

OASIS E: Never Too Early to Get Started

Presented By:

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Principal

SimiTree



Objectives

- The learner will be able to identify the differences in OASIS D1 and OASIS E
- The learner will understand new items for behavioral health and transfer of health information
- The learner will be able to identify processes needed to be in place prior to implementation
- The learner will be able to identify an education plan implementation for the agency

Background

- OASIS was initially implemented in 1998
- There have been several revisions of the data set
- It is possible, therefore, that at any given time records could be received by CMS's data systems under more than one version of the data specs
- Normally, the record's completion date (M0090_INFO_COMPLETED_DT) controls which version of the data specs applies to that record

Post Acute Care/IMPACT Act

- On October 6, 2014, the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 was signed into law
- The Act intends for standardized post-acute care data to improve Medicare beneficiary outcomes through shared-decision making, care coordination, and enhanced discharge planning.

Administrative Burden

Table 1. Number of Data Elements Added and Removed for OASIS-E

Time Point	#DE in OASIS-D (D1)	#DE added for OASIS-E	#DE removed for OASIS-E	Net change (+)	#DE in OASIS-E
SOC	158	59	14	45	203
ROC	131	49	8	41	172
FU	36	8	0	8	44
TOC	22	1	1	0	22
DAH	9	0	0	0	9
DC	97	51	2	49	146
Totals	444	168	25	143	596

57.3 min
48 min
13.2 min
6.6 min
2.7 min
40.2 min

Table 6. Proposed Change in Clinician Burden Costs*

OASIS-E	OASIS-D	DIFFERENCE
\$900,679,044.53	\$559,827,580.49	\$340,851,464.04
		(\$30,020.39 per HHA)

Sections of OASIS E

- A - Administrative Section
- B - Hearing, Speech, and Vision
- C - Cognitive Patterns
- D - Mood
- E - Behavior
- F - Preferences for Customary Routine Activities
- G - Functional Status
- GG - Functional Abilities
- H - Bladder and Bowel
- I - Active Diagnoses
- J - Health Conditions
- K - Swallowing/nutritional status
- M - Skin Conditions
- N - Medications
- O - Special treatment, Procedures, Programs
- Q - Participation in Assessment and Goal Setting

Administrative Section

Section A



OASIS-D1

Home Health Patient Tracking Sheet

(M0010) CMS Certification Number:

(M0014) Branch State:

(M0016) Branch ID Number:

(M0018) National Provider Identifier (NPI) for the attending physician who has signed the plan of care:
 UK – Unknown or Not Available

(M0020) Patient ID Number:

(M0030) Start of Care Date: / /
month day year

(M0032) Resumption of Care Date: / / NA – Not Applicable
month day year

(M0040) Patient Name:
(First) (M I) (Last) (Suffix)

(M0050) Patient State of Residence:

(M0060) Patient ZIP Code: -

(M0063) Medicare Number: NA – No Medicare
(including suffix)

(M0064) Social Security Number: - - UK – Unknown or Not Available

(M0065) Medicaid Number: NA – No Medicaid

(M0066) Birth Date: / /
month day year

(M0069) Gender	
Enter Code	1 Male
<input type="checkbox"/>	2 Female

MOVED

OUTCOME ASSESSMENT INFORMATION SET VERSION E (OASIS-E)

All Items

Section A	Administrative Information
M0018. National Provider Identifier (NPI) for the attending physician who has signed the plan of care	
<input type="text"/> <input type="checkbox"/> UK – Unknown or Not Available	
M0010. CMS Certification Number	
<input type="text"/>	
M0014. Branch State	
<input type="text"/>	
M0016. Branch ID Number	
<input type="text"/>	
M0020 Patient ID Number	
<input type="text"/>	
M0040. Patient Name	
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>(First) (M I) (Last) (Suffix)</small>	
M0050. Patient State of Residence	
<input type="text"/>	
M0060. Patient ZIP Code	
<input type="text"/> - <input type="text"/>	
M0064. Social Security Number	
<input type="text"/> - <input type="text"/> - <input type="text"/> <input type="checkbox"/> UK – Unknown or Not Available	
M0063. Medicare Number	
<input type="text"/> <input type="checkbox"/> NA – No Medicare	
M0065. Medicaid Number	
<input type="text"/> <input type="checkbox"/> NA – No Medicaid	
M0069. Gender	
Enter Code	1. Male
<input type="checkbox"/>	2. Female
M0066. Birth Date	
<input type="text"/> - <input type="text"/> - <input type="text"/> <small>Month Day Year</small>	

(M0140) Race/Ethnicity: (Mark all that apply.)

- 1 - American Indian or Alaska Native
- 2 - Asian
- 3 - Black or African-American
- 4 - Hispanic or Latino
- 5 - Native Hawaiian or Pacific Islander
- 6 - White

(M0150) Current Payment Sources for Home Care: (Mark all that apply.)

- 0 - None; no charge for current services
- 1 - Medicare (traditional fee-for-service)
- 2 - Medicare (HMO/managed care/Advantage plan)
- 3 - Medicaid (traditional fee-for-service)
- 4 - Medicaid (HMO/managed care)
- 5 - Workers' compensation
- 6 - Title programs (for example, Title III, V, or XX)
- 7 - Other government (for example, TriCare, VA)
- 8 - Private insurance
- 9 - Private HMO/managed care
- 10 - Self-pay
- 11 - Other (specify) _____
- UK - Unknown

A1005. Ethnicity	
Are you of Hispanic, Latino/a, or Spanish origin?	
↓ Check all that apply	
<input type="checkbox"/>	A. No, not of Hispanic, Latino/a, or Spanish origin
<input type="checkbox"/>	B. Yes, Mexican, Mexican American, Chicano/a
<input type="checkbox"/>	C. Yes, Puerto Rican
<input type="checkbox"/>	D. Yes, Cuban
<input type="checkbox"/>	E. Yes, another Hispanic, Latino, or Spanish origin
<input type="checkbox"/>	X. Patient unable to respond
<input type="checkbox"/>	Y. Patient declines to respond

A1010. Race	
What is your race?	
↓ Check all that apply	
<input type="checkbox"/>	A. White
<input type="checkbox"/>	B. Black or African American
<input type="checkbox"/>	C. American Indian or Alaska Native
<input type="checkbox"/>	D. Asian Indian
<input type="checkbox"/>	E. Chinese
<input type="checkbox"/>	F. Filipino
<input type="checkbox"/>	G. Japanese
<input type="checkbox"/>	H. Korean
<input type="checkbox"/>	I. Vietnamese
<input type="checkbox"/>	J. Other Asian
<input type="checkbox"/>	K. Native Hawaiian
<input type="checkbox"/>	L. Guamanian or Chamorro
<input type="checkbox"/>	M. Samoan
<input type="checkbox"/>	N. Other Pacific Islander
<input type="checkbox"/>	X. Patient unable to respond
<input type="checkbox"/>	Y. Patient declines to respond
<input type="checkbox"/>	Z. None of the above

NEW-ish

M0150. Current Payment Sources for Home Care	
↓ Check all that apply	
<input type="checkbox"/>	0. None; no charge for current services
<input type="checkbox"/>	1. Medicare (traditional fee-for-service)
<input type="checkbox"/>	2. Medicare (HMO/managed care/Advantage plan)
<input type="checkbox"/>	3. Medicaid (traditional fee-for-service)
<input type="checkbox"/>	4. Medicaid (HMO/managed care)
<input type="checkbox"/>	5. Workers' compensation
<input type="checkbox"/>	6. Title programs (for example, Title III, V, or XX)
<input type="checkbox"/>	7. Other government (for example, TriCare, VA)
<input type="checkbox"/>	8. Private insurance
<input type="checkbox"/>	9. Private HMO/managed care
<input type="checkbox"/>	10. Self-pay
<input type="checkbox"/>	11. Other (specify)
<input type="checkbox"/>	UK. Unknown

This is where M0030 and M0032 went



CLINICAL RECORD ITEMS

(M0080) Discipline of Person Completing Assessment	
Enter Code	1 RN
<input type="checkbox"/>	2 PT
	3 SLP/ST
	4 OT

(M0090) Date Assessment Completed:

/ /
 month day year

(M0100) This Assessment is Currently Being Completed for the Following Reason:	
Enter Code	Start/Resumption of Care
<input type="checkbox"/>	1 Start of care – further visits planned
	3 Resumption of care (after Inpatient stay)
	Follow-Up
	4 Recertification (follow-up) reassessment [Go to M0110]
	5 Other follow-up [Go to M0110]
	Transfer to an Inpatient Facility
	6 Transferred to an inpatient facility – patient not discharged from agency [Go to M1041]
	7 Transferred to an inpatient facility – patient discharged from agency [Go to M1041]
	Discharge from Agency – Not to an Inpatient Facility
	8 Death at home [Go to M2005]
	9 Discharge from agency [Go to M1041]

(M0906) Discharge/Transfer/Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient.

