AXXESS

OASIS-E

RESOURCE BOOKLET

Table of Contents

Introduction

The Outcome and Assessment Information Set (OASIS) is a group of standard data elements for home health organizations to integrate into their comprehensive assessment to collect and report quality data to CMS. Home health organizations must prepare for the transition from OASIS-D to OASIS-E on January 1, 2023.

According to the Centers for Medicare and Medicaid Services, the OASIS instrument was revised to increase standardization across post-acute care settings to uniformly collect social determinants of health data and have a standardized quality measure that can be used across different settings.

Additionally, the OASIS will play a key role with patient outcomes in the value-based purchasing environment. OASIS information will serve as a primary data source in calculating up to a 5% bonus or 5% reduction in reimbursements. Therefore, exceptional OASIS skills must be a priority for every clinician in every organization.

This resource booklet covers each new item added to the OASIS-E instrument, provides OASIS intent with guidance instructions, tips for proper coding and clinical examples that support decision-making.

We have included a crosswalk that offers a high-level review of the new instrument items, their section identifier and the potential impact. For your convenience, the crosswalk also includes a list of the items that are removed in OASIS-E. Our comprehensive training will provide you with all the necessary information and tools for maximum success.

ABC's of OASIS-E | Items Added

Following is a list of OASIS items to be added to the 2023 instrument.

Instrument Section - New Item	Item Number / Instrument Impact	Impact/Outcome*
Section A - Administrative	**A1005:** Ethnicity (SOC) **A1010:** Race (SOC) **A1110:** Language (SOC) **A1250:** Transportation (SOC, ROC) **A2120:** Provision of Current Reconciled Medication List to Subsequent Provider at Transfer (Transfer) **A2121:** Provision of Current Reconciled Medication List to Subsequent Provider at Discharge (DC) **A2122:** Route of Current Reconciled Medication List to Subsequent Provider (Transfer and DC) **A2123:** Provision of Current Reconciled Medication List to Patient at Discharge (DC) **A2124:** Route of Current Medication List Transmission to Patient (DC)	A1250 Quality Measures Risk Adjustment All other A items have a quality impact
Section B - Hearing, Speech, Vision	**B0200:** Ability to Hear (SOC) **B1000:** Vision (SOC) **B1300:** Health Literacy (SOC, ROC, DC)	Quality Measures Risk Adjustment
Section C - Cognitive Patterns	**C0100:** Should Brief Interview for Mental Status Be Conducted? (SOC, ROC, DC) **C0200:** Repetition of Three Words (SOC, ROC, DC) **C0300:** Temporal Orientation (SOC, ROC, DC) **C0400:** Recall (SOC, ROC, DC) **C0500:** BIMS Summary Score (SOC, ROC, DC) **C1310:** Signs and Symptoms of Delirium (from CAM) (SOC, ROC, DC)	Quality Measures Risk Adjustment
Section D - Mood	**D0150:** Patient Mood Interview (PHQ-2 to 9) (SOC, ROC, DC) **D0160:** Total Severity Score (SOC, ROC, DC) **D0700:** Social Isolation (SOC, ROC, DC)	Quality Measures Risk Adjustment
Section J - Health Conditions	**J0510:** Pain Effect on Sleep (SOC, ROC, DC) **J0520:** Pain Interference with Therapy Activities (SOC, ROC, DC) **J0530:** Pain Interference with Day-to-Day Activities (SOC, ROC, DC)	Quality Measures Risk Adjustment
Section K - Swallowing/ Nutritional Status	**K0520:** Nutritional Approaches (SOC, ROC, DC)	Quality Measures Risk Adjustment

Section N - Medications	**N0415:** High-Risk Drug Classes: Use and Indication (SOC, ROC, DC)	Quality Measures Risk Adjustment
Section O - Special Treatment, Procedures, Programs	**O0110:** Special Treatments, Procedures, and Programs (SOC, ROC, DC)	Potential Quality Measures Risk Adjustment

ABC's of OASIS-E | Items Removed

Following is a list of OASIS items to be removed from the 2023 instrument.

Instrument Section - Removed Item	Item Number	Time Points Removed
Section A - Administrative	**M0140:** Race/Ethnicity **M1200:** Vision	All OASIS instruments
Section D - Mood	**M1730:** Depression Screening	All OASIS instruments
Section H – Bladder and Bowel	**M1610:** Urinary Incontinence/Catheter **M1620:** Bowel Incontinence Frequency **M1630:** Ostomy	Only Follow Up (FU) Instrument
Section I – Active Diagnoses	**M1021** Primary Dx **M1023:** Secondary Dx	Only Follow Up (FU) Instrument
Section J - Health Conditions	**M1242:** Frequency of Pain Interfering with Activity **M1910:** Fall Risk Assessment	All OASIS instruments
	M1400: Dyspnea	Only Follow Up (FU) Instrument
Section K - Swallowing/ Nutritional Status	**M1030:** Therapies Received at Home	All OASIS instruments
Section M – Skin Conditions	**M1311:** Current Number of Unhealed PU **M1322:** Current Number of Stage 1 PU **M1330:** Presence of Stasis Ulcer **M1332:** Current Number of Observable Stasis Ulcers **M1334:** Status of Most Problematic Stasis Ulcer **M1340:** Presence of Surgical Wound **M1342:** Status or Most Problematic Surgical Wound	Only Follow Up (FU) Instrument
Section N – Medication	**M2016:** Drug Education Intervention	All OASIS instruments
	M2030: Management of Injectable Meds	Only Follow Up (FU) Instrument
Section O – Special Treatment, Procedures, Programs	**M1051:** Pneumococcal Vaccine **M1056:** Reason PPV Not Received	Only from Transfer and Discharge (TFR/DC) Instruments
	M2200: Therapy Need	Only Follow Up (FU) Instrument
Section Q – Participation in Assessment and Goal Setting	**M2401:** Line A Diabetic Foot Care Intervention Synopsis	All OASIS instruments

AXXESS

OASIS-E

SECTION A:

ADMINISTRATIVE INFORMATION

PATIENT TRACKING

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

Section A contains new items for patient tracking and general administrative information.

Intent: The intent of this item is to identify the patient's self-reported ethnicity data.

Rationale:

- The ability to improve understanding of and address racial and ethnic disparities in healthcare outcomes requires the availability of better data related to social determinants of health, including ethnicity.
- The ethnicity and race data elements use a two-question format. Collection of A1005, Ethnicity and A1010, Race provide data granularity important for documenting and tracking health disparities and conform to the 2011 Health and Human Services Data Standards.
- Collection of ethnicity data is an important step in improving quality of care and health outcomes.
- Standardizing self-reported data collection for ethnicity allows for the comparison of data within and across multiple post-acute care settings.
- These categories are NOT used to determine eligibility for participation in any Federal program.

Section A contains new items for patient tracking and general administrative information.

Intent: The intent of this item is to identify the patient's self-reported ethnicity data.

Rationale:

- The ability to improve understanding of and address racial and ethnic disparities in healthcare outcomes requires the availability of better data related to social determinants of health, including ethnicity.
- The ethnicity and race data elements use a two-question format. Collection of A1005, Ethnicity and A1010, Race provide data granularity important for documenting and tracking health disparities and conform to the 2011 Health and Human Services Data Standards.
- Collection of ethnicity data is an important step in improving quality of care and health outcomes.
- Standardizing self-reported data collection for ethnicity allows for the comparison of data within and across multiple post-acute care settings.
- These categories are NOT used to determine eligibility for participation in any Federal program.

Response (Coding) Tips:

Example	Response	Instructions
The patient had an acute CVA with mental status changes. During the SOC assessment the patient is unable to respond to questions regarding their ethnicity. The patient's spouse informs the nurse that they are Cuban.	A1005 would be coded as D – Yes, Cuban and X – Patient is unable to respond.	**1. Code X** **Patient unable to respond** A response can be determined by proxy input or medical record documentation. If a proxy is used, select the appropriate boxes and include Code X. If no proxy or resources are available to answer, only mark Code X. **2. Code Y** **Patient declines to respond** In the cases where the patient declines to respond, Code Y – Patient declines to respond, only. If the patient declines to respond, do not code based on a proxy input or medical record documentation.
The patient is admitted following a THA and declines to respond to questions regarding their ethnicity.	A1005 would be coded as 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

Intent: The intent of this item is to identify the patient's self-reported race data.

Rationale:

- The ability to improve understanding of and address racial and ethnic disparities in healthcare outcomes requires the availability of better data related to social determinants of health, including race.

- The ethnicity and race data elements use a two-question format. Collection of A1005, Ethnicity and A1010, Race provides data granularity important for documenting and tracking health disparities and conform to the 2011 Health and Human Services Data Standards.

- Collection of the race data is an important step in improving quality of care and health outcomes.

- Standardizing self-reported data collection for race allows for the equal comparison of data across multiple post-acute care settings.

- These categories are NOT used to determine eligibility for participation in any Federal program.

Response (Coding) Tips:

- **Code X, Patient unable to respond,** if the patient is unable to respond.
  - In the cases where the patient is unable to respond, a response may be determined via proxy input. If a proxy is not able to provide a response, medical record documentation may be used.
  - If the response(s) is/are determined via proxy input and/or medical documentation, check all boxes that apply, including Code X – Patient unable to respond.
  - If the patient is unable to respond and no other resources (proxy input or medical record documentation) provided the necessary information, Code X – Patient unable to respond, only.

- **Code Y, Patient declines to respond,** if the patient declines to respond. In the cases where the patient declines to respond, Code Y – Patient declines to respond, only. If the patient declines to respond, do not code based on proxy input or medical record documentation to complete this item.

- **Code Z, None of the above,** if the patient reports or it is determined from proxy or medical record documentation that none of the listed races apply to the patient.

- **Dash** is **not** a valid response for this item.

Example	Response	Instructions
The patient has severe dementia with agitation. During the SOC assessment the patient is unable to respond. The patient's child informs the nurse that the patient is Korean and African American.	A1010 would be coded as B – Black or African American, H – Korean, and X – Patient unable to respond. Why? A proxy provided the response of more than one race and the patient was not able to respond.	**1.** Ask the patient to select the category or categories that most closely correspond to the patient's race from the list in A1010, Race. Individuals may be more comfortable if this and the preceding question are introduced by saying, "We want to make sure that all our patients get the best care possible, regardless of their racial background." **2.** Respondents should be offered the option of selecting one or more race category. **3.** If a patient is unable to respond, a proxy response may be used. **4.** If neither the patient nor a proxy is able to respond to this item, use medical record documentation. **5.** If the patient declines to respond, do not code based on a proxy response or medical record documentation. **6.** If the patient can provide a response: • Check all that apply • Check the box(es) for indicating the race category or categories identified by the patient **7.** Complete as close to the time of SOC as possible.
The patient declines to provide their race during the admission assessment stating, "I'd rather not answer."	A1010 would be coded as Y – Patient declines to respond. Why? If the patient can answer but declines, no other information source or person should be used to answer the question.	
The patient is admitted to the HHA following a recent CVA resulting in confusion and is unable to inform the assessing clinician which race applies to them. The proxy reports that none of the listed races apply to the patient.	A1010 would be coded as X – Patient unable to respond and Z – None of the above. Why? The patient is unable to answer, but a proxy can. This requires two codes to be complete.	

A1110. Language	
Enter Code.	
☐	**A.** What is your preferred language? ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **B.** Do you need or want an interpreter to communicate with a doctor or healthcare staff? 0. **No** 1. **Yes** 9. **Unable to determine**

Intent: The intent of this item is to identify the patient's self-reported preferred language and need for an interpreter.

Rationale:

- Language barriers can lead to social isolation, depression, and patient safety issues.
- Language barriers can interfere with accurate assessment.

Response (Coding) Tip:

An organized system of signing, such as American Sign Language (ASL), can be reported as the preferred language if the patient needs or wants to communicate in this manner.

Instructions	Coding Instructions for A1110A	Coding Instructions for A1110B
1. Ask for the patient's preferred language. **2.** Ask if the patient needs or wants an interpreter to communicate with a doctor or healthcare staff. **3.** If the patient themselves – or with the assistance of an interpreter – is unable to respond to A1110A, What is your preferred language? or A1110B, Do you need or want an Interpreter? a proxy response is permitted. **4.** If neither the patient nor a proxy is able to provide a response to A1110A or A1110B, medical record documentation may be used. **5.** Complete as close to the time of SOC as possible.	**1.** Enter the preferred language the patient primarily speaks or understands. **2. Dash** is a valid response for this item. If the patient or any available source cannot or does not identify preferred language, enter a dash ("-") in the first box.	**1. Code 0, No:** if the patient indicates no want or need of an interpreter to communicate with a doctor or healthcare staff. If the patient is unable to indicate the need or want of an interpreter, proxy input may be used. If the patient is unable and a proxy response is not available, then medical record documentation may be used. **2. Code 1, Yes:** if the patient indicates the need or want of an interpreter to communicate with a doctor or healthcare staff. Ensure that preferred language is indicated. If the patient is unable to indicate the need or want of an interpreter, proxy input may be used. If the patient is unable and a proxy response is not available, then medical record documentation may be used. **3. Code 9, Unable to determine:** if no source can identify whether the patient needs or wants an interpreter. **4. Dash** is **not** a valid response for this item.

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

Intent: Access to transportation for ongoing healthcare and medication access needs is essential to effective care management. Understanding patient transportation needs can help organizations assess barriers to care and facilitate connections with available community resources.

Response (Coding) Tips:

- **Code A, Yes,** if the patient indicates that lack of transportation has kept the patient from medical appointments or from getting medications.
- **Code B, Yes,** if the patient indicates that lack of transportation has kept the patient from non-medical meetings, appointments, work, or from getting things that the patient needs.
- **Code C, No,** if the patient indicates that a lack of transportation has not kept the patient from medical appointments, getting medications, non-medical meetings, appointments, work, or getting things that the patient needs.
- **Code X, Patient unable to respond,** if the patient is unable to respond.
  - In the cases where the patient is unable to respond, a response may be determined via proxy input. If a proxy is not able to provide a response, medical record documentation may be used.
  - If the response(s) is/are determined via proxy input and/or medical record documentation, check all boxes that apply, including Code X - Patient unable to respond.
  - If the patient is unable to respond and no other resources (proxy or medical record documentation) provided the necessary information, Code X – Patient unable to respond, only.

Example	Response	Instructions
The patient has Multiple Sclerosis. During the SOC assessment the patient is confused and unable to understand when asked if they have had a lack of transportation that has kept them from medical appointments, meetings, work, or from getting things needed for daily living. No proxy with related information is available, but the patient's medical record indicates that their sibling uses their car to transport the patient wherever the patient needs to go.	A1250 would be coded as Code C – No and Code X – Patient unable to respond.	**1.** Ask the patient: **a.** "In the past six months to a year, has lack of transportation kept you from medical appointments or from getting your medications?" **b.** "In the past six months to a year, has lack of transportation kept you from non-medical meetings, appointments, work, or from getting things that you need?" **2.** Patient should be offered the option of selecting more than one yes designation, if applicable. **3.** If the patient is unable to respond, a proxy response may be used. **4.** If neither the patient nor a proxy is able to provide a response to this item, medical record documentation may be used. **5.** If the patient declines to respond, do not code based on proxy input or medical record documentation. **6.** Complete as close to the time of SOC/ROC as possible and within three days of discharge. **7.** Check all that apply.

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 B1300, Health Literacy*

☐ **1. Yes – Current reconciled medication list provided to the subsequent provider** → *Continue to A2122, Route of Current Reconciled Medication List Transmission to Subsequent Provider*

Special Note: The guidance for items A2120 and A2121 is the same, except that one item is used for home health transfers and the other one for discharges. The guidance is combined here, with specific instructions for either transfer or discharge as needed.

Intent: The intent of these items is to identify if the home health agency provided a current reconciled medication list to the subsequent provider.

Rationale:

The transfer of a current reconciled medication list at the time of discharge or transfer can improve care coordination, quality of care, help subsequent providers reconcile medications and may mitigate adverse outcomes related to medications. Communication of medication information at discharge/transfer is critical to ensure safe and effective transitions from one healthcare setting to another.

