Chapter 8: ADLs/IADLs

In a roundabout way, these OASIS questions help determine the patient's homebound status. Ideally, your agency should assign a physical therapist to assess the patient's ADL/IADL competencies. In addition, clinicians should condition themselves to "think like a therapist." How do you do that? Read on to learn dozens of practical, proven strategies.

ADL questions pose the biggest headache

The OASIS questions related to activities of daily living (ADLs) create the biggest headache for clinicians, says Rhonda Will, a senior consultant with Fazzi Associates and a key contributor to a 2003 study in which 57 home health clinical experts developed consistent ways to answer OASIS questions.

Case in point: M0650 (ability to dress upper body). It was a favorite of the Fazzi workgroup, says Will, adding they would like to see CMS rework it. Meanwhile, the group recommends you take the following approach:

Optimal question: *Have you changed what you wear to make it easier to get dressed? What do you wear to the doctor's office? Where are your clothes located?*

✓ **Optimal technique:** "Show me how you take your shirt off and put it back on." Observe the patient's ability to reach above his shoulders to get clothes out of closet. Note the patient's flexibility, coordination, balance, strength, and ability to safely gather and carry items.

Straight from the source
Quick Q & A with CMS

Q: M0640-M0800. At OASIS items M0640-M0800, what does IADL mean and what's the difference between IADLs and ADLs?
A: ADL stands for 'activities of daily living' while IADL stands for 'instrumental activities of daily living'. ADLs refer to basic self-care activities (e.g., bathing, dressing, toileting, etc.), while IADLs include activities associated with independent living
necessary to support the ADLs (e.g., use of telephone, ability to do laundry, shopping, etc.). There is a more complete discussion of this topic in the *OASIS User's Manual*, Chapter 8, Item-by-Item tips, on the page preceding the tips for items M0640-M0800.

The location of the clothing is important, says Will, because most field clinicians aren't recognizing that inaccessibility interferes with the ability to dress safely and that means the need for assistance. For example, if a hip patient temporarily relocates to a lower-floor bedroom, but his or her closet is on the second level, someone else would need to retrieve the clothing (even though the patient may be able to put them on).

Accuracy also likely to boost functional case-mix points per case

Better inter-rater reliability won't just help your outcomes picture. By more accurately identifying higher patient acuity, it also may help your HHA's financial outlook. In OASIS audits conducted before the report, Fazzi Associates estimated that, if assessed accurately, the HHRG for 61% of patients would have been higher.

And watch out: With significant ramifications like that, the ability to produce an accurate OASIS assessment will be more often used to determine clinicians' compensation and promotions

predicts Ruth McCain, in-service performance improvement coordinator for Twin County Regional Home Health, in Galax, Va.

Straight from the source
Quick Q & A with CMS

Q: M0640-M0800. I know it is imperative that the assessing clinician be accurate on answering what the patient's status was on the "14th day prior to". Can you explain to me the importance of that 14th day? What bearing this has on their outcomes/payment? If we mark "unknown", does it hurt the agency?
A: Prior status contributes to the Case Mix Report categories of "ADL Status Prior to SOC" and "IADL Status Prior to SOC" and is utilized in risk adjustment for some of the outcome measures. The "prior status" variables have proven to be particularly useful in risk adjustment for the OBQI reports, as they indicate the chronicity of a functional impairment (thus impacting the patient's expected ability to improve in a specific outcome of interest).

The 14th day prior to SOC/ROC serves as a proxy for the patient's prior functional status. While it may not represent the "true" prior functional status, it allows the data collection of thousands of assessors to be standardized. General OASIS conventions state that data collectors should minimize the use of "unknown" as a response option, and to limit its use to situations where no other response is possible or appropriate. Under the current reimbursement for Medicare home care services, the "14 days prior" responses do not affect payment. However, since the responses from the prior status items do currently contribute to risk adjustment, it is possible that they may have a reimbursement impact in the future, depending on the parameters used to determine payment under the home health benefit and other programs.

Other examples of problems tackled by the Fazzi-led group:

- **What is "assistance?"** Consider a scenario in which a family member or other caregiver has to remind a patient to eat. Most clinicians would indicate on the OASIS assessment question **M0710** (feeding or eating) that such a patient can eat without assistance. OASIS reasoning, however, would characterize the reminder as a verbal prompt, or assistance, Will says.

- **What is "ability?"** Will offers the example of a patient who routinely receives assistance from a spouse in putting on his shoes, which is addressed in **M0660** (ability to dress lower body). In this scenario, a patient has the ability to put on his shoes, but he and his spouse have developed this habit over a period of years. In this case, a clinician might be tempted to focus on the practice, while OASIS is more concerned with the patient's ability, regardless of the practice.

  In response to inquires about **M0670** (bathing), patients tend to assure a clinician they certainly bathe every day, and a conventional home health assessment might not pursue the point, Will says. The OASIS assessment, however, seeks to document whether a patient needs assistance bathing, something that might not be obvious unless a clinician inquired carefully or observed the task being done.

- **Is the assessment consistent?** Consider this common problem: A patient receiving help with medication management is simultaneously characterized as having no memory deficit on **M0610** (behaviors demonstrated). Will suggests that while patients may need medication assistance because of some type of physical limitation, a more likely explanation is that the assessment response overlooked some type of cognitive impairment.

  In the same vein, Will has seen patient records that document "poor safety awareness,"

but at the same time fail to note any "impaired decision making" in response to **M0610.** In both examples, the therapist has underestimated the acuity of care and, potentially, reimbursement levels, she says. ◆

Make educated guess before marking "unknown"

Be sure to extrapolate the patient's prior functional status -- even when he or she can't definitively answer the seven activities of daily living (ADL) questions.

While a guess may not be 100% correct or reliable, it's better for statistical analyses to make an educated guess rather than simply check "unknown," says Rhonda Will, head of Fazzi Associate's 3M National OASIS Integrity Project, Northampton, Mass.

Although the OASIS answers in the "prior" column don't directly impact payment, they do have an affect on your outcomes. If you dismiss the importance of prior data, outcomes may suffer because they won't accurately indicate rehabilitation potential, cautions Mary St. Pierre, National Association for Home Care & Hospice VP for regulatory affairs.

For example, when clinicians incorrectly code a patient as "able to dress without assistance" 14 days prior to start of care for M0650 (ability to dress upper body) when the patient required assistance, then there's no room for the agency to show the improvement the patient has made under its care, St. Pierre adds.

Clinicians marked "unknown" in the prior column for one or more OASIS ADL questions in 2% of assessments (5,000 cases) during the fourth quarter of 2003, data from benchmark vendor Outcome Concept Systems indicate.

In 1.6% of assessments (4,000 cases), clinicians marked "unknown" for *all seven* of the ADL questions. Seattle-based OCS pulled the data from 250,000 assessments for 750 agencies during the fourth quarter of 2003.

While higher than it should be, the number of "unknown" answers is not surprising given how hard it can be to collect this information, says Linda Krulish, OASIS training expert and head of Home Therapy Services, Redmond, Wash. Since clinicians are unable to assess their patients prior to home care, they must glean information via interviews with patient and caregiver, she explains.

But it's difficult to obtain accurate information from patients who suffer from memory deficits or are taking narcotics, says Sparkle Sparks, PPS analyst and home health educator, Lee Memorial Hospital, Ft. Myers, Fla., and an advisor for Fazzi Associate's National 3M OASIS Integrity Project.

Don't give up, though. Here are a few points from Will to help clinicians determine the patients' prior status based on their previous condition. Ask yourself, "Where was the patient 14 days ago?" If the patient was:

- **On the operating table –** it's safe to say that the patient was dependent in their activities of daily living.
- **Not sick yet –** he or she probably is independent at the normal state of dependence.

Recovering or rehabbing from a less acute event-- these patients typically are somewhat dependent. ◆

Clinicians nail functional questions, but still need improvement

Have you noticed your patients' functional OASIS scores are improving? If so, you're like the majority of home health agencies, new benchmark data show. But do you know why?

While it's possible the improved functional scores simply reflect more patients getting better, home health experts believe it's the clinicians who are getting better -- at answering the OASIS questions.

A look at a group of patients' functional OASIS scores from 2001 to 2004 shows across-the-board increases in the number of patients who improved or stabilized from start-of-care to discharge in nine functional skills: ability to dress upper and lower body, groom, bathe, toilet,

transfer, ambulate, do laundry and perform basic housekeeping tasks. The data from Outcome Concept Systems Inc. compares the first quarter of 2004 to the same period in 2001. The Seattle-based benchmark vendor's database includes 750 agencies and 250,000 cases for 2004 and 700 agencies/180,000 cases for 2001.

Agencies' commitment to OASIS training has paid off and clinicians are getting wiser about OASIS, says Sparkle Sparks, OASIS educator, Lee Memorial Hospital, Ft. Myers, Fla.

When CMS first implemented OASIS, clinicians commonly overestimated the patient's functional ability at the start-of-care, Sparks says. Without an accurate baseline, the agency had no way to show the patient's improvement upon discharge.

But agencies have since recognized that OASIS is a complex document with many layers and there's still room for training, Sparks adds.

Connect the dots: OASIS & adverse events

You can make further improvements in your scores by teaching clinicians how their OASIS responses can lead to unnecessary adverse events, Sparks suggests.

Here are a few examples of OASIS questions that could, if answered incorrectly, lead to an unwarranted adverse event:

- **ADL questions** could reflect a needless adverse event for a "decline in three or more activities of daily living." The ADLs are: M0640 (grooming), M0650 (ability to dress upper body), M0660 (ability to dress lower body), M0670 (bathing), M0680 (toileting), M0690 (transferring) and M0700 (locomotion).

Agencies would receive this adverse event when clinicians give a patient a higher numerical score from one assessment to the next for three different OASIS ADL questions, Sparks explains.

This most often occurs when two different clinicians, each with a different understanding of OASIS, assess the same patient, Sparks says.

Here's how two clinicians could answer the same question differently: At the start-of-care, clinician A assesses a patient who uses a walker to move around

Straight from the source

Quick Q & A with CMS

Q: M0650, M0660, M0780. For M0650 & M0660, we know you count things like prostheses & TED hose as part of the clothing. But the interpretation is that they have to only be independent with the "majority" of the dressing items & then they are considered independent. Because of the importance of being able to put a prostheses on and for a diabetic being able to put shoes & socks on, clinicians want to mark a patient who can do all their dressing except those items NOT independent. However, does this fit the criteria of "majority"?

The same issue can exist for medication compliance.....if a patient can take the majority of their meds (Vitamins, stool softeners, etc.) but cannot remember their digoxin....does that make them independent with the majority even though we know how important the digoxin is?"

A**:** Your understanding of the majority rule is correct. If a patient's ability varies among the tasks included in a single OASIS item (like M0660 lower body dressing, or M0780 Oral Medications), select the response that represents the patient's status in a "majority" of the tasks. The concerns of clinicians focus on critical issues that need to be addressed in the plan of care. It may help to remember that the OASIS is a standardized data set designed to measure patient outcomes. In order to standardize the data collected, there must be objective rules that apply to the data collection (e.g. the percentage of medications a patient can independently take). Less objective criteria, like which medications are more important, or which lower body dressing items are more important than others, have limitations in consistency in which a similar situation would likely be interpreted differently between various data collectors from one agency to the next. While these rules may cause the assessing clinician to pick an item response that lacks the detail or specificity that may be observable when assessing a given patient, as long as the clinician is abiding by scoring guidelines, he/she is scoring the OASIS accurately and the agency's outcome data will be a standardized comparison between other agencies. In any situation where the clinician is concerned that the OASIS score does not present as detailed or accurate representation as is possible, the clinician is encouraged to provide explanatory documentation in the patient's clinical record, adding the necessary detail which is required for a comprehensive

his home. When answering M0700 (ambulation/locomotion), Clinician A answers "1" (requires use of a device, cane or walker).

