Home Health
Quality Reporting Program Provider Training

Introduction to OASIS-D

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Qualidigm

August 28, 2018

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How to Download Training Materials

- Training materials can be downloaded from:
  - Home Health Quality Reporting Training page: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Training.html
- The **Downloads** section is at the bottom of the Training web pages

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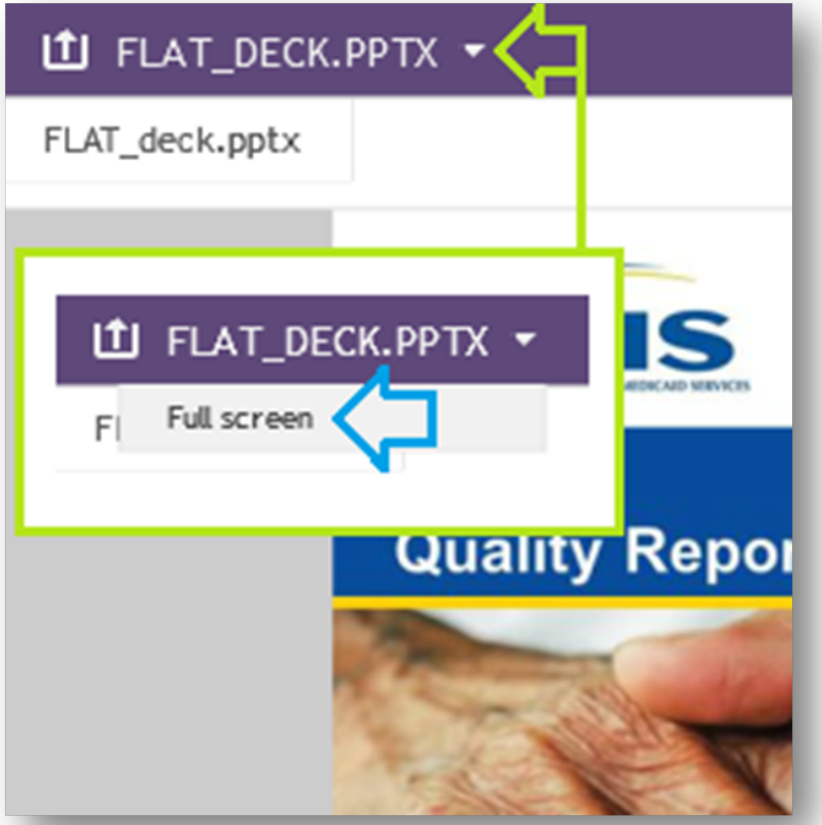

Knowledge Check Questions

- During this presentation, you will be asked to respond to questions that test your knowledge of the material presented
- When prompted with a question, review the options offered and select your answer
- Once you select your answer, it will automatically be submitted for you
- Following a brief pause, the presenter will review the correct responses and rationale for each question

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A. Just me—I am the only one participating

B. Two people

C. Three or four people

D. Five or more people

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Today's Presenters

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Acronyms in This Presentation

- Activities of Daily Living (ADL)
- Certification and Survey Provider Enhancement Reports (CASPER)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Diabetes Mellitus (DM)
- Drug Regimen Review (DRR)
- Home and Community-Based Services Continuity Assessment Record and Evaluation (HCBS CARE)
- Home Health (HH)
- Home Health Agency (HHA)

Acronyms in This Presentation (cont. 1)

- Home Health Quality Reporting Program (HH QRP)
- Home Health Value-Based Purchasing (HH VBP)
- Instrumental Activities of Daily Living (IADL)
- Improving Medicare Post-Acute Care Transformation (IMPACT) Act
- Inpatient Rehabilitation Facility (IRF)
- Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI)
- Long-Term Care Hospital (LTCH)

Acronyms in This Presentation (cont. 2)

- Long-Term Care Hospital Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS)
- Medicare Learning Network (MLN)
- Minimum Data Set (MDS)
- National Pressure Ulcer Advisory Panel (NPUAP)
- Outcome and Assessment Information Set (OASIS)
- Peripheral Arterial Disease (PAD)
- Peripheral Vascular Disease (PVD)
- Post-Acute Care (PAC)

Acronyms in This Presentation (cont. 3)

- Potentially Avoidable Event (PAE)
- Pressure Ulcer (PU)
- Prospective Payment System (PPS)
- Quality Improvement and Evaluation System (QIES)
- QIES Technical Support Office (QTSO)
- Quality Reporting Program (QRP)
- Registered Nurse (RN)
- Resumption of Care (ROC)
- Start of Care (SOC)
- Standardized Patient Assessment Data Elements (SPADEs)

Learning Objectives

1. Describe the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 and resulting changes to Outcome and Assessment Information Set (OASIS)
2. Identify the major changes from OASIS-C2 to OASIS-D
3. Identify available resources for implementing OASIS-D

OASIS-D Training Opportunities

Presentation and recording will be posted on the CMS website

- Introduction to OASIS-D Webinar

August 28, 2018

September 5, 2018

- Introduction to OASIS-D Section GG Webinar

- Q&A Teleconference

Anticipated October/November 2018

Webcast available!

Anticipated October/November 2018

- In-Person Home Health Provider Training, Baltimore, MD

Training Information and Updates

Spotlight and Announcements

- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Spotlight-and-Announcements.html

Home Health Quality Reporting Training

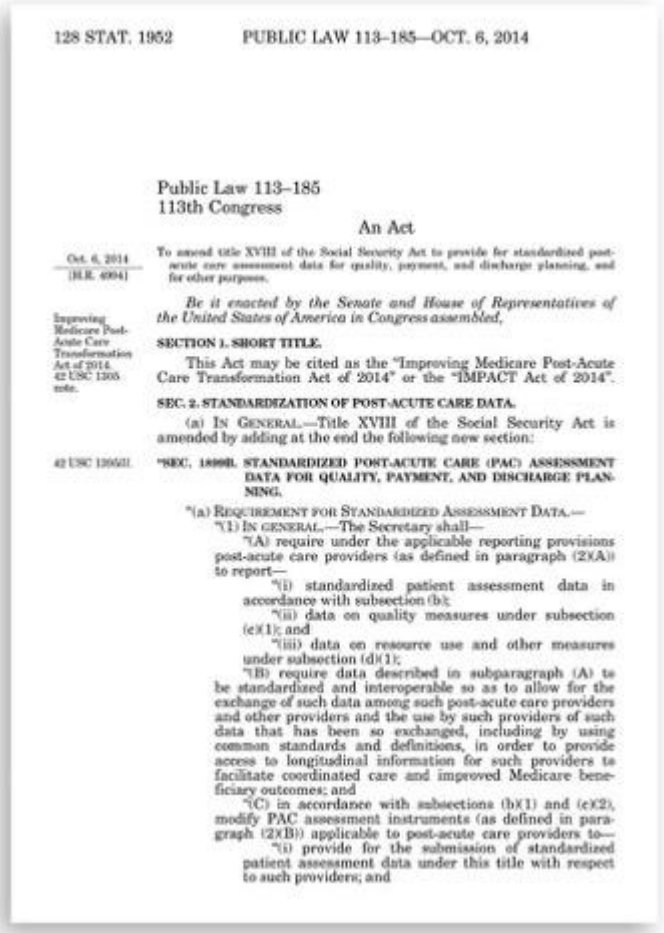
- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Training.html

Overview of OASIS-D and IMPACT Act of 2014

Overview

- IMPACT Act of 2014
- Changes from OASIS-C2 to OASIS-D
  - New, revised, and removed assessment items
  - Rationale for OASIS changes

IMPACT Act of 2014



128 STAT. 1952 PUBLIC LAW 113–185—OCT. 6, 2014

Public Law 113–185
113th Congress

An Act

Oct. 6, 2014 [H.R. 4994]

To amend title XVIII of the Social Security Act to provide for standardized post-acute care assessment data for quality, payment, and discharge planning, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Improving Medicare Post-Acute Care Transformation Act of 2014. 42 USC 1305 note.

SECTION 1. SHORT TITLE.

This Act may be cited as the "Improving Medicare Post-Acute Care Transformation Act of 2014" or the "IMPACT Act of 2014".

SEC. 2. STANDARDIZATION OF POST-ACUTE CARE DATA.

