OASIS-C1 / ICD-9

Changed Items
& Data Collection Resources

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Presented by:

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OASIS-C1/ICD-9 data set – What's changed?

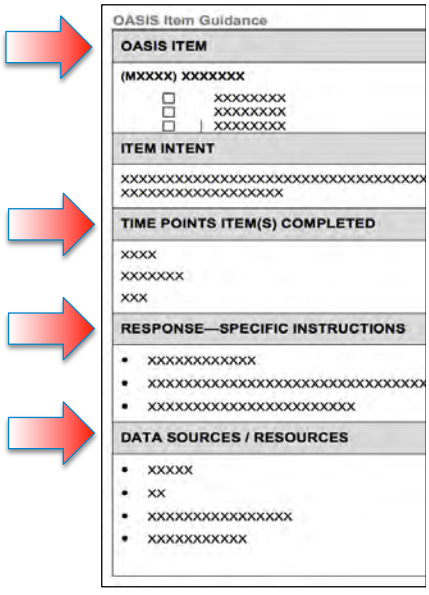
OASIS-C1/ICD-9 data set

- **TYPES OF CHANGES MADE**
  - — Some C items deleted
  - — Data collection dropped at various time points
  - — Existing C items revised/refined
  - — Existing C items replaced with a new -C1 item
  - — Existing C Item split into 2 items

OASIS-C1/ICD-9 Guidance Manual – What's changed?

TYPES OF CHANGES MADE

- OASIS-C1 Items added
- Guidance added for new -C1 items
  - —Item Intent, Time points Collected, Response-Specific Instructions, Data sources/ Resources
- URLs validated
- Key guidance from OASIS Quarterly Q&As added
- Grammatical & punctuation corrections
- Some changes made to standardize guidance
  - —Capitalization, terminology, language
- **Referred to as OASIS-C1 Guidance Manual in this presentation**



CMS OASIS Q&As - What's changed?

June 2014 CMS Q&A Update

- Reviewed existing CMS OASIS Q&As, Categories 1, 2, 3, & 4 and following actions were taken:
  - Added Quarterly Q&As (01/13 through 4/14) to CMS OASIS Q&A database, when appropriate
  - Retired outdated Q&As and those for deleted M items
  - Revised Q&As in order to:
    - Clarify guidance
    - Update –C1 numbers
    - Incorporate revised guidance
    - Correct typos
    - Standardize capitalization and language
  - Web links tested and updated as needed.
- Both versions of Q&As (-C & -C1) will be available until 12/31
  -C Q&As will be archived after 01/01/15

Quarterly Q&As – What's changed?

No change in current process

- Questions regarding data collection using the C or C1 data set may be submitted to cmsoasisquestions@oasisanswers.com
- Pertinent Q&As will be published quarterly
- January, April, July, October
  - Released on the Wednesday following the third Tuesday

WOCN Wound Guidance – What's changed?

- Updated to reflect changes in –C1 data set
- Clarifications from Quarterly Q&As added
  - — Added M1309 Worsening in Pressure Ulcers
  - — Removed M1310/1312/1314 Pressure Ulcer length/ width/depth
  - — Removed Response "0" from M1334 Status of Most Problematic Stasis Ulcer
  - — Glossary Updates:
    - o Revised Epidermis, Non-granulating
    - o Added Stage IV structures

CMS OASIS Web Modules – What's the plan?

Modules currently posted include OASIS-C instruction on the following OASIS domains:

- Overview and Conventions
- Patient Tracking
- Clinical Record Items
- Patient History & Diagnoses Medication
- Integumentary Status
- Pressure Ulcers (2 parts)
- Integumentary Status: Stasis Ulcers, Surgical Wounds, and Skin Lesions
- ADLs/IADLs (2 parts)
- Living Arrangements and Sensory Status
- Respiratory and Cardiac Status
- Elimination Status
- Neuro/Emotional/Behavioral
- Care Management Therapy Need and Emergent Care
- Care Planning & Intervention

Plan

•Revise existing modules to update to -C1
•Beginning early 2015

Why did we need to change to -C1?

- Originally planned to coincide with transition to ICD-10
- Once ICD-10 was delayed, decision made that -C1 changes were too valuable to delay
- M items updated to simplify & clarify
- Impact of change to -C1
  - For a data collector knowledgeable regarding current OASIS guidance, there will only be a few notable changes

Why did M1830 Bathing change?

OASIS-C

(M1830) Bathing: Current ab… body safely. **Excludes grooming (washing… washing hands, and shampooing hair).**

☐ 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 throughout the bath.

☐ 6 - Unable to participate effectively in bathing and is bathed totally by another person.

OASIS-C Guidance Manual Response-Specific Instructions state

"Select Response 5 if the patient is unable to bathe in the tub/shower and needs intermittent or continuous assistance to wash their entire body safely at a sink, in a chair or on a commode."

OASIS-C1

(M1830) Bathing: Current …bility to … body safely. **Excludes grooming (washing face, washing hands, and shampooing hair).**

☐ 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.

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☐ 6 - Unable to participate effectively in bathing and is bathed totally by another person.

Why did M1900 Prior Functioning ADL/ IADL change?

OASIS-C

Functional Area	Independent	Needed Some Help	Depend
a. Self-Care (e.g., grooming, dressing, and bathing)	☐0	☐1	☐2
b. Ambulation	☐0	☐1	☐2
c. Transfer	☐0	☐1	☐2
d. Household tasks (e.g., light meal preparation, laundry, shopping)	☐0	☐1	☐2

OASIS-C Guidance Manual Response-Specific Instructions state

"Self-care" refers specifically to grooming, dressing, bathing, and toileting hygiene.
"Household tasks" refers specifically to light meal preparation, laundry, shopping, and phone use.

OASIS-C1

Functional Area	Independent	Needed Some Help	Dependent
a. Self-Care (specifically: grooming, dressing, bathing, and toileting hygiene)	☐0	☐1	☐2
b. Ambulation	☐0	☐1	☐2
c. Transfer	☐0	☐1	☐2
d. Household tasks (specifically: light meal preparation, laundry, shopping, and phone use)	☐0	☐1	☐2

Why did M1334 Stasis Ulcer Healing Status change?

OASIS-C

M1334) Status of Most Problematic (Observable) Stasis Ulcer:

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

OASIS-C Guidance Manual Response-Specific Instructions state

"The response option "Newly epithelialized" should not be selected for a healed stasis ulcer, as a completely epithelialized (healed) stasis ulcer is not reported as a stasis ulcer on OASIS."

(M1334) Status of Most Problematic Stasis Ulcer that is Observable:

- ☐ 1 - Fully granulating
- ☐ 2 - Early/partial granulation
- ☐ 3 - Not healing

OASIS-C1

Today's presentation

- Includes all revised items, minor and substantive
  - — Change highlighted with red text box & Change described
- Includes scoring guidance from OASIS-C1/ICD-9 Guidance Manual
  - — Only for items with substantive changes
    - o Not every change made in the revised manual
- Application scenarios for selected new items
- Presentation is based on DRAFT versions of the OASIS-C1/ICD-9 Data Set and Guidance Manual – Chapter 3.
  - — Users should access & review final files for any updates

M0060 Patient ZIP Code

OASIS-C1

(M0060)Patient ZIP Code: _ _ _ _ _ _ _ _ _

Word "ZIP" capitalized.

M0100 Reason for Assessment

(M0100) This Assessment is Currently Being Completed for the Following Reason:

OASIS-C1

New skip directions due to changes in item numbering.

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 *[Go to M0110]*
- ☐ 5-Other follow-up *[Go to M0110]*

Transfer to an Inpatient Facility

- ☐ 6-Transferred to an inpatient facility—patient not discharged from agency *[Go to M1041]*
- ☐ 7-Transferred to an inpatient facility—patient discharged from agency *[Go to M1041]*

Discharge from Agency — Not to an Inpatient Facility

- ☐ 8-Death at home *[Go to M0903]*
- ☐ 9-Discharge from agency *[Go to M1041]*

M0150 Current Payment Sources

(M0150) Current Payment Sources for Home Care: (Mark all that apply.)

- ☐ 0 – None; no charge for current services
- ☐ 1 – Medicare (traditional fee-for-service)
- ☐ 2 – Medicare (HMO/managed care/Advantage plan)
- ☐ 3 – Medicaid (traditional fee-for-service)
- ☐ 4 – Medicaid (HMO/managed care)
- ☐ 5 – Workers' compensation
- ☐ **6 – Title programs (for example, Title III, V, or XX)**
- ☐ **7 – Other government (for example, TriCare, VA, ~~etc.~~)**
- ☐ 8 – Private insurance
- ☐ 9 – Private HMO/managed care
- ☐ 10 – Self-pay
- ☐ 11 – Other (specify) _____
- ☐ UK – Unknown

Eliminated "e.g." abbreviation and replaced with "for example" for clarity in Responses 6 & 7.

Removed ", etc." in Response 7

OASIS-C1

M1000 Inpatient Facility Discharge

(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 (IPP S)
- ☐ 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 M1016]***

OASIS-C1

"During the past 14 days" changed to "within the past 14 days" and underlining removed for consistency with other similar items.

M1018 Conditions Prior to Regimen Change or Inpatient Stay Within 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

OASIS-C1

"which" changed to "that"

M1033 Risk for Hospitalization

OASIS-C1

(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

Revised to:

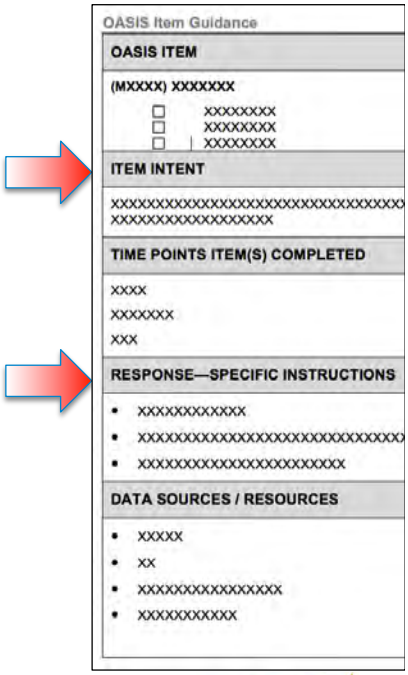
Collect data on factors identified in literature as predictive of hospitalization.

Provide guidance on time period under consideration for responses.

Responses reordered to reflect length of look back period.

M1033 Ch. 3 Guidance – What's changed?

- **Item Intent**
  - Removed statement to use professional judgment
    - -C1 signs and symptoms are objective
    - Fewer risk factors require clinical judgment
- **Response-Specific Instructions**
  - Revised to reflect changed responses
  - Deleted definition of frailty as it is no longer a response option



M1041 Influenza Vaccine

(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?

