OASIS-C1
Time for a Check-Up!

WY Department of Health, State Surveying & Licensing and Mountain-Pacific Quality Health

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Presented by:
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Senior Consultant
OASIS Answers, Inc.

Presentation Outline:

• Review Types of changes in OASIS-C1
• Item Guidance Review and Application Scenarios related to the most challenging OASIS-C1 items
• Discuss importance of accurate OASIS-C1 data collection
• Review CMS OASIS resources for OASIS-C1
What’s New About “C1”?

OASIS-C1/ICD-9 data set

TYPES OF CHANGES MADE:

• Some C items deleted
• Data collection dropped at various time points
• Existing C items revised/refined
• Existing C items replaced with a new -C1 item
• Existing C Item split into 2 items

Change: Item Deleted

Directions for M1310, M1312, and M1314: If the patient has one or more unhealed (non-epithelialized) Stage III or IV pressure ulcers, identify the Stage III or IV pressure ulcer with the largest surface dimension (length x width) and record in centimeters. If no Stage III or Stage IV pressure ulcers, go to M1320.

(M1310) Pressure Ulcer Length: Longest length “head-to-toe” | ___ | ___ | ___ | ___ | (cm)

(M1312) Pressure Ulcer Width: Width of the same pressure ulcer; greatest width perpendicular to the length | ___ | ___ | ___ | ___ | (cm)

(M1314) Pressure Ulcer Depth: Depth of the same pressure ulcer, from visible surface to the deepest area | ___ | ___ | ___ | ___ | (cm)
(M2110) How often does the patient receive ADL or IADL assistance from any caregiver(s) (other than home health agency staff)?

- 1 - At least daily
- 2 - Three or more times per week
- 3 - One to two times per week
- 4 - Received, but less often than weekly
- 5 - No assistance received
- UK - Unknown

Will Be No Longer Collected at Discharge with OASIS-C1

Collected at SOC, ROC & DC

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(M2015) Patient/Caregiver Drug Education Intervention: At the time of, or at any time since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur?

- 0 - No
- 1 - Yes
- NA - Patient not taking any drugs

Important Wording Refinements
**M1033 Risk for Hospitalization** (M1032 in OASIS-C)

(M1033) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply.)

- 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months)
- 2. Unintentional weight loss of a total of 10 pounds or more in the past 12 months
- 3. Multiple hospitalizations (2 or more) in the past 6 months
- 4. Multiple emergency department visits (2 or more) in the past 6 months
- 5. Decline in mental, emotional, or behavioral status in the past 3 months
- 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
- 7. Currently taking 5 or more medications
- 8. Currently reports exhaustion
- 9. Other risk(s) not listed in 1 - 8
- 10. None of the above

**M1309 Worsening in Pressure Ulcer Status since SOC/ROC**

*(replacing column 2 of M1308 in OASIS-C)*

(M1309) Worsening in Pressure Ulcer Status since SOC/ROC:

**Instructions for a - c:** For Stage II, III, and IV pressure ulcers, report the number that are new or have increased in numerical stage since the most recent SOC/ROC.

<table>
<thead>
<tr>
<th></th>
<th>Enter Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Stage II</td>
<td>(Enter “0” if there are no current Stage II, III or IV pressure ulcers OR if all current Stage II, III or IV pressure ulcers existed at the same numerical stage at most recent SOC/ROC)</td>
</tr>
<tr>
<td>b. Stage III</td>
<td></td>
</tr>
<tr>
<td>c. Stage IV</td>
<td></td>
</tr>
</tbody>
</table>

**Instructions for d:** For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were a Stage I or II at the most recent SOC/ROC.

<table>
<thead>
<tr>
<th></th>
<th>Enter Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>d. Unstageable due to coverage of wound bed by slough or eschar</td>
<td>(Enter “0” if there are no Unstageable pressure ulcers at discharge OR if all current Unstageable pressure ulcers were Stage III or IV or were Unstageable at most recent SOC/ROC)</td>
</tr>
</tbody>
</table>
Let’s Take a Closer Look...

(M1830) Bathing: Current ability to wash entire body 
safely. Excludes grooming (washing face, washing 
hands, and shampooing hair).