(a) IN GENERAL.—Title XVIII of the Social Security Act is amended by adding at the end the following new section:

42 USC 1395lll.

"**SEC. 1899B. STANDARDIZED POST-ACUTE CARE (PAC) ASSESSMENT DATA FOR QUALITY, PAYMENT, AND DISCHARGE PLANNING.**

"(a) REQUIREMENT FOR STANDARDIZED ASSESSMENT DATA.—

"(1) IN GENERAL.—The Secretary shall—

"(A) require under the applicable reporting provisions post-acute care providers (as defined in paragraph (2)(A)) to report—

"(i) standardized patient assessment data in accordance with subsection (b);

"(ii) data on quality measures under subsection (c)(1); and

"(iii) data on resource use and other measures under subsection (d)(1);

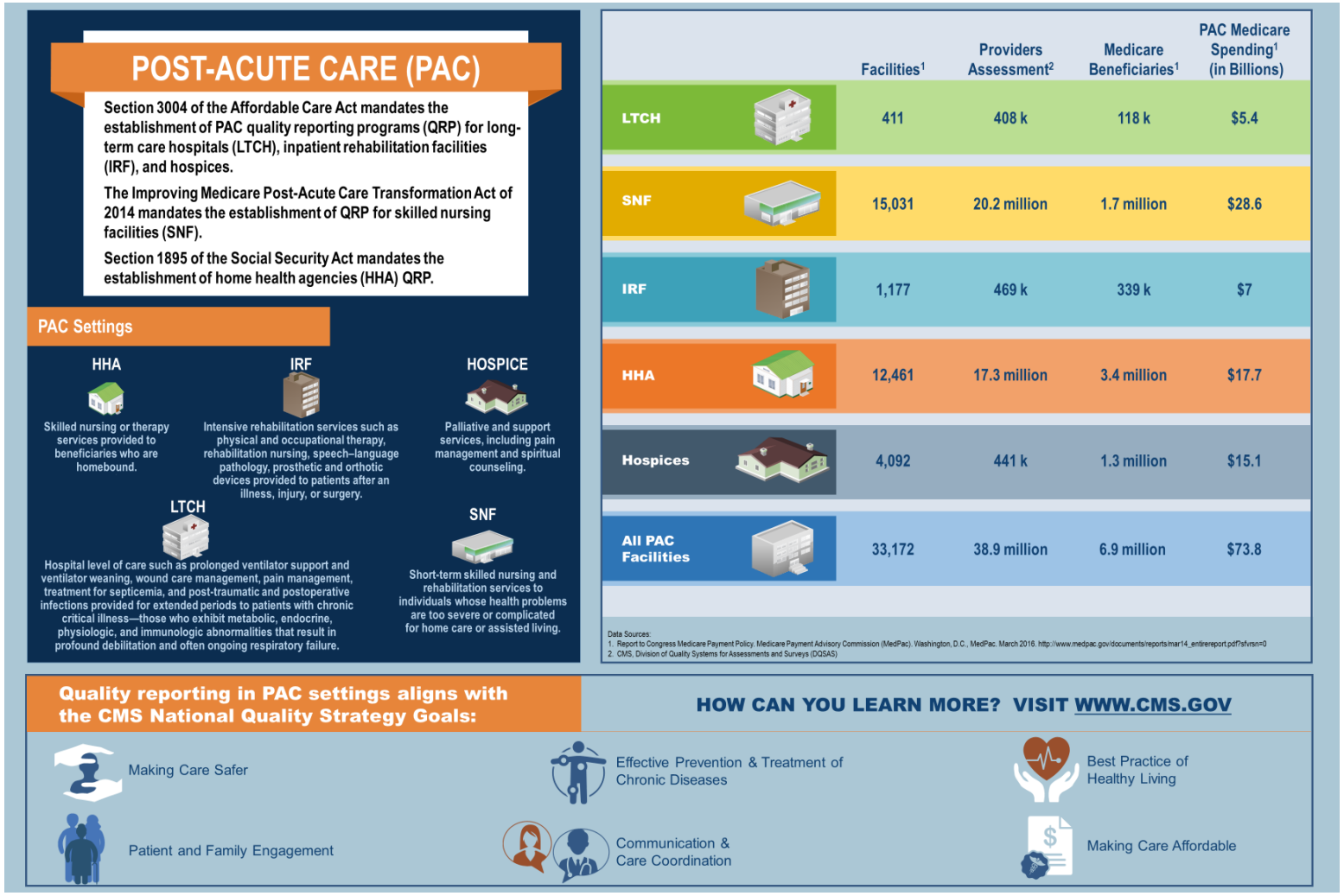
"(B) require data described in subparagraph (A) to be standardized and interoperable so as to allow for the exchange of such data among such post-acute care providers and other providers and the use by such providers of such data that has been so exchanged, including by using common standards and definitions, in order to provide access to longitudinal information for such providers to facilitate coordinated care and improved Medicare beneficiary outcomes; and

"(C) in accordance with subsections (b)(1) and (c)(2), modify PAC assessment instruments (as defined in paragraph (2)(B)) applicable to post-acute care providers to—

"(i) provide for the submission of standardized patient assessment data under this title with respect to such providers; and

- Bipartisan bill signed into law by President Obama on October 6, 2014
- Requires post-acute care (PAC) providers to report standardized patient assessment data and quality measure data

PAC Matters
LTCH, IRF, HHA, Nursing Homes



Driving Forces of the IMPACT Act

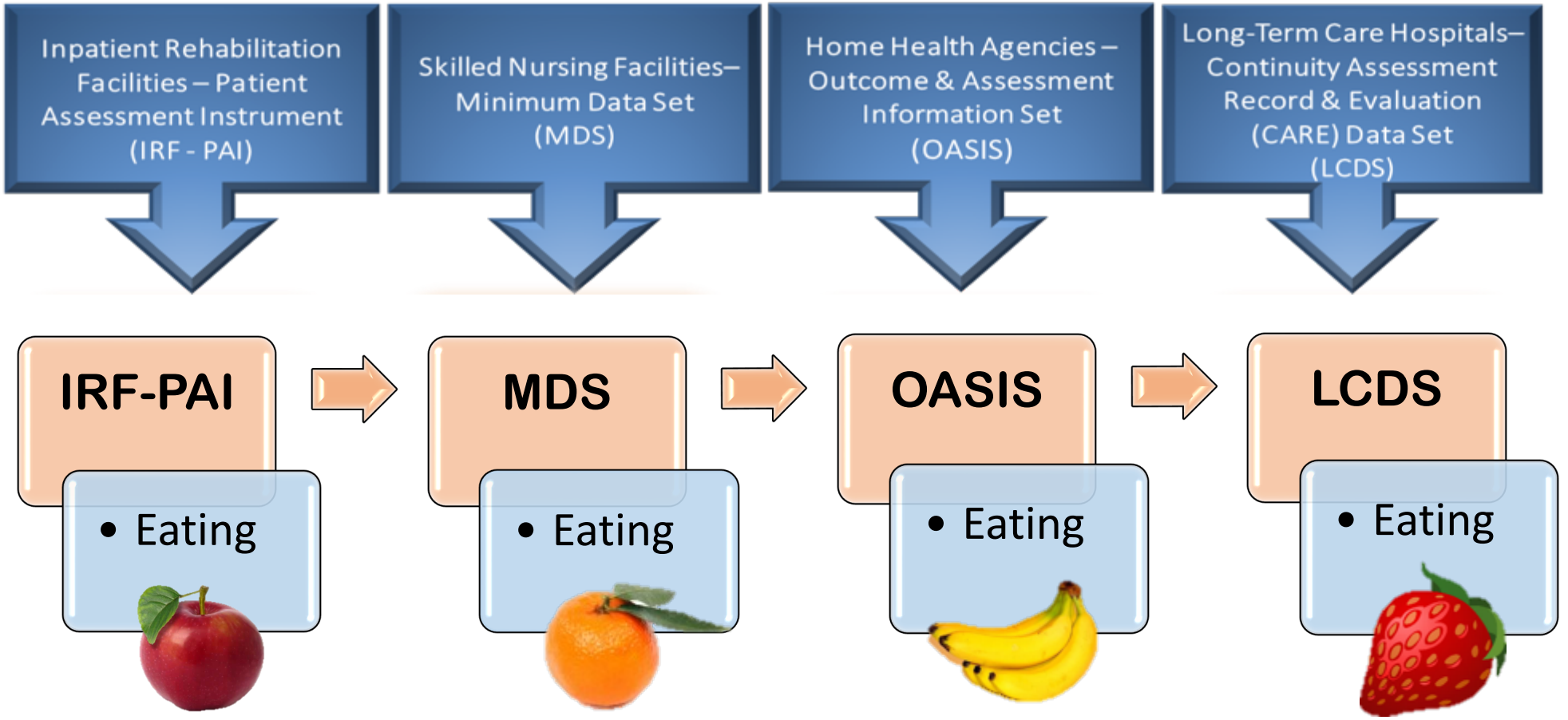
Purpose:

- Improve Medicare beneficiary outcomes
- Provide access to longitudinal data to facilitate coordinated care
- Enable comparable data and quality across PAC settings
- Improve hospital discharge planning
- Research