- ☐ 0 – No ***[Go to M1051]***
- ☐ 1 – Yes

OASIS-C1

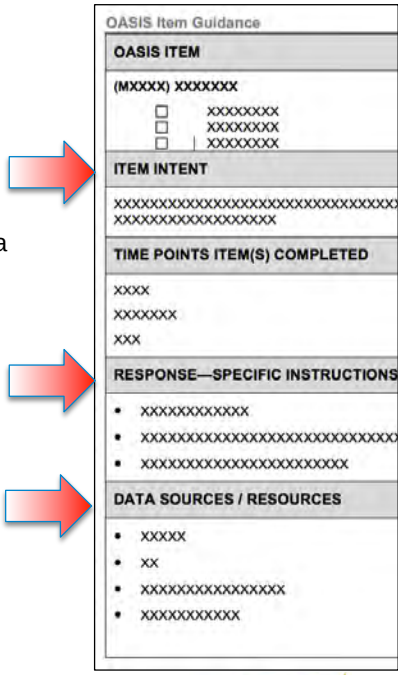
Revised item title to reflect changed content being collected.

Revised item stem to clarify time period for reporting influenza vaccine status.

Skip directions revised due to numbering changes.

M1041 Ch. 3 Guidance – What's changed?

- **Item Intent**
  - — Changed to reflect new purpose of the item
    - o Identifies whether the patient was receiving services from the home health agency during the time period for which influenza vaccine data are collected (October 1 and March 31).
  - — Description of process measure use removed
- **Response-Specific Instructions (RSI)**
  - — With the simplification of the item, most -C instructions no longer needed
  - — -C1 RSI define "care episode"
    - o Definition unchanged from –C
- **Data Sources/Resources**
  - — Dropped reference to CDC website
  - — Dropped pt./cg as resource and added calendar



M1046 Reason Influenza Vaccine not Received

M1046 Influenza Vaccine Received: Did the patient receive the influenza vaccine for this year's flu season?

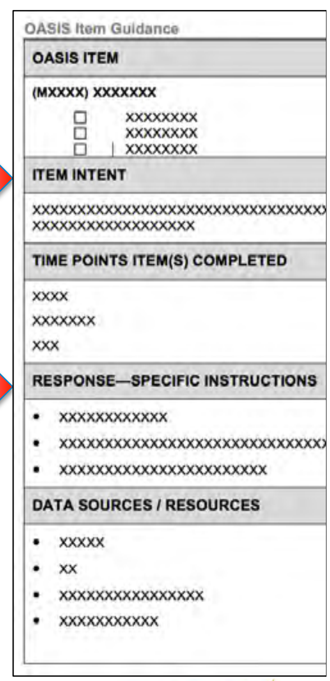
- ☐ 1 - Yes; received from your agency during this episode of care (SOC/ROC to Transfer/Discharge)
- ☐ 2 - Yes; received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge)
- ☐ 3 - Yes; received from another health care provider (for example, physician, pharmacist)
- ☐ 4 - 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.

OASIS-C1

Simplified item to report reason patient did or did not receive influenza vaccine from any source.
Eliminated "during this episode of care" and "from your agency" from the item stem.
Added explanatory language from OASIS-C1 Guidance Manual.

M1046 Ch. 3 Guidance – What changed?

- **Item Intent**
  - — Changed to reflect new scope of the item
  - — States item meets National Quality Forum standards
- **Response-Specific Instructions (RSI)**
  - — Guidance is essentially unchanged from -C, just re-organized
  - — Episode of care definition the same
  - — Guidance unchanged regarding age/condition guidelines, contraindications, offered and declined, and shortage
  - — -C response "None of the above" changed in -C1 to Response 8 which clearly states when it would be selected.



Influenza Scenario Question

Scenario: Mrs. Slade is being discharged on May 1, 2015. Upon review of the medical record, the assessing clinician determines the SOC was October 15, 2014 followed by 3 Recertifications and no Transfers. Clinical documentation states the patient received her influenza vaccine from her neighborhood pharmacist on October 7, 2014.

How would M1041 and M1046 be answered?

(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?

- ☐ 0 – No ***[Go to M1051]***
- ☐ 1 – Yes

(M1046) Influenza Vaccine Received: Did the patient receive the influenza vaccine for this year's flu season?

- ☐ 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.

Influenza Scenario Answer & Rationale

Scenario: Mrs. Slade is being discharged on May 1, 2015. Upon review of the medical record, the assessing clinician determines the SOC was October 15, 2014 followed by 3 Recertifications and no Transfers. Clinical documentation states the patient received her influenza vaccine from her neighborhood pharmacist on October 7, 2014.

How would M1041 and M1046 be answered?

(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?

- ☐ 0 – No ***[Go to M1051]***
- **X** 1 – Yes

(M1046) Influenza Vaccine Received: Did the patient receive the influenza vaccine for this year's flu season?

- ☐ 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)
- **X** 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.

M1041 = "1-Yes" because the care episode began on 10/15/14 and ended on 05/01/15.
M1046 = "3-Yes" because she received the flu vaccine for the current flu season from the pharmacist, not the agency.

Influenza Scenario Question

Scenario: Mr. Reed was transferred to the hospital on 09/28/15. You are completing the Transfer OASIS on 09/29/2015. Record review reveals the patient's SOC was 08/15/15. Documentation states an RN administered the flu vaccine on 08/17/15.

How would M1041 and M1046 be answered?

(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?

- ☐ 0 – No ***[Go to M1051]***
- ☐ 1 – Yes

(M1046) Influenza Vaccine Received: Did the patient receive the influenza vaccine for this year's flu season?

- ☐ 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.

Influenza Scenario Answer & Rationale

Scenario: Mr. Reed was transferred to the hospital on 09/28/15. You are completing the Transfer OASIS on 09/29/2015. Record review reveals the patient's SOC was 08/15/15. Documentation states an RN administered the flu vaccine on 08/17/15.

How would M1041 and M1046 be answered?

(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?

- ☒ 0 – No ***[Go to M1051]***
- ☐ 1 – Yes

(M1046) Influenza Vaccine Received: Did the patient receive the influenza vaccine for this year's flu season?

- ☐ 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.

Skipped

M1041 = "0-No" because the entire episode of care, from Transfer back to SOC, was outside of the influenza vaccine data collection period (October 1-March 31). M1046 would be skipped.

M1051 Pneumococcal Vaccine

(M1051) Pneumococcal Vaccine: Has the patient ever received the pneumococcal vaccination (for example, pneumovax)?

☐ 0 - No

☐ 1 - Yes ***[Go to M1500 at TRN; Go to M1230 at DC]***

Simplified item to report if patient has ever received pneumococcal vaccine.

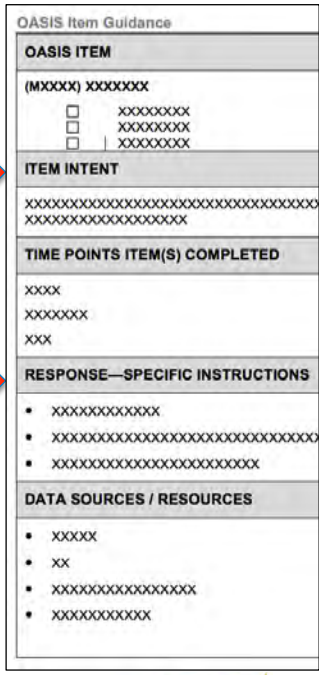
Eliminated "during the episode of care" and "from your agency" from the item stem.

Changed "PPV" to "pneumococcal vaccine"

OASIS-C1

M1051 Ch. 3 Guidance – What's changed?

- **Item Intent**
  - — Simplified to: "Identifies whether the patient has ever received the pneumonia vaccine"
  - — Care episode removed
  - — Changed "PPV" to pneumococcal vaccine
- **Response-Specific Instructions**
  - — Simplified to "Select Response 1 if the patient has ever received the pneumococcal vaccine."
  - — Changed "PPV" to pneumococcal vaccine



M1056 Reason Pneumococcal Vaccine not received

(M1056) Reason Pneumococcal Vaccine not received: If patient has never received the pneumococcal vaccination (for example, pneumovax), state reason:

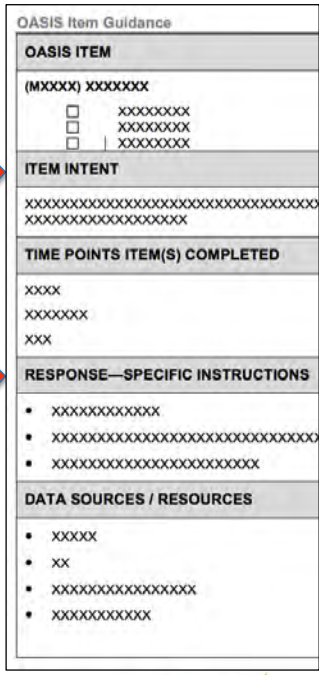
- ☐ 1 - Offered and declined
- ☐ 2 - Assessed and determined to have medical contraindication(s)
- ☐ 3 - Not indicated; patient does not meet age/condition guidelines for Pneumococcal Vaccine.
- ☐ 4 - None of the above

OASIS-C1

Simplified item to report reason patient never received pneumococcal vaccination.
Eliminated "during the episode of care" and "from your agency" from the item stem.
Dropped "polysaccharide".
Changed "PPV" to "pneumovax."

M1056 Ch. 3 Guidance – What's changed?

- **Item Intent**
  - — Simplified to "Explains why the patient has never received the pneumococcal vaccination."
  - — Description of process measure use removed.
- **Response-Specific Instructions**
  - — CDC recommendations removed
    - o It is the agency's responsibility to make current guidelines available to clinicians
  - — RSI focuses on guidance for Responses 1, 2 & 3
    - o Unchanged from prior –C guidance
  - — Removed all references to "PPV"



M1100 Patient Living Situation

(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

OASIS-C1

Eliminated “e.g.” abbreviation and replaced with “for example”.
Added “residential care home” as an example of congregate living situation.

M1210 Ability to Hear

(M1210) Ability to Hear (with hearing aid or hearing appliance if normally used):

- ☐ 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.

OASIS-C1

Capitalized the “h” in “Hear” to be consistent with formatting in other items.

M1230 Speech and Oral Expression

(M1230) Speech and Oral (Verbal) Expression of Language (in patient's own language):

- ☐ 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.

OASIS-C1

Eliminated "e.g." abbreviation and replaced with "for example".

M1240 Pain Assessment

(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)?

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

OASIS-C1

Added "validated" to item stem and Response 0 since both "standardized" and "validated" are specified in the OASIS-C1 Guidance Manual.

