Home Health Agency Risk-Adjusted and Descriptive Outcome Reports: Description and Definitions

Source of Data

The data upon which the home health agency risk-adjusted and descriptive outcome reports are based consist of OASIS (Outcome and Assessment Information Set) data submitted by home health agencies to the states, which are then transmitted to the Centers for Medicare & Medicaid Services. Assessments incorporating OASIS are completed at admission to and discharge from home health care, and at sixty-day intervals in between. An abbreviated form of OASIS is collected if a patient is admitted to a hospital or other inpatient facility, and if the patient subsequently resumes home health care a resumption of care assessment is conducted.

Patient Outcomes Defined

Patient outcome measures are calculated based on a completed "episode of care," which begins with admission to a home health agency (or resumption of care) and ends with discharge or transfer to inpatient facility. A patient outcome is defined as a change (or lack of change) in patient condition during an episode of care.

Categories of Outcome Measures

Outcome measures fall into the following categories:

Improvement/Stabilization in Health Status: Improvement indicates that the patient's condition is better at the end of an episode of care than at the beginning. Stabilization indicates that the patient's condition at the end of the episode of care is no worse than at the beginning, in other words, the patient's health did not get worse. Improvement and Stabilization measures are calculated for the following categories of health status:

> **Functional status** reflects the patient's ability to perform routine activities of daily living (ADL) and instrumental activities of daily living (IADL). ADL measures include grooming, upper body dressing, lower body dressing, bathing, toileting, transferring, ambulation/locomotion, and eating. IADL measures include light meal preparation, laundry, housekeeping, shopping, phone use, and management of oral medications.
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> **Physiological/Behavioral status** measures include urinary tract infection, urinary and bowel incontinence, dyspnea (shortness of breath), and frequency of confusion.

Utilization Outcomes indicate whether the patient has experienced an event or change in condition requiring medical intervention, including acute care hospitalization and emergency care. This category also includes discharge from home health care with the patient remaining in the community.

Outcome Rates Defined

For an individual patient, a specific patient outcome is either achieved (coded as 1) or not achieved (coded as 0). A home health agency's outcome rate is calculated as the percentage of patients who achieve a specific outcome during their home health care stay, out of all eligible patients (see exclusions below). The state outcome rate is calculated across all patients served by agencies in that state. Similarly, a national rate is calculated for all home health care patients in the United States.

Time Period Covered by Outcome Reports

For both risk-adjusted and descriptive outcome reports, rates are reported for episodes of care that are completed during a specified twelve month period of time. For this report

series, outcome rates are updated quarterly, based on rolling twelve month time periods. Reports for each quarterly update will be maintained to allow comparison of rates over time.

Exclusions

Outcome measures are not calculated for patients who die at home while still a home health care patient. In addition, patients who are assessed at start of care as nonresponsive (unable to respond) are excluded from all outcome measure calculations. In addition to these general exclusion rules, there are specific eligibility criteria for each outcome measure, as explained in the measure-specific documentation.

An episode of care must start and end within a specific twelve-month period to be included in a particular report. For this reason, home health care patients who are on service for an extremely long period of time will be excluded from reports unless they are admitted to an inpatient facility.

Calculation of Risk-Adjusted State Rates

On the risk-adjusted outcome report, outcome rates are adjusted to compensate for differences in the patient population served by different home health agencies, including difference between states. For each patient episode of care, a predicted outcome probability is calculated based on the patient's condition (as reflected by multiple measures of health status) at the time of admission to home health care. Predicted and observed (actual) outcomes are aggregated across all eligible patients served by home health agencies in each state and further aggregated to obtain national observed and predicted rates. These predicted and observed rates are used to calculate risk-adjusted state rates as follows:

Risk-Adjusted State Rate = Observed State Rate + (Predicted National Rate – Predicted State Rate)

Calculation of Descriptive State Rates

On the descriptive outcome report, outcome rates are not adjusted. Observed (actual) outcomes are aggregated across all eligible patients served by home health agencies in each state and further aggregated to obtain national observed rates. These observed rates are what appear in the report.

Measure Documentation: Risk-Adjusted Outcome Measures

Measure	OASIS Item(s) Used	Measure Specifications
Improvement in Grooming	**(M0640) Grooming:** Ability to tend 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.	**Improvement in Grooming** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0640 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0640 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or more impairment at discharge compared to start of care. **Exclusions**: Improvement in Grooming is not calculated if either of the following conditions applies: The value recorded for the OASIS item M0640 on the start (or resumption) of care assessment is zero, indicating minimal or no impairment. These patients are excluded because it would be impossible for them to show measurable improvement. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.
Improvement in Dressing Upper Body	**(M0650) Ability to Dress Upper Body** (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.	**Improvement in Dressing Upper Body** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0650 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0650 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or more impairment at discharge compared to start of care. **Exclusions:** Improvement in Dressing Upper Body is not calculated if either of the following conditions applies: The value recorded for the OASIS item M0650 on the start (or resumption) of care assessment is zero, indicating minimal or no impairment. These patients are excluded because it would be impossible for them to show measurable improvement. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.