/ /
 month day year

A1110. Language	
Enter Code	A. What is your preferred language?
<input type="checkbox"/>	<input type="text"/>
	B. Do you need or want an interpreter to communicate with a doctor or health care staff?
	0. No
	1. Yes
	9. Unable to determine



M0030. Start of Care Date	
	<input type="text"/> - <input type="text"/> - <input type="text"/>
	Month Day Year

M0032. Resumption of Care Date	
	<input type="text"/> - <input type="text"/> - <input type="text"/>
	Month Day Year

M0080. Discipline of Person Completing Assessment	
Enter Code	1. RN
<input type="checkbox"/>	2. PT
	3. SLP/ST
	4. OT

M0090. Date Assessment Completed	
	<input type="text"/> - <input type="text"/> - <input type="text"/>
	Month Day Year

M0100. This Assessment is Currently Being Completed for the Following Reason	
Enter Code	Start/Resumption of Care
<input type="checkbox"/>	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

M0906. Discharge/Transfer/Death Date	
Enter the date of the discharge, transfer, or death (at home) of the patient.	
	<input type="text"/> - <input type="text"/> - <input type="text"/>
	Month Day Year

CLINICAL RECORD ITEMS, continued

(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

(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

(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?												
Enter Code	<table> <tr><td><input type="checkbox"/></td><td>1</td><td>Early</td></tr> <tr><td><input type="checkbox"/></td><td>2</td><td>Later</td></tr> <tr><td><input type="checkbox"/></td><td>UK</td><td>Unknown</td></tr> <tr><td><input type="checkbox"/></td><td>NA</td><td>Not Applicable: No Medicare case mix group to be defined by this assessment.</td></tr> </table>	<input type="checkbox"/>	1	Early	<input type="checkbox"/>	2	Later	<input type="checkbox"/>	UK	Unknown	<input type="checkbox"/>	NA	Not Applicable: No Medicare case mix group to be defined by this assessment.
<input type="checkbox"/>	1	Early											
<input type="checkbox"/>	2	Later											
<input type="checkbox"/>	UK	Unknown											
<input type="checkbox"/>	NA	Not Applicable: No Medicare case mix group to be defined by this assessment.											

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.
<input type="text"/> - <input type="text"/> - <input type="text"/>	→ Skip to M0110, Episode Timing, if date entered
<input type="checkbox"/>	NA - No specific SOC/ROC date ordered by physician

M0104. Date of Referral	Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.
<input type="text"/> - <input type="text"/> - <input type="text"/>	
<input type="checkbox"/>	NA - No specific SOC/ROC date ordered by physician

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?												
Enter Code	<table> <tr><td><input type="checkbox"/></td><td>1.</td><td>Early</td></tr> <tr><td><input type="checkbox"/></td><td>2.</td><td>Later</td></tr> <tr><td><input type="checkbox"/></td><td>UK</td><td>Unknown</td></tr> <tr><td><input type="checkbox"/></td><td>NA</td><td>Not Applicable: No Medicare case mix group to be defined by this assessment.</td></tr> </table>	<input type="checkbox"/>	1.	Early	<input type="checkbox"/>	2.	Later	<input type="checkbox"/>	UK	Unknown	<input type="checkbox"/>	NA	Not Applicable: No Medicare case mix group to be defined by this assessment.
<input type="checkbox"/>	1.	Early											
<input type="checkbox"/>	2.	Later											
<input type="checkbox"/>	UK	Unknown											
<input type="checkbox"/>	NA	Not Applicable: No Medicare case mix group to be defined by this assessment.											

A1250. Transportation (NACHC ©)	Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?
<input type="checkbox"/>	↓ Check all that apply
<input type="checkbox"/>	A. Yes, it has kept me from medical appointments or from getting my medications
<input type="checkbox"/>	B. Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
<input type="checkbox"/>	C. No
<input type="checkbox"/>	X. Patient unable to respond
<input type="checkbox"/>	Y. Patient declines to respond

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M1000. From which of the following Inpatient Facilities was the patient discharged within the past 14 days?	Check all that apply
<input type="checkbox"/>	1. Long-term nursing facility (NF)
<input type="checkbox"/>	2. Skilled nursing facility (SNF/TCU)
<input type="checkbox"/>	3. Short-stay acute hospital (IPPS)
<input type="checkbox"/>	4. Long-term care hospital (LTCH)
<input type="checkbox"/>	5. Inpatient rehabilitation hospital or unit (IRF)
<input type="checkbox"/>	6. Psychiatric hospital or unit
<input type="checkbox"/>	7. Other (specify) _____
<input type="checkbox"/>	NA Patient was not discharged from an inpatient facility → Skip to B0200, Hearing at SOC, Skip to B1300, Health Literacy at ROC

M1005. Inpatient Discharge Date (most recent)	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="checkbox"/> UK - Unknown
	<small>Month Day Year</small>	

PATIENT HISTORY AND DIAGNOSES

(M1000) From which of the following Inpatient Facilities was the patient discharged within 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 (IPPS)
- 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 M1021]

(M1005) Inpatient Discharge Date (most recent):

/ /
month day year

UK - Unknown

EMERGENT CARE

(M2301) Emergent Care: At the time of or at any time since the most recent SOC/ROC assessment has the patient utilized a hospital emergency department (includes holding/observation status)?	
Enter Code	0 No [Go to M2401] 1 Yes, used hospital emergency department WITHOUT hospital admission 2 Yes, used hospital emergency department WITH hospital admission UK Unknown [Go to M2401]

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

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

(M2410) To which Inpatient Facility has the patient been admitted?	
Enter Code	1 Hospital 2 Rehabilitation facility 3 Nursing home 4 Hospice NA No inpatient facility admission [Omit "NA" option on TRM]
(M2420) Discharge Disposition: Where is the patient after discharge from your agency? (Choose only one answer.)	
Enter Code	1 Patient remained in the community (without formal assistive services) 2 Patient remained in the community (with formal assistive services) 3 Patient transferred to a non-institutional hospice 4 Unknown because patient moved to a geographic location not served by this agency UK Other unknown

M2301. Emergent Care At the time of or at any time since the most recent SOC/ROC assessment has the patient utilized a hospital emergency department (includes holding/observation status)?	
Enter Code	0. No → Skip to M2410, Inpatient Facility 1. Yes, used hospital emergency department WITHOUT hospital admission 2. Yes, used hospital emergency department WITH hospital admission UK Unknown → Skip to M2410, Inpatient Facility

M2310. Reason for Emergent Care For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)?	
↓ Check all that apply	
<input type="checkbox"/>	1. Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
<input type="checkbox"/>	10. Hypo/Hyperglycemia, diabetes out of control
<input type="checkbox"/>	19. Other than above reasons
<input type="checkbox"/>	UK Reason unknown

M2410. To which Inpatient Facility has the patient been admitted?	
Enter Code	1. Hospital 2. Rehabilitation facility 3. Nursing home 4. Hospice NA No inpatient facility admission [Omit "NA" option on TRN]

M2420. Discharge Disposition Where is the patient after discharge from your agency? (Choose only one answer.)	
Enter Code	1. Patient remained in the community (without formal assistive services) → Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge 2. Patient remained in the community (with formal assistive services) → Continue to A2121, Provision of Current Reconciled Medication List to Subsequent Provider at Discharge 3. Patient transferred to a non-institutional hospice → Continue to A2121, Provision of Current Reconciled Medication List to Subsequent Provider at Discharge 4. Unknown because patient moved to a geographic location not served by this agency → Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge 5. UK Other unknown → Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge

A2120. Provision of Current Reconciled Medication List to Subsequent Provider at Transfer At the time of transfer to another provider, did your agency provide the patient's current reconciled medication list to the subsequent provider?	
Enter Code	0. No – Current reconciled medication list not provided to the subsequent provider → Skip to J1800, Any Falls Since SOC/ROC 1. Yes – Current reconciled medication list provided to the subsequent provider → Continue to A2122, Route of Current Reconciled Medication List Transmission to Subsequent Provider 2. NA – The agency was not made aware of this transfer timely → Skip to J1800, Any Falls Since SOC/ROC

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge At the time of discharge to another provider, did your agency provide the patient's current reconciled medication list to the subsequent provider?	
Enter Code	0. No – Current reconciled medication list not provided to the subsequent provider → Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge 1. Yes – Current reconciled medication list provided to the subsequent provider → Continue to A2122, Route of Current Reconciled Medication List Transmission to Subsequent Provider



Reconciled Medications

Medication Reconciliation -- The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider.

