OASIS ITEM

(M1700) Cognitive Functioning: Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

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

ITEM INTENT

Identifies the patient's current (at the time of the assessment and in the preceding 24 hours) level of cognitive functioning, including alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Discharge from agency - not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Responses progress from no impairment to severely impaired. Consider the degree of impairment.
- Consider the patient's signs/symptoms of cognitive dysfunction that have occurred over the past 24 hours.
- Consider the amount of supervision and care the patient has required due to cognitive deficits.
- Patients with diagnoses such as dementia, delirium, development delay disorders, mental retardation, etc., will have various degrees of cognitive dysfunction.
- Patients with neurological deficits related to stroke, mood/anxiety disorders, or who receive opioid therapy may have cognitive deficits.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Links to cognitive assessment tools can be found in Chapter 5 of this manual.
- Review of past health history
- Physician

OASIS ITEM

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

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

ITEM INTENT

Identifies the time of day or situations when the patient experienced confusion, if at all.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Discharge from agency - not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- This item may not relate directly to Item M1700. Assess specifically for confusion in the last 14 days.
- The term "last 14 days" is the two-week period immediately preceding the start/resumption of care or discharge. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient's SOC date is August 20, any confusion occurring on or after August 6 would be considered.
- Select Response 0 if the patient had no confusion in the last 14 days. Responses 1-4 are selected if the patient has experienced confusion and each response represents a worsening of confusion frequency. Response 1 is selected when the patient's confusion is isolated to a new or a complex situation; for example, the patient became confused when a new caregiver was introduced or when a procedure was performed the first time. Responses 2, 3, & 4 are selected when confusion occurs without the stimulus of a new or complex situation, or when confusion that initially presented with a new or complex situation persists days after the new or complex situation becomes more routine. Responses 2, 3 & 4 differ from each other based on the time when the confusion occurred. Response 2 is selected if the confusion only occurred when the patient was awakening from a sleep or during the night. Response 3 is selected if the confusion occurs during the day and evening, but is not constant. If confusion was not constant, but occurred more often than just upon awakening or at night, select Response 3.
- "Nonresponsive" means that the patient is unable to respond or the patient responds in a way that you cannot make a clinical judgment about the patient's level of orientation. If the patient is nonresponsive at the time of assessment, report whether the patient experienced any confusion during the last 14 days if this information can be elicited from the caregiver or other source. If the patient is nonresponsive at the time of assessment and the information cannot be elicited from the caregiver or other source, select "NA – Patient nonresponsive."

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Review of recent (last 14 days) health history
- Physician
- Links to a resource for patients with Alzheimer's disease or dementia can be found in Chapter 5 of this manual.

OASIS ITEM

(M1720) When Anxious (Reported or Observed Within the Last 14 Days):

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

ITEM INTENT

Identifies the frequency with which the patient has felt anxious within the last 14 days.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Discharge from agency - not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Anxiety includes:
  - Worry that interferes with learning and normal activities,
  - Feelings of being overwhelmed and having difficulty coping, or
  - Symptoms of anxiety disorders.
- Responses appear in order of increasing frequency of anxiety.
- "Nonresponsive" means that the patient is unable to respond or the patient responds in a way that you can't make a clinical judgment about the patient's level of anxiety. If the patient is nonresponsive at the time of assessment, report whether the patient experienced any anxiety during the last 14 days if this information can be elicited from the caregiver or other source. If the patient is nonresponsive at the time of assessment and the information cannot be elicited from the caregiver or other source, select "NA – Patient nonresponsive."
- The term "last 14 days" is the two-week period immediately preceding the start/resumption of care. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient's SOC date is August 20, any anxiety occurring on or after August 6 would be considered.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Referral information
- Review of recent (last 14 days) health history
- Physician
- Links to standardized anxiety screening tools can be found in Chapter 5 of this manual.

OASIS ITEM

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

☐ 0 - No

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

Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems?"					
PHQ-2©*	Not at all 0 - 1 day	Several days 2 - 6 days	More than half of the days 7 – 11 days	Nearly every day 12 – 14 days	NA Unable to respond
a) Little interest or pleasure in doing things	☐0	☐1	☐2	☐3	☐NA
b) Feeling down, depressed, or hopeless?	☐0	☐1	☐2	☐3	☐NA

