Part 3:
OASIS-C2 Accuracy

Presented by:
Sharon Molinari, RN, HCS-D, HCS-O

For:
HealthCare Synergy

Let’s Review!
What would you list in M1017?

- Mr. J went to his doctor yesterday with complaints of painful urination. During the visit, the physician diagnosed a UTI and found his blood pressure to be high. He ordered an antibiotic and made a referral to home health nursing for management of the UTI and for blood pressure monitoring daily for 5 days. Mr. J had a fungal infection on his right hand, which had been treated for the past 3 weeks, which is now resolved. So, the physician discontinued his anti-fungal medication.

- Which diagnosis(es) would be reported in M1017?

**M1017 Diagnoses Requiring Medical or Treatment Change Regimen Change Within Past 14 Days:**

a) UTI, fungal infection
b) UTI, hypertension
c) UTI, hypertension, fungal infection
d) UTI

Answer: M1017

d) UTI

**Rationale:** M1017 identifies if any change has occurred in the patient’s treatment regimen, health care services, or medications within the past 14 days...not diagnoses that solely improved during this timeframe.

There was no diagnosis of hypertension noted, nor was the high blood pressure treated.

The fungal infection was diagnosed 3 weeks ago and resolved during the past 14 days. Therefore, it is not coded in M1016.
Item Intent: 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 pressure ulcer(s).

The diseases and conditions in this item require a physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) documented diagnosis at the time of assessment.

M1028: Guidance

Diagnostic information, including past medical and surgical history obtained from family members and close contacts, must also be documented in the medical record by the physician to ensure validity, follow-up and coordination of care.

It is also essential that diagnoses communicated verbally be documented in the medical record by the physician to ensure follow-up and coordination of care.

If patient does not have an active diagnosis of PVD, PAD, or diabetes within the assessment timeframe, leave boxes in M1028 unchecked. (CMS Quarterly Q&A #6-7, 10/16)

Use a dash (–) if information is not available or could not be assessed. (CMS Quarterly Q&A #5, 10/16)
M1028: Guidance (cont.)

- **Active diagnoses**: those that have a direct relationship to the patient’s current functional, cognitive, mood or behavior status, medical treatments, nurse monitoring or risk of death at the time of assessment.
  - **DO NOT** include diseases or conditions that have been resolved or do **not** affect the patient’s current functional, cognitive, mood or behavior status, medical treatments, nurse monitoring or risk of death at the time of assessment.
  - **Nurse monitoring**: includes clinical monitoring by a licensed nurse (e.g., serial blood pressure evaluations, medication management).
  - A diagnosis may **not** be inferred by association with other conditions (i.e., weight loss inferred to mean “malnutrition”).

- Leave M1028 blank if no active diagnoses of PVD, PAD, or DM. Do **not** use a dash (–).

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M1028: Active Diagnoses

- **Select Response 1** if the patient has an active diagnosis of:
  - Peripheral Vascular Disease (PVD)
    - Codes that start with the first 3 characters of I73
  - Peripheral Arterial Disease (PAD)
    - Codes that start with the first 4 characters of: I70.2, I70.3, I70.4, I70.5, I70.6, I70.7, and I70.91 and I70.92
    - **Excludes**: I70.90 (Unspecified atherosclerosis)

- **Select Response 2** if the patient has an active diagnosis of Diabetes Mellitus (DM) indicated by any one of the following diagnosis codes that start with:
  - E08. – Diabetes mellitus due to underlying condition
  - E09. – Drug or chemical induced diabetes mellitus
  - E10. – Type 1 diabetes mellitus
  - E11. – Type 2 diabetes mellitus
  - E13. – Other specified diabetes mellitus
M1028: Tips

- There must be specific documentation in the medical record by a physician of the disease or condition being an active diagnosis.

- The physician may specifically indicate that a diagnosis is active. Specific documentation areas in the medical record may include, but are not limited to, progress notes, admission history and physical, transfer notes, and the hospital discharge summary.

- The physician may, for example, document at the time of assessment that the patient has inadequately controlled diabetes and requires adjustment of the medication regimen. This would be sufficient documentation of an active diagnosis and would require no additional confirmation because the physician documented the diagnosis and also confirmed that the medication regimen needed to be modified.

M1028: Example 1

Mr. A is prescribed insulin for diabetes mellitus. He requires regular blood glucose monitoring to determine whether blood glucose goals are achieved by the current medication regimen. The physician progress note documents diabetes.

- **Response 2:** Diabetes Mellitus would be checked.
- **Rationale:** Diabetes Mellitus is considered an active diagnosis because the physician progress note documents the diagnosis and there is ongoing medication management and glucose monitoring.
M1028: Example 2

Mrs. B is admitted to home health for physical therapy following a hip replacement. She has type 2 diabetes, which is controlled by diet, and she independently monitors her blood sugars. She is knowledgeable about diabetic foot care and checks her feet daily using a mirror. The PT will be monitoring the patient holistically to identify problems and to modify the POC as appropriate with physician collaboration. Orders do not list any active interventions related to her diabetes.

- **Response 2:** Diabetes mellitus would be checked.
- **Rationale:** Diabetes Mellitus is considered an active diagnosis since the patient’s change in activity could affect her blood sugar levels and diabetes could affect the healing of her surgical wound. Monitoring of the patient/wound healing with specific knowledge that the patient is a diabetic, would make diabetes an active diagnosis for this patient. *(CMS Quarterly Q&A #8, 10/16)*

M1028: Example 3

Mr. C is referred to home health for speech language pathology interventions related to his dysphagia. He also has PAD, which is documented by the physician in the medical history. However, there are no interventions associated with the PAD, nor is it felt that this diagnosis will have an impact on the patient’s prognosis related to his dysphagia.

- **M1028 would be blank.**
- **Rationale:** Since the PAD is not addressed in the POC and isn’t felt to have the potential to affect the patient’s responsiveness to treatment, it does not appear to have a direct relationship to the patient’s current functional, cognitive, mood or behavior status, medical treatment, nurse monitoring or risk of death at the time of assessment. Therefore, PVD would not be reported as an Active Diagnosis in M1028.
Scenario #1

- Patient has SOC assessment done on Monday. The H&P does not indicate a diagnosis of Diabetes, PVD or PAD, and M1028 is left blank. On Thursday, the RN is notified that the patient was given a new diagnosis of PVD during her physician visit on Wednesday.

➤ Since this is within the 5-day window, should M1028 be changed?

Scenario #1 – Answer

- Patient has SOC assessment done on Monday. The H&P does not indicate a diagnosis of Diabetes, PVD or PAD, and M1028 is left blank. On Thursday, the RN is notified that the patient was given a new diagnosis of PVD during her physician visit on Wednesday.

➤ Since this is within the 5-day window, should M1028 be changed?
- **No.** *Per the Guidance Manual, the OASIS should NOT be changed, and M1028 would remain blank. The OASIS should reflect what was known and documented at the time of the assessment.*
Scenario #2

- Your patient underwent a below the knee amputation due to gangrene associated with peripheral vascular disease. She requires dressing changes to the stump and monitoring for wound healing. In addition, peripheral pulse monitoring is ordered. The physician’s progress note documents peripheral vascular disease and a left below the knee amputation.

