CHAPTER 1 – INTRODUCTION

The Outcome and ASsessment Information Set (OASIS) is a group of standard data elements developed, tested, and refined over the past two decades through a research and demonstration program funded primarily by the Centers for Medicare & Medicaid Services (CMS), with additional funding from the Robert Wood Johnson Foundation and the New York State Department of Health. OASIS data elements are designed to enable systematic comparative measurement of home health care patient outcomes at two points in time. Outcome measures are the basis for outcome-based quality improvement (OBQI) efforts that home health agencies (HHAs) can employ to assess and improve the quality of care they provide to patients. Under OBQI, CMS provides HHAs with agency-patient related characteristic (case mix), risk-adjusted outcome, potential avoidable event (adverse event outcome), and patient tally reports for their patients for a 12-month period. The agency also is provided with comparison data from the HHA’s prior 12-month period and national reference data.

Comparisons are risk adjusted for patient differences (both over time for the agency and between the agency and the reference group). OBQI requires uniform measures that are calculated from standardized data elements. Further details on OASIS and OBQI are included in Appendix F of this manual, and a full description of OBQI is available in the Outcome-Based Quality Improvement Manual, which can be found at OASIS OBQI Home Health Quality Initiatives. OASIS-C allows for the computation and reporting of measures of clinical processes to supplement currently reported outcome measures. In addition to quality measurement, a subset of OASIS items is used to calculate payment algorithms under the Medicare Prospective Payment System (PPS).

In 1999, Medicare-certified HHAs began collecting and submitting OASIS data related to all adult (18 years or older) nonmaternity patients receiving skilled services with Medicare or Medicaid as a payer source. The OASIS items have been revised several times since 1999 to address the burden of data collection, refine items for payment algorithms, and enhance outcome reporting. In 2008, CMS began a large-scale effort to revise OASIS for three reasons:

- To address issues raised by the HHA provider community for specific OASIS items;
- To incorporate the measurement of selected processes of care to supplement the measurement of outcomes, and
- To align OASIS measures and items with other instruments being developed to measure care across post-acute care settings (i.e., the nursing home Minimum Data Set [MDS] and the Continuity Assessment Record Evaluation [CARE]).

A draft version of OASIS-C was developed and tested for inter-rater reliability and burden estimates in 11 HHAs in three states: Ohio, Massachusetts, and Colorado. The instrument was extensively revised based on both quantitative findings and provider feedback, then posted by the Office of Management and Budget (OMB) for public comment. During that time, a set of 55 new or refined outcome and process measures that could be calculated from OASIS-C items was submitted to the National Quality Forum (NQF) for endorsement. OASIS-C items were further revised based on the public comments to the OMB notice and feedback obtained during

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1 http://www.cms.hhs.gov/HomeHealthQualityInits/16_HHQIOASISOBQI.asp#TopOfPage
the NQF endorsement process. More information about OASIS-C can be found on the CMS web page (OASIS-C Home Health Quality Initiatives).²

A. Manual Overview

The OASIS Implementation Manual, originally developed in 1999, was intended to serve as a resource for HHAs implementing the new OASIS data collection requirements. Many of the chapters of the OASIS Implementation Manual primarily were relevant to new HHAs seeking Medicare certification. While the manual has been revised several times over the past decade to reflect changes to the OASIS, the basic structure of the manual has not changed.

This revised manual, the OASIS Guidance Manual, is a streamlined version of the original manual that contains content most relevant for HHAs experienced with OASIS requirements, with an emphasis on OASIS item guidance. Selected content from the OASIS Implementation Manual has been incorporated into the appendix to provide additional context for OASIS data collection requirements. Sections relevant to first-time implementation of OASIS data have been deleted. HHAs new to OASIS collection, or those interested in reviewing sections of the retired OASIS Implementation Manual, may access it at the following link: Archives Home Health Quality Initiatives.³ However, please note that the OASIS Implementation Manual has not been updated to reflect the most recent revisions to OASIS.

In addition to streamlining the manual contents, the format of the manual has changed to facilitate future updates and to decrease burden for those who access OASIS guidance electronically. Item-specific guidance is no longer contained in a single document, but has been divided into sections that can be accessed through individual links. Thus, when accessing guidance for a specific OASIS item, the user can more easily locate the OASIS question, rather than scrolling through a large document. All manual sections can be viewed online or printed. This manual is divided into five chapters:

- **Chapter 1** – The Introduction, which provides contextual information and other general information relevant to OASIS data collection.
- **Chapter 2** – Includes versions of the OASIS-C data set for each time point.
- **Chapter 3** – Contains item-specific guidance, subdivided into sections.
- **Chapter 4** – Contains sample clinical record forms for OASIS data collection time points.
- **Chapter 5** – Includes relevant resources for HHAs, with hyperlinks when available.

**Appendices** – Includes additional contextual information, including sections on OBQI, home health care regulations related to OASIS data collection, and recommendations for ensuring accuracy of OASIS data. Appendix D, formerly Attachment D, addresses the OASIS diagnosis items that pertain to the home health episode (i.e., M1020, M1022, and M1024).

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² http://www.cms.hhs.gov/HomeHealthQualityInits/06_OASISC.asp#TopOfPage
³ http://www.cms.hhs.gov/HomeHealthQualityInits/20_HHQIArchives.asp#TopOfPage
B. *Why is OASIS Being Revised Now?*

HHAs began collecting and transmitting OASIS data for adult skilled Medicare and Medicaid patients (with the exception of maternity patients) in 1999. During the past 10 years, numerous changes have occurred within the health care system, including specific recommendations for changes in the area of home health care quality measurement:

- **2001** – Institute of Medicine (IOM) identified six focus areas for improving health care quality (safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity).

- **2005** – National Quality Forum (NQF) endorsed the initial set of home health quality measures for public reporting along with recommendations for future changes to the measures.

- **2006** – Medicare Payment Advisory Commission (MedPAC) Report to Congress included recommendations for expanding home health quality measures to a) broaden the patient population covered by the OASIS, b) capture safety as an aspect of quality, c) capture an aspect of care directly under providers’ influence, d) reduce variation in practice, and e) provide incentives to improve information technology.

- **2008** – NQF developed a new set of guidelines/frameworks for measures and priorities.

Current efforts are underway to create a system for assessing patients using consistent terminology and measuring quality across post-acute care settings. The instrument being developed for this program is the Continuity Assessment Record Evaluation (CARE), which will harmonize data elements across three well-known CMS clinical assessment instruments: the Minimum Data Set (MDS) for nursing homes, the Uniform Data Set for Medical Rehabilitation (FIM™) for rehabilitation facilities, and the OASIS for home care. In addition, the National Quality Forum has called for harmonization of influenza and pneumonia immunization assessment items and is working to develop a framework for measuring pressure ulcers across provider settings.

At the time OASIS was initially implemented, it was anticipated that the data set would evolve to reflect changes in quality priorities, health research, health care policy, payment, and care practices. To oversee this evolution of OASIS, CMS convened several technical expert panels to consider provider feedback on OASIS — along with the IOM aims and MedPAC recommendations — and recommend potential revisions. These recommendations, along with efforts to align OASIS-C elements with other data collection instruments where possible, were the basis for OASIS revisions being made for 2010. Because revisions to OASIS-B1 were extensive, this current version has been renamed OASIS-C.