Response (Coding) Tips:

- **Code 0, No,** if at transfer or discharge to a subsequent provider, your agency did not provide the patient's current reconciled medication list to the subsequent provider.
- **Code 1, Yes,** if at transfer or discharge to a subsequent provider, your agency did provide the patient's current reconciled medication list to the subsequent provider. This can be by active means (mail, electronic, verbal) or by passive means (EHRs, physician portals).
- **A2120 only: Code 2, NA,** if at transfer to a subsequent provider, your agency was not made aware of the transfer timely and was, therefore, unable to provide the patient's current reconciled medication list to the subsequent provider.
- **Dash** is **not** a valid response for this item.

Additional Considerations for Important Medication List Content:
Defining the completeness of that medication list is left to the discretion of the providers and patient who are coordinating this care.

Documentation sources for reconciled medication list information include electronic and/or paper records. Some examples of such records are discharge summary records, a Medication Administration Record, an Intravenous Medication Administration Record, a home medication list, and physician orders.

Information That May Be Contained in the Reconciled Medication List	Prescription, OTC medication, nutritional supplements, vitamins, herbal and homeopathic products by any route Patient demographics, diagnoses, allergies, drug sensitivities and reactions Medication name, dose, route and strength

Example	Response	Instructions
The patient is being transferred from home health to an acute care hospital in the same healthcare system which uses the same electronic health record (EHR), also sometimes referred to as an electronic medical record (EMR). The patient's current reconciled medication list at the time of transfer from the agency is accessible to the subsequent acute care hospital staff admitting them and this is how the medication list is shared.	A2120 would be coded 1, Yes. Why? Having access to the same EHR system is one way to transfer a medication list. This is considered a passive means of transferring the list.	For Home Health at **Transfer**: Complete A2120 only if: • M0100, This Assessment is Currently Being Completed for the Following Reason = **6.** Transferred to an inpatient facility – patient not discharged from agency **- or -** **7.** Transferred to an inpatient facility – patient discharged from agency For Home Health at **Discharge**: Complete A2121 only if: • M0100, This Assessment is Currently Being Completed for the Following Reason = **9.** Discharge from Agency, **and** • M2420, Discharge Disposition = **2.** Patient remained in the community (with formal assistive services) **- or -** **3.** Patient transferred to a non-institutional hospice
A patient is not taking any prescribed or over-the-counter medications at the time of discharge.	If the lack of any medications for a patient is clearly documented and communicated to the subsequent provider when the patient is discharged, code 1, Yes, that the medication list was transferred. If this information is not communicated to the subsequent provider, code 0, No. Why? Marking Yes or No depends on whether the provider communicated no medications being taken. The process is still followed regardless of whether medications are taken or not.	
When the nurse visited a patient for their monthly Foley catheter change, the patient informed the nurse that they had been admitted to the hospital last week for a urinary tract infection.	Code A2120, 2, NA – the agency was not made aware of this transfer timely. Why? If a transfer happens without the agency's knowledge, it is not possible to provide a reconciled list at the time of transfer.	

Tip From Axxess:

The research and reconciliation of medications is the area that will take the most time in Section A of OASIS-E. Having a caregiver or family member in the home during the assessment will assist the clinician in assuring all medications in the home are evaluated for high risk and overall reconciliation.

The review of all current medications and the transfer of information (including reconciled medications) are frequently cited items in state surveys. Home health organizations should ensure there is considerable effort placed in training on both information and timeliness of patient transfers, as well as medication reconciliation.

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	☐
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)*	☐

After completing A2122, skip to B1300, Health Literacy at Discharge

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, and/or caregiver.

Route of Transmission	Check all that apply
A. Electronic Health Record	☐
B. Health Information Exchange	☐
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)*	☐

Special Note: The guidance for items A2122 and A2124 is the same, except that one item is used for the subsequent provider at transfer/discharge and the other one at discharge for the patient, family, and/or caregiver. The guidance addresses coding the route(s) of transmission to the subsequent provider at transfer (A2120) and at discharge (A2121) and to the patient (A2123). The guidance is combined here, with specific instructions for either transfer or discharge as needed.

Intent: The intent of these items is to identify all routes used in the transmission of the current reconciled medication list to the subsequent provider at transfer or discharge or to the patient.

Rationale:

These items collect important data to monitor how medication lists are transmitted at transfer/discharge to the subsequent provider and at discharge to the patient, family, and caregiver.

Response (Coding) Tips:

- **Code A2122A/A2124A, Electronic Health Record,** if your agency has an EHR and used it to transmit or provide access to the reconciled medication list to the subsequent provider, patient, family, and/or caregiver. This would include situations where both the discharging and receiving provider have direct access to a common EHR system. This could also include providing the patient with direct access to their EHR medication information through a patient portal. Checking this route does not require confirmation that the patient has accessed the medication list from the portal or the subsequent provider has accessed the common EHR system for the medication list.

- **Code A2122B/A2124B, Health Information Exchange,** if your agency participates in a Health Information Exchange (HIE) and used the HIE to electronically exchange the current reconciled medication list with the subsequent provider, patient, family, and/or caregiver.

- **Code A2122C/A2124C, Verbal,** if the current reconciled medication list information was verbally communicated (e.g., in-person, telephone, video conferencing) to the subsequent provider, patient, family, and/or caregiver.

- **Code A2122D/A2124D, Paper-Based,** if the current reconciled medication list was transmitted to the subsequent provider, patient, family, and/or caregiver using a paper-based method such as a printout, fax or efax.

- **Code A2122E/A2124E, Other Methods,** if the current reconciled medication list was transmitted to the subsequent provider, patient, family, and/or caregiver using another method, not listed above (e.g., texting, email, CDs).

- **Dash** is **not** a valid response for this item.

Example	Response	Instructions
A patient receives a paper copy of their medication list, receives education about their medications by the home health nurse at discharge, and is notified that the home health patient portal is another means that the patient can obtain their discharge medication list.	Code Electronic Health Record (A), Verbal (C), and Paper-Based (D) for A2124. Why? The nurse provided the option of using the patient portal (A), gave verbal instruction on medications (C) and issued a paper version of the list (D).	For Home Health at **Transfer**: Complete A2122 only if: • M0100, This Assessment is Currently Being Completed for the Following Reason = **6.** Transferred to an inpatient facility – patient not discharged from agency **- or -** **7.** Transferred to an inpatient facility – patient discharged from agency For Home Health at **Discharge**: Complete A2122 only if: • M0100, This Assessment is Currently Being Completed for the Following Reason = **9.** Discharge from Agency, **and** • M2420, Discharge Disposition = **2.** Patient remained in the community (with formal assistive services) **- or -** **3.** Patient transferred to a non-institutional hospice Complete A2124 only if: • M0100, This Assessment is Currently Being Completed for the Following Reason = **9.** Discharge from Agency, **and** • M2420, Discharge Disposition = **1.** Patient remained in the community (without formal assistive services) **- or -** **4.** Unknown, because patient moved to a geographic location not served by this agency **- or -** UK. Other unknown
A PAC provider participates in a regional HIE as does a local acute care hospital. When patients are transferred to this acute care hospital, the PAC provider's medication list is included in the medications section of a transfer summary document from their EHR which is electronically exchanged through the HIE. The acute care hospital is then able to obtain and integrate the medication information into their EHR.	Code Electronic Health Record (A) and Health Information Exchange (B) for A2122. Why? There is use of an EHR (A) and a larger information network (B). Including both is relevant in this question.	
A home health agency has developed an interface that allows documents from their EHR to be electronically faxed to the subsequent provider.	Code Paper-Based (D) for A2122. Why? Faxing information is considered paper-based as faxed documents are comparable to hard copy documents, and not computable.	
A home health agency created a process to automatically send a patient summary document containing medications and other information using Direct Messaging (Direct Exchange) to the receiving acute care hospital's EHR when a patient is transferred to this hospital. The EHR vendors are members of a health information service provider, or HISP, and are in compliance with DirectTrust requirements. The hospital clinicians can readily access the latest medication and other medical information which is 'pushed' or sent to their EHR.	Code Electronic Health Record (A) and Health Information Exchange (B) for A2122. Why? There is use of an EHR (A) and a larger information network (B). Including both is relevant in this question.	

Tip From Axxess:

Inadequate information at transfers to other settings is a source of errors that can lead to adverse events. Some studies show that adverse events are associated with critical care transfers, and many of these errors have high potential for patient harm. Errors in communication are frequently found to be a source of inadequate care.

Taking the necessary time and care to accurately complete Section A of OASIS-E is key to ensuring safe transitions, accurate patient information and effective plans of care

A2123. Provision of Current Reconciled Medication List to Patient at Discharge
At the time of discharge, did your agency 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*

Intent: The intent of this item is to identify if the home health agency provided a current reconciled medication list to the patient, family, and/or caregiver at discharge.

Rationale:

Communication of medication information to the patient at discharge is critical to ensuring safe and effective discharges. The item, collected at the time of discharge, can improve care coordination, quality of care, aids in medication reconciliation, and may mitigate adverse outcomes related to medications.

It is recommended that a reconciled medication list that is provided to the patient, family, or caregiver use consumer-friendly terminology and plain language to ensure that the information provided to patients and caregivers is clear and understandable.

Response (Coding) Tips:

1. **At the time of discharge –** This is the period of time as close to the actual time of discharge as possible. This time may be based on facility/agency, State, or Federal guidelines for data collection at discharge.

2. **Patient/family/caregiver –** The recipient of the current reconciled medication list can be the patient and/or a family member and/or other caregiver in order to code 1, Yes, a current reconciled medication list was transferred. It is not necessary to provide the current reconciled medication list to all of these recipients in order to code 1, Yes.

Example	Response	Instructions
A patient will not be taking any prescribed or over-the-counter medications at the time of discharge.	If it is clearly documented that the patient is taking no medications and this is then clearly communicated to the patient, family, and/or caregiver when the patient is discharged, A2123 would be coded 1, Yes, that the medication list was transferred. If this information is not communicated to the patient, family and/or caregiver, code 0, No.	**Code 0, No,** if at discharge to a home setting, your agency did not provide the patient's current reconciled medication list to the patient, family, and/or caregiver. **Code 1, Yes,** if at discharge to a home setting, your agency did provide the patient's current reconciled medication list to the patient, family, and/or caregiver. **Dash** is **not** a valid response for this item.

Tip From Axxess:

Medication errors or omissions are often the cause of rehospitalizations. Coordinating this assessment with pharmacists, physicians, family members and caregivers will prove invaluable when applying the most accurate responses to medication items.

OASIS-E

SECTION B:

HEARING, SPEECH AND VISION

B0200. Hearing	
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

Section B assesses the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions.

Intent: Identifies the patient's ability to hear (with assistive devices if they are used).

Rationale:

- Problems with hearing can contribute to sensory deprivation, social isolation, and mood and behavior disorders.
- Unaddressed communication problems related to hearing impairment can be mistaken for confusion or cognitive impairment.

Response (Coding) Tip:

- Patients who are unable to respond to a standard hearing assessment due to cognitive impairment will require alternate assessment methods. The patient can be observed in their normal environment. Do they respond (e.g., turn their head) when a noise is made at a normal level? Does the patient seem to respond only to specific noise in a quiet environment? Assess whether the patient responds only to loud noise or do they not respond at all.

Example	Response	Instructions
When asked about whether they can hear normal conversation without difficulty, patient responds, "When I'm at home, I usually keep the TV on a low volume and hear it just fine. When I have visitors, I can hear people from across the room."	B0200 would be coded as 0, Adequate.	**1.** Ensure that the patient is using their normal hearing appliance, if they have one. Hearing devices may not be as conventional as a hearing aid. Some patients by choice may use hearing amplifiers or a microphone and headphones as an alternative to hearing aids. Ensure the hearing appliance is operational. **2.** Interview the patient and ask about hearing function in different situations (e.g., hearing staff or family members, talking to visitors, using telephone, watching TV, participation in group discussion). **3.** Observe the patient during your verbal interactions and when interacting with others. **4.** Review the clinical record or other available documentation. **5.** Consult the patient's family/ caregiver, and/or speech or hearing specialists.
"Sitting at the dinner table, I can hear people who are sitting closer to me (e.g., within 5 feet) but not from farther across the table (e.g., 8 feet) speaking at a normal volume."	B0200 would be coded as 1, Minimal difficulty.	
"I have trouble following normal conversations, especially when a lot of different people are talking at the same time. I can usually make out what someone is saying if they talk a little louder and make sure they speak clearly and I can see their face when they are talking to me."	B0200 would be coded as 2, Moderate difficulty.	
"I cannot hear one person speaking, even at a high volume, if others are speaking at the same time. I tend to listen to the TV at a high volume even if I am alone and I still struggle to hear what is being said. People complain that they need to scream at me for me to hear anything."	B0200 would be coded as 3, Highly impaired.	

B1000. Vision	
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. **Moderately 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 to not appear to follow objects

Intent: Identifies the patient's ability to see objects nearby in their environment, in adequate light, and with glasses or other visual appliances.

Rationale:

- A person's reading vision often diminishes over time.
- If uncorrected, vision impairment can limit the enjoyment of everyday activities such as reading newspapers, books, or correspondence, and maintaining and enjoying hobbies and other activities. It also limits the ability to manage personal business, such as reading and signing consent forms.
- Moderate, high, or severe impairment can contribute to sensory deprivation, social isolation, and depressed mood.

Response (Coding) Tips:

1. Adequate lighting is defined as lighting that is sufficient or comfortable for a person with normal vision to see fine details. Ensure the room lighting is appropriate for assessing this item.

2. Some patients have never learned to read or are unable to read English. In such cases, ask the patient to read numbers, such as dates or page numbers, or to name items in small pictures. Be sure to display this information in two sizes (equivalent to regular and large print).

3. If the patient is unable to communicate or follow your directions for testing vision, observe the patient's eye movements to see if their eyes seem to follow movement and objects. Though these are gross measurements of visual acuity, they may assist you in assessing whether or not the patient has any visual ability. For patients who appear to do this, code 3, highly impaired.

4. Dash is a valid response for this item but should be used on rare occurrences.

Example	Response	Instructions
When asked about whether they can see fine detail, including regular print in newspaper/books, patient responds, "When I wear my glasses, I can read the paper fine. If I forget to wear glasses, it is harder to see unless I hold the paper a little closer."	B1000 would be coded as 0, Adequate. Why? The patient can read regular print when wearing glasses	**1.** Ask the patient, family, caregivers and/or staff if possible about the patient's usual vision patterns (e.g., is the patient able to see newsprint, menus, greeting cards?). **2.** Ensure that the patient's customary visual appliance for close vision is in place (e.g., eyeglasses, magnifying glass). **3.** Ensure adequate lighting. **4.** Ask the patient to look at regular-size print in a book or newspaper. Then ask the patient to read aloud, starting with larger headlines and ending with the finest, smallest print. If the patient is unable to read a newspaper, provide material with larger print, such as a flyer or large textbook. **5.** When the patient is unable to read out loud (e.g., due to aphasia, illiteracy), you should test this by another means such as, but not limited to: **a.** Substituting numbers or pictures for words that are displayed in the appropriate print size (regular-size print in a book or newspaper).
The assessor asks the patient to read aloud from a newspaper, starting with larger headlines and then the smaller print. The patient is able to read the headlines but not the regular newspaper print.	B1000 would be coded as 1, Impaired. Why? The patient sees large print, but not regular print in newspapers/books.	
"I cannot read the newspaper headlines, even with glasses." When the assessor presents the patient with newspaper text, while wearing glasses, the patient is not able to correctly read the headlines. The patient can identify objects in their environment.	B1000 would be coded as 2, Moderately impaired. Why? The patient cannot read newspaper headlines.	
"I can't see much of anything at this point. I can see blurry shapes and I can tell what things are, but I can't read books anymore – even the ones with giant print. I do okay recognizing my caregivers by their voices, but I couldn't tell you what they look like. Everyone's just a blob of color, even with my glasses on." The patient's eyes appear to follow the assessor when they move about the room. When the assessor presents the patient with newspaper text, while wearing glasses, the patient is able to appropriately reach for and successfully hold the paper, but is not able to correctly read the headlines.	B1000 would be coded as 3, Highly impaired. Why? The patient is able to follow objects and track movement in the environment (e.g., people moving throughout the room), but is unable to see people or objects in detail.	

