Understanding High-Level OASIS E Changes

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06/09/2022

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Objectives

- The learner will be able to identify the differences in OASIS D1 and OASIS E
- The learner will understand new items for behavioral health and transfer of health information
- The learner will be able to understand why the new items are being introduced

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Post Acute Care/IMPACT Act

On October 6, 2014, the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 was signed into law

The Act intends for standardized post-acute care data to improve Medicare beneficiary outcomes through shared-decision making, care coordination, and enhanced discharge planning.

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IMPACT Act

CMS Meaningful Measure priority areas are:

- Promote effective communication and coordination of care
- Promote effective prevention and treatment of chronic disease
- Work with communities to promote best practices of healthy living
- Make care affordable
- Make care safer by reducing harm, cost in the delivery of care
- Strengthen person and family engagement as partners in their care

(Reference: Search “Impact Act” or use this link)

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IMPACT Act

Quality Measure Domains:

- Skin integrity and changes in skin integrity;
- Functional status, cognitive function, and changes in function and cognitive function;
- Medication reconciliation;
- Incidence of major falls;
- Transfer of health information and care preferences when an individual transitions.

(Reference: Search “Impact Act” or use this link)

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IMPACT Act

Resource Use and Other Measure Domains:

- Resource use measures, including total estimated Medicare spending per beneficiary;
- Discharge to community; and
- All-condition risk-adjusted potentially preventable hospital readmissions rates.

(Reference: Search “Impact Act” or use this link)

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Administrative Burden

Table 1. Number of Data Elements Added and Removed for OASIS-E

Time Point	#DE in OASIS-D (D1)	#DE added for OASIS-E	#DE removed for OASIS-E	Net change (+)	#DE in OASIS-E	
SOC	158	59	14	45	203	57.3 min
ROC	131	49	8	41	172	48 min
FU	36	8	0	8	44	13.2 min
TOC	22	1	1	0	22	6.6 min
DAH	9	0	0	0	9	2.7 min
DC	97	51	2	49	146	40.2 min
Totals	444	168	25	**143**	596	

Table 6. Proposed Change in Clinician Burden Costs*

OASIS-E	OASIS-D	DIFFERENCE
$900,679,044.53	$559,827,580.49	$340,851,464.04 ($30,020.39 per HHA)

OASIS E: What are the differences?

- Added items in three categories:
  - Standardized Patient Assessment Data Elements (SPADEs)
  - Brief Interview for Mental Status (BIMS)
  - Social Determinants of Health (SDH)
- Elimination of items that don't meet the criteria for inclusion

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OASIS Item Criteria

To be included in the OASIS data set, an item must meet one or more of these criteria:

1. Calculate a measure for Home Health Quality Reporting Program (HHQRP)
2. Contribute to calculation of payment
3. Be used in the Medicare survey process
4. Calculate a measure in Care Compare

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OASIS E (Draft) Notable Differences

- Standardization of formatting
- Items sequenced differently
- Some items separated (Race/Ethnicity for example)
- In the revised OASIS E draft, “Patient declines to respond” was added as an option to the SDH items
  - A1005 Ethnicity
  - A1010 Race
  - A1250 Transportation
  - B1300 Health literacy
  - D0700 Social Isolation

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Sections of OASIS E

A - Administrative Section
B - Hearing, Speech, and Vision
C - Cognitive Patterns
D - Mood
E - Behavior
F - Preferences for Customary Routine Activities
G - Functional Status
GG - Functional Abilities

H - Bladder and Bowel
I - Active Diagnoses
J - Health Conditions
K - Swallowing/nutritional status
M - Skin Conditions
N - Medications
O - Special treatment, Procedures, Programs
Q - Participation in Assessment and Goal Setting

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Note: No L or P Sections

OASIS E Comparison

OASIS D1 Sections	OASIS E Sections
Patient Tracking Clinical Record Items Patient History & Diagnosis Living Arrangement Sensory Status Integumentary Respiratory Status Elimination Status	**A** = Administrative Information **B** = Hearing, Speech and Vision **C** = Cognitive Patterns **D** = Mood **E** = Behavior **F** = Preferences for Customary Routine Activities **G** = Functional Status **GG** = Functional Abilities and Goals

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OASIS E Comparison

OASIS D1 Sections

- Neuro, Emotional, and Behavioral Status
- ADLs/IADLs
- Medications
- Care Management
- Therapy Need
- Emergent Care
- Discharge
- Functional Abilities & Goals
- Health Conditions

OASIS E Sections

- **H** = Bladder and Bowel
- **I** = Active Diagnoses
- **J** = Health Conditions
- **K** = Swallowing/Nutritional Status
- **M** = Skin Conditions
- **N** = Medications
- **O** = Special Treatment, Procedures, and Programs
- **Q** = Participation in Assessment and Goal Setting

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OASIS E Comparison

Items Added

- **A1005** Ethnicity
- **A1010** Race
- **A1110** Language (preferred)
- **A1250** Transportation
- **A2120** Provision of Current Reconciled Medication List to Subsequent Provider at Transfer
- **M2121** Provision of Current Reconciled Medication List to Subsequent Provider at Discharge
- **A2122** Route of Current Reconciled Medication List Transmission to Subsequent Provider

Items Deleted

- **M0140** Race/Ethnicity

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OASIS E Comparison

Items Added

A2123 Provision of Current Reconciled Medication List to Patient at Discharge
A2124 Route of Current Reconciled Medication List Transmission to Patient
B0200 Hearing
B1000 Vision
B1300 Health Literacy
C0100 Should BIMS be conducted
C0200 Repetition of Three Words
C0300 Temporal Orientation
C0400 Recall
C0500 BIMS Summary Score
C1310 Signs and Symptoms of Delirium

Items Deleted

M1030 Therapies (received at home)
M1051 Pneumococcal Vaccine
M1056 Reason Pneumococcal Vaccine not received
M1200 Vision

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OASIS E Comparison

Items Added

D0150 Patient Mood Interview (PHQ-2 to 9)
D0160 Total Severity Score
D0700 Social Isolation
J0510 Pain Effect on Sleep
J0520 Pain Interference with Therapy Activities
J0530 Pain Interference with Day-to-Day Activities
K0520 Nutritional Approaches
N0415 High-Risk Drug Classes: Use and Indication
O0110 Special Treatments, Procedures, and Programs

Items Deleted

M1242 Frequency of Pain Interfering
M1730 Depression Screening
M2016 Patient/Caregiver Drug Education Intervention
M2401 Intervention Synopsis (a) Diabetic Foot Care

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Administrative Information

Section A

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Section A **Administrative Information**

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

☐ UK – Unknown or Not Available

M0010. CMS Certification Number

M0014. Branch State

M0016. Branch ID Number

M0020. Patient ID Number

M0030. Start of Care Date

Month - Day - Year

M0032. Resumption of Care Date

Month - Day - Year ☐ NA – Not Applicable

M0040. Patient Name

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

M0050. Patient State of Residence

M0060. Patient ZIP Code

M0064. Social Security Number

☐ UK – Unknown or Not Available

M0063. Medicare Number

☐ NA – No Medicare

M0065. Medicaid Number

☐ NA – No Medicaid

M0069. Gender

Enter Code

1. Male
2. Female

M0066. Birth Date

Month - Day - Year

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

A1005. Ethnicity
Are you of Hispanic, Latino/a, or Spanish origin?
Check all that apply