C. *What’s New About OASIS-C*

The OASIS-C represents the most comprehensive revision to OASIS since its original release. A summary of the types of revisions made to OASIS is provided below. A crosswalk of OASIS-B1 and OASIS-C items is provided in Appendix G. In the discussion below, examples are given to highlight the types of changes incorporated into OASIS-C.

Please note that, with the exception of the tracking items and M0903/M0906, the OASIS-C items have been renumbered; thus the OASIS-B1 M0 item numbers do not correspond to the
new OASIS-C numbering scheme. This was necessary because new OASIS items were placed within the existing sequence of items and other OASIS items were resequenced. Attempting to align the new items with the previous numbering system proved impossible for some sections. Instead, each section has been assigned to a range of numbers (e.g., Integumentary Status items are numbered M1300-M1350). This was determined to be a better long-term solution and one that mirrors systems being used by the data sets in other settings and the CARE instrument. See Table 1 for a list of OASIS items and their numbering sequence.

**TABLE 1: OASIS-C Numbering System.**

<table>
<thead>
<tr>
<th>Category</th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Tracking Items</td>
<td>M0010 – M0069; M0140 – M0150</td>
</tr>
<tr>
<td>Clinical Record Items</td>
<td>M0080 – M0110</td>
</tr>
<tr>
<td>Patient History and Diagnoses</td>
<td>M1000s</td>
</tr>
<tr>
<td>Living Arrangements</td>
<td>M1100</td>
</tr>
<tr>
<td>Sensory Status</td>
<td>M1200s</td>
</tr>
<tr>
<td>Integumentary Status</td>
<td>M1300s</td>
</tr>
<tr>
<td>Respiratory Status</td>
<td>M1400s</td>
</tr>
<tr>
<td>Cardiac Status</td>
<td>M1500s</td>
</tr>
<tr>
<td>Elimination Status</td>
<td>M1600s</td>
</tr>
<tr>
<td>Neuro/Emotional/Behavioral Status</td>
<td>M1700s</td>
</tr>
<tr>
<td>ADLs/IADLs</td>
<td>M1800s + M1900s</td>
</tr>
<tr>
<td>Medications</td>
<td>M2000s</td>
</tr>
<tr>
<td>Care Management</td>
<td>M2100s</td>
</tr>
<tr>
<td>Therapy Need and Plan of Care</td>
<td>M2200s</td>
</tr>
<tr>
<td>Emergent Care</td>
<td>M2300s</td>
</tr>
<tr>
<td>Data Collected at Transfer/Discharge</td>
<td>M2400s, M0903+M0906</td>
</tr>
</tbody>
</table>
Elimination of OASIS-B1 Items

OASIS-B1 items not used for payment, quality measures (including those used in the survey process), case mix, or risk adjustment purposes (e.g., Transportation and Shopping), were eliminated. In some cases, eliminated items were replaced with items intended to capture the assessment parameter in a more efficient way. For example, the “prior status” items for all the ADLs/IADLs have been eliminated. Two new OASIS-C items were developed to capture the patient’s prior level of dependence with ADLs/IADLs (M1900) and medication management (M2040).

New OASIS Items

OASIS-C items were created to a) increase clarity in measurement; b) replace OASIS-B1 items being eliminated; or c) measure processes of care in home health agencies.

a. New items to increase clarity in measurement: An example of such an item is (M1845), Toileting Hygiene, which was created to supplement measurement of toilet transferring (M1840). Together, these items are intended to more accurately capture toileting ability. Similarly, an item for understanding of verbal content (M1220) supplements the item for ability to hear (M1210) to provide a more comprehensive understanding of the patient’s receptive communication ability.

b. New items to replace OASIS-B1 items: As noted above, two new OASIS-C items were developed to capture patient prior level of dependence with ADLs/IADLs (M1900) and medication management (M2040). As another example, (M1730) Depression Screening replaces the OASIS-B1 data item that assessed the presence of depressive feelings. M1730 includes a two-item screening tool (the PHQ-2©) for agencies choosing to use this standardized screening instrument.

c. New items to measure processes of care: Care processes refer to the use of assessment tools (included in a comprehensive assessment) or the planning and delivery of specific clinical interventions. Several evidence-based screening tools and interventions that can be considered “best practices” in home health care were identified through literature review and expert panel input. OASIS-C includes data items to measure the use of these “best practice” care processes. To reflect Institute of Medicine (IOM) aims and MedPAC recommendations, and to focus on high-risk, high-volume, problem-prone conditions in home health care, data items were created to measure processes of care in the following domains:

- Date of referral and physician-ordered start of care (timeliness)
- Patient-specific parameters for physician notification (care coordination)
- Influenza and pneumococcal vaccines (population health and prevention)
- Formal pain assessment, pain interventions, and pain management steps (effectiveness of care)
- Pressure ulcer risk assessment, prevention measures, and use of moist healing principles (effective care and prevention)
• Diabetic foot care plan, education and monitoring (disease specific: high risk, high volume, problem prone)
• Heart failure symptoms of volume overload and follow-up (disease specific: high risk, high volume, problem prone)
• Depressive symptom screening and intervention/referral (influences self-management abilities)
• Falls risk assessment, planning and interventions (safety)
• Medication adverse events/reaction, reconciliation and follow up; drug education (high priority for safety – care coordination)

It is anticipated that processes of care implemented according to evidence-based guidelines will ultimately lead to better clinical outcomes. The process items are a logical follow-up to the Quality Improvement Organizations (QIOs) 8th Scope of Work on Best Practices (MedQIC - HHQI Campaign). Agencies participating in reliability testing of OASIS-C felt process items gave them “credit” for excellent patient care practices already in place.

The care processes documented in the OASIS-C are not mandated under the current Conditions of Participation. Clinicians may find that these processes of care have no application for a particular patient and therefore no related assessment or intervention is needed. Clinicians may document in the clinical record any appropriate additional information. With the exception of the OASIS-C items, CMS does not prescribe the content of agency clinical assessment forms nor mandate specific processes of care.

However, some of the OASIS-C process items will support publicly-reported measures and agencies choosing not to adopt those processes of care will see their decisions reflected in Home Health Compare scores. It should also be noted that it is possible that the process measures may be incorporated in a future quality-based purchasing (pay for performance) system for home health care. While the OASIS-C process items will be used for quality reporting, CMS understands that the evidence-based practices being measured are not appropriate for every patient, and a rate of 100% is not expected for any agency or any measure.

OASIS-C process data items address use of screening assessments (e.g., for falls or depression), inclusion of specific evidence-based care processes in the plan of care (M2250), and whether clinical interventions were provided to the patient during the care episode. For example, M2400 asks if pain management steps to monitor and mitigate pain were implemented during the care episode. Many of the process items are skipped at certain time points if patients do not exhibit these problems. It should be noted that some of the process data items require review of care provided since the most recent OASIS assessment to determine if assessment and interventions for certain conditions occurred during that specified time period. This will require some new data collection strategies as discussed in detail in Section D below.

4 http://www.qualitynet.org/dcs/ContentServer?c=MQParents&pagename=Medqic%2FContent%2FParentShellTemplate&cid=1196689997847&parentName=Topic
Number of items

Overall, agencies pilot testing OASIS-C noted that the new version of OASIS required little additional time to complete when compared to OASIS-B1 assessment time, regardless of the overall item increase. The net changes are shown in Table 2.

