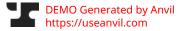


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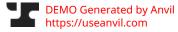
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OUTCOME AND ASSESSMENT INFORMATION SET VERSION E1 All Items

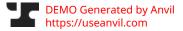
Section A Administrative Information	
M0018. National Provider Identifier (NPI) for the attending physician who has signed the pla	an of care
M00- 18 - M0018 National Brovider Identifier N-P Full FieldX UK — Unknown or N	ot Available
N0010. CMS (Centification Number	
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M0040. Patient Name	
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M0050. Patient State of Residence	Sinici
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Wind 60. Patient ZIP Code	
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Mo064. Social Security Number	
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M0063. Medicare Number	
M0063 - Medicare Number X NA — No M	edicare

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M0065. Medicaid Number			
Me-dic-aid Number Digits 2-14 X NA — No Medicaid			
M0069. Gender			
menter Code er Dig Ge it 1			
M0066 Birth Date			
12 de 12 12 - 25 - 2025 Month Day Year			
A1005. Ethnicity Are you of Hispanic, Latino/a, or Spanish origin?			
↓ Check all that apply			
X A. No, not of Hispanic, Latino/a, or Spanish origin			
B. Yes, Mexican, Mexican American, Chicano/a			
C. Yes, Puerto Rican			
D. Yes, Cuban			
E. Yes, another Hispanic, Latino, or Spanish origin Ethnicity - Another Hispanic, Latino, or Spanish origin			
X. Patient unable to respond Specification			
Y. Patient declines to respond			
A1010. Race What is your race?			
↓ Check all that apply			
X A. White			
B. Black or African American			
C. American Indian or Alaska Native Race - American Indian or Alaska Native Specification			
D. Asian Indian			
E. Chinese			
F. Filipino			
G. Japanese			
H. Korean			
K. Native Hawaiian			
L. Guamanian or Chamorro			
L. Guamanian or Chamorro M. Samoan			
L. Guamanian or Chamorro M. Samoan N. Other Pacific Islander			
L. Guamanian or Chamorro M. Samoan			
F. Filipino G. Japanese H. Korean I. Vietnamese J. Other Asian			

Check all that apply X 0. None; no charge for current services 1. Medicare (traditional fee-for-service) 2. Medicare (traditional fee-for-service) 3. Medicaid (traditional fee-for-service) 4. Medicaid (thMO/managed care) 5. Worker's compensation 6. Title programs (for example, Title III, V, or XX) 7. Other government (for example, TriCare, VA) 8. Private insurance 9. Private HMO/managed care 10. Self-pay 11. Other (specify) Other payment source (specify) UK. Unknown A110. Language A. What is your preferred language? Preferred language A. What is your preferred language? Preferred language 1. Self-pay 1. RN 2. Preferred language M0086. Discipline of Person Completing Assessment Enter Code O. No 1. Yes 9. Unable to determine M0090. Date Assessment Completed Discipline of person Completed Discipline of Person Completed Start/Resumption of Care Code 1. Start of care — further visits planned 3. Resumption of Care (after inpatient stary) Follow-up 0. Other follow-up) reassessment 35- Se- Se- Se- Se- Se- Tritle III, V, or XX) 1. Proferred language? Proferred language? Proferred language? Proferred language Proferred language 1. RN 2. Proferred language 1. RN 2. Proferred language 1. RN 2. Proferred language 1. RN 3. Resumption of Care Code 1. Start of care — further visits planned 3. Resumption of Care (after inpatient stary) Follow-up 0. Other follow-up) reassessment 5. Other follow-up) reassessment 5. Other follow-up) reassessment 5. Other follow-up) reassessment	M0150. Current Payment Sources for Home Care					
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6. Transferred to an inpatient facility — patient not discharged from agency		6. Transferred to an inpatient facility — patient not discharged from agency				
7. Transferred to an inpatient facility — patient discharged from agency						
Discharge from Agency — Not to an Inpatient Facility be- 8. Death at home						
ing 9. Discharge from agency						



M0906. Discharge/Transfer/Death Date

Enter the date of the discharge, transfer, or death (at home) of the patient.

M0906 Discharge /Transfer/ Death

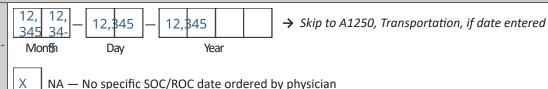


Date

M0102. Date of Physician-ordered Start of Care (Resumption of Care)

If the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified.

M0102 Date of Physicianordered Start of



M0104. Date of Referral

Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.

M0104 Date of Referral

Care

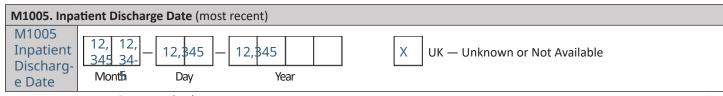


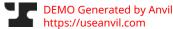
A1250. Transportation (NACHC©)

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?			
\	Check all that apply		
X	A. Yes, it has kept me from medical appointments or from getting my medications		
	B. Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need		
	C. No		
	X. Patient unable to respond		
	Y. Patient declines to respond		

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M1000. From which of the following Inpatient Facilities was the patient discharged within the past 14 days?		
↓	Check all that apply	
X	1. Long-term nursing facility (NF)	
X	2. Skilled nursing facility (SNF/TCU)	
X	3. Short-stay acute hospital (IPPS)	
X	4. Long-term care hospital (LTCH)	
X	5. Inpatient rehabilitation hospital or unit (IRF)	
X	6. Psychiatric hospital or unit	
X	7. Other (specify)	
X	NA Patient was not discharged from an inpatient facility → Skip to B0200, Hearing at SOC, Skip to B1300, Health Literacy at ROC	





M2301. Emergent Care

At the time of or at any time since the most recent SOC/ROC assessment has the patient utilized a hospital emergency department (includes holding/observation status)?

Enter Code

Χ

- 0. No → Skip to M2410, Inpatient Facility
- 1. Yes, used hospital emergency department WITHOUT hospital admission
- 2. Yes, used hospital emergency department WITH hospital admission
- UK **Unknown** → Skip to M2410, Inpatient Facility

M2310. Reason for Emergent Care

For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)?		
\	Check all that apply	
X	1. Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis	
	10. Hypo/Hyperglycemia, diabetes out of control	
	19. Other than above reasons	
	UK Reason unknown	

M2410. To which Inpatient Facility has the patient been admitted?

Enter Code

M-

24-

10

1. Hospital

- 2. Rehabilitation facility
- 3. Nursing home
- 4. Hospice

NA No inpatient facility admission [Omit "NA" option on TRN]

M2420. Discharge Disposition

Where is the patient after discharge from your agency? (Choose only one answer.)