Transition of Care – The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.

A2122 Route of Current Reconciled Medication List Transmission to Subsequent Provider	
Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.	
Route of Transmission	↓ Check all that apply ↓
A. Electronic Health Record	<input type="checkbox"/>
B. Health Information Exchange Organization	<input type="checkbox"/>
C. Verbal (e.g., in-person, telephone, video conferencing)	<input type="checkbox"/>
D. Paper-based (e.g., fax, copies, printouts)	<input type="checkbox"/>
E. Other Methods (e.g., texting, email, CDs)	<input type="checkbox"/>

A2123. Provision of Current Reconciled Medication List to Patient at Discharge	
At the time of discharge, did your facility provide the patient's current reconciled medication list to the patient, family and/or caregiver?	
Enter Code	0. No – Current reconciled medication list not provided to the patient, family and/or caregiver → Skip to B1300, Health Literacy
<input type="checkbox"/>	1. Yes – Current reconciled medication list provided to the patient, family and/or caregiver → Continue to A2124, Route of Current Reconciled Medication List Transmission to Patient.

A2124. Route of Current Reconciled Medication List Transmission to Patient	
Indicate the route(s) of transmission of the current reconciled medication list to the patient/family/caregiver.	
Route of Transmission	↓ Check all that apply ↓
A. Electronic Health Record	<input type="checkbox"/>
B. Health Information Exchange Organization	<input type="checkbox"/>
C. Verbal (e.g., in-person, telephone, video conferencing)	<input type="checkbox"/>
D. Paper-based (e.g., fax, copies, printouts)	<input type="checkbox"/>
E. Other Methods (e.g., texting, email, CDs)	<input type="checkbox"/>

Why Do I Need to Do Med Reconciliation at Discharge?

- Ensure new caregivers (or patient and family) are aware of current medications, doses and reasons
- Medication reconciliation should be ongoing rather than a single process



Why Do I Need to Do Med Reconciliation at Discharge?

- 67% of patients facing unintended medication discrepancies in the hospital
- More than 40% of medication reconciliation errors result from miscommunications in handoff
- Medication safety has become a leading priority for patients and caregivers
- Differences in communication styles, distracting environments, and the lack of standardization are the primary factors contributing to the 80% of medical errors resulting from transitional miscommunication.

Medication Reconciliation Process

Create a Best Possible Medication History

- Review Medication Information Sources
- Patient/Caregiver Interview
- Document the BPMH (Best Possible Medication History)

Reconcile

- Compare
- Resolve Discrepancies

Document and Communicate

- Document
- Communicate considering both patient and circle of care provider needs

Discharge Summary (CoPs-484.55)

- **Standard: Discharge planning.**
- A home health agency must develop and implement an effective discharge planning process. For patients who are transferred to another HHA or who are discharged to a SNF, IRF or LTCH, the HHA must assist patients and their caregivers in selecting a post-acute care provider by using and sharing data that includes, but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The HHA must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.

Discharge Summary (CoPs-484.55)

- **Standard: Discharge or transfer summary content.**
- (1) The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care.
- (2) The HHA must comply with requests for additional clinical information as may be necessary for treatment of the patient made by the receiving facility or health care practitioner.

Hearing, Speech, Vision

Section B

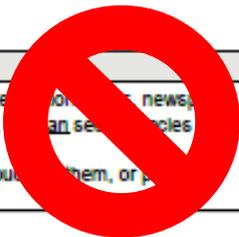


Section B

Hearing, Speech, and Vision

SENSORY STATUS

(M1200)	Vision (with corrective lenses if the patient usually wears them):
Enter Code	
<input type="checkbox"/>	<p>0 Normal vision: sees adequately in most situations; can see medication labels, newspaper newsprint, and the surrounding layout; can count fingers at arm's length.</p> <p>1 Partially impaired: cannot see medication labels or newsprint, cannot see faces clearly, and the surrounding layout; can count fingers at arm's length.</p> <p>2 Severely impaired: cannot locate objects without hearing or touching them, or is nonresponsive.</p>



B0200. Hearing

NEW

Enter Code

Ability to hear (with hearing aid or hearing appliances if normally used)

0. **Adequate** – no difficulty in normal conversation, social interaction, listening to TV
1. **Minimal difficulty** – difficulty in some environments (e.g., when person speaks softly, or setting is noisy)
2. **Moderate difficulty** – speaker has to increase volume and speak distinctly
3. **Highly impaired** – absence of useful hearing

B1000. Vision

NEW-ish

Enter Code

Ability to see in adequate light (with glasses or other visual appliances)

0. **Adequate** – sees fine detail, such as regular print in newspapers/books
1. **Impaired** – sees large print, but not regular print in newspapers/books
2. **Moderate impaired** – limited vision; not able to see newspaper headlines but can identify objects
3. **Highly impaired** – object identification in question, but eyes appear to follow objects
4. **Severely impaired** – no vision or sees only light, colors or shapes; eyes do not appear to follow objects

B1300. Health Literacy (From Creative Commons ©)

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

Enter Code

0. Never
1. Rarely
2. Sometimes
3. Often
4. Always
7. Patient declines to respond
8. Patient unable to respond

NEW

Health Literacy

- Personal health literacy is the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.
- The new definitions:
 - Emphasize people’s ability to *use* health information rather than just understand it
 - Focus on the ability to make “well-informed” decisions rather than “appropriate” ones
 - Acknowledge that organizations have a responsibility to address health literacy
 - Incorporate a public health perspective

Cognitive Patterns

Section C





New cognitive status items for OASIS-E

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?	
Attempt to conduct interview with all patients.	
Enter Code <input type="checkbox"/>	<p>0. No (patient is rarely/never understood) → Skip to C1310, Signs and Symptoms of Delirium (from CAM ©)</p> <p>1. Yes → Continue to C0200, Repetition of Three Words</p>

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words	
Enter Code <input type="checkbox"/>	<p>Ask patient: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed. Now tell me the three words."</p> <p>Number of words repeated after first attempt</p> <p>0. None</p> <p>1. One</p> <p>2. Two</p> <p>3. Three</p> <p>After the patient's first attempt, repeat the words using cues ("sock, something to wear; blue, a color; bed, a piece of furniture"). You may repeat the words up to two more times.</p>

C0300. Temporal Orientation (Orientation to year, month, and day)	
Enter Code <input type="checkbox"/>	<p>Ask patient: "Please tell me what year it is right now."</p> <p>A. Able to report correct year</p> <p>0. Missed by > 5 years or no answer</p> <p>1. Missed by 2-5 years</p> <p>2. Missed by 1 year</p> <p>3. Correct</p>
Enter Code <input type="checkbox"/>	<p>Ask patient: "What month are we in right now?"</p> <p>B. Able to report correct month</p> <p>0. Missed by > 1 month or no answer</p> <p>1. Missed by 6 days to 1 month</p> <p>2. Accurate within 5 days</p>
Enter Code <input type="checkbox"/>	<p>Ask patient: "What day of the week is today?"</p> <p>C. Able to report correct day of the week</p> <p>0. Incorrect or no answer</p> <p>1. Correct</p>

