OASIS - “The Basics & Beyond”

2 Day Workshop OASIS Workshop
June 12 - 13, 2018

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Objectives

• Day 1:
  • Understand the basics of the OASIS Data Set
  • Discuss the concept and flow of OASIS and the comprehensive assessment
  • Outline the rationale and the intent of M items
    • Medicare OASIS guidance Manual used
    • Work through patient scenarios and how to correlate to M items

• Day 2:
  • Outline the rationale and the intent of M items (continued)
  • Discuss how OASIS leads to outcomes and identify what we see in outcome reports
  • Understand how to do OASIS comprehensive assessments to get accurate scores and increased outcomes
  • Review the upcoming OASIS D updates
CMS describes OASIS as “a key component of Medicare’s partnership with the home care industry to foster and monitor improved home health care outcomes”.
History of OASIS

- In 1999, CMS revised the CoPs - HHAs have to do OASIS integrated into HHA's comprehensive assessment.
- Goal was to evaluate the extent to which the quality & scope of services furnished by the HHA attain and maintain the highest practicable functional capacity of the patient as reflected in the plan of care.
- Each patient receives a patient-specific, comprehensive assessment that identifies the patient's need for home care and that meets the patient's medical, nursing, rehabilitative, social, and discharge planning needs.
- The rule requires HHAs use OASIS when evaluating adult, non-maternity patients.

Quality Measures

- Home health quality measurements derived from OASIS are used to address six aims - safety, timeliness, effectiveness, efficiency, equity, and patient-centeredness
- Input from the NQF, (National Quality Forum), a nonprofit organization that endorses national consensus standards for measuring and publicly reporting on performance, has been especially valuable in guiding the evolution of OASIS and associated performance reports.
- These measurements lead to our CASPER Outcome reports
Reimbursement

- OASIS scores and diagnoses drive the reimbursement given to a HHA patient for a 60 day period.
- This is especially important for traditional Medicare patients.
- The Medicare Advantage, Medicaid and private insurance mostly pay by a visit rate regardless of the OASIS data.
- There are reimbursement points from the OASIS data that lead to the amount for 60 days episode.

OASIS Guidance Manual
OASIS Guidance Manual

- The OASIS manual provides guidance for home health agencies (HHAs) on how to ensure the collection of high-quality (accurate) OASIS data.
- It includes both general data collection conventions and item-specific guidance, intent to be utilized, as well as links to quality-related resources for agencies.
- This manual, particularly Chapter 3, gives the details on how to assess the patient and score the items most accurately.
- 388 Pages! Chapter 3 is main one to know
- Very important to follow these guidelines and intent!

OASIS Guidance Manual - Example

- (M1800) Grooming: Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).
  - 0- Able to groom self-unaided, with or without the use of assistive devices or adapted methods.
  - 1- Grooming utensils must be placed within reach before able to complete grooming activities.
  - 2- Someone must assist the patient to groom self.
  - 3- Patient depends entirely upon someone else for grooming needs.
**OASIS Guidance Manual - Example**

M1800 – Grooming (continued)

**ITEM INTENT**

- Identifies the patient’s ability to tend to personal hygiene needs, excluding bathing, shampooing hair, and toileting hygiene.

- The intent of the item is to identify the patient’s ABILITY, not necessarily actual performance. “Willingness” and “adherence” 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: physical impairments (for example, limited range of motion, impaired balance)
  - Emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)
  - Sensory impairments, (for example, impaired vision or pain)
  - Environmental barriers (for example, accessing grooming aids, mirror and sink).

**TIME POINTS ITEM(S) COMPLETED**

- Start of care
- Resumption of care
- Discharge from agency—not to an inpatient facility.
OASIS Guidance Manual - Example

M1800 – Grooming (continued)

RESPONSE—SPECIFIC INSTRUCTIONS

• 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 able to do 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.

OASIS Guidance Manual - Example

M1800 – Grooming (continued)

RESPONSE—SPECIFIC INSTRUCTIONS

• Grooming includes several activities. The frequency with which selected activities are performed (such as washing face and hands vs. fingernail care) must be considered in responding. Patients able to do more frequently performed activities (for example, 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, enter 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.
OASIS Guidance Manual - Example

M1800 – Grooming (continued)

DATA SOURCES / RESOURCES
- Observation/demonstration is the preferred method.
- Patient/caregiver interview.
- Physical assessment.
- Environmental assessment.

M0100 - OASIS Timepoints
- SOC: Initial Assessment - within 48 hours of referral
  - The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care
- ROC: Within 48 hours of patients return home from inpatient facility admission of 24 hours or more for reasons other than diagnostic tests
  - ⭐ NEW CoP ALERT – On physician ordered resumption of care date
- Recert: Not less frequently than last 5 days of every 60 day episode beginning with SOC date (day 56-60 of each cert period)
- Other follow Up - Major decline or improvement in health status
- Transfer to inpatient facility – Not discharged
- Transfer to inpatient facility – Discharged
- Death at Home
- Discharge
Initial / Comprehensive Assessment

Who Completes:

- RN
  - If skilled nursing ordered at SOC
    - Even just a one-time nursing order
    - If agency policy/practice is RN completing on all patients

Qualifying therapist (PT or ST)

- If “therapy only” case and need for service establishes program eligibility
  - OT may not establish program eligibility for Medicare
    - May for other payers

Comprehensive Assessment

The comprehensive assessment MUST

1. Identify the patient's continuing need for home care;
2. Meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs; and
3. For Medicare patients, identify eligibility for the home health benefit, including the patient's homebound status

- Identifies patient progress toward desired outcomes or goals of the care plan
- Direct observation is the preferred method for data collection, but some historical data may only be obtained by interview
  - The interview should supplement, not replace, observational techniques
- OASIS data must accurately reflect the patient's status at the time the information is collected
OASIS Conventions (Rules)

• Time Period - must know what it is for each M item.
  • Report what is true on day of assessment unless a different time period has been indicated in the item or guidance.
  • Day of assessment is defined as 24 hours immediately preceding the visit.

• A Care episode or quality episode must have beginning (SOC, ROC assessment) & a conclusion (transfer or discharge) to be considered a complete care episode.
OASIS Conventions (Rules)

- If patient’s ability or status varies on day of assessment, report patient’s ‘usual status’ or what is true > than 50% of the assessment time frame. Unless the item specified differently.
- Minimize use of NA and Unknown responses
- Some items allow a dash response. A dash (–) value indicates that no information is available, and/or an item could not be assessed. This most often occurs when the patient is unexpectedly transferred, discharged or dies before assessment of the item could be completed. CMS expects dash use to be a rare occurrence.

OASIS Conventions (Rules)

- Response to patient current status should be independent observation of the patient’s condition & ability at time of assessment without referring back to prior assessments.
  - Several process items require documentation of prior care, at the time of or since the time of the most recent assessment. Instructions in guidance and M items
- Combine observation, interview, & other relevant strategies to complete OASIS data items as needed (for example: discharge summary from hospital), however when assessing physiologic or functional health status, direct observation is the preferred strategy.
- OASIS items refer to assistance, this means assistance from another person unless otherwise specified within the item. Assistance is not limited to physical contact & includes both verbal cues and supervision.
Expansion of the One Clinician Convention

- Was effective as of January 1, 2018
- Comprehensive assessment will continue to be the responsibility of one clinician as required by the CoPs but……
  - Now allows the assessing clinician to get feedback from other agency staff to complete any or all OASIS items
- MOO90 – Date assessment completed may need changed
  - The last day the assessing clinician gathered or received any input to complete the comprehensive assessment document
- References:
  - Chapter 1 in the 2018 Guidance Manual

Expansion of the One Clinician Convention - Unplanned or Unexpected Discharges

Should happen very infrequent but does require the following:

- Patient visit with comprehensive assessment
  - If unable, a qualified clinician completes the assessment based on their last visit AND may supplement information from visits made to the patient within the last 5 days of the unexpected/unplanned discharge
  - Ensure collaboration documentation is documented within chart

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<thead>
<tr>
<th>Sunday</th>
<th>Monday</th>
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<td>2 - PT</td>
<td>3</td>
<td>4 - RN</td>
<td>5 - AIDE</td>
<td>6 - PTA</td>
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<td>8</td>
<td>9 - PTA</td>
<td>10 - MD Appt: Received call to D/C</td>
<td>11 – Patient scheduled for outpatient therapy</td>
<td>12</td>
<td>13</td>
<td>14</td>
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</table>
Unplanned or Unexpected Discharges

M0090: Date assessment completed
  • The date that the agency completes the assessment

M0903: Date of the last home visit
  • Last visit that was made by ANY agency staff

M0906: Discharge date
  • Follow agency policy but remember that it can’t be before the last visit

<table>
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<tr>
<th>Sunday</th>
<th>Monday</th>
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Last 5 days patient received visits

OASIS Conventions (Rules)

• When OASIS item includes language specifying “One Calendar Day” (for example, medical follow-up M2002), this means until the end of the next calendar day. When says “Same Day”
  • Example: M1510 Heart Failure follow-up, this means by the End of Today.

• Conventions specific to ADL/IADL items

• Follow rules in Item specific guidance (Chapter 3 of OASIS Manual)

• Complete OASIS items accurately & comprehensively

• Understand definitions of words in OASIS

• Stay current with evolving CMS OASIS guidance updates. CMS may post updates up to quarterly
LET’S TAKE A LOOK AT THE OASIS DATA SETS!

- These do not have the comprehensive assessment incorporated.
- CMS mandates that each HHA includes within the OASIS a full comprehensive assessment.
OASIS M Items

Part 2(a)

Reviewing the Intent & How to Assess and Answer
Clinical Record Items

OASIS Time Points

Outcome and Assessment Information Set
Items to be Used at Specific Time Points

<table>
<thead>
<tr>
<th>Time Point</th>
<th>Items Used</th>
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<tbody>
<tr>
<td>Follow-Up</td>
<td>M0080-M0100, M0110, M1011, M1021-M1025, M1030, M1200, M1242, M1306, M1311, M1322-M1342, M1400, M1410, M1600, M1620, M1630, M1810-M1840, M1850, M1860, M2030, M2200</td>
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<tr>
<td>Transfer to an Inpatient Facility</td>
<td>M0080-M0100, M1041-M1056, M1501, M1511, M2005, M2016, M2301-M2410, M2430, M9003, M9006</td>
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<tr>
<td>Discharge from Agency — Not to an Inpatient Facility</td>
<td>M0030-M0100, M2005, M9003, M9006</td>
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| Discharge from agency                      | M0080-M0100, M1041-M1056, M1230, M1242, M1306-M1342, M1400, M1501-M1520, M1700-M1720, M1740, M1745, M1800-M1890, M2005, M2016-M2030, M2102,  

OASIS-G2 – SOC Item Set
Effective 1/1/15
Centers for Medicare & Medicaid Services
M0080 - Discipline of Person Completing Assessment

1 – RN
2 – PT
3 – SLP / ST
4 - OT

M0090 - Date Assessment Completed

- If agency policy allows assessments to be performed over more than one visit date, the last date (when the final assessment data are collected) is the appropriate date to record.

- If the clinician needs to follow-up, off site, with the patient’s family or physician in order to complete an OASIS or non-OASIS portion of the comprehensive assessment, M0090 should reflect the date that last needed information is collected.

- If the original assessing clinician gathers additional information during the SOC 5-day assessment time frame that would change a data item response, the M0090 date would be changed to reflect the date the information was gathered and the response change was made.
M0090 - Date Assessment Completed (continued)

• Does not have to be the date of the initial SOC visit
• There are 5 days to complete the assessment
• The date may be on a date that does not coincide with a visit
• This is the date you get your last piece of information for the OASIS
• Example: Waiting to hear back from doctor for clarification, drug regimen review, orders, etc.
• Example: Waiting for therapy to assess patient to confer about M2200 and plan of care

M0100 - OASIS Timepoints

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Start/Resumption of Care</th>
<th>Follow-Up</th>
<th>Transfer to an Inpatient Facility</th>
<th>Discharge from Agency — Not to an Inpatient Facility</th>
<th>Death at home</th>
<th>Discharge from agency</th>
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<td>8</td>
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<td>Resumption of care (after inpatient stay)</td>
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<td>Recertification (follow-up) reassessment [Go to M0110]</td>
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**M0100-OASIS Timepoints**

- SOC - initial assessment
- ROC - within 48 hours of pts return home from inpatient facility admission of 24 hours or more for reasons other than diagnostic tests
  - NEW CoP – OR physician ordered resumption of care date
- Recert - not less frequently than last 5 days of every 60 day episode beginning with SOC date (day 56-60 of each cert period)
- Other Follow Up - Major decline or improvement in health status
- Transfer to Inpatient Facility - Not discharged
- Transfer to Inpatient Facility - Discharged
- Death at Home
- Discharge

**Initial / Comprehensive Assessment**

Initial Assessment
- Determines immediate care, support needs, eligibility & homebound status

Comprehensive Assessment
- Is consistent with the patient’s immediate care needs
- Can not be started before the SOC date
- Has to be completed within 5 calendar days of the SOC
Initial / Comprehensive Assessment

Who Completes

• RN
  • If skilled nursing ordered at SOC
  • Even just a one time nursing order
  • If agency policy/practice is RN completing on all patients

• Qualified therapist (PT or ST)
  • If “therapy only” case and need for service establishes program eligibility
  • OT may not establish program eligibility for Medicare

M0110 - Episode Timing

• Is the HH payment episode for which this assessment will define a case mix group an ‘early’ episode or a ‘later episode’ in the patients current sequence of adjacent Medicare HH payment episodes?
  • 1-early
  • 2-later
  • UK- unknown
  • NA- no Medicare case mix group to be defined by the assessment.
M0110 - Episode Timing

- There is more payment given for later episodes as CMS feels they cost more money.
- Early is 1st or 2nd episode in a series of ‘adjacent’ episodes
- Not just your agency
- Adjacent is if there is not more than 60 days between episodes
- Later is 3rd or later episode series of adjacent episodes
- Determines RAP
- Will be corrected at claims processing center if incorrect

M0110 - Scenario

Your patient was under care with a Medicare HMO for three episodes until Sept. 30th. The patient transferred to traditional Medicare, effective October 1st, and was admitted to your agency on October 2nd. How should the clinician answer M0110 (Episode timing)?

Possible Answers:
- a. Early
- b. Late
- c. UK – Unknown
- d. NA – Not Applicable
(M1000) From which of the following Inpatient Facilities was the patient discharged within the past 14 days? (Mark all that apply.)

- Long-term nursing facility (NF)
- Skilled nursing facility (SNF / TCU)
- Short-stay acute hospital
- Long-term care hospital (LTCH)
- Inpatient rehabilitation hospital or unit (IRF)
- Psychiatric hospital or unit
- Other (specify)
- Patient was not discharged from an inpatient facility [Go to M1017]
**M1000- Intent**

- 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.

**M1005 - Inpatient Discharge Date (most recent):**

- Identifies the date of the most recent discharge from an inpatient facility (within last 14 days). (Past 14 days encompasses the two-week period immediately preceding the Start/Resumption of Care date.)
- 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.
Diagnosis Coding M Items:

- (M1011) List each Inpatient Diagnosis...for only those conditions actively treated during an inpatient stay having a discharge date within the last 14 days...

- (M1017) Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days: List ...for those conditions requiring changed medical or treatment regimen within the past 14 days

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 prior to the inpatient stay or change in medical or treatment regimen. (Mark all that apply.)

- Urinary incontinence
- Indwelling/suprapubic catheter
- Intractable pain
- Impaired decision-making
- Disruptive or socially inappropriate behavior
- Memory loss to the extent that supervision required
- None of the above
- NA- No inpatient facility discharge and no change in medical or treatment regimen in past 14 days
- UK- Unknown
A patient is admitted to home health for new blood pressure medication teaching. The patient was recently discharged from the hospital where he was treated for uncontrolled hypertension.

He tells you that prior to his hospital admission he had never had a problem with his blood pressure. However, he relates that he was experiencing a stressful time in his personal life prior to his hospitalization and thinks that the stress may have contributed to his high blood pressure.

How should you answer M1018 (Conditions prior to medical/treatment regimen change or inpatient stay)?

Possible Answers:

a. 1 – Urinary incontinence
b. 2 – Indwelling/suprapubic catheter
c. 3 – Intractable pain
d. 4 – Impaired decision-making
e. 5 – Disruptive or socially inappropriate behavior
f. 6 – Memory loss to the extent that supervision required
g. 7 – None of the above
h. NA – No inpatient facility discharge and no change in medical or treatment regimen in past 14 days
i. UK – Unknown
M1021/1023/1025 - Diagnoses, Symptom Control, and Optional Diagnoses

- (M1021) Primary Diagnosis
- (M1023) Other Diagnoses
- (M1025) Optional Diagnoses (OPTIONAL) (not used for payment)

- The patient's primary home health diagnosis is defined as the chief reason the patient is receiving home care and the diagnosis most related to the current home health Plan of Care.

- Secondary diagnoses are comorbid conditions that exist at the time of the assessment, that are actively addressed in the patient's Plan of Care, or that have the potential to affect the patient's responsiveness to treatment and rehabilitative prognosis.

Identifying the Patient’s Primary and Secondary Home Health Diagnoses

- The assessing clinician is expected to complete the patient’s comprehensive assessment and understand the patient’s overall medical condition and care needs before selecting and assigning diagnoses.

- The determination of the patient’s primary and secondary home health diagnoses must be made by the assessing clinician based on the findings of the assessment, information in the medical record, and input from the physician.

- The primary diagnosis may or may not relate to the patient’s most recent hospital stay, but must relate to the skilled services (skilled nursing, physical therapy, occupational therapy, and speech language pathology) rendered by the HHA.
Identifying the Patient's Primary and Secondary Home Health Diagnoses

- When determining secondary diagnoses, the assessing clinician should consider diagnoses that are actively addressed in the Plan of Care as well as diagnoses that affect the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself.

- Diagnoses may change during the course of the home health stay due to a change in the patient's health status or a change in the focus of home health care. At each required OASIS time point, the clinician must assess the patient's clinical status and determine the primary and secondary diagnoses based on patient status and treatment plan at the time of the assessment.

- Only current medical diagnoses should be reported as primary or secondary diagnoses in M1021 and M1023. Diagnoses should be excluded if they are resolved or do not have the potential to impact the skilled services provided by the HHA. An example of a resolved condition is cholecystitis following a cholecystectomy.

Reporting the Symptom Control Rating in Column 2 of M1021 and M1023

- At each required time point, the assessing clinician should record the symptom control ratings for each primary and secondary diagnosis in column 2 of M1021 and M1023.

- 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.
M1021/ 1023/ 1025: Diagnoses, Symptom Control and Optional Diagnoses

- (M1021) Primary Diagnosis
- (M1023) Other Diagnoses
- (M1025) Optional Diagnoses (OPTIONAL) - not used for payment

The patient’s primary home health diagnosis is defined as the chief reason the patient is receiving home care and the diagnosis most related to the current home health plan of care.

Secondary diagnoses are co-morbid conditions that exist at the time of the assessment, that are actively addressed in the patient’s plan of care, or that have the potential to affect the patient’s responsiveness to treatment and rehabilitative prognosis.

Identifying the Patient’s Primary Home Health Diagnosis

- The assessing clinician is expected to complete the patient’s comprehensive assessment and understand the patient’s overall medical condition and care needs before selecting and assigning diagnoses.

- The determination of the patient’s primary and secondary home health diagnoses must be made by the assessing clinician based on the findings of the assessment, information in the medical record, and input from the physician.

- The primary diagnosis may or may not relate to the patient’s most recent hospital stay, but must relate to the skilled services rendered by the HHA.
  - Skilled nursing, physical therapy, occupational therapy, and speech language pathology
Identifying the Patient’s Primary Home Health Diagnosis

• Secondary diagnoses those that are actively addressed in the POC as well as diagnoses that affect the patient’s responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself.

• Diagnoses may change during the course of the home health stay due to a change in the patient’s health status or a change in the focus of home health care.
  • At each required OASIS time point, the clinician must assess the patient’s clinical status and determine the primary and secondary diagnoses based on patient status and treatment plan at the time of the assessment.