During the follow up assessment, the patient's functional status hasn't changed. The patient still requires a walker to move around the home. Yet when Clinician B answers M0700, she marks "2" (able to walk only with supervision or assistance of another person at all times). Clinician B understands the underlying intent of these questions, to assess the patient's ability to *safely* maneuver around the home, Sparks says.

Result: Three or more differences like this will result in a needless adverse event, Sparks says.◆

ADLs help determine homebound status

In a roundabout way, these OASIS items help determine whether the patient is truly homebound, since a patient who can shop and drive a car does not meet Medicare's homebound criteria, says Margaret Cesario, executive director of Care Partners, Inc., in Morgantown, WV.

You must gauge whether the patient can care for herself independently and how much assistance the she requires to meet her basic needs. M0770 is particularly critical, since it asks you to assess the patient's ability to effectively use the telephone.

Ideally, your agency should send a physical therapist in to assess the patient's ADL/IADL competencies. If that's not feasible, you can at least condition yourself to "think like a therapist," says Cesario, who served as a clinical expert advisor to the 3M National OASIS Integrity Project.

Here's why: A nurse, for example, may ask a patient whether she has any trouble ambulating to the bathroom or combing her hair. A therapist would ask the patient to demonstrate these actions, she says.

You'll get more accurate data by observing the patient, Cesario says, since "a lot of times, patients don't want to tell you they can't take care of themselves.

When answering these questions, remember to asses how "safely and effectively" they can perform these activities, Cesario stresses.

"The patient may be able to put his socks on, but will he topple over while doing it?"

Six more tricks for answering these correctly

✓ **Tip:** Note in your comprehensive assessment any medical restrictions that might prevent a patient from completing a particular task, such as a physician's restriction against walking 20 feet because the patient is recovering from a total knee replacement.

✓ **Tip:** Include notes on a patient's cardiopulmonary and nutritional status, because it affects their energy level and ability to do strengthening exercises. Both may affect a patient's ability to recover and their improvement on ADL outcomes, an educator advised.

✓ **Tip:** Base your assessment of a patient's grooming abilities on routine grooming, such as washing the face and clipping toenails. Never base your assessment on how well-groomed the patient may appear, since a caregiver may have cleaned the patient up before your visit, or someone may be untidy but physically and mentally capable of grooming.

✓ **Tip:** When answering M0750 (housekeeping), understand that the "light housekeeping" referred to in response "1" includes wiping counters and light dusting, says Therese Rossman, director of Community Nursing Service in Johnstown, PA. It *doesn't* refer to heaver tasks such as vacuuming and washing floors.

✓ **Tip:** Don't just select Response "2 – Unable to go shopping but is able to identify items needed, place orders, and arrange home delivery" in M0760 (shopping) if the patient relies on someone else to do his shopping, warns Rossman. This question is asking you to assess the patient's cognitive and physical functioning, since it requires "a lot of physical and mental functioning for a patient to find out what he doesn't have, make a list of what he needs, phone it in to someone, place the order, and then put the groceries away once the order arrives, says Rossman.

"Jotting a few things down on a list so that his daughter can do the shopping and put the groceries away is not what Response 2 refers to, she says.

✓ **Tip:** Observe the patient's ability to perform ADLs and IADLs *independently*. For example, Mrs. Smith may be able to use the bathroom just fine while her daughter is visiting following her discharge from the hospital, but what about once her daughter leaves?

If she can't safely use her toiled on her own and instead must use her bedside commode, you should mark M0680 as "2 – Unable to get to and from the toilet but is able to sue a bedside commode (with our without assistance)," says Cesario.

Why this distinction is important: Your patient will appear to experience a decline in condition if you initially answer "0 – Able to get to and from the toilet independently with our without a device," on M0680 because Mrs. Smith's daughter is helping her, and another clinician later reassesses the patient as a "2," Cesario points out. ◆

M0640 –M0660: Grooming & dressing

(M0640) Grooming: Ability to tend to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care).

Prior Current

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.

UK - Unknown

🕮 *The OASIS Implementation Manual says:*

Patients who can do more frequently performed activities but can't do less frequently performed activities should be considered to have more grooming ability.

Response "2" in M0640 includes standby assistance or verbal cueing. Mark "UK - Unknown" only if there is no way for you to determine the patient's prior ability on this item.

Observe the patient gathering items necessary for grooming. The patient can verbally report these steps and demonstrate the motions he/she uses while grooming (e.g., hand to head for combing, hand to mouth for teeth care, etc.). Verify the patient's upper extremity strength, coordination, and manual dexterity to determine whether he/she requires assistance. A poorly groomed patient who possesses the coordination, manual dexterity, upper-extremity range of motion, and cognitive/emotional status to perform grooming activities should be evaluated according to his/her ability to groom.

🗁 *3M OASIS Integrity Project* says:*

Grooming also includes gathering equipment. Assessing the patient's "ability" includes considering her:

- Cognition, emotional and behavioral state (alertness, comprehension, fear, anxiety, etc).
- Physical function (ROM, strength, dexterity, ambulation, endurance, etc).
- Ability to complete tasks safely, effectively and efficiently
- Medical restrictions (sling and swath to immobilize arm, shoulder, etc).
- Activity limitations (bed rest, joint replacement patient with inability to climb multiple stairs to second floor where grooming items located, etc). ❖

Straight from the source

Quick Q & A with CMS

M0670

Q: Please clarify how the patient's ability to access the tub/shower applies to M0670.

A: M0670 defines the bathing item to identify the patient's ability to wash the entire body. Guidance for this item also indicates that when medical restrictions prevent the patient from accessing the tub/shower, his/her bathing ability will be 'scored' at a lower level. Tasks related to transferring in and out of the tub or shower are evaluated and scored when responding to M0690 – Transferring, and they are not considered part of the bathing tasks for M0670. ❖

(M0650) Ability to Dress Upper Body (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

Prior Current

0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.
2 - Someone must help the patient put on upper body clothing.
3 - Patient depends entirely upon another person to dress the upper body.
UK - Unknown

(M0660) Ability to Dress Lower Body (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

Prior Current

0 - Able to obtain, put on, and remove clothing and shoes without assistance.
1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
2 - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.
3 - Patient depends entirely upon another person to dress lower body.
UK - Unknown

Straight from the source
Quick Q & A with CMS

M0670
Q: Please clarify how the patient's ability to access the tub/shower applies to M0670.
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HHAs reveal secret to good outcomes scores

She was the belle of the ball from a "grand old Southern family." But by the time she became a patient of Care America, her dignity suffered with the onset of rheumatoid arthritis and other co-morbidities, recalls Mac Keener, the Orlando, Fla., home health agency's director. The 85-year-old patient couldn't put on her makeup, clasp bras or button shirts.

So Care America's occupational therapists worked with the woman on exercises to help her move her fingers and elbows, while simultaneously teaching her to wear clothes that she could more easily put on or remove.

In 120 days, the patient went from being a "sick old lady" discharged from the hospital to resuming her social events, Keener says.

This two-pronged approach is what the Florida HHA believes is behind its 74% average on the "patients getting better at getting dressed (upper body)" outcome. The score is fourth highest in Brevard County, amongst 54 agencies, and eighth in the state, reveals a public comparison of Florida HHAs online.

Improvement in upper body dressing

Identify your patients who most likely will have trouble with upper body dressing and have occupational therapists visit them within a day or two of their start-of-care assessments.

It's one of the biggest keys to the 83% "improvement in upper body dressing" score at Webster, Mo.-based Lutheran Senior Services Home Health, believes Lucia Bellovich, the agency's quality improvement coordinator. The rural 50-patient HHA's average is the best in Saint Louis County.

At Lutheran, nurses are keen to certain cues for OT evaluation, says Shauna Walt, one of the agency's three full-time OTs. Most likely in need are patients with arm or shoulder fractures, arthritis or CVA. Nurses also look for articles of clothing that are soiled or appear as if they haven't been changed in a couple of days, Walt says.

On their first visit to such a patient, OTs evaluate and set goals, ranging from putting on a shirt with buttons to putting on a T-shirt.

Lutheran also employs three part-time OT assistants, who help patients with exercises and perform most of the follow-up OT visits, Walt says. Following evaluations, therapists go over plans of care with their assistants and provide instructions. Dual, supervisory visits are performed with assistants at least every 30 days, Walt says.

While contract therapists tend to use assistants a lot, some HHAs have opted not to use them at all, notes Linda Krulish, physical therapist and home care consultant-head of Home Therapy Services, Redmond, Wash. They can't make initial evaluations, recertify patients or change the treatment plan without approval from the OT, but "certified occupational therapy assistants" are able to carry out an established treatment plan, and are accustomed to focusing on ADLs and IADLs, Walt says.

By the second visit, patients are taught to use appropriate adaptive equipment, including dress sticks, Velcro clothing, dressing hooks, long-handed reachers, sock aides, shoe horns, ped hose donners or anti-embolism stockings, she says.

It's important for clinicians to teach patients one goal at a time, Walt stresses. Clinicians may teach a stroke patient during the first two visits, for example, how to put on a pullover shirt by leaning the body forward as he or she sits in a chair. The patient puts the shirt over the affected arm first, and then the mobile arm. After accomplishing that task, the third visit might be focused on teaching the patient to put on a shirt with buttons.

However, while teaching patients to use easy to wear clothes may make outcomes better, it's important that HHAs not let their desire to look good overshadow the goal of helping a patient gain as much independence as possible, Krulish warns. Teaching all patients to avoid buttons, for example, is tantamount to teaching all children who can't tie their shoes to wear Velcro sneakers, she says. ◆

M0670: Bathing

 (M0670) Bathing: Ability to wash entire body. Excludes grooming (washing face and hands only).

Prior Current

0 - Able to bathe self in shower or tub independently.
1 - With the use of devices, is able to bathe self in shower or tub independently.
2 - Able to bathe in shower or tub with the 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 - Participates 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 and is bathed in bed or bedside chair.
5 - Unable to effectively participate in bathing and is totally bathed by another person.
UK - Unknown

M0670 asks about bathing not transferring ability

Response item No. 2 in M0670 guides clinicians to mark this response when patients require the assistance of another person to get in and out of the shower or tub. Yet, in the OASIS Implementation Manual, CMS instructs clinicians to mark response "0 or 1" when the patient's ability to transfer into and out of the tub or shower "is the only bathing task requiring human assistance".

Clinicians should focus on the patient's ability to bathe, not transfer, when answering M0670, a CMS official says. That's always been the intent of the OASIS question, the official says.

The issue: A response of "0 or 1" doesn't yield any functional domain points while a response of "2-5" would yield eight points.

Don't get hung up when patient needs help transferring

It isn't enough to mark a "2" in M0670 (bathing) when a patient only requires bathing assistance to transfer in and out of the shower or tub.

To mark a "2," clinicians are asked to consider three different points:

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

Even though each response is separated with an "or," in some cases it takes more than one to justify a "2," a CMS official tells *Home Care Outcomes*. If part "b" is the only one that is true, then the patient should be scored a '0' or '1,' depending on the patient's need for devices, the official says.

