

The Times They Are a Changin'

The Missouri Alliance for Home Care
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The Reality of OASIS-C

- **A Survivors Delight**
 - You do the record audit post every episode
 - You connect the dots on what's not done
 - You notify the state regarding CoP Compliance
 - You notify state regarding lack of timely physician orders
- **Medicare Delight**
 - Payment risk or alteration for episodes with delayed verbal orders
 - Payment risk for episodes with quality issues at transfer/discharge
- **Attorney Delight (or Nightmare).....**
 - Depends on your vantage point

Imagine This.....

- Your patient scored as a high risk for falls, but the Plan of Care (485) did not have any interventions to prevent or minimize falls
 - This patient fell down the cellar stairs and was hospitalized for severe injuries
- Your patient was on insulin, but did not have education at the time of the Start of Care OASIS regarding the effects, side effects and when to report adverse effects.
 - This patient was found unresponsive by her daughter and hospitalized due to diabetic coma & hyperosmolarity.

Timed Up & Go (TUG) Directions

Timed Up and Go Test

Overview:

The Timed Up and Go (TUG) test measures, in seconds, the time taken by an individual to stand up from a standard arm chair (approximate seat height of 46 cm [18in], arm height 65 cm [25.6 in]), walk a distance of 3 meters (118 inches, approximately 10 feet), turn, walk back to the chair, and sit down. The subject wears his/her regular footwear and uses his/her customary walking aid (cane, walker, etc.). No physical assistance is given. The subject starts with his/her back against the chair, his/her arms resting on the armrests, and walking aid at hand. The subject is instructed that, on the word “**go**” he/she is to get up and walk at a comfortable and safe pace to a line on the floor 3 meters away, turn, return to the chair and sit down again. *The subject walks through the test **once** before being timed in order to become familiar with the test.*

Use either a stopwatch or wristwatch with a second hand to time the test. If using a stopwatch, start the time once the subject is standing and stop the time once the subject is seated.

Instructions to the patient:

“When I say ‘go’ I want you to stand up and walk to the line, turn and then walk back to the chair and sit down again. Walk at your normal pace.”

Scoring:

TUG Score _____sec.

Walking aid used? Type of aid: _____

Older adults (age 65+) who took 13.5 seconds or longer to perform the TUG¹ were classified as fallers with an overall correct prediction rate of 90%².

¹ Podsiadlo, D., & Richardson, S. (1991). The timed “up & go”: A test of basic functional mobility for frail elderly persons. *Journal of the American Geriatrics Society*, 39, 142-148.

² Shumway-Cook A, Baldwin M, Polissar NL, Gruber W. Predicting the probability for falls in community-dwelling older adults. *Phys Ther*. 1997;77:812

Objectives



- Identify elements and processes associated with the revised OASIS-C that present ongoing risk management issues for certified home health providers;
- Discuss *proactive initiatives* to address heightened risk management issues identified with the OASIS-C;
- Detail *revised tools* that support clinician documentation of vital care practices to reduce agency risks(s);
- Apply revised processes to inherent OASIS-C risks that minimize agency liability and enhance clinician documentation.
- Take Away Tools: **Expanded Revised** Transfer/DC Audit Tool
Rehab Audit Tool
Tools will be provided to program attendees

What Are Your Agency's Risks with C?

- **Inconsistent Use of Risk Assessments?**
 - Wound assessment measurements
 - Risk assessments (Falls)
 - Standardized assessment tools (Pain; Integument)
- **Lack of Follow-Up on the POC for High Risk Patients?**
- **Lack of Agency Protocols for Process Items?**
 - Medications; Pain; Integument; Falls
- **Inability to Track POC (During Episode & D/C)**
 - Implementation of POC
 - Change POC if indicated

The Context

- **Current CMS Administration focuses on Fraud & Abuse**
 - Home Health & Hospice is #1
- **Congress expands Revenue Audit (RAC) Contracts**
 - Focus on Therapy
- **2010 OIG Work Plan**
 - Focus on Therapy
- **Congress awards MAC contracts**
 - Still in Process Now
- **MAC increases therapy audits and denials**
- **OASIS-C Poses Industry Challenges**

