

OASIS ITEM

(M2400) Intervention Synopsis: (Check only one box in each row.) At the time of or at any time since the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

Plan / Intervention	No	Yes	Not Applicable
a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
b. Falls prevention interventions	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Every standardized, validated multi-factor fall risk assessment conducted at or since the last OASIS assessment indicates the patient has no risk for falls.
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the last OASIS assessment indicates the patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.
d. Intervention(s) to monitor and mitigate pain	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Every standardized, validated pain assessment conducted at or since the last OASIS assessment indicates the patient has no pain.
e. Intervention(s) to prevent pressure ulcers	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Every standardized, validated pressure ulcer risk assessment conducted at or since the last OASIS assessment indicates the patient is not at risk of developing pressure ulcers.
f. Pressure ulcer treatment based on principles of moist wound healing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

ITEM INTENT

Identifies if specific interventions focused on specific problems were both included on the physician-ordered home health Plan of Care AND implemented as part of care provided during the home health care episode (at the time of or at any time since the previous OASIS assessment). "Included in the physician-ordered Plan of Care" means that the patient condition was discussed and there was agreement as to the Plan of Care between the home health agency staff and the patient's physician.

This item is used to calculate process measures to capture the use of best practices. The problem-specific interventions referenced in the item may or may not directly correlate to stated requirements in the Conditions of Participation.

The formal assessment that is referred to in the last column for rows b – e refers to the assessment defined in OASIS items for M1240, M1300, M1730, and M1910.

TIME POINTS ITEM(S) COMPLETED (cont'd for OASIS Item M2400)
Transfer to inpatient facility - with or without agency discharge Discharge from agency - not to an inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> • Select "Yes" if the physician-ordered Plan of Care includes the specified best practice interventions as specified in each row, at the time of or at any time since the previous OASIS assessment, and there is evidence of implementation in the clinical record. If orders are present and implemented, "Yes" may be selected even if the formal assessment was not conducted, or did not suggest a need for the particular intervention. • Select "No" if the interventions are not on the Plan of Care OR if the interventions are on the Plan of Care but the interventions were not implemented by the time the Discharge or Transfer assessment was completed, unless "NA" applies. • Select "NA" if the plans/interventions specified in the row are not applicable for this patient. See guidance on selecting "NA" for each row below. • Interventions provided by home health agency staff, including the assessing clinician, may be reported by the assessing clinician in M2400. For example, if the RN finds a patient to be at risk for falls, and the physical therapist implements fall prevention interventions included on the Plan of Care prior to the end of the allowed assessment time frame, the RN may select "Yes" for row b of M2400. The M0090 Date Assessment Completed should report the date the last information was gathered to complete the comprehensive assessment. • For each row a-f, select one response. • For rows b, c, e, and f, the intervention specified in the first column must be both on the physician-ordered Plan of Care AND implemented for "Yes" to be selected. • For rows a and d, BOTH of the interventions specified in the first column must be both on the physician-ordered Plan of Care AND implemented for "Yes" to be selected. • For rows b-e, a formal assessment (as defined in the relevant OASIS item M1240, M1300, M1730, and M1910) must have been performed to select "NA." <p>— An evaluation of clinical factors is not considered a formal assessment for M1300 pressure ulcer risk.</p> <ul style="list-style-type: none"> • Row a: If the physician-ordered Plan of Care contains both orders for a) monitoring the skin of the patient's lower extremities for evidence of skin lesions AND b) patient education on proper foot care and the clinical record contains documentation that these interventions were performed at the time of or at any time since the previous OASIS assessment, select "Yes." If the physician-ordered Plan of Care contains orders for only one of the interventions and/or only one type of intervention (monitoring or education) or no intervention is documented in the clinical record, select "No," unless "NA" applies. Select "NA" if the patient does not have a diagnosis of diabetes mellitus or is missing lower legs due to congenital or acquired condition (bilateral amputee). • Row b: If the physician-ordered Plan of Care contains specific interventions to reduce the risk of falls and the clinical record contains documentation that these interventions were performed at the time of or at any time since the previous OASIS assessment, select "Yes." Environmental changes, strengthening exercises, and consultation with the physician regarding medication concerns are examples of possible falls prevention interventions. If the Plan of Care does not include interventions for fall prevention, and/or there is no documentation in the clinical record that these interventions were performed at the time of or at any time since the previous OASIS assessment, select "No," unless "NA" applies. If all formal multi-factor falls risk assessments conducted at the time of or at any time since the previous OASIS assessment indicates the patient was not at risk for falls (if a single-threshold assessment is used), or at low, minimal, or no risk for falls (if a multi-threshold tool is used), select "NA" (unless orders for fall prevention are present and were implemented).