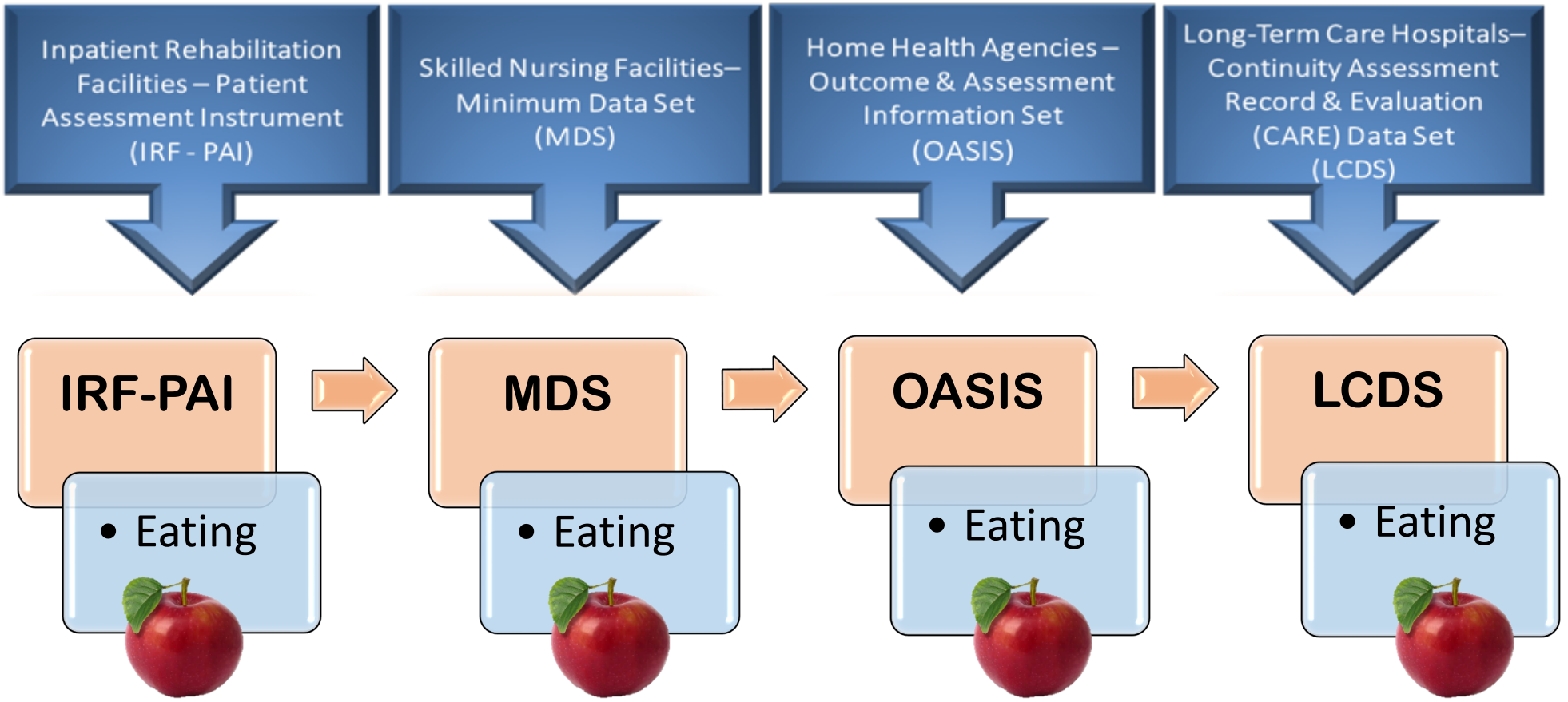
Why the attention on Post-Acute Care?

- Escalating costs associated with PAC
- Lack of data standards/interoperability across PAC
- Goal of establishing payment rates according to the individual characteristics of the patient, not the care setting

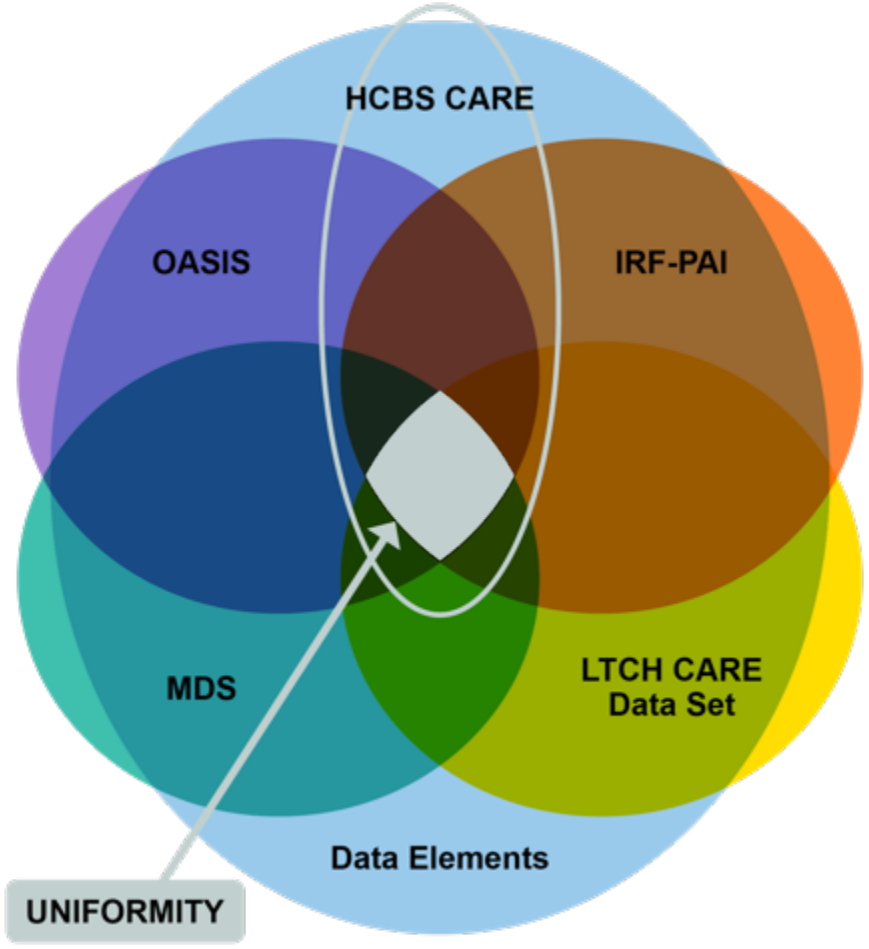
What Is Standardization?
Standardizing Function at the Item Level



What Is Standardization?
Standardizing Function at the Item Level (cont.)



Standardized Patient Assessment Data Elements (SPADEs)



- **SPADEs**:
  - Question and response options that are identical in all four PAC assessment instruments
  - Identical standards and definitions apply
- The move toward standardized assessment data elements facilitates cross-setting data collection, quality measurement, outcome comparison, and interoperable data exchange

CMS YouTube Channel

- **Overview of the IMPACT Act**
  - This video from the November 2016 HH Quality Reporting Program (QRP) Provider Training held November 16 and 17, 2016, presents an overview of the IMPACT Act of 2014

https://www.youtube.com/watch?v=xyoC-ZnrZMw

Overview of OASIS Changes, Effective January 1, 2019

6 New Items

- GG0100
- GG0110
- GG0130
- GG0170
- J1800
- J1900

7 Revised Items

- M1028
- M1306
- M1311
- M1322
- M1324
- M2102
- M2310

28 Removed Items

- M0903, M1011, M1017, M1018, M1025, M1034, M1036, M1210, M1220, M1230, M1240, M1300, M1302, M1313, M1320, M1350, M1410, M1501, M1511, M1615, M1750, M1880, M1890, M1900, M2040, M2110, M2250, M2430

Overview of Guidance Manual Changes

Guidance Manual Changes for 33 Items

M0080, M0090, M0102, M1021, M1023, M1046, M1056, M1060, M1307, M1332, M1334, M1342, M1610, M1730, M1800, M1810, M1820, M1830, M1840, M1845, M1850, M1860, M1870, M1910, M2001, M2003, M2005, M2010, M2016, M2020, M2030, M2301, M2401

Why Is OASIS Being Changed?

IMPACT Act/ Standardization

New Standardized Items

- Section J: J1800 & J1900
- Section GG: GG0100, GG0110, GG0130 & GG0170

Cross-Setting Alignment

Alignment in content of items that support cross-setting measures

- Drug Regimen Review (DRR)
- Pressure Ulcers
- Active Diagnoses
- Height & Weight

Comprehensive Item Use Evaluation

Reduction of burden

- Quality measure changes
- Survey and certification

Updates/ Corrections

General updates/ corrections made as necessary

OASIS-D: New Items

Section J: Health Conditions (Falls)

- J1800. Any Falls Since SOC/ROC
- J1900. Number of Falls Since SOC/ROC

Section GG: Functional Abilities and Goals

- GG0100. Prior Functioning: Everyday Activities
- GG0110. Prior Device Use
- GG0130. Self-Care
- GG0170. Mobility

OASIS-D: New Items and Time Points

Section	Item	Time Points Completed
Section J: Health Conditions (Falls)	• J1800. Any Falls Since SOC/ROC • J1900. Number of Falls Since SOC/ROC	• Transfer • Discharge from Agency – Not to an Inpatient Facility • Death at home
Section GG: Functional Abilities and Goals	• GG0100. Prior Functioning: Everyday Activities • GG0110. Prior Device Use	• Start of care (SOC) • Resumption of care (ROC)
	• GG0130. Self-Care • GG0170. Mobility	• SOC • ROC • Follow-Up • Discharge from Agency – Not to an Inpatient Facility

OASIS-D: Revised Items

M1028	Active Diagnoses
M1306	Unhealed Pressure Ulcer/Injury at Stage 2 or Higher?
M1311	Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage
M1322	Current Number of Stage 1 Pressure Injuries
M1324	Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable
M2102	Types and Sources of Assistance
M2310	Reason for Emergent Care

Data Items Removed From OASIS

- In 2017, CMS undertook a comprehensive review of the OASIS
- **28** OASIS items identified for removal to reduce data collection burden

Why Were These Items Removed?

