

CHAPTER 8

OASIS IN DETAIL

A. INTRODUCTION

The OASIS data set has multiple purposes within a home health agency. Because of this, it is imperative to ensure that accurate, high quality data are collected. All clinical staff who collect OASIS data should be aware of five specific aspects of data collection: (1) the patients from whom data are collected, (2) the time points for data collection, (3) the conventions or "rules" to observe in collecting and recording data, (4) the meaning of each OASIS item, and (5) how OASIS data are collected in the context of the comprehensive assessment. The patients who are to receive the comprehensive assessment (and OASIS data collection) were discussed in Chapter 4 of this manual, and the time points also were identified in that chapter. This chapter will address the remaining three aspects of data collection.

B. CONVENTIONS (RULES) TO FOLLOW

Both clinical assessment and outcome measurement depend on the collection and analysis of accurate data. All clinical staff who collect OASIS data should be aware of the basic conventions or "rules" to observe in collecting and recording OASIS data.

- *All the items refer to the patient's USUAL STATUS or condition at the time period or visit under consideration — unless otherwise indicated.* Though patient status can vary from day to day and during a given day, the OASIS response should be selected that describes the patient's status most of the time during the specific day under consideration. While learning or becoming familiar with the OASIS, care providers should read through all scale levels of the activity or attribute being evaluated before selecting the level that best describes the patient's status or capability on the day of the assessment.

The patient status that is recorded pertains to the day of the assessment unless otherwise indicated. A few OASIS items address events or circumstances that occurred within the 14-day period immediately preceding the assessment (e.g., M0175 - Inpatient Facility Discharge, M0200 - Medical or Treatment Regimen Change, M0510 - Urinary Tract Infection, etc.). These items specifically identify this time period in the wording of the question. Item M0830 - Emergent Care identifies a more open-ended time period of "since the last time OASIS data were collected," which might be up to 60 days. Other than these situations, which are noted in the specific item

instructions, all other items address the patient's status, circumstance, or condition on the day of the assessment.

- *OASIS items should be completed accurately and comprehensively, and skip patterns should be used correctly.* Clinicians should monitor the accuracy and completeness of their own responses as they utilize the data set. Supervisory or clerical staff also may perform visual review to monitor correct observance of the skip logic, particularly when the clinician is being oriented and trained in OASIS data collection. Completeness of the OASIS information is critical for care planning as well as case mix reporting and performance improvement based on outcomes.

As noted, "skip patterns" are included for selected OASIS items. These patterns allow the care provider to move quickly through the sections of the OASIS that do not apply to the particular patient. Other than items that are specifically noted to be "skipped," all OASIS items should be answered.

- *The follow-up and discharge assessments must be done without reference to the previous values for any health status item.* It is critical for data accuracy that the clinician does not merely duplicate items from the prior assessment rather than perform a new comprehensive assessment. Such "carry forward" of data results in error-ridden outcome reports, which are not usable by agencies for performance improvement.
- *Minimize the use of "Not Applicable" and "Unknown" answer options.* For some OASIS items, response options for "Not Applicable" or "Unknown" are available. We encourage clinicians to limit their use of these categories to situations where no other response is possible or appropriate. OASIS items have been reviewed carefully to determine whether "Not Applicable" or "Unknown" responses for patient health status items are consistent with good clinical practice. In several instances, "Unknown" is an acceptable response at start of care, but is not included as a response for the follow-up or discharge versions of the item because the care provider is expected to be sufficiently aware of the patient's condition or circumstances to provide the information. In almost all cases it is possible to collect the needed information without undue intrusiveness or burden for the patient. If a patient declines to provide information, that should be respected. At the same time the HHA should recognize the clinician's responsibility to complete the assessment using available information.

Because the OASIS items have been worded carefully to include most (item) instructions in the item itself, few specific instructions are required. However, some clinicians are more comfortable if they actually have a list of general

instructions for reference. Such a list is found in Attachment A to this chapter. This instruction page can be duplicated and used for agency training.

C. UNDERSTANDING THE MEANING OF EACH OASIS ITEM

The OASIS has undergone several years of development and refinement, as well as use by many home care agencies in various research and demonstration projects. During this process, the most common questions and misunderstandings about the items have been identified. The item-by-item review of the data set is found in Attachment B to this chapter. Each OASIS item is documented, the item definition is provided, the time points for data collection identified, response-specific issues or questions are addressed, and assessment strategies for obtaining the data are suggested. Agencies are encouraged to use this section in training staff and as the first reference source for answering questions.

D. COLLECTING OASIS DATA IN THE CONTEXT OF THE COMPREHENSIVE ASSESSMENT

Agency supervisory and administrative personnel occasionally question how the OASIS items are to be administered. Should the clinician use the OASIS as a structured interview tool by reading all of the items to the patient or family? Unequivocally, this is **not** an appropriate way to complete a patient assessment including OASIS. Instead, the clinician should perform the comprehensive assessment, gathering both interview and observation (or measurement) data as indicated. A few OASIS items clearly require interview of the patient/client or family (e.g., M0380 - Type of Primary Caregiver Assistance), while others are best obtained through observation (e.g., M0464 - Status of Most Problematic [Observable] Pressure Ulcer). Attachment B to this chapter provides specific assessment strategies for each item, to assist clinicians to collect the required information effectively and without unnecessary intrusiveness or burden for the patient. Experience with OASIS items indicates that the requisite information is easily obtained within the context of a routine complete assessment.

Table 8.1 presents the primary components of a home care patient assessment. Clinicians assess and collect information on these components in their own unique sequence, as dictated by circumstances, patient needs, and anticipated care requirements. The table depicts how various OASIS items relate to each of these assessment components, thereby showing where and how the OASIS items are best integrated into the patient assessment activity.

TABLE 8.1: Mapping of OASIS Items into Major Components of An Illustrative Patient Assessment at Start of Care.

Assessment Component and Elements Within Each Component	Related Patient Tracking Sheet/OASIS Item(s)
PREVISIT	
Telephone call prior to visit <ul style="list-style-type: none"> • Telephone availability • Setting appointment time 	M0770 M0770, M0400, M0410, M0560
VISIT	
Basic demographic information <ul style="list-style-type: none"> • Name, address, age, gender, pay source, etc. 	M0010-M0150
Entrance to home <ul style="list-style-type: none"> • Patient's ambulatory status • Patient remembered telephone call & appointment 	M0700 M0560, M0570
Interior of home (as move from one room to another) <ul style="list-style-type: none"> • Odors (urine, feces) • Kitchen (where you might wash your hands) <ul style="list-style-type: none"> - medications present in bottles or scattered • Bathroom (where you might wash your hands or what you ask to see to set up aide care plan) <ul style="list-style-type: none"> - bathtub or shower - assistive equipment (grab bars, shower chair) - toilet - soiled clothes with urine or fecal odor - medications present in bottles or scattered 	M0750 also M0520-M0540 also M0780-M0800 M0670, M0680 also M0520-M0540 also M0780-M0800
History of present condition and symptoms <ul style="list-style-type: none"> • Hospitalization and reasons • Onset of current illness • Other comorbidities (severity and management) • Presence of high risk factors • Life expectancy 	M0175-M0190 M0200-M0220 M0250, M0500, M0510 M0290 M0280
Family/caregiver assistance <ul style="list-style-type: none"> • Living situation • Availability of family/caregiver assistance • Other assistance needed and received 	M0300, M0340 M0350, M0360 M0360-M0380, M0820
Medication inventory <ul style="list-style-type: none"> • Walk to where meds are kept • Assess knowledge of medication schedule, dosage, etc. • Assess ability to administer prescribed medications 	M0690-M0700 M0410, M0560 M0780-M0800

TABLE 8.1: Mapping of OASIS Items into Major Components of An Illustrative Patient (Cont'd) Assessment at Start of Care.

Assessment Component and Elements Within Each Component	Related Patient Tracking Sheet/OASIS Item(s)
VISIT (continued)	
Physical assessment	
• Vital signs	M0690
- orthostatic BP	M0400, M0560-M0570
- comprehension of instructions	
• Weight	M0400, M0560-M0570
- comprehension of instructions	M0690-M0700
- ability to stand, step on scale	
• Head	
- vision	M0390
- hearing	M0400
- speech	M0410
• Skin condition	M0440-M0488
• Musculoskeletal and neurological	M0640-M0660, M0780-
- joint function, grasp, pain, etc.	M0820
- neurologic	also M0410-M0430, M0560
• Cardiorespiratory	
- dyspnea	M0490
- lung sounds; check ability to dress upper body	M0650
- circulation in lower extremities; check ability to dress lower body	M0660
• GI/GU	
- urinary status	M0510-M0530
- bowel status	M0540-M0550
• Nutritional status	M0710-M0720, M0760
Emotional/behavioral status assessment	M0560-M0590, M0610, M0620
ADLs/IADLs	
• Review any information not gathered already in sufficient detail	M0670-M0680, M0730- M0760
POSTVISIT	
Data review (in preparation for care planning)	
• Primary diagnosis and comorbidities	M0230, M0240
• Severity index	M0240
• Prognosis and rehab prognosis	M0260, M0270
• Need for psychiatric nursing services	M0630
• Need for physical, occupational, or speech therapy	M0826

The "discipline-neutrality" of the OASIS refers to the fact that the items were designed so nurses and therapists can use and administer the OASIS equally effectively. This property of discipline-neutrality has been built into the OASIS to ensure its utility for all planned applications. Staff training and open discussion of the items between and among staff from all disciplines are encouraged. This facilitates uniformity in cross-discipline data collection and reporting.

Some case examples of OASIS items are presented in Attachment C to this chapter. These scenarios provide an opportunity to practice answering OASIS items in response to patient situations. Agencies can also utilize their own patient situations as additional scenarios for the same purpose.

E. SOME UNUSUAL SITUATIONS: HOW TO USE OASIS

A variety of situations that produce questions about patient assessment and OASIS data collection can arise during the home care episode. Following are the situations which most often generate questions and the appropriate agency actions.

Situation	Appropriate Agency Action
Patient's primary pay source for skilled home care changes during the episode of care—from Medicare to an alternate pay source.	<ol style="list-style-type: none"> 1. If the original start of care date is maintained, continue assessments and OASIS data collection/reporting according to that date. Report any new pay source (or delete any that no longer pertain) in an update to M0150 – Current Pay Sources for Home Care or the Patient Tracking Sheet. 2. If the start of care (SOC) date changes to coincide with the pay source change, the patient must be discharged (discharge date to coincide with last visit of "old" pay source). A new comprehensive assessment must occur with the new SOC date.
Patient's primary pay source for home care changes during the episode of care—from other-than-Medicare to Medicare.	This situation parallels response 2 (above). Follow the actions described there (i.e., discharge patient on last visit of "old" pay source, conduct new comprehensive assessment at new SOC date). A SOC comprehensive assessment and OASIS data collection is required when Medicare becomes the payer source.

Situation	Appropriate Agency Action
<p>A patient is seen at very infrequent intervals (e.g., every 30 days, every 60 days, every 90 days, etc.). What should be done about the every 60 day comprehensive assessment?</p>	<p>For Medicare and Medicaid patients, an assessment will need to be performed during the five-day period immediately preceding the end of each certification period. Visits scheduled on a monthly or every two-month basis usually can be scheduled into this period. A patient needing a skilled visit only every 90 days will require other arrangements. The visit will be reimbursed only if specifically ordered by the physician and considered to be reasonable, necessary, and a medically predictable skilled need. (The required assessment must occur in the presence of the patient, not be conducted over the telephone.)</p>
<p>My agency has a nurse conduct a comprehensive assessment before the therapist begins a therapy-only case. Thus, the nurse's assessment is done <u>before</u> the start of care (SOC) date. Can we continue this practice?</p>	<p>An assessment done in this manner is not in compliance with the Conditions of Participation. If agency policy dictates that an RN complete the comprehensive assessment, then the RN can complete the assessment after the start of care is established by the PT. The data entry software (HAVEN) and the State system software will generate an error message for a comprehensive assessment done before the SOC date. The SOC comprehensive assessment therefore will be considered to be missing for the episode. Your agency can continue to have a nurse conduct a comprehensive assessment within the first five days of the episode, but it will need to be done either the same date as the therapist's SOC date or afterward. In a therapy-only case, only the therapist's performance of a skilled (reimbursable) service can begin the episode. Alternatively, your agency could modify its policy and allow the therapist to conduct the SOC comprehensive assessment for the therapy-only cases.</p>
<p>What should I do if I learn later that the patient was hospitalized for more than 24 hours? Sometimes I do not learn of this hospitalization until my next visit.</p>	<p>Complete the Transfer to Inpatient Facility form (with or without agency discharge according to your agency's policy). (For M0090 – Date Assessment Completed, record the date you learned of the hospitalization. For M0906 – Discharge/Transfer/Death Date, record the date the patient was transferred to the inpatient facility.) The date you are now seeing the patient becomes the new start (or resumption) of care date, depending on your agency policy.</p>

FREQUENTLY ASKED QUESTIONS

- 1. *How can I make sure that my staff is answering the OASIS items correctly? I'm particularly concerned about one clinician substituting for another when there are vacations, sick days, or other absences.***

There are actually two parts to the response to this question (and your concern). First, your agency has considerable potential to impact the accuracy of the OASIS data -- starting with your early training and orientation to OASIS items. Using the training materials provided in this manual (and other updates issued through the OASIS web site) and adhering to the item definitions included in Attachment B to this chapter are a good beginning. Encourage your clinicians to refer to the item-by-item information provided in Attachment B when they have questions. The OASIS Web-based Training also provides an excellent training approach. (<http://www.oasistraining.org>)

This early training and orientation continues as you respond to frequently asked questions in your agency. Include the appropriate responses to these questions in newsletters or post them in highly-viewed places in your agency. Staff or team meetings can have a few minutes devoted to OASIS items during the early weeks and months of using the data set. Approaches to data accuracy and data quality monitoring that are included in later sections of this manual also help you to pinpoint areas of difficulty in the way your staff utilizes and responds to OASIS items. Your ongoing attention to data accuracy and integrity will serve as a good example to your clinical staff of the importance of high quality data.

The second part of the response concerns the OASIS items themselves. Recall that the items have been tested for interrater reliability at several points during their development, testing, and ultimate use in demonstration projects. Such reliability testing will continue to occur as the items are modified for various reasons over time.

FREQUENTLY ASKED QUESTIONS

- 2. Do different disciplines assess the patient in the same way? I wonder whether the nurse and therapist, when encountering the same situation, actually “see” the same thing.**

The precise assessment methods used by different clinicians can vary, not only between disciplines but also between different clinicians in the same discipline. This is the reason why OASIS items that are scales contain more detailed descriptive responses than simply numerical levels. Regardless of the assessment method, the description assists the clinician to determine the appropriate response level for the patient.

As noted in the response to Question 1 (above), the orientation, training, and ongoing monitoring of data accuracy within the agency also can focus on drawing similar conclusions from specific situations. It is particularly appropriate to utilize “real” agency patients in discussions of both assessment practices and appropriate responses to OASIS items. Many agencies have reported that such discussions actually serve to increase the overall clinical competencies of their staff in performing patient assessments.

- 3. Will there be any further revisions to the OASIS-B1 data set currently posted on the OASIS web site?**

The OASIS-B1 (1/2008) data set posted on the Web site is the most current version. It was updated as part of the Department of Health and Human Services (HHS) department-wide initiative to reduce regulatory burdens in health care and to address the concerns of health care providers, state and local governments, and individual Americans who are affected by HHS rules. Please continue to check the OASIS Web site for updates.

ATTACHMENT A TO CHAPTER 8

GENERAL OASIS INSTRUCTIONS

1. OASIS items can be completed by any clinician who performs the comprehensive assessment. The Conditions of Participation and agency policy should determine who is responsible for completing the comprehensive assessment (and OASIS items) if individuals from more than one discipline (e.g., PT and OT) are seeing the patient concurrently.
2. All items refer to the patient's usual status or condition at the time period or visit under consideration -- unless otherwise indicated. Though patient status can vary from day to day and during a given day, the response should be selected that describes the patient's status most of the time during the specific day under consideration.
3. Some items inquire about events occurring within the past 14 days or at a specified point (e.g., discharge from an inpatient facility, ADL status at 14 days prior to start of care, etc.). In these situations, the specific time interval included in the item should be followed exactly.
4. OASIS items that are scales (e.g., shortness of breath, transferring, etc.) are arranged in order from least impaired to most impaired. For example, higher values (further down the list of options) on the transferring scale refer to greater dependence in transferring. This is true whether the scale describes a functional, physiologic, or emotional health status attribute.
5. Collection of data through direct observation is preferred to that obtained through interview, but some items (e.g., frequency of primary caregiver assistance) are most often obtained through interview. When interview data are collected, the patient should be the primary source (or a caregiver residing in the home). An out-of-home caregiver can be an alternate source of information if neither of the others are available, but should be considered only in unusual circumstances. In many instances, a combined observation-interview approach is necessary. For example, by speaking with the patient or informal caregiver while conducting the assessment, the provider can determine whether the observed ability to ambulate is typical or atypical at that time. Such combined approaches of observation and interview occur frequently during most well-conducted assessments, but warrant mention here in order to clarify the meaning of OASIS items.
6. The OASIS items may be completed in any order. Because the data collection is integrated into the clinician's usual assessment process, the clinician actually performing the patient assessment is responsible for determining the precise order in which the items are completed.

7. Unless a skip pattern is indicated (and followed), every OASIS item for the specific time point should be completed.
8. Unless the item is noted as "Mark all that apply," only one answer should be marked.
9. Minimize the selection of "Not Applicable" and "Unknown" answer options.
10. Each agency is responsible for monitoring the accuracy of the assessment data and the adequacy of the assessment process.

ATTACHMENT B TO CHAPTER 8

OASIS ITEM-BY-ITEM TIPS

OASIS ITEM:
(M0010) Agency Medicare Provider Number: _ _ _ _ _
DEFINITION:
Agency's Medicare provider number
TIME POINTS ITEM(S) COMPLETED:
SOC (Patient Tracking Sheet)
RESPONSE—SPECIFIC INSTRUCTIONS:
Enter the agency's Medicare provider number, if applicable. If agency is not a Medicare provider, leave blank.
ASSESSMENT STRATEGIES:
Agency administrator and billing staff can provide this information. This number may be preprinted on clinical documentation (recommended).

OASIS ITEM:
(M0012) Agency Medicaid Provider Number: _ _ _ _ _
DEFINITION:
Agency's Medicaid provider number
TIME POINTS ITEM(S) COMPLETED:
SOC (Patient Tracking Sheet)
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none">• Enter the agency's Medicaid provider number, if applicable. If agency is not a Medicaid provider, leave blank. If there are fewer digits than spaces provided, leave spaces at the end blank.
ASSESSMENT STRATEGIES:
Agency administrator and billing staff can provide this information. This number may be preprinted on your clinical documentation (recommended).

OASIS ITEM:
(M0014) Branch State: __ __
DEFINITION:
The State where the agency branch office is located.
TIME POINTS ITEM(S) COMPLETED:
SOC (Patient Tracking Sheet) and updated if change occurs during the episode.
RESPONSE—SPECIFIC INSTRUCTIONS:
Enter the two-letter postal service abbreviation of the State in which the branch office is located. Leave blank if your agency has no branches or all branches are located in the same State.
ASSESSMENT STRATEGIES:
Agency or branch administrator can provide this information.

OASIS ITEM:
(M0016) Branch ID: _ _ _ _ _
DEFINITION:
Branch identification code, as assigned by the Centers for Medicare & Medicaid Services (CMS). As assigned by CMS, the identifier consists of 10 digits -- the State code as the first two digits, followed by Q (upper case), followed by the last four digits of the current Medicare provider number, ending with the three-digit CMS-assigned branch number.
TIME POINTS ITEM(S) COMPLETED:
SOC (Patient Tracking Sheet) and updated if change occurs during the episode.
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none">• Enter the Federal branch identification number specified for this branch as assigned by CMS.• If you are an HHA with no branches, enter "N" followed by 9 spaces.• If you are a parent HHA that has branches, enter "P" followed by 9 spaces.
ASSESSMENT STRATEGIES:
Agency or branch administrator can provide this information.

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

OASIS ITEM:
(M0030) Start of Care Date: __ __ / __ __ / __ __ __ __ month day year
DEFINITION:
The date that reimbursable care begins. When the first reimbursable service is delivered, this is the start of care.
TIME POINTS ITEM(S) COMPLETED:
SOC (Patient Tracking Sheet)
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • If the date or month is only one digit, that digit is preceded by a “0” (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year. • In multidiscipline cases, regulatory requirements (such as the Conditions of Participation) and agency policy will establish which discipline’s visit is considered the start of care. A reimbursable service must be delivered to be considered the start of care. For Medicare reimbursement, as explained in 42 CFR 409.46, a physician must specifically order that a particular covered service be furnished and all other coverage criteria must be met for this initial service to be billable and to establish the start of care. • For skilled PT or SLP to perform the start of care visit for a Medicare patient: <ul style="list-style-type: none"> • the HHA is expected to have orders from the patient’s physician indicating the need for physical therapy or SLP prior to the initial assessment visit; • no orders are present for nursing at the start of care; • a reimbursable service must be provided; and • the need for this service establishes program eligibility for the Medicare home health benefit (42 CFR 484.55(a)(2)). • Accuracy of this date is essential; many other aspects of data collection are based on this date.
ASSESSMENT STRATEGIES:
If questions exist as to the start of care date, clarify the exact date with agency administrative personnel.

OASIS ITEM:
(M0040) Patient Name: <div style="border-bottom: 1px dashed black; display: flex; justify-content: space-between; padding: 5px 0;"> (First) (MI) (Last) Suffix) </div>
DEFINITION:
The full name of the patient: first name, middle initial, last name, and suffix (e.g., Jr., III, etc.).
TIME POINTS ITEM(S) COMPLETED:
SOC (Patient Tracking Sheet) and updated if change occurs during the episode.
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • Enter all letters of the first and last names, the middle initial, and the abbreviated suffix. Correct spelling is important. • If no suffix, leave blank. If middle initial is not known, leave blank. • The name entered should be the patient's legal name, even if the patient consistently uses a "nickname." • The sequence of the names may be reordered (i.e., last name, first name, etc.), if desired.
ASSESSMENT STRATEGIES:
Use the same name as found on the patient's Medicare card, private insurance card, HMO identification card, etc.

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

OASIS ITEM:
(M0060) Patient Zip Code: _ _ _ _ _
DEFINITION:
The zip code for the address at which the patient is currently residing while receiving home care.
TIME POINTS ITEM(S) COMPLETED:
SOC (Patient Tracking Sheet) and updated if change occurs during the episode.
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none">• Enter the zip code for the address of the patient's CURRENT residence.• Enter at least five digits (nine digits if known).• The patient's zip code is used on <i>Home Health Compare</i> to determine places where your agency provided service. Be sure to use the zip code where the service is provided.
ASSESSMENT STRATEGIES:
Verify the zip code with the local post office, if necessary.

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

OASIS ITEM:
(M0064) Social Security Number: ____ - ____ - ____ <input type="checkbox"/> UK - Unknown or Not Available
DEFINITION:
Refers to the patient's Social Security number only.
TIME POINTS ITEM(S) COMPLETED:
SOC (Patient Tracking Sheet)
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none">• Include all nine numbers. Mark "UK" if unknown or not available (e.g., information cannot be obtained or patient refused to provide information).
ASSESSMENT STRATEGIES:
Ask to see the patient's Social Security card, if available. The number may be available from the referring physician, but should be verified with the patient.

OASIS ITEM:
(M0065) Medicaid Number: _____ <input type="checkbox"/> NA – No Medicaid
DEFINITION:
The patient's <u>Medicaid</u> number only.
TIME POINTS ITEM(S) COMPLETED:
SOC (Patient Tracking Sheet) and updated if change occurs during the episode.
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none">• Include all digits and letters. If patient does not have Medicaid coverage, mark "NA - No Medicaid."• If the patient has Medicaid, answer this item whether or not Medicaid is the reimbursement source for the home care episode.• This number is assigned by an individual state and is found on the patient's Medicaid card.
ASSESSMENT STRATEGIES:
Ask to see the patient's Medicaid card or other verifying documentation. Make sure that the coverage is still in effect. The number may be available from the referring physician, but should be verified with the patient. Depending on specific State regulations or procedures, you may need to verify coverage and effective dates with the social services agency.

