OASIS-C1

OASIS-C1 is a modification to the Outcome and Assessment Information Set (OASIS) that Home Health Agencies must collect in order to participate in the Medicare program.

This is the second update of the OASIS since it was implemented in 2000.

Will start on January 1, 2015.

Other Changes

- Some C items deleted
- Some M numbers have changed
- Data collection dropped at various time points
- Grammatical and punctuation corrections

M1033 – Risk for Hospitalization

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

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

Revised to collect data on factors identified in literature as predictive of hospitalization. Responses reordered to reflect length of look back period.

M1041 – Influenza Vaccine

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

- ☐ 0 - No **[*Go to M1051*]**
- ☐ 1 - Yes

Revised to clarify the time period for reporting influenza vaccine status. If answered “No” will skip to question M1051.

M1046 – Reason Influenza Vaccine not Received

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

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

Simplified item to report reason patient did or did not receive influenza vaccine from any source. Eliminated "during this episode of care" and "from your agency."

M1051 – Pneumococcal Vaccine

(M1051) Pneumococcal Vaccine: Has the patient ever received the pneumococcal vaccination (for example, pneumovax)?

☐ 0 - No

☐ 1 - Yes [*Go to M1500 at TRN; Go to M1230 at DC*]

Simplified item to report if the patient has never received the pneumococcal vaccine. Eliminated “during the episode of care” and “from your agency.” Changed “PPV” to “pneumococcal vaccine.”

M1056 – Reason Pneumococcal Vaccine not received

(M1056) Reason Pneumococcal Vaccine not received: If patient has never received the pneumococcal vaccination (for example, pneumovax), state reason:

- ☐ 1 - Offered and declined
- ☐ 2 - Assessed and determined to have medical contraindication(s)
- ☐ 3 - Not indicated; patient does not meet age/condition guidelines for Pneumococcal Vaccine
- ☐ 4 - None of the above

Simplified item to report reason patient never received pneumococcal vaccination. Eliminated “during the episode of care” and “from your agency.” Changed “PPV” to “pnemovax.”

M1306 – Unhealed Pressure Ulcers

(M1306) Does this patient have at least one **Unhealed Pressure Ulcer at Stage II or Higher** or designated as Unstageable? (Excludes Stage I pressure ulcers and healed Stage II pressure ulcers)

☐ 0 - No [*Go to M1322*]

☐ 1 - Yes

Wording change to improve clarity. Added clarification to exclude Stage 1 and healed Stage II ulcers.

M1307 – Oldest Stage II Pressure Ulcer present at discharge

(M1307) The **Oldest Stage II Pressure Ulcer** that is present at discharge: (Excludes healed Stage II Pressure Ulcers)

☐ 1 - Was present at the most recent SOC/ROC assessment

☐ 2 - Developed since the most recent SOC/ROC assessment. Record date pressure ulcer first identified:

__ __ / __ __ / __ __ __ __
month / day / year

☐ NA - No Stage II pressure ulcers are present at discharge

The term “non-epithelialized” was eliminated from the question and the NA response in order to improve clarity . The question excludes healed Stage II ulcers.

M1308 – Current Number of Unhealed Ulcers

(M1308) Current Number of Unhealed Pressure Ulcers at Each Stage or Unstageable:
(Enter "0" if none; Excludes Stage I pressure ulcers and healed Stage II pressure ulcers)

Stage Descriptions—unhealed pressure ulcers	Number Currently Present
a. **Stage II:** Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.	___
b. **Stage III:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.	___
c. **Stage IV:** Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.	___
d.1 Unstageable: Known or likely but Unstageable due to non-removable dressing or device	___
d.2 Unstageable: Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar.	___
d.3 Unstageable: Suspected deep tissue injury in evolution.	___

Column 2 was deleted. The term "non-epithelialized" was eliminated from the item to improve clarity.