☐	A.	No, not of Hispanic, Latino/a, or Spanish origin
☐	B.	Yes, Mexican, Mexican American, Chicano/a
☐	C.	Yes, Puerto Rican
☐	D.	Yes, Cuban
☐	E.	Yes, another Hispanic, Latino, or Spanish origin
☐	X.	Patient unable to respond
☐	Y.	Patient declines to respond

A1010. Race
What is your race?
Check all that apply

☐	A.	White
☐	B.	Black or African American
☐	C.	American Indian or Alaska Native
☐	D.	Asian Indian
☐	E.	Chinese
☐	F.	Filipino
☐	G.	Japanese
☐	H.	Korean
☐	I.	Vietnamese
☐	J.	Other Asian
☐	K.	Native Hawaiian
☐	L.	Guamanian or Chamorro
☐	M.	Samoan
☐	N.	Other Pacific Islander
☐	X.	Patient unable to respond
☐	Y.	Patient declines to respond
☐	Z.	None of the above

NEW -ish

M0150. Current Payment Sources for Home Care
Check all that apply

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

CLINICAL RECORD ITEMS, continued

(M0102) 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 [*Go to M0110, if date entered*]
☐ NA - No specific SOC date ordered by physician

(M0104) Date of Referral: Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.
month / day / year

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

PATIENT HISTORY AND DIAGNOSES

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

- ☐ 1 - Long-term nursing facility (NF)
- ☐ 2 - Skilled nursing facility (SNF/TCU)
- ☐ 3 - Short-stay acute hospital (IPPS)
- ☐ 4 - Long-term care hospital (LTCH)
- ☐ 5 - Inpatient rehabilitation hospital or unit (IRF)
- ☐ 6 - Psychiatric hospital or unit
- ☐ 7 - Other (specify) _____
- ☐ NA - Patient was not discharged from an inpatient facility [*Go to M1021*]

(M1005) Inpatient Discharge Date (most recent):
month / day / year
☐ UK - Unknown

M0102. 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 → Skip to M0110, Episode Timing, if date entered
☐ NA – No specific SOC/ROC date ordered by physician

M0104. Date of Referral
Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.
Month - Day - Year

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?
Enter Code ☐

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

A1250. Transportation (NACHC ©)
Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?
Check all that apply

☐	A.	**Yes, it has kept me from medical appointments or from getting my medications**
☐	B.	**Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need**
☐	C.	**No**
☐	X.	**Patient unable to respond**
☐	Y.	**Patient declines to respond**

New

M1000. From which of the following Inpatient Facilities was the patient discharged within the past 14 days?
Check all that apply

☐	1.	**Long-term nursing facility (NF)**
☐	2.	**Skilled nursing facility (SNF/TCU)**
☐	3.	**Short-stay acute hospital (IPPS)**
☐	4.	**Long-term care hospital (LTCH)**
☐	5.	**Inpatient rehabilitation hospital or unit (IRF)**
☐	6.	**Psychiatric hospital or unit**
☐	7.	**Other (specify)**
☐	NA	**Patient was not discharged from an inpatient facility** → *Skip to B0200, Hearing at SOC, Skip to B1300, Health Literacy at ROC*

M1005. Inpatient Discharge Date (most recent)
Month - Day - Year ☐ UK – Unknown

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EMERGENT CARE

(M2301)	**Emergent Care**: At the time of or at any time since the most recent SOC/ROC assessment has the patient utilized a hospital emergency department (includes holding/observation status)?
Enter Code ☐	0 No [*Go to M2401*] 1 Yes, used hospital emergency department WITHOUT hospital admission 2 Yes, used hospital emergency department WITH hospital admission UK Unknown [*Go to M2401*]

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

- ☐ 1 - Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
- ☐ 10 - Hypo/Hyperglycemia, diabetes out of control
- ☐ 19 - Other than above reasons
- ☐ UK - Reason unknown

(M2410)	To which **Inpatient Facility** has the patient been admitted?
Enter Code ☐	1 Hospital 2 Rehabilitation facility 3 Nursing home 4 Hospice NA No inpatient facility admission [*Omit "NA" option on TRN*]
(M2420)	**Discharge Disposition**: Where is the patient after discharge from your agency? **(Choose only one answer.)**
Enter Code ☐	1 Patient remained in the community (without formal assistive services) 2 Patient remained in the community (with formal assistive services) 3 Patient transferred to a non-institutional hospice 4 Unknown because patient moved to a geographic location not served by this agency UK Other unknown

M2301. Emergent Care
At the time of or at any time since the most recent SOC/ROC assessment has the patient utilized a hospital emergency department (includes holding/observation status)?

Enter Code ☐	0. **No** → Skip to M2410, Inpatient Facility 1. **Yes, used hospital emergency department WITHOUT hospital admission** 2. **Yes, used hospital emergency department WITH hospital admission** UK **Unknown** → Skip to M2410, Inpatient Facility

M2310. Reason for Emergent Care
For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)?

↓	Check all that apply
☐	1. **Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis**
☐	10. **Hypo/Hyperglycemia, diabetes out of control**
☐	19. **Other than above reasons**
☐	UK **Reason unknown**

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

Enter Code ☐	1. **Hospital** 2. **Rehabilitation facility** 3. **Nursing home** 4. **Hospice** NA **No inpatient facility admission** [Omit "NA" option on TRN]

M2420. Discharge Disposition
Where is the patient after discharge from your agency? (Choose only one answer.)

Enter Code ☐	1. **Patient remained in the community (without formal assistive services)** → Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge 2. **Patient remained in the community (with formal assistive services)** → Continue to A2121, Provision of Current Reconciled Medication List to Subsequent Provider at Discharge 3. **Patient transferred to a non-institutional hospice** → Continue to A2121, Provision of Current Reconciled Medication List to Subsequent Provider at Discharge 4. **Unknown because patient moved to a geographic location not served by this agency** → Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge 5. UK **Other unknown** → Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge

A2120. Provision of Current Reconciled Medication List to Subsequent Provider at Transfer
At the time of transfer to another provider, did your agency provide the patient's current reconciled medication list to the subsequent provider?

Enter Code ☐	0. **No – Current reconciled medication list not provided to the subsequent provider** → *Skip to J1800, Any Falls Since SOC/ROC* 1. **Yes – Current reconciled medication list provided to the subsequent provider** → Continue to A2122, Route of Current Reconciled Medication List Transmission to Subsequent Provider 2. **NA** – The agency was not made aware of this transfer timely → *Skip to J1800, Any Falls Since SOC/ROC*

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge
At the time of discharge to another provider, did your agency provide the patient's current reconciled medication list to the subsequent provider?

Enter Code ☐	0. **No – Current reconciled medication list not provided to the subsequent provider** → *Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge* 1. **Yes – Current reconciled medication list provided to the subsequent provider** → Continue to A2122, Route of Current Reconciled Medication List Transmission to Subsequent Provider

New

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Reconciled Medications

Medication Reconciliation -- The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider.