The time point with the largest increase in data items is Transfer. This increase was needed to (a) calculate additional quality measures related to reasons for hospitalization, and (b) assess care processes that potentially can reduce the rate of acute care hospitalization. Many process items, like other OASIS items, are simple yes/no responses or are skipped if the patient does not have the relevant condition. For example, (M1510) Heart Failure Follow-Up is skipped for patients who do not have a diagnosis of heart failure.

<table>
<thead>
<tr>
<th>Time Point</th>
<th>Total Number of OASIS-C Items</th>
<th>Net Change in Number of Items from OASIS-B1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Tracking</td>
<td>17</td>
<td>-1</td>
</tr>
<tr>
<td>SOC</td>
<td>79</td>
<td>+2</td>
</tr>
<tr>
<td>ROC</td>
<td>79</td>
<td>+2</td>
</tr>
<tr>
<td>Follow-up</td>
<td>32</td>
<td>+1</td>
</tr>
<tr>
<td>Transfer</td>
<td>19</td>
<td>+8</td>
</tr>
<tr>
<td>Discharge</td>
<td>61</td>
<td>-11</td>
</tr>
<tr>
<td>Death at home</td>
<td>5</td>
<td>+1</td>
</tr>
</tbody>
</table>

D. Collecting OASIS-C Data

Techniques for collecting OASIS-C data are the same used for OASIS-B1, with the exception of the process items. This section will provide a basic overview for collecting OASIS-C data. For more detail on clinical strategies for collecting OASIS data as part of a comprehensive assessment, refer to Appendix A of this manual.

Eligible Patients

OASIS data are collected for Medicare and Medicaid patients, 18 years and older, receiving skilled services, with the exception of patients receiving services for pre- or postnatal conditions. Patients receiving only personal care, homemaker, or chore services exclusively are excluded since these are not considered skilled services. Note, OASIS data collection and submission are not required for patients who have a single visit in a quality episode. See OASIS Management for Single Visit at SOC or ROC on the OASIS link of the QIES Technical Support Office web page.

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**Time Points**

OASIS-C data are collected at the following time points:

- Start of Care
- Resumption of Care following inpatient facility stay
- Recertification within the last five days of each 60-day recertification period
- Other Follow-Up
- Transfer to inpatient facility
- Discharge from home care
- Death at Home

All of these assessments, with the exception of transfer to inpatient facility and death at home, must be conducted during a home visit because all require the clinician to have an in-person encounter with the patient. The transfer to an inpatient facility requires collection of limited OASIS data (most of which may be obtained through a telephone call).

Not all OASIS items are completed at every assessment time point. Some items are completed only at start of care, some only at discharge, and still others only when a patient is admitted to a specific type of inpatient facility (e.g., M2400 - Reason for Nursing Home Admission). The table of “Items to be Used at Specific Time Points” included at the beginning of the OASIS data set allows the clinician conducting the assessment to identify the necessary OASIS items at each time point.

Hospitalization rates are a CMS priority across settings and an important quality measure; therefore, admission to an inpatient facility during the home care episode is a significant event that must be considered in the computation of home care outcomes. Thus, the transfer of a patient to an inpatient facility for a period of 24 hours (or more) for any reason other than diagnostic testing and the resumption of care after this inpatient facility stay (which necessitates a comprehensive assessment during a home visit) also require the reporting of assessment data. Understanding the reasons for these potentially avoidable events will help agencies improve care.

At the start of care time point, the comprehensive assessment should be completed within five days of the start of care date. At the resumption of care, the comprehensive assessment must be completed within 48 hours of inpatient facility discharge. For the transfer to inpatient facility, discharge from home care, death at home, and other follow-up, the assessments must be completed within 48 hours of becoming aware of the transfer, discharge, death, or significant change in condition.

**Who Completes OASIS-C**

As identified in (M0080) Discipline of Person Completing Assessment, the comprehensive assessment and OASIS data collection should be conducted by a registered nurse (RN) or any of the therapies (PT, SLP/ST, OT). An LPN/LVN, PTA, OTA, MSW, or Aide may not complete OASIS assessments.

In cases involving nursing, the RN completes the comprehensive assessment at SOC. Any discipline qualified to perform assessments – RN, PT, SLP, OT – may complete subsequent assessments. For a therapy-only case, the therapist usually conducts the comprehensive
assessment. It is acceptable for a PT or SLP to conduct and complete the comprehensive assessment at SOC. An OT may conduct and complete the assessment when the need for occupational therapy establishes program eligibility. Note: Occupational therapy alone does not establish eligibility for the Medicare home health benefit at the start of care; however, occupational therapy may establish eligibility under other programs, such as Medicaid. The Medicare home health patient who is receiving services from multiple disciplines (i.e., skilled nursing, physical therapy, and occupational therapy) during the episode of care, can retain eligibility if, over time, occupational therapy is the only remaining skilled discipline providing care. At that time, an OT can conduct OASIS assessments.

Multidisciplinary cases may have multiple points of discipline-specific discharge, though only one is the agency discharge, which must include OASIS data collection and completion of the OASIS discharge comprehensive assessment. Other non-OASIS required documentation for recertification and discharge are specified in the Home Health Services Conditions for Coverage (CfCs) & Conditions of Participations (CoPs). OASIS items were designed to be discipline-neutral and have been tested and validated with clinicians from various disciplines.

**Comprehensive Assessment and Plan of Care**

OASIS-C data are collected as part of the comprehensive assessment required by the Medicare Conditions of Participation (see Appendix A of this manual). As with OASIS-B1, OASIS-C is not intended to represent a comprehensive assessment in and of itself. Each agency is expected to incorporate the OASIS items into its own comprehensive assessment documentation and follow its own assessment policies and procedures. Agencies are free to rearrange OASIS-C item sequence in a way that permits logical ordering within their own forms, as long as the actual item content, skip patterns, and OASIS number remain the same. OASIS data, like the rest of the comprehensive assessment, are collected using a variety of strategies, including observation, interview, review of pertinent documentation (e.g., hospital discharge summaries to obtain information on inpatient facility procedures and diagnoses), discussions with other care team members where relevant (e.g., phone calls to the physician to verify diagnoses), and measurement (e.g., wound length/width, intensity of pain). As with OASIS-B1, OASIS-C data should be collected at each time point based on a unique patient assessment, not simply carried over from a previous assessment. Comprehensive assessment data form the basis of the physician-ordered plan of care. Thus, there should be congruency between documentation of findings from the comprehensive assessment and the plan of care. As specified in the Medicare Conditions of Participation for Home Health (see link to the Conditions of Participation in Chapter 5 of this manual), the plan of care should be updated to reflect revised care orders and current diagnoses throughout the period the patient is receiving home health care services.

**Process of Care Data Items**

Process of care data items collected at transfer and discharge time points may require the clinician completing the assessment to review the entire care episode, defined as the time since the most recent OASIS assessment. The purpose of this review is to determine if a condition (e.g., pain, symptoms of heart failure) was present during the episode and whether interventions to address the condition were a) incorporated into the plan of care and b) implemented as part of patient care (see example in Table 3).

