Deliverable 27: OASIS Field Test Summary Report

Outcome and Assessment Information Set (OASIS) Quality Measure Development and Maintenance Project

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Executive Summary

The Centers for Medicare & Medicaid Services (CMS) is committed to ensuring high quality care for beneficiaries. Section 1895(b)(3)(B)(v)(II) of the Social Security Act requires home health agencies (HHAs) to submit data for quality measurement, as specified by the Secretary. As well, the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 mandates the reporting of standardized patient assessment data elements in several domains across post-acute care (PAC) settings, including HHAs. Development and testing of data items is a critical task and the validity and utility of quality measures rest on the underlying source data.

CMS contracted with Abt Associates to conduct a comprehensive field test of the Outcome and Assessment Information Set (OASIS) for home health (HH) patients, to assess the reliability, validity and feasibility of selected existing and potential new OASIS items, including cross-setting standardized patient assessment data elements (SPADEs) that could be used to meet the mandate of the IMPACT Act. Items tested included a subset of OASIS-C2 items, a draft OASIS nutritional risk item, and SPADEs. The SPADEs represented categories including pain, comprehension, cognition, delirium, continence, self-care, mobility and falls.

Researchers recruited twelve HHAs in four states for a mixed methods, non-experimental field test design, and provided individualized training and ongoing support to each agency. HHA registered nurses (RNs) and physical therapists (PTs), trained by the study team, collected data during home visits at the following time points: start of care (SOC) or resumption of care (ROC), and/or discharge (DC). Follow-up visits were conducted within 24 hours of the initial field test visit, by a different RN or PT, to test interrater reliability (IRR). Additional data collection included a PROMIS® (for Patient Report Outcomes Measurement Information System®) survey, a Patient Global Rating of Outcomes (PGRO) survey, a HHA field test participant clinical record review to validate a subset of field test assessment items, and, quantitative and qualitative data collection from participating HHA clinicians on the items tested. Data collection was conducted between August 2016 and July 2017.

A total of 213 HH patients participated in the field test. These field test participants were predominately older adults, and generally cognitively intact in order to consent to the study. The field test findings suggest that most items tested showed reasonable levels of reliability. Differences in values between familiar (existing OASIS) and unfamiliar (SPADEs) items at both SOC/ROC and DC suggest the need for agency-level training and detailed guidance as new items are introduced. Some differences in RN and PT performance during this field test may indicate that more training was needed before beginning data collection. Reliability of the OASIS items that underlie HH quality metrics, value-based purchasing and prospective payment is essential to lend confidence to their continued use and for maintaining consensus endorsement.

Clinicians contributed substantial qualitative information about their experiences with, and understanding of, the items tested, particularly the SPADEs. Qualitative data support validity and feasibility of most items tested, although testing identified several items with low interrater reliability that can be addressed with focused training and guidance. The field test also

demonstrated that implementation of the patient self-administered PROMIS v1.1 Global health survey is feasible among this sample of cognitively intact HH patients. These findings may inform potential future data collection and quality measure development activities for CMS.

Overall, findings suggest that the field test items tested measure the underlying constructs reliably. Clinicians' feedback underscores the importance of focused guidance in the OASIS Guidance Manual that addresses areas of confusion. Effective guidance and training will support clinicians' ability to complete OASIS items accurately for submission to CMS of consistent, high quality data.

1. Introduction

1.1 Overview

The Centers for Medicare & Medicaid Services (CMS) is committed to ensuring high quality care for beneficiaries. Section 1895(b)(3)(B)(v)(II) of the Social Security Act requires home health agencies (HHAs) to submit data for quality measurement, as specified by the Secretary. As well, the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 mandates the reporting of standardized patient assessment data elements (SPADEs) in several domains across post-acute care (PAC) settings, including HHAs.

CMS mandates collection of important patient clinical, functional and resource use information via the Outcome and Assessment Information Set (OASIS) data set at specified intervals in the HH episode of care. OASIS data are reported to CMS and used in calculation of quality measures (QM), for public reporting and in determining reimbursement through the HH Prospective Payment System (PPS), among other uses. Field testing is one method to establish and confirm the reliability and validity of the items included in the OASIS data set for use in multiple CMS initiatives.

1.1.1 Background and Significance

The Outcome and Assessment Information Set

The OASIS is the post-acute care (PAC) assessment instrument used by HHAs to collect and report patient assessment data to CMS. The OASIS includes items for patient clinical, functional and resource domains. Medicare regulations (Code of Federal Regulations [CFR] 42 Section 484.255(i)) require HHAs to meet quality data reporting requirements, including collection and submission of OASIS data. HHAs must also comply with Home Health Conditions of Participation (CoPs, CFR 42 Section 484.25) requirements, including those specifying periodic update and revision of the comprehensive patient assessment, which includes OASIS.[1]

HHAs are required to collect OASIS data for all Medicare and Medicaid patients, including the Advantage programs, aged 18 and older and receiving skilled services.. Patients receiving pre- or post-partum services are excluded from the requirement, as are patients under the age of 18, or those who receive only non-skilled services.[2] Changes to the OASIS are occurring as a result of IMPACT Act requirements, which underscore the need to ensure items intended for standardization across the PAC settings are reliable and feasible in HH.

The Home Health Quality Reporting Program

HH care services are covered under the Medicare Part A benefit, when ordered by a physician and represent “skilled” care from nursing, physical therapy, occupational therapy and/or speech-

[1] Home Health Quality Reporting Requirements. CMS web page available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Requirements.html

[2] ibid

language pathology.[3] HHAs are required to report data, including OASIS data, to CMS in support of the HH QRP, as well as for other purposes, or be subject to a two percentage point (2%) reduction to the HH market basket increase.[4] CMS provides confidential quality reports to HHAs on demand to use in agency-level quality improvement initiatives. Selected OASIS-based quality performance measures are publicly reported on the Medicare.gov website Home Health Compare (https://www.medicare.gov/homehealthcompare). CMS initiatives, including the Home Health Quality of Patient Care star ratings and the HH value-based purchasing (HH VBP) model, rely on OASIS data. Broadly, these and other initiatives aim to ensure high quality care for beneficiaries.

Patient Reported Outcomes

Patient self-report, according to the National Institutes of Health (NIH)-funded Health Measures initiative, is "a person's direct report on his or her feelings, function, well-being, symptoms, or life satisfaction."[5] A multitude of tools have been developed in response to interest in patient reported outcomes (PROs). Four measurement systems are described on the Health Measures site[6]: the Patient Reported Outcome Measurement Information System® (PROMIS®), Neuro-Qol, ASCQ-Me® and the NIH Toolbox®.

To the best of our knowledge, PROs have not previously been tested in HH. CMS and NIH jointly recommend PROMIS for potential incorporation into CMS quality reporting programs. The PROMIS Global health survey includes self-reported measures of overall, physical, mental and social health designed for use in the general population, or among individuals with chronic conditions. Versions are available for adults and children. The PROMIS v1.1 10-item Global health survey is a valid and reliable tool, relevant to HH patients.

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3 Home Health Quality Initiative. Centers for Medicare & Medicaid Services (CMS) web page available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html

4 Home Health Quality Reporting Requirements. Centers for Medicare & Medicaid Services (CMS) web page available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Requirements.html

5 Introduction to Person-Centered Assessment. Health Measures.net web page available at http://www.healthmeasures.net/resource-center/measurement-science/intro-to-person-centered-assessment

6 HealthMeasures.net web page, available at http://www.healthmeasures.net

2. OASIS Field Test 2016–2017

Under contract to CMS, Abt Associates and its partners conducted a comprehensive field test from August 2016 to July 2017 of a subset of existing OASIS-C2 items, a draft OASIS nutritional risk item, and a sample of SPADEs. Testing also included PROs, with the Patient Global Rating of Outcomes (PGRO) survey for sensitivity testing and the PROMIS v1.1 10-item Global health survey, which was selected for a proof-of-concept study. The sections below provide additional detail about the field test purpose and procedures.

2.1 Purpose and Objectives

The field test had three overarching goals. The first was to assess sensitivity, reliability and validity of existing and potential new OASIS items, including SPADEs, through collection of primary quantitative data. Second, qualitative information was sought on item validity and feasibility, and the instructions for use, to inform future guidance development and training. Finally, researchers explored the feasibility of HH patient self-administration of a PRO survey. Specific objectives are listed below:

- Update or establish reliability and validity of items tested.
- Test the responsiveness of selected OASIS-C2 items associated with publicly-reported outcomes by testing sensitivity of the items to detect small, medium or large changes (effects).[7]
- Compare a subset of OASIS-C2 items with selected SPADEs for feasibility, reliability, and validity.
- Explore feasibility and usability of SPADEs and their associated instructions for use.
- Explore feasibility of implementing the PROMIS v.1.1 Global health survey in a HH patient population.

2.2 Design

The field test used a non-experimental mixed methods approach to address the objectives noted above. The design required recruitment of HHAs as clinical sites, quantitative data collection by trained HHA clinicians—registered nurses (RNs) and physical therapists (PTs)—in home visits to patients, and quantitative and qualitative data collection by field test team members during HHA site visits. Existing data collection tools for OASIS assessment and SPADEs were used; the field test team designed additional data collection instruments and instructions for consistent measurement.

[7] See Section 4 for a discussion of limitations, as data collection targets were not achieved for sensitivity analyses.

2.3 Methods

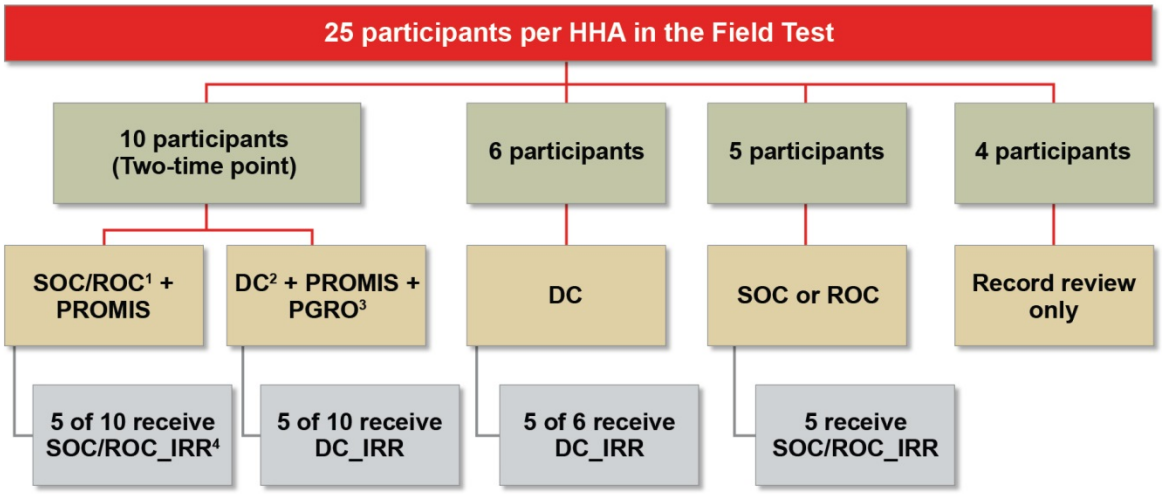
The field test methods and procedures are described in this section, including sampling, outreach and enrollment, data collection, data submission and management, and the analytic approach. Institutional Review Board (IRB) approval was obtained for this human subjects research prior to field test implementation.

2.3.1 Sampling Plan

The field test sampling plan was designed to identify the minimum number of data points required to sufficiently power the study to achieve the objectives (Section 2.1). The plan specified recruitment of three HHAs in each of four states (Colorado, Massachusetts, North Carolina, and Ohio). These states were selected to align with the availability of local field test team members to help recruit and enroll HHAs and serve as Clinical Site Coordinators.

The minimum number of data collection events was calculated for each HHA to sufficiently power the subsequent analyses. Each HHA was asked to recruit 21 patients to participate in the field test, and to identify four additional patients for medical record review only, for a total of 25 participants per HHA. Home visits were required at start or resumption of care (SOC, ROC) and discharge (DC) for ten field test participants, called "two-time point" participants. OASIS field test assessments and PROMIS surveys were to be completed at these visits for sensitivity testing and PROMIS feasibility testing. The PGRO was to be completed during the DC home visits for data to support sensitivity testing. A minimum of 15 field test participants would receive an initial home visit at SOC/ROC or DC plus a second home visit within 24 hours for interrater reliability (IRR) testing. Individual patients could supply multiple data points. The sampling plan requirements for participant enrollment and data collection events at each HHA are illustrated in Exhibit 1, below.

Exhibit 1. Field Test Sampling Plan Requirements for Each HHA*



Notes: *HHA = home health agency; (1) SOC/ROC = start/resumption of care; (2) DC = discharge; (3) PGRO = patient global rating of outcomes; (4) IRR = interrater reliability. Source: Abt Associates' sampling plan for field test, 2017.

2.3.2 Eligibility Criteria

Home Health Agency Eligibility

All Medicare-certified HHAs in the Denver, Colorado; Greater Boston, Massachusetts; Raleigh-Durham, North Carolina; and Cleveland, Ohio regions were eligible to participate in the field test. Recruitment focused on HHAs with motivated teams that had the staffing and referral capacity to complete data collection. Although enrolling a diverse set of HHAs with respect to characteristics such as ownership type (i.e., for profit, nonprofit, government/other) or rural/urban status was encouraged, fixed quotas for agency type and location were not used.

Exclusion Criteria

The study criteria excluded HHAs if:

- The HHA was not Medicare-certified and thus did not participate in the collection and submission of OASIS data.
- Staffing was inadequate to support the study design. The field test protocol required a minimum of two RNs and two PTs at each HHA.
- The HHA was unable to meet patient sampling requirements. Agencies were required to collect data from 21 participants, thus each agency needed sufficient numbers of referrals each week to support this level of enrollment. (The field test team collected data for the four participants receiving only medical record review).

Field Test Participant Eligibility

The HHA liaisons worked with other agency staff as needed to identify potentially eligible field test participants from the referrals received at each agency. Inclusion and exclusion criteria for participant eligibility are outlined below.

Inclusion criteria

A patient was eligible for participation if s/he was:

- Referred for skilled services,
- A Medicare or Medicaid patient (including all Advantage programs)
- Aged 18 years and older, and
- Able to speak and understand English.

Exclusion criteria

A patient was excluded from participation if s/he was:

- Receiving hospice, or pre- or post-natal care, or
- Not able to provide informed consent and respond to clinical assessment questions.

2.3.3 Outreach and Home Health Agency Enrollment

With CMS support, the field test team conducted national, regional and local outreach to Medicare-certified HHAs to solicit interest in field test participation. HH leaders' response to outreach was positive. The field test team screened all HHAs that indicated interest in

participation. The field test team sought to balance the characteristics of the HHAs to diversify the sample, to the extent possible, given the team's geographic constraints.

Members of the field test team with nursing and home health expertise served as Clinical Site Coordinators. Two to three Coordinators worked directly with HHAs in each state to implement the field test. The Clinical Site Coordinators played an active role in outreach, identification and recruitment of agencies. Recruitment leveraged the team's previous relationships with HHAs. Agency representatives contacted the Abt team to express interest in participation. Clinical Site Coordinators used this opportunity to provide an overview of testing requirements, including staffing, procedures and logistics. The field test team answered any questions and conducted conference calls with HHA teams when asked to provide additional details.

Twelve HHAs were enrolled initially, three each in Colorado, Massachusetts, North Carolina and Ohio. Shortly after data collection began, leaders at two of the HHAs reported they would not be able to manage the field test workload as they had anticipated, and needed to withdraw. Two additional HHAs were recruited in the relevant regions as replacements.

Once an HHA was enrolled, a Clinical Site Coordinator established a relationship with an agency employee designated as a liaison for the field test. Establishing one contact at each agency facilitated the completion of required paperwork for approvals so sites could start data collection. The liaisons became the point of contact, working directly with the Clinical Site Coordinators to implement the field test at their respective HHAs.

2.3.4 Training and Communication

Prior to data collection, the Principal Investigator provided an in-person, all-day train-the-trainer session to the Clinical Site Coordinators who would be responsible for delivering the field test training at their assigned HHAs. The goal of this on-site training was to ensure a consistent understanding of field test procedures and materials, including the assessment items for testing, across Clinical Site Coordinators, and to support consistent training across all HHAs.

The Clinical Site Coordinators then provided a half-day training session at each HHA for the staff that would participate in the field test directly and assist in the coordination and execution of the field test at each site. The participants included the individual, generally a clinical manager, identified as the HHA liaison to the field test, the RNs and PTs designated to collect field test data, and support staff.

Following completion of training, the HHA teams began participant enrollment and data collection, and Clinical Site Coordinators set up a schedule for weekly telephone contact with the liaisons. Clinical Site Coordinators developed dynamic, close relationships with HHA liaisons, a key element contributing to testing success. Clinical Site Coordinators continuously assessed HHA team needs for support and team or individual training. When needed, Clinical Site Coordinators either provided virtual guidance or returned to the HHA to provide in-person support and reinforce procedures.

2.3.5 Data Collection

Data were collected from August 2016 to July 2017[8] using two approaches. First, RNs and PTs conducted home visits at SOC/ROC and/or DC to collect patient-level data to support the calculation of IRR and sensitivity and to assess the feasibility of obtaining PROs. IRR required paired assessments: two home visits conducted within 24 hours, by different clinicians, to independently conduct the OASIS field test assessment. IRR visits were required at SOC or ROC to calculate IRR for SOC/ROC items. IRR visits were required at DC to calculate IRR for DC items. Sensitivity analysis required assessments from either SOC (or ROC), and DC for two time points of data. PGRO were collected at DC for two-time point patients to provide additional data in support of sensitivity testing. PROMIS surveys were collected at SOC, ROC and/or DC. Data collection instruments used by clinicians in home visits are described below. In the second approach for data collection, online clinician surveys were collected, and Clinical Site Coordinators conducted focus groups and record reviews for data on validity and feasibility.

Home Visits

HHA RNs and PTs collected field test data using the following instruments. These are included as Appendix I.

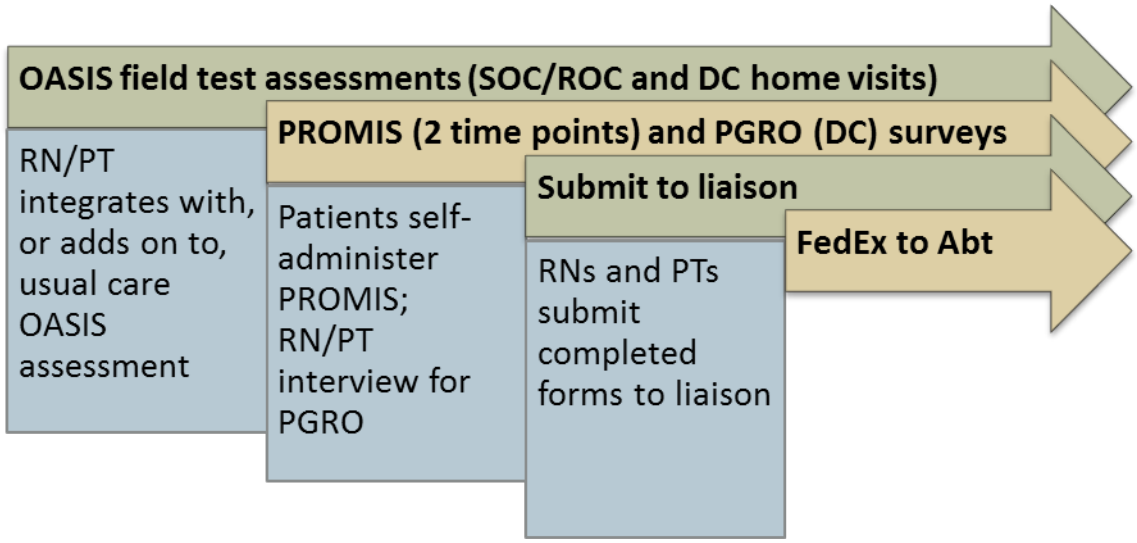
- OASIS Field Test SOC/ROC assessment
  - Combination of OASIS-C2, draft OASIS and SPADEs for collection at SOC/ROC
- OASIS Field Test DC assessment
  - Combination of OASIS-C2, draft OASIS and SPADEs for collection at DC
- PROMIS v1.1 Global health survey.
  - A 10-item scale designed for adult participants to self-report perceptions of their overall health, functional, social and emotional status at SOC/ROC and/or at DC.
- PGRO survey
  - An investigator-developed 7-item survey[9] for participants to self-report, at DC, perceptions of improvement from SOC/ROC to DC, and extent of improvement, in selected health status domains.

The data collection and submission process is illustrated in Exhibit 2, below. HH clinicians used clinical judgment during a home visit to determine whether a participant was well enough to complete the assessment visit.

[8] When data collection began, OASIS-C1-ICD10 was the current version of the data set in use by HHA. The next version of the data set, OASIS-C2, went into effect January 1, 2017. The item M1308 on OASIS-C1-ICD10 was revised to M1311 on OASIS-C2, to assess the number of pressure ulcers present at each stage, and unstageable. Clinicians received training from their agencies on the changes in OASIS-C2, and applied this understanding to the field test assessments as well as their usual care OASIS assessments.

[9] The survey was developed by Dr. Eugene Nuccio and Dr. Angela Richard to provide data for the sensitivity testing objective.

Exhibit 2. Data Collection and Submission Process



Source: Abt Associates' field test data collection and submission process, 2017.

Modifications to Data Collection Protocol

Early in data collection, HHA liaisons reported to their Clinical Site Coordinators that clinicians were having difficulty collecting data for items appearing on both the required usual care OASIS assessment (OASIS-C1/ICD-10 or OASIS-C2 depending on the date of the visit) and the OASIS field test assessment. In response, the field test team developed a procedure that ensured that data collected for the OASIS items the agency was required to submit to CMS and also needed for the field test were collected only once by the clinician and submitted to the agency by the clinician (via their documentation on agency paperwork), and additionally submitted once to the field test team by the liaison (via the documentation for the field test). There was not a significant delay in development of the procedure so that, still early in data collection, Clinical Site Coordinators trained the HHA teams on this procedure and process. Training was conducted in-person or by webinar. Data collection proceeded without further modification.

Clinician Surveys, Focus Groups and Record Reviews

HHA clinicians had the opportunity to complete an online survey about test items' feasibility, at the end of data collection and prior to the on-site focus group. The field test team developed the web-based survey, using the FluidSurvey™ online data collection tool. A field test team member monitored the secure Abt Associates survey account, downloaded completed surveys and compiled data into summary reports. When available, survey data were incorporated into the discussion guide for the focus groups.

At the end of data collection, Clinical Site Coordinators conducted one 90-minute, on-site focus group at each HHA for staff that participated in the field test. Clinical Site Coordinators facilitated focus groups with a semi-structured discussion guide. The discussion gathered qualitative data on HHA staff perceptions of feasibility of the items tested, associated

instructions for use, and the PROMIS survey. Discussions were recorded for validation purposes only, and not transcribed.