A2122 Route of Current Reconciled Medication List Transmission to Subsequent Provider
Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.

Route of Transmission	↓ Check all that apply ↓
A. **Electronic Health Record**	☐
B. **Health Information Exchange Organization**	☐
C. **Verbal** (e.g., in-person, telephone, video conferencing)	☐
D. **Paper-based** (e.g., fax, copies, printouts)	☐
E. **Other Methods** (e.g., texting, email, CDs)	☐

New

A2123. Provision of Current Reconciled Medication List to Patient at Discharge
At the time of discharge, did your facility provide the patient's current reconciled medication list to the patient, family and/or caregiver?

Enter Code ☐	0. **No– Current reconciled medication list not provided to the patient, family and/or caregiver** → Skip to B1300, Health Literacy 1. **Yes – Current reconciled medication list provided to the patient, family and/or caregiver**→ Continue to A2124, Route of Current Reconciled Medication List Transmission to Patient.

New

A2124. Route of Current Reconciled Medication List Transmission to Patient
Indicate the route(s) of transmission of the current reconciled medication list to the patient/family/caregiver.

Route of Transmission	↓ Check all that apply ↓
A. **Electronic Health Record**	☐
B. **Health Information Exchange Organization**	☐
C. **Verbal** (e.g., in-person, telephone, video conferencing)	☐
D. **Paper-based** (e.g., fax, copies, printouts)	☐
E. **Other Methods** (e.g., texting, email, CDs)	☐

New

Transition of Care – The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.

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Why Do I Need to Do Med Reconciliation at Discharge?

Ensure new caregivers (or patient and family) are aware of current medications, doses and reasons

Medication reconciliation should be ongoing rather than a single process

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Hearing, Speech, Vision

Section B

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Section B	Hearing, Speech, and Vision

SENSORY STATUS

(M1200)	Vision (with corrective lenses if the patient usually wears them):
Enter Code	0 Normal vision: sees adequately in most situ…ion labels, newsprint. 1 Partially impaired: cannot see medication …sprint, d… see obstacles in path, and the surrounding layout; can count fing… arm's … 2 Severely impaired: cannot locate objects wit… …g them, or patient nonresponsive.

B0200. Hearing — New

Enter Code	Ability to hear (with hearing aid or hearing appliances if normally used)
	0. **Adequate** – no difficulty in normal conversation, social interaction, listening to TV 1. **Minimal difficulty** – difficulty in some environments (e.g., when person speaks softly, or setting is noisy) 2. **Moderate difficulty** – speaker has to increase volume and speak distinctly 3. **Highly impaired** – absence of useful hearing

B1000. Vision — New

Enter Code	Ability to see in adequate light (with glasses or other visual appliances)
	0. **Adequate** – sees fine detail, such as regular print in newspapers/books 1. **Impaired** – sees large print, but not regular print in newspapers/books 2. **Moderate impaired** – limited vision; not able to see newspaper headlines but can identify objects 3. **Highly impaired** – object identification in question, but eyes appear to follow objects 4. **Severely impaired** – no vision or sees only light, colors or shapes; eyes do not appear to follow objects

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Health Literacy

B1300. Health Literacy *(From Creative Commons ©)*

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

Enter Code	
	0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Patient declines to respond 8. Patient unable to respond

New

The Single Item Literacy Screener is licensed under a Creative Commons Attribution Noncommercial 4.0 International License.

Personal health literacy is the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

The new definitions:

- Emphasize people's ability to *use* health information rather than just understand it
- Focus on the ability to make "well-informed" decisions rather than "appropriate" ones
- Acknowledge that organizations have a responsibility to address health literacy
- Incorporate a public health perspective

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Cognitive

Section C

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New cognitive status items for OASIS-E

New

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?
Attempt to conduct interview with all patients.

Enter Code

0. No (patient is rarely/never understood) → *Skip to C1310, Signs and Symptoms of Delirium (from CAM ®)*
1. Yes → Continue to C0200, Repetition of Three Words

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Enter Code

Ask patient: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: **sock, blue, and bed**. Now tell me the three words."*

Number of words repeated after first attempt

0. None
1. One
2. Two
3. Three

After the patient's first attempt, repeat the words using cues *("sock, something to wear; blue, a color; bed, a piece of furniture")*. You may repeat the words up to two more times.

C0300. Temporal Orientation (Orientation to year, month, and day)

Enter Code

Ask patient: *"Please tell me what year it is right now."*

A. **Able to report correct year**
0. **Missed by > 5 years** or no answer
1. **Missed by 2-5 years**
2. **Missed by 1 year**
3. **Correct**

Enter Code

Ask patient: *"What month are we in right now?"*

B. **Able to report correct month**
0. **Missed by > 1 month** or no answer
1. **Missed by 6 days to 1 month**
2. **Accurate within 5 days**

Enter Code

Ask patient: *"What day of the week is today?"*

C. **Able to report correct day of the week**
0. **Incorrect** or no answer
1. **Correct**

C0400. Recall

Enter Code

Ask patient: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"*
If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

A. **Able to recall "sock"**
0. **No** – could not recall
1. **Yes, after cueing** ("something to wear")
2. **Yes, no cue required**

Enter Code

B. **Able to recall "blue"**
0. **No** – could not recall
1. **Yes, after cueing** ("a color")
2. **Yes, no cue required**

Enter Code

C. **Able to recall "bed"**
0. **No** – could not recall
1. **Yes, after cueing** ("a piece of furniture")
2. **Yes, no cue required**

C0500. BIMS Summary Score

Enter Score

Add scores for questions C0200-C0400 and fill in total score (00-15)
Enter 99 if the patient was unable to complete the interview

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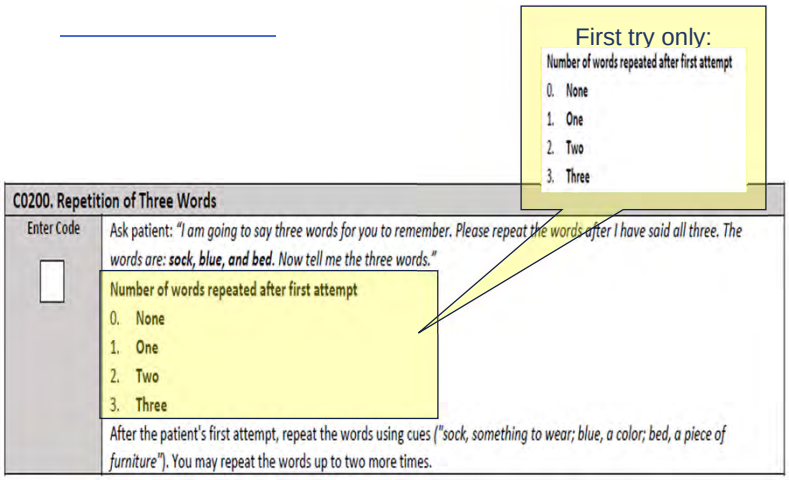
C0200: Repetition of Three Words