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6 [http://www.cms.hhs.gov/CFCsAndCoPs/12_homehealth.asp#TopOfPage](http://www.cms.hhs.gov/CFCsAndCoPs/12_homehealth.asp#TopOfPage)
This review must consider care provided by all disciplines during the episode, not limited to care provided by the discipline of the clinician completing the OASIS assessment. This evaluation of the care episode can be accomplished in several different ways. The care provider may find it necessary to review clinical records, including the plan of care, updated orders, and visit notes. Alternatively, the agency may elect to create a flowsheet with the appropriate parameters that are checked off on each visit. Review of the flowsheet may provide the needed information, such that a review of the clinical record would be unnecessary. Another strategy for agencies using electronic health records is to create a report template that could pull the needed information from data fields incorporated into visit notes. Regardless of the technique that an agency chooses, the process data items completed at transfer and discharge will require knowledge of patient symptoms, initial and subsequent physician’s orders, and clinical interventions performed to address patient symptoms across the episode of care.

**TABLE 3: Illustrative Process Items.**

Since the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

<table>
<thead>
<tr>
<th>Plan / Intervention</th>
<th>No</th>
<th>Yes</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care</td>
<td>☐</td>
<td>☐</td>
<td>☐ (Patient is not diabetic or is bilateral amputee)</td>
</tr>
<tr>
<td>b. Falls prevention interventions</td>
<td>☐</td>
<td>☐</td>
<td>☐ (Formal multi-factor Fall Risk Assessment indicates the patient was not at risk for falls since the last OASIS assessment)</td>
</tr>
<tr>
<td>c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment</td>
<td>☐</td>
<td>☐</td>
<td>☐ (Formal assessment indicates patient did not meet criteria for depression AND patient did not have diagnosis of depression since the last OASIS assessment)</td>
</tr>
</tbody>
</table>

**Conventions for Completing OASIS-C**

Table 4 lists conventions, or general rules, that should be observed when completing OASIS-C. Item-specific guidance is provided in Chapter 3. The OASIS-C Guidance provides clarification of item intent based on "Frequently Asked Questions" posted to CMS since OASIS was initially implemented. We do, however, anticipate that we will not clarify all of the situations that are unique and the exceptions that may be encountered in clinical practice.

Each patient scenario, clinical status, social and environmental situation is unique, requiring professional/clinical judgment and care coordination. In the event you cannot resolve your understanding of the OASIS questions, CMS will continue to provide avenues to accept and respond to questions.
TABLE 4: Conventions for Completing OASIS-C Items.

General OASIS item conventions

1. Understand the time period under consideration for each item. Report what is true on the day of assessment unless a different time period has been indicated in the item or related guidance. Day of assessment is defined as the 24 hours immediately preceding the home visit and the time spent by the clinician in the home.

2. If the patient’s ability or status varies on the day of the assessment, report the patient’s “usual status” or what is true greater than 50% of the assessment time frame, unless the item specifies differently (e.g., for M2020 Management of Oral Medications, M2030 Management of Injectable Medications, and M2100e Management of Equipment, instead of “usual status” or “greater than 50% of the time,” consider the medication or equipment for which the most assistance is needed).

3. Minimize the use of NA and Unknown responses.

4. Responses to items documenting a patient’s current status should be based on independent observation of the patient’s condition and ability at the time of the assessment without referring back to prior assessments unless collection of the item includes review of the care episode (e.g., process items). For OASIS items that require review of the episode, the phrase “since the previous OASIS assessment” should be interpreted to mean “at or since the time of the last OASIS assessment.” These instructions are included in item guidance for the relevant OASIS questions.

5. Combine observation, interview, and other relevant strategies to complete OASIS data items as needed (e.g., it is acceptable to review the hospital discharge summary to identify inpatient procedures and diagnoses at Start of Care, or to examine the care notes to determine if a physician-ordered intervention was implemented at Transfer or Discharge). However, when assessing physiologic or functional health status, direct observation is the preferred strategy.

6. When an OASIS item refers to assistance, this means assistance from another person unless otherwise specified within the item. Assistance is not limited to physical contact and includes both verbal cues and supervision.

7. Complete OASIS items accurately and comprehensively, and adhere to skip patterns.

8. Understand what tasks are included and excluded in each item and score item based only on what is included.

9. Consider medical restrictions when determining ability. For example, if the physician has ordered activity restrictions, these should be considered when selecting the best response to functional items related to ambulation, transferring, etc.

10. Understand the definitions of words as used in the OASIS.

11. Follow rules included in the Item Specific Guidance.

12. Stay current with evolving CMS OASIS guidance updates.

13. Only one clinician takes responsibility for accurately completing a comprehensive assessment, although for selected items, collaboration is appropriate (e.g., Medication items M2000 – M2004). These exceptions are noted in the Item Specific Guidance.

14. When the OASIS item includes language specifying “one calendar day” (e.g., M2002 Medication Follow-up), this means until the end of the next calendar day.

15. The use of i.e., means “only in these circumstances” or “that is” and scoring of the item should be limited to the examples listed. The use of e.g., means “for example” and the clinician may consider other relevant examples when scoring this item.

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OASIS-C Guidance Manual
September 2009 for 2010 Implementation
Centers for Medicare & Medicaid Services
TABLE 4: Conventions for Completing OASIS-C Items. (cont’d)

ADL/IADL item-specific conventions

1. Report the patient’s ability, not actual performance or willingness, to perform a task. While the presence or absence of a caregiver may impact actual performance of activities, it does not impact the patient’s ability to perform a task.

2. The level of ability refers to the patient’s ability to safely complete specified activities.

3. If the patient’s ability varies between the different tasks included in a multi-task item, report what is true in a majority of the included tasks, giving more weight to tasks that are more frequently performed.

E. OASIS Data Accuracy

In any data-driven system, the quality of the output is only as good as the quality of the data input. OASIS data are used to produce quality reports for agencies and for public reporting on the Medicare Home Health Compare website, as well as to determine payment. At some point in the future, OASIS data may be used to determine incentive payments under a quality-based purchasing program. Thus, it is imperative that the OASIS data that HHAs collect and submit be accurate and complete. Regulatory language specifying accuracy of OASIS data can be found in the Medicare Conditions of Participation §484.20(b) Standard: Accuracy of Encoded OASIS Data (2005 CFR Title 42, Volume 3).7 (Also, see Appendix B of this manual.)8

CMS recommends that agencies develop internal systems for monitoring data accuracy in addition to data checking features incorporated into HAVEN and other data entry systems. These may include clinical record audits, data entry audits, and other activities that are explained in detail in Appendix B of this manual, which incorporates Chapter 12 of the OASIS Implementation Manual (Archives Home Health Quality Initiatives).9

HHAs can correct nearly all erroneous assessments themselves following professional standards for correcting documents. Inactivation procedures to correct assessments containing key field errors can be found at https://www.qtso.com/download/hha/HHAcollectionpolicy.pdf. Additional information related to correction of erroneous OASIS data is provided in the April 20, 2001 Survey and Certification memorandum on this topic (https://www.qtso.com/download/hha/HHAcollectionpolicy.pdf).10 A copy of the memorandum is also provided in Appendix B of this manual.

