U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

OPPORTUNITIES FOR ENGAGING LONG-TERM AND POST-ACUTE CARE PROVIDERS IN HEALTH INFORMATION EXCHANGE ACTIVITIES:

EXCHANGING INTEROPERABLE PATIENT ASSESSMENT INFORMATION

APPENDIX J: OVERVIEW OF PATIENT ASSESSMENT SUMMARY

December 2011

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BACKGROUND

National policy promotes the use of health information technology (IT) to advance health care delivery, payment and outcomes. Post-acute and long-term care (LTPAC) providers are a vital part of the healthcare system, but have not been included in federal incentives to promote adoption of health information technology and electronic exchange of health information.

Nationally, there are approximately:

- 16,000 nursing homes providing services to over 2 million individuals on an annual basis; and
- 9,000 home health agencies providing services to over 3 million individuals on an annual basis.

Persons receiving services from LTPAC providers have numerous encounters and contacts with acute care and ambulatory providers.

- In 2006, more than one-third of Medicare beneficiaries discharged from acute care hospitals were transferred to PAC settings.[1]
- In 2006, over half of the Medicare beneficiaries discharged from hospitals to PAC settings had episodes of care that involved multiple PAC placements and/or multiple hospital admissions.[2]
- In 2005, persons living in nursing homes made approximately 2.2 million visits to Emergency Departments.[3]
- In 2008, almost 23.8 million Part B Medicare claims were allowed for nursing home physician visits.[4]

The Centers for Medicare and Medicaid Services (CMS) requires Medicare and/or Medicaid participating providers to complete and electronically submit on a routine schedule the:

- Minimum Data Set 3.0 (MDS3.0) assessment instrument for each resident of a nursing home participating in Medicare and/or Medicaid; and
- Outcome and Assessment Information Set (OASIS-C) for each Medicare or Medicaid client of a home health agency over the age of 18 receiving skilled services.

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[1] Gage, Barbara, Melissa Morley, Pamela Spain, and Melvin Ingber. *Examining Post Acute Care Relationships in an Integrated Hospital System*. Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2009.

[2] Ibid.

[3] Nawar, Eric, Richard Niska, and Jianmin Xu. "National Hospital Ambulatory Medical Care Survey: 2005 Emergency Department Summary." *Advance Data From Vital and Health Statistics*, June 29, 2007.

[4] "Medicare Part B Physician/Supplier Data By Berenson And Eggers Type Of Service Code (BETOS) CY 2008." *Centers for Medicare and Medicaid Services*. N.p., 2008. Web. July 19, 2010. <http://www.cms.gov/MedicareFeeforSvcPartsAB/Downloads/BETOS08.pdf>.

The MDS and OASIS offer feasible entrance points for nursing home and home health agency providers to participate in health information exchange activities and develop awareness of the need for full interoperability. For example, in the third quarter 2010, the CMS MDS Reason for Assessment Count Report showed a total of 4.5 million MDS2.0 assessment documents being received by the National MDS Repository.[5] Two benefits of this approach are that it uses existing information technology capabilities and would engage the majority of LTPAC providers. Once engaged, LTPAC stakeholders can then focus on building and using the technical infrastructure to support more sophisticated types of information exchange and sharing.

The Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services has contracted with the American Health Information Management Association (AHIMA) Foundation seeking to advance the interoperable use of health IT and EHRs by LTPAC providers by leveraging federal requirements for the electronic submission of patient assessment instruments. The project was tasked with:

- identifying and applying health IT standards such as LOINC, HL7 Clinical Document Architecture (CDA) Release 2, and SNOMED CT to the MDS and OASIS assessment instruments;
- identifying issues to consider to support the wide spread use of interoperable patient assessment instruments; and
- supporting the reuse and exchange of standardized assessment content in patient assessment summary documents.

This document describes project efforts in support of the task on reuse and exchange of standardized assessment content in patient assessment summary documents.

[5] *CMS MDS 2.0 Public Quality Indicator and Resident Reports -- Assessment Counts Report*. (2010, Third Quarter). Retrieved from http://www.cms.gov/MDSPubQIandResRep/05_assesscntreport.asp.

CREATING THE PATIENT ASSESSMENT SUMMARY DOCUMENT

The MDS3.0 and OASIS-C assessment instruments offer a rich repository of patient information designed to present the nursing home and home health professional with a holistic picture of patient strengths and needs, gathering information germane to both quality of care and quality of life. While this wealth of information is invaluable to the LTPAC provider, it can be cumbersome to the acute care clinician. This wealth of information far exceeds the needs -- and capacity for rapid consumption -- of the hospital/ER/physician office clinician. With the increased focus on the exchange of information crucial to transitions of care, the value of creating an electronic summary of MDS and OASIS assessment data for use in health information exchange activities is evident. To this end, this project has worked with expert panels to identify the subset MDS3.0 and OASIS-C data elements that could be clinically usefully to include in a Patient Assessment Summary Document at times of transitions in care (e.g., when a home health patient is being treated in an emergency room or admitted to acute care hospital).

Identifying Content for the Patient Assessment Summary

A two-phased approach was used in identifying the subset of MDS3.0 and OASIS-C data elements for a Patient Assessment Summary Document.

- Phase 1 -- Identification of an initial subset of MDS3.0 and OASIS-C data elements for the Patient Assessment Summary by clinical expert from the Keystone Beacon Community.

- Phase 2 -- Validation of the initial MDS3.0 and OASIS-C subset of data elements and determination of a final Patient Assessment Summary data set by a panel of national experts.

Phase 1 -- Identification of an Initial Subset of MDS3.0 and OASIS-C Data Elements

The Keystone Health Information Exchange (KeyHIE), and its' affiliated Keystone Beacon Community, was identified as a volunteer partner for the Phase 1 activities to tap the synergy of this ASPE project and the grants awarded by the Office of the National Coordinator (ONC) and the Agency for Healthcare Research and Quality (AHRQ) to KeyHIE that includes expansion of HIE activities to additional healthcare providers such as nursing homes and home health agencies.

A series of Webex-supported conference calls were conducted during fourth quarter 2010 with clinical experts convened by the Keystone Beacon Community.

These calls were used to identify an initial subset of data items from the MDS3.0 and OASIS-C that would be clinically relevant to include in Patient Assessment Summary documents. Each MDS3.0 and OASIS-C data item was reviewed and discussed to determine clinical relevance to the patient assessment summary. Decisions on the applicability of the MDS3.0 and OASIS-C data elements for a Patient Assessment Summary document were documented in spreadsheets for use in the Phase 2 review process.

Keystone Beacon Community

Geisinger Health System, an integrated delivery network recognized for its innovative use of healthcare IT-supported care coordination and a founding participant in KeyHIE, recently received a $16 million Beacon Community award from ONC. As part of that award, the Keystone Beacon Community will use KeyHIE to extend patient-focused care coordination across a community of more than 250,000 residents.