M1300 Pressure Ulcer Assessment

(M1300) Pressure Ulcer Assessment: Was this patient assessed for **Risk of Developing Pressure Ulcers**?

☐ 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)

OASIS-C1

Eliminated "e.g." abbreviation and replaced with "for example". Removed "etc." and added parentheses to Response 1

In Response 2, added "validated" & "Scale" for clarity; added parentheses.

M1306 Unhealed Pressure Ulcers

(M1306) Does this patient have at least one **Unhealed Pressure Ulcer at Stage II or Higher** or designated as Unstageable ? (Excludes Stage I pressure ulcers and healed Stage II pressure ulcers)

☐ 0 - No **[*Go to M1322*]**

☐ 1 - Yes

OASIS-C1

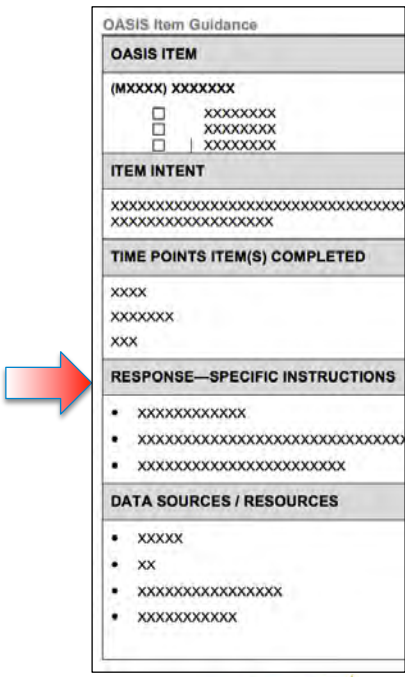
Wording change to item stem for improved clarity.

Added clarification to exclude Stage I and healed Stage II ulcers

"Unstageable" capitalized in all pressure ulcer items.

M1306 Ch.3 Guidance – What's changed?

- **Response-Specific Instructions**
  - — References to pressure ulcer stages changed to Roman numerals (stage 3 changed to III)
  - — "Unstageable" capitalized.
  - — Added language from revised WOCN Wound Guidance document & Q&As
    - o Pressure ulcers that the care provider suspects may be present based on clinical assessment, but that cannot be staged because no bone, muscle, tendon, or joint capsule (Stage IV structures) are visible, and some degree of necrotic tissue (eschar or slough) or scabbing is present that the clinician believes may be obscuring the visualization of Stage IV structures.



M1307 Oldest Stage II Pressure Ulcer present at discharge

(M1307) **The Oldest Stage II Pressure Ulcer** that is present at discharge: (Excludes healed Stage II Pressure Ulcers)

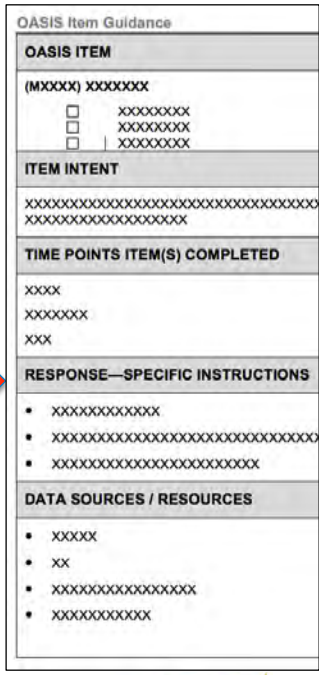
☐ 1 - Was present at the most recent SOC/ROC assessment
☐ 2 - Developed since the most recent SOC/ROC assessment.
Record date pressure ulcer first identified:
__ __ /__ __ /__ __ __ __
month / day / year
☐ NA - No Stage II pressure ulcers are present at discharge

OASIS-C1

The term "non-epithelialized" was eliminated from the item stem and the NA response to improve clarity and be consistent with the OASIS-C1 Guidance manual.
Added exclusion of healed Stage II ulcers.

M1307 Ch.3 Guidance – What's changed?

- **Response-Specific Instructions**
  - — Warning that item refers only to non-epithelialized Stage II ulcers removed.
  - — Changed references to "fully epithelialized" Stage II pressure ulcers to "healed" Stage II pressure ulcers.


OASIS Item Guidance

OASIS ITEM

(MXXXX) XXXXXXX

☐ XXXXXXXX
☐ XXXXXXXX
☐ XXXXXXXX

ITEM INTENT

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

TIME POINTS ITEM(S) COMPLETED

XXXX
XXXXXXX
XXX

RESPONSE—SPECIFIC INSTRUCTIONS

- XXXXXXXXXXXX
- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
- XXXXXXXXXXXXXXXXXXXXXXXX

DATA SOURCES / RESOURCES

- XXXXX
- XX
- XXXXXXXXXXXXXXXX
- XXXXXXXXXXX

M1308 Current Number of Unhealed Ulcers

(M1308) **Current Number of Unhealed Pressure Ulcers at Each Stage or Unstageable:** (Enter "0" if none; Excludes Stage I pressure ulcers and healed Stage II pressure ulcers)

Stage Descriptions—unhealed pressure ulcers	Number Currently Present
a. **Stage II:** 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 serum-filled blister.	___
b. **Stage III:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.	___
c. **Stage IV:** Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.	___
d.1 Unstageable: Known or likely but Unstageable due to non-removable dressing or device	___
d.2 Unstageable: Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar.	___
d.3 Unstageable: Suspected deep tissue injury in evolution.	___

Column 2 Deleted

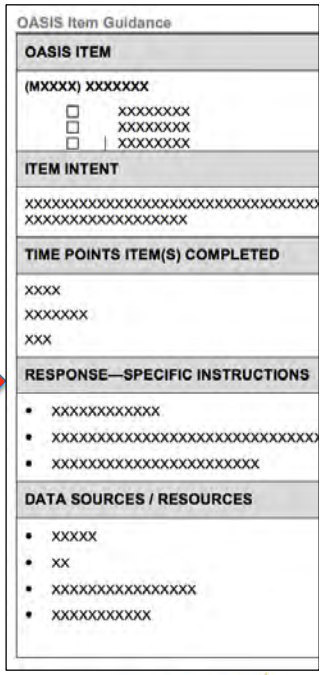
Column 2 deleted. The term "non-epithelialized" was eliminated from the item stem to improve clarity and be consistent with the OASIS-C1 Guidance Manual.
Improved word order. "Unstageable" capitalized.

OASIS-C1

Collected at SOC, ROC, FU & DC

M1308 Ch.3 Guidance – What's changed?

- **Response-Specific Instructions**
  - — Removed references to and guidance for Column 2
  - — Added language from revised WOCN Wound Guidance document & Q&As
    - o Response d.2 refers to pressure ulcers that the care provider suspects may be present based on clinical assessment findings, but that cannot be staged because no bone, muscle, tendon, or joint capsule (Stage IV structures) are visible, and some degree of necrotic tissue (eschar or slough) or scabbing is present that the clinician believes may be obscuring the visualization of Stage IV structures.



M1309 Worsening in Pressure Ulcer Status since SOC/ROC

(M1309) Worsening in Pressure Ulcer Status since SOC/ROC:

Instructions for a – c: For Stage II, III and IV pressure ulcers, report the number that are new or have increased in numerical stage since the most recent SOC/ROC	
	Enter Number (Enter "0" if there are no current Stage II, III or IV pressure ulcers OR if all current Stage II, III or IV pressure ulcers existed at the same numerical stage at most recent SOC/ROC)
a. Stage II	
b. Stage III	
c. Stage IV	
Instructions for d: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were a Stage I or II at the most recent SOC/ROC.	
	Enter Number (Enter "0" if there are no Unstageable pressure ulcers at discharge OR if all current Unstageable pressure ulcers were Stage III or IV or were Unstageable at most recent SOC/ROC)
d. Unstageable due to coverage of wound bed by slough or eschar	

OASIS-C1

Collects information at Discharge which was previously collected in M1308 Column 2 on worsening pressure ulcer status. Harmonized with nursing home (MDS) and CARE instruments. Includes pressure ulcers that at DC are Unstageable due to slough/eschar.

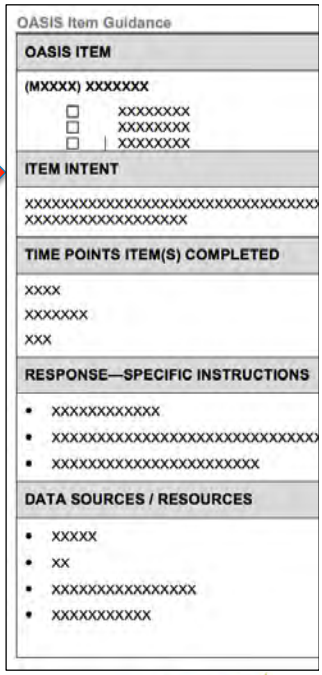
Collected at DC

M1309 Ch. 3 Guidance Manual

Item Intent

Documents the number of pressure ulcers that are new or have “worsened” (increased in numerical stage) since the most recent Start or Resumption of Care assessment.

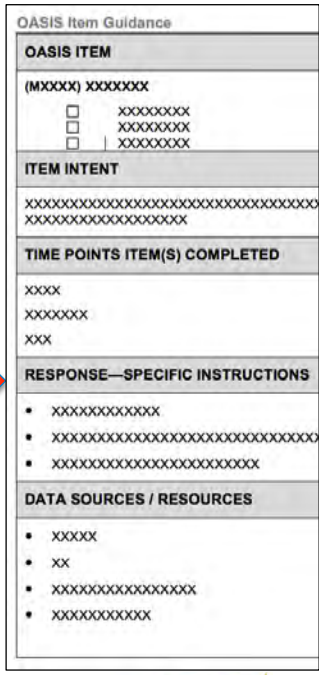
Definitions of pressure ulcer stages are derived from the National Pressure Ulcer Advisory Panel (NPUAP).



M1309 Ch. 3 Guidance Manual

Response-Specific Instructions

- Review the history of each current pressure ulcer.
- Specifically, compare the current stage of the pressure ulcer to the stage of that ulcer at the most recent SOC/ROC
- Determine whether the pressure ulcer currently present is new or worsened when compared to the presence or stage of that pressure ulcer at the most recent SOC/ROC.
- For definitions of pressure ulcer stages, see M1308 and the NPUAP staging system.



