



Reference Manual

Tab 3:
OASIS-C Guidance
Manual, Chapter 3 –
OASIS Item Guidance

CHAPTER 3 – OASIS ITEM GUIDANCE

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

- A - Patient Tracking
- B - Clinical Record Items
- C - Patient History & Diagnoses
- D - Living Arrangements
- E - Sensory Status
- F - Integumentary Status
- G - Respiratory Status
- H - Cardiac Status
- I - Elimination Status
- J - Neuro/Emotional/Behavioral Status
- K - ADLs/IADLs
- L - Medications
- M - Care Management
- N - Therapy Need and Plan of Care
- O - Emergent Care
- P - Discharge

OASIS Item Guidance**Patient Tracking**

| |
|--|
| OASIS ITEM |
| (M0010) CMS Certification Number: _____ |
| ITEM INTENT |
| Specifies the agency's Centers for Medicare and Medicaid Services (CMS) certification number (CCN/Medicare provider number). |
| TIME POINTS ITEM(S) COMPLETED |
| SOC (Patient Tracking Sheet) |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Enter the agency's CMS certification (Medicare provider) number, if applicable. If agency is not Medicare-certified, leave blank. • This is NOT the Provider's NPI number. • Preprinting this number on clinical documentation is allowed and recommended. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Agency administrator and billing staff |

| |
|---|
| OASIS ITEM |
| (M0014) Branch State: ___ ___ |
| ITEM INTENT |
| Specifies the State where the agency branch office is located. |
| TIME POINTS ITEM(S) COMPLETED |
| SOC (Patient Tracking Sheet) and updated if change occurs during the episode. |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Enter the two-letter postal service abbreviation of the State in which the branch office is located. Leave blank if your agency has no branches or all branches are located in the same State. • Preprinting this number on clinical documentation is allowed and recommended. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Agency or branch administrator |

| |
|--|
| OASIS ITEM |
| (M0016) Branch ID: _____ |
| ITEM INTENT |
| Specifies the branch identification code, as assigned by CMS. The identifier consists of 10 digits – the State code as the first two digits, followed by Q (upper case), followed by the last four digits of the current Medicare provider number, ending with the three-digit CMS-assigned branch number. |
| TIME POINTS ITEM(S) COMPLETED |
| SOC (Patient Tracking Sheet) and updated if change occurs during the episode. |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Enter the Federal branch identification number specified for this branch as assigned by CMS. • If you are an HHA with no branches, enter "N" followed by 9 blank spaces. • If you are a parent HHA that has branches, enter "P" followed by 9 blank spaces. • Preprinting this number on clinical documentation is allowed and recommended. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Agency or branch administrator |

OASIS Item Guidance

Patient Tracking

| |
|--|
| OASIS ITEM |
| (M0020) Patient ID Number: _____ |
| ITEM INTENT |
| Specifies the agency-specific patient identifier. This is the identification code the agency assigns to the patient and uses for record keeping purposes for this episode of care. The patient ID number may stay the same from one admission to the next or may change with each subsequent admission, depending on agency policy. However, it should remain constant throughout a single episode of care (e.g., from admission to discharge). |
| TIME POINTS ITEM(S) COMPLETED |
| SOC (Patient Tracking Sheet) |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • If there are fewer digits than spaces provided, leave spaces at the end blank. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Agency medical records department |

OASIS Item Guidance

Patient Tracking

| OASIS ITEM |
|--|
| <p>(M0040) Patient Name:</p> <p>_____</p> <p>(First) _____ (MI) _____ (Last) _____ Suffix)</p> |
| ITEM INTENT |
| Specifies the full name of the patient: first name, middle initial, last name, and suffix (e.g., Jr., III, etc.). |
| TIME POINTS ITEM(S) COMPLETED |
| SOC (Patient Tracking Sheet) and updated if change occurs during the episode. |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Enter all letters of the first and last names, the middle initial, and the abbreviated suffix. Correct spelling is important. • If no suffix, leave blank. If middle initial is not known, leave blank. • The name entered should be exactly as it appears on the patient's Medicare or other insurance card. • The name entered should be the patient's legal name, even if the patient consistently uses a nickname. • The sequence of the names may be reordered (i.e., last name, first name, etc.) in agency forms, if desired. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient's Medicare card, private insurance card, HMO identification card, etc. |

OASIS Item Guidance**Patient Tracking**

| |
|---|
| OASIS ITEM |
| (M0050) Patient State of Residence: __ __ |
| ITEM INTENT |
| Specifies the State in which the patient is currently residing while receiving home care. |
| TIME POINTS ITEM(S) COMPLETED |
| SOC (Patient Tracking Sheet) and updated if change occurs during the episode. |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> Enter the two-letter postal service abbreviation of the State in which the patient is CURRENTLY residing, even if this is not the patient's usual (or legal) residence. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> Clarify the exact (State) location of the residence with municipal, county, or State officials, if necessary. |

OASIS Item Guidance

Patient Tracking

| |
|--|
| OASIS ITEM |
| (M0060) Patient Zip Code: _____ |
| ITEM INTENT |
| Specifies the zip code for the address at which the patient is currently residing while receiving home care. |
| TIME POINTS ITEM(S) COMPLETED |
| SOC (Patient Tracking Sheet); updated if change occurs during the episode. |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Enter the zip code for the address of the patient's CURRENT residence, even if this is not the patient's usual (or legal) residence. • Enter at least five digits (nine digits if known). • The patient's zip code is used for <i>Home Health Compare</i> to determine places where your agency provided service. Be sure to use the zip code where the service is provided. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Verify the zip code with the local post office, if necessary. |

OASIS Item Guidance

Patient Tracking

| | |
|--|--|
| OASIS ITEM | |
| (M0063) Medicare Number: _____ (including suffix, if any) | <input type="checkbox"/> NA – No Medicare |
| ITEM INTENT | |
| For Medicare patients only. Specifies the patient's Medicare number, including any prefixes or suffixes. Use RRB number for railroad retirement program. | |
| TIME POINTS ITEM(S) COMPLETED | |
| SOC (Patient Tracking Sheet); updated if change occurs during the episode. | |
| RESPONSE—SPECIFIC INSTRUCTIONS | |
| <ul style="list-style-type: none"> • Enter the number identified as "Claim No." on the patient's Medicare card. (NOTE: This may or may not be the patient's Social Security number.) • If the patient does not have Medicare, mark "NA - No Medicare." • If the patient is a member of a Medicare HMO, another Medicare Advantage plan, or Medicare Part C, enter the Medicare number if available. If not available, mark "NA - No Medicare." Do <u>not</u> enter the HMO identification number. • Enter Medicare number (if known) whether or not Medicare is the primary payment source for this episode of care. • If there are fewer digits than spaces provided, leave spaces at the end blank. | |
| DATA SOURCES / RESOURCES | |
| <ul style="list-style-type: none"> • Patient's Medicare card. Referral information may include the number, but it should be verified with the patient. | |

OASIS Item Guidance

Patient Tracking

| |
|---|
| OASIS ITEM |
| (M0064) Social Security Number: ____ - ____ - _____ <input type="checkbox"/> UK - Unknown or Not Available |
| ITEM INTENT |
| Specifies the patient's Social Security number. |
| TIME POINTS ITEM(S) COMPLETED |
| SOC (Patient Tracking Sheet) |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Include all nine numbers. Mark "UK" if unknown or not available (e.g., information cannot be obtained or patient refuses to provide information). |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient's Social Security card, if available. Referral information may include the number, but it should be verified with the patient. |

OASIS Item Guidance

Patient Tracking

| |
|---|
| OASIS ITEM |
| (M0065) Medicaid Number: _____ <input type="checkbox"/> NA – No Medicaid |
| ITEM INTENT |
| Specifies the patient's <u>Medicaid</u> number. |
| TIME POINTS ITEM(S) COMPLETED |
| SOC (Patient Tracking Sheet); updated if change occurs during the episode. |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Include all digits and letters. If patient does not have Medicaid coverage or Medicaid coverage is pending, mark "NA - No Medicaid." • If the patient has Medicaid, answer this item whether or not Medicaid is the payer source for the home care episode. • This number is assigned by an individual state and is found on the patient's Medicaid card. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient's Medicaid card or other verifying documentation. Make sure that the coverage is still in effect, such as checking the expiration date. Depending on specific State regulations or procedures, you may need to verify coverage and effective dates with the social services agency. • Referral information may include the number, but it should be verified with the patient. |

OASIS Item Guidance**Patient Tracking**

| |
|---|
| OASIS ITEM |
| <p>(M0069) Gender:</p> <p><input type="checkbox"/> 1 - Male</p> <p><input type="checkbox"/> 2 - Female</p> |
| ITEM INTENT |
| Specifies the gender of the patient. |
| TIME POINTS ITEM(S) COMPLETED |
| SOC (Patient Tracking Sheet) |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Observation • Physical assessment |

OASIS Item Guidance

Patient Tracking

| OASIS ITEM |
|--|
| <p>(M0140) Race/Ethnicity: (Mark all that apply.)</p> <p><input type="checkbox"/> 1 - American Indian or Alaska Native</p> <p><input type="checkbox"/> 2 - Asian</p> <p><input type="checkbox"/> 3 - Black or African-American</p> <p><input type="checkbox"/> 4 - Hispanic or Latino</p> <p><input type="checkbox"/> 5 - Native Hawaiian or Pacific Islander</p> <p><input type="checkbox"/> 6 - White</p> |
| ITEM INTENT |
| <p>Specifies the racial/ethnic groups or populations with which the patient is affiliated, as identified by the patient or caregiver. Office of Management and Budget (OMB) regulations state that "unknown" is not a permissible response for this item. The major purpose of this item is to track health disparities.</p> |
| TIME POINTS ITEM(S) COMPLETED |
| <p>SOC (Patient Tracking Sheet); updated if change occurs during the episode.</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Response 1 – American Indian or Alaska Native. A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. • Response 2 – Asian. A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. • Response 3 – Black or African American. A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American." • Response 4 – Hispanic or Latino. A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino." • Response 5 – Native Hawaiian or Other Pacific Islander. A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. • Response 6 – White. A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/family interview • If the patient does not self-identify, referral information (including hospital or physician office clinical record data); observation |

| OASIS ITEM |
|---|
| <p>(M0150) Current Payment Sources for Home Care: (Mark all that apply.)</p> <p><input type="checkbox"/> 0 - None; no charge for current services</p> <p><input type="checkbox"/> 1 - Medicare (traditional fee-for-service)</p> <p><input type="checkbox"/> 2 - Medicare (HMO/managed care/Advantage plan)</p> <p><input type="checkbox"/> 3 - Medicaid (traditional fee-for-service)</p> <p><input type="checkbox"/> 4 - Medicaid (HMO/managed care)</p> <p><input type="checkbox"/> 5 - Workers' compensation</p> <p><input type="checkbox"/> 6 - Title programs (e.g., Title III, V, or XX)</p> <p><input type="checkbox"/> 7 - Other government (e.g., TriCare, VA, etc.)</p> <p><input type="checkbox"/> 8 - Private insurance</p> <p><input type="checkbox"/> 9 - Private HMO/managed care</p> <p><input type="checkbox"/> 10 - Self-pay</p> <p><input type="checkbox"/> 11 - Other (specify) _____</p> <p><input type="checkbox"/> UK Unknown</p> |
| ITEM INTENT |
| <p>This item is limited to identifying payers to which any services provided during this home care episode and included on the plan of care will be billed by your home health agency.</p> |
| TIME POINTS ITEM(S) COMPLETED |
| <p>SOC (Patient Tracking Sheet) and updated when change occurs during the episode.</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Exclude "pending" payment sources. • Accurate recording of this item is important because assessments for Medicare and Medicaid patients are handled differently than assessments for other payers. If the patient's care is being reimbursed by multiple payers (e.g., Medicare and Medicaid; private insurance and self-pay; etc.), include all sources. If one or more payment sources are known but additional sources are uncertain, mark those that are known. • Mark all current pay sources, whether considered primary or secondary. • Do not consider any equipment, medications, or supplies being paid for by the patient, in part or in full. • Select Response 2 if the payment source is a Medicare HMO, another Medicare Advantage Plan, or Medicare Part C. • Select Response 3 if the patient is receiving services provided as part of a Medicaid waiver or home and community-based waiver (HCBS) program. • Select Response 6 if the patient is receiving services through one of the following programs: <ul style="list-style-type: none"> - Title III - State Agency on Aging grants, which encourage State Agencies on Aging to develop and implement comprehensive and coordinated community-based systems of service for older individuals via Statewide planning and area planning. The objective of these services and centers is to maximize the informal support provided to older Americans to enable them to remain in their homes and communities. This program insures that elders receive the services they need to remain independent by providing transportation services, in-home services and caregiver support services, |

OASIS Item Guidance

Patient Tracking

RESPONSE—SPECIFIC INSTRUCTIONS

- Title V - State programs to maintain and strengthen their leadership in planning, promoting, coordinating and evaluating health care for pregnant women, mothers, infants, and children, and children with special health care needs in providing health services for mothers and children who do not have access to adequate health care;
- Title XX - Social service block grants available to states to provide homemaking, chore service, home management or home health aide services and enable each State to furnish social services best suited to the needs of the individuals residing in the State. Federal block grant funds may be used to provide services directed toward one of the following five goals specified in the law: (1) To prevent, reduce, or eliminate dependency, (2) to achieve or maintain self-sufficiency, (3) to prevent neglect, abuse, or exploitation of children and adults, (4) to prevent or reduce inappropriate institutional care, and (5) to secure admission or referral for institutional care when other forms of care are not appropriate.
- Select Response 7 if the patient is a member of a Tri-Care program, which replaced CHAMPUS.
- Select Response 10 if patient is self pay for all or part of the care (e.g., copayments).

DATA SOURCES / RESOURCES

- Referral information regarding coverage. This can be verified with patient/caregiver.
- Copies of health insurance identification cards. The card(s) will provide the patient ID number as well as current status of coverage.

OASIS Item Guidance

Clinical Record Items

| |
|--|
| OASIS ITEM |
| <p>(M0080) Discipline of Person Completing Assessment:</p> <p><input type="checkbox"/> 1-RN <input type="checkbox"/> 2-PT <input type="checkbox"/> 3-SLP/ST <input type="checkbox"/> 4-OT</p> |
| ITEM INTENT |
| Specifies the discipline of the clinician completing the comprehensive assessment during an actual visit to the patient's home at the specified OASIS time points or the clinician reporting the transfer to an inpatient facility or death at home. |
| TIME POINTS ITEM(S) COMPLETED |
| All |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Only one individual completes the comprehensive assessment. Even if two disciplines are seeing the patient at the time a comprehensive assessment is due, while care coordination and consultation are needed, only one individual actually completes and records the assessment. • According to the comprehensive assessment regulation, when both the RN and PT/SLP are ordered on the initial referral, the RN must perform the SOC comprehensive assessment. An RN, PT, SLP, or OT may perform subsequent assessments. • LPNs, PTAs, COTAs, MSWs and home health aides do not meet the requirements specified in the comprehensive assessment regulation for disciplines authorized to complete the comprehensive assessment or collect OASIS data. • When both the RN and qualified therapist are scheduled to conduct discharge visits on the same day, the last qualified clinician to see the patient is responsible for conducting the discharge comprehensive assessment. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Agency policy • Conditions of Participation |

| OASIS ITEM |
|---|
| <p>(M0100) This Assessment is Currently Being Completed for the Following Reason:</p> <p><u>Start/Resumption of Care</u></p> <p><input type="checkbox"/> 1 – Start of care—further visits planned</p> <p><input type="checkbox"/> 3 – Resumption of care (after inpatient stay)</p> <p><u>Follow-Up</u></p> <p><input type="checkbox"/> 4 – Recertification (follow-up) reassessment [<i>Go to M0110</i>]</p> <p><input type="checkbox"/> 5 – Other follow-up [<i>Go to M0110</i>]</p> <p><u>Transfer to an Inpatient Facility</u></p> <p><input type="checkbox"/> 6 – Transferred to an inpatient facility—patient not discharged from agency [<i>Go to M1040</i>]</p> <p><input type="checkbox"/> 7 – Transferred to an inpatient facility—patient discharged from agency [<i>Go to M1040</i>]</p> <p><u>Discharge from Agency — Not to an Inpatient Facility</u></p> <p><input type="checkbox"/> 8 – Death at home [<i>Go to M0906</i>]</p> <p><input type="checkbox"/> 9 – Discharge from agency [<i>Go to M1032</i>]</p> |
| ITEM INTENT |
| <p>Identifies the “time points” - reason why the assessment data are being collected and reported. Accurate recording of this response is important as the logic in the data reporting software will accept or reject certain data according to the specific response that has been selected for this item.</p> |
| TIME POINTS ITEM(S) COMPLETED |
| <p>All</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Mark only one response. • Response 1: This is the start of care comprehensive assessment. A plan of care is being established, whether or not further visits will be provided after the start of care visit. This is the appropriate response anytime an initial HIPPS code (for a Home Health Resource Group) is required. • Response 3: This comprehensive assessment is conducted when the patient resumes care following an inpatient stay of 24 hours or longer for reasons other than diagnostic tests. Remember to update the Patient Tracking Sheet ROC date (M0032) when this response is marked. When a patient is discharged from an inpatient facility and care is resumed within the last 5 days of the episode (i.e., a recertification assessment is due), a ROC assessment, rather than a recertification assessment, is completed. • Response 4: This comprehensive follow-up assessment is conducted during the last five days of the 60-day certification period and is completed to continue the patient's services for an additional 60 day episode of care. • Response 5: This comprehensive assessment is conducted due to a major decline or improvement in patient's health status occurring at a time <u>other than</u> during the last five days of the episode. This assessment is done to reevaluate the patient's condition, allowing revision to the patient's care plan as appropriate. • Response 6: This “Transfer to an Inpatient Facility” OASIS is completed when the home care patient is admitted to an inpatient facility for 24 hours or longer for reasons other than diagnostic tests with the expectation that home health care will be resumed following inpatient discharge; thus the patient is not discharged from the agency. (When the patient resumes care, a Resumption of Care comprehensive assessment is conducted.) This response <u>does not</u> require a home visit; a telephone call may provide the information necessary to complete the required data items. Short stay observation periods in a hospital, regardless of duration, do not meet the definition for transfer to an inpatient facility. |

OASIS Item Guidance

Clinical Record Items

RESPONSE—SPECIFIC INSTRUCTIONS (Cont'd for OASIS ITEM M0100)

- Response 7: This “Transfer to an Inpatient Facility” OASIS is completed when the home care patient is admitted to an inpatient facility for 24 hours or longer (for reasons other than diagnostic tests) and the patient is discharged from the agency. This response does not require a home visit; a telephone call may provide the information necessary to complete the required data items. No additional OASIS discharge data are required. Short stay observation periods in a hospital, regardless of duration, do not meet the definition for transfer to an inpatient facility
- Response 8: Data regarding patient death anywhere other than death in an Emergency Department or inpatient facility. A patient who dies **before** being treated in an emergency department or before being admitted to an inpatient facility would have this response marked. Note the “skip pattern” included in the response. A home visit is not required to mark this response; the information necessary to complete the data items may be obtained by telephone.
- Response 9: This comprehensive assessment is conducted when a patient is discharged from the agency for any reason other than transfer to an inpatient facility or death at home. This response includes transfer and **discharge** to another home health agency or an in-home hospice. A patient visit is required to complete this assessment. Note the “skip pattern” present in the response.
- Assessment strategies: Why is the assessment being conducted (or the information being recorded)? What has happened to the patient? Accuracy of this response is critical.

DATA SOURCES / RESOURCES

- Agency case manager or other care team provider
- Clinical record
- Hospital or other health care provider information regarding transfer to inpatient facility or death at home

OASIS Item Guidance

Clinical Record Items

| OASIS ITEM |
|---|
| <p>(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.</p> <p style="text-align: center;"> ___ / ___ / _____ <i>(Go to M0110, if date entered)</i> month / day / year </p> <p><input type="checkbox"/> NA –No specific SOC date ordered by physician (or physician designee)</p> |
| ITEM INTENT |
| <p>Specifies the date that home care services are ordered to begin, if the date was specified by the physician. The item refers to the order to start home care services (i.e., provide the first covered service), regardless of the type of services ordered (e.g., therapy only).</p> |
| TIME POINT ITEM(S) COMPLETED |
| <p>Start of care Resumption of care</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • If the originally ordered start of care is delayed due to the patient's condition or physician request (e.g., extended hospitalization), then the date specified on the updated/revised order to start home care services would be considered the date of physician-ordered start of care (resumption of care). For example, a patient discharged home on May 15 but for whom the physician orders home care to begin May 20 for a specified order (e.g., PT or administration of a subcutaneous drug), would have a physician-ordered start-of-care date of May 20. • If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year. • Mark "N/A" if the initial orders did not specify a SOC date. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Physician orders to initiate home care or resume home care following inpatient facility stay. |

OASIS Item Guidance

Clinical Record Items

| OASIS ITEM |
|--|
| <p>(M0104) Date of Referral: Indicate the date that the written or documented referral for initiation or resumption of care was received by the HHA.</p> <p style="text-align: center;"> ____ / ____ / _____ month / day / year </p> |
| ITEM INTENT |
| <p>Specifies the referral date, which is the most recent date that verbal, written, or electronic authorization to begin home care was received by the home health agency.</p> |
| TIME POINT ITEM(S) COMPLETED |
| <p>Start of care Resumption of care</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • If start of care is delayed due to the patient's condition or physician request (e.g., extended hospitalization), then the date the agency received updated/revised referral information for home care services to begin would be considered the date of referral. This does not refer to calls or documentation from others such as assisted living facility staff or family who contact the agency to prepare the agency for possible admission. • If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year. |
| DATA SOURCES/ RESOURCES |
| <ul style="list-style-type: none"> • Agency referral form • Agency records specifying the date the referral was received by the agency • Hospital or nursing home discharge information |

| OASIS ITEM |
|---|
| <p>(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?</p> <p><input type="checkbox"/> 1 - Early</p> <p><input type="checkbox"/> 2 - Later</p> <p><input type="checkbox"/> UK - Unknown</p> <p><input type="checkbox"/> NA - Not Applicable: No Medicare case mix group to be defined by this assessment.</p> |
| ITEM INTENT |
| Identifies the placement of the current Medicare PPS payment episode in the patient’s current sequence of adjacent Medicare PPS payment episodes. |
| TIME POINT ITEM(S) COMPLETED |
| Start of care Resumption of care Follow-up |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • A “sequence of adjacent Medicare home health payment episodes” is a continuous series of Medicare PPS payment episodes, regardless of whether the same home health agency provided care for the entire series. <ul style="list-style-type: none"> - Low utilization payment adjustment (LUPA) episodes (less than 5 total visits) are counted. - “Adjacent” means that there was no gap between Medicare-covered episodes of more than 60 days. - Periods of time when the patient is "outside" a Medicare payment episode but on service with a different payer - such as HMO, Medicaid, or private pay - are counted as <i>gap</i> days when counting the sequence of Medicare payment episodes. • “Early” includes the only PPS episode in a single episode case OR the first or second PPS episode in a sequence of adjacent PPS episodes. Select Response 1 – Early – if the episode of care you are assessing the patient for is the patient’s first or second episode of care in a current sequence of adjacent Medicare home health PPS payment episodes. • “Later” means the third or later PPS episode in a sequence of adjacent episodes. Select Response 2 – Later – if this episode is the third or later episode of care in a current sequence of adjacent Medicare home health PPS payment episodes. • Select the “UK - Unknown” response if the placement of this PPS payment episode in the sequence of adjacent episodes is unknown. For the purposes of assigning a case mix code to the episode, this will have the same effect as selecting the “Early” response. • Enter “NA” if no Medicare case mix group is to be defined for this episode. • If the patient needs a case mix code for billing purposes (a HIPPS code), a response other than “NA” is required to generate the code. Some sources that are not Medicare-fee-for-service payers will use this information in setting an episode payment rate. |

OASIS Item Guidance

Clinical Record Items

RESPONSE—SPECIFIC INSTRUCTIONS (continued for M0110 Episode Timing)

- Assessment strategies: Consult all available sources of information to code this item. Medicare systems, such as Health Insurance Query for Home Health (HIQH), can provide this information. If calculating manually, note that the Medicare home health payment episode ordinarily comprises 60 days beginning with the start of care date, or 60 days beginning with the recertification date, and that there can be a gap of up to 60 days between episodes in the same sequence, counting from the last day of one episode until the first day of the next. Remember that a sequence of adjacent Medicare payment episodes continues as long as there is no 60-day gap, even if Medicare episodes are provided by different home health agencies. Episodes where Medicare fee-for-service is not the payer (such as HMO, Medicaid, or private pay) do NOT count as part of a sequence. If the period of service with those payers is 60 days or more, the next Medicare home health payment episode would begin a new sequence.