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C0300: Temporal Orientation

C0300. Temporal Orientation (Orientation to year, month, and day)	
Enter Code ☐	Ask patient: *"Please tell me what year it is right now."* A. **Able to report correct year** 0. **Missed by > 5 years** or no answer 1. **Missed by 2-5 years** 2. **Missed by 1 year** 3. **Correct**
Enter Code ☐	Ask patient: *"What month are we in right now?"* B. **Able to report correct month** 0. **Missed by > 1 month** or no answer 1. **Missed by 6 days to 1 month** 2. **Accurate within 5 days**
Enter Code ☐	Ask patient: *"What day of the week is today?"* C. **Able to report correct day of the week** 0. **Incorrect** or no answer 1. **Correct**

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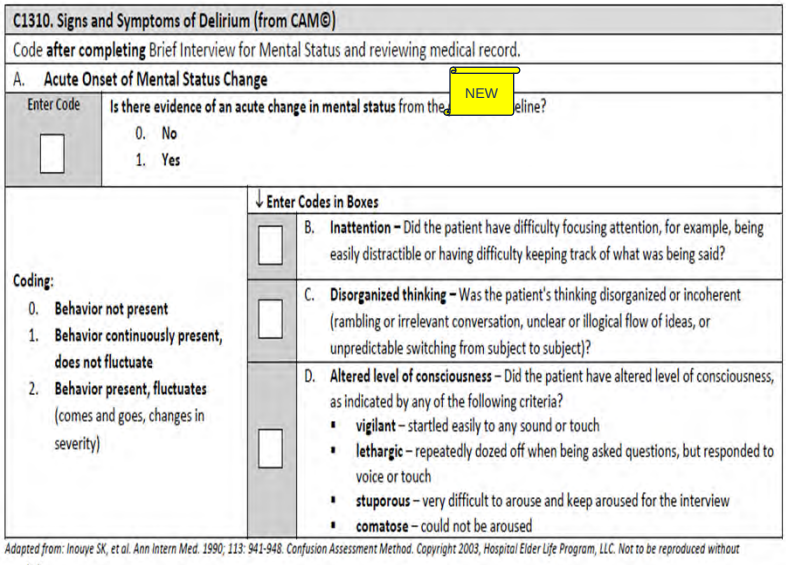
CAM (Confusion Assessment Method)



C1310. Signs and Symptoms of Delirium (from CAM©)

Code **after completing** Brief Interview for Mental Status and reviewing medical record.

A. **Acute Onset of Mental Status Change**

NEW

Enter Code ☐ — **Is there evidence of an acute change in mental status** from the[illegible]eline?

0. No
1. Yes

Coding:

0. **Behavior not present**
1. **Behavior continuously present, does not fluctuate**
2. **Behavior present, fluctuates** (comes and goes, changes in severity)

↓ **Enter Codes in Boxes**

☐ B. **Inattention –** Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?

☐ C. **Disorganized thinking –** Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?

☐ D. **Altered level of consciousness** – Did the patient have altered level of consciousness, as indicated by any of the following criteria?

- **vigilant** – startled easily to any sound or touch
- **lethargic** – repeatedly dozed off when being asked questions, but responded to voice or touch
- **stuporous** – very difficult to arouse and keep aroused for the interview
- **comatose** – could not be aroused

Adapted from: Inouye SK, et al. Ann Intern Med. 1990; 113: 941-948. Confusion Assessment Method. Copyright 2003, Hospital Elder Life Program, LLC. Not to be reproduced without

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Purpose of the CAM

CAM is a standardized evidence-based tool that enables non-psychiatrically trained clinicians to identify and recognize delirium quickly and accurately in both clinical and research settings.

The screening tool alerts clinicians to the presence of possible delirium.

https://www.youtube.com/watch?v=GGmp32-l5rg

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Purpose of the CAM

CAM is a standardized evidence-based tool that enables non-psychiatrically trained clinicians to identify and recognize delirium quickly and accurately in both clinical and research settings.

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https://www.youtube.com/watch?v=GGmp32-l5rg

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Mood

Section D

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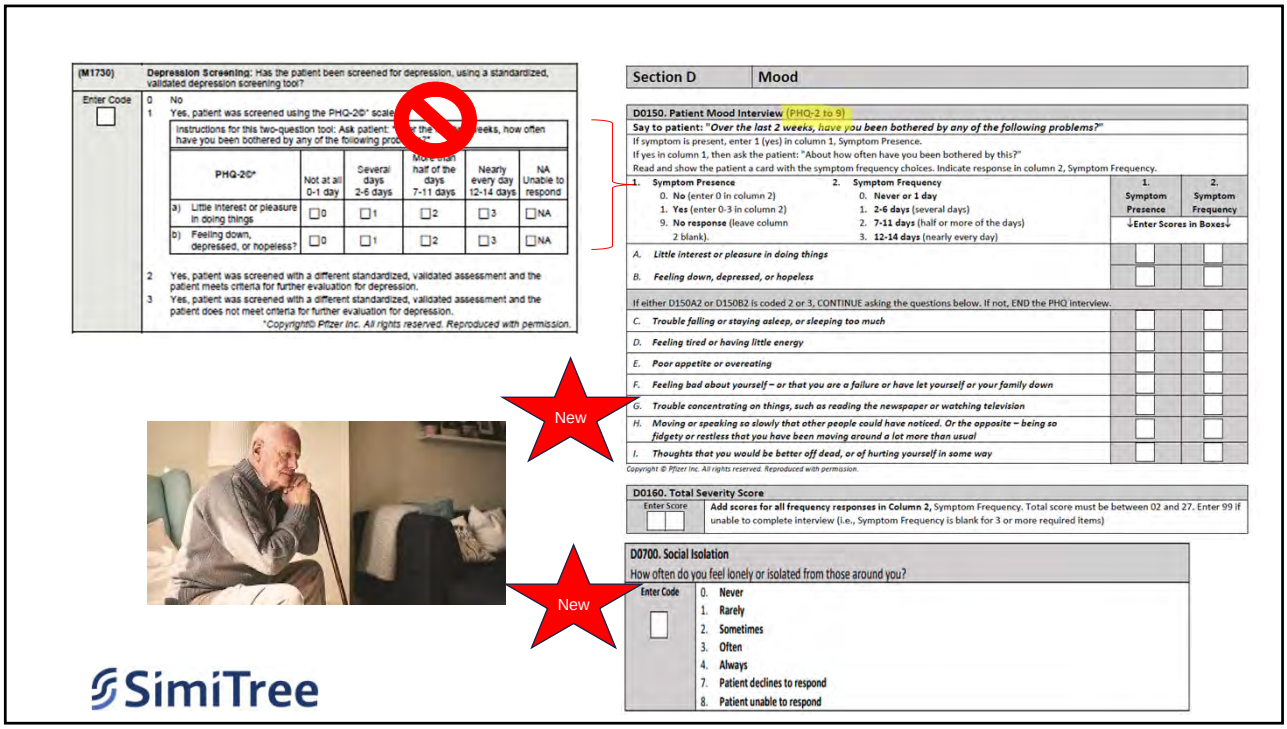
34



Behavior

Section E

SimiTree

M1740. Cognitive, Behavioral, and Psychiatric Symptoms that are demonstrated at least once a week (Reported or Observed):

↓ Check all that apply

- ☐ 1. **Memory deficit:** failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
- ☐ 2. **Impaired decision-making:** failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
- ☐ 3. **Verbal disruption:** yelling, threatening, excessive profanity, sexual references, etc.
- ☐ 4. **Physical aggression:** aggressive or combative to self and others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- ☐ 5. **Disruptive, infantile, or socially inappropriate behavior** (excludes verbal actions)
- ☐ 6. **Delusional, hallucinatory, or paranoid behavior**
- ☐ 7. **None of the above behaviors demonstrated**

M1745. Frequency of Disruptive Behavior Symptoms (Reported or Observed):
Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.