Measure Documentation: Risk-Adjusted Outcome Measures (continued)

Measure	OASIS Item(s) Used	Measure Specifications
Improvement in Dressing Lower Body	**(M0660) Ability to Dress Lower Body** (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.	**Improvement in Dressing Lower Body** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0660 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0660 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or more impairment at discharge compared to start of care. **Exclusions:** Improvement in Dressing Lower Body is not calculated if either of the following conditions applies: The value recorded for the OASIS item M0660 on the start (or resumption) of care assessment is zero, indicating minimal or no impairment. These patients are excluded because it would be impossible for them to show measurable improvement. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.
Improvement in Bathing	**(M0670) Bathing:** Ability to wash entire body. Excludes grooming (washing face and hands only). 0 - Able to bathe self in shower or tub independently. 1 - With the use of devices, is able to bathe self in shower or tub independently. 2 - Able to bathe in shower or tub with the 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 - Participates 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 and is bathed in bed or bedside chair. 5 - Unable to effectively participate in bathing and is totally bathed by another person.	I**mprovement in Bathing** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0670 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0670 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or more impairment at discharge compared to start of care. **Exclusions:** Improvement in Bathing is not calculated if either of the following conditions applies: The value recorded for the OASIS item M0670 on the start (or resumption) of care assessment is zero, indicating minimal or no impairment. These patients are excluded because it would be impossible for them to show measurable improvement. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.

Measure Documentation: Risk-Adjusted Outcome Measures (continued)

Measure	OASIS Item(s) Used	Measure Specifications
Improvement in Toileting	**(M0680) Toileting:** Ability to get to and from the toilet or bedside commode. 0 - Able to get to and from the toilet independently with or without a device. 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet. 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.	**Improvement in Toileting** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0680 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0680 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or more impairment at discharge compared to start of care. **Exclusions** Improvement in Toileting is not calculated if either of the following conditions applies: The value recorded for the OASIS item M0680 on the start (or resumption) of care assessment is zero, indicating minimal or no impairment. These patients are excluded because it would be impossible for them to show measurable improvement. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.
Improvement in Transferring	**(M0690) Transferring**: Ability to move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if patient is bedfast. 0 - Able to independently transfer. 1 - Transfers 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.	**Improvement in Transferring** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0690 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0690 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or more impairment at discharge compared to start of care. **Exclusions:** Improvement in Transferring is not calculated if either of the following conditions applies: The value recorded for the OASIS item M0690 on the start (or resumption) of care assessment is zero, indicating minimal or no impairment. These patients are excluded because it would be impossible for them to show measurable improvement. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.

Measure Documentation: Risk-Adjusted Outcome Measures (continued)

Measure	OASIS Item(s) Used	Measure Specifications
Improvement in Ambulation/Locomotion	**(M0700) Ambulation/Locomotion:** Ability to SAFELY walk, 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 - Requires use of a device (e.g., cane, walker) to walk alone or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces. 2 - Able to walk only with the supervision or assistance of another person at all times. 3 - Chairfast, unable to ambulate but is able to wheel self independently. 4 - Chairfast, unable to ambulate and is unable to wheel self. 5 - Bedfast, unable to ambulate or be up in a chair.	**Improvement in Ambulation/Locomotion** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0700 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0700 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or more impairment at discharge compared to start of care. **Exclusions:** Improvement in Ambulation/Locomotion is not calculated if either of the following conditions applies: The value recorded for the OASIS item M0700 on the start (or resumption) of care assessment is zero, indicating minimal or no impairment. These patients are excluded because it would be impossible for them to show measurable improvement. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.
Improvement in Eating	**(M0710) Feeding or Eating:** Ability to feed self meals and snacks. 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.	**Improvement in Eating** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0710 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0710 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or more impairment at discharge compared to start of care. **Exclusions:** Improvement in Eating is not calculated if either of the following conditions applies: The value recorded for the OASIS item M0710 on the start (or resumption) of care assessment is zero, indicating minimal or no impairment. These patients are excluded because it would be impossible for them to show measurable improvement. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.

Measure Documentation: Risk-Adjusted Outcome Measures (continued)

