Winter Conference
Thursday, February 9, 2023
10:15am-3:45pm

1d. Assessment and Strategies and Support Tools for OASIS-E

Presented by:

Linda Krulish, PT, MHS, COS-C President, CEO, OASIS Answers, Inc.
and
Lori Marmon, PT, MBA, COS-C, Clinical Consultant, OASIS Answers, Inc.

Thank you to our event Sponsor:
Session Goal:
Provide strategies and tools to support field clinicians in integrating the new OASIS-E items into the comprehensive assessment process.

- Pairing this session with comprehensive OASIS data collection training will promote accuracy and efficiency.

ASSESSMENT STRATEGIES/TOOLS  +  OASIS DATA COLLECTION TRAINING
## Agenda

<table>
<thead>
<tr>
<th>Section</th>
<th>Activities</th>
</tr>
</thead>
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<tr>
<td>BIMS</td>
<td>Quick refresh of data collection rules, Introduction to training tools, Flip Book - Break-out Activity, Role-Playing Scenario Cards - Break-out Activity</td>
</tr>
<tr>
<td>PHQ-2 to 9</td>
<td>Quick refresh of data collection rules, Flip Book - Break-out Activity, Role-Playing Scenario Cards - Break-out Activity</td>
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<tr>
<td>CAM</td>
<td>Quick refresh of data collection rules, Role Playing Scenario Cards – Break-out Activity</td>
</tr>
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<td>SDOH</td>
<td>Quick refresh of data collection rules, Flip Book - Break-out Activity</td>
</tr>
<tr>
<td>Pain Interview</td>
<td>Quick refresh of data collection rules, Flip Book - Break-out Activity</td>
</tr>
</tbody>
</table>

## Train-the-Trainer:

### Materials:
- Presentation
- Flipbook
- Flipbook file (for printing)
- Role Playing Scenario Cards
- Role Playing Scenario Cards file (for printing)
- Answers for Role Playing activities

### Recorded session, available:
- for purchase from TAHCH
- only to attendees at today’s session
- only for the next 30 days
C0100: Should Brief Interview for Mental Status be Conducted? (BIMS)

- Most patients are able to attempt the Brief Interview for Mental Status (BIMS).
- Attempt to conduct the interview with ALL patients.
- Interact with the patient using their preferred language. Be sure the patient can hear you and/or has access to their preferred method for communication.
- Determine if the patient is rarely/never understood verbally, in writing, or using another method. If rarely/never understood: skip items C0200-C0500.
### C0200: Repetition of Three Words and C0300: Temporal Orientation

**C0200. Repetition of Three Words**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. None</td>
<td></td>
</tr>
<tr>
<td>1. One</td>
<td></td>
</tr>
<tr>
<td>2. Two</td>
<td></td>
</tr>
<tr>
<td>3. Three</td>
<td></td>
</tr>
</tbody>
</table>

Number of words repeated after the first attempt:

- 0. None
- 1. One
- 2. Two
- 3. 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)**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Able to report correct year</td>
<td></td>
</tr>
<tr>
<td>1. Missed by 1 year</td>
<td></td>
</tr>
<tr>
<td>2. Correct</td>
<td></td>
</tr>
</tbody>
</table>

**B. Able to report correct month**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Missed by &gt;1 month or no answer</td>
<td></td>
</tr>
<tr>
<td>1. Missed by 1-6 days</td>
<td></td>
</tr>
<tr>
<td>2. Accurate within 5 days</td>
<td></td>
</tr>
</tbody>
</table>

**C. Able to report correct day of the week**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Incorrect or no answer</td>
<td></td>
</tr>
<tr>
<td>1. Correct</td>
<td></td>
</tr>
</tbody>
</table>

### C0400: Recall and C0500: BIMS Summary Score

**C0400. Recall**

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.

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Able to recall “sock”</td>
<td></td>
</tr>
<tr>
<td>0. No – could not recall</td>
<td></td>
</tr>
<tr>
<td>1. Yes, after cueing (“something to wear”).</td>
<td></td>
</tr>
<tr>
<td>2. Yes, no cue required</td>
<td></td>
</tr>
</tbody>
</table>

**B. Able to recall “bed”**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No – could not recall</td>
<td></td>
</tr>
<tr>
<td>1. Yes, after cueing (“a color”).</td>
<td></td>
</tr>
<tr>
<td>2. Yes, no cue required</td>
<td></td>
</tr>
</tbody>
</table>

**C. Able to recall “bed”**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No – could not recall</td>
<td></td>
</tr>
<tr>
<td>1. Yes, after cueing (“a piece of furniture”).</td>
<td></td>
</tr>
<tr>
<td>2. Yes, no cue required</td>
<td></td>
</tr>
</tbody>
</table>

**C0500. BIMS Summary Score**

<table>
<thead>
<tr>
<th>Enter Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add scores for questions C0200-C0400 and fill in total score (00-15)</td>
<td></td>
</tr>
<tr>
<td>Enter 99 if the patient was unable to complete the interview</td>
<td></td>
</tr>
</tbody>
</table>
Basic Interview Instructions for the BIMS C0200-C0500

- Conduct the interview in a private setting if possible
- Be sure the patient can hear you
- Sit so that the patient can see your face
- Give an introduction before starting the interview
  
  "I would like to ask you some questions. We ask everyone these same questions. This will help us provide you with better care. Some of the questions may seem very easy, while others may be more difficult."

- Directly ask the patient each item in C0200 through C0400 at one sitting and in the order provided.
- If the patient chooses not to answer a particular item, accept their refusal and move on to the next questions.

Basic Interview Instructions for the BIMS C0200-C0500 IN WRITING

- Conduct the interview in a private setting if possible
- Patients with visual impairment should be tested using their usual visual aids.
- Same introduction, provision of questions in direct order and acceptance of refusal interview instructions apply
- The agency may develop their own signs for this process. If the agency develops their own, they must use the exact language as that used in the item set.
Basic Interview Instructions for the BIMS
C0200-C0500
Verbal and Written

- Code 0 is used to represent three types of responses:
  1. Incorrect responses
  2. Nonsensical responses, and
  3. Questions the patient chooses not to answer (or “refusals”).