The AHRQ also awarded Geisinger a $2.3M grant to extend the KeyHIE connected community to additional regional hospitals, long-term care facilities, home health organizations, and physician practices. In addition to expanding participation across the community, KeyHIE will use the five-year AHRQ grant to make new clinical applications and document types available within the HIE.[6]

Phase 2 -- Validation of the Initial MDS3.0 and OASIS-C Subset of Data Elements

Step #1 -- Identify participants for MDS3.0 and OASIS-C Expert Panels

With the assistance of the ONC LTPAC/HIE Affinity Group and the LTPAC HIT Collaborative, and approval by the ASPE Project Officer, expert panels were identified to validate the appropriateness of data elements identified in Phase 1 for inclusion in MDS3.0 and OASIS-C Patient Assessment Summary documents.

LTPAC/HIE Affinity Group -- ONC has established Affinity Groups (i.e., groups of HIE stakeholders among the ONC grantees that share similar interests). One such Affinity Group is the LTPAC/HIE Affinity Group.

LTPAC HIT Collaborative -- The Long-Term and Post-Acute Care (L TPAC) HIT Collaborative, formed in 2005, is a group of LTPAC provider and vendor associations, researchers, and other public and private sector stakeholders who recognized their common interests and vision for health information technology. The collaborative was formed to advance HIT issues for providers of long-term and post-acute care through coordinated efforts.

Participants in the MDS3.0 and OASIS-C expert panels are identified in Table J-1 and Table J-2.

[6] *GE and KeyHIE Expand Health Information Exchange Collaboration: Next Stage of Project to Enhance Chronic Disease Management Model*. (January 11, 2011). Retrieved from https://www.keystonebeaconcommunity.org/news/2011/01/ge-keyhie-expand-health-information-exchange.cfm.

Step #2 -- Capture Panelists Agreement/Disagreement with Phase 1 Recommendations

Members of the MDS3.0 and OASIS-C expert panels were provided with an orientation to the project and to the spreadsheet that had been designed for their use in validating the Phase 1 recommendations for MDS3.0 and OASIS-C Patient Assessment Summary data elements. The spreadsheet contained:

- MDS3.0 IDs and descriptions for all sections, questions and answers as identified in the CMS data specifications v1.01.0, December 2010.
- OASIS-C IDs and descriptions for all questions and answers as identified in the CMS data specifications v2.00, Revision 3, October 2009.
- Recommendations of the Phase 1 expert panel regarding the inclusion or exclusion of each data element in the MDS3.0 Patient Assessment Summary and the OASIS-C Patient Assessment Summary.
- Cells to capture the panelist's agreement or disagreement with the recommendations of the Phase 1 panel for the inclusion or exclusion of each data element.

Panelists were given several weeks to review the data elements and return their completed spreadsheets to the project team.

Step #3 -- Identify Final Slate of MDS3.0 and OASIS-C Data Elements for Patient Assessment Summary Documents

To identify the final slate of MDS3.0 and OASIS-C data elements recommended as clinically useful for Patient Assessment Summary documents, panelist's spreadsheets were amalgamated to determine points of consensus and points of disagreement. Data elements were flagged for group discussion if two or more panelists disagreed with the Phase 1 recommendation. A series of Webex-supported conference calls were held for the MDS3.0 and the OASIS-C expert panels to discuss their respective data elements flagged for reconciliation. Consensus recommendations were reached through group discussion and documented in the amalgamated MDS3.0 and OASIS-C spreadsheets.

In finalizing the slate of MDS3.0 and OASIS-C questions/check-list data elements for inclusion in the Patient Assessment Summary, the expert panels identified two important considerations for conveyance of the selected data elements in a manner readily consumable to the receiving clinician:

1. Clinicians consuming MDS/OASIS Patient Assessment Summary documents in acute care settings (hospitals/ERs/physician offices) would be more interested in "problem" conditions than "normal" conditions. To that end, **MDS3.0 and OASIS-C questions/responses selected for the Assessment Summary would NOT**

include items that indicated a "normal" status except for basic cognitive and functional status items (e.g. hearing, vision, memory, ADLs).

Example of excluded question/response:

MDS question B0100 (Comatose) was selected for inclusion in the MDS3.0 Patient Assessment Summary. Available responses to this question are:

- 0 = No
- 1 = Yes

A "0" for MDS question B0100 would indicate the resident is not comatose and therefore the question/response would not be displayed in the Patient Assessment Summary. However, a response of “1” for MDS question B0100 would indicate the resident was comatose and the question/ response would be displayed on the Summary.

2. There are several clinical assessment scales used in the MDS3.0 and OASIS-C such as the Brief Interview for Mental Status (BIMS) and the PHQ-9 (nine item depression scale). The expert panels identified the summary scores for these scales as the salient information to include in the Patient Assessment Summary, however there was concern that the receiving clinician may not be aware of the scale associated with the score. To address this issue, the expert panels recommended that the implementation guide for the Patient Assessment Summary stipulate that, **whenever summary scores are conveyed, corresponding scales be displayed in the Assessment Summary to allow interpretation of the score**.

Final Slate of Patient Assessment Summary Data Elements

From the 502 questions and checklist items found in Sections A-Q of the MDS3.0, 263 questions/checklist data elements were selected by the Phase 2 expert panel for inclusion in the MDS3.0 Patient Assessment Summary. The final slate of MDS3.0 data elements selected for the Summary document is listed in Table J-3.

From the 180 questions and checklist items found in the Oasis-C, 141 questions/checklist data elements were selected by the Phase 2 expert panel for inclusion in the OASIS-C Patient Assessment Summary. The final slate of OASIS-C data elements selected for the Summary document is listed in Table J-4.

HIT Standards and Patient Assessment Summary Documents

The final step in the Patient Assessment Summary project was the application of HIT standards in support of the interoperable exchange of Assessment Summary content across providers. “Toolkits” for the MDS3.0 and OASIS-C Patient Assessment

Summary documents were compiled to assist in the transition to conveyance of Assessment Summary content using:

- Logical Object Identifiers Names and Codes (LOINC) and SNOMED CT as the primary terminologies of choice (other vocabularies were used as appropriate).

- HL7 Continuity of Care Document (CCD)/HITSP C32 standards for patient summaries as identified in the July 28, 2010 ONC Final Rule: HIT -- Initial Set of Standards, Implementation Specifications, and Certification Criteria for EHR Technology.

Building on the MDS3.0 and OASIS-C Rosetta Stones described in Appendix A, the “Toolkit: OASIS-C Extract for Health Information Exchange” and the “Toolkit: MDS3.0 Extract for Health Information Exchange” each contain mappings of the Assessment Summary data elements to:

- Logical Object Identifiers Names and Codes (LOINC) codes expressing MDS/OASIS concepts in a one-to-one exact representation using a standardized, computable terminology.

- SNOMED CT codes expressing MDS/OASIS concepts in a "best available" representation using a standardized, computable terminology.

- Other vocabularies and code sets as appropriate (i.e., ICD-9-CM, ICD-10-CM, CDC Race & Ethnicity Codes, CVX).

In addition, an analysis was undertaken of the compatibility of the MDS3.0 and OASIS-C Patient Assessment Summary data elements with the ONC named standards for patient summaries (i.e., the HL7 Continuity of Care Document (CCD) standard and the HITSP C32 component specification). Compatibility, to the extent possible, with the ONC named standards is important for supporting efficient and cost-effective interoperable health information exchange across health care providers. Each MDS3.0 and OASIS-C Assessment Summary data element was matched to:

- HITSP C32 identified C83 component modules;
- HITSP C83 identified C154 data elements;
- HL7 CCD header or body section.