DATA SOURCES / RESOURCE

- Medicare systems, such as Health Insurance Query for Home Health (HIQH).
- Manual calculations. Note that the Medicare home health payment episode ordinarily comprises 60 days beginning with the start of care date, or 60 days beginning with the recertification date, and that there can be a gap of up to 60 days between episodes in the same sequence, counting from the last day of one episode until the first day of the next. A sequence of adjacent Medicare payment episodes continues as long as there is no 60-day gap, even if Medicare episodes are provided by different home health agencies. Episodes where Medicare fee-for-service is not the payer (such as HMO, Medicaid, or private pay) do NOT count as part of the sequence. If the period of service with those payers is 60 days or more, the next Medicare home health payment episode would begin a new sequence. Remember that the 60-day gap is counted from the end of the Medicare payment episode, not from the date of the last visit or discharge, which can occur earlier. (If the episode is ended by an intervening event that causes it to be paid as a partial episode payment [PEP] adjustment, then the last visit date is the end of the episode).

OASIS Item Guidance

Patient History & Diagnoses

| OASIS ITEM |
|--|
| <p>(M1000) From which of the following Inpatient Facilities was the patient discharged <u>during the past 14 days</u>? (Mark all that apply.)</p> <p><input type="checkbox"/> 1 - Long-term nursing facility (NF)</p> <p><input type="checkbox"/> 2 - Skilled nursing facility (SNF / TCU)</p> <p><input type="checkbox"/> 3 - Short-stay acute hospital</p> <p><input type="checkbox"/> 4 - Long-term care hospital (LTCH)</p> <p><input type="checkbox"/> 5 - Inpatient rehabilitation hospital or unit (IRF)</p> <p><input type="checkbox"/> 6 - Psychiatric hospital or unit</p> <p><input type="checkbox"/> 7 - Other (specify) _____</p> <p><input type="checkbox"/> NA - Patient was not discharged from an inpatient facility [<i>Go to M1016</i>]</p> |
| ITEM INTENT |
| <p>Identifies whether the patient has been discharged from an inpatient facility within the 14 days (two-week period) immediately preceding the start of care/resumption of care. The purpose of this item is to establish the patient's recent health care history before formulating the plan of care. This determination must be made with sufficient accuracy to allow appropriate care planning. For example, the amount and types of rehabilitation treatment the patient has received and the type of institution that delivered the treatment are important to know when developing the home health plan of care.</p> |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Start of care</p> <p>Resumption of care</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Mark all that apply. For example, patient may have been discharged from both a hospital <u>and</u> a rehabilitation facility within the past 14 days. • An inpatient facility discharge that occurs on the day of the assessment does fall within the 14-day period. • The term “past fourteen days” is the two-week period immediately preceding the start/resumption of care. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient's SOC date is August 20, any inpatient discharges falling on or after August 6 and prior to the HHA admission would be reported. Discharges on Day 0 should be included. • Facility type is determined by the facility's state license. • If the patient was discharged from a Medicare-certified skilled nursing facility, but did not receive care under the Medicare Part A benefit in the 14 days prior to home health care, select Response 1 - Long-term nursing facility. • Response 2 – Skilled nursing facility means a (a) Medicare certified nursing facility where the patient received a skilled level of care under the Medicare Part A benefit or (b) transitional care unit (TCU) within a Medicare-certified nursing facility. |

OASIS Item Guidance

Patient History & Diagnoses

| RESPONSE—SPECIFIC INSTRUCTIONS (Cont'd for OASIS ITEM M1000) |
|---|
| <p>Determine responses to the questions below. If all three of the criteria below apply, select Response 2. 1) Was the patient discharged from a Medicare-certified skilled nursing facility? If so, then:</p> <p>2) While in the skilled nursing facility was the patient receiving skilled care under the Medicare Part A benefit? If so, then:</p> <p>3) Was the patient receiving skilled care under the Medicare Part A benefit during the 14 days prior to admission to home health care?</p> <ul style="list-style-type: none"> • Response 3 – Short-stay acute hospital applies to most hospitalizations • Response 4 – Long-term care hospital, applies to a hospital that has an average inpatient length of stay of greater than 25 days. • Response 5 – Inpatient rehabilitation hospital or unit (IRF) means a freestanding rehab hospital or a rehabilitation bed in a rehabilitation distinct part unit of a general acute care hospital. • Intermediate care facilities for the mentally retarded (ICF/MR) should be considered Response 7 – Other. • If patient has been discharged from a swing-bed hospital, it is necessary to determine whether the patient was occupying a designated hospital bed (Response 3), a skilled nursing bed under Medicare Part A (Response 2), or a nursing bed at a lower level of care (Response 1). The referring hospital can answer this question regarding the bed status. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Physician • Referral Information • For Medicare patients, Medicare's Common Working File (CWF) can be accessed to assist in determining the type of inpatient services received and the date of inpatient facility discharge if the claim for inpatient services has been received by Medicare. |

OASIS Item Guidance

Patient History & Diagnoses

| OASIS ITEM |
|---|
| <p>(M1005) Inpatient Discharge Date (most recent):</p> <p style="text-align: center;">_ _ / _ _ / _ _ _ _ month / day / year</p> <p><input type="checkbox"/> UK - Unknown</p> |
| ITEM INTENT |
| Identifies the date of the <u>most recent</u> discharge from an inpatient facility (within last 14 days). (Past 14 days encompasses the two-week period immediately preceding the start/resumption of care.) |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Start of care</p> <p>Resumption of care</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • The term “past fourteen days” is the two-week period immediately preceding the start/resumption of care. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient’s SOC date is August 20, any inpatient discharges falling on or after August 6 and prior to the HHA admission would be reported. Discharges on Day 0 should be included. • Even though the patient may have been discharged from more than one facility in the past 14 days, use the most recent date of discharge from any inpatient facility. • If the date or month is only one digit, that digit is preceded by a “0” (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Physician • Referral information • For Medicare patients, data in Medicare's Common Working File (CWF) can be accessed to assist in determining the type of inpatient services received and the date of inpatient facility discharge if the claim for inpatient services has been received by Medicare |

OASIS Item Guidance

Patient History & Diagnoses

| OASIS ITEM | | | | | | | | | | | | | | | |
|---|----------------------|-------------------------------------|----------------------|----------|--------------|----------|--------------|----------|--------------|----------|--------------|----------|--------------|----------|--------------|
| <p>(M1010) List each Inpatient Diagnosis and ICD-9-CM code at the level of highest specificity for only those conditions treated during an inpatient stay within the last 14 days (no E-codes, or V-codes):</p> <table border="0"> <thead> <tr> <th style="text-align: center;"><u>Inpatient Facility Diagnosis</u></th> <th style="text-align: center;"><u>ICD-9-CM Code</u></th> </tr> </thead> <tbody> <tr> <td>a. _____</td> <td>_____ . ____</td> </tr> <tr> <td>b. _____</td> <td>_____ . ____</td> </tr> <tr> <td>c. _____</td> <td>_____ . ____</td> </tr> <tr> <td>d. _____</td> <td>_____ . ____</td> </tr> <tr> <td>e. _____</td> <td>_____ . ____</td> </tr> <tr> <td>f. _____</td> <td>_____ . ____</td> </tr> </tbody> </table> | | <u>Inpatient Facility Diagnosis</u> | <u>ICD-9-CM Code</u> | a. _____ | _____ . ____ | b. _____ | _____ . ____ | c. _____ | _____ . ____ | d. _____ | _____ . ____ | e. _____ | _____ . ____ | f. _____ | _____ . ____ |
| <u>Inpatient Facility Diagnosis</u> | <u>ICD-9-CM Code</u> | | | | | | | | | | | | | | |
| a. _____ | _____ . ____ | | | | | | | | | | | | | | |
| b. _____ | _____ . ____ | | | | | | | | | | | | | | |
| c. _____ | _____ . ____ | | | | | | | | | | | | | | |
| d. _____ | _____ . ____ | | | | | | | | | | | | | | |
| e. _____ | _____ . ____ | | | | | | | | | | | | | | |
| f. _____ | _____ . ____ | | | | | | | | | | | | | | |
| ITEM INTENT | | | | | | | | | | | | | | | |
| <p>Identifies diagnosis(es) for which patient was receiving treatment in an inpatient facility within the past 14 days. This list of diagnoses is intended to include only those diagnoses that required treatment during the inpatient stay and may or may not correspond with the hospital admitting diagnosis. This expanded list allows for a more comprehensive picture of the patient's condition prior to the initiation or resumption of home care.</p> | | | | | | | | | | | | | | | |
| TIME POINTS ITEM(S) COMPLETED | | | | | | | | | | | | | | | |
| <p>Start of care Resumption of care</p> | | | | | | | | | | | | | | | |
| RESPONSE—SPECIFIC INSTRUCTIONS | | | | | | | | | | | | | | | |
| <ul style="list-style-type: none"> • The term “past fourteen days” is the two-week period immediately preceding the start/resumption of care. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient's SOC date is August 20, any diagnoses related to inpatient stays with discharges falling on or after August 6 and prior to the HHA admission would be reported. • If a diagnosis was not treated during an inpatient admission, it should not be listed. (Example: The patient has a long-standing diagnosis of “osteoarthritis,” but was treated during hospitalization only for “peptic ulcer disease.” Do <u>not</u> list “osteoarthritis” as an inpatient diagnosis.) • No surgical codes. List the underlying diagnosis that was surgically treated. If a joint replacement was done for osteoarthritis, list the disease, not the procedure. • No V-codes or E-codes. List the underlying diagnosis. • It is not necessary to fill in every line (a-f) if the patient had fewer than six inpatient diagnoses. | | | | | | | | | | | | | | | |
| DATA SOURCES / RESOURCES | | | | | | | | | | | | | | | |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Physician • Referral information (may include inpatient facility discharge summary, physician history and physical, progress notes, etc.) • The current ICD-9-CM code book should be the source for coding. | | | | | | | | | | | | | | | |

OASIS Item Guidance

Patient History & Diagnoses

| OASIS ITEM | | | | | | | | | | | |
|---|-----------------------|----------------------------|-----------------------|----------|-----------|----------|-----------|----------|-----------|----------|-----------|
| <p>(M1012) List each Inpatient Procedure and the associated ICD-9-CM procedure code relevant to the plan of care.</p> <table border="0"> <thead> <tr> <th style="text-align: center;"><u>Inpatient Procedure</u></th> <th style="text-align: center;"><u>Procedure Code</u></th> </tr> </thead> <tbody> <tr> <td>a. _____</td> <td>____.____</td> </tr> <tr> <td>b. _____</td> <td>____.____</td> </tr> <tr> <td>c. _____</td> <td>____.____</td> </tr> <tr> <td>d. _____</td> <td>____.____</td> </tr> </tbody> </table> <p> <input type="checkbox"/> NA - Not applicable <input type="checkbox"/> UK - Unknown </p> | | <u>Inpatient Procedure</u> | <u>Procedure Code</u> | a. _____ | ____.____ | b. _____ | ____.____ | c. _____ | ____.____ | d. _____ | ____.____ |
| <u>Inpatient Procedure</u> | <u>Procedure Code</u> | | | | | | | | | | |
| a. _____ | ____.____ | | | | | | | | | | |
| b. _____ | ____.____ | | | | | | | | | | |
| c. _____ | ____.____ | | | | | | | | | | |
| d. _____ | ____.____ | | | | | | | | | | |
| ITEM INTENT | | | | | | | | | | | |
| <p>Identifies medical procedures that the patient received during an inpatient facility stay within the past 14 days that are relevant to the home health plan of care. This item is intended to allow for a more comprehensive picture of the patient's condition prior to the initiation of home care.</p> | | | | | | | | | | | |
| TIME POINTS ITEM(S) COMPLETED | | | | | | | | | | | |
| <p>Start of care Resumption of care</p> | | | | | | | | | | | |
| RESPONSE—SPECIFIC INSTRUCTIONS | | | | | | | | | | | |
| <ul style="list-style-type: none"> • Include only those procedures that occurred during the inpatient stay that are relevant to the home health plan of care, based on the information available at start or resumption of care (i.e., a joint replacement surgery that requires home rehabilitation services). • Do not include inpatient procedures that are not relevant to the home health plan of care. For example, a diagnostic procedure (CT scan) may have been done during the inpatient stay but may have no implications for home health care services. In this case, it is not necessary to list the procedure code for the CT scan. • The term "past fourteen days" is the two-week period immediately preceding the start/resumption of care. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient's SOC date is August 20, any procedures related to inpatient stays with discharges falling on or after August 6 and prior to the HHA admission would be reported. | | | | | | | | | | | |
| DATA SOURCES / RESOURCES | | | | | | | | | | | |
| <ul style="list-style-type: none"> • Patient/caregiver interviews • Physician • Referral information (may include hospital discharge summary, physician history and physical, progress notes, etc.) • Home health plan of care • The current ICD-9-CM code book should be the source for coding | | | | | | | | | | | |

OASIS Item Guidance

Patient History & Diagnoses

| OASIS ITEM | | | | | | | | | | | | | | | |
|---|----------------------|--|----------------------|----------|--------------|----------|--------------|----------|--------------|----------|--------------|----------|--------------|----------|--------------|
| <p>(M1016) Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days: List the patient's Medical Diagnoses and ICD-9-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days (no surgical, E-codes, or V-codes):</p> <table border="0"> <thead> <tr> <th style="text-align: left;"><u>Changed Medical Regimen Diagnosis</u></th> <th style="text-align: left;"><u>ICD-9-CM Code</u></th> </tr> </thead> <tbody> <tr> <td>a. _____</td> <td>_____ . ____</td> </tr> <tr> <td>b. _____</td> <td>_____ . ____</td> </tr> <tr> <td>c. _____</td> <td>_____ . ____</td> </tr> <tr> <td>d. _____</td> <td>_____ . ____</td> </tr> <tr> <td>e. _____</td> <td>_____ . ____</td> </tr> <tr> <td>f. _____</td> <td>_____ . ____</td> </tr> </tbody> </table> <p><input type="checkbox"/> NA - Not applicable (no medical or treatment regimen changes within the past 14 days)</p> | | <u>Changed Medical Regimen Diagnosis</u> | <u>ICD-9-CM Code</u> | a. _____ | _____ . ____ | b. _____ | _____ . ____ | c. _____ | _____ . ____ | d. _____ | _____ . ____ | e. _____ | _____ . ____ | f. _____ | _____ . ____ |
| <u>Changed Medical Regimen Diagnosis</u> | <u>ICD-9-CM Code</u> | | | | | | | | | | | | | | |
| a. _____ | _____ . ____ | | | | | | | | | | | | | | |
| b. _____ | _____ . ____ | | | | | | | | | | | | | | |
| c. _____ | _____ . ____ | | | | | | | | | | | | | | |
| d. _____ | _____ . ____ | | | | | | | | | | | | | | |
| e. _____ | _____ . ____ | | | | | | | | | | | | | | |
| f. _____ | _____ . ____ | | | | | | | | | | | | | | |
| ITEM INTENT | | | | | | | | | | | | | | | |
| <p>Identifies if any change has occurred to the patient's treatment regimen, health care services, or medications within the past 14 days. The purpose of this question is to help identify the patient's recent history by identifying new diagnoses or diagnoses that have exacerbated over the past 2 weeks. This information helps the clinician develop an appropriate plan of care, since patients who have recent changes in treatment plans have a higher risk of becoming unstable.</p> | | | | | | | | | | | | | | | |
| TIME POINTS ITEM(S) COMPLETED | | | | | | | | | | | | | | | |
| <p>Start of care Resumption of care</p> | | | | | | | | | | | | | | | |
| RESPONSE—SPECIFIC INSTRUCTIONS | | | | | | | | | | | | | | | |
| <ul style="list-style-type: none"> • No surgical codes - list the underlying diagnosis. • No V-codes or E-codes - list the appropriate diagnosis. • Response to this item may include the same diagnoses as M1010 if the condition was treated during an inpatient stay AND caused changes in the treatment regimen. • Mark "NA" if changes in the medical or treatment regimen were made because a diagnosis improved. • The term "past fourteen days" is the two-week period immediately preceding the start/resumption of care. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient's SOC date is August 20, any diagnoses requiring medical or treatment regimen change on or after August 6 and prior to the HHA admission would be reported. | | | | | | | | | | | | | | | |
| DATA SOURCES / RESOURCES | | | | | | | | | | | | | | | |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Physician • Physician orders • Referral information • The current ICD-9-CM code book should be the source for coding | | | | | | | | | | | | | | | |

OASIS Item Guidance

Patient History & Diagnoses

| OASIS ITEM |
|---|
| <p>(M1018) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days: If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions that existed <u>prior to</u> the inpatient stay or change in medical or treatment regimen. (Mark all that apply.)</p> <p><input type="checkbox"/> 1 - Urinary incontinence</p> <p><input type="checkbox"/> 2 - Indwelling/suprapubic catheter</p> <p><input type="checkbox"/> 3 - Intractable pain</p> <p><input type="checkbox"/> 4 - Impaired decision-making</p> <p><input type="checkbox"/> 5 - Disruptive or socially inappropriate behavior</p> <p><input type="checkbox"/> 6 - Memory loss to the extent that supervision required</p> <p><input type="checkbox"/> 7 - None of the above</p> <p><input type="checkbox"/> NA - No inpatient facility discharge <u>and</u> no change in medical or treatment regimen in past 14 days</p> <p><input type="checkbox"/> UK - Unknown</p> |
| ITEM INTENT |
| Identifies existence of condition(s) <u>prior to</u> medical regimen change or inpatient stay within past 14 days. This information is important for care planning and setting goals. |
| TIME POINTS ITEM(S) COMPLETED |
| Start of care Resumption of care |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Select Response 7 – None of the above – if the patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, and none of the indicated conditions existed <u>prior to</u> the inpatient stay or change in medical or treatment regimen. • Select Response “NA” if no inpatient facility discharge <u>and</u> no change in medical or treatment regimen in past 14 days. Note that both situations must be true for this response to be marked “NA.” • Select Response “Unknown” if the patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, and it is unknown whether the indicated conditions existed <u>prior to</u> the inpatient stay or change in medical or treatment regimen. • The term “past fourteen days” is the two-week period immediately preceding the start/resumption of care. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Physician • Referral information (e.g., history and physical) |

OASIS ITEM

(M1020/1022/1024) Diagnoses, Symptom Control, and Payment Diagnoses: List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-CM code at the level of highest specificity (no surgical/procedure codes) (Column 2). Diagnoses are listed in the order that best reflect the seriousness of each condition and support the disciplines and services provided. Rate the degree of symptom control for each condition (Column 2). Choose one value that represents the degree of symptom control appropriate for each diagnosis: V-codes (for M1020 or M1022) or E-codes (for M1022 only) may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V-code is reported in place of a case mix diagnosis, then optional item M1024 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare PPS case mix group. Do not assign symptom control ratings for V- or E-codes.

Code each row according to the following directions for each column:

Column 1: Enter the description of the diagnosis.

Column 2: Enter the ICD-9-CM code for the diagnosis described in Column 1;

Rate the degree of symptom control for the condition listed in Column 1 using the following scale:

- 0 - Asymptomatic, no treatment needed at this time
- 1 - Symptoms well controlled with current therapy
- 2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring
- 3 - Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring
- 4 - Symptoms poorly controlled; history of re-hospitalizations

Note that in Column 2 the rating for symptom control of each diagnosis should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Column 3: (OPTIONAL) If a V-code is assigned to any row in Column 2, in place of a case mix diagnosis, it may be necessary to complete optional item M1024 Payment Diagnoses (Columns 3 and 4). Refer to Appendix D for additional instruction related to the coding of M1024.

Column 4: (OPTIONAL) If a V-code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-CM coding guidelines, enter the diagnosis descriptions and the ICD-9-CM codes in the same row in Columns 3 and 4. For example, if the case mix diagnosis is a manifestation code, record the diagnosis description and ICD-9-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(Continued on next page)

OASIS Item Guidance

Patient History & Diagnoses

OASIS ITEM (M1020/1022/1024) Diagnoses, Symptom Control, and Payment Diagnoses (cont'd)

| (M1020) Primary Diagnosis & (M1022) Other Diagnoses | | (M1024) Payment Diagnoses (OPTIONAL) | |
|---|--|--|---|
| Column 1 | Column 2 | Column 3 | Column 4 |
| Assigning or Coding Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.) | ICD-9-C M and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses | Complete if a V-code is assigned under certain circumstances to Column 2 in place of a case mix diagnosis**. | Complete only if the V-code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code). |
| Description | ICD-9-C M / Symptom Control Rating | Description/ ICD-9-C M | Description/ ICD-9-C M |
| (M1020) Primary Diagnosis | (V-codes are allowed) | (V- or E-codes NOT allowed) | (V- or E-codes NOT allowed) |
| a. _____ | a. (____.____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 | a. _____ (____.____) | a. _____ (____.____) |
| (M1022) Other Diagnoses | (V- or E-codes are allowed) | (V- or E-codes NOT allowed) | (V- or E-codes NOT allowed) |
| b. _____ | b. (____.____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 | b. _____ (____.____) | b. _____ (____.____) |
| c. _____ | c. (____.____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 | c. _____ (____.____) | c. _____ (____.____) |
| d. _____ | d. (____.____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 | d. _____ (____.____) | d. _____ (____.____) |
| e. _____ | e. (____.____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 | e. _____ (____.____) | e. _____ (____.____) |
| f. _____ | f. (____.____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 | f. _____ (____.____) | f. _____ (____.____) |

ITEM INTENT

The intent of this item is to accurately code each diagnosis in compliance with Medicare's rules and regulations for coverage and payment. CMS expects HHAs to understand each patient's specific clinical status before selecting and assigning each diagnosis. Each patient's overall medical condition and care needs must be comprehensively assessed **BEFORE** the HHA identifies and assigns each diagnosis for which the patient is receiving home care. Each diagnosis (other than an E-code) must comply with the "Criteria for OASIS Diagnosis Reporting." (See Appendix D – if a patient has a resolved condition that has no impact on the patient's current plan of care, then the condition does not meet the criteria for a home health diagnosis and should not be coded.) The primary diagnosis (M1020) should be the diagnosis most related to the patient's current plan of care, the most acute diagnosis and, therefore, the chief reason for providing home care.

Secondary diagnoses in M1022 are defined as "all conditions that coexisted at the time the plan of care was established, or which developed subsequently, or affect the treatment or care." In general, M1020 should include not only conditions actively addressed in the patient's plan of care but also any co-morbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself. Ensure that the secondary diagnoses assigned to M1022 are listed in the order to best reflect the seriousness of the patient's condition and justify the disciplines and services provided. Agencies should avoid listing diagnoses that are of mere historical interest and without impact on patient progress or outcome. The diagnosis may or may not be related to a patient's recent hospital stay but must relate to the services rendered by the HHA. Skilled services (skilled nursing, physical, occupational, and speech language pathology) are used in judging the relevancy of a diagnosis to the plan of care and to the OASIS.

OASIS Item Guidance

Patient History & Diagnoses

| ITEM INTENT (cont'd for OASIS Items M1020/1022/1024) |
|---|
| <p>The order that secondary diagnoses are entered should be determined by the degree that they impact the patient's health and need for home health care, rather than the degree of symptom control. For example, if a patient is receiving home health care for Type 2 diabetes that is "controlled with difficulty," this diagnosis would be listed above a diagnosis of a fungal infection of a toenail that is receiving treatment, even if the fungal infection is "poorly controlled."</p> <p>A case-mix diagnosis (Column 3) is a diagnosis that gives a patient a score for Medicare Home Health PPS case-mix group assignment. A case mix diagnosis may be the primary diagnosis, "other" diagnosis, or a manifestation associated with a primary or other diagnosis. Each diagnosis listed in M1020 and M1022 should be supported by the patient's medical record documentation (i.e., the patient's Plan of Care is in compliance with 42 CFR 484.18(a)). The list of case mix diagnosis codes is included in the HH PPS Grouper documentation available on the CMS web site (see Chapter 5 of this manual for a link to this website).</p> |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Start of care</p> <p>Resumption of care</p> <p>Follow-up</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • V-codes may be entered in row "a" of Column 2 (item M1020); V-codes and E-codes may be entered in the other rows in Column 2 (item M1022). CMS expects HHAs to avoid assigning excessive V-codes to the OASIS. V-codes are less specific to the clinical condition of the patient than are numeric diagnosis codes. In the home health setting, V-codes are appropriately assigned to M1020 and M1022 when a patient with a resolving disease or injury requires specific aftercare of that disease or injury (i.e., surgical aftercare or aftercare for rehabilitation). • V-codes and E-codes <u>may not</u> be entered in optional Columns 3 or 4 as these columns pertain to the Medicare PPS case mix diagnosis only. • In optional Columns 3 and 4, complete only if a V-code is assigned under certain circumstances to column 2 in place of a case mix diagnosis. (Refer to below and Appendix D, Section D (4)). • To prevent the loss of case mix points when an underlying case mix diagnosis is associated with the primary V-code diagnosis, HHAs should code the numeric case mix code to the primary diagnosis line (a) of M1024 when the following conditions apply: (1) the primary diagnosis (M1020) is a V-code; (2) the V-code displaces a numeric diagnosis that is a case mix diagnosis, and (3) the numeric case mix diagnosis is contained within one of the following three HH PPS diagnosis groups and to comply with ICD-9-CM coding guidelines, the secondary diagnosis, if needed to support the primary V-code diagnosis, (if appropriate for ICD-9-CM reporting in the home health setting), is reported in M1022 sequenced immediately following the V-code. The three HH PPS diagnosis groups are: <ul style="list-style-type: none"> - Diabetes - Skin 1-Traumatic Wounds, burns, and post-operative complications - Neuro 1-Brain disorders and paralysis • ICD-9-CM coding guidelines stipulate that the acute fracture code is only to be used for the initial, acute episode of care, which is why the acute fracture code is no longer appropriate once the patient has been discharged from the hospital to home health care. In this scenario, if a V-code replaces the fracture code in either M1020 or M1022, the HHA can code the acute fracture code in the corresponding occurrence of M1024. • Complete Columns 1 and 2 from top to bottom, leaving any blank entries at the bottom. • In Columns 3 and 4 (optional), there may be blank entries in any row. When code(s) are entered in Columns 3 and 4 (optional), ensure that they are placed in the row that shows the corresponding V-code. • No surgical codes – list the underlying diagnosis. |

OASIS Item Guidance

Patient History & Diagnoses

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Items M1020/1022/1024)**Assessment strategies: M1020/M1022: Primary and Other Diagnoses**

- Interview patient/caregiver to obtain past health history; additional information may be obtained from the physician.
- Review current medications and other treatment approaches. Determine if additional diagnoses are suggested by current treatment regimen, and verify this information with the patient/caregiver and physician.
- The current ICD-9-CM guidelines should be followed in coding these items.
- Assessing degree of symptom control includes review of presenting signs and symptoms, type and number of medications, frequency of treatment readjustments, and frequency of contact with health care provider. Inquire about the degree to which each condition limits daily activities. Assess the patient to determine if symptoms are controlled by current treatments. Clarify which diagnoses/symptoms have been poorly controlled in the recent past.