- Since zeros resulting from these three situations are treated differently when coding the summary score in C0500, the assessing clinician may find it valuable to track the reason for the zero response to aid in accurately calculating the summary score.

Basic Interview Instructions for the BIMS
C0200-C0500
Verbal and Written

- If all responses to C0200 (Repetition of Three Words), C0300A, C0300B, and C0300C (Temporal Orientation) are 0 because answers are incorrect, continue the interview.

- Stop the interview after completing (C0300C) “Day of the Week” if:
  - All responses have been nonsensical OR
  - There has been no verbal or written response to any of the questions up to this point (refusals). OR
  - There has been no verbal or written response to some questions up to this point and for all others, the patient has given a nonsensical response.
Basic Interview Instructions for the BIMS C0200-C0500 Verbal and Written

- If the interview is stopped, do the following:

  Code "-" (dash) in C0400A, C0400B, and C0400C (Recall).

  Code 99 in the summary score in C0500.

C0200: Repetition of Three Words

<table>
<thead>
<tr>
<th>C0200. Repetition of Three Words</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Circle</td>
</tr>
<tr>
<td>Ask patient: &quot;I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are, sock, blue, and bed. Now tell me the three words.&quot;</td>
</tr>
<tr>
<td>Number of words repeated after first attempt</td>
</tr>
<tr>
<td>0. None</td>
</tr>
<tr>
<td>1. One</td>
</tr>
<tr>
<td>2. Two</td>
</tr>
<tr>
<td>3. Three</td>
</tr>
</tbody>
</table>

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.
C0200: Repetition of Three Words

- Assessing clinicians need to use the words and related category cues as indicated.
  
  "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed. "Now please tell me the three words."

- Record the maximum number of words that the patient correctly repeated on the first attempt. The words may be recalled in any order and in any context.

- After the patient’s first attempt to repeat the items, if the patient correctly stated all three words:
  
  “That’s right, the words are sock, something to wear; blue, a color; and bed, a piece of furniture” (category cues)

- If the patient recalled two or fewer words:
  
  “Let me say the three words again. They are sock, something to wear; blue, a color; and bed, a piece of furniture. Now tell me the three words.”

Three attempts. Do not code the number of repeated words on the second or third attempt.

- Code 0, none, if the patient did not repeat any of the 3 words on the first attempt.
- Code 1, one, if the patient repeated only 1 of the 3 words on the first attempt.
- Code 2, two, if the patient repeated only 2 of the 3 words on the first attempt.
- Code 3, three, if the patient repeated all 3 words on the first attempt.
C0300: Temporal Orientation

- Ask the patient each of the 3 questions in Item C0300 separately.

- Allow the patient up to 30 seconds for each answer and do not provide clues.

- If the patient specifically asks for clues (e.g., “Is this the day my daughter always visits?”) respond by saying,

  "I need to know if you can answer this question without any help from me."
C0300A: Able to Report Correct Year

"Please tell me what year it is right now,"

- **Code 0**, missed by >5 years or no answer, if the patient’s answer is incorrect and is greater than 5 years from the current year or the patient chooses not to answer the item.
- **Code 1**, missed by 2-5 years, if the patient’s answer is incorrect and is within 2 to 5 years from the current year.
- **Code 2**, missed by 1 year, if the patient’s answer is incorrect and is within one year from the current year.
- **Code 3**, correct, if the patient states the correct year.

C0300B: Able to Report Correct Month

"What month are we in right now?"

- **Code 0**, missed by >1 month or no answer, if the patient’s answer is incorrect by more than 1 month or if the patient chooses not to answer the item.
- **Code 1**, missed by 6 days to 1 month, if the patient’s answer is accurate within 6 days to 1 month.
- **Code 2**, accurate within 5 days, if the patient’s answer is accurate within 5 days, count current date as day 1.

*Count the current day as day 1 when determining whether the response was accurate within 5 days or missed by 6 days to 1 month.*
C0300C: Able to Report Correct Day of the Week

“What day of the week is it today?”

- Code 0, incorrect, or no answer, if the answer is incorrect or the patient chooses not to answer the item.
- Code 1, correct, if the answer is correct.

C0400: Recall

C0400: Recall

Enter Code
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”
   0. No – could not recall
   1. Yes, after cueing (“something to wear”)

B. Able to recall “book”
   0. No – could not recall
   1. Yes, after cueing (“a color”)

C. Able to recall “bed”
   0. No – could not recall
   1. Yes, after cueing (“a piece of furniture”)
C0400: Recall

“Let’s go back to an earlier question. What were those three words that I asked you to repeat?”

- Allow up to 5 seconds for spontaneous recall of each word
- For any word that is not correctly recalled after 5 seconds, provide the category cue used in C0200
  - “something to wear”
  - “a color”
  - “a piece of furniture”
- Category cues should be used only after the patient is unable to recall one or more of the three words.
- Allow up to 5 seconds after category cueing for each missed word to be recalled.

C0400: Recall

- **Code 0**, no—could not recall, if the patient cannot recall the word even after being given the category cue OR if the patient responds with a nonsensical answer OR chooses not to answer the item.

- **Code 1**, yes, after cueing, if the patient requires the category cue to remember the word.

