Preparing for D-Day

OASIS-D, effective Jan 1, 2019
M1800 – M1940

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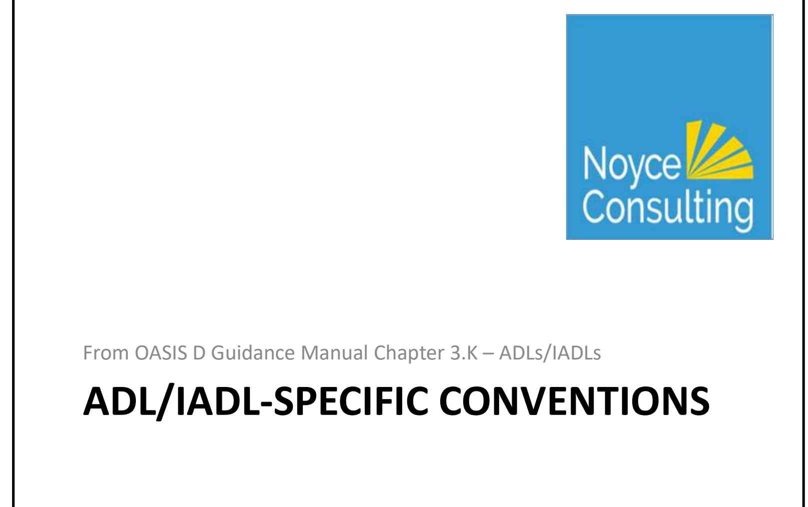
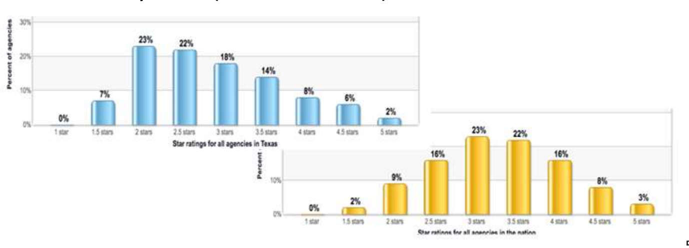


From OASIS D Guidance Manual Chapter 3.K – ADLs/IADLs

ADL/IADL-SPECIFIC CONVENTIONS

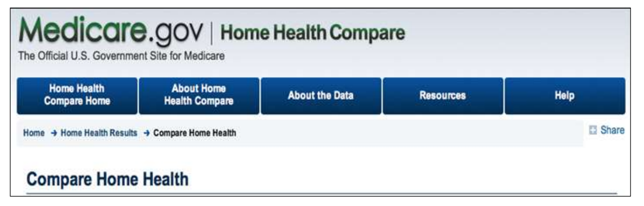
Rules for *all* ADL/IADL items

- ADL/IADL items can affect risk adjustment.
  - One wrong response could skew:
    - Home Health Compare 5-Star Ratings.
    - Individual Home Health Compare patient outcomes.
    - Home health value-based purchasing (HHVBP).
    - Payment (PPS and PDGM).



Rules for *all* ADL/IADL items

- All are quality measures, except GG items.
- Three currently display outcome scores on Home Health Compare.
  - CMS could enter to display any of them.



Rules for *all* ADL/IADL items

- Many quality measures impact agency prospective payment system (PPS) amounts.
  - Case-mix OASIS items;
  - Directly affects reimbursement for payment episodes.
  - With PDGM capturing impairment will be even more *critical* for patients whose therapy visits would have raised reimbursement.

Rules for *all* ADL/IADL items

- Report the patient's physical and cognitive ability to perform a task.
- Do not report on the patient's preference or willingness to perform a specified task.
- The level of ability refers to the level of assistance (if any) that the patient requires to **safely** complete a specified task.

Rules for *all* ADL/IADL items

- While the presence or absence of a caregiver may impact the way a patient carries out an activity, it does not impact the assessing clinician's ability to assess the patient in order to determine and report the level of assistance that the patient requires to safely complete a task.

Rules for *all* ADL/IADL items

- Document what the patient is able to do **on the day of the assessment**.
  - During assessment and prior 24 hours.
- If ability varies over time, enter the response describing the patient's ability more than 50% of the time period under consideration.

Rules for *all* ADL/IADL items

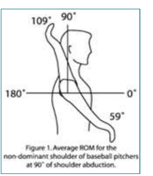
- Understand what tasks are included and excluded in each item and respond based only on included tasks.
- If ability varies between tasks in a multi-task item:
  - Report what is true in a majority of the included tasks.
  - Give more weight to tasks performed more frequently.

Rules for *all* ADL/IADL items

- Assess the patient's **ability to safely perform** each activity, given the patient's current status:
  - Physically.
  - Mentally.
  - Emotionally.
  - Cognitively.
- Activities permitted.
  - Any medical restrictions.
- Environment.
- View the patient holistically.

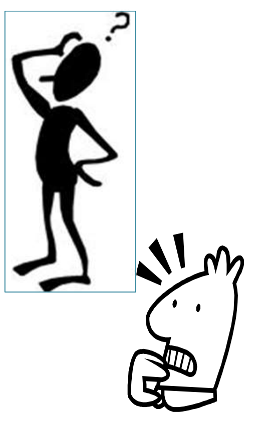
Rules for *all* ADL/IADL items

- Ability can be temporarily or permanently limited by:
  - Physical impairments, such as:
    - Limited range of motion.
    - Impaired balance.
  - Environmental barriers.