How should M1028 be answered?

Scenario #2 – Answer

- Your patient underwent a below the knee amputation due to gangrene associated with peripheral vascular disease. She requires dressing changes to the stump and monitoring for wound healing. In addition, peripheral pulse monitoring is ordered. The physician’s progress note documents peripheral vascular disease and a left below the knee amputation.

How should M1028 be answered?

- **Response 1:** Peripheral Vascular Disease (PVD) would be checked.

- **Rationale:** Consider PVD an active diagnosis because the physician’s note documents the diagnosis, which is associated with the below the knee amputation, and there is an order for peripheral pulse monitoring.
History and Diagnosis
M1030 – M1055

$$$ (M1030)

- Identifies whether the patient is receiving intravenous, parenteral nutrition, or enteral nutrition therapy at home, whether or not the home health agency is administering the therapy. This item is not intended to identify therapies administered in outpatient facilities or by any provider outside the home setting.

$$$ M1030 = 1, 2, or 3
M1030: Guidance

- This item addresses only therapies administered at home, defined as the patient’s place of residence, when:
  - Patient/Caregiver administers therapy.
  - Therapy is administered by another provider in the home.
  - Therapy will be started as a result of the assessment visit – e.g., IV will be started at the SOC/ROC visit or a subsequent specified visit, the physician will be contacted for an enteral nutrition order, etc.
  - There is a PRN order for IV or enteral therapy, and the assessment indicates need for therapy now.

- Excludes therapies administered in outpatient facilities or by any provider outside the home setting.

M1030: #1 - Intravenous or infusion therapy

- Includes:
  - In-home intrathecal, epidural, and subcutaneous infusions, whether via implanted pump or external infusion device
  - Insulin pump; eclipse bulb infusion device
  - Fluids or flushes; central line or peripheral IV meds
  - Hemodialysis at home, including flush of peritoneal dialysis catheter when dialysis on hold

- Excludes:
  - Therapy not administered at home or patient refuses therapy
  - IV catheter present but no infusion or flushing at home
  - PRN order for IV at SOC, but there is no current need for it
  - Medications by transdermal, SQ, or IM route
  - Irrigation or infusion of bladder
  - Flushing catheters used for drainage of urine (such as a nephrostomy tube), ascites or wound, or biliary tube
M1030: #2 - Parenteral nutrition

**Includes:**

- **In-home** TPN or lipids
  - Single lumen utilized for TPN with pre and post flush as part of parenteral nutrition protocol – mark **Response 2**
  - Triple lumen with TPN/lipids infusing in one port and other lumens flushed to maintain patency – mark **Response 1 and 2**

**Excludes:**

- Parenteral therapy administered in another setting

M1030: #3 - Enteral nutrition

**Includes:**

- Nutrition received by:
  - Nasogastric (NG) tube
  - Gastrostomy (PEG tube);
  - Jejunostomy
  - Any other artificial opening into the alimentary canal

**Excludes:**

- Feeding tube ONLY:
  - Flushed to maintain patency
  - Used to hydrate with water
  - Used for administration of medications
- PRN tube feed and no need for feeding in **prior 24 hours or currently**
- Oral electrolyte maintenance solutions, such as Pedalyte
### M1030: Infusion Inclusions/Exclusions

<table>
<thead>
<tr>
<th>Response 1 – Infusion Therapy IF</th>
<th>Do NOT Respond 1 – Infusion therapy IF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency will administer infusion</td>
<td>infusion administered in another setting</td>
</tr>
<tr>
<td>Patient / Caregiver administers infusion</td>
<td>IM or Sub-Q injection given over 10 minutes</td>
</tr>
<tr>
<td>PRN order for infusion – assessment indicates need for therapy now</td>
<td>PRN order for infusion – assessment indicates NO need for therapy at this time</td>
</tr>
<tr>
<td>Infusion therapy being administered by another provider in the home</td>
<td>IV line is present but site is only observed and/or dressing changes provided (no flushing of line)</td>
</tr>
<tr>
<td>Fluids and flushes to maintain an IV line</td>
<td>Patient refuses ordered IV therapy</td>
</tr>
<tr>
<td>Flushing of peritoneal catheter to maintain patency while dialysis is on hold (order for flushing must be in place)</td>
<td>Flushing of tubes or catheters, urinary drainage catheters for drainage of urine (e.g., nephrostomy tube), ascites or wound, biliary tube</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Types of Infusion Therapy Delivery Systems</th>
<th>NOT Infusion Therapy Delivery Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central line</td>
<td>Transdermal route of medication administration</td>
</tr>
<tr>
<td>Subcutaneous infusion</td>
<td>IM or Sub-Q injection given over 10 minutes</td>
</tr>
<tr>
<td>Epidural infusion</td>
<td>Irrigation or infusion of the bladder</td>
</tr>
<tr>
<td>Intrathecal infusion</td>
<td>MammoSite brachytherapy delivery system</td>
</tr>
<tr>
<td>Implanted or external pump</td>
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<tr>
<td>Insulin pump</td>
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<tr>
<td>Eclipse bulb (for local infusion of pain medication into a wound)</td>
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<tr>
<td>Home dialysis, including peritoneal dialysis</td>
<td></td>
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</tbody>
</table>

**Flushing of a TPN catheter is parenteral therapy not IV therapy!**

### M1030: Parenteral and Enteral Therapy

<table>
<thead>
<tr>
<th>Response 2 – Parenteral Therapy IF</th>
<th>Do NOT Respond 2 – Parenteral Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency will administer parenteral therapy – includes TPN and lipids</td>
<td>Parenteral therapy administered in another setting</td>
</tr>
<tr>
<td>Patient / Caregiver administers parenteral therapy</td>
<td></td>
</tr>
<tr>
<td>Parenteral therapy being administered by another provider in the home</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Response 3 – Enteral Therapy IF</th>
<th>Do NOT Respond 3 – Enteral Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency will provide enteral therapy for patient – includes nutrition by NG tube, PEG tube, jejunostomy, or other artificial opening into alimentary canal</td>
<td>PEG tube, G-tube, J-tube used only for medication administration</td>
</tr>
<tr>
<td>Patient / Caregiver provides enteral therapy</td>
<td>Patient refuses ordered enteral therapy</td>
</tr>
<tr>
<td>Order for PRN enteral therapy for nutritional reasons and patient has received PRN enteral therapy within last 24 hours</td>
<td>Order for PRN enteral therapy for nutritional reasons and patient has NOT received PRN enteral therapy within last 24 hours and does NOT need currently</td>
</tr>
<tr>
<td></td>
<td>PEG tube, G-tube, J-tube used only for hydration, including oral electrolyte maintenance solutions such as Pedialyte®</td>
</tr>
</tbody>
</table>
How would you score M1030?

- Patient receives PRN feedings through PEG tube and has not required one in the last 2 days, but probably will tomorrow.

- Patient with triple lumen catheter has TPN infusing in one port, and the nurse flushes the others to maintain patency in between his visits to the MD’s office for chemotherapy.