However, either of the two options, "a" or "c" can stand alone to justify this response. For example, if the patient needs help bathing, intermittent supervision or bathing reminders *or* needs help washing difficult-to-reach areas, the correct choice would be "2," CMS tells HCO.

This guidance is a significant change and may seem counter-intuitive to clinicians, says Dianne Hansen, clinical advisor to Fazzi's 3M National OASIS Integrity Project and manager of administrative services, Partners in Home Care, Missoula, Mont. It's difficult for clinicians to answer the bathing question without considering the patient's ability to get in and out of the tub, Hansen says.

Straight from the source
Quick Q & A with CMS

Q: M0670. I understand that recent clarification reveals that the transfer in/out of the tub/shower should not be included in the scoring of M0670. Previous guidance stated that in order for the patient to be able to bathe in the tub/shower they had to be able to get there (e.g., if a patient is restricted from stair climbing and their only tub/shower is upstairs, then they are unable to bathe in the tub/shower) Is this still true or is M0670 now limited to just the patient's ability to wash their entire body once in the tub/shower? It seems strange that walking up the stairs *would* impact the bathing item score, but getting into the tub/shower *wouldn't.*

A: Guidance for this item has evolved over time and additional clarification has been provided, allowing objective measurement of improvement in a specific portion of the bathing process; the patient's ability to wash their entire body. If a patient can get to
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the tub/shower and in/out of the tub/shower (by any safe means), then their ability to wash their entire body while in the tub/shower should be assessed, and the score reported as "0" if they need no human assistance or equipment, "1" if they need no human assistance but require equipment, "2" if they require intermittent assistance, "3" if they require constant supervision/assistance, "4" if they are unable to use the shower or tub and is bathed in bed or bedside chair, or "5" if they are unable to participate at all in washing their body. If medical restrictions prohibit the patient from activities which would be required for the patient to get to/from the tub/shower (e.g., restricted stair climbing), in/out of the tub/shower (e.g., some joint precautions), or from bathing or showering in the tub or shower (e.g., some cast or incision precautions), then the patient should be considered "unable to bath in the tub or shower" and would be scored a "4" or "5", depending on their ability to participate in washing their body at any location outside of the tub/shower.

And this interpretation makes it more difficult for agencies to show patient improvement if clinicians can't mark a response of "2" when the patient requires assistance to get in and out of the tub or shower, Hansen says.

For example, the OASIS bathing question won't capture the improvement of a patient who needed assistance getting in and out of the tub before your OT had grab bars and shower seats installed in the patient's bathroom, Hansen says.

Tasks related to getting in and out of the tub or shower are evaluated and scored when responding to M0690 (transferring), but they are not considered part of the bathing tasks for M0670, CMS clarified in its most recent Q&As posted on www.qtso.com/hhadownload.htm in June. Note: Improvement in bathing is one of the ten outcomes listed on Home Health Compare.

"If the patient is able to wash their entire body in the tub or shower without help, but chooses to wash at the sink because they don't have help with the shower/tub transfer, you should mark "0" (if they don't require equipment to bathe) or "1" (if they do require equipment to bathe), says OASIS training expert Linda Krulish, Redmond, Wash.

9 more strategies to help you answer M0670

1. **Hard-to-reach body parts do count.** If the patient can perform most of the bathing tasks (i.e. can wash most of his/her body) in the shower or tub using assistive devices, but needs help washing hard-to-reach places, the correct response would be "2–Able to bathe in the shower or tub with the assistance of another person: c) for washing difficult to reach areas," CMS says.
2. **Bathing-related tasks don't count.** Tasks such as gathering supplies, preparing the bath water, shampooing hair, or drying off should *not* be considered here, CMS says.
3. **Consider medical restrictions.** This is one of the points that clinicians miss most often when answering the bathing question, Hansen says. When medical restrictions prevent a patient from accessing the tub or shower, score his bathing at a lower level, CMS instructs. This applies to post-op patients who can't take a bath or a shower because their physician has instructed them not to get their wound wet. Note: Fear, anxiety or other reasons may prompt a patient to choose *not* to bathe by tub or shower, but that that is not an assessment of his "ability," according to the 3M OASIS Integrity Project by 3M Home Health Systems, Fazzi Associates and the National Association for Home Care.
4. **Develop assessment reminder cards.** Interim Healthcare gives its nurses assessment reminder cards with clues for getting the right answer to certain OASIS questions, says Susan Brown, home health manager, Interim Healthcare franchisee in Columbus, Ohio. For example, the agency's assessment strategies related to bathing include:
   - ✓ Assessing the patient's ability to bathe in the tub or shower even if the patient bathes in the sink. Brown instructs her staff to answer the bathing question based on ability, not preference. Many home care patients prefer to bathe at the sink even though they're physically able to bathe in the shower, she says.
   - ✓ Asking what type of assistance the patient needs when washing his entire body in the tub or shower.
   - ✓ Observing the patient's general appearance to determine whether he's been bathing. This provides clues even when patients aren't willing to admit that they can't bathe themselves.
   - ✓ Asking patients to demonstrate *how* they get in and out of the shower rather than simply asking *whether* they can.
   - ✓ Evaluating how much assistance the patient needs to get in and out of tub safely by assessing balance, endurance muscle strength, range of motion, and pain that may limit ability to bathe safely, Brown says.
   - ✓ Observing the patient's mobility. Example, does the patient stand up to greet you?

✓ Asking the patient for a tour of the kitchen or bathroom to better assess his ability to maneuver around these areas.

5. **Gather clues for multiple OASIS questions at one time.** You can gather clues about the patient's ability to bathe when assessing for other OASIS questions. For example, when you ask the patient to get his medication out of the cabinet, the patient's dexterity can provide clues for bathing potential, Hansen says.
6. **Refer to OTs for assistive devices,** such as grab bars, shower chairs, handheld shower devices and reachers for the soap, Brown says.
7. **Verbal cueing counts as assistance**. If your patients require the help of caregivers to remind them to take a bath or shower, this counts as assistance when answering M0670. Score the patient as a "2" if the patient requires intermittent help to bathe in the shower or tub. Score the patient a "3" if the patient requires constant help to bathe in the shower or tub.
8. **Be mindful of medical restrictions**. If a patient is medically restricted, per physician's orders, from climbing the stairs or if the only bathroom available requires the use of stairs, then the patient is temporarily unable to bathe due to medical restrictions or environmental barriers. You would answer "4" or "5," depending on the level of patient participation. Also, consider other factors such as physician-ordered bed rest, joint mobilization for post joint-replacement patients, non-weight bearing status and dressings and staples that can't get wet for patients who have undergone surgical procedures.
9. **Assess the patient's safety.** Answer the OASIS bathing question based on the patient's ability to *safely* bathe in the tub or shower, even if this conflicts with the patient's current habits. ◆

Straight from the source

Quick Q & A with CMS

Q: M0670. Given the following situations, what would be the appropriate responses to M0670?
a) The patient's tub or shower is nonfunctioning or is not safe for use.
b) The patient is on physician-ordered bed rest.
c) The patient fell getting out of the shower on two previous occasions and is now afraid and unwilling to try again.
d) The patient chooses not to navigate the stairs to the tub/shower.
A: a) The patient's environment can impact his/her ability to complete specific ADL tasks. If the patient's tub or shower is nonfunctioning or not safe, then the patient is currently unable to use the facilities. Response 4 or 5 would apply, depending on the patient's ability to participate in bathing activities outside the tub/shower.
b) The patient's medical restrictions mean that the patient is unable to bathe in the tub or shower at this time. Select response 4 (unable to bathe in shower or tub and is bathed in bed or bedside chair) or 5 (unable to effectively participate in bathing and is totally bathed by another person), whichever most closely describes the patient's ability at the time of the assessment.
c) If the patient's fear is a realistic barrier to her ability to get in/out of the shower safely, then her ability to bathe in the tub/shower may be affected. If due to fear, she refuses to enter the shower even with the assistance of another person, either response 4 or 5 would apply, depending on the patient's ability at the time of assessment. If she is able to bathe in the shower when another person is present to provide required supervision/assistance, then response 3 would describe her ability.
d) The patient's environment must be considered when responding to the OASIS items. If the patient chooses not to navigate the stairs, but is able to do so with supervision, then her ability to bathe in the tub or shower is dependent on that supervision to allow her to get to the tub or shower. While this may appear to penalize the patient whose tub or shower is on another floor, it is within this same environment that improvement or decline in the specific ability will subsequently be measured.

Top HHA reveals secrets to improving/stabilizing bathing

If you want to improve or stabilize your scores in bathing (M0670), you may want to start by looking at the communication between your nurses, physical therapists, patients and family caregivers, advises Doris Mosocco, director of quality management, Riverside Home Health, Newport News, Va.

Problem: Riverside, which participated in the national OBQI pilot study, found that nurses and therapists were not drawing on the same criteria when answering M0670. For example, therapists based their interventions on American Physical Therapy Association guidelines, while nurses used a variety of methodologies. No clinicians were consistently documenting patients' preferences for bathing (tub, shower, sink, bath) or any barriers to improvement (structural, emotional).

Solution: Riverside developed best practices that required clinicians to document clients' preference for bathing in the medical record, assess and document any barriers, and make an immediate recommendation for equipment necessary for a client's independence in care. The agency also opted for high home health aide frequency at start of care and resumption of care.

The result was a 10% improvement in scores for this outcome at the HHA's smaller branch, and a 4% improvement for the parent HHA.

The difference in scores helps prove that keeping your patient mix in mind when designing interventions is key. For example, nearly 80% of the 45 patients on any given day at Sierra Vista Hospital Home Health are cardiac or pulmonary, and 41% need oxygen, reports Bobbie West, the agency's director.

So getting patients to improve or stabilize on bathing or other ADLs is typically not a simple task. Sierra Vista's difficulty is further compounded by the fact that the agency, and many of its patients, reside in Truth or Consequences, N.M., at an altitude of 4,500 feet.

That makes the fact that Sierra Vista bathing improvement rates are 75% -- fourth in the state -- even more impressive. The average for all states in CMS' pilot project was 58%.

Key to Sierra Vista's success is the agency's lessons on how to conserve energy, West says. At the start of care, "patients that are compromised in their oxygen levels are confused, forgetful, and have much less endurance," she explains. Clinicians measure the patient's oxygen saturation on room air (without the assistance of a breathing machine). If it's below 89%, that means the patient is going to need oxygen with their activities. Clinicians also watch patients perform basic daily activities in order to determine the extent to which energy conservation should be recommended, West says.

Clinicians teach patients who need the most oxygen to pace themselves and rest between activities. For example, a patient may be told to wash his or her hair one day and shower the next.

Meanwhile, it's a more realistic goal for many of the wound-care patients being treated by the Visiting Nurse Association of Southeastern Massachusetts to attain high "stabilization in bathing" scores, rather than improvement, says Julie Lizotte, director of community relations. With an average stabilization rate of 35%, the Fall River, Mass.-based agency tops both of its two closest competitors on this outcome. ◆

Good OT, aide communication and teamwork = better bathing

If you're trying to figure out why your improvement in bathing scores aren't higher, your agency's nurses may not be calling therapists into the game soon enough.

Holding group training sessions to better educate nurses on how and when to make both occupational therapy and physical therapy referrals is what Complete Home Health Care credits for helping it to achieve a score of 71% for "patients who get better at bathing," as published by CMS in the Nov. 4 *Denver Post*. The Pueblo, Colo.-based agency, which has 150 patients (60% of which are chronic, long-term Medicaid), has increased its number of PT and OT referrals for non-ortho patients, reports Diedra Daugherty, the agency's administrator.