Enter Cpgle 以上

<u>7</u>8

BE.

SC-

- 1. Patient remained in the community (without skilled services from a Medicare Certified HHA or non-institutional hospice) → Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge
- 2. Patient remained in the community (with skilled services from a Medicare Certified HHA) → Continue to A2121, Provision of Current Reconciled Medication List to Subsequent Provider at Discharge
- 3. **Patient transferred to a non-institutional hospice** → Continue to A2121, Provision of Current Reconciled Medication List to Subsequent Provider at Discharge
- 4. Unknown because patient moved to a geographic location not served by this agency → Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge
- UK **Other unknown** → Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge

A2 190. Provision of Current Reconciled Medication List to Subsequent Provider at Transfer

At the time of transfer to another provider, did your agency provide the patient's current reconciled medication list to the subsequent provider?

Enter Code

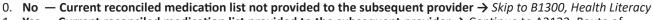
Χ

- 0. No Current reconciled medication list not provided to the subsequent provider → Skip to J1800, Any Falls Since SOC/ROC
- Yes Current reconciled medication list provided to the subsequent provider → Continue to A2122, Route of Current Reconciled Medication List Transmission to Subsequent Provider
- 2. NA The agency was not made aware of this transfer timely → Skip to J1800, Any Falls Since SOC/ROC

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge

At the time of discharge to another provider, did your agency provide the patient's current reconciled medication list to the subsequent provider?

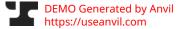
Enter Code



 Yes — Current reconciled medication list provided to the subsequent provider → Continue to A2122, Route of Current Reconciled Medication List Transmission to Subsequent Provider



A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider					
Indi	Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.				
Route of Transmission		mission	Route of Transmission to Subsequent Provider		
			↓ Check a	ıll that apply ↓	
A.	Electronic	Health Record		X Check all that apply -	
В.	Health Info	ormation Exchange		Subsequent Provider	
C.	Verbal (e.g	., in-person, telephone, video conferencing)		Verbal examples -	
D.	Paper-base	ed (e.g., fax, copies, printouts)		Subsequent Provider	
E.	Other Met	hods (e.g., texting, email, CDs)	After completing A2122	Other Methods examples	
			instruction After completing A2122, Sk	kip to B1300, Field the Ther act at bis Erlarge	
At t	the time of c	on of Current Reconciled Medication List to Patien lischarge to another provider, did your agency provand/or caregiver?	•	iled medication list to the	
Er	nter Code	No — Current reconciled medication list no B1300, Health Literacy	t provided to the patient, family	y, and/or caregiver → Skip to	
	12-	Yes — Current reconciled medication list pro A2124, Route of Current Reconciled Medicat		d/or caregiver → Continue to	
A21		f Current Reconciled Medication List Transmission	n to Patient		
Indi	OV- icate_the rou	ite(s) of transmission of the current reconciled me	dication list to the patient, family	y, and/or caregiver.	
on of Route of Transmission A2123 Response Code					
	rr-		↓ Check a	all that apply ↓ Skip to	
A.	Electronic	Health Record		X B1300 instructi-	
В.	Health Info	ormation Exchange		on	
C.	Verbal (e.g M-	., in-person, telephone, video conferencing)			
D.	Paper-base	ed (e.g., fax, copies, printouts)			
E.	Other Met	hods (e.g., texting, email, CDs)			
	n List				
	Section B	0, 1			
B02	200 Hearing				
	nter(Code	Ability to hear (with hearing aid or hearing applia	ances if normally used)		
	 Adequate – no difficulty in normal conversation, social interaction, listening to TV Minimal difficulty – difficulty in some environments (e.g., when person speaks softly, or setting is noisy) Moderate difficulty – speaker has to increase volume and speak distinctly Highly impaired – absence of useful hearing 				
B10	rge 000. Vision				
	nter Code	Ability to see in adequate light (with glasses or o	ther visual appliances)		
	12, 34- 5	·			



B1300. Health Literacy (From Creative Commons ©)

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

Enter Code



- 0. Never
- 1. Rarely
- 2. Sometimes
- 3. Often
- 4. Always
- 7. Patient declines to respond
- 8. Patient unable to respond

The Single Item Literacy Screener is licensed under a Creative Commons Attribution Noncommercial 4.0 International License.

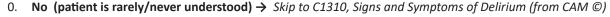
Section C Cognitive Patterns

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?

Attempt to conduct interview with all patients.

Enter Code

Χ





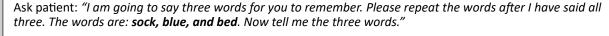
1. Yes → Continue to C0200, Repetition of Three Words

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Enter Code

Χ



Number of words repeated after first attempt:

- 0. None
- 1. **One**
- 2. **Two**
- Three

After the patient's first attempt, repeat the words using cues ("sock, something to wear; blue, a color; bed, a piece of furniture"). You may repeat the words up to two more times.

C0300. Temporal Orientation (Orientation to year, month, and day)			
Enter Code X	Ask patient: "Please tell me what year it is right now." A. Able to report correct year 0. Missed by > 5 years or no answer 1. Missed by 2-5 years 2. Missed by 1 year 3. Correct	emporal Orientation - Year Details	
Enter Code X	Ask patient: "What month are we in right now?" B. Able to report correct month O. Missed by > 1 month or no answer 1. Missed by 6 days to 1 month 2. Accurate within 5 days	emporal Orientation - Month Details	
Enter Code	Ask patient: "What day of the week is today?" C. Able to report correct day of the week O. Incorrect or no answer 1. Correct	Temporal Orientation - Day of Week Details	

C0400. Recall	
Enter Code X	Ask patient: "Let's go back to an earlier question. What were those three words that I asked you to repeat?" If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word. A. Able to recall "sock" O. No — could not recall 1. Yes, after cueing ("something to wear") 2. Yes, no cue required
Enter Code	B. Able to recall "blue" O. No — could not recall 1. Yes, after cueing ("a color") 2. Yes, no cue required Recall 'blue' response
Enter Code	C. Able to recall "bed" 0. No — could not recall 1. Yes, after cueing ("a piece of furniture") Recall 'bed' response 2. Yes, no cue required

C0500. BIMS Summary Score

Enter Code

12,345

Add scores for questions C0200-C0400 and fill in total score (00-15)

Enter 99 if the patient was unable to complete the interview

C1310. Signs and Symptoms of Delirium (from CAM©)

Code after completing Brief Interview for Mental Status and reviewing medical record.

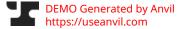
A. Acute Onset of Mental Status Change

Enter Code

Is there evidence of an acute change in mental status from the patient's baseline?