M1309 Ch. 3 Guidance Manual

Instructions for a – c: For Stage II, III and IV pressure ulcers, report the number that are new or have increased in numerical stage since the most recent SOC/ROC	
	Enter Number (Enter "0" if there are no current Stage II, III or IV pressure ulcers OR if all current Stage II, III or IV pressure ulcers existed at the same numerical stage at most recent SOC/ROC)
a. Stage II	
b. Stage III	
c. Stage IV	

Response-Specific Instructions

- Mark a response for each row of this item: a, b, and c. If there are NO ulcers at a given stage, enter "0" for that stage/row.
- Report the number of current pressure ulcers at each stage that are new or have worsened since the most recent SOC/ROC assessment.
- For pressure ulcers that are currently Stage II, III or IV, "worsening" refers to a pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of I-IV (the NPUAP staging system) at the time of discharge in comparison to the most recent SOC/ ROC assessment.

M1309 Ch. 3 Guidance Manual

Instructions for a – c: For Stage II, III and IV pressure ulcers, report the number that are new or have increased in numerical stage since the most recent SOC/ROC	
	Enter Number (Enter "0" if there are no current Stage II, III or IV pressure ulcers OR if all current Stage II, III or IV pressure ulcers existed at the same numerical stage at most recent SOC/ROC)
a. Stage II	
b. Stage III	
c. Stage IV	

Response-Specific Instructions

For row a: Stage II.

- Enter the number of current pressure ulcers at discharge, whose deepest anatomical stage is Stage II, that were not present or were a Stage I at most recent SOC/ROC.
- Enter "0" if there are no current Stage II pressure ulcers or no Stage II pressure ulcers that have worsened since most recent SOC/ROC.

M1309 Ch. 3 Guidance Manual

Instructions for a – c: For Stage II, III and IV pressure ulcers, report the number that are new or have increased in numerical stage since the most recent SOC/ROC	
	Enter Number (Enter "0" if there are no current Stage II, III or IV pressure ulcers OR if all current Stage II, III or IV pressure ulcers existed at the same numerical stage at most recent SOC/ROC)
a. Stage II	
b. Stage III	
c. Stage IV	

Response-Specific Instructions

For row b: Stage III.

- Enter the number of current pressure ulcers at discharge, whose deepest anatomical stage is Stage III, that were not present or were a Stage I or II at the most recent SOC/ROC.
- Enter "0" if there are no current Stage III pressure ulcers or no Stage III pressure ulcers that have worsened since most recent SOC/ROC.

M1309 Ch. 3 Guidance Manual

Instructions for a – c: For Stage II, III and IV pressure ulcers, report the number that are new or have increased in numerical stage since the most recent SOC/ROC	
	Enter Number (Enter "0" if there are no current Stage II, III or IV pressure ulcers OR if all current Stage II, III or IV pressure ulcers existed at the same numerical stage at most recent SOC/ROC)
a. Stage II	
b. Stage III	
c. Stage IV	

Response-Specific Instructions

For row c: Stage IV.

- Enter the number of current pressure ulcers at discharge, whose deepest anatomical stage is Stage IV, that were not present or were at Stage I, II, or III at the most recent SOC/ROC.
- Enter "0" if there are no current Stage IV pressure ulcers or no Stage IV pressure ulcers that have worsened since most recent SOC/ROC.

M1309 Ch. 3 Guidance Manual

Instructions for d: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were a Stage I or II at the most recent SOC/ROC.	
	Enter Number (Enter "0" if there are no Unstageable pressure ulcers at discharge OR if all current Unstageable pressure ulcers were Stage III or IV or were Unstageable at most recent SOC/ROC)
d. Unstageable due to coverage of wound bed by slough or eschar	

Response-Specific Instructions

For pressure ulcers that are currently Unstageable due to coverage of wound bed by slough or eschar, row d.

- Pressure ulcers that are Unstageable due to slough or eschar are those in which the wound bed is not visible due to some degree of necrotic tissue or scabbing that the clinician believes may be obscuring the visualization of bone, muscle, tendon or joint capsule (Stage IV structures).
- Note that if a Stage IV structure is visible, the pressure ulcer is not considered "Unstageable" – it is a Stage IV even if slough or eschar is present.

M1309 Ch. 3 Guidance Manual

Instructions for d: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were a Stage I or II at the most recent SOC/ROC.	
	Enter Number (Enter "0" if there are no Unstageable pressure ulcers at discharge OR if all current Unstageable pressure ulcers were Stage III or IV or were Unstageable at most recent SOC/ROC)
d. Unstageable due to coverage of wound bed by slough or eschar	

Response-Specific Instructions

For pressure ulcers that are currently Unstageable due to slough or eschar, **"worsening"** refers to a pressure ulcer that was either not present, or was a Stage I or II pressure ulcer at the most recent SOC/ ROC and is now Unstageable due to slough or eschar.

- Pressure ulcers that are currently Unstageable due to presence of slough or eschar and were Stage III or IV at the most recent SOC/ROC are not considered worsened.

M1309 Ch. 3 Guidance Manual

Instructions for d: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were a Stage I or II at the most recent SOC/ROC.	
	Enter Number (Enter "0" if there are no Unstageable pressure ulcers at discharge OR if all current Unstageable pressure ulcers were Stage III or IV or were Unstageable at most recent SOC/ROC)
d. Unstageable due to coverage of wound bed by slough or eschar	

Response-Specific Instructions

Enter "0" if:

- currently there are no pressure ulcers Unstageable due to slough or eschar.
- all current Unstageable pressure ulcers were Stage III or IV or were Unstageable at most recent SOC/ROC.

Pressure ulcers that cannot be reported as new or worsened:

- Pressure ulcers Unstageable for any reason at most recent SOC/ROC
- Pressure ulcers covered with non-removable dressing/device at DC
- Suspected deep tissue injury in evolution present at SOC/ROC or DC

M1309 Reporting Algorithm

CURRENT STAGE *at Discharge*	*Look back to most recent SOC/ROC.*	PRIOR STAGE *at most recent SOC/ROC*	*REPORT AS NEW OR WORSENED?*
a. Stage II *at discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	**Not present** **Stage I**	**YES**
		Stage II	NO
		Stage III Stage IV	NA (reverse staging not allowed)
		Unstageable	NO
b. Stage III *at discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	**Not present** **Stage I** **Stage II**	**YES**
		Stage III	NO
		Stage IV	NA (reverse staging not allowed)
		Unstageable	NO
c. Stage IV *at discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	**Not present** **Stage I** **Stage II** **Stage III**	**YES**
		Stage IV Unstageable	NO
d. Unstageable due to slough or eschar at discharge	*If same pressure ulcer at most recent SOC/ROC was:*	**Not present** **Stage I** **Stage II**	**YES**
		Stage III Stage IV Unstageable	NO

M1309 Scenario Question

Scenario: You are completing Mrs. Sanchez's Discharge comprehensive assessment. When assessing her skin, you determine there are two pressure ulcers – a Stage IV on her left buttock, that is 50% covered in slough, with observable muscle and one on her left elbow completely covered with eschar. Chart review reveals at SOC the left elbow was a Stage II and the buttock ulcer was a Stage III.

How would M1309 Worsening in Pressure Ulcer Status since SOC/ROC be completed?

Instructions for a – c: For Stage II, III and IV pressure ulcers, report the number that are new or have increased in numerical stage since the most recent SOC/ROC	
	Enter Number (Enter "0" if there are no current Stage II, III or IV pressure ulcers OR if all current Stage II, III or IV pressure ulcers existed at the same numerical stage at most recent SOC/ROC)
a. Stage II	
b. Stage III	
c. Stage IV	
Instructions for d: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were a Stage I or II at the most recent SOC/ROC.	
	Enter Number (Enter "0" if there are no Unstageable pressure ulcers at discharge OR if all current Unstageable pressure ulcers were Stage III or IV or were Unstageable at most recent SOC/ROC)
d. Unstageable due to coverage of wound bed by slough or eschar	

M1309 Scenario Answer & Rationale

Scenario: You are completing Mrs. Sanchez's Discharge comprehensive assessment. When assessing her skin, you determine there are two pressure ulcers – a Stage IV on her left buttock, that is 50% covered in slough, with observable muscle and one on her left elbow completely covered with eschar. Chart review reveals at SOC the left elbow was a Stage II and the buttock ulcer was a Stage III.

How would M1309 Worsening in Pressure Ulcer Status since SOC/ROC be completed?

Instructions for a – c: For Stage II, III and IV pressure ulcers, report the number that are new or have increased in numerical stage since the most recent SOC/ROC	
	Enter Number (Enter "0" if there are no current Stage II, III or IV pressure ulcers OR if all current Stage II, III or IV pressure ulcers existed at the same numerical stage at most recent SOC/ROC)
a. Stage II	0
b. Stage III	0
c. Stage IV	1
Instructions for d: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were a Stage I or II at the most recent SOC/ROC.	
	Enter Number (Enter "0" if there are no Unstageable pressure ulcers at discharge OR if all current Unstageable pressure ulcers were Stage III or IV or were Unstageable at most recent SOC/ROC)
d. Unstageable due to coverage of wound bed by slough or eschar	1

The Stage IV was a Stage III at SOC. It advanced in numerical stage since SOC. The Unstageable pressure ulcer was a Stage II at SOC and at DC is Unstageable due to complete coverage of the pressure ulcer by eschar.

M1309 Scenario Question

Scenario: You are completing Mr. Stone's Discharge comprehensive assessment. When assessing his skin, you discover a Stage II on his right heel and suspected deep tissue injury on his left heel. Chart review reveals no pressure ulcers were present at SOC.

How would M1309 Worsening in Pressure Ulcer Status since SOC/ROC be completed?

Instructions for a – c: For Stage II, III and IV pressure ulcers, report the number that are new or have increased in numerical stage since the most recent SOC/ROC	
	Enter Number (Enter "0" if there are no current Stage II, III or IV pressure ulcers OR if all current Stage II, III or IV pressure ulcers existed at the same numerical stage at most recent SOC/ROC)
a. Stage II	
b. Stage III	
c. Stage IV	
Instructions for d: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were a Stage I or II at the most recent SOC/ROC.	
	Enter Number (Enter "0" if there are no Unstageable pressure ulcers at discharge OR if all current Unstageable pressure ulcers were Stage III or IV or were Unstageable at most recent SOC/ROC)
d. Unstageable due to coverage of wound bed by slough or eschar	

M1309 Scenario Answer & Rationale

Scenario: You are completing Mr. Stone's Discharge comprehensive assessment. When assessing his skin, you discover a Stage II on his right heel and suspected deep tissue injury on his left heel. Chart review reveals no pressure ulcers were present at SOC.

How would M1309 Worsening in Pressure Ulcer Status since SOC/ROC be completed?