OASIS ITEM:
(M0066) Birth Date: __ __ / __ __ / __ __ __ __ month day year
DEFINITION:
Birthdate of the patient, including month, day, and four digits for the year.
TIME POINTS ITEM(S) COMPLETED:
SOC (Patient Tracking Sheet)
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none">• If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for year.
ASSESSMENT STRATEGIES:
Ask the patient or caregiver for the complete birth date. The date may also be obtained from other legal documents (e.g., driver's license, state-issued ID card, etc.).

OASIS ITEM:
(M0069) Gender: <input type="checkbox"/> 1 - Male <input type="checkbox"/> 2 - Female
DEFINITION:
The gender of the patient.
TIME POINTS ITEM(S) COMPLETED:
SOC (Patient Tracking Sheet)
RESPONSE—SPECIFIC INSTRUCTIONS:
ASSESSMENT STRATEGIES:
Observation or interview.

OASIS ITEM:
(M0072) Primary Referring Physician ID: _____ <input type="checkbox"/> UK – Unknown or Not Available
DEFINITION:
The six-digit UPIN number.
TIME POINTS ITEM(S) COMPLETED:
SOC (Patient Tracking Sheet) and updated if change occurs during the episode.
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none">• Write the six digits of the UPIN number. Leave spaces at the end blank if not needed.• Mark “UK - Unknown or Not Available” if UPIN number is not available.• This is the same number utilized for Medicare claims information.• If the referring physician is different from the physician signing the plan of care, use the UPIN number of the latter physician.
ASSESSMENT STRATEGIES:
Obtain physician ID number from physician, medical office, or other provider location.

OASIS ITEM:
(M0080) Discipline of Person Completing Assessment: <input type="checkbox"/> 1-RN <input type="checkbox"/> 2-PT <input type="checkbox"/> 3-SLP/ST <input type="checkbox"/> 4-OT
DEFINITION:
<p>Identifies the discipline of the clinician completing the comprehensive assessment at the specified time points or the clinician reporting the transfer to an inpatient facility or death at home. LPNs, PTAs, COTAs, MSWs and home health aides do not meet the requirements specified in the comprehensive assessment regulation for disciplines authorized to complete the comprehensive assessment.</p>
TIME POINTS ITEM(S) COMPLETED:
All
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> Only one individual completes the comprehensive assessment. Even if two disciplines are seeing the patient at the time a comprehensive assessment is due, only one actually completes and records the assessment.
ASSESSMENT STRATEGIES:
<p>The OASIS data set is designed to be discipline neutral in the wording of the items. According to the comprehensive assessment regulation, when both the RN and PT/SLP are ordered on the initial referral, the RN must perform the SOC comprehensive assessment. An RN, PT, SLP, or OT may perform subsequent assessments. The skilled provider must perform the comprehensive assessment during an actual visit to the patient's home and may not rely on a phone interview with the patient/caregiver or other health care providers.</p> <p>The only exceptions to this requirement for being "in the physical presence of the patient" are the OASIS data provided for Transfer to an Inpatient Facility (with or without agency discharge) or Death at Home. See information on M0100 - Reason for Assessment, Responses 6, 7, and 8 for additional clarification.</p> <p>When both the RN and Physical Therapist are scheduled to conduct discharge visits on the same day, the last qualified clinician to see the patient is responsible for conducting the discharge comprehensive assessment.</p>

OASIS ITEM:

(M0090) Date Assessment Completed: ____/____/____
month day year

DEFINITION:

The actual date the assessment is completed. If agency policy allows assessments to be performed over more than one visit date, the last date (when the assessment is finished) is the appropriate date to record.

TIME POINTS ITEM(S) COMPLETED:

All

RESPONSE—SPECIFIC INSTRUCTIONS:

- If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year.
- For three of the responses to M0100 (Transfer to Inpatient Facility - patient not discharged from agency; Transfer to Inpatient Facility - patient discharged from agency or Death at Home) record the date the agency learns of the event, as a visit is not necessarily associated with these events. See information on M0100 - Reason for Assessment for additional clarification.

ASSESSMENT STRATEGIES:

Note today's date.

OASIS ITEM:**(M0100) This Assessment is Currently Being Completed for the Following Reason:****Start/Resumption of Care**

- ☐ 1 – Start of care—further visits planned
- ☐ 3 – Resumption of care (after inpatient stay)

Follow-Up

- ☐ 4 – Recertification (follow-up) reassessment [**Go to M0110**]
- ☐ 5 – Other follow-up [**Go to M0110**]

Transfer to an Inpatient Facility

- ☐ 6 – Transferred to an inpatient facility—patient not discharged from agency [**Go to M0830**]
- ☐ 7 – Transferred to an inpatient facility—patient discharged from agency [**Go to M0830**]

Discharge from Agency — Not to an Inpatient Facility

- ☐ 8 – Death at home [**Go to M0906**]
- ☐ 9 – Discharge from agency [**Go to M0200**]

DEFINITION:

Identifies the reason why the assessment data are being collected and reported. Accurate recording of this response is important as the data reporting software will accept or reject certain data according to the specific response that has been selected for this item.

TIME POINTS ITEM(S) COMPLETED:

All

RESPONSE—SPECIFIC INSTRUCTIONS:

- Mark only one response.
- Response 1: This is the start of care comprehensive assessment. A plan of care is being established, and further visits are planned. This is the appropriate response anytime an initial HIPPS code (for a Home Health Resource Group) is required, whether or not the patient will be receiving ongoing services.
- Response 3: This comprehensive assessment is conducted when the patient resumes care following an inpatient stay of 24 hours or longer (for reasons other than diagnostic tests). Remember to update the Patient Tracking Sheet ROC date (M0032) when this response is marked.
- Response 4: This comprehensive assessment is conducted during the last five days of the 60-day certification period.
- Response 5: This comprehensive assessment is conducted due to a significant change (a major decline or improvement) in patient condition at a time other than during the last five days of the episode. This assessment is done to update the patient's care plan.

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

- Response 6: Data regarding the patient's transfer to an inpatient facility for 24 hours or longer (for reasons other than diagnostic tests) are reported. The patient is expected to resume care and is not discharged from the agency. When the patient resumes care, a Resumption of Care comprehensive assessment is conducted. Note the "skip pattern" included in the response. This response does not require a home visit; a telephone call may provide the information necessary to complete the required data items.
- Response 7: Data regarding the patient's transfer to an inpatient facility for 24 hours or longer (for reasons other than diagnostic tests) are reported. The patient is discharged from the agency. Note the "skip pattern" included in the response. This response does not require a home visit; a telephone call may provide the information necessary to complete the required data items. No additional OASIS discharge data are required.
- Response 8: Data regarding patient death other than death in an inpatient facility. A patient who dies before being admitted to an inpatient facility would have this response marked. Note the "skip pattern" included in the response. A home visit is not required to mark this response; a telephone call may provide the information necessary to complete the data items.
- Response 9: This comprehensive assessment is conducted at the patient's discharge from the agency. This discharge is not occurring due to an inpatient facility admission or patient death. An actual patient interaction (i.e., a visit) is required to complete this assessment. Note the "skip pattern" present in the response.

ASSESSMENT STRATEGIES:

Why is the assessment being conducted (or the information being recorded)? What has happened to the patient? Accuracy of this response is critical.

OASIS ITEM:
<p>(M0110) Episode Timing: Is the Medicare home health payment episode for which this assessment will define a case mix group an “early” episode or a “later” episode in the patient’s current sequence of adjacent Medicare home health payment episodes?</p> <p> <input type="checkbox"/> 1 - Early <input type="checkbox"/> 2 - Later <input type="checkbox"/> UK - Unknown <input type="checkbox"/> NA - Not Applicable: No Medicare case mix group to be defined by this assessment </p> <p>At Follow-up, go to M0230.</p>
DEFINITION:
<p>Identifies the placement of the current Medicare payment episode in the patient’s current sequence of adjacent Medicare payment episodes.</p> <ul style="list-style-type: none"> A “sequence of adjacent Medicare home health payment episodes” is a continuous series of Medicare payment episodes, regardless of whether the same home health agency provided care for the entire series. <ul style="list-style-type: none"> Low utilization payment adjustment (LUPA) episodes (less than 5 total visits) are counted. “Adjacent” means that there was no gap between Medicare-covered episodes of more than 60 days. Periods of time when the patient is “outside” a Medicare payment episode but on service with a different payer - such as HMO, Medicaid, or private pay - are counted as <i>gap</i> days when counting the sequence of Medicare payment episodes. “Early” means the only episode OR the first or second episode in a sequence of adjacent episodes. “Later” means the third or later episode in a sequence of adjacent episodes.
TIME POINT ITEM(S) COMPLETED:
<p>Start of care Resumption of care Follow-up</p>
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> Answer “Early” if the Medicare payment episode is the only episode OR the first or second episode in a current sequence of adjacent Medicare home health payment episodes. Answer “Later” if the Medicare payment episode is the third or higher in the current sequence of adjacent Medicare home health payment episodes. Use the “UK - Unknown” response if the placement of this payment episode in the sequence of adjacent episodes is unknown. For the purposes of assigning a case mix code to the episode, this will have the same effect as selecting the “Early” response. Enter “NA” if no Medicare case mix group is to be defined for this episode.
ASSESSMENT STRATEGIES:
<ul style="list-style-type: none"> Consult all available sources of information to code this item. Medicare systems, such as Health Insurance Query for Home Health (HIQH), can provide this information. If calculating manually, note that the Medicare home health payment episode ordinarily comprises 60 days beginning with the start of care date, or 60 days beginning with the recertification date, and that there can be a gap of up to 60 days between episodes in the same sequence, counting from the last day of one episode until the first day of the next. Remember that a sequence of adjacent Medicare payment episodes continues as long as there is no 60-day gap, even if Medicare episodes are provided by different home health agencies. <ul style="list-style-type: none"> Episodes where Medicare fee-for-service is not the payer (such as HMO, Medicaid, or private pay) do NOT count as part of an adjacent episode sequence. If the period of service with those payers is 60 days or more, the next Medicare home health payment episode would begin a new sequence.

ASSESSMENT STRATEGIES: (cont'd)

- Remember that the 60-day gap is counted from the end of the Medicare payment episode, not from the date of the last visit or discharge, which can occur earlier. (If the episode is ended by an intervening event that causes it to be paid as a partial episode payment [PEP] adjustment, then the last visit date is the end of the episode).
- If the patient needs a case mix code for billing purposes (a "HIPPS" code), a response to this item is required to generate the code. Some sources that are not Medicare-fee-for-service payers will use this information in setting an episode payment rate; refer to those payers' guidance on how to respond to this item.

OASIS ITEM:
(M0140) Race/Ethnicity (as identified by patient): (Mark all that apply.) <ul style="list-style-type: none"> <input type="checkbox"/> 1 - American Indian or Alaska Native <input type="checkbox"/> 2 - Asian <input type="checkbox"/> 3 - Black or African-American <input type="checkbox"/> 4 - Hispanic or Latino <input type="checkbox"/> 5 - Native Hawaiian or Pacific Islander <input type="checkbox"/> 6 - White <input type="checkbox"/> UK - Unknown
DEFINITION:
The groups or populations to which the patient is affiliated, as identified by the patient or caregiver.
TIME POINTS ITEM(S) COMPLETED:
SOC (Patient Tracking Sheet)
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> Response 1: American Indian or Alaska Native. A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. Response 2: Asian. A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. Response 3: Black or African American. A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American." Response 4: Hispanic or Latino. A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino." Response 5: Native Hawaiian or Other Pacific Islander. A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. Response 6: White. A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
ASSESSMENT STRATEGIES:
Interview patient/caregiver. The patient may self-identify with more than one group; mark all that are noted.

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

RESPONSE—SPECIFIC INSTRUCTIONS (Cont'd for OASIS ITEM M0150)

- Title XX - Social service block grants available to states to provide homemaking, chore service, home management or home health aide services and enable each State to furnish social services best suited to the needs of the individuals residing in the State. Federal block grant funds may be used to provide services directed toward one of the following five goals specified in the law: (1) To prevent, reduce, or eliminate dependency, (2) to achieve or maintain self-sufficiency, (3) to prevent neglect, abuse, or exploitation of children and adults, (4) to prevent or reduce inappropriate institutional care, and (5) to secure admission or referral for institutional care when other forms of care are not appropriate.
- Select Response 7 if the patient is a member of a Tri-Care program, which are replacements for CHAMPUS.
- If one or more payment sources are known but additional sources are uncertain, mark those that are known.
- Mark all current pay sources, whether considered primary or secondary.
- Do not consider any equipment, medications, or supplies being paid for by the patient, in part or in full.

ASSESSMENT STRATEGIES:

Referral source may provide information regarding coverage. This can be verified with patient/caregiver. Ask patient/caregiver to provide copy of card(s) for any insurance or Medicare coverage. This card will provide the patient ID number as well as current status of coverage. The agency billing office may also have this information. Determine if the patient has any out-of-pocket expenses for services received in the home.

OASIS ITEM:
<p>(M0175) From which of the following Inpatient Facilities was the patient discharged <u>during the past 14 days?</u> (Mark all that apply.)</p> <p> <input type="checkbox"/> 1 - Hospital <input type="checkbox"/> 2 - Rehabilitation facility <input type="checkbox"/> 3 - Skilled nursing facility <input type="checkbox"/> 4 - Other nursing home <input type="checkbox"/> 5 - Other (specify) _____ <input type="checkbox"/> NA - Patient was not discharged from an inpatient facility [If NA, go to M0200] </p>
DEFINITION:
Identifies whether the patient has been discharged from an inpatient facility within the 14 days (two-week period) immediately preceding the start of care/resumption of care.
TIME POINTS ITEM(S) COMPLETED:
Start of care Resumption of care
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> Mark all that apply. For example, patient may have been discharged from both a hospital <u>and</u> a rehabilitation facility within the past 14 days. Rehabilitation facility is a freestanding rehab hospital or a rehabilitation bed in a rehabilitation distinct part unit of a general acute care hospital. A skilled nursing facility means a Medicare certified nursing facility where the patient received a skilled level of care under the Medicare Part A benefit. Determine the following: <ol style="list-style-type: none"> Was the patient discharged from a Medicare-certified skilled nursing facility? If so, then: While in the skilled nursing facility was the patient receiving skilled care under the Medicare Part A benefit? If so, then: Was the patient receiving skilled care under the Medicare Part A benefit up to 14 days prior to admission to home health care? If all three of the above criteria apply, select Response 3. If any of the criteria are not satisfied, but the patient was in some type of nursing facility in the past 14 days, select Response 4. Other nursing home includes intermediate care facilities for the mentally retarded (ICF/MR) and nursing facilities (NF). If patient has been discharged from a swing-bed hospital, it is necessary to determine whether the patient was occupying a designated hospital bed (Response 1), a skilled nursing bed under Medicare Part A (Response 3), or a nursing bed at a lower level of care or under (Response 4). If a patient was discharged from a long term care hospital, the correct response is 1.
ASSESSMENT STRATEGIES:
Information can be obtained from patient/caregiver or physician's office. When uncertain about the type of facility or whether the facility is an <u>inpatient facility</u> , it may be necessary to check with the facility regarding licensure/designation. For Medicare patients, data in Medicare's Common Working File (CWF) can be accessed to assist in determining the type of inpatient services received and the date of inpatient facility discharge if the claim for inpatient services has been received by Medicare. An inpatient facility discharge that occurs on the day of the assessment does fall within the 14-day period.

OASIS ITEM:
<p>(M0180) Inpatient Discharge Date (most recent):</p> <p>____/____/____</p> <p>month day year</p> <p><input type="checkbox"/> UK - Unknown</p>
DEFINITION:
<p>Identifies the date of the <u>most recent</u> discharge from an inpatient facility (within last 14 days). (Past 14 days encompasses the two-week period immediately preceding the start/resumption of care.)</p>
TIME POINTS ITEM(S) COMPLETED:
<p>Start of care</p> <p>Resumption of care</p>
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • Even though the patient may have been discharged from more than one facility in the past 14 days, use the most recent date of discharge from any inpatient facility. • If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year.
ASSESSMENT STRATEGIES:
<p>Obtain information from patient, caregiver, or referring physician. For Medicare patients, data in Medicare's Common Working File (CWF) can be accessed to assist in determining the type of inpatient services received and the date of inpatient facility discharge if the claim for inpatient services has been received by Medicare.</p>

OASIS ITEM:

(M0190) List each **Inpatient Diagnosis** and ICD-9-CM code at the level of highest specificity for only those conditions treated during an inpatient facility stay within the last 14 days (no surgical, E-codes, or V-codes):

	<u>Inpatient Facility Diagnosis</u>	<u>ICD-9-CM</u>
a.	_____	(____ . ____)
b.	_____	(____ . ____)

DEFINITION:

Identifies diagnosis(es) for which patient was receiving treatment in an inpatient facility within the past 14 days. (Past 14 days encompasses the two-week period immediately preceding the start/resumption of care.)

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS:

- Include only those diagnoses that required treatment during the inpatient stay. If a diagnosis was not treated during an inpatient admission, do not list it. (Example: The patient has a long-standing diagnosis of “osteoarthritis,” but was hospitalized for “peptic ulcer disease.” Do not list “osteoarthritis” as an inpatient diagnosis.)
- This is the diagnosis for which the patient received treatment, not necessarily the hospital admitting diagnosis (though it can be the same).
- No surgical codes. List the underlying diagnosis that was surgically treated. If a joint replacement was done for osteoarthritis, list the disease, not the procedure.
- No V-codes or E-codes. List the underlying diagnosis.

ASSESSMENT STRATEGIES:

Obtain information from patient, caregiver, or referring physician. The current ICD-9-CM code book should be the source for coding.

OASIS ITEM:
<p>(M0200) Medical or Treatment Regimen Change Within Past 14 Days: Has this patient experienced a change in medical or treatment regimen (e.g., medication, treatment, or service change due to new or additional diagnosis, etc.) within the last 14 days?</p> <p> <input type="checkbox"/> 0 - No [If No, go to <i>M0220</i>; if No at Discharge, go to <i>M0250</i>] <input type="checkbox"/> 1 - Yes </p>
DEFINITION:
<p>Identifies if any change has occurred to the patient's treatment regimen, health care services, or medications due to a new diagnosis or exacerbation of an existing diagnosis within past 14 days. (Past 14 days encompasses the two-week period immediately preceding the start/resumption of care, or the discharge date.)</p>
TIME POINTS ITEM(S) COMPLETED:
<p>Start of care Resumption of care Discharge from agency – not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> If "No" is selected at discharge, the clinician should be directed to skip to M0250 (Therapies).
ASSESSMENT STRATEGIES:
<p>Obtain information from patient, caregiver, or referring physician. Note that the item addresses any change in the medical or treatment regimen within the past 14 days. A physician appointment alone or a referral for home health services does NOT qualify as a medical or treatment regimen change. A treatment regimen change that occurs on the day of the assessment does fall within the 14-day period.</p>

OASIS ITEM:

(M0210) List the patient's **Medical Diagnoses** and ICD-9-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen (no surgical, E-codes, or V-codes):

	<u>Changed Medical Regimen Diagnosis</u>	<u>ICD-9-CM</u>
a.	_____	(_____.____)
b.	_____	(_____.____)
c.	_____	(_____.____)
d.	_____	(_____.____)

DEFINITION:

Identifies the diagnosis(es) that have caused an addition or change to the patient's treatment regimen, health care services received, or medications within the past 14 days. (Past 14 days encompasses the two-week period immediately preceding the start/resumption of care [or the date of the discharge visit].)

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Can be a new diagnosis or an exacerbation to an existing condition.
- No surgical codes - list the underlying diagnosis.
- No V-codes or E-codes - list the appropriate diagnosis.
- Response to this item may include the same diagnoses as M0190 if the condition was treated during an inpatient stay AND caused changes in the treatment regimen.

ASSESSMENT STRATEGIES:

Obtain diagnosis from patient, caregiver, or referring physician. The current ICD-9-CM code book should be the source for coding.

OASIS ITEM:
<p>(M0220) 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 which existed <u>prior to</u> the inpatient stay or change in medical or treatment regimen. (Mark all that apply.)</p> <p> <input type="checkbox"/> 1 - Urinary incontinence <input type="checkbox"/> 2 - Indwelling/suprapubic catheter <input type="checkbox"/> 3 - Intractable pain <input type="checkbox"/> 4 - Impaired decision-making <input type="checkbox"/> 5 - Disruptive or socially inappropriate behavior <input type="checkbox"/> 6 - Memory loss to the extent that supervision required <input type="checkbox"/> 7 - None of the above <input type="checkbox"/> NA - No inpatient facility discharge <u>and</u> no change in medical or treatment regimen in past 14 days <input type="checkbox"/> UK - Unknown </p>
DEFINITION:
<p>Identifies existence of condition(s) <u>prior to</u> medical regimen change or inpatient stay within past 14 days. (Past 14 days encompasses the two-week period immediately preceding the start/resumption of care, or the discharge date.)</p>
TIME POINTS ITEM(S) COMPLETED:
<p>Start of care Resumption of care Discharge from agency – not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • Mark "NA" if no inpatient facility discharge <u>and</u> no change in medical or treatment regimen in past 14 days. Note that both situations must be true for this response to be correct. • All references to inpatient facility stay or facility discharge are omitted at the discharge assessment (from the home health agency). • At discharge, omit "NA" and "UK."
ASSESSMENT STRATEGIES:
<p>Interview patient/caregiver to obtain past health history. Additional information may be obtained from the physician. Determine any conditions existing before the inpatient facility stay or before the change in medical or treatment regimen.</p>

OASIS ITEM:

M0230/240/246 Diagnoses, Severity Index, and Payment Diagnoses: List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-CM code at the level of highest specificity (no surgical/procedure codes) (Column 2). Rate each condition (Column 2) using the severity index. (Choose one value that represents the most severe rating appropriate for each diagnosis.) V codes (for M0230 or M0240) or E codes (for M0240 only) may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V code is reported in place of a case mix diagnosis, then optional item M0246 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare PPS case mix group.

Code each row as follows:

Column 1: Enter the description of the diagnosis.

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

Rate the severity of the condition listed in Column 1 using the following scale:

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

Column 3: (OPTIONAL) If a V code reported in any row in Column 2 is reported in place of a case mix diagnosis, list the appropriate case mix diagnosis (the description and the ICD-9-CM code) in the same row in Column 3. Otherwise, leave Column 3 blank in that row.

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

(M0230) Primary Diagnosis & (M0240) Other Diagnoses		(M0246) Case Mix Diagnoses (OPTIONAL)	
Column 1	Column 2	Column 3	Column 4
	ICD-9-CM and severity rating for each condition	Complete only if a V code in Column 2 is reported in place of a case mix diagnosis.	Complete only if the V code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
Description	ICD-9-CM / Severity Rating	Description / ICD-9-CM	Description / ICD-9-CM
(M0230) Primary Diagnosis	(V codes are allowed)	(V or E codes NOT allowed)	(V or E codes NOT allowed)
a. _____	a. (____ . ____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	a. _____ (____ . ____)	a. _____ (____ . ____)
(M0240) Other Diagnoses	(V or E codes are allowed)	(V or E codes NOT allowed)	(V or E codes NOT allowed)
b. _____	b. (____ . ____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	b. _____ (____ . ____)	b. _____ (____ . ____)
c. _____	c. (____ . ____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	c. _____ (____ . ____)	c. _____ (____ . ____)

(M0230) Primary Diagnosis & (M0240) Other Diagnoses		(M0246) Case Mix Diagnoses (OPTIONAL)	
Column 1	Column 2	Column 3	Column 4
	ICD-9-CM and severity rating for each condition	Complete only if a V code in Column 2 is reported in place of a case mix diagnosis.	Complete only if the V code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
Description	ICD-9-CM / Severity Rating	Description/ ICD-9-CM	Description/ ICD-9-CM
d. _____	d. (____ . ____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	d. _____ (____ . ____)	d. _____ (____ . ____)
e. _____	e. (____ . ____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	e. _____ (____ . ____)	e. _____ (____ . ____)
f. _____	f. (____ . ____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	f. _____ (____ . ____)	f. _____ (____ . ____)

DEFINITION:

Identifies each diagnosis for which the patient is receiving home care and its ICD-9-CM code. Each diagnosis (other than an E code) is categorized according to its severity. The primary diagnosis (M0230) should be the condition that is the chief reason for providing home care.

Secondary diagnoses in M0240 are defined as "all conditions that coexisted at the time the plan of care was established, or which developed subsequently, or affect the treatment or care." In general, M0240 should include not only conditions actively addressed in the patient's plan of care but also any co-morbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself. Agencies should avoid listing diagnoses that are of mere historical interest and without impact on patient progress or outcome.