- **Code 2**, yes, no cue required, if the patient correctly remembers the word spontaneously without cueing.
**C0500: BIMS Summary Score**

- After completing C0200-C0400: Add up the values for all questions from C0200 through C0400.
- To be considered a completed interview, the patient had to attempt and provide relevant answers to at least four of the questions included in C0200-C0400. To be relevant, a response only has to be related to the question (logical); it does not have to be correct.
- Code 99, unable to complete interview, if:
  - (a) the patient chooses not to participate in the BIMS,
  - (b) if four or more items were coded 0 because the patient chose not to answer or gave a nonsensical response, or
  - (c) if any but not all of the BIMS items is coded with a “-” (dash).
- Note: a zero score does not mean the BIMS was incomplete. To be incomplete, a patient had to choose not to answer or give completely unrelated, nonsensical responses to four or more items.
D0150: Patient Mood Interview (PHQ-2 to 9)

**D0150. Patient Mood Interview (PHQ-2 to 9)** (Copyright © Pfizer Inc. All rights reserved. Reproduced with permission)

*Say to patient: "Over the last 2 weeks, have you been bothered by any of the following problems?"

If symptom 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?"
Indicate your answer in column 2. Symptom Frequency.

<table>
<thead>
<tr>
<th>1. Symptom Presence</th>
<th>2. Symptom Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No (enter 0 in column 2)</td>
<td>0. Never or 1 day</td>
</tr>
<tr>
<td>1. Yes (enter 0-3 in column 2)</td>
<td>1. 2-4 days (several days)</td>
</tr>
<tr>
<td>2. 7-11 days (half or more of the days)</td>
<td></td>
</tr>
<tr>
<td>3. 12-14 days (nearly every day)</td>
<td></td>
</tr>
</tbody>
</table>

A. Little interest or pleasure in doing things
B. Feeling down, depressed, or hopeless
C. Trouble falling or staying asleep, or sleeping too much
D. Feeling tired or having little energy
E. Poor appetite or overeating
F. Feeling bad about yourself – or that you are a failure or have let yourself or your family down
G. Trouble concentrating on things, such as reading the newspaper or watching television
H. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual
I. Thoughts that you would be better off dead, or of hurting yourself in some way

**D0150 Mood Interview Instructions**

- Attempt to conduct the interview with ALL patients.
- Conduct the interview in a private setting, if possible.
- Interact with the patient using their preferred language.
- If the patient appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards.
- Explain the reason for the interview before beginning:

  "I am going to ask you some questions about your mood and feelings over the past 2 weeks. I will also ask about some common problems that are known to go along with feeling down. Some of the questions might seem personal, but everyone is asked to answer them. This will help us provide you with better care."

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D0150: Patient Mood Interview (PHQ-2 to 9) Interviewing Tips and Techniques

- Repeat a question if you think that it has been misunderstood or misinterpreted.
- If a person strays from the topic at hand, gently guide the conversation back to the topic.
- If the patient has difficulty selecting a frequency response, start by offering a single frequency response and follow with a sequence of more specific questions. This is known as unfolding.
- Noncommittal responses such as “not really” should be explored. Patients may be gently encouraged to tell you if the symptom bothered them. This is known as probing.
- Sometimes respondents give a long answer to interview items. To narrow the answer to the response choices available, it can be useful to summarize their longer answer and then ask them which response option best applies. This is known as echoing.

D0150 Mood Interview Instructions

- Explain and/or show the interview response choices. A cue card with the response choices clearly written in large print might help the patient comprehend the response choices.

  "I am going to ask you how often you have been bothered by a particular problem over the last 2 weeks. I will give you the choices that you see on this card." (Say while pointing to cue card): "0-1 days—never or 1 day, 2-6 days—several days, 7-11 days—half or more of the days, or 12-14 days—nearly every day."

- Read the item as it is written
- Don’t provided definitions as the meaning MUST BE based on the patient’s interpretation.
D0150: Patient Mood Interview (PHQ-2 to 9)

- Each question MUST BE asked in sequence to assess presence (column 1) and frequency (column 2) before proceeding to the next question.
- Ask the first two questions (D0150A & D0150B) of the Patient Mood Interview (PHQ-2 to 9).

"Over the last 2 weeks, have you been bothered by any of the following problems?"

<table>
<thead>
<tr>
<th>1. Symptom Presence</th>
<th>2. Symptom Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No (enter 0 in column 2)</td>
<td>0. Never or 1 day</td>
</tr>
<tr>
<td>1. Yes (enter 0-3 in column 2)</td>
<td>1. 2-6 days (several days)</td>
</tr>
<tr>
<td>9. No response (leave column 2 blank)</td>
<td>2. 7-11 days (half or more of the days)</td>
</tr>
<tr>
<td>9. No response (leave column 2 blank)</td>
<td>3. 12-14 days (nearly every day)</td>
</tr>
<tr>
<td>A. Little interest or pleasure in doing things</td>
<td></td>
</tr>
<tr>
<td>B. Feeling down, depressed, or hopeless</td>
<td></td>
</tr>
</tbody>
</table>

- **Code 0**, no: if patient indicates symptoms listed are not present. Enter 0 in Column 2 – Symptom Frequency, as well.
- **Code 1**, yes: if patient indicates symptom listed is present. Enter 0, 1, 2, or 3 in Column 2 - Symptom Frequency.
- **Code 9**, no response, if the patient was unable or chose not to complete the interview or responded nonsensically. Leave Column 2 - Symptom Frequency, blank.
- **Dash** is a valid response for this item. Enter a Dash in Column 1 if the symptom presence was not assessed. Leave Column 2 - Symptom Frequency, blank.

  - Dash indicates “no information.” CMS expects dash use to be a rare occurrence.
D0150: Patient Mood Interview (PHQ-2 to 9)

Coding Instructions

Column 2 - Symptom Frequency

- **Code 0**, never or 1 day, if the patient indicates that during the past 2 weeks they have never been bothered by the symptom or have only been bothered by the symptom on 1 day.
- **Code 1**, 2-6 days (several days), if the patient indicates that during the past 2 weeks they have been bothered by the symptom for 2-6 days.
- **Code 2**, 7-11 days (half or more of the days), if the patient indicates that during the past 2 weeks they have been bothered by the symptom for 7-11 days.
- **Code 3**, 12-14 days (nearly every day), if the patient indicates that during the past 2 weeks they have been bothered by the symptom for 12-14 days.
- **Dash** is not a valid response for this item.