Instructions for a – c: For Stage II, III and IV pressure ulcers, report the number that are new or have increased in numerical stage since the most recent SOC/ROC	
	Enter Number (Enter "0" if there are no current Stage II, III or IV pressure ulcers OR if all current Stage II, III or IV pressure ulcers existed at the same numerical stage at most recent SOC/ROC)
a. Stage II	1
b. Stage III	0
c. Stage IV	0
Instructions for d: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were a Stage I or II at the most recent SOC/ROC.	
	Enter Number (Enter "0" if there are no Unstageable pressure ulcers at discharge OR if all current Unstageable pressure ulcers were Stage III or IV or were Unstageable at most recent SOC/ROC)
d. Unstageable due to coverage of wound bed by slough or eschar	0

The Stage II at DC was not present at SOC. The suspected deep tissue injury was not present at SOC, but is not reported in M1309.

M1320 Pressure Ulcer Healing Status

(M1320) **Status of Most Problematic Pressure Ulcer that is Observable:** (Excludes pressure ulcer that cannot be observed due to a non-removable dressing/device.)

- ☐ 0 - Newly epithelialized
- ☐ 1 - Fully granulating
- ☐ 2 - Early/partial granulation
- ☐ 3 - Not healing
- ☐ NA- No observable pressure ulcer

OASIS-C1

Wording change to item stem to clarify exclusion of nonobservable ulcer(s).
Improved word order.
Added explanatory text from OASIS-C1 Guidance Manual.

M1320 Ch.3 Guidance – What's changed?

Response-Specific Instructions

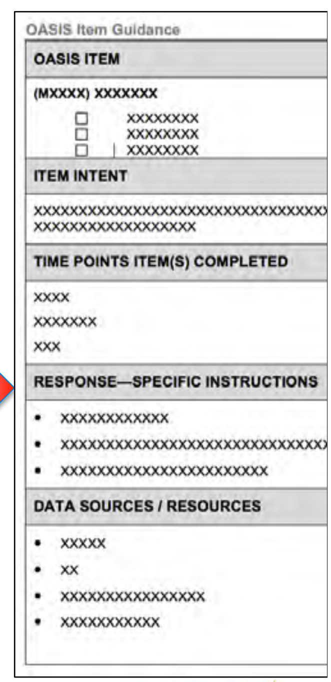
Reorganized to move data collector through 3 step process

- — Determine which pressure ulcers are observable
- — Determine which observable pressure ulcer is most problematic, then
- — Determine and report healing status

Dropped explanation of pressure ulcers that cannot be observed due to re-wording of item

WOCN Guidance added

- — Descriptions for Newly Epithelialized, Fully Granulating, Early/Partial Granulation and Not Healing.



M1324 Pressure Ulcer Stage

(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.)

- ☐ 1 - Stage I
- ☐ 2 - Stage II
- ☐ 3 - Stage II
- ☐ 4 - Stage IV
- ☐ NA - Patient has no pressure ulcers or no stageable pressure ulcers

OASIS-C1

Wording change to item stem and NA response to distinguish “observable” from “stageable”.
Improved word order.
Clarified NA response by removing the words “observable” and “unhealed”.

M1324 Ch.3 Guidance – What’s changed?

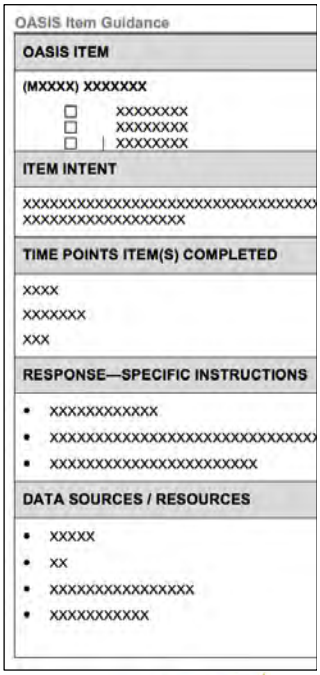
Response-Specific Instructions

Reorganized to move data collector through 3 step process

- Determine which pressure ulcers are stageable
- Determine which stageable pressure ulcer is most problematic, then
- Determine and report stage

Added language from revised WOCN Wound Guidance document & Q&As

- A pressure ulcer is considered Unstageable if the wound bed is obscured by some degree of necrotic tissue or scabbing AND no bone, muscle, tendon, or joint capsule (Stage IV structures) are visible. Note that if a Stage IV structure is visible, the pressure ulcer is reportable as a Stage IV even if slough or eschar is present.



M1330 Does patient have a Stasis Ulcer?

(M1330) 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]***

Added the word "device" in Response 3 to make it consistent with OASIS-C1 Guidance Manual.

OASIS-C1

M1332 Number of Stasis Ulcers

(M1332) **Current Number of Stasis Ulcer(s) that are Observable:**

☐ 1 - One
☐ 2 - Two
☐ 3 - Three
☐ 4 - Four or more

Revised item stem word order for improved clarity.

OASIS-C1

M1334 Stasis Ulcer Healing Status

(M1334) Status of Most Problematic Stasis Ulcer that is Observable:

- ☐ 1 - Fully granulating
- ☐ 2 - Early/partial granulation
- ☐ 3 - Not healing

OASIS-C1

Revised item stem word order for improved clarity.
Eliminated "Response 0-Newly epithelialized" since it is an inappropriate option for this item

- No longer reported as a current stasis ulcer after complete epithelialization occurs.

M1334 Ch.3 Guidance – What's changed?

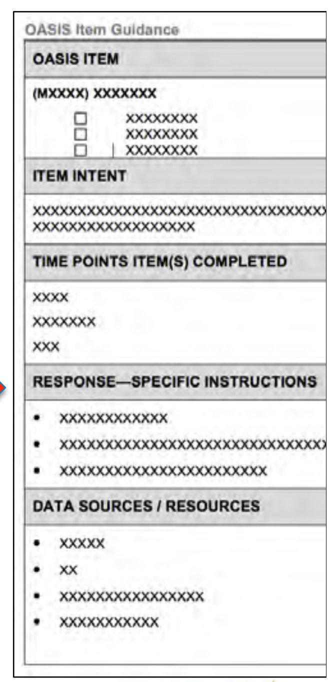
Response-Specific Instructions

Reorganized to move data collector through 3 step process

- — Determine which stasis ulcers are observable
- — Determine which stasis ulcer is most problematic, then
- — Determine and report healing status

WOCN Guidance added

- — Descriptions for Newly Epithelialized, Fully Granulating, Early/Partial Granulation and Not Healing.


OASIS Item Guidance

OASIS ITEM

(MXXXX) XXXXXXX

☐ XXXXXXXX
☐ XXXXXXXX
☐ XXXXXXXX

ITEM INTENT

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXX

TIME POINTS ITEM(S) COMPLETED

XXXX
XXXXXXX
XXX

RESPONSE—SPECIFIC INSTRUCTIONS

- XXXXXXXXXXXX
- XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
- XXXXXXXXXXXXXXXXXXXXXX

DATA SOURCES / RESOURCES

- XXXXX
- XX
- XXXXXXXXXXXXXXX
- XXXXXXXXXXX

M1340 Does patient have a Surgical Wound?

(M1340) 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***]

OASIS-C1

Punctuation change to Response 1.
Added the word “device” to make Response 2 consistent with OASIS-C1 Guidance Manual.
New skip directions due to deletion of M1350 at FU and DC.

M1342 Surgical Wound Healing Status

(M1342) **Status of Most Problematic Surgical Wound that is Observable**

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

OASIS-C1

Wording change to item stem.
Improved word order for clarity.

M1342 Ch.3 Guidance – What's changed?

Response-Specific Instructions

Reorganized to move data collector through 3 step process

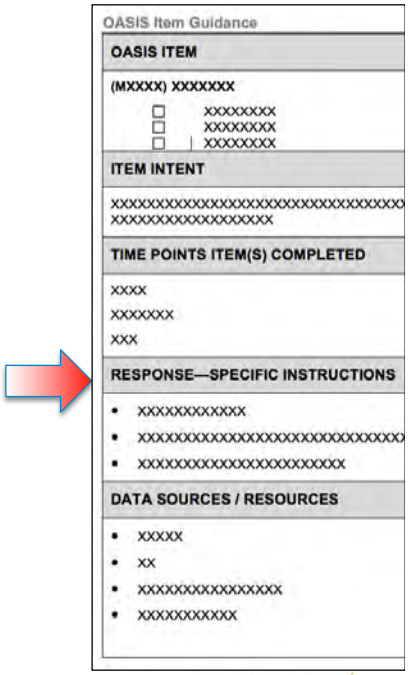
— Determine which surgical wounds are observable

— Determine which observable surgical wound is most problematic, then

— Determine and report healing status

WOCN Guidance added

— Descriptions for Fully Granulating, Early/Partial Granulation and Not Healing.



M1350 Skin Lesion or Open Wound

(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?

☐ 0 - No

☐ 1 - Yes

OASIS-C1

Punctuation changes: Parenthesis and commas added to item stem.
No longer collected at FU or DC.

Collected at SOC, ROC, ~~FU~~, & ~~DC~~

M1350 Ch.3 Guidance – What's changed?

Item Intent

Deleted bolding

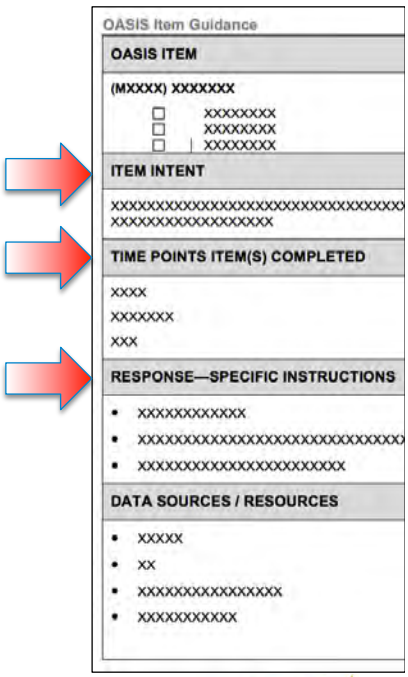
Time Points Item Completed

Deleted Follow-up and Discharge

Response-Specific Instructions

Guidance reorganized

- Excluded Wounds/Lesions
- Details when Response "0-No" is appropriate
- Details when Response "1-Yes" is appropriate



M1400 Dyspneic or Noticeably Short of Breath?

(M1400) When is the patient dyspneic or noticeably **Short of Breath**?

- ☐ 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)

OASIS-C1

Eliminated "e.g." abbreviation and replaced with "for example" to increase clarity in Responses 2 and 3.

M1410 Respiratory Treatments

(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

OASIS-C1

No longer collected at DC.

~~Collected at SOC, ROC & DC~~

M1500 Symptoms in Heart Failure Patients

(M1500) 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 previous OASIS assessment?

