OASIS ITEM

(M2401) Intervention Synopsis: (Check only **one** box in each row.) 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?

Plan / Intervention	No	Yes	Not Applicable	
a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	☐ 0	☐ 1	☐ NA	Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
b. Falls prevention interventions	☐ 0	☐ 1	☐ 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	☐ 0	☐ 1	☐ 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	☐ 0	☐ 1	☐ 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	☐ 0	☐ 1	☐ 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	☐ 0	☐ 1	☐ NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

ITEM INTENT

- Identifies if specific interventions focused on specific problems were both included on the physician-ordered home health Plan of Care AND implemented as part of care provided at the time of or at any time since the most recent SOC/ROC assessment. “Included in the physician-ordered Plan of Care” means that the patient condition was discussed and there was agreement as to the Plan of Care between the home health agency staff and the patient’s physician.
- The problem-specific interventions referenced in the item may or may not directly correlate to stated requirements in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED

- Transfer to an inpatient facility
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- Select “Yes” if the physician-ordered Plan of Care includes the specified best practice interventions as specified in each row, at the time of or at any time since the most recent SOC/ROC assessment, and there is evidence of implementation in the clinical record. If orders are present and implemented, “Yes” may be selected even if the formal assessment was not conducted, or did not suggest a need for the particular intervention.
- Select “No” if the interventions are not on the Plan of Care OR if the interventions are on the Plan of Care but the interventions were not implemented by the time the Discharge or Transfer assessment was completed, unless “NA” applies.
- Select “NA” if the plans/interventions specified in the row are not applicable for this patient. See guidance on selecting “NA” for each row below.
- Interventions provided by home health agency staff, including the assessing clinician, may be reported by the assessing clinician in M2401. For example, if the RN finds a patient to be at risk for falls, and the physical therapist implements fall prevention interventions included on the Plan of Care prior to the end of the quality episode, the RN may select “Yes” for row b of M2401. The M0090 Date Assessment Completed should report the date the last information was gathered to complete the comprehensive assessment.
- For each row a-f, select one response.
- For rows b, c, e, and f, the intervention specified in the first column must be both on the physician-ordered Plan of Care AND implemented for “Yes” to be selected.
- For rows a and d, **BOTH** of the interventions specified in the first column must be both on the physician-ordered Plan of Care AND implemented for “Yes” to be selected.
- For rows b, c, d and e, the standardized, validated assessment that is referred to in the last column refers to a tool that has been scientifically tested on a population with characteristics similar to that of the patient being assessed (for example, community-dwelling elderly, noninstitutionalized adults with disabilities, etc.); and 2) includes a standard response scale (for example, a scale where patients rate pain from 0-10). The standardized, validated tool must be appropriately administered as indicated in the instructions and must be relevant for the patient’s ability to respond.
    - For rows b and c, a formal assessment (as defined in the relevant OASIS item M1730, and M1910) must have been performed to select “NA.”

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M2401)