Assessment strategies: M1024: Case Mix Diagnoses (OPTIONAL)

- Select the code(s) that would have been reported as the primary diagnosis under the OASIS-B1 (8/2000) instructions.
- No surgical codes —list the underlying diagnosis.
- V-codes cannot be used in case mix group assignment. If a provider reports a V-code in M1020/1022 in place of a case mix diagnosis, the provider has the option of reporting the case mix diagnosis in M1024.
- If the case mix diagnosis requires multiple diagnoses under ICD-9-CM coding guidelines, enter these codes in Columns 3 and 4 (e.g., if coded as a combination of an etiology and a manifestation code, the etiology code should be entered in Column 3 and the manifestation code should be entered in Column 4).

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician
- Physician orders
- Referral information
- Current medication list
- The current ICD-9-CM code book should be the source for coding
- See Appendix D for further guidance on assigning and coding diagnoses in M1020/M1022
- For degree of symptom control, data sources may include patient/caregiver interview, physician, physical assessment, and review of past health history.

OASIS Item Guidance

Patient History & Diagnoses

| OASIS ITEM |
|--|
| <p>(M1030) Therapies the patient receives <u>at home</u>: (Mark all that apply.)</p> <p><input type="checkbox"/> 1 - Intravenous or infusion therapy (excludes TPN)</p> <p><input type="checkbox"/> 2 - Parenteral nutrition (TPN or lipids)</p> <p><input type="checkbox"/> 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)</p> <p><input type="checkbox"/> 4 - None of the above</p> |
| ITEM INTENT |
| <p>Identifies whether the patient is receiving intravenous, parenteral nutrition, or enteral nutrition therapy at home, whether or not the home health agency is administering the therapy. This item is not intended to identify therapies administered in outpatient facilities or by any provider outside the home setting.</p> |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Start of care</p> <p>Resumption of care</p> <p>Follow-up</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • This item addresses only therapies administered at home, defined as the patient's place of residence. Exclude therapies administered in outpatient facilities or by any provider outside the home setting. • If the patient will receive such therapy as a result of this SOC/ROC or follow-up assessment (e.g., the IV will be started at this visit or a specified subsequent visit; the physician will be contacted for an enteral nutrition order; etc.), mark the applicable therapy. • Select Response 1 if a patient receives intermittent medications or fluids via an IV line (including heparin or saline flushes). If IV catheter is present but not active (e.g., site is observed only or dressing changes are provided), do <u>not</u> mark Response 1. • Select Response 1 if ongoing infusion therapy is being administered at home via central line, subcutaneous infusion, epidural infusion, intrathecal infusion, or insulin pump. • Select Response 1 if the patient receives hemodialysis or peritoneal dialysis in the home. • Do not select Response 1 if there are orders for an IV infusion to be given when specific parameters are present (e.g., weight gain), but those parameters are not met on the day of the assessment. • Select Response 3 if any enteral nutrition is provided. If a feeding tube is in place, but not currently used for nutrition, Response 3 does <u>not</u> apply. A flush of a feeding tube does <u>not</u> provide nutrition. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Physician orders • Referral information • Review of past health history • Physical assessment |

OASIS Item Guidance

Patient History & Diagnoses

| OASIS ITEM |
|---|
| <p>(M1032) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply.)</p> <p><input type="checkbox"/> 1 - Recent decline in mental, emotional, or behavioral status</p> <p><input type="checkbox"/> 2 - Multiple hospitalizations (2 or more) in the past 12 months</p> <p><input type="checkbox"/> 3 - History of falls (2 or more falls - or any fall with an injury - in the past year)</p> <p><input type="checkbox"/> 4 - Taking five or more medications</p> <p><input type="checkbox"/> 5 - Frailty indicators, e.g., weight loss, self-reported exhaustion</p> <p><input type="checkbox"/> 6 - Other</p> <p><input type="checkbox"/> 7 - None of the above</p> |
| ITEM INTENT |
| Identifies patient characteristics that may indicate the patient is at risk for hospitalization in the care provider's professional judgment. |
| TIME POINTS ITEM(S) COMPLETED |
| Start of care Resumption of care |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Select all responses 1-6 that apply. • If Response 7 is selected, none of the other responses should be selected • Response 3 includes witnessed and reported (unwitnessed) falls. • In Response 4, medications includes OTC medications • Recent decline in mental, emotional, or behavioral status refers to significant changes occurring over the past year that may impact the patient's ability to remain safely in the home and increase the likelihood of hospitalization. • Frailty includes weight loss in the last year, self-reported exhaustion, and slower movements (sit to stand and while walking). |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Physician • Review of health history • Referral information • Physical assessment |

OASIS Item Guidance

Patient History & Diagnoses

| OASIS ITEM |
|---|
| <p>(M1034) Overall Status: Which description best fits the patient's overall status? (Check one)</p> <p><input type="checkbox"/> 0 - The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age).</p> <p><input type="checkbox"/> 1 - The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient's age).</p> <p><input type="checkbox"/> 2 - The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death.</p> <p><input type="checkbox"/> 3 - The patient has serious progressive conditions that could lead to death within a year.</p> <p><input type="checkbox"/> UK - The patient's situation is unknown or unclear.</p> |
| ITEM INTENT |
| Identifies the general potential for health status stabilization, decline, or death in the care provider's professional judgment. |
| TIME POINTS ITEM(S) COMPLETED |
| Start of care Resumption of care |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Use information from other providers and clinical judgment to select the response that best identifies the patient's status. • Consider current health status, medical diagnoses, and information from the physician and patient/family on expectations for recovery or life expectancy. • A "Do Not Resuscitate" order does not need to be in place for Responses 2 or 3. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Physician • Review of health history • Referral information • Physical assessment • Advance Directive |

OASIS Item Guidance

Patient History & Diagnoses

| OASIS ITEM |
|--|
| <p>(M1036) Risk Factors, either present or past, likely to affect current health status and/or outcome: (Mark all that apply.)</p> <p><input type="checkbox"/> 1 - Smoking</p> <p><input type="checkbox"/> 2 - Obesity</p> <p><input type="checkbox"/> 3 - Alcohol dependency</p> <p><input type="checkbox"/> 4 - Drug dependency</p> <p><input type="checkbox"/> 5 - None of the above</p> <p><input type="checkbox"/> UK - Unknown</p> |
| ITEM INTENT |
| Identifies specific factors that may exert a substantial impact on the patient's health status, response to medical treatment, and ability to recover from current illnesses, in the care provider's professional judgment. |
| TIME POINTS ITEM(S) COMPLETED |
| Start of care Resumption of care |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Select all responses, 1-4, that apply. • If Response 5 is selected, none of the other responses should be selected • CMS does not provide a specific definition for each of these factors. • Amount and length of exposure should be considered when responding (e.g., smoking one cigarette a month may not be considered a risk factor). • Care providers should use judgment in evaluating risks to current health conditions from behaviors that were stopped in the past. • For determination of obesity, consider using Body Mass Index guidelines. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Physician • Review of past health history • Physical assessment • Links to Body Mass Index guidelines for obesity can be found in Chapter 5 of this manual. |

OASIS Item Guidance

Patient History & Diagnoses

| OASIS ITEM |
|--|
| <p>(M1040) Influenza Vaccine: Did the patient receive the influenza vaccine from your agency for this year's influenza season (October 1 through March 31) during this episode of care?</p> <p><input type="checkbox"/> 0 - No</p> <p><input type="checkbox"/> 1 - Yes [<i>Go to M1050</i>]</p> <p><input type="checkbox"/> NA - Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season. [<i>Go to M1050</i>]</p> |
| ITEM INTENT |
| Identifies whether the patient received an influenza vaccine for the current influenza season from the home health agency during this episode of care |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Transfer to inpatient facility</p> <p>Discharge from agency – not to an inpatient facility</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • The definition of episode of care for this item is the period of time from SOC/ROC to transfer or discharge. For each influenza season, the Centers for Disease Control (CDC) recommends the timeframes for administration of the influenza vaccines. This item meets NQF requirements for harmonization of influenza measures across care settings. • Only select Responses 0 or 1 if any portion of the home health episode (from SOC/ROC to transfer or discharge) occurs during the influenza season as identified by the Centers for Disease Control. • Only select Response 1 if the patient received the flu vaccine from your agency during this episode (SOC/ROC to Transfer/Discharge). This item does not assess influenza vaccines given by another health care provider or provision of the flu vaccine by your agency previously (i.e., during a previous episode of care) in the flu season. These situations are reported in the next item, M1045. • If the entire home health episode (from most recent SOC/ROC to transfer or discharge) occurs outside the influenza season, mark "NA." |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Clinical record • Patient/caregiver interview • For each influenza season, identify the period of time for which the Centers for Disease Control recommends influenza vaccines be administered. See Chapter 5 of this manual for links to CDC resources. |

OASIS Item Guidance

Patient History & Diagnoses

| OASIS ITEM | |
|---|--|
| <p>(M1045) Reason Influenza Vaccine not received: If the patient did not receive the influenza vaccine from your agency during this episode of care, state reason:</p> <ul style="list-style-type: none"> <input type="checkbox"/> 1 - Received from another health care provider (e.g., physician) <input type="checkbox"/> 2 - Received from your agency previously during this year's flu season <input type="checkbox"/> 3 - Offered and declined <input type="checkbox"/> 4 - Assessed and determined to have medical contraindication(s) <input type="checkbox"/> 5 - Not indicated; patient does not meet age/condition guidelines for influenza vaccine <input type="checkbox"/> 6 - Inability to obtain vaccine due to declared shortage <input type="checkbox"/> 7 - None of the above | |
| ITEM INTENT | |
| <p>Specifies the reason that a patient did not receive an influenza vaccine from your agency during this home health care episode of care (from SOC/ROC to transfer or discharge). For each influenza season, the Centers for Disease Control (CDC) recommend the timeframes for administration of the influenza vaccines.</p> | |
| TIME POINTS ITEM(S) COMPLETED | |
| <p>Transfer to an inpatient facility Discharge from agency - not to an inpatient facility</p> | |
| RESPONSE—SPECIFIC INSTRUCTIONS | |
| <ul style="list-style-type: none"> • Complete if Response 0 for M1040 is selected. Select one response. • Select Response 1 if there is documentation in the medical record that the patient received the influenza vaccine for the current flu season from another provider. The provider can be the patient's physician, a clinic or health fair providing influenza vaccines, etc. • Select Response 2 if your agency provided the flu vaccine for this year's flu season prior to this home health episode, (e.g., if the SOC/ROC for this episode was in winter, but your agency provided the vaccine for the current flu season during a previous home health episode in the fall when the vaccine for the current flu season became available). • Select Response 3 if the patient and/or healthcare proxy (e.g., someone with power of attorney) refused the vaccine. • Select Response 4 if the influenza vaccine is contraindicated for medical reasons. Medical contraindications include anaphylactic hypersensitivity to eggs or other component(s) of the vaccine, history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination, or bone marrow transplant within 6 months. • Select Response 5 if age/condition guidelines indicate that influenza vaccine is not indicated for this patient. For example, as of 2009, the CDC recommends influenza vaccine for patients age 50 and older or 6 mo. – 18 yrs; OR if the patient resides in a long-term care facility (including nursing homes and skilled nursing facilities); OR is age 19-49 with high-risk conditions of pregnancy, diabetes, end-stage renal disease (ESRD), congestive heart failure (CHF), asthma, chronic obstructive pulmonary disease (COPD), or human immunodeficiency virus (HIV). • Select Response 7 only if the home health agency did not provide the vaccine due to a reason other than responses 1-6. | |
| DATA SOURCES / RESOURCES | |
| <ul style="list-style-type: none"> • Clinical record • Patient/caregiver interview • Physician or other health care provider | <ul style="list-style-type: none"> • For each influenza season, identify the period of time for which the Centers for Disease Control recommends influenza vaccines be administered. A link to CDC Guidelines can be found in Chapter 5 of this manual. |

OASIS Item Guidance

Patient History & Diagnoses

| OASIS ITEM |
|---|
| <p>(M1050) Pneumococcal Vaccine: Did the patient receive pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge)?</p> <p><input type="checkbox"/> 0 - No</p> <p><input type="checkbox"/> 1 - Yes [<i>Go to M1500 at TRN; Go to M1100 at DC</i>]</p> |
| ITEM INTENT |
| <p>Identifies whether the patient received a PPV from the home health agency during this episode of care (from SOC/ROC to transfer or discharge). This item does not assess PPVs given by another care provider or provision of the PPV by your agency prior to the most recent SOC/ROC, as that information will be reported in M1055.</p> |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Transfer to an inpatient facility</p> <p>Discharge from agency - not to an inpatient facility</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> Select Response1 only if the patient received the pneumococcal (PPV) vaccine from your agency during this episode (most recent SOC/ROC to Transfer/Discharge). |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> Clinical record Patient/caregiver interview |

OASIS Item Guidance

Patient History & Diagnoses

| OASIS ITEM |
|--|
| <p>(M1055) Reason PPV not received: If patient did not receive the pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge), state reason:</p> <ul style="list-style-type: none"> <input type="checkbox"/> 1 - Patient has received PPV in the past <input type="checkbox"/> 2 - Offered and declined <input type="checkbox"/> 3 - Assessed and determined to have medical contraindication(s) <input type="checkbox"/> 4 - Not indicated; patient does not meet age/condition guidelines for PPV <input type="checkbox"/> 5 - None of the above |
| ITEM INTENT |
| Explains why the patient did not receive a PPV from the home health agency during this episode of care (from SOC/ROC to transfer or discharge). |
| TIME POINTS ITEM(S) COMPLETED |
| Transfer to an inpatient facility Discharge from agency - not to an inpatient facility |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Response 1 should be selected if the patient received the PPV from your agency or from another provider, (including the patient's physician, a clinic or health fair, etc.) at any time in the past. The patient's PPV does not need to be up-to-date to select this response. • Response 2 should be selected if the patient and/or healthcare proxy (e.g., someone with power of attorney) refused the vaccine. • Response 3 should be selected if PPV administration is medically contraindicated for this patient. Medical contraindications include anaphylactic hypersensitivity to component(s) of the vaccine, acute febrile illness bone marrow transplant within past 12 months, or receiving course of chemotherapy or radiation therapy within past 2 weeks. • Select Response 4 if CDC age/condition guidelines indicate that PPV is not indicated for this patient. For example, the 2009 CDC recommendations are that the following patients receive PPV vaccination: <ul style="list-style-type: none"> - all adults 65 years of age or older should get the PPV once in a lifetime, with certain exceptions for medical contraindications as noted above, - all patients who reside in a long-term care facility (including nursing homes and skilled nursing facilities), - all patients age 5-64 with the high-risk conditions of diabetes, nephrotic syndrome, ESRD, CHF, COPD, HIV, asplenia. • When responding to this item, the clinician only needs to report whether the patient has ever received PPV. However, when determining whether PPV is appropriate for a patient, the clinician should also consider the following CDC recommendations: <ul style="list-style-type: none"> - Persons 65 years or older should be administered a second dose of vaccine (booster vaccine) if they received the first dose of vaccine <u>more than</u> 5 years earlier and were less than 65 years old at the time of the first dose. - Persons less than 65 years of age who smoke or who are living in environments or social settings (e.g., nursing homes, assisted living, or board and care facilities) in which the risk for invasive pneumococcal disease or its complications is increased should receive the PPV if they do not have medical contraindications, as should patients age 5-64 with the high-risk conditions of diabetes, nephrotic syndrome, ESRD, CHF, COPD, HIV, or asplenia. |

OASIS Item Guidance

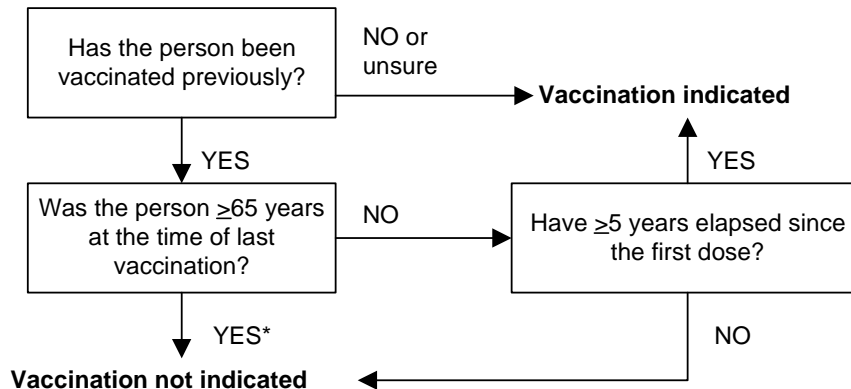
Patient History & Diagnoses

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1055)

- Also, note that the CDC has evaluated inactivated Influenza vaccine co-administration with the Pneumococcal Polysaccharide Vaccine (PPV) systematically among adults. Simultaneous vaccine administration is safe when administered by a separate injection in the opposite arm. If the patient is an amputee or intramuscular injections are contraindicated in the upper extremities, administer the vaccine(s) according to clinical standards of care.

Note: The following algorithm may be used to assist in determining if PPV should be administered to immunocompetent patients ages 65 and older.

FIGURE 1. Algorithm for vaccinating immunocompetent persons aged 65 years and older.



*For any immunocompetent person who has received a dose of pneumococcal polysaccharide vaccine at age ≥ 65 years, revaccination is not indicated.

Figure 1 Adapted from the CDC Recommendations and Reports. Prevention of Pneumococcal Disease: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR April 1997;46(RR-08);1-24.

The CDC also recommends a second (booster) dose for persons who are immunocompromised due to:

- A damaged spleen or no spleen
- Sickle-cell disease
- HIV infections or AIDS
- Cancer, leukemia, lymphoma, multiple myeloma
- Kidney failure
- Nephrotic syndrome
- History of an organ or bone transplant
- Medication regimens that lowers immunity (such as chemotherapy or long-term steroids)

When any of the above conditions are present, persons older than 10 years old (including those 65 years of age and older) should get the second (booster) dose 5 years after the first dose.

- Response 5 should only be selected if the home health agency did not provide the vaccine due to a reason other than Responses 1-4.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician
- Resources for CDC Guidelines for PPV administration can be found in Chapter 5 of this manual.

OASIS Item Guidance

Living Arrangements

| OASIS ITEM | | | | | |
|---|-----------------------------|-----------------------------|-----------------------------|------------------------------------|-----------------------------|
| (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 (e.g., assisted living) | <input type="checkbox"/> 11 | <input type="checkbox"/> 12 | <input type="checkbox"/> 13 | <input type="checkbox"/> 14 | <input type="checkbox"/> 15 |
| ITEM INTENT | | | | | |
| This item identifies, using the care provider's professional judgment, a) whether the patient is living alone or with other(s) and b) the availability of the people who live with the patient to provide physical assistance. Availability of assistance can impact the patient's ability to remain safely in the home. | | | | | |
| TIME POINTS ITEM(S) COMPLETED | | | | | |
| Start of care Resumption of care | | | | | |
| RESPONSE—SPECIFIC INSTRUCTIONS | | | | | |
| <ul style="list-style-type: none"> To answer this question: <ul style="list-style-type: none"> First, determine where the patient lives, Second, determine who lives with the patient, and Third, determine how much assistance home-mates can/will be available. Only one response should be marked. Select the appropriate row (a, b, or c) to reflect the patient's living situation, then select the one response in the column that best describes the availability of assistance at the time of the OASIS assessment. The care provider should identify the frequency with which in-person physical assistance is provided. Physical assistance includes assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL), including meal preparation and medication management. This does not include assistance from someone by phone or emergency assistance that can be accessed by Lifeline or 911 call. It is possible that a person living in the patient's home may not provide any ADL/IADL assistance, in which case Response Box 10 would be selected. Select a response from Row a if the patient lives alone in an independent (non-assisted) setting. For example, the patient lives alone in a home, in their own apartment, or in their own room at a boarding house. A patient with only live-in paid help is considered to be living alone. A patient who lives alone but can obtain emergency help by phone or life-line, is still living alone. Select a response from Row b if the patient lives with others in an independent (non-assisted) setting. For example, the patient lives with a spouse, family member or another significant other in an independent (non-assisted) setting. | | | | | |

OASIS Item Guidance

Living Arrangements

| RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1100) |
|--|
| <ul style="list-style-type: none"> • Select a response from Row c if the patient lives in an “assisted living” setting (assistance, supervision and/or oversight are provided as part of the living arrangement). For example, the patient lives alone or with a spouse or partner in an apartment or room that is part of an assisted living facility, residential care home, or personal care home. • Use your professional judgment to determine if the people the patient lives with can/will provide physical assistance to the patient if needed. Consider home-mates’ cognitive, physical, and emotional ability to provide needed physical assistance with ADLs and IADLs. Consider when they are in the home and the relationship the patient has with home-mates. • If the patient living situation varies (e.g., a caregiver temporarily staying with the patient to provide care, a family member living with the patient who occasionally travels out of town), select the response that best reflects the usual living arrangements. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Physical assessment • Observation • Referral information |

OASIS Item Guidance

Sensory Status

| OASIS ITEM |
|---|
| <p>(M1200) Vision (with corrective lenses if the patient usually wears them):</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0 - Normal vision: sees adequately in most situations; can see medication labels, newsprint. <input type="checkbox"/> 1 - Partially impaired: cannot see medication labels or newsprint, but <u>can</u> see obstacles in path, and the surrounding layout; can count fingers at arm's length. <input type="checkbox"/> 2 - Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive. |
| ITEM INTENT |
| Identifies the patient's ability to see and visually manage (function) safely within his/her environment, wearing corrective lenses if these are usually worn. |
| TIME POINTS ITEM(S) COMPLETED |
| Start of care Resumption of care Follow-up |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • "Nonresponsive" means that the patient is not <u>able</u> to respond. • As specified within the OASIS question, only assess functional vision with corrective lenses if the patient usually wears corrective lenses. • A magnifying glass (as might be used to read newsprint) is <u>not</u> an example of corrective lenses. • Reading glasses (including "grocery store" reading glasses) <u>are</u> considered to be corrective lenses. • Assessment strategies: In the health history interview, ask the patient about vision problems (e.g., cataracts) and whether or not the patient uses glasses. Observe ability to locate signature line on consent form, to count fingers at arm's length and ability to differentiate between medications, especially if medications are self-administered. Be sensitive to requests to read, as patient may not be able to read though vision is adequate. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Observation • Physical assessment • Referral information (e.g., history and physical) |

OASIS Item Guidance

Sensory Status

| OASIS ITEM |
|---|
| <p>(M1210) Ability to hear (with hearing aid or hearing appliance if normally used):</p> <p><input type="checkbox"/> 0 - Adequate: hears normal conversation without difficulty.</p> <p><input type="checkbox"/> 1 - Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly.</p> <p><input type="checkbox"/> 2 - Severely Impaired: absence of useful hearing.</p> <p><input type="checkbox"/> UK - Unable to assess hearing.</p> |
| ITEM INTENT |
| Identifies the patient's ability to hear spoken language and other sounds (e.g., alarms). |
| TIME POINTS ITEM(S) COMPLETED |
| Start of care Resumption of care |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Hearing is evaluated with the patient wearing hearing aids or devices if he/she usually uses them. • Select the "UK" response if the patient is not <u>able</u> to respond or if it is otherwise impossible to assess hearing (e.g., severe dementia, schizophrenia, unconscious). • If evaluating ability to hear with hearing aids, be sure that the devices are in place, turned on, and that the hearing aids are working (i.e., batteries are functional). |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Observation • Physical assessment • Referral information (e.g., history and physical) |