Clinical Site Coordinators conducted record reviews at each HHA according to the sampling plan. Records were reviewed to identify documentation to validate OASIS responses. These results will be presented in a separate report. The team developed the record review tool in an iterative process that included pilot testing in two of the participating HHAs. Consistency in review was established through dual reviews at each HHA. Inconsistencies were resolved with discussion and consensus decision-making. Questions that arose during reviews were shared with all Clinical Site Coordinators and consensus responses were developed.

2.3.6 Data Management

Field test team members reviewed HHAs' data collection forms upon submission. If any missing data were identified, the team notified Clinical Site Coordinators, who worked with the HHA liaisons to resolve. When a missing data element could not be recovered it was coded as permanently missing. The team identified one systematic pattern of missing data. For the field test item GG0170: Mobility, the Discharge Goal response was confusing to many of the HHA clinicians collecting data in the beginning stages of the field test. Missing data in this response decreased over the course of the field test. Other missing data occurred at random, with no systematic pattern identified.

2.3.7 Data Analyses

The team used simple statistics to describe the participating HHAs and participant demographics. IRR of the OASIS field test items was calculated with percent of agreement between the two observers, and linear weighted kappa, as described below. Insufficient data were collected to complete sensitivity testing.

> ***Percent Agreement.*** The percent observed agreement across the item scale or yes/no dichotomy was computed. The assumption is that a higher percent agreement indicates a higher item reliability than lower percent agreements.
>
> ***Kappa***. Linear weighted kappa statistics were computed. The kappa statistic is generally considered to be the "gold standard" statistic associated with item reliability. Kappa computation is similar to percent agreement, except that kappa takes into consideration that agreement can occur by chance. Linear weighted kappa was selected instead of quadratic weighted kappa because the magnitude of the difference between rater scores, a requirement for the latter calculation, cannot be validly inferred given the sample size used in analyses.

The team used qualitative content analysis of focus group data, an iterative and evolving analysis aimed at understanding and describing multiple perspectives. Descriptive analyses are planned for clinician survey and record review data.

2.3.8 Data and Information Security

Due to the nature of the person-level data collected, every OASIS field test team member completed training on the Health Insurance Portability and Accountability Act (HIPAA), and data and information security. All data were securely stored on Abt's servers. To protect participant confidentiality, the study generated a unique identifier for every HH agency enrolled, and within HHAs, a different level of unique identifier for participants selected for assessment visits and record reviews. Data collection forms were coded with the study identifiers for agency and participant. Privacy of HHA staff participating in the focus groups and completing the clinician surveys was protected by not using or recording names during the focus group and not requiring individually-identifiable information from participants.

2.3.9 Human Subjects

The Abt Associates IRB designated the OASIS field test human subjects research, and IRB approval was obtained prior to beginning data collection. Collaborative Institutional Training Initiative (CITI) training was completed as required. HHA clinicians signed Individual Investigator Agreements when trained to participate in data collection. The IRB approved a waiver of the signature requirement for informed consent and a waiver of privacy authorization for field test participants (signed forms would be the only documents linking participants to the study, a potential threat to confidentiality). The IRB approved a waiver of informed consent and a waiver of privacy authorization for the subset of participants at each agency for whom only record reviews were conducted. And, for HHA staff completing online surveys and participating in focus groups, a waiver of the signature requirement for informed consent was approved.

3. Results

3.1 Overview

The sections below first describe HHA field test sites and field test participants, and then summarize the total field test data collected. Selected field test participant characteristics are described in relation to the national 2016 complete OASIS data file from which 6,437,455 million quality episodes were constructed. This is followed by a summary of reliability results for the items tested, subject to sufficient observations. Then qualitative findings are presented for validity and feasibility of items and guidance, followed finally by PRO results.

3.1.1 Home Health Agency Field Test Sites

The twelve HHAs that completed data collection ranged in size from small to large, representing a mix of ownership types with diverse service areas (Exhibit 3).

Exhibit 3. Description of Home Health Agencies

State	HHA* Size	Ownership	Service Area
CO*	Medium branch	National for-profit chain	Urban-suburban
CO	Small	Independent for-profit	Suburban-rural
CO	Large	Independent for-profit	Urban-suburban-rural
MA*	Large	Not-for-profit, hospital affiliated	Urban-suburban
MA	Small	Local independent	Urban-suburban
MA	Medium branch	National for-profit chain	Suburban-rural
NC*	Medium branch	Regional not-for-profit chain	Suburban-rural
NC	Medium branch	National for-profit chain	Suburban-rural
NC	Small	Public health department	Rural
OH*	Small	Local not-for-profit independent	Rural
OH	Small	Hospital affiliated not-for-profit	Rural
OH	Large branch	Independent not-for-profit	Urban-suburban-rural

*HHA = home health agency; CO = Colorado; MA = Massachusetts; NC = North Carolina; OH = Ohio; Source: Abt Associates' summary of field test HHA characteristics, 2017.

3.1.2 Field Test Participant Demographics

The HHA teams enrolled a total of 213 participants in the field test. No consented field test participants withdrew from the study. Two enrolled field test participants did not complete the second home visit for data collection because their conditions worsened and they were readmitted to the hospital.

Demographic characteristics of the field test participants are displayed in Exhibit 4, below. These were mostly older adults (age 65 and older). Those who were age 85 and older comprised the largest proportion (32.2 percent). About 83 percent were white and 62 percent were female. Medicare was the primary payer identified for HH services.

Exhibit 4. Description of Field Test Participants (N = 213) relative to the 2016 HH patient population (n=6,437,455 million quality episodes)

	Field Test Participants (n=213)		2016 HH* Patient Population (n=6,437,455 episodes)
	n	%	%
Age groups	**(n=202)**		
0-64	49	24.3	18.29%
65-74	42	20.8	26.36%
75-84	46	22.8	29.68%
85+	65	32.2	25.67%
Gender	**(n=202)**		
Male	76	38	38.95%
Female	126	62	61.05%
Race/ethnicity[10] (mark all that apply*)	**(n=175)**		
Black or African American	24	13.6	13.73%
Hispanic or Latino	4	2.3	7.56%
White	147	83.1	76.23%
Current payment sources for home care[11] (mark all that apply)	**(n=203)**		
Medicare (traditional fee for service)	133	66.2	69.22%
Medicare (HMO*/Managed care/Advantage plan)	30	14.9	24.37%
Medicaid (traditional fee for service)	23	11.4	4.82%
Medicaid (HMO/managed care)	4	2	4.63%
Private insurance	7	3.5	2.08%
Private HMO/managed care	6	3	0.63%

*HH = home health; HMO = health maintenance organization; VA = Veterans Administration; Mark all that apply items: Totals may sum to more than total sample size and more than 100%. Source: Abt Associates' analyses of field test and CMS 2016 OASIS data set demographic data.

3.1.3 Summary of Field Test Data Collected

Exhibit 5 below summarizes the distribution of field test participants enrolled by time point, and types of data collected.

[10] Other options for this item reflecting less than 2 percent total are not reported.

[11] Other options for this item reflecting less than 4 percent total are not reported.

Exhibit 5. Field Test Participants Enrolled and Types of Data Collected

Field Test Participants Enrolled	n (%)
Two-time point (SOC/ROC* + DC*)	67 (31.5)
SOC/ROC only	87 (40.8)
DC only	59 (27.7)
Total	**213**

Assessments Completed	# Assessments
SOC/ROC	154
SOC/ROC IRR*	106
DC	126
DC IRR	84
Total	**470**

PROMIS* Surveys Completed	# Surveys
SOC/ROC + DC	56
Single time point only	94
Total	**150**

Other Data Collected	n
Record Reviews	103
PGRO* Surveys	77
Focus Groups	12
Clinician Surveys	25

*SOC/ROC = start of care/resumption of care, DC = discharge, IRR = interrater reliability, PROMIS = Patient Reported Outcomes Measurement Information System, PGRO = Patient Global Rating of Outcomes.

Source: Abt Associates' summary of field test data collected and participants enrolled, 2017.

3.1.4 Selected Field Test Participant Characteristics

Appendix II includes detailed descriptive tables for field test items with comparative 2016 HH patient population frequencies for selected items. This section includes a description of key characteristics of field test participants relative to the HH patient population. This information is intended as context for understanding the field test participant sample; field test recruitment did not seek a representative sample.

Compared to the HH patient population, more field test participants had a skilled nursing facility (SNF) DC prior to HH SOC/ROC (20.92 versus 14.7 percent, respectively) and fewer had a short-term acute hospital DC (41.83 versus 50.9 percent, respectively). To take part in the field test, HH patients had to be able to provide informed consent. Thus, we expect the field test sample to be essentially cognitively intact. At SOC/ROC, 66.45 percent of field test participants were assessed as alert and oriented, compared with 51 percent in the HH patient population. This difference is more striking at DC, when 83.33 percent of field test participants were assessed as alert and oriented, compared with 69.3 percent in the HH patient population. More field test participants were independent with activities of daily living and instrumental activities of daily living than the HH patient population, and differences were greater at DC than at SOC/ROC, with three exceptions. The proportion of patients scored as independent at DC was essentially the

same for bathing (23.58 and 23.42 percent), transferring (48.78 and 45.86 percent) and ambulation/locomotion (21.31 and 23.29 percent).

3.2 Reliability

Among the 213 enrolled participants, a proportion (n=106) had paired assessments completed at SOC/ROC, and 84 had paired assessments completed at DC. Percent observed agreement was calculated by dividing the number of pairs in agreement by the total number of pairs. Paired assessments were used to compute the kappa statistic for IRR.

The kappa statistic is generally considered to be the "gold standard" statistic associated with item reliability as it factors in the possibility of chance agreement. Kappa values are reported as decimal values between 0.00 (poor) and 1.00 (perfect). These can be interpreted using the following seven categories[12]:

- Poor < 0.10
- Slight = 0.10 to 0.20
- Fair = 0.21 to 0.40
- Moderate = 0.41 to 0.60
- Substantial = 0.61 to 0.80
- Near perfect= 0.81 to 0.99
- Perfect = 1.00

The remainder of this section describes the IRR results for the paired SOC/ROC and DC assessments. Findings are organized by OASIS domain, with a narrative description of findings followed by presentation of item-level data.

3.2.1 OASIS Functional Items

For the majority of OASIS functional items (Exhibit 6), moderate levels of agreement were found for the SOC/ROC assessment ($0.40 < \kappa < 0.60$). For all but one item, the level of agreement for DC assessments was higher than the level of agreement from SOC/ROC assessments. On DC assessments, five of the 11 functional items had substantial agreement ($0.60 < \kappa < 0.80$).

Agreement for grooming (M1800) was fair ($\kappa = 0.37$) at SOC/ROC but increased to moderate at DC ($\kappa = 0.57$). The percentage of assessments where the two assessors agreed increased from 60.8 percent for SOC/ROC assessments to 77.1 percent for DC assessments. For the two dressing items (M1810 and M1820), only moderate levels of agreement for SOC/ROC assessments were found but the level of agreement increased to substantial for DC assessments. At both SOC/ROC and DC, the level of agreement for upper body dressing (M1820) was higher than the level of agreement for lower body dressing (M1810).

[12] Landis JR, Koch GG. The measurement of observer agreement for categorical data. Biometrics, 1977. 33(1):159-174.

Exhibit 6. Kappa Values for OASIS Functional Items

	N[1]	Weighted Kappa	Kappa Rating[2]	% Observed Agreement
SOC/ROC*				
M1800 Grooming	104	0.37	Fair	60.8%
M1810 Dress upper body	104	0.51	Moderate	66.0%
M1820 Dress lower body	104	0.58	Moderate	65.0%
M1830 Bathing	104	0.51	Moderate	58.3%
M1840 Toilet transferring	104	0.49	Moderate	68.9%
M1845 Toilet hygiene	104	0.51	Moderate	53.4%
M1850 Transferring	104	0.42	Moderate	66.0%
M1860 Ambulation	105	0.43	Moderate	67.0%
M1870 Eating	105	0.22	Fair	62.5%
M1880 Prepare light meals	105	0.41	Moderate	60.6%
M2020 Management of oral meds.	105	1.00	Perfect	100.0%
Discharge				
M1800 Grooming	84	0.57	Moderate	77.1%
M1810 Dress upper body	84	0.72	Substantial	68.7%
M1820 Dress lower body	84	0.77	Substantial	77.1%
M1830 Bathing	83	0.43	Moderate	55.4%
M1840 Toilet transferring	83	0.56	Moderate	86.7%
M1845 Toilet hygiene	84	0.59	Moderate	84.3%
M1850 Transferring	83	0.45	Moderate	69.9%
M1860 Ambulation	83	0.67	Substantial	77.1%
M1870 Eating	84	0.32	Fair	75.9%
M1880 Prepare light meals	83	0.60	Substantial	77.1%
M2020 Management of oral meds.	84	0.65	Substantial	74.4%

Notes: *SOC = start of care; ROC = resumption of care; 1) the SOC/ROC and DC sample size reported in the table is for the first assessor; the sample sizes for the two assessors tended to be virtually identical; sample size varies due to missing data; 2) Kappa values are grouped into categories using these thresholds:

- Poor < 0.10
- Slight = 0.10 to 0.20
- Fair = 0.21 to 0.40
- Moderate = 0.41 to 0.60
- Substantial = 0.61 to 0.80
- Near perfect= 0.81 to 0.99
- Perfect = 1.00

Source: Abt Associates' analysis of paired SOC/ROC and DC OASIS assessments, 2017.

Unlike the other functional items, the level of agreement for bathing (M1830) was actually lower at DC than at SOC/ROC, although both sets of assessments indicated moderate levels of agreement. While agreement was higher for DC assessments, the level of agreement for the two toileting items (M1840 and M1845) was in the moderate range for both SOC/ROC and DC assessments. For DC assessments, the percentage observed agreement between the two assessors was 86.7 percent for M1840 and 84.3 percent for M1845.Transferring (M1850) had almost the same level of moderate agreement for SOC/ROC ($\kappa = 0.42$) and DC ($\kappa = 0.45$) assessments.

Agreement for ambulation (M1860) was moderate ($\kappa = 0.43$) for SOC/ROC assessments, but increased to substantial agreement ($\kappa = 0.67$) for DC assessments.

The kappa values for eating (M1870) were much lower for SOC/ROC assessments ($\kappa = 0.22$) and for DC assessments ($\kappa = 0.32$) than those for any other functional item tested, reflecting only a fair level of agreement. While the percent observed agreement for this item was relatively high (62.5 percent for SOC/ROC and 75.9 percent for DC assessments), there were some cases where there were substantial differences in assessor values for this item, causing the kappa values to be low. For prepare light meals (M1880), there was a moderate level of agreement for SOC/ROC assessments ($\kappa = 0.41$) and a substantial level of agreement for DC assessments ($\kappa = 0.60$). The percentage of assessments with agreement between the two assessors for this item increased from 60.6 percent for SOC/ROC assessments to 77.1 percent for DC assessments. The management of oral medications item (M2020) had perfect agreement ($\kappa = 1.00$) for SOC/ROC assessments and substantial agreement ($\kappa = 0.65$) for DC assessments.

3.2.2 OASIS Physiological/Psychological Items

For all but two of the OASIS physiological/psychological items included in the field test (Exhibit 7), agreements were in the fair or moderate range at SOC/ROC ($0.20 < \kappa < 0.55$). At DC, the levels of agreement for four of the five physiological/psychological items were also in the fair or moderate range ($0.26 < \kappa < 0.57$).

The level of agreement varied widely for the four sensory status items included in the field test, ranging from fair for vision (M1200) to moderate for understand verbal content (M1220) to substantial for speech (M1230) to perfect for hearing (M1210) Note that even though the percent observed agreement on M1200 was higher than that of M1220 and M1230, the weighted kappa value is lower for M1200, as M1200 only has three response categories compared to four for M1220 and six for M1230.

Agreement for the two pain items [pain assessment (M1240) and frequency of pain (M1242)] were both moderate ($\kappa = 0.55$ and 0.53, respectively). The percent observed agreement for M1240 was higher (78.4 percent) than the agreement for M1242 (62.1 percent), but M1240 has only three response categories versus five for M1242. Agreement was lower for M1242 at DC ($\kappa = 0.45$) than at SOC/ROC ($\kappa = 0.53$).

For the respiratory item, shortness of breath (M1400), the kappa value was 0.38, which indicates only a fair level of agreement. The percent observed agreement on this item was only 52 percent, likely reflecting assessor difficulties in distinguishing the different categories that this item uses (e.g., minimal vs. moderate exertion).

There were two neuro/emotional/behavioral status items—memory deficits and impaired decision making—with sufficient numbers of responses for reliability testing. Both of these items are response options for M1740, which captures information on cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week. While the overall percent observed agreement was over 90 percent for both of these items, the kappa values at SOC/ROC

were in the 0.40 to 0.49 range, indicating a moderate level of agreement. At DC, the kappa values were 0.26 and 0.33, indicating only fair agreement.

Exhibit 7. Kappa Values for OASIS Physiological/Psychological Items

	N[1]	Weighted Kappa	Kappa Rating[2]	% Observed Agreement
SOC/ROC*				
M1200 Vision	105	0.36	Fair	75.0%
M1210 Hearing	105	1.00	Perfect	100.0%
M1220 Understand verbal content	105	0.42	Moderate	60.2%
M1230 Speech	105	0.61	Substantial	67.0%
M1240 Standard pain assessment	103	0.55	Moderate	78.4%
M1242 Frequency of pain	105	0.53	Moderate	62.1%
M1400 Shortness of breath	105	0.38	Fair	52.0%
M1740 Memory deficits	105	0.49	Moderate	90.3%
M1740 Impaired decision making	104	0.42	Moderate	91.3%
M1033 Hosp**. Risk: exhaustion	104	0.28	Fair	80.6%
M1033 Hosp. risk: falls	104	0.54	Moderate	68.0%
M1033 Hosp. risk: mental decline	104	0.37	Fair	78.6%
M1033 Hosp. risk: multiple hospitalizations	104	0.55	Moderate	85.4%
M1033 Hosp. risk: other	105	0.22	Fair	86.4%
M1033 Hosp. risk: 5+ medications	104	0.20	Fair	87.4%
M2001 Drug regimen review	102	0.54	Moderate	85.1%
M2003 Medication follow-up	20	NC	NC	NC
Discharge				
M1230 Speech	81	0.57	Moderate	92.6%
M1242 Frequency of pain	84	0.45	Moderate	50.6%
M1400 Shortness of breath	83	0.69	Substantial	66.3%
M1740 Memory deficits	82	0.33	Fair	91.5%
M1740 Impaired decision making	84	0.26	Fair	93.9%

Notes: *SOC/ROC = start of care/resumption of care; **Hosp. = hospitalization; 1) the sample size reported in the table is for the first assessor; the sample sizes for the two assessors tended to be virtually identical; sample size varies due to missing data; 2) Kappa values are grouped into categories using these thresholds:

- Poor < 0.10
- Slight = 0.10 to 0.20
- Fair = 0.21 to 0.40
- Moderate = 0.41 to 0.60
- Substantial = 0.61 to 0.80
- Near perfect= 0.81 to 0.99
- Perfect = 1.00

Source: Abt Associates' analysis of paired SOC/ROC and DC OASIS assessments, 2017.

Kappa values were calculated for six indicators of risk for hospitalization, response options for M1033. The kappa values for these items ranged from 0.20 (for whether the patient was taking five or more medications) to 0.55 (for whether the patient had multiple hospitalizations in the past 12 months). For all six of these items, the levels of agreement were in the fair or moderate

range. Note that data for the hospitalization risk factors is only collected for the SOC/ROC assessment.

The kappa value for the SOC/ROC item drug regimen review (M2001) was 0.54, indicating moderate level of agreement. Medication follow-up (M2003), is only assessed for patients who are reported as having issues found during the drug regimen review. Data for this item were only available for 20 patients; thus, no kappa statistics are reported for M2003.

3.2.3 Standardized Patient Assessment Data Elements (SPADEs)

The SPADEs fall into several groupings including function, communication, memory, indicators of delirium, pain and falls. A summary of interrater reliability results by these subsets of items follows, along with presentation of the data in Exhibits 8 and 9.

3.2.4 SPADE Section GG Functional Items

Kappa values for the majority of GG functional items at SOC/ROC ranged between 0.43 and 0.59, indicating moderate levels of agreement. For most items, kappa values were higher at DC than at SOC/ROC, with the exception of four items: sit to stand (GG0170D), chair transfer (GG0170E), walk 10 feet (GG0170I), and walk 50 feet (GG0170J). For two of these functional items (GG0170E and GG0170I) the decrease in kappa value at DC resulted in a change in the associated level of agreement. Specifically, the kappa value at SOC/ROC for GG0170I was 0.43 (moderate), declining to -0.02 (poor) at DC; and the kappa value for GG0170E was 0.45 (moderate) at SOC/ROC, declining to 0.35 (fair) at DC . The kappa values for GG0170D and GG0170J decreased but stayed essentially the same between SOC/ROC and DC, remaining in the moderate and fair rating categories, respectively.

3.2.5 SPADE Physiological/Psychological Items

The verbal communication item (BB0800) had fair interrater agreement at both SOC/ROC and DC, while express wants (BB0700) had moderate agreement ($\kappa = 0.47$) at SOC/ROC and fair agreement ($\kappa = 0.21$) at DC.

The Brief Interview for Mental Status (BIMS) items repetition of three words (C0200), temporal orientation items (C0300A, C0300B, C0300C) and recall items (C0400A, C0400B, C0400C) had fair to moderate agreement at SOC/ROC and DC, though percent observed agreement for these items was relatively good. Several of these items had only slight agreement on the DC assessment, such as temporal orientation: month (C0300B), recall sock (C0400A) and recall bed (C0400C), with kappa values of 0.12, 0.19 and 0.14, respectively.

Exhibit 8. Kappa Values for GG Functional Items

	N[1]	Weighted Kappa	Kappa Rating[2]	% Observed Agreement
SOC/ROC*				
GG0130 Eating	103	0.14	Slight	63.3%
GG0130 Oral hygiene	101	0.52	Moderate	62.8%
GG0130 Toileting hygiene	103	0.24	Fair	21.0%
GG0130 Wash upper body	99	0.32	Fair	22.1%
GG0170A Roll left and right	98	0.23	Fair	51.1%
GG0170B Sit to lying	101	0.47	Moderate	37.9%
GG0170C Lying to sitting	101	0.59	Moderate	53.2%
GG0170D Sit to stand	101	0.48	Moderate	14.9%
GG0170E Chair transfer	103	0.45	Moderate	11.0%
GG0170F Toilet transfer	103	0.50	Moderate	19.6%
GG0170I Walk 10 ft.	99	0.43	Moderate	47.3%
GG0170J Walk 50 ft.	85	0.29	Fair	7.4%
Discharge				
GG0130 Eating	84	0.26	Fair	86.6%
GG0130 Oral hygiene	83	0.76	Substantial	87.8%
GG0130 Toileting hygiene	83	0.80	Substantial	78.0%
GG0130 Wash upper body	81	0.74	Substantial	75.0%
GG0170A Roll left and right	81	1.00	Perfect	93.5%
GG0170B Sit to lying	84	0.67	Substantial	90.9%
GG0170C Lying to sitting	83	0.85	Almost perfect	87.2%
GG0170D Sit to stand	83	0.46	Moderate	87.7%
GG0170E Chair transfer	83	0.35	Fair	83.5%
GG0170F Toilet transfer	84	0.54	Moderate	87.5%
GG0170I Walk 10 ft.	81	-0.02	Poor	87.8%
GG0170J Walk 50 ft.	84	0.25	Fair	85.5%

Notes: *SOC/ROC = start of care/resumption of care; 1) the sample size reported in the table is for the first assessor; the sample sizes for the two assessors tended to be virtually identical; sample size varies due to missing data 2) Kappa values are grouped into categories using these thresholds:

- Poor < 0.10
- Slight = 0.10 to 0.20
- Fair = 0.21 to 0.40
- Moderate = 0.41 to 0.60
- Substantial = 0.61 to 0.80
- Near perfect= 0.81 to 0.99
- Perfect = 1.00

Source: Abt Associates' analysis of paired SOC/ROC and DC OASIS assessments, 2017.