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7 http://www.access.gpo.gov/nara/cfr/waisidx_05/42cfr484_05.html
8 http://www.cms.hhs.gov/CFCsAndCoPs/12_homehealth.asp#TopOfPage
9 http://www.cms.hhs.gov/HomeHealthQualityInits/20_HHQIArchives.asp#TopOfPage
F. **OASIS Data Encoding and Transmission**

OASIS-C revisions do not change the requirements for OASIS data encoding within 30 days of assessment completion (M0090). The requirements are specified in the Medicare Conditions of Participation §484.20(a) Standard: Encoding OASIS Data, §484.20(c) Standard: Transmittal of OASIS Data, and §484.20(d) Standard: Data Format. (Available at [Home Health Services Conditions of Participations (CoPs)](https://www.qtso.com/hhadownload.html); and summarized in Appendix E of this manual. Detailed instructions on encoding and transmitting OASIS data are found in the HHA System User's Guide and the OASIS Validation Report Messages and Description Guide (both available at [QIES Technical Support Office - OASIS Download](https://www.qtso.com/hhadownload.html)) and the HAVEN System Reference Manual ([QIES Technical Support Office - HAVEN Download](https://www.qtso.com/havendownload.html)) for those agencies using HAVEN to meet these requirements.
Chapter 2 contains the full set of **all OASIS-C items** and the following individual timepoint versions:

- Patient Tracking Sheet of OASIS-C1
- Start of Care (SOC) (also used for Resumption of Care Following Inpatient Stay)
- Resumption of Care (ROC)
- Follow-Up (FU)
- Transfer (TRN) (used for Transfer to an Inpatient Facility)
- Discharge (DC) (also used for Transfer to an Inpatient Facility)
- Death at Home (Death)
CHAPTER 3 – OASIS ITEM GUIDANCE

Chapter 3 contains item-specific guidance for each OASIS item. Item-specific guidance is no longer contained in a single document, but has been divided into sections that can be accessed through individual links. The sections contained in this chapter are as follows:

A  - Patient Tracking
B  - Clinical Record Items
C  - Patient History & Diagnoses
D  - Living Arrangements
E  - Sensory Status
F  - Integumentary Status
G  - Respiratory Status
H  - Cardiac Status
I  - Elimination Status
J  - Neuro/Emotional/Behavioral Status
K  - ADLs/IADLs
L  - Medications
M  - Care Management
N  - Therapy Need and Plan of Care
O  - Emergent Care
P  - Discharge
Chapter 4 of this manual contains sample illustrative clinical record forms showing the integration of OASIS-C items. These one-page illustrative forms are included for the following timepoints:

Illustration 1 -- Start of Care Assessment
Illustration 2 – Start of Care Assessment
Illustration 3 – Discharge Assessment
Illustration 4 – Transfer to Inpatient Facility
ILLUSTRATION 1
Sample Page from Clinical Record Form with Integrated OASIS Items.

START OF CARE ASSESSMENT
(Also used for Resumption of Care Following Inpatient Stay)

| Client's Name: ____________________________ | Client Record No. ____________________________ |

A. DEMOGRAPHIC INFORMATION - Update Patient Tracking Sheet at ROC

1. (M0080) Discipline of Person Completing Assessment:
   - □ 1 - RN
   - □ 2 - PT
   - □ 3 - SLP/ST
   - □ 4 - OT

2. (M0090) Date Assessment Completed:
   __ __ / __ __ / __ __ __ __
   month / day / year

3. (M0100) This Assessment is Currently Being Completed for the Following Reason:
   - □ 1 - Start of care—further visits planned
   - □ 2 - Resumption of care (after inpatient stay)

   Follow-Up
   - 4 - Recertification (follow-up reassessment)
   - 5 - Other follow-up

   Transfer to an Inpatient Facility
   - 6 - Transferred to an inpatient facility—patient not discharged from agency
   - 7 - Transferred to an inpatient facility—patient discharged from agency
   - Discharge From Agency — Not to an Inpatient Facility
   - 8 - Death at home
   - 9 - Discharge from agency

4. (M0102) Date of Physician-ordered Start of Care (Resumption of Care): If the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified.
   __ __ / __ __ / __ __ __ __ (Go to M0110, if date entered)
   month / day / year
   □ NA - No specific SOC date ordered by physician

5. (M0104) Date of Referral: Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.
   __ __ / __ __ / __ __ __ __
   month / day / year

6. (M0110) Episode Timing: Is the Medicare home health payment episode for which this assessment will define a case mix group an “early” episode or a “later” episode in the patient’s current sequence of adjacent Medicare home health payment episodes?
   - □ 1 - Early
   - □ 2 - Later
   - □ UK - Unknown
   - □ NA - Not Applicable: No Medicare case mix group to be defined by this assessment.

7. Economic/Financial Problems or Needs (describe):

8. (M1000) From which of the following Inpatient Facilities was the patient discharged during the past 14 days? (Mark all that apply.)
   - □ 1 - Long-term nursing facility (NF)
   - □ 2 - Skilled nursing facility (SNF / TCU)
   - □ 3 - Short-stay acute hospital (IPP S)
   - □ 4 - Long-term care hospital (LTCH)
   - □ 5 - Inpatient rehabilitation hospital or unit (IRF)
   - □ 6 - Psychiatric hospital or unit
   - □ 7 - Other (specify)
   - □ NA - Patient was not discharged from an inpatient facility [Go to M1016]

9. (M1005) Inpatient Discharge Date (most recent):
   __ __ / __ __ / __ __ __ __
   month / day / year
   □ UK - Unknown

10. (M1010) List each Inpatient Diagnosis and ICD-9-CM code at the level of highest specificity for only those conditions treated during an inpatient stay within the last 14 days (no E-codes, or V-codes):
<table>
<thead>
<tr>
<th>Inpatient Facility Diagnosis</th>
<th>ICD-9-CM Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. ________________________</td>
<td>__ __ __ __ __</td>
</tr>
<tr>
<td>b. ________________________</td>
<td>__ __ __ __ __</td>
</tr>
<tr>
<td>c. ________________________</td>
<td>__ __ __ __ __</td>
</tr>
<tr>
<td>d. ________________________</td>
<td>__ __ __ __ __</td>
</tr>
<tr>
<td>e. ________________________</td>
<td>__ __ __ __ __</td>
</tr>
<tr>
<td>f. ________________________</td>
<td>__ __ __ __ __</td>
</tr>
</tbody>
</table>
START OF CARE ASSESSMENT
(Also used for Resumption of Care Following Inpatient Stay)

L. REVIEW OF SYSTEMS/PHYSICAL ASSESSMENT (cont’d)

14. NEURO / EMOTIONAL / BEHAVIORAL STATUS

☐ Hx of previous psych. illness
☐ Other (specify)

(M1700) **Cognitive Functioning:** Patient’s current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

☐ 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.

☐ 1 - Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.

☐ 2 - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.

☐ 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.

☐ 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

(M1710) **When Confused (Reported or Observed Within the Last 14 Days):**

☐ 0 - Never

☐ 1 - In new or complex situations only

☐ 2 - On awakening or at night only

☐ 3 - During the day and evening, but not constantly

☐ 4 - Constantly

☐ NA - Patient nonresponsive

(M1720) **When Anxious (Reported or Observed Within the Last 14 Days):**

☐ 0 - None of the time

☐ 1 - Less often than daily

☐ 2 - Daily, but not constantly

☐ 3 - All of the time

☐ NA - Patient nonresponsive

(M1730) **Depression Screening:** Has the patient been screened for depression, using a standardized depression screening tool?