Enter Code ☐

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**

Section E **Behavior**

M1740. Cognitive, Behavioral, and Psychiatric Symptoms that are demonstrated at least once a week (Reported or Observed):

↓ Check all that apply

- ☐ 1. **Memory deficit:** failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
- ☐ 2. **Impaired decision-making:** failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
- ☐ 3. **Verbal disruption:** yelling, threatening, excessive profanity, sexual references, etc.
- ☐ 4. **Physical aggression:** aggressive or combative to self and others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- ☐ 5. **Disruptive, infantile, or socially inappropriate behavior** (excludes verbal actions)
- ☐ 6. **Delusional, hallucinatory, or paranoid behavior**
- ☐ 7. **None of the above behaviors demonstrated**

M1745. Frequency of Disruptive Behavior Symptoms (Reported or Observed):
Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.

Enter Code ☐

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**

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Preferences for Customary Routine Activities

Section F

SimiTree

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 (for example, assisted living, residential care home)	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15

Section F	Preferences for Customary Routine Activities

M1100. Patient Living Situation
Which of the following best describes the patient's residential circumstance and availability of assistance?

Living Arrangement	Availability of Assistance: Around the Clock	Regular Daytime	Regular Nighttime	Occasional/ Short-Term Assistance	No Assistance Available
	↓Check one box only↓				
A. **Patient lives alone**	☐01	☐02	☐03	☐04	☐05
B. **Patient lives with other person(s) in the home**	☐06	☐07	☐08	☐09	☐10
C. **Patient lives in congregate situation** (for example, assisted living, residential care home)	☐11	☐12	☐13	☐14	☐15

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CARE MANAGEMENT

SOC/ROC

(M2102)	**Types and Sources of Assistance:** Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.
Enter Code ☐	f. **Supervision and safety** (for example, due to cognitive impairment) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available

Discharge

(M2102)	**Types and Sources of Assistance:** Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.
Enter Code ☐	a. **ADL assistance** (for example, transfer/ ambulation, bathing, dressing, toileting, eating/feeding) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	c. **Medication administration** (for example, oral, inhaled or injectable) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	d. **Medical procedures/ treatments** (for example, changing wound dressing, home exercise program) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	f. **Supervision and safety** (for example, due to cognitive impairment) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available

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SOC/ROC

M2102. Types and Sources of Assistance
Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.

Enter Code	
☐	F. **Supervision and safety** (for example, due to cognitive impairment) 0. **No assistance needed – patient is independent or does not have needs in this area** 1. **Non-agency caregiver(s) currently provide assistance** 2. **Non-agency caregiver(s) need training/supportive services to provide assistance** 3. **Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance** 4. **Assistance needed, but no non-agency caregiver(s) available**

Discharge

M2102. Types and Sources of Assistance
Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.

Enter Code	
☐	A. **ADL assistance** (for example, transfer/ambulation, bathing, dressing, toileting, eating/feeding) 0. **No assistance needed –patient is independent or does not have needs in this area** 1. **Non-agency caregiver(s) currently provide assistance** 2. **Non-agency caregiver(s) need training/supportive services to provide assistance** 3. **Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance** 4. **Assistance** needed, **but no non-agency caregiver(s) available**
Enter Code ☐	C. **Medication administration** (for example, oral, inhaled or injectable) 0. **No assistance needed –patient is independent or does not have needs in this area** 1. **Non-agency caregiver(s) currently provide assistance** 2. **Non-agency caregiver(s) need training/supportive services to provide assistance** 3. **Non-agency caregiver(s) are not likely to provide assistance, OR it is unclear if they will provide assistance** 4. **Assistance** needed, **but no non-agency caregiver(s) available**
Enter Code ☐	D. **Medical procedures/treatments** (for example, changing wound dressing, home exercise program) 0. **No assistance needed –patient is independent or does not have needs in this area** 1. **Non-agency caregiver(s) currently provide assistance** 2. **Non-agency caregiver(s) need training/supportive services to provide assistance** 3. **Non-agency caregiver(s) are not likely to provide assistance, OR it is unclear if they will provide assistance** 4. **Assistance needed, but no non-agency caregiver(s) available**
Enter Code ☐	F. **Supervision and safety** (for example, due to cognitive impairment) 0. **No assistance needed –patient is independent or does not have needs in this area** 1. **Non-agency caregiver(s) currently provide assistance** 2. **Non-agency caregiver(s) need training/supportive services to provide assistance** 3. **Non-agency caregiver(s) are not likely to provide assistance, OR it is unclear if they will provide assistance** 4. **Assistance** needed, **but no non-agency caregiver(s) available**

Functional and Functional Ability

Section G and GG

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GG and GG Items

No changes to M18-- items except M1870 moved to a different category

No changes to GG items

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Bladder and Bowel

Section H

SimiTree

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ELIMINATION STATUS

(M1600)	Has this patient been treated for a **Urinary Tract Infection** in the past 14 days?
Enter Code ☐	0 No 1 Yes NA Patient on prophylactic treatment UK Unknown *[Omit "UK" option on DC]*
(M1610)	**Urinary Incontinence or Urinary Catheter Presence:**
Enter Code ☐	0 No incontinence or catheter (includes anuria or ostomy for urinary drainage) 1 Patient is incontinent 2 Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic)
(M1620)	**Bowel Incontinence Frequency:**
Enter Code ☐	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 *[Omit "UK" option on FU, DC]*
(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?
Enter Code ☐	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.

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Section H	Bladder and Bowel

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

Enter Code ☐

0. No
1. Yes
NA Patient on prophylactic treatment
UK Unknown [Omit "UK" option on DC]

M1610. Urinary Incontinence or Urinary Catheter Presence

Enter Code ☐

0. **No incontinence or catheter** (includes anuria or ostomy for urinary drainage)
1. **Patient is incontinent**
2. **Patient requires a urinary catheter** (specifically: external, indwelling, intermittent, or suprapubic)

M1620. Bowel Incontinence Frequency

Enter Code ☐

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 [Omit "UK" option on DC]

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?

Enter Code ☐

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.

Active Diagnoses

Section I

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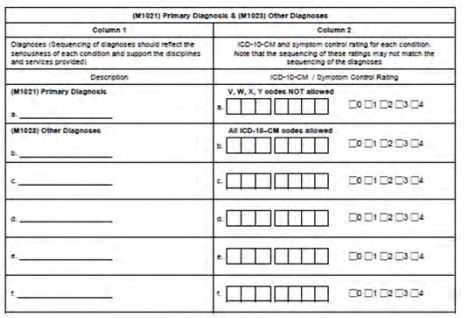

(M1021) Primary Diagnosis & (M1023) Other Diagnoses

Column 1	Column 2
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided)	ICD-10-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses
Description	ICD-10-CM / Symptom Control Rating
(M1021) Primary Diagnosis a. _____	V, W, X, Y codes NOT allowed a. ☐☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4
(M1023) Other Diagnoses b. _____	All ICD-10-CM codes allowed b. ☐☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4
c. _____	c. ☐☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4
d. _____	d. ☐☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4
e. _____	e. ☐☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4
f. _____	f. ☐☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4

(M1028) Active Diagnoses – Comorbidities and Co-existing Conditions – Check all that apply
See OASIS Guidance Manual for a complete list of relevant ICD-10 codes.