Exhibit 9. Kappa Scores for Non-OASIS/New OASIS Items

	N[1]	Weighted Kappa	Kappa Rating[2]	% Observed Agreement
SOC/ROC*				
BB0700 Express wants	105	0.47	Moderate	81.0%
BB0800 Understand verbal	105	0.37	Fair	58.1%
C0200 Repetition of three words	106	0.27	Fair	89.6%
C0300A Temporal orientation (year)	106	0.52	Moderate	91.5%
C0300B Temporal orientation (month)	106	0.44	Moderate	98.1%
C0300C Temporal orientation (day)	106	0.39	Fair	92.5%
C0400A Recall “sock”	106	0.38	Fair	70.8%
C0400B Recall “blue”	106	0.34	Fair	77.4%
C0400C Recall “bed”	106	0.36	Fair	77.4%
C0500 BIMS summary score	106	n/a	n/a	n/a
C1310A Acute onset mental status change	106	0.48	Moderate	96.2%
C1310B Inattention	105	0.31	Fair	86.7%
C1310C Disorganized thinking	106	0.20	Fair	90.5%
C1310D Altered consciousness	106	0.89	Near perfect	99.0%
H0400 Bowel continence	105	0.25	Fair	79.2%
J0400 Pain frequency	102	0.34	Fair	55.4%
J0500A Pain effect on sleep	91	0.56	Moderate	78.0%
J0500B Pain effect on day-to-day activities	94	0.20	Slight	67.5%
MXXXX Nutritional risk assessment	94	0.23	Fair	55.3%
Discharge				
BB0700 Express wants	83	0.21	Fair	84.3%
BB0800 Understand verbal	82	0.26	Fair	84.1%
C0200 Repetition of three words	84	0.27	Fair	97.6%
C0300A Temporal orientation (year)	83	0.48	Moderate	94.0%
C0300B Temporal orientation (month)	83	0.12	Slight	92.8%
C0300C Temporal orientation (day)	84	0.22	Fair	88.0%
C0400A Recall “sock”	84	0.19	Slight	73.5%
C0400B Recall “blue”	84	0.48	Moderate	86.7%
C0400C Recall “bed”	83	0.14	Slight	84.1%
C0500 BIMS summary score	84	n/a	n/a	n/a
H0400 Bowel continence	80	0.32	Fair	82.3%
J0400 Pain frequency	46	0.49	Moderate	69.2%
J0500A Pain effect on sleep	51	0.63	Substantial	82.1%
J0500B Pain effect on day-to-day activities	46	0.39	Fair	69.2%
J1800 Any falls	83	0.69	Substantial	92.8%
J1900 Falls with no injury	10	0.25	Fair	66.7%

Notes: *SOC/ROC = start of care/resumption of care; 1) the sample size reported in the table is for the first assessor; the sample sizes for the two assessors tended to be virtually identical; sample size varies due to missing data; 2) Kappa values are grouped into categories using these thresholds:

- Poor < 0.10
- Slight = 0.10 to 0.20
- Fair = 0.21 to 0.40
- Moderate = 0.41 to 0.60
- Substantial = 0.61 to 0.80
- Near perfect= 0.81 to 0.99
- Perfect = 1.00

Source: Abt Associates’ analysis of paired SOC/ROC and DC OASIS assessments, 2017.

The Confusion Assessment Method (CAM) items (C1301A, B, C and D) assess signs and symptoms of delirium and were captured at SOC/ROC only. These items all had high percent observed agreement between raters, and kappa values ranged from fair (C1310C - disorganized thinking, $\kappa = 0.20$) to moderate (C1310A - acute onset mental status change, $\kappa = 0.48$) to near perfect agreement (C1310D - altered consciousness, $\kappa = 0.89$).

Interrater agreement for the pain items (J0400, J0500A, J0500B) was relatively good, with the exception of pain effect on day-to-day activities (J0500B) at SOC/ROC ($\kappa = 0.20$, and observed agreement = 67.5 percent).

The two falls items (J1800 - any falls, and J1900 - falls with injury) were collected at DC only and found to have substantial ($\kappa = 0.69$) and fair ($\kappa = 0.25$) agreement, respectively. Findings related to J1900 must be taken with caution, however, as only 10 paired assessments of this item were obtained during the field test.

3.3 Validity and Feasibility

3.3.1 Focus Group Results

The focus group discussions provided rich qualitative data on HHA clinicians' understanding of individual items, the feasibility of collecting the requested information, perceived value and areas of potential confusion or need for additional guidance. Clinician survey responses were echoed in focus group discussions. Survey comments are integrated with the focus group summary. Key findings are summarized below by item or item groupings.

M1028 Active Diagnoses

Focus group participants generally agreed this item was easy to understand but identified issues with collecting complete, accurate information. Several participants expressed confusion or questioned the intent of the item, and specifically what "active" meant, despite the presence of a specific definition in the guidance. A majority of participants reported referral information and patient self-report as the data sources for this item. Several noted, however, that limited or absent records for patient history and diagnoses was a barrier. All agreed patients were familiar with diabetes and were aware of whether they had this diagnosis. In contrast, clinicians across multiple focus groups reported that patients did not know what peripheral vascular or arterial disease was, and were not able to report whether they had the condition.

A large majority of participants expressed confusion about why diabetes and peripheral vascular or peripheral arterial disease were selected for the item. Nearly all clinicians suggested that heart failure (HF) and chronic obstructive pulmonary disease were more prevalent and appropriate to identify and consider for risk adjustment in the HH patient population. Clinicians across several groups asked why item M1028 was needed when these conditions, if present, would likely be noted in the M1021 Primary Diagnosis and M1023 Other Diagnoses items.

M1060 Height and Weight

Across all focus groups, participants had substantial and similar feedback on the M1060 (height and weight) item, which was new in OASIS-C2. The HHA participants in general did not

perceive that measurement of height was as important as measurement of weight. Among all clinicians who responded to the question, patient self-report was the data source used historically to collect height information. Clinicians agreed that multiple clinical and environmental barriers were present in the HH setting that interfered with accurate and reliable measurement of weight. Clinical issues described included orthopedic patients who are non-weight-bearing or toe-touch only at SOC/ROC; older and/or frail patients with impaired balance; and, patients whose weight exceeds capacity of the equipment. Environmental issues included home settings with carpeted and/or uneven floors, limited space and inadequate lighting. These focus group participants also discussed access to scales, noting that when their agencies provided scales for clinicians to carry from patient to patient, they had encountered issues with re-calibration, quality checks and infection control. According to these clinicians, patients' scales may produce inconsistent measurement and, patients may lack the resources to purchase new scales or may decline to do so despite recommendations from clinicians. Some suggested measured weight in HH was only relevant for certain conditions and a few participants questioned how the data would support risk adjustment when collection of accurate weight is infeasible for as many as 50 percent of their patient population.

The focus group participants had multiple suggestions for tailoring the height and weight item in HH to increase the reliability of the information recorded. These included measurement after SOC, or measurement at DC, to provide accurate information for the care transition. Several possible additional response options were suggested, such as 'not performed due to safety concerns,' or 'unable to obtain.' Some suggested adding a place in the item to identify whether the weight recorded was self-report, measured, or most recent measured weight, with date.

Mxxx Nutritional Risk Assessment

The field test instrument included one new item that was not included on OASIS-C2 or other PAC assessment tools: a test item (Mxxx) asking about screening for nutritional risk. The team added this item due to the importance of nutritional risk among community-dwelling older adults. Most participants characterized nutritional assessment as important, with discussions about this item centered on the type of risk assessment tool their agencies used. Most already have a nutritional risk screening tool embedded in the comprehensive assessment and the major concern brought forth by clinicians was the lack of resources and interventions to address problems identified in screening. The general consensus among participants across all groups was that beyond basic and condition specific nutrition assessment and education, they are not experts in nutrition assessment and intervention for advanced or complex problems. Recommendations that emerged from the discussions included the need for HHAs to work with electronic health record (EHR) vendors to integrate nutritional risk assessment into the assessment or to identify a screening or assessment tool to incorporate into OASIS.

J1800 & J1900 Falls

Participants agreed that falls is a relevant issue for HH; however, some participants questioned the implications of public reporting of fall rates. They suggested comparison of HH rates with

facility-based rates would not be meaningful, given the lack of environmental control and the lack of control over patients' safety decisions in the HH setting.

Clinicians across all groups noted that tracking falls in their current EHR was difficult or impossible—the record was not organized with a standard location to identify and document falls, or to track and retrieve information about prior falls during DC assessment. Clinicians also reported that they believe they are unaware of most falls that occur among patients receiving HH; that is, patients do not report falls, especially falls that do not result in major injury.

Suggestions for standard documentation on falls included having an option for noting whether a fall was witnessed or not witnessed; a space for documentation of associated factors (such as the dog tripped the patient or the patient was dizzy); and a space to note compliance issues (such as the patient left the walker in the corner or the patient does not use assistance as recommended).

J0300–J0500 Pain Assessment

Focus group participants liked these items, finding them specific, clear and easy to understand. In general, they preferred these items to OASIS-C2 items related to pain. Although a few said the five-day look-back was too long, adding that their patients could not really remember clearly or accurately, most liked the five-day look-back better than the day of assessment, noting it provided a more realistic, accurate picture of patients' pain. Clinicians also liked J0500, which specifically asks the effect of pain on function and sleep. Participants liked having the response option "unable to answer" but noted they would find more guidance about when to use this response helpful. Recommendations for the items and guidance included need for a distinction between acute and chronic pain; the need to document when pain is being managed to the extent possible and there is no expectation it will improve; and, the need for an option to indicate the patient is independent with pain management.

C0200–C0500 Brief Interview for Mental Status (BIMS)

Focus group participants liked the BIMS and noted they did not have any tool or assessment currently that captured this information. A few said they were concerned that the questions would make patients uncomfortable, or would make the patient feel bad (e.g., as though something was wrong with them). Some noted it provided insight into patient abilities and helped guide care planning and teaching. Clinicians expressed a preference for the BIMS compared with current OASIS-C2 items related to cognition. They identified a need for guidance about how to assess patients with minimal or absent hearing, or patients for whom English is a second language.

C1310 Signs and Symptoms of Delirium

Some clinicians thought this item was useful in the HH assessment, while others did not. A concern was expressed that this assessment would be burdensome to complete at the SOC/ROC visit, and overwhelming for patients, so should instead be completed at subsequent visits. One participant questioned the usefulness of the item, noting presence of acute delirium would require intervention and assessment would be deferred.

RNs were more likely than PTs to express comfort with their understanding of signs of delirium. Some therapists noted the guidance section was helpful, which detailed what delirium is and how to assess. Some participants noted baseline mental status is hard to determine in HH due to a lack of access to patient history records and sometimes because no caregiver or family member is present. They recommended a response option for "unable to establish baseline" or "unable to determine."

GG0130 Self-care and GG0170 Mobility

Although participants were asked specific questions about these items individually, discussion typically addressed the items together, particularly in consideration of the response scale. Many participants, both RNs and PTs, maintained that the comprehensive functional assessment should be completed by physical and occupational therapists, not nurses. Feedback about DC goals was similar. Many RN participants said rehabilitation goal setting was the practice of therapists; PT participants tended to agree. A minority held the opinion that a basic functional assessment and identification of preliminary goals was within the scope of both nursing practice and rehabilitation therapy. Participants in one group mentioned that collaborative assessment of functional assessment would be helpful for RNs, in the same way that collaborative assessment of medication management and drug regimen review was helpful for PTs.

PTs were more likely than RNs to like the items, and to like to the response scale. Many, but not all, PTs preferred the GG items to the OASIS-C2 items for assessment of function, pointing to clear and concrete language defining activities and the response scale. Some PTs questioned the relevance of including the activity "walk 150 feet" for HH. Some PTs expressed concern that the GG0170 item did not address levels of function within the score for independent with ambulation preventing identification of improvements in function within this category.

Clinicians across most of the focus groups identified challenges associated with observation or performance testing for every activity, noting this did not reflect actual practice, where performance is assessed for key activities, and inferred for less essential activities. Some participants noted that the assessment was not realistic because there were too many activities in the mobility item (GG0170). Others expressed that performance assessment of all activities was too burdensome for the patient, noting the initial visit is lengthy and fatiguing for patients.

BB0700 Expression of Ideas and Wants & BB0800 Understands Verbal Content

These two items are similar to the extant OASIS-C2 items M1220 Understanding verbal content and M1230 Speech. Overall, focus group participants did not identify any significant difference between the OASIS-C2 items versus the standardized items, and did not express any preference for one set over another. The only difficulty participants identified was the response scale for BB0700 and BB0800, which is formatted in reverse order compared to that of OASIS items.

H0400 Bowel Continence

Participants' feedback was mixed about this item in comparison to the parallel OASIS-C2 item, M1240 Bowel incontinence. Some preferred the OASIS-C2 item over the standardized item, while others did not. Some liked the seven-day look-back; others thought it was too long. Some

participants suggested simplifying the item by including only two response options: "incontinent" and "not incontinent."

Pressure Ulcer Items and Guidance

Most participants had no significant concerns or suggestions related to these items, or the associated guidance. Participants in two focus groups mentioned they liked the revised guidance for the improved clarity of definitions. Some of the PTs said they are not comfortable assessing pressure ulcers; the complexity of the assessment increased burden for the clinicians. When asked about the DC items, many participants described the look-back required to complete the items as too time-consuming, and difficult to accomplish with the way their EHR was set up. Participants went on to note that all items where a look-back to the most recent SOC/ROC, or follow-up assessment, were difficult to accomplish, time-consuming and burdensome.

M2001–M2005 Drug Regimen Review Items

Participants across all focus groups expressed two primary concerns with these items. First, clinicians said they had difficulty identifying which issues were "true" issues. One participant suggested changing the wording from "clinically significant" to "life-threatening." The second major concern participants identified was poor communication with physicians.[13] All participants reported physicians not calling back, especially on weekends. Many characterized this as a routine and long-standing problem, some describing this in terms of having "tried everything" to improve communication without success.

Additional Topics

Revised look-back period to the most recent SOC/ROC instead of most recent OASIS: Participants were asked for feedback about the revised look-back period, applicable to items M1500 and M1511 (HF); M2410 Emergent care, and M2005 Medication interventions. The revised look-back called for reviewing the record from the most recent SOC/ROC, rather than the most recent OASIS (which includes Follow-up/Recertification). Overall, the issue participants identified was challenges associated with reconfiguring tracking sheets and electronic records to facilitate identification of the relevant events. Several participants commented the revised process would be more burdensome, in terms of the amount of time required to read clinical notes all the way back to the SOC/ROC.

Use of the dash as a valid response: Participants reported that they did not often use the dash during the field test, in part because it is a new option, unfamiliar to them. Historically, every OASIS item must be answered before the assessment may be submitted (except in the case of legitimate skip patterns). Participants noted that the EHRs will have to be adapted to allow this response type.

Guidance: Participants had access to the existing OASIS-C1/ICD-10 and OASIS-C2 guidance for current items included in the field test. For the SPADEs guidance from settings where the

[13] Facilitators did not ask participants to distinguish specifically between physicians, nurse practitioners, physician assistants, etc.

items are used was provided to clinicians. The field test team wanted to understand clinicians' perspectives on the guidance.

When asked, participants reported they reviewed the guidance for the field test items initially, but then did not return to it during the field test. A few mentioned they referenced the guidance for the functional items during the field test. None reported any difficulty or concern with the different format and structure of standardized item guidance, compared to OASIS guidance.

When asked about current use of the OASIS guidance, a majority described using the tips and noted these were linked to the items in the EHR. These participants did not use the printed guidance manual. Participants also identified the clinical manager at their agency as another resource for assistance with OASIS items.

3.4 Patient Reported Outcomes

The field test included two data collection instruments for PRO; the PROMIS v1.1 Global health survey; and the PGRO survey. We present results of these surveys in this section; copies of each instrument can be found in Appendix I.

3.4.1 PROMIS Results[14]

PROMIS surveys were completed by 150 patients at SOC/ROC or DC. These participants were similar to the total field test sample in terms of age, gender and race/ethnicity. Thirty-two percent of the total sample was aged 85 years and older, compared to 31.5 percent of SOC/ROC survey respondents and 26.4 percent of DC survey respondents. Nearly two-thirds of the total sample (62 percent) was female compared to 61 percent of SOC/ROC survey respondents and 54 percent of DC respondents. And a majority across all three groups was white (83.1 - 83.9 percent).

The PROMIS v1.1 Global Health survey supports two subscales: Global Physical Health (GPH), and Global Mental Health (GMH) [15] Exhibit 10 displays the items used in each.

[14] A version of these results was presented September 27, 2017: **Riggs**, Madigan, Gonzaga, Gillis, Starr, Roczen and **Nuccio**. *Feasibility of home health care patients' self-administration of the PROMIS Global Health Survey.* HealthMeasures User Conference, Northwestern University, Chicago, IL.

[15] Hays RD, Bjorner JB, Revicki DA, Spritzer KL, Cella D. Development of physical and mental health summary scores from the patient-reported outcomes measurement information system (PROMIS) global items. *Qual Life Res* 2009 Sep; 18(7):873-80. doi: 10.1007/s11136-009-9496-9.

Exhibit 10. Global Health Scale Subscales*

Global Physical Health (GPH)	Global Mental Health (GMH)
Global 03 How would you rate your physical health?	*Global 02* Would you say your quality of life is…
Global 06 To what extent are you able to carry out your everyday activities?	*Global 04* How would you rate your mental health?
Global 07 How would you rate your pain on average?	*Global 05* How would you rate your satisfaction with your social activities and relationships?
Global 08 How would you rate your fatigue on average?	*Global 10* How often have you been bothered by emotional problems?

*Item descriptions abbreviated. Source: Hays et al, 2009[16]

The GPH and GMH scores for the sample were computed and compared with the reference population subgroup of adults age 65 and older, based on the United States General Census 2000[17]. The field test patients reported significantly worse global physical and mental health, compared to the reference population (Exhibit 11).

Exhibit 11. Field Test Participants' Global Physical and Global Mental Health Scores

	Number of Observations	Mean	Standard Deviation	Significance (p value)
Global Physical Health (GPH)				
Field test patients' GPH scores	106	38.5	4.9	
Reference population	1,396	50.5	9.6	< .001
Global Mental Health (GMH)				
Field test patients' GMH scores	108	45.7	6.9	
Reference population	1,394	53.3	8.6	< .001

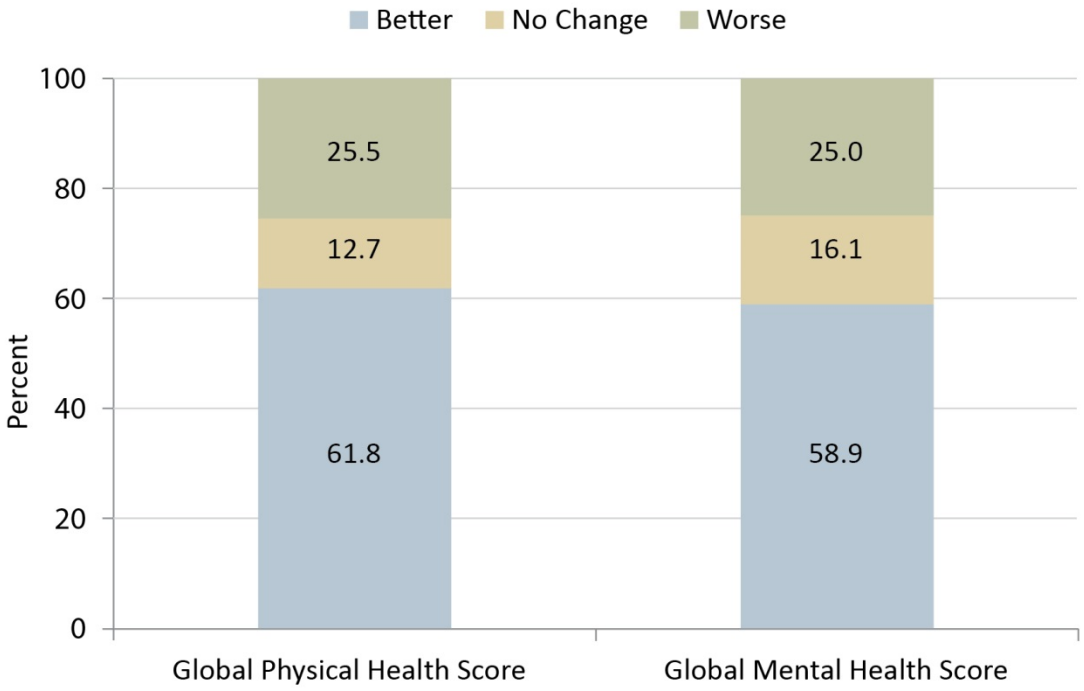
Source: Abt Associates' analysis of field test participants' global physical and global mental health scores, 2017.

When DC scores were compared with those from SOC/ROC for the field test sample, we found a majority of patients' self-reported GPH and GMH scores improved during the home health episode (62 percent and 59 percent, respectively). Results are shown in Exhibit 12 below.