- 1 - Able to bathe self in shower or tub independently, including 
  getting in and out of tub/shower.
- 2 - With the use of devices, able to bathe self in shower or tub 
  independently, including getting in and out of the tub/shower.
- 3 - Able to bathe in shower or tub with the intermittent 
  assistance of another person.
  (a) for intermittent supervision or encouragement or reminders. OR
  (b) to get in and out of the shower or tub.
- 4 - Unable to use the shower or tub, but able to bathe 
  independently with or without the use of devices at the sink, in chair, 
or on commode.
- 5 - Unable to use the shower or tub, but able to participate in 
bathing self in bed, at the sink, in bed, bedside chair, or on 
commode, with the assistance or supervision of another person.
  Throughout the bath.
- 6 - Unable to participate independently in bathing and is bathed 
totally by another person. (You feel about)

Guidance:

“Select Response 5 if the patient is unable to bathe in the tub/shower 
and needs intermittent or continuous assistance to wash their entire body 
safely at a sink, in a chair or on a commode.”

(M1830) Bathing: Current ability to wash entire body 
safely. Excludes grooming (washing face, washing 
hands, and shampooing hair).

- 1 - Able to bathe self in shower or tub independently, including 
  getting in and out of tub/shower.
- 2 - With the use of devices, able to bathe self in shower or tub 
  independently, including getting in and out of the tub/shower.
- 3 - Able to bathe in shower or tub with the intermittent 
  assistance of another person.
  (a) for intermittent supervision or encouragement or reminders. OR
  (b) to get in and out of the shower or tub.
- 4 - Unable to use the shower or tub, but able to bathe 
  independently with or without the use of devices at the sink, in chair, 
or on commode.
- 5 - Unable to use the shower or tub, but able to participate in 
bathing self in bed, at the sink, in bed, bedside chair, or on 
commode, with the assistance or supervision of another person.
  Throughout the bath.
- 6 - Unable to participate independently in bathing and is bathed 
totally by another person.
What about “M1900 Prior Functioning ADL/IADL” change?

Guidance
“Self-care” refers specifically to grooming, dressing, bathing, and toileting hygiene.
“Household tasks” refers specifically to light meal preparation, laundry, shopping, and phone use.

Does the “M1334 Stasis Ulcer Status” change make perfect sense?

Guidance
“The response option "Newly epithelialized" should not be selected for a healed stasis ulcer, as a completely epithelialized (healed) stasis ulcer is not reported as a stasis ulcer on OASIS.”
M1033 Risk for Hospitalization

(M1033) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply.)

- 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months)
- 2. Unintentional weight loss of a total of 10 pounds or more in the past 12 months
- 3. Multiple hospitalizations (2 or more) in the past 6 months
- 4. Multiple emergency department visits (2 or more) in the past 6 months
- 5. Decline in mental, emotional, or behavioral status in the past 3 months
- 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
- 7. Currently taking 5 or more medications
- 8. Currently reports exhaustion
- 9. Other risk(s) not listed in 1 - 8
- 10. None of the above

Revised to:
Collect data on factors identified in literature as predictive of hospitalization. Provide guidance on time period under consideration for responses. Responses reordered to reflect length of look back period.

Application Scenario – M1033

SCENARIO: At the SOC, Miss Ginsburg complained that for over a month, she’s been exhausted all the time, to the point of forgetting to take her medications and eat her prescribed diet. Her weight has been stable at 110 pounds for years but she has lost 5 pounds in the last 3 months. On the day of assessment, she was taking 7 medications. Her personal assistant reported Miss Ginsburg has required 4 trips to the hospital’s ER over the last 5 months.

Based on this information, how should M1033, Risk for Hospitalization be answered?

Select correct answer:
A) 4, 6, 7 and 8
B) 2, 4, 6, 7 and 8
C) 6, 7 and 8
D) 4 and 7
M1041 Influenza Vaccine

(M1041) Influenza Vaccine Data Collection Period: Does this episode of care (SOC/ROC to Transfer/Discharge) include any dates on or between October 1 and March 31?

☐ 0 – No [Go to M1051]
☐ 1 – Yes

Revised item title to reflect changed content being collected.
Revised item stem to clarify time period for reporting influenza vaccine status.
Skip directions revised due to numbering changes.

