensive Assessment of Patients
- First (initial) time patient is seen by agency staff
- Purpose is to determine immediate care and support needs of patient
  - What does this patient need?
  - Can our agency meet the patient’s identified needs?
  - Should we admit this patient?
- If Medicare patient, determines eligibility for benefit and homebound status
- Must be conducted within 48 hours of referral or return home from inpatient facility or on physician ordered SOC date.

(Conditions of Participation 484.55)

Who Performs the Initial Assessment?

- If orders are present for skilled nursing at SOC, RN must conduct the initial assessment visit
- If therapy only
  - Appropriate therapy may perform initial assessment
  - OT may only complete assessment if need for OT establishes program eligibility
    - Not for Medicare
    - Possible for other payers

Initial versus Comprehensive Assessment

- Initial assessment begins to occur when the patient opens their door
  - Determines the patient’s immediate care & support needs, if the patient meets both the agency’s admission criteria and the payer’s benefit requirements
- If time allows, the comprehensive assessment is completed during the same visit
- If unable to complete comprehensive assessment on the first visit, e.g. very late at night & patient is exhausted, it must be completed within 5 days after the SOC, as long as the patient’s immediate needs are met in a timely manner
When does OASIS get collected?

- Time points regulated by the Conditions of Participation & OASIS data collection requirements
- OASIS Reasons for Assessment or RFAs
  - Start of Care (RFA 1)
  - Resumption of Care (RFA 3)
  - Follow-up
    - Recertification (RFA 4)
    - Other Follow-up (RFA 5)
  - Transfer to Inpatient Facility
    - Not Discharged (RFA 6)
    - Discharged (RFA 7)
  - Discharge from Agency – Not to an Inpatient Facility
    - Death at Home (RFA 8)
    - Discharge from agency (RFA 9)

RFA 1 - Start of Care

- OASIS data items are part of the Start of Care comprehensive assessment
- Must be conducted during a home visit
- Completed within 5 days after SOC date

RFA 3 - Resumption of Care

- Following an inpatient stay of 24 hours or longer
- For reasons other than diagnostic tests
- Requires home visit
- Must be completed within 2 calendar days of patient’s return home (or knowledge of the patient’s return home)
RFA 4 - Recertification (Follow-up)

- Comprehensive assessment during the last five days of the 60-day certification period
- Requires a home visit
- If agency misses recert window, but still provides care:
  - Do not discharge & readmit
  - Make a visit and complete Recertification assessment as soon as oversight identified
  - M0090 = the date the assessment
  - A warning message will result
  - Explain circumstances in clinical documentation
  - (CMS Q&A Cat 3 Q11)

RFA 5 - Other Follow-up

- Comprehensive assessment due to a major decline or improvement in patient condition
  - At time other than during last 5 days of the episode or when another OASIS assessment is due
  - Requires a home visit
  - Updates the patient’s plan of care
  - Policies regarding trigger for RFA 5 must be determined by individual agencies
  - (CMS Q&A Cat 3 Q12)

  - Must be completed within 2 calendar days of identification of major change in patient’s condition
  - Agency may call this a “SCIC” assessment
    - Significant Change in Condition
    - Not part of the 2008 PPS
  - (OASIS Assessment Reference Sheet)

RFA 6 - Transfer to Inpatient Facility, (Not Discharged)

- All 3 criteria must be met
  - Transferred and admitted to inpatient facility
  - Stay of 24 hours or longer (in the inpatient bed, not ER)
  - Reasons other than diagnostic tests
- Must be completed within 2 calendar days of Transfer date (M0906) or knowledge of transfer that meets criteria
- Agency’s choice to place “on hold” (vs. D/C)
- Does not require a home visit
- If patient does not return to HHA after inpatient admission, no further assessment required
- This data collection triggers the Acute Care Hospitalization utilization outcome measure
RFA 6 - Transfer to Inpatient Facility, *(Not Discharged)*

- You make a routine visit and discover the patient had a qualifying stay in an inpatient facility and did not inform you.
  - Within 2 calendar days of knowledge of transfer
    - Complete the RFA 6 – Transfer to Inpatient Facility
    - Then, complete the RFA 3 – Resumption of Care

