Drug Regimen Review

- M2000 is a new item
- The intent of this item is to identify if a review of the patient's medications indicated the presence of potential clinically significant problems
- Assessment of medications is in the conditions, so be careful before you mark "0"

Drug Regimen Review

- If your response is "0-Not assessed/reviewed" you must have supporting documentation in the clinical record

Drug Regimen Review

- Prior to answering this question refer to the OASIS Item Guidance Specific Instructions
  - Pay close attention to the Note regarding what is determined to be a drug reaction and side effects
  - This item is not a quality measure but is a risk adjustment

Medication Follow-Up

- M2002 is a new item
  - This item is asking if the physician-designee was notified within one calendar day to address any potential clinically significant problems identified through the medication review

Medication Follow-Up

- The OASIS Item Guidance Specific Instructions will assist you in answering the question and help you determine what is a clinically significant medication issue

Medication Follow-Up

- Faxing information with out physician-designee communication does not justify a "yes" answer
- If you communicate with the physician-designee other than on the day of the SOC/ROC remember to answer M0090 correctly
- This item is a quality measure and is a risk adjustment

Medication Interventions

- M2004 is a new item
  - This item is asking if the physician-designee was contacted with in one calendar day if there were any clinically significant medication issues since the last OASIS
- You must know what happened since the previous OASIS assessment to answer this question

Medication Interventions

  - If your response is "0-No" you must have supporting documentation in the clinical record
- This item is a quality measure and is a risk adjustment

Patient/Caregiver High Risk Drug Education

- M2010 is a new item
  - This item is targeted to high-risk medications such as hypoglycemics and anticoagulants

Patient/Caregiver High Risk Drug Education

  - This item is asking if the patient/caregiver was instructed on special precautions for all high-risk medications they are taking, and how and when to report problems that may occur

Patient/Caregiver High Risk Drug Education

  - If your response is "0-No" you must have supporting documentation in the clinical record
  - You may respond NA if your patient is on a high-risk medication and is fully knowledgeable about special precautions associated with all high risk medication

Patient/Caregiver High Risk Drug Education

    - However, documentation should be noted somewhere in the clinical record to support your response
- This item is a quality measure and is a risk adjustment

Patient/Caregiver Drug Education Intervention

- M2015 is a new item
  - This item is asking if the clinician, since the last OASIS Assessment, instructed the patient/caregiver how to monitor the effectiveness of drug therapy, reactions, and side effects and how/when to report problems that may occur

Patient/Caregiver Drug Education Intervention

- This intervention refers to prescribed and over-the-counter medications – by any route
- You must know what happened since the previous OASIS assessment to answer this question
- This item is a quality measure and is a risk adjustment

Management of Oral Medications

- M2020 is a modified item
  - In OASIS B the item is M0780
- The intent is to identify the patient's ability, not actual performance, willingness or compliance

Management of Oral Medications

- Verbiage now includes key words such as patient's current ability to prepare and take all oral medications
  - This refers to prescribed and over-the-counter medications

Management of Oral Medications

- Option choices have changed
  - UK-Unknown is no longer a choice
- This item is a quality measure and is a risk adjustment

Management of Injectable Medications

- M2030 is a modified item
  - In OASIS B the item is M0800
- The intent is to identify the patient's ability, not necessarily actual performance, willingness or compliance

Management of Injectable Medications

- Verbiage now includes key words such as patient's current ability to prepare and take all injectable medications
- This item addresses the patient's ability to safely manage injectable medications

Management of Injectable Medications

- This item is not a quality measure but is a risk adjustment

Prior Medication Management

- M2040 is a new item
- The intent of this item is to identify the patient's prior ability to managing oral and injectable medications prior to this current illness, exacerbation, or injury

Prior Medication Management

- This item is not looking at necessarily identifying their actual performance, willingness or compliance
- This item is not a quality measure but is a risk adjustment

M2100 New Category!!!

- Question
  - Types and Sources of Assistance
    - Determine the level of caregiver ability and willingness to provide assistance for the following activities, if assistance is needed (Check only one box in each row)

M2100 New Category!!!

- Item intent
  - Identifies availability and ability of the caregiver(s) to provide categories of assistance needed by the patient
    - Note that this question is concerned broadly with types of assistance, not just the ones specified in the other OASIS items

M2110 New Category!!!

- Question
  - How often does the patient receive ADL or IADL assistance from any caregiver(s) (other than home health agency staff)?

M2110 New Category!!!