While they are often referred for patients with joint replacements, OTs are underutilized for patients with such chronic conditions as CHF, Daugherty says. OTs teach patients how to conserve energy, in addition to showing home health aides how to help patients set up equipment for bathing so they're not expending too much energy. OTs work on fine motor skills and make sure adaptive bathing equipment is installed. By contrast, PTs work on strength training exercises related to an activity of daily living (ADL) such as transferring to the tub bench safely, which involves strengthening of large muscle groups.

The OT "will be able to see if there is a need for a shower bed or a hand-held shower handle," offers Stephanie Wakefield, administrator and director of patient care services for 165-patient Addus HealthCare in Concord, Calif.

At Addus, any patient that scores at least "2" in the functional or "2" in the service index as part of the HHRG is a candidate for an occupational therapy referral -- regardless of diagnosis, Wakefield tells *CSA*. In fact, if she doesn't see an OT referral for patients with these scores, she'll call the patient's case manager and ask why an OT wasn't considered.

Addus, which put this policy in place a little more than a year ago, has a 73% bathing improvement score -- the highest in the San Francisco area, according to CMS' ad in the Nov. 4 edition of the *San Francisco Chronicle*. Wakefield also attributes the increased OT referrals to the group training it's provided in which clinicians are instructed to consider therapy for ANY patients with functional limitations. The innovation could spread beyond the San Francisco area; Palatine, Ill.-based Addus provides health care services throughout the nation. ◆

> 📖 ***The OASIS Implementation Manual****
>
> Mark "0" if the patient can get to and from the toilet during the day but uses the commode at night for convenience.
>
> **Assessment strategy**: Tasks related to personal hygiene and management of clothing are not considered in toileting.

M0680: Toileting

💰 **(M0680) Toileting:** Ability to get to and from the toilet or bedside commode.

Prior Current

- 0 - Able to get to and from the toilet independently with or without a device.
- 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet.
- 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.
- UK - Unknown

Common M0680 mistake could hurt reimbursement

Read OASIS toileting responses from the bottom up to prevent common M0680 mistakes.

Clinicians often incorrectly choose "0- able to get to and from the toilet independently with or without a device" when the patient can independently access a bedside commode, a mistake that could cost functional domain points and hurt your agency's reimbursement.

Solution: Read OASIS responses from the bottom up so you're more likely to realize cases where response "2 – unable to get to and from the toilet but is able to use a bedside commode," is the correct answer, says Rhonda Will, head of the Fazzi Associates 3M National OASIS Integrity Project, Northampton, Mass.

Responses "2" and higher will earn two to three points in the functional domain while responses "0" and "1" will earn zero points. ◆

Inaccurate toileting answer could cost 2 - 3 functional points

Your agency could lose functional domain points for M0680 (the toileting question) if you confuse patients' using a regular toilet with using a bedside commode or bedpan -- a common mistake, OASIS experts say.

Clinicians are inaccurately answering M0680 with "0" (able to get to and from the *toilet* independently with or without a device) for patients who instead warrant a "2" (unable to get to and from the toilet but is able to use a bedside commode with or without assistance), says Karen Vance, senior consultant, BKD, LLP, Springfield, Miss.

That's because often they don't take the time to read the responses carefully and understand the intent of the question, Vance says.

Straight from the source
Quick Q & A with CMS

Q: M0680. Is the transfer on/off the toilet included in responding to M0680? What about the transfer on/off the bedside commode? What about the transfer on/off the bed pan?
A: M0680 does not include the transfer on and off the toilet (for response levels 0 and 1) or on/off the bedside commode (for response 2), as both these transfers are specifically addressed in responding to M0690 - Transferring. The transfer on and off the bedpan *is* considered for M0680 response level 3. If the patient requires assistance to get on/off the bedpan, then he/she would not be considered independent in using the bedpan and response 4 would be the best response.

This question has two components, says Rhonda Will, head of the Fazzi Associates 3M National OASIS Integrity Project, Northampton, Mass. First, it assesses the patient's ability to get to one of three kinds of toilets (the regular toilet in the bathroom, a bedside commode or a bedpan/urinal). Second, this question assesses the patient's independence, she adds. The integrity project offers recommended answers and techniques for OASIS questions.

Clinicians often choose "0" when the patient can independently access a bedside commode without reading down further to learn that "2" specifies the patient's ability to access a *bedside commode* rather than a toilet, she says.

Train clinicians to read through all responses from the bottom up before they answer OASIS questions, suggests Angi Johnson, executive vice president of clinical services, the VNA of Greater Cincinnati and Northern Kentucky. You'll immediately see an increase in the functional domain scores as clinicians more accurately answer this question, she adds.

It's about access to the toilet

Make sure your clinicians understand that this question assesses ability get to and from the toilet, bedside commode or bedpan, but excludes the patient's ability to wash hands, clean themselves and get undressed and dressed, Johnson says.

Clinicians can answer this question by asking the patient to take them to the place where they go to the bathroom and then sit down on the toilet and get back up again, says Johnson. The patient does not need to remove his or her clothes for the clinician, she adds.

And, clinicians shouldn't let the patient's physiological ability to go to the bathroom interfere with the way they answer this question, warns Will. "Ignore the presence of urinary catheter, urostomy, colostomy, etc., when making this assessment and determine patient ability if urinary/fecal diversions did not exist," according to the CMS *OASIS Implementation Manual*. ◆

Tips for toileting improvement

If the patient's general ability to ambulate and/or transfer is poor, the patient probably can't use the toilet safely and vice versa, says Colo.-based physical therapist Joan Padgitt.

Padgitt has spoken on rehab-related issues for national and state associations. That's because OASIS question M0680 doesn't ask about the patient's personal hygiene or clothing management, but whether or not he or she can get to or from the toilet or bedside commode.

But don't stop there. You should also check out where the bathroom is located in the home– if it's down a long hall or up stairs and the patient's mobility is limited, note that in your comprehensive assessment, says OASIS expert and Maryland-based consultant Pat Sevast.

If transferring is the stumbling block to improving the ability to use the toilet, such assistive devices as a raised toilet seat or grab bars in the bathroom may help, Sevast notes. And on toileting, unlike on other "Getting Around" questions, patients who use adaptive devices are marked "0," indicating the highest possible functioning.

If you're unclear on the answer to this item, your first option is to ask the patient a question such as, "Do you have any trouble getting in and out of the bathroom?," Sevast says. If you still feel observation is necessary, ask the patient to sit down on a closed toilet seat and rise from that position, Padgitt suggests. ◆

📖 *The OASIS Implementation Manual

M0690
Assessment strategy - Taking extra time or pushing up with both arms can help ensure the patient's stability and safety during the transfer process but they do not mean that the patient is not independent.

M0700
Response-specific instructions Medical restrictions should be taken into consideration (as with other ADL items) as the restrictions address what the patient is able to do safely.

If chairfast, assess ability to safely propel wheelchair independently, whether the wheelchair is a powered or manual version.

M0690 – M0700: Moving around the house

💰 **(M0690) Transferring:** Ability to move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if patient is bedfast.

Prior Current
- 0 - Able to independently transfer.
- 1 - Transfers with minimal human assistance or with use of an assistive device.
- 2 - Unable to transfer self but is able to bear weight and pivot during the transfer process.
- 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.
- UK - Unknown

💰 **(M0700)Ambulation/Locomotion:** Ability to SAFELY walk, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

Prior Current
- 0 - Able to independently walk on even and uneven surfaces and climb stairs with or without railings (i.e., needs no human assistance or assistive device).
- 1 - Requires use of a device (e.g., cane, walker) to walk alone or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- 2 - Able to walk only with the supervision or assistance of another person at all times.
- 3 - Chairfast, unable to ambulate but is able to wheel self independently.
- 4 - Chairfast, unable to ambulate and is unable to wheel self.

5 - Bedfast, unable to ambulate or be up in a chair.
UK - Unknown

2 tests improve ambulation and transferring scores

Start using a standardized assessment for functional mobility and one for balance and you'll see your improvement in transferring and ambulation scores skyrocket by more than 10 percentage points, if one agency's success is any indication.

When Integrity Home Health Care started using the Timed Get Up and Go test and a functional reach test, the agency improved its scores for ambulation to 40.0% for October 2006, from 25.3% two years prior and its transferring scores to 69.4%, from 56.5% for that same time period, says Diana Kornetti, administrator and owner for the Ocala, Fla.-based agency.

The tests provide a standardized way for the agency's nurses and therapists to observe and measure the patients' ability to safely transfer and ambulate so they can consistently answer OASIS questions M0690 (transfer) and M0700 ambulation at start of care, resumption of care, recertification and discharge, Kornetti says.

Prior to using this tool, clinicians frequently interviewed patients. Because patients don't always recognize or admit their deficiencies, clinicians were scoring patients as more independent than they were. This made it difficult to show improvement, Kornetti says.

Bur the tests they use now force nurses and therapists to get patients up out of their chair to observe patients' ability to transfer and ambulate, she says.

Integrity Home Health isn't the only agency looking into such standardized tests. "It's one of my goals as we head towards P4P," says Lynette Ludwig, home health & hospice coordinator for the Denison, Iowa-based agency. "My staff is very aware of safety issues and concerns with ambulation and transfers, and they do a thorough assessment of safety and risk factors. But we have not yet begun to use a formal tool," Ludwig says.

"With such a small staff and limited time, it is hard to formalize all the plans in my head," she says.

2 functional tests defined

Clinical managers at Integrity Home Health Care observe patients performing each of the following assessments two times, Kornetti says. Then, clinicians take the average of the two tests to provide clues for the patients' functional ability.

1. **Mobility Assessment: Timed Up & Go (TUG) test**: Clinicians time how long it takes patients to get up out of a standard armchair, walk 10 feet, turn around, walk back to the chair and sit down again. This test provides the following clues:

- ✓ **<10 seconds** indicates free mobility
- ✓ **<14 seconds** indicates decreased risk for falls
- ✓ **<20 seconds** indicates patient is mostly independent
- ✓ **20-29 seconds** indicates moderately impaired/variable mobility
- ✓ **>30 seconds** means significantly impaired mobility with ADL/self-care limitations

This test provides a standard measure of the patient's ability and supports the clinicians' answers to M0690 (transferring) and M0700 (ambulation). When patients score moderately impaired on this test, for instance, it's probably not correct for clinicians to answer that the patient is independent in these OASIS items, Kornetti says.

It could uncover the need for an assistive device to help the patient safely ambulate around the home if patients aren't steady on their feet or take a long time to complete this test. In this case, clinicians should score the patient as at least a "1-transfers with minimal assistance or use of an assistive device," Kornetti says.

Note: For more on the TUG test, see the article titled "The Timed (Up & Go: a Test of Basic Functional Mobility for Frail Elderly Persons" in the Journal of the American Geriatric Society in February 1991.

2. **Functional reach test**: Clinicians ask patients to extend one arm in front of their body at 90 degrees. Then clinicians hold a ruler parallel to the patient's arm. Patients are instructed to keep their fingers extended and to reach forward as far as they can without touching the ruler, taking a step forward, twisting their body or loosing their balance.

Clinicians record the distance the client is able to reach forward parallel to the ruler.

The distance that patients can reach provides clues for their functional ability. For instance:

- **< 10 inches** indicates impaired balance
- **10 inches** indicates no impaired balance

Note: To read more on this test, see "Functional Reach: A new clinical measure of balance" in the Journal of Gerontology in November 1990.