X 1. Yes		
Coding	↓ Ente	r codes in boxes
Behavior not present Behavior continuous	sly	B. Inattention – Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?
2. Behavior present, flu (comes and goes, cha	uctuates	C. Disorganized thinking – Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
severity)		 D. Altered level of consciousness — Did the patient have altered level of consciousness, as indicated by any of the following criteria? vigilant — startled easily to any sound or touch
	X	 lethargic — repeatedly dozed off when being asked questions, but responded to voice or touch stuporous — very difficult to arouse and keep aroused for the interview
		comatose — could not be aroused

Adapted from: Inouye SK, et al. Ann Intern Med. 1990; 113: 941-948. Confusion Assessment Method. Copyright 2003, Hospital Elder Life Program, LLC. Not to be reproduced without permission.



M1700. Cognitive Functioning

Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

Enter Code



- Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
- 1. Requires prompting (cueing, repetition, reminders) only under stressful or unfamiliar conditions.
- Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility.
- Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

M1710. When Confused

(Reported or Observed Within the Last 14 Days):

M1700 Cognitive Functioning Level 0 Description

Enter Code



Never

- In new or complex situations only 1.
- On awakening or at night only
- M1710 When Confused Options During the day and evening, but not constantly 3.
- Constantly 4.
- **NA Patient nonresponsive**

M1720. When Anxious

(Reported or Observed Within the Last 14 Days):

M1700 Cognitive Functioning Level 1 Description

Enter Code



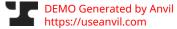
1. Less than often daily

2. Daily, but not constantly

All of the time

NA Patient nonresponsive

M1720 When Anxious Options



Section D | Mood

D0150. Patient Mood Interview (PHQ-2 to 9)

Determine if the patient is rarely/never understood verbally, in writing, or using another method. If rarely/never understood, code D0150A1 and D0150B1 as 9, No response, leave D0150A2 and D0150B2 blank, end the PHQ-2 interview, and leave D0160, Total Severity Score blank. Otherwise, say to patient: "Over the last 2 weeks, have you been bothered by any of the following problems?"

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.

If yes in column 1, then ask the patient: "About how often have you been bothered by this?"

Read and show the patient a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1.	Symptom Presence 0. No (enter 0 in column 2)	Symptom Frequency O. Never or 1 day	1. Symptom Presence	2. Symptom Frequency	
	 Yes (enter 0-3 in column 2) No response (leave column 2 blank) 	 2-6 days (several days) 7-11 days (half or more of the days) 12-14 days (nearly every day) 	↓ Enter Scores in Boxes ↓		
A.	Little interest or pleasure in doing th	ings	X	X	
В.	Feeling down, depressed, or hopeles	s	X	X	
	If both D0150A1 and D0150B1 are coded 9, OR both D0150A2 and D0150B2 are coded 0 or 1, END the PHQ interview; otherwise, continue.				
C.	C. Trouble falling or staying asleep, or sleeping too much				
D.	D. Feeling tired or having little energy				
E.	Poor appetite or overeating		X	X	
F.	F. Feeling bad about yourself — or that you are a failure or have let yourself or your family down			X	
G.	G. Trouble concentrating on things, such as reading the newspaper or watching television			X	
Н.	Moving or speaking so slowly that the other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual			X	
1.	Thoughts that you would be better o	off dead, or of hurting yourself in some way	X	X	

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D0160. Total Severity Score

Enter Score

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items)



D0160 Total Severity Score Instructions

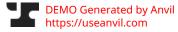
D0700. Social Isolation

How often do you feel lonely or isolated from those around you?

Enter Code



- 0. Never
- 1. Rarely
- 2. Sometimes
- 3. Often
- 4. Always
- 7. Patient declines to respond
- 8. Patient unable to respond



Section E Behavior

M1740. Cognitive, Behavioral, and Psychiatric Symptoms that are demonstrated at least once a week (Reported or Observed):				
↓	heck all that apply			
X	. Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required			
	 Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities jeopardizes safety through actions 	,		
	. Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.			
	 Physical aggression: aggressive or combative to self and others (for example, hits self, throws objects, pundangerous maneuvers with wheelchair or other objects) 	ches,		
	. Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions)			
	. Delusional, hallucinatory, or paranoid behavior			
	. None of the above behaviors demonstrated			
M1745. Frequency of Disruptive Behavior Symptoms (Reported or Observed): Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.				
Fr- eq- ue- ncy	 Never Less than once a month Once a month Several times each month Several times a week At least daily 			

Cabbase	Duefenen	fan Cartana	. Davidina and	A -44:44
Section F	Preferences	for Customary	/ Kouπne and	Activities

sr-

M1100 Patient Living Situation					
Whick of the following best describe	Whick of the following best describes the patient's residential circumstance and availability of assistance?				
Be- ha-	Availability of Assistance				
Living Arrangement or Sy-	Around the Clock	Regular Daytime	Regular Night- time	Occasional/ Short-Term Assistance	No Assistance Available
m- pt-		\	Check one box or	nly ↓	
A. Patient lives alone	X 01	02	03	04	05
B. Patient lives with other person(s) in the home	X 06	07	08	09	10
C. Patient lives in congregate situation (for example, assisted living, residential care home)	X 11	12	13	14	15

SOC/ROC

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.

Enter Code

- Χ
- **Supervision and safety** (due to cognitive impairment)
- 0. No assistance needed patient is independent or does not have needs in this area
- 1. 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

Discharge

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.

ADL assistance (for example, transfer/ambulation, bathing, dressing, toileting, eating/feeding) **Enter Code** No assistance needed — patient is independent or does not have needs in this area Non-agency caregiver(s) currently provide assistance X 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 4. Assistance needed, but no non-agency caregiver(s) available Medication administration (for example, oral, inhaled, or injectable) **Enter Code** 0. No assistance needed — patient is independent or does not have needs in this area 1. Non-agency caregiver(s) currently provide assistance Χ Non-agency caregiver(s) need training/supportive services to provide assistance 2.

- 3. 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 4.

Enter Code



- Medical procedures/treatments (for example, changing wound dressing, home exercise program)
 - 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
 - 4. Assistance needed, but no non-agency caregiver(s) available

Enter Code

Χ

- Supervision and safety (due to cognitive impairment)
 - 0. 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 2.
 - Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide 3. assistance
 - Assistance needed, but no non-agency caregiver(s) available

Section G Functional Status

M1800. Grooming

Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).

Enter Code

Χ

- Able to groom self unaided, with or without the use of assistive devices or adapted methods.
- Grooming utensils must be placed within reach before able to complete grooming activities. 1.
- Someone must assist the patient to groom self.
 - Patient depends entirely upon someone else for grooming needs.

M1810. Current Ability to Dress <u>Upper</u> Body safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps.

