

<b>OASIS ITEM</b>
<p><b>(M1700) Cognitive Functioning:</b> Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.</li> <li><input type="checkbox"/> 1 - Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.</li> <li><input type="checkbox"/> 2 - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.</li> <li><input type="checkbox"/> 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.</li> <li><input type="checkbox"/> 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.</li> </ul>
<b>ITEM INTENT</b>
Identifies the patient's current (at the time of the assessment and in the preceding 24 hours) level of cognitive functioning, including alertness, orientation, comprehension, concentration, and immediate memory for simple commands.
<b>TIME POINTS ITEM(S) COMPLETED</b>
Start of care Resumption of care Discharge from agency - not to inpatient facility
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>
<ul style="list-style-type: none"> <li>• Responses progress from no impairment to severely impaired.</li> <li>• Consider the patient's signs/symptoms of cognitive dysfunction that have occurred over the past 24 hours.</li> <li>• Consider the amount of supervision and care the patient has required due to cognitive deficits.</li> <li>• Patients with diagnoses such as dementia, delirium, development delay disorders, mental retardation, etc., <u>will</u> have various degrees of cognitive dysfunction. Consider the degree of impairment.</li> <li>• Patients with neurological deficits related to stroke, mood/anxiety disorders, or who receive opioid therapy <u>may</u> have cognitive deficits.</li> </ul>
<b>DATA SOURCES / RESOURCES</b>
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Observation</li> <li>• Physical assessment</li> <li>• Links to cognitive assessment tools can be found in Chapter 5 of this manual.</li> <li>• Review of past health history</li> <li>• Physician</li> </ul>

<b>OASIS ITEM</b>
<p><b>(M1710) When Confused (Reported or Observed Within the Last 14 Days):</b></p> <p> <input type="checkbox"/> 0 - Never  <input type="checkbox"/> 1 - In new or complex situations only  <input type="checkbox"/> 2 - On awakening or at night only  <input type="checkbox"/> 3 - During the day and evening, but not constantly  <input type="checkbox"/> 4 - Constantly  <input type="checkbox"/> NA - Patient nonresponsive         </p>
<b>ITEM INTENT</b>
Identifies the time of day or situations when the patient experienced confusion, if at all.
<b>TIME POINTS ITEM(S) COMPLETED</b>
Start of care Resumption of care Discharge from agency - not to inpatient facility
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>
<ul style="list-style-type: none"> <li>• This item may not relate directly to Item M1700. Assess specifically for confusion in the past 14 days.</li> <li>• The term “past fourteen days” is the two-week period immediately preceding the start/resumption of care or discharge. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient’s SOC date is August 20, any confusion occurring on or after August 6 would be considered.</li> <li>• If it is reported that the patient is “occasionally” confused, identify the situation(s) in which confusion has occurred within the last 14 days, if at all.</li> <li>• “Nonresponsive” means that the patient is unable to respond or the patient responds in a way that you can’t make a clinical judgment about the patient’s level of orientation.</li> </ul>
<b>DATA SOURCES / RESOURCES</b>
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Observation</li> <li>• Physical assessment</li> <li>• Review of past health history</li> <li>• Physician</li> <li>• Links to a resource for patients with Alzheimer’s disease or dementia can be found in Chapter 5 of this manual.</li> </ul>