Base answer to M0690 on ability to transfer in common activities

Esther can independently transfer from bed to chair and on and off the toilet, but she needs caregiver help to get in and out of the bathtub. How would you answer M0690, the transfer question, for Esther?

You would check "1" (able to transfer independently) even though Esther requires caregiver supervision for one of the activities, OASIS experts say.

In other words, look at the frequency of the activities. If the patient transfers from bed to chair and gets on and off the toilet *several times a day* but only gets in and out of the tub *several times a week*, then clinicians would answer the transfer question based on the patient's ability to perform the first two activities, because they constitute the "majority of the patient's activities," says Ruth McCain, Performance Improvement Coordinator, Twin County Regional Home Health, Va., and clinical advisor to the Fazzi's 3M National OASIS Integrity Project.

CMS' OASIS Implementation Manual states: "If ability varies between transfer activities listed, record the level of ability applicable to the majority of those activities."

It's tricky for nurses and therapists to grasp this point because they want to answer this question based on the most complex transfer, explains Sparkle Sparks, home health educator, Lee Memorial Hospital, Fort Meyers, Fla. The hardest transfer is the activity that will require the most clinical attention and will also accurately reflect the patient's improvement throughout the episode, Sparks adds.

Clinicians should rely on the narrative description or notes section of the comprehensive assessment to explain the patient's need for human supervision or assistive devices to get in and out of the shower and to justify the need for therapy, Sparks advises.

Straight from the source
Quick Q & A with CMS

M0680

Q: If a patient can't get to the toilet or bedside commode and uses a bedpan for elimination, what response applies if the patient is able to safely and independently complete all tasks except removing and emptying the bedpan/urinal?

A: The patient does not need to empty the bedpan or urinal to be considered independent. If the patient required assistance to use the bedpan/urinal, Response 4 would be the best response. If the patient could position the urinal or get on/off the bedpan independently, Response 3 would be appropriate.

Q: If a patient can safely get to and from the toilet with help from another person but they live alone and have no caregiver so they are using a bedside commode, what should be the response to M0680?

A: The response should reflect the patient's ability to safely perform a task, regardless of the presence or absence of a caregiver. If the patient is able to safely get to and from the toilet with assistance, then Response 1 should be selected, as this reflects their ability, regardless of the availability of a consistent caregiver in the home.

Q: Is the transfer on/off the toilet included in M0680? What about the transfer on/off the bedside commode or bed pan?

A: M0680 does not include the transfer on and off the toilet (for response levels 0 and 1) or on/off the bedside commode (for response 2). Both of these transfers are specifically addressed in M0690 - Transferring. The transfer on and off the bedpan *is* considered for M0680 response level 3. If the patient needs help to get on/off the bedpan, then he wouldn't be considered independent in using the bedpan and response 4 would be the best response.

Q: If a patient uses a bedside commode over the toilet, is this considered "getting to the toilet?"

A: Yes, a patient who can safely get to and from the toilet should be scored at response levels 0 or 1, even if they use a commode over the toilet. Note that the commode is not at the "bedside," and is functioning much like a raised toilet seat. ❖

> 🕮 ***The OASIS Implementation Manual says***: If the patient can transfer by him/herself but requires standby assistance to do so safely, or requires verbal cueing/reminders, then Response 1 applies.
> "Able to bear weight" refers to the patient's ability to support most of his/her body weight through any combination of weight-bearing extremities (e.g., a patient with a weight-bearing restriction of one lower extremity may be able to support his/her entire weight through the other lower extremity and upper extremities). The patient must be able to bear weight and pivot in order for Response "2" to apply. If both do not apply, select Response "3." If the patient is bed-bound, then assess his/her ability to turn and position him/herself in bed.
>
> ***3M OASIS Integrity Project says:*** Observe the patient's physical and cognitive ability to safely wash and dry his/her entire body, including transferring to the bathing area.
>
> A patient may "choose" not to bathe by tub or shower but that is not an assessment of "ability." Such an assessment includes consideration of the patient's:
> • cognition, emotional and behavioral state (alertness, comprehension, fear, anxiety, etc).
> • Physical function
> • Safe, effective and efficient completion of tasks
> • Medical restrictions (no showering till staples removed, keep dressing dry, etc).
> • Activity limitations
> • Current clinical condition
> • Location of bathroom, shower facilities.
> Your assessment of the patient's "ability" may be in conflict with reporting how the patient routinely performs the task. ❖

Here are four more OASIS tips to ensure an accurate response in M0690:

- **Limit transfer activities to the three activities listed in the OASIS question** (bed to chair, on and off toilet or commode and into and out of tub), says Rhonda Will head of the 3M project. Activities that are not applicable this question include: car transfers and floor transfers if patient falls on the floor, says McCain. But you should document the patient's ability to transfer in and out of the car in the comments section of your comprehensive assessment, advises McCain.
- **Patients who use a hoyer lift to get out of bed several times a day may not be bedfast.** As long as the patient uses a hoyer lift to get out of bed several times a day, you'll check response "3" (unable to participate in these three transfers by weight bearing and or pivoting) for patients, Will says. But if the patient can't leave the bed even with a hoyer lift, then check "4" or "5" to indicate that the patient is truly bedfast, explains Will.
- **Chair arms are not an assistive device**, says Will. Even if the patient uses the arms to transfer out of the wheelchair, check "0" (able to independently transfer), Will adds. But if the patient requires caregiver supervision and uses the arms of the chair to transfer, check "1" (transfers with minimal human assistance or with an assistive device), she adds.

Time to transfer doesn't count. The answer to M0690 doesn't depend on how much time it takes the patient to transfer, but rather the patient's ability to do so, McCain says. ◆

Armrests aren't assistive devices

Question: If a patient uses the armrests of a chair to rise from the seated to standing position, do the armrests count as an assistive device when choosing between a "0- Able to independently transfer" and "1- Transfers with minimal human assistance or with an assistive device," in M0690 (transferring)?

Answer: The arms of a chair are not considered an assistive device when a patient uses them to rise from a seated position in answer M0690, a CMS official says in response to this *Home Care Outcomes* inquiry.

You won't find the answer to this question in your OASIS Implementation Manual. So be sure you understand that taking extra time and pushing up with both arms can help ensure the

patient's stability and safety during the transfer process but does not mean that the patient is dependant, a CMS official advises.

If standby human assistance was necessary to assure safety or if the patient must use a device for the bed/chair and/or toilet transfers, then a "1" would be the correct response to these types of transfers, a CMS official says.

Remember that M0690 evaluates the patient's ability to safely perform three types of transfers: bed to chair, on and off toilet or commode, and into and out of tub or shower. "Pushing up with both arms" could apply to two of these transfer types -- bed to chair and on/off toilet or commode, confirms a CMS official.

While the transfer ability can vary across these three activities, you should record the ability level applicable to the majority of the activities, a CMS official says. ◆

Functional acuity increases when therapists verify answers

Chances are, not all nurses realize that *human supervision or assistance* goes beyond hands-on assistance to include verbal cueing or reminders when answering M0700 (ambulation /locomotion). Unaware of the guideline stated in the CMS Implementation Manual, they're incorrectly answering, "0 – Able to independently walk…," even if the patient relied on verbal cueing at the start of care.

Then later, when a therapist discharges the patient, he or she correctly responds with a "1- requires the use of an assistive device… or requires human supervision or assistance." The inconsistency among clinicians inaccurately portrays a functional decline.

That's what Care South of San Diego discovered when it started having therapists also complete the seven ADL questions (M0640-M0700) and 12 IADLs (M0710-M0820) as part of their comprehensive assessments for patients receiving therapy services. Fixing this mistake and others helped the agency increase its functional acuity by 35% between June 2003 and December 2004 and increase its HIPPS code for an average Medicare episode by one functional level, from F0 to F1, reports LaRita Sorrell, director.

Translation for the CEO: An average difference of $204.71 per episode, though in

Straight from the source
Quick Q & A with CMS

M0700

Q: If a patient uses a wheelchair for 75% of their mobility, and walks for 25% of their mobility, should he be scored based on his wheelchair status (which is his mode of mobility >50% of the time)? Or should he be scored based on his ambulatory status, because he doesn't fit the definition of "chairfast"?

A: Item M0700 addresses the patient's ability to ambulate, so that is where the clinician's focus must be. Endurance is not included in this item. The clinician must determine the level of assistance the patient needs to ambulate and choose response 0, 1 or 2, whichever is the most appropriate.

Q: What if my patient has physician-ordered activity restrictions due to a joint replacement? What they are able to do and what they are allowed to do may be different. How should I respond to this item?

A: The patient's medical restrictions must be considered in responding to the item, as the restrictions address what the patient is able to safely accomplish at the time of the assessment.

Q: Does M0700 include the ability to use a powered wheelchair or only a manual one?

A: The OASIS item does not differentiate between the ability to use a powered or a manual wheelchair.

Q: How would I score a patient who does not use an assistive device, but who sometimes needs help on level/even surfaces?

A: A patient who needs intermittent assistance (including any combination of hands-on assistance, supervision, and /or verbal cueing) to ambulate safely would be scored as a "1" on M0700. A patient who needs continuous assistance (including any combination of hands-on assistance, supervision, and/or verbal cueing) to ambulate safely would be scored as a "2." ❖

some cases the patients jumped from an F1 to an F2.

But that's just one of catches that Care South is making now that it has its therapists double checking its nurses' assessments of therapy patients.

Therapists are trained to observe patients' functional abilities and develop an effective home exercise program, Sorrell notes. Nurses, by contrast, are trained to focus more on clinical issues such as wound care, pain and medication management, and often rely on interviewing, rather than observation, when answering the ADLs, she adds.

To make sure they meet the five-day window for opening and submitting an OASIS, start-of care assessment, CareSouth's therapists visit the patient within two days of the start-of-care assessment. This allows enough time for the therapist and the nurse to collaborate on their answers and for the nurse to make the changes within the five-day window that the nurse has to submit the start-of-care assessment after it's been opened, Sorrell says.

At some point during the therapist's comprehensive assessment he or she gathers all of the necessary answers to the OASIS ADLs and IADLs. After the visit, the therapist enters this data into the patient chart using a laptop, a process which only takes about one or two minutes, Sorrell says.

If any of the therapists' answers differ from the nurses', the two disciplines discuss the discrepancy -- either on the phone or in person. If the nurse believes the discrepancy was due to an incomplete assessment-- as is often the case-- the nurse will change the OASIS answer to reflect the patient's true condition and to agree with the therapist's response, Sorrell says.

Therapists train nurses to look for clues in the home

CareSouth also uses its therapists to train nurses to look for clues that could help them answer the ADLs and IADLs.

Therapists teach nurses to look for soiled linens, diapers and architectural barriers, which could point to the patient's inability to access the bathroom for toileting or bathing and could indicate a functional deficiency in M0690 (transferring), says Jerry Tibbetts, lead physical therapist at CareSouth of San Diego.

When answering M0740, piles of clothing or evidence that the patient is wearing the same outfit for several days may indicate the patient's inability to do laundry. And empty convenience food boxes could indicate trouble cooking when answering M0720 (planning and preparing light meals). ◆

Tactics for getting the most out of OASIS M0700

If the hallway from Al's living room to his bathroom contains a shag rug and two steps, assess him walking or propelling over each of these surfaces before you answer OASIS question M0700 (ambulation/locomotion), several OASIS experts say.