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

- Row c: If the physician-ordered Plan of Care contains interventions for evaluation or treatment of depression and the clinical record contains documentation that these interventions were performed at the time of or at any time since the previous OASIS assessment, select "Yes." Interventions for depression may include new medications, adjustments to already-prescribed medications, psychotherapy or referrals to agency resources (for example, social worker). If the patient is already under physician care for a diagnosis of depression, interventions may include monitoring medication effectiveness, teaching regarding the need to take prescribed medications, etc. If the Plan of Care does not include interventions for treating depression and/or if no interventions related to depression are documented in the clinical record at the time of or at any time since the previous OASIS assessment, select "No," unless "NA" applies. If every standardized, validated assessment conducted at the time of or any time since the previous OASIS assessment indicates patient did not meet criteria for further evaluation of depression AND patient did not have diagnosis of depression, select "NA" (unless orders for further evaluation or treatment of depression are present and were implemented).
- Row d: If the physician-ordered Plan of Care contains interventions to monitor AND mitigate pain and the clinical record contains documentation that these interventions were performed at the time of or at any time since the previous OASIS assessment, select "Yes." Medication, massage, visualization, biofeedback, and other intervention approaches have successfully been used to mitigate pain severity. If the physician-ordered Plan of Care contains orders for only one of the interventions (for example, pain medications but no pain monitoring plan) and/or only one type of intervention (for example, administering pain medications but no pain monitoring) or no interventions were documented at the time of or at any time since the previous OASIS assessment, select "No," unless "NA" applies. If every standardized, validated pain assessment conducted at or since the last OASIS assessment was negative for pain, select "NA" (unless orders for monitoring and mitigating pain are present and were implemented).
- Row e: If the physician-ordered Plan of Care includes planned clinical interventions to reduce pressure on bony prominences or other areas of skin at risk for breakdown and the clinical record contains documentation that these interventions were performed at the time of or at any time since the previous OASIS assessment, select "Yes." Planned interventions can include teaching on frequent position changes, proper positioning to relieve pressure, careful skin assessment and hygiene, use of pressure-relieving devices such as enhanced mattresses, etc. If the Plan of Care does not include interventions to prevent pressure ulcers and/or no interventions were documented in the clinical record at the time of or at any time since the previous OASIS assessment, select "No," unless "NA" applies. If every standardized, validated pressure ulcer risk assessment conducted at or since the last OASIS assessment indicates the patient is not at risk of developing pressure ulcers, select "NA" (unless orders for interventions to reduce pressure on areas of skin at risk for breakdown are present and were implemented).
- Row f: If the physician-ordered Plan of Care contains orders for pressure ulcer treatments based on principles of moist wound healing (for example, moisture retentive dressings) and the clinical record contains documentation that these interventions were performed at the time of or at any time since the previous OASIS assessment, select "Yes." If the Plan of Care does not contain orders for pressure ulcer treatments based on principles of moist wound healing and/or no pressure ulcer treatments based on principles of moist wound healing were documented at the time of or at any time since the previous OASIS assessment, select "No," unless "NA" applies. If patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated per physician, select "NA" (unless orders for pressure ulcer treatments based on principles of moist wound healing are present and were implemented).