If no assessment is conducted for Symptom Presence, enter a **dash (–)** in Column 1 and skip Column 2 in each row of D0150A-I, then code 99 for D0160 - Total Severity Score.

- A **dash (–)** is a valid response for **D0150 Column 1**: Symptom Presence.
- A **dash (–)** is not a valid response for **D0150 Column 2**: Symptom Frequency or **D0160 - Total Severity Score**.

**D0150: Patient Mood Interview (PHQ-2 to 9)**

Say to patient: “Over the last 2 weeks, have you been bothered by any of the following problems?”

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**
   - No (enter 0 in column 2)
   - Yes (enter 0-3 in column 2)
   - No response (leave column 2 blank).

2. **Symptom Frequency**
   - Never or 1 day
   - 2-6 days (several days)
   - 7-11 days (half or more of the days)
   - 12-14 days (nearly every day)

**A. Little interest or pleasure in doing things**

**B. Feeling down, depressed, or hopeless**
D0150: Patient Mood Interview (PHQ-2 to 9)

Coding Tips

Column 2 - Symptom Frequency

- If the patient has difficulty selecting between two frequency responses, code for the higher frequency.
- Some items contain more than one phrase. If a patient gives different frequencies for the different parts of a single item, select the highest frequency as the score for that item.
  
  *For example: Poor appetite or overeating*
- Patients may respond to questions:
  - verbally,
  - by pointing to their answers on the cue card, OR
  - by writing out their answers

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Whether or not further evaluation of a patient’s mood is needed depends on the patient’s responses to the PHQ-2 (D0150A and D0150B).

- If both D0150A1 and D0150B1 are coded 9, leave D0150A2 and D0150B2 blank, then end the PHQ-2 and skip D0160, Total Severity Score.
- If both D0150A2 and D0150B2 are coded 0 or 1 then end the PHQ-2 and enter the total sum of D0150A2 and D0150B2 in D0160, Total Severity Score.

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<table>
<thead>
<tr>
<th>1. Symptom Presence</th>
<th>2. Symptom Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No (enter 0 in column 2)</td>
<td>0. Never or 1 day</td>
</tr>
<tr>
<td>1. Yes (enter 0-3 in column 2)</td>
<td>1. 2-6 days (several days)</td>
</tr>
<tr>
<td>9. No response (leave column 2 blank)</td>
<td>2. 7-11 days (half or more of the days)</td>
</tr>
<tr>
<td></td>
<td>3. 12-14 days (nearly every day)</td>
</tr>
</tbody>
</table>

A. Little interest or pleasure in doing things

B. Feeling down, depressed, or hopeless
D0150: Patient Mood Interview (PHQ-2 to 9)

- For all other scenarios proceed to ask the remaining seven questions (D0150C to D0150I) of the PHQ-9 and complete D0160, Total Severity Score.

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

Say to patient: “Over the last 2 weeks, have you been bothered by any of the following problems?”

If symptom 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?”

<table>
<thead>
<tr>
<th>Symptom Presence</th>
<th>Symptom Frequency</th>
<th>Symptom Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>0: No (enter 0 in Column 2)</td>
<td>Never or 1 day</td>
<td>P-2-4 days (several days)</td>
</tr>
<tr>
<td>1: No response (leave Column 2 blank)</td>
<td>2-3 days (half of the day)</td>
<td>3 or 4 days (most days)</td>
</tr>
<tr>
<td>2: Little interest or pleasure in doing things</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3: Feeling down, depressed, or hopeless</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If Column 1 equals 0, enter 0 in Column 2.

If Column 1 equals a 1, enter a 0, 1, 2 or 3 in Column 2.

If Columns 1 equals 9 or dash, leave Column 2 blank.

If a symptom presence item is not assessed, code Column 1 with a dash and leave Column 2 blank.

D0150: Patient Mood Interview (PHQ-2 to 9) Coding Tips Recap

- If Column 1 equals 0, enter 0 in Column 2.
- If Column 1 equals a 1, enter a 0, 1, 2 or 3 in Column 2.
- If Columns 1 equals 9 or dash, leave Column 2 blank.
- If a symptom presence item is not assessed, code Column 1 with a dash and leave Column 2 blank.
D0160: Total Severity Score

**D0160. TotalSeverity Score**

<table>
<thead>
<tr>
<th>Enter Score</th>
<th>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).</th>
</tr>
</thead>
</table>

- If only the PHQ-2 is completed because both D0150A1 and D0150B1 are coded 9, leave D0150A2 and D0150B2 blank, then end the PHQ interview and skip D0160, Total Severity Score.
- If only the PHQ-2 is completed because both D0150A2 and D0150B2 are coded 0 or 1, add the numeric scores from these two frequency items and enter the value in D0160, Total Severity Score.
- If the PHQ-9 was completed (D0150C-I were not skipped due to the responses in D0150A and B), and if the patient answered the frequency responses of at least 7 of the 9 items on the PHQ-9; add the numeric scores from D0150A2-D0150I2 and enter in D0160 Total Severity Score.
  
  *See guidance manual for score reweighting when symptom frequency is blank for 1 or 2 items.
- If symptom frequency is blank for 3 or more items, the interview is deemed NOT complete. D0160, Total Severity Score should be coded as “99”
- The Total Severity Score will be between 00 and 27 (or “99” if symptom frequency is blank for 3 or more items).
CUE CARDS & CLINICIAN SCRIPT FLIP BOOK
PHQ-2 to 9
Breakout session

ROLE PLAY SCENARIO CARDS
PHQ-2 to 9
Breakout session
C1310: Signs and Symptoms of Delirium (CAM)

Delirium is defined as a mental disturbance characterized by new or acutely worsening confusion, disordered expression of thoughts, change in level of consciousness or hallucinations.