More Context

- **April 2009: GAO reports to Congress**
 - Inadequate administration of the Medicare Home Health Benefit has left program vulnerable to improper payments
- **MAC's (RHHI's) Respond**
 - Increased ADR Efforts
 - Average Therapy Claim Overpayment = \$950
 - Non wage adjusted
- **ADR Focus**
 - Therapy only
 - Therapy only recerts
 - Disease specific recerts: DM; Alzheimer's; Parkinson's

2010 OIG Work Plan



- **Accurately Coding Claims for HHRG**
 - **Rehab Services** – Determine *reasonable & medical necessity* and over payments due to *unnecessary HHA therapy*
 - Analyze **therapy thresholds** with therapy services
- **Diabetes Self-Management Training Services**
- **Outlier Payments: Increased past 3 years**
 - Insulin Injections
 - Wounds
- **Cost Report Trends for Profitability**
 - Hospital based vs Free Standing

2010 Medical Review Priorities

- **Therapy Evaluation, Plans of Care and Visit Notes**
 - Do they **substantiate** the number of therapy visits?
 - Do they indicate **reasonable and medical necessity**?
 - **Are they consistent with other clinical assessments & visit notes?**
 - Ensure **no duplication** of therapy interventions
- **Case Mix Diagnoses**
 - Substantiated diagnoses
 - Co-exist at the time of the Plan of Care, or developed subsequently, or affect the treatment or care
 - Plan of Care & visit notes address dx

Home Health Opportunities

- **Clearly demonstrate Quality Process Outcomes not currently reflected on the OASIS-B**
 - Pain Management
 - Heart Failure
 - Diabetic Foot Care
- Increased **precision** with assessment language
- Assessment review of focused **high risk** interventions (Falls; Integument; Depression)
- Evidence **Best Practices** already verified in the industry (Diabetic Foot Care; Pain)
- **Refine care planning to enhance practice**

How Will Your New Report Card Look?

You Fill In the Blanks for Your Agency

Quality Measures	Your Agency	National	State
Timely Care*	90%	85%	88%
Immunizations	%	%	%
Plan of Care to Mitigate Pain*	90%	82%	80%
Risk Assessment & Plan of Care for Pressure Ulcers*	90%	88%	78%
Diabetic Foot Care*	%	%	%
Heart Failure Follow Up*	90%	%	%
Depression Screen & Plan of Care*	%	%	%
Falls Risk & Plan of Care*	99%	94%	98%
Medication Assessment & Follow-up*	99%	99%	98%
Education on High Risk Drugs*	90%	90%	%
* Outcomes for P4P			

OASIS-C: The Game Changer

- **Process and Quality Outcomes**
 - **2010 Changes**
 - Process **and** Quality Outcomes: Home Care Compare
 - CAHPS: www.homehealthcahps.org
 - P4P: Potential 2012
 - **HHQI Summit:** www.homehealthquality.org
 - **Compliance & Risk Management**
- **Leadership Role**
 - **Data Based Decision-Making**
 - **Accountability**
 - **Staff support and feedback to refine OASIS-C practices**
- **2010 Goals: Where will you be in 2011?**

OASIS-C & Outcome Measures

- **25 OASIS-C Process Measures** in all
- **13 will be Publically Reported Process Measures on HCC**
- All will be reported to agencies via CASPER & OBQI
 - 37 Outcome & Utilization Items
- **Ten Publically Reported Quality Outcome Measures**
 - Acute Care Hospitalization
 - Emergency Department Care Without Hospitalization
 - Improvement in Ambulation/Locomotion
 - Improvement in Bathing
 - Improvement in Bed Transferring
 - Improvement in Management of Oral Medications
 - Improvement in Dyspnea
 - Increase in Number of Unhealed Pressure Ulcers
 - Improvement in Pain Interfering with Activity or Movement
 - Improvement in Status of Surgical Wounds

OASIS-C & Process Measures

- **Thirteen Publically Reported Outcome Measures**
 - **Timeliness of Care** (MO102; 104)
 - **Immunizations** (M1040; 1050)
 - Seasonal Influenza
 - Pneumonia (PPV)
 - **Four standardized assessment screens** (M1730; 1910; 1240; 1300)
 - Depression
 - Multifactor falls risk
 - Pain
 - Pressure ulcer risk
 - **Heart Failure Follow-up** (M1510)
 - **Plan of Care Synopsis** (M2250)
 - Pressure Ulcer Prevention
 - **Care Plan Implementation** (M2400)
 - Diabetic foot care; Pain intervention; Pressure ulcer treatment based on moist wound healing