Tip From Axxess:

Accurately assessing the items in Section B of OASIS-E is crucial, as a patient's hearing, speech and vision could impact how clinicians develop the plan of care. For instance, a patient with vision problems that make it difficult for them to see obstacles in their path could be at a higher risk of falling.

B1300. Health Literacy (From Creative Commons ©)	
Enter Code ☐	**How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?**
	0. **Never**
	1. **Rarely**
	2. **Sometimes**
	3. **Often**
	4. **Always**
	7. **Patient declines to respond**
	8. **Patient unable to respond**

Intent: The intent of this item is to identify the patient's self-reported health literacy.

Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Rationale:

- Similar to language barriers, low health literacy interferes with communication between provider and patient.
- Health literacy can also affect the ability for patients to understand and follow treatment plans, including medication management.
- Poor health literacy is linked to lower levels of knowledge of health, worse outcomes, and the receipt of fewer preventive services, higher medical costs and rates of emergency department use.

Response (Coding) Tip:

- Complete as close to the time of SOC/ROC as possible and within three days of discharge.

Tip From Axxess:

While it may be tempting to answer this item based on the opinions of others or observation, the response to this item must be based on the patient's answer alone. The assessing clinician should remove any barriers that could impact the patient's health literacy such as obstacles around hearing, vision, presentation of information, etc.

Example	Response	Instructions
When asked how often they need help when reading the instructions provided by their doctor, the patient reports that they never need help. The patient's son is present and shares that a family member must always accompany the patient to doctors' visits and that the patient often needs someone to explain the written materials to them multiple times before they understand, providing examples of needing to frequently explain to the patient why they are on a special diet and why and how to take some of their medications.	B1300 would be coded as 0, Never. Why? The patient stated that they never need help reading instructions from their doctor or pharmacist. B1300 is answered based solely on the patient's response. No other input should be used to answer this question, regardless of conflicting information from family or caregivers.	**1.** This item is intended to be a patient self-report item. No other source should be used to identify the response. **2.** Ask the patient, "How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?"

Tip From Axxess:

All practitioners have the responsibility to educate individuals on various aspects of care and treatment. Sometimes those individuals are unable to learn and retain such information for various reasons, including cognitive dysfunction, functional issues, illiteracy and even embarrassment. Assessing health literacy is new to home health clinicians, and organizations will need to place considerable effort into educating each clinician on the accuracy of such assessments.

Proper focus on health literacy as a goal in care planning will enable clinicians to improve the quality and safety of healthcare, while reducing costs and improving quality of life.

OASIS-E

SECTION C:
COGNITIVE PATTERNS

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

Section C contains guidance for nine items that assess cognitive function, including the Brief Interview for Mental Status (BIMS) and Signs and Symptoms of Delirium from CAM©.

There is general guidance for C0200 – C0500, including basic BIMS interview instruction and cue cards for administering the BIMS in written format, as well as specific guidance on the individual items.

Intent: The intent of this item is to identify if the BIMS, a structured cognitive interview, should occur.

Rationale:

Most patients are able to attempt the BIMS. The BIMS is a structured cognitive interview. A structured cognitive test is more accurate and reliable than observation alone for observing cognitive performance.

- Without an attempted structured cognitive interview, a patient might be mislabeled based on their appearance or assumed diagnosis.
- Structured interviews will efficiently provide insight into the patient's current condition that will enhance good care.

Response (Coding) Tip:

- If SOC/ROC assessment, complete as close to the time of SOC/ROC as possible. If discharge assessment, complete as close to the time of discharge as possible.

Coding	Instructions
Code 0, No, if the interview should not be conducted because the patient is rarely/never understood; cannot respond verbally, in writing, or using another method; or an interpreter is needed but not available. Skip items C0200-C0500.	**1.** Interact with the patient using their preferred language. Be sure the patient can hear you and/or has access to their preferred method for communication. If the patient appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards. **2.** Determine if the patient is rarely/never understood verbally, in writing, or using another method. If rarely/never understood, skip items C0200-C0500.
Code 1, Yes, if the interview should be conducted because the patient is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available. Proceed to C0200, Repetition of Three Words.	
Dash is a valid response for this item. A dash indicates "no information." CMS expects dash use to be a rare occurrence.	

Tip From Axxess:

When clinicians respond to items that involve the cognitive status of a patient, it is important they attempt to include caregivers or family members to ensure the most accurate responses. For instance, a patient is unlikely to remember or admit to frequency of confused episodes. This is especially important for C0100. If a caregiver or family member is not available at the time of the assessment, the clinician should consider taking the entire five days allotted by the Centers for Medicare and Medicaid Services to complete the assessment, so they have time to speak with the caregiver or family member.

C0200. Repetition of Three Words
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."

Enter Code	**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.

Rationale:

The inability to repeat three words on first attempt may indicate:

- a memory impairment,
- a hearing impairment,
- a language barrier, or
- inattention that may be a sign of delirium or another health issue.

Response (Coding) Tips:

- Record the maximum number of words that the patient correctly repeated on the **first** attempt. This will be any number between 0 and 3.
- The words may be recalled in any order and in any context. For example, if the words are repeated back in a sentence, they would be counted as repeating the words.
- Do not score the number of repeated words on the second or third attempt. These attempts help with learning the item, but only the number correct on the first attempt go into the total score. Do not record the number of attempts that the patient needed to complete.
- After the initial attempt, provide cues. (See instructions in the chart below.)

A category cue is a phrase that puts a word in context to help with learning and to serve as a hint that helps prompt the patient.

Example	Response	Instructions
The assessing clinician says, “The words are sock, blue, and bed. Now please tell me the three words.” The patient replies, “Bed, sock, and blue.” The clinician repeats the three words with category cues, by saying, “That’s right, the words are sock, something to wear; blue, a color; and bed, a piece of furniture.”	C0200 would be coded 3, three words correct. Why? The patient repeated all three words. Order does not matter.	**1.** Say to the 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.” Assessing clinicians need to use the words and related category cues as indicated. If the interview is being conducted with an interpreter present, the interpreter should use the equivalent words and similar, relevant prompts for category cues. **2.** Immediately after presenting the three words, say to the patient: “Now please tell me the three words.” **3.** After the patient’s first attempt to repeat the items: • If the patient correctly stated all three words, say, “That’s right, the words are sock, something to wear; blue, a color; and bed, a piece of furniture” [category cues]. • Category cues serve as a hint that helps prompt patients’ recall ability. Putting words in context stimulates learning and fosters memory of the words that patients will be asked to recall in item C0400, even among patients able to repeat the words immediately. • If the patient recalled two or fewer words, code C0200 according to the patient’s recall on this first attempt. Next say to the patient: “Let me say the three words again. They are sock, something to wear; blue, a color; and bed, a piece of furniture. Now tell me the three words.” If the patient still does not recall all three words correctly, you may repeat the words and category cues one more time. Do not code the number of repeated words on the second or third attempt. • If the patient does not repeat all three words after three attempts, reassess ability to hear. If the patient can hear, move on to the next question. If they are unable to hear, attempt to maximize hearing (alter environment, use hearing amplifier) before proceeding.
The assessing clinician says, “The words are sock, blue, and bed. Now please tell me the three words.” The patient replies, “Sock, bed, black.” The clinician repeats the three words plus the category cues, saying, “Let me say the three words again. They are sock, something to wear; blue, a color; and bed, a piece of furniture. Now tell me the three words.” The patient says, “Oh yes, that’s right, sock, blue, bed.”	C0200 would be coded 2, two of three words correct. Why? The patient repeated two of the three words on the first attempt. Patients are scored based on the first attempt.	
The assessing clinician says, “The words are sock, blue, and bed. Now please tell me the three words.” The patient says, “Blue socks belong in the dresser.” The clinician codes according to the patient’s response. Then the clinician repeats the three words plus the category cues, saying, “Let me say the three words again. They are sock, something to wear; blue, a color; and bed, a piece of furniture. Now tell me the three words.” The patient says, “Oh yes, that’s right, sock, blue, bed.”	C0200 would be coded 2, two of the three words correct. Why? The patient repeated two of the three words on the first attempt. The patient put the words into a sentence, resulting in the patient repeating two of the three words.	
The assessing clinician says, “The words are sock, blue, and bed. Now please tell me the three words.” The patient replies, “What were those three words?” The patient’s response is coded and then the clinician repeats the three words plus the category cues.	C0200 would be coded 0, none of the words correct. Why? The patient did not repeat any of the three words on the first attempt.	

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**

Temporal orientation is the ability to place oneself in correct time. For the BIMS, it is the ability to indicate the correct date in current surroundings. There are three distinct questions within C0300 to address temporal orientation.

Rationale:

- A lack of temporal orientation may lead to decreased communication or participation in activities.
- Not being oriented may be frustrating or frightening.

Response (Coding) Tips for C0300A, Able to Report Correct Year:

- **Code 0, missed by >5 years or no answer,** if the patient's answer is incorrect and is greater than 5 years from the current year or the patient chooses not to answer the item, or the answer is nonsensical.
- **Code 1, missed by 2-5 years,** if the patient's answer is incorrect and is within 2 to 5 years from the current year.
- **Code 2, missed by 1 year,** if the patient's answer is incorrect and is within one year from the current year.
- **Code 3, correct,** if the patient states the correct year.
- **Dash** is a valid response for this item.

Example	Response	Instructions
The date of interview is May 5, 2020. The patient, responding to the statement, "Please tell me what year it is right now," states that it is 2020.	C0300A would be coded 3, correct.	**1.** Ask the patient each of the three questions in item C0300 separately. **2.** Allow the patient up to 30 seconds for each answer and do not provide clues. **3.** If the patient specifically asks for clues (e.g., "Is this the day my daughter always visits?") respond by saying, "I need to know if you can answer this question without any help from me."
The date of interview is June 16, 2020. The patient, responding to the statement, "Please tell me what year it is right now," states that it is 2017.	C0300A would be coded 1, missed by 2-5 years.	
The date of interview is January 10, 2020. The patient, responding to the statement, "Please tell me what year it is right now," states that it is 1920.	C0300A would be coded 0, missed by more than 5 years.	
The date of interview is April 1, 2020. The patient, responding to the statement, "Please tell me what year it is right now," states that it is "'20." The assessing clinician asks, "Can you tell me the full year?" The patient still responds "'20," and the assessing clinician asks again, "Can you tell me the full year, for example, nineteen-eighty-two." The patient states, "2020."	C0300A would be coded 3, correct.	

Response (Coding) Tips for C0300B, Able to Report Correct Month:

Count the current day as day 1 when determining whether the response was accurate within 5 days or missed by 6 days to 1 month.

- **Code 0, missed by >1 month or no answer,** if the patient's answer is incorrect by more than 1 month or if the patient chooses not to answer the item, or the answer is nonsensical.
- **Code 1, missed by 6 days to 1 month,** if the patient's answer is accurate within 6 days to 1 month.
- **Code 2, accurate within 5 days,** if the patient's answer is accurate within 5 days, count current date as day 1
- **Dash** is a valid response for this item.

Example	Response	Instructions
The date of interview is June 25, 2020. The patient, responding to the question, "What month are we in right now?" states that it is June.	C0300B would be coded 2, accurate within 5 days.	**1.** Ask the patient each of the three questions in item C0300 separately. **2.** Allow the patient up to 30 seconds for each answer and do not provide clues. **3.** If the patient specifically asks for clues (e.g., "Is this the day my daughter always visits?") respond by saying, "I need to know if you can answer this question without any help from me."
The date of interview is June 28, 2020. The patient, responding to the question, "What month are we in right now?" states that it is July.	C0300B would be coded 2, accurate within 5 days.	
The date of interview is June 25, 2020. The patient, responding to the question, "What month are we in right now?" states that it is July.	C0300B would be coded 1, missed by 6 days to 1 month.	
The date of interview is June 30, 2020. The patient, responding to the question, "What month are we in right now?" states that it is August.	C0300B would be coded 0, missed by more than 1 month.	
The date of interview is June 2, 2020. The patient, responding to the question, "What month are we in right now?" states that it is May.	C0300B would be coded 2, accurate within 5 days.	

Response (Coding) Tips for C0300C, Able to Report Correct Day of the Week:

- **Code 0, incorrect, or no answer,** if the answer is incorrect or the patient chooses not to answer the item, or the answer is nonsensical.
- **Code 1, correct,** if the answer is correct.
- **Dash** is a valid response for this item.

Example	Response	Instructions
The day of interview is Monday, June 27, 2020. The assessing clinician asks: "What day of the week is it today?" The patient responds, "It's Monday."	C0300C would be coded 1, correct.	**1.** Ask the patient each of the three questions in item C0300 separately. **2.** Allow the patient up to 30 seconds for each answer and do not provide clues. **3.** If the patient specifically asks for clues (e.g., "Is this the day my daughter always visits?") respond by saying, "I need to know if you can answer this question without any help from me."
The day of interview is Monday, June 27, 2020. The patient, responding to the question, "What day of the week is it today?" states, "Tuesday."	C0300C would be coded 0, incorrect.	
The day of interview is Monday, June 27, 2020. The patient, responding to the question, "What day of the week is it today?" states, "Today is a good day."	C0300C would be coded 0, incorrect.	

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**

Rationale:

- Many persons with cognitive impairment can be helped to recall if provided cues.
- Providing memory cues can help maximize patient cognitive function and decrease frustration for those patients who respond.

Guidance:

- If on the first try (without cueing), the patient names multiple items in a category, one of which is correct, they should be coded as correct for that item.
- If, however, the assessing clinician gives the patient the cue and the patient then names multiple items in that category, the item is coded as could not recall, even if the correct item was in the list.

Response (Coding) Tips:

For each of the three words the patient is asked to remember:

- **Code 0, no—could not recall, i**f the patient cannot recall the word even after being given the category cue or if the patient responds with a nonsensical answer or chooses not to answer the item.
- **Code 1, yes, after cueing,** if the patient requires the category cue to remember the word.
- **Code 2, yes, no cue required,** if the patient correctly remembers the word spontaneously without cueing.
- **Dash** is a valid response for this item.

Example	Response	Instructions
The patient is asked to recall the three words that were initially presented. The patient chooses not to answer the question and states, "I'm tired, and I don't want to do this anymore."	C0400A-C0400C would be coded 0, no—could not recall, could not recall for each of the three words.	**1.** Ask the patient the following: "Let's go back to an earlier question. What were those three words that I asked you to repeat?" **2.** Allow up to 5 seconds for spontaneous recall of each word. **3.** For any word that is not correctly recalled after 5 seconds, provide the category cue used in C0200 (refer to page 3 for the definition of category cue). Category cues should be used only after the patient is unable to recall one or more of the three words. **4.** Allow up to 5 seconds after category cueing for each missed word to be recalled.
The patient is asked to recall the three words. The patient replies, "Socks, shoes, and bed." The examiner then cues, "One word was a color." The patient says, "Oh, the shoes were blue."	C0400A, sock, would be coded 2, yes, no cue required. C0400B, blue, would be coded 1, yes, after cueing. C0400C, bed, would be coded 2, yes, no cue required.	
The patient is asked to recall the three words. The patient answers, "I don't remember." The assessor then says, "One word was something to wear." The patient says, "Clothes." The assessor then says, "OK, one word was a color." The patient says, "Blue." The assessor then says, "OK, the last word was a piece of furniture." The patient says, "Couch."	C0400A, sock, would be coded 0, no—could not recall. C0400B, blue, would be coded 1, yes, after cueing. C0400C, bed, would be coded 0, no—could not recall.	

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**

Rationale:

The total score:

- Decreases the chance of incorrect labeling of cognitive ability and improves detection of delirium.
- Provides staff with a more reliable estimate of patient function and allows staff interactions with patients that are based on more accurate impressions about patient ability.