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

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

ITEM INTENT

Identifies if the home health agency screened the patient for depression using a standardized, validated depression screening tool. CMS does not mandate that clinicians conduct depression screening for all patients, nor is there a mandate for the use of the PHQ-2© or any other particular standardized, validated tool. This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- Depressive feelings, symptoms, and/or behaviors may be observed by the clinician or reported by the patient, family, or others as allowed by the standardized, validated tool's administration instructions.
- To meet the definition of "standardized, validated," the depression screening tool must 1) have been scientifically tested on a population with characteristics similar to that of the patient being assessed (for example, community-dwelling elderly, noninstitutionalized adults with disabilities, etc.) and 2) include a standard response scale. The standardized, validated tool must be both appropriate for the patient based on their cognitive and communication deficits and appropriately administered per the tool's instructions.
- If a standardized, validated depression screening tool is used, use the scoring parameters specified for the tool to identify if a patient meets criteria for further evaluation of depression.
  - In order to select Responses 1, 2 or 3, the standardized, validated depression screening must be conducted by the clinician responsible for completing the comprehensive assessment during the time frame specified by CMS for completion of the assessment (specifically, within five days of SOC or within two days of discharge from the inpatient facility at ROC).

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1730)

- Select Response 0 if a standardized, validated depression screening was not conducted.
  - If the clinician chooses not to assess the patient (because there is no appropriate depression screening tool available or for any other reason), Response 0 – No should be selected.
- Select Response 1 if the PHQ-2© is completed, and mark the appropriate responses in rows a and b. Please note that the PHQ-2© instructions indicate that the patient is interviewed, not family or others. If the patient scores three points or more on the PHQ-2©, then further depression screening is indicated.
  - If the PHQ-2© is not used to assess the patient, you may choose to administer a different standardized, validated depression screening tool with instructions that may allow for information to be gathered by observation and caregiver interview as well as self-report. In this case, the clinician would select Response 2 or 3 for M1730, depending on the outcome of the assessment.
- Select Response 2 if the patient is screened with a different standardized, validated assessment AND the tool indicated the need for further evaluation.
- Select Response 3 if the patient is screened with a different standardized, validated assessment BUT the tool indicates no need for further evaluation.

DATA SOURCES / RESOURCES

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

OASIS ITEM

(M1740) Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week **(Reported or Observed): (Mark all that apply.)**

- ☐ 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
- ☐ 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
- ☐ 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- ☐ 4 - Physical aggression: aggressive or combative to self and others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- ☐ 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)
- ☐ 6 - Delusional, hallucinatory, or paranoid behavior
- ☐ 7 - None of the above behaviors demonstrated

ITEM INTENT

Identifies specific behaviors associated with significant neurological, developmental, behavioral, or psychiatric disorders.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Behaviors may be observed by the clinician or reported by the patient, family, or others.
- Include behaviors which are severe enough to:
  - make the patient unsafe to self or others,
  - cause considerable stress to the caregivers, or
  - require supervision or intervention.
- If Response 7 is selected, none of the other responses should be selected.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Referral information
- Physician
- Links to standardized cognitive screening tools can be found in Chapter 5 of this manual.

OASIS ITEM

(M1745) Frequency of Disruptive Behavior Symptoms (Reported or Observed): Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.

- ☐ 0 - Never
- ☐ 1 - Less than once a month
- ☐ 2 - Once a month
- ☐ 3 - Several times each month
- ☐ 4 - Several times a week
- ☐ 5 - At least daily

ITEM INTENT

Identifies frequency of any behaviors that are disruptive or dangerous to the patient or the caregivers.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Consider if the patient has any problematic behaviors – not just the behaviors listed in M1740 – which jeopardize or could jeopardize the safety and well-being of the patient or caregiver. Then consider how frequently these behaviors occur.
- Include behaviors considered symptomatic of neurological, cognitive, behavioral, developmental, or psychiatric disorders. Use clinical judgment to determine if the degree of the behavior is disruptive or dangerous to the patient or caregiver.
- Behaviors can be observed by the clinician or reported by the patient, family, or others.
- Examples of disruptive/dangerous behaviors include sleeplessness, “sun-downing,” agitation, wandering, aggression, combativeness, getting lost in familiar places, etc.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Referral information
- Review of past health history
- Physician
- Links to additional information sources can be found in Chapter 5 of this manual.

OASIS ITEM

(M1750) Is this patient receiving **Psychiatric Nursing Services** at home provided by a qualified psychiatric nurse?

☐ 0 - No

☐ 1 - Yes

ITEM INTENT

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

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Referral information
- Physician orders/Plan of Care
- Clinical record
- HHAs may elect to reference Section 40.1.2.15 of Chapter 7 in the Medicare Benefit Policy Manual for additional information