- OASIS items were removed if they were not used to support:
  - HH QRP measures
  - HH Prospective Payment System (PPS)
  - Survey process for Medicare certification
  - HH Value-Based Purchasing (VBP) demonstration measures
  - Critical risk-adjustment factors
  - Conditions of Participation

OASIS-D: Removed Items

Item	Item Description	SOC	ROC	Follow-Up	Transfer to an Inpatient Facility	Death at Home	Discharge from Agency
M0903	Date of Last Home Visit				X	X	X
M1011	Inpatient Diagnosis	X	X	X			
M1017	Diagnoses, Treatment Regimen Change	X	X				
M1018	Conditions Prior	X	X				
M1025	Optional Diagnoses	X	X	X			
M1034	Overall Status	X	X				
M1036	Risk Factors	X	X				

OASIS-D: Removed Items (cont. 1)

Item	Item Description	SOC	ROC	Follow-Up	Transfer to an Inpatient Facility	Death at Home	Discharge from Agency
M1210	Ability to Hear	X	X				
M1220	Understanding Verbal Content	X	X				X
M1230	Speech and Oral Expression	X	X				
M1240	Pain Assessment	X	X				
M1300	Pressure Ulcer (PU) Assessment	X	X				
M1302	Risk of Developing PUs	X	X				
M1313	Worsening in PU Status						X
M1320	Status of Most Problematic PU	X	X				X
M1350	Skin Lesion or Open Wound	X	X				

OASIS-D: Removed Items (cont. 2)

Item	Item Description	SOC	ROC	Follow-Up	Transfer to an Inpatient Facility	Death at Home	Discharge from Agency
M1410	Respiratory Treatments	X	X				
M1501	Symptoms in Heart Failure Patients				X		X
M1511	Heart Failure Follow-up				X		X
M1615	When does Urinary Incontinence occur?	X	X				X
M1750	Psychiatric Nursing Services	X	X				
M1880	Ability to Plan and Prepare Light Meals	X	X				X
M1890	Ability to Use Telephone	X	X				X

OASIS-D: Removed Items (cont. 3)

Item	Item Description	SOC	ROC	Follow-Up	Transfer to an Inpatient Facility	Death at Home	Discharge from Agency
M1900	Prior Functioning	X	X				
M2040	Prior Medication Management	X	X				
M2110	How often does the patient receive ADL or IADL assistance?	X	X				
M2250	Plan of Care Synopsis	X	X				
M2430	Reason for Hospitalization				X		

OASIS-D: Removal From Discharge Time Point Only

Item	Item Description	SOC	ROC	Follow-Up	Transfer to an Inpatient Facility	Death at Home	Discharge from Agency
M1610	Urinary Incontinence or Urinary Catheter Presence	✓	✓	✓			X
M1322	Current Number of Stage 1 Pressure Ulcers	✓	✓	✓			X
M1332	Current Number of Stasis Ulcers that are Observable	✓	✓	✓			X
M2030	Management of Injectable Medications	✓	✓	✓			X

OASIS-D: Select Item Response Removals

Item	Item Description	SOC	ROC	Follow-Up	Transfer to an Inpatient Facility	Death at Home	Discharge from Agency
M2102	Types and Sources of Assistance	6* out of 7 response options removed	6* out of 7 response options removed				3** out of 7 response options removed
M2310	Reason for Emergent Care				15*** out of 19*** response options removed		15*** out of 19*** response options removed

* M2102 row f to remain collected at SOC, ROC, and Discharge From Agency as part of the HH VBP program

** M2102 rows a, c, and d to remain collected at Discharge From Agency for survey purposes

*** M2310 responses 1, 10, OTH, UK to remain collected at Transfer to an Inpatient Facility and Discharge From Agency for survey purposes

Revised Skip Patterns

- Skip pattern changes resulting from item removals:

M1000	Inpatient Facility Discharge
M1051	Pneumococcal Vaccine
M1306	Unhealed Pressure Ulcer/Injury at Stage 2 or Higher
M1311	Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage
M1340	Does This Patient Have a Surgical Wound?
M1610	Urinary Incontinence or Urinary Catheter Presence
M2001	Drug Regimen Review
M2410	Which Inpatient Facility Has the Patient Been Admitted?
M2420	Discharge Disposition

New OASIS-D Assessment Items

Section J: Health Conditions

Section J: Overview

- Describe the new assessment items in Section J: Health Conditions
  - Time points completed
  - Item intent
  - Definitions
  - Coding instructions
- Apply coding instructions to accurately code practice scenarios

Section J: New Items

J1800: Any Falls Since SOC/ROC, whichever is more recent

Time Points Completed:
- Transfer
- Discharge – not to an Inpatient Facility
- Death at Home

J1900: Number of Falls Since SOC/ROC, whichever is more recent

Time Points Completed:
- Transfer
- Discharge – not to an Inpatient Facility
- Death at Home

Section J: New Items (cont.)

J1800.	**Any Falls Since SOC/ROC,** whichever is more recent
Enter Code ☐	Has the patient **had any falls since SOC/ROC,** whichever is more recent**?** 0. **No** → Skip J1900 1. **Yes** → Continue to J1900, Number of Falls Since SOC/ROC, whichever is more recent

J1900.	**Number of Falls Since SOC/ROC,** whichever is more recent	
CODING: 0. None 1. One 2. Two or more	↓ **Enter Codes in Boxes**	
	☐	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	☐	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	☐	**C. Major injury:** Bone **fractures**, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

J1800:

Any Falls Since SOC/ROC,

whichever is more recent

New OASIS-D Item: J1800

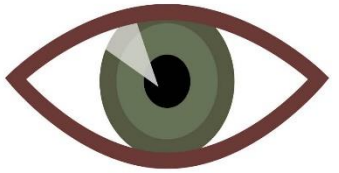
J1800.	**Any Falls Since SOC/ROC,** whichever is more recent
Enter Code ☐	Has the patient **had any falls since SOC/ROC,** whichever is more recent**?** 0. **No** → Skip J1900 1. **Yes** → Continue to J1900, Number of Falls Since SOC/ROC, whichever is more recent

J1800 Intent

- Identifies if the patient had any witnessed or unwitnessed falls since the most recent SOC/ROC

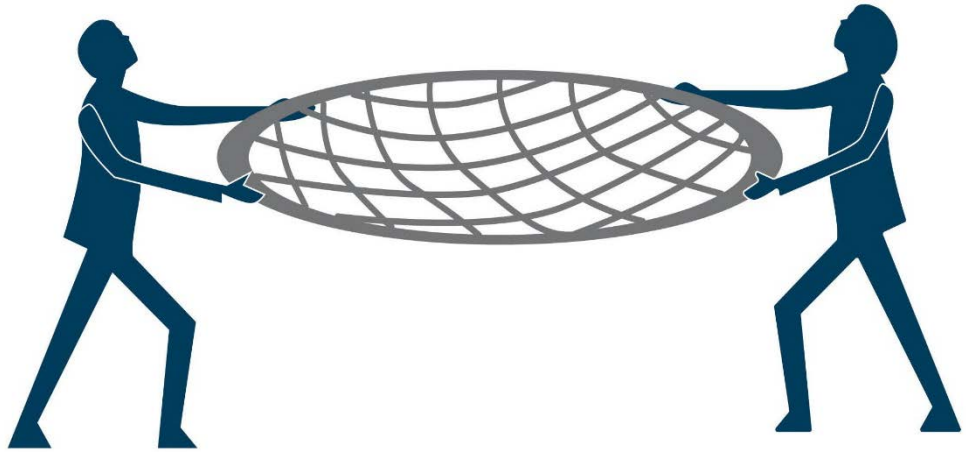
Definition of a Fall

- Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface
  - E.g., a bed or chair
- Fall may be witnessed or unwitnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground
- Not a result of an overwhelming external force
  - E.g., a person pushes a patient



Definition of Intercepted Fall

- An **intercepted fall** occurs when the patient would have fallen if he or she:
  - Had not caught him/herself
  - Had not been intercepted by another person
- **An intercepted fall is considered a fall**



Challenging a Patient's Balance

- CMS understands that challenging a patient's balance and training him/her to recover from a loss of balance is an intentional therapeutic intervention and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls

J1800 Response-Specific Instructions

- **Review:**
  - Home health clinical record
  - Incident reports
  - Other relevant clinical documentation
    - Fall logs
- **Interview** patient and/or caregiver about occurrence of falls

J1800 Coding Instructions

- **Code 0, No,** if the patient has not had any fall since the most recent SOC/ROC
- **Code 1, Yes,** if the patient has fallen since the most recent SOC/ROC
  - Code falls no matter where the fall occurred
- **A dash** is a valid response for this item. CMS expects dash use to be a rare occurrence

J1800.	**Any Falls Since SOC/ROC,** whichever is more recent
Enter Code ☐	Has the patient **had any falls since SOC/ROC,** whichever is more recent**?** 0. **No** → Skip J1900 1. **Yes** → Continue to J1900, Number of Falls Since SOC/ROC, whichever is more recent

J1800 Practice Coding Scenario 1

- The discharging registered nurse (RN) reviews the clinical record and interviews the patient and caregiver, Mrs. K and her daughter Susan, determining that a single fall occurred since the most recent SOC/ROC
- The fall is documented on a clinical note from an RN home visit in which Susan reported her mother slipped from her wheelchair to the floor the previous day

How would you code J1800. Any Falls Since SOC/ROC?

A. Code **0**, No

B. Code **1**, Yes

J1800 Practice Coding Scenario 2

- An incident report describes an event in which Mr. S appeared to slip on a wet spot on the floor during a home health aide bath visit
- He lost his balance and bumped into the wall, but was able to steady himself and remain standing

How would you code J1800. Any Falls Since SOC/ROC?

A. Code **0**, No

B. Code **1**, Yes

J1800 Practice Coding Scenario 3

- A patient is participating in balance retraining activities during a therapy visit
- The therapist is intentionally challenging patient's balance, anticipating a loss of balance
- The patient has a loss of balance to the left due to hemiplegia, and the physical therapist provides minimal assistance to allow the patient to maintain standing

How would you code J1800. Any Falls Since SOC/ROC?