- Patient receives medications with water and pedialyte only via NG tube.

Answers: M1030

- Patient receives PRN feedings through PEG tube and has not required one in the last 2 days, but probably will tomorrow.
  ✓ **Response 4 (None of the above). The patient is not receiving enteral therapy in the home. Day of assessment convention applies.**

- Patient with triple lumen catheter has TPN infusing in one port, and the nurse flushes the others to maintain patency in between his visits to the MD’s office for chemotherapy.
  ✓ **Response 1 and 2. Saline flushes (#1) and parenteral nutrition (#2) are being administered at home.**

- Patient receives medications with water and pedialyte only via NG tube.
  ✓ **Response 4. When a patient receives only hydrating fluids, including electrolytes, or medications via an NG or PEG tube, it is not enteral therapy.**
(M1033)

(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.

- Identifies patient characteristics predictive of hospitalization.
- Responses ordered based on length of look back period.

M1033: Responses

- Response 1 includes witnessed and reported (unwitnessed) falls.
- In Response 5, decline in mental, emotional, or behavioral status refers to significant changes occurring within the past 3 months that may impact the patient’s ability to remain safely in the home and increase the likelihood of hospitalization.
- In Response 7, medications include OTC medications.
- Response 8 refers to physical and/or mental exhaustion at the current time (day of assessment).
- Response 9 - Other risk(s), may be selected if the assessing clinician finds characteristics other than those listed in Responses 1-8 that may indicate risk for hospitalization (for example, slower movements during sit to stand and walking).
  - Specify other risks in clinical documentation.
- If Response 10 is selected, none of the other responses should be selected.
(M1034)

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

M1034: Guidance

- Consider current health status, medical diagnoses, and information from the physician and patient/family on expectations for recovery or life expectancy.

- Do not limit OVERALL STATUS to home health POC focus.

- A patient with serious, progressive conditions is NOT “temporarily” facing high health risks.

- A “Do Not Resuscitate” order does not need to be in place for Responses 2 or 3.
(M1036)

- Identifies specific factors that may exert a substantial impact on the patient’s health status, response to medical treatment, and ability to recover from current illnesses, in the care provider’s professional judgment.

M1036: Guidance

- The intent is not to address medications/drugs the patient takes/consumes/administers to achieve a therapeutic effect.
  - Must determine when the once-therapeutic use of medication becomes a true dependency situation – e.g., pain medications

- Includes present and past risk factors.
  - Use judgment in evaluating risks to current health conditions from behaviors that were stopped in the past – e.g., former smoker or drug addict, recovering alcoholic, or formerly obese.
    - For determination of obesity, consider using Body Mass Index guidelines.
    - If no diagnosis of obesity, confirm with physician.

- Consider the amount and length of exposure – e.g., smoking one cigarette a month may not be considered a risk factor.
(M1041)

- 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).
- 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.”
- When completing at Transfer or DC, only go back to the most recent SOC/ROC to determine if the patient was receiving agency services on or between 10/1 through 3/31.
- “Gateway” to M1046, if episode falls within specified date range.

M1041: Scenario

- You admitted a patient to your home health agency on July 4th and discharged the patient on September 29th. The agency nurse administered the flu vaccine on September 4th.

➤ At discharge, how should you respond to M1041?
Answer: M1041

- You admitted a patient to your home health agency on July 4th and discharged the patient on September 29th. The agency nurse administered the flu vaccine on September 4th.

At discharge, how should you respond to M1041?

- Response 0 (No)
  - The entire episode of care is outside the data collection period (10/1 - 3/31).
  - M1046 is skipped.

- What if patient was discharged on October 1st?

(M1046)

- For a patient with any part of the home health episode (SOC/ROC to Transfer/Discharge) occurring between October 1 and March 31, identifies whether the patient received an influenza vaccine for this year’s flu season, and if not, the reason why.
**M1046: Responses**

Enter Response 1, if your agency provided the influenza vaccine to the patient during this episode of care (SOC/ROC to Transfer/Discharge).

Enter Response 2, if your agency provided the flu vaccine for this year’s flu season prior to this home health episode, (for example, if the SOC/ROC for this episode was in winter, but your agency provided the vaccine for the current flu season during a previous home health episode in the fall when the vaccine for the current flu season became available).

- You may enter Response 2, if a current patient was given a flu vaccine by your agency during a previous roster billing situation during this year’s flu season.
  
  ➢ *Roster billing is a simplified billing process that allows mass immunizers to submit one claim form with a list of several immunized beneficiaries.*

Enter Response 3, if the patient or caregiver reports (or there is documentation in the clinical record) that the patient received the influenza vaccine for the current flu season from another provider – e.g., the patient’s physician, a clinic, or health fair providing influenza vaccines, etc.

- Response 1, 2, or 3 may be entered even if the flu vaccine for this year’s influenza season was provided prior to October 1 (that is, flu vaccine was made available early).

Enter Response 4, if the patient was offered the vaccine and the patient or healthcare proxy (for example, someone with power of attorney) refused the vaccine.

- *Note:* It is not required that the agency offered the vaccine. Enter Response 4 only if the patient was offered the vaccine and he/she refused.
M1046: Responses (cont.)

Enter Response 5, if the influenza vaccine is contraindicated for medical reasons. Medical contraindications include anaphylactic hypersensitivity to eggs or other component(s) of the vaccine, history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination, or bone marrow transplant within 6 months.

- Enter Response 6, if age/condition guidelines, provided by the CDC, indicate that influenza vaccine is not indicated for this patient.

- Enter Response 7, only in the event that the vaccine is unavailable due to a CDC-declared shortage.

- Enter Response 8, only if the patient did not receive the vaccine due to a reason other than Responses 4–7, including situations where the assessing clinician is unable to determine whether the patient received the influenza vaccination.

How would you score M1041/M1046?

- Patient admitted to agency 9/20. Received flu vaccine 9/29 from agency. Discharged 10/30.

- Patient admitted to agency 10/1 and discharged 11/15. Received flu vaccine at local drugstore on 10/5.

- Patient admitted 1/8. Received flu vaccine on 10/15 from your agency while in another episode of care.
Answers: M1041 and M1046

- Patient admitted to agency 9/20. Received flu vaccine 9/29 from agency. Discharged 10/30.
  - M1041 = 1 - Yes. The episode of care (SOC/ROC to Transfer/Discharge) includes dates on or between October 1 and March 31.
  - M1046 = 1. Patient received the flu vaccine from your agency during this episode of care.

- Patient admitted to agency 10/1 and discharged 11/15. Received flu vaccine at local drugstore on 10/5.
  - M1041 = 1 - Yes. The episode of care (SOC/ROC to Transfer/Discharge) includes dates on or between October 1 and March 31.
  - M1046 = 3 - Yes; received from another health care provider. Documentation as to where should be in the medical record.

- Patient admitted 1/8. Received flu vaccine on 10/15 from your agency while in another episode of care.
  - M1041 = 1 - Yes. The episode of care (SOC/ROC to Transfer/Discharge) includes dates on or between October 1 and March 31.
  - M1046 = 2 – Yes; received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge).

