Oasis Class 2

Oasis Class 2

- Active Diagnoses
- Therapies received at home
- *Influenza vaccine
- PN vaccine
- Risk for re-hospitalization
- Risk factors
- Pt living situation
- Vision
- *Dyspnea
- Urinary incontinence
- Cognitive functioning
- Confusion
- Anxiety
- *Pain

*Star Rating Item

MO102 104

(M0102) **Date of Physician-ordered Start of Care (Resumption of Care):** If the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified.

		/			/					[*Go to M0110, if date entered*]
month			day			year			

☐ NA - No specific SOC date ordered by physician

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

		/			/				
month			day			year			

M1028 Active Diagnoses Comorbidities and Co- existing Conditions

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

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

- **This item identifies whether two specific diagnoses are present, and active. These diagnoses influence a patient's functional outcomes or increase a patient's risk for development or worsening of a pressure ulcer.**
- **Disease process can have a significant effect on an individual's health status and quality of life.**

THERAPIES RECEIVED AT HOME IV OR INFUSION THERAPY M1030

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

*Mark all that apply
*Must be receiving at home
*Regardless of who is managing therapy

Response 1 – IV or infusion therapy

SQ (infusion not injection)

- Epidural
- Intrathecal
- Insulin pump
- Eclipse bulb infusion device
- Hemodialysis at home
- Peritoneal dialysis (when at home)

  Flush of peritoneal catheter when dialysis is on hold

DO NOT include flushing catheters utilized for urinary drainage e.g. nephrostomy tube or PD catheter used to drain ascites and then flushed

Response 1 if…

- Intermittent flush and/or infusion is occurring at home
- Medication is both infusing via a q-pump and the q-pump is also discontinued on the day of assessment

DO NOT SELECT RESPONSE 1

- If IV catheter is present but not active (no flushing or infusion while at home)
- PRN IV order presents at SOC/ROC but pt doesn't meet assessment parameters for administration on day of assessment

RESPONSE 2
Parenteral Nutrition

Includes:

- Parenteral Nutrition
- Includes TPN or lipids
- Triple lumen utilized with TPN/Lipids infusing in one port and other lumens flushed to maintain patency
- Mark both 1 and 2

- Single lumen utilized for TPN with pre and post flushes as part of parenteral nutrition protocol

  Mark only 2

Response 3 –ENTERAL NUTRITION

- Includes nutrition by NG-tube, G-tube, J-tube or any other artificial entry into the alimentary canal

DO NOT MARK 3 if the feeding tube is …

- Only flushed to maintain patency
- Only used to hydrate with water
- Only used for medicine
- Only pedialyte is administered

- Do not mark 3 if tube feed is prn and pt did not receive feeding in the prior 24 hours or as result of your assessment

Response 4 – None of the above

- Select if patient is not receiving any of the therapies listed OR pt is receiving a listed therapy including flush outside the home

APPLY WHAT YOU LEARNED

At SOC Mr. Brown has a port- a- cath and all the flushes and infusions will be administered at the MD office. He requires daily peritoneal dialysis and you will be assisting him to become independent with managing it all at home.

M1030 therapies receive at home

1. intravenous or infusion therapy (excludes TPN)
2. parenteral nutrition (TPN or lipids)
3. enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)
4. none of the above

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

- ☐ 1 - History of falls (2 or more falls - or any fall with an injury - in the past 12 months)
- ☐ 2 - Unintentional weight loss of a total of 10 pounds or more in the past 12 months
- ☐ 3 - Multiple hospitalizations (2 or more) in the past 6 months
- ☐ 4 - Multiple emergency department visits (2 or more) in the past 6 months
- ☐ 5 - Decline in mental, emotional, or behavioral status in the past 3 months
- ☐ 6 - Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
- ☐ 7 - Currently taking 5 or more medications
- ☐ 8 - Currently reports exhaustion
- ☐ 9 - Other risk(s) not listed in 1 - 8

