Home Health Patient Tracking Sheet

(M0010) CMS Certification Number: __ __ __ __ __ __

(M0014) Branch State: __ __

(M0016) Branch ID Number: __ __ __ __ __ __ __ __ __ __

(M0018) National Provider Identifier (NPI) for the attending physician who has signed the plan of care**:**

__ __ __ __ __ __ __ __ __ __ ☐ UK – Unknown or Not Available

(M0020) Patient ID Number: __

(M0030) Start of Care Date: __ __ /__ __ /__ __ __ __
month / day / year

(M0032) Resumption of Care Date: __ __ /__ __ /__ __ __ __ ☐ NA - Not Applicable
month / day / year

(M0040) Patient Name:

__ __
(First) (MI) (Last) (Suffix)

(M0050) Patient State of Residence: __ __

(M0060) Patient Zip Code: __ __ __ __ __ __ __ __ __ __

(M0063) Medicare Number: __ __ __ __ __ __ __ __ __ __ __ __ **☐ NA – No Medicare**
(including suffix)

(M0064) Social Security Number: __ __ __ - __ __ - __ __ __ __ ☐ UK – Unknown or Not Available

(M0065) Medicaid Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ ☐ NA – No Medicaid

(M0066) Birth Date: __ __ /__ __ /__ __ __ __
month / day / year

(M0069) Gender:

- ☐ 1 - Male
- ☐ 2 - Female

(M0140) Race/Ethnicity: (Mark all that apply.)

- ☐ 1 - American Indian or Alaska Native
- ☐ 2 - Asian
- ☐ 3 - Black or African-American
- ☐ 4 - Hispanic or Latino
- ☐ 5 - Native Hawaiian or Pacific Islander
- ☐ 6 - White

(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 (e.g., Title III, V, or XX)
- ☐ 7 - Other government (e.g., TriCare, VA, etc.)
- ☐ 8 - Private insurance
- ☐ 9 - Private HMO/managed care
- ☐ 10 - Self-pay
- ☐ 11 - Other (specify) _____
- ☐ UK - Unknown

Outcome and Assessment Information Set (OASIS-C draft)

Items to be Used at Specific Time Points

Start of Care ----------	M0010-M0030, M0040- M0150, M1000-M1038, M1100-M1244, M1300-M1304, M1308-M1326, M1330-M1360, M1400, M1410, M1600-M1734, M1740-M1940, M2000, M2002, M2010, M2020-M2200
Start of care—further visits planned	
Resumption of Care ----------	M0032, M0080-M0110, M1000-M1038, M1100-M1244, M1300-M1304, M1308-M1326, M1330-M1360, M1400, M1410, M1600-M1734, M1740-M1940, M2000, M2002, M2010, M2020-M2200
Resumption of care (after inpatient stay)	
Follow-Up ----------	M0080-M0100, M0110, M1020-M1030, M1200, M1240, M1308, M1310, M1324, M1330-M1350, M1400, M1610, M1620, M1630, M1810-M1860, M2030, M2200
Recertification (follow-up) assessment	
Other follow-up assessment	
Transfer to an Inpatient Facility ----------	M0080-M0100, M1040-M1055, M1246, M1306, M1328, M1365, M1500, M1510, M1736, M1930, M1945, M2004, M2015, M2300-M2400, M2420-M2440, M0903, M0906
Transferred to an inpatient facility—patient not discharged from an agency	
Transferred to an inpatient facility—patient discharged from agency	
Discharge from Agency — Not to an Inpatient Facility	
Death at home ----------	M0080-M0100, M0906
Discharge from agency ----------	M0080-M0100, M1032-M1036, M1040-M1100, M1230, M1240, M1246, M1306-M1324, M1328-M1350, M1365-M1620, M1700-M1720, M1732, M1736-M1870, M1900, M1910, M1930, M1945, M2004, M2015-M2030, M2100-M2120, M2300-M2410, M2430, M2440, M0903, M0906

CLINICAL RECORD ITEMS

(M0080) Discipline of Person Completing Assessment:

☐ 1-RN ☐ 2-PT ☐ 3-SLP/ST ☐ 4-OT

(M0090) Date Assessment Completed: __ __ /__ __ /__ __ __ __
month / day / year

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

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 M2300*** **]**
☐ 7 – Transferred to an inpatient facility—patient discharged from agency **[** ***Go to M2300*** **]**

Discharge from Agency — Not to an Inpatient Facility

☐ 8 – Death at home **[** ***Go to M0906*** **]**
☐ 9 – Discharge from agency **[** ***Go to M1032*** **]**

(M0102) Date of Referral: Indicate the date the physician made the referral for this home health Start of Care (Resumption of Care).
__ __ /__ __ /__ __ __ __
month / day / year

(M0104) Date of Physician-ordered Start of Care (Resumption of Care): If the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified.

__ __ /__ __ /__ __ __ __
month / day / year

☐ NA – No specific SOC date ordered by physician.