(M1051)

- Identifies whether the patient has ever received the pneumonia vaccine.
- Select Response 0 - No, if the assessing clinician is unable to determine in the patient received the vaccine.
- “Gateway” to M1056, if not received.
o Explains why the patient has *never* received the pneumococcal vaccine.

**M1056: Responses**

- Enter Response 1, if the patient and/or healthcare proxy (for example, someone with power of attorney) refused the vaccine.
- Enter Response 2, if pneumococcal vaccine administration is medically contraindicated for this patient. Contraindications include anaphylactic hypersensitivity to component(s) of the vaccine, acute febrile illness, bone marrow transplant within past 12 months, or receiving course of chemotherapy or radiation therapy within past 2 weeks.
- Enter Response 3, if CDC age/condition guidelines indicate that pneumococcal vaccination is *not* indicated for this patient.
- Enter Response 4 only if the agency did not provide the vaccine due to a reason other than Responses 1-3 including situations where the assessing clinician is unable to determine whether the patient has ever received the pneumococcal vaccine.

*Guidelines for influenza and pneumococcal vaccine recommendations and contraindications are found on the CDC website.*
How would you score M1051 and M1056?

- Mr. B was transferred to the hospital. His record shows he has never had the PPV vaccine. It was not given by the home health agency due to his bone marrow transplant 3 months ago.

- What would be the correct response for M1051 & M1056?

Answers: M1051 and M1056

- Mr. B was transferred to the hospital. His record shows he has never had the PPV vaccine. It was not given by the home health agency due to his bone marrow transplant 3 months ago.

- What would be the correct response for M1051 & M1056?
  - M1051 = 0 - No. Patient has never received the PPV vaccine.
  - M1056 = 2 - Assessed and determined to have medical contraindication(s). PPV is medically contraindicated in patients who have had a bone marrow transplant within the past 12 months.
(M1060) Impact

(M1060) Height and Weight—While measuring, if the number is X.1 – X.4 round down; X.5 or greater round up

- Collected at SOC/ROC only.
- Height and weight support calculation of the patient’s body mass index (BMI).
- Diminished nutritional and hydration status can lead to debility that can adversely affect wound healing and increase risk for the development of pressure ulcers.
- Weight measurement is also used in assessment of heart failure.

M1060a: Assessing Height

- Measure height in accordance with the agency’s policies and procedures, which should reflect current standards of practice (shoes off, etc.).
- Measure and record height to the nearest whole inch using mathematical rounding (i.e., if height measurement is X.5 inches or greater, round height upward to the nearest whole inch. If height measurement number is X.1 to X.4 inches, round down to the nearest whole inch).
  - For example, a height of 62.5 inches would be rounded to 63 inches, and a height of 62.4 inches would be rounded to 62 inches.
- When reporting height for a patient with bilateral lower extremity amputation, measure and record the patient’s current height (i.e., height after bilateral amputation). If the height of the extremities varies, record the greatest measurement.
- A dash (–) value is a valid response for this item, when no information is available and/or it could not be assessed.
M1060b: Assessing Weight

- Measure weight in accordance with the agency’s policies and procedures, which should reflect current standards of practice (shoes off, etc.).

- Measure and record the patient’s weight in pounds using mathematical rounding (e.g., if weight is X.5 pounds [lbs.] or more, round weight upward to the nearest whole pound. If weight is X.1 to X.4 lbs., round down to the nearest whole pound).
  - For example, a weight of 152.5 lbs. would be rounded to 153 lbs. and a weight of 152.4 lbs. would be rounded to 152 lbs.

- If a patient cannot be weighed, for example, because of extreme pain, immobility, or risk of pathological fractures, enter the dash value (–) and document the rationale on the patient’s medical record.

M1060: Q&A Guidance

CMS Q&A #10, October 2016

Question:

For the new OASIS item M1060, can the agency gather the patient's height and weight by patient/caregiver report? M1060a requests most recent height measure since SOC/ROC, but M1060b allows most recent weight measurement in last 30 days. So does that mean that height must be actually measured after the home health admission, but weight can be entered based on hospital discharge paperwork documented within the last 30 days? Can we ask the patient or caregiver the patient’s height and/or weight?
**M1060: Q&A Guidance**

CMS Q&A #10, October 2016

**Answer:**

The assessing clinician should measure the patient’s height and weight in accordance with the agency’s policies and procedures, which should reflect current standards of practice (shoes off, etc.). The assessing clinician is expected to weigh and measure the patient as part of the comprehensive assessment. *Data collection for M1060 by self-report or from paperwork from another provider setting is not acceptable.* If a patient cannot be weighed/measured, enter the dash value ("-"), and document the rationale on the patient’s medical record. A dash (−) value indicates that no information is available and/or an item could not be assessed. CMS expects dash use to be a rare occurrence.

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**Living Arrangements**

**M1100**
(M1100)

This item identifies, using the care provider’s professional judgment, a) whether the patient is living alone or with other(s) and b) the availability of caregiver(s) (other than home health agency staff) to provide in-person assistance.

M1100: Guidance

Response is based on clinician’s professional judgment:
- Whether patient is living alone or with others; and
- Expected availability and willingness of caregiver(s) (other than home health agency staff) to provide physical assistance.

Two time periods under consideration:
1. Living arrangement – report “usual” status
2. Availability of assistance refers to:
   - The upcoming outcome episode of care
   - In-person assistance provided in the home of patient
“Usual” Status

- Report the patient’s usual status prior to the current illness, exacerbation, or injury, unless there is a new arrangement that is expected to be permanent.
- If situation varies (e.g., temporarily staying with relative or caregiver travels out of town) – choose response that reflects the usual living arrangement.

M1100: Guidance (cont.)

- To answer this item:
  - First, determine living arrangement – whether patient lives alone, in a home with others, or in a congregate setting.
  - Second, determine availability of assistance – how frequently caregiver(s) are in the home and available to provide assistance, if needed.
  - Only one response should be marked. Select the appropriate row (a, b, or c) to reflect the patient’s living situation, then select the one response in the column that best describes the availability of in-person assistance at the time of the OASIS assessment.
### Living Arrangement: Response a

**First, determine living arrangement.**

<table>
<thead>
<tr>
<th>Living Arrangement</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Patient lives alone</td>
<td></td>
</tr>
<tr>
<td>b. Patient lives with other person(s) in the home</td>
<td></td>
</tr>
<tr>
<td>c. Patient lives in congregate situation (for example, assisted living, residential care home)</td>
<td></td>
</tr>
</tbody>
</table>

- **Row a = Lives alone:**
  - In a non-assisted, independent setting
  - In home, apartment, or room in boarding house
  - Has live-in paid help
  - Has a caregiver temporarily staying in home
  - Lives alone but can receive help by phone or life-line
  - *Consider coding Z60.2, Problems related to living alone, if appropriate.*

### Living Arrangement: Response b

**First, determine living arrangement.**

<table>
<thead>
<tr>
<th>Living Arrangement</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Patient lives alone</td>
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<td></td>
</tr>
<tr>
<td>c. Patient lives in congregate situation (for example, assisted living, residential care home)</td>
<td></td>
</tr>
</tbody>
</table>

- **Row b = Lives with other person(s) in the home:**
  - Others in an independent (non-assisted) setting – for example, with a spouse, family member, or a significant other
  - A family member who is paid to provide help – e.g., lives with niece who is paid through a state-funded program or by other family to provide care
  - Patient normally lives with others but is alone when caregiver travels out of town occasionally
**Living Arrangement:**

**Response c**

First, determine living arrangement.