M1021 / M023: Diagnoses

• Only current medical diagnoses should be reported as primary or secondary diagnoses in M1021 and M1023
  • Diagnoses should be excluded if they are resolved or do not have the potential to impact the skilled services provided by the HHA.
M1021 / M023: Diagnoses

Three steps to accuracy:

• Complete comprehensive assessment
• Develop the plan of care
• Paint the patient’s diagnostic picture vertically
  • Not by symptom control rating

Reporting the Symptom Control Rating

• At each required time point, the assessing clinician should record the symptom control ratings for each primary and secondary diagnosis in column 2 of M1021 and M1023
• 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
**M1028 - Active Diagnoses Comorbidities and Co-Existing Conditions**

Check all that apply

- (See OASIS Guidance Manual for a complete list of relevant ICD-10 codes)
  - 1 - Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
  - 2 - Diabetes Mellitus (DM)

**ITEM INTENT**

- This item identifies whether two specific diagnoses are present, and active. These diagnoses influence a patient's functional outcomes or increase a patient's risk for development or worsening of pressure ulcers.

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**M1028 - PVD/ PAD and DM**

**Item Rationale**

- Disease processes can have a significant adverse effect on an individual's health status and quality of life.

- This section identifies active diagnoses that are associated with a patient's home health episode of care.

- A Dash (–) value is a valid response for this item. A dash (–) value indicates that no information is available and/or an item could not be assessed. This most often occurs when the patient is unexpectedly transferred, discharged or dies before the assessment of the item could be completed. CMS expects dash use to be a rare occurrence.

- TIME POINTS ITEM(S) COMPLETED - Start of Care/ Resumption of Care
**M1028**

Select Response 1 if the patient has an active diagnosis of Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD), indicated by any of the following diagnosis codes:

- Codes that start with the first 4 characters of I70 (256 codes!)
- I70.2 – Atherosclerosis of native arteries of the extremities
- I70.3 – Atherosclerosis of bypass graft(s) of the extremities
- I70.4 – Atherosclerosis of autologous vein bypass graft(s) of the extremities
- I70.5 – Atherosclerosis of nonautologous biological bypass graft(s) of the extremities
- I70.6 – Atherosclerosis of nonbiological bypass graft(s) of the extremities
- I70.7 – Atherosclerosis of other type of bypass graft(s) of the extremities
- I70.91 – Generalized atherosclerosis
- I70.92 – Chronic total occlusion of artery of the extremities AND MANY MORE!

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**M1028**

- Select Response 1 if the patient has an active diagnosis of Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD), indicated by any of the following diagnosis codes:

  - Codes that start with the first 3 characters of I73. – Other peripheral vascular diseases
  - I73.0 Raynaud’s syndrome
  - I73.1 Thromboangiitis obliterans [Buerger’s disease]
  - I73.8 Other specified peripheral vascular diseases
    - I73.81 Erythromelalgia
    - I73.89 Other specified peripheral vascular diseases
  - I73.9 Peripheral vascular disease, unspecified
M1028

- Select Response 2 if the patient has an active diagnosis of Diabetes Mellitus (DM) indicated by any of the following diagnosis codes:
  - Codes that start with the first 3 characters of:
    - E08. – Diabetes mellitus due to underlying condition
    - E09. – Drug or chemical induced diabetes mellitus
    - E10. – Type 1 diabetes mellitus
    - E11. – Type 2 diabetes mellitus
    - E13. – Other specific diabetes mellitus

M1028 - Scenario

Scenario: The referral does not state your patient has either DM or PVD. What is the correct response for M1028?

Possible Answers:

a. 1 - PVD/PAD
b. 2 - Diabetes Mellitus (DM)
c. (-) dash
d. Skip
M1028 - Scenario

A patient is admitted to home health following hip replacement surgery. The patient is an insulin dependent Type 2 Diabetic which is well controlled at this time.

The therapist is completing the OASIS assessment and knows the patient is at increased risk for exacerbation of the DM due to change in activity level, stress of surgery, wound healing issues etc.

The PT will be observing the patient for signs of any complications while treating but has no specific DM interventions on the POC.

The PT is unsure how to answer M1028 since currently the DM is controlled and the patient is very knowledgeable and compliant.

M1030 - Therapies the Patient Receives at Home: (mark all that apply)

1- Intravenous or infusion therapy (excludes TPN)

2- Parenteral nutrition (TPN or lipids)

3- Enteral Nutrition (NG, Gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)

4- None of the above

- This item is not intended to identify therapies administered in outpatient facilities or by any provider outside the home setting.
M1030- CMS Guidance

1- Infusion Therapy

- Infusion – Agency or patient/caregiver administers; prn order for infusion with assessment indicating need for therapy now; IV administered by another provider in the home; peritoneal dialysis catheter with an order to flush while in the home to maintain patency
- Types- central line, sub-Q infusion, epidural infusion, implanted or external pump, insulin pump, eclipse bulb (for local infusion of pain med into a wound), home dialysis, including peritoneal

M1030- CMS guidance

2- Parenteral therapy

- Agency, patient/caregiver administers
- Being administered by another provider in home
- 3- Enteral Therapy
- Agency or patient/caregiver provides enteral therapy
- Order for prn enteral therapy for nutritional reasons and patient has received prn enteral therapy within last 24 hours
M1030 - Scenario

Your patient has a central line and the physician has ordered IV fluids PRN when the patient's systolic BP goes below 100.

At the SOC assessment, the patient's BP is 110/74, and he doesn't need IV fluids. How should you answer M1030 (Therapies at home)?

Possible Answers:

a. 1 – Intravenous or infusion therapy (excludes TPN)

b. 2 – Parenteral nutrition (TPN or lipids)

c. 3 – Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)

d. 4 – None of the above

Home health patient has a triple lumen line for TPN continuously the agency is flushing the other 2 lines daily.
M1033 - Risk for Hospitalization

• Collects data on factors identified as predictive of hospitalization
• Time periods specific and grouped to reflect length of look back period
• Removed statement to use professional judgment- signs/symptoms are objective

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

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

The patient also has a history of hypertension.

The patient is on four medications for his diabetes and hypertension and also takes an aspirin a day.

The patient's wife reports that he has "slipped" and fallen in the home twice in the past month but that the falls were "no big deal."

How should the clinician answer M1033 (Risk for hospitalization)?

Possible Answers:

a. 1 - History of falls (2 or more falls - or any fall with an injury - in the past 12 months)
b. 2 - Unintentional weight loss of a total of 10 pounds or more in the past 12 months
c. 3 - Multiple hospitalizations (2 or more) in the past 6 months
d. 4 - Multiple emergency department visits (2 or more) in the past 6 months
e. 5 - Decline in mental, emotional, or behavioral status in the past 3 months
f. 6 - Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
g. 7 - Currently taking 5 or more medications
h. 8 - Currently reports exhaustion
i. 9 - Other risk(s) not listed in 1 - 8
j. 10 - None of the above
M1034 - Scenario

During your start-of-care assessment, you determine that your patient has several co-morbidities that are all getting progressively worse and could lead to the death of the patient within a year.

However, the family tells you that the patient does not have a "do not resuscitate" (DNR) order in place. How should you answer M1034 (Overall status)?

Possible Answers:

a. 0 – The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient’s age).

b. 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).

c. 2 – The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death.

d. 3 – The patient has serious progressive conditions that could lead to death within a year.

e. UK – The patient's situation is unknown or unclear.
**M1041 & M1046: Influenza Vaccine**

**M1041**

- Does this episode of care (SOC/ROC to transfer/discharge) include any dates on or between October 1 and March 31?
- Identifies whether the patient was receiving services from the HHA during the time period for which influenza vaccine data are collected
- October 1 – March 31

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**M1041 & M1046: Influenza Vaccine**

**M1046**

- When 1041 is “Yes” then complete
- Identifies:
  - If the patient received the flu vaccine for this year’s flu season
  - Flu season is defined by CDC
  - Flu season begins with vaccine is available for administration and typically ends 03/31
  - Who gave the vaccine
  - Reason why flu vaccine was not received
- Suggest including this question in discharge review process
M1046- Influenza Vaccine Received:

Did the patient receive the Influenza Vaccine for this year’s flu season?

- Yes, received from your agency during this episode of care (SOC/ROC to Transfer/DC)
- Yes, from your agency during a prior episode
- Yes, received from another healthcare provider (example: physician, pharmacist)
- No, patient offered and declined
- No, patient assessed and determined to have has medical contraindications
- No, not indicated-patient doesn’t meet age/condition guidelines for influenza vaccine
- No, inability to obtain due to declared shortage
- No, patient didn’t receive due to OTHER reasons

M1046 - SCENARIO

Did the patient receive the influenza vaccine for this year’s flu season?

- Mrs. Smith received her flu vaccine from the senior community center where your agency was giving them on October 15.
- Your agency submitted a flu vaccine roster billing for this clinic.
- Mrs. Smith was then admitted to your agency on November 15.
- How do you answer?
M1046 - Scenario

You are performing an OASIS discharge visit on December 14th for a patient whose episode began November 1st.

The patient had previously received the flu vaccine on October 5th while attending a flu vaccine clinic offered by your agency at his church. What is the appropriate response to M1046?

Possible Answers:

a. 1 - Yes; received from your agency during this episode of care (SOC/ROC to Transfer/Discharge)
b. 2 - Yes; received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge)
c. 3 - Yes; received from another health care provider (for example: physician, pharmacist)
d. 4 - No; patient offered and declined
e. 5 - No; patient assessed and determined to have medical contraindication(s)
f. 6 - No; not indicated - patient does not meet age/condition guidelines for influenza vaccine
g. 7 - No; inability to obtain vaccine due to declared shortage
h. 8 - No; patient did not receive the vaccine due to reasons other than those listed in Responses 4-7.
M1051 & M1056: Pneumococcal Vaccine

M1051

- Identifies if the patient as EVER received the vaccine
  - Does not need to be up to date
    - Simplified item and eliminated “during episode of care” and “from your agency”

M1056

- When 1051 is “No” then complete
- Explains why the patient has NEVER received the vaccine:
  1 - Offered and declined
  2 - Assessed and determined to have medical contraindication(s)
  3 - Not indicated; patient does not meet age/condition guidelines for vaccine
  4 - None of the above

M1056 - Scenario

Your agency admits a home health patient on July 24th (SOC date). During the SOC assessment, the patient tells the clinician that he has never received the pneumonia vaccine. Since there are no contraindications for taking the vaccine, the clinician offers to set up an appointment for him to get the vaccine at his local drug store. The patient tells the clinician that he does not wish to receive the vaccine. What is the appropriate response in M1056 (Reason PPV not received)?

Possible Answers:

a. 1 - Offered and declined
b. 2 - Assessed and determined to have medical contraindication(s)
c. 3 - Not indicated; patient does not meet age/condition guidelines for pneumococcal vaccine
d. 4 - None of the above
M1060 - Height and Weight

• Completed at SOC and ROC
• Height and Weight – While measuring, if the number is X.1 – X.4 round down; X.5 or greater round up
• Height (in inches)
  • Record most recent height measure since the most recent SOC/ROC
  • When reporting height for a patient with bilateral lower extremity amputation, measure and record the patient’s current height (i.e., height after bilateral amputation).
• Weight (in pounds)
  • Measure weight consistently, according to standard agency practice
  • For example: In a.m. after voiding / before meal / with shoes off, etc.

M1060 - Height and Weight

• Assessing clinician is expected to weigh and measure the patient directly
  • If the agency has weighed patient within the last 30 days that weight can be used
  • Values from physician’s office / hospital discharge are not acceptable
  • Values that are self-reported are not acceptable
• Use of dash (-) if no information available
  • Should be a rare occurrence
  • If a patient cannot be weighed, for example, because of extreme pain, immobility, or risk of pathological fractures, enter the dash value (-) and document the rationale in the patient’s medical record
**M1060- Height and Weight**

ITEM INTENT

- These items support calculation of the patient's body mass index (BMI) using the patient's height and weight.
- Item Rationale
  - Diminished nutritional and hydration status can lead to debility that can adversely affect wound healing and increase risk for the development of pressure ulcers.
  - Height and weight measurements (and BMI calculation*) assist staff in assessing the patient's nutrition and hydration status by providing a mechanism for monitoring stability of weight and BMI over a period of time. The measurement of height and weight for the calculation of BMI is one guide for determining nutritional status.

* NOTE - NOT REQUIRED TO DOCUMENT BMI WITHIN THE COMPREHENSIVE ASSESSMENT

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**M1060 - Scenario**

- At SOC, Mr. Jones is unable to get out of bed at the time of assessment due to pain to his lower legs and back after he had fallen and sustained a lumbar compression fracture.
- His height when measured in bed is 72.5 inches.
- The referral information from the hospital identifies his weight is 200 lbs. Mr. Jones confirms that he weighed 200 lbs. when he was discharged yesterday.
M1060 Scenario

• The home health nurse is completing a ROC for her patient.
• The patient is unable to be out of bed to obtain her weight at this visit but at her SOC 22 days ago her weight was obtained and documented by the agency.
• Does the RN enter that weight in her assessment at M1060b?

M1060 - Scenario

Your patient is bedfast with a comorbidity of severe dementia.

He cannot state what his height or weight is, but the referral indicates his measured weight on discharge from the hospital was 212 lbs.

The clinician takes a tape measure and measures his height at 6 feet 1 inch. What is the correct entry for M1060a (Height) and M1060b (Weight)?

Possible Answers:

a. Height: 6.1, Weight: 212
b. Height: 73 inches, Weight: 212
c. Height: 6.1, Weight: (-) dash
d. Height: 73 inches, Weight: (-) dash
**M1011/ M1017 Guidance Clarifies Use of M1017**

- Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days:
  - List the patient’s Medical Diagnoses and ICD-10-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days
  - A diagnosis reported in M1011 – Inpatient Diagnosis may also be reported in M1017 if within the 14 days prior to the SOC/ROC date the condition was:
    - New or exacerbated,
    - Required changes in the treatment regimen, AND
    - The patient was discharged from an inpatient facility where the condition was actively treated.

**M1100- Patient Living Situation**

Which of the following best describe the patient’s residential circumstance and availability of assistance (check one box only)

- Determine living arrangement & availability of assistance
- If the patient has recently changed their living arrangement due to their condition, report the usual living arrangement prior to the illness, injury or exacerbation for which the patient is receiving care, unless the new living arrangement is expected to be permanent
- Availability of assistance refers to the expected availability and willingness of caregiver for this upcoming care episode.
Sensory Status

SENSORY STATUS

• (M1200) Vision (with corrective lenses if the patient usually wears them)
• (M1210) Ability to Hear (with hearing aid or hearing appliance if normally used)
• (M1220) Understanding of Verbal Content in patient's own language (with hearing aid or device if used)
• (M1230) Speech and Oral (Verbal) Expression of Language (in patient's own language)
M1240: Pain Assessment

Has this patient had a formal pain assessment using a standardized, validated pain assessment tool?

0 - No standardized, validated assessment conducted
1 - Yes, and it does not indicate severe pain
2 - Yes, and it indicates severe pain

M1240: Pain Assessment

- A standardized, validated tool is one that:
  - Has been scientifically tested on a population with characteristics similar to that of the patient being assessed, and
  - Includes a standard response scale
    - Example, a scale where patients rate pain from 0 - 10.
  - The tool must be relevant to the patient's ability to respond
  - CMS doesn't endorse a particular pain assessment
M1240 Scenario

During your SOC assessment, you find that the patient has a pain level of 8 out of 10 and is taking pain medications as ordered.

How should you answer the OASIS Drug Regimen Review item?

Possible Answers:

a. 0 – Not assessed/reviewed [Go to M2010]
b. 1 – No problems found during review [Go to M2010]
c. 2 – Problems found during review
d. NA – Patient is not taking any medications [Go to M2040]
**M1240: Pain Assessment**

- Be thorough in the pain assessment
  - Describe the pain?
  - How often is the pain present?
  - Does the patient take their pain medications?
    - If so and the pain is not relieved by medications, contact the physician
    - Deficiencies given on surveys if no notification to physician for Pain!

- Severe pain
  - Defined according to the scoring system for the tool being used
  - Clinicians need to know what rating on scale is severe – consistency is key
    - 7 is what many use for ‘severe pain’

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**M1242 Frequency of Pain Interfering with Patient’s Activity or Movement**

- Intent indicates that inference in activities does not just include ADL’s and may include:
  - Sleep / watching TV / recreational activities

- Look at frequency with which pain interferes with patient’s activities and with treatments

- Pain interferes with activity when pain results in:
  - Activity being performed less often than otherwise desired,
  - Required the patient to have additional assistance in performing the activity, or
  - Causes the activity to take longer to complete
Ms. Jenkins tells the nurse that she doesn’t climb the stairs and she limits walking distances over 20 feet in order to be pain free.

**Would you answer:**

0 - patient has no pain
1 - patient has pain that does not interfere with activity or movement
2 - less often than daily
3 - daily, but not constantly
4 - all of the time

Your home health patient reports that she has severe hip pain, but is able to do all her daily activities by taking her pain medication every four to six hours around the clock.

How should you respond to M1242 (Frequency of pain interfering with activity)?

**Possible Answers:**

a. 0 – Patient has no pain
b. 1 – Patient has pain that does not interfere with activity or movement
c. 2 – Less often than daily
d. 3 – Daily, but not constantly
e. 4 – All of the time
Integumentary Status

M1300  M1302  M1306  M1307
M1311  M1313  M1320  M1322
M1324  M1330  M1332  M1334
M1340  M1342  M1350

Always use OASIS scoring instructions in the guidance manual

Resource

• WOCN
• Wound, Ostomy and Continence Nurse’s Society Guidance
**Pressure Ulcers & OASIS C-2**

- ALL pressure ulcers can heal
- Pressure ulcers should be assessed as close to actual time of the SOC/ROC as possible
- Report Stage identified on the initial clinical assessment
- Once a Stage 2, 3, or 4 pressure ulcer is 100% covered with new epithelized tissue it is considered healed and no longer reported
- A pressure ulcer that has been treated with a skin graft is a surgical wound until edges completely heal

---

**Integumentary**

- CMS Guidance Manual – WOCN- used for OASIS-C2 (some variances from NPUAP):
  - CMS Guidance Manual
    - Home health agencies may adopt the NPUAP guidelines in their clinical practice and documentation. However, since CMS has adapted the NPUAP guidelines for OASIS purposes, the definitions do not perfectly align with each stage as described by NPUAP.
    - When discrepancies exist between the NPUAP definitions and the OASIS scoring instructions provided in the OASIS Guidance Manual and CMS Q&As, providers should rely on the CMS OASIS instructions.
    - Changes to some descriptions but do not match NPUAP exactly:
M1300- Pressure Ulcer Assessment

Was this patient assessed for Risk of Developing Pressure Ulcers?

0- No assessment conducted
1- Yes, based on evaluation of clinical factors for example...without use of standardized tool
2- Yes, using a standardized, validated tool for example, Braden Scale, Norton Scale

If both a standardized, validated screening tool and an evaluation of clinical factors are utilized, enter Response 1 (Yes), if either assessment is positive for risk.

M1306- Unhealed Pressure Ulcers

Does this patient have at least one Unhealed Pressure Ulcer at Stage 2 or Higher or designated as Unstageable?

Excludes:

• Stage I pressure ulcers
• Healed Stage 2 pressure ulcers
• Closed Stage 3 and 4 pressure ulcers
Part 2A

Guidance Manual - M1306

- Stage 3 and 4 (full thickness) pressure ulcers heal through a process of granulation (filling of the wound with connective/scar tissue), contraction (wound margins contract and pull together), and re-epithelialization (covers with epithelial tissue from within wound bed and/or from wound margins).

- Once the pressure ulcer has fully granulated and the wound surface is completely covered with new epithelial tissue, the wound is considered closed, and will continue to remodel and increase in tensile strength.