Rules for *all* ADL/IADL items

- Ability can be temporarily or permanently limited by:
  - Emotional/cognitive/behavioral impairments, including:
    - Memory deficits.
    - Impaired judgment.
    - Fear.



Rules for *all* ADL/IADL items

- Ability can be temporarily or permanently limited by:
  - Sensory impairments, such as:
    - Impaired vision.
    - Pain.
  - Environmental barriers.

Rules for *all* ADL/IADL items

- Remember to **coordinate care with other clinicians** who also assess the patient.
  - To capture the patient's full impairment at SOC.
  - Allows capture of patient's improvements by DC.
  - Care coordination is a condition of participation.
    - Emphasis increased with new COPs.

Rules for *all* ADL/IADL items

- Avoid clinical contradictions in documentation.
- Other entries must support OASIS item responses.
  - Reflect the same patient.

Rules for *all* ADL/IADL items

- A service animal is considered an assistive device, not assistance.
  - **CMS OASIS Q&A, CAT 4b, 10.16, Q127.1**

Rules for *all* ADL/IADL items

- Scale presents:
  - Least-dependent level first.
  - Most-dependent level last.
- **Read carefully from the bottom up.**
- Opposite of GG and JJ items.

M1700, M1710, M1720 Home Health Compare 5-Star Ratings

- For ALL ADLs:
  - If M1700, M1710, or M1720 is entered as most severely impaired possible, the patient's score is excluded from Home Health Compare calculations.

Measure-specific Exclusions	
Home health quality episodes for which the patient, at start/resumption of care, was able to ambulate independently, episodes that end with inpatient facility transfer or death, or patient is nonresponsive.	(M1860) Ambulation/ Locomotion (M1700) Cognitive Functioning (M1710) When Confused (M1720) When Anxious

OASIS-BASED OUTCOME MEASURES									
Type	Measure Title	HH Compare	NQF Status	Risk Adjusted	Measure Description	Numerator	Denominator	Measure-specific Exclusions	OASIS-C2 Item(s) Used
End Result Outcome - Functional	Improvement in Ambulation-Locomotion	Yes	Endorsed (0167)	Yes	Percentage of home health quality episodes during which the patient improved in ability to ambulate.	Number of home health quality episodes where the value recorded on the discharge assessment indicates less impairment in ambulation/locomotion at discharge than at start (or resumption) of care.	Number of home health quality episodes ending with a discharge during the reporting period, other than those covered [illegible] generic or measure-specific exclusions.	Home health quality episodes for which the patient, at start/resumption of care, was able to ambulate independently, episodes that end with inpatient facility transfer or death, or patient is nonresponsive.	(M1860) Ambulation/ Locomotion (M1700) Cognitive Functioning (M1710) When Confused (M1720) When Anxious

Home Health Outcome Measures

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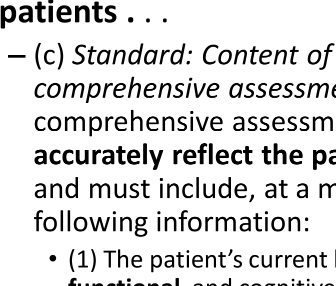
From OASIS-D Guidance Manual Chapter 3.K – ADLs

ADLS FUNCTIONAL STATUS

ADLs Functional Status & COPs

- HH COPs' intent:
  - "Develop a more continuous, integrated care process across all aspects of home health services, based on a **patient-centered assessment, care planning,** service delivery, and quality assessment and performance improvement."

ADLs Functional Status & COPs



- **§ 484.55 Condition of participation: Comprehensive assessment of patients . . .**
  - (c) *Standard: Content of the comprehensive assessment.* The comprehensive assessment must **accurately reflect the patient's status**, and must include, at a minimum, the following information:
    - (1) The patient's current health, psychosocial, **functional**, and cognitive **status.**

M1800 Grooming

(M1800) **Grooming:** Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).		
Enter Code ☐	0	Able to groom self unaided, with or without the use of assistive devices or adapted methods.
	1	Grooming utensils must be placed within reach before able to complete grooming activities.
	2	Someone must assist the patient to groom self.
	3	Patient depends entirely upon someone else for grooming needs.

- Identifies the patient's ability to tend to personal hygiene needs, **excluding** bathing, shampooing hair, and toileting hygiene.
- Identifies ABILITY, not necessarily actual performance.
  - "Willingness" and "adherence" are not the focus.
  - Addresses ability to safely perform grooming, given the current physical and mental/emotional/cognitive status, activities permitted, and environment.
- Q, PRA

M1800 Grooming

(M1800) **Grooming:** Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).		
Enter Code ☐	0	Able to groom self unaided, with or without the use of assistive devices or adapted methods.
	1	Grooming utensils must be placed within reach before able to complete grooming activities.
	2	Someone must assist the patient to groom self.
	3	Patient depends entirely upon someone else for grooming needs.

- Consider patients to have more ability when:
  - Able to safely do the activities more frequently performed.
    - Such as washing hands and face.
  - But unable to do the activities less frequently performed.
    - Such as trimming fingernails.

M1800 Grooming

(M1800) **Grooming:** Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).		
Enter Code ☐	0	Able to groom self unaided, with or without the use of assistive devices or adapted methods.
	1	Grooming utensils must be placed within reach before able to complete grooming activities.
	2	Someone must assist the patient to groom self.
	3	Patient depends entirely upon someone else for grooming needs.