M1309 – Worsening in Pressure Ulcer

(M1309) Worsening in Pressure Ulcer Status since SOC/ROC:

Instructions for a – c: For Stage II, III and IV pressure ulcers, report the number that are new or have increased in numerical stage since the most recent SOC/ROC	
	Enter Number (Enter "0" if there are no current Stage II, III or IV pressure ulcers OR if all current Stage II, III or IV pressure ulcers existed at the same numerical stage at most recent SOC/ROC)
a. Stage II	___
b. Stage III	___
c. Stage IV	___
Instructions for d: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were a Stage I or II at the most recent SOC/ROC.	
	Enter Number (Enter "0" if there are no Unstageable pressure ulcers at discharge OR if all current Unstageable pressure ulcers were Stage III or IV or were Unstageable at most recent SOC/ROC)
d. Unstageable due to coverage of wound bed by slough or eschar	___

Collects information at Discharge which was previously collected in M1308 Column 2 on worsening pressure ulcer status. Includes pressure ulcers that at DC are Unstageable due to slough/eschar.

M1309 – Worsening in Pressure Ulcer Status since SOC/ROC

- Documents the number of pressure ulcers that are new or have “worsened” (increased in numerical stage) since the most recent Start or Resumption of Care assessment.
- Review the history of each current pressure ulcer.
- Specifically, compare the current stage of the pressure ulcer to the stage of that ulcer at the most recent SOC/ROC.

M1309 – Worsening in Pressure Ulcer Status since SOC/ROC

- Determine whether the pressure ulcer currently present is new or worsened when compared to the presence or stage of that pressure ulcer at the most recent SOC/ROC.

M1320 – Pressure Ulcer Healing Status

(M1320) Status of Most Problematic Pressure Ulcer that is Observable: (Excludes pressure ulcer that cannot be observed due to a non-removable dressing/device)

- ☐ 0 - Newly epithelialized
- ☐ 1 - Fully granulating
- ☐ 2 - Early/partial granulation
- ☐ 3 - Not healing
- ☐ NA - No observable pressure ulcer

Wording change to clarify exclusion of nonobservable ulcer(s).

M1324 Pressure Ulcer Stage

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

- ☐ 1 - Stage I
- ☐ 2 - Stage II
- ☐ 3 - Stage III
- ☐ 4 - Stage IV
- ☐ NA - Patient has no pressure ulcers or no stageable pressure ulcers

Wording change to question to improve clarification and NA response to distinguish “observable” from “stageable.”

M1334 – Stasis Ulcer Healing Status

(M1334) Status of Most Problematic Stasis Ulcer that is Observable:

- ☐ 1 - Fully granulating
- ☐ 2 - Early/partial granulation
- ☐ 3 - Not healing

Eliminated "Response 0 – Newly epithelialized" since it is an inappropriate option for this item. No longer reported as a current stasis ulcer after complete epithelialization occurs.

M1342 – Surgical Wound Healing Status

(M1342) Status of Most Problematic Surgical Wound that is Observable

- ☐ 0 - Newly epithelialized
- ☐ 1 - Fully granulating
- ☐ 2 - Early/partial granulation
- ☐ 3 - Not healing

Choice 0 changed to “Newly epithelialized.” The old Choice 0 was “Re-epitheliazed.”

M1730 - Depression Screening

(M1730) Depression Screening: Has the patient been screened for depression, using a standardized, validated depression screening tool?

☐ 0 - No

☐ 1 - Yes, patient was screened using the PHQ-2©* scale.

Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems?"					
PHQ-2©*	Not at all 0 - 1 day	Several days 2 - 6 days	More than half of the days 7 – 11 days	Nearly every day 12 – 14 days	NA Unable to respond
a) Little interest or pleasure in doing things	☐0	☐1	☐2	☐3	☐NA
b) Feeling down, depressed, or hopeless?	☐0	☐1	☐2	☐3	☐NA

☐ 2 - Yes, patient was screened with a different standardized, validated assessment and the patient meets criteria for further evaluation for depression.

☐ 3 - Yes, patient was screened with a different standardized, validated assessment and the patient does not meet criteria for further evaluation for depression.

Added "Validated" to the question and Response 2 & 3. Added phrase "patient was screened" to Response 2.

M1830 - Bathing

(M1830) Bathing: Current ability to wash entire body safely. **Excludes grooming (washing face, washing hands, and shampooing hair).**

- ☐ 0 - Able to bathe self in shower or tub independently, including getting in and out of tub/shower.
- ☐ 1 - With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.
- ☐ 2 - Able to bathe in shower or tub with the intermittent assistance of another person:
  (a) for intermittent supervision or encouragement or reminders, OR
  (b) to get in and out of the shower or tub, OR
  (c) for washing difficult to reach areas.
- ☐ 3 - Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
- ☐ 4 - Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.
- ☐ 5 - Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.
- ☐ 6 - Unable to participate effectively in bathing and is bathed totally by another person.