A case-mix diagnosis is a diagnosis that gives a patient a score for Medicare Home Health PPS case-mix group assignment. A case mix diagnosis may be the primary diagnosis, "other" diagnosis, or a manifestation associated with a primary or other diagnosis. Diagnoses listed under columns 3 and 4 should be documented on the patient's Plan of Care in compliance with 42 CFR 484.18(a). The list of case mix diagnosis codes is included in the HH PPS Grouper documentation available on the CMS web site at the following address: http://www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp; click on HH PPS Grouper Software and Documentation.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Follow-up

RESPONSE—SPECIFIC INSTRUCTIONS:

- V codes may be entered in row “a.” of Column 2 (item M0230); V codes and E codes may be entered in the other rows in Column 2 (item M0240).
- V codes and E codes may not be entered in optional Columns 3 or 4 as these columns pertain to the Medicare PPS case mix diagnosis only.
- In optional Columns 3 and 4, complete only those rows in which a V code has been reported in place of a case mix diagnosis in Column 2.
- Complete Columns 1 and 2 from top to bottom, leaving any blank entries at the bottom.
- In optional Columns 3 and 4, There may be blank entries in any row. When optional code(s) are entered in Columns 3 and 4, ensure that they are placed in the row that shows the corresponding V-code.
- No surgical codes -- list the underlying diagnosis.

ASSESSMENT STRATEGIES:**M0230/240: Primary and Other Diagnoses**

Interview patient/caregiver to obtain past health history; additional information may be obtained from the physician. Review current medications and other treatment approaches. Determine if additional diagnoses are suggested by current treatment regimen, and verify this information with the patient/caregiver and physician.

The current ICD-9-CM guidelines should be followed in coding these items.

Assessing severity 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.

M0246: Case Mix Diagnoses (OPTIONAL)

Select the code(s) that would have been reported as the primary diagnosis under the OASIS-B1 (8/2000) instructions:

- No surgical codes -- list the underlying diagnosis.
- V codes cannot be used in case mix group assignment. If a provider reports a V code in M0230/240 in place of a case mix diagnosis, the provider has the option of reporting the case mix diagnosis in M0246.
- If the case-mix diagnosis requires multiple diagnosis under ICD-9-CM coding guidelines, enter these codes in Columns 3 and 4, e.g., if the code is coded as a combination of an etiology and a manifestation code, the etiology code should be entered in Column 3 and the manifestation code should be entered in Column 4.

OASIS ITEM:
<p>(M0250) Therapies the patient receives <u>at home</u>: (Mark all that apply.)</p> <p> <input type="checkbox"/> 1 - Intravenous or infusion therapy (excludes TPN) <input type="checkbox"/> 2 - Parenteral nutrition (TPN or lipids) <input type="checkbox"/> 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal) <input type="checkbox"/> 4 - None of the above </p>
DEFINITION:
<p>Identifies whether the patient is receiving intravenous, parenteral nutrition, or enteral nutrition therapy at home, whether or not the home health agency is administering the therapy.</p>
TIME POINTS ITEM(S) COMPLETED:
<p>Start of care Resumption of care Follow-up Discharge from agency – not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • This item addresses only therapies administered at home. Exclude similar therapies administered in outpatient facilities. • If the patient will receive such therapy as a result of this assessment (e.g., the IV will be started at this visit; the physician will be contacted for an enteral nutrition order; etc.), mark the applicable therapy. • Select Response 1 if a patient receives intermittent medications or fluids via an IV line (e.g., heparin or saline flush). If IV catheter is present but not active (e.g., site is observed only or dressing changes are provided), do <u>not</u> mark Response 1. • Select Response 1 if ongoing infusion therapy is being administered at home via central line, subcutaneous infusion, epidural infusion, intrathecal infusion, or insulin pump. • Do not select Response 1 if there are orders for an IV infusion to be given when specific parameters are present (e.g., weight gain), but those parameters are not met on the day of the assessment. • Select Response 3 if any enteral nutrition is provided. If a feeding tube is in place, but not currently used for nutrition, Response 3 does <u>not</u> apply. A flush of a feeding tube does <u>not</u> provide nutrition.
ASSESSMENT STRATEGIES:
<p>Determine from patient/caregiver interview, nutritional assessment, review of past health history, and referral orders. Assessment of hydration status or nutritional status may result in an order for such therapy (therapies).</p>

OASIS ITEM:
(M0260) Overall Prognosis: BEST description of patient's overall prognosis for <u>recovery from this episode of illness</u> . <input type="checkbox"/> 0 - Poor: little or no recovery is expected and/or further decline is imminent <input type="checkbox"/> 1 - Good/Fair: partial to full recovery is expected <input type="checkbox"/> UK - Unknown
DEFINITION:
Identifies the patient's expected overall prognosis for recovery at the start of this home care episode.
TIME POINTS ITEM(S) COMPLETED:
Start of care Resumption of care
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none">Note that "Good" and "Fair" are both included in Response 1.
ASSESSMENT STRATEGIES:
Interview for past health history and observe current health status. Consider diagnosis and referring physician's expectations for this patient. Based on information received from these data sources, make informed judgment regarding overall prognosis.

OASIS ITEM:
(M0270) Rehabilitative Prognosis: BEST description of patient's prognosis for <u>functional status</u> . <input type="checkbox"/> 0 - Guarded: minimal improvement in functional status is expected; decline is possible <input type="checkbox"/> 1 - Good: marked improvement in functional status is expected <input type="checkbox"/> UK - Unknown
DEFINITION:
Identifies the patient's expected prognosis for functional status improvement at the start of this episode of home care.
TIME POINTS ITEM(S) COMPLETED:
Start of care Resumption of care
RESPONSE—SPECIFIC INSTRUCTIONS:
ASSESSMENT STRATEGIES:
Interview for past health history and observe the current functional status. Consider diagnosis and referring physician's expectations for this patient. Based on information received from these data sources, make informed judgment regarding rehabilitative prognosis.

OASIS ITEM:
(M0280) Life Expectancy: (Physician documentation is not required.) <input type="checkbox"/> 0 - Life expectancy is greater than 6 months <input type="checkbox"/> 1 - Life expectancy is 6 months or fewer
DEFINITION:
Identifies those patients for whom life expectancy is fewer than six months.
TIME POINTS ITEM(S) COMPLETED:
Start of care Resumption of care Discharge from agency – not to an inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none">• A “Do Not Resuscitate” order does not need to be in place.
ASSESSMENT STRATEGIES:
Interview the patient/caregiver to obtain past health history. Observe current health status. Consider medical diagnosis and referring physician’s expectations for patient. If the patient is frail and highly dependent on others, ask the family whether the physician has informed them about life expectancy. Based on information received from these data sources, make informed judgment regarding life expectancy.

OASIS ITEM:
(M0290) High Risk Factors characterizing this patient: (Mark all that apply.) <input type="checkbox"/> 1 - Heavy smoking <input type="checkbox"/> 2 - Obesity <input type="checkbox"/> 3 - Alcohol dependency <input type="checkbox"/> 4 - Drug dependency <input type="checkbox"/> 5 - None of the above <input type="checkbox"/> UK - Unknown * * At discharge, omit "UK - Unknown."
DEFINITION:
Identifies specific factors that may exert a high impact on the patient's health status and ability to recover from this illness.
TIME POINTS ITEM(S) COMPLETED:
Start of care Resumption of care Discharge from agency – not to an inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none">Utilize agency assessment guidelines and informed professional decision-making. Consider amount and length of exposure when responding (e.g., smoking one cigarette a month may not be considered a high risk factor). Specific definitions for each of these factors do not exist.
ASSESSMENT STRATEGIES:
Interview patient/caregiver for past health history. Observe environment and current health status.

OASIS ITEM:
(M0300) Current Residence: <ul style="list-style-type: none"> <input type="checkbox"/> 1 - Patient's owned or rented residence (house, apartment, or mobile home owned or rented by patient/couple/significant other) <input type="checkbox"/> 2 - Family member's residence <input type="checkbox"/> 3 - Boarding home or rented room <input type="checkbox"/> 4 - Board and care or assisted living facility <input type="checkbox"/> 5 - Other (specify) _____
DEFINITION:
Identifies where the patient is residing during the current home care episode (e.g., where the patient is receiving care).
TIME POINTS ITEM(S) COMPLETED:
Start of care Resumption of care Discharge from agency – not to an inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • Response 1: Dwelling considered to be the patient's own. • Response 2: Dwelling considered to belong to family member. Patient may be a temporary or permanent resident. • Response 3: Room rented in a larger dwelling. Patient's room may be the only one rented or one of many. No specific health-related services or supervision are provided, though meals can be included. • Response 4: Some care or health-related services are provided in conjunction with living quarters.
ASSESSMENT STRATEGIES:
Observe the environment in which the visit is being conducted. Interview the patient/caregiver regarding others living in the residence, their relationship to the patient, and any services being provided.

OASIS ITEM:
(M0340) Patient Lives With: (Mark all that apply.) <input type="checkbox"/> 1 - Lives alone <input type="checkbox"/> 2 - With spouse or significant other <input type="checkbox"/> 3 - With other family member <input type="checkbox"/> 4 - With a friend <input type="checkbox"/> 5 - With paid help (other than home care agency staff) <input type="checkbox"/> 6 - With other than above
DEFINITION: Identifies whomever the patient is living with at this time, even if the arrangement is temporary.
TIME POINTS ITEM(S) COMPLETED: Start of care Resumption of care Discharge from agency – not to an inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS: <ul style="list-style-type: none">• “Other family member” could include in-laws, children, cousins, etc.• “Paid help” would include help provided under a special program (e.g., Medicaid), even though the patient may not be directly paying for this help.• Intermittent (e.g., a few hours each day, one to two days a week, etc.) paid help is not considered as help the patient “lives with.”
ASSESSMENT STRATEGIES: This is information all agencies need to know in planning care and services. Try to incorporate this question into the conversation, so the patient does not feel an investigation is being conducted.

OASIS ITEM:
(M0350) Assisting Person(s) Other than Home Care Agency Staff: (Mark all that apply.) <ul style="list-style-type: none"> <input type="checkbox"/> 1 - Relatives, friends, or neighbors living outside the home <input type="checkbox"/> 2 - Person residing in the home (EXCLUDING paid help) <input type="checkbox"/> 3 - Paid help <input type="checkbox"/> 4 - None of the above [If None of the above, go to M0390] <input type="checkbox"/> UK - Unknown [If Unknown, go to M0390]
DEFINITION:
Identifies the individuals who provide assistance to the patient (EXCLUDING the home care agency).
TIME POINTS ITEM(S) COMPLETED:
Start of care Resumption of care Discharge from agency – not to an inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • Response 3 – Paid help includes all individuals who are paid to provide assistance to the patient, whether paid by the patient, family, or a specific program (e.g., a non-agency community program). An agency other than the home care agency doing the assessment that provides assistance to the patient would be classified as paid help. A patient living in an assisted living facility receives assistance from paid help. • If patient does not receive assistance from others, mark Response 4 – None of the above. • If "None of the above" is selected at discharge, clinician should be directed to skip to M0410. • At discharge, change M0390 to M0410. • At discharge, omit "UK - Unknown."
ASSESSMENT STRATEGIES:
If the patient mentions a friend or relative helping or coming to visit, interview to find out more about who helps patient, how often, what helpers do, etc. (applies to M0360, M0370, M0380). In obtaining the health history, interview to determine whether ADL/IADL assistance is needed. If it is, request information on whether patient receives such assistance and from whom.

OASIS ITEM:

(M0360) Primary Caregiver taking lead responsibility for providing or managing the patient's care, providing the most frequent assistance, etc. (other than home care agency staff):

- ☐ 0 - No one person [If No one person, go to **M0390**]
- ☐ 1 - Spouse or significant other
- ☐ 2 - Daughter or son
- ☐ 3 - Other family member
- ☐ 4 - Friend or neighbor or community or church member
- ☐ 5 - Paid help
- ☐ UK - Unknown [If Unknown, go to **M0390**]

DEFINITION:

Identifies the person who is "in charge" of providing and coordinating the patient's care. A case manager hired to oversee care, but who does not provide any assistance is not considered the primary caregiver. This person may employ others to provide direct assistance, in which case "paid help" is considered the primary caregiver.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- If one person assumes lead responsibility for managing care, but another provides most frequent assistance, assess further to determine if one should be designated as primary caregiver or if Response 0 – No one person, is most appropriate.
- Response 5 – Paid help includes all individuals who are paid to provide assistance to the patient, whether paid by the patient, family, or a specific program (e.g., a non-agency community program). An agency other than the home care agency doing the assessment who provides assistance to the patient would be classified as paid help.
- If the primary caregiver is the patient himself (or herself), mark Response 0 - No one person.
- If "No one person" is selected at discharge, clinician should be instructed to go to M0410.
- At discharge, change M0390 to M0410.
- At discharge, omit "UK - Unknown."

ASSESSMENT STRATEGIES:

From M0350, it is known that the patient receives assistance. Interview to determine whom the patient considers to be the primary caregiver. For example, ask, "Of the people who help you, is there one person who is 'in charge' of making sure things get done?" "Who would you call if you needed help or assistance?"

OASIS ITEM:
<p>(M0370) How Often does the patient receive assistance from the primary caregiver?</p> <p> <input type="checkbox"/> 1 - Several times during day and night <input type="checkbox"/> 2 - Several times during day <input type="checkbox"/> 3 - Once daily <input type="checkbox"/> 4 - Three or more times per week <input type="checkbox"/> 5 - One to two times per week <input type="checkbox"/> 6 - Less often than weekly <input type="checkbox"/> UK - Unknown </p>
DEFINITION:
Identifies the frequency of the help provided by the primary caregiver (identified in M0360).
TIME POINTS ITEM(S) COMPLETED:
Start of care Resumption of care Discharge from agency – not to inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • Responses are arranged in order of most to least assistance received from primary caregiver. • This item is skipped if no primary caregiver. • At discharge, omit "UK - Unknown."
ASSESSMENT STRATEGIES:
Ask, in various ways, how often the primary caregiver provides various types of assistance (e.g., "How often does your daughter come by? Does she go shopping for you every week? When she is here, does she do the laundry?"). As you proceed through the assessment (particularly the ADLs and IADLs), several opportunities arise to learn details of the help the patient receives.

OASIS ITEM:
<p>(M0380) Type of Primary Caregiver Assistance: (Mark all that apply.)</p> <p> <input type="checkbox"/> 1 - ADL assistance (e.g., bathing, dressing, toileting, bowel/bladder, eating/feeding) <input type="checkbox"/> 2 - IADL assistance (e.g., meds, meals, housekeeping, laundry, telephone, shopping, finances) <input type="checkbox"/> 3 - Environmental support (housing, home maintenance) <input type="checkbox"/> 4 - Psychosocial support (socialization, companionship, recreation) <input type="checkbox"/> 5 - Advocates or facilitates patient's participation in appropriate medical care <input type="checkbox"/> 6 - Financial agent, power of attorney, or conservator of finance <input type="checkbox"/> 7 - Health care agent, conservator of person, or medical power of attorney <input type="checkbox"/> UK - Unknown </p>
DEFINITION:
Identifies categories of assistance provided by the primary caregiver (identified in M0360).
TIME POINTS ITEM(S) COMPLETED:
Start of care Resumption of care Discharge from agency – not to inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • Response 3: Includes home repair and upkeep, mowing lawn, shoveling snow, and painting. • Response 4: Includes frequent visits or phone calls, going with patient for outings, church services, other events. • Response 5: Takes patient to medical appointments, follows up with filling prescriptions or making subsequent appointments, etc. • Responses 6 and 7: Legal arrangements that exist for finances or health care. • At discharge, omit "UK - Unknown."
ASSESSMENT STRATEGIES:
Interview questions about types of assistance are likely to produce answers that relate to ADLs and IADLs. More specific questions need to address other aspects of assistance. At start of care, discussion of advance directives can provide information about existing legal arrangements for decision-making.

OASIS ITEM:
<p>(M0390) Vision with corrective lenses if the patient usually wears them:</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0 - Normal vision: sees adequately in most situations; can see medication labels, newsprint. <input type="checkbox"/> 1 - Partially impaired: cannot see medication labels or newsprint, but <u>can</u> see obstacles in path, and the surrounding layout; can count fingers at arm's length. <input type="checkbox"/> 2 - Severely impaired: cannot locate objects without hearing or touching them <u>or</u> patient nonresponsive.
DEFINITION:
<p>Identifies the patient's ability to see and visually manage (function) within his/her environment, wearing corrective lenses if these are usually worn.</p>
TIME POINTS ITEM(S) COMPLETED:
<p>Start of care Resumption of care Follow-up</p>
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • A magnifying glass (as might be used to read newsprint) is <u>not</u> an example of corrective lenses. • Reading glasses (including "grocery store" reading glasses) <u>are</u> considered to be corrective lenses. • "Nonresponsive" means that the patient is not <u>able</u> to respond.
ASSESSMENT STRATEGIES:
<p>In the health history interview, ask the patient about vision problems (e.g., cataracts) and whether or not the patient uses glasses. Observe ability to locate signature line on consent form, to count fingers at arm's length and ability to differentiate between medications, especially if medications are self-administered. Be sensitive to requests to read, as patient may not be able to read though vision is adequate.</p>

OASIS ITEM:
<p>(M0400) Hearing and Ability to Understand Spoken Language in patient's own language (with hearing aids if the patient usually uses them):</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0 - No observable impairment. Able to hear and understand complex or detailed instructions and extended or abstract conversation. <input type="checkbox"/> 1 - With minimal difficulty, able to hear and understand most multi-step instructions and ordinary conversation. May need occasional repetition, extra time, or louder voice. <input type="checkbox"/> 2 - Has moderate difficulty hearing and understanding simple, one-step instructions and brief conversation; needs frequent prompting or assistance. <input type="checkbox"/> 3 - Has severe difficulty hearing and understanding simple greetings and short comments. Requires multiple repetitions, restatements, demonstrations, and additional time. <input type="checkbox"/> 4 - <u>Unable</u> to hear and understand familiar words or common expressions consistently, <u>or</u> patient nonresponsive.
DEFINITION:
<p>Identifies the patient's ability to hear and to understand spoken language, in the patient's primary language. Hearing is evaluated with the patient wearing aids if he/she usually uses them.</p>
TIME POINTS ITEM(S) COMPLETED:
<p>Start of care Resumption of care</p>
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • "Nonresponsive" means that the patient is not able to respond.
ASSESSMENT STRATEGIES:
<p>Interaction with the patient during the assessment process provides information to answer this item. Be alert to what is required to adequately communicate with the patient. If he/she uses a hearing appliance, be sure that it is in place, has a battery, and is turned on.</p> <p>A patient whose primary language differs from the clinician's requires additional evaluation. Can a family member or friend interpret? Does the agency provide an interpreter? Is another clinician (who speaks the patient's primary language) available? If an interpreter provides assistance, visit clinical documentation should note the assistance of this individual.</p>

OASIS ITEM:
<p>(M0410) Speech and Oral (Verbal) Expression of Language (in patient's own language):</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment. <input type="checkbox"/> 1 - Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance). <input type="checkbox"/> 2 - Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences. <input type="checkbox"/> 3 - Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases. <input type="checkbox"/> 4 - <u>Unable</u> to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (e.g., speech is nonsensical or unintelligible). <input type="checkbox"/> 5 - Patient nonresponsive or unable to speak.
DEFINITION:
<p>Identifies the patient's ability to communicate verbally (by mouth) in the patient's primary language. The item does not address communicating in sign language, in writing, or by any nonverbal means. Augmented speech (e.g., a trained esophageal speaker, use of an electrolarynx) is considered verbal expression of language.</p>
TIME POINTS ITEM(S) COMPLETED:
<p>Start of care Resumption of care Discharge from agency – not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • “Nonresponsive” means that the patient is not able to respond. • Presence of a tracheostomy requires further evaluation of the patient's ability to speak. Can the trach be covered to allow speech? If so, to what extent can the patient express him/herself? • Augmented speech through the use of esophageal speech or an electrolarynx is considered oral/verbal expression of language. • Select Response 5 for a patient who communicates entirely by sign language or writing or is unable to speak.
ASSESSMENT STRATEGIES:
<p>Interaction with the patient during the assessment process provides information to answer this item. Patient responses to interview questions are evaluated to determine speaking ability.</p>

OASIS ITEM:
<p>(M0420) Frequency of Pain interfering with patient's activity or movement:</p> <p> <input type="checkbox"/> 0 - Patient has no pain or pain does not interfere with activity or movement <input type="checkbox"/> 1 - Less often than daily <input type="checkbox"/> 2 - Daily, but not constantly <input type="checkbox"/> 3 - All of the time </p>
DEFINITION:
Identifies frequency with which pain interferes with patient's activities, with treatment if prescribed.
TIME POINTS ITEM(S) COMPLETED:
Start of care Resumption of care Follow-up Discharge from agency – not to an inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • Responses are arranged in order of least to most interference with activity or movement. • Pain interferes with activity when the pain results in the activity being performed less often than otherwise desired, requires the patient to have additional assistance in performing the activity, or causes the activity to take longer to complete.
ASSESSMENT STRATEGIES:
<p>When reviewing patient's medications, the presence of medication for pain or joint disease provides an opportunity to explore the presence of pain, when the pain is the most severe, activities with which the pain interferes, and the frequency of this interference with activity or movement. Be careful not to overlook seemingly unimportant activities, e.g., the patient says she/he sits in the chair all day and puts off going to the bathroom, because it hurts so much to get up from the chair or to walk.</p> <p>Evaluating the patient's ability to perform ADLs and IADLs can provide additional information about such pain.</p> <p>Assessing pain in a nonverbal patient involves observation of facial expression (e.g., frowning, gritting teeth), monitoring heart rate, respiratory rate, perspiration, pallor, pupil size, irritability, or use of visual analog pain scales.</p> <p>The patient's treatment for pain (whether pharmacologic or nonpharmacologic treatment) must be considered when evaluating whether pain interferes with activity or movement. Pain that is well controlled with treatment may not interfere with activity or movement at all.</p>

OASIS ITEM:
<p>(M0430) Intractable Pain: Is the patient experiencing pain that is <u>not easily relieved</u>, occurs at least daily, and affects the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity?</p> <p> <input type="checkbox"/> 0 - No <input type="checkbox"/> 1 - Yes </p>
DEFINITION:
<p>Identifies the presence of intractable pain, as defined in the item. To be considered 'intractable,' the pain must meet all three criteria listed in the item:</p> <ul style="list-style-type: none"> • not be easily relieved, • be present at least daily, and • affect the patient's quality of life as outlined in the item wording.
TIME POINTS ITEM(S) COMPLETED:
<p>Start of care Resumption of care Discharge from agency – not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS:
ASSESSMENT STRATEGIES:
<p>Intractable pain is pain that occurs at least daily, may make the patient more irritable or less tolerant of frustrations, awakens her/him at night, and makes it difficult to get back to sleep. It may cause the patient to refrain from participating in activities that have been an important part of life, because she/he knows the activity will increase the pain or that the pain will be so significant that he/she can no longer enjoy the activity. A patient who has intractable pain may express much frustration (e.g., crying or anger) at how the pain is interfering with life. As you assess the patient's medications and activities, elicit whether or not the patient's pain fits these descriptions. Ask the patient if the pain is present despite taking analgesic medication regularly as prescribed.</p> <p>Assessing pain in a nonverbal patient involves observation of facial expression (e.g., frowning, gritting teeth), monitoring heart rate, respiratory rate, perspiration, pallor, pupil size, irritability, or use of visual analog pain scales.</p>