(M0110) Episode Timing: Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode or a "later" episode in the patient's current sequence of adjacent Medicare home health payment episodes?

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

(M0903) Date of Last (Most Recent) Home Visit:

__ __ /__ __ / __ __ __ __
month / day / year

(M0906) Discharge/Transfer/Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient.

__ __ /__ __ / __ __ __ __
month / day / year

DEMOGRAPHICS AND PATIENT HISTORY

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

☐ 1 - Hospital
☐ 2 - Rehabilitation facility
☐ 3 - Skilled nursing facility
☐ 4 - Other nursing home
☐ 5 - Other (specify) _____
☐ NA - Patient was not discharged from an inpatient facility **[*Go to M1014*]**

(M1005) Inpatient Discharge Date (most recent):

__ __ /__ __ / __ __ __ __
month / day / year

☐ UK - Unknown

(M1010) List each **Inpatient Diagnosis** and ICD-9-CM code at the level of highest specificity for only those conditions treated during an inpatient stay within the last 14 days (no E-codes, or V-codes):

	Inpatient Facility Diagnosis	ICD-9-CM Code
a.	_____	__ __ __ __ __ __ __
b.	_____	__ __ __ __ __ __ __
c.	_____	__ __ __ __ __ __ __
d.	_____	__ __ __ __ __ __ __
e.	_____	__ __ __ __ __ __ __
f.	_____	__ __ __ __ __ __ __

(M1012) List each Inpatient Procedure and the associated ICD-9-CM procedure code

	Inpatient Procedure	Procedure Code
a.	_____	__ __ __ __ __ __ __
b.	_____	__ __ __ __ __ __ __
c.	_____	__ __ __ __ __ __ __
d.	_____	__ __ __ __ __ __ __

(M1014) Medical or Treatment Regimen Change Within Past 14 Days: Has this patient experienced a change in medical or treatment regimen (e.g., medication, treatment, or service change due to new or additional diagnosis, etc.) within the last 14 days?

☐ 0 - No **[** ***Go to M1018 at SOC/ROC; Go to M1032at DC*** **]**
☐ 1 - Yes

(M1016) List the patient's **Medical Diagnoses** and ICD-9-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen (no surgical, E-codes, or V-codes):

	Changed Medical Regimen Diagnosis	ICD-9-CM Code
a.	_____	__ __ __ __ __ __ __
b.	_____	__ __ __ __ __ __ __
c.	_____	__ __ __ __ __ __ __
d.	_____	__ __ __ __ __ __ __
e.	_____	__ __ __ __ __ __ __
f.	_____	__ __ __ __ __ __ __

(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 which 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

(M1020/1022/1024) Diagnoses, Severity Index, and Payment Diagnoses: List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-CM code at the level of highest specificity (no surgical/procedure codes) (Column 2). Rate each condition (Column 2) using the severity index. (Choose one value that represents the most severe rating appropriate for each diagnosis.) V codes (for M1020 or M1022) or E codes (for M1022 only) may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V code is reported in place of a case mix diagnosis, then optional item M1024 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare PPS case mix group.

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

Column 1: Enter the description of the diagnosis.

Column 2: Enter the ICD-9-CM code for the diagnosis described in Column 1;
Rate the severity of the condition listed in Column 1 using the following scale:
0 - Asymptomatic, no treatment needed at this time
1 - Symptoms well controlled with current therapy
2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring
3 - Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring
4 - Symptoms poorly controlled; history of re-hospitalizations

Column 3: (OPTIONAL) If a V code reported in any row in Column 2 is reported in place of a case mix diagnosis, list the appropriate case mix diagnosis (the description and the ICD-9-CM code) in the same row in Column 3. Otherwise, leave Column 3 blank in that row.

Column 4: (OPTIONAL) If a V code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-CM coding guidelines, enter the diagnosis descriptions and the ICD-9-CM codes in the same row in Columns 3 and 4. For example, if the case mix diagnosis is a manifestation code, record the diagnosis description and ICD-9-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(M1020) Primary Diagnosis & (M1022) Other Diagnoses		**(M1024) Case Mix Diagnoses (OPTIONAL)**	
Column 1	Column 2	Column 3	Column 4
	ICD-9-CM and severity rating for each condition	Complete **only if** a V code in Column 2 is reported in place of a case mix diagnosis.	Complete **only if** the V code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
Description	ICD-9-CM / Severity Rating	Description/ ICD-9-CM	Description/ ICD-9-CM
(M1020) Primary Diagnosis a. _____	**(V codes are allowed)** a. (__ __ __ __ __ __ __) ☐0 ☐1 ☐2 ☐3 ☐4	**(V or E codes NOT allowed)** a._____ (__ __ __ __ __ __ __)	**(V or E codes NOT allowed)** a._____ (__ __ __ __ __ __ __)
(M1022) Other Diagnoses b. _____	**(V or E codes are allowed)** b. (__ __ __ __ __ __ __) ☐0 ☐1 ☐2 ☐3 ☐4	**(V or E codes NOT allowed)** b._____ (__ __ __ __ __ __ __)	**(V or E codes NOT allowed)** b._____ (__ __ __ __ __ __ __)
c. _____	c. (__ __ __ __ __ __ __) ☐0 ☐1 ☐2 ☐3 ☐4	c._____ (__ __ __ __ __ __ __)	c._____ (__ __ __ __ __ __ __)
d. _____	d. (__ __ __ __ __ __ __) ☐0 ☐1 ☐2 ☐3 ☐4	d._____ (__ __ __ __ __ __ __)	d._____ (__ __ __ __ __ __ __)
e. _____	e. (__ __ __ __ __ __ __) ☐0 ☐1 ☐2 ☐3 ☐4	e._____ (__ __ __ __ __ __ __)	e._____ (__ __ __ __ __ __ __)
f. _____	f. (__ __ __ __ __ __ __) ☐0 ☐1 ☐2 ☐3 ☐4	f._____ (__ __ __ __ __ __ __)	f._____ (__ __ __ __ __ __ __)