Measure	OASIS Item(s) Used	Measure Specifications
Stabilization in Grooming	**(M0640) Grooming:** Ability to tend 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.	**Stabilization in Grooming** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0640 on the discharge assessment is numerically less than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or less impairment at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0640 on the discharge assessment is numerically greater than the value recorded on the start (or resumption) of care assessment, indicating more impairment at discharge compared to start of care. **Exclusions:** Stabilization in Grooming is not calculated if any of the following conditions apply: The value recorded for the OASIS item M0640 on the start (or resumption) of care assessment is equal to three, indicating maximum impairment. These patients are excluded because it would be impossible for them to show measurably greater impairment at discharge compared to start of care. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.
Stabilization in Bathing	**(M0670) Bathing:** Ability to wash entire body. Excludes grooming (washing face and hands only). 0 - Able to bathe self in shower or tub independently. 1 - With the use of devices, is able to bathe self in shower or tub independently. 2 - Able to bathe in shower or tub with the 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 - Participates 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 and is bathed in bed or bedside chair. 5 - Unable to effectively participate in bathing and is totally bathed by another person.	**Stabilization in Bathing** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0670 on the discharge assessment is numerically less than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or less impairment at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0670 on the discharge assessment is numerically greater than the value recorded on the start (or resumption) of care assessment, indicating more impairment at discharge compared to start of care. **Exclusions:** Stabilization in Bathing is not calculated if either of the following conditions applies: The value recorded for the OASIS item M0670 on the start (or resumption) of care assessment is equal to five, indicating maximum impairment. These patients are excluded because it would be impossible for them to show measurably greater impairment at discharge compared to start of care. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.

Measure Documentation: Risk-Adjusted Outcome Measures (continued)

Measure	OASIS Item(s) Used	Measure Specifications
Stabilization in Transferring	**(M0690) Transferring**: Ability to move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if patient is bedfast. 0 - Able to independently transfer. 1 - Transfers 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.	**Stabilization in Transferring** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0690 on the discharge assessment is numerically less than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or less impairment at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0690 on the discharge assessment is numerically greater than the value recorded on the start (or resumption) of care assessment, indicating more impairment at discharge compared to start of care. **Exclusions:** Stabilization in Transferring is not calculated if either of the following conditions applies: The value recorded for the OASIS item M0690 on the start (or resumption) of care assessment is equal to five, indicating maximum impairment. These patients are excluded because it would be impossible for them to show measurably greater impairment at discharge compared to start of care. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.
Improvement in Light Meal Preparation	**(M0720) Planning and Preparing Light Meals** (e.g., cereal, sandwich) or reheat delivered meals: 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.	**Improvement in Li**ght Meal Preparation is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0720 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0720 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or more impairment at discharge compared to start of care. **Exclusions:** Improvement in Light Meal Preparation is not calculated if either of the following conditions applies: The value recorded for the OASIS item M0720 on the start (or resumption) of care assessment is zero, indicating minimal or no impairment. These patients are excluded because it would be impossible for them to show measurable improvement. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.

Measure Documentation: Risk-Adjusted Outcome Measures (continued)

Measure	OASIS Item(s) Used	Measure Specifications
Improvement in Laundry	**(M0740) Laundry:** Ability to do own laundry — to carry laundry to and from washing machine, to use washer and dryer, to wash small items by hand. 0 - (a) Able to independently take care of all laundry tasks; OR (b) Physically, cognitively, and mentally able to do laundry and access facilities, but has not routinely performed laundry tasks in the past (i.e., prior to this home care admission). 1 - Able to do only light laundry, such as minor hand wash or light washer loads. Due to physical, cognitive, or mental limitations, needs assistance with heavy laundry such as carrying large loads of laundry. 2 - Unable to do any laundry due to physical limitation or needs continual supervision and assistance due to cognitive or mental limitation.	**Improvement in Laundry** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0740 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0740 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or more impairment at discharge compared to start of care. **Exclusions:** Improvement in Laundry is not calculated if either of the following conditions applies: The value recorded for the OASIS item M0740 on the start (or resumption) of care assessment is zero, indicating minimal or no impairment. These patients are excluded because it would be impossible for them to show measurable improvement. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.
Improvement in Housekeeping	**(M0750) Housekeeping:** Ability to safely and effectively perform light housekeeping and heavier cleaning tasks. 0 - (a) Able to independently perform all housekeeping tasks; OR (b) Physically, cognitively, and mentally able to perform all housekeeping tasks but has not routinely participated in housekeeping tasks in the past (i.e., prior to this home care admission). 1 - Able to perform only light housekeeping (e.g., dusting, wiping kitchen counters) tasks independently. 2 - Able to perform housekeeping tasks with intermittent assistance or supervision from another person. 3 - Unable to consistently perform any housekeeping tasks unless assisted by another person throughout the process. 4 - Unable to effectively participate in any housekeeping tasks.	**Improvement in Housekeeping** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0750 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0750 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or more impairment at discharge compared to start of care. **Exclusions:** Improvement in Housekeeping is not calculated if either of the following conditions applies: The value recorded for the OASIS item M0750 on the start (or resumption) of care assessment is zero, indicating minimal or no impairment. These patients are excluded because it would be impossible for them to show measurable improvement. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.