(CMS OASIS O&A Cat 4b Q23.3)

RFA 7 - Transfer to Inpatient Facility, *(Discharged from Agency)*

- Same as RFA 6, but agency decides to discharge patient
  - May be close to end of 60 day episode and patient condition is such that return home during episode is highly unlikely

RFA 8 - Death at Home

- RFA 8 Death at Home = Death anywhere except:
  - Inpatient facility, or
  - The emergency department

- If Patient dies in ER or in inpatient facility (before or after 24 hours)
  - NOT an RFA 8 Death at Home
    - Complete RFA 7 Transfer to Inpatient Facility
      - Usual requirements for RFA 7 waived
        » Admission to an inpatient facility
        » 24 hours or greater
        » for reasons other than diagnostic testing

(CMS O&A Cat 2 Q22)

(OASIS Assessment Reference Sheet)
RFA 8 – Death at Home

- Must be completed within 2 calendar days of death date (M0906)
- Does not require a home visit

Discharge from Agency

- Not due to an inpatient facility admission
- Not due to death
- Must be completed within 2 calendar days of discharge date (M0906) or knowledge of discharge
- Visit is required to complete this assessment

Unexpected or Unplanned Discharge from Agency

- Examples
  - Patient sees physician and physician orders discharge from agency
  - Patient refuses further home care and won’t allow final discharge visit
  - Patient moves unexpectedly
Unexpected or Unplanned Discharge from Agency

• Requirements must be met
  – Discharge assessment must report patient status at an actual visit – not on information gathered during a telephone call
  – Assessment data should be based on the last visit conducted by a qualified clinician - RN, PT, OT, SLP
    • Don't include events that occurred after the last visit by a qualified clinician, e.g. ER visit, Foley DC, change in med/tx regimen

OASIS Data Items

• Standardized items provide ability to measure outcomes and make comparisons across agencies.
• Tested to ensure validity and reliability
• Incorporated into the agency's comprehensive assessment
• Identified by a number beginning with "M"
  – Often referred to as "M00" or "MO" items
• Organized by domain

OASIS Item Domains

• Demographic Items
  – Clinical Record Items (M0010–M0100, M0140 & M0150)
  – Demographics & Patient History (M0175–M0290)
  – Living Arrangements (M0300 & M0340)
  – Supportive Assistance (M0350–M0380)
• Physiologic and Mental Status Domain
  – Sensory Status (M0390–M0430).
  – Integumentary Status (M0440–M0488).
  – Respiratory Status (M0490–M0500).
  – Elimination Status (M0510–M0550).
  – Neuro/Emotional/Behavioral Status (M0560–M0630).
OASIS Item Domains

- **Functional Status**
  - ADLs (M0640–M0710)
  - IADLs (M0720–M0770)
  - Medications/Equipment (M0780–M0820)
  - Therapy Need (M0825)

- **Transfer and Discharge**
  - OASIS items M0830 through M0906

OASIS Item

(M0420) Frequency of Pain interfering with patient's activity or movement:

- □ 0 – Patient has no pain or pain does not interfere with activity or movement
- □ 1 – Less often than daily
- □ 2 – Daily, but not constantly
- □ 3 – All the time

OASIS Item Responses

- "0" Response usually represents the least impaired or most independent status or ability
  - Example: M0690 Transferring
    0 = Able to independently transfer

- Response options usually progress to most impaired or dependent status or ability
  - Example: M0990 Transferring
    5 = Bedfast, unable to transfer and is unable to turn and position self

- Some items require a simple Yes or No
  - Example: M0440 Does this patient have a Skin Lesion or an Open Wound?
    0 = No, 1= Yes
OASIS Item Responses

- NA means the item is not applicable to this patient
- M0770 Ability to Use Telephone
  - NA-Patient does not have a telephone
- M0540 Bowel Incontinence Frequency
  - NA-Patient has ostomy for bowel elimination
- M0464 Status of Most Problematic (Observable Pressure Ulcer)
  - NA-No observable pressure ulcer
- M0570 When Confused
  - NA-Patient nonresponsive