- ☐ 0 - No **[*Go to M2004 at TRN; Go to M1600 at DC*]**
- ☐ 1 - Yes
- ☐ 2 - Not assessed **[*Go to M2004 at TRN; Go to M1600 at DC*]**
- ☐ NA - Patient does not have diagnosis of heart failure **[*Go to M2004 at TRN; Go to M1600 at DC*]**

OASIS-C1

Wording in item stem revised to clarify that reporting period includes the time of the assessment.

M1510 Heart Failure Follow-up

(M1510) 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 previous OASIS 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)

OASIS-C1

Wording in item stem revised to clarify that reporting period includes the time of the assessment. Eliminated "e.g." abbreviation and replaced with "for example" in Responses 2 and 5. Deleted "etc." from Response 5.

M1610 Urinary Incontinence or Catheter

(M1610) Urinary Incontinence or Urinary Catheter Presence:

- ☐ 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*]**

OASIS-C1

Eliminated "i.e." abbreviation and replaced with "specifically" to improve clarity in Response 2.

M1630 Ostomy for Bowel Elimination

(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?

- ☐ 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.

OASIS-C1

Punctuation change to item stem

M1700 Cognitive Functioning

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

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

OASIS-C1

Eliminated "e.g." abbreviation and replaced with "for example" to improve clarity in Response 2.

M1730 Depression Screening

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

☐ 0 - No
☐ 1 - Yes, patient was screened using the PHQ-2©* scale.

Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems?"

PHQ-2©*	Not at all 0 - 1 day	Several days 2 - 6 days	More than half of the days 7 – 11 days	Nearly every day 12 – 14 days	NA Unable to respond
a) Little interest or pleasure in doing things	☐0	☐1	☐2	☐3	☐NA
b) Feeling down, depressed, or hopeless?	☐0	☐1	☐2	☐3	☐NA

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

Added "validated" to item stem and Response 2 and 3 for clarity since both "standardized" and "validated" are specified in the OASIS-C1 Guidance Manual. Moved instructions inside box.
Added phrase 'patient was screened' to Response 2 for clarity and consistency. Capitalization of NA for consistency throughout document.

OASIS-C1

M1730 Ch.3 Guidance – What's changed?

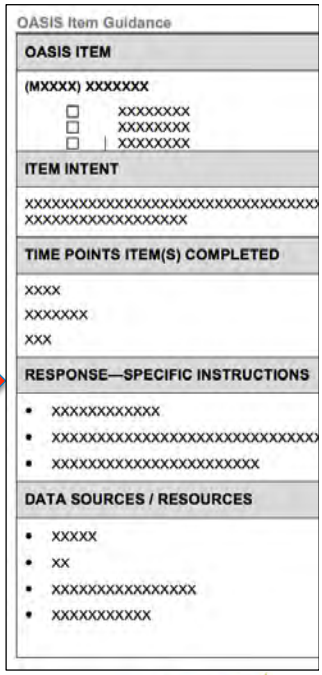
Response-Specific Instructions

Guidance clarified

— Depressive feelings, symptoms, and/or behaviors may be observed by the clinician or reported by the patient, family, or others as allowed by the standardized, validated tool's administration instructions.

— Select Response 1 if the PHQ-2© is completed, and mark the appropriate responses in rows a and b. Please note that the PHQ-2© instructions indicate that the patient is interviewed, not family or others. If the patient scores three points or more on the PHQ-2©, then further depression screening is indicated.

— Allowed assessment timeframes defined



M1740 Cognitive, Behavioral, and Psychiatric Symptoms

(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

OASIS-C1

Bolding added to item stem for clarity.
Eliminated "e.g." abbreviation and replaced with "for example" to improve clarity in Response 4.

M1800 Grooming

(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).

- ☐ 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.

OASIS-C1

Eliminated "i.e." abbreviation in item stem and replaced with "specifically" to improve clarity in item stem.

M1830 Bathing

(M1830) Bathing: Current ability to wash entire body safely. **Excludes grooming (washing face, washing hands, and shampooing hair).**

- ☐ 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.

OASIS-C1

Deleted the phrase "throughout the bath" from Response 5 to also include patients who need intermittent assistance bathing self in bed, at the sink, in bedside chair, or on the commode.

M1860 Ambulation/Locomotion

(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.

- ☐ 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.

OASIS-C1

Eliminated "i.e." abbreviation and replaced with "specifically" to improve clarity in Response 0. Eliminated "e.g." abbreviation and replaced with "for example" to improve clarity in Response 1 and 2.

M1880 Ability to Prepare Light Meals

(M1880) Current **Ability to Plan and Prepare Light Meals** (for example, cereal, sandwich) or reheat delivered meals safely:

- ☐ 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.

OASIS-C1

Eliminated "e.g." abbreviation and replaced with "for example" to improve clarity in the item stem. Eliminated "i.e." abbreviation and replaced with "specifically" to improve clarity in Response 0.

M1890 Telephone Use

(M1890) Ability to Use Telephone: Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate.

- ☐ 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.

OASIS-C1

Eliminated "e.g." abbreviation and replaced with "for example" to improve clarity in Response 1.

M1900 Prior Functioning ADL/IADL

(M1900) Prior Functioning ADL/IADL: Indicate the patient's usual ability with everyday activities prior to his/her most recent illness, exacerbation, or injury. Check only **<u>one</u>** box in each row.

Functional Area	Independent	Needed Some Help	Dependent
a. Self-Care (specifically: grooming, dressing, bathing, and toileting hygiene)	☐ 0	☐ 1	☐ 2
b. Ambulation	☐ 0	☐ 1	☐ 2
c. Transfer	☐ 0	☐ 1	☐ 2
d. Household tasks (specifically: light meal preparation, laundry, shopping, and phone use)	☐ 0	☐ 1	☐ 2

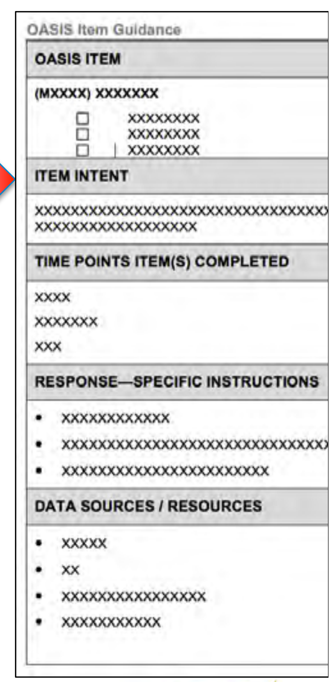
OASIS-C1

Wording change in stem to make consistent with M2040 Prior Medication Management.
To improve clarity, responses modified so that the relevant ADLs/IADLs are listed and abbreviations were eliminated ("e.g." replaced with "specifically").

M1900 Ch. 3 Guidance – What's changed?

Item Intent

- Word "compliance" changed to "adherence"
  - Note: This change in language was made throughout Ch. 3 (ADL/IADL domain, Medication domain, etc.) Each of these changes are not illustrated in this presentation.
- Reference to use for risk adjustment removed


OASIS Item Guidance

OASIS ITEM

(MXXXX) XXXXXXX
☐ XXXXXXXX
☐ XXXXXXXX
☐ XXXXXXXX

ITEM INTENT

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXX

TIME POINTS ITEM(S) COMPLETED

XXXX
XXXXXXX
XXX

RESPONSE—SPECIFIC INSTRUCTIONS

- XXXXXXXXXXXX
- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
- XXXXXXXXXXXXXXXXXXXXXXX

DATA SOURCES / RESOURCES

- XXXXX
- XX
- XXXXXXXXXXXXXXXX
- XXXXXXXXXXX

M1910 Fall Risk Assessment

(M1910) Has this patient had a multi-factor **Falls Risk Assessment** using a standardized, validated assessment tool?

- ☐ 0 - No
- ☐ 1 - Yes, and it does not indicate a risk for falls.
- ☐ 2 - Yes, and it does indicate a risk for falls.

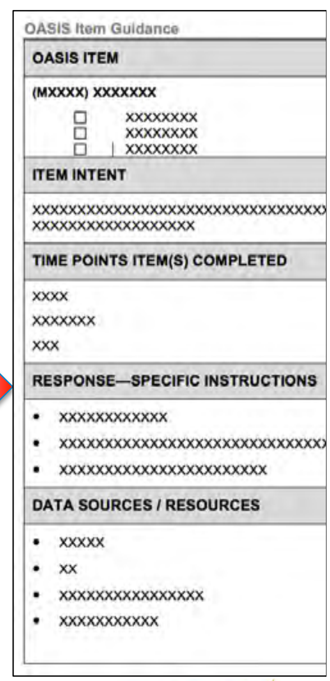
OASIS-C1

Unnecessary wording was deleted from the item stem.
Words “standardized, validated” have been added for consistency with the instructions in the OASIS-C1 Guidance Manual.
Wording of Response 0 and 2 were revised for clarity.

M1910 Ch. 3 Guidance – What’s changed?

Response-Specific Instructions

- — OASIS guidance from Q&As added
- — If the tool does not provide various levels, but simply has a single threshold separating those “at risk” from those “not at risk,” then the patient scoring “at risk” should be scored as Response 2.



M2000 Drug Regimen Review

(M2000) Drug Regimen Review: Does a complete drug regimen review indicate potential clinically significant medication issues (for example, adverse drug reactions, ineffective drug therapy, significant side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance [non-adherence])?

- ☐ 0 - Not assessed/reviewed **[*Go to M2010*]**
- ☐ 1 - No problems found during review **[*Go to M2010*]**
- ☐ 2 - Problems found during review
- ☐ NA - Patient is not taking any medications **[*Go to M2040*]**

OASIS-C1

Abbreviations eliminated for clarity ("e.g." replaced with "for example").
Item stem wording revised to reflect OASIS-C1 Guidance Manual.
"Adverse" added to describe drug reactions; “significant” added to describe side effects; and “non-adherence” added to “noncompliance”.

M2004 Medication Intervention

(M2004) Medication Intervention: If there were any clinically significant medication issues at the time of, or at any time since the previous OASIS assessment, was a physician or the physician-designee contacted within one calendar day to resolve any identified clinically significant medication issues, including reconciliation?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - No clinically significant medication issues identified at the time of or at any time since the previous OASIS assessm

OASIS-C1

Wording in item stem and NA response revised to clarify that reporting period includes the time of the previous assessment. The measure refers to physician contact for medication issues that have been identified.

M2015 Patient/Caregiver Drug Education Intervention

(M2015) Patient/Caregiver Drug Education Intervention: At the time of, or at any time since the previous OASIS 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
☐ NA - Patient not taking any drugs

OASIS-C1

Wording in item stem revised to clarify that reporting period includes the time of the assessment.
The word “significant” was added to item stem to describe side effects and “adverse” to drug reactions.