Enter Code



- Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
- 1. Able to dress upper body without assistance if clothing is laid out or handed to the patient.
- 2. Someone must help the patient put on upper body clothing.
- 3. Patient depends entirely upon another person to dress the upper body.

M1820. Current Ability to Dress <u>Lower</u> Body safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes.

Enter Code

Χ



- 0. Able to obtain, put on, and remove clothing and shoes without assistance.
- 1. Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
- 2. Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.
 - B. Patient depends entirely upon another person to dress lower body.

M1830. Bathing

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

Enter Code



- 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, <u>but</u> 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.

M1840. Toilet Transferring

Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.

Enter Code



- O. Able to get to and from the toilet and transfer independently with or without a device.
- 1. When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.
- 2. Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).
- 3. <u>Unable</u> to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
- 4. Is totally dependent in toileting.

M1845. Toileting Hygiene

Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.

Enter Code



- 0. Able to manage toileting hygiene and clothing management without assistance.
- 1. Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.
- 2. Someone must help the patient to maintain toileting hygiene and/or adjust clothing.
- 3. Patient depends entirely upon another person to maintain toileting hygiene.

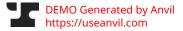
M1850. Transferring

Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

Enter Code



- 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.



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.

Enter Code

M-18-

60

Am-

bulat-

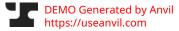
ion /1 -

- 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).
 - 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.
- 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.
- 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.
- Chairfast, unable to ambulate and is unable to wheel self.
- Bedfast, unable to ambulate or be up in a chair.

Section GG | Functional Abilities

0-			
GG0100: Prior Functioning: Everyday Activities			
Indicate the patient's usual ability with everyday activities prior to	the current illness, ex	acerbation, or injury.	
Co-			
de	l Enter co	ode in boxes	
	₩ Enter Co	ode ili boxes	
 Independent – Patient completed all the activities by themself, with or without an assistive device, with no 	ior Func <mark>tio</mark> ning Self	A. Self Care: Code the patient's need for assistance with bathing, dressing, Care sing the toilet, and eating prior to the current illness, exacerbation, or injury.	
 assistance from a helper. Needed Some Help – Patient needed partial assistance from another person to complete any activities GGD 00 Prior Dependent – A helper completed all the activities for the patient. Unknown 	Function <mark>ing</mark> Indoor	B. Indoor Mobility (Ambulation): Code the patient's need for assistance with walking from room to room (with or without a device such as cane, crutch or walker) prior to the current illness, exacerbation, or injury.	
Not Applicable Lorem ipsum dolor sit amet, consectetur adipiscing	Prior Fun <mark>cti</mark> oning St	C. Stairs: Code the patient's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.	
GG0100 Prior Fu	nctionin <mark>g F</mark> unctiona	D. Functional Cognition: Code the patient's need for assistance with planning regular tasks, such as Coghoping ordermembering to take medication prior to the current illness, exacerbation, or injury.	

GG0110. Prior	GG0110. Prior Device Use		
Indicate device	es and aids used by the patient prior to the current illness, exacerbation, or injury.		
↓	Check all that apply		
X	A. Manual wheelchair		
	B. Motorized wheelchair and/or scooter		
	C. Mechanical lift		
	D. Walker		
	E. Orthotics/prosthetics		
	Z. None of the above Document Footer		



SOC/ROC

GG0130. Self-Care

Code the patient's usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason.

Coding:

Safety and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

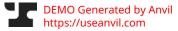
- 06. Independent Patient completes the activity by themself with no assistance from a helper.
- 05. **Setup or clean-up assistance** Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
- 04. **Supervision or touching assistance** Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
- 03. **Partial/moderate assistance** Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
- 02. **Substantial/maximal assistance** Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- 01. **Dependent** Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

- 07. Patient refused
- 09. **Not applicable** Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
- 10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)
- 88. Not attempted due to medical conditions or safety concerns

	56. Not attempted due to medical conditions of surety conterns		
1. SOC/ROC Performance	SOC/ROC Performance - Enter Codes in Boxes		
Enter Codes in Boxes ↓	SOC/ROC Performance - Enter Codes in Boxes (continued)		
Eatin- g - SOC/	A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.		
Root Paygi-	B. Oral Hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from mouth, and manage denture soaking and rinsing with use of equipment.		
SOME Blacki-	C. Toileting Hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.		
Short	E. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.		
E PATE - SETTI-	F. Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable		
Eleng-	G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.		
SOME SOME Port-	H. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.		

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Follow-up

GG0130. Self-Care

Code the patient's usual performance at Follow-up for each activity using the 6-point scale. If activity was not attempted at Follow-up, code the reason.

Coding:

Safety and Quality of Performance – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

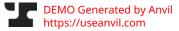
- 06. Independent Patient completes the activity by themself with no assistance from a helper.
- 05. **Setup or clean-up assistance** Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
- 04. **Supervision or touching assistance** Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
- 03. **Partial/moderate assistance** Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
- 02. **Substantial/maximal assistance** Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- 01. **Dependent** Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

- 07. Patient refused
- 09. **Not applicable** Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
- 10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)
- 88. Not attempted due to medical conditions or safety concerns

4. Follow-up Performance	Follow up Berformance Entry Area
Enter Codes in Boxes ↓	Follow-up Performance Entry Area
Eatin- g Perf-	A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.
Onal- Hiyot- Ende	B. Oral Hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from mouth, and manage denture soaking and rinsing with use of equipment.
Parities Arrigan Profis Code	C. Toileting Hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.

ance Code Box



Discharge

GG0130. Self-Care

Code the patient's usual performance at Discharge for each activity using the 6-point scale. If activity was not attempted at Discharge, code the reason.

Coding:

Safety and Quality of Performance – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

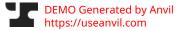
- 06. Independent Patient completes the activity by themself with no assistance from a helper.
- 05. **Setup or clean-up assistance** Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
- 04. **Supervision or touching assistance** Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
- 03. **Partial/moderate assistance** Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
- 02. **Substantial/maximal assistance** Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- 01. **Dependent** Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

- 07. Patient refused
- 09. **Not applicable** Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
- 10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)
- 88. Not attempted due to medical conditions or safety concerns

33. 1101 4110	inpled due to medical conditions of safety concerns
3. Discharge Performance	Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do eiusmod tempor.
Enter Codes in	
Boxes	
↓	
Disc- harg-	A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.
Désé- bang- ence	B. Oral Hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from mouth, and manage denture soaking and rinsing with use of equipment.
Diff- Diff- narg- gnce	C. Toileting Hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
Pisci- avid- ane-	E. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
Pist- being- tinge	F. Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable
Pigrofi-	G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.
Beiter-	H. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

Body Dunce Sody Budeti=



SOC/ROC

GG0170. Mobility

Code the patient's usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason.

