**Objectives**

- Understand the CMS OASIS manual and its intent and guidance for each item
- Understand the timepoints for OASIS completion
- Understand how the OASIS and comprehensive assessment correlate in the development of an individualized plan of care
- Understand how M items are to be considered and answered
- Understand ways to increase OASIS accuracy and consistency

**OASIS**

CMS describes the OASIS as “a key component of Medicare’s partnership with the home care industry to foster and monitor improved home health care outcomes.”
History of OASIS

- In 1999, CMS revised the CoPs that HHAs have to do OASIS integrated into HHA’s comprehensive assessment.
- Goal was to evaluate the extent to which the quality & scope of services furnished by the HHA attain and maintain the highest practicable functional capacity of the patient as reflected in the plan of care.
- Each patient receives a patient-specific, comprehensive assessment that identifies the patient’s need for home care and that meets the patient’s medical, nursing, rehabilitative, social, and discharge planning needs.
- The rule requires HHAs use OASIS when evaluating adult, non-maternity patients.

Quality Measures

- Home health quality measurements derived from OASIS.
- Input from the NQF (National Quality Forum) a nonprofit organization that endorses national consensus standards for measuring and publicly reporting on performance, has been especially valuable in guiding the evolution of OASIS and associated performance reports.
- These measurements lead to our CASPER - OBQI Outcome reports.

Reimbursement

- OASIS scores and diagnoses drive the reimbursement given to a HHAs patient for a 60 day period.
- 153 payment groups.
- This is especially important for traditional Medicare patients.
- The Medicare Advantage, Medicaid and private insurance mostly pay by a visit rate regardless of the OASIS data.
OASIS C-3 OR OASIS-D

- OASIS - D
  - Implementation date: January 1, 2019
  - Draft coming out: July 2018
  - Final approval: November 2018
  - Removing many items
    - Example: Removing M1200 (Vision) but adding another version such as 'Vision: Ability to see in adequate light'

- Adding many items

- Example: Removing M1200 (Vision) but adding another version such as 'Vision: Ability to see in adequate light'

OASIS D Coming

- Key changes:
  - Removing elements that are not used in quality measures / payments
    - M0221: Inpatient diagnosis / M0225: Optional diagnosis / M1410: Respiratory Treatments
    - M2250: going away
  - Additions
    - Percent of patients experiencing one or more falls with major injury
    - Functional assessment items to reflect additional mobility and self-care assessments
    - More GG items

PPS Case Mix Adjustment Model - 2018

<table>
<thead>
<tr>
<th>Index</th>
<th>Description</th>
<th>Value</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>M1010</td>
<td>Episode timing</td>
<td>M1850</td>
<td>Dyspnea**</td>
</tr>
<tr>
<td>M1021</td>
<td>Primary diagnosis</td>
<td>M1821</td>
<td>Other (secondary) diagnosis</td>
</tr>
<tr>
<td>M1022</td>
<td>Other (secondary) diagnosis</td>
<td>M1822</td>
<td>Urinary/urodynamic or urinary catheter</td>
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<tr>
<td>M1030</td>
<td>IV/Infusion/Parenteral/Enteral/Therapies</td>
<td>M1823</td>
<td>Knee incoherence</td>
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<td>M1031</td>
<td>Knee activity</td>
<td>M1824</td>
<td>Dressing upper body</td>
</tr>
<tr>
<td>M1032</td>
<td>Multiple pressure ulcers</td>
<td>M1825</td>
<td>Dressing lower body</td>
</tr>
<tr>
<td>M1033</td>
<td>Current number of larger pressure ulcers</td>
<td>M1826</td>
<td>Bathtime</td>
</tr>
<tr>
<td>M1034</td>
<td>Stage of most problematic pressure ulcer</td>
<td>M1827</td>
<td>Total transferring</td>
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<td>M1035</td>
<td>Any skin ulcer</td>
<td>M1828</td>
<td>Bed transferring</td>
</tr>
<tr>
<td>M1036</td>
<td>Number of observable mosaic ulcers</td>
<td>M1829</td>
<td>Ambulation/Translocation</td>
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<td>M1037</td>
<td>Stage area status</td>
<td>M1830</td>
<td>Injectable medications**</td>
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<tr>
<td>M1038</td>
<td>Surgical wound status</td>
<td>M1831</td>
<td>Therapy need</td>
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</table>

*No PPS model, but no points assigned
**Points assigned again in 2018
The OASIS manual provides guidance for home health agencies (HHAs) on how to ensure the collection of high-quality (accurate) OASIS data. It includes both general data collection conventions and item-specific guidance, intent to be utilized, as well as links to quality-related resources for agencies.

This manual, particularly Chapter 3, gives the details on how to assess the patient and score the items most accurately.

Very important to follow these guidelines and intent!
M0100 – OASIS Timepoints

SOC: Initial Assessment - within 48 hours of referral
- The comprehensive assessment must be completed in a timely manner, consistent with the patient’s immediate needs, but no later than 5 calendar days after the start of care.