12 Potentially Avoidable Events

- Development of UTI
- Discharged to Community with unhealed Stage II Pressure Ulcer Present for more than 30 days
- Discharged to Community with Behavioral Problems
- Discharged to Community Needing Toileting Assistance
- Discharged to the Community Needing Wound Care or Education Assistance
- Emergent Care for Hypo/Hyperglycemia
- Emergent Care for Improper Medication Administration, Education Side Effects
- Emergent Care for Injury Caused by Fall
- Emergent Care for Wound Infections, Deteriorating Wound Status
- Increase number of unhealed Pressure Ulcers
- Substantial decline in 3 or more ADL's
- Substantial Decline in Management of Oral Medications

How Do You Track Your Data?

- **Can You Identify Your Current Process Outcomes?**
 - Software report access?
 - Other Benchmark Vendors?
 - Other Customized Reports?
- **Can You Ensure That Physician Orders Reflect Agency Required Best Practices?**
 - Audit Process & Tools?
- **How Do You Track Plan of Care Progression?**
 - Look Back Item Accuracy
- **How Do You Provide Specific Clinician Feedback?**
 - OASIS Consistency
 - Outcome Data

OASIS-C Risk Items

- **Consider These OASIS-C Risk Items**
 - **Timeliness of Care M0102; 104**
 - **Risk Assessments (Pain; Integument; Fall; Depression)**
 - Accurate use of *standardized* risk assessments
 - Accurate *scoring* of risk assessments
 - Plan of Care & *Implementation of Prevention Items*
 - **Other Risk Items**
 - Medication Reconciliation
 - High Risk Drug Education
 - Risk for Hospitalization M1032 & Overall Status M1034
 - **Types and Sources of Assistance (M2100)**
 - **Plan of Care Synopsis (M2250): Standardized Risk Tools**
 - **Look Back Period (M2400): Representative of Care**

Timeliness of Care

Surveyor Focus

- **Condition of Participation (Interpretive G 484.55)**
 - The initial assessment visit must be held within 48 hours of referral, **OR** within 48 hours of the patient's return home, **OR** on the physician-ordered start of care date.
 - In the absence of a physician-specified start of care date, the initial assessment visit is conducted within 48 hours of the referral. If the physician specified a start of care date, this supersedes the 48 hours time frame. Check the intake or clinical record for documentation of a specified start of care date.
 - **How Do You Ensure Your assessment visit within 48 hours of referral?**

What Will Surveyors Check?

- **Surveyors may compare**
 - M0030 Start of Care Date with
 - M0102 & M0104
- **Surveyors may also review**
 - Intake & referral data (Dates)
 - Dates on referral data & faxes
 - Other
- **Ensure your processes that update referral data and dates**
 - Revised date of referral (notes)
 - Delays in return home (notes)
 - **Uncorrected revised dates in automated systems**

New Items: Timeliness

- **M0102 Date of Physician-ordered SOC/ROC:** If the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified.
 __/__/__ (Go to MO 110, if date entered)
 month/ day/ year
 - NA – No specific SOC date ordered by physician
- **Identifies date home care services are ordered to begin, if the date was specified by the physician**
- **If ordered SOC is delayed (extended hospitalization), then date specified on the updated/revised order**
- **Mark N/A if the initial orders did not specify a SOC date**
- **If physician agrees with revised SOC date, complete M0104**

New Items: Timeliness

- **MO104 Date of Referral:** Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.
 __/__/__
 month/ day/ year
- Specifies the **referral date** which is the **most recent date** that verbal, written, or electronic authorization to begin home care was received by the home health agency
- If the start of care date is delayed, then list the **updated/revised** referral information for home care services to begin
- This does **NOT** refer to calls or documentation from others such as assisted living facility staff or family who contact the agency to prepare the agency for possible admission
- **Ensure automated date is accurate on admission (corrected as indicated)**