Deleted the phrase “throughout the bath” from the end of Response 5 to also include patients who need intermittent assistance bathing self in bed, at the sink, in bedside chair, or on the commode.

M2000 – Drug Regimen Review

(M2000) Drug Regimen Review: Does a complete drug regimen review indicate potential clinically significant medication issues (for example, adverse drug reactions, ineffective drug therapy, significant side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance [non-adherence])?

- ☐ 0 - Not assessed/reviewed [*Go to M2010*]
- ☐ 1 - No problems found during review [*Go to M2010*]
- ☐ 2 - Problems found during review
- ☐ NA - Patient is not taking any medications [*Go to M2040*]

"Adverse" added to describe drug reactions. "Significant" added to describe side effects; and "non-adherence" added to "noncompliance."

M2004 – Medication Intervention

(M2004) Medication Intervention: If there were any clinically significant medication issues at the time of, or at any time since the previous OASIS assessment, was a physician or the physician-designee contacted within one calendar day to resolve any identified clinically significant medication issues, including reconciliation?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - No clinically significant medication issues identified at the time of or at any time since the previous OASIS assessment

The measure refers to physician contact for medication issues that have been "identified."

M2102 – Types and Sources of Assistance

CARE MANAGEMENT

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

Type of Assistance	No assistance needed – patient is independent or does not have needs in this area	Non-agency caregiver(s) currently provide assistance	Non-agency caregiver(s) need training/ supportive services to provide assistance	Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance	Assistance needed, but no non-agency caregiver(s) available
a. **ADL assistance** (for example, transfer/ ambulation, bathing, dressing, toileting, eating/feeding)	☐0	☐1	☐2	☐3	☐4
b. **IADL assistance** (for example, meals, housekeeping, laundry, telephone, shopping, finances)	☐0	☐1	☐2	☐3	☐4

Clarifies that "caregiver" refers to non-agency caregivers and excludes care by agency staff. Added text to column heading to clarify that "No assistance needed from Caregiver in this area" means that the patient is independent or does not have needs in this area.

M2102 – Types and Sources of Assistance

CARE MANAGEMENT

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

Type of Assistance	No assistance needed – patient is independent or does not have needs in this area	Non-agency caregiver(s) currently provide assistance	Non-agency caregiver(s) need training/ supportive services to provide assistance	Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance	Assistance needed, but no non-agency caregiver(s) available
a. **ADL assistance** (for example, transfer/ ambulation, bathing, dressing, toileting, eating/feeding)	☐0	☐1	☐2	☐3	☐4
b. **IADL assistance** (for example, meals, housekeeping, laundry, telephone, shopping, finances)	☐0	☐1	☐2	☐3	☐4

Simplified response options by combining “Caregiver(s) not likely to provide assistance” and “Caregiver(s) unwilling/unable to provide assistance.”

M2102 – Types and Sources of Assistance

c. **Medication administration** (for example, oral, inhaled or injectable)	☐0	☐1	☐2	☐3	☐4
d. **Medical procedures/ treatments** (for example, changing wound dressing, home exercise program)	☐0	☐1	☐2	☐3	☐4
e. **Management of Equipment** (for example, oxygen, IV/infusion equip-ment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies)	☐0	☐1	☐2	☐3	☐4

Wording change to Response “d”. Added example of “home exercise program.”

M2250 – Plan of Care Synopsis

(M2250) Plan of Care Synopsis: (Check only **one** box in each row.) Does the physician-ordered plan of care include the following:

Plan / Intervention	No	Yes	Not Applicable	
a. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings	☐0	☐1	☐NA	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.
b. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	☐0	☐1	☐NA	Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
c. Falls prevention interventions	☐0	☐1	☐NA	Falls risk assessment indicates patient has no risk for falls.
d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment and/or physician notified that patient screened positive for depression	☐0	☐1	☐NA	Patient has no diagnosis of depression AND depression screening indicates patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.

Clarified the "NA" responses except for response "a". Response "d" added physician notification for positive depression screening.

Deleted Items

- M1012 – Inpatient Procedures
- M1310 – Pressure Ulcer Length
- M1312 – Pressure Ulcer Width
- M1314 – Pressure Ulcer Depth
- M2440 – Nursing Home Admission Reason