OASIS Item Guidance

Sensory Status

| OASIS ITEM |
|--|
| <p>(M1220) Understanding of Verbal Content in patient's own language (with hearing aid or device if used):</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0 - Understands: clear comprehension without cues or repetitions. <input type="checkbox"/> 1 - Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand. <input type="checkbox"/> 2 - Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand. <input type="checkbox"/> 3 - Rarely/Never Understands <input type="checkbox"/> UK - Unable to assess understanding. |
| ITEM INTENT |
| Identifies the patient's functional ability to comprehend spoken words and instructions in the patient's primary language. Both hearing and cognitive abilities may impact a patient's ability to understand verbal content. |
| TIME POINTS ITEM(S) COMPLETED |
| Start of care Resumption of care |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • The "UK" response should be selected if the patient is not <u>able</u> to respond or if it is otherwise impossible to assess understanding of spoken words and instructions. • For patients whose primary language differs from the clinician's, an interpreter may be necessary. • If a patient can comprehend lip reading, they have the ability to understand verbal content, even if they are deaf. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Observation • Physical assessment • Referral information (e.g., history and physical) • Interpreter |

OASIS Item Guidance

Sensory Status

| OASIS ITEM |
|--|
| <p>(M1230) Speech and Oral (Verbal) Expression of Language (in patient's own language):</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment. <input type="checkbox"/> 1 - Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance). <input type="checkbox"/> 2 - Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences. <input type="checkbox"/> 3 - Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases. <input type="checkbox"/> 4 - <u>Unable</u> to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (e.g., speech is nonsensical or unintelligible). <input type="checkbox"/> 5 - Patient nonresponsive or unable to speak. |
| ITEM INTENT |
| Identifies the patient's physical and cognitive ability to communicate with words in the patient's primary language. The item does not address communicating in sign language, in writing, or by any nonverbal means. |
| TIME POINTS ITEM(S) COMPLETED |
| Start of care Resumption of care Discharge from agency – not to an inpatient facility |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Augmented speech (e.g., a trained esophageal speaker, use of an electrolarynx) is considered verbal expression of language. • Presence of a tracheostomy requires further evaluation of the patient's ability to speak. Can the trach be covered to allow speech? If so, to what extent can the patient express him/herself? • Select Response 5 for a patient who communicates entirely nonverbally (e.g., by sign language or writing) or is unable to speak. • "Nonresponsive" means that the patient is not <u>able</u> to respond. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Observation • Physical assessment • Referral information (e.g., history and physical) • Interpreter |

OASIS Item Guidance

Sensory Status

| OASIS ITEM |
|--|
| <p>(M1240) Has this patient had a formal Pain Assessment using a standardized pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?</p> <p><input type="checkbox"/> 0 - No standardized assessment conducted</p> <p><input type="checkbox"/> 1 - Yes, and it does not indicate severe pain</p> <p><input type="checkbox"/> 2 - Yes, and it indicates severe pain</p> |
| ITEM INTENT |
| <p>Identifies if a standardized pain assessment is conducted and whether a clinically significant level of pain is present, as determined by the assessment tool used. This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.</p> |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Start of Care</p> <p>Resumption of Care</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • A standardized tool is one that includes a standard response scale (e.g., a scale where patients rate pain from 0-10). The standardized tool must be appropriately administered as indicated in the instructions and must be relevant for the patient's ability to respond. Severe pain is defined according to the scoring system for the standardized tool being used. CMS does not endorse a specific tool. • Select Response 0 if such a tool was not used to assess pain. • In order to select Response 1 or 2, the pain assessment must be conducted by agency staff during the time frame specified by CMS for completion of the assessment (SOC within 5 days; ROC within 48 hours following inpatient discharge). |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Physical assessment • Clinical record • A variety of standardized pain assessment approaches have been tested and are available for provider use in patient assessment. These approaches include visual analog scales, the Wong-Baker FACES Pain Rating Scale, numerical scales, and the Memorial Pain Assessment Card. Links to these and other assessment tools can be found in Chapter 5 of this manual. |

OASIS Item Guidance

Sensory Status

| OASIS ITEM |
|--|
| <p>(M1242) Frequency of Pain Interfering with patient's activity or movement:</p> <p><input type="checkbox"/> 0 - Patient has no pain</p> <p><input type="checkbox"/> 1 - Patient has pain that does not interfere with activity or movement</p> <p><input type="checkbox"/> 2 - Less often than daily</p> <p><input type="checkbox"/> 3 - Daily, but not constantly</p> <p><input type="checkbox"/> 4 - All of the time</p> |
| ITEM INTENT |
| Identifies frequency with which pain interferes with patient's activities, with treatments if prescribed. |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Start of care</p> <p>Resumption of care</p> <p>Follow-up</p> <p>Discharge from agency – not to an inpatient facility</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Responses are arranged in order of least to most interference with activity or movement. • Pain interferes with activity when the pain results in the activity being performed less often than otherwise desired, requires the patient to have additional assistance in performing the activity, or causes the activity to take longer to complete. • When reviewing patient's medications, the presence of medication for pain or joint disease provides an opportunity to explore the presence of pain, when the pain is the most severe, activities with which the pain interferes, and the frequency of this interference with activity or movement. Be careful not to overlook seemingly unimportant activities (for example, the patient says she/he sits in the chair all day and puts off going to the bathroom, because it hurts so much to get up from the chair or to walk). Evaluating the patient's ability to perform ADLs and IADLs can provide additional information about such pain. Assessing pain in a nonverbal patient involves observation of facial expression (e.g., frowning, gritting teeth), monitoring heart rate, respiratory rate, perspiration, pallor, pupil size, irritability, or use of visual pain scales (e.g., FACES). The patient's treatment for pain (whether pharmacologic or nonpharmacologic) must be considered when evaluating whether pain interferes with activity or movement. Pain that is well controlled with treatment may not interfere with activity or movement at all. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Observation of nonverbal indications of pain • Physical assessment • Referral information (e.g., history and physical) • Standardized pain assessment tools. Links to these tools can be found in Chapter 5 of this manual. |

OASIS Item Guidance

Integumentary Status

| OASIS ITEM |
|---|
| <p>(M1300) Pressure Ulcer Assessment: Was this patient assessed for Risk of Developing Pressure Ulcers?</p> <p><input type="checkbox"/> 0 - No assessment conducted [<i>Go to M1306</i>]</p> <p><input type="checkbox"/> 1 - Yes, based on an evaluation of clinical factors, e.g., mobility, incontinence, nutrition, etc., without use of standardized tool</p> <p><input type="checkbox"/> 2 - Yes, using a standardized tool, e.g., Braden, Norton, other</p> |
| ITEM INTENT |
| <p>Identifies whether the home health agency care providers assessed the patient's risk of developing pressure ulcers. CMS does not require the use of standardized tools, nor does it endorse one particular tool.</p> <p>This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.</p> |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Start of Care</p> <p>Resumption of Care</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Select Response 0 if the patient was not assessed for pressure ulcer risk • Select Response 1 if the patient's risk for pressure ulcer development was clinically assessed, but no formal pressure ulcer screening tool was used. • Select Response 2 only if the patient was screened using a validated standardized screening tool (i.e., a tool that has been scientifically tested and evaluated with a population with characteristics similar to the patient who is being evaluated). |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Observation • Physical Assessment • Referral documentation • Physician • See link in Chapter 5 of this manual to the Braden Scale for Predicting Pressure Sore Risk and the Norton Scale |

OASIS Item Guidance

Integumentary Status

| OASIS ITEM |
|--|
| <p>(M1302) Does this patient have a Risk of Developing Pressure Ulcers?</p> <p><input type="checkbox"/> 0 - No</p> <p><input type="checkbox"/> 1 - Yes</p> |
| ITEM INTENT |
| Identifies if the patient is at risk for developing pressure ulcers. This item should be skipped if response 0 was selected for M1300 (no pressure ulcer risk assessment). |
| TIME POINTS ITEM(S) COMPLETED |
| Start of Care Resumption of Care |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> If pressure ulcer risk was assessed using a validated standardized screening tool, use the scoring parameters specified for the tool to identify if a patient is at risk for developing pressure ulcers. If the tool does not define levels of risk or if the evaluation was based on clinical factors (without a validated standardized screening tool), then the agency or care provider may define what constitutes risk. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> Patient/caregiver interview Observation Physical Assessment Referral documentation Physician Established, validated pressure ulcer risk tools include the Braden Scale for Predicting Pressure Sore Risk and the Norton Scale. Links can be found in Chapter 5 of this manual. |

**Wound items are under review by
CMS and the NPUAP**

OASIS Item Guidance

Respiratory Status

| OASIS ITEM |
|---|
| <p>(M1400) When is the patient dyspneic or noticeably Short of Breath?</p> <p><input type="checkbox"/> 0 - Patient is not short of breath</p> <p><input type="checkbox"/> 1 - When walking more than 20 feet, climbing stairs</p> <p><input type="checkbox"/> 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)</p> <p><input type="checkbox"/> 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation</p> <p><input type="checkbox"/> 4 - At rest (during day or night)</p> |
| ITEM INTENT |
| Identifies the level of exertion/activity that results in a patient's dyspnea or shortness of breath. |
| TIME POINTS ITEM(S) COMPLETED |
| Start of care Resumption of care Follow-up Discharge from agency – not to inpatient facility |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • If the patient uses oxygen continuously, select the response based on assessment of the patient's shortness of breath while using oxygen. If the patient uses oxygen intermittently, mark the response based on the patient's shortness of breath WITHOUT the use of oxygen. • The responses represent increasing severity of shortness of breath. • For a chairfast or bedbound patient, evaluate the level of exertion required to produce shortness of breath. The chairfast patient can be assessed for level of dyspnea while performing ADLs or at rest. Response 0 would apply if the patient has not been short of breath during the day of assessment. Response 1 would be appropriate if demanding bed-mobility activities produce dyspnea in the bedbound patient (or physically demanding transfer activities produce dyspnea in the chairfast patient). See Responses 2, 3, and 4 for assessment examples for these patients as well as ambulatory patients. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Observation • Physical assessment • Patient/caregiver interview • Review of health history |

OASIS Item Guidance

Respiratory Status

| OASIS ITEM |
|--|
| <p>(M1410) Respiratory Treatments utilized at home: (Mark all that apply.)</p> <p><input type="checkbox"/> 1 - Oxygen (intermittent or continuous)</p> <p><input type="checkbox"/> 2 - Ventilator (continually or at night)</p> <p><input type="checkbox"/> 3 - Continuous / Bi-level positive airway pressure</p> <p><input type="checkbox"/> 4 - None of the above</p> |
| ITEM INTENT |
| Identifies any of the listed respiratory treatments being used by this patient in the home. |
| TIME POINTS ITEM(S) COMPLETED |
| Start of care Resumption of care Discharge from agency – not to inpatient facility |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Excludes any respiratory treatments that are not listed in the item (e.g., does not include nebulizers, inhalers). • Option 3 reflects both CPAP and BiPAP. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Observation • Physician's orders • Referral information • Review of health history |

OASIS Item Guidance

Cardiac Status

| OASIS ITEM |
|--|
| <p>(M1500) Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (such as dyspnea, orthopnea, edema, or weight gain) at any point since the previous OASIS assessment?</p> <p><input type="checkbox"/> 0 - No [<i>Go to M2004 at TRN; Go to M1600 at DC</i>]</p> <p><input type="checkbox"/> 1 - Yes</p> <p><input type="checkbox"/> 2 - Not assessed [<i>Go to M2004 at TRN; Go to M1600 at DC</i>]</p> <p><input type="checkbox"/> NA - Patient does not have diagnosis of heart failure [<i>Go to M2004 at TRN; Go to M1600 at DC</i>]</p> |
| ITEM INTENT |
| <p>Identifies whether a patient with a diagnosis of heart failure experienced one or more symptoms of heart failure at the time of the most recent OASIS assessment or since that time.</p> <p>This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices/assessments stated in the item are not necessarily required in the Conditions of Participation.</p> |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Transfer to inpatient facility</p> <p>Discharge from agency – not to inpatient facility</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Select only response options 0, 1, or 2 if the patient has a diagnosis of heart failure in any one or all of: <ul style="list-style-type: none"> - M1010: Inpatient Diagnoses, - M1016: Diagnoses Causing Change in Treatment, or - M01020/1022/1024: Primary/Secondary diagnoses for home care. • Select "NA" if the patient does not have a diagnosis of heart failure. • Consider any new or ongoing heart failure symptoms that occurred at the time of the previous OASIS assessment or since that time. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Review of clinical record including physical assessment data, weight trends, clinical notes using HHA systems put into place to accomplish such a review (e.g., flow sheets, reports from electronic health record data). • A complete list of symptoms of heart failure can be found in clinical heart failure guidelines in Chapter 5 of this manual. |

OASIS Item Guidance

Cardiac Status

| OASIS ITEM |
|--|
| <p>(M1510) Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure since the previous OASIS assessment, what action(s) has (have) been taken to respond? (Mark all that apply.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0 - No action taken <input type="checkbox"/> 1 - Patient's physician (or other primary care practitioner) contacted the same day <input type="checkbox"/> 2 - Patient advised to get emergency treatment (e.g., call 911 or go to emergency room) <input type="checkbox"/> 3 - Implement physician-ordered patient-specific established parameters for treatment <input type="checkbox"/> 4 - Patient education or other clinical interventions <input type="checkbox"/> 5 - Obtained change in care plan orders (e.g., increased monitoring by agency, change in visit frequency, telehealth, etc.) |
| ITEM INTENT |
| <p>Identifies actions the home health care providers took in response to symptoms of heart failure that occurred at the time of the most recent OASIS assessment or since that time. This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.</p> |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Transfer to an inpatient facility Discharge from agency - not to an inpatient facility</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Include any actions that were taken at least one time at the time of the last OASIS assessment or since that time. • If the interventions are not completed as outlined in this item, select Response 0 – No action taken. However, in this case, the care provider should document rationale in the clinical record. • If Response 0 is selected, none of the other responses should be selected. • Response 1 includes communication to the physician or primary care practitioner made by telephone, voicemail, electronic means, fax, or any other means that appropriately conveys the message of patient status. Response 1 is an appropriate response only if a physician responds to the agency communication with acknowledgment of receipt of information and/or further advice or instructions. In many situations, other responses also will be marked that indicate the action taken as a result of the contact (i.e., any of responses 2-5). • Response 3 would be the best response for a situation in which either the home care clinician reminds the patient to implement or is aware that the patient is following physician-established parameters for treatment |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Review of clinical record including physical assessment data, weight trends, clinical notes, etc., at the time of the previous OASIS assessment or since that time. • Physician-ordered home health plan of care • Examples of standard clinical guidelines can be found in Chapter 5 of this manual. |

OASIS Item Guidance

Elimination Status

| OASIS ITEM |
|--|
| <p>(M1600) Has this patient been treated for a Urinary Tract Infection in the past 14 days?</p> <p><input type="checkbox"/> 0 - No</p> <p><input type="checkbox"/> 1 - Yes</p> <p><input type="checkbox"/> NA - Patient on prophylactic treatment</p> <p><input type="checkbox"/> UK - Unknown</p> |
| ITEM INTENT |
| Identifies treatment of urinary tract infection during the past 14 days. |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Start of care</p> <p>Resumption of care</p> <p>Discharge from agency – not to inpatient facility</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • The term “past fourteen days” is the two-week period immediately preceding the start/resumption of care or discharge. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient’s SOC date is August 20, any treatment for a UTI occurring on or after August 6 would be considered. • Unknown is not an option at discharge from agency. • Select Response 0 – No, if patient has not been treated for a UTI within the past two weeks, including if the patient had symptoms of a UTI or a positive culture for which the physician did not prescribe treatment, or the treatment ended more than 14 days ago. • Select Response 1 – Yes, when the patient has been prescribed an antibiotic within the past 14 days specifically for a confirmed or suspected UTI. • Select Response 1 – Yes, if the patient is on prophylactic treatment <u>and</u> develops a UTI. • Select Response NA – if the patient is on prophylactic treatment to prevent UTIs. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Physician orders • Review of health history • Referral information • Physician • Medication list |

OASIS Item Guidance

Elimination Status

| OASIS ITEM |
|---|
| <p>(M1610) Urinary Incontinence or Urinary Catheter Presence:</p> <p><input type="checkbox"/> 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) [<i>Go to M1620</i>]</p> <p><input type="checkbox"/> 1 - Patient is incontinent</p> <p><input type="checkbox"/> 2 - Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) [<i>Go to M1620</i>]</p> |
| ITEM INTENT |
| Identifies presence of urinary incontinence or condition that requires urinary catheterization of any type, including intermittent or indwelling. The etiology (cause) of incontinence is not addressed in this item. |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Start of care</p> <p>Resumption of care</p> <p>Follow-up</p> <p>Discharge from agency - not to inpatient facility</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Select Response 0 if the patient has anuria or an ostomy for urinary drainage (e.g., an ileal conduit), or if the patient has a urinary diversion that is pouched (ileal conduit, urostomy, ureterostomy, nephrostomy), with or without a stoma • Select Response 1 if the patient is incontinent AT ALL (i.e., “occasionally,” “only when I sneeze,” “sometimes I leak a little bit,” etc.). • Select Response 1 if the patient is incontinent or is dependent on a timed-voiding program. Timed voiding is defined as scheduled toileting assistance or prompted voiding to manage incontinence based on identified patterns. Time voiding is a compensatory strategy; it does not cure incontinence. • Select Response 2 if a catheter or tube is utilized for drainage (even if catheterizations are intermittent). • Select Response 2 if the patient requires the use of a urinary catheter for any reason (e.g., retention, post-surgery, incontinence). Select Response 2 and follow the skip pattern if the patient is <u>both</u> incontinent and requires a urinary catheter. • A leaking urinary drainage appliance is not incontinence. • Assessment strategies: Review the urinary elimination pattern as you take the health history. Does the patient admit having difficulty controlling the urine, or is he/she embarrassed about needing to wear a pad so as not to wet on clothing? Do you have orders to change a catheter? Is your stroke patient using an external catheter? Be alert for an odor of urine, which might indicate there is a problem with bladder sphincter control. If the patient receives aide services for bathing and/or dressing, ask for input from the aide (at follow-up assessment). This information can then be discussed with the patient. Urinary incontinence may result from multiple causes, including physiologic reasons, cognitive impairments, or mobility problems. |

OASIS Item Guidance**Elimination Status**

| DATA SOURCES / RESOURCES (cont'd for OASIS Item M1610) |
|--|
| <ul style="list-style-type: none">• Patient/caregiver interview• Observation• Physical assessment• Physician orders• Review of health history• Referral information |

OASIS Item Guidance

Elimination Status

| OASIS ITEM |
|--|
| <p>(M1615) When does Urinary Incontinence occur?</p> <p><input type="checkbox"/> 0 - Timed-voiding defers incontinence</p> <p><input type="checkbox"/> 1 - Occasional stress incontinence</p> <p><input type="checkbox"/> 2 - During the night only</p> <p><input type="checkbox"/> 3 - During the day only</p> <p><input type="checkbox"/> 4 - During the day and night</p> |
| ITEM INTENT |
| Identifies when the urinary incontinence occurs. |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Start of care</p> <p>Resumption of care</p> <p>Discharge from agency - not to inpatient facility</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Select Response 0 if timed-voiding defers incontinence. Timed voiding determines the patient's pattern for voiding and schedules toileting to prevent episodes of leaking. The patient can self-schedule toileting or the caregiver can prompt or bring the patient to the toilet. Time voiding is a compensatory strategy; it does not cure incontinence. If timed voiding does not defer incontinence, do not select Response 0. • Select Response 1 – Occasional stress incontinence - when the patient is unable to prevent escape of relatively small amounts of urine when coughing, sneezing, laughing, lifting, moving from sitting to standing position, or other activities (stress), which increase abdominal pressure. • If urinary incontinence happens with regularity or in other circumstances than those described in the definition of stress incontinence, determine when the incontinence usually occurs and select Response 2, 3, or 4 as appropriate. • Select Response 2 – During the night only – when the patient's incontinence occurs while the patient is sleeping at night. • Select Response 3 – During the day only – when the patient's incontinence occurs while the patient is up/awake during the day. Includes incontinence during daytime naps. • Select Response 4 – During the day and night – when the patient is incontinent when sleeping at night and up/awake during the day. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Observation • Physical assessment • Review of health history • Referral information |

OASIS Item Guidance

Elimination Status

| OASIS ITEM |
|---|
| <p>(M1620) Bowel Incontinence Frequency:</p> <p><input type="checkbox"/> 0 - Very rarely or never has bowel incontinence</p> <p><input type="checkbox"/> 1 - Less than once weekly</p> <p><input type="checkbox"/> 2 - One to three times weekly</p> <p><input type="checkbox"/> 3 - Four to six times weekly</p> <p><input type="checkbox"/> 4 - On a daily basis</p> <p><input type="checkbox"/> 5 - More often than once daily</p> <p><input type="checkbox"/> NA - Patient has ostomy for bowel elimination</p> <p><input type="checkbox"/> UK - Unknown</p> |
| ITEM INTENT |
| <p>Identifies how often the patient experiences bowel incontinence. Refers to the frequency of a symptom (bowel incontinence), not to the etiology (cause) of that symptom. This item does <u>not</u> address treatment of incontinence or constipation (e.g., a bowel program).</p> |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Start of care</p> <p>Resumption of care</p> <p>Follow-up</p> <p>Discharge from agency - not to inpatient facility</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Responses are arranged in order of least to most frequency of bowel incontinence. • Response 4 – On a daily basis – indicates that the patient experiences bowel incontinence once per day. • Response NA is used if patient has an ostomy for bowel elimination. • Unknown is not an option at follow-up or discharge. • Assessment strategies: Review the bowel elimination pattern as you take the health history. Observe the cleanliness around the toilet when you are in the bathroom. Note any visible evidence of soiled clothing. Ask the patient if she/he has difficulty controlling stools, has problems with soiling clothing, uncontrollable diarrhea, etc. The patient's responses to these items may make you aware of an as yet unidentified problem that needs further investigation. If the patient is receiving aide services, question the aide about evidence of bowel incontinence at follow-up time points. This information can then be discussed with the patient. Incontinence may result from multiple causes, including physiologic reasons, mobility problems, or cognitive impairments. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Observation • Physical assessment • Review of health history • Referral information |

OASIS Item Guidance

Elimination Status

| OASIS ITEM |
|--|
| <p>(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?</p> <p><input type="checkbox"/> 0 - Patient does <u>not</u> have an ostomy for bowel elimination.</p> <p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> 2 - The ostomy <u>was</u> related to an inpatient stay or <u>did</u> necessitate change in medical or treatment regimen.</p> |
| ITEM INTENT |
| Identifies whether the patient has an ostomy for bowel elimination and, if so, whether the ostomy was related to a recent inpatient stay or caused a change in medical treatment plan. |
| TIME POINTS ITEM(S) COMPLETED |
| Start of care Resumption of care Follow-up |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Applies to any type of ostomy for bowel elimination (e.g., colostomy, ileostomy). This item only addresses bowel ostomies, not other types of ostomies (e.g., urinary ostomies, tracheostomies). • If an ostomy has been reversed, then the patient does <u>not</u> have an ostomy at the time of assessment. • If patient does not have an ostomy for bowel elimination, select Response 0 – Patient does <u>not</u> have an ostomy for bowel elimination. • If the patient does have an ostomy for bowel elimination, determine whether the ostomy was related to an inpatient stay or necessitated a change in the medical or treatment regimen within the last 14 days. • The term “past fourteen days” is the two-week period immediately preceding the start/resumption of care or follow-up assessment. This means that for purposes of counting the 14-day period, the date of admission/assessment is day 0 and the day immediately prior to the date of admission/assessment is day 1. For example, if the patient’s SOC date is August 20, any ostomy related to an inpatient stay or requiring medical or treatment regimen change that occurred on or after August 6 would be considered. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Physician orders • Review of health history • Referral information • Physician • Supplies list |

OASIS Item Guidance

Neuro/Emotional/Behavioral Status

| OASIS ITEM |
|---|
| <p>(M1700) Cognitive Functioning: Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently. <input type="checkbox"/> 1 - Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions. <input type="checkbox"/> 2 - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility. <input type="checkbox"/> 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. <input type="checkbox"/> 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium. |
| ITEM INTENT |
| Identifies the patient's current (at the time of the assessment and in the preceding 24 hours) level of cognitive functioning, including alertness, orientation, comprehension, concentration, and immediate memory for simple commands. |
| TIME POINTS ITEM(S) COMPLETED |
| Start of care Resumption of care Discharge from agency - not to inpatient facility |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Responses progress from no impairment to severely impaired. • Consider the patient's signs/symptoms of cognitive dysfunction that have occurred over the past 24 hours. • Consider the amount of supervision and care the patient has required due to cognitive deficits. • Patients with diagnoses such as dementia, delirium, development delay disorders, mental retardation, etc., <u>will</u> have various degrees of cognitive dysfunction. Consider the degree of impairment. • Patients with neurological deficits related to stroke, mood/anxiety disorders, or who receive opioid therapy <u>may</u> have cognitive deficits. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Observation • Physical assessment • Links to cognitive assessment tools can be found in Chapter 5 of this manual. • Review of past health history • Physician |