<b>OASIS ITEM</b>
<p><b>(M1720) When Anxious (Reported or Observed Within the Last 14 Days):</b></p> <p><input type="checkbox"/> 0 - None of the time</p> <p><input type="checkbox"/> 1 - Less often than daily</p> <p><input type="checkbox"/> 2 - Daily, but not constantly</p> <p><input type="checkbox"/> 3 - All of the time</p> <p><input type="checkbox"/> NA - Patient nonresponsive</p>
<b>ITEM INTENT</b>
Identifies the frequency with which the patient has felt anxious within the past 14 days.
<b>TIME POINTS ITEM(S) COMPLETED</b>
<p>Start of care</p> <p>Resumption of care</p> <p>Discharge from agency - not to inpatient facility</p>
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>
<ul style="list-style-type: none"> <li>Anxiety includes: <ul style="list-style-type: none"> <li>- Worry that interferes with learning and normal activities,</li> <li>- Feelings of being overwhelmed and having difficulty coping, or</li> <li>- Symptoms of anxiety disorders.</li> </ul> </li> <li>Responses appear in order of increasing frequency of anxiety.</li> <li>“Nonresponsive” means that the patient is unable to respond.</li> <li>The term “past fourteen days” is the two-week period immediately preceding the start/resumption of care. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient’s SOC date is August 20, any anxiety occurring on or after August 6 would be considered.</li> </ul>
<b>DATA SOURCES / RESOURCES</b>
<ul style="list-style-type: none"> <li>Patient/caregiver interview</li> <li>Observation</li> <li>Physical assessment</li> <li>Referral information</li> <li>Review of recent (past 14 days) health history</li> <li>Physician</li> <li>Links to standardized anxiety screening tools can be found in Chapter 5 of this manual.</li> </ul>

**OASIS ITEM**

**(M1730) Depression Screening:** Has the patient been screened for depression, using a standardized depression screening tool?

- ☐ 0 - No
- ☐ 1 - Yes, patient was screened using the PHQ-2©\* scale. (Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems")

PHQ-2©*	Not at all 0 - 1 day	Several days 2 - 6 days	More than half of the days 7 - 11 days	Nearly every day 12 - 14 days	N/A Unable to respond
a) Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> na
b) Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> na

- ☐ 2 - Yes, with a different standardized assessment-and the patient meets criteria for further evaluation for depression.
- ☐ 3 - Yes, patient was screened with a different standardized assessment-and the patient does not meet criteria for further evaluation for depression.

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**ITEM INTENT**

Identifies if the home health agency screened the patient for depression using a standardized depression screening tool. CMS does not mandate that clinicians conduct depression screening for all patients, nor is there a mandate for the use of the PHQ-2© or any other particular standardized tool. This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.

**TIME POINTS ITEM(S) COMPLETED**

Start of care

Resumption of care

**RESPONSE—SPECIFIC INSTRUCTIONS**

- Depressive feelings, symptoms, and/or behaviors may be observed by the clinician or reported by the patient, family, or others.
- To meet the definition of "standardized," the depression screening tool must 1) be scientifically tested on a population with characteristics similar to that of the patient being assessed and shown to be effective in identifying people with depression; and 2) include a standard response scale. The standardized tool must be appropriately administered as indicated in the instructions.
- If a standardized depression screening tool is used, use the scoring parameters specified for the tool to identify if a patient meets criteria for further evaluation of depression.
- Select Response 0 if a standardized depression screening was not conducted.
- Select Response 1 if the PHQ-2© is completed when responding to the question. (The results for rows a & b are for agency use only and will not be encoded and transmitted with OASIS data.) If the patient/caregiver scores three points or more on the PHQ-2©, then further depression screening is indicated.

*Guidance for this item updated 12/18/2009*

**RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1730)**

- Select Response 2 if the patient is screened with a different standardized assessment AND the tool indicated the need for further evaluation.
- Select Response 3 if the patient is screened with a different standardized assessment BUT the tool indicates no need for further evaluation.

**DATA SOURCES / RESOURCES**

- Patient/caregiver interview
- Observation
- Physical assessment
- Referral information
- Physician
- A link with more information on the PHQ-2© can be found in Chapter 5 of this manual.
- There are many depression screening tools available. Links to several tools can be found in Chapter 5 of this manual.