- **Row c = Lives in an “assisted living” setting:**
  - Receives assistance, supervision, and/or oversight provided as part of living arrangement
  - Includes patient who lives alone or with a spouse or partner in an apartment or room that is part of an assisted living facility, residential care home, or personal care home

---

**Availability of Assistance**

- Availability of assistance refers to the expected availability and willingness of caregiver(s) for the upcoming care episode.

- In-person assistance in the home of the patient:
  - **Includes** any type of in-person assistance including, but not limited to ADLs and IADLs, including meal prep and medication management, and assistance available via a “call bell” 24 hours a day.
  - **Excludes** phone or emergency assistance (Lifeline or 911).

- The caregiver(s) need **not** live in the home with the patient, but assistance via telephone is **not** included.
Availability of Assistance (cont.)

- This item documents the time caregiver(s) are in the home and available, without regard to the amount or types of assistance the patient requires or whether the caregiver(s) are able to meet all or only some of the patient’s needs.
  - Adequacy of caregiver assistance for different types of needs is captured in M2102 (Types and Sources of Assistance).

- Use professional judgment to determine if someone will be available to provide any assistance to the patient. If a person is living in the patient’s home but is completely unable to or unwilling to provide any assistance to the patient, do not count them as a caregiver.

Availability of Assistance (cont.)

- In the large care continuum complexes, a patient is living in a congregate setting when “assistance, supervision and/or oversight are provided as part of the living arrangement” — e.g., housekeeping, meals, and laundry — even if living in an independent cottage or independent apartment.

- To determine the frequency of assistance, the clinician may refer to the ALF service contract or may gather information from the patient or family.

- In a congregate housing situation, if the patient has available in-person assistance in response to a call bell 24 hours a day, the correct answer would be “around the clock.”
Availability of Assistance (cont.)

- Identify the frequency any in-person assistance is available:
  - **Around the clock**
    - 24 hours a day (with infrequent exceptions)
  - **Regular daytime/nighttime**
    - During daytime/nighttime hours every day/night (with infrequent exceptions)
    - Regular daytime/nighttime not defined by CMS
    - Clinical judgment determines which hours constitute “regular” daytime and nighttime for patient, based on patient’s specific activities and routines
  - **Occasional/short-term assistance**
    - Only for a few hours a day or on an irregular basis
    - May be only able to help occasionally
  - **No assistance available**
    - No one available to provide any in-person assistance

M1100: Scenarios

- Patient underwent hip replacement. She lives alone, and her daughter is staying with her here until she regains mobility. Her daughter is in the home most of the time, except for running occasional errands.

- Patient lives in ALF with husband who requires supervision. She is independent with ADLs/IADLS and assists her husband. A call bell system is available during the day and night to summon help.
Answers: M1100

- Patient underwent hip replacement. She lives alone, and her daughter is staying with here until she regains mobility. Her daughter is in the home most of the time, except for running occasional errands.
  - **Response 01** - Refers to patient’s usual living situation prior to her surgery. She usually lives alone in her home and has help available when needed.

- Patient lives in ALF with husband who requires supervision. She is independent with ADLs/IADLS and assists her husband. A call bell system is available during the day and night to summon help.
  - **Response 11** - Patient lives in a congregate setting with 24-hour help available – can be by call bell or other means.

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**Sensory Status**

**M1200 – M1242**
**M1200: Guidance**

- Consider physical deficits/impairments that limit the patient’s ability to use vision in a functional way, such as limited ROM of neck due to an injury or kyphosis. If patient is unable to see objects in path, affecting safe functioning in environment, M1200 should be “2 - severely impaired.”

- Clinician may use professional judgment to determine if the patient *usually* wears corrective lenses to see and visually manage safely within his/her environment. “For a patient with presbyopia who only requires reading glasses, there would be no expectation that they would wear their glasses greater than 50% of the time (hours).

- Eyeglasses (prescription or “grocery store”) and contact lenses are considered corrective lenses.

- Magnifying glasses and *electronic magnifiers* (“adaptive devices”) are not considered a corrective lens.
M1200: Guidance (cont.)

- When a patient is cognitively impaired, the clinician will need to observe the patient functioning within their environment and assess their ability to see functionally.
  - Does it appear the patient can see adequately in most situations?
  - Can they see eating and grooming utensils?
  - Do they appear to see the buttons on their shirt/blouse?

- If so, the patient would be reported as a “0 - Normal vision” even though the constraints of the dementia may not allow the patient to communicate whether they can see newsprint or medication labels.

M1200: Responses

- **Response 1:** Based on the patient’s *functional* vision, *not* visual acuity. For example:
  - Can patient read medication labels or differentiate pills?
  - Can patient see obstacles in path?
  - Can patient read medical equipment dials, gauges, scales?
  - Does patient have glasses but refuse to wear them?
  - Does patient need new prescription for glasses?

- **Response 2:** Severe impairment
  - Patient is blind.
  - Patient is unable to respond appropriately or is unresponsive.

  ➤ *Note:* If selecting Response 1 or 2, ensure that impaired vision is addressed in documentation and on the POC.
How would you score M1200?

Patient is clearly visually impaired without his glasses, which he doesn’t wear because they’re too tight and hurt his nose. He has a lighted magnifying glass that he uses when he needs to read something. The nurse assessed him using this and his glasses, and he’s able to read his medication labels and newsprint with both, which he’s unable to do without them.

How would you score M1200 (Vision)?

Answer: M1200

Patient is clearly visually impaired without his glasses, which he doesn’t wear because they’re too tight and hurt his nose. He has a lighted magnifying glass that he uses when he needs to read something. The nurse assessed him using this and his glasses, and he’s able to read his medication labels and newsprint with both, which he’s unable to do without them.

How would you score M1200 (Vision)?

Response 1 - Partially impaired: Patient doesn’t usually wear his glasses, and a magnifying glass is not a corrective lens.
How about this situation?

Patient with severe kyphosis limiting ROM in her neck. She cannot see obstacles in her path when ambulating but can read the newspaper and labels on her medication bottles.

What is the best response to M1200?

Answer: M1200

Patient with severe kyphosis limiting ROM in her neck. She cannot see obstacles in her path when ambulating but can read the newspaper and labels on her medication bottles.

What is the best response to M1200?

Response 2 - Severely impaired: Due to the patient’s limited ROM of her neck, she is unable to see objects in her path, which affects her ability to safely function in her environment.
(M1240)

- Identifies if a standardized, validated pain assessment is conducted and whether a clinically significant level of pain is present, as determined by the assessment tool used.

- In order to enter Response 1 or 2, the pain assessment must be conducted by the clinician responsible for completing the comprehensive assessment during the allowed time frame (that is, within five days of SOC and within two days of discharge from the inpatient facility at ROC).

