Star Rating – Received Flu Shot for Current Season

(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

OASIS Time Points Completed
- Transfer to inpatient facility
- Discharge from agency – not to an inpatient facility

Item 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).

Documentation in MobileWyse
- At anytime, you can enter Immunization History in the Patient Profile. Use this form to access vaccine information required to answer future OASIS questions regarding flu and pneumonia vaccines.
- Add the “Immunization Hx” form in the Patient Profile if you do not already see it there.
- Tap Hx button to display the Immunization Details form. Enter the Vaccine History/date here. In the Notes section include where the immunization was received if known.
- In the OASIS – Vaccines Tab tap the Immunizations bar to enter Vaccine History. Note previously entered Vaccine History displays in the OASIS Clinical Assistant.
- Flu shots – Always document flu shots provided by the Agency in the Immunization form during the visit.
- To enter information about a declined flu or pneumonia vaccine, click “Custom”, then enter vaccine declined in the next line (not in the notes section).
- Immunization information flows to OASIS Clinical Assistant for viewing during transfer and discharge OASIS when vaccine questions are asked.
- Providing a Flu Vaccine is best practice for any patient with chronic disease; providing the vaccine can also help improve the agency’s hospitalization rate

**Agency Average Score = 28%  Goal = 86%**

*We are currently scoring in the “1 STAR” range for this outcome which means that 95% of agencies nationally are doing better than we are in answering this item.*
Star Rating – Drug Education on All Medications

(M2015) Patient/Caregiver Drug Education Intervention: At the time of, or at any time since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur?

0  - No
1  - Yes
NA – Patient not taking any drugs

OASIS Time Points Completed
  ...  Transfer to inpatient facility
  ...  Discharge from agency – not to an inpatient facility

Item Intent
Identifies if clinicians instructed the patient/caregiver about how to manage medications effectively and safely. Drug education interventions for M2015 should address all medications the patient is taking – prescribed and over-the-counter – by any route. Effective, safe management of medications includes knowledge of effectiveness, potential side effects and drug reactions, and when to contact the appropriate care provider. This item is used to calculate process measures to capture the agency’s use of best practices following the completion of the comprehensive assessment.

Current agency best-practice and established procedure is that all patients receive medication education on effective and adverse reactions. Teaching is ongoing throughout the course of care, and is documented in the Med Review section of the clinical note.

Current Agency Average Score = 97% Goal = 99%

Documentation in MobileWyse
  ...  Document med teaching in “Med Review” and “Meds” (see below).
### Patient Chart | SN Note

**Vitals**
- Lung/Edema
- Meds
- Systems
- Additions
- Teach
- Homebound
- Communication
- Skilled Supervision
- HT/WT
- HCA
- Caregiver Rating
- Assessment
- MedReview
- Plan
  - Summary
  - Changes

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**Medications**

**MED EFFECT**
- Side effects, adverse reactions
- Interactions and duplications

**SIDE EFFECTS REPORTED/OBSERVED**

**KNOWLEDGE**
- FINDINGS INDICATE MEDICATIONS TAKEN AS ORDERED
- CONCERN NOTED ABOUT ADMINISTRATION OF CORRECT MEDICATION
- MEDICATION MANAGER CANNOT STATE MEDICATION

**SN SETUP MED ORGANIZER / SYSTEM THROUGH**
Star Rating – Improved Walking or Moving Around

(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.
0  - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).
1  - With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
2  - Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
3  - Able to walk only with the supervision or assistance of another person at all times.
4  - Chairfast, unable to ambulate but is able to wheel self independently.
5  - Chairfast, unable to ambulate and is unable to wheel self.
6  - Bedfast, unable to ambulate or be up in a chair.

OASIS Time Points Completed
...  Start of Care
...  Resumption of Care
...  Follow-up
...  Discharge from Agency – not to an inpatient facility

Item Intent
Identifies the patient’s ability and the type of assistance required to Safely ambulate or propel self in a wheelchair over a variety of surfaces. The intent of the item is to identify the patient’s ABILITY, not necessarily actual performance. “Willingness” and “adherence” are not the focus of these items. This item address the patient’s ability to Safely ambulate or use a wheelchair, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:
...  Physical impairments (for example, limited range of motion, impaired balance)
...  Emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)
...  Sensory impairments (for example, impaired vision or pain)
...  Environmental barriers (for example, stairs, narrow doorways, unsafe flooring)