A. Code **0**, No

B. Code **1**, Yes

J1900:

Number of Falls Since SOC/ROC,

whichever is more recent

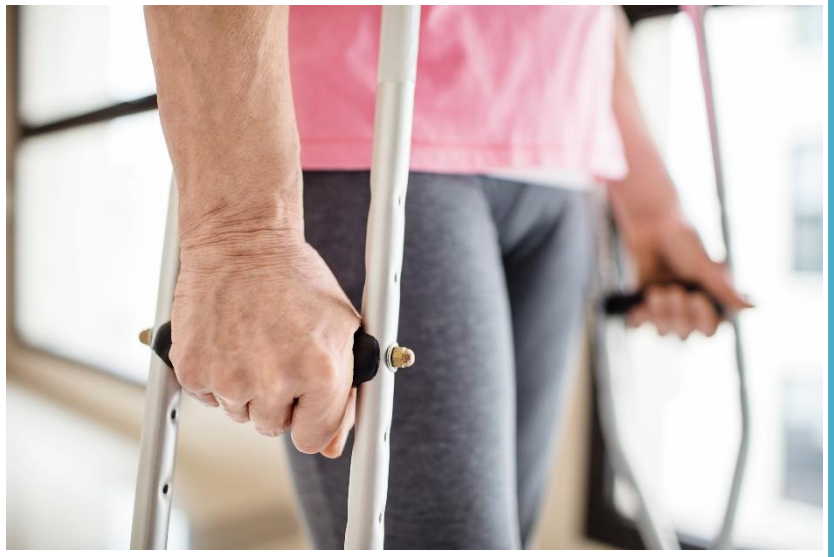
New OASIS-D Item: J1900

J1900.	**Number of Falls Since SOC/ROC,** whichever is more recent	
CODING: 0. None 1. One 2. Two or more	↓ **Enter Codes in Boxes**	
	☐	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
		B. Injury (except major): Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
		C. Major injury: Bone **fractures**, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

J1900 Intent

- Identifies the number of falls a patient had since the most recent SOC/ROC, and fall-related injury

Definition: Injury Related to a Fall



Any documented injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall

J1900 Response-Specific Instructions

Review

Review the home health clinical record, incident reports, and any other relevant clinical documentation, such as fall logs

Interview

Interview the patient and/or caregiver about occurrence of falls

Determine

Determine the number of falls that occurred since the most recent SOC/ROC and code the level of fall-related injury for each

Code

Code falls no matter where the fall occurred

Code each fall only once

- If the patient has multiple injuries in a single fall, code the fall for the highest level of injury

Coding Instructions: J1900A. No Injury

- **Code 0, None,** if the patient had no injurious falls since the most recent SOC/ROC
- **Code 1, One,** if the patient had one non-injurious fall since the most recent SOC/ROC
- **Code 2, Two or more,** if the patient had two or more non-injurious falls since the most recent SOC/ROC
- **A dash** is a valid response for this item. CMS expects dash use to be a rare occurrence

A. No injury:

J1900.	Number of Falls Since SOC/ROC, whichever is more recent	
CODING: 0. None 1. One 2. Two or more	↓ Enter Codes in Boxes	
	☐	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	☐	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	☐	**C. Major injury:** Bone **fractures**, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Definition: No Injury

- No evidence of any injury noted on assessment
- No complaints of pain or injury by the patient
- No change in the patient's behavior is noted after the fall

Coding Instructions: J1900B. Injury, Except Major

- **Code 0, None,** if the patient had no falls with injury, except major, since the most recent SOC/ROC
- **Code 1, One,** if the patient had one fall with injury, except major, since the most recent SOC/ROC
- **Code 2, Two or more,** if the patient had two or more falls with injury, except major, since the most recent SOC/ROC
- **A dash** is a valid response for this item. CMS expects dash use to be a rare occurrence

B. Injury (except major):

J1900.	Number of Falls Since SOC/ROC, whichever is more recent	
CODING: 0. None 1. One 2. Two or more	↓ Enter Codes in Boxes	
	☐	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	☐	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	☐	**C. Major injury:** Bone **fractures**, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Definition: Injury (Except Major)

- Examples include:
  - Skin tears
  - Abrasions
  - Lacerations
  - Superficial bruises
  - Hematomas
  - Sprains
  - Any fall-related injury that causes the patient to complain

Coding Instructions: J1900C. Major Injury

- **Code 0, None,** if the patient had no falls with major injury since the most recent SOC/ROC
- **Code 1, One,** if the patient had one fall with major injury since the most recent SOC/ROC
- **Code 2, Two or more,** if the patient had two or more falls with major injury since the most recent SOC/ROC
- **A dash** is a valid response for this item. CMS expects dash use to be a rare occurrence

C. Major injury:

J1900.	Number of Falls Since SOC/ROC, whichever is more recent	
CODING: 0. None 1. One 2. Two or more	↓ Enter Codes in Boxes	
	☐	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	☐	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	☐	**C. Major injury:** Bone **fractures**, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Definition: Major Injury

- Examples Include:
  - Bone fractures
  - Joint dislocations
  - Closed head injuries with altered consciousness
  - Subdural hematoma

J1900 Practice Coding Scenario 4

- Review of the clinical record and incident reports and patient and caregiver report identify that a single fall occurred since the most recent SOC/ROC
- The fall is documented on a clinical note from an RN home visit that describes the patient Mr. R's report of a fall that occurred between visits, in which he tripped on the dog, fell against the wall, and banged his elbow, sustaining a skin tear that he treated himself
- Documentation of the RN assessment during the home visit details the healing skin tear and no other injury or symptom identified related to the fall

How would you code J1800. Any Falls Since SOC/ROC?

A. Code **0**, No

B. Code **1**, Yes

How would you code J1900. Number of Falls Since SOC/ROC?

J1900.	**Number of Falls Since SOC/ROC,** whichever is more recent	
CODING: 0. None 1. One 2. Two or more	↓ **Enter Codes in Boxes**	
	☐	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	☐	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	☐	**C. Major injury:** Bone **fractures**, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

How would you code J1900. Number of Falls Since SOC/ROC? (cont. 1)

A. Code J1900A = **1**, J1900B = **0**, J1900C = **0**

B. Code J1900A = **0**, J1900B = **0**, J1900C = **1**

C. Code J1900A = **0**, J1900B = **1**, J1900C = **0**

D. Enter a **dash** for J1900A, J1900B, and J1900C

J1900.	**Number of Falls Since SOC/ROC,** whichever is more recent	
CODING: 0. None 1. One 2. Two or more	↓ **Enter Codes in Boxes**	
	☐	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	☐	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	☐	**C. Major injury:** Bone **fractures**, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Summarizing J1800 and 1900

Knowledge Check 1: J1800 and J1900 are **not** completed at which of the following time points?

A. Transfer

B. Discharge – not to an Inpatient Facility

C. SOC/ROC

D. Death at Home

Knowledge Check 2: Which example below does not meet the definition of a fall?

A. Ms. T reports losing her balance while going down the stairs but catching herself on the railing to remain standing

B. Mrs. B's daughter reports her mother falling while walking to her mailbox

C. Mr. W reports falling after being pushed by his roommate

D. All of the above meet the fall definition

Section J: Highlights

- **J1800.** Any Falls Since SOC/ROC, and **J1900.** Number of Falls Since SOC/ROC, are completed at:
  - Transfer
  - Discharge – not to an Inpatient Facility
  - Death at Home
- An intercepted fall is considered a fall
- CMS does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls
- There are three levels of fall-related injury:
  - No Injury
  - Injury (Except Major)
  - Major Injury

Revised OASIS-D Assessment Items

Overview: Revised Items

- Identify assessment items that have been revised in OASIS-D
- Summarize the changes to each revised assessment item

Overview of OASIS-D Revisions

Revisions to OASIS-D involve either:

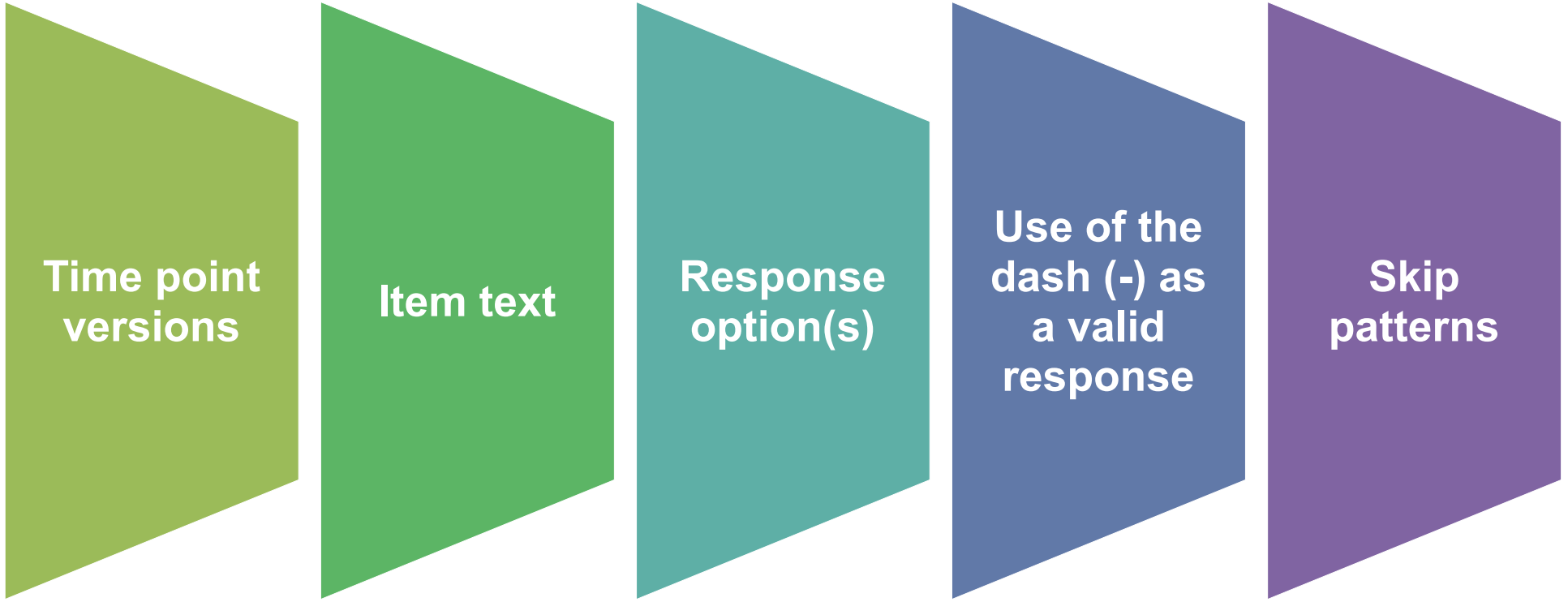
- Changes to assessment items and related guidance
- Revisions to the Guidance Manual only

OASIS-D: Seven Revised Assessment Items

M1028	• Active Diagnoses
M1306	• Unhealed Pressure Ulcer/Injury at Stage 2 or Higher?
M1311	• Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage
M1322	• Current Number of Stage 1 Pressure Injuries
M1324	• Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable
M2102	• Types and Sources of Assistance
M2310	• Reason for Emergent Care

OASIS-D: Seven Revised Assessment Items (cont.)