☐ 0 - No

☐ 1 - Yes, patient was screened using the PHQ-2© scale. (Instructions for this two-question tool: Ask patient: “Over the last two weeks, how often have you been bothered by any of the following problems”)

<table>
<thead>
<tr>
<th>PHQ-2©</th>
<th>Not at all 0 - 1 day</th>
<th>Several days 2 - 6 days</th>
<th>More than half of the days 7 – 11 days</th>
<th>Nearly every day 12 – 14 days</th>
<th>N/A Unable to respond</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Little interest or pleasure in doing things</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ na</td>
</tr>
<tr>
<td>b) Feeling down, depressed, or hopeless?</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ na</td>
</tr>
</tbody>
</table>

☐ 2 - Yes, with a different standardized assessment-and the patient meets criteria for further evaluation for depression.

☐ 3 - Yes, patient was screened with a different standardized assessment-and the patient does not meet criteria for further evaluation for depression.

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(M1740) **Cognitive, behavioral, and psychiatric symptoms** that are demonstrated at least once a week (Reported or Observed): (Mark all that apply.)

☐ 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required

☐ 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions

☐ 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.

☐ 4 - Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)

☐ 5 - Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions)

☐ 6 - Delusional, hallucinatory, or paranoid behavior

☐ 7 - None of the above behaviors demonstrated

(M1745) **Frequency of Disruptive Behavior Symptoms (Reported or Observed)** Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.

☐ 0 - Never

☐ 1 - Less than once a month

☐ 2 - Once a month

☐ 3 - Several times each month

☐ 4 - Several times a week

☐ 5 - At least daily

(M1750) **Is this patient receiving Psychiatric Nursing Services** at home provided by a qualified psychiatric nurse?

☐ 0 - No

☐ 1 - Yes
C. IMMUNIZATION/SCREENING TESTS

1. Immunizations:
   - Flu: Yes ___ No ___ Date ____________
   - Tetanus: Yes ___ No ___ Date ____________

2. Screening:
   - Cholesterol level: Yes ___ No ___ Date ____________
   - Colon cancer screen: Yes ___ No ___ Date ____________
   - Mammogram: Yes ___ No ___ Date ____________
   - Prostate cancer screen: Yes ___ No ___ Date ____________
   - Other: Yes ___ No ___ Date ____________

3. Self-Exam Frequency:
   - Breast self-exam frequency ____________
   - Testicular self-exam frequency ____________

4. (M1040) Influenza Vaccine: Did the patient receive the influenza vaccine from your agency for this year's influenza season (October 1 through March 31) during this episode of care?
   - 0 - No
   - 1 - Yes [ Go to M1050 ]
   - NA - Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season. [ Go to M1050 ]

5. (M1045) Reason Influenza Vaccine not received: If the patient did not receive the influenza vaccine from your agency during this episode of care, state reason:
   - 1 - Received from another health care provider (e.g., physician)
   - 2 - Received from your agency previously during this year's flu season
   - 3 - Offered and declined
   - 4 - Assessed and determined to have medical contraindication(s)
   - 5 - Not indicated; patient does not meet age/condition guidelines for influenza vaccine
   - 6 - Inability to obtain vaccine due to declared shortage
   - 7 - None of the above

D. RISK FACTORS

1. (M1032) Risk for Rehospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply.)
   - 1 - Recent decline in mental, emotional, or behavioral status
   - 2 - Multiple hospitalizations (2 or more) in the past 12 months
   - 3 - History of falls (2 or more falls - or any fall with an injury - in the past year)
   - 4 - Taking five or more medications
   - 5 - Frailty indicators, e.g., weight loss, self-reported exhaustion
   - 6 - Other
   - 7 - None of the above

2. (M1034) Overall Status: Which description best fits the patient's overall status? (Check one)
   - 0 - The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age).
   - 1 - The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient’s age).
   - 2 - The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death.
   - 3 - The patient has serious progressive conditions that could lead to death within a year.
   - UK - The patient's situation is unknown or unclear.
ILLUSTRATION 4
Sample Page from Clinical Record Form with Integrated OASIS Items.

TRANSFER TO INPATIENT FACILITY

Client’s Name: ____________________________________________
Client Record No. __________________________________________

A. DEMOGRAPHIC/GENERAL INFORMATION - Update Patient Tracking Sheet as needed.

1. (M0080) Discipline of Person Completing Assessment:
   - □ 1 - RN
   - □ 2 - PT
   - □ 3 - SLP/ST
   - □ 4 - OT

2. (M0090) Date Assessment Completed:
   __ __ / __ __ / __ __ __ __ month / day / year

3. (M0100) This Assessment is Currently Being Completed for the Following Reason:

   - Start/Resumption of Care
     - 1 - Start of care—further visits planned
     - 3 - Resumption of care (after inpatient stay)

   - Follow-Up
     - 4 - Recertification (follow-up) reassessment
     - 5 - Other follow-up

   - Transfer to an Inpatient Facility
     - □ 6 - Transferred to an inpatient facility—patient not discharged from agency
     - □ 7 - Transferred to an inpatient facility—patient discharged from agency

   - Discharge from Agency — Not to an Inpatient Facility
     - 8 - Death at home
     - 9 - Discharge from agency

B. EMERGENT CARE

(M2300) Emergent Care: Since the last time OASIS data were collected, has the patient utilized a hospital emergency department (includes holding/observation)?
   - □ 0 - No [ Go to M2400 ]
   - □ 1 - Yes, used hospital emergency department WITHOUT hospital admission
   - □ 2 - Yes, used hospital emergency department WITH hospital admission
   - □ UK - Unknown [ Go to M2400 ]

(M2310) Reason for Emergent Care: For what reason(s) did the patient receive emergent care (with or without hospitalization)? (Mark all that apply.)
   - □ 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
   - □ 2 - Injury caused by fall
   - □ 3 - Respiratory infection (e.g., pneumonia, bronchitis)
   - □ 4 - Other respiratory problem
   - □ 5 - Heart failure (e.g., fluid overload)
   - □ 6 - Cardiac dysrhythmia (irregular heartbeat)
   - □ 7 - Myocardial infarction or chest pain
   - □ 8 - Other heart disease
   - □ 9 - Stroke (CVA) or TIA
   - □ 10 - Hypo/Hyperglycemia, diabetes out of control
   - □ 11 - GI bleeding, obstruction, constipation, impaction
   - □ 12 - Dehydration, malnutrition
   - □ 13 - Urinary tract infection
   - □ 14 - IV catheter-related infection or complication
   - □ 15 - Wound infection or deterioration
   - □ 16 - Uncontrolled pain
   - □ 17 - Acute mental/behavioral health problem
   - □ 18 - Deep vein thrombosis, pulmonary embolus
   - □ 19 - Other than above reasons
   - □ UK - Reason unknown

(M2400) Intervention Synopsis: (Check only one box in each row.) Since the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