M0700 asks clinicians to assess patients' ability to walk or propel the wheelchair safely on a "variety of surfaces." However, clinicians should take this one step further and assess patients walking or propelling over the *most difficult* surfaces in the home, says Kim Kirk, clinical advisor for Fazzi's 3M National OASIS Integrity Project and director of Riverview Regional Medical Center Home Health Agency, Gadsden, Ala.

Observe patients moving through all areas of the house necessary for performing the activities of daily living, adds Rhonda Will, head of the 3M Project. During the assessment, if Al mentions he likes to go outside, ask him if he wants to get some fresh air while you are there and assess him walking over the uneven ground and pavement, Susan Manzo, staff educator, VNA of South Central Connecticut, and clinical advisor for Fazzi's 3M project advises.

Don't ask Al to just "show you how he walks," because he will be thinking about walking correctly rather than walking the way he normally does, Manzo adds. Instead, ask Al to perform a task such as getting medication from the bathroom medicine cabinet or retrieving an insurance card or phone number from a phone book, she suggests.

Supervision/assistance for patients living alone

For patients living alone, clinicians can still answer M0700 with a "2" (able to walk only with the supervision or assistance of another person at all times), Will points out.

Some clinicians incorrectly assume they can't check this response for patients who live alone, but the question asks if the patient *should* have supervision or assistance, not if the patient *does* have supervision or assistance available, Will explains. For example, post-knee replacement patients often require supervision while walking for at least three days after surgery because of the affects of anesthesia, pain medication and general weakness, Will says.

Where a patient lives alone and cannot walk without supervision, the clinician should mark "2" in M0700 and develop a plan to help the patient ambulate safely, Will adds. The clinician might order physical or occupational therapy, ask family to stay with the patient or suggest private duty care, says Will. The plan might also call for a cane, walker or wheelchair, Will adds.

Document patient progress in clinical notes

Because M0700 doesn't reflect all possible steps of a patient's progress -- for example, moving from a walker to a cane -- you have to rely on clinical notes to show improved outcomes, Will says. Response "1" (requires use of device to walk alone or requires human supervision or assistance to negotiate steps) lumps patients who use a cane or walker into one category.

Clinicians should document in clinical notes any changes in assistive devices, weight bearing status and patient outcomes, says Will.

Here are some other facts about M0700 to tell clinicians at the next staff meeting:

- **"Wheel self" refers to both manual and power wheelchairs.** Response "3" (chairfast, unable to ambulate, but is able to wheel self independently) refers to patients who can self-propel a manual wheelchair or a power wheelchair, Will says. Clinicians sometimes get confused by the wording of this question and assume that "wheel self" only refers to manual wheelchairs, she adds.
- **When a patient leans on the wall or the back of the couch to walk, it is considered an assistive device,** Kirk says. If the patient leans on furniture to get around the home, then he or she could probably use a walker or cane and the clinician should check "1," agrees Manzo. ◆

Plan of attack: Strategies to improve your patient's ambulation

When working to improve ambulation, it's important to recognize what the limitations may be and work within them to achieve improvement, says home care consultant Pat Sevast,

Straight from the source
Quick Q & A with CMS

M0680

Q: If a patient is unable to get to the toilet or bedside commode, and uses a bedpan for elimination, what score would apply if the patient were able to safely and independently complete all tasks except removing and emptying the bedpan/urinal?

A: The patient does not need to empty the bedpan or urinal to be considered independent. If the patient required assistance to use the bedpan/urinal (i.e., get on or off the bedpan or position the urinal), he/she would not be considered independent and Response "4" would be the best response. If the patient could position the urinal or get on/off the bedpan independently, Response "3" would be appropriate.

Q: Should tasks related to personal hygiene and management of clothing be considered when scoring M0680?

A: No. Tasks related to personal hygiene and management of clothing should not be considered when scoring M0680. ❖

American Express Tax & Business Services, Timonium, Md.

For example, patients with fractured hips may be under physician's orders not to put weight on their hip for most or all of an episode of care. While that will slow recovery, a therapist can still work with the patient to use a walker to allow ambulation without putting weight on the hip during the initial episode. Upon recertification for a second episode, when the patient is allowed by the physician to bear weight, work can begin to help the patient ambulate when putting weight on the hip without the assistive device, Sevast says.

So too, if you aren't using Tinetti and other fall-risk assessment tools, you may not have all the information you need to improve your patients' ability to ambulate during the course of an episode, warns Joan Padgitt, a physical therapist who served until recently as therapy director for Best Care Inc., Englewood, Colo., which serves a patient population that's almost half orthopedic. Padgitt has spoken on rehab-related issues for national and state associations.

Having a variety of test results like these to work from ensures agency staff can "customize" patient therapy approaches. For example, if a patient scores poorly on the cognitive portion of Tinetti – a tool that measures how well a patient responds to simple instruction – therapists may need to work closely with the patient's family to ensure they understand the kind of help the patient needs to perform ADLs, Padgitt says.

Padgitt cites studies that show a reach of less than 10 inches doubles the fall risk in elderly men. For that reason, Best Care clinicians perform a "functional reach" test during assessments. How it works: Standing alongside a wall, the patient is instructed to raise his or her arm so that it is perpendicular with the floor (a 90 degree angle). The therapist marks the point where the fingers end to serve as a baseline. Then she asks the patient to reach forward with arm still extended as far as he or she can. That point is marked. The distance between the two marks is measured and recorded in the patient record.

In addition to treatment interventions, keep a close eye on how your nurses and therapists answer M0700 – particularly if the answer choice is "1" or "2," adds Padgitt. She has found a tendency for nurses to assess patients at a higher functional level than therapists, and poor inter-rater reliability among nurses themselves – all of which can give the appearance of a change in outcome where there may not have been one.

The inconsistency isn't surprising given the similarity among the answer choices ("1 – requires use of a device to walk alone or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces;" "2 – able to walk only with the supervision or assistance of another person at all times"). Advise your clinicians to consider their answer based on what the patient can safely do, Padgitt says. For example, if someone can walk with a device most of the time, but needs human help on stairs, he or she is probably a 1; if someone always seems unsteady, nurses should mark option two, says PT Linda Krulish, president, Home Therapy Services, Redmond, Wash, who spoke on therapy services at the New Orleans OASIS training.

Krulish adds that therapists should remember to consider the patient's environment in determining the score. A patient who can walk about 20 feet might be a 1 in a small apartment, but a 2 if he or she lived in a multi-level home, she points out. Environmental concerns should be explained in the complete assessment, Krulish says. ◆

Quick fact: M0700

If a patient is "getting around" on his or her own but needs to hold on to walls or furniture, the patient should probably be a "1" on M0700—even if the patient doesn't currently use a cane or walker. The patient's safety is the key, says Cathy Davenport, CMS Regional Office VIII, Denver.

Patients will improve if PTs lead a show-and-tell

You may have already been given the mantra of "show, don't tell" when it comes to assessing how well patients can perform ADLs. But if your agency's scores are still in the doldrums for "improvement in ambulation," you may need to get a little more show-and-tell training by a PT.

Doctors Home Care, in Camden, Ark., decided to do just that a little more than a year ago when it discovered outcome woes in "improvement in ambulation" were often caused by interpretation differences between nurses and physical therapists.

More often, nurses simply would ask a patient if they were having trouble walking, rather than seeing whether a patient used walls to lean on, for instance. As a result, their scores on M0700 would tend to be more favorable at the start of care than therapists', recalls Kathy Grissom, the 120-patient agency's administrator. That's not good when patients are determined by therapists at discharge to be less mobile.

To solve this problem, nurses and PTs were trained on standard definitions of the level of ability a patient must demonstrate to safely ambulate at each response level for each M0700 answer. Typed guidelines have been given to clinicians to refer to if they have questions – and are stored in the same point-of-care laptops they use to make assessments.

Training on standards isn't the only thing the agency did to put nurses and therapists on the same page. For cases where both disciplines are involved and improvement in ambulation is a major goal, the nurse performs the start-of-care assessment and makes her best guess, based on her own notes, as to the patient's ability to walk safely using demonstration techniques. Later that same day, the PT visits the patient and does a separate assessment of the patient's ADLs and checks to make sure her answers are in line with the nurse's answers before setting goals.

Making the two visits as close together as possible is the best way to ensure accurate ADL-related assessments, though it's easier to accomplish for HHAs with an abundance of PTs, notes Terri Ayer, a former home health clinical and operational consultant from Phoenix, Ariz. Agencies not blessed with lots of PTs should have their nurses call the PTs involved in their patients' care, let them know their findings and how they scored the patient on ADL questions, by describing the patient's abilities and limitations.

If you can't mesh nursing and PT visits close together, prioritize your most elderly patients, she adds. They are going to take longer to rehabilitate. In addition, goals need to be set sooner, because they will likely need more time and motivation than younger patients in reaching goals.

Doctors' reward for getting PT visits in sooner has been an increase in the agency's ambulation-improvement scores to 56% -- the highest in the state, according to CMS' Nov. 4 advertisement in the *Little Rock Democrat Gazette*. The agency also attributes its #1 outcomes in all three measures featured in the *Gazette* to what others might call an obsession with OASIS and documentation review.

Clinicians undergo about an hour of training every week that includes reviewing guidelines for different OASIS questions. It's set up like a lunch meeting so clinicians can plan their patient visits accordingly and not lose productivity. Plus, therapy notes are reviewed daily to ensure patient goals are being pursued and the plan of treatment doesn't need adjusted, says Sharon Bennett, the agency's clinical supervisor for therapy services.. ◆

VNA shares secrets for 29% cut in falls rate

Consistent assessment and patient education has allowed VNA Care Network, Worcester, Mass., to cut the percentage of patients experiencing emergent care for falls or injury from 2.08% to 1.47% -- a 29% improvement -- in just one year.

The VNA emphasized fall prevention after two sets of data alarmed the agency in early 2002, explains Noreen Basque, the VNA's director of quality improvement (QI) and privacy officer. Agency data showed that more patients were experiencing falls than ever before. And adverse event reports for 200l showed that the agency's score was 26% greater than the national average of 1.52% shown in 2000 CMS data based on Medicare certified agencies.

The VNA began auditing records to determine common factors among patients who fell, says Quality Improvement (QI) Specialist Priscilla Machacz. The agency found that 35% of its fall-prone patients lived alone and 85% used four or more medications. It identified 20 risks in all,

including age of 80 or over, cognitive impairments, medication non-compliance, muscle weakness and balance problems.

A Fall Prevention Task Force was formed, with Machacz as chair and facilitator. Members included two rehabilitation directors, a rehabilitation RN, QI Director Basque and the VNA's patient educator, a nurse.

The working group initially met to brainstorm goals for a revamped fall protocol or tool that would be used by staff, Machacz says. Before the session, staff identified articles about falls and any other relevant information to best determine the direction of the tool and the fall program. At the time, the VNA was using the Tinetti scale as a part of its fall information assessment.

"Our goal through all of this was the development of a tool that was easy to use and -- based on our auditing data -- what we should be looking at," Basque says.

The group created a three-tiered "Fall Risk Assessment Tool" with ratings of mild, moderate and high risk. Specific interventions are associated with each level.

The form is completed for all patients over age 70 and those seen as at risk, as a mandatory part of the admission process. Information from the form is taken on paper and entered into the computerized assessment records.