OASIS ITEM:
<p>(M0440) Does this patient have a Skin Lesion or an Open Wound? This excludes "OSTOMIES."</p> <p><input type="checkbox"/> 0 - No [If No, go to M0490]</p> <p><input type="checkbox"/> 1 - Yes</p>
DEFINITION:
<p>Identifies the presence of a skin lesion or open wound. A lesion is a broad term used to describe an area of pathologically altered tissue. Sores, skin tears, burns, ulcers, rashes, surgical incisions, crusts, etc. are all considered lesions. All alterations in skin integrity are considered to be lesions, except alterations that end in "ostomy" (e.g., tracheostomy, gastrostomy, etc.) or peripheral IV sites. Persistent redness without a break in the skin is also considered a lesion.</p>
TIME POINTS ITEM(S) COMPLETED:
<p>Start of care Resumption of care Follow-up Discharge from agency – not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • If the patient has any skin condition which should be observed and described, mark "yes" to this item. • Only certain types of wounds are described by specific OASIS items, but other wounds (e.g., burns, diabetic ulcers, wounds caused by trauma of various kinds, etc.), should be documented in a manner determined by each agency. You may mark "1 – Yes" to this item and correctly mark "No" to questions M0445 (Pressure Ulcer), M0468 (Stasis Ulcer), and M0482 (Surgical Wound), if the patient has a different type of wound. • Pin sites, central lines, PICC lines, implanted infusion devices or venous access devices, surgical wounds with staples or sutures, etc. are all considered lesions/wounds. • There are many types of "ostomies," all of which involve a surgically formed opening from outside the body to an internal organ or cavity. A suprapubic tube site is a cystostomy; an ileal conduit opens in an ileostomy; etc. All "ostomies" are <u>excluded</u> from consideration under this item. • This item does not address cataract surgery of the eye or gynecological surgical procedures by a vaginal approach.
ASSESSMENT STRATEGIES:
<p>Interview the patient to determine the existence of any known lesions. Follow by visual inspection of the skin. Inspection may reveal additional areas on which to focus interview questions. The comprehensive assessment should include additional documentation of lesion/wound location, size, appearance, status, drainage, etc. if applicable.</p>

OASIS ITEM:
<p>(M0445) Does this patient have a Pressure Ulcer?</p> <p><input type="checkbox"/> 0 - No [If No, go to M0468]</p> <p><input type="checkbox"/> 1 - Yes</p>
DEFINITION:
<p>Identifies the presence of a pressure ulcer, defined as any lesion caused by unrelieved pressure resulting in tissue hypoxia and damage of the underlying tissue. Pressure ulcers most often occur over bony prominences.</p>
TIME POINTS ITEM(S) COMPLETED:
<p>Start of care Resumption of care Discharge from agency – not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • Select Response "Yes" if this patient has a pressure ulcer at any stage. (See OASIS item M0450 for definitions of pressure ulcers by stage.) • Select Response "No" if <u>a former Stage 1 or 2 pressure ulcer has healed AND the patient has no other pressure ulcers.</u> • Select Response "No" if the patient's skin lesion is any other kind of ulcer or wound. • Select Response "Yes" if this patient has a Stage 3 or 4 pressure ulcer at any healing status level. (See OASIS item M0450 for definitions of pressure ulcers by stage.)
ASSESSMENT STRATEGIES:
<p>Interview for the presence of risk factors for pressure ulcers (i.e., immobility, activity limitations, skin moisture or incontinence, poor nutrition, limited sensory-perceptual ability). Inspect the skin over bony prominences carefully.</p> <p>It is important to differentiate pressure ulcers from other types of skin lesions.</p> <p>If the home health clinician conducting the assessment is not sure the wound fits the definition of a pressure ulcer, the clinician should contact the physician for clarification.</p>

OASIS ITEM:						
(M0450) Current Number of Pressure Ulcers at Each Stage: (Circle one response for each stage.)						
Pressure Ulcer Stages		Number of Pressure Ulcers				
a)	Stage 1: Nonblanchable erythema of intact skin; the heralding of skin ulceration. In darker-pigmented skin, warmth, edema, hardness, or discolored skin may be indicators.	0	1	2	3	4 or more
b)	Stage 2: Partial thickness skin loss involving epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.	0	1	2	3	4 or more
c)	Stage 3: Full-thickness skin loss involving damage or necrosis of subcutaneous tissue which may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.	0	1	2	3	4 or more
d)	Stage 4: Full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule, etc.)	0	1	2	3	4 or more
e)	In addition to the above, is there at least one pressure ulcer that cannot be observed due to the presence of eschar or a nonremovable dressing, including casts?					
	<input type="checkbox"/> 0 - No <input type="checkbox"/> 1 - Yes					
DEFINITION:						
Identifies the number of pressure ulcers at each stage present at the time of assessment. Definitions of pressure ulcer stages derive from the National Pressure Ulcer Advisory Panel.						
TIME POINTS ITEM(S) COMPLETED:						
Start of care Resumption of care Follow-up Discharge from agency – not to inpatient facility						
RESPONSE—SPECIFIC INSTRUCTIONS:						
<ul style="list-style-type: none"> • Circle the number of ulcers appropriate for each stage. • If there are NO ulcers at a given stage, circle "0" for that stage. • Mark a response for each part of this item: a), b), c), d), and e). • A pressure ulcer covered by eschar obscuring the depth of tissue loss or covered by a nonremovable cast or dressing cannot be staged, and "yes" should be selected for response (e). • A muscle flap performed to surgically replace a pressure ulcer is a surgical wound and is no longer a pressure ulcer. • A pressure ulcer that has been surgically debrided remains a pressure ulcer. It <u>does not</u> become a surgical wound. 						
ASSESSMENT STRATEGIES:						
<p>Inspect the skin over bony prominences carefully, particularly for patients with known risk factors for pressure ulcers. (See M0445 for listing of risk factors.)</p> <p>Recognizing erythema (a Stage 1 ulcer) in darker-skinned individuals requires close examination. Inspect for change in texture, a bluish/purplish skin tone, or extremely dry skin in areas over bony prominences. Palpate for warmth, tissue consistency (firm or boggy feel), or slight edema in these areas. Interview for sensation changes (pain, itching).</p> <p>The depth of tissue involvement must be visible to accurately determine the stage. If the bed of the pressure ulcer is covered by necrotic tissue (slough or eschar) to the extent that the deepest level of tissue involvement cannot be visualized, the ulcer cannot be staged until sufficient necrotic tissue is removed to allow visualization of the depth of tissue loss. Even a previously-identified Stage 4 ulcer cannot be categorized as a Stage 4 if necrotic tissue currently obscures visualization of involvement of bone, tendon or muscle.</p>						

ASSESSMENT STRATEGIES: (Cont'd for OASIS ITEM M0450)

In 2004, based on advances in wound care research and the opinion of the National Pressure Ulcer Advisory Panel (NPUAP), it was determined that Stage 1 and Stage 2 pressure ulcers can heal. If, on assessment, the patient is found to have a healed Stage 1 or a healed Stage 2 pressure ulcer, this ulcer would not be included in any count of pressure ulcers.

In 2007, the NPUAP released an update to the staging system adding 2 stages, Suspected Deep Tissue Injury and Unstageable pressure ulcers. Pressure ulcers meeting the NPUAP's new definition of "unstageable" would be reported as not observable – "Yes" to M0450(e). Pressure ulcers meeting the NPUAP's new definition of "Suspected Deep Tissue Injury" would only be reported as pressure ulcers on OASIS if additional physical wound characteristics meet the descriptors included in the staging definitions currently listed in M0450.

Reverse staging of granulating pressure ulcers is NOT an appropriate clinical practice according to the National Pressure Ulcer Advisory Panel (NPUAP). If a pressure ulcer is Stage 3 at SOC and is granulating at the follow-up visit, the ulcer remains a Stage 3 ulcer. If the patient has been in an inpatient setting for some time, it is conceivable that the wound has already started to granulate, thus making it impossible to know the stage of the wound at its worst. The clinician should make every effort to contact previous providers (including patient's physician) to determine the stage of the wound at its worst. An ulcer's stage can worsen, and this item should be answered appropriately if this occurs.

A healed Stage 3 or Stage 4 pressure ulcer continues to be regarded as a pressure ulcer at its worst stage. A previously-healed Stage 3 or Stage 4 pressure ulcer that breaks down again should be staged at its worst stage.

Consult published guidelines of NPUAP (www.npuap.org) for additional clarification and/or resources for training.

OASIS ITEM:
<p>(M0460) [At Follow-up, skip to M0470 if patient has no pressure ulcers.] Stage of Most Problematic (Observable) Pressure Ulcer:</p> <p> <input type="checkbox"/> 1 - Stage 1 <input type="checkbox"/> 2 - Stage 2 <input type="checkbox"/> 3 - Stage 3 <input type="checkbox"/> 4 - Stage 4 <input type="checkbox"/> NA - No observable pressure ulcer </p>
DEFINITION:
<p>Identifies the most problematic pressure ulcer of those observable pressure ulcers noted in M0450. "Most problematic" may be the largest, the most advanced stage, the most difficult to access for treatment, the most difficult to relieve pressure, etc., depending on the specific situation.</p>
TIME POINTS ITEM(S) COMPLETED:
<p>Start of care Resumption of care Follow-up Discharge from agency – not to inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • If the patient has only one observable pressure ulcer, then that ulcer is the most problematic. • In evaluating the most problematic ulcer, do not include any ulcer to which response "e" in M0450 applied. If that is the only ulcer, mark "NA." • Insert directions at follow-up to skip this item if the patient has no pressure ulcer(s). • "Nonobservable" pressure ulcers include <u>only</u> those that cannot be observed due to the presence of necrotic tissue (including eschar or slough) which obscures the depth of tissue loss, or a nonremovable dressing (see M0450). Utilize the Wound, Ostomy, and Continence Nurses' guidelines (<i>OASIS Guidance Document – revised July 2006</i>) for specific guidance. The web site for WOCN is found at: http://www.wocn.org.
ASSESSMENT STRATEGIES:
<p>Incorporate the information from M0450 and the status of each pressure ulcer and utilize clinical reasoning to determine the most problematic (observable) ulcer.</p>

OASIS ITEM:
(M0464) Status of Most Problematic (Observable) Pressure Ulcer: <ul style="list-style-type: none"> <input type="checkbox"/> 1 - Fully granulating <input type="checkbox"/> 2 - Early/partial granulation <input type="checkbox"/> 3 - Not healing <input type="checkbox"/> NA - No observable pressure ulcer
DEFINITION:
Identifies the degree of healing visible in the ulcer identified in M0460 as the most problematic observable pressure ulcer.
TIME POINTS ITEM(S) COMPLETED:
Start of care Resumption of care Discharge from agency – not to inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> Mark the response which most accurately describes the healing process you see occurring in the most problematic pressure ulcer (identified in M0460). A Stage 1 pressure ulcer or an infected pressure ulcer is not healing (Response 3). "Nonobservable" pressure ulcers include <u>only</u> those that cannot be observed due to the presence of a nonremovable dressing, including casts. (When determining the healing status of a pressure ulcer for answering M0464, the presence of necrotic tissue does NOT make the pressure ulcer NA – No observable pressure ulcer.) A pressure ulcer with necrotic tissue (eschar/slough) obscuring the wound base cannot be staged, but its healing status is Response 2 – Early/partial granulation if necrotic or avascular tissue covers < 25% of the wound bed, or its status is Response 3 - Not healing, if the wound has ≥ 25% necrotic or avascular tissue. See the WOCN <i>OASIS Guidance Document</i> for specific guidelines.
ASSESSMENT STRATEGIES:
Visualization of the wound is necessary to identify the degree of healing evident in the ulcer identified in M0460. Utilize the Wound, Ostomy, and Continence Nurses' guidelines (<i>OASIS Guidance Document - revised July 2006</i>) to identify the degree of healing evident. The web site for the WOCN is found at: http://www.wocn.org .

OASIS ITEM:
(M0468) Does this patient have a Stasis Ulcer ? <input type="checkbox"/> 0 - No [If No, go to M0482] <input type="checkbox"/> 1 - Yes
DEFINITION:
A response of "Yes" identifies the presence of an ulcer caused by inadequate venous circulation in the area affected (usually lower legs). This lesion is often associated with stasis dermatitis. Stasis ulcers <u>do not</u> include arterial circulatory lesions or arterial ulcers.
TIME POINTS ITEM(S) COMPLETED:
Start of care Resumption of care Discharge from agency – not to inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS:
ASSESSMENT STRATEGIES:
Interview for presence of circulatory disorders and lower extremity skin change in the past health history. Inspect the skin carefully, especially the lower extremities. It is important to differentiate stasis ulcers from other types of skin lesions. If the home health clinician conducting the assessment is not sure the wound fits the definition of a stasis ulcer, the clinician should contact the physician for clarification.

OASIS ITEM:
(M0470) Current Number of Observable Stasis Ulcer(s): <input type="checkbox"/> 0 - Zero <input type="checkbox"/> 1 - One <input type="checkbox"/> 2 - Two <input type="checkbox"/> 3 - Three <input type="checkbox"/> 4 - Four or more
DEFINITION:
Identifies the number of visible (observable) stasis ulcers.
TIME POINTS ITEM(S) COMPLETED:
Start of care Resumption of care Follow-up Discharge from agency – not to inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS:
"Non-observable" stasis ulcers include <u>only</u> those that are covered by a nonremovable dressing.
ASSESSMENT STRATEGIES:
Inspect the skin carefully, especially the lower extremities. Count the ulcerations that can be seen.

OASIS ITEM:
(M0474) Does this patient have at least one Stasis Ulcer that Cannot be Observed due to the presence of a nonremovable dressing? <input type="checkbox"/> 0 - No <input type="checkbox"/> 1 - Yes
DEFINITION:
Identifies the presence of a stasis ulcer which is covered by a dressing that home care staff are not to remove (e.g., an Unna's paste-boot).
TIME POINTS ITEM(S) COMPLETED:
Start of care Resumption of care Follow-up Discharge from agency – not to inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS:
"Non-observable" stasis ulcers include <u>only</u> those that are covered by a nonremovable dressing.
ASSESSMENT STRATEGIES:
The past health history and current referral information provide knowledge of the reason for any nonremovable dressing. Uncertainty regarding the reason for the nonremovable dressing can be resolved through communication with the physician.

OASIS ITEM:
(M0476) [At Follow-up, skip to M0488 if patient has no stasis ulcers.] Status of Most Problematic (Observable) Stasis Ulcer: <input type="checkbox"/> 1 - Fully granulating <input type="checkbox"/> 2 - Early/partial granulation <input type="checkbox"/> 3 - Not healing <input type="checkbox"/> NA - No observable stasis ulcer
DEFINITION:
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, one which is infected, etc., depending on the specific situation.
TIME POINTS ITEM(S) COMPLETED:
Start of care Resumption of care Follow-up Discharge from agency – not to inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • If the patient has only one stasis ulcer, that ulcer is the most problematic. • Insert directions at follow-up to skip this item if the patient has no stasis ulcers. • "Nonobservable" stasis ulcers include <u>only</u> those that are covered by a nonremovable dressing.
ASSESSMENT STRATEGIES:
Inspect each ulcer to determine its status. Based on this information and that from the health history, use clinical reasoning to determine the most problematic (observable) stasis ulcer. Utilize the Wound, Ostomy, and Continence Nurses' guidelines (<i>OASIS Guidance Document - revised July 2006</i>) to determine healing status of the stasis ulcer.

OASIS ITEM:
<p>(M0482) Does this patient have a Surgical Wound?</p> <p><input type="checkbox"/> 0 - No [If No, go to M0490]</p> <p><input type="checkbox"/> 1 - Yes</p>
DEFINITION:
<p>Identifies the presence of any wound resulting from a surgical procedure. A wound that has completely healed (thus becoming a scar) no longer is identified as a surgical wound.</p>
TIME POINTS ITEM(S) COMPLETED:
<p>Start of care Resumption of care Discharge from agency – not to inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • Orthopedic pin sites, central line sites, stapled or sutured incisions, and wounds with drains are all considered surgical wounds. A surgical incision with approximated edges and a scab (i.e., crust) from dried blood or tissue fluid is considered a current surgical wound. • A PICC line is not a surgical wound, as it is peripherally inserted, although it could be considered a skin lesion (see M0440). • Medi-port sites and other implanted infusion devices or venous access devices are considered surgical wounds. • "Old" surgical wounds that have resulted in scar or keloid formation are not considered current surgical wounds. • A muscle flap performed to surgically replace a pressure ulcer is a surgical wound and is no longer a pressure ulcer. • A pressure ulcer that has been surgically debrided remains a pressure ulcer. It <u>does not</u> become a surgical wound. • Cataract surgery of the eye or a gynecological surgical procedure via a vaginal approach does not create a surgical wound for this item. • Debridement or the placement of a skin graft do not create a surgical wound, as these are treatments performed to an existing wound. The wound would continue to be defined as the type of wound previously identified. • A "take-down" procedure of a previous ostomy produces a surgical wound. An ostomy being allowed to close on its own is excluded.
ASSESSMENT STRATEGIES:
<p>During the comprehensive head-to-toe assessment, if health history or diagnoses indicate recent surgical procedures performed on the integumentary system, inspect surgical sites.</p> <p>If the home health clinician conducting the assessment is not sure the wound fits the definition of a surgical incision, the clinician should contact the physician for clarification.</p>

OASIS ITEM:
<p>(M0484) Current Number of (Observable) Surgical Wounds: (If a wound is partially closed but has <u>more</u> than one opening, consider each opening as a separate wound.)</p> <p> <input type="checkbox"/> 0 - Zero <input type="checkbox"/> 1 - One <input type="checkbox"/> 2 - Two <input type="checkbox"/> 3 - Three <input type="checkbox"/> 4 - Four or more </p>
DEFINITION:
Identifies the number of observable surgical wounds.
TIME POINTS ITEM(S) COMPLETED:
Start of care Resumption of care Discharge from agency – not to inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • A wound is not observable if it is covered by a dressing (or cast) which is not to be removed, per physician's orders. • When a single surgical wound heals in a manner that results in one (or more) areas of complete epithelialization with other area(s) of partial healing, each non-epithelialized opening is counted as a separate wound. For example, a vertical laparotomy incision which is epithelialized in some areas, but has an opening at the mid-point and another at the distal point would count as two wounds. • Each orthopedic pin site is considered a separate wound. • Each suture or staple insertion site is <u>not</u> considered a separate wound.
ASSESSMENT STRATEGIES:
Count the number of visible wounds.

OASIS ITEM:
(M0486) Does this patient have at least one Surgical Wound that Cannot be Observed due to the presence of a nonremovable dressing? <input type="checkbox"/> 0 - No <input type="checkbox"/> 1 - Yes
DEFINITION:
Identifies the presence of a surgical wound which is covered by a dressing (or cast) which is not to be removed, per physician's orders.
TIME POINTS ITEM(S) COMPLETED:
Start of care Resumption of care Discharge from agency – not to inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none">Answer yes if there is a wound for which the dressing cannot be removed by home care clinicians (e.g., a plastic surgeon may order that he/she is the only one to remove the dressing over a new skin graft).
ASSESSMENT STRATEGIES:
Review referral information; interview patient; inspect surgical site(s). Contact physician if uncertain about removing dressing.

OASIS ITEM:
<p>(M0488) [At Follow-up, skip to M0490 if patient has no surgical wound(s).] Status of Most Problematic (Observable) Surgical Wound:</p> <p> <input type="checkbox"/> 1 - Fully granulating <input type="checkbox"/> 2 - Early/partial granulation <input type="checkbox"/> 3 - Not healing <input type="checkbox"/> NA - No observable surgical wound </p>
DEFINITION:
<p>Identifies the degree of healing visible in the most problematic surgical wound. The "most problematic" wound is the one that may be complicated by the presence of infection; location of wound, large size, difficult management of drainage, or slow healing.</p>
TIME POINTS ITEM(S) COMPLETED:
<p>Start of care Resumption of care Follow-up Discharge from agency – not to inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • Requires identification of the most problematic surgical wound. • If there is only one surgical wound, the status of that one should be noted. • Insert directions at follow-up to skip this item if the patient has no surgical wounds(s). • "Nonobservable" surgical wounds include <u>only</u> those that are covered by a nonremovable dressing (or cast). • Clinical palpation of a healing ridge is not conclusive and should not be utilized to determine the status of a surgical wound.
ASSESSMENT STRATEGIES:
<p>If there is more than one wound, determine which is the most problematic. Visualize this wound to identify the degree of healing.</p> <p>Utilize the Wound, Ostomy, and Continence Nurses' guidelines (<i>OASIS Guidance Document - revised July 2006</i>) to determine the degree of healing. For surgical wounds, note the variation in guidance between those wounds healing by primary intention and those healing by secondary intention.</p>

OASIS ITEM:
<p>(M0490) When is the patient dyspneic or noticeably Short of Breath?</p> <p> <input type="checkbox"/> 0 - Never, patient is not short of breath <input type="checkbox"/> 1 - When walking more than 20 feet, climbing stairs <input type="checkbox"/> 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet) <input type="checkbox"/> 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation <input type="checkbox"/> 4 - At rest (during day or night) </p>
DEFINITION:
Identifies the patient's level of shortness of breath.
TIME POINTS ITEM(S) COMPLETED:
Start of care Resumption of care Follow-up Discharge from agency – not to inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • If the patient usually uses oxygen continuously, mark the response that best describes the patient's shortness of breath while using oxygen. • If the patient uses oxygen intermittently, mark the response that best describes the patient's shortness of breath WITHOUT the use of oxygen. • The responses represent increasing severity of shortness of breath.
ASSESSMENT STRATEGIES:
<p>Request to see the bathroom setup, allowing you the opportunity to observe and evaluate the occurrence of shortness of breath with a walk of a distance you can estimate (if less than 20 feet, ask the patient to extend the distance back to a chair). During conversation with the patient, does he/she stop frequently to catch his/her breath? Review symptoms and their severity in past health history.</p> <p>For a chairfast or bedbound patient, evaluate the level of exertion required to produce shortness of breath. The chairfast patient can be assessed for level of dyspnea while performing ADLs or at rest. Response 0 would apply if the patient is never short of breath. Response 1 would be appropriate if demanding bed-mobility activities produce dyspnea in the bedbound patient (or physically demanding transfer activities produce dyspnea in the chairfast patient). See Responses 2, 3, and 4 for assessment examples for these patients as well as ambulatory patients.</p>

OASIS ITEM:
<p>(M0500) Respiratory Treatments utilized at home: (Mark all that apply.)</p> <p> <input type="checkbox"/> 1 - Oxygen (intermittent or continuous) <input type="checkbox"/> 2 - Ventilator (continually or at night) <input type="checkbox"/> 3 - Continuous positive airway pressure <input type="checkbox"/> 4 - None of the above </p>
DEFINITION:
<p>Identifies any of the listed respiratory treatments being used by this patient in the home.</p>
TIME POINTS ITEM(S) COMPLETED:
<p>Start of care Resumption of care Discharge from agency – not to inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> Excludes any respiratory treatments that are not listed in the item (e.g., does not include nebulizers, inhalers, Bi-PAP, etc.). These treatments should be documented in the clinical record.
ASSESSMENT STRATEGIES:
<p>Interview patient/caregiver. Review referral information and medication orders. Observe for presence of such equipment in the home.</p>

OASIS ITEM:
<p>(M0510) Has this patient been treated for a Urinary Tract Infection in the past 14 days?</p> <p> <input type="checkbox"/> 0 - No <input type="checkbox"/> 1 - Yes <input type="checkbox"/> NA - Patient on prophylactic treatment <input type="checkbox"/> UK - Unknown </p>
DEFINITION:
Identifies treatment of urinary tract infection during the past 14 days.
TIME POINTS ITEM(S) COMPLETED:
Start of care Resumption of care Discharge from agency – not to inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • If 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, mark Response 0 – No. • Answer “Yes” when the patient had a UTI for which the patient received treatment during the past 14 days. • Note that if the patient is on prophylactic treatment to prevent UTIs, the appropriate response is “NA.” • If the patient is on prophylactic treatment <u>and</u> develops a UTI, mark Response 1 – Yes. • At discharge, omit "UK - Unknown."
ASSESSMENT STRATEGIES:
Interview for symptoms and treatment in past health history. Review referral orders. Question the patient about new medications. Confirm with physician if necessary.

OASIS ITEM:
(M0520) Urinary Incontinence or Urinary Catheter Presence: <ul style="list-style-type: none"> <input type="checkbox"/> 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) [If No, go to M0540] <input type="checkbox"/> 1 - Patient is incontinent <input type="checkbox"/> 2 - Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) [Go to M0540]
DEFINITION:
Identifies presence of urinary incontinence or condition that requires urinary catheterization of any type, including intermittent or indwelling. The etiology (cause) of incontinence is not addressed in this item.
TIME POINTS ITEM(S) COMPLETED:
Start of care Resumption of care Follow-up Discharge from agency - not to inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • If the patient has anuria or an ostomy for urinary drainage (e.g., an ileal conduit), mark Response 0. • If the patient is incontinent AT ALL (i.e., “occasionally”, “only once-in-a-while”, “sometimes I leak a little bit”, etc.), mark Response 1. • If the patient requires the use of a urinary catheter for any reason (retention, post-surgery, incontinence, etc.), mark Response 2. • If the patient is <u>both</u> incontinent and requires a urinary catheter, mark Response 2 and follow the skip pattern. • A leaking urinary drainage appliance is not incontinence.
ASSESSMENT STRATEGIES:
Review the urinary elimination pattern as you take the health history. Does the patient admit having difficulty controlling the urine, or is he/she embarrassed about needing to wear a pad so as not to wet on clothing? Do you have orders to change a catheter? Is your stroke patient using an external catheter? Be alert for an odor of urine, which might indicate there is a problem with bladder sphincter control. If the patient receives aide services for bathing and/or dressing, ask for input from the aide (at follow-up assessment). This information can then be discussed with the patient. Urinary incontinence may result from multiple causes, including physiologic reasons, cognitive impairments, or mobility problems.