<table>
<thead>
<tr>
<th>Plan / Intervention</th>
<th>No</th>
<th>Yes</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Diabetic foot care including monitoring for the presence of skin lesions on the</td>
<td>□ 0</td>
<td>□ 1</td>
<td>□ na</td>
</tr>
<tr>
<td>lower extremities and patient/caregiver education on proper foot care</td>
<td></td>
<td></td>
<td>Patient is not diabetic or is bilateral amputee</td>
</tr>
<tr>
<td>b. Falls prevention interventions</td>
<td>□ 0</td>
<td>□ 1</td>
<td>□ na</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Formal multi-factor Fall Risk Assessment indicates the patient was not at risk for falls since the last OASIS assessment</td>
</tr>
<tr>
<td>c. Depression intervention(s) such as medication, referral for other treatment, or</td>
<td>□ 0</td>
<td>□ 1</td>
<td>□ na</td>
</tr>
<tr>
<td>a monitoring plan for current treatment</td>
<td></td>
<td></td>
<td>Formal assessment indicates patient did not meet criteria for depression AND patient did not have diagnosis of depression since the last OASIS assessment</td>
</tr>
<tr>
<td>d. Intervention(s) to monitor and mitigate pain</td>
<td>□ 0</td>
<td>□ 1</td>
<td>□ na</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Formal assessment did not indicate pain since the last OASIS assessment</td>
</tr>
<tr>
<td>e. Intervention(s) to prevent pressure ulcers</td>
<td>□ 0</td>
<td>□ 1</td>
<td>□ na</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Formal assessment indicates the patient was not at risk of pressure ulcers since the last OASIS assessment</td>
</tr>
<tr>
<td>f. Pressure ulcer treatment based on principles of moist wound healing</td>
<td>□ 0</td>
<td>□ 1</td>
<td>□ na</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dressings that support the principles of moist wound healing not indicated for this patient’s pressure ulcers OR patient has no pressure ulcers with need for moist wound healing</td>
</tr>
</tbody>
</table>
CHAPTER 5 – RESOURCES / LINKS

This chapter provides information on print and electronic resources available to support you in OASIS accuracy, quality, safety and best practice.

Disclaimer

CMS does not control the content of the websites that are not listed as CMS. The links are valid at the time this document is being prepared but we cannot determine whether they will remain valid indefinitely. The opinions expressed may or may not match those of CMS policy. Users are urged to work with their OASIS Education Coordinators for questions regarding official CMS policy.

General Sources, Publications, and Web Sites

<table>
<thead>
<tr>
<th>CMS websites</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS Internet-Only Manuals (IOMs)</td>
</tr>
<tr>
<td>NPI Registry</td>
</tr>
<tr>
<td>OASIS Archives</td>
</tr>
<tr>
<td>OASIS-C</td>
</tr>
<tr>
<td>OBQI</td>
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<tr>
<td>OBQM</td>
</tr>
<tr>
<td>Home Health PPS Payment</td>
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### General Sources, Publications, and Web Sites (continued)

#### CMS websites

<table>
<thead>
<tr>
<th>Source</th>
<th>URL</th>
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<tbody>
<tr>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td><a href="http://www.cms.hhs.gov/OASIS/03_Regulations.asp#TopOfPage">http://www.cms.hhs.gov/OASIS/03_Regulations.asp#TopOfPage</a></td>
</tr>
<tr>
<td>Home Health Quality</td>
<td><a href="http://www.cms.hhs.gov/HomeHealthQualityInits/">http://www.cms.hhs.gov/HomeHealthQualityInits/</a></td>
</tr>
<tr>
<td>OASIS Regulations</td>
<td><a href="http://www.cms.hhs.gov/OASIS/03_Regulations.asp#TopOfPage">http://www.cms.hhs.gov/OASIS/03_Regulations.asp#TopOfPage</a></td>
</tr>
<tr>
<td>Rulemaking</td>
<td><a href="http://www.cms.hhs.gov/eRulemaking/">http://www.cms.hhs.gov/eRulemaking/</a></td>
</tr>
<tr>
<td>State OAC/OEC information</td>
<td><a href="http://www.cms.hhs.gov/OASIS/06_EducationCoord.asp#TopOfPage">http://www.cms.hhs.gov/OASIS/06_EducationCoord.asp#TopOfPage</a></td>
</tr>
<tr>
<td>State by State Comparison of Measures</td>
<td><a href="http://www.cms.hhs.gov/OASIS/09b_hhareports.asp#TopOfPage">http://www.cms.hhs.gov/OASIS/09b_hhareports.asp#TopOfPage</a></td>
</tr>
<tr>
<td>CMS Survey and Certification</td>
<td><a href="http://www.cms.hhs.gov/SurveyCertificationGenInfo/01_Overview.asp#TopOfPage">http://www.cms.hhs.gov/SurveyCertificationGenInfo/01_Overview.asp#TopOfPage</a></td>
</tr>
<tr>
<td>OASIS Q&amp;A’s</td>
<td>Submit and Review questions</td>
</tr>
<tr>
<td>Q&amp;A Tracking Table</td>
<td><a href="https://www.gtso.com/hhadownload.html">https://www.gtso.com/hhadownload.html</a></td>
</tr>
<tr>
<td>Mailbox</td>
<td><a href="http://www.cms.hhs.gov/OASIS/09_HHAQA.asp#TopOfPage">http://www.cms.hhs.gov/OASIS/09_HHAQA.asp#TopOfPage</a></td>
</tr>
<tr>
<td>(to be updated in association with OASIS C)</td>
<td></td>
</tr>
</tbody>
</table>

#### Guidelines and Best Practices

- **Home Health Best Practice Intervention Packages (QIO)**

- **Falls Prevention Best Practice Intervention Package** (A comprehensive Best Practice Implementation Package from the Home Health Quality Improvement Campaign that helps home health agencies to design and implement a fall prevention program for their patients.)

- **Evidence-Based Practice Guidelines, University of Iowa, College of Nursing**
  - [http://www.ahrq.gov/clinic/cpgonline.htm](http://www.ahrq.gov/clinic/cpgonline.htm)

- **National Guideline Clearinghouse™ (NGC):**
  - [http://www.guideline.gov/browse/guideline_index.aspx](http://www.guideline.gov/browse/guideline_index.aspx)

- **VNSNY Geriatric Home Care Excellence**
  - [http://www.champ-program.org/](http://www.champ-program.org/)
General Sources, Publications, and Web Sites (continued)

Healthcare Technology


Office of the National Coordinator for Health Information Technology (ONC)  http://healthit.hhs.gov

  http://www.hhs.gov/healthit/onc/mission/
  http://www.himss.org/ASP/index.asp
  http://www.hhs.gov/healthit/initiatives/
  http://www.nationalehealth.org/
  http://nhinwatch.com/