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

- ☐ 1 - Intravenous or infusion therapy (excludes TPN)
- ☐ 2 - Parenteral nutrition (TPN or lipids)
- ☐ 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)
- ☐ 4 - None of the above

(M1032) **Frailty Indicators:** Which of the following signs or symptoms characterize this patient as at risk for major decline or hospitalization? **(Mark all that apply.)**

- ☐ 1 - Unstable vital signs
- ☐ 2 - Debilitating pain
- ☐ 3 - Recent decline in mental status
- ☐ 4 - Recent functional decline
- ☐ 5 - Multiple hospitalizations (>1) in the past 12 months
- ☐ 6 - History of falls (2 or more falls - or any fall with an injury - in the past year)
- ☐ 7 - Other
- ☐ 8 - None of the above

(M1034) **Stability Prognosis:** Which description best fits the patient's overall status? **(Check one)**

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

(M1036) **Risk Factors** characterizing this patient: **(Mark all that apply.)**

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

(M1038) **Guidelines for Physician Notification:** Does the physician-ordered plan of care establish parameters (limits) for physician notification of changes in vital signs or other clinical findings?

- ☐ 0 - No
- ☐ 1 - Yes

(M1040) **Influenza Vaccine:** Did the patient receive the influenza vaccine from your agency for this year's influenza season (October 1 through March 31) during this episode of care?

- ☐ 0 - No
- ☐ 1 - Yes **[** *Go to M1050* **]**
- ☐ NA - Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season. **[** *Go to M1050* **]**

(M1045) Reason Influenza Vaccine not received: If the patient did not receive the influenza vaccine from your agency during this episode of care, state reason:

- ☐ 1 - Received from another health care provider (e.g., physician)
- ☐ 2 - Received from your agency previously during this year's flu season
- ☐ 3 - Offered and declined
- ☐ 4 - Assessed and determined to have medical contraindication(s)
- ☐ 5 - Not indicated; patient does not meet age/condition guidelines for influenza vaccine
- ☐ 6 - Inability to obtain vaccine due to declared shortage
- ☐ 7 - None of the above

(M1050) Pneumococcal Vaccine: Did the patient receive pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge)?

- ☐ 0 - No
- ☐ 1 - Yes **[** *Go to M1246 at TRN*; *Go to M1100 at DC* **]**

(M1055) Reason PPV not received: If patient did not receive the pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge), state reason:

- ☐ 1 - Patient has received PPV in the past
- ☐ 2 - Offered and declined
- ☐ 3 - Assessed and determined to have medical contraindication(s)
- ☐ 4 - Not indicated; patient does not meet age/condition guidelines for PPV
- ☐ 5 - None of the above

LIVING ARRANGEMENTS

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

Living Arrangement	Availability of Assistance				
	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 (e.g., assisted living)	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15

SENSORY STATUS

(M1200) Vision with corrective lenses if the patient usually wears them:

- ☐ 0 - Normal vision: sees adequately in most situations; can see medication labels, newsprint.
- ☐ 1 - Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length.
- ☐ 2 - Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive.

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

- ☐ 0 - Adequate: hears normal conversation without difficulty.
- ☐ 1 - Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly.
- ☐ 2 - Severely Impaired: absence of useful hearing.
- ☐ UK - Unable to assess hearing.

(M1220) Understanding of Verbal Content in patient's own language (with hearing aid or device if used):

- ☐ 0 - Understands: clear comprehension without cues or repetitions.
- ☐ 1 - Usually/Sometimes Understands: Comprehends only basic conversations or simple, direct phrases or requires cues to understand.
- ☐ 2 - Rarely/Never Understands
- ☐ UK - Unable to assess understanding.

(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 (e.g., speech is nonsensical or unintelligible).
- ☐ 5 - Patient nonresponsive or unable to speak.