The requirements identified for each Assessment Summary data element, and any issues or discrepancies discovered, are captured in the MDS3.0 Extract Toolkit and the OASIS-C Extract Toolkit. In general though, the issues identified in the mapping to HL7 CCD and HITSP C32 requirements fell into the following categories:

Issue	Example
1. HITSP specifications require a data element that is not supported by MDS/OASIS	HITSP C83 requires the data element “Encounter ID” for an “Encounter Event Entry”. Neither the MDS3.0 nor the OASIS-C has an “Encounter ID”.
2. HITSP data element specifications do not support MDS/OASIS item	The format of the MDS3.0 pneumococcal vaccination data item does not lend itself to parameters of the C83 Immunization Content module data elements.
3. HITSP specifications are not completed	HITSP has not defined a Content Module nor Data Elements for Functional Status items.
4. The HITSP Value set does not fully support MDS/OASIS response options	The HITSP value set for "No Immunization Reason" detailed in C80 Table 2-90 does not fully support the MDS3.0 responses for this question (i.e., "Resident not in facility during this year's flu season", "Received outside of this facility", "Not offered").

Future work will be required to ensure that MDS3.0 and OASIS-C Patient Assessment Summary data can be appropriately conveyed in accordance with ONC named standards for patient summaries.

TABLE J-1: Participants in the MDS3.0 Expert Panel		
Sponsoring Organization	**Panelists**	
Nursing Facility Experts		
Kindred Healthcare	Larry Wolf	Health IT Strategist
	Tami Johnson	Kindred Healthcare -- Health Services Division
Vermont Healthcare Association	Laura Pelosi	Executive Director Vermont Healthcare Association
	Deborah Badger	MDS Coordinator Woodridge Nursing Home
	Paula Ducharme	Director of Nursing Services & MDS Coordinator Derby Green Nursing Home
	Kristina Laychak	MDS Coordinator The Manor Nursing Home
	Melinda Sanborn	Director of Nursing Services The Pines @ Rutland Nursing Home
Integrated Delivery Networks		
Citizens Memorial Healthcare	Chad Cahow	Citizens Memorial Healthcare
	Valerie Noblitt	Director of Home Care Citizens Memorial Healthcare
University of Pittsburgh/ University of Pittsburgh Medical Center (UPMC)	Steven M. Handler MD, PhD, CMD	Assistant Professor; Medical Director Long-term Care Health Information Technology, University of Pittsburgh/ UPMC
Home Health Experts		
Visiting Nurse Service of New York (VNSNY)	Sally Sobolewski	VNSNY
	Thomas Check	Chief Information Officer VNSNY
Nurse Informaticists		
Alliance in Nursing (in conjunction with the AMIA Nursing Informatics Working Group)	Bonnie Westra, PhD, RN, FAAN	Associate Professor, Co-Director ICNP Research Center University of Minnesota, School of Nursing
	Dana Alexander	GE Healthcare
	Gregory L. Alexander, PhD, MHA, MIS, RN	Assistant Professor University of Missouri-Columbia, Sinclair School of Nursing
	Rosemary Kennedy, MBA, RN, FAAN	Associate Professor Thomas Jefferson University, Jefferson School of Nursing
	Lori L. Popejoy, PhD, APRN, GNS-BC	Assistant Professor University of Missouri-Columbia, Sinclair School of Nursing
	Charlotte Weaver RN, PhD, FAAN	Senior Vice President & Chief Clinical Officer Gentiva® Health Services
Researchers		
Health Management Strategies -- LTPAC/Emergency Department "On-Time" Project	Siobhan Sharkey	Project Director/Facilitator Health Management Strategies
	Sandy Hudak	Project Director/Facilitator Health Management Strategies

TABLE J-1 (*continued*)		
Sponsoring Organization	**Panelists**	
ONC Challenge Grant Awardees		
Maryland Health Care Commission -- Facilitating Effective Transitions of Care between Long-Term Care Facilities and Hospital Emergency Departments (ONC Challenge Grant Awardee)	Kathleen Francis	Chief, HIE Maryland Health Care Commission
	Angela Plunkett	Health Policy Analyst, Advanced Maryland Health Care Commission
	David Sharp	Director Maryland Health Care Commission
Massachusetts -- IMPACT Project (ONC Challenge Grant Awardee)	Larry Garber, MD	Medical Director for Informatics Fallon Clinic/SAFEHealth
	Kris Cyr	Project Manager, Health Information Exchange Massachusetts e-Health Institute
	Dawn Heisey-Grove	Senior Business Analyst Massachusetts e-Health Institute
	Rick Shoup	Director Massachusetts e-Health Institute
	Michele Visconti	Senior Consultant
	Terrence A. O'Malley, MD	Medical Director for Non-Acute Care Services Partners. HealthCare System

TABLE J-2: Participants in the OASIS-C Expert Panel		
Sponsoring Organization	**Panelists**	
Home Health Experts		
Home Care Alliance	Karen Carnes RN	Vice President, Clinical Ops Amedisys
	Maryann Choi, MD	CMO Harden Healthcare
	Leann Darnes, RN	Director, Clinical Compliance LHC Group
	Barbara McCann, RN	Chief Industry Officer Interim Healthcare
	Mark McDuff	Managing Director, IT Amedisys
	Pamela Teenier, RN	AVP, Clinical Ops Gentiva® Health Services
	Julie Vandre RN	Vice President, Quality & Compliance Girling Healthcare
	Charlotte Weaver, RN	Senior Vice President, Chief Clinical Officer Gentiva® Health Services
Visiting Nurse Service of New York (VNSNY)	Sally Sobolewski	VNSNY
Integrated Delivery Networks		
University of Pittsburgh/ University of Pittsburgh Medical Center (UPMC)	Suzanne Keitzer	Utilization Supervisor UPMC-Jefferson Regional Home Health
	Chris Lombardo	Vice President Reimbursement & Compliance UPMC-Jefferson Regional Home Health
Nurse Informaticists		
Alliance in Nursing (in conjunction with the AMIA Nursing Informatics Working Group)	Bonnie Westra, PhD, RN, FAAN	Associate Professor, Co-Director ICNP Research Center University of Minnesota, School of Nursing
	Dana Alexander	GE Healthcare
	Gregory L. Alexander, PhD, MHA, MIS, RN	Assistant Professor University of Missouri-Columbia, Sinclair School of Nursing
	Rosemary Kennedy, MBA, RN, FAAN	Associate Professor Thomas Jefferson University, Jefferson School of Nursing
	Lori L. Popejoy, PhD, APRN, GNS-BC	Assistant Professor University of Missouri-Columbia, Sinclair School of Nursing
	Charlotte Weaver RN, PhD, FAAN	Senior Vice President & Chief Clinical Officer Gentiva® Health Services
	Karen S. Martin	Omaha System
ONC Challenge Grant Awardees		
Maryland Health Care Commission -- Facilitating Effective Transitions of Care between Long-Term Care Facilities and Hospital Emergency Departments (ONC Challenge Grant Awardee)	Kathleen Francis	Chief, HIE Maryland Health Care Commission
	Angela Plunkett	Health Policy Analyst, Advanced Maryland Health Care Commission
	David Sharp	Director Maryland Health Care Commission