- For the purposes of scoring the OASIS, the wound is considered healed at this point, and should no longer be reported as an unhealed pressure ulcer.

Guidance Manual - M1306

- Agencies should be aware that the patient is at higher risk of having the site of a closed pressure ulcer open up due to damage, injury, or pressure, because of the loss of tensile strength of the overlying tissue.

- Tensile strength of the skin overlying a closed full thickness pressure ulcer is only 80% of normal skin tensile strength.

- Agencies should pay careful attention that preventative measures are put into place that will mitigate the re-opening of a closed ulcer.
**M1307 at Discharge**

The Oldest Stage 2 Pressure Ulcer that is present at discharge: (Excludes healed Stage 2 Pressure Ulcers)

1- Was present at the most recent SOC/ROC assessment
2- Developed since the most recent SOC/ROC assessment. Record date pressure ulcer first identified: month day year
NA- No Stage 2 pressure ulcers are present at discharge

---

**M1307 at Discharge**

The intent of this item is to:

a) identify the oldest Stage 2 pressure ulcer that is present at the time of discharge and is not fully epithelialized (healed).

b) assess the length of time this ulcer remained unhealed while the patient received care from the home health agency and

c) identify patients who develop Stage 2 pressure ulcers while under the care of the agency.
Guidance

• Do not reverse stage pressure ulcers as a way to document healing as it does not accurately characterize what is physiologically occurring as the ulcer heals.

• For example, over time, even though a Stage 4 pressure ulcer has been healing and contracting such that it is less deep, wide, and long, the tissues that were lost (muscle, fat, dermis) will never be replaced with the same type of tissue.

• Stage 2 (partial thickness) pressure ulcers heal through the process of regeneration of the epidermis across a wound surface called, “re-epithelialization.”

Guidance - OASIS C2 Does Not Document Healed / Closed Stage 3 and 4

• A stage 3 or 4 pressure ulcer with a skin graft is now reported as a surgical wound until graft edges healed.

• Then once it is healed, the pressure ulcer is closed and is not reported.

• Interventions still apply as there is nothing more over the pressure ulcer than the layer of skin from the graft. So could reopen fairly easily.

• A pressure ulcer sutured closed without a flap is unstageable due to non-removable dressing or device since wound bed cannot be observed.
**M1307: The Oldest Stage 2 Pressure Ulcer**

- The oldest Stage 2 pressure ulcer that is present at discharge: (Excludes healed Stage 2 pressure ulcers)
  1. Was present at the most recent SOC/ROC assessment
  2. Developed since the most recent SOC/ROC assessment. Record date pressure ulcer first identified: month / day / year
  NA - No Stage 2 pressure ulcers are present at discharge

- Completed at discharge

- Guidance:
  - Do not reverse Stage pressure ulcers as a way to document healing as it does not accurately characterize what is physiologically occurring as the ulcer heals.

**M1307: The Oldest Stage 2 Pressure Ulcer - Specific Instructions**

- Enter response 1 only if the oldest Stage 2 pressure ulcer that is present at discharge was already present as a Stage 2 pressure ulcer when first assessed at the SOC/ROC.

- Enter response 2 if the oldest Stage 2 pressure ulcer that is present at discharge was NOT a Stage 2 pressure ulcer at the most recent SOC/ROC.
  - If response 2 is entered, specify the date the Stage 2 pressure ulcer was first identified.
M1307: The Oldest Stage 2 Pressure Ulcer – Specific Instructions

- If no pressure ulcer existed at the SOC, then a Stage 1 pressure ulcer developed, which progressed to a Stage 2 by discharge, enter response 2, and specify the date that the pressure ulcer was first identified as a Stage 2 ulcer.
- Enter “NA” if the patient has no Stage 2 pressure ulcers at the time of discharge, or all previous Stage 2 pressure ulcers have healed.
- An ulcer that is suspected of being a Stage 2, but is unstageable due to non-removable dressing/device at the time of discharge, should not be identified as the “oldest Stage 2 pressure ulcer”
  - See M1311 for definition of ‘unstageable due to non-removable dressing/device’

M1311 - Current Number of Unhealed Pressure Ulcers at Each Stage

- For each pressure ulcer, determine whether the pressure ulcer was present at the time of the most recent SOC/ROC, and did not form during this home health quality episode.
- Identifies the number of Stage 2 or higher pressure ulcers at each stage present at the time of assessment.
- Stage 1 pressure ulcers and ulcers that have healed or closed are not reported in this item.
M1311 Guidance

- Terminology referring to “healed” vs. “unhealed” ulcers refers to whether the ulcer is “closed” vs. “open”.

- Recognize, however, that Stage 1 pressure ulcers and Suspected Deep Tissue Injury (SDTI), although closed (intact skin), would not be considered healed.

- Unstageable pressure ulcers, whether covered with a non-removable dressing or eschar or slough, would not be considered healed.

- Determining “Present on Admission”

- For the OASIS, “Present on Admission” and “Present at SOC/ROC” have equivalent meanings.
M1311 Guidance

- A previously closed Stage 3 or Stage 4 pressure ulcer that is currently open again should be reported at its worst stage.

- A muscle flap, skin advancement flap, or rotational flap (defined as full thickness skin and subcutaneous tissue partially attached to the body by a narrow strip of tissue so that it retains its blood supply) performed to surgically replace a pressure ulcer is a surgical wound. It should not be reported as a pressure ulcer on M1311.

- A pressure ulcer treated with a skin graft (defined as transplantation of skin to another site) should now be reported as a pressure ulcer and until the graft edges completely heal, should be reported as a surgical wound on M1340.

Scenario M1311 - Current number of unhealed pressure ulcers at each stage

- You observe that Mr. Green has a scar on his coccyx. You interview the family and they say the patient had a bad pressure ulcer but they do not know what stage it was.

- There is nothing on the referral re: a previous pressure ulcer.

- You call the physician, but he does not have a definitive answer on what the stage of the pressure ulcer was at its worst point.

- How would this pressure ulcer be documented in M1311?
**M1313: Current Number of Unhealed Pressure Ulcers at Each Stage**

(M1313) Worsening in Pressure Ulcer Status since SOC/ROC:

<table>
<thead>
<tr>
<th>Instructions for a-c: Indicate the number of current pressure ulcers that were not present or were at a lesser stage at the most recent SOC/ROC. If no current pressure ulcer at a given stage, enter 0.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 2</td>
</tr>
<tr>
<td>Stage 3</td>
</tr>
<tr>
<td>Stage 4</td>
</tr>
</tbody>
</table>

Instructions for d-e: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were at Stage 1 or 2 at the most recent SOC/ROC.

d. Unstageable – Known or likely but Unstageable due to non-removable dressing

<table>
<thead>
<tr>
<th>Instructions for e: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were at Stage 1 or 2 at the most recent SOC/ROC.</th>
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</tr>
<tr>
<td>Stage 3</td>
</tr>
<tr>
<td>Stage 4</td>
</tr>
</tbody>
</table>

**M1313 Guidance**

- If the pressure ulcer was unstageable for any reason at the most recent SOC/ROC, do not consider it new or worsened if at some point between SOC/ROC and Discharge it became stageable and remained at that same stage at Discharge.

- If the pressure ulcer was unstageable at SOC/ROC, then was stageable on a routine visit and/or Follow-Up assessment, and by Discharge the pressure ulcer had increased in numerical stage since the routine visit and/or Follow-Up assessment, is should be considered worsened at Discharge.

- If a previously stageable pressure ulcer becomes unstageable, then was debrided sufficiently to be restaged by Discharge, compare its stage before and after it was deemed unstageable. If the pressure ulcer’s stage has increased in numerical staging, report this as worsened.

- Pressure ulcers that are Unstageable at Discharge due to a dressing/device, such as a cast that cannot be removed to assess the skin underneath cannot be reported as new or worsened unless no pressure ulcer existed at that site at the most recent SOC/ROC.
CMS Guidance - for M1313
A Lot of Great Information for In-services

One Example:

- Review the history of each current pressure ulcer. Specifically, compare the current stage at Discharge to past stages to determine whether any pressure ulcer currently present is new or at an increased numerical stage (worsened) when compared to the most recent SOC/ROC. Then, for each current stage, count the number of current pressure ulcers that are new or have increased in numerical stage since the last SOC/ROC was completed. This allows a more accurate assessment than simply comparing total counts at Discharge and most recent SOC/ROC.

- If a pressure ulcer increased in numerical stage from SOC (or ROC) to Discharge, it is considered worsened and would be included in counts of worsened pressure ulcers on M1313 at Discharge.

M1313: Worsening in Pressure Ulcer Status Since SOC/ROC - Guidance

- Collecting information at discharge on worsening pressure ulcer status
- Makes it the same as for nursing homes (MDS) and acute care (CARE) tools
- Includes pressure ulcers that at discharge are unstageable due to slough/eschar
- Documents the number that are NEW or have worsened (increase in numerical Stage) since the most recent SOC or ROC
- Compare current Stage to the prior Stage of that ulcer
  - It’s “present on admission” is considered the Stage at which it first becomes numerically Stage able
**M1313 - Scenario**

- Mr. Johnson had a Stage 4 right heel ulcer in the skilled nursing facility (SNF).
- He was admitted to home care on 03/01/18 with an unstageable right heel ulcer.
- The ulcer was debrided and was noted to be a Stage 3 on 03/15/18. Patient was discharged on 04/01/18 with a Stage 3 right heel ulcer.
- Report as new or worsened on M1313?

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**M1320 - Status of Most Problematic Pressure Ulcer that is Observable:** *(Excludes pressure ulcer that cannot be observed due to a non-removable dressing/device)*

- Newly epithelialized
- Fully granulating
- Early/partial granulation
- Not healing
- No observable pressure ulcer
- ITEM INTENT-Identifies the degree of closure visible in the most problematic observable pressure ulcer, Stage 2 or higher.
- Stage 1 pressure ulcers and ulcers that have healed are not considered for this item.
M1320 - Pressure Ulcer Healing Status

- Visualization of wound bed is necessary to identify the healing status of the ulcer.
  - When the wound bed is covered with eschar, slough or non-removable dressing, wound status can’t be determined and N/A is to be selected.
- DTPI are included here.
- Most problematic may be the largest, the most advanced stage, the most difficult to access for treatment, the most difficult to relieve pressure, etc.
- WOCN guidance is followed to determine the most problematic observable pressure ulcer.
- Because Stage 2 ulcers and DTPI do not granulate & newly epithelialized Stage II ulcers are not counted, the only appropriate response for a Stage II ulcer is 3- Not Healing.

M1320 - Scenario

Your home health patient has a Stage 3 pressure ulcer filled with granulation tissue to the surface. It is 85% covered with new epithelial tissue. How should you answer M1320 (Status of most problematic pressure ulcer that is observable)?

Possible Answers:

a. 0 – Newly epithelialized
b. 1 – Fully granulating
c. 2 – Early/partial granulation
d. 3 – Not healing
e. NA – No observable pressure ulcer
M1322- Current number of Stage 1 Pressure Ulcers

- Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.

- Caution to ascertain if the redness is a previous stage 3 or 4!
  - Look at historical medical records, ask physicians and family
  - There are NRS points so be Sure to document supplies used for stage 1 ulcers

M1324-Stage of Most Problematic Unhealed Pressure Ulcer That is Stageable:

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

- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Patient has no pressure ulcers or no stageable pressure ulcers

- Note: most problematic- do not include an ulcer reported in m1311 as un stagable due to non-removable dressings or devices may be the most advanced stage or most difficult to access for treatment or most difficult to relieve pressure

- Ulcers that have healed are not considered for this item.
**M1306-M1324 - Scenario**

Mr. Lake has his pressure ulcer debrided the day before you do his recertification OASIS assessment.

- Would you score the wound now as a pressure ulcer, a surgical wound or both?

**M1324 - Scenario**

You conduct a SOC assessment on your home health patient and assess pressure ulcer risk using a variety of clinical factors, such as mobility, nutrition and incontinence status. Using those clinical factors, you find the patient is not at risk for developing pressure ulcers.

- The patient is not assessed for pressure ulcer risk again during the care episode. There are no pressure ulcer prevention interventions on the plan of care.

- At discharge, what is the most appropriate response to Intervention synopsis – interventions to prevent pressure ulcers?
M1324 - Scenario

Possible Answers:
a. 0 - No
b. 1 - Yes
c. Not applicable

M1330: Stasis Ulcer

Does this patient have a stasis Ulcer?
0 - No [Go to M1340 ]
1 - Yes, patient has BOTH observable and unobservable stasis ulcers
2 - Yes, patient has observable stasis ulcers ONLY
3 - Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing/device) [Go to M1340 ]
Stasis Ulcers

- It is important to differentiate stasis ulcers from other types of skin lesions.
- Once a stasis ulcer has completely epithelialized, it is considered healed and should not be reported as a current stasis ulcer.
- Enter Response 1 if the patient has both an observable stasis ulcer AND a reported stasis ulcer that cannot be observed because of a dressing or device, such as a cast or Unna boot) that cannot be removed.
- Enter Response 3 ONLY if the patient has a reported stasis ulcer that cannot be observed because of a dressing or device, such as a cast or Unna boot that cannot be removed, and has no observable stasis ulcers.
- Information may be obtained from the physician or patient/caregiver regarding the presence of a stasis ulcer underneath the cast or dressing.

M1330 Stasis Ulcer - Guidance

- Stasis ulcers DO NOT include arterial lesions or arterial ulcers
- Once a stasis ulcer has completely epithelialized, it is considered healed and should not be reported as a current stasis ulcer
- Enter response 1 if the patient has both an observable stasis ulcer AND a reported stasis ulcer that cannot be observed because of a dressing or device, such as a cast or Unna boot) that cannot be removed.
  - Information may be obtained from the physician or patient/caregiver regarding the presence of a stasis ulcer underneath the cast or dressing.
M1330 - Scenario- Does the patient have a stasis ulcer?

- Miss Z fell and has a lower extremity wound as a result. She also has diagnoses of venous insufficiency and stasis dermatitis.
- The physician said that the wound is not healing due to the venous insufficiency.
- Is there a point in time when the wound is no longer classified as a traumatic wound and is considered instead a stasis ulcer for M1330?

M1334- Status of Most Problematic Stasis Ulcer that is Observable:

- Fully granulating
- Early/partial granulation
- Not healing

- Identifies the degree of healing present in the most problematic, observable stasis ulcer.
- The “most problematic” ulcer may be the largest, the most resistant to treatment, an ulcer that is infected, etc., depending on the specific situation.
Utilize the Wound Ostomy and Continence Nurses (WOCN) Society’s Guidance on OASIS to Determine Status of The Most Problematic Observable Stasis Ulcer

- Response 1 – Fully Granulating: Enter Response 1 when a stasis ulcer has a wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium; no dead space, no avascular tissue; no signs or symptoms of infection; wound edges are open.

- Response 2 – Early/Partial Granulation: Enter Response 2 when ≥25% of the wound bed is covered with granulation tissue; there is minimal avascular tissue (that is, <25% of the wound bed is covered with avascular tissue); may have dead space; no signs or symptoms of infection; wound edges open.

- Response 3 – Not Healing: Enter Response 3 when wound has ≥25% avascular tissue OR signs/symptoms of infection OR clean but non-granulating wound bed OR closed/hyperkeratotic wound edges OR persistent failure to improve despite appropriate comprehensive wound management.

- Once a stasis ulcer has completely epithelialized and is without signs/symptoms of infection, it is considered
Surgical Wounds

M1340: Surgical Wounds

Does this patient have a surgical wound?

0 - No [At SOC/ROC, go to M1350; At FU/DC, go to M1400]

1 - Yes, patient has at least one observable surgical wound

2 - Surgical wound known but not observable due to non-removable dressing/device [At SOC/ROC, go to M1350; At FU/DC, go to M1400]
M1342: Status of Surgical Wound

Status of most problematic surgical wound that is observable:

0 - Newly epithelialized
1 - Full granulating
2 - Early/partial granulation
3 - Not healing

CMS- Follow WOCN Guidelines When Assessing Status of a Surgical Wound:

• Surgical wounds healing by primary intention do not granulate
• A surgical site closed primarily (with sutures, staples, or a chemical bonding agent) is a surgical wound until re-epithelialization has been present for approximately 30 days, unless it dehisces or present signs of infection.
• After 30 days, it is generally described as a scar and is no longer reportable as a surgical wound.
• A surgical wound that has dehisced or has incision separation is considered to be healing by secondary intention.
• A dehisced wound or one healing by secondary intention is ‘not healing when the amt of avascular tissue is ≥25%.
**M1342 - Status of Most Problematic Surgical Wound That is Observable**

- The presence of staples does not mean surgical wound is not healing.
- Do not consider openings in the skin adjacent to the incision line, caused by staples or suture removal, as part of the surgical wound. This would instead go into M1350-skin lesion/open wound.
- Steri strips are skin closures and not a dressing or device.
  - If they allow sufficient visualization of the wound, report appropriate healing response. If they completely obscure the incision to the point cannot visualize the incision to determine healing status, then response 2- not observable to m1340 surgical wound.
- An implanted vascular device is an observable surgical wound whether or not its being accessed.
  - Not healing is the appropriate response if it has a scab at puncture site or is currently accessed with a device.
  - Newly epithelialized is appropriate response when insertion site has healed.

**M1342 - Surgical Wound - Implanted Venous device:**

- When first implanted, the incision is the surgical wound.
- The assessing clinician will follow the 12/09 WOCN guidance to determine the healing status of the incision.
- Once it is fully epithelialized, the site due to the implanted device will remain a current surgical wound with a status of “Newly epithelialized” for as long as it is present in the patient's body, unless it later develops complications.
- This guidance clarifies and supersedes CMS OASIS Q&A Category 4b, Q105.3.
**Q&A**

Question No. 7 - if a surgical wound gapes open at opposite ends with an area of intact skin between, is it still addressed on OASIS as one surgical wound.

- CMS says Yes.
- Clinicians should consider the portion of the wound bed that is healing by secondary intention when applying the WOCN criteria related to the percentage of the wound bed covered with granulation tissue or the percentage of wound bed covered with avascular tissue.

**M1342 - Status of Surgical Wound - Guidance**

- A dehisced wound or one healing by secondary intention is ‘not healing when the amount of avascular tissue is ≥25%.
- The presence of staples does not mean surgical wound is not healing
- Steri-strips are skin closures and not a dressing or device
  - If they allow sufficient visualization of the wound, report appropriate healing
M1340 & 1342: Surgical Wounds - Guidance

• A pressure ulcer is surgically closed with a flap or graft should be reported as a surgical wound until healed.

• Orthopedic pin sites, central line sites (centrally-inserted venous catheters), stapled or sutured incisions, and wounds with drains are all considered surgical wounds.

• Medi-port sites and other implanted infusion devices or venous access devices are considered surgical wounds.

M1340 & 1342: Surgical Wounds - Guidance

• A bowel ostomy is excluded as a surgical wound, unless a "take-down" procedure of a previous bowel ostomy is performed, in which case the surgical take-down produces a surgical wound.
  • A bowel ostomy being allowed to close on its own is excluded as a surgical wound.

• All other ostomies are excluded from consideration under this item and should not be counted as surgical wounds.
  • Examples: Cystostomy, urostomy, thoracotomy, tracheostomy, gastrostomy, etc.)
  • These may be reported in M1350 (other skin lesion / open wound) if the home health agency is providing intervention specific to the ostomy
M1350 - Skin Lesion or Open Wound

Does this patient have a skin lesion or open wound (excluding bowel ostomy) other than those described above, that is receiving intervention by the home care agency?

0 – No

1 - Yes

Includes
- Burns
- PICC lines & peripheral IV sites
- Diabetic & arterial ulcers
- Ostomies (excluding bowel) if care is provided
  - Gastrostomy, thoracotomy, cystostomy
- Cellulitis & abscess
- Wounds due to trauma
- Edema
- Rashes

Excludes
- Bowel ostomies
- Tattoos, piercings, other skin alterations
- Mucosal surface ulcers
- Surgery for cataracts
- GYN procedures via vaginal
**What Goes Into M1350?**

- A lesion is a broad term used to describe an area of pathologically altered tissue.
- All alterations in skin integrity are considered to be lesions.
- “Receiving clinical assessment or intervention from the home health agency” means the lesion is being clinically assessed on an ongoing basis as indicated on the home health agency’s Plan of Care (for example, wound measurements for a traumatic laceration).