[16] ibid

[17] HealthMeasures.net, Score and Interpret PROMIS web page, available at http://www.healthmeasures.net/score-and-interpret/interpret-scores/promis

Exhibit 12. Change in Global Physical and Mental Health Scores

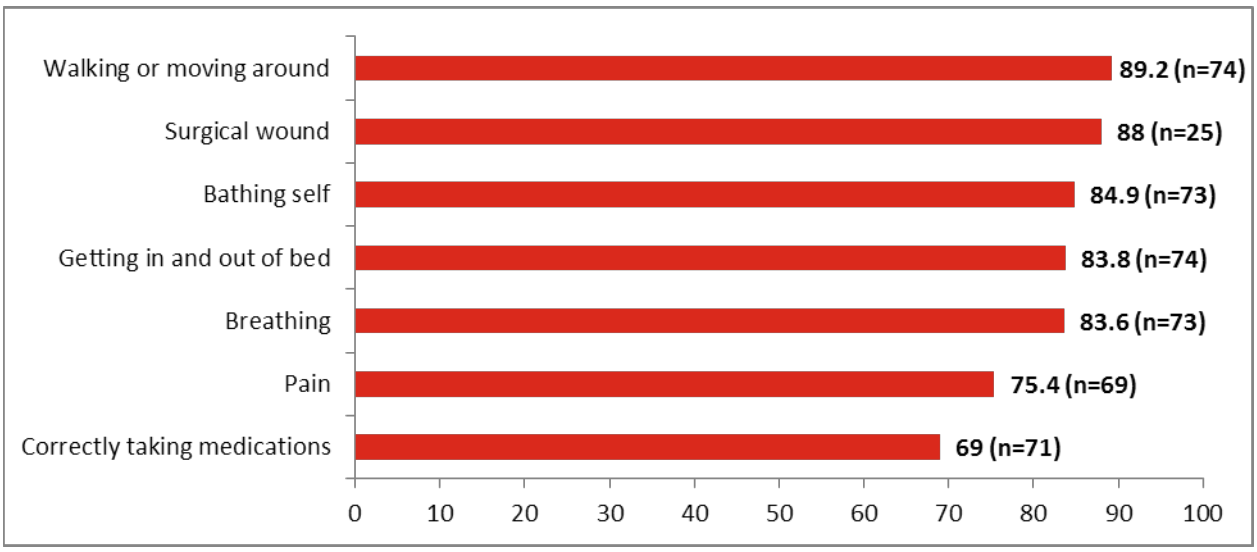


Source: Abt Associates' analysis of field test participants' global physical health and global mental health scores, 2017.

3.4.2 Patient Global Rating of Outcomes Results

Across the 12 participating HHAs, 77 patients completed the PGRO survey. These surveys were collected only at DC. Patients were asked whether they thought they had improved "between your first home visit and today" in the following domains: walking or moving around, getting in and out of bed, bathing, correctly taking medications by mouth, breathing, pain, and surgical wounds. Exhibit 13 shows the percentage of patients reporting improvement, by domain. Of all the domains queried, improvement was most often reported in walking or moving around (89.2 percent of patients) and least often reported for correctly taking medications by mouth (69 percent of patients).

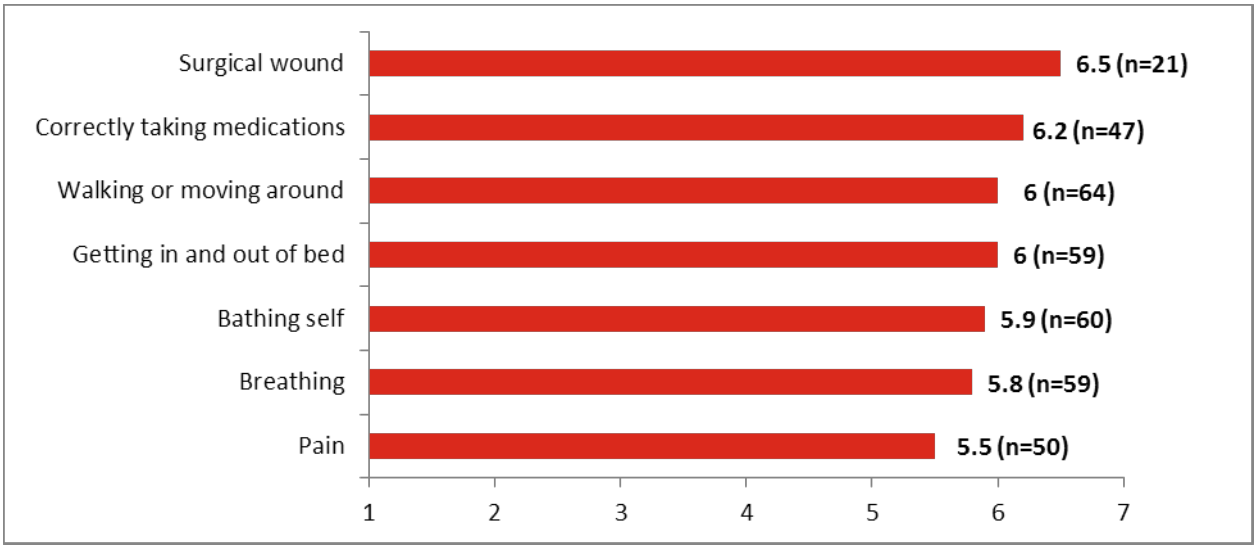
Exhibit 13. Percentage of Patients Reporting Improvement*



*Excludes "NA" and missing responses. Source: Abt Associates' analysis of field test Patient Global Rating of Outcomes data, 2017.

Patients indicating improvement were also asked to rate their improvement on the scale of 1 (not at all improved) to 7 (very much improved). Exhibit 14 shows the average extent of improvement reported, by domain. The greatest gains were reported in surgical wounds (mean response=6.5), while the lowest were reported in pain (mean response=5.5)

Exhibit 14. Average Extent of Improvement Reported by Patients (1=Lowest - 7=Highest)*



*Not all of the patients indicating improvement answered this question. Source: Abt Associates' analysis of Patient Global Rating of Outcomes data, 2017.

3.4.3 Focus Group Results related to the PROMIS survey

PROMIS

Overall, clinicians reported that they believe PROs have value and relevance for patient care. Some described being able (during the field test visits) to integrate the patient's self-report into discussion of goals for care and, at DC, discussion of whether goals were achieved by comparing self-report at DC to report at SOC/ROC. Some clinicians, however, reported they did not think the patients' self-report was useful, and that collecting these data would add work and burden. One clinician said the survey gave her insight into the patient's perceptions that differed from her own: *"You walk in and think they're doing terrible and they're like, 'hey…I'm good.'"*

The clinicians were about evenly divided in concluding that their patients found the survey confusing or difficult. Their conclusions were based in part on questions patients asked, and in part on their observations during the home visit. Some clinicians reported that patients found the seven-point response scale confusing: *"They are more used to the 0-10 scale, like for pain."* Others reported that patients had difficulty distinguishing between items and asked questions about the difference between overall health and physical health, for example. Several clinicians noted the activities listed as examples in the 'day-to-day activities' item, such as carrying groceries and moving a chair, did not apply to their older, more frail patients, for whom these examples would never be part of their day-to-day activities.

Clinicians noted that the PROMIS surveys would not apply to their patients with cognitive impairments sufficient to prevent self-report (which reportedly constituted a substantial proportion of their patient population). The RNs and PTs also questioned how their patients' caregivers could be included, describing the central role caregivers serve in home care, not only for assistance with care activities but in discussions of care preferences and decision-making about goals.

Perceptions of Self-report

The HHA teams shared their perspectives of self-report based on what they learned and experienced during the field test. Clinicians in about half of the focus groups characterized patient self-report as 'subjective' and 'unrealistic.' Focus group participants questioned what the information would be used for, if the PROMIS surveys were eventually required by CMS. The RNs and PTs compared patient self-report with their clinical assessments and questioned if employers or external stakeholders would favor patient self-report over clinical assessment in the event of discrepancies between the two. Some questioned how a quality measure for patient self-report of improvement, or lack of improvement, would be considered: *"Will there be a penalty if patients don't agree there's been improvement?"* Participants were in general agreement that HH patients overstate health and functional status. According to these clinicians, patients overstate independence to avoid family or care team pressure to move from home to a more restrictive, higher level of care setting. Clinicians reported commonly encountering this scenario in their clinical practice.

4. Discussion and Conclusions

The field test findings suggest that most items tested showed reasonable levels of reliability. Differences in agreement between familiar (existing OASIS) and unfamiliar (SPADEs) items at both SOC/ROC and DC suggest the need for agency-level training and detailed guidance as new items are introduced. Some differences in the field test item agreement may indicate that more training for RNs and PTs was needed prior to beginning data collection. Reliability of the OASIS items that underlie HH quality metrics, value-based purchasing and prospective payment is essential to lend confidence to their continued use and for maintaining consensus endorsement.

Clinicians contributed substantial qualitative information about their experiences with, and understanding of, the items tested, particularly the SPADEs. Qualitative data support validity and feasibility of most items tested, and highlight items that will benefit from focused training and guidance. The study also demonstrated that implementation of the patient self-administered PROMIS v1.1 Global health survey is feasible among this sample of HH patients. These findings may inform potential future data collection and quality measure development activities for CMS.

4.1 Limitations

This study had several limitations. Regional comparisons were not an objective of this test; HHAs were recruited based on ability to participate, and location of the study team. Convenience sampling was used to enroll patient participants within HHA. The sampling plan for this test was aimed at powering specific reliability and validity analyses. Data collection targets were not achieved for all analyses, specifically for responsiveness testing. Delays in beginning the study resulted in data collection occurring first while OASIS-C1/ICD10 was in effect, then OASIS-C2, which may have impacted clinicians' understanding of the items being tested.

Limitations in reliability testing included that comparison of reliability results by discipline (RN or PT) was not possible. Further, when assessing percent agreement and interpreting the kappa results, the fact that the assessors were more familiar with the OASIS-C2 items and the associated response option scales when compared with the SPADE items and scales is one factor that may have influenced the values observed. Finally, for several of the SPADE functional assessment items, high numbers of patients were rated as independent at SOC/ROC, and exceptionally high numbers of patients were rated as independent at DC, which may skew kappa computations.

4.2 Reliability

With these limitations in mind, the kappa values for most OASIS-C2 items were typically in the moderate range, with slightly higher agreement for DC than for SOC/ROC. Similarly, the kappa values for all SPADEs were slightly higher for DC than for SOC/ROC. At SOC/ROC, the kappa values for SPADE physiological/psychological items were higher than those for SPADE functional items. Considering functional items at SOC/ROC, kappa values were higher for

OASIS-C2 items than for SPADEs. At DC, kappa values for all SPADEs were slightly higher than the values for all OASIS-C2 items.

Overall, findings suggest the items tested measure the underlying constructs reliably. Differences in values between familiar and unfamiliar items at SOC/ROC, and higher kappa values at DC compared with SOC/ROC may also suggest, in part, the impact of learning as clinicians gained familiarity with items. This underscores the importance of detailed guidance and availability of training specific to any new items incorporated into the OASIS.

4.3 Validity and Feasibility

Some SPADEs, such as the pain items and the BIMS, appealed to clinicians as easy to understand, easy to ask patients and helpful in clinical assessment. The parallel items related to comprehension and continence did not pose significant problems to clinicians in testing, suggesting that future replacement of extant OASIS items with similar items may be feasible in terms of clinical assessment. Feedback received on the height and weight item highlights the unique nature of the HH setting, delineating potential clinical and environmental barriers to accurate measurement. These findings underscore the need for HH-specific consideration in guidance and training for new items.

Clinicians responded positively to some aspects of the SPADE Section GG functional items, such as the clarity and specificity of the activities listed for assessment. Questions were raised about variation in functional assessment by RNs versus PTs, and whether identification of functional DC goals was an appropriate activity for RNs. These are similar to questions raised about functional assessment with OASIS, suggesting a potential need to revise existing guidance and training.

Overall, clinicians' feedback and questions about the items tested illuminate opportunities for development of focused guidance in the OASIS Guidance Manual that addresses known questions and clarifies areas of confusion. Effective guidance and training supports clinicians' ability to complete OASIS items accurately for submission of consistent, high quality data to CMS.

4.4 Patient Reported Outcomes

Use of the PROMIS survey was found to be feasible among cognitively intact HH patients, and the clinicians found value in the patient self-report. Future testing could expand to non-English speaking patients, incorporate a larger sample, and consider how to include proxy or caregiver report.

4.5 Implementation Lessons Learned

In addition to providing evidence on the psychometric properties of current OASIS-C2 items and PAC assessment items, the field test yielded important lessons learned that can be applied to future testing efforts.

4.5.1 Home Health Agency Staff Engagement with Testing

Throughout the field test, HHA leaders and clinicians were very motivated to participate, expressing ongoing interest in contributing to the OASIS. In provider feedback sessions following completion of the field test, participants expressed interest in taking part in the design process for future testing, to further enhance the feasibility and minimize the burden of testing procedures. We expect the inclusion of HH leaders and clinicians in testing design and development of procedures will improve the success of future field tests.

4.5.2 Data Collection

The HHA teams experienced challenges in data collection, due to staffing and logistical issues. In sharp contrast to past field tests, the workload associated with participation was more challenging, despite enhanced support by the field test team. In future testing, design and procedures need to be tailored to better align with HHA operations and to minimize burden. This could include, for example, concurrent assessment to measure IRR, in place of a second visit, use of non-HHA assessors, or an expanded pool of clinicians trained to conduct data collection at each participating agency.

Appendix I. Data Collection Instruments

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OASIS Field Test Start/Resumption of Care Assessment

(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?	
Enter Code ☐	1. Early 2. Later UK. Unknown NA. Not Applicable: No Medicare case mix group to be defined by this assessment.

PATIENT HISTORY AND DIAGNOSES

(M1000) From which of the following **Inpatient Facilities** was the patient discharged within the past 14 days? **(Mark all that apply.)**

- ☐ 1 - Long-term nursing facility (NF)
- ☐ 2 - Skilled nursing facility (SNF/TCU)
- ☐ 3 - Short-stay acute hospital (IPPS)
- ☐ 4 - Long-term care hospital (LTCH)
- ☐ 5 - Inpatient rehabilitation hospital or unit (IRF)
- ☐ 6 - Psychiatric hospital or unit
- ☐ 7 - Other (specify) _____
- ☐ NA - Patient was not discharged from an inpatient facility **[*Go to M1017*]**

(M1011) List each **Inpatient Diagnosis** and ICD-10-CM code at the level of highest specificity for only those conditions actively treated during an inpatient stay having a discharge date within the last 14 days (no V, W, X, Y, or Z codes or surgical codes):

	Inpatient Facility Diagnosis	ICD-10-CM Code
a.	_____	☐☐☐ ☐☐☐☐
b.	_____	☐☐☐ ☐☐☐☐
c.	_____	☐☐☐ ☐☐☐☐
d.	_____	☐☐☐ ☐☐☐☐
e.	_____	☐☐☐ ☐☐☐☐
f.	_____	☐☐☐ ☐☐☐☐

(M1017) Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days: List the patient's Medical Diagnoses and ICD-10-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days (no V, W, X, Y, or Z codes or surgical codes):

	Changed Medical Regimen Diagnosis	ICD-10-CM Code
a.	_____	☐☐☐ ☐☐☐☐
b.	_____	☐☐☐ ☐☐☐☐
c.	_____	☐☐☐ ☐☐☐☐
d.	_____	☐☐☐ ☐☐☐☐
e.	_____	☐☐☐ ☐☐☐☐
f.	_____	☐☐☐ ☐☐☐☐

☐ NA - Not applicable (no medical or treatment regimen changes within the past 14 days)

(M1018) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days: If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions that existed prior to the inpatient stay or change in medical or treatment regimen. **(Mark all that apply.)**

☐ 1 - Urinary incontinence
☐ 2 - Indwelling/suprapubic catheter
☐ 3 - Intractable pain
☐ 4 - Impaired decision-making
☐ 5 - Disruptive or socially inappropriate behavior
☐ 6 - Memory loss to the extent that supervision required
☐ 7 - None of the above
☐ NA - No inpatient facility discharge and no change in medical or treatment regimen in past 14 days
☐ UK - Unknown

(M1021/1023/1025) **Diagnoses, Symptom Control, and Optional Diagnoses**: List each diagnosis for which the patient is receiving home care in Column 1, and enter its ICD-10-CM code at the level of highest specificity in Column 2 (diagnosis codes only - no surgical or procedure codes allowed). Diagnoses are listed in the order that best reflects the seriousness of each condition and supports the disciplines and services provided. Rate the degree of symptom control for each condition in Column 2. ICD-10-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a Z-code is reported in Column 2 in place of a diagnosis that is no longer active (a resolved condition), then optional item M1025 (Optional Diagnoses - Columns 3 and 4) may be completed. Diagnoses reported in M1025 will not impact payment.

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

Column 1: Enter the description of the diagnosis. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Column 2: Enter the ICD-10-CM code for the condition described in Column 1 - no surgical or procedure codes allowed. Codes must be entered at the level of highest specificity and ICD-10-CM coding rules and sequencing requirements must be followed. Note that external cause codes (ICD-10-CM codes beginning with V, W, X, or Y) may not be reported in M1021 (Primary Diagnosis) but may be reported in M1023 (Secondary Diagnoses). Also note that when a Z-code is reported in Column 2, the code for the underlying condition can often be entered in Column 2, as long as it is an active on-going condition impacting home health care.

Rate the degree of symptom control for the condition listed in Column 1. Do not assign a symptom control rating if the diagnosis code is a V, W, X, Y or Z-code. Choose one value that represents the degree of symptom control appropriate for each diagnosis using the following scale:

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

Note that the rating for symptom control in Column 2 should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide.

Column 3: (OPTIONAL) There is no requirement that HHAs enter a diagnosis code in M1025 (Columns 3 and 4). Diagnoses reported in M1025 will not impact payment.

Agencies may choose to report an underlying condition in M1025 (Columns 3 and 4) when:

- a Z-code is reported in Column 2 AND
- the underlying condition for the Z-code in Column 2 is a resolved condition . An example of a resolved condition is uterine cancer that is no longer being treated following a hysterectomy.

Column 4: (OPTIONAL) If a Z-code is reported in M1021/M1023 (Column 2) and the agency chooses to report a resolved underlying condition that requires multiple diagnosis codes under ICD-10-CM coding guidelines, enter the diagnosis descriptions and the ICD-10-CM codes in the same row in Columns 3 and 4. For example, if the resolved condition is a manifestation code, record the diagnosis description and ICD-10-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-10-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(Form on next page)

(M1021) Primary Diagnosis & (M1023) Other Diagnoses		(M1025) Optional Diagnoses (OPTIONAL) (not used for payment)	
Column 1	Column 2	Column 3	Column 4
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided)	ICD-10-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	May be completed if a Z-code is assigned to Column 2 and the underlying diagnosis is resolved	Complete only if the Optional Diagnosis is a multiple coding situation (for example: a manifestation code)
Description	ICD-10-CM / Symptom Control Rating	Description/ ICD-10-CM	Description/ ICD-10-CM
(M1021) Primary Diagnosis a. _____	**V, W, X, Y codes NOT allowed** a. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	**V, W, X, Y, Z codes NOT allowed** a. _____ (☐☐☐.☐☐☐☐)	**V, W, X, Y, Z codes NOT allowed** a. _____ (☐☐☐.☐☐☐☐)
(M1023) Other Diagnoses b. _____	**All ICD-10–C M codes allowed** b. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	**V, W, X, Y, Z codes NOT allowed** b. _____ (☐☐☐.☐☐☐☐)	**V, W, X, Y, Z codes NOT allowed** b. _____ (☐☐☐.☐☐☐☐)
c. _____	c. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	c. _____ (☐☐☐.☐☐☐☐)	c. _____ (☐☐☐.☐☐☐☐)
d. _____	d. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	d. _____ (☐☐☐.☐☐☐☐)	d. _____ (☐☐☐.☐☐☐☐)
e. _____	e. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	e. _____ (☐☐☐.☐☐☐☐)	e. _____ (☐☐☐.☐☐☐☐)
f. _____	f. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	f. _____ (☐☐☐.☐☐☐☐)	f. _____ (☐☐☐.☐☐☐☐)

(M1028) Active Diagnoses: Comorbidities and Co-existing Conditions – Check all that apply.
See OASIS Guidance Manual for a complete list of relevant ICD-10 codes.

☐ 1 - Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)

☐ 2 - Diabetes Mellitus (DM)

(M1030) Therapies the patient receives at home: **(Mark all that apply.)**

☐ 1 - Intravenous or infusion therapy (excludes TPN)

☐ 2 - Parenteral nutrition (TPN or lipids)

☐ 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)

☐ 4 - None of the above

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

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

(M1034) Overall Status: Which description best fits the patient's overall status?	
Enter Code ☐	0. The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age). 1. The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient's age). 2. The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death. 3. The patient has serious progressive conditions that could lead to death within a year. UK. The patient's situation is unknown or unclear.

(M1036) Risk Factors, either present or past, likely to affect current health status and/or outcome: **(Mark all that apply.)**

- ☐ 1 - Smoking
- ☐ 2 - Obesity
- ☐ 3 - Alcohol dependency
- ☐ 4 - Drug dependency
- ☐ 5 - None of the above
- ☐ UK - Unknown

(M1060) Height and Weight: While measuring, if the number is X.1 – X.4 round down; X.5 or greater round up

☐☐ inches

a. Height (in inches). Record most recent height measure since the most recent SOC/ROC

☐☐☐ pounds

b. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard agency practice (for example, in a.m. after voiding, before meal, with shoes off, etc.)

(MXXXX) Nutritional Risk Assessment: Has this patient had a formal Nutritional Risk Assessment, using a standardized, validated nutritional risk assessment tool?	
Enter Code ☐	0. No. 1. Yes, and it does not indicate nutritional risk. 2. Yes, and it does indicate nutritional risk.

LIVING ARRANGEMENTS

(M1100) Patient Living Situation: Which of the following best describes the patient's residential circumstance and availability of assistance? **(Check one box only.)**

	Availability of Assistance				
Living Arrangement	Around the clock	Regular daytime	Regular nighttime	Occasional / short-term assistance	No assistance available
a. Patient lives alone	☐ 01	☐ 02	☐ 03	☐ 04	☐ 05
b. Patient lives with other person(s) in the home	☐ 06	☐ 07	☐ 08	☐ 09	☐ 10
c. Patient lives in congregate situation (for example, assisted living, residential care home)	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15

SENSORY STATUS

(M1200) Vision (with corrective lenses if the patient usually wears them)	
Enter Code ☐	0. Normal vision: sees adequately in most situations; can see medication labels, newsprint. 1. Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length. 2. Severely impaired: cannot locate objects without hearing or touching them, or patient nonresponsive.
(M1210) Ability to Hear (with hearing aid or hearing appliance if normally used)	
Enter Code ☐	0. Adequate: hears normal conversation without difficulty. 1. Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly. 2. Severely Impaired: absence of useful hearing. UK. Unable to assess hearing.
(M1220) Understanding of Verbal Content in patient's own language (with hearing aid or device if used)	
Enter Code ☐	0. Understands: clear comprehension without cues or repetitions. 1. Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand. 2. Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand. 3. Rarely/Never Understands. UK. Unable to assess understanding.

(M1230) Speech and Oral (Verbal) Expression of Language (in patient's own language)	
Enter Code ☐	0. Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment. 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). 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. 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. 4. Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (for example, speech is nonsensical or unintelligible). 5. Patient nonresponsive or unable to speak.

(BB0700) Expression of Ideas and Wants	
Enter Code ☐	Expression of Ideas and Wants (consider both verbal and non-verbal expression and excluding language barriers) 1. Rarely/never expresses self or speech is very difficult to understand 2. Frequently exhibits difficulty with expressing needs and ideas 3. Exhibits some difficulty with expressing needs and ideas (e.g., some words or finishing thoughts) or speech is not clear. 4. Expresses complex messages without difficulty and with speech that is clear and easy to understand.
(BB0800) Understanding Verbal Content	
Enter Code ☐	Understanding Verbal Content (with hearing aid or device, if used and excluding language barriers) 1. Rarely/never understands 2. Sometimes understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand. 3. Usually understands: Understands most conversations, but misses some part/intent of the message. Requires cues at times to understand. 4. Understands: Clear comprehension without cues or repetitions.