Coding:

Safety and Quality of Performance – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

- 06. Independent Patient completes the activity by themself with no assistance from a helper.
- 05. **Setup or clean-up assistance** Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
- 04. **Supervision or touching assistance** Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
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- 01. **Dependent** Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

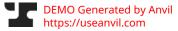
If activity was not attempted, code reason:

- 07. Patient refused
- 09. **Not applicable** Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
- 10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)
- 88. Not attempted due to medical conditions or safety concerns

1. SOC/ROC Performance	Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do eiusmod tempor.
Enter Codes in Boxes ↓	
Roll left	A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
giteo right	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
Lying	C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed with no back support.
siltig- Stand	D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
Side Chair of 70ed-	E. Chair/bed-to-chair transfer The ability to transfer to and from a bed to a chair (or wheelchair).
To let	F. Toilet transfer: The ability to get on and off a toilet or commode.
efan-	G. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
Walk 10	 I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If SOC/ROC performance is coded 07, 09, 10 or 88 → Skip to GG0170M, 1 step (curb)
₩	J. Walk 50 feet with two turns: Once standing, the ability to walk 50 feet and make two turns.
to atk	K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.
Walk- tugns	L. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.

SOC/ROC GO	60170. Mobility — Continued
1. SOC/ROC Performance Enter Codes in Boxes	SOC/ROC Performance Enter Codes in Boxes
M 1	 M. 1 step (curb): The ability to go up and down a curb or up and down one step. If SOC/ROC performance is coded 07, 09, 10 or 88 → Skip to GG0170P, Picking up object.
M. H. Steps	 N. 4 steps: The ability to go up and down four steps with or without a rail. If SOC/ROC performance is coded 07, 09, 10 or 88 → Skip to GG0170P, Picking up object.
0.	O. 12 steps: The ability to go up and down 12 steps with or without a rail.
s teps Picki-	P. Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
ng up obje- ct	Q. Does patient use wheelchair and/or scooter? 0. No → Skip to M1600, Urinary Tract Infection 1. Yes → Continue to GG170R, Wheel 50 feet with two turns
R. Whe-	R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
RR1el 50 Indicate the typowith when the	RR1. Indicate the type of wheelchair or scooter used 1. Manual 2. Motorized
or segroter	S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
SS1el Indicate the type of wheelchair	SS1. Indicate the type of wheelchair or scooter used 1. Manual 2. Motorized

or scooter used



Follow-up

GG0170. Mobility

Code the patient's usual performance at Follow-up for each activity using the 6-point scale. If activity was not attempted at Follow-up code the reason.

Coding:

Safety and Quality of Performance – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

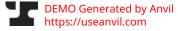
Activities may be completed with or without assistive devices.

- 06. Independent Patient completes the activity by themself with no assistance from a helper.
- 05. **Setup or clean-up assistance** Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
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- 02. **Substantial/maximal assistance** Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- 01. **Dependent** Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

- 07. Patient refused
- 09. **Not applicable** Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
- 10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)
- 88. Not attempted due to medical conditions or safety concerns

4. Follow-up Performance	Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do eiusmod tempor.
Enter Codes in Boxes ↓	
RdII left	A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
Sit to right	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
<u> </u>	C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed with no back support.
Siblica Scarce Stand	D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
Side GFlair Arm-	E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).
Dellet Dellet Dellet Uran-	F. Toilet transfer: The ability to get on and off a toilet or commode
Trans Walk Serie	I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If Follow-up performance is coded 07, 09, 10 or 88 → Skip to GG0170M, 1 step (curb)
Whi.	J. Walk 50 feet with two turns: Once standing, the ability to walk 50 feet and make two turns.
Wik-	L. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
TOTAL TELET DEFT SIED OUTTO	M. 1 step (curb): The ability to go up and down a curb or up and down one step. If Follow-up performance is coded 07, 09, 10 or 88 → Skip to GG0170Q, Does patient use wheelchair and/or scooter?



Follow-up GG0170. Mobility — Continued

Follow-up GG0170. Mobility — Continued			
4. Follow-up Performance	Follow-up GG0170 Mobility Section Header		
Enter Codes in Boxes ↓			
Follo- W-up	N. 4 steps: The ability to go up and down four steps with or without a rail.		
Follow Repf- Performance Enter Capdes in Boxes Nabel	Q. Does patient use wheelchair and/or scooter? 0. No → Skip to M1033, Risk of Hospitalization 1. Yes → Continue to GG170R, Wheel 50 feet with two turns R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.		
FEMILE WAS			

Discharge m-

GG0170 Mebility

Code the patient's usual performance at Discharge for each activity using the 6-point scale. If activity was not attempted at Discharge, 50de the reason.

Coding: Feet

Safety and quality of Performance – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

- 06. Independent Patient completes the activity by themself with no assistance from a helper.
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- 04. **Supervision or touching assistance** Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
- 03. **Partial/moderate assistance** Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
- 02. **Substantial/maximal assistance** Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- 01. **Dependent** Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

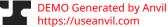
- 07. Patient refused
- 09. **Not applicable** Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
- 10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)
- 88. Not attempted due to medical conditions or safety concerns

	,
3. Discharge Performance	Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do eiusmod tempor.
Enter Codes in Boxes	
In Boxes ↓	
Disc- harg-	A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
Disc- Rert-	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
Bisc- pisc-	C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed with no back support.

Discharge G	G0170. Mobility — Continued	
X	D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.	
X	E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).	
X	F. Toilet transfer: The ability to get on and off a toilet or commode.	
X	G. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.	
X	 Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If Discharge performance is coded 07, 09, 10 or 88 → Skip to GG0170M, 1 step (curb) 	
X	J. Walk 50 feet with two turns: Once standing, the ability to walk 50 feet and make two turns.	
X	K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.	
X	L. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.	
X	 M. 1 step (curb): The ability to go up and down a curb or up and down one step. If Discharge performance is coded 07, 09, 10 or 88 → Skip to Skip to GG0170P, Picking up object. 	
X	N. 4 steps: The ability to go up and down four steps with or without a rail. If Discharge performance is coded 07, 09, 10 or 88 → Skip to GG0170P, Picking up object.	
X	O. 12 steps: The ability to go up and down 12 steps with or without a rail.	
X	P. Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.	
	Q. Does patient use wheelchair and/or scooter?	
X	0. No → Skip to M1600, Urinary Tract Infection	
	1. Yes → Continue to GG170R, Wheel 50 feet with two turns	
X	R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.	
	RR1. Indicate the type of wheelchair or scooter used	
X	1. Manual	
	2. Motorized	
X	S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.	
	SS1. Indicate the type of wheelchair or scooter used	
Χ	1. Manual	
	2. Motorized	
^		

X Section H Bladder and Bowel

M1600. Has this patient been treated for a Urinary Tract Infection in the past 14 days?				
Ur- in-		No Yes Patient on prophylactic treatment Unknown [Omit "UK" option on DC]		



M1610. Urinary Incontinence or Urinary Catheter Presence Enter Code D. No incontinence or catheter (includes anuria or ostomy for urinary drainage) Patient is incontinent Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic) M1620. Bowel Incontinence Frequency Enter Code D. Very rarely or never has bowel incontinence Less than once weekly Done to three times weekly Sour to six times weekly

M1630. Ostomy for Bowel Elimination

4. On a daily basis

5. More often than once daily

NA Patient has ostomy for bowel elimination UK Unknown [Omit "UK" option on DC]

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

Enter Code

Χ

- 0. Patient does not have an ostomy for bowel elimination.
- 1. Patient's ostomy was <u>not</u> related to an inpatient stay and did <u>not</u> necessitate change in medical or treatment regimen.
- 2. The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen.