The BIMS total score is highly correlated with Mini-Mental State Exam (MMSE; Folstein, Folstein, & McHugh, 1975) scores. Scores from a carefully conducted BIMS assessment where patients can hear all questions and the patient is not delirious suggest the following distributions:

- 13-15: cognitively intact
- 8-12: moderately impaired
- 0-7: severe impairment

Response (Coding) Tips:

- Enter the total score as a two-digit number. The total possible BIMS score ranges from 00 to 15.
  - o If the patient chooses not to answer a specific question(s), that question is coded as incorrect and the item(s) counts in the total score. If, however, the patient chooses not to answer four or more items, then the interview is coded as incomplete.
  - o To be considered a completed interview, the patient had to attempt and provide relevant answers to at least four of the questions included in C0200-C0400C. To be relevant, a response only has to be related to the question (logical); it does not have to be correct. See coding tips that follow below for patients who choose not to participate at all.
  - o **Code 99, unable to complete interview,** if (a) the patient chooses not to participate in the BIMS, (b) if four or more items were coded 0 because the patient chose not to answer or gave a nonsensical response, or (c) if any of the BIMS items is coded with a “-” (dash).

Note: a zero score does not mean the BIMS was incomplete. To be incomplete, a patient had to choose not to answer or give completely unrelated, nonsensical responses to four or more items.

- **Dash** is a valid response for this item.

Example	Response	Instructions
The patient's scores on items C0200-C0400 were as follows: C0200 (repetition)..... 3 C0300A (year)..... 2 C0300B (month)..... 2 C0300C (day)..... 1 C0400A (recall "sock")..... 2 C0400B (recall "blue")..... 2 C0400C (recall "bed")..... 0	C0500 would be coded 12 (sum of C0200-C0400C).	After completing C0200-C0400, add up the values for all questions from C0200 through C0400.
The patient's scores on items C0200-C0400 were as follows: C0200 (repetition)..... 2 C0300A (year)..... 2 C0300B (month)..... 2 C0300C (day)..... 1 C0400A (recall "sock")..... 0 C0400B (recall "blue")..... 0 C0400C (recall "bed")..... 0	C0500 would be coded 07 (sum of C0200-C0400C).	
STOP the interview if each of items C0200-C0300C are coded as 0, because a patient chose not to participate in the BIMS and/or has provided nonsensical answers and/or does not provide verbal or written responses, then stop the interview after C0300C. The patient's score on items C0200-C0400C were as follows: C0200 (repetition)..... 0 C0300A (year)..... 0 C0300B (month)..... 0 C0300C (day)..... 0 (Interview is stopped after C0300C) C0400A (recall "sock")..... (-) C0400B (recall "blue")..... (-) C0400C (recall "bed")..... (-)	C0200-C0300C are coded 0 and dashes entered for C0400A-C. C0500 would be coded 99, unable to complete interview. Note: a zero score does not mean the BIMS was incomplete. To be incomplete, a patient had to choose not to answer or give completely unrelated, nonsensical responses to four or more items. If one or more of the zeros in C0200-C0300 are due to incorrect answers, the interview should continue.	

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

Enter Code	**Is there evidence of an acute change in mental status** from the patient's baseline?
☐	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 distractable 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

Intent: The intent of this item is to identify any signs or symptoms of acute mental status changes as compared to the patient's baseline status.

Rationale:

Delirium is associated with:

- increased mortality,
- functional decline,
- development or worsening of incontinence,
- behavior problems,
- withdrawal from activities,
- rehospitalizations and increased length of home health stay.

Delirium: A mental disturbance characterized by new or acutely worsening confusion, disordered expression of thoughts, change in level of consciousness or hallucinations.

- Delirium can be misdiagnosed as dementia.
- A recent deterioration in cognitive function may indicate delirium, which may be reversible if detected and treated in a timely fashion.
- Examples of acute mental status changes include:
  - o A patient who is usually noisy or belligerent becomes quiet, lethargic, or inattentive.
  - o A patient who is normally quiet and content suddenly becomes restless or noisy.
  - o A patient who is usually able to find their way around their living environment begins to get lost.

Inattention: Reduced ability to maintain attention to external stimuli and to appropriately shift attention to new external stimuli. Patient seems unaware or out of touch with environment (e.g., dazed, fixated or darting attention).

Fluctuation: The behavior tends to come and go and/or increase or decrease in severity. The behavior may fluctuate over the course of the interview or during the assessment period. Fluctuating behavior may be noted by the assessing clinician, reported by staff or family or documented in the medical record.

CAM Assessment Scoring Methodology

The indication of delirium by the CAM requires the presence of:

Item A = 1 **OR** Item B, C, or D = 2
AND
Item B = 1 OR 2
AND EITHER
Item C = 1 **OR** Item D = 1 OR 2

Tip From Axxess:

The Confusion Assessment Method (CAM) is a standardized evidence-based tool that enables clinicians who have not been formally trained in psychiatric testing to identify and recognize confusion and delirium accurately. The CAM assessment includes four areas that help clinicians distinguish delirium and confusion from other kinds of cognitive impairment.

Predisposing risk factors include, but are not limited to, increased aging, current forms of dementia, comorbidities, impaired vision or hearing and a history of delirium and confusion. Risk factors include pain, dehydration, sepsis, electrolyte disturbance, urinary retention, fecal impaction and high-risk medications. Many of these risk factors correlate with other OASIS-E items. For instance, B0200 Hearing and B1000 Vision should be considered when responding to the CAM items. Clinicians should also consider items A2120 and A2121 as they relate to high-risk medications.

Response (Coding) Tips for C1310A, Acute Mental Status Change:

- **Code 0, no,** if there is no evidence of acute mental status change from the patient's baseline.
- **Code 1, yes,** if patient has an alteration in mental status observed or reported or identified that represents an acute change from baseline.
- **Dash** is a valid response for this item.

Example	Response	Instructions
Patient was admitted to home health. The family reports that the patient was alert and oriented prior to the day of assessment. During the BIMS interview and assessment, the patient is lethargic and incoherent.	C1310A would be coded 1, yes.	**1.** If SOC/ROC assessment, complete as close to the time of SOC/ROC as possible. If discharge assessment, complete as close to the time of discharge as possible. **2.** Observe patient behavior during the assessment for the signs and symptoms of delirium. **3.** Review medical record documentation and consult with other staff, family members/caregivers and others in a position to determine the patient's baseline status compared to status on the day of assessment. **4.** Consider all relevant information and use clinical judgment to determine if an acute change in mental status has occurred.
Caregiver reports that a patient with poor short-term memory and disorientation to time has suddenly become agitated, calling out to their dead spouse, tearing off their clothes, and being completely disoriented to time, person, and place.	C1310A would be coded 1, yes.	

Response (Coding) Tips for C1310B, Inattention:

- **Code 0, behavior not present,** if the patient remains focused during the assessment and all other sources agree that the patient was attentive during other activities.
- **Code 1, behavior continuously present, does not fluctuate,** if the patient had difficulty focusing attention, was easily distracted, or had difficulty keeping track of what was said AND the inattention did not vary. All sources must agree that inattention was consistently present to select this code.
- **Code 2, behavior present, fluctuates,** if inattention is noted during the assessment or any source reports that the patient had difficulty focusing attention, was easily distracted, or had difficulty keeping track of what was said AND the inattention varied or if information sources disagree in assessing level of attention.
- **Dash** is a valid response for this item.

Example	Response	Instructions
A patient tries to answer all questions during the BIMS. Although they answer several items incorrectly and respond "I don't know" to others, the patient pays attention to the assessing clinician. The family indicates that this is the patient's consistent behavior.	C1310B would be coded 0, behavior not present.	**1.** Assess attention separately from level of consciousness. **2.** An additional step to identify difficulty with attention is to ask the patient to count backwards from 20.
Questions during the BIMS must be frequently repeated because the patient's attention wanders. This behavior occurs throughout the assessment. The family agrees that this behavior is consistently present. The patient has a diagnosis of dementia.	C1310B would be coded 1, behavior continuously present, does not fluctuate.	
During the BIMS interview, the patient was not able to focus on all questions asked and their gaze wandered. However, the family confirmed that the patient was attentive prior to the nurse arriving for the home health visit.	C1310B would be coded 2, behavior present, fluctuates.	
Patient is dazedly staring at the television for the first several questions. When you ask a question, the patient looks at you momentarily but does not answer. Midway through questioning, they pay more attention and try to answer.	C1310B would be coded 2, behavior present, fluctuates.	

Response (Coding) Tips for C1310C, Disorganized Thinking:

- **Code 0, behavior not present,** if all sources agree that the patient's thinking was organized and coherent, even if answers were inaccurate or wrong.
- **Code 1, behavior continuously present, does not fluctuate,** if, during the assessment and according to other sources, the patient's responses were consistently disorganized or incoherent, conversation was rambling or irrelevant, ideas were unclear or flowed illogically, or the patient unpredictably switched from subject to subject.
- **Code 2, behavior present, fluctuates,** if, during the assessment or according to other data sources, the patient's responses fluctuated between disorganized/incoherent and organized/clear. Also code as fluctuating if information sources disagree.
- **Dash** is a valid response for this item.

Disorganized Thinking: Evidenced by rambling, irrelevant, or incoherent speech.

Example	Response	Instructions
The assessing clinician asks a patient, who is often confused, to give the date, and the patient's response is: "Let's go get the sailor suits!" The patient continues to provide irrelevant or nonsensical responses throughout the interview, and their family indicates this is constant.	C1310C would be coded 1, behavior continuously present, does not fluctuate.	**1.** If SOC/ROC assessment, complete as close to the time of SOC/ROC as possible. If discharge assessment, complete as close to the time of discharge as possible. **2.** Observe patient behavior during the assessment for the signs and symptoms of delirium. **3.** Review medical record documentation and consult with other staff, family members/caregivers and others in a position to determine the patient's baseline status compared to status on the day of assessment. **4.** Consider all relevant information and use clinical judgment to determine if an acute change in mental status has occurred.
A patient responds that the year is 1837 when asked to give the date. Their family indicates that the patient is never oriented to time but has relevant conversations and does not ramble with incoherent speech. For example, the family reports the patient often discusses their passion for baseball.	C1310C would be coded 0, behavior not present.	
During the BIMS interview, the patient was not able to focus on all questions asked and their gaze wandered. However, the family confirmed that the patient was attentive prior to the nurse arriving for the home health visit.	C1310C would be coded 2, behavior present, fluctuates.	

Response (Coding) Tips for C1310D, Altered Level of Consciousness:

- **Code 0, behavior not present,** if all sources agree that the patient was alert and maintained wakefulness during conversation, interview(s), and activities
- **Code 1, behavior continuously present, does not fluctuate,** if, during the assessment and according to other sources, the patient was consistently lethargic, stuporous, vigilant, or comatose.
- **Code 2, behavior present, fluctuates,** if, during the assessment or according to other sources, the patient's level of consciousness varied. For example, the patient was at times alert and responsive, while at other times the patient was lethargic, stuporous, or vigilant. Code as fluctuating if information sources disagree.
- **Dash** is a valid response for this item.

Altered Level of Consciousness:

- Vigilant – startles easily to any sound or touch
- Lethargic – repeatedly dozes off when you are asking questions but responds to voice or touch
- Stupor – very difficult to arouse and keep aroused for the interview
- Comatose – cannot be aroused despite shaking and shouting

Example	Response	Instructions
At discharge, a patient is alert and conversational and answers all questions during the BIMS interview, although not all answers are correct. Medical record documentation and family reports consistently note that the patient was alert.	C1310D would be coded 0, behavior not present.	**1.** If SOC/ROC assessment, complete as close to the time of SOC/ROC as possible. If discharge assessment, complete as close to the time of discharge as possible. **2.** Observe patient behavior during the assessment for the signs and symptoms of delirium. **3.** Review medical record documentation and consult with other staff, family members/caregivers and others in a position to determine the patient's baseline status compared to status on the day of assessment. **4.** Consider all relevant information and use clinical judgment to determine if an acute change in mental status has occurred.
The patient is lying in bed. They arouse to soft touch but only converse for a short time before their eyes close, and they appear to be sleeping. Again, the patient arouses to voice or touch but only for short periods during the assessment. Information from the caregivers indicates that this has been the patient's condition.	C1310D would be coded 1, behavior continuously present, does not fluctuate.	
The patient is usually alert, oriented to time, place, and person per family report. Today, at the time of the BIMS interview, the patient is conversant at the beginning of the interview but becomes lethargic and difficult to arouse.	C1310D would be coded 2, behavior present, fluctuates.	

Tip From Axxess:

The biggest challenge any clinician will face with this section of the OASIS-E assessment is taking the time to understand the meaning behind the assessment items and using the information in other parts of the assessment to respond accurately. As mentioned above, there are other OASIS items that might lead to the clinical response but once corrected could improve the scoring. For instance, confusion and delirium are frequently a symptom of a urinary tract infection. However, once the infection is cleared, the confusion resolves itself. This understanding and corrective action can lead to significantly better outcomes.

The most valuable strategy is to educate staff on the intent of each item and understand how other items in the assessment may be impacted by inaccurate responses. This is not an easy assessment section. Time and effort must be put into learning how to use and score the screening tools required.

OASIS-E

SECTION D:

MOOD

D0150. Patient Mood Interview (PHQ-2 to 9)

Say to patient: "Over the last 2 weeks, have you been bothered by any of the following problems?"

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.

If yes in column 1, then ask the patient: "About how often have you been bothered by this?"

Read and show the patient a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

	1. Symptom Presence	2. Symptom Frequency
	0. **No** (enter 0 in column 2) 1. **Yes** (enter 0-3 in column 2) 9. **No response** (leave column 2 blank)	0. **Never or 1 day** 1. **2-6 days** (several days) 2. **7-11 days** (half or more of the days) 3. **12-14 days** (nearly every day)
	1. Symptom Presence	**2. Symptom Frequency**
	↓ **Enter Scores in** ↓ **Boxes**	
A. **Little interest or pleasure in doing things**		
B. **Feeling down, depressed, or hopeless**		
If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview.		
C. **Trouble falling or staying asleep, or sleeping too much**		
D. **Feeling tired or having little energy**		
E. **Poor appetite or overeating**		
F. **Feeling bad about yourself - or that you are a failure or have let yourself or your family down**		
G. **Trouble concentrating on things, such as reading the newspaper or watching television**		
H. **Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual**		
I. **Thoughts that you would be better off dead, or hurting yourself in some way**		

Section D contains items that address mood distress. The presence of indicators does not automatically mean that the patient has a diagnosis of depression or other mood disorder.

Intent: This item identifies the presence of signs and symptoms of mood distress, a serious condition that is underdiagnosed and undertreated in home health and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among home health patients because these signs and symptoms can be treatable.

Rationale:

Depression can be associated with:

- psychological and physical distress,
- decreased participation in therapy and activities,
- decreased functional status, and
- poorer outcomes.

Mood disorders are common in home health and are often underdiagnosed and undertreated.

Response (Coding) Tips:

- Attempt to conduct the interview with ALL patients.
- For question D0150I, Thoughts That You Would Be Better Off Dead or of Hurting Yourself in Some Way:
  - Beginning interviewers may feel uncomfortable asking this item because they may fear upsetting the patient or may feel that the question is too personal. Others may worry that it will give the patient inappropriate ideas. However:
    - Experienced interviewers have found that most patients who are having this feeling appreciate the opportunity to express it.
    - Asking about thoughts of self-harm does not give the person the idea. It does let the provider better understand what the patient is already feeling.
    - The best interviewing approach is to ask the question openly and without hesitation.

- If the patient uses their own words to describe a symptom, this should be briefly explored. If you determine that the patient is reporting the intended symptom but using their own words, ask them to tell you how often they were bothered by that symptom.
  - Select only one frequency response per item.
    - If the patient has difficulty selecting between two frequency responses, code for the higher frequency.
    - If Column 1 equals 0, enter 0 in Column 2.
    - If Column 1 equals 9, leave Column 2 blank.
    - If the patient describes the presence of a symptom, but cannot quantify a frequency, code the presence of the symptom as "1: Yes" in Column 1 and enter a dash in Column 2.
    - Some items (e.g., item F) contain more than one phrase. If a patient gives different frequencies for the different parts of a single item, select the highest frequency as the score for that item.
- Patients may respond to questions:
  - verbally,
  - by pointing to their answers on the cue card, OR
  - by writing out their answers.