M2040 Prior Medication Management

(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. Check only **one** box in each row.

Functional Area	Independent	Needed Some Help	Dependent	Not Applicable
a. Oral medications	☐0	☐1	☐2	☐NA
b. Injectable medications	☐0	☐1	☐2	☐NA

OASIS-C1

Data collection period clarified in item stem.
Item stem wording changed to “…prior to his/her most recent illness, …”
NA capitalized.

M2102 Types and Sources of Assistance

(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. (Check only **one** box in each row.)

Type of Assistance	No assistance needed–patient is independent or does not have needs in this area	Non-agency caregiver(s) currently provide assistance	Non-agency caregiver(s) need training/ supportive services to provide assistance	Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance	Assistance needed, but no non-agency caregiver(s) available
a. **ADL assistance** (for example, transfer/ ambulation, bathing, dressing, toileting, eating/feeding)	☐0	☐1	☐2	☐3	☐4
b. **IADL assistance** (for example, meals, housekeeping, laundry, telephone, shopping, finances)	☐0	☐1	☐2	☐3	☐4

OASIS-C1

Revised stem and column headings to clarify that "caregiver" refers to non-agency caregivers and excludes care by agency staff.
Added text to column heading to clarify that “No assistance needed from Caregiver in this area” means that the patient is independent or does not have needs in this area.
Simplified response options by combining “Caregiver(s) not likely to provide assistance” and “Caregiver(s) unwilling/unable to provide assistance.”
Abbreviations eliminated for clarity ("e.g.“ replaced with "for example").

M2102 Types and Sources of Assistance (Continued)

(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. (Check only **one** box in each row.)

c. **Medication administration** (for example, oral, inhaled or injectable)	☐0	☐1	☐2	☐3	☐4
d. **Medical procedures/ treatments** (for example, changing wound dressing, home exercise program)	☐0	☐1	☐2	☐3	☐4
e. **Management of Equipment** (for example, oxygen, IV/infusion equip-ment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies)	☐0	☐1	☐2	☐3	☐4

OASIS-C1

Wording change made to Response “d”.
Added example of “home exercise program”.
Abbreviations eliminated for clarity ("e.g.“ replaced with "for example").

M2102 Types and Sources of Assistance (Continued)

(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. (Check only **one** box in each row.)

f. **Supervision and safety** (for example, due to cognitive impairment)	☐0	☐1	☐2	☐3	☐4
g. **Advocacy or facilitation** of patient's participation in appropriate medical care (for example, transportation to or from appointments)	☐0	☐1	☐2	☐3	☐4

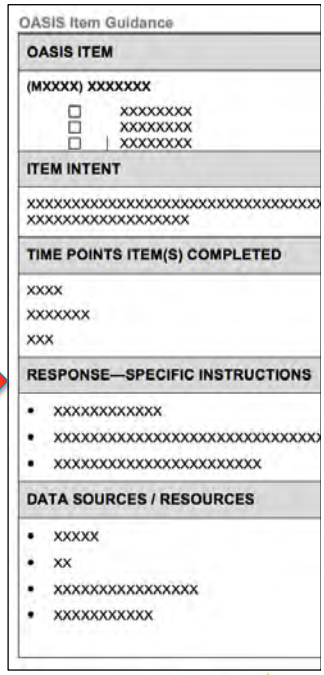
OASIS-C1

Abbreviations eliminated for clarity ("e.g." replaced with "for example").

M2102 Ch. 3 Guidance - What's changed?

(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. (Check only **one** box in each row.)

Type of Assistance	No assistance needed – patient is independent or does not have needs in this area	Non-agency caregiver(s) currently provide assistance	Non-agency caregiver(s) need training/ supportive services to provide assistance	Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance	Assistance needed, but no non-agency caregiver(s) available
a. **ADL assistance** (for example, transfer/ ambulation, bathing, dressing, toileting, eating/feeding)	☐0	☐1	☐2	☐ 3	☐4



Response-Specific Instructions

— Guidance regarding Response 3 modified to indicate that caregivers "not likely" and "unclear" if they will provide assistance are now merged into one response option.

M2102 Scenario Question

Scenario: After interviewing Mrs. McNichols and her son at SOC, you discover she needs help with most ADLs and IADLs. Her son is her only caregiver and he willingly helps with everything except bathing and dressing. He states he is just not comfortable providing that needed care for his mother. The patient can use the phone independently and the son assists her with all other IADL tasks.
What is the appropriate response for M2102, Types and Sources of Assistance, Rows a & b?

(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. (Check only **one** box in each row.)

Type of Assistance	No assistance needed–patient is independent or does not have needs in this area	Non-agency caregiver(s) currently provide assistance	Non-agency caregiver(s) need training/ supportive services to provide assistance	Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance	Assistance needed, but no non-agency caregiver(s) available
a. **ADL assistance** (for example, transfer/ ambulation, bathing, dressing, toileting, eating/feeding)	☐0	☐1	☐2	☐3	☐4
b. **IADL assistance** (for example, meals, housekeeping, laundry, telephone, shopping, finances)	☐0	☐1	☐2	☐3	☐4

M2102 Scenario Answer & Rationale

Scenario: After interviewing Mrs. McNichols and her son at SOC, you discover she needs help with most ADLs and IADLs. Her son is her only caregiver and he willingly helps with everything except bathing and dressing. He states he is just not comfortable providing that care for his mother. The patient can use the phone independently and the son assists her with all other IADL tasks.
What is the appropriate response for M2102, Types and Sources of Assistance, Rows a & b?

(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. (Check only **one** box in each row).

Type of Assistance	No assistance needed –patient is independent or does not have needs in this area	Non-agency caregiver(s) currently provide assistance	Non-agency caregiver(s) need training/ supportive services to provide assistance	Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance	Assistance needed, but no non-agency caregiver(s) available
a. **ADL assistance** (for example, transfer/ ambulation, bathing, dressing, toileting, eating/feeding)	☐0	☐1	☐2	X3	☐4
b. **IADL assistance** (for example, meals, housekeeping, laundry, telephone, shopping, finances)	☐0	X1	☐2	☐3	☐4

Ch. 3, Response-Specific Instructions state:
If more than one response in a row applies, select the response that represents the greatest need.
The son is providing some ADL assist, but unwilling to help with the ADL tasks of bathing/dressing.
If patient needs assistance with any aspect of a category of assistance, consider the aspect that represents the most need and the availability and ability of the caregiver(s) to meet that need.
Patient is independent in one IADL; son is providing needed assistance with the dependent IADLs.

M2110 How Often Does the Patient Receive ADL or IADL assistance

(M2110) How Often does the patient receive **ADL or IADL assistance** from any caregiver(s) (other than home health agency staff)?

- ☐ 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

OASIS-C1

No longer collected at DC.

Deleted "Omit "UK" option on DC" from Response UK, since this item is no longer collected at discharge.

~~Collected at SOC, ROC & DC~~

CMS

M2250 – Plan of Care Synopsis

OASIS-C1

(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.

M2250 – Plan of Care Synopsis (Continued)

(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 (bilatera 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.

OASIS-C1

Revised the "Not Applicable" responses for all rows except “a”
Response “d” added physician notification for positive depression screening.
Removed the line between NA and the text boxes to improve clarity.

M2250 – Plan of Care Synopsis (Continued)

(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
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.

OASIS-C1

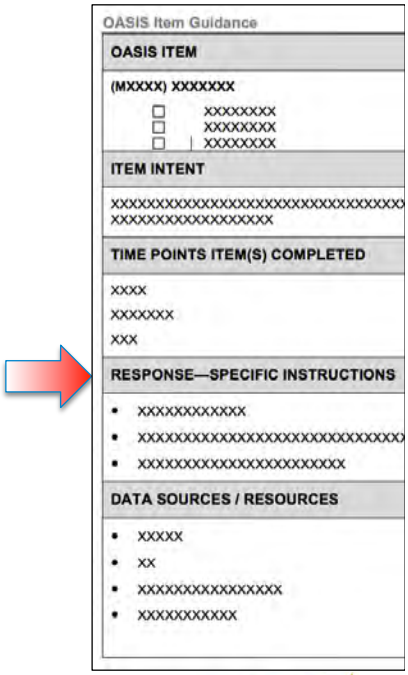
Revised the "Not Applicable" responses for all rows except “a”.

M2250 Ch. 3 Guidance – What's changed?

Response-Specific Instructions

— Clarified that "If "NA" criteria does not apply, select "No" if orders for interventions have been requested but not authorized by the end of the Comprehensive Assessment time period, unless otherwise indicated in rows d & g."

— Criteria for selecting "NA" modified to reflect existing Q&As



M2250 Ch. 3 Guidance – What's changed?

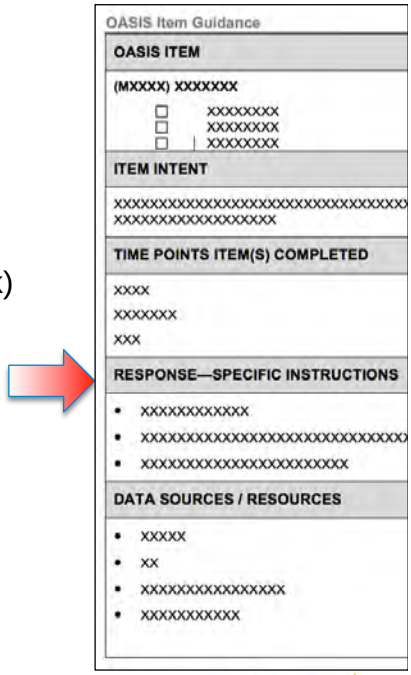
Response-Specific Instructions

— For rows c-f, clarification from existing Q&A added

  — If more than one assessment (fall risk, depression screening, pain, pressure ulcer risk) completed, all must be negative in order to select "NA"

— Row d, instruction regarding physician notification of positive depression screening added

  — If the physician-ordered Plan of Care contains orders for further evaluation or treatment of depression, AND/OR if the physician has been notified about a positive depression screen, select "Yes."



M2250 Scenario Question

Scenario: After completing Miss Burke's SOC comprehensive assessment the RN called the physician's office and left a message regarding all her assessment findings, including a positive PHQ-2 score of "4". When the physician's nurse called back the next day, no further instructions or interventions were provided regarding the positive depression screening.
How would M2250, Row d be completed?

(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
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.

M2250 Scenario Answer & Rationale

Scenario: After completing Miss Burke's SOC comprehensive assessment the RN called the physician's office and left a message regarding all her assessment findings, including a PHQ-2 score of "4". When the physician's nurse called back the next day, no further instructions or interventions were provided regarding the positive depression screening.
How would M2250, Row d be completed?

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
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	X1	☐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.