Measure Documentation: Risk-Adjusted Outcome Measures (continued)

Measure	OASIS Item(s) Used	Measure Specifications
Improvement in Shopping	**(M0760) Shopping:** Ability to plan for, select, and purchase items in a store and to carry them home or arrange delivery. 0 - (a) Able to plan for shopping needs and independently perform shopping tasks, including carrying packages; OR (b) Physically, cognitively, and mentally able to take care of shopping, but has not done shopping in the past (i.e., prior to this home care admission). 1 - Able to go shopping, but needs some assistance: (a) By self is able to do only light shopping and carry small packages, but needs someone to do occasional major shopping; OR (b) Unable to go shopping alone, but can go with someone to assist. 2 - Unable to go shopping, but is able to identify items needed, place orders, and arrange home delivery. 3 - Needs someone to do all shopping and errands.	**Improvement in Shopping** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0760 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0760 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or more impairment at discharge compared to start of care. **Exclusions:** Improvement in Shopping is not calculated if either of the following conditions applies: The value recorded for the OASIS item M0760 on the start (or resumption) of care assessment is zero, indicating minimal or no impairment. These patients are excluded because it would be impossible for them to show measurable improvement. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.
Improvement in Phone Use	**(M0770) Ability to Use Telephone:** Ability to answer the phone, dial numbers, and effectively use 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.	**Improvement in Phone** Use is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0770 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0770 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or more impairment at discharge compared to start of care. **Exclusions:** Improvement in Phone Use is not calculated if any of the following conditions apply: The value "NA" is recorded for the OASIS item M0770 on either the start (or resumption) of care assessment or the discharge assessment. The value recorded for the OASIS item M0770 on the start (or resumption) of care assessment is zero, indicating minimal or no impairment. These patients are excluded because it would be impossible for them to show measurable improvement. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.

Measure Documentation: Risk-Adjusted Outcome Measures (continued)

Measure	OASIS Item(s) Used	Measure Specifications
Improvement in Management of Oral Medications	**(M0780) Management of Oral Medications:** Patient's ability to prepare and take all prescribed 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) given daily reminders; OR (c) someone develops a drug diary or chart. 2 - Unable to take medication unless administered by someone else. NA - No oral medications prescribed.	**Improvement in Management** of Oral Medications is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0780 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0780 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or more impairment at discharge compared to start of care. **Exclusions:** Improvement in Management of Oral Medications is not calculated if any of the following conditions apply: The value "NA" is recorded for the OASIS item M0780 on either the start (or resumption) of care assessment or the discharge assessment. The value recorded for the OASIS item M0780 on the start (or resumption) of care assessment is zero, indicating minimal or no impairment. These patients are excluded because it would be impossible for them to show measurable improvement. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.
Stabilization in Light Meal Preparation	**(M0720) Planning and Preparing Light Meals** (e.g., cereal, sandwich) or reheat delivered meals: 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.	**Stabilization in Light Meal Preparation** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0720 on the discharge assessment is numerically less than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or less impairment at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0720 on the discharge assessment is numerically greater than the value recorded on the start (or resumption) of care assessment, indicating more impairment at discharge compared to start of care. **Exclusions:** Stabilization in Light Meal Preparation is not calculated if any of the following conditions apply: The value recorded for the OASIS item M0720 on the start (or resumption) of care assessment is equal to two, indicating maximum impairment. These patients are excluded because it would be impossible for them to show measurably greater impairment at discharge compared to start of care. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.

Measure Documentation: Risk-Adjusted Outcome Measures (continued)

Measure	OASIS Item(s) Used	Measure Specifications
Stabilization in Laundry	**(M0740) Laundry:** Ability to do own laundry to carry laundry to and from washing machine, to use washer and dryer, to wash small items by hand. 0 - (a) Able to independently take care of all laundry tasks; OR (b) Physically, cognitively, and mentally able to do laundry and access facilities, but has not routinely performed laundry tasks in the past (i.e., prior to this home care admission). 1 - Able to do only light laundry, such as minor hand wash or light washer loads. Due to physical, cognitive, or mental limitations, needs assistance with heavy laundry such as carrying large loads of laundry. 2 - Unable to do any laundry due to physical limitation or needs continual supervision and assistance due to cognitive or mental limitation.	**Stabilization in Laundry** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0740 on the discharge assessment is numerically less than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or less impairment at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0740 on the discharge assessment is numerically greater than the value recorded on the start (or resumption) of care assessment, indicating more impairment at discharge compared to start of care. **Exclusions:** Stabilization in Laundry is not calculated if any of the following conditions apply: The value recorded for the OASIS item M0740 on the start (or resumption) of care assessment is equal to two, indicating maximum impairment. These patients are excluded because it would be impossible for them to show measurably greater impairment at discharge compared to start of care. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.
Stabilization in Housekeeping	**(M0750) Housekeeping:** Ability to safely and effectively perform light housekeeping and heavier cleaning tasks. 0 - (a) Able to independently perform all housekeeping tasks; OR (b) Physically, cognitively, and mentally able to perform all housekeeping tasks but has not routinely participated in housekeeping tasks in the past (i.e., prior to this home care admission). 1 - Able to perform only light housekeeping (e.g., dusting, wiping kitchen counters) tasks independently. 2 - Able to perform housekeeping tasks with intermittent assistance or supervision from another person. 3 - Unable to consistently perform any housekeeping tasks unless assisted by another person throughout the process. 4 - Unable to effectively participate in any housekeeping tasks.	**Stabilization in Housekeeping** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0750 on the discharge assessment is numerically less than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or less impairment at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0750 on the discharge assessment is numerically greater than the value recorded on the start (or resumption) of care assessment, indicating more impairment at discharge compared to start of care. **Exclusions:** Stabilization in Housekeeping is not calculated if any of the following conditions apply: The value recorded for the OASIS item M0750 on the start (or resumption) of care assessment is equal to four, indicating maximum impairment. These patients are excluded because it would be impossible for them to show measurably greater impairment at discharge compared to start of care. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.