The tool asks clinicians to evaluate patients' risk factors in three areas: general risks, such as age, alcoholism, or general weakness; physical environment, such as inadequate lighting, unsafe footwear, or cluttered walkways; and physical health status, such as incontinence, confusion or dementia, or dizziness. Each of the 20 items on the scale has a numeric value between zero and three. Patients with a risk assessment totaling zero to five are categorized as being at mild risk, while those totaling six to 17 are at moderate risk and those scoring 18 or more are designated as being at high risk.

For patients categorized as mild risk, clinicians review the home safety checklist found in the VNA's Patient Handbook. Moderate-risk patients are referred to therapists within the agency. If a patient is at high risk, clinicians hold a team conference within 24 hours to customize a high-risk plan of action.

The case manager initiates the conference, which brings together agency clinicians, management and the patient's physician. The meeting also may include a social worker to help prepare an action plan, which involves the patient's family and other caregivers if possible. The care plan takes into account any special issues related to the patient's home setting.

In one high-risk case, a patient was safe when using her cane, but didn't like carrying it with her around the apartment. After the case conference, the patient agreed to use the cane at all times and to have a personal emergency response system installed. To reinforce these commitments, she was provided with a list of her responsibilities related to staying in the elder housing apartment safely.

Mild- and moderate-risk patients receive a booklet titled "Fall Prevention at VNA CARE Network." This 14-page booklet is written in a large font size with graphics and plenty of illustrations to support the written information. The booklet addresses numerous fall safety issues related to home care. For example, one page addresses three areas often seen in home care: obstructive cords, inadequate lighting, and no handrails or only one handrail. The information lists the problem, and both an "ideal option" (such as removing the obstructive cord) and a "quick fix" (like securing electrical and telephone cords with brightly-colored tape to minimize tripping hazards).

Rolling out and reinforcing the program

With more than 400 nurses and physical therapists providing admission visits for the VNA, there was much front-end planning to make this important component of the PI program a success. The program was presented to VNA clinicians in late spring and early summer of 2001 by task force team members.

Machacz explained that the curriculum covered three main points: why the fall program was chosen; the fall risk assessment tool and how to complete it; and how to react to various levels of patient fall risk.

The in-service was planned for 45 minutes, with 15 minutes allotted for questions and answers. Some of the meetings were held solely to discuss the fall program. At other times, it was incorporated into regular meetings.

And the education continues. It's part of every new clinician's orientation to help promote quality care, Case Coordinator Sandra Whittier says.

"The Fall Risk Assessment form and the handout make it easy to identify those at risk and helps us teach [patients] how to stay safely at home," she explains.

To reinforce the lessons and their importance, storyboards are posted and updated in all offices. Recently, a voice mail reminder about the falls program and risk assessment tool was sent to all staff PTs and nurses.

Every six months patient records are checked to ensure that patients' plans of action reflects their fall risk.

The task force, which met monthly for the first six months, meets for 90 minutes each quarter to hear the results of the audits and entertain recommendations for improvement of the fall program – including the tool questions, the interventions by risk category and the patient education information. ◆

M0710 – M0770: Eating, going out, laundry & housekeeping

(M0710) Feeding or Eating: Ability to feed self meals and snacks. **Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.**

Prior Current

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.
UK - Unknown

(M0720) Planning and Preparing Light Meals or reheat delivered meals:

Prior Current

0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR
(b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission).
1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
2 - Unable to prepare any light meals or reheat any delivered meals.
UK - Unknown

The OASIS Implementation Manual*

M0710
Response-specific instructions: Meal "set-up" (in Response 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. .

Assessment strategies: Determine the amount and type of assistance that is needed by the patient to feed himself/herself once the food is placed in front of him/her.

M0720
Assessment strategy: The patient's own dietary requirements should be considered when evaluating the ability to plan and prepare light meals. Implementation Manual

Define "eat, chew, swallow" before tackling M0710

How would you answer OASIS M0710 (ability to feed meals and snacks) if a patient requires meal setup but can feed himself after the meal is placed before him?

This scenario occasionally stumped Pro-Care Home Health's clinicians, admits Terri Minton, compliance specialist for the Hartford, Ky. agency. Clinicians got confused because response "1" mentions meal setup, yet CMS instructs clinicians to answer this question based on the patient's ability to eat, chew and swallow the food once it is placed in front of him, Minton points out.

The key to answering this question accurately, therefore, is ensuring that your clinicians understand the "eat, chew and swallow," specification as listed above, Minton says.

"You have to provide examples of meal setup as the pureeing or grinding of food," she says.

Response "0 - Able to independently feed self" applies if the patient doesn't require assistance. And it the patient does require some assistance, such as pureeing or grinding of food, clinicians should respond with a "1 - Able to feed self independently but requires (a) meal setup; OR (b) intermittent assistance or supervision from another person; OR (c) a liquid, pureed or ground meat diet," CMS states.

Minton also instructs her clinicians to observe the patient getting a drink and snack during the assessment. This helps them gather clues to answer other OASIS questions including M0700 (ambulation/locomotion) and M0490 (dyspnea), she says. ◆

***The OASIS Implementation Manual says*:** Responses "3," "4" and "5" in **M0710** refer to non-oral intake. Response 1 in **M0720** indicates that the patient can intermittently (i.e., sometimes) prepare light meals. Response "2" indicates that the patient cannot prepare light meals.

Consider the patient's environment when answering **M0740**, since the patient's ability to do laundry is impacted by his/her environment (i.e., whether the washing machine is on the same floor, in the same building, etc.).

3M OASIS Integrity Project says: When assessing **M0710**, ask the patient, "How much help do you need to cut up your food or feeding yourself? How much of a problem do you have with chewing or swallowing your food? Do you ever choke on your food?"

For **M0720**, ask, "If you had to prepare your next meal what could you make and how would you do it? What do you eat when you have no one to prepare a meal for you?"

For **M0740,** ask the patient how he/she does laundry. Observe his/her comprehension, judgment, coordination, balance, strength, lifting restrictions, weight bearing status, etc., and use all reported and observed information to make necessary inferences about patient's ability to do laundry. Note the location of the laundry facilities. ❖

(M0730) Transportation: Physical and mental ability to safely use a car, taxi, or public transportation (bus, train, subway).

Prior Current

0 - Able to independently drive a regular or adapted car; OR uses a regular or handicap-accessible public bus.
1 - Able to ride in a car only when driven by another person; OR able to use a bus or handicap van only when assisted or accompanied by another person.
2 - Unable to ride in a car, taxi, bus, or van, and requires transportation by ambulance.
UK - Unknown

(M0740) Laundry: Ability to do own laundry -- to carry laundry to and from washing machine, to use washer and dryer, to wash small items by hand.

Prior Current

0 - (a) Able to independently take care of all laundry tasks; OR
(b) Physically, cognitively, and mentally able to do laundry and access facilities, but has not routinely performed laundry tasks in the past (i.e., prior to this home care admission).
1 - Able to do only light laundry, such as minor hand wash or light washer loads. Due to physical, cognitive, or mental limitations, needs assistance with heavy laundry such as carrying large loads of laundry.
2 - Unable to do any laundry due to physical limitation or needs continual supervision and assistance due to cognitive or mental limitation.
UK - Unknown

(M0750) Housekeeping: Ability to safely and effectively perform light housekeeping and heavier cleaning tasks.

Prior Current

0 - (a) Able to independently perform all housekeeping tasks; OR
(b) Physically, cognitively, and mentally able to perform all housekeeping tasks but has not routinely participated in housekeeping tasks in the past (i.e., prior to this home care admission).
1 - Able to perform only light housekeeping (e.g., dusting, wiping kitchen counters) tasks independently.
2 - Able to perform housekeeping tasks with intermittent assistance or supervision from another person.
3 - Unable to consistently perform any housekeeping tasks unless assisted by another person throughout the process.
4 - Unable to effectively participate in any housekeeping tasks.
UK - Unknown

(M0760) Shopping: Ability to plan for, select, and purchase items in a store and to carry them home or arrange delivery.

(b) Unable to go shopping alone, but can go with someone to assist.
2 - Unable to go shopping, but is able to identify items needed, place orders, and arrange home delivery.

3 - Needs someone to do all shopping and errands.
UK - Unknown

Prior Current

0 - (a) Able to plan for shopping needs and independently perform shopping tasks, including carrying packages; OR

(b) Physically, cognitively, and mentally able to take care of shopping, but has not done shopping in the past (i.e., prior to this home care admission).

1 - Able to go shopping, but needs some assistance:
(a) By self is able to do only light shopping and carry small packages, but needs someone to do occasional major shopping; OR

(M0770) Ability to Use Telephone: Ability to answer the phone, dial numbers, and effectively use the telephone to communicate.

Prior Current

0 - Able to dial numbers and answer calls appropriately and as desired.
1 - Able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers.
2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.
3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation.
4 - Unable to answer the telephone at all but can listen if assisted with equipment.
5 - Totally unable to use the telephone.
NA - Patient does not have a telephone.
UK - Unknown

Quick tips: M0750

✓ **Tip:** This item refers to a patient's ability to perform light housekeeping, such as dusting or wiping off counters, not necessarily whether or not they do it, OASIS educational coordinators advised at CMS' meeting. Read other IADL questions in the same fashion, they advised.

✓ **Tip:** Like other ADL OASIS items, M0750 refers to the patient's ability to perform light housekeeping, such as dusting or wiping off counters, not necessarily whether or not they do it.

Use this ADL scenario to quiz staff

Family Home Health Care in Columbia, Ky., designed this competency quiz to assess how well its 60 nurses answer OASIS questions when physical therapy and nursing provide services for a post hip replacement patient, says Stacey Benner, staff development coordinator. The agency uses the results to pinpoint areas that require additional OASIS education.

Following each question, you'll find the correct answer and a few training pointers from Benner to help your staff navigate the tricky parts of each OASIS item.

Scenario:

A 72-year-old female recently fell and fractured her left hip, requiring surgical repair. She was released from the hospital on Jan. 4. She has hypertension, which exacerbated on Jan. 2 when she was in the hospital. The exacerbation required a medication change.

The patient has a history of neoplasm to the breast five years ago. Prior to hospital admission, the patient was independent with grooming, upper and lower body dressing and toileting, but required assistance getting into the shower for bathing and used a cane for transfers and ambulation. She also has a history of a fall.

Now, the patient requires assistance with lower-body dressing cannot bathe in the shower due to staples and uses a bedside commode for toileting because she can't walk to the toilet.

The patient was referred to your home health agency for staple removal, therapy and nursing to monitor healing, and education on how to administer her Lovenox injections.

How would you answer the "current" column for the following OASIS items?

M0670 (Bathing: Ability to wash entire body) This question excludes grooming (washing face and hands only)

Answer: 4 – Unable to use shower or tub and is bathed in bed or bedside chair.

Explanation:

Clinicians should default to a response of "4" in this case because the patient is restricted by a medical condition – a staple wound – and the physician has instructed the patient not to bathe in the shower or tub, Benner says.

When patients have a medical restriction that prevents them from bathing in the shower or tub, clinicians should mark "4" (unable to bathe in shower or tub and is bathed in bed or bedside chair) or "5" (unable to effectively participate in bathing and is totally bathed by another person), whichever most closely describes the patient's ability at the time of the assessment, CMS stated in its online Q&As posted in June 2005 (https://www.qtso.com/download/guides/hha/cat4.pdf).

What's tricky about this?

"This example even throws therapists off," Benner recalls. Therapists get confused because they want to answer it based on the patient's ability to bathe if she didn't have the staples, Benner says.