C0400. Recall	
Enter Code <input type="checkbox"/>	<p>Ask patient: "Let's go back to an earlier question. What were those three words that I asked you to repeat?"</p> <p>If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.</p> <p>A. Able to recall "sock"</p> <p>0. No – could not recall</p> <p>1. Yes, after cueing ("something to wear")</p> <p>2. Yes, no cue required</p>
Enter Code <input type="checkbox"/>	<p>B. Able to recall "blue"</p> <p>0. No – could not recall</p> <p>1. Yes, after cueing ("a color")</p> <p>2. Yes, no cue required</p>
Enter Code <input type="checkbox"/>	<p>C. Able to recall "bed"</p> <p>0. No – could not recall</p> <p>1. Yes, after cueing ("a piece of furniture")</p> <p>2. Yes, no cue required</p>

C0500. BIMS Summary Score	
Enter Score <input type="text"/>	<p>Add scores for questions C0200-C0400 and fill in total score (00-15)</p> <p>Enter 99 if the patient was unable to complete the interview</p>

BIMS

- Consists of three components:
 - C0200 - Repetition of 3 words
 - C0300 - Temporal orientation (orientation to year, month and day)
 - C0400 - Recall
- Results are totaled into a summary score
 - C0500 - BIMS summary score

BIMS

- Interview any patient not screened out by C0100.
 - The interview should not be attempted if the patient is rarely/never understood, cannot respond verbally or in writing, or an interpreter is needed but not available. If not, follow the skip patterns. (remember your assessment time frame)
- Conduct the interview in a private setting
- Make sure patient can hear you
- Sit so the patient can see your face

BIMS

- Give an introduction before starting the interview
- If the patient expresses concern:
 - We ask these questions of everyone so we can make sure that our care will meet your needs.
- Conduct the interview in one sitting and in the order provided.
- If the patient chooses not to answer a particular item, accept his or her refusal and move on to the next question.

BIMS

- If the patient's primary method of communication is in written format, the BIMS can be administered in writing.
- The administration of the BIMS in writing should be limited to the circumstance
- <https://www.youtube.com/watch?v=DAj3TA5w11Y>

C0200: Repetition of Three Words

First try only:

Number of words repeated after first attempt

0. None
1. One
2. Two
3. Three

C0200. Repetition of Three Words

Enter Code

Ask patient: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: **sock, blue, and bed**. Now tell me the three words."*

Number of words repeated after first attempt

0. None
1. One
2. Two
3. Three

After the patient's first attempt, repeat the words using cues (*"sock, something to wear; blue, a color; bed, a piece of furniture"*). You may repeat the words up to two more times.

C0200 Tips

- Words may be recalled in any order and in any context
 - If the words are repeated back in a sentence, they would be counted as repeating words
- Score the number of words repeated on the first attempt only.
- If the interviewer can not say words clearly, have another staff member conduct the interview.

C0300: Temporal Orientation

C0300. Temporal Orientation (Orientation to year, month, and day)	
Enter Code <input type="checkbox"/>	Ask patient: <i>"Please tell me what year it is right now."</i> A. Able to report correct year 0. Missed by > 5 years or no answer 1. Missed by 2-5 years 2. Missed by 1 year 3. Correct
Enter Code <input type="checkbox"/>	Ask patient: <i>"What month are we in right now?"</i> B. Able to report correct month 0. Missed by > 1 month or no answer 1. Missed by 6 days to 1 month 2. Accurate within 5 days
Enter Code <input type="checkbox"/>	Ask patient: <i>"What day of the week is today?"</i> C. Able to report correct day of the week 0. Incorrect or no answer 1. Correct

C0400: Recall Steps for Assessment

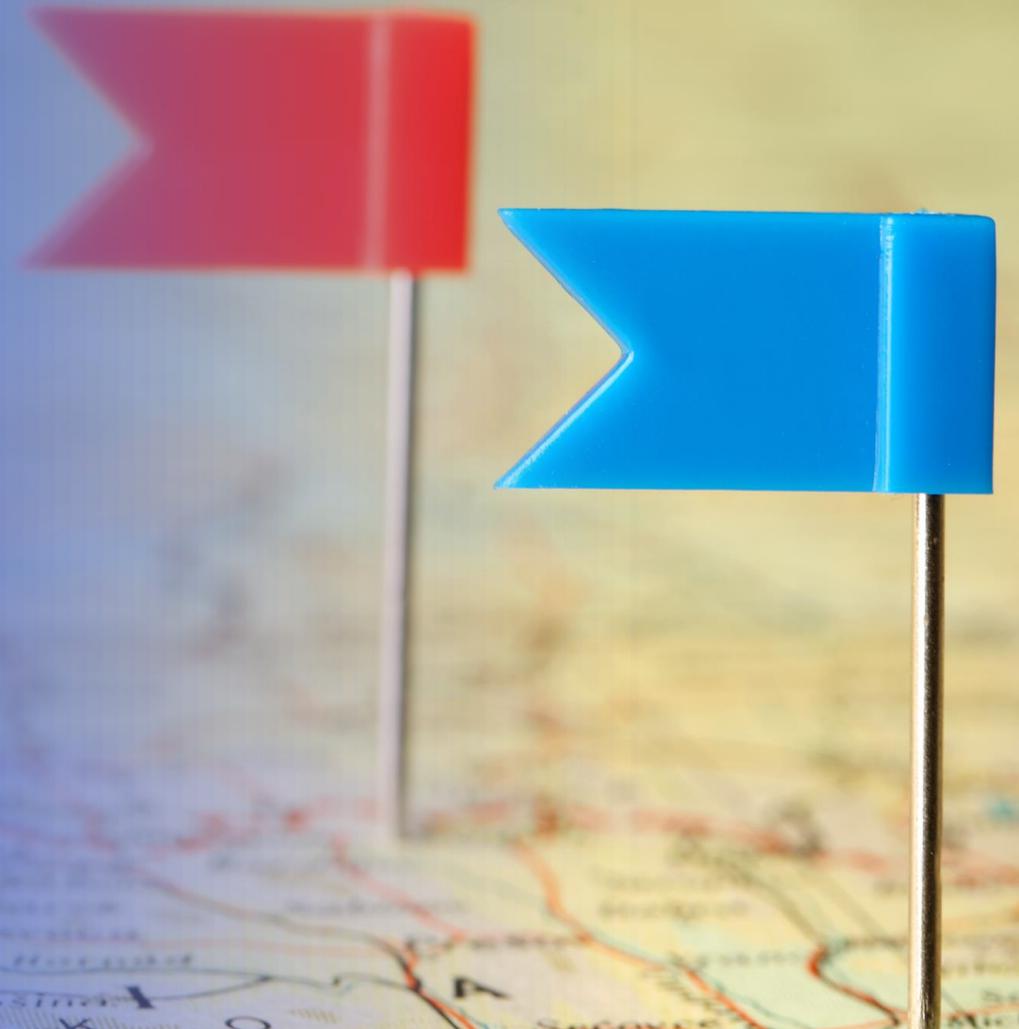
- Ask the patient the following: “Lets go back to an earlier question. What were those three words that I asked you to repeat?”
- Allow up to 5 seconds for spontaneous recall of each word.
- For any word that is not correctly recalled after 5 seconds, provide a category cue.
- Allow up to 5 seconds after category cueing for each missed word to be recalled

Stopping the BIMS Interview

- Step the interview after completing “Day of the Week” if:
 - All responses nonsensical, OR
 - No verbal or written response to any of the questions up to this point, OR
 - No verbal or written response to some questions and nonsensical responses to other questions.