OASIS ITEM:
(M0530) When does Urinary Incontinence occur? <input type="checkbox"/> 0 - Timed-voiding defers incontinence <input type="checkbox"/> 1 - During the night only <input type="checkbox"/> 2 - During the day and night
DEFINITION:
Identifies the time of day when the urinary incontinence occurs.
TIME POINTS ITEM(S) COMPLETED:
Start of care Resumption of care Follow-up Discharge from agency - not to inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none">• If patient is only “occasionally” incontinent, determine when the incontinence usually occurs.• Any incontinence that occurs during the day should be marked with Response 2.
ASSESSMENT STRATEGIES:
Once the existence of incontinence is known, ask when the incontinence occurs.

OASIS ITEM:
(M0540) Bowel Incontinence Frequency: <ul style="list-style-type: none"> <input type="checkbox"/> 0 - Very rarely or never has bowel incontinence <input type="checkbox"/> 1 - Less than once weekly <input type="checkbox"/> 2 - One to three times weekly <input type="checkbox"/> 3 - Four to six times weekly <input type="checkbox"/> 4 - On a daily basis <input type="checkbox"/> 5 - More often than once daily <input type="checkbox"/> NA - Patient has ostomy for bowel elimination <input type="checkbox"/> UK - Unknown
DEFINITION:
<p>Identifies how often the patient experiences bowel incontinence. Refers to the frequency of a symptom (bowel incontinence), not to the etiology (cause) of that symptom. This item does <u>not</u> address treatment of incontinence or constipation (e.g., a bowel program).</p>
TIME POINTS ITEM(S) COMPLETED:
Start of care Resumption of care Follow-up Discharge from agency - not to inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • Responses are arranged in order of least to most frequency of bowel incontinence. • Response "NA" is used if patient has an ostomy for bowel elimination. • At follow-up and discharge, omit "UK - Unknown."
ASSESSMENT STRATEGIES:
<p>Review the bowel elimination pattern as you take the health history. Observe the cleanliness around the toilet when you are in the bathroom. Note any visible evidence of soiled clothing. Ask the patient if she/he has difficulty controlling stools, has problems with soiling clothing, uncontrollable diarrhea, etc. The patient's responses to these items may make you aware of (an as yet unidentified) problem which needs further investigation. If the patient is receiving aide services, question the aide about evidence of bowel incontinence at follow-up time points. This information can then be discussed with the patient. Incontinence may result from multiple causes, including physiologic reasons, mobility problems, or cognitive impairments.</p>

OASIS ITEM:

(M0550) Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay, or b) necessitated a change in medical or treatment regimen?

- ☐ 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.

DEFINITION:

Identifies whether the patient has an ostomy for bowel elimination and, if so, whether the ostomy was related to a recent inpatient stay or a change in medical treatment plan.

TIME POINTS ITEM(S) COMPLETED:

Start of care
 Resumption of care
 Follow-up
 Discharge from agency - not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Applies to any type of ostomy for bowel elimination (i.e., colostomy, ileostomy, etc.).
- If patient does not have an ostomy for bowel elimination, the correct response is 0 - Patient does not have an ostomy for bowel elimination.
- If an ostomy has been reversed, then the patient does not have an ostomy at the time of assessment.
- If the patient does have an ostomy for bowel elimination, determine whether the ostomy was related to an inpatient stay or change in the medical or treatment regimen.
- At discharge, omit references to inpatient facility stay.

ASSESSMENT STRATEGIES:

Unless an ostomy is mentioned in the referral orders, interview the patient about the presence of an ostomy (or you may have done so when responding to M0540). If the patient has such an ostomy, determine by asking the patient or the physician, whether there have been recent problems with the ostomy, which have necessitated an inpatient facility stay or a change in the medical or treatment regimen.

**OASIS ITEMS M0560 through M0590, M0610, and M0620:
Neuro/Emotional/Behavioral Status Assessment**

The next group of OASIS items (M0560 through M0590, M0610, and M0620) addresses aspects of the home care patient's neurologic and mental status. The objective of this portion of the patient assessment is to determine those mental processes or thoughts that interfere with the individual's ability to reach optimal level of function. This assessment includes observation of the patient during the entire assessment process, as well as interview strategies to obtain more specific data about the patient's behavior and interactions with the environment. In addition to the patient, the family, caregiver, physician, or past health history all are important data sources for this assessment.

Observation. The clinician carefully observes the patient's: (1) posture and motor behavior, (2) manner of dress, (3) facial expressions, (4) grooming and personal hygiene, (5) affect, and (6) manner of speech. All are indicators of the patient's mental status.

Interview. The interview (of the patient or others) involves a combination of asking questions and waiting as the patient provides the answers in his/her own words. The interview allows the clinician to assess the patient's orientation, attention span, and memory. The clinician begins the interview with open-ended (less directive) questions and proceeds to more specific information gathering as the patient responds. In the interview process, the patient's own perception of his/her mood and how this has varied with current health status is explored. The clinician may begin by reporting observations of behavior or mood to the patient: "I notice that you ----." This is followed by assessment of symptoms related to thought processes and behavior, similar to the investigation of physical symptoms such as pain or bleeding. If no symptoms are present, no detailed investigation is warranted; if symptoms are present, a more detailed assessment is necessary. In addition to interview questions about mood or feelings, data concerning current sleep habits, appetite changes, and weight changes are also relevant to the mental status assessment.

An interview protocol to assist the clinician in assessing the patient's current emotional status might include the following suggested questions. If no indications of mood or affective disturbance are present in response to the first few questions, the clinician need not follow the entire protocol. If these indications are present, then follow-up questions are needed.

Can you describe your mood for me?
How are your spirits?
Do you feel this way most of the time?
Are you happy (or unhappy) most of the time?
Have you noticed any change in your feelings or your mood?
Has there been any change in your interest in daily activities?
Have you noticed any change in your outlook on life?
Do you let people know how you feel?
How do you feel life has treated you?
What does the future look like? (If a negative reply, Do things look hopeless?)

Additional assessment strategies are found with each OASIS item in this section.

OASIS ITEM:
<p>(M0560) Cognitive Functioning: (Patient's current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently. <input type="checkbox"/> 1 - Requires prompting (cueing, repetition, reminders) only under stressful or unfamiliar conditions. <input type="checkbox"/> 2 - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility. <input type="checkbox"/> 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time. <input type="checkbox"/> 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.
DEFINITION:
<p>Identifies the patient's current level of cognitive functioning, including alertness, orientation, comprehension, concentration, and immediate memory for simple commands.</p>
TIME POINTS ITEM(S) COMPLETED:
<p>Start of care Resumption of care Discharge from agency - not to inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • Refers to patient's usual level of functioning. • Level of cognitive impairment increases as you move down the list of responses.
ASSESSMENT STRATEGIES:
<p>The patient's description of current illness, past health history, and ability to perform ADLs and IADLs allows the clinician to assess cognitive functioning through observation. If the patient is having trouble remembering questions, ask if this is common or because a stranger is asking a lot of questions. Does the patient have trouble remembering friends and/or relatives' names? Does the patient forget to eat or bathe, or get disoriented when walking or traveling (in a car) around the neighborhood or city? If there is a caregiver in the home, gather information from that person also.</p>

OASIS ITEM:
(M0570) When Confused (Reported or Observed): <ul style="list-style-type: none"> <input type="checkbox"/> 0 - Never <input type="checkbox"/> 1 - In new or complex situations only <input type="checkbox"/> 2 - On awakening or at night only <input type="checkbox"/> 3 - During the day and evening, but not constantly <input type="checkbox"/> 4 - Constantly <input type="checkbox"/> NA - Patient nonresponsive
DEFINITION:
Identifies the time of day the patient is likely to be confused, if at all.
TIME POINTS ITEM(S) COMPLETED:
Start of care Resumption of care Discharge from agency - not to inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> If it is reported that the patient is “occasionally” confused, identify the situation(s) in which confusion occurs. “Nonresponsive” means that the patient is unable to respond.
ASSESSMENT STRATEGIES:
Information can be collected by observation or by report. Observe patient's response to questions about current health status, past health history, symptoms, and ability to perform ADLs and IADLs. Ask the patient whether or not he/she ever feels somewhat confused (e.g., “you don’t know where you are or how you got here”), and under what circumstances that occurs. Is there a change in attention span? Has recent memory declined? Mild confusion can be masked in patients with well-developed social skills, so careful assessment is needed. If a caregiver or family member is present, they may be able to describe their observations.

OASIS ITEM:
(M0580) When Anxious (Reported or Observed): <ul style="list-style-type: none"> <input type="checkbox"/> 0 - None of the time <input type="checkbox"/> 1 - Less often than daily <input type="checkbox"/> 2 - Daily, but not constantly <input type="checkbox"/> 3 - All of the time <input type="checkbox"/> NA - Patient nonresponsive
DEFINITION:
Identifies the frequency with which the patient feels anxious.
TIME POINTS ITEM(S) COMPLETED:
Start of care Resumption of care Discharge from agency - not to inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • “Nonresponsive” means that the patient is unable to respond. • Responses appear in order of increasing frequency of anxiety.
ASSESSMENT STRATEGIES:
Information can be collected by observation or by report. Observe posture, motor behavior, facial expressions, affect, and manner of speech. Ask the patient if she/he ever has episodes of feeling very anxious about things. Does the patient wake up at night feeling fearful and anxious and possibly unable to go back to sleep? Is there an increase in irritability or restlessness? Anxiety is often prevalent in patients with chronic respiratory disease, so you may be able to relate the anxiety to increased respiratory difficulty. Consult with family member(s) or caregiver with knowledge of patient behavior.

OASIS ITEM:
(M0590) Depressive Feelings Reported or Observed in Patient: (Mark all that apply.) <ul style="list-style-type: none"> <input type="checkbox"/> 1 - Depressed mood (e.g., feeling sad, tearful) <input type="checkbox"/> 2 - Sense of failure or self reproach <input type="checkbox"/> 3 - Hopelessness <input type="checkbox"/> 4 - Recurrent thoughts of death <input type="checkbox"/> 5 - Thoughts of suicide <input type="checkbox"/> 6 - None of the above feelings observed or reported
DEFINITION:
Identifies presence of symptoms of depression.
TIME POINTS ITEM(S) COMPLETED:
Start of care Resumption of care Discharge from agency - not to an inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> Feelings may be observed by the clinician or reported by the patient, family, or others.
ASSESSMENT STRATEGIES:
Observe for indicators of these feelings throughout the assessment. Validate initial impressions with interview questions, (e.g., "I noticed that---. Can you describe your mood for me?"). Follow the suggested protocol on page 8.82 to assess for presence of any depressive symptoms. If depressive feelings are present, inquire about the presence of suicidal thoughts. (If suicidal thoughts are present, inquire whether these have evolved into a plan for self-harm.)

OASIS ITEM:
(M0610) Behaviors Demonstrated at Least Once a Week (Reported or Observed): (Mark all that apply.) <ul style="list-style-type: none"> <input type="checkbox"/> 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required <input type="checkbox"/> 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions <input type="checkbox"/> 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc. <input type="checkbox"/> 4 - Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects) <input type="checkbox"/> 5 - Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions) <input type="checkbox"/> 6 - Delusional, hallucinatory, or paranoid behavior <input type="checkbox"/> 7 - None of the above behaviors demonstrated
DEFINITION:
Identifies specific behaviors which may reflect alterations in a patient's cognitive or neuro/emotional status.
TIME POINTS ITEM(S) COMPLETED:
Start of care Resumption of care Discharge from agency - not to an inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • Behaviors may be observed by the clinician or reported by the patient, family, or others.
ASSESSMENT STRATEGIES:
Observe patient for the presence of these behaviors throughout the entire assessment. If present, validate the frequency of their occurrence. In the health history, interview for the current presence of these behaviors at the stated frequency, i.e., at least weekly. Consult with family or caregiver familiar with patient behavior.

OASIS ITEM:
<p>(M0620) Frequency of Behavior Problems (Reported or Observed) (e.g., wandering episodes, self abuse, verbal disruption, physical aggression, etc.):</p> <p> <input type="checkbox"/> 0 - Never <input type="checkbox"/> 1 - Less than once a month <input type="checkbox"/> 2 - Once a month <input type="checkbox"/> 3 - Several times each month <input type="checkbox"/> 4 - Several times a week <input type="checkbox"/> 5 - At least daily </p>
DEFINITION:
<p>Identifies frequency of behavior problems which may reflect an alteration in a patient's cognitive or neuro/emotional status. "Behavior problems" are not limited to only those identified in M0610. For example, "wandering" is included as an additional behavior problem. Any behavior of concern for the patient's safety or social environment can be regarded as a problem behavior.</p>
TIME POINTS ITEM(S) COMPLETED:
<p>Start of care Resumption of care Discharge from agency - not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> Behavior problems may be observed by the clinician or reported by the patient, family, or others.
ASSESSMENT STRATEGIES:
<p>Observe patient for the presence of these behaviors throughout the entire assessment. If present, validate the frequency of their occurrence. In the health history, interview for the presence of these behaviors at the stated frequency, over a period of time sufficient to determine the current frequency of occurrence. Consult with family or caregiver familiar with patient behavior.</p>

OASIS ITEM:

(M0630) Is this patient receiving **Psychiatric Nursing Services** at home provided by a qualified psychiatric nurse?

- ☐ 0 - No
☐ 1 - Yes

DEFINITION:

Identifies whether the patient is receiving psychiatric nursing services at home as provided by a qualified psychiatric nurse. "Psychiatric nursing services" address mental/emotional needs; a "qualified psychiatric nurse" is so qualified through educational preparation or experience.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:**ASSESSMENT STRATEGIES:**

If the clinician performing the assessment is not the qualified psychiatric nurse, review the current plan of care to determine whether such services are currently being provided.

**OASIS ITEMS M0640 through M0820:
Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)**

The next group of OASIS items (M0640 through M0820) addresses the patient's functional status. Level of functioning is an important indicator of the patient's ability to remain in the home setting, as the goals of many home care interventions are to assist the patient to restore capability or to maintain maximum capacity as long as possible. Patient functioning is not the domain of only one professional group, but typically requires coordinated efforts among disciplines to achieve functional goals.

Activities of Daily Living (ADLs) include basic self-care activities (e.g., bathing, grooming, dressing, etc.), while Instrumental Activities of Daily Living (IADLs) include activities associated with independent living necessary to support the ADLs (e.g., housekeeping, laundry, shopping, etc.). IADLs usually require some degree of both cognitive and physical ability. Because home care patients have health-related needs, OASIS IADL items include management of medications and health-care related equipment.

The clinician should complete the OASIS items according to the patient's ABILITY, not necessarily actual performance for the defined item. "Willingness" and "compliance" are not the focus of these items. The patient who is able to bathe in the shower with assistance, but chooses to sponge bathe independently at the sink, should be scored on ability to bathe in tub/shower, not actual performance.

These items address the patient's ability to safely perform the specified activities, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a wholistic perspective in assessing ability to perform ADLs and IADLs. Ability can be temporarily or permanently limited by:

- physical impairments (e.g., limited range of motion, impaired balance)
- emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
- sensory impairments, (e.g., impaired vision or hearing, pain)
- environmental barriers (e.g., stairs, narrow doorways, location of bathroom or laundry).

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, choose the response describing the patient's ability more than 50% of the time.

Direct observation, supplemented by interview, is the preferred method for assessing a patient's ADL and IADL abilities. If direct observation of an activity is not possible, item score(s) should be based on all observed and reported information available. Specific assessment strategies for each OASIS ADL/IADL item are included with the item definitions.

All OASIS ADL/IADL scales present the most independent level first, then proceed to the most dependent. The word "unable" is underlined the first time it describes a change from "able" to "unable" in the responses. Read each response carefully to determine which one best describes what the patient is able to do.

The "current" ADL/IADL status must be completed for all assessments. "Prior" status is included for start (or resumption) of care. Prior refers to the patient's status 14 days before the start/resumption of care. Adhere rigidly to the 14-day criterion: If the patient was in a hospital at that time, describe the ADL/IADL status as of that day. Obtaining prior status information nearly always requires an interview approach.

OASIS ITEM:	
(M0640) Grooming: Ability to tend to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care).	
Prior	Current
<input type="checkbox"/>	<input type="checkbox"/> 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods.
<input type="checkbox"/>	<input type="checkbox"/> 1 - Grooming utensils must be placed within reach before able to complete grooming activities.
<input type="checkbox"/>	<input type="checkbox"/> 2 - Someone must assist the patient to groom self.
<input type="checkbox"/>	<input type="checkbox"/> 3 - Patient depends entirely upon someone else for grooming needs.
<input type="checkbox"/>	UK - Unknown
DEFINITION:	
Identifies the patient's ability to tend to personal hygiene needs, excluding bathing. The prior column should describe the patient's ability <u>14 days prior to the start (or resumption) of care visit</u> . The focus for today's assessment – the "current" column – is on what the patient is <u>able</u> to do today.	
TIME POINTS ITEM(S) COMPLETED:	
Start of care - prior and current ability Resumption of care - prior and current ability Discharge from agency - not to an inpatient facility -- current ability	
RESPONSE—SPECIFIC INSTRUCTIONS:	
<ul style="list-style-type: none"> Grooming includes several activities. The frequency with which selected activities are necessary (i.e., washing face and hands vs. fingernail care) must be considered in responding. Patients able to do more frequently performed activities but unable to do less frequently performed activities should be considered to have more grooming ability. Response 2 includes standby assistance or verbal cueing. "UK - Unknown" is an option only in the "Prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item. 	
ASSESSMENT STRATEGIES:	
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Observe the patient gathering equipment needed for grooming. The patient can verbally report the procedure used for grooming and demonstrate the motions utilized in grooming (e.g., hand to head for combing, hand to mouth for teeth care, etc.). The clinician should also observe the general appearance of the patient (to assess grooming deficiencies) and verify upper extremity strength, coordination, and manual dexterity to determine if the patient requires assistance with grooming. A poorly groomed patient who possesses the coordination, manual dexterity, upper-extremity range of motion, and cognitive/emotional status to perform grooming activities should be evaluated according to his/her ability to groom.	

OASIS ITEM:	
(M0650) Ability to Dress <u>Upper</u> Body (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:	
<u>Prior</u>	<u>Current</u>
<input type="checkbox"/>	<input type="checkbox"/> 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
<input type="checkbox"/>	<input type="checkbox"/> 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.
<input type="checkbox"/>	<input type="checkbox"/> 2 - Someone must help the patient put on upper body clothing.
<input type="checkbox"/>	<input type="checkbox"/> 3 - Patient depends entirely upon another person to dress the upper body.
<input type="checkbox"/>	<input type="checkbox"/> UK - Unknown
DEFINITION:	
Identifies the patient's ability to dress upper body, including the ability to obtain, put on and remove upper body clothing. The prior column should describe the patient's ability <u>14 days prior to the start (or resumption) of care visit</u> . The focus for today's assessment – the "current" column – is on what the patient is <u>able</u> to do today.	
TIME POINTS ITEM(S) COMPLETED:	
Start of care - prior and current ability Resumption of care - prior and current ability Follow-up - current ability Discharge from agency - not to an inpatient facility -- current ability	
RESPONSE—SPECIFIC INSTRUCTIONS:	
<ul style="list-style-type: none"> If the patient requires standby assistance (a "spotter") to dress <u>safely</u> or requires verbal cueing/reminders, then Response 2 applies. "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item. 	
ASSESSMENT STRATEGIES:	
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient if he/she has difficulty dressing upper body. Observe the patient's general appearance and clothing to determine if the patient has been able to dress appropriately. Opening and removing upper body garments during the physical assessment of the heart and lung provides an excellent opportunity to evaluate the upper extremity range of motion, coordination, and manual dexterity needed for dressing. The patient can also be asked to demonstrate the body motions involved in dressing. Assess ability to put on whatever clothing is routinely worn.	

OASIS ITEM:

(M0660) Ability to Dress Lower Body (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

Prior Current

- | | | | | |
|--------------------------|--------------------------|----|---|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 | - | Able to obtain, put on, and remove clothing and shoes without assistance. |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 | - | Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 | - | Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3 | - | Patient depends entirely upon another person to dress lower body. |
| <input type="checkbox"/> | | UK | - | Unknown |

DEFINITION:

Identifies the patient's ability to dress lower body, including the ability to obtain, put on and remove lower body clothing. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

TIME POINTS ITEM(S) COMPLETED:

Start of care - prior and current ability
 Resumption of care - prior and current ability
 Follow-up - current ability
 Discharge from agency - not to an inpatient facility -- current ability

RESPONSE—SPECIFIC INSTRUCTIONS:

- If the patient must apply a lower-extremity prosthesis, this prosthesis should be considered as part of the lower-body apparel.
- If the patient requires standby assistance (a "spotter") to dress safely or verbal cueing/reminders, Response 2 applies.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

ASSESSMENT STRATEGIES:

A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. The patient can report the lower body dressing procedure. Observe spinal flexion, joint range of motion, shoulder and upper arm strength, and manual dexterity during the assessment. Ask the patient to demonstrate the body motions involved in dressing. Assess ability to put on whatever clothing is routinely worn.

OASIS ITEM:	
(M0670) Bathing: Ability to wash entire body. <u>Excludes grooming (washing face and hands only).</u>	
Prior	Current
<input type="checkbox"/>	<input type="checkbox"/> 0 - Able to bathe self in <u>shower or tub</u> independently.
<input type="checkbox"/>	<input type="checkbox"/> 1 - With the use of devices, is able to bathe self in shower or tub independently.
<input type="checkbox"/>	<input type="checkbox"/> 2 - Able to bathe in shower or tub with the assistance of another person: (a) for intermittent supervision or encouragement or reminders, <u>OR</u> (b) to get in and out of the shower or tub, <u>OR</u> (c) for washing difficult to reach areas.
<input type="checkbox"/>	<input type="checkbox"/> 3 - Participates in bathing self in shower or tub, <u>but</u> requires presence of another person throughout the bath for assistance or supervision.
<input type="checkbox"/>	<input type="checkbox"/> 4 - <u>Unable</u> to use the shower or tub and is bathed in <u>bed or bedside chair</u> .
<input type="checkbox"/>	<input type="checkbox"/> 5 - Unable to effectively participate in bathing and is totally bathed by another person.
<input type="checkbox"/>	<input type="checkbox"/> UK - Unknown
DEFINITION:	
Identifies the patient's ability to bathe entire body and the assistance which may be required to <u>safely</u> bathe in shower or tub. The prior column should describe the patient's ability <u>14 days prior to the start (or resumption) of care visit</u> . The focus for today's assessment – the "current" column – is on what the patient is <u>able</u> to do today.	
TIME POINTS ITEM(S) COMPLETED:	
Start of care - prior and current ability Resumption of care - prior and current ability Follow-up - current ability Discharge from agency - not to an inpatient facility -- current ability	
RESPONSE—SPECIFIC INSTRUCTIONS:	
<ul style="list-style-type: none"> The patient who bathes independently at the sink must be assessed in relation to his/her ability to bathe in tub or shower. Is assistance needed for the patient to bathe in tub or shower? If so, what type of assistance? "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item. If the patient requires standby assistance to bathe <u>safely</u> in the tub or shower or requires verbal cueing/reminders, then Response 2 or Response 3 applies, depending on the quantity of assistance needed. If a patient is medically restricted from stair climbing, and the only tub/shower requires climbing stairs, the patient is temporarily unable to bathe in the tub or shower due to combined medical restrictions and environmental barriers. Response 4 or 5 would apply, depending on the patient's ability to participate in bathing activities. If the patient's ability to transfer into/out of the tub or shower is the <u>only</u> bathing task requiring human assistance, Response 0 or 1 would apply, depending on the need for devices to safely perform the task independently. 	
ASSESSMENT STRATEGIES:	
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient what type of assistance is needed to wash entire body in tub or shower. Observe the patient's general appearance to determine if the patient has been able to bathe self as needed. Observe patient actually stepping into shower or tub to determine how much assistance the patient needs to perform the activity safely. The patient who only performs a sponge bath may be able to bathe in the tub or shower if person or device is available to assist. Evaluate the amount of assistance needed for the patient to be able to <u>safely</u> bathe in tub or shower.	