Initial Assessment
- Determines immediate care, support needs, eligibility & homebound status

Comprehensive Assessment
- Is consistent with the patient’s immediate care needs
- Can not be started before the SOC date
- Has to be completed with 5 calendar days of the SOC

Initial / Comprehensive Assessment

Who Completes
- RN
  - If skilled nursing ordered at SOC
  - Even just a one time nursing order
  - If agency policy/practice is RN completing on all patients
- Qualifying therapist (PT or ST)
  - If "therapy only" case and need for service establishes program eligibility
- OT may not establish program eligibility for Medicare
  - May for other payers

Comprehensive Assessment

- The comprehensive assessment MUST
  1. Identify the patient's continuing need for home care;
  2. Meet the patient’s medical, nursing, rehabilitative, social, and discharge planning needs; and
  3. For Medicare patients, identify eligibility for the home health benefit, including the patient's homebound status
- Identifies patient progress toward desired outcomes or goals of the care plan
- Direct observation is the preferred method for data collection, but some historical data may only be obtained by interview
- The interview should supplement, not replace, observational techniques
- OASIS data must accurately reflect the patient’s status at the time the information is collected
M0100 – OASIS Timepoints

- ROC: Within 48 hours of patient return home from inpatient facility admission of 24 hours or more for reasons other than diagnostic tests
- NEW CoP ALERT – On physician ordered resumption of care date
- Recert: Not less frequently than last 5 days of every 60 day episode beginning with SOC date (day 56-60 of each cert period)
- Other follow up – Major decline or improvement in health status
- Transfer to inpatient facility – Not discharged
- Death at Home
- Discharge

OASIS Conventions (Rules)

- Time Period – must know what it is for each M-item
  - Report what is true on day of assessment unless a different time period has been indicated in the item or guidance
  - Day of assessment is defined as 24 hours immediately preceding the visit
  - A care episode or quality episode must have beginning (SOC, ROC assessment) & a conclusion (transfer or discharge) to be considered a complete care episode
  - Look-back period is back to SOC/ROC
  - Not Recertifications
OASIS Conventions (Rules)

- If patient’s ability or status varies on day of assessment, report patient’s ‘usual status’ or what is true > than 50% of the assessment time frame
  - Unless the item specified differently
  - Minimize use of “NA” and Unknown responses
  - Response to patient current status should be independent observation of the patients condition & ability at time of assessment without referring back to prior assessments.
  - Several process items require documentation of prior care, at the time of or since the time of the most recent assessment. Instructions in guidance and M items

- Combine observation, interview, & other relevant strategies to complete OASIS data items as needed (for example: discharge summary from hospital), however when assessing physiologic or functional health status, direct observation is the preferred strategy
- OASIS items refer to assistance, this means assistance from another person unless otherwise specified within the item
- Complete OASIS items accurately & comprehensively

- Understand definitions of words in OASIS
  - Assistance / ability / safely
  - One calendar day / same day
  - Medical restrictions
  - Conventions specific to ADL/IADL items
  - Stay current with evolving CMS OASIS guidance updates
  - Follow rules in item specific guidance (Chapter 3 of OASIS Manual)
Expansion of the One Clinician Convention

Was effective as of January 1, 2018

- Comprehensive assessment will continue to be the responsibility of one clinician as required by the CoPs but ...
- Now allows the assessing clinician to get feedback from other agency staff to complete any or all OASIS items
- NACOGD - Date assessment completed may need changed
- The last day the assessing clinician gathered or received any input to complete the comprehensive assessment document

References:
- Chapter 1 in the 2018 Guidance Manual

Expansion of the One Clinician Convention - Unplanned or Unexpected Discharges

Should happen very infrequent but does require the following:

- Patient visit with comprehensive assessment
- If unable, a qualified clinician completes the assessment based on their last visit and may supplement information from visits made to the patient within the last 5 days of the unexpected/unplanned discharge
- Ensure collaboration documentation is documented within chart

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
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<tr>
<td>8</td>
<td>9-10 PM</td>
<td>11-12 PM</td>
<td>1-2</td>
<td>3-4 PM</td>
<td>5-6 PM</td>
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<tr>
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<td>AIDE</td>
<td>PTA</td>
<td>MD Appt</td>
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<td>Received call to D/C</td>
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<td>Patient scheduled for outpatient therapy</td>
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</table>
Unplanned or Unexpected Discharges

M0090: Date assessment completed
  - The date that the agency completes the assessment
M0903: Date of the last home visit
  - Last visit that was made by ANY agency stuff
M0906: Discharge date
  - Follow agency policy but remember that it can’t be before the last visit

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<thead>
<tr>
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<th>Monday</th>
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<th>Wednesday</th>
<th>Thursday</th>
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<td>3</td>
<td>4-RN</td>
<td>5-AIDE</td>
<td>6-PTA</td>
<td>7</td>
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<tr>
<td>8</td>
<td>9-PTA</td>
<td>10-11MD Appointment for Follow-up</td>
<td>12-13-PTA</td>
<td>14-PTA</td>
<td>15-PTA</td>
<td>16-PTA</td>
</tr>
</tbody>
</table>

Scenario

The agency referral for Mrs. Jones includes an order for RN and PT. The nurse completes the SOC comprehensive assessment on Tuesday by choosing independent responses for the OASIS transferring and ambulation/locomotion based on the patient’s report. The RN reviews the documentation from Wednesday’s PT evaluation and sees that the patient needed assistance of another person and a walker to transfer and to ambulate. The RN considers the PT’s observation to be more comprehensive and wants to change the SOC assessment based on the PT evaluation.