Stopping the BIMS Interview

- If the interview is stopped prior to completion, do the following:
 - Code “-” (dash) in C0400A, C0400B, and C0400C
 - Code 99 in the summary score in C0500



CAM (Confusion Assessment Method)

C1310. Signs and Symptoms of Delirium (from CAM©)		
Code after completing Brief Interview for Mental Status and reviewing medical record.		
A. Acute Onset of Mental Status Change		
Enter Code <input type="checkbox"/>	Is there evidence of an acute change in mental status from the patient's baseline? 0. No 1. Yes	
↓ Enter Codes in Boxes		
Coding: 0. Behavior not present 1. Behavior continuously present, does not fluctuate 2. Behavior present, fluctuates (comes and goes, changes in severity)	<input type="checkbox"/>	B. Inattention – Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?
	<input type="checkbox"/>	C. Disorganized thinking – Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
	<input type="checkbox"/>	D. Altered level of consciousness – Did the patient have altered level of consciousness, as indicated by any of the following criteria? ▪ vigilant – startled easily to any sound or touch ▪ lethargic – repeatedly dozed off when being asked questions, but responded to voice or touch ▪ stuporous – very difficult to arouse and keep aroused for the interview ▪ comatose – could not be aroused



Purpose of the CAM

- CAM is a standardized evidence-based tool that enables non-psychiatrically trained clinicians to identify and recognize delirium quickly and accurately in both clinical and research settings.
- The screening tool alerts clinicians to the presence of possible delirium.
- <https://www.youtube.com/watch?v=GGmp32-l5rg>

NEURO/EMOTIONAL/BEHAVIORAL STATUS

(M1700)		Cognitive Functioning: Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.
Enter Code <input type="checkbox"/>	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 (for example, 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):
Enter Code <input type="checkbox"/>	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):
Enter Code <input type="checkbox"/>	0	None of the time
	1	Less often than daily
	2	Daily, but not constantly
	3	All of the time
	NA	Patient nonresponsive

Section C	Cognitive Patterns
M1700. Cognitive Functioning	
Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.	
Enter Code <input type="checkbox"/>	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 (for example, 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.	
Enter Code <input type="checkbox"/>	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.	
Enter Code <input type="checkbox"/>	0. None of the time
	1. Less often than daily
	2. Daily, but not constantly
	3. All of the time
	NA Patient nonresponsive

Mood

Section D



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

Enter Code 0 No
 1 Yes, patient was screened using the PHQ-20* scale

Instructions for this two-question tool: Ask patient: "Over the last 2 weeks, how often have you been bothered by any of the following problems?"

PHQ-20*	Not at all 0-1 day	Several days 2-6 days	More than half of the days 7-11 days	Nearly every day 12-14 days	NA Unable to respond
a) Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> NA
b) Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> NA

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

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Section D Mood

D0150. Patient Mood Interview (PHQ-2 to 9)

Say to patient: "Over the last 2 weeks, have you been bothered by any of the following problems?"

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
 If yes in column 1, then ask the patient: "About how often have you been bothered by this?"
 Read and show the patient a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence 0. No (enter 0 in column 2) 1. Yes (enter 0-3 in column 2) 9. No response (leave column 2 blank).	2. Symptom Frequency 0. Never or 1 day 1. 2-6 days (several days) 2. 7-11 days (half or more of the days) 3. 12-14 days (nearly every day)	1. Symptom Presence	2. Symptom Frequency
		↓Enter Scores in Boxes↓	↓Enter Scores in Boxes↓
A. Little interest or pleasure in doing things		<input type="checkbox"/>	<input type="checkbox"/>
B. Feeling down, depressed, or hopeless		<input type="checkbox"/>	<input type="checkbox"/>
If either D150A2 or D150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, skip to next interview.			
C. Trouble falling or staying asleep, or sleeping too much		<input type="checkbox"/>	<input type="checkbox"/>
D. Feeling tired or having little energy		<input type="checkbox"/>	<input type="checkbox"/>
E. Poor appetite or overeating		<input type="checkbox"/>	<input type="checkbox"/>
F. Feeling bad about yourself – or that you are a failure or have let yourself or your family down		<input type="checkbox"/>	<input type="checkbox"/>
G. Trouble concentrating on things, such as reading the newspaper or watching television		<input type="checkbox"/>	<input type="checkbox"/>
H. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual		<input type="checkbox"/>	<input type="checkbox"/>
I. Thoughts that you would be better off dead, or of hurting yourself in some way		<input type="checkbox"/>	<input type="checkbox"/>

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D0160. Total Severity Score

Enter Score Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 02 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items)

D0700. Social Isolation

How often do you feel lonely or isolated from those around you?

Enter Code 0. Never
 1. Rarely
 2. Sometimes
 3. Often
 4. Always
 7. Patient declines to respond
 8. Patient unable to respond

Behavior

Section E



M1740. Cognitive, Behavioral, and Psychiatric Symptoms that are demonstrated <u>at least once a week</u> (Reported or Observed):	
↓ Check all that apply	
<input type="checkbox"/>	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
<input type="checkbox"/>	2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
<input type="checkbox"/>	3. Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
<input type="checkbox"/>	4. Physical aggression: aggressive or combative to self and others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
<input type="checkbox"/>	5. Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions)
<input type="checkbox"/>	6. Delusional, hallucinatory, or paranoid behavior
<input type="checkbox"/>	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.	
Enter Code	0. Never
<input type="checkbox"/>	1. Less than once a month
	2. Once a month
	3. Several times each month
	4. Several times a week
	5. At least daily

Section E	Behavior
M1740. Cognitive, Behavioral, and Psychiatric Symptoms that are demonstrated <u>at least once a week</u> (Reported or Observed):	
↓ Check all that apply	
<input type="checkbox"/>	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
<input type="checkbox"/>	2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
<input type="checkbox"/>	3. Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
<input type="checkbox"/>	4. Physical aggression: aggressive or combative to self and others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
<input type="checkbox"/>	5. Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions)
<input type="checkbox"/>	6. Delusional, hallucinatory, or paranoid behavior
<input type="checkbox"/>	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.	
Enter Code	0. Never
<input type="checkbox"/>	1. Less than once a month
	2. Once a month
	3. Several times each month
	4. Several times a week
	5. At least daily

Preferences for Customary Routine Activities

Section F



LIVING ARRANGEMENTS

(M1100) Patient Living Situation: Which of the following best describes the patient's residential circumstance and availability of assistance? (Check one box only.)

Living Arrangement	Availability of Assistance				
	Around the clock	Regular daytime	Regular nighttime	Occasional / short-term assistance	No assistance available
a. Patient lives alone	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 03	<input type="checkbox"/> 04	<input type="checkbox"/> 05
b. Patient lives with other person(s) in the home	<input type="checkbox"/> 06	<input type="checkbox"/> 07	<input type="checkbox"/> 08	<input type="checkbox"/> 09	<input type="checkbox"/> 10
c. Patient lives in congregate situation (for example, assisted living, residential care home)	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 13	<input type="checkbox"/> 14	<input type="checkbox"/> 15

Section F

Preferences for Customary Routine Activities

M1100. Patient Living Situation

Which of the following best describes the patient's residential circumstance and availability of assistance?

Living Arrangement	Availability of Assistance				
	Around the Clock	Regular Daytime	Regular Nighttime	Occasional/ Short-Term Assistance	No Assistance Available
↓Check one box only↓					
A. Patient lives alone	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 03	<input type="checkbox"/> 04	<input type="checkbox"/> 05
B. Patient lives with other person(s) in the home	<input type="checkbox"/> 06	<input type="checkbox"/> 07	<input type="checkbox"/> 08	<input type="checkbox"/> 09	<input type="checkbox"/> 10
C. Patient lives in congregate situation (for example, assisted living, residential care home)	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 13	<input type="checkbox"/> 14	<input type="checkbox"/> 15

CARE MANAGEMENT

SOC/ROC

(M2102) Types and Sources of Assistance: Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.	
Enter Code <input type="checkbox"/>	f. Supervision and safety (for example, due to cognitive impairment) <ol style="list-style-type: none"> 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available

Discharge

(M2102) Types and Sources of Assistance: Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.	
Enter Code <input type="checkbox"/>	a. ADL assistance (for example, transfer/ ambulation, bathing, dressing, toileting, eating/feeding) <ol style="list-style-type: none"> 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code <input type="checkbox"/>	c. Medication administration (for example, oral, inhaled or injectable) <ol style="list-style-type: none"> 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code <input type="checkbox"/>	d. Medical procedures/ treatments (for example, changing wound dressing, home exercise program) <ol style="list-style-type: none"> 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code <input type="checkbox"/>	f. Supervision and safety (for example, due to cognitive impairment) <ol style="list-style-type: none"> 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available

SOC/ROC

M2102. Types and Sources of Assistance Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.	
Enter Code <input type="checkbox"/>	F. Supervision and safety (for example, due to cognitive impairment) <ol style="list-style-type: none"> 0. No assistance needed – patient is independent or does not have needs in this area 1. Non-agency caregiver(s) currently provide assistance 2. Non-agency caregiver(s) need training/supportive services to provide assistance 3. Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4. Assistance needed, but no non-agency caregiver(s) available