(M1240) Frequency of Pain interfering with patient's activity or movement:

- ☐ 0 - Patient has no pain
- ☐ 1 - Patient has pain that does not interfere with activity or movement
- ☐ 2 - Less often than daily
- ☐ 3 - Daily, but not constantly
- ☐ 4 - All of the time

(M1242) Has this patient had a formal **Pain Assessment** using a standardized pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?

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

(M1244) Planned Pain Intervention: Does the current physician-ordered plan of care include intervention(s) to monitor and mitigate pain?

- ☐ 0 - No
- ☐ 1 - Yes

(M1246) Pain Intervention: Since the previous OASIS assessment, have pain management steps in the physician-ordered plan of care been implemented to monitor and mitigate pain?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - No pain intervention included in physician-ordered plan of care

INTEGUMENTARY STATUS

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

- ☐ 0 - No assessment conducted **[** *Go to M1308* **]**
- ☐ 1 - Yes, using a standardized tool (e.g., Braden, Norton, other)
- ☐ 2 - Yes, based on an evaluation of clinical factors (e.g., mobility, incontinence, nutrition, etc.)

(M1302) Does this patient have a **Risk of Developing Pressure Ulcers**?

- ☐ 0 - No **[** *Go to M1308* **]**
- ☐ 1 - Yes

(M1304) Planned Pressure Ulcer Prevention: Does the current physician-ordered plan of care include intervention(s) to prevent pressure ulcers?

- ☐ 0 - No
- ☐ 1 - Yes

(M1306) Pressure Ulcer Prevention: Since the previous OASIS assessment, were intervention(s) on the current physician-ordered plan of care to prevent pressure ulcers implemented?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - No pressure ulcer prevention in physician-ordered plan of care

(M1308) Does this patient have at least one unhealed (non-epithelialized) **Pressure Ulcer** at Stage II or higher or designated as "not stageable"?

☐ 0 - No **[** *Go to M1322 at SOC/ROC/DC; Go to M1324 at FU* **]**
☐ 1 - Yes

(M1310) **Current Number of Unhealed** (non-epithelialized) **Pressure Ulcers at Each Stage:** (Enter "0" if none; enter "4" if "4 or more"; enter "UK" for rows d.1 – d.3 if "Unknown")

Stage description – unhealed pressure ulcers	Number Present	Number of these that were present on admission
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 not stageable due to non-removable dressing or device	☐	☐
d.2 Unstageable: Known or likely but not stageable due to coverage of wound bed by slough and/or eschar.	☐	☐
d.3 Unstageable: Suspected deep tissue injury in evolution.	☐	☐

Directions for M1312 and M1314: If the patient has one or more unhealed (non-epithelialized) Stage III or IV pressure ulcers, identify the **pressure ulcer with the longest dimension** and record in centimeters:

(M1312) **Pressure Ulcer Length:** Longest length in any direction | ___ | ___ | . | ___ | (cm)

(M1314) **Pressure Ulcer Width:** Width of the same pressure ulcer, greatest width measured at right angles to length | ___ | ___ | . | ___ | (cm)

(M1320) **Status of Most Problematic (Observable) Pressure Ulcer:**

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

(M1322) **Current Number of Stage I Pressure Ulcers:** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

(M1324) **Stage of Most Problematic (Observable) Pressure Ulcer:**

☐ 1 - Stage I **[***Go to M1330 at SOC/ROC/FU***]**
☐ 2 - Stage II
☐ 3 - Stage III
☐ 4 - Stage IV
☐ NA - No observable pressure ulcer **[***Go to M1330 at SOC/ROC/FU***]**

(M1326) Pressure Ulcer Intervention: Are moisture retentive dressings specified on the physician-ordered plan of care?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ 2 - Order requested from physician
- ☐ 3 - Moisture retentive dressings not indicated for this patient.

(M1328) Pressure Ulcer Intervention: Since the previous OASIS assessment, were moisture retentive dressings used?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ 2 - Moisture retentive dressings not indicated for this patient
- ☐ NA - Patient had no Stage II or higher unhealed pressure ulcers on previous OASIS assessment.

(M1330) Does this patient have a **Stasis Ulcer**?

- ☐ 0 - No **[** *Go to M1340* **]**
- ☐ 1 - Yes, patient has one or more (observable) stasis ulcers
- ☐ 2 - Stasis ulcer known or likely but not observable due to non-removable dressing **[** *Go to M1340* **]**

(M1332) Current Number of (Observable) Stasis Ulcer(s):

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

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

- ☐ 0 - Re-epithelialized or healed
- ☐ 1 - Fully granulating
- ☐ 2 - Early/partial granulation
- ☐ 3 - Not healing

(M1340) Does this patient have a **Surgical Wound?**

- ☐ 0 - No **[** *Go to M1350* **]**
- ☐ 1 - Yes, patient has at least one (observable) surgical wound
- ☐ 2 - Surgical wound known or likely but not observable due to non-removable dressing **[** *Go to M1350* **]**

(M1342) Status of Most Problematic (Observable) Surgical Wound:

- ☐ 0 - Re-epithelialized or healed
- ☐ 1 - Fully granulating
- ☐ 2 - Early/partial granulation
- ☐ 3 - Not healing

(M1350) Does this patient have a **Skin Lesion** or **Open Wound,** excluding bowel ostomy, other than those described above that is receiving assessment and/or intervention by the home health agency?