NA - Nonresponsive

- Nonresponsive has an OASIS specific definition
- Unresponsive means unconscious or unable to voluntarily respond
  - A patient with language or cognitive deficits are not automatically considered "unresponsive".
  - May respond by blinking eyes or raising finger
  - A refusal to answer questions is not = "unresponsive"
  - Complete comprehensive assessment and select correct responses based on observation and caregiver interview
- Selection of NA-Nonresponsive for Confusion or Anxiety means the patient episode is not included in the OBQI report

OASIS Item Responses

- ADL (Activities of Daily Living) and IADL (Instrumental Activities of Daily Living) items require two responses at SOC & ROC
- Prior and Current
  - Prior – the patient’s ability on the 14th day directly before the start of home care
    - The exact day even if patient was in the hospital
  - Current – the patient’s ability on the day of assessment
Getting it Right

- You can’t just read the M0 item and think you know what it means.
- You must understand & follow the data collection rules:
  - Chapter 8, OASIS User’s manual
  - Additional guidance provided through Q&As
  - CMS OASIS Q&As at www.qtsq.com website
  - CMS OASIS OCCB Q&As at www.oasiscertificate.org website

Rules & Guidance

Chapter 8:
OASIS User’s Manual

**ASSessment Strategies:**

- Feelings may be observed by the clinician or reported by the patient, family, or others.

**RESPONSE—SPEcific Instructions:**

- Start of care
- Resumption of care
- Discharge from agency - not to an inpatient facility

**TIME POINTS ITEM(S) COMPLETED:**

- Identifies presence of symptoms of depression.

**DEFINITION:**

(M0590) Depressive Feelings Reported or Observed in Patient: (Mark all that apply.)

- 1 - Depressed mood (e.g., feeling sad, tearful)
- 2 - Sense of failure or self reproach
- 3 - Hopelessness
- 4 - Recurrent thoughts of death
- 5 - Thoughts of suicide
- 6 - None of the above feelings observed or reported

Chapter 8 – Item Specific Guidance

**OASIS ITEM:**

(M0855) To which Inpatient Facility has the patient been admitted?

- 1- Hospital [ Go to M0890 ]
- 2- Rehabilitation facility [ Go to M0903 ]
- 3- Nursing home [ Go to M0900 ]
- 4- Hospice [ Go to M0903 ]
- NA - No inpatient facility admission *
  * At inpatient transfer, omit "NA."

**DEFINITION:**

Identifies the type of inpatient facility to which the patient was admitted.
Chapter 8 – Item Specific Guidance

**TIME POINTS ITEM(S) COMPLETED:**
- Transfer to inpatient facility - with or without agency discharge
- Discharge from agency - not to an inpatient facility

**RESPONSE – SPECIFIC INSTRUCTIONS:**
1. Admission to a freestanding rehabilitation hospital or a rehabilitation distinct part unit of a general acute care hospital is considered a rehabilitation facility admission.
2. Admission to a skilled nursing facility (SNF), an intermediate care facility for the mentally retarded (ICF/MR), or a nursing facility (NF) is a nursing home admission.

**ASSESSMENT STRATEGIES:**
Often the family or medical service provider informs the agency that the patient has been admitted to an inpatient facility. Clarify with this informant as to which type facility the patient has been admitted. As a last resort, you may have to contact the facility to determine how it is licensed.

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OASIS Conventions

**Usual Status/Most of the Time**
- Report patient’s usual status during assessment time frame
  - The patient’s status may change from day to day or during a given day
- If ability varies, select response reflecting what’s true most of the time during the day under consideration
  - Greater than 50% of the time

(Chapter 8, pg. A-11)
Usual Status/Most of the Time

Mrs. Jones has taken four meds every morning for 3 years and safely takes each at the right dose and time. After discharge from the hospital, a new PM med was added to her regimen. She forgets to take the PM med 4 out of 7 nights each week.

Is Mrs. Jones independent in the management of her oral medications?