OASIS Item Guidance

Neuro/Emotional/Behavioral Status

| OASIS ITEM |
|---|
| <p>(M1710) When Confused (Reported or Observed Within the Last 14 Days):</p> <p><input type="checkbox"/> 0 - Never</p> <p><input type="checkbox"/> 1 - In new or complex situations only</p> <p><input type="checkbox"/> 2 - On awakening or at night only</p> <p><input type="checkbox"/> 3 - During the day and evening, but not constantly</p> <p><input type="checkbox"/> 4 - Constantly</p> <p><input type="checkbox"/> NA - Patient nonresponsive</p> |
| ITEM INTENT |
| Identifies the time of day or situations when the patient experienced confusion, if at all. |
| TIME POINTS ITEM(S) COMPLETED |
| Start of care Resumption of care Discharge from agency - not to inpatient facility |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • This item may not relate directly to Item M1700. Assess specifically for confusion in the past 14 days. • The term “past fourteen days” is the two-week period immediately preceding the start/resumption of care or discharge. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient’s SOC date is August 20, any confusion occurring on or after August 6 would be considered. • If it is reported that the patient is “occasionally” confused, identify the situation(s) in which confusion has occurred within the last 14 days, if at all. • “Nonresponsive” means that the patient is unable to respond or the patient responds in a way that you can’t make a clinical judgment about the patient’s level of orientation. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Observation • Physical assessment • Review of past health history • Physician • Links to a resource for patients with Alzheimer’s disease or dementia can be found in Chapter 5 of this manual. |

OASIS Item Guidance

Neuro/Emotional/Behavioral Status

| OASIS ITEM |
|---|
| <p>(M1720) When Anxious (Reported or Observed Within the Last 14 Days):</p> <p><input type="checkbox"/> 0 - None of the time</p> <p><input type="checkbox"/> 1 - Less often than daily</p> <p><input type="checkbox"/> 2 - Daily, but not constantly</p> <p><input type="checkbox"/> 3 - All of the time</p> <p><input type="checkbox"/> NA - Patient nonresponsive</p> |
| ITEM INTENT |
| Identifies the frequency with which the patient has felt anxious within the past 14 days. |
| TIME POINTS ITEM(S) COMPLETED |
| Start of care Resumption of care Discharge from agency - not to inpatient facility |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Anxiety includes: <ul style="list-style-type: none"> - Worry that interferes with learning and normal activities, - Feelings of being overwhelmed and having difficulty coping, or - Symptoms of anxiety disorders. • Responses appear in order of increasing frequency of anxiety. • “Nonresponsive” means that the patient is unable to respond. • The term “past fourteen days” is the two-week period immediately preceding the start/resumption of care. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient’s SOC date is August 20, any anxiety occurring on or after August 6 would be considered. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Observation • Physical assessment • Referral information • Review of recent (past 14 days) health history • Physician • Links to standardized anxiety screening tools can be found in Chapter 5 of this manual. |

OASIS Item Guidance

Neuro/Emotional/Behavioral Status

| OASIS ITEM | | | | | | | | | | | | | | | | | | | | | | | |
|--|----------------------------|-------------------------------|---|--|-----------------------------|---------|-------------------------|-------------------------------|---|--|-----------------------------|--|----------------------------|----------------------------|----------------------------|----------------------------|--------------------------|--|----------------------------|----------------------------|----------------------------|----------------------------|--------------------------|
| <p>(M1730) Depression Screening: Has the patient been screened for depression, using a standardized depression screening tool?</p> <p><input type="checkbox"/> 0 - No</p> <p><input type="checkbox"/> 1 - Yes, patient was screened using the PHQ-2©* scale. (Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems")</p> <table border="1"> <thead> <tr> <th>PHQ-2©*</th> <th>Not at all 0 - 1 day</th> <th>Several days 2 - 6 days</th> <th>More than half of the days 7 - 11 days</th> <th>Nearly every day 12 - 14 days</th> <th>N/A Unable to respond</th> </tr> </thead> <tbody> <tr> <td>a) Little interest or pleasure in doing things</td> <td><input type="checkbox"/> 0</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 3</td> <td><input type="checkbox"/></td> </tr> <tr> <td>b) Feeling down, depressed, or hopeless?</td> <td><input type="checkbox"/> 0</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 3</td> <td><input type="checkbox"/></td> </tr> </tbody> </table> <p><input type="checkbox"/> 2 - Yes, with a different standardized assessment-and the patient meets criteria for further evaluation for depression.</p> <p><input type="checkbox"/> 3 - Yes, patient was screened with a different standardized assessment-and the patient does not meet criteria for further evaluation for depression.</p> <p><i>* Copyright© Pfizer Inc. All rights reserved. Reproduced with permission.</i></p> | | | | | | PHQ-2©* | 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 | N/A 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"/> | 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"/> |
| PHQ-2©* | 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 | N/A 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"/> | | | | | | | | | | | | | | | | | | |
| 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"/> | | | | | | | | | | | | | | | | | | |
| ITEM INTENT | | | | | | | | | | | | | | | | | | | | | | | |
| <p>Identifies if the home health agency screened the patient for depression using a standardized depression screening tool. CMS <u>does not mandate</u> that clinicians conduct depression screening for all patients, nor is there a mandate for the use of the PHQ-2© or any other particular standardized tool. This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.</p> | | | | | | | | | | | | | | | | | | | | | | | |
| TIME POINTS ITEM(S) COMPLETED | | | | | | | | | | | | | | | | | | | | | | | |
| <p>Start of care</p> <p>Resumption of care</p> | | | | | | | | | | | | | | | | | | | | | | | |
| RESPONSE—SPECIFIC INSTRUCTIONS | | | | | | | | | | | | | | | | | | | | | | | |
| <ul style="list-style-type: none"> • Depressive feelings, symptoms, and/or behaviors may be observed by the clinician or reported by the patient, family, or others. • If a standardized depression screening tool is used, use the scoring parameters specified for the tool to identify if a patient meets criteria for further evaluation of depression. • Select Response 0 if a <u>standardized</u> depression screening was not conducted. • Select Response 1 if the PHQ-2© is completed when responding to the question. (The results for rows a & b are for agency use only and will not be encoded and transmitted with OASIS data.) If the patient/caregiver scores three points or more on the PHQ-2©, then further depression screening is indicated. • Select Response 2 if the patient is screened with a different standardized assessment AND the tool indicated the need for further evaluation. • Select Response 3 if the patient is screened with a different standardized assessment BUT the tool indicates no need for further evaluation. | | | | | | | | | | | | | | | | | | | | | | | |

OASIS Item Guidance**Neuro/Emotional/Behavioral Status****DATA SOURCES / RESOURCES (cont'd for OASIS Item M1730)**

- Patient/caregiver interview
- Observation
- Physical assessment
- Referral information
- Physician
- A link with more information on the PHQ-2© can be found in Chapter 5 of this manual.
- There are many depression screening tools available. Links to several tools can be found in Chapter 5 of this manual.

OASIS Item Guidance

Neuro/Emotional/Behavioral Status

| OASIS ITEM |
|---|
| <p>(M1740) Cognitive, behavioral, and psychiatric symptoms that are demonstrated <u>at least once a week</u> (Reported or Observed): (Mark all that apply.)</p> <ul style="list-style-type: none"> <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 (e.g., 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 |
| ITEM INTENT |
| Identifies specific behaviors associated with significant neurological, developmental, behavioral or psychiatric disorders. |
| TIME POINTS ITEM(S) COMPLETED |
| Start of care Resumption of care Discharge from agency - not to an inpatient facility |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Behaviors may be observed by the clinician or reported by the patient, family, or others. • Include behaviors which are severe enough to <ul style="list-style-type: none"> - make the patient unsafe to self or others, - cause considerable stress to the caregivers, or - require supervision or intervention. • If Response 7 is selected, none of the other responses should be selected. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Observation • Physical assessment • Referral information • Physician • Links to standardized cognitive screening tools can be found in Chapter 5 of this manual. |

OASIS Item Guidance

Neuro/Emotional/Behavioral Status

| OASIS ITEM |
|--|
| <p>(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.</p> <p> <input type="checkbox"/> 0 - Never <input type="checkbox"/> 1 - Less than once a month <input type="checkbox"/> 2 - Once a month <input type="checkbox"/> 3 - Several times each month <input type="checkbox"/> 4 - Several times a week <input type="checkbox"/> 5 - At least daily </p> |
| ITEM INTENT |
| Identifies frequency of any behaviors that are disruptive or dangerous to the patient or the caregivers. |
| TIME POINTS ITEM(S) COMPLETED |
| Start of care Resumption of care Discharge from agency - not to an inpatient facility |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> ● Consider if the patient has any problematic behaviors – not just the behaviors listed in M1740 – which jeopardize or could jeopardize the safety and well-being of the patient or caregiver. Then consider how frequently these behaviors occur. ● Include behaviors considered symptomatic of neurological, cognitive, behavioral, developmental, or psychiatric disorders. Use clinical judgment to determine if the degree of the behavior is disruptive or dangerous to the patient or caregiver. ● Behaviors can be observed by the clinician or reported by the patient, family, or others. ● Examples of disruptive/dangerous behaviors include sleeplessness, “sun-downing,” agitation, wandering, aggression, combativeness, getting lost in familiar places, etc. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> ● Patient/caregiver interview ● Observation ● Physical assessment ● Referral information ● Review of past health history ● Physician ● Links to additional information sources can be found in Chapter 5 of this manual. |

OASIS Item Guidance

Neuro/Emotional/Behavioral Status

| OASIS ITEM |
|---|
| <p>(M1750) Is this patient receiving Psychiatric Nursing Services at home provided by a qualified psychiatric nurse?</p> <p><input type="checkbox"/> 0 - No</p> <p><input type="checkbox"/> 1 - Yes</p> |
| ITEM INTENT |
| <p>Identifies whether the patient is receiving psychiatric nursing services at home as provided by a qualified psychiatric nurse. "Psychiatric nursing services" address mental/emotional needs; a "qualified psychiatric nurse" is so qualified through educational preparation, certification, or experience.</p> |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Start of care</p> <p>Resumption of care</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Observation • Referral information • Physician orders/plan of care • Clinical record • HHAs may elect to reference Section 40.1.2.15 of Chapter 7 in the Medicare Benefit Policy Manual for additional information |

OASIS Item Guidance

ADLs / IADLs

| OASIS ITEM | |
|---|--|
| <p>(M1800) Grooming: Current ability to tend safely to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care).</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods. <input type="checkbox"/> 1 - Grooming utensils must be placed within reach before able to complete grooming activities. <input type="checkbox"/> 2 - Someone must assist the patient to groom self. <input type="checkbox"/> 3 - Patient depends entirely upon someone else for grooming needs. | |
| ITEM INTENT | |
| <p>Identifies the patient's ability to tend to personal hygiene needs, excluding bathing, shampooing hair, and toileting hygiene.</p> <p>The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely perform grooming, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:</p> <ul style="list-style-type: none"> - physical impairments (e.g., limited range of motion, impaired balance) - emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear) - sensory impairments, (e.g., impaired vision or pain) - environmental barriers (e.g., accessing grooming aids, mirror and sink). | |
| TIME POINTS ITEM(S) COMPLETED | |
| <p>Start of care</p> <p>Resumption of care</p> <p>Discharge from agency – not to an inpatient facility</p> | |
| RESPONSE—SPECIFIC INSTRUCTIONS | |
| <ul style="list-style-type: none"> • The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is <i>able to do</i> on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration. • The grooming scale presents the most independent level first, then proceeds to the most dependent. Read each response carefully to determine which one best describes what the patient is currently able to do. • Grooming includes several activities. The frequency with which selected activities are necessary (i.e., washing face and hands vs. fingernail care) must be considered in responding. Patients able to do more frequently performed activities (e.g. washing hands and face) but unable to do less frequently performed activities (trimming fingernails) should be considered to have more ability in grooming. • In cases where a patient's ability is different for various grooming tasks, select the response that best describes the patient's level of ability to perform the majority of grooming tasks. • Response 2 includes standby assistance or verbal cueing. | |
| DATA SOURCES / RESOURCES | |
| <ul style="list-style-type: none"> • Observation/demonstration is the preferred method • Patient/caregiver interview • Physical assessment • Environmental assessment | |

OASIS-C Item Guidance

ADLs / IADLs

| OASIS ITEM |
|---|
| <p>(M1810) Current Ability to Dress Upper Body safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance. <input type="checkbox"/> 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient. <input type="checkbox"/> 2 - Someone must help the patient put on upper body clothing. <input type="checkbox"/> 3 - Patient depends entirely upon another person to dress the upper body. |
| ITEM INTENT |
| <p>Identifies the patient's ability to dress upper body, including the ability to obtain, put on and remove upper body clothing. Assess ability to put on whatever clothing is routinely worn. This specifically includes the ability to manage zippers, buttons, and snaps if these are routinely worn.</p> <p>The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely dress the upper body, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:</p> <ul style="list-style-type: none"> - physical impairments (e.g., limited range of motion, impaired balance) - emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear) - sensory impairments, (e.g., impaired vision or pain) - environmental barriers (e.g., stairs, narrow doorways, location of bathroom or laundry). |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Start of care</p> <p>Resumption of care</p> <p>Follow-up</p> <p>Discharge from agency - not to an inpatient facility</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Prosthetic, orthotic, or other support devices applied to the upper body (e.g., upper extremity prosthesis, cervical collar, or arm sling) should be considered as upper body dressing items. • The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is <i>able to do</i> on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration. • The ability to dress upper body scale presents the most independent level first then proceeds to the most dependent. Read each response carefully to determine which one best describes what the patient is able to do. • In cases where a patient's ability is different for various dressing upper body tasks, pick the response that best describes the patient's level of ability to perform the majority of dressing upper body tasks. • If the patient requires standby assistance (a "spotter") to dress <u>safely</u> or requires verbal cueing/reminders, select Response 2. |

OASIS-C Item Guidance**ADLs / IADLs**

| RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1810) |
|--|
| <ul style="list-style-type: none"> • Assessment strategies: A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient if he/she has difficulty dressing upper body. Observe the patient's general appearance and clothing to determine if the patient has been able to dress appropriately. Opening and removing upper body garments during the physical assessment of the heart and lung provides an excellent opportunity to evaluate the upper extremity range of motion, coordination, and manual dexterity needed for dressing. The patient can also be asked to demonstrate the body motions involved in dressing. Assess ability to put on whatever clothing is routinely worn. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Observation • Patient/caregiver interview • Physical assessment • Environmental assessment |

OASIS-C Item Guidance

ADLs / IADLs

| OASIS ITEM |
|---|
| <p>(M1820) Current Ability to Dress Lower Body safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0 - Able to obtain, put on, and remove clothing and shoes without assistance. <input type="checkbox"/> 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient. <input type="checkbox"/> 2 - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes. <input type="checkbox"/> 3 - Patient depends entirely upon another person to dress lower body. |
| ITEM INTENT |
| <p>Identifies the patient's ability to dress lower body, including the ability to obtain, put on and remove lower body clothing. Assess ability to put on whatever clothing is routinely worn.</p> <p>The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely dress the lower body, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:</p> <ul style="list-style-type: none"> - physical impairments (e.g., limited range of motion, impaired balance), - emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear), - sensory impairments, (e.g., impaired vision or pain), - environmental barriers (e.g., stairs, narrow doorways, location of bathroom or laundry). |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Start of care</p> <p>Resumption of care</p> <p>Follow-up</p> <p>Discharge from agency - not to an inpatient facility</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Prosthetic, orthotic, or other support devices applied to the lower body (e.g., lower extremity prosthesis, ankle-foot orthosis [AFO], or TED hose) should be considered as lower body dressing items. • The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is <i>able to do</i> on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration. • The ability to dress lower body scale presents the most independent level first, then proceeds to the most dependent. Read each response carefully to determine which one best describes what the patient is able to do. • In cases where a patient's ability is different for various dressing lower body tasks, pick the response that best describes the patient's level of ability to perform the majority of dressing lower body tasks. • If the patient requires standby assistance (a "spotter") to dress <u>safely</u> or verbal cueing/reminders, select Response 2. • Assessment strategies: A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. The patient can report the lower body dressing procedure. Observe spinal flexion, joint range of motion, shoulder and upper arm strength, and manual dexterity during the assessment. Ask the patient to demonstrate the body motions involved in dressing. Assess ability to put on whatever clothing is routinely worn. |

OASIS-C Item Guidance**ADLs / IADLs****DATA SOURCES / RESOURCES (cont'd for OASIS Item M1820)**

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

OASIS-C Item Guidance

ADLs / IADLs

| OASIS ITEM |
|---|
| <p>(M1830) Bathing: Current ability to wash entire body safely. <u>Excludes grooming (washing face and hands and shampooing hair only).</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> 0 - Able to bathe self in <u>shower or tub</u> independently, including getting in and out of tub/shower. <input type="checkbox"/> 1 - With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower. <input type="checkbox"/> 2 - Able to bathe in shower or tub with the intermittent assistance of another person: <ul style="list-style-type: none"> (a) for intermittent supervision or encouragement or reminders, <u>OR</u> (b) to get in and out of the shower or tub, <u>OR</u> (c) for washing difficult to reach areas. <input type="checkbox"/> 3 - Able to participate in bathing self in shower or tub, <u>but</u> requires presence of another person throughout the bath for assistance or supervision. <input type="checkbox"/> 4 - Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode. <input type="checkbox"/> 5 - Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person throughout the bath. <input type="checkbox"/> 6 - Unable to participate effectively in bathing and is bathed totally by another person. |
| ITEM INTENT |
| <p>Identifies the patient's ability to bathe entire body and the assistance that may be required to <u>safely</u> bathe, including transferring in/out of the tub/shower. The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely bathe, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:</p> <ul style="list-style-type: none"> - physical impairments (e.g., limited range of motion, impaired balance), - emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear), - sensory impairments, (e.g., impaired vision or pain), - environmental barriers (e.g., stairs, narrow doorways, location of bathroom or laundry). |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Start of care</p> <p>Resumption of care</p> <p>Follow-up</p> <p>Discharge from agency - not to an inpatient facility</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Specifically excludes washing face and hands, and shampooing hair. • The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is <i>able to do</i> on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration. • The bathing scale presents the most independent level first, then proceeds to the most dependent. Read each response carefully to determine which one best describes what the patient is able to do. • If the patient requires standby assistance to bathe <u>safely</u> in the tub or shower or requires verbal cueing/reminders, then select Response 2 or Response 3, depending on whether the assistance needed is intermittent ("2") or continuous ("3"). |

OASIS-C Item Guidance

ADLs / IADLs

| RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1830) |
|---|
| <ul style="list-style-type: none"> • If the patient's ability to transfer into/out of the tub or shower is the <u>only</u> bathing task requiring human assistance, select Response 2. If a patient requires one, two, or all three of the types of assistance listed in Response 2 of M1830 but not the continuous presence of another person as noted in Response 3, then Response 2 is the best response. • If a patient is medically restricted from stair climbing, and the only tub/shower requires climbing stairs, the patient is temporarily unable to bathe in the tub or shower due to combined medical restrictions and environmental barriers. Responses 4, 5, or 6 would apply, depending on the patient's ability to participate in bathing activities. For Response 4, the patient must be able to safely and independently bathe outside the tub/shower, including independently accessing water at the sink, or setting up basin at the bedside, etc. For Response 5, the patient must be unable to bathe in the tub/shower, can participate in bathing self but needs assistance. • If the patient does not have a tub or shower in the home, or if the tub/shower is nonfunctioning or not safe for patient use, the patient should be considered unable to bathe in the tub or shower, select Response 4 or 5, based on the patient's ability to bathe outside the tub/shower. The patient's status should not be based on an assumption of a patient's ability to perform a task with equipment they do not currently have. • If the patient is totally unable to participate in bathing and is totally bathed by another person, select Response 6 regardless of where bathing occurs or if patient has a functioning tub or shower. • Assessment strategies: A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient what type of assistance is needed to wash entire body in tub or shower. Observe the patient's general appearance to determine if the patient has been able to bathe self as needed. Observe patient actually stepping into shower or tub to determine how much assistance the patient needs to perform the activity safely. The patient who only performs a sponge bath may be able to bathe in the tub or shower if person or device is available to assist. Evaluate the amount of assistance needed for the patient to be able to <u>safely</u> bathe in tub or shower. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Observation/demonstration is the preferred method. • Patient/caregiver interview • Physical assessment • Environmental assessment |

OASIS-C Item Guidance

ADLs / IADLs

| OASIS ITEM |
|---|
| <p>(M1840) Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely <u>and</u> transfer on and off toilet/commode.</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0 - Able to get to and from the toilet and transfer independently with or without a device. <input type="checkbox"/> 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer. <input type="checkbox"/> 2 - <u>Unable</u> to get to and from the toilet but is able to use a bedside commode (with or without assistance). <input type="checkbox"/> 3 - <u>Unable</u> to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently. <input type="checkbox"/> 4 - Is totally dependent in toileting. |
| ITEM INTENT |
| <p>Identifies the patient's ability to <u>safely</u> get to and from and transfer on and off the toilet or bedside commode.</p> <p>The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely perform toilet transferring, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:</p> <ul style="list-style-type: none"> - physical impairments (e.g., limited range of motion, impaired balance), - emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear), - sensory impairments, (e.g., impaired vision or pain), - environmental barriers (e.g., stairs, narrow doorways, location of bathroom). |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Start of care</p> <p>Resumption of care</p> <p>Follow-up</p> <p>Discharge from agency - not to an inpatient facility</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Excludes personal hygiene and management of clothing when toileting. • The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is <i>able to do</i> on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration. • The toilet transferring scale presents the most optimal level first, then proceeds to less optimal toileting methods. Read each response carefully to determine which one best describes what the patient is able to do. • If the patient can get to and from the toilet during the day independently, but uses the commode at night for convenience, select Response 0. • If the patient requires standby assistance to get to and from the toilet <u>safely</u> or requires verbal cueing/reminders, select Response 1. • If the patient needs assistance getting to/from the toilet or with toileting transfer or both, then Response 1 is the best option. • A patient who can independently get to the toilet, but who requires assistance to get on and off the toilet would be scored as a "1." |

OASIS-C Item Guidance**ADLs / IADLs**

| RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1840) |
|---|
| <ul style="list-style-type: none"> • A patient who is unable to get to/from the toilet or bedside commode, but is able to place and remove a bedpan/urinal independently, should be marked Response 3. This is the best response whether or not a patient requires assistance to empty the bedpan/urinal. • Assessment Strategies: A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient if he/she has any difficulty getting to and from the toilet or bedside commode. Observe the patient during transfer and ambulation to determine if the patient has difficulty with balance, strength, dexterity, pain, etc. Determine the level of assistance needed by the patient to <u>safely</u> use the toilet or commode. Tasks related to personal hygiene and management of clothing are not considered when responding to this item. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Observation/demonstration is the preferred method. • Patient/caregiver interview • Physical assessment • Environmental assessment |

OASIS-C Item Guidance

ADLs / IADLs

| OASIS ITEM |
|--|
| <p>(M1845) Toileting Hygiene: Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0 - Able to manage toileting hygiene and clothing management without assistance. <input type="checkbox"/> 1 - Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient. <input type="checkbox"/> 2 - Someone must help the patient to maintain toileting hygiene and/or adjust clothing. <input type="checkbox"/> 3 - Patient depends entirely upon another person to maintain toileting hygiene. |
| ITEM INTENT |
| <p>Identifies the patient's ability to manage personal hygiene and clothing when toileting.</p> <p>The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely perform toileting hygiene, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:</p> <ul style="list-style-type: none"> - physical impairments (e.g., limited range of motion, impaired balance), - emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear), - sensory impairments, (e.g., impaired vision or pain), - environmental barriers (e.g., stairs, narrow doorways, location of bathroom or laundry). |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Start of care Resumption of care Follow-up Discharge from agency - not to an inpatient facility</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Toileting hygiene includes several activities, including pulling clothes up or down and adequately cleaning (wiping) the perineal area. • The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is <i>able to do</i> on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration. • The toileting hygiene scale presents the most independent level first, then proceeds to the most dependent. Read each response carefully to determine which one best describes what the patient is able to do. • This item refers the patient's ability to manage personal hygiene and clothing with or without assistive devices. The word "assistance" in this question refers to assistance from another person by verbal cueing/reminders, supervision, and/or stand-by or hands-on assistance. • Select Response 0 if the patient is independent in managing toileting hygiene and managing clothing. • Select Response 1 if the patient is able to manage toileting hygiene and manage clothing IF supplies are laid out for the patient. |

OASIS-C Item Guidance**ADLs / IADLs**

| RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1845) |
|--|
| <ul style="list-style-type: none">• If the patient can participate in hygiene and/or clothing management but needs some assistance with either or both activities, select Response 2.• Response 2 includes standby assistance or verbal cueing. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none">• Observation/demonstration is the preferred method• Patient/caregiver interview• Physical assessment• Environmental assessment |