**What Doesn’t Go Into M1350**

- Bowel ostomies
- Tattoos, piercings, other skin alterations
- Mucosal surface ulcers
- Surgery for cataracts
- GYN procedures via vaginal
M1342 - Scenario

At SOC, your patient has a 7cm-long surgical wound that has approximated edges, except for a 3cm area of dehiscence at the lower end of the wound.

The wound appears clean and without evidence of infection. The base of the dehisced area is red and smooth. How should you answer M1342 (Surgical wound status)?

Possible Answers:

a. 0 – Newly epithelialized
b. 1 – Fully granulating
c. 2 – Early/partial granulation
d. 3 – Not healing

M1342 - Scenario

• Mr. Johnson is being discharged from the hospital and will be admitted to home health following an exacerbation of his CHF.
• He had a cholecystectomy performed laparoscopically 8 days ago.
• During assessment the RN noted his incision was closed with a chemical bonding agent and is closed with no signs/symptoms of infection.
• Mr. Johnson has a Baclofen infusion pump and the puncture site was noted to be red, warm and tender to touch.
M1342 - Scenario

A Home Health patient has a triple lumen central line for TPN continuously.
The agency is flushing the other 2 lines daily.

M1340 - Scenario

Your patient was admitted eight weeks ago for aftercare following a coronary artery bypass graft (CABG).
Agency staff has provided wound care for the sternal incision, medication management and therapy.
The patient’s wound has healed well over the past eight weeks and showed evidence of full epithelialization about three weeks ago. At discharge, how should you answer M1340 (Does this patient have a surgical wound)?

Possible Answers:

a. 0 – No [At SOC/ROC go to M1350; At FU/DC go to M1400]
b. 1 – Yes, patient has at least one (observable) surgical wound
c. 2 – Surgical wound known but not observable due to non-removable dressing [At SOC/ROC go to M1350; At FU/DC go to M1400]
Respiratory Status

M1400 - When is the Patient Dyspneic or Noticeably Short of Breath?

0- Patient not Short Of Breath
1- When walking more than 20 ft, climbing stairs
2- With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet)
3- With minimal exertion or with agitation (for example, while eating, talking, or performing other ADLs) or with agitation
4- At rest (during day or night)
**M1400 - Respiratory Status**

- Item: When is the patient dyspneic or noticeable short of breath
- Report what is true on the day of assessment
- Observe if patient is noticeably short of breath
- Interview - 24 hours preceding assessment and during the assessment
- Assessment is based on patients USE of oxygen, not what is ordered
  - If patient uses oxygen continuously – assess WITH oxygen
  - If patient uses oxygen intermittently – assess WITHOUT oxygen

**M1400 - Dyspnea**

- Use clinical judgment to determine the level of effort required to complete a task
  - Particularly distinguishing between minimal and moderate for eating, talking, etc.
  - Consider the effort required
- TUG can be used to assess walking 20 feet or more
- Use ADLs to assess dyspnea
- If patient is only sob when supine, pick response 4- at rest
- If patient modifies environment and is not dyspneic because of this for more than 24 hour period, then pick 0
- Sleep apnea is not dyspnea, unless patient is SOB during
M1400 - Scenario - When is the patient dyspneic or noticeably short of breath?

- Mr. Green says he is never short of breath. But upon further questioning he admits that he gets very short of breath when he lies flat on bed and he needs his O2 at night.
- The nurse checks and the patient is not short of breath when walking more than 20 feet or climbing stairs.
- How would you answer?

M1400 - Scenario

Miss Q has exacerbation of chronic bronchitis and uses O2 PRN.

To correctly assess the patient’s level of dyspnea the clinician should have the patient ambulate 20 feet while wearing the oxygen.

True or False
M1400 - Scenario

Mr. W states he wears his oxygen when he gets “Winded” which is a few times a day. He doesn’t feel the need to wear his O2 all of the time as he has improved so much and hates to have to wear the Oxygen all of the time.

The physician’s order is for 2L continuously.

Would the clinician:

a. Tell the patient to let his doctor know this at his appointment in 2 days.
b. Celebrate with the patient because he has improved and doesn’t need his Oxygen continuously.
c. Notify the physician due to the conflict in the order and the patient’s use. Inform her that the patient does not want to wear oxygen all of the time because he is only moderately short of breath (“winded”) in the patient’s terms) a few times each day with moderate exertion.

M1501- Symptoms in Heart Failure Patients

If patient has been diagnoses with Heart Failure, did patient exhibit symptoms indicated by clinical heart failure guidelines (incl dyspnea, orthopnea, edema or weight gain) At the time of or any time since the SOC/ROC OASIS assessment

0- No
1- Yes
2- Not accessed
NA- patient does not have diagnosis of heart failure
M1501 - Symptoms in Heart Failure Patients

- Review of clinical record including physical assessment data, weight trends, and clinical notes using HHA systems put into place to accomplish such a review (for example, flow sheets, reports from electronic health record data) at the time of, or at any time since, the most recent SOC/ROC assessment.

- A complete list of symptoms of heart failure can be found in clinical heart failure guidelines in Chapter 5 of OASIS manual.

- Be sure to have documentation in the clinical record.

M1501 - Scenario

- You called Dr. Howard yesterday at 2 pm, and his nurse called you back today at 1 pm with orders to increase the pts Lasix.

- Would you mark: Response 1 - Pt's physician contacted the same day.
M1511 - Heart Failure Follow-Up

If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure at the time of or at any time since the most recent SOC/ROC assessment, what action(s) has (have) been taken to respond? (Mark all that apply.)

- No action taken
- Patient's physician (or other primary care practitioner) contacted the same day
- Patient advised to get emergency treatment (for example, call 911 or go to emergency room)
- Implemented physician-ordered patient-specific established parameters for treatment
- Patient education or other clinical interventions
- Obtained change in care plan orders (for example, increased monitoring by agency, change in visit frequency, telehealth)

M1511- GUIDANCE

- Include any actions that were taken in response to HF symptoms at least one time at the time of or at any time since the most recent SOC/ROC assessment.
- 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 appropriate only if a physician responds to the agency communication with acknowledgment of receipt of information and/or further advice or instructions on the same day.
- In many situations, other responses also will be marked that indicate the action taken as a result of the contact (that is, any of Responses 2-5).
M1511 - Scenario

The focus of care for your patient is COPD exacerbation. The history and physical documentation notes that the patient has a “history of heart failure” but the patient is not currently being treated for heart failure.

Heart failure is not coded in M1011, M1017, M1021 and M1023 as a diagnosis.

The SOC clinical note indicates that the patient was short of breath with the use of oxygen intermittently at 2 L per nasal cannula when admitted to the agency.

The physician was notified about the patient's dyspnea and provided an order for continuous oxygen at the time of the SOC visit. The patient's SOB was improved before the end of the SOC visit and at the next visit.

At discharge the patient is comfortable, using continuous oxygen and is not exhibiting any symptoms of heart failure.

How should you answer M1511 (Heart failure follow-up)? (Mark all that apply.)

a. 0 – No action taken
b. 1 – Patient’s physician (or other primary care practitioner) contacted the same day
c. 2 – Patient advised to get emergency treatment (for example, for example, call 911 or go to emergency room)
d. 3 – Implement physician-ordered patient-specific established parameters for treatment
e. 4 – Patient education or other clinical interventions
f. 5 – Obtained change in care plan orders (for example, for example, increased monitoring by agency, change in visit frequency, telehealth, etc.)
END OF PART 2 A

PART 2 B PICKS UP M ITEMS WHERE WE LEFT OFF!

😊 Thank you!
OASIS M Items, continued

Part 2(b)

Reviewing the Intent & How to Assess and Answer
M1600 - Has this patient been treated for a Urinary Tract Infection in the past 14 days?

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.

1 – Yes:
• when the patient has been prescribed an antibiotic within the past 14 days specifically for a confirmed or suspected UTI or
• if the patient is on prophylactic treatment and develops a UTI.

“NA” – if the patient is on prophylactic treatment to prevent UTIs.

Unknown is not an option at Discharge from Agency.

M1610 - Urinary Incontinence or Urinary Catheter Presence:

0- No incontinence or catheter (includes anuria or ostomy for urinary drainage) \(\rightarrow\) [Go to M1620]

1- Patient is incontinent

2- Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic) [Go to M1620]

• Enter Response 1:
  • If the patient is incontinent at any time (including “occasionally,” “only when I sneeze,” “sometimes I leak a little bit,” etc.).
  • If the patient is incontinent or is dependent on a timed-voiding program.
  • Time voiding is a compensatory strategy; it does not cure incontinence.
**M1610 - Urinary Incontinence or Urinary Catheter Presence:**

- Enter Response 2 if a catheter was inserted during the comprehensive assessment.
- A leaking urinary drainage appliance is not incontinence.
- A catheter solely utilized for irrigation of the bladder or installation with an antibiotic is not reported in this item.
- If a catheter was discontinued during the comprehensive assessment or if a catheter is both inserted and discontinued during the comprehensive assessment, Response 0 or 1 would be appropriate, depending on whether or not the patient is continent.

**M1610 - Scenario**

Your home health patient tells you that she is on a scheduled toileting program to avoid incontinence during the night. She tells you that it has been working "wonderfully" since she started it two months ago. How should you answer M1610 (Urinary incontinence or urinary catheter present)?

**Possible Answers:**

a. 0 – No incontinence or catheter (includes anuria or ostomy for urinary drainage) [Go to M1620]

b. 1 – Patient is incontinent

c. 2 – Patient requires a urinary catheter (specifically, external, indwelling, intermittent, suprapubic) [Go to M1620]
Guidance Manual – Assessment Strategies to Accurately Score And Increase Outcomes

• 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.

M1620 - Bowel Incontinence Frequency

0 - Very rarely or never has bowel incontinence
1 - Less than once weekly
2 - One to three times weekly
3 - Four to six times weekly
4 - On a daily basis
5 - More often than once daily
NA - Patient has ostomy for bowel elimination
UK - Unknown [Omit “UK” option on FU, DC]
M1620 - Scenario

At the SOC assessment of Mr. Y, there was no reported bowel incontinence for the past seven days in M1620.

At a scheduled skilled nurse visit on day four of the episode, the patient tells the nurse who completed the SOC assessment that he has experienced three episodes of bowel incontinence since the SOC visit. This would change the response on M1620 from a Response 0 - "Very rarely or never" to a Response 2 - "One to three times weekly".

Can the clinician amend M1620 on the SOC OASIS to reflect this additional assessment information?

- Possible Answers:
  a. No, it is too late to make changes in the assessment once the OASIS has been completed and the M0090 date assigned
  b. Yes, it is within the 5-day window for a SOC assessment

M1630 - Ostomy for Bowel Elimination:

- Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay; or b) necessitated a change in treatment regimen?
  0-Patient does not have an ostomy for bowel elimination.
  1-Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen.
  2-The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen.

- Applies to any type of ostomy for bowel elimination (for example: colostomy, ileostomy). This item only addresses bowel ostomies, not other types of ostomies (for example: urinary ostomies, tracheostomies).

- If an ostomy has been reversed, then the patient does not have an ostomy at the time of assessment.
M1700 - Cognitive Functioning

Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

0-Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
1-Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.
2-Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility.
3-Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
4-Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

M1700- Guidance

• Identifies the patient’s current (at the time of the assessment and in the preceding 24 hours) level of cognitive functioning.

• Responses progress from no impairment to severely impaired. Consider the degree of impairment.

• 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., will have various degrees of cognitive dysfunction.

• Patients with neurological deficits related to stroke, mood/anxiety disorders, or who receive opioid therapy may have cognitive deficits.
M1700 - Scenario

Your home health patient suffered a mild stroke two weeks ago.
She went to rehab for a week after being discharged from the hospital.
Home health has been ordered to provide teaching on new medications.
During your assessment, the patient is able to identify the meds she takes and when and how to take them.
She was able to follow directions to complete the TUG test.
How should you answer M1700 (Cognitive functioning)?

a. 0 – Alert, oriented, able to focus and shift attention, comprehends and recalls task directions independently
b. 1 – Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions
c. 2 – Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention), or consistently requires low-stimulus environment due to distractibility
d. 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
e. 4 – Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.
M1710 - When Confused (Reported or Observed Within the Last 14 Days):

0-Never
1-In new or complex situations only
2-On awakening or at night only
3-During the day and evening, but not constantly
4-Constantly
NA-Patient nonresponsive

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

- This item may not relate directly to Item M1700.
- 1 is entered when the patient’s confusion is isolated to a new or a complex situation; for example, the patient became confused when a new caregiver was introduced or when a procedure was performed the first time.
- 2, 3, or 4 is entered when confusion occurs without the stimulus of a new or complex situation, or when confusion that initially presented with a new or complex situation persists days after the new or complex situation becomes more routine.
- 2, 3 and 4 differ from each other based on the time when the confusion occurred.
- 2 if the confusion only occurred when the patient was awakening from a sleep or during the night.
- 3 if the confusion occurs during the day and evening, but is not constant. If confusion was not constant, but occurred more often than just upon awakening or at night, enter Response 3.
M1720 - When Anxious (Reported or Observed Within the Last 14 Days):

0 - None of the time
1 - Less often than daily
2 - Daily, but not constantly
3 - All of the time
NA - Patient nonresponsive

- Anxiety includes: 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.

M1720 - Scenario

While assessing your home health patient, she tells you she worries about how she will pay for the medications she needs to treat her CHF and COPD.

This occurs at least once a week or whenever she has to pay for new medication or a refill.

She says she gets "panicky" and has to lie down and rest for a few hours.

How would you answer M1720 (When anxious [reported or observed] within the last 14 days):

a. 0 – None of the time
b. 1 – Less often than daily
c. 2 – Daily, but not constantly
d. 3 – All of the time
e. NA – Patient nonresponsive
M1730 - Depression Screening:

Has the patient been screened for depression, using a standardized, validated depression screening tool?

0-No

1-Yes, patient was screened using the PHQ-2© scale.

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

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

M1730- Depression Screening

- Identifies if the home health agency screened the patient for depression using a standardized, validated depression-screening tool.

- CMS does not mandate 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, validated 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 PHQ-2© instructions indicate that the patient is interviewed, not family or others.
M1730 - Depression Screening

• If the patient scores three points or more on the PHQ-2©, then further depression screening is indicated.
  • Physician to be notified
  • PHQ-9 can then utilized

• If the PHQ-2© is not used to assess the patient, you may administer a different standardized, validated depression screening tool with instructions that may allow for information to be gathered by observation and caregiver interview as well as self-report.

• In this case, the clinician would enter Response 2 or 3 for M1730, depending on the outcome of the assessment.

• Enter Response 2 if the patient is screened with a different standardized, validated assessment.

M1730 - Scenario

During the SOC visit, the patient, who is cognitively capable of responding to the depression screening tool, tells you she won’t answer the questions because they are “too personal.” How should you answer M1730 (Depression screening)?

a. 0 – No

b. 1 – Yes, patient was screened using the PHQ2© scale

c. 2 – Yes, with a different standardized, validated assessment and the patient meets the criteria for further evaluation for depression

d. 3 – Yes, patient was screened with a different standardized, validated assessment and the patient does not meet criteria for further evaluation for depression.
M1740 - Cognitive, Behavioral, and Psychiatric Symptoms

- That are Demonstrated at Least Once a Week (Reported or Observed): (Mark all that apply) Update to Guidance Manual

- Behaviors _may be observed by the clinician or reported by the patient, family, or others._

- Behaviors reported could be identified by a formal diagnosis and/or determined by the assessing clinician to be associated with a significant neurological, developmental, behavioral and/or psychiatric disorder.

- Include behaviors which are severe enough to: make the patient unsafe to self or others, cause considerable stress to the caregivers, or require supervision or intervention.

M1740 - Scenario

True or False? When answering M1740, the clinician should select any or all of the listed patient behaviors that are severe enough to make the patient unsafe to his or her self or others, cause considerable stress to the caregivers or that require supervision or intervention.

Possible Answers:

- a. True
- b. False
**ADLs/ IADLs- Review of Guidance**

- 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 able to do on the day of the assessment.
- Consider what the patient is able to do 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.
ADLs/IADLs - Review of Guidance:

- Ability of patient means Safely completing specified activities.
- If ability varies between tasks in a multi task item, report what is true in a majority of the included tasks, giving more weight to tasks that are more frequently performed.
- Presence or absence of a caregiver does not impact the patient's ability to perform the task.

M1800 - Grooming:

- Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care)
- Identifies the patient's ability to tend to personal hygiene needs, excluding bathing, shampooing hair, and toileting hygiene.
- The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" (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.
M1800 - Grooming:

- The patient must be viewed from a holistic perspective in assessing ability to perform ADLs.

- Ability can be temporarily or permanently limited by:
  - Physical impairments (for example, limited range of motion, impaired balance),
  - Emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear),
  - Sensory impairments, (for example, impaired vision or pain),
  - Environmental barriers (for example, accessing grooming aids, mirror and sink).

Grooming (and other ADL Guidelines)

- The grooming scale presents the most independent level first, then proceeds to the most dependent.

- Grooming includes several activities. The frequency of selected activities that are performed (such as washing face and hands vs. fingernail care) must be considered in responding.

- Patients able to do more frequently performed activities (for example, washing hands and face) but unable to do less frequently performed activities (trimming fingernails) should be considered to have more ability in grooming.

- Remember, in cases where a patient's ability is different for various grooming tasks, enter 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.
M1800 - Scenario

Your patient is able to wash his hands and face, shave and brush his teeth if implements are laid out for him. He is unable to clip his fingernails and perform cuticle care weekly without assistance from his wife. How should you respond to M1800 (Grooming)?

a. 0 – Able to groom self unaided, with or without the use of assistive devices or adapted methods
b. 1 – Grooming utensils must be placed within reach before able to complete grooming activities
c. 2 – Someone must assist the patient to groom self
d. 3 – Patient depends entirely upon someone else for grooming needs

M1810- Current Ability To Dress Upper Body Safely

(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:

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.</td>
</tr>
<tr>
<td>1</td>
<td>Able to dress upper body without assistance if clothing is laid out or handed to the patient.</td>
</tr>
<tr>
<td>2</td>
<td>Someone must help the patient put on upper body clothing.</td>
</tr>
<tr>
<td>3</td>
<td>Patient depends entirely upon another person to dress the upper body.</td>
</tr>
</tbody>
</table>
M1820- Current Ability To Dress Lower Body Safely

- Assess ability to put on whatever clothing is routinely worn.
- Includes the ability to manage zippers, buttons, and snaps if these are routinely worn.
- Includes undergarments
- 0- able to get clothes out of closets & drawers, put them on & remove them from upper (or lower) body without assistance
- Patient needs help dressing IF patient requires standby by assist or verbal cueing to dress SAFELY.
- Includes prosthetic & compression devices, but not wound dressings
Assessment Strategies- Dressing Upper & Lower Body

• A combined observation/Interview approach with the patient or caregiver is helpful in determining the most accurate response for this item.

• Ask patient if he/she has difficulty dressing upper and lower body.

• Observe the patient’s general appearance and clothing and ask questions to determine if the patient has been able to dress independently and safely.

• 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 also can be asked to demonstrate the body motions involved in dressing.

• Have patient take off shoes and socks and then put them back on!

M1810 / M1820 - Scenario

Your patient is admitted for management of lower extremity stasis ulcers using compression dressings.

The patient also has a wound dressing on his right forearm that is secured with a gauze wrap and must be changed daily.