Interviewing Tips and Techniques	Examples
Repeat a question if you think that it has been misunderstood or misinterpreted.	
Some patients may be eager to talk with you and will stray from the topic at hand. When a person strays, you should gently guide the conversation back to the topic.	Say, "That's interesting, now I need to know…"; "Let's get back to…"; "I understand, can you tell me about…."
Validate your understanding of what the patient is saying by asking for clarification.	Say, "I think I hear you saying that…"; "Let's see if I understood you correctly."; "You said…. Is that right?"

Interviewing Tips and Techniques	Examples
If the patient has difficulty selecting a frequency response, start by offering a single frequency response and follow with a sequence of more specific questions. This is known as unfolding.	Say, "Would you say [name symptom] bothered you more than half the days in the past 2 weeks?" • If the patient says "yes," show the cue card and ask whether it bothered them nearly every day (12-14 days) or on half or more of the days (7-11 days). • If the patient says "no," show the cue card and ask whether it bothered them several days (2- 6 days) or never or 1 day (0-1 day).
Noncommittal responses such as "not really" should be explored. Patients may be reluctant to report symptoms and should be gently encouraged to tell you if the symptom bothered them, even if it was only some of the time. This is known as probing.	Probe by asking neutral or nondirective questions such as: • "What do you mean?" • "Tell me what you have in mind." • "Tell me more about that." • "Please be more specific." • "Give me an example."
Sometimes respondents give a long answer to interview items. To narrow the answer to the response choices available, it can be useful to summarize their longer answer and then ask them which response option best applies. This is known as echoing.	**Item D0150E, Poor Appetite or Overeating** The patient responds "the food is always cold and it just doesn't taste like it does at home. The doctor won't let me have any salt." • Possible clinician response: "You're telling me the food isn't what you eat at home and you can't add salt. How often would you say that you were bothered by poor appetite or overeating during the last 2 weeks?" **Item D0150A, Little Interest or Pleasure in Doing Things** The patient, when asked how often they have been bothered by little interest or pleasure in doing things, responds, "There's nothing to do here, all you do is eat, bathe, and sleep. They don't do anything I like to do." • Possible clinician response: "You're saying there isn't much to do here and I want to come back later to talk about some things you like to do. Thinking about how you've been feeling over the past 2 weeks, how often have you been bothered by little interest or pleasure in doing things?"

Interviewing Tips and Techniques	Examples
	Item D0150B, Feeling Down, Depressed, or Hopeless The patient, when asked how often they have been bothered by feeling down, depressed, or hopeless, responds: "How would you feel if you were here?" • Possible clinician response: "You asked how I would feel, but it is important that I understand **your** feelings right now. How often would you say that you have been bothered by feeling down, depressed, or hopeless during the last 2 weeks?"
If the patient has difficulty with longer items, separate the item into shorter parts, and provide a chance to respond after each part. This method, known as disentangling, is helpful if a patient has moderate cognitive impairment but can respond to simple, direct questions.	**Item D0150E, Poor Appetite or Overeating** • You can simplify this item by asking: "In the last 2 weeks, how often have you been bothered by poor appetite?" (pause for a response) "Or overeating?" **Item D0150C, Trouble Falling or Staying Asleep, or Sleeping Too Much** • You can break this item down as follows: "In the past 2 weeks, how often have you been bothered by having problems falling asleep?" (pause for response) "How often have you been bothered by having problems staying asleep?" (pause for response) "How often have you been bothered by feeling you are sleeping too much?" **Item D0150H, Moving or Speaking So Slowly That Other People Could Have Noticed. Or the Opposite—Being So Fidgety or Restless That You Have Been Moving Around a Lot More than Usual** • You can simplify this item by asking: "In the past 2 weeks, how often have you been bothered by having problems with moving or speaking so slowly that other people could have noticed?" (pause for response) "How often have you been bothered by feeling so fidgety or restless that you move around a lot more than usual?"

Coding Instructions for Column 1: Symptom Presence	Coding Instructions for Column 2: Symptom Frequency
Record the patient's responses as they are stated, regardless of whether the patient or the assessor attributes the symptom to something other than mood.	**Code 0, never or 1 day,** if the patient indicates that during the past 2 weeks they have never been bothered by the symptom or have only been bothered by the symptom on 1 day.
Code 0, no, if the patient indicates symptoms listed are not present. Enter 0 in Column 2 as well.	**Code 1, 2-6 days (several days),** if the patient indicates that during the past 2 weeks they have been bothered by the symptom for 2-6 days.
Code 1, yes, if the patient indicates symptom listed is present. Enter 0, 1, 2, or 3 in Column 2.	**Code 2, 7-11 days (half or more of the days),** if the patient indicates that during the past 2 weeks they have been bothered by the symptom for 7-11 days.
Code 9, no response, if the patient was unable or chose not to complete the interview, responded nonsensically and/or the agency was unable to complete the assessment. Leave Column 2 blank.	**Code 3, 12-14 days (nearly every day),** if the patient indicates that during the past 2 weeks they have been bothered by the symptom for 12-14 days.
Dash is a valid response for this item. A dash indicates "no information." CMS expects dash use to be a rare occurrence.	**Dash** is a valid response for this item. A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Example	Response
Assessing clinician: "Over the past 2 weeks, have you been bothered by any of the following problems? Little interest or pleasure in doing things?" **Patient:** "I'm not interested in doing much. I just don't feel like it. I used to enjoy visiting with friends, but I don't do that much anymore. I'm just not interested." **Assessing clinician:** "In the past two weeks, how often would you say you have been bothered by this? Would you say never or 1 day, 2-6 days, 7-11 days, or 12-14 days? **Patient:** "7-11 days."	D0150A1 (symptom presence) would be coded 1, yes and D0150A2 (symptom frequency) would be coded 2, 7-11 days.
Assessing clinician: "Over the past 2 weeks, have you had trouble concentrating on things, such as reading the newspaper or watching television?" **Patient:** "Television? I used to like watching the news. I can't concentrate on that anymore." **Assessing clinician:** "In the past 2 weeks, how often have you been bothered by having difficulty concentrating on things like television? Would you say never or 1 day, 2-6 days, 7-11 days, or 12-14 days?" **Patient:** "I'd say every day. It bothers me every day."	D0150G1 (symptom presence) would be coded 1, yes and D0150G2 (symptom frequency) would be coded 3, 12-14 days.

Instructions

1. If SOC/ROC assessment, complete as close to the time of SOC/ROC as possible. If discharge assessment, complete as close to the time of discharge as possible.

2. Conduct the interview in a private setting, if possible.

3. Interact with the patient using their preferred language.

- If the patient appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards.
- If an interpreter is used during patient interviews, the interpreter should not attempt to determine the intent behind what is being translated, the outcome of the interview, or the meaning or significance of the patient's responses.

4. Explain the reason for the interview before beginning.

- Suggested language: "I am going to ask you some questions about your mood and feelings over the past 2 weeks. I will also ask about some common problems that are known to go along with feeling down. Some of the questions might seem personal, but everyone is asked to answer them. This will help us provide you with better care."

5. Explain and/or show the interview response choices. A cue card with the response choices clearly written in large print might help the patient comprehend the response choices.

- Suggested language: "I am going to ask you how often you have been bothered by a particular problem over the last 2 weeks. I will give you the choices that you see on this card." (Say while pointing to cue card): "0-1 days—never or 1 day, 2-6 days—several days, 7-11 days—half or more of the days, or 12-14 days—nearly every day."

6. Ask the first two questions (D0150A and D0150B) of the Patient Mood Interview (PHQ-2 to 9).

- "Over the last 2 weeks, have you been bothered by any of the following problems?"

7. For each of the questions:

- Read the item as it is written.
- Do not provide definitions because the meaning must be based on the patient's interpretation. For example, the patient defines for themself what "feeling down" means; the item should be scored based on the patient's interpretation.
- Each question must be asked in sequence to assess presence (column 1) and frequency (column 2) before proceeding to the next question.
- Enter code 9 if the patient was unable or chose not to complete the interview or responded nonsensically and/or the agency was unable to complete the assessment. A nonsensical response is one that is unrelated, incomprehensible, or incoherent or if the patient's response is not informative with respect to the item being rated (e.g., when asked the question about "poor appetite or overeating," the patient answers, "I always win at poker.").
- For a yes response, ask the patient to tell you how often they were bothered by the symptom over the last 2 weeks. Use the response choices in D0150 Column 2, Symptom Frequency. Start by asking the patient the number of days that they were bothered by the symptom and read and show cue card with frequency categories/descriptions (0-1 days—never or 1 day, 2-6 days—several days, 7-11 days—half or more of the days, or 12-14 days—nearly every day).

Instructions
8. Determine if the patient is rarely/never understood verbally, in writing, or using another method. If rarely/never understood, code D0150A1 and D0150B1 as 9 (no response) and leave D0150A2 and D0150B2 blank, end the PHQ-2 interview and skip D0160.
9. Determine whether to complete the PHQ-9 (i.e., ask the remaining seven questions: D0150C to D0150I). Whether or not further evaluation of a patient's mood is needed depends on the patient's responses to the PHQ-2 (D0150A and D0150B). • If **both** D0150A2 and D0150B2 are **less than 2** there is no need to continue to the PHQ-9. End the PHQ-2 and enter the total score from D0150A2 and D0150B2 in D0160 – Total Severity Score. • If **both** D0150A2 and D0150B2 are **blank,** then end the PHQ-2 and skip D0160. • If **either** D0150A2 or D0150B2 are **2 or 3,** then you must complete the PHQ-9. Proceed to ask the remaining seven questions (D0150C to D0150I) of the PHQ-9 and complete D0160 – Total Severity Score.

Tip From Axxess:

A patient with a mood disorder may be pessimistic, withdrawn or uninterested in activities they used to enjoy. They may have difficulty participating in programs or treatments designed to improve their overall health. While the OASIS-E Patient Mood Interview is not a diagnostic tool, it is beneficial in determining the potential for moderate to serious depression requiring further treatment and intervention.

Underdiagnosed or undertreated mood disorders are often associated with non-compliance and significant morbidity. Identifying potential mood disorders at the beginning of care provides clinicians with the opportunity to intervene early and help patients access the treatment they need. Communicating findings with the physician or practitioner in charge will be an additional responsibility for every clinician involved in this process.

D0160. Total Severity Score	
Enter Score	**Add scores for all frequency responses in Column 2,** Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items)

Intent: This item identifies the severity score calculated from responses to the PHQ-2 to 9, item D0150.

Rationale:

- The score does not diagnose a mood disorder or depression but provides a standard score which can be communicated to the patient's physician, other clinicians and mental health specialists for appropriate follow-up.

- The Total Severity Score is a summary of the frequency scores on the PHQ-2 to 9 that indicates the extent of potential depression symptoms.

Response (Coding) Tips:

- Responses to PHQ-2 to 9 can indicate possible depression if the full PHQ-2 to 9 is completed (i.e., interview is not stopped after D0150B due to responses). Responses can be interpreted as follows:

  - Major Depressive Syndrome is suggested if – of the nine items – five or more items are identified at a frequency of half or more of the days (7-11 days) during the look-back period.

  - Minor Depressive Syndrome is suggested if – of the nine items – (1) feeling down, depressed or hopeless, (2) trouble falling or staying asleep, or sleeping too much, or (3) feeling tired or having little energy are identified at a frequency of half or more of the days (7-11 days) during the look-back period.

- In addition, PHQ-2 to 9 Total Severity Score can be used to track changes in severity over time. Total Severity Score can be interpreted as follows:
  - 0-4: minimal depression
  - 5-9: mild depression
  - 10-14: moderate depression
  - 15-19: moderately severe depression
  - 20-27: severe depression

Scoring Rules for Patient Mood Interview Total Severity Score D0160:

If only the PHQ-2 is completed because both D0150A2 and D0150B2 are less than 2 (but not blank), add the numeric scores from these two frequency items and enter the value in D0160.

If items D0150C through D0150I were asked, calculate the Total Severity Score:

- Item D0160 is used to store the total severity score for the Patient Mood Interview. The score in item D0160 is based upon the sum of the values that are contained in the nine items, A-I. These are referred to as the "items in Column 2" below.

A. **Little interest or pleasure in doing things**	☐	☐
B. **Feeling down, depressed, or hopeless**	☐	☐
If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview.		
C. **Trouble falling or staying asleep, or sleeping too much**	☐	☐
D. **Feeling tired or having little energy**	☐	☐
E. **Poor appetite or overeating**	☐	☐
F. **Feeling bad about yourself - or that you are a failure or have let yourself or your family down**	☐	☐
G. **Trouble concentrating on things, such as reading the newspaper or watching television**	☐	☐
H. **Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual**	☐	☐
I. **Thoughts that you would be better off dead, or hurting yourself in some way**	☐	☐

The following rules explain how to compute the score that is placed in item D0160. These rules consider the "number of missing items in Column 2" which is the number of items in Column 2 that are either skipped or are equal to dash. An item in Column 2 is skipped if the corresponding item in Column 1 was equal to 9 (no response). An item in Column 2 could be equal to dash if the item could not be assessed for some other reason (e.g., if the patient was unexpectedly discharged before the interview could be completed).

IF	THEN
All of the items in Column 2 have a value of 0, 1, 2, or 3 (i.e., they all contain non-missing values)…	Item D0160 is equal to the simple sum of those values.
Any of the items in Column 2 are skipped or equal to dash…	Omit their values when computing the sum.
The number of missing items in Column 2 is equal to one…	Compute the simple sum of the eight items in Column 2 that have non-missing values, multiply the sum by 9/8 (1.125), and place the result rounded to the nearest integer in item D0160.
The number of missing items in Column 2 is equal to two…	Compute the simple sum of the seven items in Column 2 that have non-missing values, multiply the sum by 9/7 (1.286), and place the result rounded to the nearest integer in item D0160.
The number of missing items in Column 2 is equal to three or more…	Item D0160 must equal [99].

Example	Rational	Instructions
All Items in Column 2 Have Non-Missing Values The following example shows how to score the patient interview when all of the items in Column 2 have non-missing values: **Item — Value** D0150A2 ..... 1 D0150B2 ..... 2 D0150C2 ..... 2 D0150D2 ..... 0 D0150E2 ..... 3 D0150F2 ..... 0 D0150G2 ..... 1 D0150H2 ..... 3 D0150I2 ..... 2 **D0160 ..... 14**	In this example, all of the items in Column 2 have non-missing values (i.e., none of the values are skipped or equal to dash). Therefore, the value of D0160 is equal to the simple sum of the values in Column 2, which is 14.	**1.** Do not add up the score while you are interviewing the patient. Instead, focus your full attention on the interview. **2.** Use the scoring guide to complete scoring: **Scoring Rules for Patient Mood Interview Total Severity Score D0160**. **3.** The maximum patient score is 27 (3 x 9). **4.** If only the PHQ-2 is completed because D0150A2 and D0150B2 are less than 2 (but not blank), add the numeric scores from these two frequency items and enter the value in D0160. **5.** If the PHQ-9 was completed (D0150C-I were not skipped due to the responses in D0150A and B), and if the patient answered the frequency responses of at least seven of the nine items on the PHQ- 9; add the numeric scores from D0150A2-D0150I2 and enter in D0160 Total Severity Score.