OASIS-C Item Guidance

ADLs / IADLs

| OASIS ITEM |
|--|
| <p>(M1850) Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0 - Able to independently transfer. <input type="checkbox"/> 1 - Able to transfer with minimal human assistance or with use of an assistive device. <input type="checkbox"/> 2 - Able to bear weight and pivot during the transfer process but unable to transfer self. <input type="checkbox"/> 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person. <input type="checkbox"/> 4 - Bedfast, unable to transfer but is able to turn and position self in bed. <input type="checkbox"/> 5 - Bedfast, unable to transfer and is unable to turn and position self. |
| ITEM INTENT |
| <p>Identifies the patient's ability to <u>safely</u> transfer from bed to chair, or position self in bed if bedfast.</p> <p>The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely transfer, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:</p> <ul style="list-style-type: none"> - physical impairments (e.g., limited range of motion, impaired balance), - emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear), - sensory impairments, (e.g., impaired vision or pain), - Environmental barriers (e.g., stairs, narrow doorways, location of bathroom or laundry). |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Start of care</p> <p>Resumption of care</p> <p>Follow-up</p> <p>Discharge from agency - not to an inpatient facility</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • For most patients, the bed to chair transfer will include transferring from a supine position in bed to a sitting position at the bedside, then some type of standing, stand-pivot or sliding board transfer to a chair. • The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is <i>able to do</i> on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration. • The transferring scale presents the most optimal level first, then proceeds to less optimal levels of transferring. Read each response carefully to determine which one best describes what the patient is able to do. • Able to bear weight refers to the patient's ability to support the majority of his/her body weight through any combination of weight-bearing extremities (e.g., a patient with a weight-bearing restriction of one lower extremity may be able to support his/her entire weight through the other lower extremity and upper extremities). • If the patient is able to transfer self from bed to chair, but requires standby assistance to transfer <u>safely</u>, or requires verbal cueing/reminders, select Response 1. • For response 1, "minimal human assistance" could include any combination of verbal cueing, environmental set-up, and/or actual hands-on assistance. |

OASIS-C Item Guidance

ADLs / IADLs

| RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1850) |
|--|
| <ul style="list-style-type: none"> • If the patient transfers either with minimal human assistance (but not device), or with the use of a device (but no human assistance), select Response 1. If the patient requires both minimal human assistance and an assistive device to transfer safely, select Response 2. • If the patient can bear weight and pivot, but requires more than minimal human assist, Response 2 should be marked. • The patient must be able to <u>both</u> bear weight and pivot for Response 2 to apply. If the patient is unable to do one or the other and is not bedfast, select Response 3. • If the patient is bedfast, select Response 4 or 5, depending on the patient's ability to turn and position self in bed. Bedfast refers to being confined to the bed, either per physician restriction or due to a patient's inability to tolerate being out of the bed. • Assessment strategies: A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about transferring ability. Taking extra time or pushing up with both arms can help ensure the patient's stability and safety during the transfer process, but they do not mean that the patient is not independent. Observe the patient during transfers and determine the amount of assistance required for <u>safe</u> transfer from bed to chair. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Observation/demonstration is the preferred method • Patient/caregiver interview • Physical assessment • Environmental assessment |

OASIS-C Item Guidance

ADLs / IADLs

| OASIS ITEM |
|---|
| <p>(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device). <input type="checkbox"/> 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings. <input type="checkbox"/> 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces. <input type="checkbox"/> 3 - Able to walk only with the supervision or assistance of another person at all times. <input type="checkbox"/> 4 - Chairfast, <u>unable</u> to ambulate but is able to wheel self independently. <input type="checkbox"/> 5 - Chairfast, <u>unable</u> to ambulate and is <u>unable</u> to wheel self. <input type="checkbox"/> 6 - Bedfast, unable to ambulate or be up in a chair. |
| ITEM INTENT |
| <p>Identifies the patient's ability and the type of assistance required to <u>safely</u> ambulate or propel self in a wheelchair over a variety of surfaces. The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely ambulate/locomote, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:</p> <ul style="list-style-type: none"> - physical impairments (e.g., limited range of motion, impaired balance), - emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear), - sensory impairments, (e.g., impaired vision or pain), - environmental barriers (e.g., stairs, narrow doorways, location of bathroom or laundry). |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Start of care Resumption of care Follow-up Discharge from agency - not to an inpatient facility</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Variety of surfaces refers to typical surfaces that the patient would routinely encounter in his/her environment, and may vary based on the individual residence. • The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is <i>able to do</i> on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration. • The ambulation/locomotion scale presents the most optimal level first, then proceeds to less optimal mobility abilities. Read each response carefully to determine which one best describes what the patient is able to do. • Regardless of the need for an assistive device, if the patient requires human assistance (hands on, supervision and/or verbal cueing) to <u>safely</u> ambulate, select Response 2 or Response 3, depending on whether the assistance required is intermittent ("2") or continuous ("3"). • If the patient is safely able to ambulate without a device on a level surface, but requires minimal assistance on stairs, steps and uneven surfaces, then Response 2 is the best response (requires human supervision or assistance to negotiate stairs or steps or uneven surfaces). |

OASIS-C Item Guidance

ADLs / IADLs

| RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1860) |
|--|
| <ul style="list-style-type: none"> • If a patient does not require human assistance, but safely ambulates with a walker in some areas of the home, and a cane in other areas (due to space limitations, distances, etc.), select the response that reflects the device that best supports safe ambulation on all surfaces the patient routinely encounters (e.g., Response 2 is appropriate if a walker is required for safe ambulation in the hallway and living room, even if there are some situations in the home where a cane provides adequate support.) • If a patient does not have a walking device but is clearly not safe walking alone, select Response 3, able to walk only with the supervision or assistance should be reported, unless the patient is chairfast. • Responses 4 and 5 refer to a patient who is unable to ambulate, even with the use of assistive devices and/or continuous assistance. A patient who demonstrates or reports ability to take one or two steps to complete a transfer, but is otherwise unable to ambulate should be considered chairfast, and would be scored 4 or 5, based on ability to wheel self. • Assessment strategies: A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about ambulation ability. Observe the patient ambulating across the room or to the bathroom and the type of assistance required. Note if the patient uses furniture or walls for support, and assess if patient should use a walker or cane for safe ambulation. Observe patient's ability and safety on stairs. If chairfast, assess ability to safely propel wheelchair independently, whether the wheelchair is a powered or manual version. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Observation • Patient/caregiver interview • Physical assessment • Environmental assessment |

OASIS-C Item Guidance

ADLs / IADLs

| OASIS ITEM |
|--|
| <p>(M1870) Feeding or Eating: Current ability to feed self meals and snacks safely. Note: This refers only to the process of <u>eating</u>, <u>chewing</u>, and <u>swallowing</u>, <u>not preparing</u> the food to be eaten.</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0 - Able to independently feed self. <input type="checkbox"/> 1 - Able to feed self independently but requires: <ul style="list-style-type: none"> (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. <input type="checkbox"/> 2 - <u>Unable</u> to feed self and must be assisted or supervised throughout the meal/snack. <input type="checkbox"/> 3 - Able to take in nutrients orally <u>and</u> receives supplemental nutrients through a nasogastric tube or gastrostomy. <input type="checkbox"/> 4 - <u>Unable</u> to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy. <input type="checkbox"/> 5 - Unable to take in nutrients orally or by tube feeding. |
| ITEM INTENT |
| <p>Identifies the patient's ability to feed him/herself, including the process of eating, chewing, and swallowing food.</p> <p>The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely self-feed, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:</p> <ul style="list-style-type: none"> - physical impairments (e.g., limited range of motion, impaired balance), - emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear), - sensory impairments, (e.g., impaired vision or hearing, pain), - environmental barriers (e.g., stairs, narrow doorways, location of bathroom or laundry). |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Start of care</p> <p>Resumption of care</p> <p>Discharge from agency - not to an inpatient facility</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • This item <u>excludes</u> evaluation of the preparation of food items, and transport to the table. Respond to this item based on the assistance needed by the patient to feed himself once the food is placed in front of him. Assistance means human assistance by verbal cueing/reminders, supervision, and/or stand-by or hands-on assistance. • The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is <i>able to do</i> on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration. • The feeding/eating scale presents the most optimal level first, then proceeds to less optimal feeding/eating abilities. Read each response carefully to determine which one best describes what the patient is able to do. • Meal "set-up" (Response 1) includes activities such as mashing a potato, cutting up meat/vegetables when served, pouring milk on cereal, opening a milk carton, adding sugar to coffee or tea, arranging the food on the plate for ease of access, etc. -- all of which are special adaptations of the meal for the patient. • Responses 4 and 5 include non-oral intake. |

OASIS-C Item Guidance**ADLs / IADLs****RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1870)**

- If a tube is being used to provide all or some nutrition, select Responses 3 or 4, depending on the patient's ability to take in nutrients orally. If a patient is being weaned from tube feeding, Responses 3 or 4 will continue to apply until the patient no longer uses the tube for nutrition, at which time, select Responses 0, 1, or 2. This is true, even if the tube remains in place, unused for a period of time.
- Response 5 is the best response for patients who are not able to take in nutrients orally or by tube feeding. This may be the case for patients who receive all nutrition intravenously (e.g. TPN) or for patients who are only receiving intravenous hydration.

DATA SOURCES / RESOURCES

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Nutritional assessment
- Physician orders
- Plan of care
- Referral information
- Review of past health history
- Environmental assessment

OASIS-C Item Guidance

ADLs / IADLs

| OASIS ITEM |
|---|
| <p>(M1880) Current Ability to Plan and Prepare Light Meals (e.g., cereal, sandwich) or reheat delivered meals safely:</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; <u>OR</u> (b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission). <input type="checkbox"/> 1 - <u>Unable</u> to prepare light meals on a regular basis due to physical, cognitive, or mental limitations. <input type="checkbox"/> 2 - Unable to prepare any light meals or reheat any delivered meals. |
| ITEM INTENT |
| <p>Identifies the patient's physical, cognitive, and mental ability to plan and prepare meals, even if the patient does not routinely perform this task.</p> <p>The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely perform light meal planning and preparation, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform IADLs. Ability can be temporarily or permanently limited by:</p> <ul style="list-style-type: none"> - physical impairments (e.g., limited range of motion, impaired balance), - emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear), - sensory impairments, (e.g., impaired vision, pain), - environmental barriers (e.g., stairs, narrow doorways). |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Start of care</p> <p>Resumption of care</p> <p>Discharge from agency - not to an inpatient facility</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is <i>able to do</i> on the day of the assessment. • In cases where a patient's ability is different for various light meal preparation tasks, pick the response that best describes the patient's level of ability to perform the majority of light meal preparation tasks • Response 0 indicates that during the day of assessment, the patient has the consistent physical and cognitive ability to plan and prepare meals. • Response 1 indicates that during the day of assessment, the patient has inconsistent ability to prepare light meals (e.g., can't prepare breakfast due to morning arthritic stiffness, but can prepare other meals throughout day). • Response 2 indicates patient does not have the ability to prepare light meals at any point during the day of assessment. • While nutritional appropriateness of the patient's food selections is not the focus of this item, any prescribed diet requirements (and related planning/preparation) should be considered when selecting a response. • When a patient's prescribed diet consists either partially or completely of enteral nutrition, the clinician must assess the patient's ability to plan and prepare their prescribed diet, including their knowledge of the feeding amount and ability to prepare the enteral feeding, based on product used. Note that the ability to set up, monitor and change the feeding equipment is excluded from M1880, as it is addressed on row "e" of M2100. |

OASIS-C Item Guidance**ADLs / IADLs****DATA SOURCES / RESOURCES (cont'd for OASIS Item M1880)**

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Nutritional assessment
- Environmental assessment

OASIS-C Item Guidance

ADLs / IADLs

| OASIS ITEM | |
|--|---|
| <p>(M1890) Ability to Use Telephone: Current ability to answer the phone safely, including dialing numbers, and <u>effectively</u> using the telephone to communicate.</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0 - Able to dial numbers and answer calls appropriately and as desired. <input type="checkbox"/> 1 - Able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers. <input type="checkbox"/> 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls. <input type="checkbox"/> 3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation. <input type="checkbox"/> 4 - <u>Unable</u> to answer the telephone at all but can listen if assisted with equipment. <input type="checkbox"/> 5 - Totally unable to use the telephone. <input type="checkbox"/> NA - Patient does not have a telephone. | |
| ITEM INTENT | |
| <p>Identifies the ability of the patient to answer the phone, dial number, and effectively use the telephone to communicate.</p> <p>The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely use the telephone, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform IADLs. Ability can be temporarily or permanently limited by:</p> <ul style="list-style-type: none"> - physical impairments (e.g., limited range of motion, impaired balance), - emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear), - sensory impairments, (e.g., impaired vision or hearing, pain), - environmental barriers (e.g., stairs, narrow doorways). | |
| TIME POINTS ITEM(S) COMPLETED | |
| <p>Start of care</p> <p>Resumption of care</p> <p>Discharge from agency - not to an inpatient facility</p> | |
| RESPONSE—SPECIFIC INSTRUCTIONS | |
| <ul style="list-style-type: none"> • The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is <i>able to do</i> on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration. • The telephone use scale presents the most independent level first, then proceeds to the most dependent. Read each response carefully to determine which one best describes what the patient is able to do. • Ability to use telephone identifies the patient's ability to safely answer the phone, dial a number and effectively use the telephone to communicate. If a speech impaired patient can only communicate using a phone equipped with texting functionality, Response "1" able to use a specially adapted telephone would be selected. | |
| DATA SOURCES / RESOURCES | |
| <ul style="list-style-type: none"> • Observation/demonstration is the preferred method • Patient/caregiver interview | <ul style="list-style-type: none"> • Physical assessment • Environmental assessment |

OASIS-C Item Guidance

ADLs / IADLs

| OASIS ITEM | | | | |
|---|--|--------------------------|--------------------------|--------------------------|
| <p>(M1900) Prior Functioning ADL/IADL: Indicate the patient's usual ability with everyday activities prior to this current illness, exacerbation, or injury. Check only one box in each row.</p> | | | | |
| | Functional Area | Independent | Needed Some Help | Dependent |
| a. | Self-Care (e.g., grooming, dressing, and bathing) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. | Ambulation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. | Transfer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. | Household tasks (e.g., light meal preparation, laundry, shopping) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ITEM INTENT | | | | |
| <p>Identifies changes that have occurred in the patient's ability to perform ADL and IADL activities since the onset of the current illness, exacerbation of a chronic condition, or injury (whichever is most recent) that initiated this episode of care. The intent of the item is to identify the patient's prior ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. This item is used for risk adjustment and can be helpful for setting realistic goals for the patient.</p> | | | | |
| TIME POINTS ITEM(S) COMPLETED | | | | |
| <p>Start of Care Resumption of Care</p> | | | | |
| RESPONSE—SPECIFIC INSTRUCTIONS | | | | |
| <ul style="list-style-type: none"> For each functional area, select a response. "Independent" means that the patient had the ability to complete the activity by him/herself (with or without assistive devices) without physical or verbal assistance from a helper. "Needed some help" means that the patient contributed effort but required help from another person to accomplish the task/activity safely. "Dependent" means that the patient was physically and/or cognitively unable to contribute effort toward completion of the task, and the helper must contribute all the effort. "Self-care" refers specifically grooming, dressing, bathing, and toileting hygiene. Medication management is not included in the definition of self-care for M1900 as it is addressed in a separate question (M2040) "Ambulation" refers to walking (with or without assistive device). Wheelchair mobility is not directly addressed in this item. A patient who is unable to ambulate safely (even with devices and/or assistance), but is able to use a wheelchair (with or without assistance) would be reported as "Dependent" in Ambulation for M1900. "Transfer" refers specifically to tub, shower, commode, and bed to chair transfers. "Household tasks" refers specifically to light meal preparation, laundry, shopping, and phone use. If the patient was previously independent in some self-care tasks (or some transfers, or some household tasks), but needed help or was completely dependent in others, pick the response that best describes the patient's level of ability to perform the majority of included tasks. | | | | |
| DATA SOURCES / RESOURCES | | | | |
| <ul style="list-style-type: none"> Patient/caregiver interview Referral information Review of past health history Physician | | | | |

OASIS-C Item Guidance

ADLs / IADLs

| OASIS ITEM |
|---|
| <p>(M1910) Has this patient had a multi-factor Fall Risk Assessment (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)?</p> <p><input type="checkbox"/> 0 - No multi-factor falls risk assessment conducted.</p> <p><input type="checkbox"/> 1 - Yes, and it does not indicate a risk for falls.</p> <p><input type="checkbox"/> 2 - Yes, and it indicates a risk for falls.</p> |
| ITEM INTENT |
| <p>Identifies whether the home health agency has assessed the patient and home environment for characteristics that place the patient at risk for falls. Patients under the age of 65 will be excluded from the denominator of the publicly reported measure. Falls assessment tool used must be appropriately validated for home care geriatric patients.</p> <p>This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation</p> |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Start of Care</p> <p>Resumption of Care</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • CMS does not mandate that clinicians conduct falls risk screening for all patients, nor is there a mandate for the use of standardized tools. If a standardized falls risk screening tool is used, use the scoring parameters specified for the tool to identify if a patient is at risk for falls. If a multi-factor risk assessment is conducted without use of a standardized falls risk tool (i.e., agency-specific falls risk tool), the clinician must use professional judgment in interpreting the findings to identify if the patient is at risk for falls. • For Responses 1 and 2, a multi-factor falls risk assessment may incorporate several tools. For example, a physical performance component (e.g., Timed Up and Go), a medication review, review of patient history of falls, assessment of lower limb function and selected OASIS items (e.g., OASIS items for cognitive status, vision, incontinence, ambulation, transferring). • For Responses 1 and 2, the assessment must have been completed by the home health agency during the CMS-specified time frames for completion of the comprehensive assessment (5 days for SOC; 48 hours following inpatient facility discharge, or knowledge of patient's return home for ROC). • For Responses 1 and 2, the fall risk assessment must have been completed by the clinician completing the SOC or ROC Comprehensive Assessment. • Select Response 0 if: <ul style="list-style-type: none"> - a multi-factor falls risk screening was not conducted by the home health agency, - a multi-factor falls risk screening was conducted by the home health agency but NOT during the required assessment time frame, - a multi-factor falls risk screening was conducted during the assessment time frame, but by someone other than the assessing clinician. |

OASIS-C Item Guidance**ADLs / IADLs****DATA SOURCES / RESOURCES (cont'd for OASIS Item M1910)**

- Observation
- Patient/caregiver interview
- Physical assessment
- Environmental assessment
- Referral information
- Review of past health history
- Several links to guidelines listing fall risk assessment factors can be found in Chapter 5 of this manual.

OASIS Item Guidance

Medications

| OASIS ITEM |
|--|
| <p>(M2000) Drug Regimen Review: Does a complete drug regimen review indicate potential clinically significant medication issues, e.g., drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance?</p> <p><input type="checkbox"/> 0 - Not assessed/reviewed [<i>Go to M2010</i>]</p> <p><input type="checkbox"/> 1 - No problems found during review [<i>Go to M2010</i>]</p> <p><input type="checkbox"/> 2 - Problems found during review</p> <p><input type="checkbox"/> NA - Patient is not taking any medications [<i>Go to M2040</i>]</p> |
| ITEM INTENT |
| <p>Identifies if a review of the patient's medications indicated the presence of potential clinically significant problems. This item captures information for calculation of a process measure to identify best practices related to medications.</p> |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Start of Care</p> <p>Resumption of Care</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> Includes all medications, prescribed and over the counter, administered by any route (e.g. oral, topical, inhalant, pump, injection). If portions of the drug regimen review (e.g., identification of potential drug-drug interactions or potential dosage errors) are completed by agency staff other than the clinician responsible for completing the SOC/ROC OASIS, information on drug regimen review findings must be communicated to the clinician responsible for the SOC/ROC OASIS assessment so that the appropriate response for M2000 may be selected. Collaboration in which the assessing clinician evaluates patient status (e.g., presence of potential ineffective drug therapy or patient noncompliance), and another clinician (in the office) assists with review of the medication list (e.g. for possible duplicate drug therapy or omissions) does not violate the requirement that the comprehensive patient assessment is the responsibility of and must be ultimately completed by one clinician. Agency policy and practice will determine this process and how it is documented. The M0090 date – the date the assessment is completed – would be the date the two clinicians collaborated and the assessment was completed. The definition of a problem for responses 1 and 2 includes the following: <p>Potential clinically significant medication issues which include adverse reactions to medications (e.g., rash), ineffective drug therapy (e.g., analgesic that does not reduce pain), side effects (e.g. potential bleeding from an anticoagulant), drug interactions (e.g., serious drug-drug, drug-food and drug-disease interactions), duplicate therapy (e.g. generic name and brand name drugs that are equivalent both prescribed), omissions (missing drugs from an ordered regimen), dosage errors (e.g., either too high or too low), noncompliance (e.g., regardless of whether the noncompliance is purposeful or accidental) or impairment or decline in an individual's mental or physical condition or functional or psychosocial status.</p> <p>Note: Medication interaction is the impact of another substance (such as another medication, nutritional supplement including herbal products, food, or substances used in diagnostic studies) upon a medication. The interactions may alter absorption, distribution, metabolism, or elimination. These interactions may decrease the effectiveness of the medication or increase the potential for adverse consequences.</p> |

OASIS Item Guidance

Medications

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M2000)

Note: Adverse drug reaction (ADR) is a form of adverse consequences. It may be either a secondary effect of a medication that is usually undesirable and different from the therapeutic effect of the medication or any response to a medication that is noxious and unintended and occurs in doses for prophylaxis, diagnosis, or treatment. The term "side effect" is often used interchangeable with ADR, however, side effects are but one of five ADR categories, the others being hypersensitivity, idiosyncratic response, toxic reactions, and adverse medication interactions. A side effect is an expected, well-known reaction that occurs with a predictable frequency and may or may not constitute an adverse consequence.

In addition to the guidance provided above:

- Select Response 1 – no problems found – when (as applicable) :
 - Patient's list of medications from the inpatient facility discharge instructions matches the medications the patient shows the clinician at the SOC/ROC assessment visit.
 - Assessment shows that diagnoses/symptoms for which patient is taking medications are adequately controlled (as able to be assessed within the clinician's scope of practice).
 - Patient possesses all medications prescribed.
 - Patient has a plan for taking meds safely at the right time.
 - Patient is not showing signs/symptoms that could be adverse reactions caused by medications.
- Select Response 2 – problems found – when (as applicable):
 - Patient's list of medications from the inpatient facility discharge instructions DO NOT match the medications the patient shows the clinician at the SOC/ROC assessment visit.
 - Assessment shows that diagnoses/symptoms for which patient is taking medications are NOT adequately controlled (as able to be assessed within the clinician's scope of practice).
 - Patient seems confused about when/how to take medications indicating a high risk for medication errors.
 - Patient has not obtained medications or indicates that he/she will probably not take prescribed medications because of financial, access, cultural, or other issues with medications.
 - Patient has signs/symptoms that could be adverse reactions from medications.
 - Patient takes multiple non-prescribed medications (OTCs, herbals) that could interact with prescribed meds.
 - Patient has a complex medication plan with meds prescribed by multiple physicians and/or obtained from multiple pharmacies so that the risk of med interactions is high.