M1046 Reason Influenza Vaccine not Received

M1046 Influenza Vaccine Received: Did the patient receive the influenza vaccine for this year’s flu season?

☐ 1 - Yes; received from your agency during this episode of care (SOC/ROC to Transfer/Discharge)
☐ 2 - Yes; received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge)
☐ 3 - Yes; received from another health care provider (for example; physician, pharmacist)
☐ 4 - No; patient offered and declined
☐ 5 - No; patient assessed and determined to have medical contraindication(s)
☐ 6 - No; not indicated – patient does not meet age/condition guidelines for influenza vaccine
☐ 7 - No; inability to obtain vaccine due to declared shortage
☐ 8 - No; patient did not receive the vaccine due to reasons other than those listed in responses 4 – 7.

Simplified item to report reason patient did or did not receive influenza vaccine from any source.
Eliminated “during this episode of care” and “from your agency” from the item stem.
Added explanatory language from OASIS-C1 Guidance Manual.
Application Scenario – M1041/M1046

SCENARIO: Mr. Marshall was admitted to Heavenly Home Care October 17th and discharged on November 2nd. Record review revealed he informed the admitting PT that he received the flu vaccine back in August from a nurse from Heavenly Home Care when they were at his ALF.

How would M1041, Influenza Vaccine Data Collection Period & M1046, Influenza Vaccine Received be answered in this case?

Select correct answer:
A) M1041 = 0-No; M1046 - Skipped
B) M1041 – Skipped; M1046 - Skipped
C) M1041 = 1-Yes; M1046 = 3-Yes; received from another health care provider (for example: physician, pharmacist)
D) M1041 = 1-Yes; M1046 = 2-Yes; received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge)

M1051 Pneumococcal Vaccine

(M1051) Pneumococcal Vaccine: Has the patient ever received the pneumococcal vaccination (for example, pneumovax)?

☐ 0 - No
☐ 1 - Yes [Go to M1500 at TRN; Go to M1230 at DC]

Simplified item to report if patient has ever received pneumococcal vaccine.
Eliminated “during the episode of care” and “from your agency” from the item stem.
Changed “PPV” to “pneumovax”
M1056 - Reason Pneumococcal Vaccine not received

(M1056) Reason Pneumococcal Vaccine not received: If patient has never received the pneumococcal vaccination (for example, pneumovax), state reason:

- 1 - Offered and declined
- 2 - Assessed and determined to have medical contraindication(s)
- 3 - Not indicated; patient does not meet age/condition guidelines for pneumococcal vaccine.
- 4 - None of the above

Simplified item to report reason patient never received pneumococcal vaccination. Eliminated “during the episode of care” and “from your agency” from the item stem. Changed “PPV” to “pneumovax.”

Application Scenario – M1051/M1056

SCENARIO: Record review at discharge reveals Mrs. Sotomayor has never had the pneumovax. A clinical note explains the RN offered it to her but she refused stating it would make her sick.

How would M1051, Pneumococcal Vaccine, M1056, Reason Pneumococcal Vaccine Not Received be answered?

Select correct answer:
A ) M1051 = NA; M1056 - Skipped
B ) M1051 = 1-Yes; M1056 - Skipped
C ) M1051 = 0-No; M1056 = 1-Offered and declined.
D ) M1051 = 0-No; M1056 = None of the above
M1309 - Worsening in Pressure Ulcer Status since SOC/ROC

**Instructions for a – c:** For Stage II, III and IV pressure ulcers, report the number that are new or have increased in numerical stage since the most recent SOC/ROC.

- **a. Stage II**
- **b. Stage III**
- **c. Stage IV**

**Instructions for d:** For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were a Stage I or II at the most recent SOC/ROC.

Collects information at Discharge which was previously collected in M1308 column 2 on worsening pressure ulcer status. Harmonized with nursing home (MDS) and CARE instruments. Includes pressure ulcers that are unstageable due to slough/eschar.