Which Action is Appropriate

A. The RN must go back out and assess the patient transferring and ambulating before changing the responses.
B. The PT may change the RN’s OASIS responses to transferring and ambulation/locomotion without consulting the RN. M0090 date assessment completed is Wednesday.
C. The RN may change the responses to transferring and ambulation/locomotion after considering the PT’s assessment. M0090 date assessment completed is Wednesday.
D. The agency’s OASIS reviewer may change the responses to transferring and ambulation/locomotion based on the PT notes on Thursday. M0090 date assessment completed is Thursday.
OASIS M ITEMS

Reviewing the intent and how to assess and answer

29  M0090 – Date Assessment Completed

- If agency policy allows assessments to be performed over more than one visit date, the last date (when the final assessment data are collected) is the appropriate date to record.
- If the clinician needs to follow up off site, with the patient’s family, or physician in order to complete a portion of the comprehensive assessment, M0090 should reflect the date that last needed information is collected.
- If the original assessing clinician gathers additional information during the SOC 5-day assessment time frame that would change a data item response, the M0090 date would be changed to reflect the date the information was gathered and the response change was made.

30  M1021/1023/1025: Diagnoses, Symptom Control and Optional Diagnoses

- [M1021] Primary Diagnosis
- [M1023] Other Diagnoses
- [M1025] Optional Diagnoses (OPTIONAL) - not used for payment
  - The patient’s primary home health diagnosis is defined as the chief reason the patient is receiving home care and the diagnosis most related to the current home health plan of care.
  - Secondary diagnoses are co-morbid conditions that exist at the time of the assessment, that are actively addressed in the patient’s plan of care, or that have the potential to affect the patient’s responsiveness to treatment and rehabilitative prognosis.
31 Identifying the Patient’s Primary Home Health Diagnosis

- The assessing clinician is expected to complete the patient’s comprehensive assessment and understand the patient’s overall medical condition and care needs before selecting and assigning diagnoses.
- The determination of the patient's primary and secondary home health diagnoses must be made by the assessing clinician based on the findings of the assessment, information in the medical record, and input from the physician.
- The primary diagnosis may or may not relate to the patient’s most recent hospital stay, but must relate to the skilled services rendered by the HHA.
- Skilled nursing, physical therapy, occupational therapy, and speech language pathology

32 Identifying the Patient’s Primary Home Health Diagnosis

- Secondary diagnoses those that are actively addressed in the POC as well as diagnoses that affect the patient’s responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself.
- Diagnoses may change during the course of the home health stay due to a change in the patient’s health status or a change in the focus of home health care.
- At each required OASIS time point, the clinician must assess the patient’s clinical status and determine the primary and secondary diagnoses based on patient status and treatment plan at the time of the assessment.

33 M1021 / M023: Diagnoses

- Only current medical diagnoses should be reported as primary or secondary diagnoses in M1021 and M1023
- Diagnoses should be excluded if they are resolved or do not have the potential to impact the skilled services provided by the HHA.
M1021 / M023: Diagnoses

Three steps to accuracy:
1. Complete comprehensive assessment
2. Develop the plan of care
3. Paint the patient’s diagnostic picture vertically

Reporting the Symptom Control Rating

At each required time point, the assessing clinician should record the symptom control ratings for each primary and secondary diagnosis in column 2 of M1021 and M1023.

Assessing degree of symptom control includes review of presenting signs and symptoms, type and number of medications, frequency of treatment readjustments, and frequency of contact with healthcare provider.

Inquire about the degree to which each condition limits daily activities.

Assess the patient to determine if symptoms are controlled by current treatments.

Clarify which diagnoses/symptoms have been poorly controlled in the recent past.

M1028 – Active Diagnoses

Check all that apply:

1. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
2. Diabetes Mellitus (DM)

Consider only diagnoses confirmed and documented by the physician.

Reflect what is known and documented at the time of the assessment.

If assessment is completed and the patient does not have a diagnosis of PVD, PAD, or DM both boxes should be left unchecked.

A dash (−) value is a valid response for this item indicating that no information is available and/or an item could not be assessed.
M1033 – Risk for Hospitalization
- Collects data on factors identified as predictive of hospitalization
- Time periods specific and grouped to reflect length of look back period

M1041 & M1046: Influenza Vaccine
- Does this episode of care (SOC/ROC to transfer/discharge) include any dates on or between October 1 and March 31?
- Identifies whether the patient was receiving services from the HHA during the time period for which influenza vaccine data are collected
- October 1–March 31

M1046
- When 1041 is “yes” then complete
- Identifies:
  1. If the patient received the flu vaccine for this year’s flu season
  2. The specific dates when the vaccine was administered
  3. Whether the vaccine was given as part of the patient’s routine care
  4. Suggest including the question in discharge review process

M1051 & M1056: Pneumococcal Vaccine

M1051
- Identifies if the patient as EVER received the vaccine
- Does not need to be up to date
- Simplified text and removed “during episode of care” and “from your agency”

M1056
- When 1051 is “No” then complete
- Explains why the patient has NEVER received the vaccine:
  1. Offered and declined
  2. Assessed and determined to have medical contraindication(s)
  3. Not indicated; patient does not meet age/condition guidelines for vaccine
  4. None of the above
M1060 – Height and Weight

Height and Weight – While measuring, if the number is X.1 – X.4 round down; X.5 or greater round up
- Height (in inches)
- Record most recent height measure since the most recent SOC/NOC
- 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.