Risk for hospitalization M1033

Mark all that apply

- Response 1 can be witnessed or un-witnessed fall
- Response 5- decline in mental emotional or behavioral status past 3 months
- May impact pt's ability to remain safely in the home and increased likelihood of hospitalization
- Response 7 =5 or more medications includes over the counter meds
- Response 9 = other any other factor you feel would increase risk for hospitalization

- Check off all options that apply
- Other can be any other reason in your clinical judgment that could contribute to a hospitalization not mentioned in the list

Influenza Vaccine M 1041 ***STAR RATING ***/VBP

Does the episode of care SOC/ROC to transfer or D/C include any dates on between Oct 1 & March 31

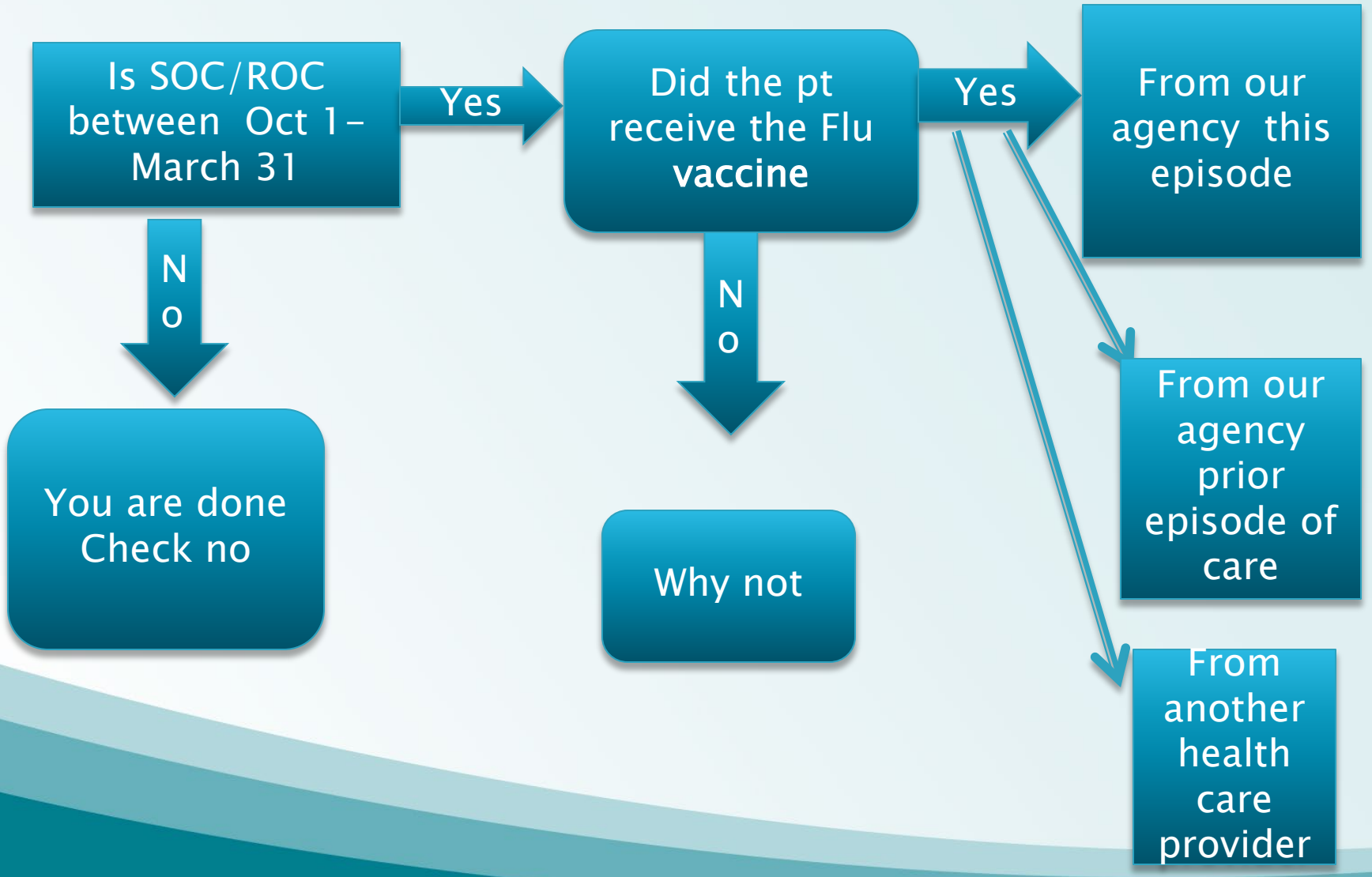
- This is the period when the measure is calculated
- It is not the actual flu season