*Guidance for this item updated 12/18/2009*

OASIS ITEM
<p><b>(M1740) Cognitive, behavioral, and psychiatric symptoms</b> that are demonstrated <u>at least once a week</u> (Reported or Observed): <b>(Mark all that apply.)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required</li> <li><input type="checkbox"/> 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions</li> <li><input type="checkbox"/> 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.</li> <li><input type="checkbox"/> 4 - Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)</li> <li><input type="checkbox"/> 5 - Disruptive, infantile, or socially inappropriate behavior (<b>excludes</b> verbal actions)</li> <li><input type="checkbox"/> 6 - Delusional, hallucinatory, or paranoid behavior</li> <li><input type="checkbox"/> 7 - None of the above behaviors demonstrated</li> </ul>
ITEM INTENT
Identifies specific behaviors associated with significant neurological, developmental, behavioral or psychiatric disorders.
TIME POINTS ITEM(S) COMPLETED
Start of care Resumption of care Discharge from agency - not to an inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Behaviors may be observed by the clinician or reported by the patient, family, or others.</li> <li>• Include behaviors which are severe enough to               <ul style="list-style-type: none"> <li>- make the patient unsafe to self or others,</li> <li>- cause considerable stress to the caregivers, or</li> <li>- require supervision or intervention.</li> </ul> </li> <li>• If Response 7 is selected, none of the other responses should be selected.</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Observation</li> <li>• Physical assessment</li> <li>• Referral information</li> <li>• Physician</li> <li>• Links to standardized cognitive screening tools can be found in Chapter 5 of this manual.</li> </ul>

<b>OASIS ITEM</b>
<p><b>(M1745) Frequency of Disruptive Behavior Symptoms (Reported or Observed)</b> Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.</p> <p> <input type="checkbox"/> 0 - Never  <input type="checkbox"/> 1 - Less than once a month  <input type="checkbox"/> 2 - Once a month  <input type="checkbox"/> 3 - Several times each month  <input type="checkbox"/> 4 - Several times a week  <input type="checkbox"/> 5 - At least daily         </p>
<b>ITEM INTENT</b>
Identifies frequency of any behaviors that are disruptive or dangerous to the patient or the caregivers.
<b>TIME POINTS ITEM(S) COMPLETED</b>
Start of care Resumption of care Discharge from agency - not to an inpatient facility
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>
<ul style="list-style-type: none"> <li>Consider if the patient has any problematic behaviors – not just the behaviors listed in M1740 – which jeopardize or could jeopardize the safety and well-being of the patient or caregiver. Then consider how frequently these behaviors occur.</li> <li>Include behaviors considered symptomatic of neurological, cognitive, behavioral, developmental, or psychiatric disorders. Use clinical judgment to determine if the degree of the behavior is disruptive or dangerous to the patient or caregiver.</li> <li>Behaviors can be observed by the clinician or reported by the patient, family, or others.</li> <li>Examples of disruptive/dangerous behaviors include sleeplessness, “sun-downing,” agitation, wandering, aggression, combativeness, getting lost in familiar places, etc.</li> </ul>
<b>DATA SOURCES / RESOURCES</b>
<ul style="list-style-type: none"> <li>Patient/caregiver interview</li> <li>Observation</li> <li>Physical assessment</li> <li>Referral information</li> <li>Review of past health history</li> <li>Physician</li> <li>Links to additional information sources can be found in Chapter 5 of this manual.</li> </ul>

<b>OASIS ITEM</b>
<b>(M1750)</b> Is this patient receiving <b>Psychiatric Nursing Services</b> at home provided by a qualified psychiatric nurse?  <input type="checkbox"/> 0 - No <input type="checkbox"/> 1 - Yes
<b>ITEM INTENT</b>
Identifies whether the patient is receiving psychiatric nursing services at home as provided by a qualified psychiatric nurse. "Psychiatric nursing services" address mental/emotional needs; a "qualified psychiatric nurse" is so qualified through educational preparation, certification, or experience.
<b>TIME POINTS ITEM(S) COMPLETED</b>
Start of care Resumption of care
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>
<b>DATA SOURCES / RESOURCES</b>
<ul style="list-style-type: none"><li>• Patient/caregiver interview</li><li>• Observation</li><li>• Referral information</li><li>• Physician orders/plan of care</li><li>• Clinical record</li><li>• HHAs may elect to reference Section 40.1.2.15 of Chapter 7 in the Medicare Benefit Policy Manual for additional information</li></ul>