(M1240) Has this patient had a formal **Pain Assessment** using a standardized, validated pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?	
Enter Code ☐	0. No standardized, validated assessment conducted 1. Yes, and it does not indicate severe pain 2. Yes, and it indicates severe pain
(M1242) Frequency of Pain Interfering with patient's activity or movement:	
Enter Code ☐	0. Patient has no pain 1. Patient has pain that does not interfere with activity or movement 2. Less often than daily 3. Daily, but not constantly 4. All of the time

PAIN ASSESSMENT

(J0300) Pain Presence: Ask patient "Have you had pain or hurting at any time in the last 5 days?"	
Enter Code ☐	0. No ***[If no, skip to M1300 Pressure Ulcer Assessment]*** 1. Yes 9. Unable to answer

(J0400) Pain Frequency: Ask patient "How much of the time have experienced pain or hurting over the last 5 days?"	
Enter Code ☐	1. Almost constantly 2. Frequently 3. Occasionally 4. Rarely 9. Unable to answer

(J0500) Pain Effect on Function A) Ask patient "Over the past 5 days, has pain made it hard for you to sleep at night?	
Enter Code ☐	0. No 1. Yes 9. Unable to answer
B) Ask patient: "Over the past 5 days, have you limited your day-to-day activities because of pain?"	
Enter Code ☐	0. No 1. Yes 9. Unable to answer

INTEGUMENTARY STATUS

(M1300) Pressure Ulcer Assessment: Was this patient assessed for **Risk of Developing Pressure Ulcers**?	
Enter Code ☐	0. No assessment conducted **[*Go to M1306*]** 1. Yes, based on an evaluation of clinical factors (for example, mobility, incontinence, nutrition) without use of standardized tool 2. Yes, using a standardized, validated tool (for example, Braden Scale, Norton Scale)
(M1302) Does this patient have a **Risk of Developing Pressure Ulcers**?	
Enter Code ☐	0. No 1. Yes
(M1306) Does this patient have at least one **Unhealed Pressure Ulcer at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure ulcers and healed Stage 2 pressure ulcers)	
Enter Code ☐	0. No **[*Go to M1322*]** 1. Yes

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers**	☐
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers**	☐
C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. **Number of Stage 4 pressure ulcers**	☐
D1. Unstageable: Non-removable dressing: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers due to non-removable dressing/device**	☐
E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar**	☐
F1. Unstageable: Deep tissue injury: Suspected deep tissue injury in evolution **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution**	☐

(M1320) Status of Most Problematic Pressure Ulcer that is Observable: (Excludes pressure ulcer that cannot be observed due to a non-removable dressing/device)	
Enter Code ☐	0. Newly epithelialized 1. Fully granulating 2. Early/partial granulation 3. Not healing NA. No observable pressure ulcer

(M1322) Current Number of Stage 1 Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.	
Enter Code ☐	0 1 2 3 4 or more
(M1324) Stage of Most Problematic Unhealed Pressure Ulcer that is Stageable: (Excludes pressure ulcer that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or suspected deep tissue injury.)	
Enter Code ☐	1. Stage 1 2. Stage 2 3. Stage 3 4. Stage 4 NA. Patient has no pressure ulcers or no stageable pressure ulcers
(M1330) Does this patient have a **Stasis Ulcer**?	
Enter Code ☐	0. No **[*Go to M1340*]** 1. Yes, patient has BOTH observable and unobservable stasis ulcers 2. Yes, patient has observable stasis ulcers ONLY 3. Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing/device) **[*Go to M1340*]**
(M1332) Current Number of Stasis Ulcer(s) that are Observable:	
Enter Code ☐	1. One 2. Two 3. Three 4. Four or more
(M1334) Status of Most Problematic Stasis Ulcer that is Observable:	
Enter Code ☐	1. Fully granulating 2. Early/partial granulation 3. Not healing
(M1340) Does this patient have a **Surgical Wound?**	
Enter Code ☐	0. No **[*go to M1350*]** 1. Yes, patient has at least one observable surgical wound 2. Surgical wound known but not observable due to non-removable dressing/device **[*go to M1350*]**
(M1342) Status of Most Problematic Surgical Wound that is Observable	
Enter Code ☐	0. Newly epithelialized 1. Fully granulating 2. Early/partial granulation 3. Not healing
(M1350) Does this patient have a **Skin Lesion** or **Open Wound** (excluding bowel ostomy), other than those described above, that is receiving intervention by the home health agency?	
Enter Code ☐	0. No 1. Yes

RESPIRATORY STATUS

(M1400) When is the patient dyspneic or noticeably **Short of Breath?**	
Enter Code ☐	0. Patient is not short of breath 1. When walking more than 20 feet, climbing stairs 2. With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet) 3. With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation 4. At rest (during day or night)

(M1410) Respiratory Treatments utilized at home: **(Mark all that apply.)**

- ☐ 1 - Oxygen (intermittent or continuous)
- ☐ 2 - Ventilator (continually or at night)
- ☐ 3 - Continuous / Bi-level positive airway pressure
- ☐ 4 - None of the above

ELIMINATION STATUS

(M1600) Has this patient been treated for a **Urinary Tract Infection** in the past 14 days?	
Enter Code ☐	0. No 1. Yes NA. Patient on prophylactic treatment UK. Unknown
(M1610) Urinary Incontinence or Urinary Catheter Presence	
Enter Code ☐	0. No incontinence or catheter (includes anuria or ostomy for urinary drainage) **[*Go to M1620*]** 1. Patient is incontinent 2. Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic) **[*Go to M1620*]**
(M1615) When does **Urinary Incontinence** occur?	
Enter Code ☐	0. Timed-voiding defers incontinence 1. Occasional stress incontinence 2. During the night only 3. During the day only 4. During the day and night
(M1620) Bowel Incontinence Frequency	
Enter Code ☐	0. Very rarely or never has bowel incontinence 1. Less than once weekly 2. One to three times weekly 3. Four to six times weekly 4. On a daily basis 5. More often than once daily NA. Patient has ostomy for bowel elimination UK. Unknown

(H0400) Bowel continence: Select the one category that best describes the patient over the past 7 days	
Enter Code ☐	0. Always continent 1. Occasionally incontinence (one episode of bowel incontinence) 2. Frequently incontinent (2 or more episodes of bowel incontinence, but at least one continent bowel movement 3. Always incontinent (No episodes of continent bowel movements) 9. Not rated, patient had an ostomy or did not have a bowel movement for the entire 7 days
(M1630) Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay; or b) necessitated a change in medical or treatment regimen?	
Enter Code ☐	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.

NEURO/EMOTIONAL/BEHAVIORAL STATUS

(M1700) Cognitive Functioning: Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.	
Enter Code ☐	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.
(M1710) When Confused (Reported or Observed Within the Last 14 Days)	
Enter Code ☐	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
(M1720) When Anxious (Reported or Observed Within the Last 14 Days)	
Enter Code ☐	0. None of the time 1. Less often than daily 2. Daily, but not constantly 3. All of the time NA. Patient nonresponsive

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

Enter Code ☐

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.

(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

(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.

Enter Code ☐

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

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

Enter Code ☐

0. No
1. Yes

BRIEF INTERVIEW FOR MENTAL STATUS (BIMS)

(C0200) Repetition of Three Words	
Enter Code ☐	Ask patient "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed. Now tell me the three words." Number of words repeated by patient after first attempt: 0. None 1. One 2. Two 3. Three After the patient's first attempt, repeat the words using cues ("sock, something to wear; blue, a color; bed, a piece of furniture"). You may repeat the words up to two more times.
(C0300) Temporal Orientation (Orientation to year, month, and day)	
Enter Code ☐	A) Ask patient "Please tell me what year it is right now." Patient's answer is: 0. Missed by > 5 years, or no answer 1. Missed by 2 to 5 years 2. Missed by 1 year 3. Correct
Enter Code ☐	B) Ask patient "What month are we in right now?" Patient's answer is: 0. Missed by > 1 month, or no answer 1. Missed by 6 days to 1 month 2. Accurate within 5 days
Enter Code ☐	C) Ask patient "What day of the week is today?" Patient's answer is: 0. Incorrect or no answer 1. Correct
(C0400) Recall	
Enter Code ☐	Ask patient: "Let's go back to an earlier question. What were those three words that I asked you to repeat?" If unable to remember a word, give cue (i.e., something to wear; a color; a piece of furniture) for that word. A) Able to recall "sock" 0. No – could not recall 1. Yes, after cueing (something to wear) 2. Yes, no cue required
Enter Code ☐	B) Able to recall "blue" 0. No – could not recall 1. Yes, after cueing (a color) 2. Yes, no cue required
Enter Code ☐	C) Able to recall "bed" 0. No – could not recall 1. Yes, after cueing (a piece of furniture) 2. Yes, no cue required
(C0500) BIMS summary Score	
Enter Score ☐	Add scores for questions C0200–C0400 and fill in total score (00 – 15). Enter 99 if the patient was unable to complete the interview

(C1310) Signs and Symptoms of Delirium (from Confusion Assessment Method [CAM]): Code after completing Brief Interview for Mental Status, and reviewing medical history A) Acute Onset Mental Status change: Is there evidence of an acute change in mental status from the patient's baseline?	
Enter Code ☐	0. No 1. Yes
B) Inattention – Did the patient have difficulty focusing attention, for example being easily distractible, or having difficulty keeping track of what was being said?	
Enter Code ☐	0. Behavior not present 1. Behavior continuously present, does not fluctuate 2. Behavior present, fluctuates (comes and goes, changes in severity)
C) Disorganized thinking – Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?	
Enter Code ☐	0. Behavior not present 1. Behavior continuously present, does not fluctuate 2. Behavior present, fluctuates (comes and goes, changes in severity)
D) Altered level of consciousness – Did the patient have altered level of consciousness as indicated by any of the following criteria? • Vigilant – startled easily to any sound or touch • Lethargic – repeatedly dozed off when being asked questions, but responded to voice or touch • Stuporous – very difficult to arouse and keep aroused for the interview • Comatose – could not be aroused	
Enter Code ☐	0. Behavior not present 1. Behavior continuously present, does not fluctuate 2. Behavior present, fluctuates (comes and goes, changes in severity)

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ADL/IADLs

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

(M1810) Current **Ability to Dress <u>Upper</u> Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:	
Enter Code ☐	0. Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance. 1. Able to dress upper body without assistance if clothing is laid out or handed to the patient. 2. Someone must help the patient put on upper body clothing. 3. Patient depends entirely upon another person to dress the upper body.

(M1820) Current **Ability to Dress Lower Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:	
Enter Code ☐	0. Able to obtain, put on, and remove clothing and shoes without assistance. 1. Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient. 2. Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes. 3. Patient depends entirely upon another person to dress lower body.
(M1830) **Bathing:** Current ability to wash entire body safely. **Excludes grooming (washing face, washing hands, and shampooing hair).**	
Enter Code ☐	0. Able to bathe self in shower or tub independently, including getting in and out of tub/shower. 1. With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower. 2. Able to bathe in shower or tub with the intermittent assistance of another person: (a) for intermittent supervision or encouragement or reminders, OR (b) to get in and out of the shower or tub, OR (c) for washing difficult to reach areas. 3. Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision. 4. Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode. 5. Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person. 6. Unable to participate effectively in bathing and is bathed totally by another person.
(M1840) **Toilet Transferring:** Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.	
Enter Code ☐	0. Able to get to and from the toilet and transfer independently with or without a device. 1. When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer. 2. Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance). 3. Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently. 4. Is totally dependent in toileting.
(M1845) **Toileting Hygiene:** Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.	
Enter Code ☐	0. Able to manage toileting hygiene and clothing management without assistance. 1. Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient. 2. Someone must help the patient to maintain toileting hygiene and/or adjust clothing. 3. Patient depends entirely upon another person to maintain toileting hygiene.

(M1850) **Transferring:** Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.	
Enter Code ☐	0. Able to independently transfer. 1. Able to transfer with minimal human assistance or with use of an assistive device. 2. Able to bear weight and pivot during the transfer process but unable to transfer self. 3. Unable to transfer self and is unable to bear weight or pivot when transferred by another person. 4. Bedfast, unable to transfer but is able to turn and position self in bed. 5. Bedfast, unable to transfer and is unable to turn and position self.

(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.	
Enter Code ☐	0. Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device). 1. With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings. 2. Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces. 3. Able to walk only with the supervision or assistance of another person at all times. 4. Chairfast, unable to ambulate but is able to wheel self independently. 5. Chairfast, unable to ambulate and is unable to wheel self. 6. Bedfast, unable to ambulate or be up in a chair.

FUNCTIONAL STATUS

GG0130. Self-Care		
Code the patient's usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Do not use codes 07, 09 or 88 to code discharge goal(s).		
1. Admission Performance	**2. Discharge Goal**	**CODING:** **Safety** and **Quality** of Performance – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided. ***Activities may be completed with or without assistive devices.*** **06. Independent** – Patient completes activity him/herself with no assistance from a helper. **05. Setup or clean-up assistance –** Helper assists only prior to or following the activity. **04. Supervision or touching assistance –** Helper provides VERBAL CUES or STEADYING assistance as patient completes activity. Assistance may be intermittent or throughout activity. **03. Partial/moderate assistance –** Helper does LESS THAN HALF the effort. Helper lifts, holds trunk or limbs but provides less than half the effort. **02. Substantial/maximal assistance –** Helper provides MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. **01. Dependent –** Patient does none of the effort, OR – the assistance of 2 or more helpers is required. **If activity was not attempted, code the reason:** **07.** Patient **refused** **09.** N**ot applicable** **88.** Not attempted due to **medical condition** or **safety concerns**
Enter Codes in Boxes		
		A. Eating: The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.
		B. Oral hygiene: The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]
		C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan or urinal. If managing an ostomy, include wiping the opening but not managing equipment.
		D. Wash upper body: The ability to wash, rinse, and dry the face, hands, chest, and arms while sitting in a chair or bed.

1. Admission Performance	2. Discharge Goal	**GG0170. Mobility**
		Code the patient's usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Do not use codes 07, 09 or 88 to code discharge goal(s).
		CODING: **Safety** and **Quality** of Performance – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided. ***Activities may be completed with or without assistive devices.*** **06. Independent** – Patient completes activity him/herself with no assistance from a helper. **05. Setup or clean-up assistance –** Helper assists only prior to or following the activity. **04. Supervision or touching assistance –** Helper provides VERBAL CUES or STEADYING assistance as patient completes activity. Assistance may be intermittent or throughout activity. **03. Partial/moderate assistance –** Helper does LESS THAN HALF the effort. Helper lifts, holds trunk or limbs but provides less than half the effort. **02. Substantial/maximal assistance –** Helper provides MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. **01. Dependent –** Patient does none of the effort, OR – the assistance of 2 or more helpers is required.
Enter Codes in Boxes		**If activity was not attempted, code the reason:** **07.** Patient **refused** **09.** N**ot applicable** **88.** Not attempted due to **medical condition** or **safety concerns**
		A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying.
		B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
		C. Lying to sitting on side of bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
		D. Sit to stand: The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
		E. Chair/bed-to-chair transfer: The ability to safely transfer to and from a bed to a chair/ wheelchair
		F. Toilet transfer: The ability to safely get on and off a toilet or commode.
		H1. Does the patient walk? **0. No** and walking goal **is not** clinically indicated. Skip to GG0170 Q1 Does patient use wheelchair/scooter? **1. No** and walking goal **is** clinically indicated. Code patient's discharge goal(s) for items GG0170 I, J and K. For Admission Performance, skip to GG0170 Q1. Does patient use a wheelchair/scooter? **2. Yes** Continue to GG0170 I Walk 10 feet.
		I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor or similar space.
		J. Walk 50 feet with two turns: Once standing, the ability to walk 50 feet and make two turns.
		K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.
		Q1. Does the patient use a wheelchair /scooter? **0. No** Skip to next item **1. Yes** Continue to GG 0170R Wheel 50 feet with 2 turns
		R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
		RR1. Indicate the type of wheelchair/ scooter used. **1. Manual** **2. Motorized**
		S. Wheel 150 feet: Once seated in wheelchair/scooter, ability to wheel at least 150 feet in a corridor or similar space.
		SS1. Indicate the type of wheelchair/scooter used. **1. Manual** **2. Motorized**

(M1870) Feeding or Eating: Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.	
Enter Code ☐	0. Able to independently feed self. 1. Able to feed self independently but requires: (a) meal set-up; OR (b) intermittent assistance or supervision from another person; OR (c) a liquid, pureed or ground meat diet. 2. Unable to feed self and must be assisted or supervised throughout the meal/snack. 3. Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy. 4. Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy. 5. Unable to take in nutrients orally or by tube feeding.
(M1880) Current **Ability to Plan and Prepare Light Meals** (for example, cereal, sandwich) or reheat delivered meals safely:	
Enter Code ☐	0. (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR (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 (specifically: prior to this home care admission). 1. Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations. 2. Unable to prepare any light meals or reheat any delivered meals.
(M1890) Ability to Use Telephone: Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate.	
Enter Code ☐	0. Able to dial numbers and answer calls appropriately and as desired. 1. Able to use a specially adapted telephone (for example, large numbers on the dial, teletype phone for the deaf) and call essential numbers. 2. Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls. 3. Able to answer the telephone only some of the time or is able to carry on only a limited conversation. 4. Unable to answer the telephone at all but can listen if assisted with equipment. 5. Totally unable to use the telephone. NA. Patient does not have a telephone.
(M1900) Prior Functioning ADL/IADL: Indicate the patient's usual ability with everyday activities prior to his/her most recent illness, exacerbation, or injury.	
Enter Code ☐	a. Self-Care (specifically: grooming, dressing, bathing, and toileting hygiene) 0 Independent 1 Needed Some Help 2 Dependent
Enter Code ☐	b. Ambulation 0 Independent 1 Needed Some Help 2 Dependent
Enter Code ☐	c.Transfer 0 Independent 1 Needed Some Help 2 Dependent
Enter Code ☐	d. Household tasks (specifically: light meal preparation, laundry, shopping, and phone use) 0 Independent 1 Needed Some Help 2 Dependent

(M1910) Has this patient had a multi-factor **Falls Risk Assessment** using a standardized, validated assessment tool?	
Enter Code ☐	0. No. 1. Yes, and it does not indicate a risk for falls. 2. Yes, and it does indicate a risk for falls.

MEDICATIONS

(M2001) Drug Regimen Review: Did a complete drug regimen review identify potential clinically significant medication issues?	
Enter Code ☐	0. No - No issues found during review **[*Go to M2010*]** 1. Yes - Issues found during review 9. NA - Patient is not taking any medications **[*Go to M2040*]**
(M2003) Medication Follow-up: Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?	
Enter Code ☐	0. No 1. Yes
(M2010) Patient/Caregiver High-Risk Drug Education: Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?	
Enter Code ☐	0. No 1. Yes NA Patient not taking any high-risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications
(M2020) Management of Oral Medications: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**	
Enter Code ☐	0. Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times. 1. Able to take medication(s) at the correct times if: (a) individual dosages are prepared in advance by another person; OR (b) another person develops a drug diary or chart. 2. Able to take medication(s) at the correct times if given reminders by another person at the appropriate times 3. Unable to take medication unless administered by another person. NA. No oral medications prescribed.

(M2030) Management of Injectable Medications: Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**	
Enter Code ☐	0. Able to independently take the correct medication(s) and proper dosage(s) at the correct times. 1. Able to take injectable medication(s) at the correct times if: (a) individual syringes are prepared in advance by another person; OR (b) another person develops a drug diary or chart. 2. Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection 3. Unable to take injectable medication unless administered by another person. NA. No injectable medications prescribed.
(M2040) Prior Medication Management: Indicate the patient's usual ability with managing oral and injectable medications prior to his/her most recent illness, exacerbation or injury.	
Enter Code ☐	a. Oral medications 0 Independent 1 Needed Some Help 2 Dependent NA Not Applicable
Enter Code ☐	b. Injectable medications 0 Independent 1 Needed Some Help 2 Dependent NA Not Applicable

CARE MANAGEMENT

(M2102) Types and Sources of Assistance: Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.	
Enter Code ☐	a. **ADL assistance** (for example, transfer/ ambulation, bathing, dressing, toileting, eating/feeding) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	b. **IADL assistance** (for example, meals, housekeeping, laundry, telephone, shopping, finances) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	c. **Medication administration** (for example, oral, inhaled or injectable) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	d. **Medical procedures/ treatments** (for example, changing wound dressing, home exercise program) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available

Enter Code ☐	e. **Management of Equipment** (for example, oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	f. **Supervision and safety** (for example, due to cognitive impairment) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	g. **Advocacy or facilitation** of patient's participation in appropriate medical care (for example, transportation to or from appointments) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available

(M2110) **How Often** does the patient receive **ADL or IADL assistance** from any caregiver(s) (other than home health agency staff)?	
Enter Code ☐	1 At least daily 2 Three or more times per week 3 One to two times per week 4 Received, but less often than weekly 5 No assistance received UK Unknown

THERAPY NEED AND PLAN OF CARE

(M2200) Therapy Need: In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? **(Enter zero ["000"] if no therapy visits indicated.)**

(☐☐☐) Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).

☐ NA - Not Applicable: No case mix group defined by this assessment.

(M2250) Plan of Care Synopsis: (Check only **one** box in each row.) Does the physician-ordered plan of care include the following:

Plan / Intervention	No	Yes	Not Applicable	
a. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings	☐0	☐1	☐NA	Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference.
b. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	☐0	☐1	☐NA	Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
c. Falls prevention interventions	☐0	☐1	☐NA	Falls risk assessment indicates patient has no risk for falls.
d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment and/or physician notified that patient screened positive for depression	☐0	☐1	☐NA	Patient has no diagnosis of depression AND depression screening indicates patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.
e. Intervention(s) to monitor and mitigate pain	☐0	☐1	☐NA	Pain assessment indicates patient has no pain.
f. Intervention(s) to prevent pressure ulcers	☐0	☐1	☐NA	Pressure ulcer risk assessment (clinical or formal) indicates patient is not at risk of developing pressure ulcers.
g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician	☐0	☐1	☐NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.
h. Interventions to monitor and mitigate nutritional risk.	0	1	☐NA	Nutritional risk assessment indicates patient has no nutritional risk.