Discharge

M2102. Types and Sources of Assistance Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.	
Enter Code <input type="checkbox"/>	A. ADL assistance (for example, transfer/ambulation, bathing, dressing, toileting, eating/feeding) <ol style="list-style-type: none"> 0. No assistance needed –patient is independent or does not have needs in this area 1. Non-agency caregiver(s) currently provide assistance 2. Non-agency caregiver(s) need training/supportive services to provide assistance 3. Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4. Assistance needed, but no non-agency caregiver(s) available
Enter Code <input type="checkbox"/>	C. Medication administration (for example, oral, inhaled or injectable) <ol style="list-style-type: none"> 0. No assistance needed –patient is independent or does not have needs in this area 1. Non-agency caregiver(s) currently provide assistance 2. Non-agency caregiver(s) need training/supportive services to provide assistance 3. Non-agency caregiver(s) are not likely to provide assistance, OR it is unclear if they will provide assistance 4. Assistance needed, but no non-agency caregiver(s) available
Enter Code <input type="checkbox"/>	D. Medical procedures/treatments (for example, changing wound dressing, home exercise program) <ol style="list-style-type: none"> 0. No assistance needed –patient is independent or does not have needs in this area 1. Non-agency caregiver(s) currently provide assistance 2. Non-agency caregiver(s) need training/supportive services to provide assistance 3. Non-agency caregiver(s) are not likely to provide assistance, OR it is unclear if they will provide assistance 4. Assistance needed, but no non-agency caregiver(s) available
Enter Code <input type="checkbox"/>	F. Supervision and safety (for example, due to cognitive impairment) <ol style="list-style-type: none"> 0. No assistance needed –patient is independent or does not have needs in this area 1. Non-agency caregiver(s) currently provide assistance 2. Non-agency caregiver(s) need training/supportive services to provide assistance 3. Non-agency caregiver(s) are not likely to provide assistance, OR it is unclear if they will provide assistance 4. Assistance needed, but no non-agency caregiver(s) available

Functional and Functional Ability

Section G and GG



(M1910)	Has this patient had a multi-factor Falls Risk Assessment using a standardized, validated assessment tool?
Enter Code	0 No.
<input type="checkbox"/>	1 Yes, and it does not indicate a risk for falls.
	2 Yes, and it does indicate a risk for falls.

Section G	Functional Status
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NO changes in M18- items Except M1870

Section GG	Functional Abilities and Goals
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NO changes in GG items

Bladder and Bowel

Section H



ELIMINATION STATUS

(M1600)	Has this patient been treated for a Urinary Tract Infection in the past 14 days?
Enter Code <input type="checkbox"/>	0 No 1 Yes NA Patient on prophylactic treatment UK Unknown [Omit "UK" option on DC]
(M1610)	Urinary Incontinence or Urinary Catheter Presence:
Enter Code <input type="checkbox"/>	0 No incontinence or catheter (includes anuria or ostomy for urinary drainage) 1 Patient is incontinent 2 Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic)
(M1620)	Bowel Incontinence Frequency:
Enter Code <input type="checkbox"/>	0 Very rarely or never has bowel incontinence 1 Less than once weekly 2 One to three times weekly 3 Four to six times weekly 4 On a daily basis 5 More often than once daily NA Patient has ostomy for bowel elimination UK Unknown [Omit "UK" option on FU, DC]
(M1630)	Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay; <u>or</u> b) necessitated a change in medical or treatment regimen?
Enter Code <input type="checkbox"/>	0 Patient does <u>not</u> have an ostomy for bowel elimination. 1 Patient's ostomy was <u>not</u> related to an inpatient stay and did <u>not</u> necessitate change in medical or treatment regimen. 2 The ostomy <u>was</u> related to an inpatient stay or <u>did</u> necessitate change in medical or treatment regimen.

Section H Bladder and Bowel

M1600. Has this patient been treated for a **Urinary Tract Infection** in the past 14 days?

Enter Code <input type="checkbox"/>	0. No 1. Yes NA Patient on prophylactic treatment UK Unknown [Omit "UK" option on DC]
--	--

M1610. Urinary Incontinence or Urinary Catheter Presence

Enter Code <input type="checkbox"/>	0. No incontinence or catheter (includes anuria or ostomy for urinary drainage) 1. Patient is incontinent 2. Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic)
--	--

M1620. Bowel Incontinence Frequency

Enter Code <input type="checkbox"/>	0. Very rarely or never has bowel incontinence 1. Less than once weekly 2. One to three times weekly 3. Four to six times weekly 4. On a daily basis 5. More often than once daily NA Patient has ostomy for bowel elimination UK Unknown [Omit "UK" option on DC]
--	---

M1630. Ostomy for Bowel Elimination

Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay; or b) necessitated a change in medical or treatment regimen?

Enter Code <input type="checkbox"/>	0. Patient does <u>not</u> have an ostomy for bowel elimination. 1. Patient's ostomy was <u>not</u> related to an inpatient stay and did <u>not</u> necessitate change in medical or treatment regimen. 2. The ostomy <u>was</u> related to an inpatient stay or <u>did</u> necessitate change in medical or treatment regimen.
--	---

Active Diagnoses

Section I



(M1021) Primary Diagnosis & (M1023) Other Diagnoses	
Column 1	Column 2
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided)	ICD-10-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses
Description	ICD-10-CM / Symptom Control Rating
(M1021) Primary Diagnosis	V, W, X, Y codes NOT allowed
a. _____	a. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
(M1023) Other Diagnoses	All ICD-10-CM codes allowed
b. _____	b. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
c. _____	c. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
d. _____	d. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
e. _____	e. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
f. _____	f. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4

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

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

M1021. Primary Diagnosis & M1023. Other Diagnoses	
Column 1	Column 2
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided)	ICD-10-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses

M1021. Primary Diagnosis	
a. _____	V, W, X, Y NOT allowed a. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4

M1023. Other Diagnoses	
B. _____	All ICD-10-CM codes allowed B. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
C. _____	C. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
D. _____	D. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
E. _____	E. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
F. _____	F. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4

M1028. Active Diagnoses – Comorbidities and Co-existing Conditions	
↓ Check all that apply	
<input type="checkbox"/>	1. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
<input type="checkbox"/>	2. Diabetes Mellitus (DM)
<input type="checkbox"/>	3. None of the above

Health Conditions

Section J



(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

Section J	Health Conditions
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M1033. Risk for Hospitalization	
Which of the following signs or symptoms characterize this patient as at risk for hospitalization?	
↓ Check all that apply	
<input type="checkbox"/>	1. History of falls (2 or more falls – or any fall with an injury – in the past 12 months)
<input type="checkbox"/>	2. Unintentional weight loss of a total of 10 pounds or more in the past 12 months
<input type="checkbox"/>	3. Multiple hospitalizations (2 or more) in the past 6 months
<input type="checkbox"/>	4. Multiple emergency department visits (2 or more) in the past 6 months
<input type="checkbox"/>	5. Decline in mental, emotional, or behavioral status in the past 3 months
<input type="checkbox"/>	6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
<input type="checkbox"/>	7. Currently taking 5 or more medications
<input type="checkbox"/>	8. Currently reports exhaustion
<input type="checkbox"/>	9. Other risk(s) not listed in 1-8
<input type="checkbox"/>	10. None of the above

J0510. Pain Effect on Sleep	
Enter Code	Ask patient: "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?"
<input type="checkbox"/>	0. Does not apply – I have not had any pain or hurting in the past 5 days → Skip to M1400, Short of Breath at SOC/ROC; Skip to J1800 Any Falls Since SOC/ROC at DC
	1. Rarely or not at all
	2. Occasionally
	3. Frequently
	4. Almost constantly
	8. Unable to answer



J0520. Pain Interference with Therapy Activities	
Enter Code	Ask patient: "Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain?"
<input type="checkbox"/>	0. Does not apply – I have not received rehabilitation therapy in the past 5 days
	1. Rarely or not at all
	2. Occasionally
	3. Frequently
	4. Almost constantly
	8. Unable to answer