M1041Influenza Vaccine Data Collection Period

- **Intent**
  - Identifies whether the patient was receiving services from the home health agency during the time period for which influenza vaccine data are collected (October 1 and March 31).

- **Instructions**
  - If no part of the care episode (from SOC/ROC to Transfer or Discharge) occurred during the time period from October 1 and March 31, mark “No.”

- Influenza question is very date specific



M1046- Influenza Vaccine Received

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

1. Yes, received from your agency during this episode of care
2. Yes, received from your agency during a prior episode of care
3. Yes, received from another health care provider
4. No, pt offered and declined
5. No pt assessed and determined to have medical contraindication
6. No, not indicated- pt does not meet age/condition guidelines
7. No, inability to obtain vaccine due declared shortage
8. No, pt did not receive the vaccine due to other reasons than 1-7

Response 5 –contraindications include

- Anaphylactic hypersensitivity to eggs or other components of vaccine
- Hx of Guillain –Barre Syndrome within 6 weeks after a previous flu vaccine
- Bone marrow transplant within 6 months
- MD medical restriction

M1051 Pneumococcal Vaccine:

- Has the patient ever received the pneumococcal vaccine?

1. 0– No
2. 1–Yes

- M1056 Reason not received

1. Offered and declined
2. Assessed and determine to have a medical contraindication
3. Not indicated; patient does not meet age/condition guidelines for Vaccine
4. None of the above

Contraindications

- Anaphylactic hypersensitivity to components of the vaccine
- Acute a febrile illness
- Bone marrow transplant within the last 12 months
- Chemo or radiation within the last 2 weeks
- MD restriction

Height and Weight Chapter 3:C-25

- See handout from orientation

M1100
LIVING SITUATION

- Which best describes pt residential circumstances **AND** availability of caregiver

- Report usual living situation-not a temporary set up

ROW A
Lives alone independent (non assisted) setting

- In home
- apartment
- own room in boarding house
- lives w/ live in paid help (not Family)
- caregiver temporarily staying to provide care

ROW B
Lives with others independent (non assisted) setting

- Lives w/ spouse, family member or significant other
- Lives w/ someone who occasionally travels out of town
- Lives w/ family paid to provide care

ROW C
Lives in congregate setting e.g. “assisted living “ setting

- Congregate = assistance, supervision, and/or oversight provide as part of the living arrangement
- ALF, residential care

STEP 2

- Select column that reflects the expected availability and willingness of caregivers (any in person assistance) for this upcoming episode of care
- How frequently is someone in the home to provide assistance?
- Without regard to amount or types of assistance required or whether person is able to meet all or only some of the pts needs

- Includes any type of in person assistance
- Not limited to adls/iadls
- Caregiver's don't have to live with pt
- A call bell that can summon on site help in any congregate setting is considered in person assistance

Consider …

- Availability for entire upcoming care episode
- Do not include someone living in the home completely unable or unwilling to provide any assistance or assistance summoned by phone

AROUND THE CLOCK

- 24 hours a hours a day with infrequent exceptions
- A call bell that can summon assistance and staff is available 24 hours a day

REGULAR DAYTIME/NIGHTTIME ASSSIST

- During daytime, nighttime hours every day/night with infrequent exceptions
- Use clinical judgment to determine which hours constitute “regular” daytime and nighttime – based on pts specific activates and routines
- Hours for “regular daytime/nighttime “not defined by CMS

OCCASIONAL/SHORT TERM AVALIBILITY

- Only for few hours a day or on an irregular basis
- May be only able to help occasionally

NO ASSISTANCE AVAILABLE

- No one available to provide in person assistance of any kind

APPLY WHAT YOU LEARNED

Mr. Jones lives alone in a room in residential care home. The room does not have a call bell but his contract includes having a home health aide assist him with ADLs 2 hours every morning. His son also comes over occasionally to assist with bills, groceries and errands.