Section I Active Diagnoses

M1021. Primary Diagnosis & M1023. Other Diagnoses				
Column 1	Column 2			
Diagnoses (Sequencing of diagnoses should reflect the serior ness of each condition and support the disciplines and service provided)				
M1021. Primary Diagnosis				
Primary Diagnosis a.	V, W, X, Y codes NOT allowed a. Primar-Primary X 0 1 2 3 4			
M1023. Other Diagnoses	Diagn- ICD-			
Other Diagnosis b	osis 10-CM ICD- Code Part 10-CM 2 All ICD-10-CM codes allowed b. Other X 0 1 2 3 4			
Other Diagnosis c	osis b b ICD- ICD- c. Other Databoots X 0 1 2 3 4			
Other Diagnosis d	Stagnos Stagno			
Other Diagnosis e e.	Bars de la Childre Diagnosis e ICD-10-CM Code e. Office Diagnosis e X 0 1 2 3 4			
Other Diagnosis f f.	other Diagnosis f ICD-10-CM Code f. Other Other X 0 1 2 3 4 Diagn- Diagnosis			

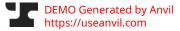
osis f

ICD-

10-CM

ICD-

10-CM



M1028. Active Diagnoses – Comorbidities and Co-existing Conditions		
→	Che	ck all that apply
X	1.	Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
	2.	Diabetes Mellitus (DM) Diabetes Mellitus (DM) - Specify
	3.	None of the above None of the above - Active Diagnoses - Specify

Section J Health Conditions

M1033. Risk for Hospitalization				
Which of the f	ollowing signs or symptoms characterize this patient as at risk for hospitalization?			
\	Check all that apply			
X	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 last 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			

J0510. Pain Effect on Sleep

Enter Code		
	J0- 51-	
	0.	
	Pa-	

in

Eff-

Ask patient: "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?" Does not apply — I have not had any pain or hurting in the past 5 days → Skip to M1400, Short of

- Breath at SOC/ROC; Skip to J1800, Any Falls Since SOC/ROC at DC
- Rarely or not at all 1.
- 2. Occasionally
- 3. Frequently
- 4. Almost constantly
- Unable to answer 8.

J0520. Pain Interference with Therapy Activities

Enter Code RP-**B**2-

0.

Pa-

in

In-

Ask patient: "Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain?"

- 1. Rarely or not at all
- 0. Does not apply I have not received rehabilitation therapy in the past 5 days Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do eiusmod
- 2. Occasionally
- tempor.
- 3. Frequently
- 4. **Almost constantly**
- Unable to answer 8.

J0530. Pain Interference with Day-to-Day Activities

Enter Code PD-

59-

wi-

Ask patient: "Over the past 5 days, how often you have limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?"

- 1. Rarely or not at all
- 2. Occasionally
- 3. Frequently
- Almost constantly 4.
- Unable to answer 8.

J1800 Any Falls Since SOC/ROC, whichever is more recent

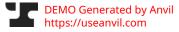
EnterCode

Has the patient had any falls since SOC/ROC, whichever is more recent?

- 0. No → Skip to M1400, Short of Breath at DC; Skip to M2005, Medication Intervention at TRN and DAH
- 1. Yes → Continue to J1900, Number of Falls Since SOC/ROC

nttps://useanvil.com				
J1900. Number of Falls Since SOC/ROC, whichever is more recent				
	↓ Enter code in boxes			
Coding: 0. None	X the nurse or pi	No evidence of any injury is noted on physical assessment by r primary care clinician; no complaints of pain or injury by the change in the patient's behavior is noted after the fall		
 One Two or more 		major): Skin tears, abrasions, lacerations, superficial bruises, and sprains; or any fall-related injury that causes the patient to in		
		Bone fractures, joint dislocations, closed head injuries with iousness, subdural hematoma		
M1400. When is the patient dysp	neic or noticeably Short of Breath?			
 Enter Code Sh-or-t				
hr	ng/Nutritional Status			
M1060. Height and Weight — Wh	ile measuring, if the number is X.1-	X.4 round down; X.5 or greater round up.		
A. Height (in inches). Record most recent height measure since the most recent SOC/ROC inches				
12, de2, 12, 34-34-34-5 pounds 5 B. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard agency practice (for example, in a.m. after voiding, before meal, with shoes off, etc.)				
SOC/ROC				
K0520. Nutritional Approaches				
1. On Admission Check all of the nutritional approaches that apply on admission 1. On Admission On Admission				
Check all that apply ↓				
A. Parenteral/IV feeding		X		
B. Feeding tube (e.g., nasogastri	ic or abdominal (PEG))			
 Mechanically altered diet — or liquids (e.g., pureed food, t 	require change in texture of food hickened liquids)			
D. Therapeutic diet (e.g., low sal	D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)			
Z. None of the above				