OASIS ITEM:**(M0680) Toileting:** Ability to get to and from the toilet or bedside commode.

Prior Current

- | | | | | |
|--------------------------|--------------------------|----|---|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 | - | Able to get to and from the toilet independently with or without a device. |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 | - | When reminded, assisted, or supervised by another person, able to get to and from the toilet. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 | - | <u>Unable</u> to get to and from the toilet but is able to use a bedside commode (with or without assistance). |
| <input type="checkbox"/> | <input type="checkbox"/> | 3 | - | <u>Unable</u> to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently. |
| <input type="checkbox"/> | <input type="checkbox"/> | 4 | - | Is totally dependent in toileting. |
| <input type="checkbox"/> | | UK | - | Unknown |

DEFINITION:

Identifies the patient's ability to safely get to and from the toilet or bedside commode. Excludes personal hygiene and management of clothing when toileting. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

TIME POINTS ITEM(S) COMPLETED:

Start of care - prior and current ability
 Resumption of care - prior and current ability
 Follow-up - current ability
 Discharge from agency - not to an inpatient facility -- current ability

RESPONSE—SPECIFIC INSTRUCTIONS:

- If the patient requires standby assistance to get to and from the toilet safely or requires verbal cueing/reminders, then Response 1 applies.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.
- If the patient can get to and from the toilet during the day, but uses the commode at night for "convenience," Response 0 applies.

ASSESSMENT STRATEGIES:

A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient if he/she has any difficulty getting to and from the toilet or bedside commode. Observe the patient during transfer and ambulation to determine if the patient has difficulty with balance, strength, dexterity, pain, etc. Determine the level of assistance needed by the patient to safely use the toilet or commode. Tasks related to personal hygiene and management of clothing are not considered when responding to this item.

OASIS ITEM:	
<p>(M0690) Transferring: Ability to move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if patient is bedfast.</p>	
Prior	Current
<input type="checkbox"/>	<input type="checkbox"/> 0 - Able to independently transfer.
<input type="checkbox"/>	<input type="checkbox"/> 1 - Transfers with minimal human assistance or with use of an assistive device.
<input type="checkbox"/>	<input type="checkbox"/> 2 - <u>Unable</u> to transfer self but is able to bear weight and pivot during the transfer process.
<input type="checkbox"/>	<input type="checkbox"/> 3 - Unable to transfer self and is <u>unable</u> to bear weight or pivot when transferred by another person.
<input type="checkbox"/>	<input type="checkbox"/> 4 - Bedfast, unable to transfer but is able to turn and position self in bed.
<input type="checkbox"/>	<input type="checkbox"/> 5 - Bedfast, unable to transfer and is <u>unable</u> to turn and position self.
<input type="checkbox"/>	UK - Unknown
DEFINITION:	
<p>Identifies the patient's ability to <u>safely</u> transfer in a variety of situations. The prior column should describe the patient's ability <u>14 days prior to the start (or resumption) of care visit</u>. The focus for today's assessment – the "current" column – is on what the patient is <u>able</u> to do today.</p>	
TIME POINTS ITEM(S) COMPLETED:	
<p>Start of care - prior and current ability Resumption of care - prior and current ability Follow-up - current ability Discharge from agency - not to an inpatient facility -- current ability</p>	
RESPONSE—SPECIFIC INSTRUCTIONS:	
<ul style="list-style-type: none"> • If the patient is able to transfer self, but requires standby assistance to transfer <u>safely</u>, or requires verbal cueing/reminders, then Response 1 applies. • Able to bear weight refers to the patient's ability to support the majority of his/her body weight through any combination of weight-bearing extremities (e.g., a patient with a weight-bearing restriction of one lower extremity may be able to support his/her entire weight through the other lower extremity and upper extremities). • The patient must be able to <u>both</u> bear weight and pivot for Response 2 to apply. If the patient is unable to do one or the other, then Response 3 must be selected. • If the patient is bedfast, the ability to turn and position self in bed is assessed. • "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item. 	
ASSESSMENT STRATEGIES:	
<p>A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about transferring ability. Taking extra time or pushing up with both arms can help ensure the patient's stability and safety during the transfer process, but they do not mean that the patient is not independent. Observe the patient during transfers and determine the amount of assistance required for <u>safe</u> transfer. If ability varies between the transfer activities listed, record the level of ability applicable to the majority of those activities. When the patient demonstrates ambulation/locomotion, shows the clinician to the bathroom/kitchen, and demonstrates ability to get into and out of tub/shower, transferring can be assessed simultaneously.</p>	

OASIS ITEM:	
<p>(M0700) Ambulation/Locomotion: Ability to <u>SAFELY</u> walk, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.</p>	
Prior	Current
<input type="checkbox"/>	<input type="checkbox"/> 0 - Able to independently walk on even and uneven surfaces and climb stairs with or without railings (i.e., needs no human assistance or assistive device).
<input type="checkbox"/>	<input type="checkbox"/> 1 - Requires use of a device (e.g., cane, walker) to walk alone <u>or</u> requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
<input type="checkbox"/>	<input type="checkbox"/> 2 - Able to walk only with the supervision or assistance of another person at all times.
<input type="checkbox"/>	<input type="checkbox"/> 3 - Chairfast, <u>unable</u> to ambulate but is able to wheel self independently.
<input type="checkbox"/>	<input type="checkbox"/> 4 - Chairfast, unable to ambulate and is <u>unable</u> to wheel self.
<input type="checkbox"/>	<input type="checkbox"/> 5 - Bedfast, unable to ambulate or be up in a chair.
<input type="checkbox"/>	<input type="checkbox"/> UK - Unknown
DEFINITION:	
<p>Identifies the patient's ability and the type of assistance required to <u>safely</u> ambulate or propel self in a wheelchair over a variety of surfaces. The prior column should describe the patient's ability <u>14 days prior to the start (or resumption) of care visit</u>. The focus for today's assessment – the "current" column – is on what the patient is <u>able</u> to do today.</p>	
TIME POINTS ITEM(S) COMPLETED:	
<p>Start of care - prior and current ability Resumption of care - prior and current ability Follow-up - current ability Discharge from agency - not to an inpatient facility -- current ability</p>	
RESPONSE—SPECIFIC INSTRUCTIONS:	
<ul style="list-style-type: none"> • If the patient requires standby assistance to <u>safely</u> ambulate or requires verbal cueing/reminders, then Response 1 or Response 2 applies, depending on the quantity of assistance needed. • Responses 3 and 4 refer to a patient who is unable to ambulate, even with the use of assistive devices and assistance. A patient who demonstrates or reports ability to take one or two steps to complete a transfer, but is otherwise unable to ambulate should be considered chairfast, and would be scored 3 or 4, based on ability to wheel self. • "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item. • Medical restrictions should be taken into consideration (as with all other ADL items), as the restrictions address what the patient is able to do safely. 	
ASSESSMENT STRATEGIES:	
<p>A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about ambulation ability. Observe the patient ambulating across the room or to the bathroom and the type of assistance required. Note if the patient uses furniture or walls for support, and assess if patient should use a walker or cane for <u>safe</u> ambulation. Observe patient's ability and safety on stairs. If chairfast, assess ability to safely propel wheelchair independently, whether the wheelchair is a powered or manual version.</p>	

OASIS ITEM:	
(M0710) Feeding or Eating: Ability to feed self meals and snacks. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.	
Prior	Current
<input type="checkbox"/>	<input type="checkbox"/> 0 - Able to independently feed self.
<input type="checkbox"/>	<input type="checkbox"/> 1 - Able to feed self independently but requires: (a) meal set-up; <u>OR</u> (b) intermittent assistance or supervision from another person; <u>OR</u> (c) a liquid, pureed or ground meat diet.
<input type="checkbox"/>	<input type="checkbox"/> 2 - <u>Unable</u> to feed self and must be assisted or supervised throughout the meal/snack.
<input type="checkbox"/>	<input type="checkbox"/> 3 - Able to take in nutrients orally <u>and</u> receives supplemental nutrients through a nasogastric tube or gastrostomy.
<input type="checkbox"/>	<input type="checkbox"/> 4 - <u>Unable</u> to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
<input type="checkbox"/>	<input type="checkbox"/> 5 - Unable to take in nutrients orally or by tube feeding.
<input type="checkbox"/>	<input type="checkbox"/> UK - Unknown
DEFINITION:	
<p>Identifies the patient's ability to feed self meals, including the process of eating, chewing and swallowing food. This item <u>excludes</u> evaluation of the preparation of food items. The prior column should describe the patient's ability <u>14 days prior to the start (or resumption) of care visit</u>. The focus for today's assessment – the "current" column – is on what the patient is <u>able</u> to do today.</p>	
TIME POINTS ITEM(S) COMPLETED:	
<p>Start of care - prior and current ability Resumption of care - prior and current ability Discharge from agency - not to an inpatient facility -- current ability</p>	
RESPONSE—SPECIFIC INSTRUCTIONS:	
<ul style="list-style-type: none"> Meal "set-up" (in Response 1) includes activities such as mashing a potato, cutting up meat/vegetables when served, pouring milk on cereal, opening a milk carton, adding sugar to coffee or tea, arranging the food on the plate for ease of access, etc. -- all of which are special adaptations of the meal for the patient. Responses 3, 4, and 5 include non-oral intake. "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item. 	
ASSESSMENT STRATEGIES:	
<p>A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Determine the amount and type of assistance that is needed by the patient to feed himself/herself once the food is placed in front of him/her. During the nutritional assessment, determine whether special preparations (i.e., pureeing, grinding, etc.) must occur for food to be swallowed or whether tube feedings are necessary.</p>	

OASIS ITEM:	
(M0720) Planning and Preparing Light Meals (e.g., cereal, sandwich) or reheat delivered meals:	
Prior	Current
<input type="checkbox"/>	<input type="checkbox"/>
0	-
	(a) Able to independently plan and prepare all light meals for self or reheat delivered meals; <u>OR</u> (b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission).
<input type="checkbox"/>	<input type="checkbox"/>
1	-
	<u>Unable</u> to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
<input type="checkbox"/>	<input type="checkbox"/>
2	-
	Unable to prepare any light meals or reheat any delivered meals.
<input type="checkbox"/>	UK
	- Unknown
DEFINITION:	
Identifies the patient's physical, cognitive and mental ability to plan and prepare meals, even if the patient does not routinely perform this task. The prior column should describe the patient's ability <u>14 days prior to the start (or resumption) of care visit</u> . The focus for today's assessment – the "current" column – is on what the patient is <u>able</u> to do today.	
TIME POINTS ITEM(S) COMPLETED:	
Start of care - prior and current ability Resumption of care - prior and current ability Discharge from agency - not to an inpatient facility -- current ability	
RESPONSE—SPECIFIC INSTRUCTIONS:	
<ul style="list-style-type: none"> Response 1 indicates patient can intermittently (i.e., sometimes) prepare light meals, while Response 2 indicates patient cannot prepare light meals. "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item. 	
ASSESSMENT STRATEGIES:	
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about the ability to plan and prepare light meals even if this task is not routinely performed. Does the patient have the cognitive ability to plan and prepare light meals (whether or not he/she currently does this)? Utilize observations made during the assessment of cognitive status, ambulation, grooming, dressing, and other activities of daily living (ADLs) to assist in determining the best response to this item. The patient's own dietary requirements should be considered when evaluating the ability to plan and prepare light meals.	

OASIS ITEM:	
(M0730) Transportation: Physical and mental ability to <u>safely</u> use a car, taxi, or public transportation (bus, train, subway).	
Prior	Current
<input type="checkbox"/>	<input type="checkbox"/>
0	-
Able to independently drive a regular or adapted car; <u>OR</u> uses a regular or handicap-accessible public bus.	
<input type="checkbox"/>	<input type="checkbox"/>
1	-
Able to ride in a car only when driven by another person; <u>OR</u> able to use a bus or handicap van only when assisted or accompanied by another person.	
<input type="checkbox"/>	<input type="checkbox"/>
2	-
<u>Unable</u> to ride in a car, taxi, bus, or van, and requires transportation by ambulance.	
<input type="checkbox"/>	UK
	-
Unknown	
DEFINITION:	
Identifies the patient's physical and mental ability to safely use a car, taxi or public transportation. The prior column should describe the patient's ability <u>14 days prior to the start (or resumption) of care visit</u> . The focus for today's assessment – the “current” column – is on what the patient is <u>able</u> to do today.	
TIME POINTS ITEM(S) COMPLETED:	
Start of care - prior and current ability Resumption of care - prior and current ability Discharge from agency - not to an inpatient facility -- current ability	
RESPONSE—SPECIFIC INSTRUCTIONS:	
<ul style="list-style-type: none"> “UK - Unknown” is an option only in the “prior” column. This response should be used only if there is no way to determine the patient's prior ability on this item. 	
ASSESSMENT STRATEGIES:	
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about the ability to safely use transportation and the type of assistance required. Utilize observations made during the assessment of ambulation, transferring, and other activities of daily living (ADLs) to assist in determining the best response to this item.	

OASIS ITEM:	
(M0740) Laundry: Ability to do own laundry -- to carry laundry to and from washing machine, to use washer and dryer, to wash small items by hand.	
Prior	Current
<input type="checkbox"/>	<input type="checkbox"/> 0
	- (a) Able to independently take care of all laundry tasks; <u>OR</u> (b) Physically, cognitively, and mentally able to do laundry and access facilities, <u>but</u> has not routinely performed laundry tasks in the past (i.e., prior to this home care admission).
<input type="checkbox"/>	<input type="checkbox"/> 1
	- Able to do only light laundry, such as minor hand wash or light washer loads. Due to physical, cognitive, or mental limitations, needs assistance with heavy laundry such as carrying large loads of laundry.
<input type="checkbox"/>	<input type="checkbox"/> 2
	- <u>Unable</u> to do any laundry due to physical limitation or needs continual supervision and assistance due to cognitive or mental limitation.
<input type="checkbox"/>	UK
	- Unknown
DEFINITION:	
Identifies the patient's physical, cognitive, and mental ability to do laundry, even if the patient does not routinely perform this task. The prior column should describe the patient's ability <u>14 days prior to the start (or resumption) of care visit</u> . The focus for today's assessment – the "current" column – is on what the patient is <u>able</u> to do today.	
TIME POINTS ITEM(S) COMPLETED:	
Start of care - prior and current ability Resumption of care - prior and current ability Discharge from agency - not to an inpatient facility -- current ability	
RESPONSE—SPECIFIC INSTRUCTIONS:	
<ul style="list-style-type: none"> The ability to do laundry is impacted by the patient's environment (i.e., is the washing machine on the same floor, in the same building, etc.). The patient's ability to do laundry in his/her own environment should be considered in responding to this item. "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item. 	
ASSESSMENT STRATEGIES:	
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about ability to do laundry, even if this task is not routinely performed. Utilize observations made during the assessment of cognitive status, ambulation, transferring, and other activities of daily living to assist in determining the best response to this item. Awareness of the location of laundry facilities (from the environmental assessment) is also needed.	

OASIS ITEM:	
(M0750) Housekeeping: Ability to safely and effectively perform light housekeeping and heavier cleaning tasks.	
Prior	Current
<input type="checkbox"/>	<input type="checkbox"/>
0	-
	(a) Able to independently perform all housekeeping tasks; <u>OR</u> (b) Physically, cognitively, and mentally able to perform <u>all</u> housekeeping tasks but has not routinely participated in housekeeping tasks in the past (i.e., prior to this home care admission).
<input type="checkbox"/>	<input type="checkbox"/>
1	-
	Able to perform only <u>light</u> housekeeping (e.g., dusting, wiping kitchen counters) tasks independently.
<input type="checkbox"/>	<input type="checkbox"/>
2	-
	Able to perform housekeeping tasks with intermittent assistance or supervision from another person.
<input type="checkbox"/>	<input type="checkbox"/>
3	-
	<u>Unable</u> to consistently perform any housekeeping tasks unless assisted by another person throughout the process.
<input type="checkbox"/>	<input type="checkbox"/>
4	-
	Unable to effectively participate in any housekeeping tasks.
<input type="checkbox"/>	UK
	- Unknown
DEFINITION:	
Identifies the physical, cognitive and mental ability of the patient to perform both heavier and lighter housekeeping tasks, even if the patient does not routinely carry out these activities. The prior column should describe the patient's ability <u>14 days prior to the start (or resumption) of care visit</u> . The focus for today's assessment – the "current" column – is on what the patient is <u>able</u> to do today.	
TIME POINTS ITEM(S) COMPLETED:	
Start of care - prior and current ability Resumption of care - prior and current ability Discharge from agency - not to an inpatient facility -- current ability	
RESPONSE—SPECIFIC INSTRUCTIONS:	
<ul style="list-style-type: none"> "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item. 	
ASSESSMENT STRATEGIES:	
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about the ability to complete housekeeping, even if these tasks are not routinely performed. Utilize observations made during the assessment of cognitive status, ambulation, transferring, and other ADLs to assist in determining the best response to this item.	

OASIS ITEM:	
(M0760) Shopping: Ability to plan for, select, and purchase items in a store and to carry them home or arrange delivery.	
Prior	Current
<input type="checkbox"/>	<input type="checkbox"/>
0	-
	(a) Able to plan for shopping needs and independently perform shopping tasks, including carrying packages; <u>OR</u> (b) Physically, cognitively, and mentally able to take care of shopping, but has not done shopping in the past (i.e., prior to this home care admission).
<input type="checkbox"/>	<input type="checkbox"/>
1	-
	Able to go shopping, but needs some assistance: (a) By self is able to do only light shopping and carry small packages, but needs someone to do occasional major shopping; <u>OR</u> (b) <u>Unable</u> to go shopping alone, but can go with someone to assist.
<input type="checkbox"/>	<input type="checkbox"/>
2	-
	<u>Unable</u> to go shopping, but is able to identify items needed, place orders, and arrange home delivery.
<input type="checkbox"/>	<input type="checkbox"/>
3	-
	Needs someone to do all shopping and errands.
<input type="checkbox"/>	UK
	- Unknown
DEFINITION:	
Identifies the physical, cognitive and mental ability of the patient to plan for, select, and purchase items from a store, even if the patient does not routinely go shopping. The prior column should describe the patient's ability <u>14 days prior to the start (or resumption) of care visit</u> . The focus for today's assessment – the "current" column – is on what the patient is <u>able</u> to do today.	
TIME POINTS ITEM(S) COMPLETED:	
Start of care - prior and current ability Resumption of care - prior and current ability Discharge from agency - not to an inpatient facility -- current ability	
RESPONSE—SPECIFIC INSTRUCTIONS:	
<ul style="list-style-type: none"> "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item. 	
ASSESSMENT STRATEGIES:	
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about the ability to plan for, select, and purchase items from the store, even if these tasks are not routinely performed. How are medications, groceries, or needed medical supplies obtained? Utilize observations made during the assessment of cognitive status, ambulation, transferring, and other ADLs to assist in determining the best response to this item.	

OASIS ITEM:	
<p>(M0780) Management of Oral Medications: Patient's ability to prepare and take all prescribed oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. <u>Excludes</u> injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)</p>	
Prior	Current
<input type="checkbox"/>	<input type="checkbox"/> 0
	- Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
<input type="checkbox"/>	<input type="checkbox"/> 1
	- Able to take medication(s) at the correct times if:
	(a) individual dosages are prepared in advance by another person; <u>OR</u>
	(b) given daily reminders; <u>OR</u>
	(c) someone develops a drug diary or chart.
<input type="checkbox"/>	<input type="checkbox"/> 2
	- <u>Unable</u> to take medication unless administered by someone else.
<input type="checkbox"/>	<input type="checkbox"/> NA
	- No oral medications prescribed.
<input type="checkbox"/>	<input type="checkbox"/> UK
	- Unknown
DEFINITION:	
<p>Identifies the patient's ability to prepare and take oral medications reliably and safely and the type of assistance required to administer the correct dosage at the appropriate times/intervals. The focus is on what the patient is able to do, not on the patient's compliance or willingness. The prior column should describe the patient's ability <u>14 days prior to the start (or resumption) of care visit</u>. The focus for today's assessment - the "current" column is on what the patient is <u>able</u> to do today.</p>	
TIME POINTS ITEM(S) COMPLETED:	
<p>Start of care - prior and current ability Resumption of care - prior and current ability Discharge from agency - not to an inpatient facility -- current ability</p>	
RESPONSE—SPECIFIC INSTRUCTIONS:	
<ul style="list-style-type: none"> Exclude injectable and IV medications. "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item. Only medications whose route of administration is "po" should be considered for this item. Medications given per gastrostomy (or other) tube are <u>not</u> administered "po," but are administered "per tube." The patient who 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 would be considered independent in administration. If another person must create the medication list or set up the "planner device" for the patient, then Response 1 applies. 	
ASSESSMENT STRATEGIES:	
<p>A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Observe patient opening medication containers. Ask the patient to state the proper dosage for each medication and the correct times for administration. The cognitive/mental status and functional assessments contribute to determining the appropriate response for this item. If patient's ability to manage medications varies from medication to medication, consider total number of medications and total daily doses in determining what is true most of the time.</p>	

OASIS ITEM:	
<p>(M0790) Management of Inhalant/Mist Medications: Patient's ability to prepare and take <u>all</u> prescribed inhalant/mist medications (nebulizers, metered dose devices) reliably and safely, including administration of the correct dosage at the appropriate times/intervals. <u>Excludes all other forms of medication (oral tablets, injectable and IV medications).</u></p>	
Prior	Current
<input type="checkbox"/>	<input type="checkbox"/> 0 - Able to independently take the correct medication and proper dosage at the correct times.
<input type="checkbox"/>	<input type="checkbox"/> 1 - Able to take medication at the correct times if: (a) individual dosages are prepared in advance by another person, <u>OR</u> (b) given daily reminders.
<input type="checkbox"/>	<input type="checkbox"/> 2 - <u>Unable</u> to take medication unless administered by someone else.
<input type="checkbox"/>	<input type="checkbox"/> NA - No inhalant/mist medications prescribed.
<input type="checkbox"/>	<input type="checkbox"/> UK - Unknown
DEFINITION:	
<p>Identifies the patient's ability to prepare and take all prescribed inhalant/mist medication reliably and safely and the type of assistance required to administer the current dosage at the appropriate times/intervals. The focus is on what the patient is able to do, not on the patient's compliance or willingness. The prior column should describe the patient's ability <u>14 days prior to the start (or resumption) of care visit</u>. The focus for today's assessment - the "current" column is on what the patient is <u>able</u> to do today.</p>	
TIME POINTS ITEM(S) COMPLETED:	
<p>Start of care - prior and current ability Resumption of care - prior and current ability Discharge from agency - not to an inpatient facility -- current ability</p>	
RESPONSE—SPECIFIC INSTRUCTIONS:	
<ul style="list-style-type: none"> Exclude oral, injectable, and IV medications. If oxygen is included in the patient's medication regimen, consider it an inhalant medication for this item. "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item. 	
ASSESSMENT STRATEGIES:	
<p>A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Observe patient opening inhalant mist/medications and preparing any other equipment required for administration. 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.</p>	

OASIS ITEM:	
<p>(M0800) Management of Injectable Medications: Patient's <u>ability</u> to prepare and take <u>all</u> prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. <u>Excludes</u> IV medications.</p>	
Prior	Current
<input type="checkbox"/>	<input type="checkbox"/> 0 - Able to independently take the correct medication and proper dosage at the correct times.
<input type="checkbox"/>	<input type="checkbox"/> 1 - Able to take injectable medication at correct times if: (a) individual syringes are prepared in advance by another person, <u>OR</u> (b) given daily reminders.
<input type="checkbox"/>	<input type="checkbox"/> 2 - <u>Unable</u> to take injectable medications unless administered by someone else.
<input type="checkbox"/>	<input type="checkbox"/> NA - No injectable medications prescribed.
<input type="checkbox"/>	<input type="checkbox"/> UK - Unknown
DEFINITION:	
<p>Identifies the patient's ability to prepare and take all injectable medications reliably and safely and the type of assistance required to administer the correct dosage at the appropriate time/intervals. The focus is on what the patient is able to do, not on the patient's compliance or willingness. The prior column should describe the patient's ability <u>14 days prior to the start (or resumption) of care visit</u>. The focus for today's assessment - the "current" column is on what the patient is <u>able</u> to do today.</p>	
TIME POINTS ITEM(S) COMPLETED:	
<p>Start of care – prior and current ability Resumption of care – prior and current ability Follow-up – current ability Discharge from agency – not to an inpatient facility – current ability</p>	
RESPONSE—SPECIFIC INSTRUCTIONS:	
<ul style="list-style-type: none"> Exclude IV medications. "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item. 	
ASSESSMENT STRATEGIES:	
<p>A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Observe patient preparing the injectable medications. If it is not time for the medication, ask the patient to describe and demonstrate the steps for administration. The cognitive/mental status and functional assessments contribute to determining the appropriate response for this item.</p>	