- Assessing coordination, manual dexterity, upper-extremity range of motion (hand to head, hand to mouth, etc.), and cognitive/emotional status will allow the clinician to evaluate the patient's ability to perform grooming activities.
- If the patient needs **ANY** verbal reminder or standby assistance, 2 is the best score possible.

M1810 & M1820 Dressing

- If a patient modifies clothing due to a physical impairment, the modified clothing is routine if not reasonable to expect a return to previous dressing style, regardless of timeframe.
- Clinician must determine which clothes are routine.
  - **Routine** = clothing the patient usually wears and will continue to wear, or a change in clothing options to styles expected to become the patient's new routine clothing.
- Q, $ PRA

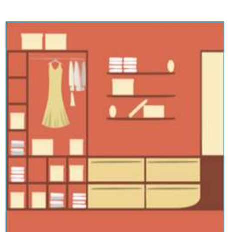
M1810 & M1820 Dressing

- Includes donning prosthetic, orthotic, or other support devices.
  - For M1810, include upper extremity prosthesis, cervical collar, or arm sling, etc.
  - For M1820, Include donning prosthetic, orthotic, other lower-body support devices.
- Enter 2 if safety requires:
  - Standby assistance (a "spotter")

  OR
  - Verbal cueing/reminders

M1810 & M1820 Dressing

- Ask where the patient's clothes are kept, and observe demonstration of:
  - Opening drawers, closets.
  - Removing clothing.
  - Transporting all clothing to where the patient will don the clothing.

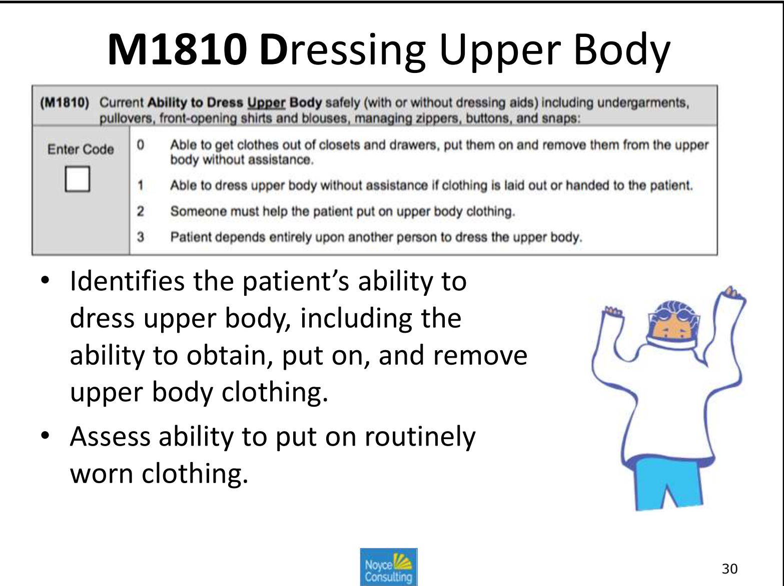


M1810 & M1820 Dressing

- Ask the patient to demonstrate body motions involved in donning whatever clothing the patient routinely wears.
- **Enter what the patient can SAFELY do!**
- Do not assume the patient will be safe.
- Do not rely on patient report.
- **Observe and score only on what you observe.**

M1810 & M1820 Dressing

- Enter 0 if the patient is able to dress herself/himself independently, even if the activities are done in steps.
- Enter 2 if the dressing activity occurs in stages because verbal cueing or reminders are necessary for the patient to be able to complete the task.
  - Note that the shortness of breath is addressed in M1400, not here.
    - CMS OASIS Q&A CAT 4b, 10.16 132



M1810 Dressing Upper Body

- This specifically includes the ability to manage zippers, buttons, and snaps if these are routinely worn.
- Ask the patient to open and remove clothing to allow for assessing the heart, lungs, and skin.
  - Observe ability.
  - Evaluate applicable upper-extremity range of motion, coordination, and manual dexterity.

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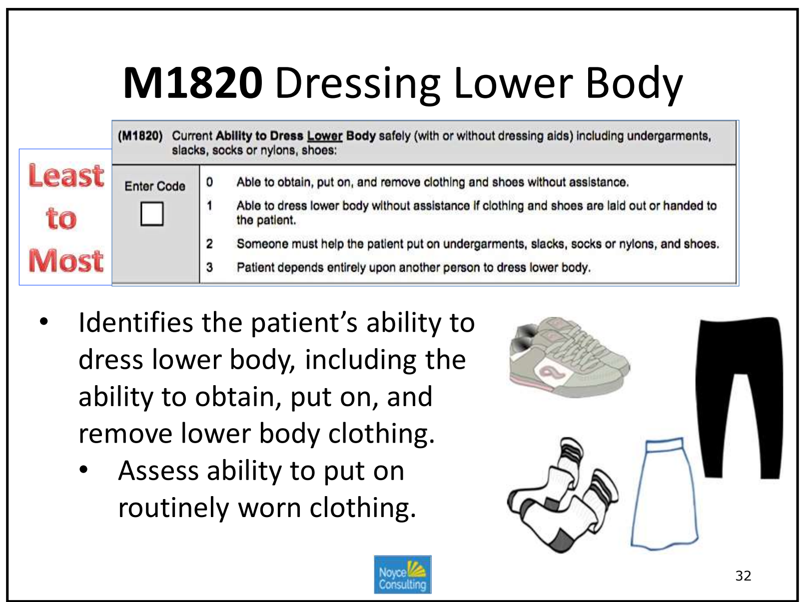

M1820 Assessment Strategies

- Ask the patient to remove clothing for you to assess feet, lower legs, and coccyx skin areas.
- As the patient complies, observe for any problems with managing routinely-worn clothing.