OASIS-C Q & A Update: M0102

- **1. If the physician provides a range of dates in which home care should begin (ex. Begin care 3/1/10 or 3/2/10), what date should be reported for M0102?**
 - In order to be considered a physician-ordered SOC date the physician must give a specific date to initiate care, not a range of dates. If a single date to initiate services is not provided, the initial contact (via the initial assessment visit) must be conducted within 48 hours of the referral OR within 48 hours of the patient's return home from the inpatient facility.
- **Source: OASIS-C Final Guidance**
 - Item Intent; Response- Specific Instructions
 - OASIS Q & A's: Category 4b: Q4

C Review: Medication Items

May be collaborative item

- **M2000 Drug Regimen Review: Does a complete drug regimen review indicate potential clinically significant medication issues, e.g. drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance?**
 - 0 – Not assessed/reviewed (*Go to M2010*)
 - 1 – No problems found during review (*Go to M2010*)
 - 2 – Problems found during review
 - NA – Patient is not taking any medications (*Go to M2040*)

Medication Clarifications

- **Best Practice Process Measures**
- **Includes ALL medications, prescribed & OTC's**
 - All routes (oral, topical, inhalant, pump, injection)
 - Interaction of other substances: food; herbs; diagnostic substances
- **Agency policy may drive process review**
 - Collaboration with review of medication list may be best practice (**DRR Nurse; Therapy DRR Protocols**)
- **Potential clinically significant issues**
 - Ineffective; side effects; omissions; dosage errors; non-compliance; adverse reactions
 - Complex medication plan; multiple pharmacies; high risk

More on Medications

May be a collaborative item

- **M2002 Medication Follow-up:** Was a physician or the physician-designee contacted within one calendar day to resolve clinically significant medication issues, including reconciliation?
0 – No
1 – Yes

Physician or physician designee must respond to communication to score “Yes” on these items

- Physician designee: Acting within legal Scope of Practice

Bottom Line on Medications

- **If you score a “Yes” on these items then**
 - The patient’s physician was contacted within one calendar day (the end of the next day) **AND**
 - There was communication with the physician with an acknowledgement of receipt of the information **and** a reconciliation or plan to reconcile the specific medication issue(s).
- **If you score a “No” on these items, you must detail in a clinical note the reason for “No”**
 - Contacted physician times 3 in regard to medication reconciliation regarding the KCL dosage. No return call **OR**
 - **Covering physician would not address medication issues.**

OASIS-C Q & A Update: M2002

- **1.** If a clinically significant med issue is identified on a *weekend*, and the agency phones the physician on call, who does respond but because he doesn’t really know the patient directs the agency to contact the primary care physician on Monday, can the clinician select “Yes” to M2002?
 - No (Meds were not reconciled, or formulated a plan to reconcile the specific medication issue identified within one calendar day)
- **Source: OASIS-C Final Guidance**
 - Item Intent
 - Response- Specific Instructions
 - *OASIS Q & A’s: Category 4: Q16 (1/2010)*

Patient/Caregiver Drug Education

May be collaborative item

- **M2010 Patient/Caregiver High Risk Drug Education:** Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics and anticoagulants) and how and when to report problems that may occur?

0 - No

1 - Yes

NA - Patient not taking any high risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications

High Risk Medications: Agency Identified

- **Process Outcome to be reported**
- High risk medications are those medications identified by quality organizations as having considerable potential for causing significant patient harm when they are used erroneously
 - Institute of Medicine
 - Joint Commission
 - Beer's Criteria
- **Provide specific agency list to staff**
 - What are your agency's identified high risk medications?
 - Can clinical staff identify these medications?
 - Have staff been instructed to be specific in their clinical documentation (Clinical Notes)



More Medication Clarifications

- **Identifies safe management of ALL medications including**
 - Knowledge of effectiveness; Potential side effects and reactions
 - When to contact the appropriate care provider
- If the interventions are not completed as outlined in this item, select Response "0"
 - Document rationale in the clinical record
- If the last time patient /caregiver instruction was given regarding medication monitoring and reporting was at the last OASIS visit, and no additional instruction at a subsequent visit has been provided, select Response "1"
 - Yes: At the time of or since the last OASIS assessment