Measure Documentation: Risk-Adjusted Outcome Measures (continued)

Measure	OASIS Item(s) Used	Measure Specifications
Stabilization in Shopping	**(M0760) Shopping:** Ability to plan for, select, and purchase items in a store and to carry them home or arrange delivery. 0 - (a) Able to plan for shopping needs and independently perform shopping tasks, including carrying packages; OR (b) Physically, cognitively, and mentally able to take care of shopping, but has not done shopping in the past (i.e., prior to this home care admission). 1 - Able to go shopping, but needs some assistance: (a) By self is able to do only light shopping and carry small packages, but needs someone to do occasional major shopping; OR (b) Unable to go shopping alone, but can go with someone to assist. 2 - Unable to go shopping, but is able to identify items needed, place orders, and arrange home delivery. 3 - Needs someone to do all shopping and errands.	**Stabilization in Shopping** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0760 on the discharge assessment is numerically less than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or less impairment at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0760 on the discharge assessment is numerically greater than the value recorded on the start (or resumption) of care assessment, indicating more impairment at discharge compared to start of care. **Exclusions:** Stabilization in Shopping is not calculated if any of the following conditions apply: The value recorded for the OASIS item M0760 on the start (or resumption) of care assessment is equal to three, indicating maximum impairment. These patients are excluded because it would be impossible for them to show measurably greater impairment at discharge compared to start of care. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.
Stabilization in Phone Use	**(M0770) Ability to Use Telephone:** Ability to answer the phone, dial numbers, and effectively use 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.	**Stabilization in Phone Use** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0770 on the discharge assessment is numerically less than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or less impairment at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0770 on the discharge assessment is numerically greater than the value recorded on the start (or resumption) of care assessment, indicating more impairment at discharge compared to start of care. **Exclusions:** Stabilization in Phone Use is not calculated if any of the following conditions apply: The value "NA" is recorded for the OASIS item M0770 on either the start (or resumption) of care assessment or the discharge assessment. The value recorded for the OASIS item M0770 on the start (or resumption) of care assessment is equal to five, indicating maximum impairment. These patients are excluded because it would be impossible for them to show measurably greater impairment at discharge compared to start of care. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.

Measure Documentation: Risk-Adjusted Outcome Measures (continued)

Measure	OASIS Item(s) Used	Measure Specifications
Improvement in Dyspnea (Shortness of Breath)	**(M0490)** When is the patient dyspneic or noticeably **Short of Breath?** 0 - Never, 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)	**Improvement in Dyspnea** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0490 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less serious condition at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0490 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or worse condition at discharge compared to start of care. **Exclusions:** Improvement in Dyspnea is not calculated if either of the following conditions applies: The value recorded for the OASIS item M0490 on the start (or resumption) of care assessment is zero, indicating patient is never short of breath. These patients are excluded because it would be impossible for them to show measurable improvement. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.
Improvement in Urinary Tract Infection	**(M0510)** 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	**Improvement in Urinary Tract Infection** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0510 on the discharge assessment is zero, and the value recorded on the start (or resumption) of care assessment is one, indicating that a urinary tract infection was resolved while the patient was receiving home health care. 0 (NO) IF: The value recorded for the OASIS item M0510 on the discharge assessment is equal to the value recorded on the start (or resumption) of care assessment, and they are both one, indicating a urinary tract infection that was not resolved. **Exclusions:** Improvement in Urinary Tract Infection is not calculated if any of the following conditions apply: The value "NA" or "UK" is recorded for the OASIS item M0510 on either the start (or resumption) of care assessment or the discharge assessment. The value recorded for the OASIS item M0510 on the start (or resumption) of care assessment is equal to zero, indicating no infection at start of care. These patients are excluded because it would be impossible for them to show improvement. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.