Examples of acute mental status changes include:

- A patient who is usually noisy or belligerent becomes quiet, lethargic, or inattentive.
- A patient who is normally quiet and content suddenly becomes restless or noisy.
- A patient who is usually able to find their way around their living environment begins to get lost.
C1310: Signs and Symptoms of Delirium

- Observe patient behavior during the assessment for the signs and symptoms of delirium.
- Review medical record documentation and consult with other staff, family members/caregivers and others in a position to determine the patient’s baseline status compared to status on the day of assessment.
- Consider all relevant information and use clinical judgment to determine if an acute change in mental status has occurred.

C1310A: Acute Mental Status Change

<table>
<thead>
<tr>
<th>A. Acute Onset of Mental Status Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
</tr>
<tr>
<td>0. No</td>
</tr>
</tbody>
</table>

- **Code 0**, no, if there is no evidence of acute mental status change from the patient’s baseline.
- **Code 1**, yes, if patient has an alteration in mental status observed or reported or identified that represents an acute change from baseline.
- Dash is a valid response for this item. Dash indicates “no information.” CMS expects dash use to be a rare occurrence.
C1310B, C1310C, and C1310D

**Coding:**

- 0. Behavior not present
- 1. Behavior continuously present, does not fluctuate
- 2. Behavior present, fluctuates (comes and goes, changes in severity)

- Fluctuation: The behavior tends to come and go, and/or increase or decrease in severity. The behavior may fluctuate over the course of the interview or during the assessment period. Fluctuating behavior may be noted by the assessing clinician, reported by staff or family or documented in the medical record.

C1310B: Inattention

- B. **Inattention** – Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?

- Inattention is the reduced ability to maintain attention to external stimuli and to appropriately shift attention to new external stimuli. Patient seems unaware or out of touch with environment.
- For example, being dazed, fixated or darting attention
- Assess attention separately from level of consciousness.
C1310B: Inattention

- **Code 0**, behavior not present, if the patient remains focused during the assessment and all other sources agree that the patient was attentive during other activities.

- **Code 1**, behavior continuously present, does not fluctuate, if the patient had difficulty focusing attention, was easily distracted, or had difficulty keeping track of what was said AND the inattention did not vary. All sources must agree that inattention was consistently present to select this code.

- **Code 2**, behavior present, fluctuates, if inattention is noted during the assessment or any source reports that the patient had difficulty focusing attention, was easily distracted, or had difficulty keeping track of what was said AND the inattention varied or if information sources disagree in assessing level of attention.

- Dash is a valid response for this item.

  Dash indicates “no information.” CMS expects dash use to be a rare occurrence.

C1310C: Disorganized Thinking

- Disorganized thinking is evidenced by rambling, irrelevant or incoherent speech.

- Even if responses are incorrect if the patient’s answer was related to the question, it is not reflective of disorganized thinking.
C1310C: Disorganized Thinking

- **Code 0**, behavior not present, if all sources agree that the patient’s thinking was organized and coherent, even if answers were inaccurate or wrong.

- **Code 1**, behavior continuously present, does not fluctuate, if, during the assessment and according to other sources, the patient’s responses were consistently disorganized or incoherent, conversation was rambling or irrelevant, ideas were unclear or flowed illogically, or the patient unpredictably switched from subject to subject.

- **Code 2**, behavior present, fluctuates, if, during the assessment or according to other data sources, the patient’s responses fluctuated between disorganized/incoherent and organized/clear. Also, code as fluctuating if information sources disagree.

- Dash is a valid response for this item.
  
  Dash indicates “no information.” CMS expects dash use to be a rare occurrence.

C1310D: Altered Level of Consciousness

- Altered Level of Consciousness Definitions:
  
  **Vigilant**: startles easily to any sound or touch
  
  **Lethargic**: repeatedly dozes off when you are asking questions but responds to voice or touch
  
  **Stupor**: very difficult to arouse and keep aroused for the interview
  
  **Comatose**: cannot be aroused despite shaking and shouting
C1310D: Altered Level of Consciousness

- **Code 0**, behavior not present, if all sources agree that the patient was alert and maintained wakefulness during conversation, interview(s), and activities.
- **Code 1**, behavior continuously present, does not fluctuate, if, during the assessment and according to other sources, the patient was consistently lethargic, stuporous, vigilant, or comatose.
- **Code 2**, behavior present, fluctuates, if, during the assessment or according to other sources, the patient’s level of consciousness varied. For example, the patient was at times alert and responsive, while at other times the patient was lethargic, stuporous, or vigilant. Code as fluctuating if information sources disagree.
- Dash is a valid response for this item.
  
  Dash indicates “no information.” CMS expects dash use to be a rare occurrence.

---

**ROLE PLAY SCENARIO CARDS**

**C1310 Breakout session**
A1005: Ethnicity

- **Introduction**

  "We want to make sure that all our patients get the best care possible, regardless of their ethnic background."

- **Ask the patient**

  "Are you of Hispanic, Latino/Latina or Spanish origin?"

- **Then ask the patient to select the category or categories that most closely corresponds to the patient’s ethnicity from the list in A1005, Ethnicity.**

- **If the patient can provide a response:**
  - Check all that apply
  - Check the box(es) indicating the ethnic category or categories identified by the patient.
A1005: Ethnicity

- If a patient is unable to respond, a proxy response may be used.
- If neither the patient nor a proxy is able to provide a response to this item, use medical record documentation.
- Code X, Patient unable to respond, if the patient is unable to respond.
  - If the response(s) is/are determined via proxy input, and/or medical record documentation, check all boxes that apply, including Code X - Patient unable to respond.
  - If the patient is unable to respond and no other resources (proxy input or medical record documentation) provided the necessary information, Code X – Patient unable to respond, only.

- If a patient declines to respond, do not code based on proxy response or medical record documentation.
- Code Y, Patient declines to respond, if the patient declines to respond.
  - In the cases where the patient declines to respond, Code Y – Patient declines to respond, only.
  - If the patient declines to respond, do not code based on a proxy input or medical record documentation.
- Dash is not a valid response for this item.
A1010: Race

Introduction

“We want to make sure that all our patients get the best care possible, regardless of their racial background.”