M1240: Guidance

- Assess for any and all pain the patient experiences, even if patient is not on pain medication.
  - Select response based on pain reported for the time period specified by the tool administration protocol.
  - If the assessment tool was administered according to the tool’s protocol, M1240 may be answered “Yes,” even if a more comprehensive assessment was not performed.

- Severe pain is defined according to the scoring parameters specified for the tool being used.
  - Numeric Pain Scale: 7 or greater = severe pain

- Pain should be documented in the clinical record and included in the Plan of Care.
  - Pain level, mitigation, patient response to interventions, and physician notification if appropriate
How should M1240 be scored?

- Patient was admitted to the hospital on 1/2 and was discharged from the hospital on 1/7. She refused a ROC visit within the required 48 hours. The ROC assessment was not performed until 1/11, at which time she was assessed for pain using the numeric 1-10 scale.

> How should the clinician score M1240?

Answer: M1240

- Patient was admitted to the hospital on 1/2 and was discharged from the hospital on 1/7. She refused a ROC visit within the required 48 hours. The ROC assessment was not performed until 1/11, at which time she was assessed for pain using the numeric 1-10 scale.

> How should the clinician score M1240?

- **Response 0 - No standardized, validated assessment conducted**
  - Physician should be notified of the delay and patient’s refusal.
  - Regulatory language does **not** allow for a change in ROC date.
  - All process measures (Pain Assessment, Pressure Ulcer Risk Depression Screening, Fall Risk Assessment, and M2250) must be answered “No,” if **not** completed within the 48 hr. time frame.
Identifies frequency with which pain interferes with patient’s activities, with treatments if prescribed.

$$M1242 = 3 \text{ or } 4$$

**M1242: Guidance**

- Responses are arranged in order of least to most interference with activity or movement.
- Response “4 - All the time” is selected, when the patient reports and/or the clinician observes that pain is interfering with the patient's ability to move and/or perform desired activities at all times. “At all times” means constantly throughout the day and night with little or no relief and must wake the patient frequently.
- Pain interferes with activity when the pain results in the activity being performed less often than otherwise desired, requires the patient to have additional assistance in performing the activity, or causes the activity to take longer to complete.
  - Assess patient while moving. Include all activities (e.g., sleeping, recreational activities, watching television), not just ADLs.
M1242: Guidance (cont.)

- Pain that is well-controlled with treatment may NOT interfere with activity or movement at all.

- If the patient has stopped an activity to be free of pain, then he/she has pain interfering with activity.

- Time frame for M1242 is the “day of assessment” and “recent pertinent past.”
  - There must be a “reasonable expectation” that patient would perform activity again, if the pain could be eliminated or managed.
  - Use clinical judgment.
    - For example, if a patient has not jogged in the past 3 years since he has pain in his knee due to arthritis when he runs, this is not considered to be the recent pertinent past.

How would you score M1242?

- Patient who has been able to do all activities for last 24 hours, since she is taking pain med every 4-6 hours around the clock.

- Patient who refuses to take pain medication because of his fear of addiction and is unable to do daily bathing because of persistent postoperative pain, which limits his activity and keeps him from sleeping well at night.

- Patient who states she has pain level at 8 all the time.
Answers: M1242

- Patient who has been able to do all activities for last 24 hours, since she is taking pain med every 4-6 hours around the clock.
  - Response 1 - No pain interfering with activity or movement

- Patient who refuses to take pain medication because of his fear of addiction and is unable to do daily bathing because of persistent postoperative pain, which limits his activity and keeps him from sleeping well at night.
  - Response 4 - All of the time

- Patient who states she has pain level at 8 all the time.
  - M1242 does not ask about pain level. More information about pain interfering with activity must be obtained.

Medications
M2001 – M2040
OASIS-C: Medication Items

- **M2001**: Drug regimen review
- **M2003**: Medication follow-up
- **M2005**: Medication intervention
- **M2010**: High-risk drug education
- **M2016**: Drug education intervention
- **M2020**: Management of oral medications
- **M2030**: Management of injectable medications
- **M2040**: Prior medication management

Drug Regimen Review Process

- Assess / Review
- Implement / Educate
- Reconcile
- Alert / Notify
- Follow-up
- Resolve
Identifies if review of the patient’s medications indicated any potential clinically significant medication issues.

**M2001: Guidance**

- **Includes**: medication reconciliation, a review of all medications a patient is currently using and review of the drug regimen to identify, and if possible, prevent potential clinically significant medication issues.
  - Includes all medications, prescribed and over the counter (including TPN and herbals), administered by any route (for example, oral, topical, inhalant, pump, injection, intravenous and via enteral tube).

- A “potential” clinically significant medication issue is an issue that, in the care provider’s clinical judgment, requires physician/physician-designee notification by midnight of the next calendar day (at the latest).
  - Also, includes an existing clinically significant medication issue.

- Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue.
Clinically Significant Issues

<table>
<thead>
<tr>
<th>Adverse Drug Reaction</th>
<th>Drug-Disease Interactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ineffective Drug Therapy</td>
<td>Duplicate Therapy</td>
</tr>
<tr>
<td>Side Effects</td>
<td>Omissions</td>
</tr>
<tr>
<td>Drug-Drug Interactions</td>
<td>Dosage Errors (high or low)</td>
</tr>
<tr>
<td>Drug-Food Interactions</td>
<td>Nonadherence – purposeful or accidental</td>
</tr>
</tbody>
</table>

Clinically Significant Issues: Any of the circumstances listed above must reach a level of clinical significance that warrants notification of the physician/physician-designee for orders or recommendations by midnight of the next calendar day, at the latest. Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue.

M2001: Guidance

- Portions of the drug regimen review may be completed by agency staff other than clinician responsible for SOC/ROC OASIS. The collaborating clinician must communicate the findings to the assessing clinician. For example, a “collaborating clinician” in the office might:
  - Evaluate the medication list to identify possible duplicate drug therapy or omissions, dosage errors, or potential drug interactions.
  - Contact the patient by phone to discuss issues regarding side effects the patient may be experiencing or effectiveness of the medication.

- Only clinicians qualified to perform the comprehensive assessments may collaborate with the assessing clinician.

- A second clinician may NOT contribute to the drug regimen review by utilizing information gathered from an in-home visit.
M2001: Guidance (cont.)

- The M0090 date reports the date the assessment is completed and should include any time the assessing clinician took to collaborate with others in order to gather all needed assessment data and determine all relevant OASIS responses.

- If a medication related problem is identified and resolved by the agency staff not requiring physician/physician-designee contact by midnight of the next calendar day, the problem does not need to be reported as an existing clinically significant problem.