OASIS ITEM:
<p>(M0810) Patient Management of Equipment (includes <u>ONLY</u> oxygen, IV/infusion therapy, enteral/parenteral nutrition equipment or supplies): <u>Patient's ability</u> to set up, monitor and change equipment reliably and safely, add appropriate fluids or medication, clean/store/dispose of equipment or supplies using proper technique. (NOTE: This refers to ability, not compliance or willingness.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0 - Patient manages all tasks related to equipment completely independently. <input type="checkbox"/> 1 - If someone else sets up equipment (i.e., fills portable oxygen tank, provides patient with prepared solutions), patient is able to manage all other aspects of equipment. <input type="checkbox"/> 2 - Patient requires considerable assistance from another person to manage equipment, but independently completes portions of the task. <input type="checkbox"/> 3 - Patient is only able to monitor equipment (e.g., liter flow, fluid in bag) and must call someone else to manage the equipment. <input type="checkbox"/> 4 - Patient is completely dependent on someone else to manage all equipment. <input type="checkbox"/> NA - No equipment of this type used in care [If NA, go to M0826]
DEFINITION:
<p>Identifies the patient's ability to set up, monitor and change equipment reliably and safely, and the amount of assistance required from another person. The focus is on what the patient is able to do, not on compliance or willingness.</p>
TIME POINTS ITEM(S) COMPLETED:
<p>Start of care Resumption of care Discharge from agency - not to inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • Include only management of oxygen, IV infusion therapy, enteral/parenteral nutrition, and ventilator therapy equipment and supplies. • If more than one type of equipment is used, consider the equipment for which the most assistance is needed. • If "NA" is selected at discharge, clinician should be instructed to skip to M0830.
ASSESSMENT STRATEGIES:
<p>Is any of the listed equipment used in care? (Note responses to M0250 and M0500 that address the specified equipment.) If so, a combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Observe the patient setting up and changing equipment. Ask the patient to describe the steps for monitoring and changing equipment if observation is not possible at the time of the home visit. Cognitive/mental status and functional assessments contribute to determining the response for this item.</p>

OASIS ITEM:
<p>(M0820) Caregiver Management of Equipment (includes <u>ONLY</u> oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies): <u>Caregiver's ability</u> to set up, monitor, and change equipment reliably and safely, add appropriate fluids or medication, clean/store/dispose of equipment or supplies using proper technique. (NOTE: This refers to ability, not compliance or willingness.)</p> <p> <input type="checkbox"/> 0 - Caregiver manages all tasks related to equipment completely independently. <input type="checkbox"/> 1 - If someone else sets up equipment, caregiver is able to manage all other aspects. <input type="checkbox"/> 2 - Caregiver requires considerable assistance from another person to manage equipment, but independently completes significant portions of task. <input type="checkbox"/> 3 - Caregiver is only able to complete small portions of task (e.g., administer nebulizer treatment, clean/store/dispose of equipment or supplies). <input type="checkbox"/> 4 - Caregiver is completely dependent on someone else to manage all equipment. <input type="checkbox"/> NA - No caregiver <input type="checkbox"/> UK - Unknown </p>
DEFINITION:
<p>Identifies the caregiver's ability to set up, monitor and change equipment reliably and safely. The focus is on what the caregiver is able to do, not on compliance or willingness. "Caregiver" is defined in M0360.</p>
TIME POINTS ITEM(S) COMPLETED:
<p>Start of care Resumption of care Discharge from agency - not to inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • The definition of equipment includes only oxygen, IV/infusion equipment, enteral/parenteral nutrition and ventilator therapy equipment or supplies. • If the patient has no caregiver, mark "NA." • If more than one type of equipment is used, consider the equipment for which the most assistance is needed. • At discharge, omit "UK - Unknown."
ASSESSMENT STRATEGIES:
<p>Is any of the listed equipment used in care? (Note responses to M0250 and M0500 that address the specified equipment.) If so, a combined observation/interview approach with the caregiver is required to determine the most accurate response for this item. Observe the caregiver setting up and changing the equipment. Ask the caregiver to describe the steps for monitoring and changing equipment if observation is not possible at the time of the home visit. Cognitive/mental status and functional ability of the caregiver (as evaluated during the visit) contribute to determining the response for this item.</p>

OASIS ITEM:
<p>(M0826) Therapy Need: In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? (Enter zero ["000"] if no therapy visits indicated.)</p> <p>(_ _ _) Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).</p> <p><input type="checkbox"/> NA - Not Applicable: No case mix group defined by this assessment.</p>
DEFINITION:
<p>Identifies the total number of therapy visits (physical, occupational or speech therapy combined) planned for the Medicare payment episode for which this assessment will determine the case mix group. 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.</p>
TIME POINTS ITEM(S) COMPLETED:
<p>Start of care Resumption of care Follow-up</p>
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • Answer "000" if no therapy services are needed. • Answer "Not Applicable" when this assessment will <u>not</u> be used to determine a Medicare case mix group. Usually, the "Not Applicable" response will be checked for patients whose payment source is not Medicare fee-for-service (i.e., M0150, Response 1 is not checked), or for an assessment that will <u>not</u> be used to determine a Medicare case mix group. However, payers other than the Medicare program may use this information in setting an episode payment rate. If the HHA needs a case mix code (HIPPS code) for billing purposes, a response to this item is required to generate the case mix code.
ASSESSMENT STRATEGIES:
<p>When the patient assessment and the care plan are complete, review the plan to determine whether therapy services are ordered by the physician. If not, answer "000." If therapy services <u>are</u> ordered, how many total visits are indicated over the 60-day payment episode? If the number of visits that will be needed is uncertain, provide your best estimate.</p> <p>The Medicare payment episode ordinarily comprises 60 days beginning with the start of care date, or 60 days beginning with the recertification date.</p>

OASIS ITEM:
<p>(M0830) Emergent Care: Since the last time OASIS data were collected, has the patient utilized any of the following services for emergent care (other than home care agency services)? (Mark all that apply.)</p> <p> <input type="checkbox"/> 0 - No emergent care services [If no emergent care, go to M0855] <input type="checkbox"/> 1 - Hospital emergency room (includes 23-hour holding) <input type="checkbox"/> 2 - Doctor's office emergency visit/house call <input type="checkbox"/> 3 - Outpatient department/clinic emergency (includes urgicenter sites) <input type="checkbox"/> UK - Unknown [If UK, go to M0855] </p>
DEFINITION:
<p>Identifies whether the patient received an unscheduled visit to any (emergent) medical services other than home care agency services. Emergent care services include all unscheduled visits occurring within 24 hours of the time the patient has contacted the medical services. A "prn" agency visit is <u>not</u> considered emergent care.</p>
TIME POINTS ITEM(S) COMPLETED:
<p>Transfer to an inpatient facility - with or without agency discharge Discharge from agency</p>
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • If a patient went to the ER, 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." It should be verified that the patient was not actually admitted to the inpatient facility; if such an admission occurred, then a transfer assessment is required in addition to the emergent care. • Exclude outpatient visits for scheduled diagnostic testing. • Responses to this item include the <u>entire</u> period since the last time OASIS data were collected, including current events. A patient who goes to the ER, then is admitted to the hospital, should be noted as having received emergent care. • A patient who dies in the ER is considered to have been under the care of the emergency room, not the home health agency. In this situation, a transfer assessment, not an assessment for "Death at Home," should be completed.
ASSESSMENT STRATEGIES:
<p>Ask the patient/caregiver if the patient has had any services for emergent care. Clarify that a doctor's office visit which is scheduled less than 24 hours in advance is considered an emergent care visit.</p>

OASIS ITEM:
<p>(M0840) Emergent Care Reason: For what reason(s) did the patient/family seek emergent care? (Mark all that apply.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis <input type="checkbox"/> 2 - Nausea, dehydration, malnutrition, constipation, impaction <input type="checkbox"/> 3 - Injury caused by fall or accident at home <input type="checkbox"/> 4 - Respiratory problems (e.g., shortness of breath, respiratory infection, tracheobronchial obstruction) <input type="checkbox"/> 5 - Wound infection, deteriorating wound status, new lesion/ulcer <input type="checkbox"/> 6 - Cardiac problems (e.g., fluid overload, exacerbation of CHF, chest pain) <input type="checkbox"/> 7 - Hypo/Hyperglycemia, diabetes out of control <input type="checkbox"/> 8 - GI bleeding, obstruction <input type="checkbox"/> 9 - Other than above reasons <input type="checkbox"/> UK - Reason unknown
DEFINITION:
Identifies the reasons for which the patient/family sought emergent care.
TIME POINTS ITEM(S) COMPLETED:
Transfer to an inpatient facility - with or without agency discharge Discharge from agency
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • If more than one reason contributed to the emergent care visit, mark all appropriate responses. For example, if a patient sought care for a fall at home and was found to have medication side effects, mark both responses. • If the reason is not included in the choices, mark Response 9 - Other than above reasons.
ASSESSMENT STRATEGIES:
Ask the patient/caregiver to state all the symptoms and reasons for which they sought emergent care. A phone call to the doctor's office or emergency room may be required to clarify the reasons for emergent care.

OASIS ITEM:
<p>(M0855) To which Inpatient Facility has the patient been admitted?</p> <p> <input type="checkbox"/> 1 - Hospital [Go to M0890] <input type="checkbox"/> 2 - Rehabilitation facility [Go to M0903] <input type="checkbox"/> 3 - Nursing home [Go to M0900] <input type="checkbox"/> 4 - Hospice [Go to M0903] <input type="checkbox"/> NA - No inpatient facility admission </p>
DEFINITION:
<p>Identifies the type of inpatient facility to which the patient was admitted.</p>
TIME POINTS ITEM(S) COMPLETED:
<p>Transfer to inpatient facility - with or without agency discharge Discharge from agency - not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • Admission to a freestanding rehabilitation hospital or a rehabilitation distinct part unit of a general acute care hospital is considered a rehabilitation facility admission. • Admission to a skilled nursing facility (SNF), an intermediate care facility for the mentally retarded (ICF/MR), or a nursing facility (NF) is a nursing home admission. • At inpatient transfer, omit "NA."
ASSESSMENT STRATEGIES:
<p>Often the family or medical service provider informs the agency that the patient has been admitted to an inpatient facility. Clarify with this informant as to which type facility the patient has been admitted. As a last resort, you may have to contact the facility to determine how it is licensed.</p>

OASIS ITEM:
<p>(M0870) Discharge Disposition: Where is the patient after discharge from your agency? (Choose only one answer.)</p> <p> <input type="checkbox"/> 1 - Patient remained in the community (not in hospital, nursing home, or rehab facility) <input type="checkbox"/> 2 - Patient transferred to a noninstitutional hospice [Go to M0903] <input type="checkbox"/> 3 - Unknown because patient moved to a geographic location not served by this agency [Go to M0903] <input type="checkbox"/> UK - Other unknown [Go to M0903] </p>
DEFINITION:
<p>Identifies where the patient resides after discharge from the home health agency.</p>
TIME POINTS ITEM(S) COMPLETED:
<p>Discharge from agency - not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • Patients who are in assisted living or board and care housing are considered to be living in the community. • Noninstitutional hospice is defined as the patient receiving hospice care at home or a caregiver's home, not in an inpatient hospice facility.
ASSESSMENT STRATEGIES:
<p>At agency discharge, determine where the patient will be living/residing.</p>

OASIS ITEM:
<p>(M0880) After discharge, does the patient receive health, personal, or support Services or Assistance? (Mark all that apply.)</p> <p><input type="checkbox"/> 1 - No assistance or services received</p> <p><input type="checkbox"/> 2 - Yes, assistance or services provided by family or friends</p> <p><input type="checkbox"/> 3 - Yes, assistance or services provided by other community resources (e.g., meals-on-wheels, home health services, homemaker assistance, transportation assistance, assisted living, board and care)</p> <p>Go to M0903</p>
DEFINITION:
Identifies services or assistance a patient receives after discharge from the home health agency.
TIME POINTS ITEM(S) COMPLETED:
Discharge from agency - not to inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none">Assistance or services in Responses 2 or 3 may be paid or unpaid.
ASSESSMENT STRATEGIES:
Ask the patient/caregiver what type of services or support the patient might be receiving after discharge. M0380 contains a list of services or assistance that can be used as a reference. Include services which the agency may have arranged or personal care/chore services that the agency may continue to provide after discharge from skilled care services.

OASIS ITEM:
<p>(M0890) If the patient was admitted to an acute care Hospital, for what Reason was he/she admitted?</p> <p> <input type="checkbox"/> 1 - Hospitalization for <u>emergent</u> (unscheduled) care <input type="checkbox"/> 2 - Hospitalization for <u>urgent</u> (scheduled within 24 hours of admission) care <input type="checkbox"/> 3 - Hospitalization for <u>elective</u> (scheduled more than 24 hours before admission) care <input type="checkbox"/> UK - Unknown </p>
DEFINITION:
Identifies the urgency of the hospital admission.
TIME POINTS ITEM(S) COMPLETED:
Transfer to inpatient facility - with or without agency discharge
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • A patient hospitalized immediately subsequent to a doctor's office, outpatient clinic, or ER visit has been hospitalized for emergent care. • A hospitalization that is scheduled is either urgent or elective depending on whether there were more than 24 hours between the scheduling and the actual admission.
ASSESSMENT STRATEGIES:
Interview the patient, family, or medical service provider to determine whether the acute hospitalization was related to emergent, urgent, or elective care.

OASIS ITEM:
<p>(M0895) Reason for Hospitalization: (Mark all that apply.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis <input type="checkbox"/> 2 - Injury caused by fall or accident at home <input type="checkbox"/> 3 - Respiratory problems (SOB, infection, obstruction) <input type="checkbox"/> 4 - Wound or tube site infection, deteriorating wound status, new lesion/ulcer <input type="checkbox"/> 5 - Hypo/Hyperglycemia, diabetes out of control <input type="checkbox"/> 6 - GI bleeding, obstruction <input type="checkbox"/> 7 - Exacerbation of CHF, fluid overload, heart failure <input type="checkbox"/> 8 - Myocardial infarction, stroke <input type="checkbox"/> 9 - Chemotherapy <input type="checkbox"/> 10 - Scheduled surgical procedure <input type="checkbox"/> 11 - Urinary tract infection <input type="checkbox"/> 12 - IV catheter-related infection <input type="checkbox"/> 13 - Deep vein thrombosis, pulmonary embolus <input type="checkbox"/> 14 - Uncontrolled pain <input type="checkbox"/> 15 - Psychotic episode <input type="checkbox"/> 16 - Other than above reasons <div style="border: 1px solid black; padding: 2px; display: inline-block;">Go to M0903</div>
DEFINITION:
Identifies the specific condition(s) necessitating hospitalization.
TIME POINTS ITEM(S) COMPLETED:
Transfer to inpatient facility - with or without agency discharge
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> Mark all that apply. For example, if a psychotic episode results from an untoward medication side effect, both Response 1 and Response 15 would be marked.
ASSESSMENT STRATEGIES:
Interview the patient, family, or medical service provider to determine the condition requiring acute hospital admission.

OASIS ITEM:
(M0900) For what Reason(s) was the patient Admitted to a Nursing Home ? (Mark all that apply.) <input type="checkbox"/> 1 - Therapy services <input type="checkbox"/> 2 - Respite care <input type="checkbox"/> 3 - Hospice care <input type="checkbox"/> 4 - Permanent placement <input type="checkbox"/> 5 - Unsafe for care at home <input type="checkbox"/> 6 - Other <input type="checkbox"/> UK - Unknown
DEFINITION:
Identifies the reason(s) the patient was admitted to a nursing home.
TIME POINTS ITEM(S) COMPLETED:
Transfer to inpatient facility - with or without agency discharge
RESPONSE—SPECIFIC INSTRUCTIONS:
ASSESSMENT STRATEGIES:
Interview the patient, family, or medical service provider to determine the reason(s) for nursing home placement. Often the agency clinician will have assessed conditions for which nursing home placement is necessary or appropriate.

OASIS ITEM:
(M0903) Date of Last (Most Recent) Home Visit: <div style="text-align: center;"> ____/____/_____ month day year </div>
DEFINITION:
<p>Identifies the last or most recent home visit of any agency provider, including skilled providers or home health aides.</p>
TIME POINTS ITEM(S) COMPLETED:
<p>Transfer to an inpatient facility - with or without agency discharge Discharge from agency</p>
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits of the year.
ASSESSMENT STRATEGIES:
<p>When more than one agency staff member is providing care, refer to agency clinical record for date of last visit. If today's visit is the last (discharge) visit, enter today's date.</p>

OASIS ITEM:
<p>(M0906) Discharge/Transfer/Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient.</p> <p>____/____/____</p> <p>month day year</p>
DEFINITION:
Identifies the actual date of discharge, transfer, or death (at home).
TIME POINTS ITEM(S) COMPLETED:
Transfer to an inpatient facility - with or without agency discharge Death at home Discharge from agency
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year. • The date of discharge is determined by agency policy or physician order. • The transfer date is the actual date the patient was transferred 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. Include death which occurs while a patient is being transported to an inpatient facility (before being admitted).
ASSESSMENT STRATEGIES:
Agency policy or physician order may establish discharge date. 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.

ATTACHMENT C TO CHAPTER 8

CASE EXAMPLES OF OASIS ITEMS

The following case examples provide an opportunity to practice answering OASIS items in response to patient situations. Each scenario presents a patient situation that might be encountered in home care. Read the case example; choose a response for each of the indicated OASIS items. In addition to selecting the best response for specific items, it is important for the clinician to know when further information is needed to respond (i.e., when additional assessment is necessary). Therefore, some items are not clearly answered in the scenario. Test yourself by indicating when you would want additional information, what information you desire, and how you would obtain the information, given the example.

SCENARIO 1

You are asked to conduct the SOC comprehensive assessment for Jane Jones. She is a 47-year-old woman who lives in a third-story apartment with her 12 cats. She was seen by a physician in the emergency room to treat a cat bite and is now on IV antibiotics. She is 5 feet, 2 inches tall and weighs 300 pounds. You are able to complete the assessment, teach Jane about self-administration of the IV therapy, and assess the healing progress of the wound. Her past health history is unremarkable, with no particular problems. **How would you answer OASIS items M0250 through M0290?**

- M0250** Therapies
- M0260** Overall Prognosis
- M0270** Rehabilitative Prognosis
- M0280** Life Expectancy
- M0290** High Risk Factors

SCENARIO 1 (RESPONSES)

M0250	Therapies	<i>Response 1</i>	<i>(IV or infusion therapy)</i>
M0260	Overall Prognosis	<i>Response 1</i>	<i>(Good/Fair: partial to full recovery is expected)</i>
M0270	Rehabilitative Prognosis	INSUFFICIENT INFORMATION TO ANSWER	
M0280	Life Expectancy	<i>Response 0</i>	<i>(Life expectancy is greater than six months)</i>
M0290	High Risk Factors	<i>Response 2</i>	<i>(Obesity) known; others?</i>

SCENARIO 2

You are conducting the start of care visit for Mr. Billis. He tells you that his nephew lives with him, though the nephew travels Monday through Friday each week. Mr. Billis says that when he needs help he tends to call on his neighbor, Sam, even though Sam works the night shift and sleeps during the day. Sam usually comes over about three times a week to bring leftover meals. He also cuts Mr. Billis' lawn and takes him to his doctor appointments. They have both lived in the neighborhood most of their adult years and greatly enjoy each other's company. Mr. Billis admits that he and his nephew don't have a lot to talk about--and the nephew "has a girlfriend, you know." No other relatives live in town, and Mr. Billis doesn't belong to any social or church groups. **How would you answer OASIS items M0350 through M0380?**

M0350 Assisting Persons

M0360 Primary Caregiver

M0370 How Often Assistance Provided

M0380 Type of Assistance

SCENARIO 2 (RESPONSES)

M0350	Assisting Persons	Response 1	(Relatives, friends, or neighbors living outside the home)
		Response 2	(Person residing in the home)
M0360	Primary Caregiver	Response 4	(Friend or neighbor or community or church member)
M0370	How Often Assistance Provided	Response 4	(Three or more times per week)
M0380	Type of Assistance	Response 2	(IADL assistance)
		Response 3	(Environmental support)
		Response 4	(Psychosocial support)
		Response 5	(Advocates or facilitates patient's participation in appropriate medical care)

SCENARIO 3

Your patient, Martha Green, complains that she doesn't sleep through the night. Because a variety of factors might be causing this, you ask her some additional questions about pain, urinary incontinence, and factors that may be causing her anxiety. She denies pain or incontinence, but does tell you that she wakes up almost every night feeling anxious and worried, that she just can't seem to get interested in anything (even her TV programs), is often sad and weepy, and sometimes is afraid to answer the door. She denies thinking much about death, but does remark that several of her friends have died and that her favorite neighbor is moving away. **How would you answer OASIS items M0580 and M0590?**

M0580 When Anxious

M0590 Depressive Feelings

SCENARIO 3 (*RESPONSES*)

M0580 When Anxious *Response 2* (*Daily, but not constantly*)

M0590 Depressive Feelings *Response 1* (*Depressed mood*)

SCENARIO 4

Mr. Linzer requires daily dressing changes for an infected abdominal incision. He is able to ambulate independently without assistive devices. His wife prepares the meals and sets the food on the table, but he eats without difficulty. When Mrs. Linzer went to visit her new grandchild and stayed overnight last week, Mr. Linzer reports that he was able to cook himself bacon and toast and warm up soup in the microwave. However, Mrs. Linzer has always done the cooking since they've been married.

Mr. Norse likes to eat. He had a stroke about two months ago. Now his daughter, Maria, stays near him the entire meal to cut his food and hand him his utensil. She must make sure that he swallows carefully as he has a tendency to choke. She thickens most liquids for him to swallow. He has significant problems with short-term memory and is unable to help with any household activities as he becomes confused easily.

How would you answer OASIS items M0710 and M0720 for these two men?

Mr. Linzer

M0710 Feeding or Eating

M0720 Planning and Preparing Light Meals

Mr. Norse

M0710 Feeding or Eating

M0720 Planning and Preparing Light Meals

SCENARIO 4 (RESPONSES)Mr. Linzer

M0710	Feeding or Eating	<i>Response 0</i>	<i>(Able to independently feed self)</i>
M0720	Planning and Preparing Light Meals	<i>Response 0</i>	<i>(Is able to independently prepare light meals but has not routinely done this in the past)</i>

Mr. Norse

M0710	Feeding or Eating	<i>Response 1</i>	<i>(Able to feed independently but requires meal set-up, intermittent assistance, and special food attention)</i>
M0720	Planning and Preparing Light Meals	<i>Response 2</i>	<i>(Unable to prepare any light meals)</i>

SCENARIO 5

Priscilla Waverly lives with her daughter and son-in-law. She was diagnosed with CHF six months ago, and the disease has progressed so that she is now unable to walk from bed to a chair or to the toilet without becoming dyspneic. She also has arthritis in her cervical spine, which has limited her ability to use her hands. Her physician has ordered oxygen at 2L continuously, Lasix 40 mg once daily, and potassium 10mEq daily. Her daughter must remind her each morning to take her medications. **How would you answer OASIS items M0780 through M0820?**

M0780 Management of Oral Medications

M0790 Management of Inhalant/Mist Medications

M0800 Management of Injectable Medications

M0810 Patient Management of Equipment

M0820 Caregiver Management of Equipment

SCENARIO 5 (RESPONSES)

M0780	Management of Oral Medications	<i>Response 1</i>	<i>(Able to take medications if given daily reminders)</i>
M0790	Management of Inhalant/Mist Medications	INSUFFICIENT INFORMATION TO ANSWER	
M0800	Management of Injectable Medications	<i>NA</i>	<i>(None prescribed)</i>
M0810	Patient Management of Equipment	INSUFFICIENT INFORMATION TO ANSWER	
M0820	Caregiver Management of Equipment	INSUFFICIENT INFORMATION TO ANSWER	

SCENARIO 6

Betty Drason, a 79-year-old female with residual right-sided weakness from a CVA six years ago, is referred to home care after a hospitalization for CHF. She received home health care for several weeks after her stroke, and she has managed independently in her apartment fairly well until now. Her daughter or grandson visits one to two times weekly to help with grocery shopping, errands, and cleaning. Prior to the hospitalization she had become progressively weaker over a period of two to three weeks, and after six days in the hospital and one week in a skilled nursing facility, she is recovering but is still weak.