Measure Documentation: Risk-Adjusted Outcome Measures (continued)

Measure	OASIS Item(s) Used	Measure Specifications
Improvement in Urinary Incontinence	**(M0520) Urinary Incontinence or Urinary Catheter Presence:** 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) [If No, go to M0540] 1 - Patient is incontinent 2 - Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) [Go to M0540] **(M0530) When** does **Urinary Incontinence** occur? 0 - Timed-voiding defers incontinence 1 - During the night only 2 - During the day and night	**Improvement in Urinary Incontinence** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0530 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less frequent urinary incontinence at discharge compared to start of care; OR: The value recorded for the OASIS item M0520 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating that urinary incontinence at start of care has been resolved by discharge, or that a urinary catheter present at start of care is no longer present at discharge. 0 (NO) IF: The value recorded for the OASIS item M0530 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or more incontinence at discharge compared to start of care. OR: The value recorded for the OASIS item M0520 on the discharge assessment is two, while the value recorded on the start (or resumption) of care assessment was one or two, indicating presence of a urinary catheter at discharge, whether or not there was a urinary catheter present at start of care. **Exclusions:** Improvement in Urinary Incontinence is not calculated if either of the following conditions applies: The value recorded for the OASIS item M0520 on the start (or resumption) of care assessment is zero, indicating no incontinence and no urinary catheter. These patients are excluded because it would be impossible for them to show measurable improvement. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.

Measure Documentation: Risk-Adjusted Outcome Measures (continued)

Measure	OASIS Item(s) Used	Measure Specifications
Improvement in Bowel Incontinence	**(M0540) 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	**Improvement in Bowel Incontinence** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0540 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less frequent incontinence at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0540 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or more frequent incontinence at discharge compared to start of care. **Exclusions:** Improvement in Bowel Incontinence is not calculated if any of the following conditions apply: The value "NA" or "UK" is recorded for the OASIS item M0540 on either the start (or resumption) of care assessment or the discharge assessment. The value recorded for the OASIS item M0540 on the start (or resumption) of care assessment is zero, indicating minimal or no incontinence. These patients are excluded because it would be impossible for them to show measurable improvement. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.
Improvement in Confusion Frequency	**(M0570) 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	**Improvement in Confusion Frequency** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0570 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less frequent confusion at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0570 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or more frequent confusion at discharge compared to start of care. **Exclusions:** Improvement in Confusion Frequency is not calculated if any of the following conditions apply: The value "NA" is recorded for the OASIS item M0570 on either the start (or resumption) of care assessment or the discharge assessment. The value recorded for the OASIS item M0570 on the start (or resumption) of care assessment is zero, indicating no confusion. These patients are excluded because it would be impossible for them to show measurable improvement. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.

Measure Documentation: Risk-Adjusted Outcome Measures (continued)

Measure	OASIS Item(s) Used	Measure Specifications
Any Emergent Care	**(M0830) Emergent Care:** Since the last time OASIS data were collected, has the patient utilized any of the following services for emergent care (other than home care agency services)? **(Mark all that apply.)** 0 - No emergent care services [If no emergent care, go to M0855] 1 - Hospital emergency room (includes 23-hour holding) 2 - Doctor's office emergency visit/house call 3 - Outpatient department/clinic emergency (includes urgicenter sites) UK - Unknown [If UK, go to M0855]	**Any Emergent Care** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0830 on the discharge or transfer to inpatient facility assessment is one, two, or three, indicating the patient required emergency medical treatment, regardless of location. 0 (NO) IF: The value recorded for the OASIS item M0830 on the discharge or transfer to inpatient facility assessment is zero, indicating that no emergency medical treatment was received. **Exclusions:** Any Emergent Care is not calculated if either of the following conditions applies: The value recorded for the OASIS item M0830 on the discharge or transfer to inpatient facility assessment is "UK." The patient did not have a discharge or transfer to inpatient facility assessment because the episode of care ended in death at home.
Discharged to Community	**(M0100) This Assessment is Currently Being Completed for the Following Reason:** **Transfer to an Inpatient Facility** 6 – Transferred to an inpatient facility—patient not discharged from agency [Go to M0830] 7 – Transferred to an inpatient facility—patient discharged from agency [Go to M0830] **Discharge from Agency — Not to an Inpatient Facility** 8 – Death at home [Go to M0906] 9 – Discharge from agency [Go to M0200] **(M0870) 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 noninstitutional hospice [Go to M0903] 3 - Unknown because patient moved to a geographic location not served by this agency [Go to M0903] UK- Other unknown [Go to M0903]	**Discharged to Community** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0870 on the discharge assessment is one, indicating the patient remained in the community after discharge. 0 (NO) IF: The value recorded for the OASIS item M0870 on the discharge assessment is two or three, indicating that the patient was transferred to non-institutional hospice care or moved to another location. OR: The home health episode of care ended with transfer to an inpatient facility (M0100 has a value of six or seven). **Exclusions:** Discharged to Community is not calculated if either of the following conditions applies: The value recorded for the OASIS item M0870 on the discharge or transfer to inpatient facility assessment is "UK." The patient did not have a discharge or transfer to inpatient facility assessment because the episode of care ended in death at home.