Assessing clinician is expected to weigh and measure the patient directly
- Values from physician’s office / hospital discharge are not acceptable
- Values that are self reported are not acceptable
- Use of dash (-) if no information available
- Should be a rare occurrence
- If a patient cannot be weighed, for example, because of extreme pain, immobility, or risk of pathological fractures, enter the dash value (-) and document the rationale in the patient’s medical record

Scenario

At SOC, Mr. Jones is unable to get out of bed at the time of assessment due to pain to his lower legs and back after he had fallen and sustained a lumbar compression fracture. His height when measured in bed is 72.5 inches. The referral information from the hospital identifies his weight is 200 lbs. Mr. Jones confirms that he weighed 200 lbs. when he was discharged yesterday.
What is the Correct Answer?

A. Height – 72 in.; Weight – 200 lbs.
B. Height – 73 in.; Weight – enter a dash (-)
C. Height – 73 in.; Weight – 200 lbs.
D. Height – 72 in.; Weight – leave blank

M1240: Pain Assessment

Has this patient had a formal pain assessment using a standardized, validated pain assessment tool?

0 - No standardized, validated assessment conducted
1 - Yes, and it does not indicate severe pain
2 - Yes, and it indicates severe pain

A standardized, validated tool is one that:

– Has been scientifically tested on a population with characteristics similar to that of the patient being assessed, and
– Includes a standard response scale
– Example, a scale where patients rate pain from 0 - 10.
– The tool must be relevant to the patient’s ability to respond
– CMS doesn’t endorse a particular pain assessment
M1240: Pain Assessment

- Be thorough in the pain assessment
  - Describe the pain?
  - How often is the pain present?
  - Does the patient take their pain medications?
  - If so and the pain is not relieved by medications, contact the physician
- Severe pain
  - Defined according to the scoring system for the tool being used
  - Clinicians need to know what rating on scale is severe – consistency is key
    - 7 is what many use for 'severe pain'

M1242: Frequency of Pain Interfering with Patient’s Activity or Movement

- Intent indicates that inference in activities does not just include ADL’s and may include:
  - Sleep / watching TV / recreational activities
- Look at frequency with which pain interferes with patient’s activities and with treatments
- Pain interferes with activity when pain results in:
  - Activity being performed less often than otherwise desired,
  - Required the patient to have additional assistance in performing the activity, or
  - Caused the activity to take longer to complete

Scenario

Mr. Jones tells the nurse on the day of assessment that his pain is a 7 on a scale from 0-10. When the nurse questions Mr. Jones about his pain over the past 24 hours, he said that during the night the pain went up to a 9. Mr. Jones also tells the nurse that he limits walking to distances less than 20 feet at time in order to be pain free.
Question/Answer

Has the patient had a formal pain assessment using a standardized, validated pain assessment tool?
- 0 - No standardized, validated assessment conducted
- 1 - Yes and it does not indicate severe pain
- 2 - Yes and it indicates severe pain

Frequency of pain interfering with patient’s activity or movement?
- 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

Integumentary System & OASIS C-2

Always use OASIS scoring instructions in the guidance manual

Resource

- Wound, Ostomy and Continence Nurse’s Society Guidance
Pressure Ulcers & OASIS C-2

- All pressure ulcers can heal
- Pressure ulcers should be assessed as close to actual time of the SOC/ROC as possible
- Report Stage identified on the initial clinical assessment
- Once a Stage 2, 3, or 4 pressure ulcer is 100% covered with new epithelialized tissue it is considered healed and no longer reported
- A pressure ulcer that has been treated with a skin graft is a surgical wound until edges completely heal

M1307: The Oldest Stage 2 Pressure Ulcer

The oldest Stage 2 pressure ulcer that is present at discharge: (Excludes healed Stage 2 pressure ulcers)
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
- Completed at discharge
- Guidance:
  - Do not reverse Stage pressure ulcers as a way to document healing as it does not accurately characterize what is physiologically occurring as the ulcer heals.

M1307: The Oldest Stage 2 Pressure Ulcer – Specific Instructions

- Enter response 1 only if the oldest Stage 2 pressure ulcer that is present at discharge was already present as a Stage 2 pressure ulcer when first assessed at the SOC/ROC.
- Enter response 2 if the oldest Stage 2 pressure ulcer that is present at discharge was NOT a Stage 2 pressure ulcer at the most recent SOC/ROC.
- If response 2 is entered, specify the date the Stage 2 pressure ulcer was first identified.
M1307: The Oldest Stage 2 Pressure Ulcer – Specific Instructions

- If no pressure ulcer existed at the SOC, then a Stage 1 pressure ulcer developed, which progressed to a Stage 2 by discharge, enter response 1, and specify the date that the pressure ulcer was first identified as a Stage 2 ulcer.
- Enter "NA" if the patient has no Stage 2 pressure ulcers at the time of discharge, or all previous Stage 2 pressure ulcers have healed.
- An ulcer that is suspected of being a Stage 2, but is unstageable due to non-removable dressing/device at the time of discharge, should not be identified as the "oldest Stage 2 pressure ulcer.”
- See M1311 for definition of 'unstageable due to non-removable dressing/device’