TABLE J-3: Final Slate of MDS3.0 Data Elements Selected for the Summary Document					
ID#	**Question/Checklist Item Description**	**ID#**	**Question/Checklist Item Description**	**ID#**	**Question/Checklist Item Description**
A	**Section A -- Identification Information** **# MDS3.0 Questions/Checklist Items -- 49** **# MDS3.0 Patient Assessment Summary Questions/Checklist Items -- 33**				
A0200	Type of provider	A0310A	Type of assessment: OBRA	A0500A	Resident first name
A0500B	Resident middle initial	A0500C	Resident last name	A0500D	Resident name suffix
A0600A	Social Security Number	A0700	Resident Medicaid number	A0800	Gender
A0900	Birthdate	A1000A	Ethnicity: American Indian or Alaska Native	A1000B	Ethnicity: Asian
A1000C	Ethnicity: Black or African American	A1000D	Ethnicity: Hispanic or Latino	A1000E	Ethnicity: Native Hawaiian/Pacific Islander
A1000F	Ethnicity: White	A1100A	Does the resident need or want an interpreter	A1100B	Preferred language
A1200	Marital status	A1300A	Medical record number	A1300C	Name by which resident prefers to be addressed
A1300D	Lifetime occupation(s)	A1550A	MR/DD status: Down syndrome	A1550B	MR/DD status: Autism
A1550C	MR/DD status: Epilepsy	A1550D	MR/DD status: other organic MR/DD condition	A1550E	MR/DD status: MR/DD with no organic condition
A1600	Entry date (date of admission/reentry in facility)	A1700	Type of entry	A1800	Entered from
A2000	Discharge date	A2100	Discharge status	A2300	Assessment reference date
B	**Section B -- Hearing, Speech, and Vision** **# MDS3.0 Questions/Checklist Items -- 8** **# MDS3.0 Patient Assessment Summary Questions/Checklist Items -- 8**				
B0100	Comatose	B0200	Hearing	B0300	Hearing aid
B0600	Speech clarity	B0700	Makes self understood	B0800	Ability to understand others
B1000	Vision	B1200	Corrective lenses		
C	**Section C -- Cognitive Patters** **# MDS3.0 Questions/Checklist Items -- 23** **# MDS3.0 Patient Assessment Summary Questions/Checklist Items -- 13**				
C0500	BIMS res interview: summary score	C0700	Staff asmt mental status: short-term memory OK	C0800	Staff asmt mental status: long-term memory OK
C0900A	Staff asmt mental status: recall current season	C0900B	Staff asmt mental status: recall location of room	C0900C	Staff asmt mental status: recall staff names/faces
C0900D	Staff asmt mental status: recall in nursing home	C1000	Cognitive skills for daily decision making	C1300A	Signs of delirium: inattention
C1300B	Signs of delirium: disorganized thinking	C1300C	Signs of delirium: altered level of consciousness	C1300D	Signs of delirium: psychomotor retardation
C1600	Acute onset mental status change				

TABLE J-3 (*continued*)					
ID#	**Question/Checklist Item Description**	**ID#**	**Question/Checklist Item Description**	**ID#**	**Question/Checklist Item Description**
D	**Section D -- Mood** **# MDS3.0 Questions/Checklist Items -- 43** **# MDS3.0 Patient Assessment Summary Questions/Checklist Items -- 2**				
D0300	PHQ res: total mood severity score	D0600	PHQ staff: total mood score		
E	**Section E -- Behavior** **# MDS3.0 Questions/Checklist Items -- 18** **# MDS3.0 Patient Assessment Summary Questions/Checklist Items -- 14**				
E0100A	Psychosis: hallucinations	E0100B	Psychosis: delusions	E0200A	Physical behav symptoms directed toward others
E0200B	Verbal behav symptoms directed toward others	E0200C	Other behav symptoms not directed toward others	E0500A	Behav symptoms put res at risk for illness/injury
E0500B	Behav symptoms interfere with resident care	E0500C	Behav symptoms interfere with social activities	E0600A	Behav symptoms put others at risk for injury
E0600B	Behav symptoms intrude on privacy of others	E0600C	Behav symptoms disrupt care or living environment	E0800	Rejection of care: presence and frequency
E0900	Wandering: presence and frequency	E1100	Change in behavioral or other symptoms		
F	**Section F -- Preferences for Customary Routine and Activities** **# MDS3.0 Questions/Checklist Items -- 40** **# MDS3.0 Patient Assessment Summary Questions/Checklist Items -- 0**				
G	**Section G -- Functional Status** **# MDS3.0 Questions/Checklist Items -- 36** **# MDS3.0 Patient Assessment Summary Questions/Checklist Items -- 13**				
G0110A1	Bed mobility: self-performance	G0110B1	Transfer: self-performance	G0110C1	Walk in room: self-performance
G0110E1	Locomotion on unit: self-performance	G0110H1	Eating: self-performance	G0110I1	Toilet use: self-performance
G0110J1	Personal hygiene: self-performance	G0400A	ROM limitation: upper extremity	G0400B	ROM limitation: lower extremity
G0600A	Mobility devices: cane/crutch	G0600B	Mobility devices: walker	G0600C	Mobility devices: wheelchair (manual or electric)
G0600D	Mobility devices: limb prosthesis				
H	**Section H -- Bladder and Bowel** **# MDS3.0 Questions/Checklist Items -- 49** **# MDS3.0 Patient Assessment Summary Questions/Checklist Items -- 33**				
H0100A	Appliances: indwelling catheter	H0100B	Appliances: external catheter	H0100C	Appliances: ostomy
H0100D	Appliances: intermittent catheterization	H0200C	Urinary toileting program: current program/trial	H0300	Urinary continence
H0400	Bowel continence	H0500	Bowel toileting program being used	H0600	Constipation