- Item intent
  - Identifies the frequency of the assistance with ADLs
    - Bathing, dressing, toileting, transferring, etc.
  - Assistance with IADLs
    - Medication management, meal preparation, housekeeping, etc.
  - Provided by any non-agency caregiver

M2200 Therapy Need

- Key factors in determining the number of therapy visits indicated
  - REASONABLE and NECESSARY
  - REASONABLE and NECESSARY
  - REASONABLE and NECESSARY
  - REASONABLE and NECESSARY
  - REASONABLE and NECESSARY

M 2250
Plan of Care Synopsis

- New OASIS item
- Process measure
- Risk adjusted
- Item intent
  - Identifies if the physician-ordered home health plan of care incorporates specific best practices

M 2250
Plan of Care Synopsis

- The "physician ordered plan of care" means that the patient condition has been discussed and there is agreement as to the plan of care between the home health agency staff and the physician

M 2250
Plan of Care Synopsis

- Item intent
  - This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment

M 2250
Plan of Care Synopsis

– The best practices stated in the item are not necessarily required in the Conditions of Participation

M 2250
Plan of Care Synopsis

- Does the physician-ordered plan of care include the following (Check only one box in each row)

A. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings

M 2250
Plan of Care Synopsis

– Physician has chosen not to establish patient-specific parameters for this patient

- Agency will use standardized clinical guidelines accessible for all care providers to reference

M 2250
Plan of Care Synopsis

B. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care

- Patient is not diabetic or is bilateral amputee

M 2250
Plan of Care Synopsis

C. Falls prevention interventions

- Patient is not assessed to be at risk for falls

M 2250
Plan of Care Synopsis

D. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment

- Patient has no diagnosis or symptoms of depression

M 2250
Plan of Care Synopsis

E. Intervention(s) to monitor and mitigate
   - No pain identified

F. Intervention(s) to prevent pressure ulcers
   - Patient is not assessed to be at risk for pressure ulcers

M 2250
Plan of Care Synopsis

G. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician
   - Patient has no pressure ulcers with need for moist wound healing

M2300

- Question
  - Emergent Care
    - Since the last time OASIS data were collected, has the patient utilized a hospital emergency department (includes holding/observation)?

M2300

- Item intent
  - Identifies whether the patient was seen in a hospital emergency department since the previous OASIS assessment
  - Responses to this include the entire period since the last time OASIS data were collected, including current events

M2310

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

M2310

- Item intent
  - Identifies the reasons for which the patient received care in the hospital emergency department

Intervention Synopsis

- M2400 is a new item
  - The intent is to identify if specific interventions focused on specific problems were both included in the Plan of Care (POC) and implemented since the previous OASIS assessment

Intervention Synopsis

- You must know what happened since the previous OASIS assessment to answer these questions

Intervention Synopsis

- Example
  - Orders on the POC were to educate the patient/caregiver on diabetic foot care. There is not documentation in the clinical record, since the previous OASIS, to support diabetic foot care was taught. The response would be "No."

Intervention Synopsis

  - To respond "Yes" the clinical intervention must have been included in the POC and implemented at the time of the previous OASIS assessment or since that time
- This item is a quality measure and is a risk adjustment

Data Collected at Transfer/Discharge M2410-M2440, M0903+M0906

M2410 Inpatient Facility Admission

- Updated guidance information
- Identifies the type of inpatient facility to which the patient was admitted
- Most significant change in the instructions
  - When a patient dies in a hospital emergency department, the Transfer to an Inpatient Facility OASIS is completed

M2410 Inpatient Facility Admission

- In this unique situation, clinicians are directed to select Response 1 – Hospital, even though the patient was not admitted to the inpatient facility

M2420-Discharge Disposition

- Numbering changed
- Accuracy important as this item can impact quality measures
- Formal assistive services include
  - Assisted Living Facilities, Community Based Waiver Programs, Meal on Wheels, Private Duty services

M2420-Discharge Disposition

- Non-institutional hospice is any hospice not in an inpatient hospice facility

M2430 Reason for Hospitalization

- List expanded from 16 responses to 21 responses
- Respiratory problems broken into two reasons
  - Infections
  - Other

M2430 Reason for Hospitalization

- Make sure not to mark a number since numbering has changed
- Mark all that apply
- UK-Reason unknown response available

M2440 Reasons for Admission to Nursing Home

- Responses are not changing
- Mark all that apply

M0903 Date of Last Home Visit
M0906 Discharge/Transfer/ Death Date

- **Items did not change**