Ask the patient:

“What is your race?”

The ask the patient to select the category or categories that most closely correspond to the patient’s race from the list in A1010, Race.

If the patient can provide a response:

Check all that apply

Check the box(es) indicating the ethnic category or categories identified by the patient
A1010: Race

- If a patient is unable to respond, a **proxy response** may be used.
- If neither the patient nor a proxy is able to provide a response to this item, use **medical record documentation**.
- Code **X**, Patient unable to respond, if the patient is unable to respond.
  - If the response(s) is/are determined via proxy input, and/or medical record documentation, **check all boxes that apply**, **including Code X** - Patient unable to respond.
  - If the patient is unable to respond and no other resources (proxy input or medical record documentation) provided the necessary information, **Code X** – Patient unable to respond, only.

- If a patient **declines** to respond, do **not** code based on proxy response or medical record documentation.
- Code **Y**, Patient **declines** to respond, if the patient declines to respond.
  - In the cases where the patient declines to respond, **Code Y** – Patient declines to respond, **only**.
  - If the patient declines to respond, do not code based on a proxy input or medical record documentation.
- Code **Z**, None of the above, if the patient reports or it is determined from proxy or medical record documentation that none of the listed races apply to the patient.
- Dash is not a valid response for this item.
A1110: Language

A1110. Language

A. What is your preferred language?

B. Do you need or want an interpreter to communicate with a doctor or health care staff?
   0. No
   1. Yes
   9. Unable to determine

A1110A: What is your preferred language?

- Ask for the patient’s preferred language.
  The preferred language the patient primarily speaks or understands
- If the patient themselves – or with the assistance of an interpreter – is unable to respond to A1110A, What is your preferred language? a proxy response is permitted.
- If neither the patient nor a proxy is able to provide a response to A1110A, medical record documentation may be used.
- Enter the preferred language in A1110A or
- **Dash** is a valid response for this item.
  If the patient or any available source cannot or does not identify preferred language, enter a dash ("-") in the first box.
A1110B: Do you need or want an interpreter?

- Ask the patient
  
  "Do you need or want an interpreter to communicate with a doctor or health care staff?"

- If the patient themselves – or with the assistance of an interpreter – is unable to respond to A1110B, Do you need or want an Interpreter? a proxy response is permitted.

- If neither the patient nor a proxy is able to provide a response to A1110B, medical record documentation may be used.

A1110B: Do you need or want an interpreter?

- **Code 0**, No: if the patient indicates no want or need of an interpreter to communicate with a doctor or health care staff.

- **Code 1**, Yes: if the patient indicates the need or want of an interpreter to communicate with a doctor or health care staff. Ensure that preferred language is indicated.

- **Code 9**, Unable to determine: if no source can identify whether the patient needs or wants an interpreter.

- Dash is **not** a valid response for this item.
A1250: Transportation

Ask the patient:

“In the past six months to a year, has lack of transportation kept you from medical appointments or from getting your medications?”

“In the past six months to a year, has lack of transportation kept you from non-medical meetings, appointments, work, or from getting things that you need?”

Check all that apply

Patient should be offered the option of selecting more than one yes designation, if applicable.
A1250: Transportation

- **Code A**, Yes, if the patient indicates that lack of transportation has kept the patient from medical appointments or from getting medications.
- **Code B**, Yes, if the patient indicates that lack of transportation has kept the patient from non-medical meetings, appointments, work, or from getting things that the patient needs.
- **Code C**, No, if the patient indicates that a lack of transportation has not kept the patient from medical appointments, getting medications, non-medical meetings, appointments, work, or getting things that the patient needs.

If the patient is unable to respond, a **proxy response** may be used.

If neither the patient nor a proxy is able to provide a response to this item, **medical record documentation** may be used.

**Code X**, Patient unable to respond, if the patient is unable to respond.

If the response(s) is/are determined via proxy input and/or medical record documentation, check all boxes that apply, including **Code X** - Patient unable to respond.

If the patient is unable to respond and no other resources (proxy or medical record documentation) provided the necessary information, **Code X** - Patient unable to respond, only.
A1250: Transportation

- If the patient declines to respond, do not code based on proxy input or medical record documentation.
- Code Y, Patient declines to respond, if the patient declines to respond.
- In the cases where the patient declines to respond, Code Y – Patient declines to respond, only.
- Dash is not a valid response for this item.

B1300: Health Literacy

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.</td>
<td>Never</td>
</tr>
<tr>
<td>1.</td>
<td>Rarely</td>
</tr>
<tr>
<td>2.</td>
<td>Sometimes</td>
</tr>
<tr>
<td>3.</td>
<td>Often</td>
</tr>
<tr>
<td>4.</td>
<td>Always</td>
</tr>
<tr>
<td>7.</td>
<td>Patient declines to respond</td>
</tr>
<tr>
<td>8.</td>
<td>Patient unable to respond</td>
</tr>
</tbody>
</table>
B1300: Health Literacy

- This item is intended to be a patient **self-report item**.
- No other source should be used to identify the response.
- Ask the patient:
  
  "How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?"

- **Code 0.** Never, if the patient indicates never needing help reading instructions, pamphlets, or other written materials from doctors or pharmacies.
- **Code 1.** Rarely, if the patient indicates rarely needing help reading instructions, pamphlets, or other written materials from doctors or pharmacies.
- **Code 2.** Sometimes, if the patient indicates sometimes needing help reading instructions, pamphlets, or other written materials from doctors or pharmacies.
- **Code 3.** Often, if the patient indicates often needing help reading instructions, pamphlets, or other written materials from doctors or pharmacies.
- **Code 4.** Always, if the patient indicates always needing help reading instructions, pamphlets, or other written materials from doctors or pharmacies.
- **Code 7.** Patient declines to respond, if the patient declines to respond.
- **Code 8.** Patient unable to respond, if the patient is unable to respond.
- **Dash** is not a valid response for this item.
D0700: Social Isolation

This item is intended to be a patient self-report item.