Example	Rational	Instructions
One Missing Value in Column 2 The following example shows how to score the patient interview when one of the items in Column 2 has a missing value: **Item** **Value** D0150A2.....1 D0150B2.....2 D0150C2 D0150D2 .....0 D0150E2.....3 D0150F2.....0 D0150G2 .....1 D0150H2 .....3 D0150I2 .....1 **D0160.....12**	In this example, one of the items in Column 2 (D0150C2) has a missing value (it is blank or skipped) and the other eight items have non-missing values. D0160 is computed as follows: 1. Compute the sum of the eight items with non-missing values. This sum is 11. 2. Multiply this sum by 1.125. In the example, 11 x 1.125 = 12.375. 3. Round the result to the nearest integer. In the example, 12.375 rounds to 12. 4. Place the rounded result in D0160.	**6.** If symptom frequency is blank for three or more items, the interview is deemed NOT complete. Total Severity Score should be coded as "99." **7.** The Total Severity Score will be between 00 and 27 (or "99" if symptom frequency is blank for three or more items). **8. Dash** is a valid response for this item. Dash indicates "no information." CMS expects dash use to be a rare occurrence.
Two Missing Values in Column 2 The following example shows how to score the patient interview when two of the items in Column 2 have missing values: **Item** **Value** D0150A2.....1 D0150B2.....2 D0150C2 D0150D2 .....0 D0150E2.....3 D0150F2.....0 D0150G2 .....1 D0150H2 .....1 D0150I2 .....- **D0160.....10**	In this example, two of the items in Column 2 have missing values: D0150C2 is blank or skipped, and D0150I2 is equal to dash. The other seven items have non-missing values. D0160 is computed as follows: 1. Compute the sum of the seven items with non-missing values. This sum is 8. 2. Multiply this sum by 1.286. In the example, 8 x 1.286 = 10.288. 3. Round the result to the nearest integer. In the example, 10.288 rounds to 10. 4. Place the rounded result in D0160.	

Example	Rational	Instructions
Three or More Missing Values in Column 2 The following example shows how to score the patient interview when three or more of the items in Column 2 have missing values and at least one of the values is not equal to dash: **Item — Value** D0150A2 ..... 1 D0150B2 ..... 2 D0150C2 D0150D2 ..... 0 D0150E2 ..... 3 D0150F2 D0150G2 ..... - D0150H2 ..... 3 D0150I2 ..... 2 **D0160 ..... 99**	In this example, three of the items in Column 2 have missing values: D0150C2 and D0150F2 are blank or skipped, and D0150G2 is equal to dash. Because three or more items have missing values, D0160 is equal to 99.	

D0700. Social Isolation	
Enter Code	**How often do you feel lonely or isolated from those around you?**
	0. **Never**
	1. **Rarely**
	2. **Sometimes**
	3. **Often**
	4. **Always**
	7. **Patient declines to respond**
	8. **Patient unable to respond**

Intent: The intent of this item is to identify the patient's actual or perceived lack of contact with other people, such as living alone or residing in a remote area.

Rationale:

Social isolation tends to increase with age, is a risk factor for physical and mental illness, and a predictor of mortality.

Response (Coding) Tip:

- **Code 0, Never,** if the patient indicates never feeling lonely or isolated from others.
- **Code 1, Rarely,** if the patient indicates rarely feeling lonely or isolated from others.
- **Code 2, Sometimes,** if the patient indicates sometimes feeling lonely or isolated from others.
- **Code 3, Often,** if the patient indicates often feeling lonely or isolated from others.
- **Code 4, Always,** if the patient indicates always feeling lonely or isolated from others.
- **Code 7, Patient declines to respond,** if the patient declines to respond.
- **Code 8, Patient unable to respond,** if the patient is unable to respond.
- **Dash** is **not** a valid response for this item.

Instructions:

- This item is intended to be a patient self-report item. No other source should be used to identify the response.
- Complete as close to the time of SOC/ROC and DC as possible.
- Data sources/resources: Ask the patient, “How often do you feel lonely or isolated from those around you?”

Tip from Axxess:

Understanding social isolation and how it impacts an individual’s health is critical for identifying issues that could impact care planning. Social isolation is associated with heightened risks of hypertension, heart disease, anxiety, depression, cognitive decline, dementia and even death. Patients who are socially isolated are also more likely to be admitted to an emergency room, hospital or nursing home. Assessing patients for social isolation enables clinicians to identify these risks, connect patients to the resources they need and significantly improve outcomes.

OASIS-E

SECTION J:
HEALTH CONDITIONS

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**

Section J includes seven items to assess risk for hospitalization, pain interfering with activities, frequency of falls and shortness of breath.

Response (Coding) Tips:

If SOC/ROC assessment, complete as close to the time of SOC/ROC as possible. If discharge assessment, complete as close to the time of discharge as possible.

- **Code 0, Does not apply,** if the patient responds that they did not have any pain or hurting in the past 5 days.
- **Code 1, Rarely or not at all,** if the patient responds that pain has been present and the pain rarely or not at all made it hard to sleep in the past 5 days.
- **Code 2, Occasionally,** if the patient responds that pain has occasionally made it hard to sleep in the past 5 days.
- **Code 3, Frequently,** if the patient responds that pain has frequently made it hard to sleep in the past 5 days.
- **Code 4, Almost constantly,** if the patient responds that pain has almost constantly made it hard to sleep in the past 5 days.
- **Code 8, Unable to answer,** if the patient is unable to answer the question, does not respond or gives a nonsensical response.
- **Dash** is **not** a valid response for this item.

Example	Response	Instructions
Assessing clinician: "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?" **Patient:** "I've had a little back pain from being in the wheelchair all day, but it's felt so much better when I go to bed. The pain hasn't kept me from sleeping at all."	J0510 would be coded 1, Rarely or not at all.	**1.** Read the question and response choices as written. **2.** No predetermined definitions are offered to the patient. The response should be based on the patient's interpretation of frequency response options. **3.** If the patient's response does not lead to a clear answer, repeat the patient's response and then try to narrow the focus of the response. For example, if the patient responded to the question, "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?" by saying, "I always have trouble sleeping," then the assessing clinician might reply, "You always have trouble sleeping. Is it your pain that makes it hard for you to sleep?" The clinician can then narrow down responses with additional follow-up questions about the frequency.
Assessing clinician: "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?" **Patient:** "All the time. It's been hard for me to sleep all the time. I have to ask for extra pain medicine, and I still wake up several times during the night because my back hurts so much."	J0510 would be coded 4, Almost constantly.	

Tip From Axxess:

The biggest challenge clinicians will face when completing Section J is collecting accurate information. Prior to the start of care comprehensive assessment, home health organizations should arrange to connect with the family and caregivers either in person or by phone to assist in gathering information about the patient's pain and other related health conditions.

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**

Response (Coding) Tips:

If SOC/ROC assessment, complete as close to the time of SOC/ROC as possible. If discharge assessment, complete as close to the time of discharge as possible.

- This item should be coded based on the patient's interpretation of the provided response options for frequency. If the patient is unable to decide between two options, then the assessing clinician should code for the option with the higher frequency.
- Rehabilitation therapies may include treatment supervised in person by a therapist or nurse or other staff, or the patient/family/caregivers carrying out a prescribed therapy program without agency staff present.

Example	Response	Instructions
Assessing clinician: "Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain?" **Patient:** "Since the surgery a week ago, the pain has made it hard to even get out of bed. I try to push myself, but the pain frequently limits how much I can do with my therapist."	J0520 would be coded 3, Frequently.	**1.** Read the question and response choices as written. **2.** No predetermined definitions are offered to the patient. The response should be based on the patient's interpretation of frequency response options. **3.** Confirm that the patient has been offered rehabilitation therapies during the reference timeframe.

Rehabilitation Therapy: Special healthcare services or programs that help a person regain physical, mental and/or cognitive (thinking and learning) abilities that have been lost or impaired as a result of disease, injury, or treatment. Can include, for example, physical therapy, occupational therapy, speech therapy, and cardiac and pulmonary therapies.

Tip From Axxess:

Pain should be evaluated frequently and adjustments in medications should be made if the current treatment is not effective.

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

Response (Coding) Tips:

If SOC/ROC assessment, complete as close to the time of SOC/ROC as possible. If discharge assessment, complete as close to the time of discharge as possible.

- This item should be coded based on the patient's interpretation of the provided response options for frequency. If the patient is unable to decide between two options, then the assessing clinician should code for the option with the higher frequency.
- Coding is selected based on the past 5 days. This window is specific.

Example	Response	Instructions
Assessing clinician: "Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?" **Patient:** "Although I have some pain in my back, I'm still able to read, eat my meals, and take walks like I usually do."	J0530 would be coded 1, Rarely or not at all. Why? The patient reports that pain has not limited participation in day-to-day activities.	**1.** Read the question and response choices as written. **2.** No predetermined definitions are offered to the patient. The response should be based on the patient's interpretation of frequency response options.
Assessing clinician: "Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?" **Patient:** "The pain has made it hard to do pretty much anything. Even getting out of bed to brush my teeth has been hard. I haven't been able to talk to my family because the pain is so bad. It's just constant. I'd say it constantly limits what I do."	J0530 would be coded 4, Almost constantly. Why? The patient reports that pain has constantly limited participation in other activities.	

Tip From Axxess:

Section J may be one of the most important sections of OASIS-E, as avoiding hospitalizations and emergency room visits will carry 35% of the weight for value-based purchasing (VBP). While new items added to Section J are not specifically measured, nor do they directly affect value-based purchasing, this entire section could have significant consequences if not assessed correctly. For instance, item M1033 Risk for Hospitalization is not a new OASIS item. However, the response here may be heavily dependent on the precise evaluation and response to items J0510-J0530 relative to pain.

Clinicians need to be aware of how these assessment areas affect the risk for hospitalization and therefore significantly impact VBP. Addressing each of these items as thoroughly as possible and designing a plan of care around the risks will help mitigate potential hospitalizations or ER visits.

If the assessment indicates risks for hospitalization, clinicians should consider recommendations for remote care monitoring with these patients. ER visits or hospitalizations can often be avoided using remote visits for recommendations of medications or treatment.

AXXESS

OASIS-E

SECTION K:

SWALLOWING

NUTRITIONAL STATUS

SOC/ROC
K0520. Nutritional Approaches

1. **On Admission** Check all of the nutritional approaches that apply on admission	1. On Admission Check all that apply ↓
A. **Parenteral/IV feeding**	☐
B. **Feeding tube** (e.g., nasogastric or abdominal (PEG))	☐
C. **Mechanically Altered Diet** - require change in texture of foods or liquids (e.g., pureed food, thickened liquids)	☐
D. **Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)	☐
Z. **None of the above**	☐

Discharge
K0520. Nutritional Approaches

4. **Last 7 days** Check all of the nutritional approaches that were received in the last 7 days 5. **At discharge** Check all of the nutritional approaches that were being received at discharge	4. Last 7 days	5. At discharge
	↓ Check all that apply ↓	
A. **Parenteral/IV feeding**	☐	☐
B. **Feeding tube** (e.g., nasogastric or abdominal (PEG))	☐	☐
C. **Mechanically Altered Diet** - require change in texture of foods or liquids (e.g., pureed food, thickened liquids)	☐	☐
D. **Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)	☐	☐
Z. **None of the above**	☐	☐

Section K includes three items: height and weight to calculate body mass, nutritional approaches and assessment of the ability to eat, chew and swallow food.

Intent: The intent of this item is to identify if any nutritional approaches listed are used by the patient.

Rational:

- Nutritional approaches such as mechanically altered food or those that rely on alternative methods (e.g., parenteral/IV or feeding tubes) can diminish an individual's sense of dignity and self-worth as well as diminish pleasure from eating.
- The patient's clinical condition may potentially benefit from the various nutritional approaches included here.

Response (Coding) Tips for SOC/ROC:

- Check all that apply during the time period under consideration for the SOC/ROC assessment. If none apply, check K0520Z, None of the above.
- **Dash** is a valid response for this item. Dash indicates "no information." CMS expects dash use to be a rare occurrence.

Response (Coding) Tips for Discharge

- Check all nutritional approaches that were received in the last 7 days (Column 1) and during the time period under consideration for the discharge assessment (Column 2). If none apply, check K0520Z, None of the above.
- **Dash** is a valid response for this item. Dash indicates "no information." CMS expects dash use to be a rare occurrence.

General Coding Tip:

If a patient will receive one of the listed nutritional approaches as a result of this SOC/ROC assessment (for example, IV hydration will be started at this visit or a specified subsequent visit; the physician is contacted for an enteral order, etc.), mark the applicable nutritional approach.

Coding Tips for K0520A, Parenteral/IV Feeding:

Parenteral/IV feeding includes parenteral or IV fluids provided for nutrition or hydration. Includes additional fluid intake specifically addressing a documented nutrition or hydration need. Excludes fluids provided solely to maintain access and patency.

The following items may be included:

- IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently.
- Hypodermoclysis and subcutaneous ports in hydration therapy.
- IV fluids can be coded in K0520A if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and hydration.

The following items are NOT to be coded in K0520A:

- IV medications—Code these when appropriate in O0110H, IV Medications.
- IV fluids used to reconstitute and/or dilute medications for IV administration.
- IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay.
- IV fluids administered to flush the IV line.
- Parenteral/IV fluids administered in conjunction with chemotherapy or dialysis.

Coding Tip for K0520B, Feeding Tube:

Code only feeding tubes used to deliver nutritive substances and/or hydration during the time period under consideration.

Coding Tips for K0520D, Therapeutic Diet:

Enteral feeding formulas:

- Should not be coded as a mechanically altered diet.
- Should only be coded as **K0520D, Therapeutic Diet** when the enteral formula is altered to manage problematic health conditions (e.g., enteral formulas specific to diabetes).

A nutritional supplement given as part of the treatment for a disease or clinical condition manifesting an altered nutrition status does not constitute a therapeutic diet, but may be part of a therapeutic diet. Therefore, supplements (whether taken with, in between, or instead of meals) are only coded in K0520D, Therapeutic Diet when they are being taken as part of a therapeutic diet to manage problematic health conditions (e.g., supplement for protein-calorie malnutrition).

- Food elimination diets related to food allergies (e.g., peanut allergy) can be coded as a therapeutic diet.

Example for SOC/ROC: K0520A, Parenteral/IV Feeding	Response	Instructions
A patient is admitted with orders for an antibiotic in 100 cc of normal saline via IV for symptoms of a urinary tract infection (UTI), fever, abnormal lab results (e.g., new pyuria, microscopic hematuria, urine culture with growth >105 colony forming units of a urinary pathogen), and documented inadequate fluid intake (i.e., output of fluids far exceeds fluid intake) with signs and symptoms of dehydration. The plan of care is updated to include a hydration intervention to ensure adequate hydration. Documentation shows IV fluids are being administered as part of the already identified need for additional hydration.	K0520A would be checked. The IV medication would be coded at IV Medications item (O0110H).	**1.** Consult the patient, family, or caregiver and/or review the clinical record or other available documentation to determine if any of the listed nutritional approaches apply during the time period under consideration for the SOC/ROC assessment.
A patient is admitted and receiving an antibiotic in 100 cc of normal saline via IV. They have a UTI, no fever, and documented adequate fluid intake. The patient is placed on an oral hydration plan to maintain adequate hydration.	K0520A would NOT be checked. The IV medication would be coded at IV Medications item (O0110H).	

Example for Discharge	Response	Instructions
The patient will be discharged today. They were receiving rehabilitation services for a stroke. The patient has longstanding Celiac disease and therefore was placed on a gluten-free diet. Because of their recent stroke, they also have documented dysphagia requiring a mechanical soft diet and honey-thick liquids to prevent aspiration and will be discharged on this same diet.	K0520C4 and K0520C5 as well as K0520D4 and K0520D5 would be checked.	**1.** Consult the patient, family, or caregiver and/or review the clinical record or other available documentation to determine if any of the listed nutritional approaches were received in the last 7 days (Column 1) and during the time period under consideration for the discharge assessment (Column 2).
Prior to their SOC/ROC with home health, the patient had been on a chopped diet due to facial trauma. They will be discharged today after rehabilitation services for multiple fractures after a car accident. The patient has been on a regular diet during their entire home health stay and has not required any parenteral or enteral nutrition.	K0520Z4 and K0520Z5 would be checked.	

Tip From Axxess:

Although K0520 is the only new item in the nutritional assessment, it is important that clinicians refer to items in other areas of Section K as well, in order to make accurate assessments. For instance, measuring the actual height and weight of every patient is essential for determining if the nutritional approaches being used in the care plan are effective. If the patient is receiving IV therapy for hydration, the admitting clinician will monitor patient weights to determine the success of the treatment ordered.