Agency Considerations for Medication Items

- **Therapy Only and State Practice Acts**
 - What do your State Practice Acts indicate?
 - DRR Oversight and Review
 - Communication & Documentation Practices
 - Therapy only admissions
- **Oversight for Week-End Admissions**
 - Case Manager Model
 - Supervisor Support (Size Dependent)
 - Other: OASIS Admissions on Week Days
- **Other Agency Process Revisions**
 - Drug Regimen Review Nurse (DRR Nurse)

Inherent Medication Risks

- **Medication Reconciliation Processes**
 - Clear agency protocol
 - Documentation for no return communication (M2002)
 - Follow up processes for patient safety (Agency instructions)
 - Therapy only processes: Documentation & report
- **High Risk Drug Items**
 - Can agency staff identify high risk drug categories?
 - Ensure agency education is specific & standardized
 - Admission packet education tools for high risk drugs
- **Does documentation indicate communication with physician to clarify discrepancies?**
 - Specific medication discrepancies (dosage; frequency, etc.)

What Standardized Tools Do You Use?

- **Standardized tools:**
 - Are scientifically tested & validated with similar populations serviced by your agency
 - Have a standard response scale
 - Must be appropriately administered on established instructions
- **CMS Expects**
 - The clinical record will detail the tool used and the related findings and analysis to support the OASIS response
- **Standardized Assessments are required for M2250**
 - Pain (M1240)
 - Depression (M1730)
 - Falls (M1910)
 - Pressure ulcer (M1300) *Optional*
- **Agency identifies & selects standardized tools used**

OASIS-C Updates: Standardized Tools

- **1. For the process measures relating to patient assessments, I am not clear when a standardized tool is required and when the assessment can be completed based on clinical factors of the clinician's choosing.**
 - Standardized assessments are required to meet the intentions of M1240 Pain Assessment; the M1730 Depression Assessment, and the M1910 Multi-factor Fall Risk Assessment. Clinical factors may be used to conduct the M1300 Pressure Ulcer Assessment, or the agency may use a standardized Pressure Ulcer Risk Assessment tool.
- **Source: OASIS-C Final Guidance**
 - Specific Item Intent; Response - Specific Instructions
 - *OASIS Q & A's 10/2009: Category 4: Q & A 13*

OASIS-C Updates: Standardized Tools

- **1. For the process measure items requiring use of a standardized assessment, can an agency develop their own "standardized tool" based on agency policy or do they need to use a tool developed by a nationally recognized authority? Define "standardized".**
 - A standardized tool is one that has been *scientifically tested* and validated as effective in identifying a specified condition or risk in population with characteristics similar to the patient being evaluated. A standardized tool includes a standard response scale, and must be appropriately administered based on established instructions. An agency may not create an assessment unless the OASIS indicates so, such as M1300 Pressure Ulcer Risk.
- **Source: OASIS-C Final Guidance**
 - Item Intent; Response - Specific Instructions
 - *OASIS Q & A's 10/2009: Category 4: Q & A 14*

C Updates: More on Standardized Tools

- **1. If I mark a process measure assessment item "Yes" (that the assessment was done), is that sufficient documentation or do I have to explain which tool I used and how I came to the decision regarding my patient's level of risk??**
 - Whether the clinician uses a standardized assessment or a combination of a clinical factors for assessment of fall risk, pain severity, depression, or pressure ulcer risk, it is expected that the clinical record would detail the clinical factors or tool that was used and the related findings and analysis to support the OASIS response selected.
- **Source: OASIS-C Final Guidance**
 - Items Intent; Response - Specific Instructions
 - *OASIS Q & A's 10/2009: Category 4: Q & A 16*

Standardized Pain

- **M1240** Has the patient had a formal Pain Assessment using a standardized pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?
 - 0 - No standardized assessment conducted
 - 1 - Yes, and it does not indicate severe pain
 - 2 - Yes, and it indicates severe pain
- **What Pain Tools Do You Use?**
 - Define Your Pain Tool(s)
 - How Does Your Tool Define "Severe Pain"?
 - What tools are used for which populations?

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How Do You Measure Pain?