- ☐ 0 - No
- ☐ 1 - Yes

(M1360) Diabetic Foot Care Plan: Does the physician-ordered plan of care include regular monitoring for the presence of skin lesions on the lower extremities and patient education on proper foot care?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - Bilateral amputee OR Patient does not have diagnosis of diabetes

(M1365) Diabetic Foot Care Plan Follow-up: Since the previous OASIS assessment, was the physician-ordered plan of care regarding patient education and regular monitoring for the presence of lesions on the lower extremities followed?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - Bilateral amputee OR Patient does not have diagnosis of diabetes OR Diabetic foot care not included in physician-ordered plan of care

RESPIRATORY STATUS

(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 (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
- ☐ 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
- ☐ 4 - At rest (during day or night)

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

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

CARDIAC STATUS

(M1500) **Symptoms of Heart Failure:** Since the previous OASIS assessment, did the patient exhibit symptoms of heart failure indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at any point?

- ☐ 0 - No **[** *Go to M1736 at TRN; Go to M1600 at DC* **]**
- ☐ 1 - Yes
- ☐ 2 - Not assessed **[***Go to M1736 at TRN; Go to M1600 at DC* **]**
- ☐ NA - Patient does not have diagnosis of heart failure

(M1510) **Heart Failure Follow-up:** Since the previous OASIS assessment, what action(s) has (have) been taken to respond to each instance of heart failure? **(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 (e.g., call 911 or go to emergency room),
- ☐ 3 - Implement physician-ordered patient-specific established parameters for treatment,
- ☐ 4 - Patient education about symptoms and management,
- ☐ 5 - Obtained change in care plan orders (e.g., increased monitoring by agency, change in visit frequency, telehealth, etc.)
- ☐ NA - Patient does not have diagnosis of heart failure

ELIMINATION STATUS

(M1600) Has this patient been treated for a **Urinary Tract Infection** in the past 14 days?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - Patient on prophylactic treatment
- ☐ UK - Unknown

(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 (i.e., external, indwelling, intermittent, suprapubic) **[** *Go to M1620* **]**

(M1615) **When** does **Urinary Incontinence** occur?

- ☐ 0 - Timed-voiding defers incontinence
- ☐ 1 - Occasional stress incontinence
- ☐ 2 - During the night only
- ☐ 3 - During the day only
- ☐ 4 - During the day and night

(M1620) Bowel Incontinence Frequency:

- ☐ 0 - Very rarely or never has bowel incontinence
- ☐ 1 - Less than once weekly
- ☐ 2 - One to three times weekly
- ☐ 3 - Four to six times weekly
- ☐ 4 - On a daily basis
- ☐ 5 - More often than once daily
- ☐ NA - Patient has ostomy for bowel elimination
- ☐ UK - Unknown

(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.

NEURO/EMOTIONAL/BEHAVIORAL STATUS

(M1700) Cognitive Functioning: (Patient's current 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 (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.
- ☐ 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- ☐ 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

(M1710) When Confused (Reported or Observed):

- ☐ 0 - Never
- ☐ 1 - In new or complex situations only
- ☐ 2 - On awakening or at night only
- ☐ 3 - During the day and evening, but not constantly
- ☐ 4 - Constantly
- ☐ NA - Patient nonresponsive

(M1720) When Anxious (Reported or Observed):

- ☐ 0 - None of the time
- ☐ 1 - Less often than daily
- ☐ 2 - Daily, but not constantly
- ☐ 3 - All of the time
- ☐ NA - Patient nonresponsive

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

- ☐ 0 - No
- ☐ 1 - Yes, and the patient exhibits no current symptoms of depression during the last 14 days. **[** ***Go to M1740*** **]**
- ☐ 2 - Yes, and the patient exhibits some symptoms of depression during the last 14 days.

(M1732) Depressive Symptoms Reported or Observed in Patient in past 14 days: (Mark all that apply.)

- ☐ 0 - No symptoms observed or reported
- ☐ 1 - Depressed mood (e.g., feeling sad, tearful)
- ☐ 2 - Sense of failure or self reproach
- ☐ 3 - Hopelessness
- ☐ 4 - Recurrent thoughts of death
- ☐ 5 - Thoughts of suicide
- ☐ 6 - Other signs or symptoms

(M1734) Depression Intervention Plan: Does the current physician-ordered plan of care include intervention(s) for symptoms of depression, such as medication, referral for other treatment, or a monitoring plan for current treatment?

- ☐ 0 - No
- ☐ 1 - Yes, medication(s), referral, and/or monitoring in physician-ordered plan of care
- ☐ NA - Patient does not have symptoms of depression, diagnosis of depression, or current treatment for depression.