While using a dash for this item is permitted, it is not recommended, as capturing specificity related to parenteral, IV or enteral feeding is essential to successful assessment and care planning. IV orders for issues other than nutrition or hydration are NOT part of this assessment.

Taking the time necessary to get an accurate account of diet and nutritional approaches is critical. Clinicians should contact the physician's office to verify the accuracy of this information at admission. Making the phone calls necessary to retrieve this information at admission will improve patient outcomes at discharge.

AXXESS

OASIS-E

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 medication in the drug class	**1.** **Is Taking**	**2.** **Indication Noted**
	↓ Check all that apply ↓	
A. **Antipsychotic**	☐	☐
E. **Anticoagulant**	☐	☐
F. **Antibiotic**	☐	☐
H. **Opioid**	☐	☐
I. **Antiplatelet**	☐	☐
J. **Hypoglycemic** (including insulin)	☐	☐
Z. **None of the above**	☐	☐

The intent of the items in this section is to record whether:

- the patient is taking any medications in high-risk drug classes, there is an indication noted and the patient/caregiver have been educated about the high-risk medications
- a drug regimen review was conducted
- the patient can manage oral and injectable medications

Intent: This item identifies if the patient is taking any prescribed medications in the specified drug classes and whether the indication was noted for all medications in the drug class.

Rational:

- Patients who take medications in these high-risk drug classes are at risk for side effects that can adversely affect health, safety, and quality of life.

Response (Coding) Tips:

- If Column 1 is checked (patient is taking medication in the drug class), review patient documentation to determine if there is a documented indication noted for all medications in the drug class (Column 2).
- Code medications according to the medication's therapeutic category and/or pharmacological classification, regardless of why the patient is taking it.
- Code a medication that is part of a patient's current drug regimen, even if it was not taken on the day of assessment.
- Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel as N0415E, Anticoagulant.
- Anticoagulants such as Target Specific Oral Anticoagulants (TSOACs), which may or may not require laboratory monitoring, should be coded in N0415E, Anticoagulant.
- **Dash** is a valid response for this item. Dash indicates "no information." CMS expects dash use to be a rare occurrence.
- Include any of these medications used by any route (e.g., PO, IM, transdermal, or IV) in any setting (e.g., at home, in a hospital emergency room, at physician office or clinic) while a patient of the home health agency.
- Medications that have more than one therapeutic category and/or pharmacological classification should be coded in all categories/classifications assigned to the medication, regardless of how it is being used. For example, prochlorperazine is dually classified as an antipsychotic and an antiemetic. Therefore, in this section, it would be coded as an antipsychotic, regardless of how it is used.
- Count long-acting medications, such as fluphenazine decanoate or haloperidol decanoate, that are given every few weeks or monthly only if they are part of the current drug regimen at the time of assessment.
- Include newly prescribed medications that are part of the current drug regimen, even if the medication is not yet in the home and/or the first dose has not been taken.

- A transdermal patch is designed to release medication over a period of time (typically 3–5 days); therefore, transdermal patches would be considered long-acting medications for the purpose of coding the OASIS and are included as long as it is part of the patient's current drug regimen.

- Combination medications should be coded in all categories/pharmacologic classes that constitute the combination.

- Herbal and alternative medicine products are considered to be dietary supplements by the Food and Drug Administration (FDA). Therefore, they should not be counted as medications (e.g., melatonin, chamomile, valerian root) for N0415.

Example	Response	Instructions
The documentation for a patient reflects that (at SOC) they are taking edoxaban and glipizide. The documentation indicates the patient has type 2 diabetes and is taking the glipizide to control high blood sugar. There is no indication documented for the edoxaban.	Medications in N0415 would be coded as follows: Column 1 (is taking) would be checked for E. Anticoagulant and J. Hypoglycemic. Column 2 (indication noted) would be checked only for J. Hypoglycemic.	**1.** Data sources/resources include medical records received from facilities where the patient received healthcare, the patient's most recent history and physical, transfer documents, discharge summaries, medication lists/records, clinical progress notes, and other resources as available. • Discussions (including with the acute care hospital, other staff and clinicians, the patient, and the patient's family/significant other) may supplement and/or clarify the information gleaned from the patient's medical records. **2.** Determine whether the patient is taking any prescribed medications in any of the drug classes (Column 1).
At discharge, a patient's documentation indicates they are taking oxycodone for pain. Tramadol is also listed but there is no indication documented for the Tramadol.	Medications in N0415 would be coded as follows: Column 1 (is taking) would be checked for H. Opioid. Column 2 (indication noted) would not be checked for H. Opioid. Note: All medications in the class must have an indication documented to check Column 2.	

Adverse Drug Reaction: Adverse drug reaction (ADR) is a form of an adverse consequence. It may be either a secondary effect of a medication that is usually undesirable and different from the therapeutic effect of the medication or any response to a medication that is noxious and unintended and occurs in doses for prophylaxis, diagnosis, or treatment. The term "side effect" is often used interchangeably with ADR; however, side effects are but one of five ADR categories, the others being hypersensitivity, idiosyncratic response, toxic reactions, and adverse medication interactions. A side effect is an expected, well-known reaction that occurs with a predictable frequency and may or may not constitute an adverse consequence.

Tip From Axxess:

Patients taking high-risk medications are at greater risk of side effects that can negatively impact their health, safety, quality of life and outcomes at discharge. The Conditions of Participation require that all medications the patient is prescribed be reconciled at SOC, ROC and discharge. High-risk drugs are of particular interest since they can adversely interact with other medications prescribed, affect patient behavior and add balance and fall risks.

N0415 requires clinicians to assess each of the high-risk drug classes, indicating if the patient is taking a drug and if there is an indication noted as to why the patient is taking the medication. Indications of why the patient is taking a medication may be found in clinical documentation from the physician's office, discharge information from the hospital, history and physicals, etc. It is important that the clinician take the time necessary to research each drug and the reason the drug is being taken. To ensure all information gathered and documented at N0415 is coordinated with all other M items addressed in Section N, communicate with individual care practitioners, family members and caregivers to get the most accurate information for the assessment.

Therapists could run into issues getting drugs reconciled quickly enough to avoid problems. It is important that the organization's reconciliation nurse perform their required duties promptly and relay results to the therapist in a timely manner. Patients with low health literacy and complex medication plans have a much higher risk of rehospitalizations if the clinician does not get the reconciliation completed promptly.

OASIS-E

SECTION O:

SPECIAL TREATMENTS, 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 medication	☐
H3. Antibiotics	☐

H4. Anticoagulation	☐
H10. Other	☐
I1. Transfusions	☐
J1. Dialysis	☐
J2. Hemodialysis	☐
J3. Peritoneal dialysis	☐
O1. IV Access	☐
O2. Peripheral	☐
O3. Midline	☐
O4. Central (e.g., PICC, tunneled, port)	☐
None of the above	
Z1. None of the above	☐

Discharge
O0110. Special Treatments, Procedures and Programs

Check all of the following treatments, procedures and programs that apply at discharge.	c. At Discharge 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 medication	☐
H3. Antibiotics	☐
H4. Anticoagulation	☐
H10. Other	☐
I1. Transfusions	☐
J1. Dialysis	☐
J2. Hemodialysis	☐
J3. Peritoneal dialysis	☐
O1. IV Access	☐
O2. Peripheral	☐
O3. Midline	☐
O4. Central (e.g., PICC, tunneled, port)	☐
None of the above	
Z1. None of the above	☐

Intent: The intent of this item is to identify any special treatments, procedures and programs that apply to the patient.

Rationale:

The treatments, procedures and programs listed can have a profound effect on an individual's health status, self-image, dignity, and quality of life.

Response (Coding) Tip:

- Check each type of treatment, procedure or program that applies.
- **Dash** is a valid response for this item.

The OASIS guidance is very detailed on how to identify if any of the special procedures apply to the patient being assessed. The following charts define each procedure and condition.

Coding Instructions for Cancer Treatments	
Code A1, Chemotherapy	If any type of chemotherapy medication is administered as an antineoplastic for cancer treatment given by any route in this item.
• **Code A2, IV**	If chemotherapy is administered intravenously.
• **Code A3, Oral**	If chemotherapy is administered orally (e.g., pills, capsules, or liquids the patient swallows). This sub-element also applies if the chemotherapy is administered enterally (e.g., feeding tube/PEG).
• **Code A10, Other**	If chemotherapy is administered in a way other than intravenously, enterally, or orally (e.g., intramuscular, intraventricular/intrathecal, intraperitoneal, or topical routes).
Code B1, Radiation	If radiation is administered intermittently or via radiation implant in this item.

Coding Instructions for Respiratory Therapies	
Code C1, Oxygen Therapy	If continuous or intermittent oxygen is used via mask, cannula, etc., including in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP). Do not include hyperbaric oxygen for wound therapy in this item.
• **Code C2, Continuous**	If oxygen therapy is continuously delivered for ≥ 14 hours per day.
• **Code C3, Intermittent**	If oxygen therapy is delivered intermittently (< 14 hours continuously).
• **Code C4, High-Concentration**	If oxygen is delivered via a high-concentration delivery system at a concentration that exceeds FiO2 of 40% (i.e., exceeding that of simple low-flow nasal cannula at a flow-rate of 4 liters per minute). A high-concentration delivery system can include either high- or low-flow systems (e.g., simple face masks, partial and non-rebreather masks, face tents, venturi masks, aerosol masks, high-flow cannula or masks). These devices may also include invasive mechanical ventilators, non-invasive mechanical ventilators, or trach masks, if the delivered FiO2 of these systems exceeds 40%. Oxygen-conserving nasal cannula systems with reservoirs (e.g., mustache, pendant) should be included only if they are used to deliver an FiO2 greater than 40%.
Code D1, Suctioning	Only if tracheal and/or nasopharyngeal suctioning is performed. Do not include oral suctioning here. This item may also be checked if the patient performs their own tracheal and/or pharyngeal suctioning.
• **Code D2, Scheduled**	If suctioning is scheduled. Scheduled suctioning is performed when the patient is assessed to clinically benefit from regular interventions, such as every hour. Scheduled suctioning applies to medical orders for performing suctioning at specific intervals and/or implementation of agency-based clinical standards, protocols, and guidelines.
• **Code D3, As Needed**	If suctioning is performed on an as-needed basis, as opposed to regular scheduled intervals, such as when secretions become so prominent that gurgling or choking is noted, or a sudden desaturation occurs from a mucus plug.
Code E1, Tracheostomy Care	If cleansing of the tracheostomy and/or cannula is performed. This item may also be checked if the patient performs their own tracheostomy care or receives assistance.

Code F1, Invasive Mechanical Ventilator (ventilator or respirator)	If any type of electrically or pneumatically powered closed-system mechanical ventilator support device is used that ensures adequate ventilation in the patient who is or who may become (such as during weaning attempts) unable to support their own respiration.
Code G1, Non-Invasive Mechanical Ventilator	If any type of respiratory support device is used that prevents airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask/device enables the individual to support their own spontaneous respiration. This item may be checked if the patient places or removes their own BiPAP/CPAP mask/device or if the family/caregiver applies it for the patient.
• **Code G2, BiPAP**	If the non-invasive mechanical ventilator support was BiPAP.
• **Code G3, CPAP**	If the non-invasive mechanical ventilator support was CPAP.

Coding Instructions for Other	
Code H1, IV Medications	If any medication or biological is given by intravenous push, epidural pump, or drip through a central or peripheral port in this item. Do **not** include flushes to keep an IV access port patent, or IV fluids without medication here. Epidural, intrathecal, and baclofen pumps may be checked here, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance. Subcutaneous pumps are **not** included in this item. Do **not** include IV medications of any kind that were administered during dialysis or chemotherapy. Dextrose 50% and/or Lactated Ringers given IV are not considered medications, and should not be included here.
• **Code H2, Vasoactive Medications**	If at least one of the IV medications was a vasoactive medication.
• **Code H3, Antibiotics**	If at least one of the IV medications was an antibiotic.
• **Code H4, Anticoagulation**	If at least one of the IV medications was an IV anticoagulant. Do not include subcutaneous administration of anticoagulant medications.
• **Code H10, Other**	If at least one of the IV medications was not an IV vasoactive medication, IV antibiotic, or IV anticoagulant. Examples include IV analgesics (e.g., morphine) and IV diuretics (e.g., furosemide).
Code I1, Transfusions	If any blood or any blood products (e.g., platelets, synthetic blood products) are administered directly into the bloodstream in this item. Do **not** include transfusions that were administered during dialysis or chemotherapy.

Code J1, Dialysis	If peritoneal or renal dialysis occurs in the home or at a facility. IV medication and blood transfusions administered during dialysis are considered part of the dialysis procedure and are **not** to be coded under items K0520A (parenteral/IV feeding), O0110H1 (IV medications), or O0110I1 (transfusions). This item is also checked if the patient performs their own dialysis.
• **Code J2, Hemodialysis**	If the dialysis was hemodialysis. In hemodialysis the patient's blood is circulated directly through a dialysis machine that uses special filters to remove waste products and excess fluid from the blood.
• **Code J3, Peritoneal Dialysis**	If the dialysis was peritoneal dialysis. In peritoneal dialysis, dialysate is infused into the peritoneal cavity and the peritoneum (the membrane that surrounds many of the internal organs of the abdominal cavity) and serves as a filter to remove the waste products and excess fluid from the blood.
Code O1, IV Access	If a catheter is inserted into a vein for a variety of clinical reasons, including long-term medication administration, hemodialysis, large volumes of blood or fluid, frequent access for blood samples, intravenous fluid administration, total parenteral nutrition (TPN), or in some instances the measurement of central venous pressure.
• **Code O2, Peripheral**	If IV access is peripheral access (catheter is placed in a peripheral vein) and remains peripheral.
• **Code O3, Midline**	If IV access is midline access. Midline catheters are inserted into the antecubital (or other upper arm) vein and do not reach all the way to a central vein such as the superior vena cava.
• **Code O4, Central (e.g., PICC, tunneled, port)**	If IV access is centrally located (e.g., peripherally inserted central catheter [PICC], tunneled, port).

Coding Instructions for None of the Above	
Code Z1, None of the Above	If none of the above treatments, procedures or programs apply. Dash is a valid response for this item. Dash indicates "no information." CMS expects dash use to be a rare occurrence.

Example	Response	Instructions
The patient's referral information indicates that they were discharged from an acute care facility following an inpatient stay for bacterial pneumonia that required placement of a tracheostomy. At start of care, the patient requires intermittent oxygen and assistance with trach care. Their tracheal suctioning needs are PRN. The patient has intermittent desaturations due to mucus plugging that have required use of a tracheostomy mask at a FiO2 of greater than 40% intermittently. The patient has orders for 1 more week of IV antibiotics, which are being delivered via a PICC line.	Check boxes O0110C1 (Oxygen Therapy), O0110C3 (Intermittent), and O0110C4 (High-Concentration), O0100D1 (Suctioning) and O0110D3 (As Needed), O0110E1 (Tracheostomy Care), O0110H1 (IV Medications) and O0110H3 (Antibiotics), and O0110O1 (IV Access) and O0110O4 (Central).	**1.** Review the patient's clinical record and consult with the patient, family, caregiver(s) and/or staff to determine whether or not any of the treatments, procedures or programs apply during the time period under consideration for the SOC/ROC assessment (for the SOC/ROC) or during the time period under consideration for the DC assessment (for the DC). **2.** Check all treatments, programs and procedures that are part of the patient's current care/treatment plan. **3.** Include treatments, programs and procedures performed by others and those the patient performed themselves independently or after set-up by agency staff or family/ caregivers. **4.** Check treatments, procedures and programs that are performed in the patient's home or in other settings (e.g., dialysis performed in a dialysis center). **5.** Do not check services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications. Surgical procedures include routine pre- and post-operative procedures. **6.** For O0110A1 (Chemotherapy), O0110B1 (Radiation), and O0110J1 (Dialysis), check if the patient is undergoing treatment at the time of assessment.
A patient has advanced prostate cancer and is receiving radiation and oral chemotherapy medication to treat the prostate cancer. They are being admitted today, following an inpatient stay for an acute pulmonary embolism. Their discharge orders include enoxaparin subcutaneously for continued anticoagulation. The patient does not have orders for other IV medications but still has a port in place.	Check boxes O0110A1 (Chemotherapy), O0110A3 (Chemotherapy, Oral), O0110B1 (Radiation), and O0110O1 (IV Access) and O0110O4 (Central).	
A patient has multiple myeloma and was discharged from an acute hospitalization after a pathologic vertebral fracture with significant pain. On admission to home health, referral documentation and physician orders include palliative radiation, lenalidomide orally for chemotherapy, and notes that frequent transfusions are required not related to the chemotherapy. They have a port for pamidronate infusions due to hypercalcemia.	Check boxes O0110A1 (Chemotherapy), O0110A3 (Oral), and O0110B1 (Radiation), O0110I1 (Transfusions), O0110H1 (IV Medications) and O0110H10 (Other) and O0110O1 (IV Access) and O0110O4 (Central).	
During the home health start of care assessment, the assessing clinician learns that a patient has sleep apnea and requires a CPAP device to be worn when sleeping. The patient's spouse sets up the humidifier element of the CPAP and the patient puts on the CPAP mask prior to falling asleep.	Check boxes O0110G1 (Non-Invasive Mechanical Ventilator) and O0110G3 (CPAP).	