No other source should be used to identify the response.

Ask the patient:

“How often do you feel lonely or isolated from those around you?”
D0700: Social Isolation

- **Code 0**, Never, if the patient indicates never feeling lonely or isolated from others
- **Code 1**, Rarely, if the patient indicates rarely feeling lonely or isolated from others
- **Code 2**, Sometimes, if the patient indicates sometimes feeling lonely or isolated from others
- **Code 3**, Often, if the patient indicates often feeling lonely or isolated from others
- **Code 4**, Always, if the patient indicates always feeling lonely or isolated from others
- **Code 7**, Patient declines to respond, if the patient declines to respond
- **Code 8**, Patient unable to respond, if the patient is unable to respond
- **Dash** is not a valid response for this item
**J0510-J0530: Pain Interview**

- Give an introduction before starting the interview.
  
  "I’d like to ask you some questions about pain. The reason I am asking these questions is to understand how pain affects your sleep and activities. This will help us to develop the best plan of care to help manage your pain."

- Directly ask the patient each item in J0510 through J0530 in the order provided.

- Use other terms for pain or follow-up discussion if the patient seems unsure or hesitant. Some patients avoid use of the term “pain” but may report that they “hurt.” Patients may use other terms such as “aching” or “burning” to describe pain.
J0510- J0530: Pain Interview

- If the patient is unsure about whether the pain effect or interference occurred in the 5-day time interval, prompt the patient to think about the most recent episode of pain and try to determine whether it occurred within the look-back period.

- For the Pain Interview items (J0510-J0530) the day of assessment is considered day 0. The time period under consideration or “look back” for the pain interview item includes the day of assessment in addition to looking back over the last 5 days.

- **Code 8**, Unable to answer, if the patient is unable to answer the question, does not respond (refuses) or gives a nonsensical response.

- **Dash** is not a valid response for this item.

---

J0510: Pain Effect on Sleep

| Enter Code | Ask patient: “Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?”
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Rarely or not at all</td>
<td>Does not apply → 2. I have not had any pain or hurting in the past 5 days → Skip to M1400. Short of Breath at SOCP/ROC. Skip to J1800. Any falls since SOCP/ROC at DC</td>
</tr>
<tr>
<td>2. Occasionally</td>
<td>3. Frequently</td>
</tr>
<tr>
<td>4. Almost constantly</td>
<td>8. Unable to answer</td>
</tr>
</tbody>
</table>
J0510: Pain Effect on Sleep

- Read the question and response choices as written.
- No pre-determined definitions are offered to the patient. The response should be based on the patient’s interpretation of frequency response options.
- Ask the patient
  
  "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?"

- If the patient is unable to decide between 2 options, then the assessing clinician should code for the option with the higher frequency.

- Code 0, Does not apply, if the patient responds that they did not have any pain or hurting in the past 5 days.
- Code 1, Rarely or not at all, if the patient responds that pain has been present and the pain rarely or not at all made it hard to sleep in the past 5 days.
- Code 2, Occasionally, if the patient responds that pain has occasionally made it hard to sleep in the past 5 days.
- Code 3, Frequently, if the patient responds that pain has frequently made it hard to sleep in the past 5 days.
- Code 4, Almost constantly, if the patient responds that pain has almost constantly made it hard to sleep in the past 5 days.
- Code 8, Unable to answer, if the patient is unable to answer the question, does not respond or gives a nonsensical response.
J0510: Pain Effect on Sleep

- Dash is not a valid response for this item.

- The key difference between code 0, Does not apply and code 1, Rarely or not at all is that for code 0, the patient reports no pain/hurting in the past 5 days, and code 1, the patient reports pain/hurting HAS been present in the past 5 days, but has rarely or not at all impacted sleep.

- If the patient reports they had pain in the past 5 days and the pain does not interfere with the patient’s sleep (e.g., because the patient is using pain management strategies successfully), code 1, Rarely or not at all.

J0520: Pain Interference with Therapy Activities

<table>
<thead>
<tr>
<th>J0520. Pain Interference with Therapy Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
</tr>
<tr>
<td>------------</td>
</tr>
<tr>
<td>0</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>8</td>
</tr>
</tbody>
</table>
J0520: Pain Interference with Therapy Activities

- Read the question and response choices as written.
- No pre-determined definitions are offered to the patient. The response should be based on the patient’s interpretation of frequency response options.
- Confirm that the patient has been offered rehabilitation therapies during the reference timeframe.
- Ask the patient:
  
  "Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain?"

- If the patient is unable to decide between 2 options, then the assessing clinician should code for the option with the higher frequency.

Definition of Rehabilitation Therapy:

Rehabilitation Therapy includes but is not limited to special healthcare service or programs that help a person regain physical, mental, and or cognitive (thinking and learning) abilities that have been lost or impaired as a result of disease, injury or treatment. Can include, for example, any services provided by PT, OT, SLP, and cardiac and pulmonary therapies.

Rehabilitation therapies may include treatment supervised in person by a therapist or nurse or other staff, or the patient/family/caregivers carrying out a prescribed therapy program without agency staff present, regardless of the rehab focus or goal(s).
J0520: Pain Interference with Therapy Activities

- **Code 0.** Does not apply, if the patient responds that they did not participate in rehabilitation therapy for reasons unrelated to pain (e.g., therapy not needed, unable to schedule) in the past 5 days.
- **Code 1.** Rarely or not at all, if the patient responds that pain has rarely or not at all limited participation in rehabilitation therapy sessions in the past 5 days.
- **Code 2.** Occasionally, if the patient responds that pain has occasionally limited participation in rehabilitation therapy sessions in the past 5 days.
- **Code 3.** Frequently, if the patient responds that pain has frequently limited participation in rehabilitation therapy sessions in the past 5 days.
- **Code 4.** Almost constantly, if the patient responds that pain has almost constantly limited participation in rehabilitation therapy sessions in the past 5 days.
- **Code 8.** Unable to answer, if the patient is unable to answer the question, does not respond or gives a nonsensical response.
- **Dash** is not a valid response for this item.