At the initial visit (during which the RN plans to do the comprehensive assessment), Ms. Drason is able to get to a standing position from her favorite chair if she uses her walker. She states that she knows she spends too much time sitting there, but just doesn't have the energy to move around very much. She walks slowly using her walker to show the nurse the bathroom set-up. In response to questions, Ms. Drason states that she doesn't always make it to the bathroom in time, so she wears a pad to help when she dribbles urine. She says she has no difficulty controlling her bowels. The nurse checks the patient's weight; she says that she was gaining weight before her hospitalization. Her legs were very swollen, but now that the swelling is down, her weight has dropped by 20 pounds.

Ms. Drason has a tub seat which extends from outside to inside the tub, and she shows the nurse how she sits down and is able to scoot across the seat for her shower. The nurse notes that Ms. Drason is heavily dragging her right side when she moves across the tub bench -- using the strength in her left leg to push herself to the right -- and she nearly loses her balance when turning to face forward. A hand-held shower is present, but the patient states she feels uneasy about showering now when alone "because I get so wobbly sometimes." The nurse asks about her ability to get up from a chair, get to the bathroom, and bathe herself just before she was hospitalized. Ms. Drason states that her daughter stayed with her for two days and nights before she went into the hospital because she had gotten so weak that she needed some help with everything.

As the nurse proceeds through the physical assessment, she notes considerable edema of the lower legs, right more than left. Recognizing clues that indicate this patient is at risk for a pressure ulcer on her buttocks, the nurse indicates to Ms. Drason that she would like to check her skin all over, including her buttocks. The patient thinks it's a good idea, because I think I have "a pimple or something on the right cheek." On inspection, the nurse finds an oval crater, 2 cm by 1 cm, with the base covered by thick yellow slough. The nurse can't tell how deep this ulcer is or what the tissue looks like under the slough. The ulcer was not mentioned on the referral from the physician or in the discharge notes from the nursing home. Ms. Drason can't remember when she first became aware of the discomfort, but thinks it must have been several days ago. **How would you answer OASIS items M0670 through M0700? What other OASIS items can be answered from this scenario?**

M0670	Bathing (Prior)	M0690	Transferring (Prior)
M0670	Bathing (Current)	M0690	Transferring (Current)
M0680	Toileting (Prior)	M0700	Ambulation/Locomotion (Prior)
M0680	Toileting (Current)	M0700	Ambulation/Locomotion (Current)

Other OASIS Items

SCENARIO 6 (RESPONSES)

M0670	Bathing (Prior)	INSUFFICIENT INFORMATION; INVESTIGATE MEANING OF "SOME HELP"	
M0670	Bathing (Current)	Response 3	(Participates, but requires presence of another throughout)
M0680	Toileting (Prior)	Response 1	(Able to get to and from toilet with assistance)
M0680	Toileting (Current)	Response 0	(Able to get to and from toilet with or without a device)
M0690	Transferring (Prior)	INSUFFICIENT INFORMATION; INVESTIGATE MEANING OF "SOME HELP"	
M0690	Transferring (Current)	Response 1	(Transfers with use of an assistive device)
M0700	Ambulation/ Locomotion (Prior)	Response 2	(Walks with supervision or assistance of another person)
M0700	Ambulation/ Locomotion (Current)	Response 1	(Requires use of device to walk alone)
<u>Other OASIS Items</u>			
M0040	Patient Name	Betty Drason	
M0069	Gender	Response 2	(Female)
M0080	Discipline of Person Completing Assessment	Response 1	(RN)
M0175	Inpatient Facilities	Responses 1	(Hospital)
NEED ADDITIONAL INFORMATION TO DETERMINE IF RESPONSE 3 OR 4 APPLIES			
M0190	Inpatient Diagnoses	CHF	
M0300	Current Residence	Response 1	(Patient's own residence)
M0350	Assisting Persons	Response 1	(Relatives living outside home)
M0440	Skin Lesion	Response 1	(Yes)
M0445	Pressure Ulcer	Response 1	(Yes)
M0450	Current Number(s)	Response e-1	(Pressure ulcer that cannot be observed, Yes)
M0460	Stage of Most Problematic Pressure Ulcer	Response NA	(No observable pressure ulcer)
M0464	Status of Most Problematic Pressure Ulcer	Response 3	(Not healing)
M0520	Urinary Incontinence	Response 1	(Patient is incontinent)
M0540	Bowel Incontinence	Response 0	(Never has bowel incontinence)

SCENARIO 7

On 03/02 you visit Nellie Williams, a Medicare PPS patient who was admitted on 01/18 with advanced cardiac disease. She complains of "pressure" in her chest, some pain radiating down her left arm, and states that she was unable to sleep most of last night because of the pressure. You call her doctor to inform him that you are sending her to the hospital in an ambulance. He agrees with your assessment. When you follow-up later that day, you learn that Ms. Williams has been hospitalized with an MI. She remains in the hospital the next day, too. **How would you answer OASIS items M0090, M0100, and M0830 through M0906 (following appropriate skip patterns)?** Your agency places patients admitted to an inpatient facility on "hold" status.

- M0090** Date Assessment Completed
- M0100** Reason Assessment Being Completed
- M0830** Emergent Care
- M0840** Emergent Care Reason
- M0855** Inpatient Facility
- M0890** Hospital Reason
- M0895** Reason for Hospitalization
- M0903** Date of Last Home Visit
- M0906** Discharge/Transfer/Date Death

On 03/10, Ms. Williams is transferred from the hospital to a SNF because she is too weak to go directly home. She is still in the SNF on 03/17, the last day of the current certification period. **What should you do about OASIS data collection at that time?**

SCENARIO 7 (RESPONSES)

M0090	Date Assessment Completed	03/03	<i>(When you learned she had been in the hospital for 24 hours)</i>
M0100	Reason Assessment Being Completed	Response 6	<i>(Transfer to inpatient facility, patient not discharged from agency)</i>
M0830	Emergent Care	Response 1	<i>(Hospital emergency room; there may be additional responses, depending on other information)</i>
M0840	Emergent Care Reason	Response 6	<i>(Cardiac problems)</i>
M0855	Inpatient Facility	Response 1	<i>(Hospital)</i>
M0890	Hospital Reason	Response 1	<i>(Emergent care)</i>
M0895	Reason for Hospitalization	Response 8	<i>(Myocardial infarction)</i>
M0903	Date of Last Home Visit	03/02	
M0906	Discharge/Transfer/ Date Death	03/02	<i>(Patient transferred to the hospital on that date)</i>

*On 03/17, after discussion with your supervisor, you discharge the patient. You complete your agency's discharge summary, but **NO** OASIS data are required. You have not seen the patient since 03/02, therefore have no patient status information to report other than the transfer to the inpatient facility.*

SCENARIO 8

Billy O'Hara is an 85-year-old man with peripheral vascular disease, severe degenerative joint disease, and diabetes. Recently his blood sugars have been consistently above 200, so the doctor changed his medication and ordered home health care. Mr. O'Hara ambulates with his walker (when he remembers to use it), but for only short distances because "I just don't have the pep I used to have. Seems like every little thing just wears me out." He has a personal care provider every morning and every evening provided by Medicaid under a Home and Community-Based Care Program.

At the SOC visit, you note that his pedal pulses are quite faint, more so in the left than the right, and there is considerable lower leg edema with the circumference of the left leg 8 cm greater than the right. The left lower leg is dark bluish-brown in color from just above the ankle to below the ankle and the right lower leg is brown/bronze from mid-calf down. Mr. O'Hara admits that his legs hurt most of the time, especially the left leg. He also has "a different kind of pain -- in my knees and hips," which gets increasingly worse with walking. The pain in his knees and hips hurts so bad he can hardly stand up to walk from the kitchen to the bathroom (about 20 feet). This often results in dribbling some urine, because he waits too long to go to the bathroom, knowing that walking will cause severe pain. He has pain medication prescribed and states that he takes the pain pills when the pain gets "really bad," but he sometimes has difficulty remembering when he took the pills last. Sometimes the pills make him drowsy and awkward, and then he wonders if he has taken them too close together. You instruct him on the use of the pain meds on a regular basis rather than waiting for severe pain and offer to prefill his med planner. He thinks that's a good idea for his pain med -- his other medication (one) is taken with breakfast and supper, and he has no trouble remembering that one.

Because the pain limits his movement, Mr. O'Hara spends hours sitting at the kitchen table reading and working crossword puzzles. You note that his elbows are very red and tender, and the redness does not fade when you apply finger pressure. He says that when he sits at the table, he nearly always rests on one or both elbows.

Which OASIS items can be completed from this situation, and what are their responses?

SCENARIO 8 (RESPONSES)

M0100	<i>Reason Assessment Being Completed</i>	Response 1	<i>(Start of care—further visits planned)</i>
M0200	<i>Medical or Treatment Regimen Change</i>	Response 1	<i>(Yes)</i>
M0210	<i>Medical Diagnoses</i>	Diabetes, ICD 250	
M0420	<i>Frequency of Pain</i>	Response 3	<i>(All the time)</i>
M0430	<i>Intractable Pain</i>	Response 0	<i>(No)</i>
M0440	<i>Skin Lesion or Open Wound</i>	Response 1	<i>(Yes, the Stage I pressure ulcer is a skin lesion)</i>
M0445	<i>Pressure Ulcer</i>	Response 1	<i>(Yes)</i>
M0450	<i>Current Number of Pressure Ulcers</i>	<i>(a, 2; b, 0; c, 0; d, 0; e, Response 0)</i>	
M0460	<i>Stage of Most Problematic Ulcer</i>	Response 1	<i>(Stage 1)</i>
M0464	<i>Status of Most Problematic Ulcer</i>	Response 3	<i>(Not healing)</i>
M0520	<i>Urinary Incontinence or Urinary Catheter Presence</i>	Response 1	<i>(Patient is incontinent)</i>
M0530	<i>When Urinary Incontinence</i>	Response 3	<i>(During the day and night)—this is the only response with “day,” therefore must be selected</i>
M0700	<i>Ambulation</i>	Response 0 or 1	<i>(Able to independently walk or Requires use of a device)—need to more fully assess safe ambulation ability</i>
M0780	<i>Management of Oral Medications</i>	Response 1	<i>(Able to take medications independently if prepared in advance)—the frequency and number of medications must be considered when differing levels of ability are assessed for different medications</i>
M0810	<i>Patient Management of Equipment</i>	NA	<i>(No equipment of this type used in care)</i>

SCENARIO 9

Theresa Estaire is a 66-year-old woman with severe right-side hemiplegia since a stroke five years ago. She is quite hard of hearing, and you had to repeat her name and why you were there four times before she heard you well enough to understand. Ms. Estaire's speech is mostly unintelligible to all but her 62-year-old sister, Adele, who is her primary caregiver. Theresa has an indwelling Foley catheter which is changed by the visiting nurse every six weeks. Theresa takes Macroductin prophylactically (by mouth, administered by Adele) and has not been treated for a UTI for nearly a year. She is incontinent of stool several times a week (more than half the time). Nurses from your agency have done extensive teaching about skin care and preventive measures, including dietary supplements. Theresa and Adele are compliant with all but the dietary changes because Theresa has no appetite. She attempts to feed herself some finger foods with her left hand, but Adele must manage utensils and assist with most foods. Theresa is able to walk with a walker and stand-by assistance to go from the bed to the commode or from the bedroom to the recliner in the living room, about 10-15 feet, but spends nearly all her time in either bed or recliner. One month ago, Adele agreed to accept home health aide assistance once or twice a week. **How would you respond to the following OASIS items?**

- M0400** Hearing and Ability to Understand Spoken Language
- M0410** Speech and Oral (Verbal) Expression of Language
- M0510** Urinary Tract Infection
- M0520** Urinary Incontinence or Urinary Catheter Presence
- M0540** Bowel Incontinence Frequency
- M0700** Ambulation/ Locomotion
- M0710** Feeding or Eating
- M0780** Management of Oral Medications

SCENARIO 9 (RESPONSES)

M0400	Hearing and Ability to Understand Spoken Language	Response 3	<i>(Has severe difficulty hearing and understanding simple greetings and short comments. Requires multiple repetitions, restatements, demonstrations, additional time)</i>
M0410	Speech and Oral (Verbal) Expression of Language	Response 3	<i>(Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases)</i>
M0510	Urinary Tract Infection	NA	<i>(Patient on prophylactic treatment)</i>
M0520	Urinary Incontinence or Urinary Catheter Presence	Response 2	<i>(Patient requires a urinary catheter)</i>
M0540	Bowel Incontinence Frequency	Response 3	<i>(Four to six times weekly)</i>
M0700	Ambulation/ Locomotion	Response 2	<i>(Able to walk only with the supervision/assistance of another person at all times)</i>
M0710	Feeding or Eating	Response 2	<i>(Unable to feed self and must be assisted or supervised throughout the meal/snack)</i>
M0780	Management of Oral Medications	Response 2	<i>(Unable to take medication unless administered by someone else)</i>

SCENARIO 10

Alan Tiller, a 76-year-old male, is recovering from an automobile accident in which he suffered a badly lacerated right leg, multiple compound fractures of his right forearm, and multiple fractures of his jaw. He has returned home after spending two weeks in acute care and two weeks in a SNF. His granddaughter will be staying with him as long as necessary. In the hospital, a venous graft was done to repair the circulation in his right leg, and three external pins were required to stabilize the fractures in his right forearm. There are two pins in his jaw, and the jaws are wired closed. Because of the jaw fractures and the need to ensure adequate nutrition for healing, a gastrostomy tube was placed for feedings, even though he takes some oral liquids through a straw. All meds are ordered and given through the gastrostomy tube. Although he had no chest injuries, he has a history of mild CHF, and his blood oxygen levels have been low, so he was sent home with oxygen. The oxygen was delivered yesterday after Mr. Tiller arrived home.

You visit the day after Mr. Tiller returns home. His granddaughter began learning to administer the gastrostomy feeding while he was still in the nursing home. She shows you how to prepare the solution, to insert the tubing, and to administer the feeding properly. She also is able to correctly explain how to read the oxygen gauges, attach the emergency generator, and fill a portable cylinder.

With your help, Mr. Tiller is able to stand up from the chair and walk about 15 feet using a rolling platform walker with his left hand. He becomes extremely short of breath and must sit down. It takes him several minutes to recover. Mr. Tiller admits to pain which is eased some by pain medications, but never really is gone. The pain often keeps him awake at night and causes him to be reluctant to move around much or even concentrate on TV. **How would you complete the following OASIS items?**

- M0250** Therapies
- M0420** Frequency of Pain
- M0430** Intractable Pain
- M0482** Surgical Wound
- M0484** Current Number of (Observable) Surgical Wounds
- M0488** Status of Most Problematic (Observable) Surgical Wound
- M0490** Short of Breath
- M0500** Respiratory Treatments
- M0710** Feeding or Eating
- M0780** Management of Oral Medications
- M0810** Patient Management of Equipment
- M0820** Caregiver Management of Equipment

SCENARIO 10 (RESPONSES)

M0250	Therapies	<i>Response 3</i>	<i>(Enteral nutrition)</i>
M0420	Frequency of Pain	<i>Response 3</i>	<i>(All of the time)</i>
M0430	Intractable Pain	<i>Response 1</i>	<i>(Yes)</i>
M0482	Surgical Wound	<i>Response 1</i>	<i>(Yes)—pin sites are surgical wounds</i>
M0484	Current Number of (Observable) Surgical Wounds	<i>Response 4</i>	<i>(Four or more)</i>
M0488	Status of Most Problematic (Observable) Surgical Wound	INSUFFICIENT INFORMATION TO ANSWER	
M0490	Short of Breath	<i>Response 2</i>	<i>(With moderate exertion)</i>
M0500	Respiratory Treatments	<i>Response 1</i>	<i>(Oxygen)</i>
M0710	Feeding or Eating	<i>Response 3</i>	<i>(Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy)</i>
M0780	Management of Oral Medications	<i>NA</i>	<i>(No oral medications prescribed)</i>
M0810	Patient Management of Equipment	INSUFFICIENT INFORMATION TO ANSWER	
M0820	Caregiver Management of Equipment	<i>Response 0</i>	<i>(Caregiver manages all tasks related to equipment completely independently)</i>

SCENARIO 11

All below examples test appropriate responses to OASIS items M0175 through M0220. The examples are brief; **how would you answer the indicated OASIS items?**

- A. An oncology patient who is receiving chemotherapy at home has a long-standing history of severe memory loss secondary to TIAs. She was discharged from the hospital (where she was diagnosed with and treated for atrial fibrillation) within the past 14 days. She returns home with a new anti-arrhythmic medication.

M0175 Inpatient Facility

M0180 Inpatient Discharge Date

M0190 Inpatient Diagnoses

M0200 Medical or Treatment Regimen
Change

M0210 Medical Diagnoses

M0220 Prior Conditions

- B. An oncology patient (who is receiving chemotherapy at home) has been discharged from the hospital within the past 14 days. She was diagnosed with and treated for atrial fibrillation in the hospital. She had none of the prior conditions listed in M0220.

M0175 Inpatient Facility

M0180 Inpatient Discharge Date

M0190 Inpatient Diagnoses

M0200 Medical or Treatment Regimen
Change

M0210 Medical Diagnoses

M0220 Prior Conditions

(continued)

SCENARIO 11 (cont'd)

- C. A patient with AIDS is seen by the physician for dehydration and weight loss. A PICC line is inserted in the physician's office, and the patient is started on TPN. Existence of prior conditions stated in M0220 is unknown.

M0175 Inpatient Facility

M0180 Inpatient Discharge Date

M0190 Inpatient Diagnoses

M0200 Medical or Treatment Regimen
Change

M0210 Medical Diagnoses

M0220 Prior Conditions

- D. Patient discharged from both hospital and nursing home within the last 14 days (recovering from ORIF of fractured right hip). Physical therapy and aide services ordered to assist patient with exercise program and ADLs. Patient has history of urinary incontinence (prior to hip fracture).

M0175 Inpatient Facility

M0180 Inpatient Discharge Date

M0190 Inpatient Diagnoses

M0200 Medical or Treatment Regimen
Change

M0210 Medical Diagnoses

M0220 Prior Conditions

SCENARIO 11 (RESPONSES)

A.	M0175	Inpatient Facility	<i>Response 1</i>	
	M0180	Inpatient Discharge Date	<i>Date of hospital discharge</i>	
	M0190	Inpatient Diagnoses	<i>Atrial fibrillation; ICD 427.31</i>	
	M0200	Medical or Treatment Regimen Change	<i>Response 1</i>	<i>(Yes); new diagnosis, new treatment</i>
	M0210	Medical Diagnoses	<i>Atrial fibrillation; ICD 427.31</i>	
	M0220	Prior Conditions	<i>Response 6</i>	<i>(Memory loss)</i>
B.	M0175	Inpatient Facility	<i>Response 1</i>	<i>(Hospital)</i>
	M0180	Inpatient Discharge Date	<i>Date of hospital discharge</i>	
	M0190	Inpatient Diagnoses	<i>Atrial fibrillation; ICD 427.31</i>	
	M0200	Medical or Treatment Regimen Change	<i>Response 1</i>	<i>(Yes); new diagnosis</i>
	M0210	Medical Diagnoses	<i>Atrial fibrillation; ICD 427.31</i>	
	M0220	Prior Conditions	<i>Response 7</i>	<i>(None of the above)</i>
C.	M0175	Inpatient Facility	<i>NA</i>	<i>(Not discharged from an inpatient facility)</i>
	M0180	Inpatient Discharge Date	<i>(Skip)</i>	
	M0190	Inpatient Diagnoses	<i>(Skip)</i>	
	M0200	Medical or Treatment Regimen Change	<i>Response 1</i>	<i>(Yes); new diagnosis, new treatment</i>
	M0210	Medical Diagnoses	<i>Dehydration; ICD 276.5</i> <i>Malnutrition; ICD 783.2</i>	
	M0220	Prior Conditions	<i>UK</i>	<i>(Unknown)</i>

(continued)

SCENARIO 11 (RESPONSES) (cont'd)

D. M0175	Inpatient Facility	Response 1 (Hospital) ADDITIONAL INFORMATION NEEDED ABOUT NURSING HOME TO DETERMINE WHETHER RESPONSE 3 OR 4 APPLIES
M0180	Inpatient Discharge Date	Date of nursing home discharge (i.e., most recent)
M0190	Inpatient Diagnoses	Hip fracture; ICD 820 (not surgical procedure)
M0200	Medical or Treatment Regimen Change	Response 1 (Yes); new treatment
M0210	Medical Diagnoses	Hip fracture; ICD 820 (not surgical procedure)
M0220	Prior Conditions	Response 1 (Urinary incontinence)

Change Page January 1, 2008

Page(s)	Change
8.5	Table 8.1 "PostVisit" section updated to delete Item M0245 from <i>Primary diagnosis and comorbidities</i> row and Item M0825 changed to reflect new Item M0826 in <i>Need for physical, occupational, or speech therapy</i> row
8.9	Point number 3 updated to indicate current version of OASIS, 01/2008
8.18	Item M0030, definition language updated to include "reimbursable care," additional clarification provided in response-specific instructions
8.31	Item M0100, follow-up time point skip pattern revised to indicate new "Go to M0110" instructions
8.33	New OASIS item M0110
8.38	M0175, follow-up time point deleted from Time Points Item(s) Completed section and skip instruction changed
8.40	M0190, bullet points revised in Response—Specific Instructions
8.41	M0200, "no" option skip pattern revised to include "if No at Discharge, go to M0250."
8.42	M0210, bullet points revised in Response—Specific Instructions
8.43	M0220, asterisks removed from OASIS item and moved to become bullet point in Response—Specific Instructions
8.44 - 8.46	OASIS items M0230/M0240/M0246 replace M0230/M0240 and updated instructions given
8.54	M0350, asterisks removed from OASIS item and moved to become bullet points in Response—Specific Instructions
8.55	M0360, asterisks removed from OASIS item and moved to become bullet points in Response—Specific Instructions
8.56	M0370, asterisk removed from OASIS item and moved to become bullet point in Response—Specific Instructions
8.57	M0380, asterisk removed from OASIS item and moved to become bullet point in Response—Specific Instructions
8.65 - 8.66	M0450, text has been revised in bullet point #4 of the Response-Specific Instructions and in the Assessment Strategies

Page(s)	Change
8.67	M0460, OASIS item title has been revised to include "At Follow-up, skip to M0470 if patient has no pressure ulcers." Text has been revised in the Definition and in the Response-Specific Instructions
8.68	M0464, text has been revised in the Response-Specific Instructions
8.70	M0470, follow-up time point added to Time Points Item(s) Completed section
8.71	M0474, follow-up time point added to Time Points Item(s) Completed section
8.72	M0476, OASIS item title has been revised to include "At Follow-up, skip to M0488 if patient has no stasis ulcers."
8.76	M0488, OASIS item title has been revised to include "At Follow-up, skip to M0490 if patient has no surgical wound(s)."
8.79	M0510, asterisk removed from OASIS item and moved to become bullet point in Response—Specific Instructions
8.80	M0520, follow-up time point added to Time Points Item(s) Completed section
8.81	M0530, asterisk information removed from OASIS item
8.82	M0540, asterisk removed from OASIS item and moved to become bullet point in Response—Specific Instructions
8.83	M0550, asterisk removed from OASIS item and moved to become bullet point in Response—Specific Instructions
8.89	M0610 follow-up time point deleted from Time Points Item(s) Completed section
8.109	M0800 follow-up time point added to Time Points Item(s) Completed section
8.110	M0810, skip instruction for NA response changed to M0826. Asterisk information removed from OASIS item
8.111	M0820, asterisk removed from OASIS item and moved to become bullet point in Response—Specific Instructions
8.112	Item M0826 and new instructions replace Item M0825
8.115	M0855, asterisk removed from OASIS item and moved to become bullet point in Response—Specific Instructions