M1200- VISION

Vision (with corrective lenses if the pt usually wears them)

- 0-normal vision can see medication labels newsprint
- 1-Partially impaired: cannot see medication labels or newsprint but can see obstacles in path and surrounding layout, can count fingers at arm's length
- 2- Severely impaired cannot locate objects without hearing or touching them or pt nonresponsive

- ability to see and manage within environment
- assess w/ glasses if usually worn
- magnifying glass cannot be used when assessing
- pt may have a vision deficit that does not limit ability to see functionally
- i.e. blindness in one eye

M1242 PAIN

Frequency of pain interfering with movement

0-Pt has no pain
1-Pt has pain that does not interfere with activity or movement
2-less often that daily
3-Daily but not constantly
4- All the time

TIME PERIOD:

- Day of assessment and recent pertinent past

- What is recent pertinent past ?

- Use observation and interview
- Assess the pt when moving
- Do not overlook activities such as sleeping, eating, and hobbies they all count
- If pt restricts activities to avoid pain = interference if so find out how often pt would usually perform that activity
- Avoidance is considered interference of that activity

Pain does not always have to stop an activity – it may..

- Take longer to complete
- Result in activity being performed less often than desired
- Require pt to have additional help

- If activity stopped some time ago in order to avoid pain it may not be relevant if no reasonable expectation that the pt will return to the activity i.e. stopped skiing 20 yrs ago due to injury
- Use your clinical judgment

Impact of pain medication

- It is possible for a pt. to have pain that does not interfere with activity or movement

YES …

- M1242 identifies frequency of pain interfering pts activity with treatment if prescribed
- Pain well controlled by treatment may not interfere with activity or movement at all

APPLY WHAT YOU LEARNED

Mrs. Jones states her pain is “no bother” as long as she walks slowly and doesn’t sit in the same position for too long. Once she takes her sleeping medication at night, though, she can sleep comfortably without taking any special precautions.

0 –no pain
1–pt has pain that doesn’t interfere with activity or movement
2– less than daily
3–daily but not constantly
4– all the time

M1400 Dyspnea
STAR RATING/VBP

When is pt dyspneic or noticeably SOB

0 No Dyspnea

1 –when walking >20 feet, climbing stairs

2– With moderate exertion e.g. while dressing , using the commode or bedpan, walking less than 20 feet

3– With minimal exertion e.g while eating, talking, or performing other ADL's or with agitation

4– At rest during the day or night

- Time frame-day of admission = prior 24 hours plus time spent in the home
- Observation in the home and interview past 24 hours
- Examples are not absolutes: Pt becomes sob when lifting arm to dress could be a “3” as minimal effort caused dyspnea even though the pt was dressing when becoming SOB
- If pt uses 02 continuously assess with 02 on
- If 02 is use intermittently test w/ 02 off

- Assessment is based on pts use of oxygen not MD order
- If a pt restricts an activity on day of assessment in order to remain free of dyspnea they had no dyspnea on that day
- If pt has already modified the environment to stop SOB then pt is not SOB w/ that activity i.e. pt sleeps up on 4 pillows so is no longer SOB w/ sleeping

- You must have the pt exert themselves in order to assess dyspnea
- Take respiration rate at rest and with activity to compare results
- Look for increase use of accessory muscles of respiration
- Look for changes in breathing pattern
- Use dyspnea Tasks and Substitution chart

Dyspnea Tasks & Substitution chart

Dyspnea	Tasks	Substitutions
1) Walking >20 feet	Walking >20 feet Climbing stairs	-Marching in place x 30 secs (standing) 45sec (sit/supine) -Sit to stand (x15 reps) -Arm raises (x1 minute)
2) Moderate exertion	Walking <20 feet Dressing Using commode Using bed pan	-Marching in place x 15 sec(standing) 25 secs (sit/stand) -sit to stand (x7 reps) -arm raises (x30 sec)
3) Minimal exertion	Eating Talking With agitation	-Combing hair -Brushing teeth -Shaving seated

APPLY WHAT YOU LEARN

At SOC Mr. Jones reports he never feels short of breath because he uses his oxygen most of the time. He takes it off when he sleeps because it hurts his ear. He became short of breath when using the bed pan when the 02 slipped off.