(M1736) Depression Intervention Implementation: Since the previous OASIS assessment, were intervention(s) in the physician-ordered plan of care to address depression implemented?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - Patient has no depression intervention on the current physician-ordered plan of care

(M1740) Behaviors Demonstrated <u>at Least Once a Week</u> (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 (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- ☐ 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)
- ☐ 6 - Delusional, hallucinatory, or paranoid behavior
- ☐ 7 - None of the above behaviors demonstrated

(M1745) Frequency of Behavior Problems (Reported or Observed) (e.g., wandering episodes, self abuse, verbal disruption, physical aggression, etc.):

- ☐ 0 - Never
- ☐ 1 - Less than once a month
- ☐ 2 - Once a month
- ☐ 3 - Several times each month
- ☐ 4 - Several times a week
- ☐ 5 - At least daily

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

- ☐ 0 - No
- ☐ 1 - Yes

<u>ADL/IADLs</u>

(M1800) Grooming: Current ability to tend safely to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, 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.

(M1810) Current **Ability to Dress Upper Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

- ☐ 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
- ☐ 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.
- ☐ 2 - Someone must help the patient put on upper body clothing.
- ☐ 3 - Patient depends entirely upon another person to dress the upper body.

(M1820) Current **Ability to Dress Lower Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

- ☐ 0 - Able to obtain, put on, and remove clothing and shoes without assistance.
- ☐ 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
- ☐ 2 - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.
- ☐ 3 - Patient depends entirely upon another person to dress lower body.

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

- ☐ 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 bath 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.

(M1840) **Toilet Transferring:** Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.

- ☐ 0 - Able to get to and from the toilet and transfer independently with or without a device.
- ☐ 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.
- ☐ 2 - Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).
- ☐ 3 - Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
- ☐ 4 - Is totally dependent in toileting.

(M1845) **Toileting Hygiene:** Current ability to maintain safely perineal hygiene, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, include cleaning opening but not managing equipment.

- ☐ 0 - Able to manage toileting hygiene and clothing management without assistance.
- ☐ 1 - Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.
- ☐ 2 - Someone must help the patient to maintain toileting hygiene or adjust clothing.
- ☐ 3 - Patient depends entirely upon another person to maintain toileting hygiene.

(M1850) **Transferring:** Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

- ☐ 0 - Able to independently transfer.
- ☐ 1 - Able to transfer with minimal human assistance or with use of an assistive device.
- ☐ 2 - Unable to transfer self but is able to bear weight and pivot during the transfer process.
- ☐ 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
- ☐ 4 - Bedfast, unable to transfer but is able to turn and position self in bed.
- ☐ 5 - Bedfast, unable to transfer and is unable to turn and position self.

(M1860) Ambulation/Locomotion: 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 climb stairs with or without railings (i.e., needs no human assistance or assistive device).
- ☐ 1 - With the use of a one-handed device **(**e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and climb stairs with or without railings.
- ☐ 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- ☐ 3 - Able to walk only with the supervision or assistance of another person at all times.
- ☐ 4 - Chairfast, unable to ambulate but is able to wheel self independently.
- ☐ 5 - Chairfast, unable to ambulate and is unable to wheel self.
- ☐ 6 - Bedfast, unable to ambulate or be up in a chair.

(M1870) Feeding or Eating: Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

- ☐ 0 - Able to independently feed self.
- ☐ 1 - Able to feed self independently but requires:
  - (a) meal set-up; OR
  - (b) intermittent assistance or supervision from another person; OR
  - (c) a liquid, pureed or ground meat diet.
- ☐ 2 - Unable to feed self and must be assisted or supervised throughout the meal/snack.
- ☐ 3 - Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.
- ☐ 4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
- ☐ 5 - Unable to take in nutrients orally or by tube feeding.

(M1880) Change in Mobility: Is the patient's ability to transfer and/or ambulate safely better, the same, or worse than prior level of functioning (i.e., before the onset of the illness or injury that initiated this episode of care)?

- ☐ 0 – Ability to transfer and/or ambulate is better or the same now than the prior level of functioning.
- ☐ 1 – Ability to transfer and/or ambulate is worse now than the prior level of functioning.
- ☐ UK – Unknown

(M1890) Change in Self-care Ability: Is the patient's ability to perform self-care activities safely (grooming, dressing, and bathing) better, the same, or worse than prior level of functioning (i.e., before the onset of the illness or injury that initiated this episode of care)?

- ☐ 0 – Ability to perform self-care activities is better or the same now than the prior level of functioning.
- ☐ 1 – Ability to perform self-care activities is worse now than the prior level of functioning.
- ☐ UK – Unknown

(M1900) Current Planning and Preparing Light Meals (e.g., 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 (i.e., 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.

(M1910) 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 (i.e., 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.