OASIS Field Test Discharge Assessment

(J1800) Any Falls Since SOC/ROC or FU/Recertification, whichever is more recent: Has the patient **had any falls since SOC/ROC or FU/Recertification,** whichever is more recent?	
Enter Code ☐	0. No **[*Skip to M1034 Overall Status*]** 1. Yes Continue to J1900, Number of Falls Since SOC/ROC or FU/Recertification, whichever is more recent

(J1900) Number of Falls Since SOC/ROC or FU/Recertification, whichever is more recent		
Coding 0. None 1. One 2. Two or more	**Enter Code in Boxes**	
	☐	**A. No injury -** no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	☐	**B. Injury (except major)** - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	☐	**C. Major injury** - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

(M1041) Influenza Vaccine Data Collection Period: Does this episode of care (SOC/ROC to Transfer/Discharge) include any dates on or between October 1 and March 31?	
Enter Code ☐	0. No *[Go to M1051]* 1. Yes
(M1046) Influenza Vaccine Received: Did the patient receive the influenza vaccine for this year's flu season?	
Enter Code ☐	1. Yes; received from your agency during this episode of care (SOC/ROC to Transfer/Discharge) 2. Yes; received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge) 3. Yes; received from another health care provider (for example, physician, pharmacist) 4. No; patient offered and declined 5. No; patient assessed and determined to have medical contraindication(s) 6. No; not indicated - patient does not meet age/condition guidelines for influenza vaccine 7. No; inability to obtain vaccine due to declared shortage 8. No; patient did not receive the vaccine due to reasons other than those listed in responses 4 – 7.
(M1051) Pneumococcal Vaccine: Has the patient ever received the pneumococcal vaccination (for example, pneumovax)?	
Enter Code ☐	0. No 1. Yes **[*Go to M1230*]**
(M1056) Reason Pneumococcal Vaccine not received: If patient has never received the pneumococcal vaccination (for example, pneumovax), state reason:	
Enter Code ☐	1. Offered and declined 2. Assessed and determined to have medical contraindication(s) 3. Not indicated; patient does not meet age/condition guidelines for Pneumococcal Vaccine 4. None of the above

(M1230) Speech and Oral (Verbal) Expression of Language (in patient's own language)	
Enter Code ☐	0. Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment. 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). 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. 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. 4. Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (for example, speech is nonsensical or unintelligible). 5. Patient nonresponsive or unable to speak.

(BB0700) Expression of Ideas and Wants (consider both verbal and non-verbal expression and excluding language barriers)	
Enter Code ☐	1. Rarely/never expresses self or speech is very difficult to understand 2. Frequently exhibits difficulty with expressing needs and ideas 3. Exhibits some difficulty with expressing needs and ideas (e.g., some words or finishing thoughts) or speech is not clear. 4. Expresses complex messages without difficulty and with speech that is clear and easy to understand.
(BB0800) Understanding Verbal Content	
Enter Code ☐	Understanding Verbal Content (with hearing aid or device, if used and excluding language barriers) 1. Rarely/never understands 2. Sometimes understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand. 3. Usually understands: Understands most conversations, but misses some part/intent of the message. Requires cues at times to understand. 4. Understands: Clear comprehension without cues or repetitions.

(M1242) Frequency of Pain Interfering with patient's activity or movement:	
Enter Code ☐	0. Patient has no pain 1. Patient has pain that does not interfere with activity or movement 2. Less often than daily 3. Daily, but not constantly 4. All of the time

PAIN ASSESSMENT

(J0300) Pain Presence: Ask patient "Have you had pain or hurting at any time in the last 5 days?"	
Enter Code ☐	0. No ***[If no, skip to M1306 Unhealed Pressure Ulcer at Stage 2 or higher]*** 1. Yes 9. Unable to answer
(J0400) Pain Frequency: Ask patient "How much of the time have you experienced pain or hurting over the last 5 days?"	
Enter Code ☐	1. Almost constantly 2. Frequently 3. Occasionally 4. Rarely 9. Unable to answer
(J0500) Pain Effect on Function A) Ask patient "Over the past 5 days, has pain made it hard for you to sleep at night?	
Enter Code ☐	0. No 1. Yes 9. Unable to answer
B) Ask patient: "Over the past 5 days, have you limited your day-to-day activities because of pain?"	
Enter Code ☐	0. No 1. Yes 9. Unable to answer

(M1306) Does this patient have at least one **Unhealed Pressure Ulcer at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure ulcers and healed Stage 2 pressure ulcers)	
Enter Code ☐	0. No **[***Go to M1322***]** 1. Yes
(M1307) The **Oldest Stage 2 Pressure Ulcer** that is present at discharge: (Excludes healed Stage 2 Pressure Ulcers)	
Enter Code ☐	1. Was present at the most recent SOC/ROC assessment 2. Developed since the most recent SOC/ROC assessment. Record date pressure ulcer first identified: / / month day year NA. No Stage 2 pressure ulcers are present at discharge

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 - Go to M1311B1] **A2. Number of <u>these</u> Stage 2 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐ ☐
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers** [If 0 - Go to M1311C1] **B2. Number of <u>these</u> Stage 3 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐ ☐
C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. **Number of Stage 4 pressure ulcers** [If 0 - Go to M1311D1] **C2. Number of <u>these</u> Stage 4 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐ ☐
D1. Unstageable: Non-removable dressing: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers due to non-removable dressing/device** [If 0 - Go to M1311E1] **D2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐ ☐
E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** [If 0 - Go to M1311F1] **E2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐ ☐
F1. Unstageable: Deep tissue injury: Suspected deep tissue injury in evolution **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** [If 0 - Go to M1313] **F2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐ ☐

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

Instructions for a-c: Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** at the most recent SOC/ROC. If no current pressure ulcer at a given stage, enter 0.	
	Enter Number
a. Stage 2	☐
b. Stage 3	☐
c. Stage 4	☐
Instructions for e: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were at a Stage 1 or 2 at the most recent SOC/ROC.	
d. Unstageable – Known or likely but Unstageable due to non-removable dressing.	☐
e. Unstageable – Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar.	☐
f. Unstageable – Suspected deep tissue injury in evolution.	☐

(M1320) Status of Most Problematic Pressure Ulcer that is Observable: (Excludes pressure ulcer that cannot be observed due to a non-removable dressing/device)	
Enter Code ☐	0 Newly epithelialized 1 Fully granulating 2 Early/partial granulation 3 Not healing NA No observable pressure ulcer
(M1322) Current Number of Stage 1 Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.	
Enter Code ☐	0 1 2 3 4 or more
(M1324) Stage of Most Problematic Unhealed Pressure Ulcer that is Stageable: (Excludes pressure ulcer that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or suspected deep tissue injury.)	
Enter Code ☐	1 Stage 1 2 Stage 2 3 Stage 3 4 Stage 4 NA Patient has no pressure ulcers or no stageable pressure ulcers

(M1330) Does this patient have a **Stasis Ulcer**?	
Enter Code ☐	0 No **[*Go to M1340*]** 1 Yes, patient has BOTH observable and unobservable stasis ulcers 2 Yes, patient has observable stasis ulcers ONLY 3 Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing/device) **[*Go to M1340*]**
(M1332) Current Number of Stasis Ulcer(s) that are Observable:	
Enter Code ☐	1 One 2 Two 3 Three 4 Four or more
(M1334) Status of Most Problematic Stasis Ulcer that is Observable:	
Enter Code ☐	1 Fully granulating 2 Early/partial granulation 3 Not healing
(M1340) Does this patient have a **Surgical Wound?**	
Enter Code ☐	0 No **[*go to M1400*]** 1 Yes, patient has at least one observable surgical wound 2 Surgical wound known but not observable due to non-removable dressing/device **[*go to M1400*]**
(M1342) Status of Most Problematic Surgical Wound that is Observable	
Enter Code ☐	0 Newly epithelialized 1 Fully granulating 2 Early/partial granulation 3 Not healing

RESPIRATORY STATUS

(M1400) When is the patient dyspneic or noticeably **Short of Breath?**	
Enter Code ☐	0 Patient is not short of breath 1 When walking more than 20 feet, climbing stairs 2 With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet) 3 With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation 4 At rest (during day or night)

CARDIAC STATUS

(M1501) Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at the time of or at any time since the most recent SOC/ROC assessment?	
Enter Code ☐	0 No **[*Go to M1600*]** 1 Yes 2 Not assessed **[*Go to M1600*]** NA Patient does not have diagnosis of heart failure **[*Go to M1600*]**

(M1511) Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure at the time of or at any time since the most recent SOC/ROC assessment, what action(s) has (have) been taken to respond? **(Mark all that apply.)**

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

ELIMINATION STATUS

(M1600) Has this patient been treated for a **Urinary Tract Infection** in the past 14 days?	
Enter Code ☐	0 No 1 Yes NA Patient on prophylactic treatment
(M1610) Urinary Incontinence or Urinary Catheter Presence:	
Enter Code ☐	0 No incontinence or catheter (includes anuria or ostomy for urinary drainage) **[*Go to M1620*]** 1 Patient is incontinent 2 Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic) **[*Go to M1620*]**
(M1615) When does **Urinary Incontinence** occur?	
Enter Code ☐	0 Timed-voiding defers incontinence 1 Occasional stress incontinence 2 During the night only 3 During the day only 4 During the day and night

(M1620) Bowel Incontinence Frequency:	
Enter Code ☐	0 Very rarely or never has bowel incontinence 1 Less than once weekly 2 One to three times weekly 3 Four to six times weekly 4 On a daily basis 5 More often than once daily NA Patient has ostomy for bowel elimination
(H0400) Bowel continence: Select the one category that best describes the patient over the past 7 days	
Enter Code ☐	0. Always continent 1. Occasionally incontinence (one episode of bowel incontinence) 2. Frequently incontinent (2 or more episodes of bowel incontinence, but at least one continent bowel movement 3. Always incontinent (No episodes of continent bowel movements) 9. Not rated, patient had an ostomy or did not have a bowel movement for the entire 7 days

NEURO/EMOTIONAL/BEHAVIORAL STATUS

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

(M1710) When Confused (Reported or Observed Within the Last 14 Days):	
Enter Code ☐	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
(M1720) When Anxious (Reported or Observed Within the Last 14 Days):	
Enter Code ☐	0 None of the time 1 Less often than daily 2 Daily, but not constantly 3 All of the time NA Patient nonresponsive

(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

(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.
Enter Code ☐	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

BRIEF INTERVIEW FOR MENTAL STATUS (BIMS)

(C0200) Repetition of Three Words	
Enter Code ☐	Ask patient "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed. Now tell me the three words." Number of words repeated by patient after first attempt: 0. None 1. One 2. Two 3. Three After the patient's first attempt, repeat the words using cues ("sock, something to wear; blue, a color; bed, a piece of furniture"). You may repeat the words up to two more times.
(C0300) Temporal Orientation (Orientation to year, month, and day)	
Enter Code ☐	A) Ask patient "Please tell me what year it is right now." Patient's answer is: 0. Missed by > 5 years, or no answer 1. Missed by 2 to 5 years 2. Missed by 1 year 3. Correct
Enter Code ☐	B) Ask patient "What month are we in right now?" Patient's answer is: 0. Missed by > 1 month, or no answer 1. Missed by 6 days to 1 month 2. Accurate within 5 days
Enter Code ☐	C) Ask patient "What day of the week is today?" Patient's answer is: 0. Incorrect or no answer 1. Correct
(C0400) Recall	
Enter Code ☐	Ask patient: "Let's go back to an earlier question. What were those three words that I asked you to repeat?" If unable to remember a word, give cue (i.e., something to wear; a color; a piece of furniture) for that word. A) Able to recall "sock" 0. No – could not recall 1. Yes, after cueing (something to wear) 2. Yes, no cue required
Enter Code ☐	B) Able to recall "blue" 0. No – could not recall 1. Yes, after cueing (a color) 2. Yes, no cue required
Enter Code ☐	C) Able to recall "bed" 0. No – could not recall 1. Yes, after cueing (a piece of furniture) 2. Yes, no cue required
(C0500) BIMS summary Score	
Enter Score ☐	Add scores for questions C0200–C0400 and fill in total score (00 – 15). Enter 99 if the patient was unable to complete the interview

ADL/IADLs

(M1800) **Grooming:** Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).	
Enter Code ☐	0. Able to groom self unaided, with or without the use of assistive devices or adapted methods. 1. Grooming utensils must be placed within reach before able to complete grooming activities. 2. Someone must assist the patient to groom self. 3. Patient depends entirely upon someone else for grooming needs.
(M1810) Current **Ability to Dress Upper Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:	
Enter Code ☐	0. Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance. 1. Able to dress upper body without assistance if clothing is laid out or handed to the patient. 2. Someone must help the patient put on upper body clothing. 3. Patient depends entirely upon another person to dress the upper body.
(M1820) Current **Ability to Dress Lower Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:	
Enter Code ☐	0. Able to obtain, put on, and remove clothing and shoes without assistance. 1. Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient. 2. Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes. 3. Patient depends entirely upon another person to dress lower body.
(M1830) **Bathing:** Current ability to wash entire body safely. **Excludes grooming (washing face, washing hands, and shampooing hair).**	
Enter Code ☐	0. Able to bathe self in shower or tub independently, including getting in and out of tub/shower. 1. With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower. 2. Able to bathe in shower or tub with the intermittent assistance of another person: (a) for intermittent supervision or encouragement or reminders, OR (b) to get in and out of the shower or tub, OR (c) for washing difficult to reach areas. 3. Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision. 4. Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode. 5. Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person. 6. Unable to participate effectively in bathing and is bathed totally by another person.
(M1840) **Toilet Transferring:** Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.	
Enter Code ☐	0. Able to get to and from the toilet and transfer independently with or without a device. 1. When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer. 2. Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance). 3. Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently. 4. Is totally dependent in toileting.

(M1845) Toileting Hygiene: Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.	
Enter Code ☐	0. Able to manage toileting hygiene and clothing management without assistance. 1. Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient. 2. Someone must help the patient to maintain toileting hygiene and/or adjust clothing. 3. Patient depends entirely upon another person to maintain toileting hygiene.
(M1850) Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.	
Enter Code ☐	0. Able to independently transfer. 1. Able to transfer with minimal human assistance or with use of an assistive device. 2. Able to bear weight and pivot during the transfer process but unable to transfer self. 3. Unable to transfer self and is unable to bear weight or pivot when transferred by another person. 4. Bedfast, unable to transfer but is able to turn and position self in bed. 5. Bedfast, unable to transfer and is unable to turn and position self.
(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.	
Enter Code ☐	0. Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device). 1. With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings. 2. Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces. 3. Able to walk only with the supervision or assistance of another person at all times. 4. Chairfast, unable to ambulate but is able to wheel self independently. 5. Chairfast, unable to ambulate and is unable to wheel self. 6. Bedfast, unable to ambulate or be up in a chair.

(M1870) Feeding or Eating: Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.	
Enter Code ☐	0. Able to independently feed self. 1. Able to feed self independently but requires: (a) meal set-up; OR (b) intermittent assistance or supervision from another person; OR (c) a liquid, pureed or ground meat diet. 2. Unable to feed self and must be assisted or supervised throughout the meal/snack. 3. Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy. 4. Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy. 5. Unable to take in nutrients orally or by tube feeding.

(M1880) Current **Ability to Plan and Prepare Light Meals** (for example, cereal, sandwich) or reheat delivered meals safely:	
Enter Code ☐	0. (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR (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 (specifically: prior to this home care admission). 1. Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations. 2. Unable to prepare any light meals or reheat any delivered meals.

(M1890) **Ability to Use Telephone:** Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate.	
Enter Code ☐	0. Able to dial numbers and answer calls appropriately and as desired. 1. Able to use a specially adapted telephone (for example, large numbers on the dial, teletype phone for the deaf) and call essential numbers. 2. Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls. 3. Able to answer the telephone only some of the time or is able to carry on only a limited conversation. 4. Unable to answer the telephone at all but can listen if assisted with equipment. 5. Totally unable to use the telephone. NA. Patient does not have a telephone.

GG0130. Self-Care

Code the patient's usual performance at Discharge for each activity using the 6-point scale. If activity was not attempted at Discharge, code the reason.

Coding:
Safety and **Quality of Performance –** If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

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

If activity was not attempted, code reason:
07. **Patient refused**
09. **Not applicable** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
88. **Not attempted due to medical conditions or safety concerns**

3. Discharge Performance	
↓ Enter Codes in Boxes	
☐☐	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal placed before the patient.
☐☐	**B. Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	**C. Toileting Hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy,include wiping the opening but not managing equipment.
	D. Wash upper body: The ability to wash, rinse, and dry the face, hands, chest, and arms while sitting in a chair or bed.

MEDICATIONS

(M2005) **Medication Intervention:** Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?	
Enter Code ☐	0 No 1 Yes 9 NA – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications
(M2016) **Patient/Caregiver Drug Education Intervention**: At the time of, or at any time since the most recent SOC/ROC assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur?	
Enter Code ☐	0 No 1 Yes NA Patient not taking any drugs
(M2020) **Management of Oral Medications:** Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**	
Enter Code ☐	0 Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times. 1 Able to take medication(s) at the correct times if: (a) individual dosages are prepared in advance by another person; OR (b) another person develops a drug diary or chart. 2 Able to take medication(s) at the correct times if given reminders by another person at the appropriate times 3 Unable to take medication unless administered by another person. NA No oral medications prescribed.
(M2030) **Management of Injectable Medications:** Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**	
Enter Code ☐	0 Able to independently take the correct medication(s) and proper dosage(s) at the correct times. 1 Able to take injectable medication(s) at the correct times if: (a) individual syringes are prepared in advance by another person; OR (b) another person develops a drug diary or chart. 2 Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection 3 Unable to take injectable medication unless administered by another person. NA No injectable medications prescribed.

CARE MANAGEMENT

(M2102) Types and Sources of Assistance: Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.	
Enter Code ☐	a. **ADL assistance** (for example, transfer/ ambulation, bathing, dressing, toileting, eating/feeding) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	b. **IADL assistance** (for example, meals, housekeeping, laundry, telephone, shopping, finances) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	c. **Medication administration** (for example, oral, inhaled or injectable) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	d. **Medical procedures/ treatments** (for example, changing wound dressing, home exercise program) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	e. **Management of Equipment** (for example, oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	f. **Supervision and safety** (for example, due to cognitive impairment) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	g. **Advocacy or facilitation** of patient's participation in appropriate medical care (for example, transportation to or from appointments) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available

EMERGENT CARE

(M2301) **Emergent Care:** At the time of or at any time since the most recent SOC/ROC assessment has the patient utilized a hospital emergency department (includes holding/observation status)?	
Enter Code ☐	0. No **[*Go to M2401*]** 1. Yes, used hospital emergency department WITHOUT hospital admission 2. Yes, used hospital emergency department WITH hospital admission UK. Unknown **[*Go to M2401*]**

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

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

(M2401) Intervention Synopsis: (Check only **one** box in each row.) At the time of or at any time since the most recent SOC/ROC assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

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	☐0	☐1	☐NA	Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
b. Falls prevention interventions	☐0	☐1	☐NA	Every standardized, validated multi-factor fall risk assessment conducted at or since the most recent SOC/ROC 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	☐0	☐1	☐NA	Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the most recent SOC/ROC 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	☐0	☐1	☐NA	Every standardized, validated pain assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no pain.
e. Intervention(s) to prevent pressure ulcers	☐0	☐1	☐NA	Every standardized, validated pressure ulcer risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient is not at risk of developing pressure ulcers.
f. Pressure ulcer treatment based on principles of moist wound healing	☐0	☐1	☐NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.
g. Interventions to prevent, monitor and/or mitigate nutritional risk	0	1	☐NA	Every standardized validated nutritional risk assessment since the most recent SOC/ROC assessment indicates the patient has no nutritional risk.

(M2410) To which **Inpatient Facility** has the patient been admitted?

Enter Code ☐

1. Hospital **[*Go to M2430*]**
2. Rehabilitation facility **[*Go to M0903*]**
3. Nursing home **[*Go to M0903*]**
4. Hospice **[*Go to M0903*]**

NA. No inpatient facility admission

(M2420) Discharge Disposition: Where is the patient after discharge from your agency? **(Choose only one answer.)**

Enter Code ☐

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

UK. Other unknown **[*Go to M0903*]**

PROMIS Global Health Survey

Please respond to each item by marking one box per row.

	Excellent	Very Good	Good	Fair	Poor
In general, would you say your health is:					
In general, would you say your quality of life is:					
In general, how would you rate your physical health?					
In general, how would you rate your mental health, including your mood and your ability to think?					
In general, how would you rate your satisfaction with your social activities and relationships?					
In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)					

	Completely	Mostly	Moderately	A little	Not at all
To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?					

In the past 7 days,

	Never	Rarely	Sometimes	Often	Always
How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?					

	None	Mild	Moderate	Severe	Very Severe
How would you rate your fatigue on average?					

	No pain 0	1	2	3	4	5	6	7	8	9	Worst pain Imaginable 10
How would you rate your pain on average?											

Patient Global Rating of Outcomes (PGRO)

1. **Between your first home care visit and today, do you think your ability to walk or move around improved?**
   (Circle one) Yes No

If so, please rate how much you improved in your ability to walk or move around from 1 to 7, with 1 = not at all improved to 7 – very much improved. Rating _____

2. **Between your first home care visit and today, do you think your ability to get in and out of bed improved?**
   (Circle one) Yes No

If so, please rate how much you improved in your ability to get in and out of bed from 1 to 7, with 1 = not at all improved to 7 – very much improved. Rating _____

3. **Between your first home care visit and today, do you think your ability to bathe yourself improved?**
   (Circle one) Yes No

If so, please rate how much you improved in your ability to bathe yourself from 1 to 7, with 1 = not at all improved to 7 – very much improved. Rating _____

4. **Between your first home care visit and today, do you think your ability to take the medications or drugs correctly by mouth improved?**
   (Circle one) Yes No N/A (patient takes no medications by mouth)

If so, please rate how much you improved in your ability to take medications or drugs by mouth from 1 to 7, with 1 = not at all improved to 7 – very much improved. Rating _____

5. **Between your first home care visit and today, do you think that you improved in pain when you move around?**
   (Circle one) Yes No

If so, please rate how much your pain improved when moving around improved from 1 to 7, with 1 = not at all improved to 7 – very much improved. Rating _____

6. **Between your first home care visit and today, do you think your breathing improved?**
   (Circle one) Yes No

If so, please rate how much you improved in your breathing from 1 to 7, with 1 = not at all improved to 7 – very much improved. Rating _____

7. **Between your first home care visit and today, do you think the wound from your surgery improved or healed?**
   (Circle one) Yes No N/A (patient has no wound from surgery)

If so, please rate how much the wound from your surgery improved or healed with 1 = not at all improved to 7 – very much improved. Rating _____

Appendix II. Descriptive Tables

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Tables in this Appendix display Abt Associates' analysis of OASIS field test data (2017), unless otherwise specified.

ACRONYMS

HH Home health

SOC Start of care

ROC Resumption of Care

DC Discharge

PRIOR INPATIENT STAY

M1000 Inpatient facility discharge*

Responses (mark all that apply)	Field Test SOC/ROC Frequency	Field Test SOC/ROC %	HH SOC/ROC pop [a] %
Long-term nursing facility	2	1.31	0.7
Skilled nursing facility	32	20.92	14.7
Short-stay acute hospital	64	41.83	50.9
Long-term care hospital	1	0.65	0.6
Inpatient rehabilitation hospital or unit	10	6.54	6.0
Psychiatric hospital or unit	3	1.96	0.4
Other	1	0.65	0.3
N/A – Patient was not discharged from an inpatient facility	47	30.72	29.2

*M1000 is a 'mark all that apply' item. Frequencies may be larger than the sample size when patients are assessed as having multiple inpatient discharges, and percent will sum to greater than 100.