M2001: Response 0

- Situations where the clinician may determine that **Response 0 (no issues found during review)** should be entered may be when:
  - Patient’s list of medications from the inpatient facility discharge instructions matches the medications the patient shows the clinician at the SOC/ROC assessment visit.
  - Assessment shows that diagnoses/symptoms for which the patient is taking medications are adequately controlled (as able to be assessed within the clinician’s scope of practice).
  - Patient possesses all medications prescribed.
  - Patient has a plan for taking medications safely at the right time.
  - Patient is not showing signs/symptoms that could be adverse reactions caused by medications.
M2001: Response 1

- Situations where the clinician may determine that **Response 1 - issues found during review** should be entered may be when:
  - Patient’s list of medications from the inpatient facility discharge instructions DO NOT match the medications the patient shows the clinician at the SOC/ROC assessment visit.
  - Assessment shows that diagnoses/symptoms for which the patient is taking medications are NOT adequately controlled (as able to be assessed within the clinician’s scope of practice).
  - Patient seems confused about when/how to take medications indicating a high risk for medication errors.

M2001: Response 1 (cont.)

- Patient has **not** obtained medications or indicates that he/she will probably **not** take prescribed medications because of financial, access, cultural, or other issues with medications.
- Patient has signs/symptoms that could be adverse reactions from medications.
- Patient takes multiple non-prescribed medications (OTCs, herbals) that could interact with prescribed medications.
- Patient has a complex medication plan with medications prescribed by multiple physicians and/or obtained from multiple pharmacies so that the risk of drug interactions is high.
M2001: Dash (–)

- A dash (–) value is a valid response for this item.
  A dash (–) value indicates that no information is available, and/or an item could not be assessed. This most often occurs when the patient is unexpectedly transferred, discharged or dies before assessment of the item could be completed. However, providers should complete transfer and discharge assessments to the best of their ability when a care episode ends unexpectedly. CMS expects dash use to be a rare occurrence.

- If elements of the drug regimen review were skipped, for example, drug-to-drug interactions, a dash (–) should be reported, indicating the drug regimen review was not completed.

Are these clinically significant issues?

- Patient does not have transportation to pick up new medication ordered at hospital discharge.

- Patient has Lasix 40 mg. 2x/day in one prescription bottle (properly labeled) filled yesterday. Old prescription was for Lasix 20 mg. 2x/day and filled a month ago. Bottle is stored on top shelf in kitchen.

- Patient has pain level of “8” and is taking pain medication as ordered.

- Patient prescription label states that patient is to take Aricept® “as directed.”
Identifies if potential clinically significant medication issues identified through a medication review were addressed with the physician (or physician-designee) by midnight of the next calendar day following their identification.

**Definition: Physician Contact**

- Contact with physician is defined as communication to the physician or physician-designee (made by telephone, voicemail, electronic means, fax, or any other means) that appropriately conveys the message of patient status.

- Communication can be directly to/from the physician or physician-designee, or indirectly through physician’s office staff on behalf of the physician or physician-designee, in accordance with the legal scope of practice.
Medication Reconciliation

- Must create the most accurate list possible of all medications a patient is taking:
  - Drug name, dosage, frequency, and route
  - Identify which ones are new, changed, or long-standing
  - Compare that list against the physician’s admission, transfer, and or discharge orders to ensure the patient is taking the correct medication at all transition points in care (or any time a comprehensive assessment is required)

- Reconciliation is not asking the patient what medications he/she is on. *It is putting your hands on the bottle!*

Medication Reconciliation (cont.)

- Medication follow-up and reconciliation require:
  - **2-way communication** with the physician or physician-designee regarding the potentially significant medication issue **AND**
  - **Completion of the prescribed / recommended actions** no later than 12 midnight of the next calendar day before the end of the allowed timeframe (5 days at SOC; 2 days at ROC).

- Physician notification alone is NOT reconciliation.
M2003: Responses

- If the physician/physician-designee recommends an action that will take longer than the allowed time to complete, enter Response 1 - Yes as long as the agency has taken whatever recommended actions are possible to comply with by midnight of the next calendar day.
  - Includes when a weekend “on-call” physician unfamiliar with the patient directs agency to call the PCP on Monday for further orders.

- When multiple potential clinically significant medication issues are identified at the SOC/ROC, all must be communicated to the physician or designee, with completion of ALL prescribed/recommended actions occurring by midnight of the next calendar day in order to enter Response 1 - Yes.

M2003: Responses

- If the physician/physician-designee provides no new orders or instruction in response to timely reported potential clinically significant medication issue(s), enter Response 1 - Yes, indicating that the physician/physician-designee was contacted and prescribed/recommended actions were completed.

- If a potential clinically significant medication issue was identified and the clinician attempted to communicate with the physician but did not receive communication back from the physician/physician designee until after midnight of the next calendar day, enter Response 0 - No.

- A dash (–) value is a valid response for this item.
(M2005) Medication Intervention: Did the agency contact and complete physician (or physician–designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
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<td>No</td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>9</td>
<td>NA — There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications</td>
</tr>
</tbody>
</table>

- Identifies if each time potential clinically significant medication issues such as adverse effects or drug reactions identified at the time of or at any time since the SOC/ROC were addressed with the physician or physician–designee.

- Collected at transfer, discharge, and death at home.

**Physician Follow-Up and Reconciliation**

- To enter Response 1 - Yes:
  - 2-way communication with the physician or physician–designee regarding the potentially significant medication issue AND
  - Completion of the prescribed/recommended actions must have occurred by midnight of the next calendar day each time a potential clinically significant issue was identified.

- If the physician/physician–designee recommends an action that will take longer than the allowed time to complete, then Response 1 - Yes should be entered as long as by midnight of the next calendar day the agency has taken whatever actions are possible to comply with the recommended action.

- If, when a potential clinically significant issue was identified, the physician/physician–designee provided no new orders or instruction in response to the timely reported concern, Response 1 - Yes should be reported.

- A dash (–) value is a valid response for this item.
Identifies if clinicians instructed the patient and/or caregiver about all high-risk medications the patient takes. High-risk medications are those identified by quality organizations as having considerable potential for causing significant patient harm when they are used erroneously.

**M2010: Guidance**

- This item is targeted to high-risk medications as it may be unrealistic to expect that patient education on all medications occur on admission and failure to provide patient education on high-risk medications at SOC/ROC could have severe negative impacts on patient safety and health.
  - Examples: Coumadin, Insulin, Opiates and narcotics, Heparin, TPN, chemotherapy, Digoxin
  - Includes discontinued high-risk meds that are being taken in error and staff had to educate patient / CG.

- If agency staff other than the clinician responsible for completing the SOC/ROC OASIS provided education to the patient/caregiver on high-risk medications, this information must be communicated to the clinician responsible for the SOC/ROC OASIS assessment so that the appropriate response for M2010 may be selected.

  ✤ *See List of High-Alert Medications*
M2010: Scenario

- Patient who has a history of HTN is being admitted for management of COPD following discharge from the hospital. The patient’s HTN is controlled now using a diuretic and a low salt diet. During the medication review, the clinician finds that the patient is currently taking an antihypertensive which was discontinued before his discharge from the hospital. The clinician knows that the antihypertensive is a high-risk drug. He validates with the physician that the drug should be discontinued and instructs the patient not to take the drug.

> How should M2010 (High Risk Drug Education) be answered?