TABLE J-3 (*continued*)					
ID#	**Question/Checklist Item Description**	**ID#**	**Question/Checklist Item Description**	**ID#**	**Question/Checklist Item Description**
I	**Section I -- Active Disease Diagnosis # MDS3.0 Questions/Checklist Items -- 67 # MDS3.0 Patient Assessment Summary Questions/Checklist Items -- 66**				
I0100	Cancer (with or without metastasis)	I0200	Anemia	I0300	Atrial fibrillation and other dysrhythmias
I0400	Coronary artery disease (CAD)	I0500	Deep venous thrombosis (DVT), PE, or PTE	I0600	Heart failure
I0700	Hypertension	I0800	Orthostatic hypotension	I0900	Peripheral vascular disease (PVD) or PAD
I1100	Cirrhosis	I1200	Gastroesophageal reflux disease (GERD) or ulcer	I1300	Ulcerative colitis, Crohn’s, inflam bowel disease
I1400	Benign prostatic hyperplasia (BPH)	I1500	Renal insufficiency, renal failure, ESRD	I1550	Neurogenic bladder
I1650	Obstructive uropathy	I1700	Multidrug resistant organism (MDRO)	I2000	Pneumonia
I2100	Septicemia	I2200	Tuberculosis	I2300	Urinary tract infection (UTI) (LAST 30 DAYS)
I2400	Viral hepatitis (includes type A, B, C, D, and E)	I2500	Wound infection (other than foot)	I2900	Diabetes mellitus (DM)
I3100	Hyponatremia	I3200	Hyperkalemia	I3300	Hyperlipidemia (e.g., hypercholesterolemia)
I3400	Thyroid disorder	I3700	Arthritis	I3800	Osteoporosis
I3900	Hip fracture	I4000	Other fracture	I4200	Alzheimer's disease
I4300	Aphasia	I4400	Cerebral palsy	I4500	Cerebrovascular accident (CVA), TIA, or stroke
I4800	Dementia	I4900	Hemiplegia or hemiparesis	I5000	Paraplegia
I5100	Quadriplegia	I5200	Multiple sclerosis	I5250	Huntington's disease
I5300	Parkinson's disease	I5350	Tourette's syndrome	I5400	Seizure disorder or epilepsy
I5500	Traumatic brain injury (TBI)	I5600	Malnutrition (protein, calorie), risk of malnutrit	I5700	Anxiety disorder
I5800	Depression (other than bipolar)	I5900	Manic depression (bipolar disease)	I5950	Psychotic disorder (other than schizophrenia)
I6000	Schizophrenia	I6100	Post-traumatic stress disorder (PTSD)	I6200	Asthma (COPD) or chronic lung disease
I6300	Respiratory failure	I6500	Cataracts, glaucoma, or macular degeneration	I8000A	Additional active ICD diagnosis 1
I8000B	Additional active ICD diagnosis 2	I8000C	Additional active ICD diagnosis 3	I8000D	Additional active ICD diagnosis 4
I8000E	Additional active ICD diagnosis 5	I8000F	Additional active ICD diagnosis 6	I8000G	Additional active ICD diagnosis 7
I8000H	Additional active ICD diagnosis 8	I8000I	Additional active ICD diagnosis 9	I8000J	Additional active ICD diagnosis 10

TABLE J-3 (*continued*)					
ID#	**Question/Checklist Item Description**	**ID#**	**Question/Checklist Item Description**	**ID#**	**Question/Checklist Item Description**
J	**Section J -- Health Conditions** **# MDS3.0 Questions/Checklist Items -- 35** **# MDS3.0 Patient Assessment Summary Questions/Checklist Items -- 15**				
J0100A	Pain: been on scheduled pain med regimen	J0400	Res pain interview: frequency	J0600A	Res pain interview: intensity rating scale
J0600B	Res pain interview: verbal descriptor scale	J1100A	Short breath/trouble breathing: with exertion	J1100B	Short breath/trouble breathing: sitting at rest
J1100C	Short breath/trouble breathing: lying flat	J1300	Current tobacco use	J1400	Prognosis: life expectancy of less than 6 months
J1700A	Fall history: fall during month before admission	J1700B	Fall history: fall 2-6 months before admission	J1700C	Fall history: fracture from fall 6 month pre admit
J1800	Falls since admit/prior asmt: any falls	J1900B	Falls since admit/prior asmt: injury (not major)	J1900C	Falls since admit/prior asmt: major injury
K	**Section K -- Swallowing/Nutritional Status** **# MDS3.0 Questions/Checklist Items -- 15** **# MDS3.0 Patient Assessment Summary Questions/Checklist Items -- 11**				
K0100A	Swallow disorder: loss liquids/solids from mouth	K0100B	Swallow disorder: holds food in mouth/cheeks	K0100C	Swallow disorder: cough/choke with meals/meds
K0100D	Swallow disorder: difficulty or pain swallowing	K0200A	Height (in inches)	K0200B	Weight (in pounds)
K0300	Weight loss	K0500A	Nutritional approaches: parenteral/IV feeding	K0500B	Nutritional approaches: feeding tube
K0500C	Nutritional approaches: mechanically altered diet	K0500D	Nutritional approaches: therapeutic diet		
L	**Section L -- Oral/Dental Status** **# MDS3.0 Questions/Checklist Items -- 8** **# MDS3.0 Patient Assessment Summary Questions/Checklist Items -- 6**				
L0200A	Dental: broken or loosely fitting denture	L0200B	Dental: no natural teeth or tooth fragment(s)	L0200C	Dental: abnormal mouth tissue
L0200D	Dental: cavity or broken natural teeth	L0200E	Dental: inflamed/bleeding gums or loose teeth	L0200F	Dental: pain, discomfort, difficulty chewing
M	**Section M -- Skin Conditions** **# MDS3.0 Questions/Checklist Items -- 49** **# MDS3.0 Patient Assessment Summary Questions/Checklist Items -- 38**				
M0150	Is resident at risk of developing pressure ulcer	M0210	Resident has Stage 1 or higher pressure ulcers	M0300A	Stage 1 pressure ulcers: number present
M0300B1	Stage 2 pressure ulcers: number present	M0300B2	Stage 2 pressure ulcers: number at admit/reentry	M0300B3	Stage 2 pressure ulcers: date of oldest
M0300C1	Stage 3 pressure ulcers: number present	M0300C2	Stage 3 pressure ulcers: number at admit/reentry	M0300D1	Stage 4 pressure ulcers: number present

TABLE J-3 (*continued*)					
ID#	**Question/Checklist Item Description**	**ID#**	**Question/Checklist Item Description**	**ID#**	**Question/Checklist Item Description**
M0300D2	Stage 4 pressure ulcers: number at admit/reentry	M0300E1	Unstaged due to dressing: number present	M0300E2	Unstaged due to dressing: number at admit/reentry
M0300F1	Unstaged slough/eschar: number present	M0300F2	Unstaged slough/eschar: number at admit/reentry	M0300G1	Unstageable -- deep tissue: number present
M0300G2	Unstageable -- deep tissue: number at admit/reentry	M0610A	Stage 3 or 4 pressure ulcer longest length	M0610B	Stage 3 or 4 pressure ulcer width (same ulcer)
M0610C	Stage 3 or 4 pressure ulcer depth (same ulcer)	M0800A	Worsened since prior asmt: Stage 2 pressure ulcers	M0800B	Worsened since prior asmt: Stage 3 pressure ulcers
M0800C	Worsened since prior asmt: Stage 4 pressure ulcers	M1030	Number of venous and arterial ulcers	M1040A	Other skin probs: infection of the foot
M1040B	Other skin probs: diabetic foot ulcer(s)	M1040C	Other skin probs: other open lesion(s) on the foot	M1040D	Other skin probs: lesions not ulcers, rashes, cuts
M1040E	Other skin probs: surgical wound(s)	M1040F	Other skin probs: burn(s) (second or third degree)	M1200A	Skin/ulcer treat: pressure reduce device for chair
M1200B	Skin/ulcer treat: pressure reducing device for bed	M1200C	Skin/ulcer treat: turning/repositioning	M1200D	Skin/ulcer treat: nutrition/hydration
M1200E	Skin/ulcer treat: ulcer care	M1200F	Skin/ulcer treat: surgical wound care	M1200G	Skin/ulcer treat: application of dressings
M1200H	Skin/ulcer treat: apply ointments/medications	M1200I	Skin/ulcer treat: apply dressings to feet		
N	**Section N -- Medications** **# MDS3.0 Questions/Checklist Items -- 11** **# MDS3.0 Patient Assessment Summary Questions/Checklist Items -- 8**				
N0350A	Insulin: insulin injections	N0400A	Medications: antipsychotic	N0400B	Medications: antianxiety
N0400C	Medications: antidepressant	N0400D	Medications: hypnotic	N0400E	Medications: anticoagulant
N0400F	Medications: antibiotic	N0400G	Medications: diuretic		
O	**Section O -- Special Treatments and Procedures** **# MDS3.0 Questions/Checklist Items -- 70** **# MDS3.0 Patient Assessment Summary Questions/Checklist Items -- 18**				
O0100A2	Treatment: chemotherapy -- while resident	O0100B2	Treatment: radiation -- while resident	O0100C2	Treatment: oxygen therapy -- while resident
O0100D2	Treatment: suctioning -- while resident	O0100E2	Treatment: tracheostomy care -- while resident	O0100F2	Treatment: vent/respirator -- while resident
O0100G2	Treatment: BIPAP/CPAP -- while resident	O0100H2	Treatment: IV medications -- while resident	O0100I2	Treatment: transfusions -- while resident
O0100J2	Treatment: dialysis -- while resident	O0100K2	Treatment: hospice care -- while resident	O0100L2	Treatment: respite care -- while resident