OASIS ITEM:

Management of Oral Medications: Patient's ability to prepare and take all prescribed oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)

Prior Current

†† 0-Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
†† 1-Able to take medication(s) at the correct times if:
   (a) individual dosages are prepared in advance by another person;
   OR
   (b) given daily reminders;
   OR
   (c) someone develops a drug diary or chart.
†† 2-Unable to take medication unless administered by someone else.
†† NA-No oral medications prescribed.
† UK-Unknown

OASIS Conventions

Skip Patterns
- Correct use important
- Skips items not relevant to patient
- Quicker completion

Example: M0350 Assisting Person(s) Other than Home Care Agency Staff
- Response 4 – None of the above [If None of the above, go to M0390]
- Skip M0360, M0370 & M0380 – all of which pertain to a caregiver/assisting person
OASIS Conventions

• No Reference to Prior Assessments
  – To standardize data collection each assessment should be an independent observation at the time point
  – Looking back at prior assessments may bias clinician and influence M0 response selected
  – Exception: Historical data that can not be obtained through assessment
  – Example: M0484 Current Number of (Observable)

Surgical Wounds - Stage of healed pressure ulcer

No Reference to Prior Assessments

Now It’s Your Turn

• Mr. White required the assistance of a walker at all times to ambulate safely at SOC, but by discharge he had made great progress only requiring a cane occasionally. The discharge clinician noted the response for M0700, Ambulation/Locomotion at SOC was “1” and decided to make him a “0” at DC to capture the great improvement.
• Was this the appropriate response for M0700?

OASIS ITEM:

|M0700| Ambulation/Locomotion: Ability to SAFELY walk, once in a standing position, or use a wheel chair, once in a seated position, on a variety of surfaces.

Prior

Current

- 0- Able to independently walk on even and uneven surfaces and climb stairs with or without railings (i.e., needs no human assistance or assistive device).
- 1- Requires use of a device (e.g., cane, walker) to walk alone or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- 2- Able to walk only with the supervision or assistance of another person at all times.
- 3- Chairfast: unable to ambulate but is able to wheel self independently.
- 4- Chairfast, unable to ambulate and is unable to wheel self independently.
- 5- Bedfast, unable to ambulate or be up in a chair.
- UK - Unknown
OASIS Conventions

- Minimize the Use of NA/Unknown
  - Only use when no other response is possible or appropriate
  - If patient refuses to answer, don’t automatically select NA/Unknown
  - If NA/Unknown response selected, patient outcome can’t be computed
  - Example: M0540 Bowel Incontinence Frequency
    - NA appropriate when patient has an ostomy for bowel elimination

Minimize the Use of NA/Unknown

During the SOC assessment, Mr. Brown, who lives alone, was asked if anyone provides him with assistance. He stated "I won’t discuss that with you, move to your next question." During the visit, Meals-on-Wheels delivered lunch and the neighbor stopped by with his medications.

What is the appropriate response for M0350, Assisting Person(s) Other than Home Care Agency Staff?

OASIS ITEM:

(M0350) Assisting Person(s) Other than Home Care Agency Staff:
(Mark all that apply.)

- 1-Relatives, friends, or neighbors living outside the home
- 2-Person residing in the home (EXCLUDING paid help)
- 3- Paid help
- 4- None of the above (If None of the above, go to M0390)
- UK- Unknown (If unknown, go to M0390)
**OASIS Conventions**

- Direct Observation is Preferred
  - The more you observe, the more accurate the assessment
  - When the assessment is accurate, payment and quality outcomes are accurate
  - Problems with relying solely on interview
    - Patients don’t truly understand question
    - Patients are not skilled at clinical assessment
    - Patients may consciously or unconsciously misled clinician
  - Combined observation-interview approach may be needed
    - M0580, When Anxious
  - Patient or in-home caregiver primary source for interview

**Direct Observation is Preferred**

- During the SOC assessment, Mr. Henderson states he is too tired to walk back to the bathroom and is uncomfortable undressing in the living room. He states he has no problems with his skin. Mrs. Henderson confides that he must have some bowel incontinence, as she has noted small stains on his underwear.

- What is the appropriate response for M0440, Skin Lesion or Open Wounds?

**OASIS ITEM:**

(M0440) Does this patient have a Skin Lesion or an Open Wound?

This excludes “OSTOMES.”