J0530. Pain Interference with Day-to-Day Activities	
Enter Code	Ask patient: "Over the past 5 days, how often you have limited your day-to-day activities (excluding rehabilitation therapy session) because of pain?"
<input type="checkbox"/>	1. Rarely or not at all
	2. Occasionally
	3. Frequently
	4. Almost constantly
	8. Unable to answer



(M1242)	Frequency of Pain interfering with patient's activity or movement:
Enter Code	0 Patient has no pain
<input type="checkbox"/>	1 Patient has pain that does not interfere with activity or movement
	2 Less often than daily
	3 Daily, but not constantly
	4 All of the time



Section J: Health Conditions

J1800. Any Falls Since SOC/ROC, whichever is more recent	
Enter Code <input type="checkbox"/>	Has the patient had any falls since SOC/ROC, whichever is more recent? 0. No → Skip J1900 1. Yes → Continue to J1900, Number of Falls Since SOC/ROC, whichever is more recent
J1900. Number of Falls Since SOC/ROC, whichever is more recent	
↓ Enter Codes in Boxes	
CODING: 0. None 1. One 2. Two or more	<input type="checkbox"/> A. No injury: No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	<input type="checkbox"/> B. Injury (except major): Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	<input type="checkbox"/> C. Major Injury: Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

RESPIRATORY STATUS

(M1400) When is the patient dyspneic or noticeably Short of Breath?	
Enter Code <input type="checkbox"/>	0 Patient is not short of breath 1 When walking more than 20 feet, climbing stairs 2 With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet) 3 With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation 4 At rest (during day or night)

J1800. Any Falls Since SOC/ROC, whichever is more recent	
Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury.	
Enter Code <input type="checkbox"/>	Has the patient had any falls since SOC/ROC, whichever is more recent? 0. No → Skip to M1400, Short of Breath at DC; Skip to M2005, Medication Intervention at TRN and DAH 1. Yes → Continue to J1900, Number of Falls Since SOC/ROC

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

M1400. When is the patient dyspneic or noticeably Short of Breath?	
Enter Code <input type="checkbox"/>	0. Patient is not short of breath 1. When walking more than 20 feet, climbing stairs 2. With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet) 3. With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation 4. At rest (during day or night)

Swallowing/Nutritional Status



(M1060) Height and Weight – While measuring, if the number is X.1-X.4 round down; X.5 or greater round up

--	--

inches

a. Height (in inches). Record most recent height measure since the most recent SOC/ROC

--	--	--

pounds

b. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard agency practice (for example, in a.m. after voiding, before meal, with shoes off, etc.)

Section K Swallowing/Nutritional Status

M1060. Height and Weight – While measuring, if the number is X.1-X.4 round down; X.5 or greater round up.

--	--

inches

A. Height (in inches). Record most recent height measure since the most recent SOC/ROC

--	--	--

pounds

B. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard agency practice (for example, in a.m. after voiding, before meal, with shoes off, etc.)

SOC/ROC

K0520. Nutritional Approaches

1. On Admission	1. On Admission
Check all of the nutritional approaches that apply on admission	
A. Parenteral/IV feeding	<input type="checkbox"/>
B. Feeding tube (e.g., nasogastric or abdominal (PEG))	<input type="checkbox"/>
C. Mechanically altered diet – require change in texture of food or liquids (e.g., pureed food, thickened liquids)	<input type="checkbox"/>
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	<input type="checkbox"/>
Z. None of the above	<input type="checkbox"/>

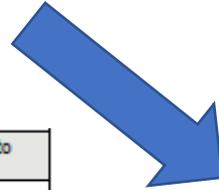


Discharge

K0520. Nutritional Approaches

4. Last 7 days	4. Last 7 days	5. At discharge
Check all of the nutritional approaches that were received in the last 7 days		
5. At discharge	↓ Check all that apply ↓	
Check all of the nutritional approaches that were being received at discharge		
A. Parenteral/IV feeding	<input type="checkbox"/>	<input type="checkbox"/>
B. Feeding tube (e.g., nasogastric or abdominal (PEG))	<input type="checkbox"/>	<input type="checkbox"/>
C. Mechanically altered diet – require change in texture of food or liquids (e.g., pureed food, thickened liquids)	<input type="checkbox"/>	<input type="checkbox"/>
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	<input type="checkbox"/>	<input type="checkbox"/>
Z. None of the above	<input type="checkbox"/>	<input type="checkbox"/>

Moved from the Functional Items



(M1870) Feeding or Eating: Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.	
Enter Code	0 Able to independently feed self.
<input type="checkbox"/>	1 Able to feed self independently but requires: (a) meal set-up; <u>OR</u> (b) intermittent assistance or supervision from another person; <u>OR</u> (c) a liquid, pureed or ground meat diet.
	2 Unable to feed self and must be assisted or supervised throughout the meal/snack.
	3 Able to take in nutrients orally <u>and</u> receives supplemental nutrients through a nasogastric tube or gastrostomy.
	4 Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
	5 Unable to take in nutrients orally or by tube feeding.

M1870. Feeding or Eating	
Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.	
Enter Code	0. Able to independently feed self.
<input type="checkbox"/>	1. Able to feed self independently but requires: a. meal set-up; <u>OR</u> b. intermittent assistance or supervision from another person; <u>OR</u> c. a liquid, pureed or ground meat diet.
	2. Unable to feed self and must be assisted or supervised throughout the meal/snack.
	3. Able to take in nutrients orally <u>and</u> receives supplemental nutrients through a nasogastric tube or gastrostomy.
	4. Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
	5. Unable to take in nutrients orally or by tube feeding.

Skin Conditions



Section M	Skin Conditions
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M1306, M1307: No change

SOC/ROC

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. Number of Stage 2 pressure ulcers	<input type="checkbox"/>

Follow-Up

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. Number of Stage 2 pressure ulcers	<input type="checkbox"/>

Discharge

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. Number of Stage 2 pressure ulcers [If 0 – Go to M1311B1, Stage 3]	<input type="checkbox"/>
A2. Number of <u>these</u> Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	<input type="checkbox"/>

SOC/ROC	
M1311. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	
Enter Number <input type="checkbox"/>	A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. Number of Stage 2 pressure ulcers

Graphics change only

Follow-up version not indicated....?

Discharge	
M1311. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	
Enter Number <input type="checkbox"/>	A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. Number of Stage 2 pressure ulcers – If 0 → Skip to M1311B1, Stage 3
Enter Number <input type="checkbox"/>	A2. Number of <u>these</u> Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC

Graphics change only

No changes....

M1322. Current Number of Stage 1 Pressure Injuries

Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.

Enter Code	0
<input type="checkbox"/>	1
	2
	3
	4 or more

M1324. Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable

Excludes pressure ulcer/injury that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or deep tissue injury.

Enter Code	1. Stage 1
<input type="checkbox"/>	2. Stage 2
	3. Stage 3
	4. Stage 4
	NA Patient has no pressure ulcers/injuries or no stageable pressure ulcers/injuries

M1330. Does this patient have a Stasis Ulcer?

Enter Code	0. No → Skip to M1340, Surgical Wound
<input type="checkbox"/>	1. Yes, patient has BOTH observable and unobservable stasis ulcers
	2. Yes, patient has observable stasis ulcers ONLY
	3. Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing/device) → Skip to M1340, Surgical Wound

M1332. Current Number of Stasis Ulcer(s) that are Observable

Enter Code	1. One
<input type="checkbox"/>	2. Two
	3. Three
	4. Four

M1334. Status of Most Problematic Stasis Ulcer that is Observable

Enter Code	1. Fully granulating
<input type="checkbox"/>	2. Early/partial granulation
	3. Not healing

(M1340) Does this patient have a Surgical Wound?	
Enter Code	0 No [Go to M1400]
<input type="checkbox"/>	1 Yes, patient has at least one observable surgical wound
	2 Surgical wound known but not observable due to non-removable dressing/device [Go to M1400]
(M1342) Status of Most Problematic Surgical Wound that is Observable	
Enter Code	0 Newly epithelialized
<input type="checkbox"/>	1 Fully granulating
	2 Early/partial granulation
	3 Not healing

M1340. Does this patient have a Surgical Wound?	
Enter Code	0. No → Skip to N0415, High-Risk Drug Classes: Use and Indication
<input type="checkbox"/>	1. Yes, patient has at least one observable surgical wound
	2. Surgical wound known but not observable due to non-removable dressing/device → Skip to N0415, High-Risk Drug Classes: Use and Indication