TABLE J-3 (*continued*)					
ID#	**Question/Checklist Item Description**	**ID#**	**Question/Checklist Item Description**	**ID#**	**Question/Checklist Item Description**
O0100M2	Treatment: isolate/quarantine -- while resident	O0250A	Was influenza vaccine received	O0250B	Date influenza vaccine received.
O0250C	If influenza vaccine not received, state reason	O0300A	Is pneumococcal vaccination up to date	O0300B	If pneumococcal vacc not received, state reason
P	**Section P -- Restraints** **# MDS3.0 Questions/Checklist Items -- 8** **# MDS3.0 Patient Assessment Summary Questions/Checklist Items -- 8**				
P0100A	Restraints used in bed: bed rail	P0100B	Restraints used in bed: trunk restraint	P0100C	Restraints used in bed: limb restraint
P0100D	Restraints used in bed: other	P0100E	Restraints in chair/out of bed: trunk restraint	P0100F	Restraints in chair/out of bed: limb restraint
P0100G	Restraints in chair/out of bed: chair stops rising	P0100H	Restraints in chair/out of bed: other		
Q	**Section Q -- Participation in Assessment and Goal Setting** **# MDS3.0 Questions/Checklist Items -- 10** **# MDS3.0 Patient Assessment Summary Questions/Checklist Items -- 1**				
Q0400B	Determination regarding discharge to community				
Z	**Section Z --**				
Z0500B	Date RN signed assessment as complete				

TABLE J-4: Final Slate of OASIS-C Data Elements Selected for the Summary Document			
ID#	**Question/Checklist Item Description**	**ID#**	**Question/Checklist Item Description**
PATIENT TRACKING	**# OASIS-C Questions/Checklist Items -- 25** **# OASIS-C Patient Assessment Summary Questions/Checklist Items -- 23**		
M0014_BRANCH_STATE	Branch State	M0016_BRANCH_ID	Branch ID (Optional)
M0018_PHYSICIAN_ID	Primary Referring Physician National Provider ID (NPI)	M0020_PAT_ID	Patient ID Number
M0030_START_CARE_DT	Start of Care Date	M0032_ROC_DT	Resumption of Care Date
M0040_PAT_FNAME	Patient's First Name	M0040_PAT_MI	Patient's Middle Initial
M0040_PAT_LNAME	Patient's Last Name	M0040_PAT_SUFFIX	Patient's Suffix
M0050_PAT_ST	Patient State of Residence	M0060_PAT_ZIP	Patient Zip Code
M0063_MEDICARE_NUM	Medicare Number, Including Suffix	M0064_SSN	Patient's Social Security Number
M0065_MEDICAID_NUM	Medicaid Number	M0066_PAT_BIRTH_DT	Date of Birth
M0069_PAT_GENDER	Gender	M0140_ETHNIC_AI_AN	Race/Ethnicity: American Indian or Alaska Native
M0140_ETHNIC_ASIAN	Race/Ethnicity: Asian	M0140_ETHNIC_BLACK	Race/Ethnicity: Black or African-American
M0140_ETHNIC_HISP	Race/Ethnicity: Hispanic or Latino	M0140_ETHNIC_NH_PI	Race/Ethnicity: Native Hawaiian or Pacific Islander
M0140_ETHNIC_WHITE	Race/Ethnicity: White		
CLINICAL RECORD ITEMS	**# OASIS-C Questions/Checklist Items -- 2** **# OASIS-C Patient Assessment Summary Questions/Checklist Items -- 2**		
M0090_INFO_COMPLETED_DT	Date Assessment Completed	M0100_ASSMT_REASON	Reason for Assessment
PATIENT HISTORY AND DIAGNOSES	**# OASIS-C Questions/Checklist Items -- 38** **# OASIS-C Patient Assessment Summary Questions/Checklist Items -- 30**		
M1000	*Inpatient discharge facility*	M1005_INP_DISCHARGE_DT	Most Recent Inpatient Discharge Date
M1010	*Inpatient Diagnosis*	M1016	*Diagnosis Requiring Regimen Change*
M1020_PRIMARY_DIAG_ICD	Primary Diagnosis ICD Code	M1022_OTH_DIAG1_ICD	Other Diagnosis 1: ICD Code
M1022_OTH_DIAG2_ICD	Other Diagnosis 2: ICD Code	M1022_OTH_DIAG3_ICD	Other Diagnosis 3: ICD Code
M1022_OTH_DIAG4_ICD	Other Diagnosis 4: ICD Code	M1022_OTH_DIAG5_ICD	Other Diagnosis 5: ICD Code
M1024_PMT_DIAG_ICD_A3	Case Mix Diagnosis: Primary, Column 3	M1024_PMT_DIAG_ICD_B3	Case Mix Diagnosis: First Secondary, Column 3
M1024_PMT_DIAG_ICD_C3	Case Mix Diagnosis: Second Secondary, Column 3	M1024_PMT_DIAG_ICD_D3	Case Mix Diagnosis: Third Secondary, Column 3
M1024_PMT_DIAG_ICD_E3	Case Mix Diagnosis: Fourth Secondary, Column 3	M1024_PMT_DIAG_ICD_F3	Case Mix Diagnosis: Fifth Secondary, Column 3
M1024_PMT_DIAG_ICD_A4	Case Mix Diagnosis: Primary, Column 4	M1024_PMT_DIAG_ICD_B4	Case Mix Diagnosis: First Secondary, Column 4
M1024_PMT_DIAG_ICD_C4	Case Mix Diagnosis: Second Secondary, Column 4	M1024_PMT_DIAG_ICD_D4	Case Mix Diagnosis: Third Secondary, Column 4
M1024_PMT_DIAG_ICD_E4	Case Mix Diagnosis: Fourth Secondary, Column 4	M1024_PMT_DIAG_ICD_F4	Case Mix Diagnosis: Fifth Secondary, Column 4
M1030	*Therapies the patient receives at home*	M1032	*Risk for hospitalization*