- 0-No [ If No, go to M0490 ]
- 1-Yes
OASIS Conventions

• Mark All that Apply
  – Agency quality initiatives depend on complete data
  – Mark all that apply but only when noted
  – Example: M0895 Reason for Hospitalization

OASIS Conventions

• Time Period or Visit Under Consideration
  – Select response that reflects patient usual status or condition on the day of assessment unless otherwise indicated
• Each M0 item has a specific assessment time period
• Most are “Day of Assessment”
• Total of 7 different assessment time periods

(M06 Q&A Cat 4a Q17)

M0 Item Assessment Time Periods

• Day of assessment = 24 hours preceding and including the assessment visit
• OASIS scoring is based on the patient’s usual status, circumstance, or condition.
• Example: M0490, Dyspnea

(M06 Q&A Cat 4a Q17)
When is the patient dyspneic or noticeably Short of Breath?

- **0**: Never, patient is not short of breath
- **1**: When walking more than 20 feet, climbing stairs
- **2**: With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
- **3**: With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
- **4**: At rest (during day or night)

Select response that reflects level of exertion that caused dyspnea during the 24 hours before you walked in the home and include dyspnea you observed while in the home.

M0 Item Assessment Time Periods

- **Day of assessment** - Include a new therapy or service which will occur based on the current assessment:
  - Example: Enteral nutrition will be initiated, psych nursing orders will be received, or antibiotics are ordered to treat a UTI, then the new therapy or service should be reported on the applicable OASIS item.
  - The new therapy or service does not have to begin on the day of the assessment, as long as an order for the new service/treatment needs was obtained on the day of the assessment (or up to 5 days after the SOC date, if allowed by agency policy), in order for it to be included in the OASIS reporting.

- **Other different time periods**
  - Day of Assessment & Recent Pertinent Past
  - During the Past 14 Days
  - Since the Last Time Oasis Data Were Collected
  - Prior to the Inpatient Stay or Prior to the Change in Medical or Treatment Regimen
  - 14 Days Prior
  - Current 60-Day Episode or Subsequent 60-Day Episode
M0 Item Assessment Time Periods

- Day of Assessment & Recent Pertinent Past
- **Example:** M0580 When Anxious
  - Report anxiety observed during assessment visit
  - Report anxiety reported by patient or caregiver
  - You will determine if reported information occurred within a timeframe pertinent to patient’s present condition
- Same for Depressive Feelings and Confusion

**CMS Q&A Cat 4b Q124**

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M0 Item Assessment Time Periods

- **During the Past 14 Days** - 14-Day Period Immediately Preceding the date of the Assessment
- OASIS scoring should be based on events or circumstances that occurred within the 14-day period (span of 14 days) immediately preceding the date of assessment.
- **Example:** M0510 – Urinary Tract Infection
  - Determine 14 day timeframe by counting back 14 days from the SOC, ROC, or Discharge assessment date
  - In addition to the preceding 14 days, events or circumstances occurring on the Day of the Assessment (Day 0) should also be considered in this item

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M0 Item Assessment Time Periods

**AT SOC/ROC:** "14-Day Period Immediately Preceding the SOC/ROC"

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Report inpatient D/C’s during these 14 days

Note: Also include DC from inpatient facilities that occur on same day as SOC/ROC
M0 Item Assessment Time Periods

• Since the Last Time Oasis Data Were Collected
• OASIS scoring should be based on events or circumstances which occurred since the last OASIS data collection time point. This time period could include a period of up to 60 days.
• Includes current events
• Example: M0830 – Emergent Care

M0 Item Assessment Time Periods

• Prior to the Inpatient Stay or Prior to the Change in Medical or Treatment Regimen
• OASIS scoring should be based on events, circumstances or status of the patient prior to the specific events identified
• Example: M0220 – Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days

M0 Item Assessment Time Periods

• 14 Days Prior
• OASIS scoring should be based on the patient’s status 14 days before the start (or resumption) of care (i.e. status on a single day, which occurred 14 days before the assessment). Adhere rigidly to the 14 day criterion.
• Example: M0720 – Planning and Preparing Light Meals (prior)
M0 Item Assessment Time Periods

- **AT SOC/ROC:** “14 Days Prior”

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**Additional Conventions Specific to ADLs/IADLs**