DATA SOURCES / RESOURCES

- Patient assessment, specifically the drug regimen review as required by Conditions of Participation (i.e., §484.55)
- Clinical record
- Communication notes
- Medication list
- Discussions with other agency staff responsible for completing drug regimen review
- Since medication issues continue to evolve and new medications are being approved regularly, it is important to refer to a current authoritative source for detailed medication information such as indications and precautions, dosage, monitoring or adverse consequences
- Physician's Drug Reference (PDR) or other clinical medication handbook or software intended to provide warning of severity levels of risk for medication review
- Several online resources for evaluating drug reactions, side effects, interactions, etc., can be found in Chapter 5 of this manual

OASIS Item Guidance

Medications

| OASIS ITEM |
|---|
| <p>(M2002) Medication Follow-up: Was a physician or the physician-designee contacted within one calendar day to resolve clinically significant medication issues, including reconciliation?</p> <p><input type="checkbox"/> 0 - No</p> <p><input type="checkbox"/> 1 - Yes</p> |
| ITEM INTENT |
| <p>Identifies if potential clinically significant problems identified through a medication review were addressed with the physician within one calendar day following identification of medication issue(s).</p> <p>This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.</p> |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Start of Care</p> <p>Resumption of Care</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Complete if Response 2 for M2000 is selected. • Clinically significant medication issues are those that, in the care provider's clinical judgment, pose an actual or potential threat to patient health and safety, such as drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, medication omissions, dosage errors, or nonadherence to prescribed medication regimen. • Contact with physician is defined as communication to the physician made by telephone, voicemail, electronic means, fax, or any other means that appropriately conveys the message of patient status. • Select Response 1 – Yes, only if a physician responds to the agency communication with acknowledgment of receipt of information and/or further advice or instructions. • If the interventions are not completed as outlined in this item, select Response 0 – No. However, in this case, the care provider should document rationale in the clinical record. • If agency staff other than the clinician responsible for completing the SOC/ROC OASIS contacted the physician to follow up on clinically significant medication issues, this information must be communicated to the clinician responsible for the SOC/ROC OASIS assessment so that the appropriate response for M2002 may be selected. This collaboration does not violate the requirement that the comprehensive patient assessment is the responsibility of, and must ultimately be completed by one clinician. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Clinical record • Communication notes • Plan of care • Medication list • Discussions with other agency staff responsible for completing drug regimen review |

OASIS Item Guidance

Medications

| OASIS ITEM |
|--|
| <p>(M2004) Medication Intervention: If there were any clinically significant medication issues since the previous OASIS assessment, was a physician or the physician-designee contacted within one calendar day of the assessment to resolve clinically significant medication issues, including reconciliation?</p> <p><input type="checkbox"/> 0 - No</p> <p><input type="checkbox"/> 1 - Yes</p> <p><input type="checkbox"/> NA - No clinically significant medication issues identified since the previous OASIS assessment</p> |
| ITEM INTENT |
| <p>Identifies if potential clinically significant problems such as adverse effects or drug reactions identified at the time of the most recent OASIS assessment or after that time were addressed with the physician.</p> <p>This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.</p> |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Transfer to inpatient facility</p> <p>Discharge from agency – not to an inpatient facility</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Clinically significant medication issues are those that, in the care provider's clinical judgment, pose an actual or potential threat to patient health and safety, such as drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, medication omissions, dosage errors, or nonadherence to prescribed medication regimen. • Contact with physician is defined as communication to the physician made by telephone, voicemail, electronic means, fax, or any other means that appropriately conveys the message of patient status. • Select Response 1 – Yes, only if a physician responds to the agency communication with acknowledgment of receipt of information and/or further advice or instructions. • If the interventions are not completed as outlined in this item, select Response 0 – No. However, in this case, the care provider should document rationale in the clinical record. • If agency staff other than the clinician responsible for completing the transfer or discharge OASIS contacted the physician to follow up on clinically significant medication issues, this information must be communicated to the clinician responsible for the transfer or discharge OASIS assessment so that the appropriate response for M2004 may be selected. This collaboration does not violate the requirement that the comprehensive patient assessment is the responsibility of, and ultimately must be completed by one clinician. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Clinical record • Communication notes • Medication list • Plan of care • Discussions with other agency staff responsible for completing drug regimen review |

OASIS Item Guidance

Medications

| OASIS ITEM |
|---|
| <p>(M2010) Patient/Caregiver High Risk Drug Education: Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?</p> <p><input type="checkbox"/> 0 - No</p> <p><input type="checkbox"/> 1 - Yes</p> <p><input type="checkbox"/> NA - Patient not taking any high risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications</p> |
| ITEM INTENT |
| <p>Identifies if clinicians instructed the patient and/or caregiver about all high-risk medications the patient takes. High-risk medications are those identified by quality organizations (Institute for Safe Medication Practices, JCAHO, etc.) as having considerable potential for causing significant patient harm when they are used erroneously.</p> <p>This item is targeted to high-risk medications as it may be unrealistic to expect that patient education on all medications occur on admission and failure to provide patient education on high-risk medications such as hypoglycemics and anticoagulants (and others) at SOC/ROC could have severe negative impacts on patient safety and health.</p> <p>This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.</p> |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Start of Care</p> <p>Resumption of Care</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Select Response 0 – No, if the interventions are not completed as outlined in this item. However, in this case, the care provider should document rationale in the clinical record unless the patient is not taking any drugs. • Select Response 1 – Yes, if high-risk medications are prescribed and education was provided. • High-risk medications should be identified based on one or more authoritative sources. • If patient/caregiver is fully knowledgeable about special precautions associated with high-risk medications, select "NA." • If agency staff other than the clinician responsible for completing the SOC/ROC OASIS provided education to the patient/caregiver on high-risk medications, this information must be communicated to the clinician responsible for the SOC/ROC OASIS assessment so that the appropriate response for M2010 may be selected. This collaboration does not violate the requirement that the comprehensive patient assessment is the responsibility of, and ultimately must be completed by one clinician. |

OASIS Item Guidance**Medications****DATA SOURCES / RESOURCES (cont'd for OASIS Item M2010)**

- Clinical record
- Communication notes
- Medication list
- Plan of care
- Discussions with other agency staff responsible for educating patient/caregivers on medications.
- Sources to identify high-risk medications for the purposes of responding to this item can include the ISMP High Alert Medication List, Beer's Criteria, Joint Commission's High Alert Medication lists, or other authoritative resources. Links to resources for identifying high-risk medications can be found in Chapter 5 of this manual.

OASIS Item Guidance

Medications

| OASIS ITEM |
|--|
| <p>(M2015) Patient/Caregiver Drug Education Intervention: Since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, drug reactions, and side effects, and how and when to report problems that may occur?</p> <p><input type="checkbox"/> 0 - No</p> <p><input type="checkbox"/> 1 - Yes</p> <p><input type="checkbox"/> NA - Patient not taking any drugs</p> |
| ITEM INTENT |
| <p>Identifies if clinicians instructed the patient/caregiver about how to manage medications effectively and safely.</p> <p>Effective, safe management of medications includes knowledge of effectiveness, potential side effects and drug reactions, and when to contact the appropriate care provider.</p> <p>This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.</p> |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Transfer to an inpatient facility</p> <p>Discharge from agency - not to an inpatient facility</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • If the interventions are not completed as outlined in this item, select Response 0 – No. However, in this case, the care provider should document rationale in the clinical record. • If the last time patient/caregiver instruction regarding medication monitoring and reporting was at the last OASIS assessment visit, and no additional instruction at a subsequent visit has been provided, select Response 0 – No (unless the patient is not taking any medications, in which case, mark "NA"). |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Review of clinical record including teaching guidelines, flow sheets, clinical notes, etc. • Medication list • Plan of care • Discussions with other agency staff responsible for educating patient/caregivers on medications • Links to a resource for drug information can be found in Chapter 5 of this manual. |

OASIS Item Guidance

Medications

| OASIS ITEM |
|--|
| <p>(M2020) Management of Oral Medications: <u>Patient's current ability</u> to prepare and take <u>all</u> oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times. <input type="checkbox"/> 1 - Able to take medication(s) at the correct times if: <ul style="list-style-type: none"> (a) individual dosages are prepared in advance by another person; <u>OR</u> (b) another person develops a drug diary or chart. <input type="checkbox"/> 2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times <input type="checkbox"/> 3 - <u>Unable</u> to take medication unless administered by another person. <input type="checkbox"/> NA - No oral medications prescribed. |
| ITEM INTENT |
| <p>This item is intended to identify the patient's ability to take all oral (p.o.) medications reliably and safely at all times. The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely take oral medications, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a wholistic perspective in assessing ability to perform medication management. Ability can be temporarily or permanently limited by:</p> <ul style="list-style-type: none"> - physical impairments (e.g., limited manual dexterity), - emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear), - sensory impairments, (e.g., impaired vision, pain), - environmental barriers (e.g., access to kitchen or medication storage area, stairs, narrow doorways). |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Start of care</p> <p>Resumption of care</p> <p>Discharge from agency - not to an inpatient facility</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Includes all prescribed and OTC (over-the-counter) medications that the patient is currently taking and are included on the plan of care. • Exclude topical, injectable, and IV medications. • Only medications whose route of administration is p.o. should be considered for this item. Medications given per gastrostomy (or other) tube are <u>not</u> administered p.o., but are administered "per tube." • If the patient sets up her/his own "planner device" and is able to take the correct medication in the correct dosage at the correct time as a result of this, select Response 0. • Select Response 1 if the patient is independent in oral medication administration if another person must prepare individual doses (e.g., set up a "planner device") and/or if another person must develop a drug diary or chart which the patient relies on to take medications appropriately. |

OASIS Item Guidance**Medications**

| RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M2020) |
|--|
| <ul style="list-style-type: none"> • Select Response 2 if daily reminders to take medications are necessary, regardless of whether the patient is independent or needs assistance in preparing individual doses (e.g., set up a “planner device”) and/or developing a drug diary or chart. (Reminders provided by a device that the patient can independently manage are not considered “assistance” or “reminders.”) • If the patient’s ability to manage oral medications varies from medication to medication, consider the medication for which the most assistance is needed when selecting a response. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Observation/demonstration is the preferred method • Patient/caregiver interview • Physical assessment • Cognitive assessment • Environmental assessment |

OASIS Item Guidance

Medications

| OASIS ITEM |
|---|
| <p>(M2030) Management of Injectable Medications: <u>Patient's current ability</u> to prepare and take <u>all</u> prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. Excludes IV medications.</p> <p><input type="checkbox"/> 0 - Able to independently take the correct medication(s) and proper dosage(s) at the correct times.</p> <p><input type="checkbox"/> 1 - Able to take injectable medication(s) at the correct times if: (a) individual syringes are prepared in advance by another person; <u>OR</u> (b) another person develops a drug diary or chart.</p> <p><input type="checkbox"/> 2 - Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection</p> <p><input type="checkbox"/> 3 - <u>Unable</u> to take injectable medication unless administered by another person.</p> <p><input type="checkbox"/> NA - No injectable medications prescribed.</p> |
| ITEM INTENT |
| <p>This item is intended to assess the patient's ability to take all injectable medications reliably and safely at all times. The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely manage injectable medications, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a wholistic perspective in assessing ability to perform medication management. Ability can be temporarily or permanently limited by:</p> <ul style="list-style-type: none"> - physical impairments (e.g., limited manual dexterity), - emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear), - sensory impairments, (e.g., impaired vision, pain), - environmental barriers (e.g., access to kitchen or medication storage area, stairs, narrow doorways). |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Start of care</p> <p>Resumption of care</p> <p>Discharge from agency – not to an inpatient facility</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Excludes IV medications, infusions (i.e., medications given via a pump), and medications given in the physician's office or other settings outside the home. • If the patient sets up her/his own individual doses and is able to take the correct medication in the correct dosage at the correct time as a result of this, select Response 0. • Select Response 1 for a patient independent in injectable medication administration if another person must prepare individual doses and/or if another person must develop a drug diary or chart. • If reminders to take medications are necessary, then select Response 2, regardless of the whether the patient is independent or needs assistance in preparing individual doses and/or developing a drug diary or chart. (Reminders provided by a device that the patient can independently manage are not considered "assistance" or "reminders.") • If the patient's ability to manage injectable medications varies from medication to medication, consider the medication for which the most assistance is needed when selecting a response. • Assessment strategies: A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Observe patient preparing the injectable medications. If it is not time for the medication, ask the patient to describe and demonstrate the steps for administration. The cognitive/mental status and functional assessments contribute to determining the appropriate response for this item. |

OASIS Item Guidance**Medications****DATA SOURCES / RESOURCES (cont'd for OASIS Item M2030)**

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Cognitive assessment
- Environmental assessment

OASIS Item Guidance

Medications

| OASIS ITEM | | | | | | | | | | | | | | | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|-----------------|-------------|------------------|-----------|----------------|---------------------|--------------------------|--------------------------|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <p>(M2040) Prior Medication Management: Indicate the patient's usual ability with managing oral and injectable medications prior to this current illness, exacerbation, or injury. Check only one box in each row.</p> <table border="1"> <thead> <tr> <th>Functional Area</th> <th>Independent</th> <th>Needed Some Help</th> <th>Dependent</th> <th>Not Applicable</th> </tr> </thead> <tbody> <tr> <td>a. Oral medications</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>b. Injectable medications</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table> | | | | | Functional Area | Independent | Needed Some Help | Dependent | Not Applicable | a. Oral medications | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | b. Injectable medications | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Functional Area | Independent | Needed Some Help | Dependent | Not Applicable | | | | | | | | | | | | | | | |
| a. Oral medications | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | |
| b. Injectable medications | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ITEM INTENT | | | | | | | | | | | | | | | | | | | |
| <p>Identifies changes that have occurred in the patient's ability to manage all prescribed oral and injectable medications since the onset of the current illness, exacerbation of a chronic condition, or injury (whichever is most recent) that initiated this episode of care. The intent of the item is to identify the patient's prior ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. This item is used for risk adjustment and can be helpful for setting realistic goals for the patient.</p> | | | | | | | | | | | | | | | | | | | |
| TIME POINTS ITEM(S) COMPLETED | | | | | | | | | | | | | | | | | | | |
| <p>Start of Care Resumption of Care</p> | | | | | | | | | | | | | | | | | | | |
| RESPONSE—SPECIFIC INSTRUCTIONS | | | | | | | | | | | | | | | | | | | |
| <ul style="list-style-type: none"> For each functional area (oral medications and injectable medications), select a response. If the patient's prior ability to manage oral or injectable medications varied from medication to medication, consider the medication for which the most assistance was needed when selecting a response. "Independent" means that the patient completed the activity by him/herself (with or without assistive devices) without physical or verbal assistance from a helper or reminders from another person. (Reminders provided by a device that the patient can independently manage are not considered "assistance" or "reminders.") "Needed some help" means that the patient required some help from another person to accomplish the task/activity. "Dependent" means that the patient was incapable of performing any of the task/activity. For oral medications, this means that the patient was capable only of swallowing medications that were given to her/him. For injectable medications, this means that someone else must have prepared and administered the medication. Select Response "NA" if there were no oral medications (row a) or no injectable medications (row b) used. | | | | | | | | | | | | | | | | | | | |
| DATA SOURCES / RESOURCES | | | | | | | | | | | | | | | | | | | |
| <ul style="list-style-type: none"> Patient/caregiver interview Referral information Review of past health history Physician | | | | | | | | | | | | | | | | | | | |

OASIS Item Guidance

Care Management

| OASIS ITEM | | | | | | |
|--|-----------------------------------|--|---|--|---|--|
| (M2100) Types and Sources of Assistance: Determine the level of caregiver ability and willingness to provide assistance for the following activities, if assistance is needed. (Check only one box in each row.) | | | | | | |
| Type of Assistance | No assistance needed in this area | Caregiver(s) currently provides assistance | Caregiver(s) need training/ supportive services to provide assistance | Caregiver(s) <u>not likely</u> to provide assistance | Unclear if Caregiver(s) will provide assistance | Assistance needed, but no Caregiver(s) available |
| a. ADL assistance (e.g., transfer/ ambulation, bathing, dressing, toileting, eating/feeding) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. IADL assistance (e.g., meals, housekeeping, laundry, telephone, shopping, finances) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Medication administration (e.g., oral, inhaled or injectable) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Medical procedures/ treatments (e.g., changing wound dressing) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Management of Equipment (includes oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Supervision and safety (e.g., due to cognitive impairment) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Advocacy or facilitation of patient's participation in appropriate medical care (includes transportation to or from appointments) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| ITEM INTENT |
|---|
| Identifies availability and ability of the caregiver(s) to provide categories of assistance needed by the patient. Note that this question is concerned broadly with types of assistance, not just the ones specified in other OASIS items. |
| TIME POINTS ITEM(S) COMPLETED |
| Start of care Resumption of care Discharge from agency – not to an inpatient facility |

OASIS Item Guidance

Care Management

| RESPONSE—SPECIFIC INSTRUCTIONS (Cont'd for OASIS Item M2100) |
|--|
| <ul style="list-style-type: none"> • For each row a-g, select one description of caregiver assistance. • If patient needs assistance with any aspect of a category of assistance (e.g., needs assistance with some IADLs but not others), consider the aspect that represents the most need and the availability and ability of the caregiver(s) to meet that need. • If more than one response in a row applies, (e.g., the caregiver(s) provides the assistance but also needs training or assistance), select the response that represents the greatest need (“caregiver(s)needs training/supporting services to provide assistance”). • “Caregiver(s) not likely to provide” indicates that the caregiver(s) has indicated an unwillingness to provide assistance, or that the caregiver(s) is/are physically and/or cognitively unable to provide needed care. • “Unclear if caregiver(s) will provide” indicates that the caregiver(s) may express willingness to provide care, but their ability to do so is in question or there is reluctance on the part of the caregiver(s) that raises questions as to whether the caregiver will provide the needed assistance. • Row a – ADLs include basic self-care activities such as the examples listed. • Row b – IADLs include activities associated with independent living necessary to support the ADLs such as the examples listed. • Row c – Medication administration refers to any type of medication (prescribed or OTC) and any route of administration including oral, inhalant, injectable, topical, or administration via g-tube/j-tube, etc. • Row d – Medical procedures/treatments include procedures/treatments that the physician or physician-designee has ordered for the purpose of improving health status. Some examples of these procedures/treatments include wound care and dressing changes, range of motion exercises, intermittent urinary catheterization, postural drainage, electromodalities, etc. • Row e – Management of equipment refers to the ability to safely use medical equipment as ordered. Examples of medical equipment include oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies, continuous passive motion machine, wheelchair, hoist lift, etc. • Row f – Supervision and safety includes needs related to the ability of the patient to safely remain in the home. This category of assistance needs includes a wide range of activities that may be necessary due to cognitive, functional, or other health deficits. Such assistance may range from calls to remind the patient to take medications, to in-person visits to ensure that the home environment is safely maintained, to the need for the physical presence of another person in the home to ensure that the patient doesn't wander, fall, or for other safety reasons (i.e., leaving the stove burner on). • Row g – Advocacy or facilitation of patient's participation in appropriate medical care includes taking patient to medical appointments, following up with filling prescriptions, or making subsequent appointments, etc. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Review of previous health history |

OASIS Item Guidance

Care Management

| OASIS ITEM |
|--|
| <p>(M2110) How Often does the patient receive ADL or IADL assistance from any caregiver(s) (other than home health agency staff)?</p> <p> <input type="checkbox"/> 1 - At least daily <input type="checkbox"/> 2 - Three or more times per week <input type="checkbox"/> 3 - One to two times per week <input type="checkbox"/> 4 - Received, but less often than weekly <input type="checkbox"/> 5 - No assistance received <input type="checkbox"/> UK - Unknown* </p> <p>*at discharge, omit Unknown response.</p> |
| ITEM INTENT |
| Identifies the frequency of the assistance with ADLs (e.g., bathing, dressing, toileting, transferring, ambulating, feeding, etc.) or IADLs (e.g., medication management, meal preparation, housekeeping, laundry, shopping, financial management) provided by any non-agency caregivers. |
| TIME POINTS ITEM(S) COMPLETED |
| Start of care Resumption of care Discharge from agency – not to an inpatient facility |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Responses are arranged in order of most to least assistance received from caregivers. • Note that this question is concerned broadly with ADLs and IADLs, not just the ones specified in other OASIS items. ADLs are defined as the tasks of everyday life. Basic ADLs include eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet. Instrumental activities of daily living (IADL) are activities related to independent living and include preparing meals, managing money, shopping, doing housework, and using a telephone. • Select the response that reports how often the patient receives assistance with any ADL or IADL. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver interview |

OASIS Item Guidance

Therapy Need & Plan of Care

| OASIS ITEM |
|--|
| <p>(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.)</p> <p>(_ _ _) Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).</p> <p><input type="checkbox"/> NA - Not Applicable: No case mix group defined by this assessment.</p> |
| ITEM INTENT |
| Identifies the total number of therapy visits (physical, occupational, or speech therapy combined) planned for the Medicare payment episode for which this assessment will determine the case mix group, and only applies to payers utilizing a payment model based on case mix group assignment. |
| TIME POINTS ITEM(S) COMPLETED |
| Start of care Resumption of care Follow-up |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Therapy visits must (a) relate directly and specifically to a treatment regimen established by the physician through consultation with the therapist(s), and (b) be reasonable and necessary to the treatment of the patient's illness or injury. The Medicare payment episode ordinarily comprises 60 days beginning with the start of care date, or 60 days beginning with the recertification date. • Report a number that is "zero filled and right justified." For example, 11 visits should be reported as "011." • Answer "000" if no therapy services are needed. • Once patient eligibility has been confirmed and the plan of care contains physician orders for the qualifying service as well as other Medicare covered home health services, the qualifying service does not have to be rendered prior to the other Medicare covered home health services ordered in the plan of care. The sequence of visits performed by the disciplines must be dictated by the individual patient's plan of care. For example, for an eligible patient in an initial 60-day episode that has both physical therapy and occupational therapy orders in the plan of care, the sequence of the delivery of the type of therapy is irrelevant as long as the need for the qualifying service is established prior to the delivery of other Medicare covered services and the qualifying discipline provides a billable visit prior to transfer or discharge in accordance with 42 CFR 409.43 (f). • For multidisciplinary cases - Nursing and Therapy may collaborate to answer this item correctly. The PT, OT, and/or SLP are responsible to communicate the number of visits ordered by the physician to the RN completing this item. Coordination of patient care is specified in the Conditions of Participation (42 CFR 484.14). • When a patient is discharged home from an inpatient facility admission in the last five days of a certification period (i.e., the requirement to complete a Resumption of Care assessment overlaps with the requirement to complete a Recert assessment), CMS allows the agency to complete a single ROC assessment to meet the requirements of both timepoints. In such cases, the total number of therapy visits planned for the upcoming 60-day episode should be reported in M2200. |

OASIS Item Guidance

Therapy Need & Plan of Care

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M2200)

- Answer "Not Applicable" when this assessment will not be used to determine a case mix group for Medicare, or other payers using a Medicare PPS-like model. Usually, the "Not Applicable" response will be checked for patients whose payment source is not Medicare fee-for-service (i.e., M0150, Response 1 is not checked), or for an assessment that will not be used to determine a Medicare case mix group. However, payers other than the Medicare program may use this information in setting an episode payment rate. If the HHA needs a case mix code (HIPPS code) for billing purposes, a response other than "Not Applicable" is required to generate the case mix code.
- Assessment strategies: When the assessment and care plan are complete, review the plan of care to determine whether therapy services are ordered by the physician. If not, answer "000." If therapy services are ordered, how many total visits are indicated over the 60-day payment episode? If the number of visits that will be needed is uncertain, provide your best estimate. As noted in item intent above, the Medicare payment episode ordinarily comprises 60 days beginning with the start of care date, or 60 days beginning with the recertification date.

DATA SOURCES / RESOURCES

- Physician's orders
- Referral information
- Plan of care
- Clinical record

OASIS Item Guidance

Therapy Need & Plan of Care

| OASIS ITEM | | | | |
|--|--------------------------|--------------------------|--------------------------|---|
| (M2250) Plan of Care Synopsis: (Check only one box in each row.) Does the physician-ordered plan of care include the following: | | | | |
| Plan / Intervention | No | Yes | Not Applicable | |
| a. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference |
| b. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Patient is not diabetic or is bilateral amputee |
| c. Falls prevention interventions | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Patient is not assessed to be at risk for falls |
| d. 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"/> | Patient has no diagnosis or symptoms of depression |
| e. Intervention(s) to monitor and mitigate pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | No pain identified |
| f. Intervention(s) to prevent pressure ulcers | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Patient is not assessed to be at risk for pressure ulcers |
| g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Patient has no pressure ulcers with need for moist wound healing |

| ITEM INTENT |
|--|
| <p>Identifies if the physician-ordered home health plan of care incorporates specific best practices. The "physician ordered plan of care" means that the patient condition has been discussed and there is agreement as to the plan of care between the home health agency staff and the physician.</p> <p>This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.</p> |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Start of care</p> <p>Resumption of care</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> This question can be answered "Yes" prior to the receipt of <u>signed</u> orders if the clinical record reflects evidence of communication with the physician to include specified best practice interventions in the plan of care. Assuming all other OASIS information is completed, the Date Assessment Completed (M0090) then becomes the date of the communication with the physician to establish the Plan of Care that includes interventions listed in M2250. Select "No" if the best practice interventions specified in this item are not included in the plan of care that was developed as a result of the comprehensive assessment |

OASIS Item Guidance

Therapy Need & Plan of Care

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item 2250)

- Select "No" when orders for interventions have been requested but not authorized by the end of the comprehensive assessment time period, unless otherwise indicated in row g. In this case, the care provider should document rationale in the clinical record. Reminder: These Plan of Care orders must be in place within the 5-day SOC window and the 2-day ROC window in order to meet the measure definition. See 42 CFR 409.43 (d).
- After reviewing physician orders for home health care and conducting a comprehensive assessment of the patient, the plan of care should be developed as required by Conditions of Participation: 484.14 Standard: Plan of Care. If the physician refers the patient under a plan of care that cannot be completed until after an initial visit and eligibility has been determined, the physician is consulted to approve additions or modification to the original plan.
- If the assessing clinician chooses to wait to complete M2250 until after discussion with another discipline that has completed their assessment and care plan development, this does not violate the requirement that the comprehensive assessment be completed by one clinician within the required time frame (five days for SOC, two days for ROC). For example, if the RN identifies fall risk during the SOC comprehensive assessment, the RN can wait until the PT conducts his/her evaluation and develops the PT care plan to determine if the patient's Plan of Care includes interventions to prevent fall risk. The M0090 date should reflect the last date that information was gathered that was necessary for completion of the assessment.
- For each row a-g, select one response.
- Row a: If the physician-ordered plan of care contains specific clinical parameters relevant to the patient's condition that, when exceeded, would indicate that the physician should be contacted, select "Yes." The parameters may be ranges and may include temperature, pulse, respirations, blood pressure, weight, wound measurements, pain intensity ratings, intake and output measurements, blood sugar levels, or other relevant clinical assessment findings. Select "NA" if the physician chooses not to identify patient-specific parameters and the agency will use standardized guidelines that are made accessible to all care team members.
- Row b: If the physician-ordered plan of care contains both orders for a) monitoring the skin of the patient's lower extremities for evidence of skin lesions AND b) patient education on proper foot care, select "Yes." If the physician-ordered plan of care contains orders for only one (or none) of the interventions, select "No." Select "NA" if the patient does not have a diagnosis of diabetes or is a bilateral amputee.
- Row c: If the physician-ordered plan of care contains specific interventions to reduce the risk of falls, select "Yes." Environmental changes and strengthening exercises are examples of possible fall prevention interventions. If the plan of care does not include interventions for fall prevention, mark "No" for the applicable line, whether or not an assessment for falls risk was conducted. Select "NA" if the patient was not assessed as being at risk for falls.
- Row d: If the physician-ordered plan of care contains orders for treating depression, select "Yes." Interventions for depression may include new medications, adjustments to already-prescribed medications, or referrals to agency resources (e.g., social worker). If the patient is already under physician care for a diagnosis of depression, interventions may include monitoring medication effectiveness, teaching regarding the need to take prescribed medications, etc. Select "NA" if the patient has no diagnosis or symptoms of depression.
- Row e: If the physician-ordered plan of care contains interventions to monitor AND mitigate pain, select "Yes." Medication, massage, visualization, biofeedback, and other intervention approaches have successfully been used to monitor or mitigate pain severity. If the physician-ordered plan of care contains orders for only one of the interventions (e.g., pain medications but no monitoring plan), select "No." Select "NA" if no pain was identified after conducting the comprehensive assessment.
- Row f: If the physician-ordered plan of care includes planned clinical interventions to reduce pressure on bony prominences or other areas of skin at risk for breakdown, select "Yes." Planned interventions can include teaching on frequent position changes, proper positioning to relieve pressure, careful skin assessment and hygiene, use of pressure-relieving devices such as enhanced mattresses, etc. Select "NA" if the patient was not identified as at risk for pressure ulcers.
- Row g: If the physician-ordered plan of care contains orders for pressure ulcer treatments based on principles of moist wound healing (e.g., moisture retentive dressings) OR if such orders have been requested from the physician, select "Yes." Select "NA" if the patient has no pressure ulcers needing moist wound healing treatments.