- Revised assessment items may have changes in one or more of the following areas:



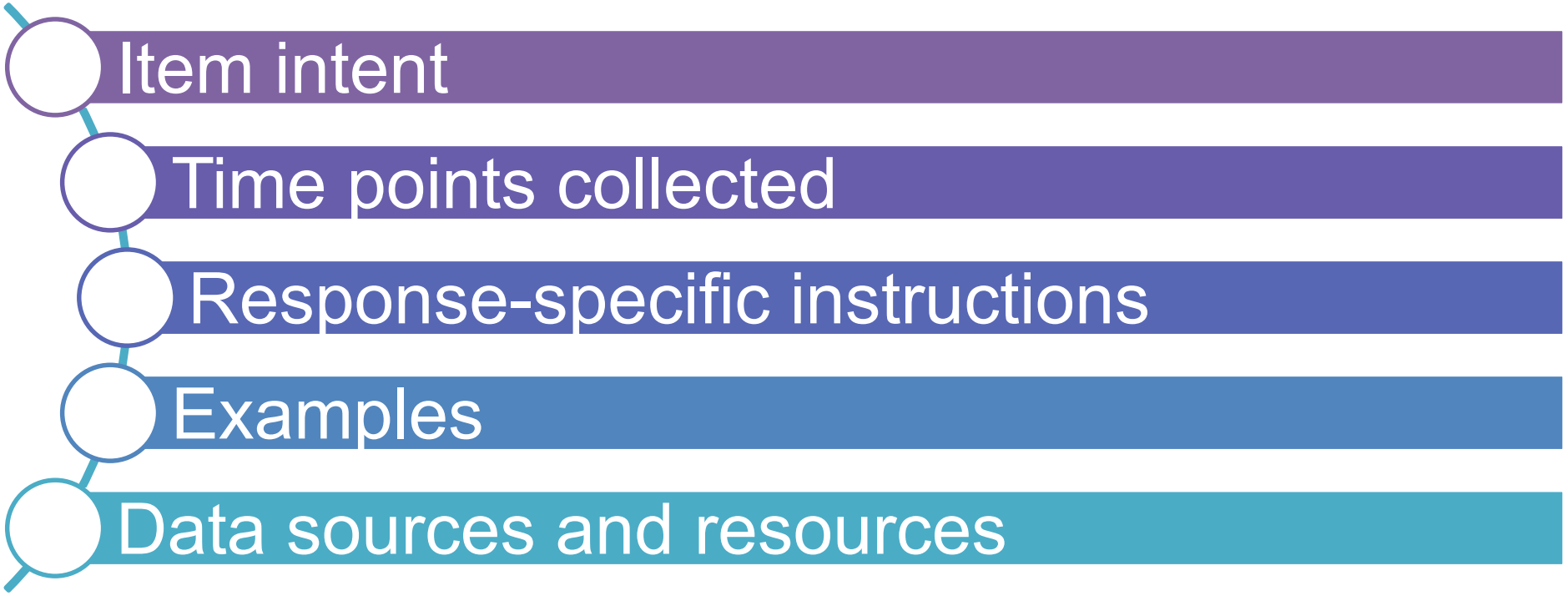
OASIS-D: Guidance Manual Changes

Guidance Manual Changes for 33 Items

M0080, M0090, M0102, M1021, M1023, M1046, M1056, M1060, M1307, M1332, M1334, M1342, M1610, M1730, M1800, M1810, M1820, M1830, M1840, M1845, M1850, M1860, M1870, M1910, M2001, M2003, M2005, M2010, M2016, M2020, M2030, M2301, M2401

OASIS-D: Guidance Manual Changes (cont.)

- For these 33 items, the Guidance Manual has been updated in one or more of the following sections:



OASIS-D: Description of Guidance Manual Changes

- Response-specific instructions revised to reflect one clinician expansion (collaboration allowed)
- Content associated with deleted items removed
- Skip language revised
- Alignment with new Conditions of Participation
- Alignment of language across PAC settings

OASIS-D: Description of Guidance Manual Changes (cont.)

- References to specific Centers for Disease Control and Prevention (CDC) content replaced with a general statement to refer to CDC
- Definitions added
- Removed references to process quality measures no longer reported
- Minor editorial changes

Knowledge Check 3: Revisions to OASIS-D involve which of the following?

A. Changes to assessment items and related guidance

B. Revisions to the Guidance Manual only

C. Both A and B

Item Specific Changes

OASIS-D: Seven Revised Assessment Items

M1028	Active Diagnoses
M1306	Unhealed Pressure Ulcer/Injury at Stage 2 or Higher?
M1311	Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage
M1322	Current Number of Stage 1 Pressure Injuries
M1324	Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable
M2102	Types and Sources of Assistance
M2310	Reason for Emergent Care

Changes to M1028. Active Diagnoses

- Standardized assessment item (present on OASIS-C2)
- Response options revised to align with other PAC instruments:
  - Option 3: “None of the above” was added

OASIS-D: M1028. Active Diagnoses

Complete at SOC/ROC

(M1028) Active Diagnoses – Comorbidities and Co-existing Conditions – Check all that apply
See OASIS Guidance Manual for a complete list of relevant ICD-10 codes.

- ☐ 1 - Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
- ☐ 2 - Diabetes Mellitus (DM)
- ☐ 3 - None of the above

Changes to M1306. Unhealed Pressure Ulcer/Injury at Stage 2 or Higher

- Incorporated National Pressure Ulcer Advisory Panel (NPUAP) terminology updates to align with other PAC instruments
- Item text revised:
  - Replaced “excludes … healed **Stage 2** pressure ulcers” with “excludes … **all** healed pressure ulcers”
  - Added the words “injury/injuries”

OASIS-D: M1306. Unhealed Pressure Ulcer/Injury at Stage 2 or Higher

Complete at SOC/ROC, Follow-Up, and Discharge

(M1306)	Does this patient have at least one **Unhealed Pressure Ulcer/Injury at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure injuries and all healed pressure ulcers/injuries)
Enter Code ☐	0 No ***[Go to M1322 at SOC/ROC/FU; Go to M1324 at DC]*** 1 Yes

Changes to M1311. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

- Item retained but different versions created for SOC/ROC, Follow-Up, and Discharge
- SOC/ROC and Discharge information used to calculate revised pressure ulcer measure
- Alignment with other PAC instruments
  - Incorporated NPUAP terminology updates
  - Skip pattern language and directions modified

Changes to M1311. Current Number of Unhealed Pressure Ulcer/Injuries at Each Stage (cont. 1)

- Dash "-" is a valid response for the Discharge time point only
- CMS expects dash use to be a rare occurrence
- Used to standardize the IMPACT measure

Changes to M1311. Current Number of Unhealed Pressure Ulcer/Injuries at Each Stage (cont. 2)

Item text revised

- Added ulcers/injuries where applicable
- Added the word “device” to the item title in D1. Unstageable: non-removable dressing/**device**
- Removed “suspected …in evolution” from F1. Unstageable: Deep tissue injury

OASIS-D: M1311. Current Number of Unhealed Pressure Ulcer/Injuries at Each Stage

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage
A1. **Stage 2:** Partial thickness loss of dermis presenting as a shallow open ulcer with a red or 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/device:** Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers/injuries 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/injuries due to coverage of wound bed by slough and/or eschar**
F1. **Unstageable: Deep tissue injury** **Number of unstageable pressure injuries presenting as deep tissue injury**

SOC/ROC and Follow-Up Version

OASIS-D: M1311. Current Number of Unhealed Pressure Ulcer/Injuries at Each Stage (cont. 1)

Discharge Version

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 – Go to M1311B1, Stage 3]	☐
A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers** [If 0 – Go to M1311C1, Stage 4]	☐
B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. **Number of Stage 4 pressure ulcers** [If 0 – Go to M1311D1, Unstageable: Non-removable dressing/device]	☐
C2. Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐

OASIS-D: M1311. Current Number of Unhealed Pressure Ulcer/Injuries at Each Stage (cont. 2)

Discharge Version (cont.)