M1311: Current Number of Unhealed Pressure Ulcers at Each Stage

- For each pressure ulcer, determine whether the pressure ulcer was present at the time of the most recent SOC/ROC, and did not form during this home health quality episode.
M1313: Worsening in Pressure Ulcer Status Since SOC/ROC - Guidance

- Collecting information at discharge on worsening pressure ulcer status
- Makes it the same as for nursing homes (MDS) and acute care (CARE) tools
- Includes pressure ulcers that at discharge are unstageable due to slough/eschar
- Documents the number that are NEW or have worsened (increase in numerical Stage) since the most recent SOC or ROC
- Compare current Stage to the prior Stage of that ulcer
  - It’s “present on admission” is considered the Stage at which it first becomes numerically Stage able
- ALWAYS use the algorithm (Handout)

Scenario

Mr. Johnson had a Stage 4 right heel ulcer in the skilled nursing facility (SNF). He was admitted to home care on 03/01/18 with an unstageable right heel ulcer. The ulcer was debrided and was noted to be a Stage 3 on 03/15/18. Patient was discharged on 04/01/18 with a Stage 3 right heel ulcer.

Report as new or worsened on M1313?
M130: Stasis Ulcer

Does this patient have a stasis ulcer?

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]

M130: Stasis Ulcer - Guidance

- Stasis ulcers DO NOT include arterial lesions or arterial ulcers
- Once a stasis ulcer has completely epithelialized, it is considered healed and should not be reported as a current stasis ulcer
- Enter response 1 if the patient has both an observable stasis ulcer AND a reported stasis ulcer that cannot be observed because of a dressing or device, such as a cast or Unna boot that cannot be removed
- Information may be obtained from the physician or patient/caregiver regarding the presence of a stasis ulcer underneath the cast or dressing

M1340: Surgical Wounds

Does this patient have a surgical wound?

0 - No [At SOC/ROC, go to M1350 ; At FU/DC, 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 [At SOC/ROC, go to M1350 ; At FU/DC, go to M1400]
M1340: Surgical Wounds - Guidance

- Old surgical wounds that are now a scar are not considered current surgical wounds and should not be included in this item.
- A wound is considered not observable if it is covered by a dressing/device, such as a cast, which is not to be removed per physician order.
- For the purpose of this OASIS item, a surgical site closed primarily (with sutures, staples, or a chemical bonding agent) is generally described in documentation as a surgical wound until re-epithelialization has been present for approximately 30 days, unless it dehisces or presents signs of infection.
- After 30 days, it is generally described as a scar and should not be included in this item.
- The incision line is considered the surgical wound.
- The staple or suture sites are not considered as surgical wounds.

M1342: Status of Surgical Wound

Status of most problematic surgical wound that is observable:

- 0 - Newly epithelialized
- 1 - Full granulating
- 2 - Early/partial granulation
- 3 - Not healing

M1342: Status of Surgical Wound - Guidance

- A dehisced wound or one healing by secondary intention is 'not healing when the amount of avascular tissue is ≥25%.
- The presence of staples does not mean surgical wound is not healing.
- Steri-strips are skin closures and not a dressing or device.
- If they allow sufficient visualization of the wound, report appropriate healing.
M1340 & 1342: Surgical Wounds - Guidance

- An implanted vascular device is an observable surgical wound whether or not its being accessed
- Not healing is the appropriate response if it has a scab at puncture site or is currently accessed with a device
- Newly epithelialized is appropriate response when insertion site has healed
- A pressure ulcer is surgically closed with a flap or graft should be reported as a surgical wound until healed
- A bowel ostomy is excluded as a surgical wound, unless a "take-down" procedure of a previous bowel ostomy is performed, in which case the surgical take-down produces a surgical wound
- A bowel ostomy being allowed to close on its own is excluded as a surgical wound

M1340 & 1342: Surgical Wounds - Guidance

- All other ostomies are excluded from consideration under this item and should not be counted as surgical wounds
- Examples: Cystostomy, urostomy, thoracostomy, tracheostomy, gastrostomy, etc.
- These may be reported in M1350 (other skin lesion / open wound) if the home health agency is providing intervention specific to the ostomy
- Orthopedic pin sites, central line sites (centrally-inserted venous catheters), stapled or sutured incisions, and wounds with drains are all considered surgical wounds
- Medi-port sites and other implanted infusion devices or venous access devices are considered surgical wounds

M1350: Skin Lesion or Open Wound

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 care agency?

0 - No
1 - Yes
**M1350: Skin Lesion or Open Wound**

**Includes**
- Burns
- PICC lines & peripheral IV sites
- Diabetic & arterial ulcers
- Ostomies (excluding bowel) if care is provided
- Gastrostomy, thoracotomy, cystoscopy
- Cellulitis & abscesses
- Wounds due to trauma
- Edema
- Rashes

**Excludes**
- Bowel ostomies
- Tattoos, piercings, other skin alterations
- Mucosal surface ulcers
- Surgery for cataracts
- GYN procedures via vaginal
- Burns
- PICC lines & peripheral IV sites
- Diabetic & arterial ulcers
- Ostomies (excluding bowel) if care is provided
- Gastrostomy, thoracotomy, cystoscopy
- Cellulitis & abscesses
- Wounds due to trauma
- Edema
- Rashes

---

**Scenario**

Mr. Johnson is being discharged from the hospital and will be admitted to home health following an exacerbation of his CHF. He had a cholecystectomy performed laparoscopically 8 days ago. During assessment the RN noted his incision was closed with a chemical bonding agent and is closed with no signs/symptoms of infection. Mr. Johnson has a Baclofen infusion pump and the puncture site was noted to be red, warm, and tender to touch.