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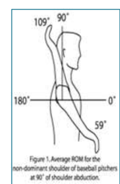
M1820 Dressing Lower Body

- Consider impairments in:
  - Spinal flexion.
  - Joint range of motion.
  - Shoulder and upper arm strength.
  - Manual dexterity.



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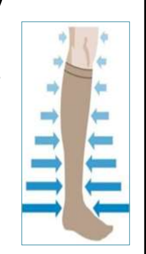
M1820 Dressing Lower Body

- Consider prescribed treatments integral to the patient's prognosis and recovery from the episode of illness.
  - Such as elastic compression stockings, air casts, etc.
  - Do not consider wraps used solely to secure a wound dressing.
  - Do consider elastic bandages, including ACE Wrap brand, worn for support and compression.



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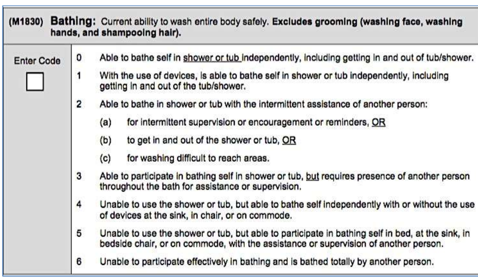
M1830 Bathing

(M1830) Bathing: Current ability to wash entire body safely. **Excludes grooming (washing face, washing hands, and shampooing hair).**

Enter Code		
☐	0	Able to bathe self in <u>shower or tub</u> independently, including getting in and out of tub/shower.
	1	With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.
	2	Able to bathe in shower or tub with the intermittent assistance of another person: (a) for intermittent supervision or encouragement or reminders, <u>OR</u> (b) to get in and out of the shower or tub, <u>OR</u> (c) for washing difficult to reach areas.
	3	Able to participate in bathing self in shower or tub, <u>but</u> requires presence of another person throughout the bath for assistance or supervision.
	4	Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.
	5	Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.
	6	Unable to participate effectively in bathing and is bathed totally by another person.

- Q, $, PRA

M1830 Bathing



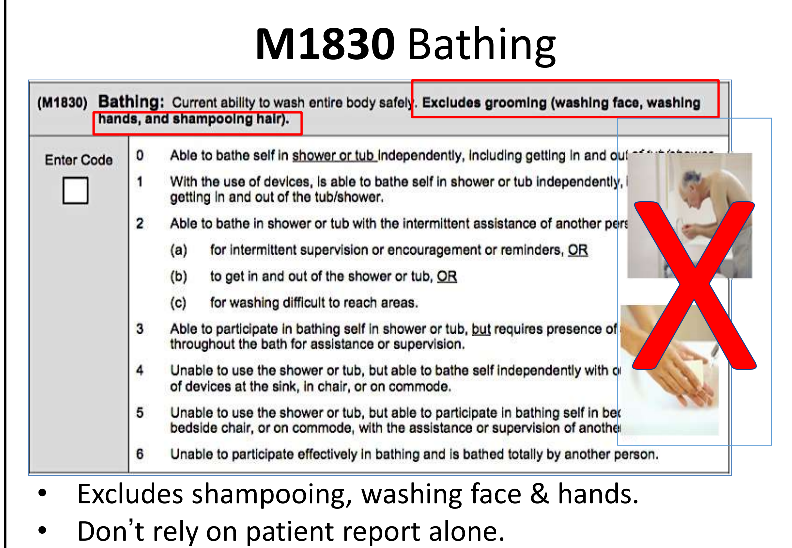
(M1830) **Bathing:** Current ability to wash entire body safely. **Excludes grooming (washing face, washing hands, and shampooing hair).**

Enter Code ☐

0 Able to bathe self in shower or tub independently, including getting in and out of tub/shower.
1 With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.
2 Able to bathe in shower or tub with the intermittent assistance of another person:
(a) for intermittent supervision or encouragement or reminders, OR
(b) to get in and out of the shower or tub, OR
(c) for washing difficult to reach areas.
3 Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
4 Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.
5 Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.
6 Unable to participate effectively in bathing and is bathed totally by another person.

- Identifies the patient's ability to bathe entire body and the assistance required to safely bathe, including transferring in/out of the tub/shower.
- Observe! Don't assume patient will perform safely with equipment unavailable during assessment.

M1830 Bathing



(M1830) **Bathing:** Current ability to wash entire body safely. **Excludes grooming (washing face, washing hands, and shampooing hair).**

Enter Code ☐

0 Able to bathe self in shower or tub independently, including getting in and out
1 With the use of devices, is able to bathe self in shower or tub independently, getting in and out of the tub/shower.
2 Able to bathe in shower or tub with the intermittent assistance of another pers
(a) for intermittent supervision or encouragement or reminders, OR
(b) to get in and out of the shower or tub, OR
(c) for washing difficult to reach areas.
3 Able to participate in bathing self in shower or tub, but requires presence of throughout the bath for assistance or supervision.
4 Unable to use the shower or tub, but able to bathe self independently with of devices at the sink, in chair, or on commode.
5 Unable to use the shower or tub, but able to participate in bathing self in bed bedside chair, or on commode, with the assistance or supervision of anothe
6 Unable to participate effectively in bathing and is bathed totally by another person.