- Ability, Not Performance
- Ability Infers Safety
- Majority/Frequency of the Tasks
- Understand Item Exclusions
- Caregiver Doesn’t Impact Ability

**M0 Item Assessment Time Periods**

- **Current 60 Day Episode or Subsequent 60 Day Episode**
- OASIS scoring should be based on the prediction of events/utilization during an upcoming time period.
- **Example:** Therapy Need [time period under consideration is either the current 60 day episode, or the subsequent 60 day episode]
Ability, not Performance

• Patient’s ability, not necessarily willingness or actual performance
  Example
  – (M0740) Laundry: Ability to do own laundry...
    • “0” – (a) Able to independently take care of all laundry tasks; OR
      (b) Physically, cognitively and mentally able to do laundry and access facilities, but has not routinely performed laundry tasks in the past

Ability, not Performance

• Ability may be temporarily or permanently limited by:
  – Physical impairments
  – Emotional/cognitive/behavioral impairments
  – Sensory impairments
  – Environmental barriers
  – Medical restriction

(Ch. 8, page preceding M0640)

Ability Not Performance

• At the SOC visit, the clinician’s assessment reveals Mr. Jones as cognitively intact with no impairments in the upper extremities or vision. During the visit, Mrs. Jones brings her husband’s medications to him and he states “I would be lost without Edna’s help with my pills.”
• What is the appropriate response for M0780, Management of Oral Medications?
Management of Oral Medications

Patient's ability to prepare and take all prescribed oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)

- Prior: Current
  - O-Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times. (a) Individual dosages are prepared in advance by another person; (b) Given daily reminders; (c) Someone develops a drug diary or chart.
  - I-Able to take medication(s) at the correct times if: (a) Individual dosages are prepared in advance by another person; (b) Given daily reminders; (c) Someone develops a drug diary or chart.
  - 2-Unable to take medication unless administered by someone else.
  - NA-No oral medications prescribed.
  - UK-Unknown

Ability Infers SAFETY

- Patient's ability to safely perform ADL/IADL tasks
  - Determine safety through skilled observation
    - Evaluate: technique used, equipment used, and risk for injury (Ch. 8, page preceding M0640)

Ability Infers Safety

- Mrs. Green can walk to the location in the house where the toilet is located without assistance. The nurse notices that the patient is incontinent of urine as she walks and appears to slip on the wet floor but did not fall.
  - What is the appropriate response for M0680, Toileting?
OASIS ITEM:
[M0690]Toileting: Ability to get to and from the toilet or bedside commode.

**0-Able to get to and from the toilet independently with or without a device.**

**1-When reminded, assisted, or supervised by another person, able to get to and from the toilet.**

**2-Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).**

**3-Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.**

**4-Is totally dependent in toileting.**

**UK-Unknown**

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**Majority/Frequency of Tasks**

**Usual Status/Most of Time**

- When ability varies over time:
  - Report ability >50% of the time

**Majority/Frequency of Tasks**

- When ability varies between tasks:
  - Consider frequency of each activity
  - Response describes patient's ability in the majority of tasks

(CMS OWBT FAQs M0690)

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**Majority/Frequency of Tasks**

Now It's Your Turn

- Ms. Henderson is a morbidly obese MS patient who is unable to bear her weight and must be lifted out of bed with a Hoyer lift. Because of her size, she is unable to use a BSC and her bathroom door is too narrow for her to pass through.

- What is the appropriate response for M0690, Transferring?
Understand OASIS-specific Item Exclusions

What specific task(s) is to be INCLUDED?
What specific task(s) have been CARVED OUT?

Example:
• (M0790) Ambulation/Locomotion: Ability to SAFELY walk, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.
  – What is specifically CARVED OUT?