☐ 1 - Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
☐ 2 - Diabetes Mellitus (DM)
☐ 3 - None of the above

Not on recert any longer

M1021. Primary Diagnosis & M1023. Other Diagnoses

Column 1	Column 2
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided)	ICD-10-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses

M1021. Primary Diagnosis

a. _____	V, W, X, Y NOT allowed a. ☐☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4

M1023. Other Diagnoses

B. _____	All ICD-10-CM codes allowed B. ☐☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4
C. _____	C. ☐☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4
D. _____	D. ☐☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4
E. _____	E. ☐☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4
F. _____	F. ☐☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4

M1028. Active Diagnoses – Comorbidities and Co-existing Conditions

↓ Check all that apply	
☐	1. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
☐	2. Diabetes Mellitus (DM)
☐	3. None of the above

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Health Conditions

Section J

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(M1033) **Risk for Hospitalization:** Which of the following signs or symptoms characterize this patient as at risk for hospitalization? **(Mark all that apply.)**

- ☐ 1 - History of falls (2 or more falls – or any fall with an injury – in the past 12 months)
- ☐ 2 - Unintentional weight loss of a total of 10 pounds or more in the past 12 months
- ☐ 3 - Multiple hospitalizations (2 or more) in the past 6 months
- ☐ 4 - Multiple emergency department visits (2 or more) in the past 6 months
- ☐ 5 - Decline in mental, emotional, or behavioral status in the past 3 months
- ☐ 6 - Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
- ☐ 7 - Currently taking 5 or more medications
- ☐ 8 - Currently reports exhaustion
- ☐ 9 - Other risk(s) not listed in 1 - 8
- ☐ 10 - None of the above

(M1242)	Frequency of Pain Interfering with patient's activity or movement:
Enter Code ☐	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

Section J	Health Conditions

M1033. Risk for Hospitalization
Which of the following signs or symptoms characterize this patient as at risk for hospitalization?
↓ Check all that apply

☐	1.	**History of falls** (2 or more falls – or any fall with an injury – in the past 12 months)
☐	2.	**Unintentional weight loss of a total of 10 pounds or more in the past 12 months**
☐	3.	**Multiple hospitalizations (2 or more) in the past 6 months**
☐	4.	**Multiple emergency department visits (2 or more) in the past 6 months**
☐	5.	**Decline in mental, emotional, or behavioral status in the past 3 months**
☐	6.	**Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months**
☐	7.	**Currently taking 5 or more medications**
☐	8.	**Currently reports exhaustion**
☐	9.	**Other risk(s) not listed in 1-8**
☐	10.	**None of the above**

J0510. Pain Effect on Sleep
Enter Code ☐
Ask patient: "*Over the past 5 days, how much of the time has pain made it hard for you to sleep at night*"
0. **Does not apply – I have not had any pain or hurting in the past 5 days** → Skip to M1400, Short of Breath at SOC/ROC; Skip to J1800 Any Falls Since SOC/ROC at DC
1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

NEW

J0520. Pain Interference with Therapy Activities
Enter Code ☐
Ask patient: "*Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain?*"
0. **Does not apply – I have not received rehabilitation therapy in the past 5 days**
1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

NEW

J0530. Pain Interference with Day-to-Day Activities
Enter Code ☐
Ask patient: "*Over the past 5 days, how often you have limited your day-to-day activities (excluding rehabilitation therapy session) because of pain?*"
1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

NEW -ish

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Section J: Health Conditions

J1800.	Any Falls Since SOC/ROC, whichever is more recent
Enter Code ☐	Has the patient had any falls since SOC/ROC, whichever is more recent? 0. No — Skip J1900 1. Yes — Continue to J1900, Number of Falls Since SOC/ROC, whichever is more recent

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

RESPIRATORY STATUS

(M1400)	When is the patient dyspneic or noticeably **Short of Breath**?
Enter Code ☐	0 Patient is not short of breath 1 When walking more than 20 feet, climbing stairs 2 With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet) 3 With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation 4 At rest (during day or night)

J1800. **Any Falls Since SOC/ROC**, whichever is more recent Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury.	
Enter Code ☐	Has the patient **had any falls since SOC/ROC**, whichever is more recent? 0. **No** → Skip to M1400, Short of Breath at DC; Skip to M2005, Medication Intervention at TRN and DAH 1. **Yes** → Continue to J1900, Number of Falls Since SOC/ROC

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

M1400. When is the patient dyspneic or noticeably **Short of Breath?**	
Enter Code ☐	0. **Patient is not short of breath** 1. **When walking more than 20 feet, climbing stairs** 2. **With moderate exertion** (for example, while dressing, using commode or bedpan, walking distances less than 20 feet) 3. **With minimal exertion** (for example, while eating, talking, or performing other ADLs) or with agitation 4. **At rest** (during day or night)

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Swallowing/Nutritional Status

Section K

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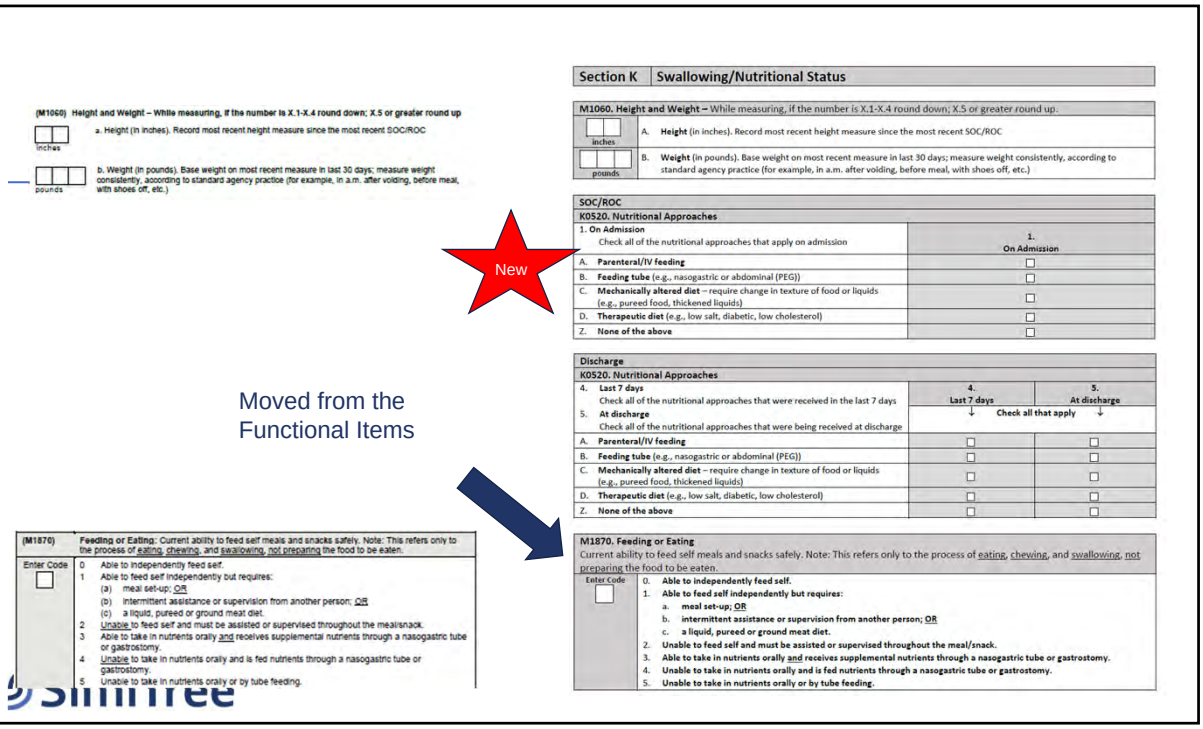