- Excludes shampooing, washing face & hands.
- Don't rely on patient report alone.

M1830 Bathing

- 6 = patient totally unable to participate & is totally bathed by someone else, regardless of:
  - –Where bathing occurs
  - –Whether patient has a functioning tub or shower.

M1830 Bathing

- Environmental barriers & medical restrictions can limit ability.
  - – Enter 4, 5 or 6 if a patient has no access to the only tub/shower:
    - 4 = patient can safely and independently bathe, but not in shower or tub.
    - 5 = patient can participate, but needs assistance.

M1830 Bathing

- Enter **3** if the patient can bathe ***safely*** in the tub or shower only with **continuous**:
  - Standby assistance.

  OR
  - Verbal cueing/reminders.

  OR
  - Human presence for any reason.

M1830 Bathing

- Enter **2** if the patient can bathe ***safely*** in the tub or shower with **intermittent** help, but not the continuous presence of another person to help with:
  - Transfers into/out of tub/shower
    - **Watch the patient do this**!
  - Standby assistance.
  - Washing difficult-to-reach areas.
  - Verbal cueing/reminders.
  - Assistance to get to the location bathing occurs.

M1840 Toilet Transferring

(M1840) **Toilet Transferring:** Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.		
Enter Code ☐	0	Able to get to and from the toilet and transfer independently with or without a device.
	1	When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.
	2	Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).
	3	Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
	4	Is totally dependent in toileting.

- Identifies the patient's ability to safely get to and from and transfer on and off the toilet or bedside commode.
- Excludes personal hygiene and management of clothing when toileting.
- Q, $, PRA.

M1840 Toilet Transferring

(M1840) **Toilet Transferring:** Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.		
Enter Code ☐	0	Able to get to and from the toilet and transfer independently with or without a device.
	1	When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.
	2	Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).
	3	Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
	4	Is totally dependent in toileting.

- This transfer is specific to toileting.
  - Always observe this transfer.
  - Beware of potential clinical inconsistencies.
    - If a patient truly is independent with toilet transfers & dependent on another person for bed-to-chair transfers, document why both are correct.

M1840 Toilet Transferring

- If no toilet is in the home, the assessing clinician must determine the level at which the patient is able to perform safely, and enter:
  - 4 if the patient can do neither safely, or if equipment is not present in the home to allow assessment.
  - 3 if the patient can use a bedpan/urinal.
  - 2 if the patient can use a bedside commode (with or without assistance).

M1840 Toilet Transferring

- Enter 3 if a patient is unable to access the toilet or bedside commode, but:
  - Can place and remove a bedpan/urinal independently.
  - Whether or not someone else must empty the bedpan/urinal.

M1840 Toilet Transferring

- Enter 1 if the patient needs:
  - Standby assistance.
  - Verbal cueing/reminders.
  - Help getting to/from the toilet, or with toilet transfer, or both.
- Enter 0 for daytime independence & commode use **for convenience** at night.

M1845 Toileting Hygiene

(M1845) **Toileting Hygiene:** Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.		
Enter Code ☐	0	Able to manage toileting hygiene and clothing management without assistance.
	1	Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.
	2	Someone must help the patient to maintain toileting hygiene and/or adjust clothing.
	3	Patient depends entirely upon another person to maintain toileting hygiene.

- Patient's ability to manage personal hygiene and clothing when toileting:
  - With or without assistive devices;
  - Quality measure calculation.
- Q, PRA.

M1845 Toileting Hygiene

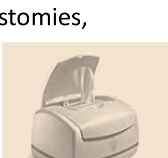
- "Assistance" refers to help from another person by:
  - Verbal cueing.
  - Reminders.
  - Supervision.
  - Standby assistance.
  - Hands-on assistance.

- Pull clothes up or down and adequately cleaning (wiping) the perineal area.

M1845 Toileting Hygiene

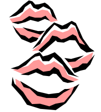
Toileting Hygiene

- Includes ability to safely maintain hygiene related to:
  - Catheter care.
  - Cleansing around all stomas that are used for urinary or bowel elimination.
    - Such as urostomies, colostomies, ileostomies.



M1845 Toileting Hygiene

- Enter 3 if the patient can't participate.
- Enter 2 if the patient
  - Can participate in hygiene and/or clothing management, but needs some assistance with either or both activities.
  - Needs standby assistance or verbal cueing.



M1845 Toileting Hygiene

- Enter 1 if the patient can safely manage toileting hygiene and clothing IF supplies are laid out for the patient.
- Enter 0 if the patient independently manages toileting hygiene & clothing.
  - No streaks on the underwear!