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**What is the Correct Response for M1342?**

Status of most problematic surgical wound that is observable:

0 - Newly epithelialized
1 - Full granulating
2 - Early/partial granulation
3 - Not healing
M1400: Respiratory Status

Item: When is the patient dyspneic or noticeable short of breath
- Report what is true on the day of assessment
- Observe if patient is noticeably short of breath
- Interview
- 24 hours preceding assessment and during the assessment
- Use clinical judgment to determine the level of effort required to complete a task
  - Particularly distinguishing between minimal and moderate for eating, talking, etc.
  - Consider the effort required
- Assessment is based on patients USE of oxygen, not what is ordered
  - If patient uses oxygen continuously – assess WITH oxygen
  - If patient uses oxygen intermittently – assess WITHOUT oxygen

M1400: Dyspnea

- Assessment of dyspnea
  - TUG can be used to assess walking 20 feet or more
  - ADLs can be used
  - If patient is only short of breath when supine
    - Choose response 4 - at rest
  - If patient modifies environment and is not dyspneic because of this for more than 24 hour period, then choose response - 0
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Common Guidance

- The patient’s ability may change as the patient’s condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified.
- The clinician must consider what the patient is able to do on the day of the assessment.
- If ability varies over time, choose the response describing the patient’s ability more than 50% of the time period under consideration.
- Ability of patient means safely completing specified activities.

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Common Guidance

- The intent of the item is to identify the patient’s ability; not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items.
- Ability can be temporarily or permanently limited by:
  - Physical impairments
    - limited range of motion, impaired balance
  - Emotional/cognitive/behavioral impairments
    - Memory deficits, impaired judgment, fear
  - Sensory impairments
    - impaired vision or pain
  - Environmental barriers
    - Accessing grooming aids, mirror and sink.
M1800: Grooming
Current ability to tend safely to personal hygiene needs

Includes
- Washing face and hands
- Hair care
- Shaving/make-up
- Teeth/denture care
- Fingernail care

Excludes
- Bathing
- Shampooing hair
- Toilet hygiene

M1800: Grooming
Response 1 indicated if:
- Patient can groom independently; however, there is an environmental barrier or other impairment causing patient to require assistance in
  - Gaining access to needed items or locations of where items are

M1810: Current Ability to Dress Upper Body
M1820: Current Ability to Dress Lower Body
- Assess ability to put on whatever clothing is routinely worn
- Includes the ability to manage zippers, buttons and snaps if these are routinely worn
- Includes undergarments
- 0 - Able to get clothes out of closets & drawers, put them on & remove them from upper (or lower) body without assistance
- Patient needs help dressing if patient requires standby assist or verbal cueing to dress safely
- Includes prosthetic & compression devices, but not wound dressings
M1830: Bathing

- Current ability to wash entire body safely
  - If afraid of falling and is unwilling to try or have assistance
  - Would choose response 4 or 5 (unable)
  - Fear is a barrier that affects ability

- Includes:
  - Transferring in/out of the tub/shower
  - Bathing related tasks NOT to be considered
  - Gathering supplies
  - Preparing bath water
  - Shampooing hair
  - Drying off

- The patient's status should not be based on an assumption of a patient's ability to perform a task with equipment they do not currently have

- If a patient is medically restricted from stair climbing, and the only tub/shower requires climbing stairs, the patient is temporarily unable to bathe in the tub or shower due to combined medical restrictions and environmental barriers

- Responses 4, 5, or 6 would apply, depending on the patient's ability to participate in bathing activities

- If the patient does not have a tub or shower in the home, or if the tub/shower is non-functioning or not safe for patient use, the patient should be considered unable to bathe in the tub or shower

- Responses 4, 5, or 6 would apply, depending on the patient's ability to participate in bathing activities

- Assessment strategies
  - Observe the patient's general appearance in determining if the patient has been able to bathe independently and safely
  - Observe patient actually stepping into shower or tub to determine how much assistance the patient needs to perform the activity safely
M1840: Toilet Transferring

- Current ability to get to & from toilet or bedside commode safely AND transfer on/off toilet / commode
- Identify the patient’s ability, not necessarily actual performance
- Observe patient during transfer on and off toilet
- If patient has pain / difficulty with balance / strength / etc.
- Determine level of assistance needed for the patient to be safe
- Don’t assume patient is safe or can use equipment that they don’t have

M1840: Toilet Transferring

- Tasks include:
  - Ability to get to and from the toilet with or without a device
  - Ability to use the bedside commode with or without help
  - Transfer on/off toilet, commode and bedpan
- Tasks exclude:
  - Personal hygiene
  - Clothing management when toileting
  - Emptying bedpan