Discharge				
K0520. Nutritional Approaches				
 4. 5. 	Last 7 days Check all of the nutritional approaches that were received in the last 7 days At discharge Check all of the nutritional approaches that were being received at discharge	4. Last 7 days ↓ Check all t Check all that apply	5. At discharge At discharge hat apply ↓	
Α.	Parenteral/IV feeding	X	X	
В.	Feeding tube (e.g., nasogastric or abdominal (PEG))			
C.	Mechanically altered diet — require change in texture of food or liquids (e.g., pureed food, thickened liquids)			
D.	Therapeutic diet (e.g., low salt, diabetic, low cholesterol)			
Z.	None of the above			
Cur	870. Feeding or Eating rent ability to feed self meals and snacks safely. Note: This refparing the food to be eaten.	ers only to the process of <u>eating</u> , <u>c</u>	chewing, and swallowing, not	
	O. Able to independently feed self Able to feed self independently but requires: a. meal set-up; OR b. intermittent assistance or supervision from another person; OR c. a liquid, pureed, or ground meat diet. 2. Unable to feed self and must be assisted or supervised throughout the meal/snack. ed- ing or or Ea- Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy. Unable to take in nutrients orally or by tube feeding.			
Section M Skin Conditions M130@Does this patient have at least one Unhealed Pressure Ulcer/Injury at Stage 2 or Higher or designated as Unstageable? (Excludes Stage 1 pressure injuries and all healed pressure ulcers/injuries)				
Enter Code O. No → Skip to M1322, Current Number of Stage 1 Pressure Injuries at SOC/ROC; Skip to M1324, Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable at DC 1. Yes				
M1		charge: (Excludes healed Stage 2 p	ressure ulcers)	
Er	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: 1. Vas present at the most recent SOC/ROC assessment. Record date pressure ulcer first identified: 1. Vas present at the most recent SOC/ROC assessment. Record date pressure ulcer first identified: 1. Vas present at the most recent SOC/ROC assessment. Record date pressure ulcer first identified: 1. Vas present at the most recent SOC/ROC assessment. Record date pressure ulcer first identified: 1. Vas present at the most recent SOC/ROC assessment. Record date pressure ulcer first identified: 1. Vas present at the most recent SOC/ROC assessment. Record date pressure ulcer first identified: 1. Vas present at the most recent SOC/ROC assessment. Record date pressure ulcer first identified: 1. Vas present at the most recent SOC/ROC assessment. Record date pressure ulcer first identified: 1. Vas present at the most recent SOC/ROC assessment. Record date pressure ulcer first identified: 1. Vas present at the most recent SOC/ROC assessment. Record date pressure ulcer first identified: 1. Vas present at the most recent SOC/ROC assessment. Record date pressure ulcer first identified: 1. Vas present at the most recent SOC/ROC assessment. Record date pressure ulcer first identified: 1. Vas present at the most recent SOC/ROC assessment. Record date pressure ulcer first identified: 1. Vas present at the most recent SOC/ROC assessment. Record date pressure ulcer first identified: 1. Vas present at the most recent SOC/ROC assessment. Record date pressure ulcer first identified: 1. Vas present at the most recent SOC/ROC assessment. Record date pressure ulcer first identified: 1. Vas present at the most recent SOC/ROC assessment. Record date pressure ulcer first identified: 1. Vas present at the most recent SOC/ROC assessment. Record date pressure ulcer first identified: 1. Vas present at the most recent SOC/ROC assessment. Record date present at the most recen			
	2. Developed since the most recent SOC/RO 12, 12, 34- 34- 12, 34- 34- 34- 5Month Day 5 5 Year5 NA. No Stage 2 pressure ulcers are present at 8 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6			



SOC/ROC				
M1311. Current	M1311. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage			
Enter Number 12, 34-	A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. Number of Stage 2 pressure ulcers			
Enter Number B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muse exposed. Slough may be present but does not obscure the depth of tissue loss. May include under tunneling. Number of Stage 3 pressure ulcers				
Enter Number	C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. Number of Stage 4 pressure ulcers			
Enter Number	D1. Unstageable: Non-removable dressing/device: Known but not stageable due to non-removable dressing/device Number of unstageable pressure ulcers/injuries due to non-removable dressing/device			
Enter Number	E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar			
Enter Number 12, 34-	F1. Unstageable: Deep tissue injury Number of unstageable pressure injuries presenting as deep tissue injury			



Discharge					
M1311. Current	M1311. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage				
Enter Number 12, 34-	A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. Number of Stage 2 pressure ulcers — If 0 → Skip to M1311B1, Stage 3 Stage 2 pressure ulcer description				
Enter Number	A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC Stage 2 pressure ulcers at most recent SOC/ROC description				
Enter Number 12, 34- 5	B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Number of Stage 3 pressure ulcers — If 0 → Skip to M1311C1, Stage 4				
Enter Number 12, 34-	B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC				
12, 34-	C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. Number of Stage 4 pressure ulcers — If 0 → Skip to M1311D1, Unstageable: Non-removable dressing/device				
Enter Number 12, 34-	C2. Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC				
12, 34- 5	D1. Unstageable: Non-removable dressing/device: Known but not stageable due to non-removable dressing/device Number of unstageable pressure ulcers/injuries due to non-removable dressing/device — If 0 → Skip to M1311E1, Unstageable: Slough and/or eschar				
Enter Number 12, 34-	D2. Number of these unstageable pressure ulcers/injuries that were present at most recent SOC/ROC — enter how many were noted at the time of most recent SOC/ROC				
12, 34-	E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar — If 0 → Skip to M1311F1, Unstageable: Deep tissue injury				
Enter Number 12, 34-	E2. Number of these unstageable pressure ulcers/injuries that were present at most recent SOC/ROC — enter how many were noted at the time of most recent SOC/ROC				
Enter Number 12, 34- 5	F1. Unstageable: Deep tissue injury Number of unstageable pressure injuries presenting as deep tissue injury — If 0 → Skip to M1324, Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable				
Enter Number 12, 34-	F2. Number of these unstageable pressure injuries that were present at most recent SOC/ROC — enter how many were noted at the time of most recent SOC/ROC				

M1322. Current Number of Stage 1 Pressure Injuries

Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only, it may appear with persistent blue or purple hues.

Enter Code

0. Zero



- 1. One
- 2. Two
- Three 3.
- 4. Four or more

M1324. Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable

Excludes pressure ulcer/injury that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or deep tissue injury.

Enter Code

1. Stage 1



- Stage 2 2.
- Stage 3 3.
- 4. Stage 4
- NA Patient has no pressure ulcers/injuries or no stageable pressure ulcers/injuries

M1330. Does this patient have a Stasis Ulcer?

Enter Code

No → Skip to M1340, Surgical Wound



- Yes, patient has BOTH observable and unobservable stasis ulcers
- Yes, patient has observable stasis ulcers ONLY
- Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing/ device) → Skip to M1340, Surgical Wound

M1332. Current Number of Stasis Ulcer(s) that are Observable

Enter Code

1. One



2. Two

3.

Three

M1334 Status of Most Problematic Stasis Ulcer that is Observable

4. Four or more

M1334. Status of Most Problematic Stasis Ulcer that is Observable

Enter Code



Fully granulating

Early/partial granulation M1342 Status of Most Problematic Surgical Wound that is Observable 2.

3. Not healing

M1340. Does this patient have a Surgical Wound?