J0530: Pain Interference with Day-to-day Activities

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Ask patient: “Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy session) because of pain?”</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Rarely or not at all</td>
</tr>
<tr>
<td>2.</td>
<td>Occasionally</td>
</tr>
<tr>
<td>3.</td>
<td>Frequently</td>
</tr>
<tr>
<td>4.</td>
<td>Almost constantly</td>
</tr>
<tr>
<td>8.</td>
<td>Unable to answer</td>
</tr>
</tbody>
</table>
J0530: Pain Interference with Day-to-day Activities

- Read the question and response choices as written.
- No pre-determined definitions are offered to the patient. The response should be based on the patient’s interpretation of frequency response options.
- Confirm that the patient has been offered rehabilitation therapies during the reference timeframe.
- Ask the patient

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

- If the patient is unable to decide between 2 options, then the assessing clinician should code for the option with the higher frequency.

---

J0530: Pain Interference with Day-to-day Activities

- **Code 1**, Rarely or not at all, if the patient responds that pain has rarely or not at all limited day-to-day activities (excluding rehabilitation therapy sessions) in the past 5 days.
- **Code 2**, Occasionally, if the patient responds that pain has occasionally limited day-to-day activities (excluding rehabilitation therapy sessions) in the past 5 days.
- **Code 3**, Frequently, if the patient responds that pain has frequently limited day-to-day activities (excluding rehabilitation therapy sessions) in the past 5 days.
- **Code 4**, Almost constantly, if the patient responds that pain has almost constantly limited day-to-day activities (excluding rehabilitation therapy sessions) in the past 5 days.
- **Code 8**, Unable to answer, if the patient is unable to answer the question, does not respond or gives a nonsensical response.
- **Dash** is not a valid response for this item.
CUE CARDS & CLINICIAN SCRIPT FLIP BOOK
Pain Interview Breakout session

PATIENT CASE STUDY
Consider each OASIS item individually... code based on guidance for that item
Scenario:

During Mrs. Jones SOC assessment, you review her active medication list from her referring physician which includes Hydrocodone PRN for back pain, per hospital discharge summary. Mrs. Jones shares that she keeps the med handy, her daughter cues her when she should take it, but hasn’t needed to take it since last week. Her only other oral medications include an antidepressant for sleeping problems and a multivitamin, both of which she has been taking independently for several months, demonstrating good knowledge of their dosing, timing and purpose.

Additionally, Mrs. Jones is compliant using her oxygen as ordered at 2L/min via nasal canula all during the day, only experiencing shortness of breath when going up and down the stairs. She reports to you that she places her nasal canula in upon awakening at 6:00 am, uses it all day, then removes it when she settles in for bed at 10:00 pm. She reports that when she gets up during the night to use the commode, she does not use her O2 and gets short of breath with toileting.

M2020: Management of Oral Medications

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.</td>
</tr>
<tr>
<td>1</td>
<td>Able to take medication(s) at the correct times if:</td>
</tr>
<tr>
<td>a.</td>
<td>Individual dosages are prepared in advance by another person; OR</td>
</tr>
<tr>
<td>b.</td>
<td>Another person develops a drug diary or chart.</td>
</tr>
<tr>
<td>2</td>
<td>Able to take medication(s) at the correct times if given reminders by another person at the appropriate times</td>
</tr>
<tr>
<td>3</td>
<td>Unable to take medication unless administered by another person.</td>
</tr>
<tr>
<td>M</td>
<td>No oral medications prescribed.</td>
</tr>
</tbody>
</table>

1. Hydrocodone PRN – needs reminder, last needed last week
2. Multivitamin - independent
3. Antidepressant - independent
N0415: High-Risk Drug Classes: Use and Indication

<table>
<thead>
<tr>
<th>N0415. High-Risk Drug Classes: Use and Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Is taking</strong> Check if patient is taking any medication by pharmacological classification, noted in the following classes</td>
</tr>
<tr>
<td><strong>2. Indication noted</strong> If Column 1 is checked, check if there is an indication noted for all medications in the drug class</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antipsychotic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anticoagulant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibiotic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opioid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antiplatelet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypoglycemic (including insulin)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None of the above</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Hydrocodone PRN – documented indication for back pain
2. Multivitamin
3. Antidepressant - sleeping problems

M1400: Dyspnea

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

1. Uses O2 continuously from 6:00 am – 10:00 pm
2. Experiences SOB w/O2, climbing stairs
3. Experiences SOB, w/o O2, toileting
00110: Special Treatments, Procedures and Programs

**Cancer Treatments**
- A1. Chemotherapy
- A2. IV
- A3. Oral
- A10. Other

**Respiratory Therapy**
- C1. Oxygen Therapy
- C2. Continuous
- C3. High/Intermediate

**General**
- D1. Suctioning
- D2. Scheduled
- D3. As needed

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<th>C. On Admission Check all that apply</th>
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1. Uses O2 continuously from 6:00 am – 10:00 pm
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FINAL TAKEAWAY

ASSESSMENT STRATEGIES/TOOLS + OASIS DATA COLLECTION TRAINING

= EFFICIENCY & ACCURACY!

RESOURCES:

OASIS DATA SET
HTTPS://WWW.CMS.GOV/FILES/ZIP/OASISFINALINSTRUMENTSEFFECTIVE112023.ZIP

OASIS-E MANUAL FINAL
HTTPS://WWW.CMS.GOV/FILES/DOCUMENT/OASIS-E-MANUAL-FINAL.PDF

OASIS QUARTERLY Q&A’S
HTTPS://QTSO.CMS.GOV/PROVIDERS/HOME-HEALTH-AGENCY-HHA-PROVIDERS/REFERENCE-MANUALS