TABLE J-4 (*continued*)			
ID#	**Question/Checklist Item Description**	**ID#**	**Question/Checklist Item Description**
M1034_PTNT_OVRAL_STUS	Patient's Overall Status	M1036	*Risk factors, either present or past, likely to affect current health status and/or outcome*
M1040_INFLNZ_RCVD_AGNCY	Influenza Vaccine: Did Patient Receive The Influenza Vaccine	M1045_INFLNZ_RSN_NOT_RCVD	Influenza Vaccine: Reason Not Received In Agency
M1050_PPV_RCVD_AGNCY	Pneumococcal Vaccine: Did Patient Receive The Influenza Vaccine	M1055_PPV_RSN_NOT_RCVD_AGNCY	Pneumococcal Vaccine: Reason Not Received In Agency
LIVING ARRANGEMENTS	**# OASIS-C Questions/Checklist Items -- 1** **# OASIS-C Patient Assessment Summary Questions/Checklist Items -- 1**		
M1100_PTNT_LVG_STUTN	Patient Living Situation		
SENSORY STATUS	**# OASIS-C Questions/Checklist Items -- 6** **# OASIS-C Patient Assessment Summary Questions/Checklist Items -- 5**		
M1200_VISION	Sensory Status: Vision	M1210_HEARG_ABLTY	Ability To Hear
M1220_UNDRSTG_VERBAL_CNTNT	Understanding Of Verbal Content In Patient's Own Language	M1230_SPEECH	Sensory Status: Speech
M1242_PAIN_FREQ_ACTVTY_MVMT	Frequency Of Pain Interfering With Patient's Activity Or Movement		
INTEGUMENTARY STATUS	**# OASIS-C Questions/Checklist Items -- 29** **# OASIS-C Patient Assessment Summary Questions/Checklist Items -- 24**		
M1302_RISK_OF_PRSR_ULCR	Does This Patient Have A Risk Of Developing PUs	M1306_UNHLD_STG2_PRSR_ULCR	Patient Has At Least 1 Unhealed PU At Stage 2 Or Higher
M1308_NBR_PRSULC_STG2	No. Pressure Ulcers -- Stage 2	M1308_NBR_STG2_AT_SOC_ROC	Number PU Stage 2 At SOC/ROC
M1308_NBR_PRSULC_STG3	No. Pressure Ulcers -- Stage 3	M1308_NBR_STG3_AT_SOC_ROC	Number PU Stage 3 At SOC/ROC
M1308_NBR_PRSULC_STG4	No. Pressure Ulcers -- Stage 4	M1308_NBR_STG4_AT_SOC_ROC	Number PU Stage 4 At SOC/ROC
M1308_NSTG_DRSG	Unstageable Due To Non-removable Dressing Or Device	M1308_NSTG_DRSG_SOC_ROC	Unstageable Due To Non-removable Dressing Or Device At SOC/ROC
M1308_NSTG_CVRG	Unstageable Due To Coverage By Slough Or Eschar	M1308_NSTG_CVRG_SOC_ROC	Unstageable Due To Coverage By Slough Or Eschar At SOC/ROC
M1308_NSTG_DEEP_TISUE	Unstageable Due To Suspected Deep Tissue Injury In Evolution	M1308_NSTG_DEEP_TISUE_SOC_ROC	Unstageable Due To Suspected Deep Tissue Injury In Evolution At SOC/ROC
M1310_PRSR_ULCR_LNGTH	Head To Toe Length Of Stage III Or IV Pu With Largest Area	M1312_PRSR_ULCR_WDTH	Width At Right Angles Of Stage III Or IV Pu With Largest Area
M1314_PRSR_ULCR_DEPTH	Depth Of Stage III Or IV Pu With Largest Area	M1320_STUS_PRBLM_PRSR_ULCR	Status Of Most Problematic Pressure Ulcer
M1322_NBR_PRSULC_STG1	No. Pressure Ulcers -- Stage 1	M1332_NUM_STAS_ULCR	No. Stasis Ulcers
M1334_STUS_PRBLM_STAS_ULCR	Status Of Most Problematic Stasis Ulcer	M1340_SRGCL_WND_PRSNT	Does This Patient Have A Surgical Wound
M1342_STUS_PRBLM_SRGCL_WND	Status Of Most Problematic Surgical Wound	M1350_LESION_OPEN_WND	Has Skin Lesion Or Open Wound

TABLE J-4 (*continued*)			
ID#	**Question/Checklist Item Description**	**ID#**	**Question/Checklist Item Description**
RESPIRATORY STATUS	**# OASIS-C Questions/Checklist Items -- 2** **# OASIS-C Patient Assessment Summary Questions/Checklist Items -- 2**		
M1400_WHEN_DYSPNEIC	When Dyspneic	M1410	*Respiratory treatments utilized at home:*
CARDIAC STATUS	**# OASIS-C Questions/Checklist Items -- 2** **# OASIS-C Patient Assessment Summary Questions/Checklist Items -- 1**		
M1500_SYMTM_HRT_FAILR_PTNTS	Symptoms In Heart Failure Patients		
ELIMINATION STATUS	**# OASIS-C Questions/Checklist Items -- 5** **# OASIS-C Patient Assessment Summary Questions/Checklist Items -- 4**		
M1600_UTI	Treated for Urinary Tract Infection in Past 14 Days	M1610_UR_INCONT	Urinary Incontinence or Urinary Catheter Present
M1615_INCNTNT_TIMING	When Urinary Incontinence Occurs	M1620_BWL_INCONT	Bowel Incontinence Frequency
NEURO/EMOTIONAL/ BEHAVIORAL STATUS	**# OASIS-C Questions/Checklist Items -- 9** **# OASIS-C Patient Assessment Summary Questions/Checklist Items -- 8**		
M1700_COG_FUNCTION	Cognitive Functioning	M1710_WHEN_CONFUSED	When Confused (Reported or Observed)
M1720_WHEN_ANXIOUS	When Anxious (Reported or Observed)	M1730_STDZ_DPRSN_SCRNG	Has The Patient Been Screened For Depression Using Stdzed Screen Tool
M1730_PHQ2_LACK_INTRST	PHQ2 Pfizer Little Interest Or Pleasure In Doing Things	M1730_PHQ2_DPRSN	PHQ2 Pfizer Feeling Down, Depressed Or Hopeless
M1740	*Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week (Reported or Observed):*	M1745_BEH_PROB_FREQ	Frequency of Behavior Problems
ADL/IADLS	**# OASIS-C Questions/Checklist Items -- 16** **# OASIS-C Patient Assessment Summary Questions/Checklist Items -- 12**		
M1800_CUR_GROOMING	Current: Grooming	M1810_CUR_DRESS_UPPER	Current: Dress Upper Body
M1820_CUR_DRESS_LOWER	Current: Dress Lower Body	M1830_CRNT_BATHG	Current: Bathing
M1840_CUR_TOILTG	Current: Toileting	M1845_CUR_TOILTG_HYGN	Current: Toileting Hygiene
M1850_CUR_TRNSFRNG	Current: Transferring	M1860_CRNT_AMBLTN	Current: Ambulation
M1870_CUR_FEEDING	Current: Feeding	M1880_CUR_PREP_LT_MEALS	Current: Prepare Light Meals
M1890_CUR_PHONE_USE	Current: Telephone Use	M1910_MLT_FCTR_FALL_RISK_ASMT	Has Patient Had A Multi-factor Fall Risk Assessment?
MEDICATIONS	**# OASIS-C Questions/Checklist Items -- 9** **# OASIS-C Patient Assessment Summary Questions/Checklist Items -- 2**		
M2020_CRNT_MGMT_ORAL_MDCTN	Current: Management Of Oral Medications	M2030_CRNT_MGMT_INJCTN_MDCTN	Current: Management Of Injectable Medications
CARE MANAGEMENT	**# OASIS-C Questions/Checklist Items -- 8** **# OASIS-C Patient Assessment Summary Questions/Checklist Items -- 8**		
M2100_CARE_TYPE_SRC_ADL	Care Mgmt, Types And Sources Of Assist: ADL	M2100_CARE_TYPE_SRC_IADL	Care Mgmt, Types And Sources Of Assist: IADL
M2100_CARE_TYPE_SRC_MDCTN	Care Mgmt, Types And Sources Of Assist: Medication Admin	M2100_CARE_TYPE_SRC_PRCDR	Care Mgmt, Types And Sources Of Assist: Med Procs Tx