[a] 2016 home health (HH) population (pop) at start/resumption of care (SOC/ROC) comprising 6,437,455 total episodes

PRIOR CONDITIONS AND RISK

M1018 Conditions prior to medical or treatment regimen change or inpatient stay in past 14 days*

Responses (mark all that apply)	SOC/ROC Frequency	SOC/ROC %
Urinary Incontinence	58	38.16
Indwelling/suprapubic catheter	1	0.66
Intractable pain	34	22.37
Impaired decision-making	12	7.89
Disruptive or socially inappropriate behavior	2	1.32
Memory loss to the extent that supervision required	11	7.24
None of the above	51	33.55
No inpatient facility discharge and no change in medical treatment	18	11.84
Unknown	2	1.32

*M1018 is a 'mark all that apply' item. Frequencies may be larger than the sample size when patients are assessed as having multiple conditions, and percent will sum to greater than 100.

M1018 Prior Conditions – Combinations of conditions selected

Combinations	N	% of total > 1
Urinary incontinence & intractable pain	20	64.5%
Urinary incontinence & impaired decision-making	3	9.7%
Intractable pain & impaired decision-making	2	6.5%
Urinary incontinence & memory loss	1	3.2%
Impaired decision-making & memory loss	1	3.2%
Urinary incontinence, intractable pain, & impaired decision-making	1	3.2%
Urinary incontinence, disruptive behavior, & memory loss	1	3.2%
Urinary incontinence, intractable pain, impaired decision-making, & memory loss	1	3.2%
Urinary incontinence, impaired decision-making, disruptive behavior, & memory loss	1	3.2%

M1033 Risk for hospitalization*

Responses (mark all that apply)	SOC/ROC Frequency	SOC/ROC %
History of falls	55	35.71
Unintentional weight loss (>10lbs)	8	5.19
Multiple hospitalizations	32	20.78
Multiple ED visits	22	14.29
Decline in mental, emotional, or behavioral status	23	14.94
Difficulty complying with medical instruction	21	13.64
Taking 5 or more medications	141	91.56
Exhaustion	51	33.12
Other	19	12.34
None of the above	8	5.19

*M1033 is a 'mark all that apply' item. Frequencies may be larger than the sample size when patients are assessed as having multiple risks, and percent will sum to greater than 100.

M1036 Risk Factors*

Responses (mark all that apply)	SOC/ROC Frequency	SOC/ROC %
Smoking	288	18.30
Obesity	38	24.84
Alcohol dependency	4	2.61
Drug dependency	2	1.31
None of the above	85	55.56
Unknown	8	5.23

*M1036 is a 'mark all that apply' item. Frequencies may be larger than the sample size when patients are assessed as having multiple risks, and percent will sum to greater than 100.

M1910 Falls Risk Assessment

Responses	SOC/ROC Frequency	SOC/ROC %
No	0	0.00
Yes, does not indicate risk	11	7.28
Yes, indicates risk	140	92.72

M1302 Risk of developing pressure ulcers

Responses	SOC/ROC Frequency	%
No	102	66.67
Yes	48	31.37
Skip	3	1.96

M1240 Pain Assessment

Responses	SOC/ROC Frequency	%
Not conducted	0	0.00
Yes, does not indicate severe pain	100	66.67
Yes, indicates severe pain	50	33.33

OVERALL STATUS AND LIVING SITUATION

M1034 Overall status

Responses	SOC/ROC Frequency	%
Stable	32	21.33
Temporary high health risk	81	54.00
Fragile health	33	22.00
Serious condition	4	2.67
Unknown	0	0.00

M1100 Living Situation (SOC/ROC)

Assistance→ ↓ **Living** situation	Around the clock	Regular daytime	Regular nighttime	Occasional/short-term assistance	No assistance available
Patient lives alone	28 (19.72)	2 (1.41)	0 (0.00)	18 (12.68)	2 (1.41)
Lives with other person(s) in the home	60 (42.25)	2 (1.41)	5 (3.52)	4 (2.82)	0 (0.00)
Lives in congregate situation	19 (13.38)	0 (0.00)	0 (0.00)	2 (1.41)	0 (0.00)

COMORBIDITIES

M1028 Active Diagnoses: Comorbidities and Co-existing Conditions

Responses	SOC/ROC Frequency	%
Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)	12	20.00
Diabetes Mellitus (DM)	40	66.67
Both PVD or PAD, and DM	8	13.33

COGNITION

M1700 Cognitive Functioning

Responses	Field Test SOC/ROC Frequency	Field Test SOC/ROC (%)	HH SOC/ROC pop [a] (%)	Field Test DC Frequency	Field Test DC (%)	HH DC pop [b] (%)
Alert/oriented	101	66.45	51.0	105	83.33	69.3
Requires prompting	40	26.32	33.6	17	13.49	21.4
Requires assistance	10	6.58	11.2	4	3.17	6.3
Requires considerable assistance	1	0.66	3.4	0	0	2.3
Totally dependent	0	0	0.8	0	0	0.7

[a] 2016 home health (HH) population (pop) at start/resumption of care (SOC/ROC) comprising 6,437,455 total episodes
[b] 2016 HH pop at discharge (DC) comprising 4,673,227 total episodes

C0200 Repetition of Three Words

Responses	SOC/ROC Frequency	SOC/ROC %	DC Frequency	DC %
No words repeated	2	1.31	0	0.00
One word repeated	1	0.65	1	0.81
Two words repeated	9	5.88	3	2.42
Three words repeated	141	92.16	120	96.77

C0300A Temporal Orientation (year)

Responses	SOC/ROC Frequency	SOC/ROC %	DC Frequency	DC %
Missed by >5 years or no answer	7	4.55	5	4.03
Missed by 2 to 5 years	1	0.65	0	0.00
Missed by 1 year	2	1.30	0	0.00
Correct	144	93.51	119	95.97

C0300B Temporal Orientation (month)

Responses	SOC/ROC Frequency	SOC/ROC %	DC Frequency	DC %
Missed by >1 month or no answer	1	0.65	4	3.23
Missed by 6 days to 1 month	4	2.60	2	1.61
Accurate within 5 days	149	96.75	118	95.16

C0300C Temporal Orientation (day)

Responses	SOC/ROC Frequency	SOC/ROC %	DC Frequency	DC %
Incorrect or no answer	12	7.79	10	8.06
Correct	142	92.21	114	91.94

C0400 Recall

Responses	A: Sock SOC/ROC Frequency (%)	A: Sock DC Frequency (%)	B: Blue SOC/ROC Frequency (%)	B: Blue DC Frequency (%)	C: Bed SOC/ROC Frequency (%)	C: Bed DC Frequency (%)
No	9 (5.84)	10 (8.13)	13 (8.44)	9 (7.26)	22 (14.29)	17 (13.71)
Yes, after cue	25 (16.23)	11 (8.94)	19 (12.34)	12 (9.68)	35 (22.73)	12 (9.68)
Yes, without cue	120 (77.92)	102 (82.93)	122 (79.22)	103 (83.06)	97 (62.99)	95 (76.61)

C0500 BIMS Summary Score

Responses	SOC/ROC Frequency (%)	DC Frequency (%)
Score 0-7: Severe Cognitive Impairment	4 (2.60)	3 (2.43)
Score 8-12: Moderate Impairment	29 (18.97)	18 (14.51)
Score 13-15: Intact Cognitive Response	120 (78.43)	103 (83.06)

C1310A Delirium: Mental status change from baseline

Responses	SOC/ROC Frequency	SOC/ROC %
No	146	96.69
Yes	5	3.31

C1310 Delirium, parts B, C and D

Responses	B. Inattention Frequency	B. Inattention %	C. Disorganized thinking Frequency	C. Disorganized thinking %	D. Altered level of consciousness Frequency	D. Altered level of consciousness %
Not present	133	88.08	145	96.03	145	96.03
Continuously present	3	1.99	1	0.66	3	1.99
Present, but fluctuates	15	9.93	5	3.31	3	1.99

M1710 When Confused

Responses	SOC/ROC Frequency	SOC/ROC %	DC Frequency	DC %
Never	96	63.16	101	80.16
In new or complex situations only	50	32.89	20	15.87
On awakening or at night only	2	1.32	3	2.38
During the day and evening, not constantly	4	2.63	2	1.59

COMPREHENSION AND EXPRESSION

SOC/ROC Parallel Items M1220 - B0800 Understanding Verbal Content

M1220 Understanding of Verbal Content			B0800 Understanding of Verbal Content		
	SOC/ROC			SOC/ROC	
Responses	Frequency	%	Responses	Frequency	%
Understands	108	70.59	Understands	108	71.05
Usually Understands	39	25.49	Usually	38	25.00
Sometimes Understands	6	3.92	Sometimes	4	2.63
Rarely or Never Understands	0	0.00	Rarely/never	2	1.32
Unable to assess	0	0.00	[no parallel response]	---	---

SOC/ROC Parallel Items M1230 - B0700 Oral Expression, Express Ideas and Wants

M1230 Speech and Oral Expression			B0700 Expression of Ideas and Wants		
	SOC/ROC			SOC/ROC	
Responses	Frequency	%	Responses	Frequency	%
No impairment	109	71.71	Expresses without difficulty	113	74.34
Minimal difficulty	33	21.71	Exhibits some difficulty	31	20.39
Moderate difficulty	8	5.26	.---	---	---
Severe difficulty	2	1.32	Frequently exhibits difficulty	3	1.97
Unable to express	0	0.00	Rarely/never expresses self	5	3.29
Nonresponsive or unable to speak	0	0.00	---	---	---

Discharge Parallel Items M1220 - BB0800 Understanding Verbal Content

M1220 Understanding of Verbal Content (not collected at DC)	BB0800 Understanding of Verbal Content		
		DC	
	Responses	Frequency	%
	Understands	103	84.43
	Usually	17	13.93
	Sometimes	2	1.64
	Rarely/never	0	0.00
	[no parallel response]	---	---

Discharge Parallel Items M1230 - BB0700 Oral Expression, Express Ideas and Wants

M1230 Speech and Oral Expression			B0700 Expression of Ideas and Wants		
	DC			DC	
Responses	Frequency	%	Responses	Frequency	%
No impairment	109	87.9	Expresses without difficulty	105	84.68
Minimal difficulty	11	8.87	Exhibits some difficulty	13	10.48
Moderate difficulty	4	3.23	.---	---	---
Severe difficulty	0	0.00	Frequently exhibits difficulty	3	2.42
Unable to express	0	0.00	Rarely/never expresses self	3	2.42
Nonresponsive or unable to speak	0	0.00	---	---	---

Textual crosswalk between M1220/1230 and BB0800/0700 items

OASIS M1220	BB0800	OASIS M1230	BB0700
Understanding of verbal content in patient's own language (with hearing aid or device if used)	Understanding Verbal Content (with hearing aid or device, if used and excluding language barriers)	Speech and Oral (Verbal) Expression of Language (in patient's own language)	Expression of Ideas and Wants (consider both verbal and non-verbal expression and excluding language barriers)
0 = Understands; clear comprehension without cues or repetitions	4 = Understands: Clear comprehension without cues or repetitions	0 = Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.	4 = Expresses complex messages without difficulty and with speech that is clear and easy to understand.
1 = Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand.	3 = Usually understands: Understands most conversations, but misses some part/intent of the message. Requires cues at times to understand.	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).	3 = Exhibits some difficulty with expressing needs and ideas (e.g., some words or finishing thoughts) or speech is not clear.
2 = Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.	2 = Sometimes understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.	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.	2 = Frequently exhibits difficulty with expressing needs and ideas
3 = Rarely/Never Understands.	1 = Rarely/never understands	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.	1 = Rarely/never expresses self or speech is very difficult to understand
UK = Unable to assess understanding		4 = Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (for example, speech is nonsensical or unintelligible).	
		5 = Patient nonresponsive or unable to speak.	

MOOD AND BEHAVIOR

M1720 When Anxious

Responses	SOC/ROC Frequency	SOC/ROC %	DC Frequency	DC %
None of the time	76	50.00	81	64.29
Less often than daily	44	28.95	35	27.78
Daily, but not constantly	28	18.42	10	7.94
All of the time	4	2.63	0	0.00
Patient nonresponsive	0	0.00	0	0.00

M1730 Depression screening

Responses	SOC/ROC Frequency	SOC/ROC %
No	2	1.32
Yes, PHQ-2© scale	150	98.68
Yes, different assessment, meets criteria	0	0.00
Yes, different assessment, does not meet criteria	0	0.00

M1730 PHQ-2© results at SOC/ROC (n=150)

	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	125 (82.24)	16 (9.87)	6 (3.95)	4 (2.63)	0 (0.00)
b) Feeling down, depressed, or hopeless	115 (75.66)	24 (9.87)	6 (3.95)	5 (3.29)	0 (0.00

M1740 Cognitive, behavioral and psychiatric symptoms*

Responses (mark all that apply)	SOC/ROC Frequency	SOC/ROC %	DC Frequency	DC %
Memory deficit	11	7.24	11	8.73
Impaired decision-making	13	8.55	4	3.17
Verbal disruption	1	0.66	0	0.00
Physical aggression	1	0.66	0	0.00
Non-verbal disruptive behavior	2	1.32	1	0.79
Delusional behavior	1	0.66	0	0.00
None of the above	127	83.55	114	90.48

*M1740 is a 'mark all that apply' item. Frequencies may be larger than the sample size when patients are assessed as having multiple behaviors, and percent will sum to greater than 100.

M1745 Frequency of disruptive behavior symptoms*

Responses (mark all that apply)	SOC/ROC Frequency	SOC/ROC %	DC Frequency	DC %
Never	140	92.72	120	95.24
Less than once a month	1	0.66	2	1.59
Once a month	2	1.32	0	0.00
Several times each month	2	1.32	1	0.79
Several times a week	2	1.32	1	0.79
At least daily	4	2.65	2	1.59

*M1745 is a 'mark all that apply' item. Frequencies may be larger than the sample size when patients are assessed as having multiple behaviors, and percent will sum to greater than 100.

M1750 Psychiatric Nursing Services

Responses	SOC/ROC Frequency	SOC/ROC %
No	150	98.68
Yes	2	1.32

FALLS

J1800 Any Falls

Responses	DC Frequency	DC %
No	111	89.52
Yes	13	10.48

J1900 Number of Falls

Responses	A. No injury Frequency (%)	B. Injury (except major) Frequency (%)	C. Major Injury Frequency (%)
None	4 (3.25)	12 (9.76)	12 (9.76)
One	7 (5.69)	0 (0.00)	0 (0.00)
Two or more	1 (0.81)	0 (0.00)	0 (0.00)
Skipped	111 (90.24)	111 (90.24)	111 (90.24)

J1800 and J1900 Detail: For each patient with falls, number of falls by type of injury

Patients with falls (J1800 = Yes)	# falls with no injury	# falls with injury (except major)	# falls with major injury
Patient 1	0	0	0
Patient 2	1	Missing	Missing
Patient 3	1	0	0
Patient 4	1	0	0
Patient 5	1	0	0
Patient 6	1	0	0
Patient 7	2	0	0
Patient 8	0	0	0
Patient 9	0	0	0
Patient 10	1	0	0
Patient 11	0	0	0
Patient 12	1	0	0
Patient 13	Missing	0	0

SENSORY STATUS

M1200 Vision

	SOC/ROC	
Responses	Frequency	%
Normal vision	101	77.92
Partially impaired	53	22.08
Severely impaired	0	0.00

M1210 Ability to hear

	SOC/ROC	
Responses	Frequency	%
Adequate	101	65.58
Mildly to Moderately impaired	53	34.42
Severely Impaired	0	0.00
Unable to assess	0	0.00

SYMPTOMS

M1242 Frequency of Pain interfering with activity or movement

	SOC/ROC		DC	
Responses	Frequency	%	Frequency	%
No pain	20	13.16	49	39.2
Pain, but does not interfere with activity or movement	8	5.26	23	18.4
Less than daily	14	9.21	19	15.20
Daily, but not constant	71	46.71	27	21.60
All of the time	39	25.66	7	5.60

J0300 Pain Presence

Responses	SOC/ROC Frequency	SOC/ROC %	DC Frequency	DC %
No	24	15.58	48	38.71
Yes	130	84.42	76	61.29
Unable to answer	0	0.00	0	0.00

J0400 Pain Frequency

Responses	SOC/ROC Frequency	SOC/ROC %	DC Frequency	DC %
Almost constantly	43	27.92	14	11.29
Frequently	49	31.82	19	15.32
Occasionally	31	20.13	40	32.26
Rarely	8	5.19	3	2.42
Unable to answer	0	0.00	0	0.00
Skip	23	14.94	48	38.71

J0500 Pain effect on function

	A) Has pain made it hard for you to sleep at night?				B) Have you limited your day-to-day activities because of pain?			
	SOC/ROC		DC		SOC/ROC		DC	
Responses	Frequency	%	Frequency	%	Frequency	%	Frequency	%
No	53	34.42	50	40.32	39	25.32	45	40.32
Yes	78	50.65	26	20.97	92	59.74	31	20.97
Unable to answer	0	0.00	0	0.00	0	0.00	0	0.00
Skip	23	14.94	48	38.71	23	14.94	48	38.71

M1400 When is patient dyspneic or short of breath

Responses	SOC/ROC Frequency	SOC/ROC %	DC Frequency	DC %
Not short of breath	40	26.32	73	57.94
Walking more than 20 feet or climbing stairs	36	23.68	35	27.78
Moderate exertion	56	36.84	14	11.11
Minimal exertion	15	9.87	3	2.38
At rest	5	3.29	1	0.79

MEDICATION MANAGEMENT

M2001 Drug regimen review

Responses	SOC/ROC Frequency (%)
No	115 (75.16)
Yes	38 (24.84)
Not taking medication	0 (0.00)

M2003 Medication follow-up

Responses	SOC/ROC Frequency (%)
No	2 (1.32)
Yes	34 (22.37)
Dash	1 (0.66)
Skip	115 (75.66)

M2005 Medication Intervention

Responses	DC Frequency (%)
No	7 (5.69)
Yes	30 (24.39)
NA*	85 (69.11)
Dash	1 (0.81)

*NA = No potential clinically significant medication issues identified since SOC/ROC - or - patient is not taking any medications.

NUTRITION, HEIGHT and WEIGHT

MXXX Nutritional risk assessment completed

Responses	SOC/ROC Frequency	%
No	15	9.80
Yes, does not indicate nutritional risk	77	50.33
Yes, does indicate nutritional risk	61	39.87

M1060 Height and Weight

M1060A Height (in.)	n = 144
Mean (SD)	
Male (n=53)	67.11 (5.26)
Female (n=83)	62.13 (4.88)
Range	
Male (n=53)	53-75
Female (n=83)	38-72

M1060B Weight (lbs.)	n = 146
Mean (SD)	
Male (n=55)	190.18 (42.89)
Female (n=83)	172.21 (54.56)
Range	
Male (n=55)	130-380
Female (n=83)	100-430

SKIN CONDITIONS

M1306 Unhealed Pressure Ulcer Stage 2 or higher, or unstageable

	SOC/ROC	
Responses	Frequency	%
No	147	96.08
Yes	6	3.92

M1311: Current number of unhealed pressure ulcers

Stage	SOC/ROC Frequency	DC Frequency
Stage 2		
One stage 2 PU	4	0
Three stage 2 PU	0	1
Four stage 2 PU	1	0
Stage 3		
One stage 3 PU	1	0

M1313 Worsening in pressure ulcer status since SOC/ROC

Stage	DC Frequency
Stage 2	0
Stage 3	0
Stage 4	0
Unstageable: non-removable dressing	0
Unstageable: Slough and/or eschar	0
Unstageable: Deep tissue injury	0

M1320 Status of most problematic observable pressure ulcer

	SOC/ROC		DC	
Responses	Frequency	%	Frequency	%
Newly epithelialized	0	0.00	0	0.00
Fully granulating	2	1.31	0	0.00
Early/partial granulation	4	2.61	0	0.00
Not healing	0	0.00	1	00.79
No observable pressure ulcer	0	0.00	0	0.00
Skip	147	96.08	125	99.21

M1322 Number of Stage 1 Pressure Ulcers

	SOC/ROC		DC	
Responses	Frequency	%	Frequency	%
0	145	94.77	122	96.83
1	7	4.58	3	2.38
2	1	0.65	1	0.79
3	0	0.00	0	0.00
4 or more	0	0.00	0	0.00

M1324 Stage of most problematic unhealed stageable pressure ulcer

Responses	SOC/ROC Frequency	SOC/ROC %	DC Frequency	DC %
Stage 1	5	3.27	3	3.17
Stage 2	4	2.61	1	0.79
Stage 3	2	1.31	0	0.00
Stage 4	1	0.65	0	0.00
No stageable pressure ulcers	0	0.00	121	96.03
Skip	141	92.16		

M1330 Stasis Ulcers

Responses	SOC/ROC Frequency	SOC/ROC %	DC Frequency	DC %
No	148	96.73	125	99.21
Yes, both observable and unobservable	0	0.00	0	0.00
Yes, observable only	5	3.27	1	0.79
Yes, unobservable only	0	0.00	0	0.00

M1332 Number of observable stasis ulcers

Responses	SOC/ROC Frequency	SOC/ROC %	DC Frequency	DC %
One	4	2.61	1	0.79
Two	1	0.65	0	0.00
Three	0	0.00	0	0.00
Four or more	0	0.00	0	0.00
Skip	148	96.73	125	99.21

M1334 Status of most problematic observable stasis ulcer

Responses	SOC/ROC Frequency	SOC/ROC %	DC Frequency	DC %
Fully granulating	0	0.00	0	0.00
Early/partial granulation	3	1.96	0	0.00
Not healing	2	1.31	1	0.79
Skip	148	96.73	125	99.21

M1340 Does patient have a surgical wound?

Responses	SOC/ROC Frequency	SOC/ROC %	DC Frequency	DC %
No	119	77.27	105	83.33
Yes, observable	28	18.18	20	15.87
Yes, but not observable	7	4.55	1	0.79

M1342 Status of most problematic surgical wound

Responses	SOC/ROC Frequency	SOC/ROC %	DC Frequency	DC %
Newly epithelized	8	5.19	15	11.90
Fully granulating	5	3.25	1	0.79
Early/partial granulation	4	2.60	1	0.79
Not healing	11	7.14	3	2.38
Skip	126	81.81	106	84.13

M1350 Other skin lesion or open wound, receiving intervention by home health agency

Responses	SOC/ROC Frequency	SOC/ROC %
No	131	85.62
Yes	22	14.38

BLADDER AND BOWEL

M1600 Has the patient been treated for urinary tract infection (UTI) within the past 14 days?