M1850 Transferring

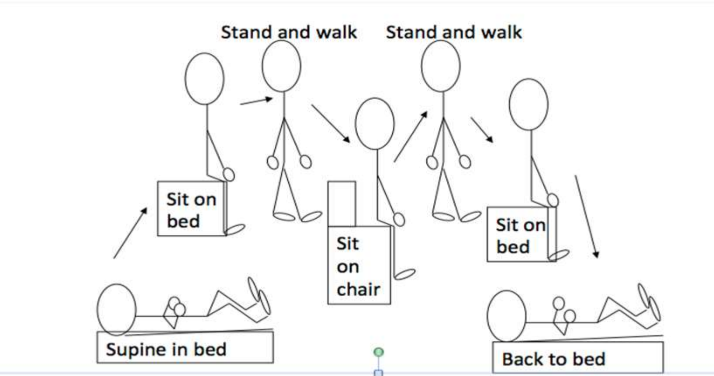
(M1850) Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.		
Enter Code ☐	0	Able to independently transfer.
	1	Able to transfer with minimal human assistance or with use of an assistive device.
	2	Able to bear weight and pivot during the transfer process but unable to transfer self.
	3	Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
	4	Bedfast, unable to transfer but is able to turn and position self in bed.
	5	Bedfast, unable to transfer and is unable to turn and position self.

- Identifies the patient's ability to safely transfer from bed to chair (and chair to bed), or position self in bed if bedfast.
- The intent of the item is to identify the patient's ABILITY, not necessarily actual performance.
- Q, $, PRA.

What is M1850 really asking?

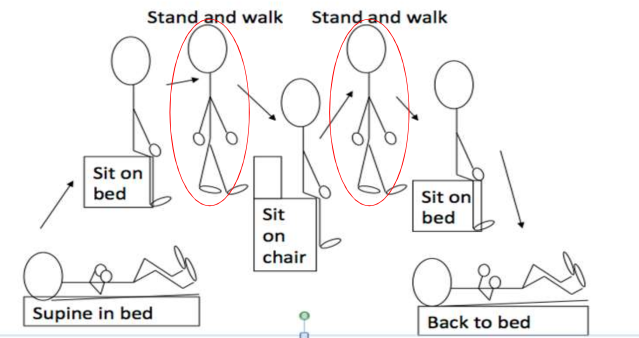
- The transfer scored at M1850 is limited to the patient's ability to SAFELY transfer from bed to chair and back again.
  – Requires multiple steps.
- Other transfers are captured elsewhere.

Assess bed to chair & back to bed



- **M1850** includes moving from lying supine in bed to sitting on the bedside, then some type of standing, stand-pivot or sliding board transfer to a chair, then back into bed, returning to supine position.

Assess bed to chair & back to bed



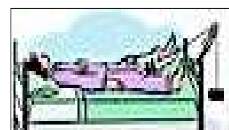
- The need for assistance with gait may impact the M1850 transferring score if the closest sitting service applicable to the patient's environment is not next to the bed.

M1850 Transferring

5 - Bedfast, unable to transfer and is unable to turn and position self.

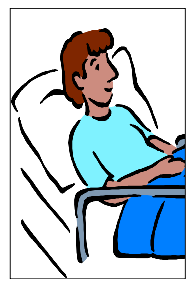
- Bedfast = confined to bed, **either** per physician order **OR** inability to tolerate being out of the bed.
  - Enter 5 if the bedfast patient can do neither:
    - Transfer.

    NOR
    - Turn and position self.



M1850 Transferring

4 - Bedfast, unable to transfer but is able to turn and position self in bed.



- Enter 4 if the bedfast patient is:
  - Unable to transfer.

  But
  - Able to turn and position self in bed.

M1850 Transferring

3 Unable to transfer self and is unable to bear weight or pivot when transferred by another person.

- The patient must be able to both bear weight and pivot for Response 2 to apply.
- If the patient is unable to do one or the other and is not bedfast, enter Response 3.
  - Such as when unable to bear weight on any extremity, but can tolerate sitting in chair when transferred by others.

M1850 Transferring

- The patient's full impairment with bed-to-chair transfers is tricky to catch because the gap between 1 and 2 seems extreme.

1 - Able to transfer with minimal human assistance or with use of an assistive device.
2 - Able to bear weight and pivot during the transfer process but unable to transfer self.

- Some clinicians hesitate to enter 2 when a patient **needs more than minimal help** with transfers from bed to chair and back, but ***does not require*** **a weight-bearing pivot transfer.**

M1850: enter 1 when it fits completely

1 - Able to transfer with minimal human assistance or with use of an assistive device.

- Enter 1 when the patient safely transfers with **either** minimal human assistance or a device, **but not both**.

OR

M1850: When 2 doesn't seem right either

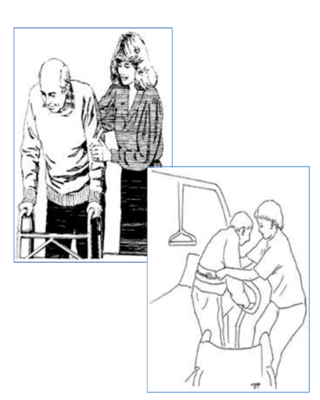
2 - Able to bear weight and pivot during the transfer process but unable to transfer self.

- OASIS items aren't meant to capture every comprehensive assessment detail.
  - Document additional, specific information elsewhere in the comprehensive assessment.

M1850: enter 2 when:

2 - Able to bear weight and pivot during the transfer process but unable to transfer self.

- The patient requires **both** minimal human assistance **and** an assistive device to transfer safely.
  - As when the patient needs to learn to use the device safely.