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
D1. Unstageable: Non-removable dressing/device: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device** [If 0 – Go to M1311E1, Unstageable: Slough and/or eschar]	☐
D2. Number of <u>these</u> unstageable pressure ulcers/injuries that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** [If 0 – Go to M1311F1, Unstageable: Deep tissue injury]	☐
E2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
F1. Unstageable: Deep tissue injury **Number of unstageable pressure injuries presenting as deep tissue injury** [If 0 – Go to M1324]	☐
F2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐

Changes to M1322. Current Number of Stage 1 Pressure Injuries

- M1322 retained at SOC/ROC and Follow-Up
- Item **removed** from the Discharge time point
  - Not needed for measure calculation (burden reduction)
- Alignment with other PAC settings (IRF, LTCH, and SNF)
  - Replaced the word “ulcers” with “injuries” (NPUAP terminology)
  - Updated Stage 1 definition
- No edits to response options

OASIS-D: M1322. Current Number of Stage 1 Pressure Injuries

Complete only at SOC/ROC and Follow-Up

- Replaced the word “ulcers” with “injuries”
- Updated Stage 1 Definition

(M1322)	**Current Number of Stage 1 Pressure Injuries:** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.
Enter Code ☐	0 1 2 3 4 or more

Changes to M1324. Stage of Most Problematic Unhealed Pressure Ulcer/Injury That Is Stageable

- Incorporated NPUAP terminology updates to align with the pressure ulcer items in the other PAC instruments
  - Added the word “injury”

OASIS-D: M1324. Stage of Most Problematic Unhealed Pressure Ulcer/Injury That Is Stageable

Complete at SOC/ROC, Follow-Up, and Discharge

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

Changes to M2102.
Types and Sources of Assistance

Different versions of this item are available for SOC/ROC and Discharge

Some response options were not essential and removed to reduce burden

Changes to M2102. Types and Sources of Assistance (SOC/ROC)

SOC/ROC Assessment

- **Response options removed:**
  - a. ADL (activities of daily living) assistance
  - b. IADL (instrumental activities of daily living) assistance
  - c. Medication administration
  - d. Medical procedures/treatments
  - e. Management of equipment
  - g. Advocacy or facilitation of patient's participation in appropriate medical care
- **Response options retained:**
  - f. Supervision and safety (lettering sequence retained)

OASIS-D: M2102. Types and Sources of Assistance

SOC/ROC Version

(M2102)	**Types and Sources of Assistance:** Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.
Enter Code ☐	f. **Supervision and safety** (for example, due to cognitive impairment) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available

Changes to M2102. Types and Sources of Assistance (Discharge)

Discharge Assessment

- **Response options removed:**
  - b. IADL (instrumental activities of daily living) assistance
  - e. Management of equipment
  - g. Advocacy or facilitation of patient's participation in appropriate medical care
- **Response options (and lettering sequence) retained:**
  - a. ADL (activities of daily living) assistance
  - c. Medication administration
  - d. Medical procedures/treatments
  - f. Supervision and safety

OASIS-D: M2102. Types and Sources of Assistance

Discharge Version

(M2102)	**Types and Sources of Assistance:** Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.
Enter Code ☐	a. **ADL assistance** (for example, transfer/ ambulation, bathing, dressing, toileting, eating/feeding) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	c. **Medication administration** (for example, oral, inhaled or injectable) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	d. **Medical procedures/ treatments** (for example, changing wound dressing, home exercise program) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	f. **Supervision and safety** (for example, due to cognitive impairment) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available

Changes to M2310. Reason for Emergent Care

- M2310 is completed on Transfer and Discharge
- The four response options needed for calculation of potentially avoidable event (PAE) measures were retained
- The remaining 15 of 19 response options not needed for measure calculation have been removed

Changes to M2310. Reason for Emergent Care (cont.)

Response Options Retained:

1 = Improper medication administration

10 = Hypo/hyperglycemia, diabetes out of control

19 = Other than above reasons

UK = Reason unknown

OASIS-D: M2310. Reason for Emergent Care

Complete at Transfer and Discharge

(M2310) Reason for Emergent Care: For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)? **(Mark all that apply.)**

- ☐ 1 - Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
- ☐ 10 - Hypo/Hyperglycemia, diabetes out of control
- ☐ 19 - Other than above reasons
- ☐ UK - Reason unknown

Knowledge Check 4: Which statement regarding M1028. Active Diagnoses is true?

A. New time point versions have been created

B. Response options have been revised to include “None of the above”

C. Dash is **not** a valid response

Knowledge Check 5: The same assessment version of M1311 is used for SOC/ROC, Follow-Up, and Discharge

M1311. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

A. True

B. False

Knowledge Check 6: Select the best response regarding M2102. Types and Sources of Assistance

A. Response options have been removed to reduce burden

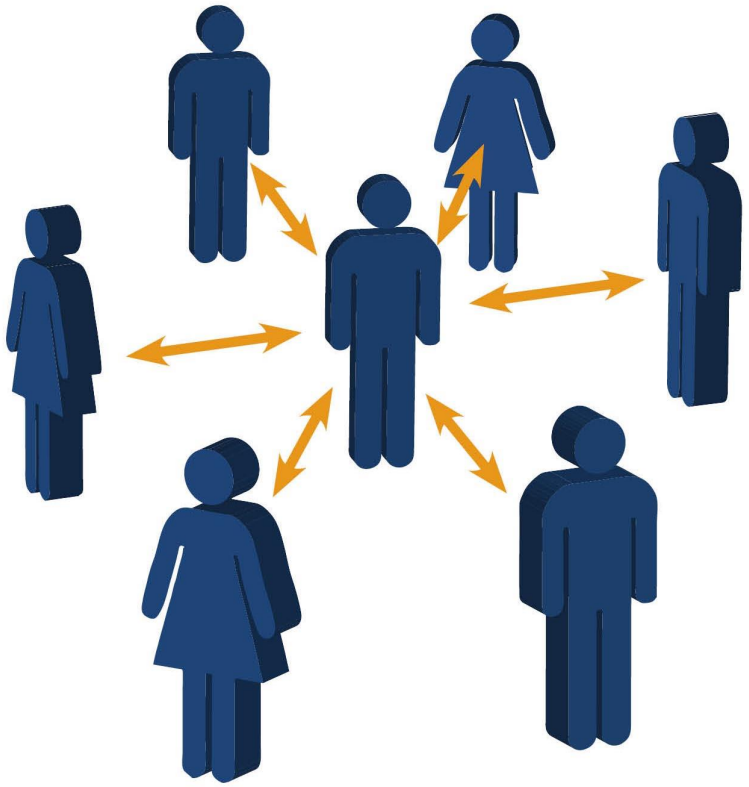
B. New time point versions created for SOC/ROC and Discharge

C. Retained lettering sequence for response option(s)

D. All of the above

Additional Guidance Clarifications

Expansion of the One Clinician Convention



- Guidance related to the one clinician convention was modified as of January 1, 2018
  - While only the assessing clinician is responsible for accurately completing and signing a comprehensive assessment, s/he may collaborate to collect data for all OASIS items, if agency policy allows

Expansion of the One Clinician Convention (cont. 1)

- Modifications in home care guidance related to the one clinician convention were made:
  - Based on feedback from home health stakeholders
  - To better align with assessment practices in other PAC settings
- Any exception to this general convention concerning collaboration is identified in item-specific guidance

Expansion of the One Clinician Convention (cont. 2)

- Additional information:
  - OASIS-D Guidance Manual, Chapter 1
  - CMS OASIS Q&A, August 2017 – "Expansion of the One Clinician Convention"
    - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/Expansion-of-the-Home-Health-One-Clinician-Convention-August-2017.pdf

Drug Regimen Review

- There are no DRR item changes in 2019
- The DRR items were first introduced to home health in 2010 and revised January 1, 2017
  - These items are being implemented in IRF, LTCH, and SNF during 2018
- Changes to the DRR items for home health in 2019 are limited to guidance refinement to promote cross-setting alignment

Knowledge Check 7: Select the best response regarding the One Clinician Convention

A. The Comprehensive Assessment, which includes OASIS, remains the responsibility of one clinician

B. The assessing clinician may elicit feedback from other agency staff in order to complete the OASIS

C. Both A and B

OASIS-D Revised Assessment Items: Highlights

- Revisions to OASIS-D involve either:
  - Changes to the assessment item and related guidance
  - Revisions to the Guidance Manual only
- Some response options have been removed to reduce provider burden
- Different time point versions created for some items

OASIS-D Revised Assessment Items: Highlights (cont.)