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ASI 78100

www.painstandards.com

www.QualityNet.org

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More on Pain Tools

- Studies indicate older community dwelling adults (65 or older)
 - 25-50% experience persistent pain
 - Barrier to effective treatment = inadequate pain assessment
- Best Tools
 - Easily understood; Used consistently
- Tool Diversity
 - Numeric Rating Scale (NRS) (Intact older adults)
 - Verbal Descriptive Scale (VDS)
 - Faces Pain Scale (Cognitively impaired adults)
- The Hartford Institute for Geriatric Nursing (2007)

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Early OASIS-C Pain Trends

- **Staff struggle to identify standardized pain tools**
 - Can agency staff name agency identified tools?
 - Can staff implement use per tool requirements?
 - Can staff justify specific tool use with certain populations?
 - Appropriate to the patient's ability to communicate the severity of pain
 - Does the OASIS assessment have documentation regarding specific pain tool(s) used?
- **Plan of Care (POC) must reflect agency interventions to monitor and mitigate pain**
 - Does the POC address monitor & mitigate pain?

Inherent Pain Assessment Risks

- **Pain control is a Quality of Life Indicator**
- **Do staff utilize the same tool(s)?**
 - Clear agency Pain Best Practice(s)
 - Pain assessment tools
 - Identification of severe pain for each tool
 - Documentation standards for pain assessment
- **Pain Toolkit**
 - Consistently assess and document pain
 - Implement pain mitigation interventions?
- **Do the per visit notes address both pain assessment and pain mitigation?**
 - Pharmacological & non-pharmacological

Pressure Ulcer Risk Assessment

- **M1300 Pressure Ulcer Assessment: Was this patient assessed for Risk of Developing Pressure Ulcers??**
 - 0 - No standardized assessment conducted
 - 1 - Yes, based on an evaluation of clinical factors, e.g. mobility, incontinence, nutrition, etc. without use of standardized tool
 - 2 - Yes, using a standardized tool, e.g. Braden, Norton, other
- **M1302 Does this patient have a Risk of Developing Pressure Ulcers?**
 - 0 - No 1 - Yes



What Are Your Scoring Parameters?

- How do you score the standardized tool?
- What parameters do you use to define your care plan?
 - Low Risk:
 - Moderate Risk:
 - High Risk:
- Is there ever a time you cannot use the standardized integument risk assessment tool?
- What diagnoses are associated with at risk for pressure ulcers?

www.npuap.org

If You Use the Braden Scale.....

- How does the tool define at risk?
 - At Risk = 15-18
 - Moderate Risk = 13-14
 - High Risk = 10-12
 - Very High Risk = 9 or lower
- Does your software modify at risk scores?
 - Example: Over 19 = Mild Risk or None?
 - If so: Do you require all patients to have Pressure ulcer interventions?
- How do you ensure your staff know the tool scoring and intervention requirements?
 - Individualize staff feedback

Inherent Integument Risks

- Score Variation Per Clinician
 - Clear agency protocol
 - Documentation for At Risk or Not at Risk (Low; Medium; High)
 - Documentation of tool or risk assessment items used
- Plan of Care Interventions
 - Are staff clear about agency expectations for Pressure Ulcer Prevention?
 - Individualize Care Plans (Software interventions)
- Does visit documentation indicate Pressure Ulcer Risk Prevention?
 - Individualized with return demonstrations?
 - Specific patient/caregiver education; Admit packet info

Why Fall Risk Assessment?

- **2002: 1.6 million falls treated in the ER**
 - 12,800 died
 - 388,000 admitted to the hospital
 - Admission rates with age (40% of fall related admissions are 85+)
- **In 1994, total cost of fall injuries among people 65+**
 - \$27.3 billion¹
 - \$43.8 billion projected for 2020¹
- **Medicare costs for hip fractures**
 - \$4.7 billion in 1991²
 - \$240 billion projected for 2040³



1. Englander F, J Forensic Science, 1996.
2. CDC, MMWR, 1996
3. Cummings SR, Osteoporosis & Related Res, 1999

Falls Risk Assessment

- **M1910** Has the patient had a multifactor Fall Risk Assessment (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)?
 - 0 – No multi factor falls risk assessment conducted
 - 1 – Yes, and it does not indicate a risk for falls
 - 2 – Yes, and it indicates a risk for falls



Research demonstrates that a multi-factor Falls Risk Assessment, linked with intervention programs, reduces Falls and hospitalizations

Dx Code: V15.88 Hx of Falls; At Risk for Falls

What Protocols Exist for the POC?