Infection Control and Immunizations

CDC  http://www.cdc.gov/vaccines/default.htm

  http://www.cdc.gov/flu/
  http://www.cdc.gov/az/

Medical Resources


Congestive Heart Failure


Diabetes

  http://www.diabetes.org/
  http://diabetes.niddk.nih.gov/

Diabetic Foot Care

  http://www.ndep.nih.gov/media/Feet_HCGuide.pdf

### Mental Health Resources

<table>
<thead>
<tr>
<th>Source</th>
<th>URL</th>
</tr>
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<tbody>
<tr>
<td>Alzheimer’s</td>
<td><a href="http://www.alz.org/living_with_alzheimers_caring_for_alzheimers.asp">http://www.alz.org/living_with_alzheimers_caring_for_alzheimers.asp</a></td>
</tr>
<tr>
<td>BIMS’ performance in national testing in</td>
<td>Saliba D, Buchanan J. 2008. “Cognitive Patterns” Chapter 5 in</td>
</tr>
<tr>
<td>community setting is included in a final</td>
<td>Development &amp; Validation of a Revised Nursing Home</td>
</tr>
<tr>
<td>report to CMS.</td>
<td>Assessment Tool: MDS 3.0.</td>
</tr>
<tr>
<td>Depression Recognition &amp; Assessment in</td>
<td><a href="http://www.geriu.org/uploads/applications/DepressionInHomecare/DinHomecare.html">http://www.geriu.org/uploads/applications/DepressionInHomecare/DinHomecare.html</a></td>
</tr>
<tr>
<td></td>
<td>Nursing Staff to Recognize Depression in Home Healthcare.” Journal</td>
</tr>
<tr>
<td></td>
<td>of the American Geriatrics Society. Retrieved from</td>
</tr>
<tr>
<td></td>
<td><a href="http://dx.doi.org/10.1111/j.1532-5415.2009.02626.x">http://dx.doi.org/10.1111/j.1532-5415.2009.02626.x</a></td>
</tr>
<tr>
<td>JA, Ouslander JG, Berlowitz DR, Streim JE</td>
<td>and Testing of a Brief Instrument of Mental Status.” Journal of the</td>
</tr>
<tr>
<td>Caregivers</td>
<td><a href="http://www.nextstepincare.org/">http://www.nextstepincare.org/</a></td>
</tr>
<tr>
<td>Cognitive assessment tools</td>
<td><a href="http://alzheimers.about.com/od/diagnosisissues/a/clock_test.htm">http://alzheimers.about.com/od/diagnosisissues/a/clock_test.htm</a>     (clock test)</td>
</tr>
<tr>
<td>Mini-Mental Status exam</td>
<td><a href="http://www.minimental.com/">http://www.minimental.com/</a></td>
</tr>
</tbody>
</table>

### Risk Assessment Tools and Condition-Specific Resources

<table>
<thead>
<tr>
<th>Source</th>
<th>URL</th>
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</thead>
<tbody>
<tr>
<td>American Heart Association Statements and Practice Guidelines</td>
<td><a href="http://www.americanheart.org">http://www.americanheart.org</a></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
</tr>
<tr>
<td>PHQ-2 resources</td>
<td><a href="http://www.innovations.ahrq.gov/content.aspx?id=2280">http://www.innovations.ahrq.gov/content.aspx?id=2280</a></td>
</tr>
<tr>
<td>Falls Risk</td>
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<tr>
<td>Home Care Fall Reduction Initiative risk Assessment Screening Tool (A multi-factor falls risk screening tool from the Missouri Alliance for Home Care, specifically designed for home care patients at Start of Care and Recertification)</td>
<td><a href="http://www.homehealthquality.org/shared/content/hhqi_campaign/bpip_falls_prevention/Fall_Risk_Assessment_Screening_Tool_final.doc">http://www.homehealthquality.org/shared/content/hhqi_campaign/bpip_falls_prevention/Fall_Risk_Assessment_Screening_Tool_final.doc</a></td>
</tr>
</tbody>
</table>
Risk Assessment Tools and Condition-Specific Resources

Timed Up and Go (TUG) Test Demonstration video  (Demonstration of how to administer the Timed Up and Go (TUG) test -- can be used as one component of a multi-factor risk assessment used to identify persons that are at risk of falling due to balance or gait problems)

http://www.qualitynet.org/dcs/ContentServer?cid=1216667046043&pagename=Medqic%2FMQPresentation%2FPresentationTemplate&c=MQPresentations

Get-up and Go Test  (A brief assessment of gait and balance – University of Iowa, Iowa Geriatric Education Center)

http://www.healthcare.uiowa.edu/igec/tools/categoryMenu.asp?categoryId=3

National Heart Lung and Blood Institute

Body Mass Index guidelines  http://www.nhlbisupport.com/bmi/

Pain

Non-verbal patient pain assessment:  http://prc.coh.org/PAIN-NOA.htm

Geriatric Pain:  http://www.champ-program.org/

Pressure Ulcers

Established, validated pressure ulcer risk tools include the Braden Scale for Predicting Pressure Sore Risk and the Norton Scale (both of which are available at http://providers.ipro.org/index/nhqtools

Braden  http://www.bradenscale.com/


NQF Framework  http://www.qualityforum.org/Projects/n-r/Pressure_Ulcer/Pressure_Ulcers.aspx

National Pressure Ulcer Advisory Panel (NPUAP) (www.npuap.org )

Pressure ulcer definitions:  http://www.npuap.org/pr2.htm

Pressure ulcer pictures:  http://www.npuap.org/resources.htm

NPUAP ’s Pressure Ulcer Scale for Healing (PUSH)  http://npuap.org/tools.htm

Wound Ostomy and Continence Nurses Society (WOCN)  http://www.wocn.org/

Leg ulcers:  http://www.wocn.org/pdfs/WOCN_Library/Fact_Sheets/C_QUICK1.pdf

OASIS guidance  http://www.wocn.org/WOCN_Library
(look for the upcoming OASIS-C Guidance Document)
General Sources, Publications, and Web Sites (continued)

Professional Organizations

ANA  http://www.nursingworld.org/

ANA Releases Revised Scope and Standards of Practice for Home Health Nurses (11/21/07)


AOTA  http://www.aota.org/

APTA  http://www.apta.org/AM/Template.cfm?Section=Home_Health1&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=55148

ASHA  http://www.asha.org/default.htm

Quality Resources

Agency for Healthcare Research and Quality  http://www.ahrq.gov/

AHRQ's Health Care Innovations Exchange Web site  http://www.innovations.ahrq.gov/

(Innovations and QualityTools classified by disease or clinical category, patient population, stage of care, setting of care, and more.)


http://www.qualitymeasures.ahrq.gov/

Commonwealth Fund Commission on a High Performance Health System: http://www.commonwealthfund.org/

Diversity: The Provider's Guide to Quality and Culture

http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English

Institute for Clinical Systems Improvement

http://www.icsi.org/

http://www.icsi.org/guidelines_and_more/patient_education_resources/

Institute for Healthcare Improvement

http://www.ihi.org/

http://www.ihi.org/ihi/workspace/

Institute of Medicine

http://www.iom.edu/CMS/28312/RT-EBM.aspx

http://www.iom.edu/CMS/3718.aspx

http://books.nap.edu/openbook.php?isbn=0309072808&page=1
General Sources, Publications, and Web Sites (continued)

<table>
<thead>
<tr>
<th>Quality Resources</th>
<th>Link</th>
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<tbody>
<tr>
<td>National Transitions of Care Coalition (NTOCC)</td>
<td><a href="http://www.ntocc.org/">http://www.ntocc.org/</a></td>
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<tr>
<th>Safety Resources</th>
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<tbody>
<tr>
<td>Joint Commission</td>
<td><a href="http://www.jointcommission.org/AccreditationPrograms/HomeCare/">http://www.jointcommission.org/AccreditationPrograms/HomeCare/</a></td>
</tr>
<tr>
<td>Geriatric</td>
<td><a href="http://www.champ-program.org/page/51/tools">http://www.champ-program.org/page/51/tools</a></td>
</tr>
<tr>
<td>Medication Safety</td>
<td>Institute for Safe Medication Practices (ISMP)</td>
</tr>
<tr>
<td>VA National Center for Patient Safety</td>
<td><a href="http://www.va.gov/NCPS/TIPS/tips.html">http://www.va.gov/NCPS/TIPS/tips.html</a></td>
</tr>
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