Responses	SOC/ROC Frequency	SOC/ROC %	DC Frequency	DC %
No	139	91.45	120	96.00
Yes	12	7.89	3	2.40
NA – Patient on prophylactic treatment	0	0.00	2	1.60
Unknown	1	0.66	0	0.00

M1610 Urinary incontinence or catheter

Responses	SOC/ROC Frequency	SOC/ROC %	DC Frequency	DC %
No incontinence or catheter	64	41.83	67	53.60
Incontinent	85	55.56	56	44.80
Requires urinary catheter	4	2.61	2	1.60

M1615 Frequency of urinary incontinence

Responses	SOC/ROC Frequency	SOC/ROC %	DC Frequency	DC %
Timed-voiding defers incontinence	6	3.92	9	7.14
Occasional stress incontinence	32	20.92	20	15.87
During the night only	3	1.96	2	1.59
During the day only	5	3.27	2	1.59
During day and night	39	25.49	24	19.05
Skipped	68	44.44	69	54.76

Parallel Items M1620 - H0400 Bowel Incontinence/Continence*

M1620 Bowel incontinence frequency					H0400 Bowel continence				
	SOC/ROC		DC			SOC/ROC		DC	
Responses	#	%	#	%	Responses	#	%	#	%
Very rarely or never	132	86.27	115	91.27	Always continent	130	84.97	107	86.29
Less than once weekly	8	5.23	2	1.59					
1 to 3 times weekly	2	1.31	3	2.38	Occasionally	14	9.15	6	4.84
4 to 6 times weekly	2	1.31	1	0.79	Frequently	4	2.61	5	4.03
On a daily basis	2	1.31	2	1.59					
More often than once daily	1	0.65	0	0.00	Always incontinent	1	0.65	3	2.42
Patient has ostomy	0	0.00	3	2.38					
Unknown	6	3.92	0	0.00	Not rated	4	2.61	3	2.42

*Comparison is approximate, for visualization of data. Items and response options differ, precluding exact comparison.

M1630 Ostomy

	SOC/ROC	
Responses	Frequency	%
Does not have ostomy	148	96.73
Ostomy not related to inpatient stay AND did not necessitate change in treatment	4	2.61
Ostomy was related to inpatient stay OR did necessitate change in treatment	1	0.65

FUNCTIONAL STATUS

M1900 Prior function (SOC/ROC)

Responses	a. Self-care Frequency (%)	b. Ambulation Frequency (%)	c. Transfer Frequency (%)	d. Household tasks Frequency (%)
Independent	80 (52.29)	78 (50.98)	95 (62.09)	43 (28.1)
Needed some help	65 (42.48)	68 (44.44)	53 (34.64)	67 (43.79)
Dependent	8 (5.23)	7 (4.58)	5 (3.27)	43 (28.1)

M1800 – M1890 OASIS ADL & IADL Items

Items	Field Test SOC/ROC n(%) (n=154)	2016 HH SOC/ROC pop %	Field Test DC n(%) (n=126)	2016 HH DC pop %
M1800 Grooming	n = 150	n=6,437,455	n = 123	n=4,673,227
Independent	38 (25.33)	10.64	94 (76.42)	58.93
Setup required	79 (52.67)	43.11	22 (17.89)	27.24
Assistance required	30 (20.00)	36.84	4 (3.25)	10.01
Dependent	3 (2.00)	9.41	3 (2.44)	3.83
M1810 Dress upper body	n = 150	n=6,437,455	n = 123	n=4,673,227
Independent	31 (20.67)	7.92	96 (78.05)	57.12
Setup required	72 (48.00)	37.67	21 (17.07)	27.17
Assistance required	44 (29.33)	43.71	4 (3.25)	11.78
Dependent	3 (2.00)	10.70	2 (1.63)	3.93
M1820 Dress lower body	n = 150	n=6,437,455	n = 123	n=4,673,227
Independent	20 (13.33)	5.95	79 (64.23)	51.58
Setup required	45 (30.00)	17.18	25 (20.33)	23.67
Assistance required	72 (48.00)	57.76	14 (11.38)	19.06
Dependent	13 (8.67)	19.11	5 (4.07)	5.69
M1830 Bathing	n = 150	n=6,437,455	n = 123	n=4,673,227
Independent	3 (2.00)	2.07	29 (23.58)	23.42
Independent with devices	16 (10.67)	5.15	34 (27.64)	28.16
Intermittent assistance	37 (24.67)	17.34	33 (26.83)	23.39
Requires presence of person	69 (46.00)	44.12	18 (14.63)	15.85
Independent at sink, chair	12 (8.00)	6.69	4 (3.25)	2.53
Assistance at sink, chair	11 (7.33)	16.51	3 (2.44)	3.14
Dependent	2 (1.33)	8.12	2 (1.63)	3.51
M1840 Toilet transferring	n = 150	n=6,437,455	n = 123	n=4,673,227
Independent	45 (30.00)	16.58	102 (82.93)	67.37
Reminder, assistance, supervision	85 (56.67)	57.42	18 (14.63)	25.06
Unable, uses commode	18 (12.00)	14.99	-	2.92
Unable, uses bedpan/urinal	1 (0.67)	2.1	-	0.65
Dependent	1 (0.67)	8.9	3 (2.44)	4
M1845 Toilet hygiene	n = 150	n=6,437,455	n = 123	n=4,673,227
Independent	40 (26.49)	13.38	99 (80.49)	62.23
Setup required	73 (48.34)	35.61	19 (15.45)	23.16
Assistance required	36 (23.84)	39.52	2 (1.63)	9.89
Dependent	2 (1.32)	11.48	3 (2.44)	4.71
M1850 Transferring	n = 151	n=6,437,455	n = 123	n=4,673,227
Independent	14 (9.27)	6.18	60 (48.78)	45.86
Minimal assistance	88 (58.28)	45.77	59 (47.97)	43.68
Bears weight	45 (29.80)	36.97	1 (0.81)	6.73
Unable to bear weight	3 (1.99)	8.72	2 (1.63)	2.4
Bedfast, dependent for mobility	1 (0.66)	0.67	1 (0.81)	0.37
		1.69		0.96
M1860 Ambulation	n = 151	n=6,437,455	n = 122	n=4,673,227
Independent	10 (6.62)	3.26	26 (21.31)	23.29
With one-handed device	12 (7.95)	6.74	31 (25.41)	25.28
With two-handed device or assist	38 (25.17)	25.26	55 (45.08)	34.98
Only with supervision	82 (54.30)	51.9	4 (3.28)	10.09

Items	Field Test SOC/ROC n(%) (n=154)	2016 HH SOC/ROC pop %	Field Test DC n(%) (n=126)	2016 HH DC pop %
Chairfast, wheels independently	7 (4.64)	5.43	3 (2.46)	2.97
Chairfast, unable to wheel self	1 (0.66)	5.91	2 (1.64)	2.59
Bedfast, unable to ambulate	1 (0.66)	1.5	1 (0.82)	0.8
M1870 Eating	n = 152	n=6,437,455	n = 123	n=4,673,227
Independent	98 (64.47)	34.83	105 (85.37)	71.11
Set-up, intermittent	54 (35.53)	57.82	17 (13.82)	25.57
NG or G-tube only	--	5.76	1 (0.81)	2.53
		0.51		0.24
		0.92		0.44
		0.16		0.12
M1880 Prepare light meals	n = 152	n=6,437,455	n = 123	n=4,673,227
Independent or capable	29 (19.08)	11.67	84 (68.29)	53.68
Unable on a regular basis	83 (54.61)	44.18	29 (23.58)	27.81
Unable	40 (26.32)	44.14	10 (8.13)	18.52
M1890 Telephone	n = 152	n=6,437,455	n = 122	n=4,673,227
Independent	120 (78.95)	61.74	104 (85.25)	75.48
Uses adapted telephone	6 (3.95)	9.7	7 (5.74)	6.44
Answers phone, difficulty placing calls	14 (9.21)	9.67	5 (4.1)	6.04
Answers phone sometimes, ltd. conversation	9 (5.92)	7.97	1 (0.82)	4.02
Unable to answer, listen if assisted	-	3.85	3 (2.46)	2.54
Totally unable	2 (1.32)	4.88	2 (1.64)	3.29
Not applicable	1 (0.66)	2.19	-	2.18

GG0130 Self-Care and GG0170 Mobility Items

Items	n (%) SOC/ROC (n=154)	DC (n=126)
GG0130 Eating	n = 153	n = 124
Dependent	1 (0.65)	-
Partial/moderate assistance	1 (0.65)	1 (0.81)
Supervision	3 (1.96)	3 (2.42)
Setup or clean-up assistance	26 (16.99)	5 (4.03)
Independent	119 (77.78)	115 (92.74)
Patient refused	1 (0.65)	-
Not applicable	2 (1.31)	-
GG0130 Oral hygiene	n = 153	n = 124
Dependent	1 (0.65)	-
Substantial/maximal assistance	1 (0.65)	1 (0.81)
Partial/moderate assistance	3 (1.96)	1 (0.81)
Supervision	10 (6.54)	1 (0.81)
Setup or clean-up assistance	31 (20.26)	8 (6.45)
Independent	100 (65.36)	113 (91.13)
Patient refused	3 (1.96)	-
Not applicable	3 (1.96)	-
Not attempted (medical/safety concerns)	1 (0.65)	-
GG0130 Toileting hygiene	n = 153	n = 124
Dependent	1 (0.65)	3 (2.42)
Substantial/maximal assistance	6 (3.92)	2 (1.61)
Partial/moderate assistance	14 (9.15)	1 (0.81)
Supervision	31 (20.26)	1 (0.81)
Setup or clean-up assistance	34 (22.22)	5 (4.03)
Independent	64 (41.83)	112 (90.32)
Patient refused	2 (1.31)	-
Not applicable	1 (0.65)	-
GG0130 Wash upper body	n = 153	n = 119
Dependent	4 (2.61)	3 (2.52)
Substantial/maximal assistance	3 (1.96)	3 (2.52)
Partial/moderate assistance	13 (8.50)	3 (2.52)
Supervision	26 (16.99)	6 (5.04)
Setup or clean-up assistance	38 (24.84)	8 (6.72)
Independent	65 (42.48)	96 (80.67)
Patient refused	4 (2.61)	-
GG0170A Roll left and right	n = 152	n = 119
Dependent	1 (0.66)	3 (2.52)
Substantial/maximal assistance	6 (3.95)	-
Partial/moderate assistance	7 (4.61)	1 (0.84)
Supervision	17 (11.18)	1 (0.84)
Setup or clean-up assistance	9 (5.92)	2 (1.68)
Independent	102 (67.11)	108 (90.76)
Patient refused	6 (3.95)	3 (2.52)
Not attempted (medical/safety concerns)	4 (2.63)	1 (0.84)

Items	n (%) SOC/ROC (n=154)	DC (n=126)
GG0170B Sit to lying	n = 151	n = 124
Dependent	-	2 (1.61)
Substantial/maximal assistance	6 (3.97)	-
Partial/moderate assistance	15 (9.93)	1 (0.81)
Supervision	24 (15.89)	2 (1.61)
Setup or clean-up assistance	10 (6.62)	1 (0.81)
Independent	88 (58.28)	112 (90.32)
Patient refused	6 (3.97)	4 (3.23)
Not applicable	1 (0.66)	-
Not attempted (medical/safety concerns)	1 (0.66)	2 (1.61)
GG0170C Lying to sitting	n = 153	n = 124
Dependent	-	2 (1.61)
Substantial/maximal assistance	8 (5.23)	1 (0.81)
Partial/moderate assistance	17 (11.11)	1 (0.81)
Supervision	30 (19.61)	2 (1.61)
Setup or clean-up assistance	11 (7.19)	4 (3.23)
Independent	77 (50.33)	109 (87.9)
Patient refused	6 (3.92)	4 (3.23)
Not applicable	1 (0.65)	-
Not attempted (medical/safety concerns)	3 (1.96)	1 (0.81)
GG0170D Sit to stand	n = 152	n = 124
Dependent	-	2 (1.61)
Substantial/maximal assistance	6 (3.95)	1 (0.81)
Partial/moderate assistance	17 (11.18)	2 (1.61)
Supervision	51 (33.55)	2 (1.61)
Setup or clean-up assistance	15 (9.87)	6 (4.84)
Independent	60 (39.47)	107 (86.29)
Patient refused	-	1 (0.81)
Not applicable	1 (0.66)	1 (0.81)
Not attempted (medical/safety concerns)	2 (1.32)	2 (1.61)
GG0170E Chair transfer	n = 152	n = 124
Dependent	1 (0.66)	2 (1.61)
Substantial/maximal assistance	5 (3.29)	1 (0.81)
Partial/moderate assistance	15 (9.87)	1 (0.81)
Supervision	60 (39.47)	4 (3.23)
Setup or clean-up assistance	17 (11.18)	6 (4.84)
Independent	50 (32.89)	106 (85.48)
Patient refused	1 (0.66)	3 (2.42)
Not applicable	1 (0.66)	-
Not attempted (medical/safety concerns)	2 (1.32)	1 (0.81)
GG0170F Toilet transfer	n = 149	n = 123
Dependent	1 (0.67)	2 (1.63)
Substantial/maximal assistance	4 (2.68)	1 (0.81)
Partial/moderate assistance	16 (10.74)	1 (0.81)
Supervision	54 (36.24)	3 (2.44)
Setup or clean-up assistance	14 (9.40)	4 (3.25)
Independent	56 (37.58)	109 (88.62)

Items	n (%) SOC/ROC (n=154)	DC (n=126)
Patient refused	3 (2.01)	2 (1.63)
Not attempted (medical/safety concerns)	1 (0.67)	1 (0.81)
GG0170H Does the patient walk?	n = 152	n = 124
Yes	141 (92.76)	117 (94.35)
No, and walking goal is not clinically indicated	10 (6.58)	7 (5.65)
No, and walking goal is clinically indicated	1 (0.66)	-
GG0170I Walk 10 ft.	n = 141	n = 112
Substantial/maximal assistance	3 (2.13)	-
Partial/moderate assistance	15 (10.64)	-
Supervision	57 (40.43)	1 (0.89)
Setup or clean-up assistance	13 (9.22)	1 (0.89)
Independent	53 (37.59)	109 (97.3)
Patient refused	-	1 (0.89)
GG0170J Walk 50 ft.	n = 141	n = 117
Dependent	1 (0.71)	-
Substantial/maximal assistance	4 (2.84)	-
Partial/moderate assistance	8 (5.67)	-
Supervision	56 (39.72)	7 (5.98)
Setup or clean-up assistance	10 (7.09)	2 (1.71)
Independent	31 (21.99)	100 (85.47)
Patient refused	2 (1.42)	2 (1.71)
Not applicable	1 (0.71)	-
Not attempted (medical/safety concerns)	28 (19.86)	6 (5.1)
GG0170K Walk 150 ft.	n = 137	n = 117
Dependent	3 (2.19)	-
Substantial/maximal assistance	3 (2.19)	-
Partial/moderate assistance	4 (2.92)	-
Supervision	43 (31.39)	11 (9.4)
Setup or clean-up assistance	5 (3.65)	1 (0.85)
Independent	20 (14.60)	89 (76.07)
Patient refused	8 (5.84)	2 (1.71)
Not applicable	3 (2.19)	3 (2.56)
Not attempted (medical/safety concerns)	47 (34.31)	11 (9.40)
Dashed	1 (0.73)	-
GG0170Q Does the patient use a wheelchair/scooter?	n = 143	n = 123
No	123 (86.01)	106 (86.18)
Yes	20 (13.99)	17 (13.83)
GG0170R Wheel 50 ft.	n = 18	n = 14
Dependent	3 (16.67)	4 (28.57)
Substantial/maximal assistance	-	1 (7.14)
Supervision	2 (11.11)	1 (7.14)
Setup or clean-up assistance	-	1 (7.14)
Independent	8 (44.44)	5 (35.71)
Patient refused	1 (5.56)	1 (7.14)
Not attempted (medical/safety concerns)	4 (22.22)	1 (7.14)

Items	n (%) SOC/ROC (n=154)	DC (n=126)
GG0170RR Type of wheelchair	n = 20	n = 14
Manual	15 (10.49)	11 (9.17)
Motorized	5 (3.5)	3 (2.5)
GG0170S Wheel 150 ft.	n = 18	n = 15
Dependent	4 (22.22)	4 (26.67)
Substantial/maximal assistance	-	1 (6.67)
Setup or clean-up assistance	-	1 (6.67)
Independent	7 (38.89)	5 (33.33)
Patient refused	1 (5.56)	1 (6.67)
Not attempted (medical/safety concerns)	5 (27.78)	3 (20.00)
Dashed	1 (5.56)	-
GG0170SS Type of wheelchair	n = 19	n = 12
Manual	13 (9.15)	9 (7.56)
Motorized	6 (4.23)	3 (2.52)

ADDITIONAL ITEMS

M0110 Episode timing

Responses	SOC/ROC Frequency	%
Early	115	76.67
Later	6	4.00
Unknown	24	16.00
Not Applicable	5	3.33

M1030 Therapies the patient receives at home

Responses	SOC/ROC Frequency	%
Intravenous or infusion therapy	0	0
Parenteral nutrition	0	0
Enteral nutrition	0	0
None of the above	151	100

M1410 Respiratory Treatments used at home

Responses	SOC/ROC Frequency	%
Oxygen	30	19.74
Ventilator	2	1.32
Continuous/Bi-level positive airway pressure	8	5.26
None of the above	117	76.97

M2010 Patient/Caregiver high risk drug education

Responses	SOC/ROC Frequency	%
No	4	2.61
Yes	112	73.2
NA – Patient not taking any high-risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications	0	0.00
Unknown	37	24.18

M1041 Influenza Vaccine Period

Responses	DC Frequency	%
No	10	7.94
Yes	116	92.06

M1046 Influenza Vaccine received

Responses	DC Frequency	%
Yes; this episode of care	4	3.17
Yes; prior episode of care	0	0.00
Yes; different provider	90	71.43
No; patient declined	12	9.52
No; medical contraindication(s)	3	2.38
No; not indicated	0	0.00
No; declared shortage	0	0.00
No; other	7	5.56
Skipped	10	7.94

M1051 Pneumococcal Vaccine

Responses	DC Frequency	%
No	26	20.63
Yes	100	79.37

M1056 Reason Pneumococcal Vaccine not received

Responses	DC Frequency	%
Declined	8	6.35
Medical contraindication(s)	1	0.79
Not indicated	9	7.14
None of the above	5	3.97
Skipped	103	81.75

M2016 Patient/Caregiver Drug Education Intervention

Responses	DC Frequency	%
No	4	3.23
Yes	120	96.77
NA – Patient not taking any drugs	0	0.00

M2110 How often the patient receives assistance from caregiver other than HHA staff

Responses	SOC/ROC Frequency	%
At least daily	113	74.34
Three or more times per week	18	11.84
One or two times per week	12	7.89
Less often than weekly	3	1.97
No assistance received	4	2.63
Unknown	1	0.66

M2250 Plan of care synopsis (SOC/ROC) and M2401 Intervention synopsis (DC)

Responses		Patient-specific parameters Frequency (%)	Diabetic foot pain Frequency (%)	Falls prevention Frequency (%)	Depression intervention Frequency (%)	Pain monitoring and mitigation Frequency (%)	Pressure ulcer prevention Frequency (%)	Pressure ulcer treatment Frequency (%)	Nutrition monitoring and mitigation Frequency (%)
NO	SOC/ROC	8 (5.23)	2 (1.31)	0 (0.00)	2 (1.31)	0 (0.00)	2 (1.31)	2 (1.31)	15 (10.2)
	DC	---*	4 (3.17)	0 (0.00)	1 (0.79)	0 (0.00)	0 (0.00)	2 (1.59)	4 (3.28)
YES	SOC/ROC	32 (20.92)	53 (34.64)	147 (96.08)	41 (26.8)	134 (87.58)	54 (35.29)	12 (7.84)	58 (39.46)
	DC	---	28 (22.22)	124 (98.41)	35 (27.78)	115 (91.27)	36 (28.57)	9 (7.14)	46 (37.7)
NA	SOC/ROC	113 (73.86)	98 (64.05)	6 (3.92)	110 (71.9)	19 (12.42)	97 (63.4)	139 (90.85)	74 (50.34)
	DC	---	94 (74.6)	2 (1.59)	90 (71.43)	11 (8.73)	90 (71.43)	115 (91.27)	72 (59.02)

*Patient-specific parameters are not included in the DC item M2410 Intervention synopsis.

M2102 Types and source of assistance

Responses	a. ADL assistance		b. IADL assistance		c. Medication administration		d. Medical procedures/treatments	
	SOC/ROC Frequency (%)	DC Frequency (%)	SOC/ROC Frequency (%)	DC Frequency (%)	SOC/ROC Frequency (%)	DC Frequency (%)	SOC/ROC Frequency (%)	DC Frequency (%)
No assistance needed	21 (13.73)	72 (57.14)	7 (4.58)	31 (24.6)	60 (39.22)	83 (65.87)	68 (44.44)	109 (86.51)
Non-agency caregiver currently provides assistance	88 (57.52)	53 (42.06)	121 (79.08)	93 (73.81)	63 (41.18)	42 (33.33)	36 (23.53)	14 (11.11)
Non-agency caregiver needs training to provide assistance	32 (20.92)	0 (0.00)	16 (10.46)	1 (0.79)	23 (15.03)	0 (0.00)	36 (23.53)	1 (0.79)
Non-agency caregiver not likely or unclear to provide assistance	5 (3.27)	1 (0.79)	4 (2.61)	0 (0.00)	4 (2.61)	1 (0.79)	7 (4.58)	1 (0.79)
Assistance needed, no non-agency caregiver available	7 (4.58)	0 (0.00)	5 (3.27)	1 (0.79)	3 (1.96)	0 (0.00)	6 (3.92)	1 (0.79)

M2102 Types and source of assistance, continued

Responses	e. Management of equipment		f. Supervision and safety		g. Advocacy or facilitation	
	SOC/ROC Frequency (%)	DC Frequency (%)	SOC/ROC Frequency (%)	DC Frequency (%)	SOC/ROC Frequency (%)	DC Frequency (%)
No assistance needed	110 (71.9)	111 (88.1)	68 (44.44)	85 (67.46)	13 (8.5)	39 (30.95)
Non-agency caregiver currently provides assistance	26 (16.99)	13 (10.32)	58 (37.91)	39 (30.95)	121 (79.08)	86 (68.25)
Non-agency caregiver needs training to provide assistance	14 (9.15)	1 (0.79)	18 (11.76)	2 (1.59)	12 (7.84)	0 (0.00)
Non-agency caregiver not likely or unclear to provide assistance	3 (1.96)	1 (0.79)	5 (3.27)	0 (0.00)	3 (1.96)	0 (0.00)
Assistance needed, no non-agency caregiver available	0 (0.00)	0 (0.00)	4 (2.61)	0 (0.00)	4 (2.61)	1 (0.79)

M2301 Emergent Care

Responses	DC Frequency (%)
No	117 (95.12)
Yes, used hospital ED without hospital admission	5 (4.07)
Yes, used hospital ED with hospital admission	1 (0.81)
Unknown	0 (0.00)

M2310 Reason for Emergent Care

Responses	DC Frequency (%)
Other respiratory problem	1 (0.80)
Stroke (CVA) or TIA	2 (1.60)
GI bleeding, obstruction, constipation, impaction	1 (0.80)
Dehydration, malnutrition	1 (0.80)
Wound infection or deterioration	1 (0.80)
Reason unknown	1 (0.80)
Skip	118 (94.4)

M2420 Discharge disposition

Responses	DC Frequency (%)
Remained in the community (without formal assistive services)	86 (68.25)
Remained in the community (with formal assistive services)	39 (30.95)
Patient transferred to a non-institutional hospice	0 (0.00)
Unknown because patient moved to a geographic location not served by this agency	1 (0.79)
Other Unknown	0 (0.00)