Are both of these “dressings” considered when responding to M1810 and M1820?

a. No

b. Yes
M1830- Bathing

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

<table>
<thead>
<tr>
<th>M1830</th>
<th>Bathing: Current ability to wash entire body safely. Excludes grooming (washing face, washing hands, and shampooing hair).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
<td></td>
</tr>
</tbody>
</table>

0. Able to bathe self in shower or tub independently, including getting in and out of tub/shower.
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.
2. Able to bathe in shower or tub with the intermittent assistance of another person:
   (a) for intermittent supervision or encouragement or reminders, OR
   (b) to get in and out of the shower or tub, OR
   (c) for washing difficult to reach areas.
3. Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
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.
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.
6. Unable to participate effectively in bathing and is bathed totally by another person.

---

3-Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.

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.

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.

6-Unable to participate effectively in bathing and is bathed totally by another person.
M1830- Bathing

- Consider ability to SAFELY:
- Wash Entire body!
- Getting in and out of tub/shower!
- If afraid of falling and is unwilling to try or have assistance then would pick response 4 or 5 (unable)
- Bathing related tasks, ex Gathering supplies, preparing bath water, shampooing hair, drying off are Not considered
- 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

Assessment strategies- Bathing

- A combined observation/interview approach with the patient or caregiver is helpful in determining 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 in determining if the patient has been able to bathe self independently and safely.
- 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 with assistance and/or a device.
- Evaluate the amount of assistance needed for the patient to be able to safely bathe in tub or shower.
M1840- Toilet Transferring

- Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.
- Observe patient during transfer on and off toilet
- If patient has pain, difficulty with balance, strength, etc, determine level of assistance needed for the patient to be safe
- Excludes personal hygiene and management of clothing when toileting.
- Assessment Strategies: 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 safely get on and off the toilet or commode.
M1840 - Scenario

Mr. X recently underwent hip replacement surgery. When you examine his bathroom, you find that he has installed a bedside commode over the toilet. He tells you he came up with this idea to raise the height of his toilet to make getting on/off the seat easier. He is able to get to and from the toilet safely using a cane but he does need occasional verbal cueing while ambulating. What is the best response to M1840 (Toilet transferring)?

a. 0 – Able to get to and from the toilet and transfer independently with or without a device.

b. 1 – When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.

c. 2 – Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).

d. 3 – Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.

e. 4 – Is totally dependent in toileting

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.

0-Able to manage toileting hygiene and clothing management without assistance.

1-Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.

2-Someone must help the patient to maintain toileting hygiene and/or adjust clothing.

3-Patient depends entirely upon another person to maintain toileting hygiene.
• Includes several activities, including pulling clothes up or down and adequately cleaning (wiping) the perineal area.
• Includes the patient’s ability to maintain hygiene related to catheter care and the ability to cleanse around all stomas that are used for urinary or bowel elimination (for example, urostomies, colostomies, ileostomies).
Scenario - M1845

Home health patient has dementia and is admitted to your agency for management of CHF. He has a full-time caregiver who states that the patient needs reminding about when to go to the bathroom. He also frequently needs verbal reminders to put his pants back on and close his zipper after sitting on the toilet. What is the correct response to M1845 (Toileting hygiene)?

a. 0 – Able to manage toileting hygiene and clothing management without assistance.

b. 1 – Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.

c. 2 – Someone must help the patient to maintain toileting hygiene and/or adjust clothing.

d. 3 – Patient depends entirely upon another person to maintain toileting hygiene.

M1850 - Transferring

(M1850) Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Able to independently transfer.</td>
</tr>
<tr>
<td>1</td>
<td>Able to transfer with minimal human assistance or with use of an assistive device.</td>
</tr>
<tr>
<td>2</td>
<td>Able to bear weight and pivot during the transfer process but unable to transfer self.</td>
</tr>
<tr>
<td>3</td>
<td>Unable to transfer self and is unable to bear weight or pivot when transferred by another person.</td>
</tr>
<tr>
<td>4</td>
<td>Bedfast, unable to transfer but is able to turn and position self in bed.</td>
</tr>
<tr>
<td>5</td>
<td>Bedfast, unable to transfer and is unable to turn and position self.</td>
</tr>
</tbody>
</table>
**M1850 - Transferring**

Current ability to move safely from bed to chair, or ability to turn & position self in bed if patient is bedfast

- For Response 1, “minimal human assistance” could include: verbal cueing, environmental set-up, and/or actual hands-on assistance.
  - In order for the assistance to be considered minimal, it would mean the individual assisting the patient is contributing less than 25% of the total effort required to perform the transfer.

- For most patients, the transfer between bed and chair 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.

- Include the ability to return back into bed from the sitting surface.

- Ask the patient about transferring ability.

- Observe the patient during transfers and determine the amount of assistance required for safe transfer from bed to chair.

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**M1850 Scenario**

Home health patient does not have a chair in the bedroom and it is impossible to bring one into the bedroom to demonstrate the bed to chair transfer.

How should you assess and report the patient’s ability to transfer in M1850 (Transferring) in this situation?

- a. You can’t, so you should skip this item – use Response 0.
- b. In this case, you must report the patient as Response 3 – ”Unable to transfer self and is unable to bear weight or pivot when transferred by another person”.
- c. Base your response on the patient’s ability to move from a supine position in bed to a sitting position at the side of the bed, and then the ability to stand and sit on whatever surface is applicable to the patient’s environment and needs.
- d. None of the above
GG0170C - Mobility

- Identifies the patient’s need for assistance with the mobility task of moving from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.

- Report a code ranging from 01 (dependent) to 06 (independent) based on safety and quality of pts performance at SOC.

- Also, project goal for performance of the mobility task for discharge time point.

ITEM RATIONALE

- Mobility limitations can adversely affect wound healing and increase risk for the development of pressure ulcers.

- Completed at SOC & ROC
GG0170C - STEPS FOR ASSESSMENT

• Assess the patient’s functional status based on direct observation and/or on report by the patient, caregiver/family.

• Patients should be allowed to perform activities as independently as possible, as long as they are safe.

• If caregiver assistance is required because patient’s performance is unsafe or of poor quality, enter the response according to amount of assistance required to be safe.

• Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect the scoring of the activity.

• If the patient’s self-care performance varies during the assessment time frame, report the patient’s usual status, not the patient’s most independent status and not the patient’s most dependent status.

Instructions

• For GG0170C1 – SOC/ROC Performance, report the patient’s usual status at SOC/ROC using the 6 point scale or, using one of the three “activity was not attempted” codes, report the reason the activity was not attempted.
GG0170C

- If the patient does not attempt the activity and a caregiver does not complete the activity for the patient, report the reason the activity was not attempted.

- If no information is available or assessment is not possible for reason other than above, enter a dash (“–”) for 1-SOC/ROC Performance.

- A dash (–) value is a valid response for this item. A dash (–) value indicates that no information is available, and/or an item could not be assessed. This most often occurs when the patient is unexpectedly transferred, discharged or dies before assessment of the item could be completed. CMS expects dash use to be a rare occurrence.

GG0170C2 - Discharge Goal

- Report the discharge goal using the 6-point scale.

- Do not enter 07, 09, or 88 to report the discharge goal.

- The assessing clinician, in conjunction with patient and family input, can establish the discharge goal.

- If the clinician, in collaboration with the patient and caregiver(s), determines that the patient is expected to make functional progress by discharge, the response reported for Discharge Goal will be higher (more independent) than the SOC/ROC Performance response.
GG0170C2 - Discharge Goal

- If the clinician, patient, and family determine that the medically complex patient is not expected to make progress during the home health episode, but it is expected that the patient would be able to maintain his/her SOC functional level, the Discharge Goal response will be the same as the patient’s SOC Performance response.

- If the clinician, in collaboration with the patient and/or caregiver(s) determine that a patient with a progressive neurological condition is expected to rapidly decline, and that skilled therapy services may slow the decline of function, the Discharge Goal would be lower (more dependent) than the SOC/ROC Performance response.

GG0170C2 - Discharge Goal

- If the assessing clinician does not establish a Discharge Goal for the patient’s bed mobility task, enter a dash (“–”) for 2-Discharge Goal.

- A dash (–) value is a valid response for this item. A dash (–) value indicates that no information is available, and/or an item could not be assessed. This most often occurs when the patient is unexpectedly transferred, discharged or dies before assessment of the item could be completed. CMS expects dash use to be a rare occurrence.
GG0170C2

Scoring

GG0170C2 Example

The patient pushes up from the bed to get himself from a lying to a seated position. The caregiver must provide steadying (touching) as the patient scoots himself to the edge of the bed and lowers his feet onto the floor.

- GG0170C1 – SOC/ROC Performance:
  - ENTER 04 – Supervision or touching assistance
  - Rationale: The patient required steadying/touching assistance in order to safely complete the task of lying on his back to sitting on the side of the bed.
**GG0170C2 Example**

- The patient pushes up on the bed to attempt to get himself from a lying to a seated position as the OT provides much of the lifting assistance necessary for him to sit upright.
- The OT provides assistance as the patient scoots himself to the edge of the bed and lowers his feet to the floor.
- Overall, the OT must provide more than half of the effort to complete the task.

**GG0170C1 - SOC/ROC Performance:**

- ENTER 02 – Substantial/maximal assistance
- Rationale: The patient required the caregiver to provide lifting and assistance that represents more than half of the effort required to complete the task of lying on his back to sitting on the side of the bed.

**GG0170C2 Scoring Example**

The patient is obese and recovering from surgery for spinal stenosis with lower extremity weakness. The caregiver partially lifts the patient's trunk to a fully upright sitting position on the bed and minimally lifts each leg toward the edge of the bed. The patient then scoots toward the edge of the bed, placing both feet flat onto the floor. The patient completes most of the activity himself.

**GG0170C1 - SOC/ROC Performance:**

- ENTER 03 – Partial/moderate assistance
- Rationale: The patient required the caregiver to provide limited assistance that represents more than just verbal cues/touching/steadying, but less than half of the effort required to complete the task of lying on his back to sitting on the side of the bed.
GG0170C2 Scoring Example

- The patient states he wishes he could get out of bed himself rather than depending on his wife to help.

- At the SOC the patient requires his wife to do most of the effort.

- Based on the patient’s prior functional status, his current diagnoses, the expected length of stay, and his motivation to improve, the clinician expects that by discharge, the patient would likely only require assistance helping his legs off the bed to complete the supine to sitting task.

GG0170C2 Scoring Example

- GG0170C1 - SOC/ROC Performance: ENTER 02 – Substantial/maximal assistance

- GG0170C2 - Discharge Goal: Enter 03 – Partial/moderate assistance

- Rationale: At the SOC, the patient required the caregiver to provide more than half of the effort required to complete the task. The assessing clinician and patient expect functional improvement so that by discharge the patient needs a caregiver to assist, providing less than half of the effort.
GG0170C
Focus on Goal Setting Across Post Acute Facilities

• Progress towards goals to support payment for services so accuracy key.
• Safety is major factor
• Patient must do the activity to assess or it is marked not assessed.
• Codes for refused, NA or Unsafe will not be allowed for DC goal.

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.

0-Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).

1-With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.

2-Requires use of a two-handed device (for example, 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.

3-Able to walk only with the supervision or assistance of another person at all times.
• Note: did not include 4/5/6-chair and bedfast
M1860 - Ambulation / Locomotion -

- Patient’s ability and type of assist required to SAFELY ambulate or propel self in a wheelchair

- If a patient safely ambulates with a walker in some areas of the home, and a cane in other areas, select the response that reflects the device that best supports safe ambulation on all surfaces the patient routinely encounters.

- If a patient does not have a walking device but is clearly not safe walking alone, select Response 3, able to walk only with supervision or asst.

- Watch the patient walk. If patient uses walls and furniture for support, assess if patient should use a walker or cane for safe ambulation.

- Having an assistive device does Not mean that the patient is walking safely.

- Observe patients ability and safety on stairs.

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M1860 - Scenario

- Mrs. S lives in an assisted living facility.
- She uses a walker to ambulate safely in the facility about 25% of the time.
- About 75% of the time she uses a motorized wheelchair independently, because it is tiring to walk up and down the long halls.
- What is the appropriate response for M1860?
- SEE NEXT SLIDE FOR OASIS SCORING
M1860 - Scenario

a. 0 – Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).

b. 1 – With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.

c. 2 – Requires use of a two-handed device (for example, 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.

d. 3 – Able to walk only with the supervision or assistance of another person at all times.

e. 4 – Chairfast, unable to ambulate but is able to wheel self independently.

f. 5 – Chairfast, unable to ambulate and is unable to wheel self.

g. 6 – Bedfast, unable to ambulate or be up in a chair.

M1870 - Feeding or Eating: Current ability to feed self meals and snacks safely

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Able to independently feed self.</td>
</tr>
<tr>
<td>1</td>
<td>Able to feed self independently but requires:</td>
</tr>
<tr>
<td></td>
<td>(a) meal set-up; OR</td>
</tr>
<tr>
<td></td>
<td>(b) intermittent assistance or supervision from another person; OR</td>
</tr>
<tr>
<td></td>
<td>(c) a liquid, pureed or ground meat diet.</td>
</tr>
<tr>
<td>2</td>
<td>Unable to feed self and must be assisted or supervised throughout the meal/snack.</td>
</tr>
<tr>
<td>3</td>
<td>Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.</td>
</tr>
<tr>
<td>4</td>
<td>Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.</td>
</tr>
<tr>
<td>5</td>
<td>Unable to take in nutrients orally or by tube feeding.</td>
</tr>
</tbody>
</table>
M1870 - Feeding or Eating: Current ability to feed self meals and snacks safely

- Identifies the patient's ability to feed him/herself, including the process of eating, chewing, and swallowing food.
- This item excludes 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.

M1880 - Current Ability to Plan and Prepare Light Meals (For Example, Cereal, Sandwich) or Reheat Delivered Meals Safely:

- Identifies patient's physical, cognitive, & mental ability to plan and prepare meals, even if the patient does not routinely perform this task.
- The intent of the item is to identify the patient's ABILITY, not necessarily actual performance.
- 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 entering a response.
M1880 - Current Ability to Plan and Prepare Light Meals
(For Example, Cereal, Sandwich) or Reheat Delivered Meals Safely:

- 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 M2102.
M1890 - Ability to Use Telephone

Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate

- Important for patient safety and to assess ability for patient to be alone.
- Can patient call:
  - 911
  - Family / caregiver
  - HHA
  - Physician
  - pharmacy
**M1900 - Prior Functioning ADL/IADL**

(M1900) Prior Functioning ADL/IADL: Indicate the patient’s usual ability with everyday activities prior to his/her most recent illness, exacerbation, or injury.

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>a. Self-Care (specifically: grooming, dressing, bathing, and toileting hygiene)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 Independent</td>
</tr>
<tr>
<td></td>
<td>1 Needed Some Help</td>
</tr>
<tr>
<td></td>
<td>2 Dependent</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Enter Code</th>
<th>b. Ambulation</th>
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<tbody>
<tr>
<td></td>
<td>0 Independent</td>
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<td></td>
<td>1 Needed Some Help</td>
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<tr>
<th>Enter Code</th>
<th>d. Household tasks (specifically: light meal preparation, laundry, shopping, and phone use)</th>
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<tr>
<td></td>
<td>0 Independent</td>
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• “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.
M1900 - Prior Functioning ADL/IADL

- “Self-care” refers specifically to 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.

M1900 - Prior Functioning ADL/IADL

- “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.
M1900 - Scenario

- Patient is admitted to home care following an ORIF for hip fracture related to a fall on stairs in the home.

- The patient was able to independently perform grooming and dressing tasks, required assistance with getting into and out of the tub and was able to perform toileting hygiene tasks. The patient did not use a device for ambulation prior to her fall, family states the patient refused to use a device, but would hold onto the wall or furniture to move around a room.

- Family would assist the patient on the stairs for patient to access her bedroom, but on the day of the fall no family was available to assist.

- The patient has a lift chair that she was able to operate independently and was able to transfer on and off the toilet with use of handrails.

- The patient was not able to prepare light meals for herself but was able to use the phone independently. She needed assistance to complete laundry and shopping tasks safely.

- SEE OASIS CHART ON NEXT SLIDE

M1900 - Prior Functioning ADL/IADL

(M1900) Prior Functioning ADL/IADL: Indicate the patient’s usual ability with everyday activities prior to his/her most recent illness, exacerbation, or injury.

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<tr>
<th>Enter Code</th>
<th>a. Self-Care (specifically: grooming, dressing, bathing, and toileting hygiene)</th>
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M1910- Fall Risk Assessment

Has this patient had a multi-factor Falls Risk Assessment using a standardized, Validated assessment tool?

0- No
1- Yes and it does not indicate a risk for falls
2- Yes and it does indicate a risk for falls

• Identifies whether the home health agency has assessed the patient and home environment for characteristics that place the patient at risk for falls.

• The multi-factor falls risk assessment must include at least one standardized, validated tool that

• 1) has been scientifically tested in a population with characteristics similar to that of the patient being assessed (for example, community-dwelling elders, noninstitutionalized adults with disabilities, etc.) and shown to be effective in identifying people at risk for falls; and

• 2) includes a standard response scale. The standardized, validated tool must be both appropriate for the patient based on their cognitive and physical status and appropriately administered per the tool’s instructions.

• This item is used to calculate process measures to capture the agency’s use of best practices following the completion of the comprehensive assessment.
M1910- Fall Risk Assessment

- HHA may use a single comprehensive multi-factor falls risk assessment tool that meets the criteria.
- Or may incorporate several tools as long as one of them meets the criteria as described in the item intent.
- For example, a physical performance component (for example, Timed Up and Go), a medication review, review of patient history of falls, assessment of lower limb function and selected OASIS items (for example, OASIS items for cognitive status, vision, incontinence, ambulation, transferring).
- Must score the tool to identify if a patient is at risk for falls.
- In order to enter Response 1 or 2, the falls risk assessment must be conducted by the clinician responsible for completing the comprehensive assessment during the time frame specified by CMS for completion of the assessment.

Enter Response 0, NO Fall Risk assessment completed if:

- A standardized, validated multi-factor falls risk screening was NOT conducted by the home health agency.
- A standardized, validated multi-factor falls risk screening was conducted by the home health agency but NOT during the required assessment time frame,
- A standardized, validated multi-factor falls risk screening was conducted during the assessment time frame, but NOT by the assessing clinician.
- The patient is not able to participate in tasks required to allow the completion and scoring of the standardized, validated assessment(s) that the agency chooses to utilize.
M1910 - Scenario Fall Risk Assessment

The nurse who is assessing the patient at SOC sees the patient is not stable when standing so cannot do the TUG. She does do the MAHC 10 and the patient is at risk for falls.

• How does the nurse answer this question?
• Has this patient had a multi-factor Falls Risk Assessment using a standardized, Validated assessment tool?
  0- No
  1- Yes and it does not indicate a risk for falls
  2- Yes and it does indicate a risk for falls.

Drug Regimen Review
M2001 - Medications

Drug Regimen Review: Did a complete drug regimen review identify potential clinically significant medication issues?

0- No - No issues found during review [Go to M2010]

1- Yes - Issues found during review

9- NA - Patient is not taking any medications [Go to M2040]

M2001 - Medications

• The drug regimen review in post-acute care is generally considered to include:
  • Medication reconciliation,
  • A review of all medications a patient is currently using and
  • Review of the drug regimen to identify, and if possible, prevent potential clinically significant medication issues.

• The drug regimen review includes all medications, prescribed and over the counter (including TPN and herbals), administered by any route (for example, oral, topical, inhalant, pump, injection, intravenous and via enteral tube).
**M2001- Drug Regimen Review**

- If portions of the drug regimen review (for example, 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, findings must be communicated to the clinician responsible so that the appropriate response for M2001 may be entered.

- Collaboration in which the assessing clinician evaluates patient status (for example, presence of potential ineffective drug therapy or patient nonadherence), and another clinician (in the office) assists with review of the medication list (for example, possible duplicate drug therapy or omissions) does not violate the of one clinician responsible.

- 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.

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**M2001 - Scenario**

Miss Tori just got home from the hospital. During the SOC assessment, the nurse finds out that the list of med from the hospital discharge summary doesn't match what is in the home.

The nurse calls the patient's physician while in the home but just left a message.

- What would the nurse answer for M2001- Drug Regimen Review?