DATA SOURCES / RESOURCES

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

OASIS ITEM
<p>(M2410) To which Inpatient Facility has the patient been admitted?</p> <p> <input type="checkbox"/> 1 - Hospital [<i>Go to M2430</i>] <input type="checkbox"/> 2 - Rehabilitation facility [<i>Go to M0903</i>] <input type="checkbox"/> 3 - Nursing home [<i>Go to M0903</i>] <input type="checkbox"/> 4 - Hospice [<i>Go to M0903</i>] <input type="checkbox"/> NA - No inpatient facility admission [<i>Omit "NA" option on TRN</i>] </p>
ITEM INTENT
Identifies the type of inpatient facility to which the patient was admitted.
TIME POINTS ITEM(S) COMPLETED
Transfer to inpatient facility - with or without agency discharge Discharge from agency - not to an inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> • If the patient was admitted to more than one facility, indicate the facility type to which the patient was admitted first (for example, the facility type that they were transferred to from their home). • When a patient dies in a hospital emergency department, the RFA 7 - Transfer to an Inpatient Facility OASIS is completed. In this unique situation, clinicians are directed to select Response 1 – Hospital for M2410, even though the patient was not admitted to the inpatient facility. • Admission to a freestanding rehabilitation hospital, a certified distinct rehabilitation unit of a nursing home, or a distinct rehabilitation unit that is part of a short-stay acute hospital is considered a rehabilitation facility admission. • Admission to inpatient drug rehabilitation is considered an inpatient admission. Select Response 1 – Hospital, whether it was a freestanding drug rehabilitation unit or a distinct drug rehabilitation unit that is part of a short-stay acute hospital. • Admission to a skilled nursing facility (SNF), an intermediate care facility for individuals with intellectual disabilities (ICF/IID), or a nursing facility (NF) is a nursing home admission • When completing a Transfer, select Response 1, 2, 3, or 4. "NA" should be omitted from this item for transfer. • When completing a Discharge from agency – Not to an Inpatient Facility, select Response "NA."
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> • Patient family interview (for agency discharge) • Telephone contact with caregiver or family if patient was transferred • Facility

OASIS ITEM
<p>(M2420) Discharge Disposition: Where is the patient after discharge from your agency? (Choose only one answer.)</p> <p><input type="checkbox"/> 1 - Patient remained in the community (without formal assistive services)</p> <p><input type="checkbox"/> 2 - Patient remained in the community (with formal assistive services)</p> <p><input type="checkbox"/> 3 - Patient transferred to a non-institutional hospice</p> <p><input type="checkbox"/> 4 - Unknown because patient moved to a geographic location not served by this agency</p> <p><input type="checkbox"/> UK - Other unknown [<i>Go to M0903</i>]</p>
ITEM INTENT
Identifies where the patient resides after discharge from the home health agency.
TIME POINTS ITEM(S) COMPLETED
Discharge from agency - not to an inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> Patients who are in assisted living or board and care housing are considered to be living in the community with formal assistive services. Formal assistive services refers to community-based services provided through organizations or by paid helpers. Examples: homemaking services under Medicaid waiver programs, personal care services provided by a home health agency, paid assistance provided by an individual, home-delivered meals provided by organizations like Meals-on-Wheels. <ul style="list-style-type: none"> – Therapy services provided in an outpatient setting would not be considered formal assistance. Informal services are provided by friends, family, neighbors, or other individuals in the community for which no financial compensation is provided. Examples: assistance with ADLs provided by a family member, transportation provided by a friend, meals provided by church members (specifically, meals not provided by the church organization itself, but by individual volunteers). Noninstitutional hospice is defined as the patient receiving hospice care at home or a caregiver's home, not in an inpatient hospice facility.
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> Patient/caregiver/family interview Physician Community resources