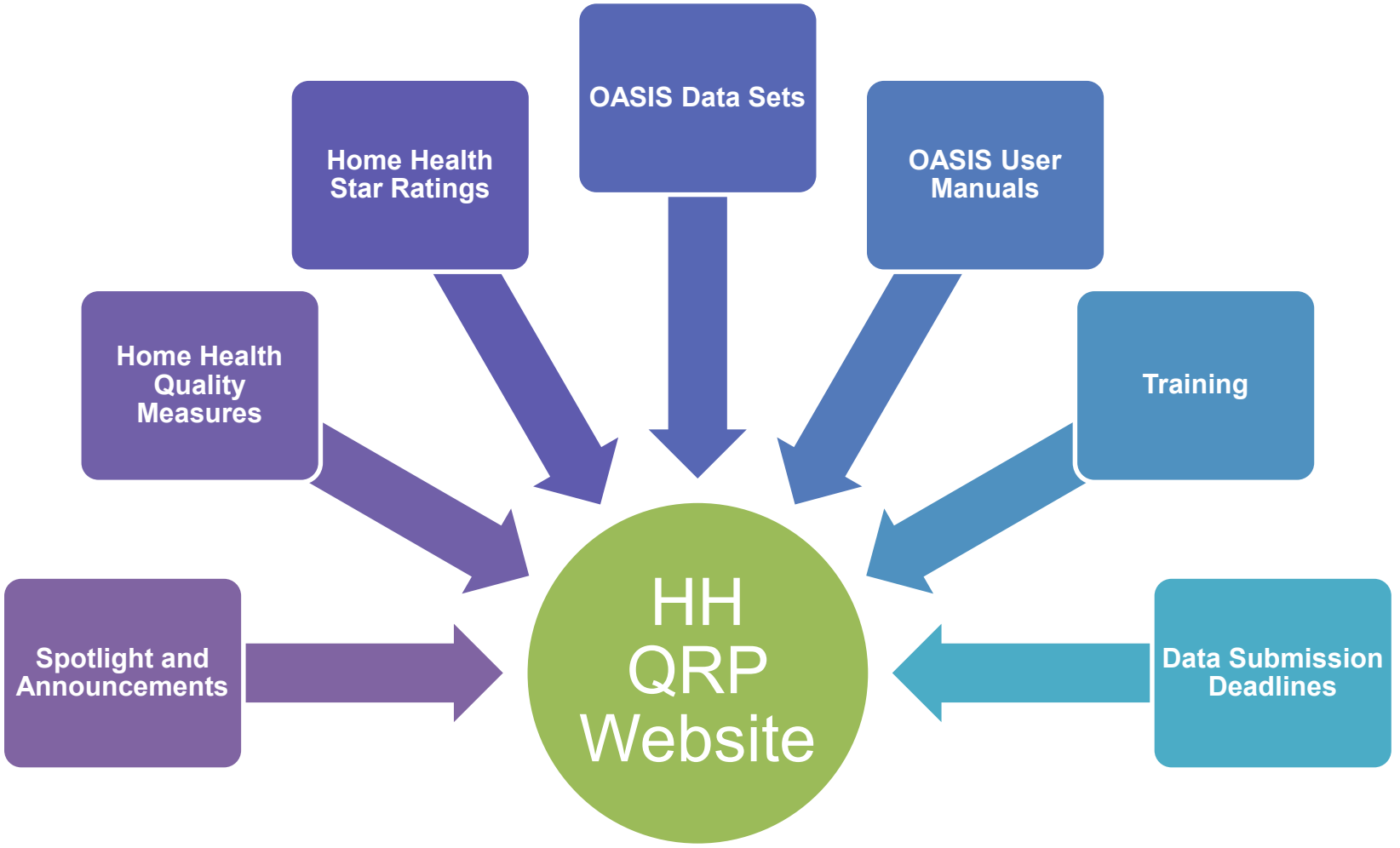
- Incorporated NPUAP terminology updates
- Revised language to align with other PAC settings
- Consult the OASIS-D Guidance Manual for specific direction

Summary and Resources

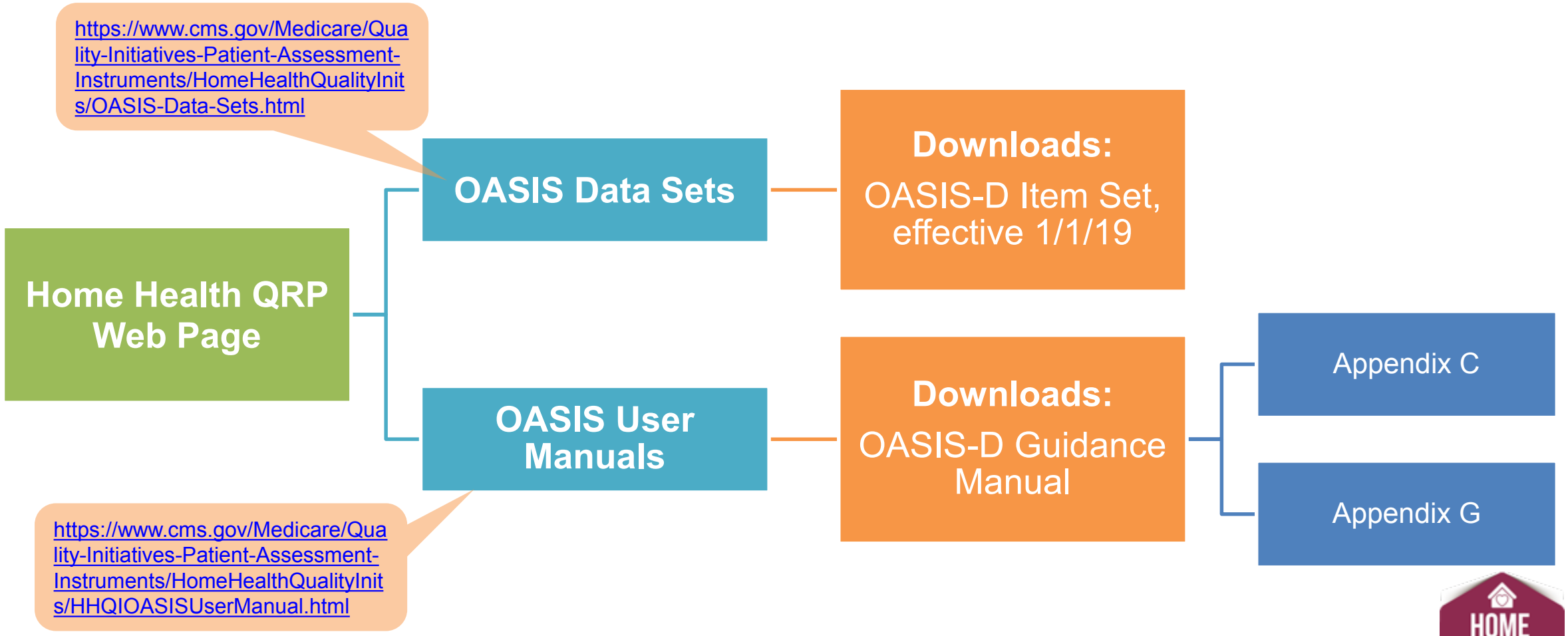
Overview: Summary and Resources

- Identify resources available to guide utilization of OASIS-D

HH QRP Website



OASIS-D Item Set and Guidance Manual



OASIS Educational Coordinators

- Each State has a designated OASIS Educational Coordinator with the responsibility to ensure that all home care providers have access to:

Training in the OASIS data set administration for assessing patients	Training and technical support in integrating the OASIS items in the agency's record-keeping system	Technical support in answering questions on the clinical aspects of OASIS

Find your OASIS Education Coordinator:
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/downloads/OASISEducationalcoordinators.pdf

Help Desks

For HH QRP and OASIS Guidance related questions

Home Health Quality Help Desk

homehealthqualityquestions@cms.hhs.gov

For Condition of Participation related questions

Home Health Agency Survey Protocols Mailbox

hhasurveyprotocols@cms.hhs.gov

For Home Health Prospective Payment System (PPS) Payment Policy questions

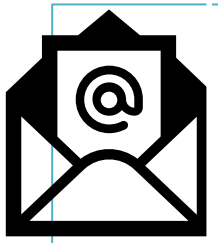
Home Health Policy Mailbox

HomehealthPolicy@cms.hhs.gov

Technical Help Desk

- Data Submission & Certification and Survey Provider Enhancement Reports (CASPER): Quality Improvement and Evaluation System (QIES) Technical Support Office (QTSO) Help Desk

Phone:
(800) 339-9313



Email:
Help@qtso.com

Website:
https://qtso.cms.gov

Help Desk Disclaimer

- **Please do not send any identifiable patient information through email, such as:**
  - Medical record numbers
  - Dates of birth
  - Service dates (including visit dates, admission dates, or discharge dates)
  - Any other data items considered identifiers or protected health information

Rulemaking

- Proposed Rules and Final Rules are published in the Federal Register and typically released each year in July and November
- Proposed and Final Rules are posted on this web page:
  - https://www.federalregister.gov/agencies/centers-for-medicare-medicaid-services

Stay Connected: Medicare Learning Network (MLN)

- Free educational materials for healthcare professionals on CMS programs, policies, and initiatives:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/Index.html
- Subscribe to MLN Connects weekly email newsletter for healthcare professionals:
  - https://public.govdelivery.com/accounts/USCMS/subscriber/new

Stay Connected: Home Health, Hospice & Durable Medical Equipment Open Door Forum

- The Home Health, Hospice & Durable Medical Equipment Open Door Forum addresses the concerns of three unique health care areas within the Medicare & Medicaid programs
- Issues related to Home Health PPS, the newly proposed competitive bidding for Durable Medical Equipment and the Medicare Hospice benefit are all topics the forum has covered:
  - https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/ODF_HHHDME.html
- Subscribe to email newsletter:
  - https://public.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_502

OASIS-D Training Opportunities

Presentation and recording will be posted on the CMS website

- Introduction to OASIS-D Webinar

August 28, 2018

September 5, 2018

- Introduction to OASIS-D Section GG Webinar

- Q&A Teleconference

Anticipated October/November 2018

Webcast available!

Anticipated October/November 2018

- In-Person Home Health Provider Training, Baltimore, MD

Training Information and Updates

Spotlight and Announcements

- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Spotlight-and-Announcements.html

Home Health Quality Reporting Training

- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Training.html

Summary

- OASIS-D to be implemented with all assessments with a M0090 Date Assessment Completed date of January 1, 2019, or later
- Changes to OASIS-D include:
  - **New** standardized patient assessment data elements
  - Alignment in content of items that support cross-setting measures **(revised)**
  - Comprehensive Item Use Evaluation, resulting in reduction of burden and quality measure changes **(removal)**
  - Updates and corrections to guidance


Questions?