(M1920) **Change in Ability to Perform Routine Household Tasks:** Is the patient's ability to perform routine household tasks safely (e.g., light meal preparation, laundry, shopping, etc.) better, the same, or worse than prior level of functioning (i.e., before the onset of the illness or injury that initiated this episode of care)?

- ☐ 0 – Ability to perform routine household tasks is better or the same now than the prior level of functioning.
- ☐ 1 – Ability to perform routine household tasks is worse now than the prior level of functioning.
- ☐ UK – Unknown

(M1930) Has this patient had a multi-factor **Fall Risk Assessment** (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)?

- ☐ 0 - No multi-factor falls risk assessment conducted.
- ☐ 1 - Yes, and it does not indicate a risk for falls. **[** *Go to M2000 at SOC/ROC; Go to M2004 at TRN/DC* **]**
- ☐ 2 - Yes, and it indicates a risk for falls.

(M1940) **Falls Risk Intervention:** Does the current physician-ordered plan of care include intervention(s) to mitigate the risk of falls?

- ☐ 0 - No
- ☐ 1 - Yes

(M1945) **Falls Risk Intervention:** Since the previous OASIS assessment, have fall prevention steps in the physician-ordered plan of care been implemented?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - No fall prevention steps included in the physician-ordered plan of care.

MEDICATIONS

(M2000) **Potential Adverse Effects/Reaction:** Does a complete drug regimen review indicate potential clinically significant adverse effects or drug reactions, including ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance?

- ☐ 0 - Not assessed/reviewed **[** *Go to M2010* **]**
- ☐ 1 - No problems found during review **[** *Go to M2010* **]**
- ☐ 2 - Problems found during review

(M2002) **Medication Follow-up:** Was the patient's physician (or other primary care practitioner) contacted within one calendar day to resolve clinically significant medication issues, including reconciliation?

- ☐ 0 - No
- ☐ 1 - Yes

(M2004) **Medication Intervention:** Since the previous OASIS assessment, was the patient's physician (or other primary care practitioner) contacted within one calendar day to resolve clinically significant medication issues, including reconciliation?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - No clinically significant medication issues identified since the previous OASIS assessment

(M2010) **Patient/Caregiver Drug Education:** Has the patient/caregiver received instruction on high-risk medications (such as hypoglycemics and anticoagulants) including monitoring the effectiveness of drug therapy, potential adverse effects, and how and when to report problems that may occur?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - Patient not taking any high risk drugs

(M2015) **Patient/Caregiver Drug Education Intervention**: Since the previous OASIS assessment, was the patient/caregiver instructed to monitor the effectiveness of drug therapy and potential adverse effects, and how and when to report problems that may occur?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - Patient not taking any drugs

(M2020) Management of Oral Medications: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**

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

(M2030) Management of Injectable Medications: Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**

- ☐ 0 - Able to independently take the correct medication and proper dosage at the correct times.
- ☐ 1 - Able to take injectable medication at correct times if:
  - (a) individual syringes are prepared in advance by another person, OR
  - (b) given reminders based on the frequency of the injection.
- ☐ 2 - Unable to take injectable medications unless administered by someone else.
- ☐ NA - No injectable medications prescribed.

(M2040) Change in Ability to Manage Oral, Inhalant, or Injectable Medications: Is the patient's ability to prepare and take all prescribed medications (oral and, if applicable, inhalant or injectable medications) reliably and safely (including administration of the correct dosage at the appropriate times/intervals) better or worse than before the onset of the illness or injury that initiated this episode of care?

- ☐ 0 – Ability to prepare and take all prescribed medications now is better or the same now than the prior level of functioning.
- ☐ 1 – Ability to prepare and take all prescribed medications now is worse now than the prior level of functioning.
- ☐ UK – Unknown

EQUIPMENT MANAGEMENT

(M2100) Patient Management of Equipment (includes ONLY oxygen, IV/infusion therapy, enteral/parenteral nutrition equipment or supplies, ventilator therapy equipment or supplies): Patient's ability to set up, monitor and change equipment reliably and safely, add appropriate fluids or medication, clean/store/dispose of equipment or supplies using proper technique. **(NOTE: This refers to ability, not compliance or willingness.)**

- ☐ 0 - Patient manages all tasks related to equipment completely independently.
- ☐ 1 - If someone else sets up equipment (i.e., fills portable oxygen tank, provides patient with prepared solutions), patient is able to manage all other aspects of equipment.
- ☐ 2 - Patient requires considerable assistance from another person to manage equipment, but independently completes portions of the task.
- ☐ 3 - Patient is only able to monitor equipment (e.g., liter flow, fluid in bag) and must call someone else to manage the equipment.
- ☐ 4 - Patient is completely dependent on someone else to manage all equipment.
- ☐ NA - No equipment of this type used in care

(M2110) Types and Sources of Assistance
(Check only **one** box in each row)