- **Drug Regimen Review: Did a complete drug regimen review identify potential clinically significant medication issues?**

  0 - No - No issues found during review  [Go to M2010]
  1 - Yes - Issues found during review
  9 - NA - Patient is not taking any medications [Go to M2040]
M2003 - Medication Follow Up

Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?

0- No
1- Yes

• One Calendar Day is defined by CMS from the time an issue is identified until the end of the next calendar day (11:59pm the next day)
• MD has to respond and resolve, or be in process of resolving, if necessary, in order to put yes
• CMS wording: Two Way Communication With Physician AND Resolution (or plan to resolve the problem)

M2003 - Medication Follow-up

• If the physician/physician-designee recommends an action that will take longer than the allowed time to complete, then Response 1 – Yes should be entered as long as by midnight of the next calendar day the agency has taken whatever actions are possible to comply with the recommended action.

• Examples of recommended actions that would take longer than the allowed time to complete might include:
  • physician instruction to agency staff to continue to monitor the issue over the weekend and call if problem persists, or
  • the physician instructs the patient to address the concern with his PCP on a visit that is scheduled in two days.
M2003 - Medication Follow-up

- The actual type of actions recommended should be considered in determining if the agency has taken whatever actions are possible by midnight of the next calendar day.

- If the physician/physician-designee provides no new orders or instruction in response to timely reported potential clinically significant medication issue(s), enter Response 1 – Yes, indicating that the physician/physician-designee was contacted and prescribed/recommended actions were completed.

M2003 - Scenario Medication Follow-up

- During the SOC comprehensive assessment visit, the RN completes a drug review and identifies that the patient is taking two anti-hypertensives; one which was newly prescribed during her recent hospital stay, and another that she was taking prior to her hospitalization.

- During the home visit, the RN contacts the physician’s office, and leaves a message with office staff providing notification of the potential duplicative drug therapy and a request for clarification.

- The next day, the RN returns to the home to complete the comprehensive assessment and again contacts the physician from the patient’s home.

- The physician’s office nurse reports to the agency and patient that the physician would like the patient to continue with only the newly prescribed antihypertensive and discontinue the previous medication.
Scenario - M2003 - Medication Follow-Up

Was a physician or physician designee contacted within one calendar day to resolve clinically significant med issues, including reconciliation

- The patient does not have 3 of his medications that are on the hospital discharge list on the initial assessment.
- The nurse returns in 2 days and finds that the family purchased and delivered the meds to the patient. The nurse notes that the meds all are reconciled now.
- How do you answer: Yes or No?

M2005 - Medication Intervention:

Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?

- No
- Yes
- NA – There were no potential clinically significant medication issues identified since SOC/ROC OR patient was not taking any medications

- At Discharge- Two Way Communication With Physician AND Resolution (or plan to resolve the problem) EVERYTIME there is a med issue identified. Look Back item.

• A dash (–) value is a valid response for this item.
• A dash (–) value indicates that no information is available, and/or an item could not be assessed.
• This most often occurs when the patient is unexpectedly transferred, discharged or dies before assessment of the item could be completed.
• However, providers should complete transfer and discharge assessments to the best of their ability when a care episode ends unexpectedly.
• CMS expects dash use to be a rare occurrence.

M2003 & M2005 Instructions

If the last OASIS assessment completed was the SOC or ROC, and a clinically significant medication issue was identified at that SOC or ROC visit,
the issue (and/or related physician/physician-designee communication) would be reported at both the SOC/ROC (on M2003) and again at Transfer, Death or Discharge (on M2005), since the time frame under consideration for M2005 is at the time of or at any time since SOC/ROC.
M2010 - Patient/Caregiver High Risk Drug Education

- Has the patient/caregiver received instruction on special precautions for all high risk meds (such as hypoglycemia, anticoagulants, etc.) and how and when to report problems that may occur?
  - 0- No
  - 1- Yes
  - NA- patient not taking any high risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high risk meds

- You must designate high risk drugs as an Agency Policy and be sure that staff know.

High-risk medications are those identified by quality organizations as having considerable potential for causing significant patient harm when they are used erroneously.

- This item is targeted to high-risk medications as it may be unrealistic to expect that patient education on all medications occur on admission.
- 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.
- Item is used to calculate process measures to capture the agency’s use of best practices following the completion of the comprehensive assessment.
- 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 of one assessing clinician.
M2016 - Patient/ Caregiver Drug Education Intervention

• At the time of, or at any time since the most recent SOC/ROC assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur?

  0  No
  1  Yes

NA  Patient not taking any drugs

M2016 - Patient/ Caregiver Drug Education Intervention

• Drug education interventions and documentation for M2016 should address all medications the patient is taking, prescribed and over-the-counter, by any route.

• Effective, safe management of medications includes knowledge of effectiveness, potential side effects and drug reactions, and when to contact the appropriate care provider.

• If the interventions are not completed as outlined in this item, enter Response 0 (No). However, in this case, the care provider should document rationale in the clinical record.

• Where in the documentation will this be located for the discharge clinician to view?
M2020- Management of Oral Medications

- Patient’s current ability to prepare & take all oral meds reliably & safely, including administration of the correct dosage at the appropriate times/_intervals. Excludes injectable & IV meds. (NOTE: this refers to ability, not compliance <adherence> or willingness)

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<tr>
<td>0</td>
<td>Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.</td>
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<tr>
<td>1</td>
<td>Able to take medication(s) at the correct times if:</td>
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<td>(a) individual dosages are prepared in advance by another person; OR</td>
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<td>(b) another person develops a drug diary or chart.</td>
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<td>2</td>
<td>Able to take medication(s) at the correct times if given reminders by another person at the appropriate times</td>
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<td>3</td>
<td>Unable to take medication unless administered by another person.</td>
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<tr>
<td>NA</td>
<td>No oral medications prescribed.</td>
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M2020- Management of Oral Medications

- Items addresses 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 holistic perspective in assessing ability to perform medication management.

- Ability can be temporarily or permanently limited by:
  - physical impairments (for example, limited manual dexterity);
  - emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear);
  - sensory impairments (for example, impaired vision, pain);
  - environmental barriers (for example, access to kitchen or medication storage area, stairs, narrow doorways).
M2020- Management of Oral Medications

• 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, enter Response 0.

• Includes assessment of the patient’s ability:
  • To obtain the medication from where it is routinely stored
  • To read the label (or otherwise identify the medication correctly, for example patients unable to read and/or write may place a special mark or character on the label to distinguish between medications),
  • Open the container,
  • Select the pill/tablet or milliliters of liquid and
  • Orally ingest it at the correct times.

M2020- Management of Oral Medications

• Enter Response 2 if daily reminders to take medications are necessary, regardless of whether the patient is independent or needs assistance in preparing individual doses (for example, setting up a “pill planner”)

• If a medication is ordered PRN and the medication is needed by the patient on the day of assessment—and the patient needed a reminder to take this PRN medication on the day of assessment, Enter Response 2.

• Enter Response 3 if the patient does not have the physical or cognitive ability on the day of assessment to take all medications correctly (right medication, right dose, right time) as ordered and it has not been established (and therefore the clinician cannot assume) that set up, diary, or reminders have already been successful.
  • The clinician would need to return to assess if the interventions, such as reminders or a med planner, were adequate assistance for the patient to take all medications safely!
M2020- Management of Oral Medications

• For a patient residing in an assisted living facility where the facility holds and administers medications,

• M2020 should continue to report the patient’s ability to take the correct oral medication(s) and proper dosage(s) at the correct times.

• Report ability based on assessment of the patient’s vision, strength and manual dexterity in the hands and fingers, as well as cognitive ability, despite the facility’s requirement.

M2020 - Scenario

• At the SOC, your patient tells you she will not be buying two of the medications her physician has ordered.

• She can afford the medications but states that she does not feel she will benefit from them.

• The patient is cognitively intact and is aware of the implications of not taking these two medications as ordered.

• She is able to take all her other medications independently. How should you respond to M2020 (Management of oral medications)?

• SEE NEXT SLIDE FOR OASIS ANSWERS
M2020 - Scenario

Possible Answers:

a. 0 – Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.

b. 1 – Able to take medication(s) at the correct times if:
   a) individual dosages are prepared in advance by another person, OR
   b) another person develops a drug diary or chart.

c. 2 – Able to take medication(s) at the correct times if given reminders by another person at the appropriate times

d. 3 – Unable to take medication unless administered by another person.

e. NA – No oral medications prescribed.

M2030 - Management of Injectable Medications:

Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/interval. Excludes IV medications.
**M2030 - Management of Injectable Medications**

- Includes one-time injections administered in the home.
- Includes assessment of the patient’s ability to obtain the medication from where it is routinely stored, draw up the correct dose accurately using aseptic technique, inject in an appropriate site using correct technique, and dispose of the syringe properly.
- 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.
- For a patient residing in an assisted living facility where the facility holds and administers medications, M2030 should continue to report the patient’s ability to administer all injectable medication(s) reliably and safely at all times.

**M2040- Prior Medication Management**

Indicate the patient’s usual ability with managing oral & injectable meds prior to his/her most recent illness.

- Identifies the patient’s ability to manage all prescribed oral and injectable medications prior to 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 "adherence" 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.
How Can We Improve Medications?

• Suggest staff request patient to gather all drugs, Prescription and OTC, at SOC. This allows assessment of physical ability and safety to get to meds.

• Assess if patient knows what the drugs are for and what to report.

• Ensure all high-risk meds are taught at SOC/ROC visits. Document these drugs by name in clinical note.

• If med box present check that planner is accurately filled for times meds are due.

• Always compare to discharge med list and call on any medication issues at SOC. This includes duplicate drugs and medication interactions.

How Can We Improve Medications?

• Have every discipline (SN, PT, OT) ask if any med changes at each visit and document if any changes.

• If medication education is documented as needed, requested by physician, or reflected in M2102 c. (checked 2 for medication education needed), then ensure ability to take meds on M2020 & M2030 show the need for education.

• Remind staff of the timeline to consider when answering the questions.
M2102 - Types and Sources of Assistance

- At SOC/ROC, and at Discharge, report what is known on the day of assessment regarding ability and willingness of non-agency caregivers to provide help in the various categories of assistance for the upcoming episode of care or upon discharge.

- If more than one response represents the non-agency caregiver’s ability to provide assistance, select the response that represents the caregiver’s greatest barrier to meet the need.

- For example, the caregiver provides assistance but also needs training or support. In this example, report that the caregiver needs training/supportive services to provide assistance, because it represents the caregiver’s greatest barrier to meeting the patient’s need.
### (M2102) Types and Sources of Assistance: Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff:

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<tbody>
<tr>
<td></td>
<td>0 No assistance needed—patient is independent or does not have needs in this area</td>
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<tr>
<td></td>
<td>1 Non-agency caregiver(s) currently provide assistance</td>
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<tr>
<td></td>
<td>2 Non-agency caregiver(s) need training/supportive services to provide assistance</td>
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<tr>
<td></td>
<td>3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance</td>
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<td>4 Assistance needed, but no non-agency caregiver(s) available</td>
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<tr>
<td></td>
<td>3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance</td>
</tr>
<tr>
<td></td>
<td>4 Assistance needed, but no non-agency caregiver(s) available</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>f. Supervision and safety (for example, due to cognitive impairment)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 No assistance needed—patient is independent or does not have needs in this area</td>
</tr>
<tr>
<td></td>
<td>1 Non-agency caregiver(s) currently provide assistance</td>
</tr>
<tr>
<td></td>
<td>2 Non-agency caregiver(s) need training/supportive services to provide assistance</td>
</tr>
<tr>
<td></td>
<td>3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance</td>
</tr>
<tr>
<td></td>
<td>4 Assistance needed, but no non-agency caregiver(s) available</td>
</tr>
</tbody>
</table>
M2102 - Types and Sources of Assistance

• Enter Response 3 if: Non-agency Caregiver(s) are not likely to provide care due to an unwillingness and/or inability, or a reluctance on the part of the non-agency caregiver(s) to provide care.

• Devices such as anti-embolism stockings, prosthetic devices, orthotic devices, or other supports that have a medical and/or therapeutic impact should be considered medical procedures/treatments, not as ADL/dressing items in Row a.

 Therapy Need and Plan of Care
M2200 - Therapy Need

In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits?

- Total of reasonable and necessary physical, occupational, and speech-language pathology visits combined?
- (Enter zero ["000"] if no therapy visits indicated.)

- NA – Not Applicable: No case mix group defined by this assessment
  - Not a traditional Medicare payor source. May be a Medicare Advantage program- Managed Care- that pays for visit.

M2200 - Therapy Need

- 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.

- If the number of therapy visits isn’t able to be predicted exactly, provide the best estimate

- 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.

- The date of the projected visits is reflected in M0090-
  - Therefore, if therapist provides the projected number of visits to the RN completing M2200 on a day other than the SOC date, but within the 5 day window, this should be reflected in the date in M0090.
M2250 - Plan of Care Synopsis
(Check only one box in each row)

Does the physician-ordered plan of care include the following:

A. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings
   • NA-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

C. Falls prevention interventions

Diabetic Foot

• SOC & ROC: M2250 b. Diabetic Foot Care included in the plan of care.

• DC: M2400 a. Diabetic foot care included monitoring for the presence of skin lesions on the lower extremities, and patient/caregiver education on proper foot care.

• Not only do staff need to instruct on Diabetic foot care, but they need to document status of the feet.

• This is frequently missing from documentation.

• If SN opens and PT does the remainder of case, they must also assess and document.
Fall Prevention

- M1910: Has this patient had a multi-factor Falls Risk Assessment using a standardized, validated assessment tool?
- SOC: M2250 c. Fall prevention interventions
- DC: M2400 b. Fall prevention interventions performed during episode of care
- If patient is homebound, and does not show risk for falls, this should cue further investigation. It is possible, but infrequent.
- If not using MAHC-10, then SN must perform TUG with the fall risk on SOC. Cannot use the TUG done by therapist for determining fall risk.

Depression

D. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment and/or physician notified that patient screened positive for depression

- NA-Patient has no diagnosis of depression AND depression screening indicates patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.

E. Intervention(s) to monitor and mitigate pain

F. Intervention(s) to prevent 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
M2250- Plan of Care Synopsis

- Included in the physician-ordered Plan of Care means that the patient has been discussed and there is agreement as to the Plan of Care between the HHA staff and the physician.

- Question can be answered “Yes” prior to the receipt of signed orders if the clinical record reflects evidence of communication with the physician to include 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.
M2250- Plan of Care Synopsis

• Select “No” if orders for interventions have been requested but not authorized by the end of the comprehensive assessment time period, unless otherwise indicated in rows d & g.

• This means Plan of Care orders must be in place within five days for SOC in order to respond “Yes.” For ROC, the Plan of Care orders must be in place within two days of inpatient discharge, or within two days of becoming aware of an inpatient discharge, in order to respond “Yes” to M2250.

M2250- Plan of Care Synopsis

• The assessing clinician can wait to complete M2250 until after discussion with another discipline that has completed their assessment.

• Example, if the RN identifies falls 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 the patient’s interventions to prevent falls risk.

• The M0090 date should reflect the last date that information was gathered that was necessary for completion of the assessment.
M2250- Plan of Care Synopsis

- Pressure Ulcer 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.

- Moist wound healing treatment is any primary dressing that hydrates or delivers moisture to a wound thus promoting an optimal wound environment and includes films, alginates, hydrocolloids, hydrogels, collagen, negative pressure wound therapy, Unna boots, medicated creams/ointments.

Scenario - M2250

You develop the plan of care (485) and add your agency’s standardized parameters, as you do for every patient you admit.

You don’t communicate specifically with the physician regarding every patient and the parameters.

- Is it OK to always answer Yes to M2250a- Patient specific parameters?
M2401 - Intervention Synopsis

<table>
<thead>
<tr>
<th>Plan / Intervention</th>
<th>No</th>
<th>Yes</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Diabetic foot care including monitoring for the presence of skin lesions on the</td>
<td>☐</td>
<td>☑</td>
<td>☐/NA</td>
</tr>
<tr>
<td>lower extremities and patient/caregiver education on proper foot care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Falls prevention interventions</td>
<td>☐</td>
<td>☑</td>
<td>☐/NA</td>
</tr>
<tr>
<td>c. Depression intervention(s) such as medication, referral for other treatment, or</td>
<td>☐</td>
<td>☑</td>
<td>☐/NA</td>
</tr>
<tr>
<td>a monitoring plan for current treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Intervention(s) to monitor and mitigate pain</td>
<td>☐</td>
<td>☑</td>
<td>☐/NA</td>
</tr>
<tr>
<td>e. Intervention(s) to prevent pressure ulcers</td>
<td>☐</td>
<td>☑</td>
<td>☐/NA</td>
</tr>
<tr>
<td>f. Pressure ulcer treatment based on principles of moist wound healing</td>
<td>☐</td>
<td>☑</td>
<td>☐/NA</td>
</tr>
</tbody>
</table>

M2401 - Intervention Synopsis (Check only one box in each row)

At the time of or at any time since the most recent SOC/ROC assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

- At Discharge - ties in with M2250 – interventions on plan of care and if you implemented the interventions.

- Select "Yes" if the physician-ordered Plan of Care includes the interventions, at the time of or at any time since the most recent SOC/ROC assessment, and there is evidence of implementation in the clinical record.

- Select "No" if the interventions are not on the Plan of Care OR if the interventions are on the Plan of Care but the interventions were not implemented by the time the Discharge or Transfer assessment was completed, unless "NA" applies.

- Interventions provided by home health agency staff, including the assessing clinician, may be reported by the assessing clinician in M2401. (collaboration with PT on implementation of fall risk interventions, for ex)
M2301 - Emergent Care

At the time of or at any time since the most recent SOC/ROC assessment has the patient utilized a hospital emergency department (includes holding/observation status)?

- No
- Yes, used hospital emergency department WITHOUT hospital admission
- Yes, used hospital emergency department WITH hospital admission
- Unknown
**M2301 - Emergent Care**

- Excludes urgent care services not provided in a hospital emergency department, including care provided at doctor's office, care provided by an ambulance crew, or care received in urgent care facilities.

- Includes holding and observation only in the hospital emergency department setting.

- 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, enter Response 2.
  - An OASIS transfer assessment is required (assuming the patient stay was for 24 hours or more 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 M2301, enter Response 1 – Yes, used hospital emergency department WITHOUT hospital admission.
Part 2B

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

- 1 - Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
- 2 - Injury caused by fall
- 3 - Respiratory infection (for example, pneumonia, bronchitis)
- 4 - Other respiratory problem
- 5 - Heart failure (for example, fluid overload)
- 6 - Cardiac dysrhythmia (irregular heartbeat)
- 7 - Myocardial infarction or chest pain
- 8 - Other heart disease
- 9 - Stroke (CVA) or TIA
- 10 - Hypo/Hyperglycemia, diabetes out of control
- 11 - GI bleeding, obstruction, constipation, impaction
- 12 - Dehydration, malnutrition
- 13 - Urinary tract infection
- 14 - IV catheter-related infection or complication
- 15 - Wound infection or deterioration
- 16 - Uncontrolled pain
- 17 - Acute mental/behavioral health problem
- 18 - Deep vein thrombosis, pulmonary embolus
- 19 - Other than above reasons
- UK - Reason unknown

M2310

ITEM INTENT

- Identifies the reasons for which the patient sought and/or 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

- This item excludes urgent care services not provided in a hospital emergency department, including care provided in a doctor's office, care provided by an ambulance crew, 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.
M2410 - To which inpatient Facility has the patient been admitted?

- Hospital [Go to M2430 ]
- Rehabilitation facility [Go to M0903 ]
- Nursing home [Go to M0903 ]
- Hospice [Go to M0903 ]
- No inpatient facility admission

M2410- To which Inpatient Facility has the patient been admitted?

- If the patient was admitted to more than one facility, indicate the facility type to which the patient was admitted first (for example, the facility type that they were transferred to from their home).