M0680 Toileting (Ability to get to and from the toilet or bedside commode)

Answer: 2- Unable to get to and from the toilet but is able to use the bedside commode (with or without assistance)

Explanation:

The scenario clearly states the patient is "unable" to get to and from the toilet, Benner says.

What's tricky about this?

If the patient used the toilet and the bedside commode at various times, then clinicians would have to choose between the two OASIS responses that best reflect the situation. Just keep in mind that CMS instructs clinicians to consider the patient's ability to "safely" complete the task the "majority" of the time, Benner says.

M0690 Transferring (Ability to move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if patient is bedfast)

Answer: 1 – Transfer with minimal assistance or with use of an assistive device

Explanation:

This patient would be scored a "1," because the physician has restricted the patient's movement of the joint to prevent complications, Benner says. The patient has medical restrictions in transferring and ambulation due to surgical repair of hip. In some instances the MD will restrict the patient movement of the joint to prevent complications, Benner says.

What's tricky about this?

The responses to this question don't leave room for clinicians to identify patients who can transfer, but not safely. In these cases, Family Home Health Care instructs clinicians to mark "1," and then to document in the clinical notes that the patient has trouble transferring, Benner says.

M0700 (Ambulation/Locomotion) Ability to safely walk, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces

Answer: 2- Able to walk only with the supervision or assistance or another person at all times

Explanation:

The scenario clearly states that the patient requires assistance to ambulate, Benner says. Plus, she has a prior history of falls and recently had a fracture repaired, which restricts her mobility, Benner says.

What's tricky about this:

This question may be more difficult for nurses to answer than therapists due to the differences in their training, Benner says. When therapists think about this question they're more cued into the patient's ability to "safely" ambulate, but nurses sometimes struggle with the safety issue. Nurses might observe a patient who relies on the walls as an assistive device to prevent them from falling, and they still might be tempted to mark a "1" because the patient "technically could" ambulate. But they have to ask themselves if the patient would be able to safely ambulate and avoid a fall even if nobody was there to caution them or catch them, Benner says.

OASIS ADL and IADL competency questions

Below you'll find 11 true/false questions that CareSouth of San Diego used to test its clinicians' knowledge of OASIS ADL- and IADL-related questions. (The correct answers to each question are in bold print.)

1. M0640 (grooming) includes the patient's ability to: wash face and hands, comb hair, shave, put on make-up, brush and care for teeth, dentures and fingernails.

A. True
B. False

2. If a patient needs a "spotter" to dress safely, or requires verbal cueing, response "2 – Someone must help the person put on upper body clothing," would be appropriate for M0650 (ability to dress <u>upper</u> body).

A. True
B. False

3. When assessing the patient's ability to dress in M0650 (ability to dress <u>upper</u> body) and M0660 (ability to dress <u>lower</u> body), the patient is *able* even if he/she has to use an adaptive dressing aide.

A. True
B. False

4. M0650 (ability to dress <u>upper</u> body) includes the ability to <u>obtain</u> clothing as well as dressing.

A. True
B. False

5. M0670 (bathing) <u>excludes</u> grooming (washing face and hands only).

A. True

B. False

6. M0670 (bathing), option No. 2 states "able to bathe in shower or tub with the assistance of another person." This includes:

Intermittent supervision or encouragement or reminders
Ability to get in and out of the tub or shower OR
Ability to wash difficult to reach areas
A. True
B. False

7. If the patient bathes independently at the sink, he/she is assumed to be able to independently bathe in a tub or shower.

A. True
B. False

8. When answering M0680 (toileting), your answers should be based on the patient's ability to safely get to and from the toilet and excludes the personal hygiene and management clothing when toileting.

A. True
B. False

9. M0690 (transferring) assesses the patient's ability to move from bed to chair, on and off the toilet or commode, in and out of the tub or shower and ability to turn and position in bed if the patient is bedfast. Response "2- unable to transfer self but is able to bear weight and pivot during the transfer process," would be applicable if the patient can do both bear weight and pivot.

A. True
B. False

10. M0700 (ambulation/locomotion) assesses the patient's ability to safely walk, once in a standing position, or use a wheelchair once in a seated position, on a variety of surfaces. Response No. 1 and No. 2 refer to human supervision or assistance of another. This includes verbal cueing or reminders, not just hands-on assistance.

A. True
B. False

11. In consideration of the patient's ability to perform a task, he or she can be given full credit for it if they can do it at least 50% of the time.

A. True
B. False

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Optimal assessment techniques for OASIS functional Items

Want to increase inter-rater reliability among those filling out your OASIS forms? Then try these tips to win consistent answers on a patient's ADL abilities by participants in the 3M National OASIS Integrity Project*. For tips on all other OASIS questions, view entire study results at www.fazzi.com.*

Best practice assessment techniques for functional items			
OASIS Item	**Optimal assessment question to ask pt.**	**Optimal technique to observe ability**	**Tip – Guidance on how to interpret and answer item**
M0640 – Grooming		Observe washing hands and/or face, or ask patient to demonstrate.	Grooming includes several activities; consider the frequency with needed for selected tasks.
M0650 – Ability to dress upper body	Have you changed what you wear to make it easier to get dressed?	Show me how you take your shirt off and put it back on.	Determine physical and cognitive ability to safely retrieve, dress, and undress upper body in clothing routinely worn by obtaining patient demonstration.
M0660 – Ability to dress lower body	Have you changed what you wear to make it easier to get dressed?	Show me how you take your shoes and socks off and put them back on.	Determine physical and cognitive ability to safely retrieve, dress, and undress lower body in clothing routinely worn by obtaining patient demonstration.
M0670 –Bathing: Ability to wash entire body	How do you bathe?	Show me how you get in and out of tub or shower.	A patient may "choose" not to bathe by tub or shower, but that is not an assessment of "ability."
M0680 – Toileting: Ability to get to and from the toilet or bedside commode	Do you use a toilet, bedside commode or bed pan/urinal to go to the bathroom?	Show me how you get to the toilet or bedside commode.	Ignore the presence of a urinary catheter, urostomy, colostomy, etc. when making this assessment and determine patient ability if urinary/fecal diversions did not exist.
M0690 –Transferring: Ability to move from bed to chair, on/off toilet or commode, into/out of tub or shower, and to turn and position self in bed	Describe how you get out of bed, on and off the toilet, in and out of the shower/tub.	Note the patient's judgment, flexibility, coordination, balance, strength, etc., and use all reported and observed information to make necessary inferences about patient's ability.	Determine physical and cognitive ability to perform only these three transfers safely by obtaining patient demonstration.
M0700 – Ambulation/ locomotion: Ability to safely walk, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces	Describe how you walk around the house, get up and down steps.	Observe the patient's judgment, coordination, balance, strength, etc., and use all reported and observed information to make necessary inferences about patient's ability to ambulate or propel wheelchair.	Determine physical and cognitive ability to safely walk (excluding coming to a standing position) on a variety of surfaces, even and uneven, including stairs.

M0710 – **Feeding or eating**: Ability to feed self meals and snacks	How much help do you need to cut up your food or feed yourself?	Observe patient eat.	Determine physical and cognitive ability to safely perform activities associated with eating once food is placed in front of the patient.
M0720 – **Planning/preparing light meals**: (e.g., cereal, sandwich) or reheat delivered meals	If you had to prepare your next meal what could you make and how would you do it?	Observe patient make a sandwich.	Determine physical and cognitive ability to safely perform all activities associated with planning and preparing a light meal; e.g., ability to retrieve items, carry them, prepare them, get them to table.
M0730 – Transportation: Physical and mental ability to safely use a car, taxi, or public transportation (bus, train, subway)	When you need to go to the doctor, how do you get there?		Determine physical and cognitive ability to safely perform all activities associated with use of car or public transportation.
M0740 – Laundry: Ability to do own laundry, i.e. to carry laundry to and from washing machine, to use washer and dryer, to wash small items by hand	Describe how you would do laundry today.	Observe the patient's comprehension, judgment, coordination, balance, strength, lifting restrictions, weight-bearing status, etc., and use all reported and observed information to make necessary inferences.	Determine physical and cognitive ability to safely manage all activities associated with completing laundry including carrying laundry to and from the washing machine, use of washer and dryer, washing small items by hand.
M0750 – Housekeeping: Ability to safely and effectively perform light housekeeping and heavier cleaning tasks	During this period of recovery, how will your housekeeping get done?	Observe the patient's comprehension, judgment, coordination, balance, strength, lifting restrictions, weight-bearing status, etc., and use all reported and observed info to make necessary inferences.	Determine the patient's physical and cognitive ability to safely perform all tasks associated with light housekeeping and heavier cleaning tasks; dusting, bed making, sweeping floors, doing dishes, cleaning bathrooms, etc.
M0760 – Shopping: Ability to plan for, select, and purchase items in a story and to carry them home or arrange delivery	How do you get your groceries or medication?	Observe the patient's comprehension, judgment, coordination, balance, strength, lifting restrictions, weight-bearing status, etc., and use all reported and observed info to make necessary inferences about patient's ability to shop and acquire at least basic necessities.	Consider the patient's physical and cognitive ability to safely perform all tasks associated with shopping including planning, selecting, and purchasing and carrying items home from the store or arranging delivery.
M0770 –**Ability to use telephone**: Including answering, dialing and effectively using phone to communicate	Describe how you would call our office on the phone you normally use.	Show me how you use the phone.	Consider the patient's physical and cognitive ability to safely perform all tasks associated with telephone use -- answering, dialing and

			effectively using the telephone to communicate if available.
M0780 – Mgmt. of oral medications: Excludes injectable and IV medications.	Does anyone help you with your medications by reminding you to take them, creating a list, filling a pill box, etc.?	Show me how and tell me when you take your medicines.	Consider the patient's physical and cognitive ability to safely perform all tasks associated with taking oral medication; preparing it (opening bottles, pouring), taking correct dose at proper time.
M0790 – Mgmt. of inhalant/mist medications: Excludes all other forms of medication (oral tablets, injectable and IV meds)	Does anyone help you with your inhalant/mist mediation by reminding you to take them, creating a list, preparing them, etc.?	Show me how and tell me when you take your inhalant/mist medications.	Consider the patient's physical and cognitive ability to safely perform all tasks associated with taking inhalant/mist medication; preparing it (opening bottles, pouring), taking correct dose at proper time.
M0800 – Mgmt. of injectable meds: Excludes IV medications	Does anyone help you with your injectable medications by reminding you to take them, preparing them or giving them?	Show me how and tell me when you take your injectable medicines.	Consider the patient's physical and cognitive ability to safely perform all tasks associated with taking injectable meds; preparing it (opening bottles, drawing up), taking correct dose at proper time.
M0810 – **Patient mgmt. of equipment**: Includes only oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equip. or supplies	Describe how you set, clean and use your oxygen.	Show me how you set, clean and use your oxygen.	Consider the patient's physical and cognitive ability to safely compete all tasks associated with managing the equipment used to perform therapies identified only in M0250 and M0500.
M0820 – Caregiver mgmt. of equipment: same items as in M0810	Describe how you set, clean and use your oxygen.	Show me how you set, clean and use your oxygen.	Consider the caregiver's physical and cognitive ability to safely compete all tasks associated with managing the equipment used to perform therapies identified only in M0250 and M0500.
M0825 – Therapy need: indicated need for 10 or more therapy (physical, occupation, or speech therapy) visits		Determine therapy need after completion of assessment and formulation of home health plan of care.	Collaborate with rehab services to determine their plan after their evaluation is performed. Answer after the physician orders are received for therapy within five days of M0090.