• Due to muscle weakness in her arms and a cervical and lumbar fusion, Mrs. Slade cannot shampoo her hair. With the assistance of a long handled brush, she is able to wash her entire body safely while she sits on a tub bench.
• What is the appropriate response for M0670, Bathing?
### OASIS ITEM:

**M0670** Bathing: Ability to wash entire body. **Excludes** grooming (washing face and hands only).

<table>
<thead>
<tr>
<th>Prior Current</th>
<th>Current</th>
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<tbody>
<tr>
<td>0 - Able to bathe self in shower or tub independently.</td>
<td>0 - Able to bathe self in shower or tub independently.</td>
</tr>
<tr>
<td>1 - With the use of devices, is able to bathe self in shower or tub independently.</td>
<td>1 - With the use of devices, is able to bathe self in shower or tub independently.</td>
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<tr>
<td>2 - Able to bathe in shower or tub with the assistance of another person: (a) for intermittent supervision or encouragement or reminders, OR (b) to get in and out of the shower or tub, OR (c) for washing difficult to reach areas.</td>
<td>2 - Able to bathe in shower or tub with the assistance of another person: (a) for intermittent supervision or encouragement or reminders, OR (b) to get in and out of the shower or tub, OR (c) for washing difficult to reach areas.</td>
</tr>
<tr>
<td>3 - Participates in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.</td>
<td>3 - Participates in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.</td>
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<tr>
<td>4 - Unable to use the shower or tub and is bathed in bed or bedside chair.</td>
<td>4 - Unable to use the shower or tub and is bathed in bed or bedside chair.</td>
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<tr>
<td>5 - Unable to effectively participate in bathing and is totally bathed by another person.</td>
<td>5 - Unable to effectively participate in bathing and is totally bathed by another person.</td>
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<tr>
<td>UK - Unknown</td>
<td>UK - Unknown</td>
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**Caregiver Doesn't Impact Ability**

- Disregard presence/absence of caregiver when determining ability to complete tasks

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**Caregiver Impact**

- After his wife gets down all his grooming utensils for him, Mr. Smith can groom himself safely. Mrs. Smith was hospitalized and now Mr. Smith is no longer able to safely groom himself.
- What is the appropriate response for M0640, Grooming?
### OASIS ITEM:

(M0640 – Grooming: Ability to tend to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care).)

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<th>Prior</th>
<th>Current</th>
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<tr>
<td>†† 0</td>
<td>Able to groom self unaided, with or without the use of assistive devices or adapted methods.</td>
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<tr>
<td>†† 1</td>
<td>Grooming utensils must be placed within reach before able to complete grooming activities.</td>
</tr>
<tr>
<td>†† 2</td>
<td>Someone must assist the patient to groom self.</td>
</tr>
<tr>
<td>†† 3</td>
<td>Patient depends entirely upon someone else for grooming needs.</td>
</tr>
<tr>
<td>†  UK</td>
<td>Unknown</td>
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### Need to Know

**Item Specific Guidance**

- Follow rules and conventions generally
- After mastering the basics of OASIS data collection, you'll next learn guidance that is specific to certain items
- Guidance found in Chapter 8 and the Q&As

### Where To Find More Information

- OASIS User’s Manual, Chapter 8
- Page 8.1  812 – Introduction, Conventions (Rules) to Follow, Understanding the Meaning of Each Item, Some Unusual Situations: How to Use OASIS, FAQs, General Instructions
- Page preceding M0560 – Neuro/Emotional/Behavioral guidance
- Page preceding M0640 – ADL & IADL guidance
Where To Find More Information

• Conditions of Participation – CoPs
  – 484.55 Comprehensive Assessment of Patients
  • Initial Assessment Visit
  • Completion of the Comprehensive Assessment
  • Drug Regimen Review
  • Update of the Comprehensive Assessment
  • Incorporation of the OASIS Data Items

Where To Find More Information

• Further Clarification of the Rules or Guidance
  – Q&As: CMS OASIS Q&As
    • https://www.qtso.com/hhadownload.html
  – CMS OCCB (OASIS Certificate & Competency Board) OASIS Q&As
    • Posted quarterly
    • www.oasiscertificate.org
  – FAQs in OWBT (OASIS Web-Based Training)
    • www.oasistraining.org

OASIS Implementation Manual

CMS OCCB Q&As

Updates planned Quarterly.
All Existing OCCB Q&As added to CMS Q&As at www.qtso.com website 08/07.

www.oasiscertificate.org

OASIS Web-Based Training (OWBT)
FAQs, Special Alerts and Guidance

Find “Important Resources” under “Reference” New Enhanced Version 3.0 www.oasistraining.org