- Row a: If the physician-ordered Plan of Care contains both orders for a) monitoring the skin of the patient's lower extremities for evidence of skin lesions AND b) patient education on proper foot care, and the clinical record contains documentation that these interventions were performed at the time of or at any time since the most recent SOC/ROC assessment, select "Yes." If the physician-ordered Plan of Care contains orders for only one of the interventions and/or only one type of intervention (monitoring or education) or no intervention is documented in the clinical record, select "No," unless "NA" applies. Select "NA" if the patient does not have a diagnosis of diabetes mellitus or is missing lower legs due to congenital or acquired condition (bilateral amputee).
- Row b: If the physician-ordered Plan of Care contains specific interventions to reduce the risk of falls and the clinical record contains documentation that these interventions were performed at the time of or at any time since the most recent SOC/ROC assessment, select "Yes." Environmental modifications, strengthening exercises, and consultation with the physician regarding medication concerns are examples of possible falls prevention interventions. If the Plan of Care does not include interventions for fall prevention, and/or there is no documentation in the clinical record that these interventions were performed at the time of or at any time since the most recent SOC/ROC assessment, select "No," unless "NA" applies. If all formal multi-factor falls risk assessments conducted at the time of or at any time since the most recent SOC/ROC assessment indicates the patient was not at risk for falls (if a single-threshold assessment is used), or at low, minimal, or no risk for falls (if a multi-threshold tool is used), select "NA" (unless orders for fall prevention are present and were implemented).
- Row c: If the physician-ordered Plan of Care contains interventions for evaluation or treatment of depression and the clinical record contains documentation that these interventions were performed at the time of or at any time since the most recent SOC/ROC assessment, select "Yes."
- Interventions for depression may include new medications, adjustments to already-prescribed medications, psychotherapy or referrals to agency resources (for example, social worker). If the patient is already under physician care for a diagnosis of depression, interventions may include monitoring medication effectiveness, teaching regarding the need to take prescribed medications, etc. If the Plan of Care does not include interventions for treating depression and/or if no interventions related to depression are documented in the clinical record at the time of or at any time since the most recent SOC/ROC assessment, select "No," unless "NA" applies. If every standardized, validated assessment conducted at the time of or any time since the most recent SOC/ROC assessment indicates patient did not meet criteria for further evaluation of depression AND patient did not have diagnosis of depression, select "NA" (unless orders for further evaluation or treatment of depression are present and were implemented).
- Row d: If the physician-ordered Plan of Care contains interventions to monitor AND mitigate pain and the clinical record contains documentation that these interventions were performed at the time of or at any time since the most recent SOC/ROC assessment, select "Yes." Medication, massage, visualization, biofeedback, and other intervention approaches have successfully been used to mitigate pain severity. If the physician-ordered Plan of Care contains orders for only one of the interventions (for example, pain medications but no monitoring plan) and/or only one type of intervention (for example, administering pain medications but no pain monitoring) or no interventions were documented at the time of or at any time since the most recent SOC/ROC assessment, select "No," unless "NA" applies. If every standardized, validated pain assessment conducted at or since the most recent SOC/ROC assessment was negative for pain, select "NA" (unless orders for monitoring and mitigating pain are present and were implemented).

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M2401)

- Row e: If the physician-ordered Plan of Care includes planned clinical interventions to reduce pressure on bony prominences or other areas of skin at risk for breakdown and the clinical record contains documentation that these interventions were performed at the time of or at any time since the most recent SOC/ROC assessment, select "Yes." Planned interventions can include teaching on frequent position changes, proper positioning to relieve pressure, careful skin assessment and hygiene, use of pressure-relieving devices such as enhanced mattresses, etc. If the Plan of Care does not include interventions to prevent pressure ulcers and/or no interventions were documented in the clinical record at the time of or at any time since the most recent SOC/ROC assessment, select "No," unless "NA" applies. If 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, select "NA" (unless orders for interventions to reduce pressure on areas of skin at risk for breakdown are present and were implemented).
- Row f: If the physician-ordered Plan of Care contains orders for pressure ulcer treatments based on principles of moist wound healing (for example, moisture retentive dressings) and the clinical record contains documentation that these interventions were performed at the time of or at any time since the most recent SOC/ROC assessment, select "Yes." If the Plan of Care does not contain orders for pressure ulcer treatments based on principles of moist wound healing and/or no pressure ulcer treatments based on principles of moist wound healing were documented at the time of or at any time since the most recent SOC/ROC assessment, select "No," unless "NA" applies. If patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated per physician, select "NA" (unless orders for pressure ulcer treatments based on principles of moist wound healing are present and were implemented).

DATA SOURCES/RESOURCES

- Plan of Care
- Physician's orders
- Clinical record
- Clinical assessment
- Communication notes

OASIS ITEM

(M2410)	To which **Inpatient Facility** has the patient been admitted?
Enter Code ☐	1 Hospital 2 Rehabilitation facility 3 Nursing home 4 Hospice NA No inpatient facility admission **[*Omit "NA" option on TRN*]**

ITEM INTENT

- Identifies the type of inpatient facility to which the patient was admitted.