Enter Code

- 0. No → Skip to NO415, High-Risk Drug Classes: Use and Indication
- Yes, patient has at least one observable surgical wound



Surgical wound known but not observable due to non-removable dressing/device → Skip to NO415, High-Risk Drug Classes: Use and Indication

M1342. Status of Most Problematic Surgical Wound that is Observable

Enter Code



- Ο. Newly epithelialized
- **Fully granulating** 1.
- Early/partial granulation 2.
- 3. Not healing

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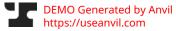
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OASIS 1 All Items Effective 01/01/2025 Centers for Medicare & Medicaid Services



Section N Medications

SOC/ROC and Discharge			
N0415. High-Risk Drug Classes: Use and Indication			
1.	Is taking Check if the patient is taking any medications by pharmacological classification, not how it is used, in the following	1. Is Taking	2. Indication Noted
2.			
	If Column 1 is checked, check if there is an indication noted for all medications in the drug class High-Risk Drug Classes Header		
Α.	Antipsychotic	X	X
E.	Anticoagulant		
F.	Antibiotic		
Н.	Opioid		
l.	Antiplatelet Label		
J.	Hypoglycemic (including insulin)		
Z.	None of the above		None of the above label
M2001. Drug Regimen Review Did a complete drug regimen review identify potential clinically significant medication issues? Enter Code M- 20- O. No — No issues found during review → Skip to M2010, Patient/Caregiver High-Risk Drug Education 1. Yes — Issues found during review 9. NA — Patient is not taking any medications → Skip to O0110, Special Treatments, Procedures, and Programs			
M20	01 003- Medication Follow-up		
	the agency contact a physician (or physician-designee) by micontact and actions in response to the identified potential clinical contact.		
Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do eiusmod tempor. 0. No 1. Yes			
	005. Medication Intervention		
	ted-agency contact and complete physician (or physician-desi		
O. No 1. Yes 9. NA — There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications			
M2010. Patient/Caregiver High-Risk Drug Education			
Has patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, antiquagulants, etc.) and how and when to report problems that may occur?			
Ent	O. No 1. Yes NA Patient not taking any high-risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications		

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M2020. Management of Oral Medications

<u>Patient's current ability</u> to prepare and take <u>all</u> oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. <u>Excludes</u> injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)

Enter Code



- 0. Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
- 1. Able to take medication(s) at the correct times if:
 - a. individual dosages are prepared in advance by another person; OR
 - b. another person develops a drug diary or chart.
- 2. Able to take medication(s) at the correct times if given reminders by another person at the appropriate times
- 3. <u>Unable</u> to take medication unless administered by another person.
- NA No oral medications prescribed.

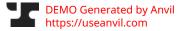
M2030. Management of Injectable Medications

<u>Patient's current ability</u> to prepare and take <u>all</u> prescribed injectable medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. <u>Excludes</u> IV medications.

Enter Code

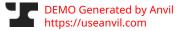


- 0. Able to independently take the correct medication(s) and proper dosage(s) at the correct times.
- 1. Able to take injectable medication(s) at the correct times if:
 - a. individual syringes are prepared in advance by another person; OR
 - b. another person develops a drug diary or chart.
- 2. Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection
- 3. <u>Unable</u> to take injectable medication unless administered by another person.
- NA No injectable medications prescribed.



Section O Special Treatment, Procedures, and Programs

SOC/ROC			
O0110. Special Treatments, Procedures, and Programs			
Check all of the following treatments, procedures, and programs that apply on admission.	a. On Admission Check all that apply ↓		
Cancer Treatments			
A1. Chemotherapy	X		
A2. I V			
A3. Oral			
A10. Other			
B1. Radiation			
Respiratory Therapies			
C1. Oxygen Therapy			
C2. Continuous			
C3. Intermittent			
C4. High-concentration			
D1. Suctioning			
D2. Scheduled			
D3. As Needed			
E1. Tracheostomy care			
F1. Invasive Mechanical Ventilator (ventilator or respirator)			
G1. Non-invasive Mechanical Ventilator			
G2. BiPAP			
G3. CPAP			
Other			
H1. IV Medications			
H2. Vasoactive medications			
H3. Antibiotics			
H4. Anticoagulation			
H10. Other			
I1. Transfusions			
J1. Dialysis			
J2. Hemodialysis			
J3. Peritoneal dialysis			
O1. IV Access			
O2. Peripheral			
O3. Mid-line			
O4. Central (e.g., PICC, tunneled, port)			
None of the Above			
Z1. None of the Above			



Discharge					
O0110. Special Treatments, Procedures, and Programs					
Check all of the following treatments, procedures, and programs that apply on discharge.	c. At Discharge Check all that apply ↓				
Cancer Treatments					
A1. Chemotherapy	X				
A2. IV	X				
A3. Oral					
A10. Other					
B1. Radiation					
Respiratory Therapies					
C1. Oxygen Therapy	X				
C2. Continuous	X				
C3. Intermittent					
C4. High-concentration					
D1. Suctioning	X				
D2. Scheduled	X				
D3. As Needed					
E1. Tracheostomy care	X				
F1. Invasive Mechanical Ventilator (ventilator or respirator)	X				
G1. Non-invasive Mechanical Ventilator	X				
G2. BiPAP	X				
G3. CPAP					
Other	Other Treatments				
H1. IV Medications	X				
H2. Vasoactive medications	X				
H3. Antibiotics	X				
H4. Anticoagulation	X				
H10. Other	X				
11. Transfusions	X				
J1. Dialysis	X				
J2. Hemodialysis	X				
J3. Peritoneal dialysis					
O1. IV Access	X				
O2. Peripheral	X				
O3. Mid-line					
O4. Central (e.g., PICC, tunneled, port)					
None of the Above					
Z1. None of the Above None of the Above Treatments	X				

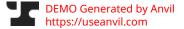
O0350. Patient's COVID-19 vaccination is up to date.

Enter Code

Χ

0. No, patient is not up to date1. Yes, patient is up to date

COVID-19 vaccination status description



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?

Enter Code



- 0. **No** → Skip to M2401, Intervention Synopsis
- 1. Yes → Continue to M1046, Influenza Vaccine Received

M1046. Influenza Vaccine Received

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

Enter Code



- 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.

Section Q Participation in Assessment and Goal Setting

M2401. Intervention Synopsis						
At the time of or at any time since the most recent SOC/ROC assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented? (Mark only one box in each row.)						
	Plan/Intervention	No	Yes	Not Applicable		
↓ Check only one box in each row ↓						
b.	Falls prevention interventions	X o		NA NA	Every standardized, validated multi-factor fall risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no risk for falls.	
c.	Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	× o	1	NA NA	Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the most recent SOC/ROC assessment indicates the 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.	
d.	Intervention(s) to monitor and mitigate pain	X o	1	NA NA	Every standardized, validated pain assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no pain.	
e.	Intervention(s) to prevent pressure ulcers	X o	1	NA NA	Every standardized, validated pressure ulcer risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient is not at risk of developing pressure ulcers.	
f.	Pressure ulcer treatment based on principles of moist wound healing	X o		□ NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.	