- What elements of your Fall Risk Assessment make it Multi-Factorial AND Standardized?
- Define At Risk and Not at Risk for Falls
 - By the Specific Agency Tool(s)
- What Specific Care Plan Interventions are Indicated for At Risk Patients?
 - Safety Checks Offs
 - Referrals
- Do You Have a Standardized At Risk Education Hand-Out for Patients?
 - Include in your Admit Packet
 - Reference: www.stopfalls.org

OASIS-C Review: M1910

- 1. For M1910 the agency can use a multi-factor, standardized, validated fall risk assessment tool, or alternatively, a standardized, validated performance assessment, like the TUG or Functional Reach Assessment, combined with one other factor, (e.g. fall history, polypharmacy, impaired vision, incontinence, etc.) to meet the requirements of the multifactor, standardized validated fall risk assessment. It is the agency's responsibility to determine if your tool includes these elements.
- Source: OASIS Q & A: Question 15 (1/2010)

Standardized Fall Risk Tools

- Timed Up & Go
- Berg Balance Scale (BBS)
- Dynamic Gait Index (DGI)
- Tinetti Performance Oriented Mobility Assessment (POMA)
- Activities-specific Balance Confidence Scale
- Falls Efficacy Scale (FES)
- Morse Fall Scale
- Hendrich Fall Risk Assessment
- St. Thomas Risk Assessment Tool (STRATIFY)

What About the TUG?

- Simple test used to identify persons at risk for falling due to balance or gait problems
- Reference Clinician TUG Guide
 - Measure **10 foot distance** from a standard chair and mark the point. Show this point to the individual before beginning the test
 - If the individual wears eyeglasses or uses an assistive device such as a cane or walker, they should do so while performing the test
 - Instruct the individual to rise from the chair that has a straight back chair, arms resting on the armrests, walking aid in hand
 - Ask the individual to rise from the chair on the word "go" and walk at a comfortable and safe pace (Begin Timing)
 - Observe the patient as he/she walks to the mark, turns and walks back to the chair
 - Stop timing when the patient sits back down in the chair
- Score: Parameters indicate high risk for Falls

What Works for Fall Prevention

- **Does Your Agency Have Referral Protocols for High Risk Fall Patients?**
 - PT; OT; MSW; Other
- **Multi-factorial intervention strategies, with exercise as a core component, are particularly effective in lowering fall rates in high-risk groups.**
- **Additional risk factors targeted:**
 - Gait training and assistive device use
 - Review and modification of medication
 - Treatment of postural hypotension
 - Modification of environmental hazards
 - Treatment of cardiovascular disorders
 - Home assessment and modification



Inherent Fall Risk Considerations

- **Score Variation Per Clinician (Combined Tool Use)**
 - Clear agency protocol
 - Documentation for At Risk or Not at Risk (Low; Medium; High)
 - Documentation of tool use and score consolidation
- **Plan of Care Interventions**
 - Are staff clear about agency expectations for Fall Prevention?
 - Individualize Care Plans (Software interventions)
- **Does visit documentation indicate Fall Prevention?**
 - Referral processes
 - Individualized with return demonstrations?
 - Specific patient/caregiver education

Depression Screening

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

0 – No

1 – Yes, patient was screened using the PHQ-2 scale. (**Instructions for this two question tool:** Ask patient: “Over the last two weeks, how often have you been bothered by any of the following problems”) **See Reference Tool**

Little interest or pleasure in doing things
Feeling down, depressed, or hopeless?

PHQ-2© Pfizer

What Score Triggers Interventions?

- Does your agency Have A Protocol for Score Specific Parameters?
 - Further screen assessment
 - Referral processes
- What Interventions are Placed on the POC (485) if
 - A patient has a dx of depression and is on antidepressants
 - A patient scores 3 or higher on the PHQ-2
- Detail Visit Notes for interventions for a patient on antidepressants
 - What other assessments are indicated for these patients?
 - Education priorities?

