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OUTCOME AND ASSESSMENT INFORMATION SET VERSION E2
Transfer to an Inpatient facility (TRN)

Section A	Administrative Information
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M0080. Discipline of Person Completing Assessment
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Enter Code <input style="width:30px; height:20px;" type="text"/>	1. RN 2. PT 3. SLP/ST 4. OT
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M0090. Date Assessment Completed

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	Month Day Year								

M0100. This Assessment is Currently Being Completed for the Following Reason

Enter Code <input style="width:30px; height:20px;" type="text"/>	Start/Resumption of Care 1. Start of care — further visits planned 3. Resumption of Care (after inpatient stay) Follow-up 4. Recertification (follow-up) reassessment 5. Other follow-up Transfer to an Inpatient Facility 6. Transferred to an inpatient facility — patient not discharged from agency 7. Transferred to an inpatient facility — patient discharged from agency Discharge from Agency — Not to an Inpatient Facility 8. Death at home 9. Discharge from agency
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M0906. Discharge/Transfer/Death Date

Enter the date of the discharge, transfer, or death (at home) of the patient.									
	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr><td style="width:20px; height:20px;"></td><td style="width:20px; height:20px;"></td></tr> </table> — <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr><td style="width:20px; height:20px;"></td><td style="width:20px; height:20px;"></td></tr> </table> — <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr><td style="width:20px; height:20px;"></td><td style="width:20px; height:20px;"></td><td style="width:20px; height:20px;"></td><td style="width:20px; height:20px;"></td></tr> </table>								
	Month Day Year								

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 <input style="width:30px; height:20px;" type="text"/>	0. No → Skip to M2410, Inpatient Facility 1. Yes, used hospital emergency department WITHOUT hospital admission 2. Yes, used hospital emergency department WITH hospital admission UK Unknown → Skip to M2410, Inpatient Facility
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M2310. Reason for Emergent Care
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For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)?

↓	Check all that apply
<input type="checkbox"/>	1. Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
<input type="checkbox"/>	10. Hypo/Hyperglycemia, diabetes out of control
<input type="checkbox"/>	19. Other than above reasons
<input type="checkbox"/>	UK Reason unknown

M2410. To which Inpatient Facility has the patient been admitted?Enter
Code

1. **Hospital**
2. **Rehabilitation facility**
3. **Nursing home**
4. **Hospice**

A2120. Provision of Current Reconciled Medication List to Subsequent Provider at Transfer

At the time of transfer to another provider, did your agency provide the patient's current reconciled medication list to the subsequent provider?

Enter
Code

0. **No** — **Current reconciled medication list not provided to the subsequent provider** → *Skip to J1800, Any Falls Since SOC/ROC*
1. **Yes** — **Current reconciled medication list provided to the subsequent provider** → Continue to A2122, Route of Current Reconciled Medication List Transmission to Subsequent Provider
2. **NA** — The agency was not made aware of this transfer timely → *Skip to J1800, Any Falls Since SOC/ROC*

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider

Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.

Route of Transmission	↓	Check all that apply	↓
A. Electronic Health Record		<input type="checkbox"/>	
B. Health Information Exchange		<input type="checkbox"/>	
C. Verbal (e.g., in-person, telephone, video conferencing)		<input type="checkbox"/>	
D. Paper-based (e.g., fax, copies, printouts)		<input type="checkbox"/>	
E. Other Methods (e.g., texting, email, CDs)		<input type="checkbox"/>	

Section J**Health Conditions****J1800. Any Falls Since SOC/ROC, whichever is more recent**

Enter Code

Has the patient **had any falls since SOC/ROC**, whichever is more recent?

0. **No** → *Skip to M2005. Medication Intervention*
1. **Yes** → Continue to J1900, Number of Falls Since SOC/ROC

J1900. Number of Falls Since SOC/ROC, whichever is more recent

Coding:	↓ Enter code in boxes	
	0. None	<input type="text"/>
1. One	<input type="text"/>	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
2. Two or more	<input type="text"/>	C. Major injury: Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Section N	Medications
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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 <div style="border: 1px solid black; width: 40px; height: 25px; margin: 5px auto;"></div>	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
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Section O	Special Treatment, Procedures, and Programs
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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 <div style="border: 1px solid black; width: 40px; height: 25px; margin: 5px auto;"></div>	0. No → Skip to M2401, Intervention Synopsis 1. Yes → Continue to M1046, Influenza Vaccine Received
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M1046. Influenza Vaccine Received

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

Enter Code <div style="border: 1px solid black; width: 40px; height: 25px; margin: 5px auto;"></div>	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.
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Section Q Participation in Assessment and Goal Setting

M2401. Intervention Synopsis

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? (Mark only one box in each row.)

Plan/Intervention	No	Yes	Not Applicable
	↓	Check only one box in each row	↓
b. Falls prevention interventions	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Every standardized, validated multi-factor fall risk assessment conducted at or since the 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.