

# OASIS-E Transfer

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## OUTCOME ASSESSMENT INFORMATION SET VERSION E (OASIS-E)

### Transfer to an Inpatient facility (TRN)

#### Section A Administrative Information

M0080. Discipline of Person Completing Assessment	
Enter Code <input type="text"/>	<ol style="list-style-type: none"><li>1. RN</li><li>2. PT</li><li>3. SLP/ST</li><li>4. OT</li></ol>

  

M0090. Date Assessment Completed	
<input type="text"/> <input type="text"/>	<input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Month	Day Year

<b>M0100. This Assessment is Currently Being Completed for the Following Reason</b>	
Enter Code <input type="checkbox"/>	<b>Start/Resumption of Care</b> 1. <b>Start of care</b> – further visits planned 3. <b>Resumption of care</b> (after inpatient stay)  <b>Follow-Up</b> 4. <b>Recertification (follow-up) reassessment</b> 5. <b>Other follow-up</b>  <b>Transfer to an Inpatient Facility</b> 6. <b>Transferred to an inpatient facility</b> – patient not discharged from agency 7. <b>Transferred to an inpatient facility</b> – patient discharged from agency  <b>Discharge from Agency – Not to an Inpatient Facility</b> 8. <b>Death at home</b> 9. <b>Discharge from agency</b>

<b>M0906. Discharge/Transfer/Death Date</b>	
Enter the date of the discharge, transfer, or death (at home) of the patient.	
<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Month                  Day                  Year

<b>M2301. Emergent Care</b>	
At the time of, or at any time since the most recent SOC/ROC assessment, has the patient utilized a hospital emergency department (includes holding/observation status)?	
Enter Code <input type="checkbox"/>	0. <b>No</b> → <i>Skip to M2410, Inpatient Facility</i> 1. <b>Yes, used hospital emergency department WITHOUT hospital admission</b> 2. <b>Yes, used hospital emergency department WITH hospital admission</b> UK <b>Unknown</b> → <i>Skip to M2410, Inpatient Facility</i>

<b>M2310. Reason for Emergent Care</b>	
For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)?	
↓ Check all that apply	
<input type="checkbox"/>	1. <b>Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis</b>
<input type="checkbox"/>	10. <b>Hypo/Hyperglycemia, diabetes out of control</b>
<input type="checkbox"/>	19. <b>Other than above reasons</b>
<input type="checkbox"/>	UK <b>Reason unknown</b>

<b>M2410. To which Inpatient Facility has the patient been admitted?</b>	
Enter Code <input type="checkbox"/>	1. <b>Hospital</b> 2. <b>Rehabilitation facility</b> 3. <b>Nursing home</b> 4. <b>Hospice</b>

<b>A2120. Provision of Current Reconciled Medication List to Subsequent Provider at Transfer</b>	
At the time of transfer to another provider, did your agency provide the patient's current reconciled medication list to the subsequent provider?	
Enter Code <input type="checkbox"/>	0. <b>No – Current reconciled medication list not provided to the subsequent provider</b> → <i>Skip to J1800, Any Falls Since SOC/ROC</i> 1. <b>Yes – Current reconciled medication list provided to the subsequent provider</b> → Continue to A2122, Route of Current Reconciled Medication List Transmission to Subsequent Provider 2. <b>NA – The agency was not made aware of this transfer timely</b> → <i>Skip to J1800, Any Falls Since SOC/ROC</i>

<b>A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider</b>	
Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.	
Route of Transmission	↓ Check all that apply ↓
A. <b>Electronic Health Record</b>	<input type="checkbox"/>
B. <b>Health Information Exchange</b>	<input type="checkbox"/>
C. <b>Verbal</b> (e.g., in-person, telephone, video conferencing)	<input type="checkbox"/>
D. <b>Paper-based</b> (e.g., fax, copies, printouts)	<input type="checkbox"/>
E. <b>Other Methods</b> (e.g., texting, email, CDs)	<input type="checkbox"/>

<b>Section J</b>	<b>Health Conditions</b>
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<b>J1800. Any Falls Since SOC/ROC, whichever is more recent</b>	
<b>Enter Code</b> <input type="checkbox"/>	Has the patient had any falls since SOC/ROC, whichever is more recent? 0. <b>No</b> → Skip to M2005, Medication Intervention 1. <b>Yes</b> → Continue to J1900, Number of Falls Since SOC/ROC

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

<b>Section N</b>	<b>Medications</b>
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<b>M2005. Medication Intervention</b>	
Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?	
<b>Enter Code</b> <input type="checkbox"/>	0. <b>No</b> 1. <b>Yes</b> 9. <b>NA</b> – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications

<b>Section O</b>	<b>Special Treatment, Procedures, and Programs</b>
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<b>M1041. Influenza Vaccine Data Collection Period</b>	
Does this episode of care (SOC/ROC to Transfer/Discharge) include any dates on or between October 1 and March 31?	
<b>Enter Code</b> <input type="checkbox"/>	0. <b>No</b> → Skip to M2401, Intervention Synopsis 1. <b>Yes</b> → Continue to M1046, Influenza Vaccine Received

**M1046. Influenza Vaccine Received**

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

Enter  
Code

1. **Yes;** received from your agency during this episode of care (SOC/ROC to Transfer/Discharge)
2. **Yes;** received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge)
3. **Yes;** received from another health care provider (for example, physician, pharmacist)
4. **No;** patient offered and declined
5. **No;** patient assessed and determined to have medical contraindication(s)
6. **No;** not indicated – patient does not meet age/condition guidelines for influenza vaccine
7. **No;** inability to obtain vaccine due to declared shortage
8. **No;** patient did not receive the vaccine due to reasons other than those listed in responses 4-7.

**Section Q****Participation in Assessment and Goal Setting****M2401. Intervention Synopsis**

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

Plan/Intervention	No	Yes	Not Applicable	
↓Check only one box in each row↓				
b. Falls prevention interventions	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA	Every standardized, validated multi-factor fall risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no risk for falls.
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA	Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the most recent SOC/ROC assessment indicates the patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.
d. Intervention(s) to monitor and mitigate pain	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA	Every standardized, validated pain assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no pain.
e. Intervention(s) to prevent pressure ulcers	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA	Every standardized, validated pressure ulcer risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient is not at risk of developing pressure ulcers.
f. Pressure ulcer treatment based on principles of moist wound healing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.