Skin Conditions

Section M

Section M	Skin Conditions

M1306, M1307: No change

SOC/ROC

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
A1. **Stage 2:** Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers**	☐

SOC/ROC	
M1311. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	
Enter Number ☐	A1. **Stage 2:** Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers**

Graphics change only

Follow-Up

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
A1. **Stage 2:** Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers**	☐

Follow-up version not indicated….?

Discharge

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
A1. **Stage 2:** Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 – Go to M1311B1, Stage 3]	☐
A2. **Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐

Discharge	
M1311. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	
Enter Number ☐	A1. **Stage 2:** Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** – If 0 → Skip to M1311B1, Stage 3
Enter Number ☐	A2. **Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC

Graphics change only

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No changes….

M1322. Current Number of Stage 1 Pressure Injuries
Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.

Enter Code	
☐	0 1 2 3 4 or more

M1324. Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable
Excludes pressure ulcer/injury that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or deep tissue injury.

Enter Code	
☐	1. **Stage 1** 2. **Stage 2** 3. **Stage 3** 4. **Stage 4** NA **Patient has no pressure ulcers/injuries or no stageable pressure ulcers/injuries**

M1330. Does this patient have a **Stasis Ulcer?**

Enter Code	
☐	0. **No** → Skip to M1340, Surgical Wound 1. **Yes, patient has BOTH observable and unobservable stasis ulcers** 2. **Yes, patient has observable stasis ulcers ONLY** 3. **Yes, patient has unobservable stasis ulcers ONLY** (known but not observable due to non-removable dressing/device) → Skip to M1340, Surgical Wound

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

Enter Code	
☐	1. **One** 2. **Two** 3. **Three** 4. **Four**

M1334. Status of Most Problematic Stasis Ulcer that is Observable

Enter Code	
☐	1. **Fully granulating** 2. **Early/partial granulation** 3. **Not healing**

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(M1340)	Does this patient have a **Surgical Wound?**
Enter Code ☐	0 No *[Go to M1400]* 1 Yes, patient has at least one observable surgical wound 2 Surgical wound known but not observable due to non-removable dressing/device *[Go to M1400]*
(M1342)	**Status of Most Problematic Surgical Wound that is Observable**
Enter Code ☐	0 Newly epithelialized 1 Fully granulating 2 Early/partial granulation 3 Not healing

M1340. Does this patient have a **Surgical Wound**?	
Enter Code ☐	0. **No** → Skip to N0415, High-Risk Drug Classes: Use and Indication 1. **Yes, patient has at least one observable surgical wound** 2. **Surgical wound known but not observable due to non-removable dressing/device** → Skip to N0415, High-Risk Drug Classes: Use and Indication

M1342. Status of Most Problematic Surgical Wound that is Observable	
Enter Code ☐	0. **Newly epithelialized** 1. **Fully granulating** 2. **Early/partial granulation** 3. **Not healing**

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Medications

Section N

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(M2016)	Patient/Caregiver Drug Education Intervention: At the time ... since the most recent SOC/ROC assessment, was the patient/caregiver ... or other health care provider to monitor the effectiveness of drug therapy, ... and significant side effects, and how and when to report problems that ma...
Enter Code ☐	0 No 1 Yes NA Patient not taking any drugs

New

Section N	Medications

SOC/ROC and Discharge N0415. High-Risk Drug Classes: Use and Indication		
1. **Is taking** Check if the patient is taking any medications by pharmacological classification, not how it is used, in the following classes 2. **Indication noted** If Column 1 is checked, check if there is an indication noted for all medications in the drug class	1. Is Taking ↓ Check all that apply ↓	2. Indication Noted
A. **Antipsychotic**	☐	☐
E. **Anticoagulant**	☐	☐
F. **Antibiotic**	☐	☐
H. **Opioid**	☐	☐
I. **Antiplatelet**	☐	☐
J. **Hypoglycemic** (including insulin)	☐	☐
Z. **None of the Above**	☐	

M2001 – M2030: No change except deletion of M2016 per 2022 Final Rule

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Special Treatment, Procedures, and Programs

Section O

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(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, any other [illegible] into the alimentary canal)
- ☐ 4 - None of the above

New

Section O	Special Treatment, Procedures, and Programs

SOC/ROC O0110. Special Treatments, Procedures, and Programs Check all of the following treatments, procedures, and programs that apply on admission.	a. On Admission Check all that apply
Cancer Treatments	
A1. Chemotherapy	☐
A2. IV	☐
A3. Oral	☐
A10. Other	☐
B1. Radiation	☐
Respiratory Therapies	
C1. Oxygen Therapy	☐
C2. Continuous	☐
C3. Intermittent	☐
C4. High-concentration	☐
D1. Suctioning	☐
D2. Scheduled	☐
D3. As needed	☐
E1. Tracheostomy Care	☐
F1. Invasive Mechanical Ventilator (ventilator or respirator)	☐
G1. Non-invasive Mechanical Ventilator	☐
G2. BiPAP	☐
G3. CPAP	☐
Other	
H1. IV Medications	☐
H2. Vasoactive medications	☐
H3. Antibiotics	☐
H4. Anticoagulation	☐
H10. Other	☐
I1. Transfusions	☐
J1. Dialysis	☐
J2. Hemodialysis	☐
J3. Peritoneal dialysis	☐
O1. IV Access	☐
O2. Peripheral	☐
O3. Mid-line	☐
O4. Central (e.g., PICC, tunneled, port)	☐
None of the Above	
Z1. None of the Above	☐

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(M1041)	**Influenza Vaccine Data Collection Period:** Does this episode of care (SOC/ROC to Transfer/Discharge) include any dates on or between October 1 and March 31?
Enter Code ☐	0 No *[Go to M1051]* 1 Yes

(M1046)	**Influenza Vaccine Received:** Did the patient receive the influenza vaccine for this year's flu season?
Enter Code ☐	1 Yes; received from your agency during this episode of care (SOC/ROC to Transfer/Discharge) 2 Yes; received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge) 3 Yes; received from another health care provider (for example, physician, pharmacist) 4 No; patient offered and declined 5 No; patient assessed and determined to have medical contraindication(s) 6 No; not indicated – patient does not meet age/condition guidelines for influenza vaccine 7 No; inability to obtain vaccine due to declared shortage 8 No; patient did not receive the vaccine due to reasons other than those listed in responses 4-7.