M1850: enter 2 when:

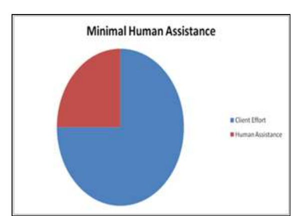
- Enter "2–Able to bear weight and pivot during the transfer process but unable to transfer self" **even when the patient can do much more than pivot transfer**.

M1850: enter 2 when:

- The patient transfers from bed to chair and back with only an assistive device, but **not safely.**

M1850: enter 2 when:

- Minimal assistance alone is not safe.
  - Meaning the assistance required is >25% of the work necessary to accomplish the transfer.
  - Including environmental set up.

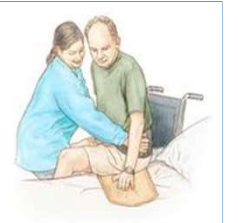


M1850: enter 2 when:

- The patient is **able** to **bear weight and pivot ONLY**.
  - **Never assume** the patient can do or use anything you did not see during the assessment.
  - Document ONLY what you observe.

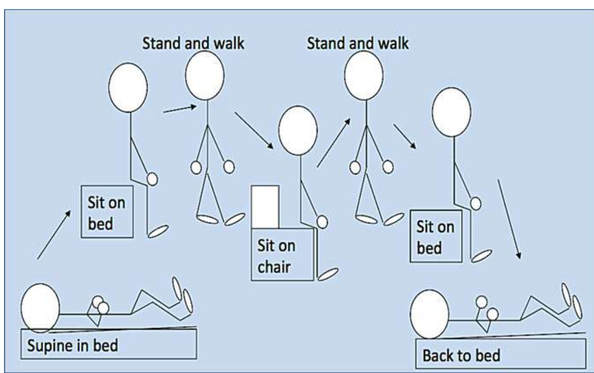
M1850 Transferring

- Able to bear weight = ability to support the majority of body weight through any combination of weight-bearing extremities.



M1850 Transferring

- Observe ***and*** interview to determine how much assistance is required for safe transfers from bed to chair & back.



M1850 Transferring

- Ask about transferring ability.
- Observe the transfers.
  - Taking extra time or pushing up with both arms **does not** mean the patient is not independent.
  - Chair arms are not assistive devices.

M1850 Transferring

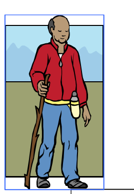
- If there is no chair in the patient's bedroom or the patient does not routinely transfer from the bed directly into a chair in the bedroom, report the patient's ability to move from a supine position in bed to a sitting position at the side of the bed, and then the ability to stand and then sit on whatever surface is applicable to the patient's environment and need, (for example, a chair in another room, a bedside commode, the toilet, a bench, etc.). Include the ability to return back into bed from the sitting surface.

M1860 Ambulation/Locomotion

(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

Enter Code		
☐	0	Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).
	1	With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
	2	Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
	3	Able to walk only with the supervision or assistance of another person at all times.
	4	Chairfast, unable to ambulate but is able to wheel self independently.
	5	Chairfast, unable to ambulate and is unable to wheel self.
	6	Bedfast, unable to ambulate or be up in a chair.

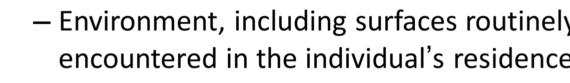
M1860 Ambulation/Locomotion



- Identifies patient's ability and the type of assistance needed to **SAFELY:**
  - Ambulate (once standing), **OR**
  - Propel self in a wheelchair, once seated.

M1860 Ambulation/Locomotion

- Address patient's ability given the patient's current:
  - Physical, mental, emotional, and cognitive status.
  - Activities permitted.
  - Environment, including surfaces routinely encountered in the individual's residence.



    - If one surface causes more problems than another, **choose the score matching the most impaired situation**.

M1860 Ambulation/Locomotion

- Ask about walking or wheeling ability.
- Observe the patient ambulating/wheeli ng across the room and to the bathroom.
- Don't assume safety you have not observed.

M1860 Ambulation/Locomotion

- Does the patient:
  - Use furniture or walls for balance or support?
    - **Not safe** simply because a patient routinely does so.
  - Need a walker or cane for ***safe*** ambulation?
  - Climb stairs ***safely***?
  - ***Safely*** propel a wheelchair independently if chairfast?
    - Assess use of the wheelchair present, whether powered or manual.

M1860 Ambulation/Locomotion

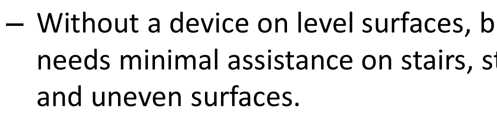
- Enter 6 for patients who are bedfast, unable to ambulate or be up in a chair.
- Enter 4 or 5 for patients unable to ambulate, even with the use of assistive devices and/or continuous assistance.
  - Includes those able to take only one or two steps to complete transfers.

M1860 Ambulation/Locomotion

- Enter 5 if patient is **unable** to wheel self.
- Enter 4 if patient **can wheel self** *independently*.

M1860 Ambulation/Locomotion

- Enter 2 if the patient can safely ambulate:
  - With **intermittent** human assistance
    - Hands on, supervision, verbal cues, etc.



  - Without a device on level surfaces, but needs minimal assistance on stairs, steps and uneven surfaces.
    - < 25% of the work.