OASIS Item Guidance**Therapy Need & Plan of Care****DATA SOURCES / RESOURCES (cont'd for OASIS Item 2250)**

- Plan of care
- Physician's orders
- Clinical record
- Communication notes
- See Chapter 5 of this manual for links to additional resources.

OASIS Item Guidance

Emergent Care

| OASIS ITEM |
|---|
| <p>(M2300) Emergent Care: Since the last time OASIS data were collected, has the patient utilized a hospital emergency department (includes holding/observation)?</p> <p><input type="checkbox"/> 0 - No [<i>Go to M2400</i>]</p> <p><input type="checkbox"/> 1 - Yes, used hospital emergency department WITHOUT hospital admission</p> <p><input type="checkbox"/> 2 - Yes, used hospital emergency department WITH hospital admission</p> <p><input type="checkbox"/> UK - Unknown [<i>Go to M2400</i>]</p> |
| ITEM INTENT |
| <p>Identifies whether the patient was seen in a hospital emergency department since the previous OASIS assessment. Responses to this item include the <u>entire</u> period since the last time OASIS data were collected, including current events.</p> |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Transfer to an inpatient facility - with or without agency discharge</p> <p>Discharge from agency</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • This item excludes urgent care services not provided in a hospital emergency department, including doctor's office visits scheduled less than 24 hours in advance, care provided by an ambulance crew without transport, or care received in urgent care facilities. This item only includes holding and observation in the emergency department setting. • An urgent care facility is defined as a freestanding walk-in clinic (not a department of a hospital) for patients in need of immediate medical care. Urgent care centers treat many problems that can be seen in a primary care physician's office, but urgent care centers offer some services that are generally not available in primary care physician offices. For example, X-ray facilities allow for treatment of minor fractures and foreign bodies, such as nail gun injuries. Most urgent care centers offer extended hours in evenings and on weekends for patients to receive treatment when their personal physician is not available. • If a patient went to a hospital emergency department, regardless of whether the patient/caregiver independently made the decision to seek emergency department services or was advised to go the emergency department by the physician, home health agency, or other health care provider, then Response 1 or 2 should be selected depending on whether or not a hospital admission occurred. • If a patient went to a hospital emergency department, was "held" at the hospital for observation, then released, the patient did receive emergent care. The time period that a patient can be "held" without admission can vary. "Holds" can be longer than 23 hours but emergent care should be reported regardless of the length of the observation "hold." An OASIS transfer assessment is not required if the patient was never actually admitted to an inpatient facility. • If a patient went to a hospital emergency department and was subsequently admitted to the hospital, select Response 2. An OASIS transfer assessment is required (assuming the patient stay was for 24 hours or more for reasons other than diagnostic testing). • If a patient is admitted to the hospital for a stay requiring an OASIS Transfer, Response 0 – No – should only be marked if the patient was directly admitted to the hospital (was not treated or evaluated in the emergency room), and had no other emergency department visits since the last OASIS assessment. |

OASIS Item Guidance

Emergent Care

| RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M2300) |
|---|
| <ul style="list-style-type: none"> • Select Response 1 for a patient who, since the last time OASIS was collected, has experienced both a direct admission to the hospital without treatment or evaluation AND accessed a hospital emergency department that did not result in an inpatient admission. • If a patient utilized a hospital emergency department more than once since the last OASIS assessment, select Response 2 if any emergency department visit since the last OASIS assessment resulted in hospital admission, otherwise select Response 1. • In Responses 1 and 2, "hospital admission" is defined as admission to a hospital where the stay is for 24 hours or longer, for reasons other than diagnostic testing. • A patient who dies in a hospital emergency department is considered to have been under the care of the emergency department, not the home health agency. In this situation, a transfer assessment, not an assessment for "Death at Home," should be completed. For M2300, the best response would be " 1 - Yes, used hospital emergency department WITHOUT hospital admission." |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver interview • Clinical record • Hospital emergency department discharge information • Referral information for the ROC, if the patient had a hospital admission and home health care ROC since the previous OASIS assessment • Physician • Hospital emergency department staff |

OASIS Item Guidance

Emergent Care

| OASIS ITEM |
|--|
| <p>(M2310) Reason for Emergent Care: For what reason(s) did the patient receive emergent care (with or without hospitalization)? (Mark all that apply.)</p> <p><input type="checkbox"/> 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis</p> <p><input type="checkbox"/> 2 - Injury caused by fall</p> <p><input type="checkbox"/> 3 - Respiratory infection (e.g., pneumonia, bronchitis)</p> <p><input type="checkbox"/> 4 - Other respiratory problem</p> <p><input type="checkbox"/> 5 - Heart failure (e.g., fluid overload)</p> <p><input type="checkbox"/> 6 - Cardiac dysrhythmia (irregular heartbeat)</p> <p><input type="checkbox"/> 7 - Myocardial infarction or chest pain</p> <p><input type="checkbox"/> 8 - Other heart disease</p> <p><input type="checkbox"/> 9 - Stroke (CVA) or TIA</p> <p><input type="checkbox"/> 10 - Hypo/Hyperglycemia, diabetes out of control</p> <p><input type="checkbox"/> 11 - GI bleeding, obstruction, constipation, impaction</p> <p><input type="checkbox"/> 12 - Dehydration, malnutrition</p> <p><input type="checkbox"/> 13 - Urinary tract infection</p> <p><input type="checkbox"/> 14 - IV catheter-related infection or complication</p> <p><input type="checkbox"/> 15 - Wound infection or deterioration</p> <p><input type="checkbox"/> 16 - Uncontrolled pain</p> <p><input type="checkbox"/> 17 - Acute mental/behavioral health problem</p> <p><input type="checkbox"/> 18 - Deep vein thrombosis, pulmonary embolus</p> <p><input type="checkbox"/> 19 - Other than above reasons</p> <p><input type="checkbox"/> UK - Reason unknown</p> |
| ITEM INTENT |
| Identifies the reasons for which the patient received care in a hospital emergency department. |
| TIME POINTS ITEM(S) COMPLETED |
| Transfer to an inpatient facility - with or without agency discharge Discharge from agency |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • This item does not address urgent care services not provided in a hospital emergency department, including doctor's office visits scheduled less than 24 hours in advance, care provided by an ambulance crew without transport, or care received in urgent care facilities. • If more than one reason contributed to the hospital emergency department visit, mark all appropriate responses. For example, if a patient received care for a fall at home and was found to have medication side effects, mark both responses. • If the reason is not included in the choices, mark Response 19 - Other than above reasons. • If the patient has received emergent care in a hospital emergency department multiple times since the last time OASIS data were collected, include the reasons for all visits. |

DATA SOURCES / RESOURCES (cont'd for OASIS Item M2310)

- Patient/caregiver interview
- Clinical record
- Hospital emergency department discharge information
- Referral information for the ROC, if the patient had a hospital admission and home health care ROC since the previous OASIS assessment
- Physician
- Hospital emergency department

OASIS Item Guidance

Discharge

| OASIS ITEM | | | | |
|---|--------------------------|--------------------------|--------------------------|--|
| (M2400) Intervention Synopsis: (Check only one box in each row.) Since the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented? | | | | |
| Plan / Intervention | No | Yes | Not Applicable | |
| a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Patient is not diabetic or is bilateral amputee |
| b. Falls prevention interventions | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Formal multi-factor Fall Risk Assessment indicates the patient was not at risk for falls since the last OASIS assessment |
| 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"/> | Formal assessment indicates patient did not meet criteria for depression AND patient did not have diagnosis of depression since the last OASIS assessment |
| d. Intervention(s) to monitor and mitigate pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Formal assessment did not indicate pain since the last OASIS assessment |
| e. Intervention(s) to prevent pressure ulcers | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Formal assessment indicates the patient was not at risk of pressure ulcers since the last OASIS assessment |
| f. Pressure ulcer treatment based on principles of moist wound healing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dressings that support the principles of moist wound healing not indicated for this patient's pressure ulcers <u>OR</u> patient has no pressure ulcers with need for moist wound healing |

| ITEM INTENT |
|---|
| <p>Identifies if specific interventions focused on specific problems were both included on the physician-ordered home health plan of care AND implemented as part of care provided during the home health care episode (at the time of the previous OASIS assessment or since that time). The physician-ordered plan of care means that the patient condition was discussed and there was agreement as to the plan of care between the home health agency staff and the patient's physician.</p> <p>This item is used to calculate process measures to capture the use of best practices. The problem-specific interventions referenced in the item may or may not directly correlate to stated requirements in the Conditions of Participation.</p> <p>The formal assessment that is referred to in the last column for rows b – e refers to the assessment defined in OASIS items for M1240, M1300, M1730, and M1910.</p> |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Transfer to inpatient facility - with or without agency discharge</p> <p>Discharge from agency - not to an inpatient facility</p> |

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M2400)

- For response “Yes” to be selected, the clinical intervention must have been included in the plan of care AND implemented at the time of the previous OASIS assessment or since that time. If the intervention was on the plan of care but not implemented, or if the intervention was implemented but not on the plan of care, select “No.”
- If the interventions are not on the plan of care or if the interventions were not implemented by the time the assessment was completed, select Response 0 – No. In this case, the care provider should document rationale in the clinical record.
- Interventions provided by home health agency staff, including the assessing clinician, may be reported by the assessing clinician in M2400. For example, if the RN finds a patient to be at risk for falls, and the physical therapist implements fall prevention interventions included on the plan of care prior to the end of the allowed assessment time frame, the RN may select “Yes” for row b of M2400. The M0090 Date Assessment Completed should report the date the last information was gathered to complete the Comprehensive Assessment.
- For each row a-f, select one response.
- For rows b, c, e, and f, the intervention specified in the first column must be both on the physician-ordered plan of care AND implemented for “Yes” to be selected.
- For rows a and d, both of the interventions specified in the first column must be both on the physician-ordered plan of care AND implemented for “Yes” to be selected.
- For rows b-e, a formal assessment (as defined in the relevant OASIS item M1240, M1300, M1730, and M1910) must have been performed to select “Not Applicable.”
- Row a: If the physician-ordered plan of care contains both orders for a) monitoring the skin of the patient's lower extremities for evidence of skin lesions AND b) patient education on proper foot care and the clinical record contains documentation that these interventions were performed at the time of the previous OASIS assessment or since that time, select “Yes.” If the physician-ordered plan of care contains orders for only one of the interventions and/or only one type of intervention (monitoring or education) or no intervention is documented in the clinical record, select “No.” Select “NA” if the patient does not have a diagnosis of diabetes or is a bilateral amputee.
- Row b: If the physician-ordered plan of care contains specific interventions to reduce the risk of falls and the clinical record contains documentation that these interventions were performed at the time of the previous OASIS assessment or since that time, select “Yes.” Environmental changes, strengthening exercises, and consultation with the physician regarding medication concerns are examples of possible falls prevention interventions. If the plan of care does not include interventions for fall prevention, and/or there is no documentation in the clinical record that these interventions were performed at the time of the previous OASIS assessment or since that time, mark “No,” whether or not an assessment for falls risk was conducted. Select “NA” if a formal multi-factor Fall Risk Assessment indicates the patient was not at risk for falls since the last OASIS assessment.
- Row c: If the physician-ordered plan of care contains interventions for treating depression and the clinical record contains documentation that these interventions were performed at the time of the previous OASIS assessment or since that time, select “Yes.” Interventions for depression may include new medications, adjustments to already-prescribed medications, or referrals to agency resources (e.g., social worker). If the patient is already under MD care for a diagnosis of depression, interventions may include monitoring medication effectiveness, teaching regarding the need to take prescribed medications, etc. If the plan of care does not include interventions for treating depression and/or if no interventions related to depression are documented in the clinical record at the time of the previous OASIS assessment or since that time, select “No,” whether or not a formal assessment for depression was conducted. Select “NA” if formal assessment indicates patient did not meet criteria for depression AND patient did not have diagnosis of depression.

OASIS Item Guidance

Discharge

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M2400)

- Row d: If the physician-ordered plan of care contains interventions to monitor AND mitigate pain and the clinical record contains documentation that these interventions were performed at the time of the previous OASIS assessment or since that time, select "Yes." Medication, massage, visualization, biofeedback, and other intervention approaches have successfully been used to mitigate pain severity. If the physician-ordered plan of care contains orders for only one of the interventions (e.g., pain medications but no monitoring plan) and/or only one type of intervention (i.e., administering pain medications but no pain monitoring) or no interventions were documented at the time of the previous OASIS assessment or since that time, select "No," whether or not a formal pain assessment was conducted. Select "NA" if formal assessment did not indicate pain.
- Row e: If the physician-ordered plan of care includes planned clinical interventions to reduce pressure on bony prominences or other areas of skin at risk for breakdown and the clinical record contains documentation that these interventions were performed at the time of the previous OASIS assessment or since that time, select "Yes." Planned interventions can include teaching on frequent position changes, proper positioning to relieve pressure, careful skin assessment and hygiene, use of pressure-relieving devices such as enhanced mattresses, etc. If the plan of care does not include interventions to prevent pressure ulcers and/or no interventions were documented in the clinical record at the time of the previous OASIS assessment or since that time, select "No," whether or not a formal pressure ulcer risk assessment was conducted. Select "NA" if formal assessment indicates the patient was not at risk of pressure ulcers.
- Row f: If the physician-ordered plan of care contains orders for pressure ulcer treatments based on principles of moist wound healing (e.g., moisture retentive dressings) and the clinical record contains documentation that these interventions were performed at the time of the previous OASIS assessment or since that time, select "Yes." If the plan of care does not contain orders for pressure ulcer treatments based on principles of moist wound healing and/or no pressure ulcer treatments based on principles of moist wound healing were documented in the at the time of the previous OASIS assessment or since that time, select "No," whether or not an assessment identified a pressure ulcer that needed moist wound healing treatment. Select "NA" if dressings that support the principles of moist wound healing were not indicated for this patient's pressure ulcers OR patient has no pressure ulcers with need for moist wound healing.

DATA SOURCES / RESOURCES

- Plan of care
- Physician's orders
- Clinical record
- Clinical assessment
- Communication notes
- Home Health Conditions of Participation
- Guidance on each particular item for the plan of care and intervention can be found in other item-by-item tips within this document.

OASIS Item Guidance

Discharge

| OASIS ITEM |
|---|
| <p>(M2410) To which Inpatient Facility has the patient been admitted?</p> <p><input type="checkbox"/> 1 - Hospital [<i>Go to M2430</i>]</p> <p><input type="checkbox"/> 2 - Rehabilitation facility [<i>Go to M0903</i>]</p> <p><input type="checkbox"/> 3 - Nursing home [<i>Go to M2440</i>]</p> <p><input type="checkbox"/> 4 - Hospice [<i>Go to M0903</i>]</p> <p><input type="checkbox"/> NA - No inpatient facility admission</p> |
| ITEM INTENT |
| Identifies the type of inpatient facility to which the patient was admitted. |
| TIME POINTS ITEM(S) COMPLETED |
| Transfer to inpatient facility - with or without agency discharge Discharge from agency - not to an inpatient facility |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • If the patient was admitted to more than one facility, indicate the facility to which the patient was admitted first (e.g. the facility type that they were transferred to from their home). • When a patient dies in a hospital emergency department, the Transfer to an Inpatient Facility OASIS is completed. In this unique situation, clinicians are directed to select Response 1 – Hospital for M2410, even though the patient was not admitted to the inpatient facility. • Admission to a freestanding rehabilitation hospital, a certified distinct rehabilitation unit of a nursing home, or a distinct rehabilitation unit that is part of a short-stay acute hospital is considered a rehabilitation facility admission. • Admission to a skilled nursing facility (SNF), an intermediate care facility for the mentally retarded (ICF/MR), or a nursing facility (NF) is a nursing home admission • When completing a Transfer, select Response 1, 2, 3, or 4. NA should be omitted from this item for transfer. • When completing a Discharge from agency – not to an inpatient facility, select Response “NA.” |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient family interview (for agency discharge) • Telephone contact with caregiver or family if patient was transferred • Facility |

OASIS Item Guidance

Discharge

| OASIS ITEM |
|--|
| <p>(M2420) Discharge Disposition: Where is the patient after discharge from your agency? (Choose only one answer.)</p> <p><input type="checkbox"/> 1 - Patient remained in the community (without formal assistive services)</p> <p><input type="checkbox"/> 2 - Patient remained in the community (with formal assistive services)</p> <p><input type="checkbox"/> 3 - Patient transferred to a non-institutional hospice</p> <p><input type="checkbox"/> 4 - Unknown because patient moved to a geographic location not served by this agency</p> <p><input type="checkbox"/> UK - Other unknown</p> <p>[<i>Go to M0903</i>]</p> |
| ITEM INTENT |
| Identifies where the patient resides after discharge from the home health agency. |
| TIME POINTS ITEM(S) COMPLETED |
| Discharge from agency - not to an inpatient facility |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • Patients who are in assisted living or board and care housing are considered to be living in the community with formal assistive services. • Formal assistive services include community-based services like homemaking services under Medicaid waiver programs, home-delivered meals, home care or private duty care from another agency, and other types of community-based services • Noninstitutional hospice is defined as the patient receiving hospice care at home or a caregiver's home, not in an inpatient hospice facility. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Patient/caregiver/family interview • Physician • Community resources |

OASIS Item Guidance

Discharge

| OASIS ITEM |
|--|
| <p>(M2430) Reason for Hospitalization: For what reason(s) did the patient require hospitalization? (Mark all that apply.)</p> <p><input type="checkbox"/> 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis</p> <p><input type="checkbox"/> 2 - Injury caused by fall</p> <p><input type="checkbox"/> 3 - Respiratory infection (e.g., pneumonia, bronchitis)</p> <p><input type="checkbox"/> 4 - Other respiratory problem</p> <p><input type="checkbox"/> 5 - Heart failure (e.g., fluid overload)</p> <p><input type="checkbox"/> 6 - Cardiac dysrhythmia (irregular heartbeat)</p> <p><input type="checkbox"/> 7 - Myocardial infarction or chest pain</p> <p><input type="checkbox"/> 8 - Other heart disease</p> <p><input type="checkbox"/> 9 - Stroke (CVA) or TIA</p> <p><input type="checkbox"/> 10 - Hypo/Hyperglycemia, diabetes out of control</p> <p><input type="checkbox"/> 11 - GI bleeding, obstruction, constipation, impaction</p> <p><input type="checkbox"/> 12 - Dehydration, malnutrition</p> <p><input type="checkbox"/> 13 - Urinary tract infection</p> <p><input type="checkbox"/> 14 - IV catheter-related infection or complication</p> <p><input type="checkbox"/> 15 - Wound infection or deterioration</p> <p><input type="checkbox"/> 16 - Uncontrolled pain</p> <p><input type="checkbox"/> 17 - Acute mental/behavioral health problem</p> <p><input type="checkbox"/> 18 - Deep vein thrombosis, pulmonary embolus</p> <p><input type="checkbox"/> 19 - Scheduled treatment or procedure</p> <p><input type="checkbox"/> 20 - Other than above reasons</p> <p><input type="checkbox"/> UK - Reason unknown</p> <p>[Go to M0903]</p> |
| ITEM INTENT |
| Identifies the specific condition(s) necessitating hospitalization. |
| TIME POINTS ITEM(S) COMPLETED |
| Transfer to inpatient facility - with or without agency discharge |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> Mark all that apply. For example, if a psychotic episode results from an untoward medication side effect, both Response 1 and Response 17 would be marked. As another example, if a patient requires hospitalization for both heart failure and pneumonia, both Response 3 and Response 5 would be marked. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> Telephone contact with patient/caregiver/family Facility discharge planner or case manager Physician Insurance case manager |

OASIS Item Guidance

Discharge

| OASIS ITEM |
|---|
| <p>(M2440) For what Reason(s) was the patient Admitted to a Nursing Home? (Mark all that apply.)</p> <p><input type="checkbox"/> 1 - Therapy services</p> <p><input type="checkbox"/> 2 - Respite care</p> <p><input type="checkbox"/> 3 - Hospice care</p> <p><input type="checkbox"/> 4 - Permanent placement</p> <p><input type="checkbox"/> 5 - Unsafe for care at home</p> <p><input type="checkbox"/> 6 - Other</p> <p><input type="checkbox"/> UK - Unknown</p> <p>[Go to M0903]</p> |
| ITEM INTENT |
| Identifies the reason(s) the patient was admitted to a nursing home. |
| TIME POINTS ITEM(S) COMPLETED |
| Transfer to inpatient facility - with or without agency discharge |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • This item excludes acute care facility and rehabilitation facility admissions, which are defined as admissions to a freestanding rehabilitation hospital, a certified distinct rehabilitation unit of a nursing home, or part of a general acute care hospital. • Mark all that apply. For example, if a patient has dementia and is unsafe for care at home and there is no plan for the patient to leave the facility, both Response 4 and Response 5 would be marked. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Telephone contact with caregiver or family • Insurance case manager • Physician • Nursing home facility |

OASIS Item Guidance

Discharge

| |
|--|
| OASIS ITEM |
| <p>(M0903) Date of Last (Most Recent) Home Visit:</p> <p style="text-align: center;"> ____/____/____ month / day / year </p> |
| ITEM INTENT |
| Identifies the last or most recent home visit by any agency provider that is included on the Plan of Care. |
| TIME POINTS ITEM(S) COMPLETED |
| <p>Transfer to an inpatient facility - with or without agency discharge</p> <p>Death at home</p> <p>Discharge from agency</p> |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits of the year. • If the agency policy is to have an RN complete the comprehensive assessment in a therapy-only case, the RN can perform the discharge assessment after the last visit by the therapist. |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Clinical record |

OASIS Item Guidance

Discharge

| OASIS ITEM |
|--|
| <p>(M0906) Discharge/Transfer/Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient.</p> <p style="text-align: center;"> ____ / ____ / ____ month / day / year </p> |
| ITEM INTENT |
| Identifies the actual date of discharge, transfer, or death (at home), depending on the reason for assessment. |
| TIME POINTS ITEM(S) COMPLETED |
| Transfer to an inpatient facility - with or without agency discharge Death at home Discharge from agency |
| RESPONSE—SPECIFIC INSTRUCTIONS |
| <ul style="list-style-type: none"> • If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year. • The date of discharge is determined by agency policy or physician order. • The transfer date is the actual date the patient was admitted to an inpatient facility. • The death date is the actual date of the patient's death at home. Exclude death occurring in an inpatient facility or in an emergency department, as both situations would result in Transfer OASIS collection and would report the date of transfer. Include death that occurs while a patient is being transported to an emergency department or inpatient facility (before being seen in the emergency department or admitted to the inpatient facility). |
| DATA SOURCES / RESOURCES |
| <ul style="list-style-type: none"> • Agency policy or physician order • Telephone contact with the family or medical service provider may be required to verify the date of transfer to an inpatient facility or death at home. |