Documentation in MobileWyse
...  SN must complete both the ADL and Mobility sections in MobileWyse (mobility section is already in the OASIS).
...  PT must complete the ADL section only, since the Mobility piece must be covered in the PT Assessment.
...  OT will pull up the ADL tab and document in the Mobility Tab.
...  ST will pull up the ADL tab and fill out both the ADL and Mobility portions.
Current Agency Average Score = 65%  Goal = 69%

Step 1: Decide if your patient is ambulatory or not

- Medically restricted to bed or unable to tolerate being out of bed
  - Bedfast Score 6

- Unable to make pt safe even with combination of device and constant human assist
  - Chair fast Score 4 or 5

- Can ambulate SAFELY alone or with assistance
  - Ambulatory Score 0, 1, 2, or 3

Step 2: Decide if pt is bed fast or chair fast

- Bedfast unable to be up in chair
  - Option 6

- Chair fast Unable to wheel self
  - Option 5

- Chair fast able to wheel self
  - Option 4

Drill down to most accurate response

- Continuous human assist/assist at all times
  - Response 3

- 2 handed device and/or intermittent human assist
  - Response 2

- One handed device and NO human assist
  - Response 1

- No assistive device and NO human assist
  - Response 0

NO HUMAN ASSIST

CAUTION

Are they SAFE?
Star Rating – Improved Getting In and Out of Bed

(M1850) Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.
0  - Able to independently transfer.
1  - Able to transfer with minimal human assistance or with use of an assistive device.
2  - Able to bear weight and pivot during the transfer process but unable to transfer self.
3  - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
4  - Bedfast, unable to transfer but is able to turn and position self in bed.
5  - Bedfast, unable to transfer and is unable to turn and position self.

OASIS Time Points Completed
  ... Start of Care
  ... Resumption of Care
  ... Follow-up
  ... Discharge from Agency – not to an inpatient facility

Item Intent
Identifies the patient’s ability to Safely transfer from bed to chair (and chair to bed), or position self in bed if bedfast. The intent of the item is to identify the patient’s ABILITY, not necessarily actual performance. “Willingness” and “adherence” are not the focus for this item. This item address the patient’s ability to Safely transfer, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:
  ... Physical impairments (for example, limited range of motion, impaired balance)
  ... Emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)
  ... Sensory impairments (for example, impaired vision or pain)
  ... Environmental barriers (for example, stairs, narrow doorways, location of current sleeping surface and sitting surface)

Documentation in MobileWyse
  ... SN must complete both the ADL and Mobility sections in MobileWyse (mobility section is already in the OASIS).
  ... PT must complete the ADL section only, since the Mobility piece must be covered in the PT Assessment.
  ... OT will pull up the ADL tab and document in the Mobility Tab.
  ... ST will pull up the ADL tab and fill out both the ADL and Mobility portions.

Current Agency Average Score = 56%       Goal = 65%
Step 1: Decide if the patient is bedfast

Step 2: If pt is able to transfer, drill down to the level of assist
Star Rating – Improved 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.

OASIS Time Points Completed
... Start of Care
... Resumption of Care
... Follow-up
... Discharge from Agency – not to an inpatient facility

Item Intent
Identifies the patient’s ability to bathe entire body and the assistance that may be required to Safely bathe, including transferring in/out of the tub/shower. The intent of the item is to identify the patient’s ABILITY, not necessarily actual performance. “Willingness” and “adherence are not the focus of this item. This item address the patient’s ability to Safely bathe, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:
... Physical impairments (for example, limited range of motion, impaired balance)
... Emotional/Cognitive/Behavioral impairments (for example, memory deficits, impaired judgment, fear)
... Sensory impairments (for example, impaired vision or pain)
... Environmental barriers (for example, stairs, narrow doorways, location of tub/shower, wash basin/sink)

Documentation in MobileWyse
... Use tapered frequencies for HHA
... Consider OT evaluation when HHA ordered
... “Cue Don’t Do”
Current Agency Average Score = 61%
Goal = 75%

Step 1: Decide if your patient can participate in bathing. If so, can they use the tub/shower?