TABLE J-4 (*continued*)			
ID#	**Question/Checklist Item Description**	**ID#**	**Question/Checklist Item Description**
M2100_CARE_TYPE_SRC_EQUIP	Care Mgmt, Types And Sources Of Assist: Equipment	M2100_CARE_TYPE_SRC_SPRVSN	Care Mgmt, Types And Sources Of Assist: Supervision And Safety
M2100_CARE_TYPE_SRC_ADVCY	Care Mgmt, Types And Sources Of Assist: Advocacy Or Facilitation	M2110_ADL_IADL_ASTNC_FREQ	How Often Recv ADL Or IADL Assistance From Any
THERAPY NEED AND PLANS OF CARE	**# OASIS-C Questions/Checklist Items -- 8** **# OASIS-C Patient Assessment Summary Questions/Checklist Items -- 5**		
M2250_PLAN_SMRY_DBTS_FT_CARE	Plan Of Care Synopsis: Diabetic Foot Care	M2250_PLAN_SMRY_FALL_PRVNT	Plan Of Care Synopsis: Falls Prevention Interventions
M2250_PLAN_SMRY_DPRSN_INTRVTN	Plan Of Care Synopsis: Depression Interventions	M2250_PLAN_SMRY_PRSULC_PRVNT	Plan Of Care Synopsis: PU Prevention
M2250_PLAN_SMRY_PRSULC_TRTMT	Plan Of Care Synopsis: PU Moist Treatment		
EMERGENT CARE	**# OASIS-C Questions/Checklist Items -- 8** **# OASIS-C Patient Assessment Summary Questions/Checklist Items -- 5**		
M2300_EMER_USE_AFTR_LAST_ASMT	Emergent Care: Use Since Last Oasis Data Collection	M2310	*Reason for emergent care*
DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY DISCHARGE ONLY	**# OASIS-C Questions/Checklist Items -- 8** **# OASIS-C Patient Assessment Summary Questions/Checklist Items -- 5**		
M2400_INTRVTN_SMRY_DBTS_FT	Intervention Synopsis: Diabetic Foot Care	M2400_INTRVTN_SMRY_FALL_PRVNT	Intervention Synopsis: Falls Prevention Intervention
M2400_INTRVTN_SMRY_DPRSN	Intervention Synopsis: Depression Intervention	M2400_INTRVTN_SMRY_PAIN_MNTR	Intervention Synopsis: Intervention To Monitor And Mitigate Pain
M2400_INTRVTN_SMRY_PRSULC_PRVN	Intervention Synopsis: Intervention To Prevent Pressure Ulcers	M2400_INTRVTN_SMRY_PRSULC_WET	Intervention Synopsis: Pressure Ulcer Treatment Based On Moist Wound Treatment
M2410_INPAT_FACILITY	Inpatient Facility	M2420_DSCHRG_DISP	Discharge Disposition
M2430	*Reason for hospitalization*	M2440	*Reason for nursing home admission*
M0903_LAST_HOME_VISIT	Date of Last Home Visit	M0906_DC_TRAN_DTH_DT	Discharge, Transfer, Death Date

OPPORTUNITIES FOR ENGAGING LONG-TERM AND POST-ACUTE CARE PROVIDERS IN HEALTH INFORMATION EXCHANGE ACTIVITIES: EXCHANGING INTEROPERABLE PATIENT ASSESSMENT INFORMATION

Files Available for This Report

Main Report [54 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/StratEng.htm
http://aspe.hhs.gov/daltcp/reports/2011/StratEng.pdf

APPENDIX A: Stakeholder Interview Summary [13 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-A.htm
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-A.pdf

APPENDIX B: Background Report on Intellectual Property Issues and the Dissemination of Standardized Federally-Required Patient Assessments [89 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-B.htm
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-B.pdf

APPENDIX C: Rosetta Stone Mapping Guidelines and Heuristics [19 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-C.htm
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-C.pdf

APPENDIX D: Rosetta Stone MDS and OASIS and Value Sets for MDS [518 PDF pages]

Full Appendix
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-D.htm
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-D.pdf

Toolkit Overview, Model of Use, Model of Meaning, and Supporting EHR Observation [135 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-D1.htm
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-D1.pdf
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-D1.xlsx

MDS Value Sets (Separate Excel files accessible through links within HTMLs and PDFs) [381 PDF pages]

Alzheimer's Disease through Cirrhosis [184 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-D2a.htm
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-D2a.pdf

Coronary Artery Disease through Wound Infection [197 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-D2b.htm
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-D2b.pdf

APPENDIX E: Rosetta Stone OASIS [71 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-E.htm
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-E.pdf
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-E.xlsx

APPENDIX F: Current Standards Landscape for Exchanging Interoperable Patient Assessment Information [9 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-F.htm
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-F.pdf

APPENDIX G: LTPAC Interoperability Toolkit for Exchanging Interoperable Patient Assessment Instruments [9 PDF pages]

Overview
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-G.htm
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-G.pdf

Several attachments are listed separately at the end of this Appendix.

APPENDIX H: Standards Development and Adoption Recommendations [6 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-H.htm
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-H.pdf

APPENDIX I: Functional Status Standardization Recommendations [13 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-I.htm
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-I.pdf

APPENDIX J: Overview of Patient Assessment Summary [23 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-J.htm
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-J.pdf

APPENDIX K: Rosetta Stone MDS Summary [162 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-K.htm
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-K.pdf
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-K.xlsx

APPENDIX L: Rosetta Stone OASIS Summary [127 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-L.htm
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-L.pdf
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-L.xlsx

APPENDIX M: Terms and Acronyms [6 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-M.htm
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-M.pdf

To obtain a printed copy of this report, send the full report title and your mailing information to:

U.S. Department of Health and Human Services
Office of Disability, Aging and Long-Term Care Policy
Room 424E, H.H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201
FAX: 202-401-7733
Email: webmaster.DALTCP@hhs.gov

NOTE: All requests must be in writing.

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