TIME POINTS ITEM(S) COMPLETED

- Transfer to an inpatient facility
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- If the patient was admitted to more than one facility, indicate the facility type to which the patient was admitted first (for example, the facility type that they were transferred to from their home).
- When a patient dies in a hospital emergency department, the RFA 7 – Transfer to an Inpatient Facility OASIS is completed. In this unique situation, clinicians are directed to enter Response 1 – Hospital for M2410, even though the patient was not admitted to the inpatient facility.
- Admission to a freestanding rehabilitation hospital, a certified distinct rehabilitation unit of a nursing home, or a distinct rehabilitation unit that is part of a short-stay acute hospital is considered a rehabilitation facility admission (Response 2).
- Admission to inpatient drug rehabilitation is considered an inpatient admission. Enter Response 1 – Hospital, whether it was a freestanding drug rehabilitation unit or a distinct drug rehabilitation unit that is part of a short-stay acute hospital.
- Admission to a skilled nursing facility (SNF), an intermediate care facility for individuals with intellectual disabilities (ICF/IID), or a nursing facility (NF) is a nursing home admission (Response 3).
- When completing a Transfer, enter Response 1, 2, 3, or 4. "NA" should not be an active/available response at transfer.
- When completing a Discharge from Agency – Not to an Inpatient Facility, enter Response "NA."

DATA SOURCES/RESOURCES

- Patient family interview (for agency discharge)
- Telephone contact with caregiver or family if patient was transferred
- Facility

OASIS ITEM

(M2420)	**Discharge Disposition:** Where is the patient after discharge from your agency? **(Choose only one answer.)**
Enter Code ☐	1 Patient remained in the community (without formal assistive services) 2 Patient remained in the community (with formal assistive services) 3 Patient transferred to a non-institutional hospice 4 Unknown because patient moved to a geographic location not served by this agency UK Other unknown

ITEM INTENT

- Identifies where the patient resides after discharge from the home health agency.

TIME POINTS ITEM(S) COMPLETED

- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- Patients who are in assisted living or board and care housing are considered to be living in the community with formal assistive services.
- Formal assistive services refers to community-based services provided through organizations or by paid helpers. Examples: homemaking services under Medicaid waiver programs, personal care services provided by a home health agency, paid assistance provided by an individual, home-delivered meals provided by organizations like Meals-on-Wheels.
    - Therapy services provided in an outpatient setting would not be considered formal assistance.
- Informal services are provided by friends, family, neighbors, or other individuals in the community for which no financial compensation is provided. Examples: assistance with ADLs provided by a family member, transportation provided by a friend, meals provided by church members (specifically, meals not provided by the church organization itself, but by individual volunteers).
- Noninstitutional hospice is defined as the patient receiving hospice care at home or a caregiver's home, not in an inpatient hospice facility.

DATA SOURCES/RESOURCES

- Patient/caregiver/family interview
- Physician
- Community resources

OASIS ITEM

(M0906) Discharge/Transfer/Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient.

		/			/				
month			day			year			

ITEM INTENT

- Identifies the actual date of discharge, transfer, or death (at home), depending on the reason for assessment.

TIME POINTS ITEM(S) COMPLETED

- Transfer to an inpatient facility
- Death at home
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- If the date or month is only one digit, that digit is preceded by a “0” (for example, May 4, 2019 = 05/04/2019). Enter all four digits for the year.
- The date of discharge is determined by agency policy or physician order.
- The transfer date is the actual date the patient was admitted to an inpatient facility.
- The death date is the actual date of the patient’s death at home. Exclude death occurring in an inpatient facility or in an emergency department, as both situations would result in Transfer OASIS collection and would report the date of transfer. Include death that occurs while a patient is being transported to an emergency department or inpatient facility (before being seen in the emergency department or admitted to the inpatient facility).

DATA SOURCES/RESOURCES

- Agency policy or physician order
- Telephone contact with the family or medical service provider may be required to verify the date of transfer to an inpatient facility or death at home.