Tip From Axxess:

Home health organizations should expect Section O to be addressed during surveys beginning in 2023. Each of the items documented in O0110 should be integrated into care planning, as surveyors will likely compare this list of items to the plan of care prepared and certified by the physician.

The benefit of documenting special treatments, procedures and programs in this item is that it can serve as a guide for care planning. When a special treatment is documented here, clinicians should include corresponding details. For instance, when coding IV Antibiotic, the clinician should document the name of the antibiotic and dose.

Clinicians are also responsible for obtaining information from all practitioners caring for the patient, other disciplines, family members and caregivers. Other information may be garnered from hospital discharge instructions, physician face-to-face information and progress notes. Any information included in this list of special treatments should be detailed in the comprehensive assessment. Surveyors will likely expect to see consistency.

OASIS-E

APPENDIX

Health literacy is the degree to which individuals can obtain, process and understand basic health information and services needed to make appropriate health decisions. A health literacy assessment provides valuable information, enabling the care team to develop teaching strategies that will improve learning outcomes, compliance and lead to positive patient clinical outcomes, and assist in identifying comprehension level. Caregivers must use appropriate techniques to ensure understanding and learning has taken place. There are many barriers that impact health literacy that are not related to cognitive ability. Examples can include language, culture, race, and mood or behavior. There are two components we need to assess: understanding words and numbers.

Assessments	
REALM-R	Requires patients to read and pronounce common medical terms
Newest Vital Sign (NVS)	Asks the patient to read and answer questions about an ice cream food label

REALM

How many of these words can you read aloud and pronounce correctly, each within five seconds? Start with the first column, reading down. Skip those you cannot read.

Fat	Fatigue	Allergic
Flu	Pelvic	Menstrual
Pill	Jaundice	Testicle
Dose	Infection	Colitis
Eye	Exercise	Emergency
Stress	Behavior	Medication
Smear	Prescription	Occupation
Nerves	Notify	Sexually
Germs	Gallbladder	Alcoholism
Meals	Calories	Irritation
Disease	Depression	Constipation
Cancer	Miscarriage	Gonorrhea
Caffeine	Pregnancy	Inflammatory
Attack	Arthritis	Diabetes
Kidney	Nutrition	Hepatitis
Hormones	Menopause	Antibiotics
Herpes	Appendix	Diagnosis
Seizure	Abnormal	Potassium
Bowel	Syphilis	Anemia
Asthma	Hemorrhoids	Obesity
Rectal	Nausea	Osteoporosis
Incest	Directed	Impetigo

Add up the number of words pronounced correctly.

0—18 words Third grade or below You will not be able to read easy materials. You will need repeated oral instructions, materials composed primarily of illustrations, or audio or videotapes

19—44 words Fourth to sixth grade You will need easy materials. You will not be able to read prescription labels.

45—60 words Seventh to eighth grade You will struggle with most patient education materials and will not be offended by low-literacy materials.

61—66 words High school You will be able to read most patient-education materials

Source: Rapid Estimate of Adult Literacy in Medicine The New York Times

Newest Vital Sign

This assessment for health literacy uses the food label for ice cream.

Whether reading a food label or following medical instructions, patients need to:

- remember numbers and make mathematical calculations;
- identify and be mindful of different ingredients that could be potentially harmful to them;
- and make decisions about their actions based on the information given.

Nutrition Facts

Serving Size	½ cup
Servings per container	4
Amount per serving	
Calories 250	Fat Cal 120
	%DV
Total Fat 13g	20%
Sat Fat 9g	40%
Cholesterol 28mg	12%
Sodium 55mg	2%
Total Carbohydrate 30g	12%
Dietary Fiber 2g	
Sugars 23g	
Protein 4g	8%

*Percentage Daily Values (DV) are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs.

Ingredients: Cream, Skim Milk, Liquid Sugar, Water, Egg Yolks, Brown Sugar, Milkfat, Peanut Oil, Sugar, Butter, Salt, Carrageenan, Vanilla Extract.

Instructions

1. Administer this assessment at the same time other vital signs are taken.

2. Ask the patient to participate. A useful way to ask the patient is an explanation similar to this:

"We are asking our patients to help us learn how well they can understand the medical information that doctors give them. Would you be willing to help us by looking at some health information and then answering a few questions about that information? Your answers will help our doctors learn how to provide information in ways that patients will understand. It will only take about three minutes."

3. Hand the nutrition label to the patient.

The patient can and should retain the nutrition label throughout administration of the newest vital sign, referring to the label as often as desired.

4. Start asking the six assessment questions, one by one, giving the patient as much time as needed to refer to the nutrition label to answer the questions.

There is no maximum time allowed to answer the questions. The average time needed to complete all six questions is about three minutes. However, if a patient is still struggling with the first or second question after two or three minutes, it is likely that the patient has limited literacy and you can stop the assessment.

- Ask the questions in sequence. Continue even if the patient gets the first few questions wrong. However, if question five is answered incorrectly, do not ask question six.
- You can stop asking questions if a patient gets the first four correct. With four correct responses, the patient almost certainly has adequate literacy.
- Do not prompt patients who are unable to answer a question. Prompting may jeopardize the accuracy of the test. Just say, “Well, then let’s go on to the next question.”
- Do not show the score sheet to patients. If they ask to see it, tell them that, “I can’t show it to you because it contains the answers, and showing you the answers spoils the whole point of asking you the questions.”
- Do not tell patients if they have answered correctly or incorrectly. If patients asks, say something like, “I can’t show you the answers until you are finished, but for now you are doing fine. Now let’s go on to the next question.”

Scoring (See score sheet on next page)

Score by giving one point for each correct answer (maximum six points):

- Score of 0-1 suggests high likelihood (50% or more) of limited literacy
- Score of 2-3 indicates the possibility of limited literacy
- Score of 4-6 almost always indicates adequate literacy

Record the NVS score in the patient’s medical record, preferably near other vital sign measures.

Score Sheet for the Newest Vital Sign Assessment		
READ TO SUBJECT: This information is on the back of a container of a pint of ice cream.	**Answer Correct?** **yes**	**no**
1. If you eat the entire container, how many calories will you eat? **Answer:** 1,000 is the only correct answer.		
2. If you are allowed to eat 60 grams of carbohydrates as a snack, how much ice cream could you have? **Answer:** Any of the following is correct: One cup (or any amount up to a cup). Note: If patient answers "two servings" ask, "How much ice cream would that be if you were to measure it into a bowl?"		
3. Your doctor advises you to reduce the amount of saturated fat in your diet. You usually have 42 grams of saturated fat each day, which includes one serving of ice cream. If you stop eating ice cream, how many grams of saturated fat would you be consuming each day? **Answer:** 33 is the only correct answer.		
4. If you usually eat 2,500 calories in a day, what percentage of your daily value of calories will you be eating if you eat one serving? **Answer:** 10% is the only correct answer.		
READ TO SUBJECT: Pretend that you are allergic to the following substances: penicillin, peanuts, latex gloves and bee stings.		
5. Is it safe for you to eat this ice cream? **Answer:** No.		
6. If "no," ask, "Why not?" **Answer:** Because it has peanut oil.		
Number of correct answers:		

Interpretation

- Score of 0-1 suggests high likelihood (50% or more) of limited literacy.
- Score of 2-3 indicates the possibility of limited literacy.
- Score of 4-6 almost always indicates adequate literacy.

How to Conduct a Brief Interview for Mental Status (BIMS) and Confusion Assessment Method (CAM) Delirium Exam

When conducting the BIMS assessment, complete the following steps to achieve accurate results. The cue cards for this assessment are located within this resource. Part of health literacy is using a method of instruction and communication that is necessary for the patient to understand. Providing visual representation of the verbal is acceptable.

Part 1: Repetition of Words

1. Begin by saying to the 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." Assessing clinicians need to use the words and related category cues as indicated. If an interpreter is present to assist, the same cues must be provided.

2. Immediately after presenting the three words, say to the patient, "Now please tell me the three words."

3. If the patient correctly states all three words, say, "That is right, the words are sock, something to wear, blue, a color, and bed, a piece of furniture." (Category Cues)

4. Score based on the number of words repeated on the first attempt without cues.

Part 2: Year, Month and Day

1. Ask the patient for the year, month and day separately.

2. Give the patient up to 30 seconds to answer each question.

3. No cues are permitted. If a patient requests assistance, state, "I need to know if you can answer this question without help from me."

4. Score is based on how close to the correct answer. Refer to C0300 guidance and image for reference.

Repetition of Three Words				
Ask resident: *"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 resident'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 two more times.				
Temporal Orientation (orientation to year, month, and day)				
Ask resident: *"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**				
Ask resident: *"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**				
Ask resident: *"What day of the week is today?"* **C. Able to report correct day of the week** 0. **Incorrect** or no answer 1. **Correct**				
Recall				
Ask resident: *"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**				
B. Able to recall "blue" 0. **No** - could not recall 1. **Yes, after cueing** ("a color") 2. **Yes, no cue required**				
C. Able to recall "bed" 0. **No** - could not recall 1. **Yes, after cueing** ("a piece of furniture") 2. **Yes, no cue required**				
SUMMARY SCORE Add scores for questions and fill in total score (00-15) Enter 99 if the resident was unable to complete the interview				

Part 3: Recall

1. State, "Let's go back to the earlier question. What were those three words that I asked you to repeat?"

2. Allow five seconds for spontaneous recall.

3. After the five seconds, you can provide the category cue. Cues are referenced in Part 1, step #3.

4. Allow another five seconds for recall for each word a cue is provided.

5. Score based on immediate recall, cue-prompted recall or no recall.

Confusion Assessment Method (CAM)

An instrument that screens for overall cognitive impairment, as well as features to distinguish delirium or reversible confusion from other types of cognitive impairments.

The OASIS item C1310 is the CAM. The diagnosis of delirium by CAM requires the presence of both features of A and B and the presence of either C or D. Below are the questions broken down by A/B and C/D to help show the separate questions' groupings.

Confusion Assessment Method (CAM) for Delirium		
A. Acute Onset of Mental Status Change	Is there evidence of an acute change in mental	___ 0. No ___ 1. Yes
B. Inattention	Did the patient have difficulty focusing attention? Are they easily distractable or having difficulty keeping track of what is being said?	___ 0. Behavior Not Present ___ 1. Behavior Continuously Present, Does Not Fluctuate ___ 2. Behavior Present, Fluctuates
C. Disorganized Thinking	Was the patient's thinking disorganized or incoherent? Rambling, irrelevant, unclear, illogical, unpredictable change of subject, etc.	___ 0. Behavior Not Present ___ 1. Behavior Continuously Present, Does Not Fluctuate ___ 2. Behavior Present, Fluctuates
D. Altered Level of Consciousness	Does the patient have altered level of consciousness, as indicated by any of the following criteria? • Vigilant • Lethargic • Stuporous • Comatose	___ 0. Behavior Not Present ___ 1. Behavior Continuously Present, Does Not Fluctuate ___ 2. Behavior Present, Fluctuates

Definitions

Altered Level of Consciousness (LOC)

1. Vigilant – Startles easily to any sound or touch
2. Lethargic - Repeatedly dozes off when you are asking questions but responds to voice or touch
3. Stupor – Very difficult to arouse and keep aroused for the interview
4. Comatose – Cannot be aroused, despite shaking and shouting

Written Introduction Card – BIMS – Items C0200 – C0400

I would like to ask you some questions, which I will show you in a moment.

We ask everyone these same questions. This will help us provide you with better care.

Some of the questions may seem very easy, while others may be more difficult.

We ask these questions so that we can make sure that our care will meet your needs.

Written Instruction Cards – Items C0200 Repetition of Three Words

I have written 3 words for you to remember.

Please read them.

Then, I will remove the card and ask you to repeat or write down the words as you remember them.

Word Card – Item C0200

Sock

Blue

Bed

Category Cue Card – Item C0200

SOCK, something to wear

BLUE, a color

BED, a piece of furniture

Written Instruction Cards – Item C0300 – Temporal Orientation Statement Card – C0300A - Year

Please tell me what year it is right now

Question Card - C0300B - Month

What month are we in right now?

Question Card – Item C0300C - Day

What day of the week is today?

Question Card – Item C0400 - Recall

Let's go back to an earlier question

What were those three words that I asked you to repeat?

Category Cue Card – Item C0400A - Sock

Something to wear

Category Card – Item C0400B - Blue

A color

Category Cue Card – Item C0400C - Bed

A piece of furniture

How to Conduct a Depression Screening PHQ-2 to 9

Ask the following question in the depression screening: “Over the past two weeks, how often have you been bothered by any of the listed problems?” The patient’s answers will be placed in Column 2 of item D0150, Symptom Frequency. You will also need to ask them if the symptom is present or not; this is recorded in Column 1.

		Not at all	Several Days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed, or hopeless	0	1	2	3
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9.	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

D0150. Patient Mood Interview (PHQ-2 to 9)

Say to patient: "Over the last 2 weeks, have you been bothered by any of the following problems?"

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.

If yes in column 1, then ask the patient: "About how often have you been bothered by this?"

Read and show the patient a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence

0. **No** (enter 0 in column 2)
1. **Yes** (enter 0-3 in column 2)
9. **No response** (leave column 2 blank)

2. Symptom Frequency

0. **Never or 1 day**
1. **2-6 days** (several days)
2. **7-11 days** (half or more of the days)
3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in ↓ Boxes	
A. **Little interest or pleasure in doing things**		
B. **Feeling down, depressed, or hopeless**		
If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview.		
C. **Trouble falling or staying asleep, or sleeping too much**		
D. **Feeling tired or having little energy**		
E. **Poor appetite or overeating**		
F. **Feeling bad about yourself - or that you are a failure or have let yourself or your family down**		
G. **Trouble concentrating on things, such as reading the newspaper or watching television**		
H. **Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual**		
I. **Thoughts that you would be better off dead, or hurting yourself in some way**		

Total severity score (TSS) of D0160 is calculated by assigning scores of 0, 1, 2 and 3 to the response categories of: “Not at all,” “Several days,” “More than half the days” and “Nearly every day,” respectively. The PHQ-2 to 9 total score for the nine items ranges from zero to 27. The following table sets out the cut points and proposed treatment actions. Scores of five, 10, 15 and 20 represent cut points for mild, moderate, moderately severe and severe depression, respectively. Sensitivity to change has also been confirmed.

This data is used for tracking and outcomes. Developing the care plan to include depression interventions will lead to more sustainable, positive outcomes.

Score	Depression Severity
0 - 4	None - Minimal
5 - 9	Mild
10 - 14	Moderate
15 - 19	Moderately Severe
20 - 27	Severe