M1845: Toilet Hygiene

- Includes several activities, including pulling clothes up or down and adequately cleaning (wiping) the perineal area
- Includes the patient’s ability to maintain hygiene related to catheter care and the ability to cleanse around all stomas that are used for urinary or bowel elimination
- Urostomies, colostomies, ileostomies
M1845: Toilet Hygiene

- This item refers the patient’s ability to manage personal hygiene and clothing with or without assistive devices
- The word “assistance” in this question refers to assistance from another person by:
  - Verbal cueing/reminders,
  - Supervision, and/or
  - Stand-by or hands-on assistance

M1850: Transferring

- Current ability to move safely from bed to chair
  OR
- Ability to turn & position self in bed if patient is bedfast
- Does the patient need:
  - Verbal cueing, environmental set up &/or hands on assistance
  - For minimal assistance the person assisting the patient must contribute less than 25% of the total effort

M1850: Transferring

- Response 2 - Able to bear weight and pivot during the transfer process but unable to transfer self
  - Requires BOTH assistance and a device
  - Bedfast
  - On day of assessment patient is either:
    - Medically restricted to bed OR unable to tolerate being out of bed
GG0170C - Mobility

Identifies the patient’s need for assistance with the mobility task of moving from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support

– Report a code ranging from 01 (dependent) to 06 (independent) based on safety and quality of patients performance at SOC
– Also, project goal for performance of the mobility task for discharge time point

Steps for Assessment

– Assess the patient’s functional status based on direct observation and/or on report by the patient, caregiver/family
– Patients should be allowed to perform activities as independently as possible, as long as they are safe
– If caregiver assistance is required because patient’s performance is unsafe or of poor quality, enter the response according to amount of assistance required to be safe
– Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect the scoring of the activity
– If the patient’s self-care performance varies during the assessment time frame, report the patient’s usual status, not the patient’s most independent status and not the patient’s most dependent status
94  GG0170C – Mobility
Steps for Assessment

- If the patient does not attempt the activity and a caregiver does not complete the activity for the patient, report the reason the activity was not attempted
  - 07, 09, or 88
- If no information is available or assessment is not possible for reason other than above, enter a dash ("–") for 1-SOC/ROC performance
- Report the discharge goal using the 6-point scale
  - Do not enter 07, 09, or 88 to report the discharge goal
- The assessing clinician, in conjunction with patient and family input, can establish the discharge goal

95  M1860: Ambulation / Locomotion

- Current ability and the type of assistance required to walk safely (once in a standing position) or propel a wheelchair (once in a seated position) on a variety of surfaces
- Assess on typical surfaces routinely encountered in patient’s environment
- Excludes:
  - Transferring
- Responses:
  - 0 – No assistive device and no human assistance
  - 1 – One-handed device AND no human assistance
  - 2 – Two-handed device and/or intermittent human assistance
  - 3 – Continuous human assistance or supervision at all times

96  M1860: Ambulation / Locomotion

- Chairfast
  - Response 4 or 5
    - Can only take one or two steps to complete a transfer
- Bedfast
  - Response 6
    - Medically restricted to bed or unable to tolerate being out of bed
- "Usual status greater than 50% of the time" does NOT apply when determining if patient is chairfast or bedfast
- Examples:
  - Patient spends most of day in bed = not chairfast
  - Patient uses wheelchair 75% of the time and walks 25% by choice = not chairfast
Scenario

Mr. Adams on discharge from the agency is able to shave, wash his face and brush his hair independently and safely. He is still needing some assistance with his denture care, which he performs at night.

How Would You Score M1800?

Currently ability to tend safely to personal hygiene needs?

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

Scenario

Mrs. Jones's bathroom is being remodeled and due to the construction she is unable to use the bathroom at the SOC. She has been using the kitchen sink to wash up and is able to wash everything independently except for washing her hair.
**Scenario**

The patient pushes up on the bed to attempt to get himself from a lying to a seated position as the OT provides much of the lifting assistance necessary for him to sit upright. The OT provides assistance as the patient scoots himself to the edge of the bed and lowers his feet to the floor. Overall, the OT must provide more than half of the effort to complete the task.

**SOC/ROC Performance?**

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**Scenario**

Mr. Clark is able to get himself to the edge of the bed but is unable to get up to a seated position. He requires assistance from his wife to help lift the upper body and you provide cues necessary for the safety of the patient and his spouse. With some therapy and a hospital bed, you think that Mr. Clark will be able to perform this task with only verbal cuing at discharge.

**SOC/ROC Performance?**

**Discharge Goal?**
Scenario

At D/C Mr. Davis is able to walk safely and independently with a cane and only requires the assistance of another person when going up and down steps.

How Would You Score M1860?