- When a patient dies in a hospital emergency department, the RFA 7 – Transfer to an Inpatient Facility OASIS is completed. Enter 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 individuals with intellectual disabilities (ICF/IID), or a nursing facility (NF) is a nursing home admission.
**M2420 - Discharge Disposition**

Where is the patient after discharge from your agency? (Choose only one answer.)

1. Patient remained in the community (without formal assistive services)
2. Patient remained in the community (with formal assistive services)
3. Patient transferred to a non-institutional hospice
4. Unknown because patient moved to a geographic location not served by this agency

UK- Other unknown [Go to M0903 ]

---

**M2420 - Discharge Disposition**

Where is the patient after discharge from your agency? (Choose only one answer.)

- Formal assistive services refers to community-based services provided through organizations or by paid helpers. Examples: homemaking services under Medicaid waiver programs, personal care services provided by a home health agency, paid assistance provided by an individual, home-delivered meals provided by organizations like Meals-on-Wheels.

- Therapy services provided in an outpatient setting would not be considered formal assistance.
**M2420 - Discharge Disposition**

- Informal services are provided by friends, family, neighbors, or other individuals in the community for which no financial compensation is provided. Examples: assistance with ADLs provided by a family member, transportation provided by a friend, meals provided by church members (specifically, meals not provided by the church organization itself, but by individual volunteers).

- Noninstitutional hospice is defined as the patient receiving hospice care at home or a caregiver’s home, not in an inpatient hospice facility.

**M2420 - Scenario**

Your home health patient currently lives with his daughter while he’s receiving home care services. But on discharge from home health, he is returning to his home at an assisted living facility (ALF). How should you answer M2420 (Discharge disposition)?

- a. 1 – Patient remained in the community (without formal assistive services)
- b. 2 – Patient remained in the community (with formal assistive services)
- c. 3 – Patient transferred to a non-institutional hospice
- d. 4 – Unknown because patient moved to a geographic location not served by this agency
- e. UK – Other unknown
M2430 - Reason for Hospitalization

(M2430) Reason for Hospitalization: For what reason(s) did the patient require hospitalization?
(Mark all that apply)

- 1 Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
- 2 Injury caused by fall
- 3 Respiratory infection (for example, pneumonia, bronchitis)
- 4 Other respiratory problem
- 5 Heart failure (for example, fluid overload)
- 6 Cardiac dysrhythmia (irregular heartbeat)
- 7 Myocardial infarction or chest pain
- 8 Other heart disease
- 9 Stroke (CVA), or TIA
- 10 Hypo/hyperglycemia, diabetes out of control
- 11 GI bleeding, obstruction, constipation, impaction
- 12 Dehydration, malnutrition
- 13 Urinary tract infection
- 14 IV catheter-related infection or complication
- 15 Wound infection or deterioration
- 16 Uncontrolled pain
- 17 Acute mental/behavioral health problem
- 18 Deep vein thrombosis, pulmonary embolus
- 19 Scheduled treatment or procedure
- 20 Other than above reasons
- UK Reason unknown

M2430 - Reason for Hospitalization

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
- Select 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 selected.
- Response 2 should be selected if patient is hospitalized for an injury caused by a fall, regardless of where the fall occurred.
- Response 20 should be selected if the patient is hospitalized for a new wound that is not the result of a fall.
- If the reason is not included in the choices, select Response 20 “Other than above reasons.”
M0903 - Date of Last (Most Recent) Home Visit

- Identifies the last or most recent home visit by any agency provider
- 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.
- Report the date of the last visit made to the home by agency staff, whether or not it was included on the Plan of Care.

M0906 - Discharge/Transfer/Death Date

Enter the date of the discharge, transfer, or death (at home) of the patient.
- Identifies the actual date of discharge, transfer, or death (at home), depending on the reason for assessment.
- 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).
- 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.
M0906 - Scenario

Which of the following is true about the transfer date in M0906?

a. It’s determined by agency policy
b. It’s determined by physician order
c. It’s the date the patient was admitted to an inpatient facility.
d. All of the above
e. None of the above

CONCLUSION

• Many OASIS timepoints and data elements!

• Remember, best assessment is to walk the patient around the house and have them show you how they do the areas within the comprehensive OASIS assessment.

• Don’t do for the patient or just ask them questions
  • We are Caregivers and want to be the “Doers” so this is against our nature!

• Read the Medicare Intent and Guidance in Chapter 3 of the OASIS Manual to be able to know how to do the best assessment and most accurate manner to score.

• Next up, we will talk about how these M items produce outcomes for your Agency! And how to improve your patient and Agency outcomes!
OASIS, OUTCOMES & YOUR AGENCY’S STAR RATINGS!

PART 3

OBJECTIVES

• Review CASPER Reports so that participants can understand the outcomes being measured and how to analyze.
• Understand the relation to the 5 Star Ratings
• Understand Home Health Compare
• Understand how to select the outcome measures to focus on
• What to do with the selected outcomes
• How to develop indicators and monitor ongoing to improve selected outcomes
**5 Star Measures**

- Outcome Measures
- Bathing
- Dyspnea
- Ambulation
- Bed transferring
- Pain

**Process Measures**

- Timely initiation of care
- Drug education all meds all episodes
- Influenza received for current flu season

**Utilization Outcomes:**

- ACH claims based

---

**End Result Outcome Measures: Risk Adjusted - OASIS Based**

<table>
<thead>
<tr>
<th>Measure</th>
<th>HH Compare</th>
<th>Star Rating</th>
<th>HHVBP</th>
<th>IMPACT Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement in Bathing</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Improvement in Bed Transferring</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Improvement in Ambulation/Locomotion</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Improvement in Management of Oral Medications</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Improvement in Dyspnea</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Improvement in Pain Interfering in Activity</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Improvement in Status of Surgical Wounds</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharged to Community</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>% of Patients with Pressure Ulcers that are New or Worsened</td>
<td>New to HHC in 2019</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
### Utilization Outcome Measures: Risk Adjusted - Claims Based

<table>
<thead>
<tr>
<th>Measure</th>
<th>HH Compare</th>
<th>Star Rating</th>
<th>HHVBP</th>
<th>IMPACT Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Hospitalization During the First 60 Days of Home Health</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>ED Use Without Hospitalization During the First 60 Days of Home Health</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Re-hospitalization During the First 30 Days of Home Health</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ED Use Without Hospitalization Readmission During the First 30 Days of Home Health</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge to Community</td>
<td></td>
<td></td>
<td>New to HHC in 2019</td>
<td>X</td>
</tr>
<tr>
<td>Potentially Preventable 30-Day Post Discharge Readmission Measure</td>
<td></td>
<td></td>
<td>New to HHC in 2019</td>
<td>X</td>
</tr>
</tbody>
</table>

### Resource Use Measure – Risk Adjusted – Claims Based

<table>
<thead>
<tr>
<th>Measure</th>
<th>HH Compare</th>
<th>Star Rating</th>
<th>HHVBP</th>
<th>IMPACT Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Estimated Medicare Spending Per Beneficiary</td>
<td>New to HHC in 2019</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

### Process Measures: No Risk Adjustment - OASIS Based

<table>
<thead>
<tr>
<th>Measure</th>
<th>HH Compare</th>
<th>Star Rating</th>
<th>HHVBP</th>
<th>IMPACT Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Education on All Medications Provided to Patient/Caregiver During All Episodes of Care</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Removed in Performance Year 3 (2018)</td>
</tr>
<tr>
<td>Timely Initiation of Care</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression Assessment Conducted</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multifactor Fall Risk Assessment Conducted for All Patients Who Can Ambulate</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetic Foot Care and Patient/Caregiver Education Implemented During all Episode of Care</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flu Immunization Received for Current Flu Season</td>
<td>X</td>
<td></td>
<td>Removed April 2018</td>
<td>X</td>
</tr>
<tr>
<td>Pneumococcal Polysaccharide Vaccine (PPV) Ever Received</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug Regimen Review Conducted with Follow-Up for Identified Issues</td>
<td>New to HHC in 2019</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
CASPER

Outcome Based Quality Improvement Reports

OASIS Leads To The Outcome Reports So What Are They??

- CASPER is the computer system that compiles the OASIS data of every certified home health agency at two time points:
  - SOC to D/C
  - ROC to D/C
- Produces outcome reports:
  - Agency Patient Related Characteristics
  - Risk Adjusted Outcome Report
  - Potentially Avoidable Events (PAE)
  - Process Measures Report

- 3 Bar is most meaningful - your current %, your prior period % and national current %
- Asterisks mean it is statistically significant data
Agency Patient Related Characteristics Report

- A Lot of great information on your agency, including:
  - Demographics,
  - Payment sources,
  - Therapy days,
  - Length of stay
  - Diagnoses,
  - Results of many M items
- Many of this report’s items contribute to your risk adjustment (like a golf handicap)
- Useful information regarding differences in your agency to others

Risk Adjusted Outcome Report

- Outcomes compared on a 3 bar report give information on the percentage of patients you have improved in various M items, current, prior and nation
- ADLs, IADLs, Ambulation
- Clinical - Medications, Dyspnea, Pain, UTIs
- Confusion, Anxiety
- Emergency Department and Re-hospitalizations
Outcomes from OASIS

- Grooming
- Dyspnea
- Bathing
- Bed Transferring
- Toilet Transferring
- Eating
- Speech & Language
- Improvement in: Management in oral meds
- Urinary Incontinence
- Confusion Frequency
- UTI
- Bowel incontinence
- Ambulation
- Status of Surgical Wounds
- Behavior problem freq
- Pain interfering with activity
- Upper body dressing
- Lower body dressing
- Light meal
- Phone Use
- Anxiety Level

Discharged to community

- Acute care hospitalization (ACH)
- Emergency (ED) use with hospitalization

Claims based:

- ACH 1st 60 days HH
- Rehosp 1st 30 days HH
- ED w/o hosp 1st 60 days hh
- ED use w/o hosp 1st 30 days HH
Potentially Avoidable Events (PAE)

- Adverse Events
  - Important to audit the patient's record to try to prevent this from occurring in the future
  - Emergent care for: falls, wound infections or deteriorating wound status, improper medication administration or medication side effects and hypo/hyperglycemia
  - Development of UTI, increase in number of pressure ulcers, decline in management of oral medications
  - Decline of 3 or more ADLs
  - Discharged to community needing wound care, med assistance, toileting assistance, behavior problems or unhealed stage 2 pressure ulcer

Potentially Avoidable Events - PAE

- Emergent care for:
  - Fall
  - Wound infections, deteriorating wound status
  - Improper med admin, med side effects
  - Hypo/hyperglycemia
  - Development of UTI
  - Increase in # pressure ulcers

Discharge to Community Needing:
  - Wound care
  - Med assistance
  - toileting
  - With behavioral problems
  - With unhealed stage 2 pressure ulcer

Substantial decline in:
  - 3 or > ADL
  - Mgmt. oral meds
**Process Based Quality Improvement - (PBQI)**

- Process Measures - Standards for Best Practices
- Timely initiation of care, physician notification
- Risk assessments – falls, pressure ulcer, depression and pain
- Interventions on the plan of care for depression, Diabetic foot care & patient education, fall prevention, pain, & pressure ulcer prevention
- Implementation of these interventions in the documentation
- Heart failure symptoms addressed
- Influenza and Pneumococcal vaccines
- Medication issues identified and timely physician contact

---

**CASPER Reports**

- Need to assign someone to look in system monthly to see if reports have been updated
- When updated, do an analysis of the data, focusing on the statistically significant areas
- Write an action plan for needed areas
- Incorporate into your QI plan- have a QI indicator for formal monitoring
- Shared with all staff! That is how you get improvement!
- Plan the episode of care for the patient in order to focus on improving outcomes as a team!
- **All of this information comes from what YOU PUT IN OASIS!!!**
**Home Health Compare**

- Some of the outcomes from CASPER reports are on this public website.
- Variances to CASPER – agency compared to state and nation and can be compared to other agencies.
- Purpose for the public to choose quality HHA’s.
- Can use this information for Marketing your agency when your outcomes are better for patients than other agencies.

---

**Home Health Compare**

Reports the quality of care provided by Medicare Certified Home Health Providers.

**Provides Information Regarding:**
- Quality of Patient Care
- Quality Measures
- Patient Survey Results
- Patient Survey Star Ratings
<table>
<thead>
<tr>
<th>MEASURE DESCRIPTION</th>
<th>ABC HAA</th>
<th>XYZ HHA</th>
<th>TEXAS AVERAGE</th>
<th>NATIONAL AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often patients got better at walking or moving around</td>
<td>68%</td>
<td>50%</td>
<td>57%</td>
<td>63%</td>
</tr>
<tr>
<td>How often patients got better at getting in and out of bed</td>
<td>63%</td>
<td>37%</td>
<td>49%</td>
<td>59%</td>
</tr>
<tr>
<td>How often patients got better at bathing</td>
<td>72%</td>
<td>53%</td>
<td>62%</td>
<td>68%</td>
</tr>
<tr>
<td>How often the home health team checked patients for pain</td>
<td>99%</td>
<td>100%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>How often the home health team treated their patients’ pain</td>
<td>99%</td>
<td>100%</td>
<td>98%</td>
<td>98%</td>
</tr>
<tr>
<td>How often patients had less pain when moving around</td>
<td>61%</td>
<td>52%</td>
<td>57%</td>
<td>68%</td>
</tr>
<tr>
<td>How often the home health team treated heart failure (weakening of the heart) patients’ symptoms</td>
<td>100%</td>
<td>Not Available</td>
<td>98%</td>
<td>98%</td>
</tr>
<tr>
<td>How often patients’ breathing improved</td>
<td>51%</td>
<td>38%</td>
<td>50%</td>
<td>65%</td>
</tr>
<tr>
<td>How often patients’ wounds improved or healed after an operation</td>
<td>98%</td>
<td>Not Available</td>
<td>87%</td>
<td>89%</td>
</tr>
<tr>
<td>How often the home health team checked patients for the risk of developing pressure sores (bed sores)</td>
<td>99%</td>
<td>98%</td>
<td>98%</td>
<td>99%</td>
</tr>
<tr>
<td>How often the home health team included treatments to prevent pressure sores (bed sores) in the plan of care</td>
<td>99%</td>
<td>98%</td>
<td>98%</td>
<td>99%</td>
</tr>
<tr>
<td>How often the home health team took doctor-ordered action to prevent pressure sores (bed sores)</td>
<td>81%</td>
<td>100%</td>
<td>96%</td>
<td>97%</td>
</tr>
<tr>
<td>How often patients receiving home health care needed any urgent, unplanned care in the hospital emergency room – without being admitted to the hospital</td>
<td>17%</td>
<td>9%</td>
<td>12%</td>
<td>12%</td>
</tr>
<tr>
<td>How often home health patients had to be admitted to the hospital</td>
<td>16%</td>
<td>14%</td>
<td>15%</td>
<td>16%</td>
</tr>
</tbody>
</table>
Quality of Patient Care Star Ratings

- Home Health Compare uses a quality of patient care star rating to show consumers how the performance of a home health agency compares to other agencies.

- Agencies get more stars when they follow recommended care practices for more patients, and when more of their patients show improvement.

- The quality of patient care star rating summarizes each agency’s performance on average across 9 of the quality measures reported on Home Health Compare.

- Text from Medicare.gov Website
  https://www.medicare.gov/HomeHealthCompare/About/Patient-Care-Star-Ratings.html

Quality of Patient Care Star Ratings continued

- These measures were selected to give a general overview of agency performance on measures that apply to the most people.

- A 4★ or 5★ rating means that the agency performed better than other agencies on the measured care practices and outcomes. A 1★ or 2★ rating means that the agency’s average performance on the 9 measured care practices and outcomes was below the averages of other agencies. Across the country, most agencies fall “in the middle” with 3★ or 3½★.

- Since the star rating calculation ranks all agencies from lowest to highest, some agencies will be ranked below others even though they’re providing good quality care.

- Text from Medicare.gov Website
  https://www.medicare.gov/HomeHealthCompare/About/Patient-Care-Star-Ratings.html
Quality Measures Divided into Categories Which Include:

- Managing Daily Activities
- Managing & Treating Pain
- Treating Wounds and Preventing Pressure Wounds
- Preventing Harm
- Preventing Unplanned Hospitalization

Quality Measures

- The INTENT that CMS provides in the OASIS guidance manual is critical to scoring the OASIS assessment correctly
- Many agencies with low Star Ratings find that OASIS training is the KEY to increasing outcomes because clinicians do not know and/or follow the intent!
- Another main weakness is that all clinicians do not perform the comprehensive OASIS assessment in the same manner.
- Therefore, one clinician at SOC may have different scores that the next clinician that performs the Discharge OASIS this will skew your outcomes and will lead to a false Star Rating.
Managing Daily Activities

**M1830 - Bathing - Current ability to wash entire body safely**

- To accurately assess and score, on SOC have the patient walk with you to the bathroom.

- Once there, have him do what he would when he bathes - he may not be taking an actual shower, but have him do a mock - show how he undresses, steps into shower, sits on shower bench, reaches to turn the water on, makes the temperature correct, washes his back, bottom and legs. Then steps out and gets to towels and clothing.

- This could be done in actuality if another visit is done within the 5 days to actually watch while patient bathes.

- Then on discharge, do the same thing!

- This is the ONLY way to get the most accurate scores and be able to improve and demonstrate improvement in your patient's outcomes

- So important as this sets the plan for the care team and patient to reach goals and outcomes!
Managing Daily Activities

• M1840 - Toilet Transferring

• Current ability to get to & from toilet or bedside commode safely AND transfer on /off toilet / commode
  • Identify the patient’s ABILITY, not necessarily actual performance
  • Observe patient during transfer on and off toilet
    • If patient has pain / difficulty with balance / strength / etc. --- determine level of assistance needed for the patient to be safe

• Don’t assume patient is safe or can use equipment that they don’t have

Managing Daily Activities

M1850 – Transferring

• Current ability to move safely from bed to chair OR ability to turn & position self in bed if patient is bedfast

• Does the patent need:
  • Verbal cueing, environmental set up &/or hands on assistance
    • For minimal assistance the person assisting the patient must contribute less than 25% of the total effort
  • Response 2 - Able to bear weight and pivot during the transfer process but unable to transfer self.
    • Requires BOTH assistance and a device
  • Bedfast
    • On day of assessment patient is either:
      • Medically restricted to bed OR unable to tolerate being out of bed
Managing Daily Activities

• M1860 - Ambulation/Locomotion

• Current ability and the type of assistance required to walk **safely** (once in a standing position) or propel a wheelchair (once in a seated position) on a **variety of surfaces**

• Assess on typical surfaces routinely encountered in patient’s environment

• Have the patient walk you around the house, including any location with steps. Include the outside steps as the patient will have to go to medical appointments and prior to discharge your team will need to know that patient is able to go out of house safely!

Watch the patient perform tasks!!!
QUALITY MEASURE
Managing Pain & Treating Symptoms

M1240: Pain Assessment

- Has this patient had a formal pain assessment using a standardized, validated pain assessment tool?
  - 0 - No standardized, validated assessment conducted
  - 1 - Yes, and it does not indicate severe pain
  - 2 - Yes, and it indicates severe pain

Wong-Baker FACES Pain Rating Scale

© 2018, 5 Star Consultants, LLC
Managing Pain & Treating Symptoms

- M1240- Pain Assessment
  M1242 - Frequency of Pain Interfering with Patient’s Activity or Movement

- Very important to do appropriate pain management in home health!

- To improve Pain in your patients, the entire interdisciplinary team caring for the patient must be working together!

- Choose this as a team outcome at start of care, have all members focus on this on visits, document, and report to all team members.

- This WILL increase your Pain Outcomes! And have a happier patient, therefore CAHPS will be higher as well!!!

Managing Pain & Treating Symptoms

Pain Assessment

- All team members must be thorough in the pain assessment!
  - Does the patient take their pain meds?
  - What is the pain then? - etc.
  - If pain is not relieved by meds, contact MD

- Severe Pain: Must ALL know your Agency’s severe pain score

- Care team Must communicate regularly regarding patients pain, what is effective and what is not.