Measure Documentation: Risk-Adjusted Outcome Measures (continued)

Measure	OASIS Item(s) Used	Measure Specifications
Acute Care Hospitalization	**(M0100) This Assessment is Currently Being Completed for the Following Reason:** **Transfer to an Inpatient Facility** 6 – Transferred to an inpatient facility—patient not discharged from agency [Go to M0830] 7 – Transferred to an inpatient facility—patient discharged from agency [Go to M0830] **Discharge from Agency — Not to an Inpatient Facility** 8 – Death at home [Go to M0906] 9 – Discharge from agency [Go to M0200] **(M0855)** To which **Inpatient Facility** has the patient been admitted? 1 - Hospital [Go to M0890] 2 - Rehabilitation facility [Go to M0903] 3 - Nursing home [Go to M0900] 4 - Hospice [Go to M0903]	**Acute Care Hospitalization** is coded as follows: 1 (YES) IF: The assessment completed at the conclusion of the episode of care is a transfer to inpatient facility assessment (M0100 has a value of six or seven), AND the value recorded for the OASIS item M0855 on that assessment is one, indicating the patient was admitted to a hospital. 0 (NO) IF: The assessment completed at the conclusion of the episode of care is a discharge assessment (M0100 has a value of nine), OR The value recorded for the OASIS item M0855 on the transfer to inpatient facility assessment is two, three, or four, indicating that the patient was admitted to an inpatient facility other than a hospital. **Exclusions:** Acute Care Hospitalization is not calculated if the following condition applies: The patient did not have a discharge or transfer to inpatient facility assessment because the episode of care ended in death at home.

Measure Documentation: Descriptive Outcome Measures

Measure	OASIS Item(s) Used	Measure Specifications
Improvement in Speech and Language	**(M0410) 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.	**Improvement in Speech and Language** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0410 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0410 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or more impairment at discharge compared to start of care. **Exclusions:** Improvement in Speech and Language is not calculated if either of the following conditions applies: The value recorded for the OASIS item M0410 on the start (or resumption) of care assessment is zero, indicating minimal or no impairment. These patients are excluded because it would be impossible for them to show measurable improvement. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.
Improvement in Pain Interfering with Activity	**(M0420) Frequency of Pain** interfering with patient's activity or movement: 0 - Patient has no pain or pain does not interfere with activity or movement 1 - Less often than daily 2 - Daily, but not constantly 3 - All of the time	**Improvement in Pain Interfering with Activity** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0420 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less frequent pain interfering with activity at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0420 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating that pain interfering with activity occurs with the same or greater frequency at discharge compared to start of care. **Exclusions:** Improvement in Pain Interfering with Activity is not calculated if either of the following conditions applies: The value recorded for the OASIS item M0420 on the start (or resumption) of care assessment is zero, indicating there is no pain that interferes with activity. These patients are excluded because it would be impossible for them to show measurable improvement. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.

Measure Documentation: Descriptive Outcome Measures (continued)

Measure	OASIS Item(s) Used	Measure Specifications
Improvement in Number of Surgical Wounds	**(M0482)** Does this patient have a **Surgical Wound?** 0 - No **[If No, go to M0490]** 1 - Yes **(M0484) Current Number of (Observable) Surgical Wounds:** (If a wound is partially closed but has more than one opening, consider each opening as a separate wound.) 0 - Zero 1 - One 2 - Two 3 - Three 4 - Four or more	**Improvement in Number of Surgical Wounds** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0484 on the discharge assessment is less than the value recorded on the start (or resumption) of care assessment, indicating fewer surgical wounds at discharge compared to start of care, **OR** the value recorded for M0484 at start/resumption of care is at least one, and the response to M0482 at discharge is zero (No), indicating no current surgical wounds remaining. 0 (NO) IF: The value recorded for the OASIS item M0484 on the discharge assessment is greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or greater number of surgical wounds at discharge compared to start of care. **Exclusions:** Improvement in Number of Surgical Wounds is not calculated if either of the following conditions applies: On the start (or resumption) of care assessment, the value recorded for the OASIS item M0484 is zero, indicating no observable surgical wounds, or the value recorded for the OASIS item M0482 is zero (No), indicating no current surgical wounds. These patients are excluded because it would be impossible to show measurable improvement. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.
Improvement in Status of Surgical Wounds	**(M0482)** Does this patient have a **Surgical Wound?** 0 - No **[If No, go to M0490]** 1 - Yes **(M0488)** [At follow-up, skip this item if patient has no surgical wounds] **Status of Most Problematic (Observable) Surgical Wound:** 1 - Fully granulating 2 - Early/partial granulation 3 - Not healing NA - No observable surgical wound	**Improvement in Status of Surgical Wounds** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0488 on the discharge assessment is less than the value recorded on the start (or resumption) of care assessment, indicating more healing at discharge compared to start of care, **OR** the response to M0482 at start/resumption of care is one (Yes) and the response to M0482 at discharge is zero (No), indicating that there are no current surgical wounds remaining. 0 (NO) IF: The value recorded for the OASIS item M0488 on the discharge assessment is greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or worse surgical wound healing at discharge compared to start of care. **Exclusions:** Improvement in Status of Surgical Wounds is not calculated if either of the following conditions applies: The value recorded for the OASIS item M0488 on the start (or resumption) of care assessment or on the discharge assessment is NA, indicating no observable surgical wound, or the value recorded for the OASIS item M0482 on the start (or resumption) of care assessment is zero (No), indicating no surgical wound. These patients are excluded because it would be impossible to show measurable improvement. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.