<table>
<thead>
<tr>
<th>M1860</th>
<th>Ambulation/Examination: Current ability to walk safely, once in a standing position, or use a wheelchair; once in a seated position, on a variety of surfaces.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or adaptive device).</td>
</tr>
<tr>
<td>1</td>
<td>With the use of a one-handed device (e.g., cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.</td>
</tr>
<tr>
<td>2</td>
<td>Requires use of a two-handed device (e.g., 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.</td>
</tr>
<tr>
<td>3</td>
<td>Unable to walk only with the supervision or assistance of another person at all times.</td>
</tr>
<tr>
<td>4</td>
<td>Chairless, unable to ambulate but is able to wheel self independently.</td>
</tr>
<tr>
<td>5</td>
<td>Chairless, unable to ambulate and is unable to wheel self.</td>
</tr>
<tr>
<td>6</td>
<td>Bedfast, unable to ambulate or lie in a chair.</td>
</tr>
</tbody>
</table>
M2003: Medication Follow-up

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

**Indicates HHA completed recommended actions given by physician
– Performed at SOC/ROC

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M2005: Medication Intervention

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

N/A - There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications
– Performed at transfer / discharge / death at home

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M2003 & M2005: Medication Follow-up & Intervention

– Actual or potential clinically significant medication issue:
– Care provider’s clinical judgement
– Warrants notification of physician for orders or recommendations by midnight of the next calendar day

Examples:
– Adverse reactions to medications
– Ineffective drug therapy
– Side effects
– Drug interactions
– Duplicate therapy
– Omissions
– Dosage errors
– Non-adherence

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109 M2003 & M2005: Medication Follow-up & Intervention

Contact with Physician / Physician-designee:
- Needs to be two way communication with the physician or physician-designee:
  - Face to face
  - By telephone, voicemail, fax, other electronic means
  - Indirectly with office staff on behalf of the physician or physician-designee

**Notification AND completion of whatever need happen to take credit**

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110 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?

0 - No
1 - Yes
9 - NA – Patient not taking any drugs

**Goal is that at D/C should be able to answer “Yes” all of the time**

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111 M2016: Patient/Caregiver Drug Education Intervention

Look Back Item – During most recent SOC/ROC assessment
- Identifies if clinicians instructed the patient/caregiver about how to manage all medications effectively and safely within the time period under consideration
- Effectiveness
- Potential side effects and drug reactions
- When to contact provider if problems with medications occur

Includes:
- All medications prescribed and over the counter by any route

Time Points Completed
- Transfer
- Discharge

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M2016: Patient/Caregiver Drug Education Intervention

Specific Instructions
- Enter "Yes" if at any time since the most recent SOC/ROIC assessment patient/caregiver has been educated on:
  - Effective, safe management of medications including knowledge of effectiveness, potential side effects and drug reactions, and when to contact the appropriate care provider
  - If the interventions are not completed as outlined in this item, enter Response 0
  - No
  - However, in this case, the care provider should document rationale in the clinical record
  - Review of clinical record including teaching guidelines, flow sheets, clinical notes, medication list

M2020: Management of 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
  - Think right med / right dose / right time
  - This refers to ability NOT compliance or willingness
  - Willful non-adherence does not equate to "inability"
  - Report on what is true on day of assessment

- Includes all prescribed and OTC medications / herbal products that patient is currently taking
- Only PO medications
  - Not sublingual / inhaled / per tube or swish and expectorate
  - Assess "ALL" BUT:
    - Report for which "most assistance needed" when selecting a response
  - Assess using observation and interview
    - Mental / emotional / cognitive status
    - Physical status
    - Activities permitted
    - Environment
    - Knowledge of drug dose and administration schedule
Scenario

Mrs. Jones was admitted to home health following a hospitalization for pneumonia. When performing the drug regimen review the RN discovered that only 7 of the 8 medications were in the home. Patient did not pick up her inhaler due to it not being covered by her insurance. The RN felt that this was something that patient needed due to recent hospitalization for pneumonia and called the physician during the SOC visit. The physician called in a prescribed alternative and arrangements were made for patient’s son to pick up at the pharmacy when he got off of work.
118 What is the Correct Response at Discharge for M2005?

(M200) Medication Intervention: Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midpoint of the next calendar day each time potential clinically significant medication issues were identified since the SOC/RCO?

- [ ] No
- [1] Yes
- [X] NA — There were no potential clinically significant medication issues identified since SOC/RCO or patient is not taking any medication.

119 Scenario

At SOC Mr. Jones states he has been independent with taking his PO medications every morning and night from his pre-filled medication planner that his daughter sets up every week. He was recently prescribed scheduled Zofran sublingually every morning 30 minutes before he takes his PO medications. During the SOC assessment, Mr. Jones stated that he hasn't started his new medication because he didn't understand what "sublingual" meant.

120 What is the Correct Response for M2020?

(M202) Management of Oral Medications: Patient's current ability to prepare and take all oral medications properly and safely, including administration of the correct dosage at the appropriate times/times/areas.

- [ ] Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
- [ ] Able to take medication(s) at the correct times if:
  1. (a) individual dosages are prepared in advance by another person; OR
  2. (b) another person develops a drug diary or chart.
- [ ] Able to take medication(s) at the correct times if given reminders by another person at the appropriate times.
- [ ] Unable to take medication unless administered by another person.
- [X] NA — No oral medications prescribed.
Conclusion

- Reference OASIS guidance manual
- Keep up to date with changes
- Yearly OASIS education
- Ensure consistency
- A combined observation/interview approach with the patient or caregiver is helpful
- The most important assessment strategy is to walk around the house with the patient
  - While doing this you are answering many OASIS items accurately
- Also have patient read you and tell you about meds and get them out of the pill planner
- Having the patient do things instead of you doing it for them is key
- And be sure you do this same type of assessment on every OASIS timepoint