How would you score him?

- 0-pt is not sob
- 1-When walking more than 20 feet, climbing stairs
- 2-With moderate exertion for example while dressing, using commode/bedpan or walking distance less than 20 feet
- 3-With minimal exertion for example while eating talking or performing other ADL or with agitation
- 4-at rest (during the day or night)

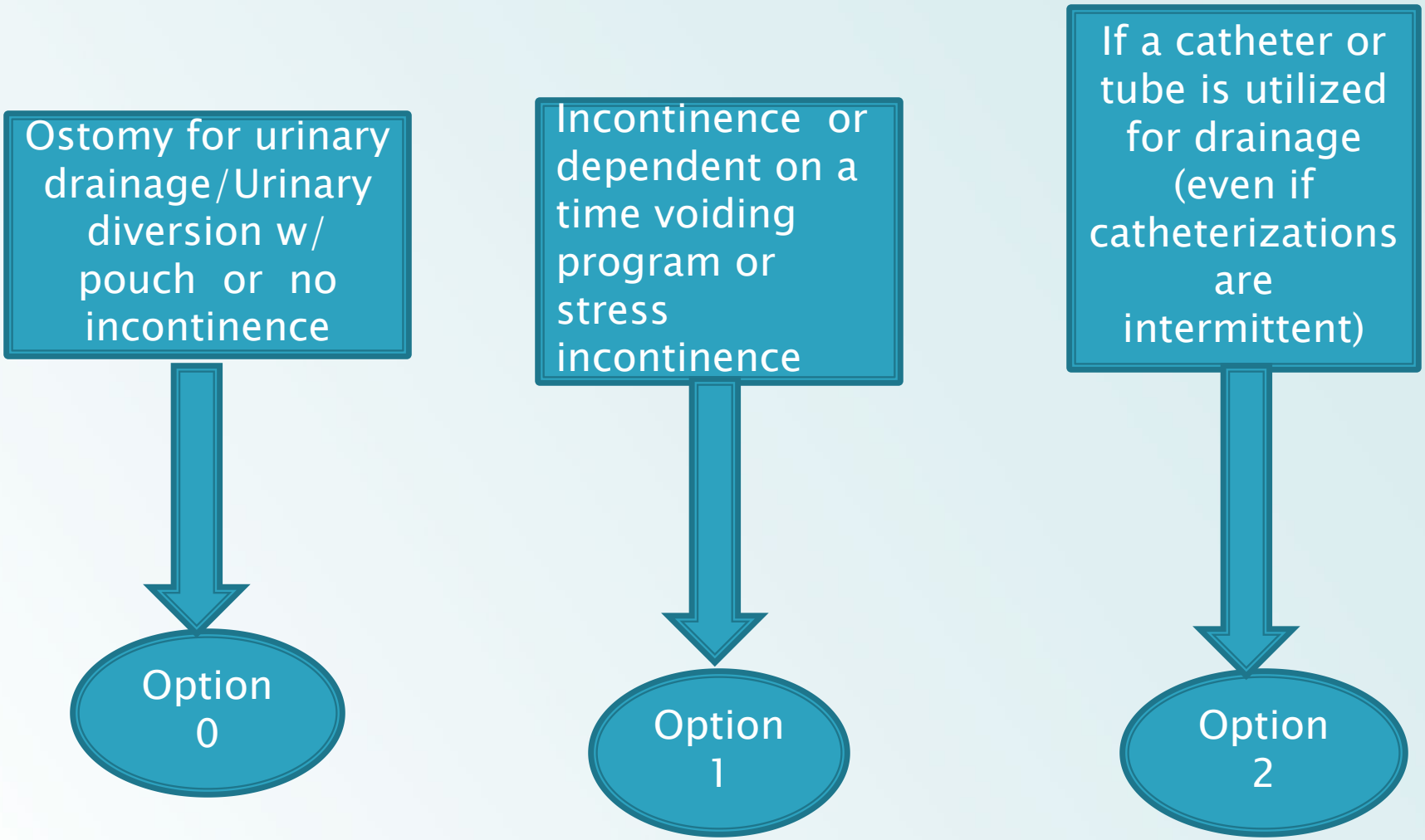
M 1610 Urinary Incontinence or Urinary Catheter Presence Chapter 3: 1-2