- Unable to effectively participate in bathing
  - Score 6
- Can’t bathe in tub/shower
  - Score 4 or 5
- Can pt bathe in tub/shower
  - Score 0, 1, 2, or 3

Step 2: Drill down to the level of assist

- Unable to use tub/shower Pt assist w/ bathing requires Intermittent OR continuous assist
  - Option 5
- Unable to use tub/shower NO human assist Needs to be able to access water at sink or set up basin at bedside
  - Option 4
- Can use tub/shower continuous human assist
  - Option 3

Step 3: Continue to drill down to the level of assist / device needed

- Can use tub/shower Intermittent human assist
  - Option 2
- Can use tub/shower NO human assist BUT needs device
  - Option 1
- Can use tub/shower NO human assist NO assistive device
  - Option 0
Star Rating – Had Less Pain Moving Around

(M1242) Frequency of Pain Interfering with patient’s activity or movement:
0  - Patient has no pain
1  - Patient has pain that does not interfere with activity or movement
2  - Less often than daily
3  - Daily, but not constantly
4  - All of the time

OASIS Time Points Completed
   ... Start of Care
   ... Resumption of Care
   ... Follow-up
   ... Discharge from Agency – not to an inpatient facility

Item Intent
Identifies frequency with which pain interferes with patient’s activities, with treatments if prescribed.
   ... Assess the patient when moving. Do not overlook activities such as sleeping, eating, and hobbies.
   ... If patient restricts activities to avoid pain = interference if so find out how often patient would usually perform that activity?
   ... Avoidance is considered interference of that activity
   ... Pain does not always have to stop an activity – it may…
         o  Take longer to complete
         o  Result in activity being performed less often than desired
         o  Require patient to have additional help
   ... If activity stopped some time ago in order to avoid pain it may not be relevant to the activity i.e. stopped skiing 20 years ago due to injury
   ... Impact of pain medication - It is possible for a patient to have pain that does not interfere with activity or movement
         o  M1242 identifies frequency of pain interfering patient’s activity with treatment prescribed
         o  Pain well controlled by treatment may not interfere with activity or movement at all

Documentation in MobileWyse
   ... In the systems always evaluate pain. Give the pain a numeric score when possible or document evidence of non verbal pain if present.
   ... Complete the detailed Pain Assessment in the other tab. Be sure to include pain location.
   ... Always address pain issues with your patient. Consider discipline referrals for modalities such as E-Stim, Ultrasound, Exercise and Positioning. Notify the MD of ineffective medication therapy and make recommendations for changes.

Current Agency Average Score = 67%   Goal = 79%
Star Rating – Breathing Improved

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

OASIS Time Points Completed
... Start of Care
... Resumption of Care
... Follow-up
... Discharge from Agency – not to an inpatient facility

Item Intent
Identifies the level of exertion/activity that results in a patient’s dyspnea or shortness of breath.

This item must be evaluated dynamically as you continuously assess the patient through the process of the OASIS walk. Count and document the respirations, at rest, while talking, while bending down to remove shoes and socks, while standing and ambulating. Changes in breathing pattern should be recognized as dyspnea and related to the OASIS scale shown above. Patients with SOB on admission may require a therapy evaluation to assist in endurance training and energy conservation. The point of identifying SOB on SOC is so that your plan of care can address and hopefully improve SOB on discharge.

Current Agency Average Score = 63% Goal = 75%.

Documentation in MobileWyse
... Document Dyspnea in Respiratory Form.
Risk Adjustment - Overall Status

(M1034) Overall Status: Which description best fits the patient’s overall status? (Check one)

0 - The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient’s age). – patient likely would not be skilled or would not require our services if this were the case
1 - The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient’s age). (example: patient had a serious condition for which he received surgery and is at heightened risk for complications, but is expected to fully recover)
2 - The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death. (example: patient has diabetes and heart failure; requires frequent monitoring and intervention from MD)
3 - The patient has serious progressive conditions that could lead to death within a year. (example: patient has serious progressive illness or combinations of illness which result in functional deficits, weight loss, repeated hospitalizations, chronic pain and other symptoms of advanced disease)
UK - The patient’s situation is unknown or unclear.

OASIS Time Points Completed

... Start of Care
... Resumption of Care

Item Intent
Identifies the general potential for health status stabilization, decline, or death in the care provider’s professional judgment.

Ask yourself if you would be surprised if the patient was hospitalized or died? If you would not be surprised, then M1034 response 2 or 3 may be appropriate choices.

Accurate scoring of this item is extremely important as it is the single biggest risk adjuster. What this means is that our adjusted scores will be more favorable than our raw scores due to the fact that our patients were judged to be more ill and higher risk when compared with other agencies. Each individual poor outcome (such as a hospitalization) weighs less when our agency has a higher risk adjustment score.