CMS OASIS Q&A - August 2017

Expansion of the One Clinician Convention

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

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

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

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

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

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

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

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

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

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

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

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