Urinary incontinence or Urinary Catheter Present

0 -no incontinence or catheter (includes anuria or ostomy for urinary drainage)

1 -pt is incontinent

2 -Pt requires a urinary catheter (specifically: external, indwelling, intermittent, suprapubic

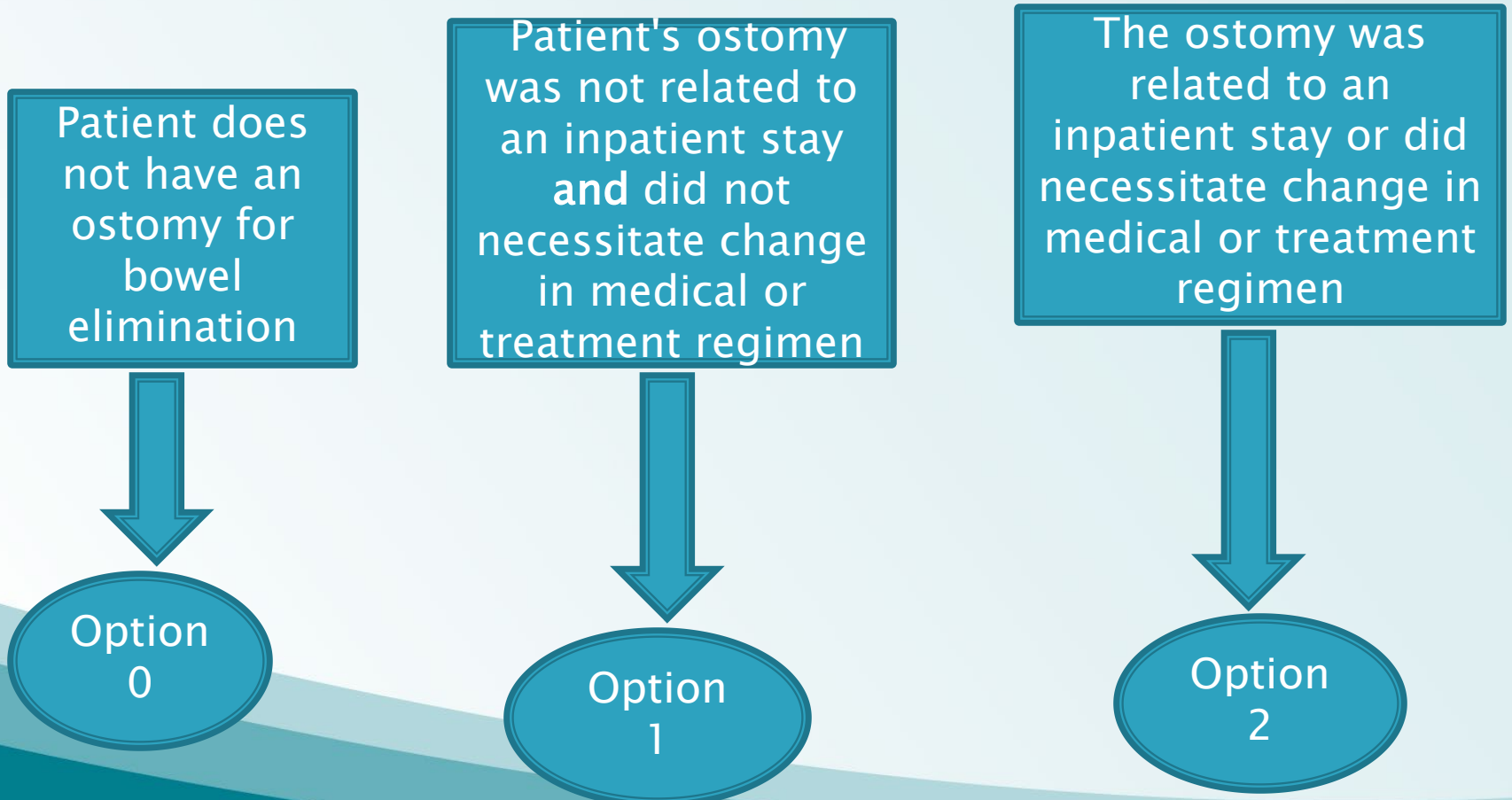


A leaky urinary drainage appliance is not incontinence
A catheter used for irrigation of the bladder is not reported here

M1620 Bowel Incontinence Chapter3:1-5

0-very rare or never
1-less than once a week
2- one to three times a week
3- four to six times a week
4- on a daily basis
5- More often than once a day
n/a-pt has ostomy for bowel elimination
uk - unknown

M1630 Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay; or b) necessitated a change in medical or treatment regimen?



M1700- Cognitive Functioning

Pts current (day of assessment) level of alertness, orientation, comprehension, concentration, immediate memory for commands

0-alert and orientated , able to focus and shift attention, comprehends and recalls task directions independently

1-requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions

2-Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility.

3-Requires considerable assistance in routine situations. Is not alert and orientated or is unable to shift attention and recall directions more than half the time

4-Totally dependent due to disturbances such as constant disorientation, coma ,persistent vegetative state or delirium

M1710 When confused (Reported or observed)

0–Never
1–In new or complex situations only
2–On awakening or at night only
3–During the day and evening, but not constantly
4–Constantly (at all times during the look back period)
NA–Pt nonresponsive

- Report any episodes of confusion occurring at any time during the past 14 days without regard to cause or potential relevance

M1720 When anxious (reported or observed within the last 14 days)

0- None of the time
1-Less often than daily
2-Daily, but not constantly