M1041. Influenza Vaccine Data Collection Period
Does this episode of care (SOC/ROC to Transfer/Discharge) include any dates on or between October 1 and March 31?

Enter Code ☐	0. **No** → Skip to M2401, Intervention Synopsis 1. **Yes** → Continue to M1046, Influenza Vaccine Received

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

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

(M1051)	**Pneumococcal Vaccine:** Has the patient ever received the pneumococcal vaccination (for example, pneumovax)?
Enter Code ☐	0 No 1 Yes *[Go to M2005 at TRN; Go to M1242 at DC]*

(M1056)	**Reason Pneumococcal Vaccine not received:** If patient has never received the pneumococcal vaccination (for example, pneumovax), state reason.
Enter Code ☐	1 Offered and declined 2 Assessed and determined to have medical contraindication(s) 3 Not indicated; patient does not meet age/condition guidelines for Pneu 4 None of the above

M1051/M1056: Removed

THERAPY NEED AND PLAN OF CARE

(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.

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.

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Participation in Assessment and Goal Setting

Section Q

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DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY DISCHARGE ONLY

(M2401) Intervention Synopsis: (Check only one box in each row.) At the time of or at any time since the most recent SOC/ROC assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

Plan / Intervention	No	Yes	Not Applicable	
a. Diabetic foot care including monitoring for the presence of ulcers, callus, or the lower extremities and patient/caregiver education on proper foot care	☐0	☐1	☐NA	Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
b. Falls prevention interventions	☐0	☐1	☐NA	Every standardized, validated multi-factor fall risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no risk for falls.
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	☐0	☐1	☐NA	Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the most recent SOC/ROC assessment indicates the patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.
d. Intervention(s) to monitor and mitigate pain	☐0	☐1	☐NA	Every standardized, validated pain assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no pain.
e. Intervention(s) to prevent pressure ulcers	☐0	☐1	☐NA	Every standardized, validated pressure ulcer risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient is not at risk of developing pressure ulcers.
f. Pressure ulcer treatment based on principles of moist wound healing	☐0	☐1	☐NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

Section Q	Participation in Assessment and Goal Setting

M2401. Intervention Synopsis
At the time of or at any time since the most recent SOC/ROC assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented? (Mark only one box in each row.)

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

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Miscellaneous

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Social Determinants of Health

- Emerging focus = Social Determinants of Health (SDOH)
  - Dually-eligible enrollees
- Focuses of CMS
  - Population health
  - Reduction of health care spending
  - Patient/caregiver satisfaction
- Past initiatives have focused on
  - Increasing access to health care
  - Treating medical conditions

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How Will OASIS E be used?

- Patient-Driven Groupings Model (PDGM) Functional Grouper Scoring
- Home Health Quality Reporting Program (HHQRP) measures
- Star Ratings on Care Compare
- Value Based Purchasing (VBP)

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PDGM Items from OASIS E

As far as we know now, these items will continue to contribute to payment calculations under PDGM:

- M1033 Risk for Hospitalization
- M1800 Grooming
- M1810 Ability to Dress Upper Body
- M1820 Ability to Dress Lower Body
- M1830 Bathing
- M1840 Toilet Transferring
- M1845 Toileting Hygiene
- M1850 Transferring
- M1860 Ambulation/Locomotion

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2022 HHQRP Measures – Claims

Claims-based	
ACH	Acute Care Hospitalization During the First 60 Days of HH (NQF #0171).
DTC	Discharge to Community-Post Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP) (NQF #3477)
ED Use	Emergency Department Use without Hospitalization During the First 60 Days of HH (NQF #0173).
MSPB	Total Estimated Medicare Spending Per Beneficiary (MSPB)—Post Acute Care (PAC) HH QRP.
PPR	Potentially Preventable 30-Day Post-Discharge Readmission Measure for HH Quality Reporting Program.

2022 HHQRP Measures – HHCAHPS

HHCAHPS-based	
CAHPS Home Health Survey	CAHPS® Home Health Care Survey (experience with care) (NQF #0517)[50] - How often the HH team gave care in a professional way. - How well did the HH team communicate with patients. - Did the HH team discuss medicines, pain, and home safety with patients. - How do patients rate the overall care from the HHA. - Will patients recommend the HHA to friends and family.

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2022 HHQRP Measures – OASIS-Based

Short Name	Measure Name & Data Source
	OASIS-based
Ambulation	Improvement in Ambulation/Locomotion (NQF #0167).
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674).
Application of Functional Assessment	Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631).
Bathing	Improvement in Bathing (NQF #0174).
Bed Transferring	Improvement in Bed Transferring (NQF # 0175).
DRR	Drug Regimen Review Conducted With Follow-Up for Identified Issues- Post Acute Care (PAC) HH QRP.
Drug Education	Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care.
Dyspnea	Improvement in Dyspnea.
Influenza	Influenza Immunization Received for Current Flu Season
Oral Medications	Improvement in Management of Oral Medications (NQF #0176).
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care
Timely Care	Timely Initiation Of Care (NQF #0526).
TOH - Provider	Transfer of Health Information to Provider-Post-Acute Care[48]
TOH - Patient	Transfer of Health Information to Patient-Post-Acute Care[49]

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Looking at Recerts/FU

- M0080-Discipline completing OASIS
- M0090-Date assessment completed
- M0100-Assessment reason
- M0110-Episode Timing
- M1800-Grooming
- M1810 & M1820-Upper and Lower Body
- M1830-Bathing
- M1840-Toilet Transferring
- M1850-Transferring
- M1860-Ambulation/Locomotion
- GG0130-Self Care
- GG0170-Mobility
- M1033-Risk of Hospitalization
- M1306-Unhealed pressure ulcer

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Preparation

1. Check with EMR to see how they are formatting the OASIS as written or for flow of EMR/Assessment
2. Educate/educate/educate
3. Look at policy and procedures (Tune in to the next in the series of webinars)
4. Start thinking about processes that may need to be put into place to ensure compliance and communication
5. Possible productivity adjustments

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OASIS-E Series

- Policies, Procedures, and Ponderations- June 23, 2022-12PM EST
  - Gain insight and tips into the Mood, Medication and Special Treatment sections to ensure your agency is aware of needed training. Agencies will recognize where policies and procedures may need development to tackle these sections as well.

https://us06web.zoom.us/webinar/register/WN_d-CoD31rSxiwFdM1Kzyj3Q

- Finding the Value In OASIS E-July 21, 2022-11AM EST
  - This webinar will demonstrate how OASIS E data is used when defining your agency's quality portfolio and performance scoring for Value Based Purchasing. Learn which items are used in these programs and why accurate data collection is imperative to agency success.

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Learning Solutions

SimiTree's Learning Solutions will be offering customized agency OASIS-E training.

https://simitreehc.com/home/healthcare-consulting-services/healthcare-consulting/learning-solutions/

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Questions?

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