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**M1309 - Reporting Algorithm**

<table>
<thead>
<tr>
<th>CURRENT STAGE at Discharge</th>
<th>PREVIOUS STAGE at most recent SOC/ROC</th>
<th>REPORT AS NEW OR UNRECOGNIZED?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Stage II at discharge</td>
<td>Stage II at most recent SOC/ROC</td>
<td>YES</td>
</tr>
<tr>
<td>b. Stage III at discharge</td>
<td>Stage III at most recent SOC/ROC</td>
<td>YES</td>
</tr>
<tr>
<td>c. Stage IV at discharge</td>
<td>Stage IV at most recent SOC/ROC</td>
<td>YES</td>
</tr>
<tr>
<td>d. Unstageable due to slough/eschar at discharge</td>
<td>Unstageable at most recent SOC/ROC</td>
<td>YES</td>
</tr>
</tbody>
</table>

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**Application Scenario – M1309**

**SCENARIO:** Mr. Scalia had a Stage II pressure ulcer on his left elbow at SOC, a reported Stage IV pressure ulcer covered with a non-removable dressing on his left buttock. At DC, the Stage IV on the left buttock could be observed and a small amount of muscle was visible, the left elbow ulcer was now a Stage IV with bone visible and there was a new Stage II on his left ear.

<table>
<thead>
<tr>
<th>Instructions for a – c: For Stage II, III and IV pressure ulcers, report the number that are new or have increased in numerical stage since the most recent SOC/ROC</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Stage II</td>
</tr>
<tr>
<td>b. Stage III</td>
</tr>
<tr>
<td>c. Stage IV</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Instructions for d: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were a Stage I or II at the most recent SOC/ROC</th>
</tr>
</thead>
<tbody>
<tr>
<td>d. Unstageable due to coverage of wound bed by slough or eschar</td>
</tr>
</tbody>
</table>

Select correct answer:

A) $a=1, b=1, c=0, d=0$
B) $a=1, b=0, c=1, d=0$
C) $a=1, b=0, c=0, d=1$
D) $a=1, b=0, c=2, d=0$

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**M2102 Types and Sources of Assistance**

**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. (Check only one box in each row.)

<table>
<thead>
<tr>
<th>Activity</th>
<th>No assistance needed if patient independent or does not have needs in this area</th>
<th>Non-agency caregiver(s) not likely to provide assistance</th>
<th>Non-agency caregiver(s) not likely to provide assistance</th>
<th>Non-agency caregiver(s) will provide assistance</th>
<th>Assistance needed, but non-agency caregiver(s) available</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADL assistance (e.g., transfer)</td>
<td>☐</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☐</td>
</tr>
<tr>
<td>ADL assistance, dressing, bathing, toileting</td>
<td>☐</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☐</td>
</tr>
<tr>
<td>ADL assistance, eating</td>
<td>☐</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☐</td>
</tr>
<tr>
<td>ADL assistance, hygiene</td>
<td>☐</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☐</td>
</tr>
<tr>
<td>ADL assistance, shopping, finance</td>
<td>☐</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☐</td>
</tr>
</tbody>
</table>

- Clarification that “caregiver” excludes care by agency staff
- Clarification that “No assistance needed from Caregiver in this area” means that the patient is independent or does not have needs in this area
- Combined “Caregiver(s) not likely to provide assistance” and “Caregiver(s) unwilling/unable to provide assistance.”
- Abbreviations eliminated for clarity ("e.g." replaced with "for example")
Application Scenario – M2102

**SCENARIO:** By the end of the SOC comprehensive assessment the RN had determined that her new patient, Mrs. O’Conner, who had memory deficits, needed assistance to safely get in/out of the shower and dressing. Those needs were currently being met by the daughter. The caregiver is having minor surgery and asked if the agency could provide a home health aide for the next two weeks. Mrs. O’Conner is ordered to begin a home exercise program. Both she and her daughter needed instruction from the PT. The caregiver stated she would be afraid to help her mother exercise.