3-All the time (all of the time during the 14 days look back)
NA- nonresponsive

- Anxiety includes worry that interferes w/ learning and normal activities
- Feelings of being overwhelmed and having difficulty coping

FOR 1710 & 1720

- Nonresponsive means that the pt is unable to respond or the pt responds in a way that you cannot make a clinical judgment about the pts level of orientation
- If pt is unresponsive at day of assessment you can ask caregivers about confusion/anxiety over the past 14 days.
- N/A Pt nonresponsive if at time of evaluation information cannot be gathered from caregiver or other source about the past 14 days

M1740- Cognitive behavioral and psychiatric symptoms that are demonstrated AT LEAST ONCE A WEEK (REPORTED OR OBSERVED)

1-Memory deficit
2-Impaired decision-making
3-Verbal disruption
4-Physical aggression
5-Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions)
6-Delusional, hallucinatory, or paranoid behavior
7-none of the above

- Include behaviors which are severe enough to make the pt unsafe to self or others
- Cause considerable stress to the caregivers or require supervision or intervention
- **At least once a week** = behavior demonstrated multiple times in recent , relevant past and frequency was at least one time a week prior to and including day of assessment

M1745- Frequency of disruptive behavior symptoms (reported or observed)

Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety

0-Never

1-Less often than once a month

2-Once a month

3-Several times a month

4-Several times a week

- Consider if the pt has any problematic behaviors not just the behaviors listed in1740 which jeopardize or could jeopardize the safety of the pt or caregiver
- Then consider how frequently these happen
- Use clinical judgment to determine if the degree of the behavior is disruptive or dangerous to the pt or caregiver
- ie. sun downing, agitation wandering, aggression, combativeness, & getting lost in familiar places