Answer: M2010

- Patient who has a history of HTN is being admitted for management of COPD following discharge from the hospital. The patient’s HTN is controlled now using a diuretic and a low salt diet. During the medication review, the clinician finds that the patient is currently taking an antihypertensive which was discontinued before his discharge from the hospital. The clinician knows that the antihypertensive is a high-risk drug. He validates with the physician that the drug should be discontinued and instructs the patient not to take the drug.

> How should M2010 (High Risk Drug Education) be answered?

✔ **Answer: Response 1 - Yes**

✈ **Rationale:** If the patient was taking a high-risk medication in error and was educated by Agency staff to discontinue the medication as well as the special precautions they need to take and how and when to report a problem that occurs as a result of taking that medication, M2010 may be answered “Yes.”
Identifies if clinicians instructed the patient/caregiver about how to manage all medications effectively and safely within the time period under consideration.

M2016: Guidance

- **All** prescribed and OTC medications by any route.
- Safe/effective management includes:
  - Knowledge of effectiveness of drug therapy, including purpose
  - Potential side effects and drug reactions
  - When and how to contact the appropriate provider
- Specific medication(s) and teaching should be documented.
- The staff at an assisted living facility (ALF) can be considered patients’ caregivers.
- Documentation should support interventions to educate patient and caregiver or reason why interventions were not completed.
This item is intended to identify the patient's ability to take all oral (p.o.) medications reliably and safely at all times.

M2020: Guidance

- The intent is to identify ABILITY not “willingness” or “adherence.
- Addresses the patient's ability to safely take the right oral medication and the right dose at the right time, given the current physical and mental/emotional/cognitive status, activities permitted, and environment.
- Ability can be temporarily or permanently limited by:
  - Physical impairments (for example, limited manual dexterity);
  - Emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear);
  - Sensory impairments (for example, impaired vision, pain);
  - Environmental barriers (for example, access to kitchen or medication storage area, stairs, narrow doorways).
- If patient's ability varies between the medications, report medication that requires the most assistance. *Majority does not rule!*
M2020: Guidance

- Includes assessment of the patient’s ability to:
  - Obtain the medication from where it is routinely stored;
  - Read the label (or otherwise identify the medication correctly – for example, patients unable to read and/or write may place a special mark or character on the label to distinguish between medications);
  - Open the container;
  - Select the pill/tablet or milliliters of liquid;
  - Orally ingest the medication; and
  - Take the medication at the correct times.

- Does not include sublingual, buccal, inhalant, and per tube medications – only those placed in the mouth and then swallowed, with absorption through the GI system.

M2020: Guidance (cont.)

- If a patient lives in an environment where the facility or caregiver may impose a barrier that limits the patient’s ability to access or prepare their medications (e.g., an Assisted Living Facility) or the caregiver routinely administers the patient’s medications, the clinician must assess the patient’s vision, strength, and manual dexterity in hands and fingers, as well as their cognitive status to determine the patient’s ability to prepare and take their oral medications.

- May not assume that if a med box, diary, or reminders were set up that the patient would be able to take medications safely.

- If assistance is needed for PRN medications in the 24 hours prior to the assessment or on the day of the assessment and a PRN medication was required, then the PRN medication is considered.
This item is intended to assess the patient’s ability to take all injectable medications reliably and safely at all times.

M2030: Guidance

- Assesses patient’s current ability to prepare and take all prescribed injectable medications reliably and safely at all times. Majority does not rule!

- Excludes IV medication, infusions (i.e., medications given via pump), and medications given in the physician’s office or other settings outside of the home.

- Includes:
  - One-time injections administered in the home – e.g., flu vaccine and B12 injections;
  - Safe disposal of sharps; and
  - PRN injectables included on the POC. If not needed at SOC, use clinical judgment regarding patient’s ability to self-administer.
M2030: Guidance (cont.)

- Includes assessment of the patient's ability to obtain the medication from where it is routinely stored, draw up the correct dose accurately using aseptic technique, inject in an appropriate site using correct technique, and dispose of the syringe properly.

- Select Response 3 (unable to administer medication), if the physician ordered the RN to administer an injection in the home – e.g., flu vaccine.

- At discharge, if there are no ongoing, current orders for an injectable medication, correct response = “NA.”

M2020/M2030 General Rules

- If a patient does not have the requisite knowledge of a drug’s dose and administration schedule to take the correct dose at the correct time (includes mental/emotional/cognitive ability):
  - Response 3, Unable to take medication (oral or injectable) unless administered by another person, is appropriate.

- If a medication (oral or injectable) is not in the home (whether currently due, due at a future point during the episode, or PRN):
  - Response 3, Unable to take medication (oral or injectable) unless administered by another person, is appropriate.
M2020/M2030 General Rules

- If medications are in the home but *not* needed or due at time of assessment, observe the patient’s ability based on asking patient to describe steps or simulate task.

- If patient requires assistance to walk to the place where medications are routinely stored or requires someone to retrieve medications for them:
  - Response 3, Unable to take medication (oral or injectable) unless administered by another person, is appropriate.

(M2040)

- Identifies the patient’s ability to manage *all* prescribed oral and injectable medications prior to the onset of the current illness, exacerbation of a chronic condition, or injury (whichever is most recent) that initiated this episode of care.
M2040: Guidance

- The intent of the item is to identify the patient’s prior ability, not necessarily actual performance.
- Includes all prescribed and OTC oral medications and all prescribed injectable medications that the patient was taking prior to most recent illness and are included on the Plan of Care.
- For each functional area (oral medications and injectable medications), enter a response.
- If the patient’s prior ability to manage oral or injectable medications varied from medication to medication, consider the medication for which the most assistance was needed when selecting a response.

M2020 and M2030: Scenarios

- Patient got home from the hospital 2 days ago. Her meds include Lasix, Lisinopril, Digoxin, and an oral antibiotic. She is also on oxygen. She uses a pill planner set up by her daughter. Although she states she took yesterday’s meds, there is a Lasix tablet still in the box. She says she meant to take it but forgot.
  - How would you score M2020?
- Patient, a long time diabetic, is independent in administration of his insulin. At SOC, post left total knee replacement, the nurse assesses that he is unsafe ambulating without supervision and his wife must get his insulin from the refrigerator for him.
  - How would you score M2030?
Answers: M2020 and M2030

- Patient got home from the hospital 2 days ago. Her meds include Lasix, Lisinopril, Digoxin, and an oral antibiotic. She is also on oxygen. She uses a pill planner set up by her daughter. Although she states she took yesterday’s meds, there is a Lasix capsule still in the box. She says she meant to take it but forgot.
  - How would you score M2020?
    - Response 3 – Unable to take medication unless administered by another person

- Patient, a long time diabetic, is independent in administration of his insulin. At SOC, following a total knee replacement, the nurse assesses that he is unsafe ambulating without supervision and his wife must get his insulin from the refrigerator for him.
  - How would you score M2030?
    - Response 3 – Unable to take injectable medication unless administered by another person

Join me!

For Part 4:

Integumentary Status: M1300-M1350

Thursday, December 8th
1:00 – 3:00 EST
Thank you for attending!

Sharon Molinari, RN, HCS-D, HCS-O
Home Health Consultant and Educator
sharon.molinari@gmail.com