Ch. 3, Response-Specific Instructions state "If the physician-ordered Plan of Care contains orders for further evaluation or treatment of depression, AND/OR if the physician has been notified about a positive depression screen, select "Yes."

M2300 Emergent Care

(M2300) Emergent Care: At the time of or at any time since the previous OASIS assessment has the patient utilized a hospital emergency department (includes holding/observation status)?

- ☐ 0 - No **[*Go to M2400*]**
- ☐ 1 - Yes, used hospital emergency department WITHOUT hospital admission
- ☐ 2 - Yes, used hospital emergency department WITH hospital admission
- ☐ UK - Unknown **[*Go to M2400*]**

OASIS-C1

Wording in item stem revised to clarify that reporting period includes the time of the assessment.
Added the word "status" to "holding/ observation" to bring into alignment with current instructions in OASIS-C1 Guidance Manual.

M2310 Reason for Emergent Care

(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

OASIS-C1

To bring into alignment with current instructions in OASIS-C1 Guidance Manual:
Wording in item stem changed to "seek and/or receive" and
Response 1 revised to include "adverse drug reactions".
Abbreviations eliminated for clarity ("e.g." replaced with "for example") in Responses 3 and 5.

M2400 Intervention Synopsis

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

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

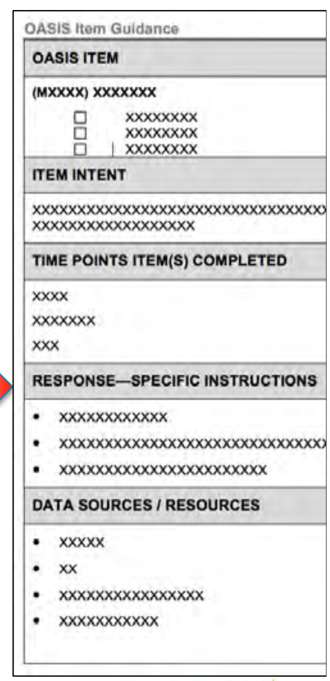
Wording in item stem revised to clarify that reporting period includes the time of the assessment.
Not Applicable responses modified to add detail, improve clarity, and be consistent with responses in M2250 and instructions in OASIS-C1 Guidance Manual.
Removed the line between NA and the text boxes to improve clarity

OASIS-C1

M2400 Ch. 3 Guidance – What's changed?

Response-Specific Instructions

- Clarified "Select "No" if the interventions are not on the Plan of Care OR if the interventions are on the Plan of Care but the interventions were not implemented by the time the Discharge or Transfer assessment was completed, unless "NA" applies."
- Clarified time frame "at the time of or at any time since the previous OASIS assessment".
- Clarifies if more than one standardized, validated assessment (fall risk, depression screening, pain, pressure ulcer risk) was completed at the time of or at any time since the previous OASIS assessment, all must be negative in order to select "NA".



M2410 To which Inpatient Facility has the patient been admitted?

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

- ☐ 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 ***[Omit "NA" option on TRN]***

OASIS-C1

New skip directions in Response 3 due to deletion of M2440, Nursing Home Admission Reason.

M2430 – Reason for Hospitalization

(M2430) Reason for Hospitalization: For what reason(s) did the patient require 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

OASIS-C1

Added "adverse drug reactions" to Response 1 for consistency with M2310.
Eliminated "e.g." abbreviation and replaced with "for example" in Responses 3 and 5.

Deleted Items

- M1012 - Inpatient Procedures
- M1310 - Pressure Ulcer Length
- M1312 - Pressure Ulcer Width
- M1314 - Pressure Ulcer Depth
- M2440 - Nursing Home Admission Reason

OASIS-C1 data collection resources

Begin using 01/1/2015

- OASIS-C1/ICD-9 data set
- OASIS-C1/ICD-9 Guidance Manual (06/14)
- CMS OASIS Q&As (06/14)
- CMS OASIS Quarterly Q&As (07/14 & forward)
- WOCN Guidance on OASIS-C1 Integumentary Items
- CMS OASIS Web Modules (Updating to -C1 to begin after 01/01/15)

OASIS-C data collection resources

From now until 12/31/2014

- OASIS-C data set
- OASIS-C Guidance Manual
- CMS OASIS Q&As (12/12)
- CMS OASIS Quarterly Q&As (01/13-10/14)
- WOCN Guidance on OASIS-C Integumentary Items
- CMS OASIS Web Modules

Accessing OASIS data set and guidance

- OASIS-C1 data set
  - http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/OASIS-C1.html
- OASIS-C1 Guidance Manual
  - http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/OASIS-C1.html
- CMS Online Training Modules
  - http://surveyortraining.cms.hhs.gov/pubs/CourseMenu.aspx?cid=0CMSOASISCWBT

Accessing OASIS data set and guidance

- CMS OASIS Q&As, Categories 1, 2, 3, 4
  - https://www.qtso.com/hhatrain.html
- CMS OASIS Quarterly Q&As
  - https://www.qtso.com/hhatrain.html
  - www.oasisanswers.com
- WOCN Guidance on OASIS-C1 Integumentary Items
  - www.wocn.org

Data submission

- The OASIS-C data set is valid until 12/31/2014.
- However, the state submission system will shut down on 12/26/2014 at 6 p.m. ET in order to transition data from the state system to Assessment Submission and Processing system (ASAP).
- Data submission will begin again, through ASAP on 01/01/15.
- Contact your state's OASIS Automation Coordinator with questions.
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/downloads/OASISautomationcoordinators.pdf

Q&As related to C1 items/guidance

CMS OASIS Q&As – July 2014 – Question 1

Question: When should we begin to use the OASIS-C1/ICD-9 data set?

Answer: The M0090 date for all assessments (SOC, ROC, Recertification, Other Follow-up, Transfer, Death at Home and Discharge) determines which version of OASIS must be completed:

If the M0090, Date Assessment Completed is 12/31/14 or before, use the OASIS-C data set.

If the M0090, Date Assessment Completed is 01/01/15 or after, use the OASIS-C1/ ICD-9 data set.

Note: If an assessment is completed on or before 12/31/14 utilizing the OASIS-C data set and the assessing clinician chooses to reassess one or more OASIS items on or after 01/01/15 during the allowed timeframe for data collection (for example: within 5 days after the SOC, within 2 days after the ROC or DC), this would change the M0090 date and the OASIS-C1/ICD-9 data set must be completed instead of the OASIS-C.

Q&As related to C1 items/guidance

CMS OASIS Q&As – July 2014 – Question 3

M1046

Question: Chapter 3 guidance states “You may select Response 2 if a current patient was given a flu vaccine by your agency during a previous roster billing situation during this year’s flu season”. Is this still true, now that the Response 2 language in the OASIS-C1 item M1046 has been changed to specifically state that your agency gave the vaccine during a prior episode of care (SOC/ROC to Transfer/Discharge)?

Answer: The M1046 Response 2 – “Yes; received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge)” should be used if prior to the individual becoming a patient of the agency, the agency gave the individual the vaccine for the current flu season, as in a roster billing situation during a community flu clinic event, etc.

Q&As related to C1 items/guidance

CMS OASIS Q&As – July 2014 – Question 5

M1309

Question: For M1309, if the patient had Stage IV pressure ulcer that became infected during the episode, at DC would the new infection be considered a “worsening” of the pressure ulcer?

Answer: No, the specific and only definition of "worsening" that should be applied to M1309 is that the pressure ulcer has increased in numerical stage, for instance worsened or progressed from a Stage 3 pressure ulcer to a Stage 4 pressure ulcer. "Worsening", as defined by M1309, does not take into consideration other aspects of the pressure ulcer, like changes in healing status due to a new infection, or increased pain intensity at DC, compared with SOC.

Q&As related to C1 items/guidance

CMS OASIS Q&As – July 2014 – Question 9

M2250d

Question: Please provide further clarification regarding when I can select “Yes” indicating the physician was notified of a positive depression screening for M2250, Plan of Care Synopsis, Row d and M2400, Intervention Synopsis, Row c. May I select “Yes” if I simply leave a voice mail for a physician regarding a positive depression screening or must I receive an acknowledgement of the message?

Answer: When completing M2250d, the assessing clinician may answer "Yes" in cases where the physician was notified of the positive depression screening by the end of the allowed assessment time period. Communication to the physician made by telephone, voicemail, electronic means, fax, or any other means that appropriately conveys the message of patient status is sufficient. There is no requirement that you receive acknowledgement of your message in order to select “Yes”.

M2400c does not offer the option of notifying the physician of a positive depression screening. When scoring M2400c, “No" must be reported if no orders for depression are received or no referral for other treatment made, unless the patient meets the criteria listed to mark “NA”.

Q&As related to C1 items/guidance

CMS OASIS Q&As – July 2014 – Question 10

M2250d

Question 10: For M2250d, except for situations of physician notification of a positive depression screening, do I have to obtain a physician's order for an intervention in order to answer "Yes"?

Answer 10: Yes, other than for situations of physician notification regarding a positive depression screen, a physician's order for the depression intervention is required.

Q&As related to C1 items/guidance

M2002

Question: Related to M2002, the new OASIS C1/ICD-9 Guidance Manual states: "If a medication related problem is identified and resolved by the agency staff ***without physician involvement*** by the time the assessment is completed, the problem does not need to be reported as an existing clinically significant problem."

Is the addition of the phrase "without physician involvement" intended to change guidance which currently states that if the problem is identified and resolved by the time the assessment is completed, the problem does not need to be reported. In other words, does physician involvement require that the problem be reported in M2002?

Answer: No, the inclusion of the phrase "without physician involvement" is provided as an example, and is not a change in guidance. You are not required to report a clinically significant medication issue that was resolved (with or without physician involvement) before the assessment was completed. An example would be family delivering medications that were not in the home at the time of the initial visit.

Note that by not reporting it, your agency may miss the positive impact to your process measure adherence rate.

(mailbox July 2014)

To submit questions unanswered by published guidance:

- Contact your state OASIS Education Coordinator (OEC)
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/downloads/OASISeducationalcoordinators.pdf
- Send to CMS OASIS Q&A Mailbox
  - cmsoasisquestions@oasisanswers.com

This webinar is being recorded and an archived file will be available on or around Oct 1, 2014. See link under “Related Links” at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/Training.html

This webinar content was finalized in August 2014 and is based on the **Draft OASIS-C1/ICD-9 Data Set** and **Draft OASIS Guidance Manual – Chapter 3**. Users should be aware that information contained in this presentation and associated handout materials are time-limited, and may be superseded by guidance published by CMS at a later date. It is each provider's responsibility to stay current with the latest CMS guidance as it becomes available.

Thank you for your commitment to OASIS Accuracy