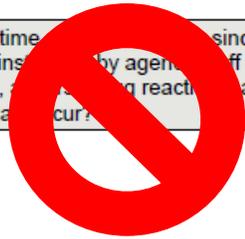
M1342. Status of Most Problematic Surgical Wound that is Observable	
Enter Code	0. Newly epithelialized
<input type="checkbox"/>	1. Fully granulating
	2. Early/partial granulation
	3. Not healing

Medications

Section N



(M2016)	Patient/Caregiver Drug Education Intervention: At the time of the most recent SOC/ROC assessment, was the patient/caregiver instructed by agent, staff or other health care provider to monitor the effectiveness of drug therapy, recognize reactions and significant side effects, and how and when to report problems that may occur?
Enter Code <input type="checkbox"/>	0 No 1 Yes NA Patient not taking any drugs



NEW

Section N Medications

SOC/ROC and Discharge		
N0415. High-Risk Drug Classes: Use and Indication		
1. Is taking Check if the patient is taking any medications by pharmacological classification, not how it is used, in the following classes	1. Is Taking	2. Indication Noted
2. Indication noted If Column 1 is checked, check if there is an indication noted for all medications in the drug class	↓ Check all that apply ↓	
A. Antipsychotic	<input type="checkbox"/>	<input type="checkbox"/>
E. Anticoagulant	<input type="checkbox"/>	<input type="checkbox"/>
F. Antibiotic	<input type="checkbox"/>	<input type="checkbox"/>
H. Opioid	<input type="checkbox"/>	<input type="checkbox"/>
I. Antiplatelet	<input type="checkbox"/>	<input type="checkbox"/>
J. Hypoglycemic (including insulin)	<input type="checkbox"/>	<input type="checkbox"/>
Z. None of the Above	<input type="checkbox"/>	

M2001 – M2030: No change except deletion of M2016 per 2022 Final Rule

Special Treatment, Procedures, and Programs

Section O



(M1030) Therapies the patient receives at home: (Mark all that apply.)

- 1 - Intravenous or infusion therapy (excludes TPN)
- 2 - Parenteral nutrition (TPN or lipids)
- 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other device placed into the alimentary canal)
- 4 - None of the above



Section O Special Treatment, Procedures, and Programs

SOC/ROC	a. On Admission Check all that apply ↓
00110. Special Treatments, Procedures, and Programs Check all of the following treatments, procedures, and programs that apply on admission.	
Cancer Treatments	
A1. Chemotherapy	<input type="checkbox"/>
A2. IV	<input type="checkbox"/>
A3. Oral	<input type="checkbox"/>
A10. Other	<input type="checkbox"/>
B1. Radiation	<input type="checkbox"/>
Respiratory Therapies	
C1. Oxygen Therapy	<input type="checkbox"/>
C2. Continuous	<input type="checkbox"/>
C3. Intermittent	<input type="checkbox"/>
C4. High-concentration	<input type="checkbox"/>
D1. Suctioning	<input type="checkbox"/>
D2. Scheduled	<input type="checkbox"/>
D3. As needed	<input type="checkbox"/>
E1. Tracheostomy Care	<input type="checkbox"/>
F1. Invasive Mechanical Ventilator (ventilator or respirator)	<input type="checkbox"/>
G1. Non-invasive Mechanical Ventilator	<input type="checkbox"/>
G2. BiPAP	<input type="checkbox"/>
G3. CPAP	<input type="checkbox"/>
Other	
H1. IV Medications	<input type="checkbox"/>
H2. Vasoactive medications	<input type="checkbox"/>
H3. Antibiotics	<input type="checkbox"/>
H4. Anticoagulation	<input type="checkbox"/>
H10. Other	<input type="checkbox"/>
I1. Transfusions	<input type="checkbox"/>
J1. Dialysis	<input type="checkbox"/>
J2. Hemodialysis	<input type="checkbox"/>
J3. Peritoneal dialysis	<input type="checkbox"/>
O1. IV Access	<input type="checkbox"/>
O2. Peripheral	<input type="checkbox"/>
O3. Mid-line	<input type="checkbox"/>
O4. Central (e.g., PICC, tunneled, port)	<input type="checkbox"/>
None of the Above	
Z1. None of the Above	<input type="checkbox"/>



(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?
Enter Code <input type="checkbox"/>	0 No [Go to M1051] 1 Yes
(M1046)	Influenza Vaccine Received: Did the patient receive the influenza vaccine for this year's flu season?
Enter Code <input type="checkbox"/>	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.

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?
Enter Code <input type="checkbox"/>	0. No → Skip to M2401, Intervention Synopsis 1. Yes → Continue to M1046, Influenza Vaccine Received
M1046. Influenza Vaccine Received	Did the patient receive the influenza vaccine for this year's flu season?
Enter Code <input type="checkbox"/>	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.

(M1051)	Pneumococcal Vaccine: Has the patient ever received the pneumococcal vaccination (for example, pneumovax)?
Enter Code <input type="checkbox"/>	0 No 1 Yes [Go to M2005 at TRN; Go to M1242 at DC]
(M1056)	Reason Pneumococcal Vaccine not received: If patient has never received the pneumococcal vaccination (for example, pneumovax), state reason:
Enter Code <input type="checkbox"/>	1 Offered and declined 2 Assessed and determined to have medical contraindication(s) 3 Not indicated; patient does not meet age/condition guidelines for Pne 4 None of the above



M1051/M1056: Removed

THErapy NEED AND PLAN OF CARE

(M2200) Therapy Need: In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? (Enter zero ["000"] if no therapy visits indicated.)

() Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).

NA - Not Applicable: No case mix group defined by this assessment.

M2200. Therapy Need

In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? (Enter zero ["000"] if no therapy visits indicated.)

Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).

NA – Not Applicable: No case mix group defined by this assessment.

Participation in Assessment and Goal Setting

Section Q



DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY DISCHARGE ONLY

(M2401) **Intervention Synopsis:** (Check only one box in each row.) At the time of or at any time since the most recent SOC/ROC assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

Plan / Intervention	No	Yes	Not Applicable
a. Diabetic foot care including monitoring for the presence of sores on the lower extremities and patient/caregiver education on proper foot care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> NA Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
b. Falls prevention interventions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> NA Every standardized, validated multi-factor fall risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no risk for falls.
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> NA Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the most recent SOC/ROC assessment indicates the 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.
d. Intervention(s) to monitor and mitigate pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> NA Every standardized, validated pain assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no pain.
e. Intervention(s) to prevent pressure ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> NA Every standardized, validated pressure ulcer risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient is not at risk of developing pressure ulcers.
f. Pressure ulcer treatment based on principles of moist wound healing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> NA Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

Section Q Participation in Assessment and Goal Setting

M2401. Intervention Synopsis				
At the time of or at any time since the most recent SOC/ROC assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented? (Mark only one box in each row.)				
Plan/Intervention	No	Yes	Not Applicable	
↓Check only one box in each row↓				
B. Falls prevention interventions	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA	Every standardized, validated multi-factor fall risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no risk for falls.
C. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA	Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the most recent SOC/ROC assessment indicates the 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.
D. Intervention(s) to monitor and mitigate pain	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA	Every standardized, validated pain assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no pain.
E. Intervention(s) to prevent pressure ulcers	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA	Every standardized, validated pressure ulcer risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient is not at risk of developing pressure ulcers.
F. Pressure ulcer treatment based on principles of moist wound healing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

Miscellaneous



Added Information

- CMS also reveals changes it plans to propose for Patient Driven Groupings Model (PDGM) in the CY 2023 home health payment update rule. Pending the adoption of these changes, CMS will add the following items to the FU assessment.
 - Shower/bathe self
 - Upper body dressing
 - Lower body dressing
 - Putting on/taking off footwear
 - Car transfer
 - Walk 150 feet
 - 12 steps
 - Wheel 150
- Public comments on the OASIS-E information collection are due April 11, 2022.

Questions?

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The logo consists of five orange curved dashes arranged in an arc above the text.

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The logo icon is a stylized blue 'S' shape composed of three curved segments.