OASIS ITEM
<p>(M2430) Reason for Hospitalization: For what reason(s) did the patient require hospitalization? (Mark all that apply.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> 1 - Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis <input type="checkbox"/> 2 - Injury caused by fall <input type="checkbox"/> 3 - Respiratory infection (for example, pneumonia, bronchitis) <input type="checkbox"/> 4 - Other respiratory problem <input type="checkbox"/> 5 - Heart failure (for example, fluid overload) <input type="checkbox"/> 6 - Cardiac dysrhythmia (irregular heartbeat) <input type="checkbox"/> 7 - Myocardial infarction or chest pain <input type="checkbox"/> 8 - Other heart disease <input type="checkbox"/> 9 - Stroke (CVA) or TIA <input type="checkbox"/> 10 - Hypo/Hyperglycemia, diabetes out of control <input type="checkbox"/> 11 - GI bleeding, obstruction, constipation, impaction <input type="checkbox"/> 12 - Dehydration, malnutrition <input type="checkbox"/> 13 - Urinary tract infection <input type="checkbox"/> 14 - IV catheter-related infection or complication <input type="checkbox"/> 15 - Wound infection or deterioration <input type="checkbox"/> 16 - Uncontrolled pain <input type="checkbox"/> 17 - Acute mental/behavioral health problem <input type="checkbox"/> 18 - Deep vein thrombosis, pulmonary embolus <input type="checkbox"/> 19 - Scheduled treatment or procedure <input type="checkbox"/> 20 - Other than above reasons <input type="checkbox"/> UK - Reason unknown
ITEM INTENT
Identifies the specific condition(s) necessitating hospitalization.
TIME POINTS ITEM(S) COMPLETED
Transfer to inpatient facility - with or without agency discharge
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> Select all that apply. For example, if a psychotic episode results from an untoward medication side effect, both Response 1 and Response 17 would be marked. As another example, if a patient requires hospitalization for both heart failure and pneumonia, both Response 3 and Response 5 would be selected. Response 2 should be selected if patient is hospitalized for an injury caused by a fall, regardless of where the fall occurred. Response 20 should be selected if the patient is hospitalized for a new wound that is not the result of a fall. If the reason is not included in the choices, select Response 20 "Other than above reasons."

DATA SOURCES / RESOURCES (cont'd for OASIS Item M2430)

- Telephone contact with patient/caregiver/family
- Facility discharge planner or case manager
- Physician
- Insurance case manager

OASIS ITEM
(M0903) Date of Last (Most Recent) Home Visit: <div style="text-align: center;"> <div style="display: inline-block; text-align: center;"> <div style="border-bottom: 1px solid black; width: 20px; margin: 0 auto;"></div> <div style="display: inline-block; text-align: center; margin: 0 5px;">/</div> <div style="border-bottom: 1px solid black; width: 20px; margin: 0 auto;"></div> <div style="display: inline-block; text-align: center; margin: 0 5px;">/</div> <div style="border-bottom: 1px solid black; width: 20px; margin: 0 auto;"></div> <div style="display: inline-block; text-align: center; margin: 0 5px;">—</div> <div style="border-bottom: 1px solid black; width: 20px; margin: 0 auto;"></div> <div style="display: inline-block; text-align: center; margin: 0 5px;">—</div> </div> <div style="text-align: center; margin-top: 5px;"> month / day / year </div> </div>
ITEM INTENT
Identifies the last or most recent home visit by any agency provider that is included on the Plan of Care.
TIME POINTS ITEM(S) COMPLETED
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” (for example, May 4, 2014 = 05/04/2014). Enter all four digits of the year. • If the agency policy is to have an RN complete the comprehensive assessment in a therapy-only case, the RN can perform the discharge assessment after the last visit by the therapist.
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> • Clinical record

OASIS ITEM
<p>(M0906) Discharge/Transfer/Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient.</p> <p style="text-align: center;"> ____ / ____ / ____ month / day / year </p>
ITEM INTENT
Identifies the actual date of discharge, transfer, or death (at home), depending on the reason for assessment.
TIME POINTS ITEM(S) COMPLETED
Transfer to an inpatient facility - with or without agency discharge Death at home Discharge from agency
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> • If the date or month is only one digit, that digit is preceded by a "0" (for example, May 4, 2014 = 05/04/2014). Enter all four digits for the year. • The date of discharge is determined by agency policy or physician order. • The transfer date is the actual date the patient was admitted to an inpatient facility. • The death date is the actual date of the patient's death at home. Exclude death occurring in an inpatient facility or in an emergency department, as both situations would result in Transfer OASIS collection and would report the date of transfer. Include death that occurs while a patient is being transported to an emergency department or inpatient facility (before being seen in the emergency department or admitted to the inpatient facility).
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> • Agency policy or physician order • Telephone contact with the family or medical service provider may be required to verify the date of transfer to an inpatient facility or death at home.