<table>
<thead>
<tr>
<th>Type of Assistance</th>
<th>No assistance needed – patient is independent or does not have needs in this area</th>
<th>Non-agency caregiver(s) currently provide assistance</th>
<th>Non-agency caregiver(s) need training/suppose services to provide assistance</th>
<th>Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance</th>
<th>Assistance needed, but no non-agency caregiver(s) available</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. ADL assistance (for example: transfer/ambulation, bathing, dressing, toileting, eating/feeding)</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
</tr>
<tr>
<td>b. Medical procedures/treatments (for example: changing wound dressing, home exercise program)</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
</tr>
</tbody>
</table>

Select correct answer:

A) Row a = 1; Row d = 2  
B) Row a = 2; Row d = 0  
C) Row a = 3; Row d = 3  
D) Row a = 3; Row d = 4

M2250 – Plan of Care Synopsis

**(M2250) Plan of Care Synopsis:** (Check only one box in each row.) Does the physician-ordered plan of care include the following:

<table>
<thead>
<tr>
<th>Plan / Intervention</th>
<th>No</th>
<th>Yes</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Patient-specific parameters for modifying physician of changes in vital signs or other clinical findings</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐/NA</td>
</tr>
<tr>
<td>b. 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>☐ 0</td>
<td>☐ 1</td>
<td>☐/NA</td>
</tr>
<tr>
<td>c. Falls prevention interventions</td>
<td>☐/0</td>
<td>☐ 1</td>
<td>☐/NA</td>
</tr>
<tr>
<td>d. Depression intervention(s), such as medication, referral for other treatment, or a monitoring plan, for current treatment and/or physician notified that patient screened positive for depression</td>
<td>☐/0</td>
<td>☐ 1</td>
<td>☐/NA</td>
</tr>
</tbody>
</table>

Revised the "Not Applicable" responses for all rows except “a”  
Response “d” added physician notification for positive depression screening.
M2250 – Plan of Care Synopsis (Continued)

(M2250) Plan of Care Synopsis: (Check only one box in each row.) Does the physician-ordered plan of care include the following:

<table>
<thead>
<tr>
<th>Plan / Intervention</th>
<th>No</th>
<th>Yes</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>e. Intervention(s) to monitor and mitigate pain</td>
<td>☐ 0</td>
<td>☑ 1</td>
<td>NA</td>
</tr>
<tr>
<td>f. Intervention(s) to prevent pressure ulcers</td>
<td>☐ 0</td>
<td>☑ 1</td>
<td>NA</td>
</tr>
<tr>
<td>g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician</td>
<td>☐ 0</td>
<td>☑ 1</td>
<td>NA</td>
</tr>
</tbody>
</table>

Revised the "Not Applicable" responses for all rows except “a”.

Application Scenario – M2250

SCENARIO: While being treated at the hospital for an exacerbation of his CHF, Mr. Reinhardt was diagnosed with depression and started on an antidepressant. At the ROC assessment, he screened positive for signs of depression that required further evaluation. Before completing the ROC assessment, the RN notified the physician of his positive screen even though she believed he would improve with continued adherence to the current antidepressant drug therapy. No additional orders for treatment of depression were obtained before completing the ROC assessment.

(M2250) Plan of Care Synopsis: (Check only one box in each row.) Does the physician-ordered plan of care include the following:

<table>
<thead>
<tr>
<th>Plan / Intervention</th>
<th>No</th>
<th>Yes</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment and physician notified that patient screened positive for depression</td>
<td>☐ 0</td>
<td>☑ 1</td>
<td>NA</td>
</tr>
</tbody>
</table>

Select correct answer:
A) 0-No
B) 1-Yes
C) NA
D) Either NA or Yes would be appropriate
OASIS-C1

Don’t Risk the consequences of poorly or partially trained data collectors.

A commitment to ongoing OASIS education at the level of the assessing clinician is the key to Success.

Importance of OASIS Accuracy

1. Quality Reporting
2. Survey Success
3. Reimbursement
Process-Based Quality Improvement (PBQI)

- A quality improvement approach, based on research that indicates patient outcomes are positively impacted by the incorporation of best practices into the plan of care.
## M2250 Plan of Care Synopsis

(Check only one box in each row.) Does the physician-ordered plan of care include the following:

<table>
<thead>
<tr>
<th>Plan / Intervention</th>
<th>No</th>
<th>Yes</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ na</td>
</tr>
<tr>
<td>Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and proper foot care</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ na</td>
</tr>
<tr>
<td>Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Falls prevention interventions</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ na</td>
</tr>
<tr>
<td>Falls risk assessment indicates patient has no risk for falls.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment and/or physician notified that patient screen positive for depression</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ na</td>
</tr>
<tr>
<td>Patient has no diagnosis of depression AND depression screening indicates patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Intervention(s) to monitor and mitigate pain</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ na</td>
</tr>
<tr>
<td>Pain assessment indicates patient has no pain.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Intervention(s) to prevent pressure ulcers</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ na</td>
</tr>
<tr>
<td>Pressure ulcer risk assessment (clinical or formal) indicates patient is not at risk of pressure ulcers.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ na</td>
</tr>
<tr>
<td>Pressure ulcer OR has no signs for which moist wound healing is indicated.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Outcome-Based Quality Improvement (OBQI)**

Using the “Other Follow-up” to reassess patient status has it’s advantages:

- No Other Follow-up (RFA 5) after ER Visit – Emergent Care captured and reported at Discharge = Higher *Any Emergent Care* Outcome
- If Other Follow-up (RFA 5) collected after ER Visit – Emergent Care not reported at Discharge (RFA 9) = Lower *Any Emergent Care* Outcome
Dividends from your OASIS training investment

1. Quality Reporting
2. Survey Success
3. Reimbursement

Conditions of Participation: OASIS Expectations

- §484.55 Comprehensive Assessment must be conducted, including use of the current version of OASIS

- §484.20 OASIS data must accurately reflect the patient’s status at the time of assessment
Outcome-Based Quality Monitoring (OBQM)

- The process by which agencies investigate specific **potentially avoidable event outcomes** to identify areas of care needing improvement, then develop and implement a plan for improving the quality of care.

### Potentially Avoidable Events

<table>
<thead>
<tr>
<th>Event</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergent Care for Injury Caused by Fall</td>
<td>DC to Community Needing Wound Care or Medication Assistance</td>
</tr>
<tr>
<td>Emergent Care for Wound Infections, Deteriorating Wound Status</td>
<td>DC to Community Needing Toileting Assistance</td>
</tr>
<tr>
<td>Emergent Care for Improper Medication Administration, Medication Side Effects</td>
<td>DC to Community With Behavioral Problems</td>
</tr>
<tr>
<td>Emergent Care for Hypo/Hyperglycemia</td>
<td>DC to Community with an Unhealed Stage II Pressure Ulcer</td>
</tr>
</tbody>
</table>

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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
3-14 ...
15. Wound infection or deterioration
16. Uncontrolled pain
17. Acute mental/behavioral health problem
18. Deep vein thrombosis, pulmonary embolus
19. Other than above reason
UK – Reason unknown

The most common mistakes will result in inaccurate data, an inaccurately unfavorable PAE Report, & unnecessary survey action.

Impact of Data Error on Survey Process

Your patient tripped over his cat, but did not fall. He hit his lower leg on the coffee table and sustained a laceration which was treated in the ER. How is this reported on M2310 Emergent Care Reason?
Dividends from your OASIS training investment

1. Quality Reporting
2. Survey Success
3. Reimbursement

Healing Status of Stage III or IV Pressure Ulcers

- Stage III and IV pressure ulcers CLOSE
  - Contraction, granulation, and epithelialization
  - Never fully HEAL

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Healing Status of a Surgical Wound

DON'T THINK THAT "NON-HEALING" IS ONLY USED IN SITUATIONS OF ABNORMAL HEALING

Guidance released April 2010
CMS OASIS Q&A Cat 4b Q112.6.1

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CMS’ National OASIS-C1 Webinar

Presented Live September 3, 2014

Patricia Sevast, RN - Centers for Medicare & Medicaid Services
Linda Krulish, PT, MHS, COS-C – OASIS Answers, Inc.


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CMS-based OASIS Resources:

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**OASIS-C1 data collection resources**

- OASIS-C1/ICD-9 data set
- OASIS-C1/ICD-9 Guidance Manual (06/14)
- CMS OASIS Q&As (06/14)
- CMS OASIS Quarterly Q&As (07/14 & forward)
- WOCN Guidance on OASIS-C1 Integumentary Items
- CMS OASIS Q&A Mailbox (cmsoasisquestions@oasisanswers.com)

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**Thank you...**

**Questions?**