  - With a walker in some areas and a cane in other areas, both without human assistance.

M1860 Ambulation/Locomotion

- Enter1 if the patient can:
  - Safely ambulate with a cane.
  - Without human assistance.
  - On even & uneven surfaces & stairs.
  - Applies to patients who are:
    - Using canes for weight bearing.

    and

    - Blind, using a white cane to detect objects in their path.

M1860 Ambulation/Locomotion

- If a patient is safely using a knee scooter as an assistive device to facilitate non-weight bearing on one lower extremity, the clinician must:
  - Determine if the patient is safe without the assistance of another person;
  - Assess the number of hands (one-hand or two-hands) the patient requires to safely use the device.
    - CMS Q&As 10.16 Q155.3.4

M1870 Feeding or Eating

(M1870)	**Feeding or Eating:** Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.
Enter Code ☐	0 Able to independently feed self. 1 Able to feed self independently but requires: (a) meal set-up; OR (b) intermittent assistance or supervision from another person; OR (c) a liquid, pureed or ground meat diet. 2 Unable to feed self and must be assisted or supervised throughout the meal/snack. 3 Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy. 4 Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy. 5 Unable to take in nutrients orally or by tube feeding.

- Identifies the patient's ability to feed him/herself, including the process of eating, chewing, and swallowing food.
  - Excludes food preparation and transport to the table. Base on the assistance needed by the patient to feed himself once the food is placed in front of him.

Noyce Consulting

M1870 Feeding or Eating

(M1870)	**Feeding or Eating:** Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.
Enter Code ☐	0 Able to independently feed self. 1 Able to feed self independently but requires: (a) meal set-up; OR (b) intermittent assistance or supervision from another person; OR (c) a liquid, pureed or ground meat diet. 2 Unable to feed self and must be assisted or supervised throughout the meal/snack. 3 Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy. 4 Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy. 5 Unable to take in nutrients orally or by tube feeding.

- Meal "set-up" (1) includes activities such as mashing a potato, cutting up meat/vegetables when served, pouring milk on cereal, opening a milk carton, adding sugar to coffee or tea, arranging the food on the plate for ease of access, etc.—all of which are special adaptations of the meal for the patient.

Noyce Consulting

M1910 Falls Risk Assessment

(M1910)	Has this patient had a multi-factor **Falls Risk Assessment** using a standardized, validated assessment tool?
Enter Code ☐	0 No. 1 Yes, and it does not indicate a risk for falls. 2 Yes, and it does indicate a risk for falls.

- Identifies if the agency assessed the patient and home environment for characteristics that place the patient at risk for falls using a multi-factor falls risk assessment that includes at least one standardized, validated tool.
  - Both:
    - Appropriate for the patient based on their cognitive and physical status.
    - Appropriately administered per the tool's instructions.
  - And . . .

M1910 Falls Risk Assessment

- Multi-factor falls risk assessment must include at least one standardized tool:
  - Validated as effective in identifying falls risk in a population with characteristics of the patient.
  - Includes a standardized scale.
- Use the scoring parameters specified in the tool.
- A single comprehensive tool that meets criteria or several tools may be used.
- Administered by assessing clinician within assessment time parameters.

M1910 Falls Risk Assessment

- Missouri Alliance for Home Care (MAHC) falls risk assessment tool validated:
  - Consolidates all of the major risk factors for a fall, such as age, visual impairment, environmental factors, poly-pharmacy and impaired functional ability into a page-long checklist, making it the first-ever multi-factorial *and* validated falls risk assessment tool that agencies can use to enter "Yes" at M1910, even for chairfast and bedbound patients.
  - Does ***not*** have a functional component and should be used "as an initial screen for fall risk, which, if identified, may warrant additional, more specific fall risk assessment."
  - A score of **4 or more** = falls risk.
    - CMS Q&A, Cat. 4b 10.16 159.5.1

M1910 Falls Risk Assessment

- Select 0 (No multi-factor falls risk assessment conducted) when:
  - No standardized, validated multi-factor test done.
  - Standardized, validated multi-factor test **not** done within the CMS OASIS-completion time frame:
    - SOC: 5 days after SOC.
    - ROC: 48 hours post inpatient DC for ROC.

M1910 Falls Risk Assessment

- Select 0 (No multi-factor falls risk assessment conducted) when:
  - Standardized, validated multi-factor test **not** done by clinician responsible for completing OASIS assessment.
  - Patient not able to participate in task required to allow completion and scoring of standardized assessment(s) that agency chooses to utilize.

M1910 Falls Risk Assessment

- Select 1 if the standardized scale rates the patient as no-risk, low-risk, OR MINIMAL RISK.
- Select 2 if:
  - The standardized scale rates the patient as anything above low-risk OR MINIMAL RISK.
  - The tool doesn't specify risk level, only at risk or not at risk.

Thank You!

QUESTIONS?

References

- Draft-OASIS-D-Guidance-Manual-7-2-2018.pdf
- OASIS-D-Guidance-Manual-Errata-08-06-2018.pdf
- Home Health Quality Reporting Program Provider Training
  - Section GG: Functional Abilities and Goals, Kathryn D. Roby and Charlotte Steniger Qualidigm, September 5, 2018
  - Introduction to OASIS-D, Kathryn D. Roby and Charlotte Steniger Qualidigm, August 28, 2018
- Home Health OASIS July 2018 FAQs