Needing assistance = patient needs assistance on any item on the "e.g." list	No assistance needed in this area	Caregiver(s) currently provides assistance	Caregiver(s) need training/ supportive services to provide assistance	Caregiver(s) not likely to provide assistance	Unclear if Caregiver(s) will provide assistance	Assistance needed, but no Caregiver(s) available
a. ADL assistance (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding)	a1. ☐	a2. ☐	a3. ☐	a4. ☐	a5. ☐	a6. ☐
b. IADL assistance (e.g., meals, housekeeping, laundry, telephone, shopping, finances)	b1. ☐	b2. ☐	b3. ☐	b4. ☐	b5. ☐	b6. ☐
c. Medication administration (e.g., oral, inhaled or injectable)	c1. ☐	c2. ☐	c3. ☐	c4. ☐	c5. ☐	c6. ☐
d. Medical procedures/ treatments (e.g., changing wound dressing)	d1. ☐	d2. ☐	d3. ☐	d4. ☐	d5. ☐	d6. ☐
e. Management of Equipment (includes oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies)	e1. ☐	e2. ☐	e3. ☐	e4. ☐	e5. ☐	e6. ☐
f. Supervision and safety	f1. ☐	f2. ☐	f3. ☐	f4. ☐	f5. ☐	f6. ☐
g. Advocacy or facilitation of patient's participation in appropriate medical care (includes transportation to or from appointments)	g1. ☐	g2. ☐	g3. ☐	g4. ☐	g5. ☐	g6. ☐

(M2120) **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*

* at discharge, omit unknown response.

THERAPY NEED

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

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

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

EMERGENT CARE

(M2300) Emergent Care: Since the last time OASIS data were collected, has the patient utilized a hospital emergency department (includes holding/observation with or without hospital admission)?

- ☐ 0 - No **[** *Go to M2400* **]**
- ☐ 1 - Yes
- ☐ UK - Unknown **[** *Go to M2400* **]**

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

- ☐ 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
- ☐ 2 - Injury caused by fall or accident at home
- ☐ 3 - Respiratory infection (e.g. pneumonia, bronchitis)
- ☐ 4 - Other respiratory problem
- ☐ 5 - Heart failure (e.g., 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 - Upper GI obstruction, constipation, impaction
- ☐ 12 - Dehydration, malnutrition
- ☐ 13 - Urinary tract infection
- ☐ 14 - IV catheter-related infection
- ☐ 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

DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY DISCHARGE ONLY

(M2400) To which **Inpatient Facility** has the patient been admitted?

- ☐ 1 - Hospital **[** *Go to M2420 at TRN; Go to M2430 at DC* **]**
- ☐ 2 - Rehabilitation facility **[** *Go to M0903* **]**
- ☐ 3 - Nursing home **[** *Go to M2440* **]**
- ☐ 4 - Hospice **[** *Go to M0903* **]**
- ☐ NA - No inpatient facility admission

(M2410) Discharge Disposition: Where is the patient after discharge from your agency? **(Choose only one answer.)**

- ☐ 1 - Patient remained in the community (not in hospital, nursing home, or rehab facility)
- ☐ 2 - Patient transferred to a non-institutional hospice
- ☐ 3 - Unknown because patient moved to a geographic location not served by this agency
- ☐ UK - Other unknown

[*Go to M0903* **]**

(M2420) If the patient was admitted to an acute care **Hospital**, for what **Reason** was he/she admitted?

- ☐ 1 - Hospitalization for emergent (unscheduled) care
- ☐ 2 - Hospitalization for urgent (scheduled within 24 hours of admission) care
- ☐ 3 - Hospitalization for elective (scheduled more than 24 hours before admission) care
- ☐ UK - Unknown

(M2430) Reason for Hospitalization: For what reason(s) did the patient require hospitalization? **(Mark all that apply.)**

- ☐ 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
- ☐ 2 - Injury caused by fall or accident at home
- ☐ 3 - Respiratory infection (e.g. pneumonia, bronchitis)
- ☐ 3 - Other respiratory problem
- ☐ 5 - Heart failure (e.g., 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 - Upper GI obstruction, constipation, impaction
- ☐ 12 - Dehydration, malnutrition
- ☐ 13 - Urinary tract infection
- ☐ 14 - IV catheter-related infection
- ☐ 15 - Wound infection or deterioration
- ☐ 16 - Uncontrolled pain
- ☐ 17 - Acute mental/behavioral health problem
- ☐ 18 - Deep vein thrombosis, pulmonary embolus
- ☐ 19 - Scheduled treatment or procedure
- ☐ 20 - Other than above reasons
- ☐ UK - Reason unknown

[*Go to M0903* **]**

(M2440) For what **Reason(s)** was the patient **Admitted** to a **Nursing Home**? **(Mark all that apply.)**

- ☐ 1 - Therapy services
- ☐ 2 - Respite care
- ☐ 3 - Hospice care
- ☐ 4 - Permanent placement
- ☐ 5 - Unsafe for care at home
- ☐ 6 - Other
- ☐ UK - Unknown

[*Go to M0903* **]**