- Must notify the physician for severe pain not relieved by pain medications and non-pharmacologic therapies
Managing Pain and Treating Symptoms

- Frequency of Pain Interfering with Patient’s Activity or Movement
- Remember to look for activities that the patient cannot do due to pain
- Focus on improving pain, functions and patient’s quality of life!
- Example:
  Mr. Z likes to play cards with his neighbor most afternoons.
  He has had to stop as his back and hands hurt so badly he cannot do it.
  This was an activity he really enjoyed and without it, he is depressed.
  
  - The team can work together to Think Outside of the Box!
  - A lot of Home Health Clinicians have been Very effective in improving patient’s pain outcome during the home health care period!
  - Think Holistically!

Scenario

- Mr. Jones tells the nurse on the day of assessment that his pain is a on a scale from 0-10.
- When the nurse questions Mr. Jones about his pain over the past 24 hours, he said that during the night the pain went up to a 9.
- Mr. Jones also tells the nurse that he limits walking to distances less than 20 feet at time in order to be pain free.
When Is The Patient Dyspneic Or Noticeably Short Of Breath

M1400

• Observe if patient is noticeably short of breath with and without activities
• As you walk around the house and have patient perform tasks, may become more SOB.
• Use clinical judgment to determine the level of effort required to complete a task
• Then interview patient / caregiver as well as the timing for this question is 24 hours preceding assessment and during the assessment
• The team, with the patient, must look for ways to improve the patient's dyspnea.
  • Use of OT for energy conservation, scheduling visits on opposite days, pulmonary rehabs with activities for the patient, etc
  • Notify physician with recommendation to improve dyspnea
M1500/1511- Symptoms in Heart Failure Patients & follow up

- Preventing CHF exacerbation is KEY in Home Health
- Care team needs to put a plan in place at SOC and ensure that they are working on preventing CHF exacerbation throughout HH admission.
- This means being each other’s eyes and ears - reporting even mild signs/symptoms seen to the RN, who then assesses and reports to the physician.
- The care team needs to continually educate the patient and caregiver(s) regarding what to call the agency to report. This can prevent the pt/cg from having to call 911 when the symptoms are severe
- This alone can prevent emergent care visits and rehospitalizations and improve the patient’s outcomes!

QUALITY MEASURE
Treating Wounds and Preventing Pressure Ulcers
**Integumentary M Items Leading To Outcomes: Potentially Avoidable Events / HH Compare / Emergent Care & Readmissions**

- M1313 - Current number of unhealed pressure ulcers at each stage
- M1320 - Pressure ulcer healing status
- M1322 - Current number of stage 1 pressure ulcers
- M1330 - Does a patient have a stasis ulcer?
- M1332 - Current number of stasis ulcer(s) that are observable
- M1340 - Does patient have a surgical wound?
- M1342 - Status of most problematic surgical wound that is observable
- M1350 - Does this patient have a skin lesion or open wound (excluding bowel ostomy), other than those described above, that is receiving intervention, by the home health agency?

**Improving wounds**

- Have guidelines for Wound Assessments, visits
- If a modality is not working after a designated time period, contact physician.
- Use Wound Consults if wounds, all types, are not healing as expected.
- Work closely with wound clinics and with the HH physician in order to improve outcomes in wounds.
- Infection Control, Infection Control, Infection Control!
  - Staff, patients, caregivers!
Assessment Strategies

- Visualization of patient’s body and wounds is imperative on SOC, ROC, DC, but also on every nursing visit.
- The care team must communicate if they see new or worsening wounds.
- The Aide sees the patient’s body, so Must report skin changes to RN- this is a new COP.
- Examples- aide sees redness, warmth on a recent incision. This must be reported to RN asap. The RN needs to assess asap and contact physician.

QUALITY MEASURE

Preventing Harm
Timely Initiation of Care

- Percentage of episodes that occur within 2 days of the referral date, or the inpatient discharge date, whichever is later

- OASIS items include:
  - SOC - initial assessment, within 48 hours or per MD ordered SOC
    - The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care
  - ROC - within 48 hours of patients return home from inpatient facility admission of 24 hours or more for reasons other than diagnostic tests
  - New COPs – On physician ordered resumption date

Timely Initiation of Care

- Recert- last 5 days of every 60 day episode beginning with SOC date (day 56-60 of each cert period)

- Other Follow Up- Major decline or improvement in health status- during episode

- Transfer to Inpatient Facility – Not discharged

- Transfer to Inpatient Facility- Discharged

- Death at Home

- Discharge
Unplanned Or Unexpected Discharges

- Should happen very infrequent but does require the following:
  - Patient visit with comprehensive assessment
  - If unable, a qualified clinician completes the assessment based on their last visit AND may supplement information from visits made to the patient within the last 5 days of the unexpected/unplanned discharge
  - Ensure collaboration documentation is documented within chart
Influenza and Pneumococcal Vaccines

M1041, 1046, M1051, 1056

• A Goal is to increase the number of patients that receive these vaccines
• Home Health is Holistic and therefore, we want to be sure that we are doing everything we can for the patient.
• It is not best for the patient if you are telling them to go to the neighborhood drug store for a flu shot, since your agency doesn’t want to give the vaccine.
• If patients refuse at a high rate in your agency, look at how you are asking the patients
• Suggest including this question in discharge review process as well.

M2016- Patient / Caregiver Drug Education Intervention

• At the time of, or at any time since the most recent SOC/ROC assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur?
• Since at discharge, very important to view documentation in clinical record to identify if there has been education provided.
• The Care Team must communicate all medications the patient is taking as they find out on their visits.
• Often see meds in visit notes but there is no order
• Ex PTA documents that Vicodan is helping the patient’s pain, but there is no order.
• Education must be coordinated between the care team in order to improve outcomes
M2020- Management of Medications

Patient’s current ability to prepare and take ALL oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.

• Think right med / right dose / right time
• Assess using observation and interview
  • Mental / emotional / cognitive status
  • Physical status
  • Activities permitted
  • Environment
  • Knowledge of drug dose and administration schedule
• Care Team Must focus on improvement in med management in working with the patient and caregiver(s) on an ongoing basis in order to improve!

Quality Measures

Preventing Unplanned Hospital Care
Unplanned Hospital Care

- M0100 – Transferred to an Inpatient Facility
- M2301 – Emergent Care
- M2310 – Reasons for Emergent Care
- Used in calculation for a Potentially Avoidable Event (PAE) report
- Utilization outcomes on CASPER
  - Acute care hospitalization
  - Emergency department with hospitalization
- Claims based outcomes on CASPER
  - Acute care hospitalization during the first 60 days of home health
  - Re-hospitalization during the first 60 days of home health
  - Emergency department without hospitalization during the first 60 days of home health
  - Emergency department without hospital readmission during the first 30 days of home health

Preventing Unplanned Hospital Care & ER Utilization

- Frontloading visits
- The Patient's Care Management Team Working Together!
- Physician notification – early and timely!
- Communication with patient between visits
  - Education on when to notify home care
- Proper utilization of services- example: OT, Aides when 3 ADL's are low
- In-depth medication reconciliation
- Know your patient's health history and level of compliance
- Continuity of care
- If poor outcomes, use a QAPI indicator Or a PIP!
Example: QAPI Indicator

- Reasons for Emergent Care

- Outcome Reports (CASPER):
  - Respiratory infection – 25% / 0 prior / 8.3% national
  - Other respiratory – 20.8% / 7.7% prior / 11.4% national
  - Uncontrolled pain – 8.3% / 0 prior / 5.2% national

- Indicator:
  - QI coordinator or designee will review 100% of patient OASIS - reason for emergent care quarterly.

Example: QAPI Indicator

- If ‘respiratory infection’ or ‘other respiratory’ or ‘uncontrolled pain’ is the reason for emergent care, then a clinical record review will be completed to identify if the agency could have done anything to prevent these occurrences

- Goal (CASPER Data):
  - Respiratory infection - 12%
  - Other respiratory - 8%
  - Uncontrolled pain - 4%
### Respiratory

**Criteria: Respiratory**

<table>
<thead>
<tr>
<th>Question</th>
<th>Patient</th>
<th>Patient</th>
<th>Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does patient not have respiratory diagnosis?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the respiratory assessment correlate with the M item for dyspnea?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was physician notified for all respiratory signs and symptoms?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was respiratory education documented?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was understanding of education by patient/caregiver documented?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the patient/caregiver contact the HHA prior to going to the ER?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, did the nurse call the physician and/or make a visit?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was there anything the HHA could have done to prevent emergent care for respiratory reasons?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total per Patient -</strong></td>
<td></td>
<td></td>
<td><strong>57</strong></td>
</tr>
<tr>
<td><strong>Total Compliance -</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Pain

**Criteria: Pain**

<table>
<thead>
<tr>
<th>Question</th>
<th>Patient</th>
<th>Patient</th>
<th>Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the pain assessment correlate with the M item for pain on OASIS?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was physician notified for all pain signs and symptoms?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were all pain assessments complete and thorough?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was pain education documented?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was understanding of education by patient/caregiver documented?</td>
<td></td>
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</tr>
<tr>
<td>If yes, did the nurse call the physician and/or make a visit?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was there anything the HHA could have done to prevent emergent care for uncontrolled pain?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total per Patient -</strong></td>
<td></td>
<td></td>
<td><strong>58</strong></td>
</tr>
<tr>
<td><strong>Total Compliance -</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Conclusion**

- OASIS leads to the patient's outcomes from SOC or ROC to Tx or DC
- The patient's outcomes roll up into all patients from the HHA to give that HHA their outcomes
- ALL agencies across the nation have outcomes benchmarked to each other
- The National / State benchmarks for outcomes is what your Agency wants to exceed
- This indicates that your Patient's have better outcomes that other Agencies!

**Conclusion**

- In order to improve your patient's outcomes you must:
- Work together as a Team – all staff taking care of a patient must focus on outcomes to improve throughout the home health care period
- The Assessments for OASIS must have the patients doing for themselves so that you can most accurately score
- All OASIS clinicians must perform this type of assessment the same on every OASIS timepoint..........or your patient and agency's outcomes will be skewed!
- OASIS Outcomes lead to 5 Star Ratings. Those with 4 or 5 stars are the highest quality agencies.
  - Those are the agencies that physicians, families, etc will choose to take care of the patients!
OASIS D

Part 4

OASIS D . . .

is Coming . . .

January 1, 2019!
**OASIS D: Time Points**

- March 2018
  - Proposed OASIS D item set was released
- July 2018
  - Draft OASIS D should be released
- November 2018
  - Final version of OASIS D is scheduled for release
- January 1, 2019
  - Implementation
    - Based on M0090: Date assessment was completed

---

**OASIS D – IMPACT ACT**

- The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act)
- The purpose of the IMPACT Act is to standardize patient assessment data collected for Post-Acute Care (PAC) providers.

- The PAC providers are:
  1. Long-Term Care Hospitals (LTCHs)
  2. Inpatient Rehabilitation Facilities (IRFs)
  3. Skilled Nursing facilities (SNFs)
  4. Home Health Agencies (HHAs)
OASIS D - IMPACTACT

- The reason for standardization of data is to develop improved quality measure (QM).
- Utilize the data to compare all four PAC providers for quality.
- Improve coordination of care and discharge planning between the PAC providers.

OASIS D: Changes

- M - Items:
  - Removing 28
  - Abbreviating 1
- Adding:
  - 4 - GG items
  - 2 - J items
- CMS estimates an overall decrease in the time it takes to complete
- BUT…what we know is that not all OASIS items are equal
OASIS D: Items Removed

- M0903: Date of Last / Most Recent Home Visit
- M1011: Inpatient Diagnosis
- M1017: Diagnosis Requiring Medical or Treatment Regimen Change Within Past 14 Days
- M1018: Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days
- M1025: Optional Payment Diagnosis
- M1034: Overall Status
- M1036: Risk Factors
- M1210: Ability to Hear
- M1220: Understanding Verbal Content
- M1230: Speech & Oral (Verbal) Expression of Language

OASIS D: Items Removed

- M1240: Pain Assessment
- M1300: Assessment for Pressure Ulcer Risk
- M1302: Risk for Pressure Ulcers Identified
- M1313: Worsening in Pressure Ulcer Status
- M1320: Healing Status of Most Problematic Pressure Ulcer
- M1350: Skin Lesion or Open Wound
- M1410: Respiratory Treatments
- M1501: Symptoms in Heart Failure
- M1511: Heart Failure Follow-up
- M1615: When Does Urinary Incontinence Occur
**OASIS D: Items Removed**

- M1750: Psychiatric Nursing Services
- M1880: Ability to Plan and Prepare Light Meals
- M1890: Ability to Use the Telephone
- M1900: Prior Functioning ADL/IADL
- M2040: Prior Medication Management
- M2110: How Often Does the Patient Receive ADL or IADL Assistance from Caregiver
- M2250: Plan of Care Synopsis
- M2430: Reason for Hospitalization

**OASIS D: Additions**

- Section GG: Functional Abilities and Goals
  - GG0100: Prior Functioning: Everyday Activities
  - GG0110: Prior Device Use
  - GG0130: Self-Care
  - GG0170: Mobility
- Section J: Health Conditions
  - J1800: Any Falls Since SOC / ROC
  - J1900: Number of Falls Since SOC/ROC
Examples of What’s New

GG0100: Prior Functioning: Everyday Activities

<table>
<thead>
<tr>
<th>Coding:</th>
<th>Enter Codes in Boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. <strong>Independent</strong> – Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.</td>
<td>A. <strong>Self Care</strong>: Code the patient’s need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.</td>
</tr>
<tr>
<td>2. <strong>Needed Some Help</strong> – Patient needed partial assistance from another person to complete activities.</td>
<td>B. <strong>Indoor Mobility (Ambulation)</strong>: Code the patient’s need for assistance with walking from room to room (with or without a device such as cane, crutch or walker) prior to the current illness, exacerbation, or injury.</td>
</tr>
<tr>
<td>1. <strong>Dependent</strong> – A helper completed the activities for the patient.</td>
<td>C. <strong>Stairs</strong>: Code the patient’s need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation or injury.</td>
</tr>
<tr>
<td>8. <strong>Unknown</strong></td>
<td>D. <strong>Functional Cognition</strong>: Code the patient’s need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.</td>
</tr>
<tr>
<td>9. <strong>Not Applicable</strong></td>
<td></td>
</tr>
</tbody>
</table>

NEW Options
### GG0110: Prior Device Use

- **GG0110. Prior Device Use**. Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury.
- **Check all that apply**
  - A. Manual wheelchair
  - B. Motorized wheelchair and/or scooter
  - C. Mechanical lift
  - D. Walker
  - E. Orthotics/Prosthetics
  - Z. None of the above

### GG0130: Self-Care

- **GG0130. Self-Care**
- **Code** the patient’s usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient’s discharge goal(s) using the 6-point scale. Use of codes 07, 09, 19 or 88 is permissible to code discharge goal(s).

#### Coding:
- **Safety and Quality of Performance** – If helper assistance is required because patient’s performance is unsafe or of poor quality, score according to amount of assistance provided.
- Activities may be completed with or without assistive devices.
- 00. Independent – Patient completes the activity by him/herself with no assistance from a helper.
- 05. Setup or clean-up assistance – Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
- 04. Supervision or touching assistance – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
- 03. Partial/moderate assistance – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
- 02. Substantial/maximal assistance – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- 01. Dependent – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

#### If activity was not attempted, code reason:
- 07. Patient refused
- 09. Not applicable – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
- 10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)
- 88. Not attempted due to medical conditions or safety concerns
GG0130: Self-Care

<table>
<thead>
<tr>
<th>SOC/ROC Performance</th>
<th>Discharge Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Codes in Boxes</td>
<td></td>
</tr>
</tbody>
</table>

A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.

B. Oral Hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures from and to the mouth, and manage equipment for soaking and rinsing them.

C. Toileting Hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.

D. Shower/bathe self: The ability to bathe self, including washing,Range of motion

EXCLUDES washing of back and hair. Does not include transferring in/out of bathtub.

E. Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable.

F. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footgear.

GG0170: Mobility

Code the patient’s usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient’s discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).

Coding:

Safety and Quality of Performance - If helper assistance is required because patient’s performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

05. Setup or clean-up assistance - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.

04. Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.

03. Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.

02. Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

01. Dependent - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

07. Patient refused

09. Not applicable - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.

10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)

88. Not attempted due to medical conditions or safety concerns
**GG0170: Mobility**

<table>
<thead>
<tr>
<th>1. SOC/ROC Performance</th>
<th>2. Discharge Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>↓ Enter Codes in Boxes ↓</strong></td>
<td></td>
</tr>
<tr>
<td>A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.</td>
<td></td>
</tr>
<tr>
<td>B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.</td>
<td></td>
</tr>
<tr>
<td>C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.</td>
<td></td>
</tr>
<tr>
<td>D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.</td>
<td></td>
</tr>
<tr>
<td>E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).</td>
<td></td>
</tr>
<tr>
<td>F. Toilet transfer: The ability to get on and off a toilet or commode.</td>
<td></td>
</tr>
<tr>
<td>G. Car Transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.</td>
<td></td>
</tr>
</tbody>
</table>

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**GG0170: Mobility (Continued)**

<table>
<thead>
<tr>
<th>1. SOC/ROC Performance</th>
<th>2. Discharge Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>↓ Enter Codes in Boxes ↓</strong></td>
<td></td>
</tr>
<tr>
<td>I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If SOC/ROC performance is coded 01, 02, 03, 04, or 05, skip to GG0170M, 1 step (curb)</td>
<td></td>
</tr>
<tr>
<td>J. Walk 50 feet with two turns: Once standing, the ability to walk 50 feet and make two turns.</td>
<td></td>
</tr>
<tr>
<td>K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space</td>
<td></td>
</tr>
<tr>
<td>L. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.</td>
<td></td>
</tr>
<tr>
<td>M. 1 step (curb): The ability to go up and down a curb and/or up and down one step.</td>
<td></td>
</tr>
<tr>
<td>N. 4 steps: The ability to go up and down four steps with or without a rail.</td>
<td></td>
</tr>
<tr>
<td>O. 12 steps: The ability to go and down 12 steps with or without a rail.</td>
<td></td>
</tr>
</tbody>
</table>
**GG0170: Mobility (Continued)**

<table>
<thead>
<tr>
<th>P. Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q. Does patient use wheelchair/scooter?</td>
</tr>
<tr>
<td>0. No → Skip GG0170R, GG0170RR1, GG0170S, and GG0170SS1.</td>
</tr>
<tr>
<td>1. Yes → Continue to GG0170R. Wheel 50 feet with two turns.</td>
</tr>
<tr>
<td>R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.</td>
</tr>
<tr>
<td>RR1. Indicate the type of wheelchair or scooter used.</td>
</tr>
<tr>
<td>1. Manual</td>
</tr>
<tr>
<td>2. Motorized</td>
</tr>
<tr>
<td>S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.</td>
</tr>
<tr>
<td>SS1. Indicate the type of wheelchair or scooter used.</td>
</tr>
<tr>
<td>1. Manual</td>
</tr>
<tr>
<td>2. Motorized</td>
</tr>
</tbody>
</table>

**J 1800 & J 1900: Health Conditions**

<table>
<thead>
<tr>
<th>J1800. Any Falls Since SOC/ROC, whichever is more recent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
</tr>
<tr>
<td>Has the patient had any falls since SOC/ROC, whichever is more recent?</td>
</tr>
<tr>
<td>0. No → Skip J1900</td>
</tr>
<tr>
<td>1. Yes → Continue to J1900: Number of Falls Since SOC/ROC, whichever is more recent</td>
</tr>
</tbody>
</table>

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

- IMPACT act felt with OASIS D as post-acute entities are effected
  - Ensuring good continuum of care
  - Standardizations
  - Identifying “On Whose Watch” did this occur
- Start OASIS D education early- (wait till after final)
- Ensure that All OASIS clinicians understand the assessment responsibilities for the new items
  - Ensure consistency among clinicians

Thank you

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5 Star Consultants
slitwin@5starconsultants.net