Measure Documentation: Descriptive Outcome Measures (continued)

Measure	OASIS Item(s) Used	Measure Specifications
Improvement in Cognitive Functioning	**(M0560) 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.	**Improvement in Cognitive Functioning** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0560 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0560 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or more impairment at discharge compared to start of care. **Exclusions:** Improvement in Cognitive Functioning is not calculated if either of the following conditions applies: The value recorded for the OASIS item M0560 on the start (or resumption) of care assessment is zero, indicating minimal or no impairment. These patients are excluded because it would be impossible for them to show measurable improvement. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.
Improvement in Anxiety Level	**(M0580) 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	**Improvement in Anxiety Level** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0580 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less frequent anxiety at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0580 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or more frequent anxiety at discharge compared to start of care. **Exclusions:** Improvement in Anxiety Level is not calculated if either of the following conditions applies: The value recorded for the OASIS item M0580 on the start (or resumption) of care assessment is zero, indicating minimal or no anxiety. These patients are excluded because it would be impossible for them to show measurable improvement. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.

Measure Documentation: Descriptive Outcome Measures (continued)

Measure	OASIS Item(s) Used	Measure Specifications
Improvement in Behavior Problem Frequency	**(M0620) 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	**Improvement in Behavior Problem Frequency** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0620 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less frequent behavior problems at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0620 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or more frequent behavior problems at discharge compared to start of care. **Exclusions:** Improvement in Behavior Problem Frequency is not calculated if either of the following conditions applies: The value recorded for the OASIS item M0620 on the start (or resumption) of care assessment is zero, indicating minimal or no behavior problems. These patients are excluded because it would be impossible for them to show measurable improvement. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.
Stabilization in Management of Oral Medications	**(M0780) Management of Oral Medications:** Patient's ability to prepare and take all prescribed 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) given daily reminders; OR (c) someone develops a drug diary or chart. 2 - Unable to take medication unless administered by someone else. NA - No oral medications prescribed. UK - Unknown	**Stabilization in Management of Oral Medications** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0780 (current status) on the discharge assessment is numerically less than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or less impairment at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0780 on the discharge assessment is numerically greater than the value recorded on the start (or resumption) of care assessment, indicating more impairment at discharge compared to start of care. **Exclusions:** Stabilization in Management of Oral Medications is not calculated if any of the following conditions apply: The value recorded for the OASIS item M0780 (current status) on the start (or resumption) of care assessment is equal to two, indicating maximum impairment. These patients are excluded because it would be impossible for them to show measurably greater impairment at discharge compared to start of care. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.

Measure Documentation: Descriptive Outcome Measures (continued)

Measure	OASIS Item(s) Used	Measure Specifications
Stabilization in Speech and Language	**(M0410) 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.	**Stabilization in Speech and Language** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0410 on the discharge assessment is numerically less than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or less impairment at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0410 on the discharge assessment is numerically greater than the value recorded on the start (or resumption) of care assessment, indicating more impairment at discharge compared to start of care. **Exclusions:** Stabilization in Speech and Language is not calculated if any of the following conditions apply: The value recorded for the OASIS item M0410 on the start (or resumption) of care assessment is equal to three, indicating maximum impairment. These patients are excluded because it would be impossible for them to show measurably greater impairment at discharge compared to start of care. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.
Stabilization in Cognitive Functioning	(M0560) **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.	**Stabilization in Cognitive Functioning** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0560 on the discharge assessment is numerically less than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or less impairment at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0560 on the discharge assessment is numerically greater than the value recorded on the start (or resumption) of care assessment, indicating more impairment at discharge compared to start of care. **Exclusions:** Stabilization in Cognitive Functioning is not calculated if any of the following conditions apply: The value recorded for the OASIS item M0560 on the start (or resumption) of care assessment is equal to three, indicating maximum impairment. These patients are excluded because it would be impossible for them to show measurably greater impairment at discharge compared to start of care. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.

Measure Documentation: Descriptive Outcome Measures (continued)

Measure	OASIS Item(s) Used	Measure Specifications
Stabilization in Anxiety Level	**(M0580) 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	**Stabilization in Anxiety Level** is coded as follows: 1 (YES) IF: The value recorded for the OASIS item M0580 on the discharge assessment is numerically less than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or less frequent anxiety at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS item M0580 on the discharge assessment is numerically greater than the value recorded on the start (or resumption) of care assessment, indicating more frequent anxiety at discharge compared to start of care. **Exclusions:** Stabilization in Anxiety Level is not calculated if any of the following conditions apply: The value recorded for the OASIS item M0580 on the start (or resumption) of care assessment is equal to three, indicating maximum frequency of anxiety. These patients are excluded because it would be impossible for them to show measurably greater anxiety at discharge compared to start of care. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.