More on Depression Screening

- Score Variation Per Clinician (Combined Tool Use)
 - Clear agency protocol
 - Documentation for At Risk or Not at Risk
 - Documentation of tool use and score indicators
- Plan of Care Interventions
 - Are staff clear about agency expectations for symptoms of Depression?
 - Individualize Care Plans (Software interventions)
- Do visit notes indicate interventions for symptoms of depression?
 - Referral processes
 - Specific patient/caregiver education

Care Management

- M2100 Types and Sources of Assistance:
Determine the level of *caregiver ability* and *willingness* to provide assistance for the following activities, if assistance is needed. (Check only one box in each row).
 - ADL assistance
 - IADL assistance
 - Medication
 - Medical procedures/treatments
 - Supervision and safety
 - Advocacy or facilitation

*Why Is This Item
on Discharge?*

Consider: Medical Necessity

Care Management Clarifications

- **Identifies availability and ability of the caregiver(s) to provide categories of assistance needed by the patient.** Note that this question is concerned broadly with types of assistance, not just the ones specified in other OASIS items
- **If more than one response in each row, select the response with greatest need**
- Caregiver(s) **not likely** to provide indicates an **unwillingness** to provide assistance, or that the caregiver(s) is/are physically and/or cognitively **unable** to provide needed care.
- **Unclear** indicates the caregiver(s) may express a willingness to provide care, but their ability to do so is in question or there is **reluctance on the part of the caregiver(s)** that raises questions as to whether the caregiver will provide needed assistance

More M2100 Clarifications

- **Row c Medication Administration**
 - Prescribed & OTC's
- **Row d Medical Procedures/treatments**
 - ROM
 - TEDS
 - Postural drainage
 - Wound treatments including (wound vac dressing, foam and drape)
 - Orthotics; Braces; Slings
- **Row e Management of Equipment (safely)**
 - Oxygen
 - IV/Infusion
 - CPM
 - Wheelchair; Hoyer Lift
 - Wound vac; emptying VAC canister; disconnection/reconnection



Some Industry Trends

- **90% of patients have a caregiver currently able to provide assistance, and apparently did not need any training to provide assistance with the new Plan of Care YET the Plan of Care indicated education and training needs**
- **Patients have wound vacs, but the caregiver column was scored a "1"**
- **Patients have Peg Tubes and ostomies that the RN indicates the patient/caregiver need education regarding the Peg Tube and/or ostomies; BUT the caregiver score = "1"**
- **Patients receiving therapy for balance; HEP; Fall Preventions; assistive devices; but the Caregiver currently able to provide assistance ("1")**

Do your staff accurately score M2100?

Risk for Hospitalization

- **M1032 Risk for Hospitalization:** Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply)

- 1 – Recent decline in mental, emotional, or behavioral status
- 2 – Multiple hospitalizations (2 or more) in the past 12 months
- 3 – History of falls (2 or more falls-or any fall with an injury – in the past year)
- 4 - Taking five or more medications
- 5 – Frailty indicators, e.g. weight loss, self reported exhaustion
- 6 – Other
- 7 – None of the above

More on Hospitalization Risks

- **Can you eliminate any documentation with this new item?**

- *HHQI National Risk Assessment Form*

- Item identifies patient characteristics that may indicate the patient is at risk for hospitalization in the care provider's **professional judgment**
- **Mark ALL that apply**
- History of falls includes reported or witnessed
- Medications includes any OTC's
- **Frailty:** weight loss, exhaustion, fatigue, slower movements (sit to stand while walking)
- **Other: Defined by agency – How Do You Define?**

Overall Status

- **M1034 Overall Status:** Which description best fits the patient's overall status? (Check one)

- 0 – The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age)
 - 1 – The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient's age).
 - 2 – The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death.
 - 3 – The patient has serious progressive conditions that could lead to death within a year.
- UK – The patient's situation is unknown or unclear

M1034: Overall Status

- **New Assessment Item consistent with CARE Tool**
- **Identifies the general potential for health status stabilization, decline, or death in the care provider's professional judgment**
- **Consider current health status, medical diagnoses, and information from the physician and patient/family on expectations for recovery or life expectancy**
- **A "Do Not Resuscitate" order does not need to be in place for Responses 2 & 3**
 - **Fragile health with ongoing high risk of serious complications and death**
 - Considerations: Oncology; advanced pulmonary and cardiac; multiple hospitalizations; treatment changes
 - **Serious progressive conditions that could lead to death within a year**
 - Considerations: Oncology; advanced pulmonary and cardiac patients; progressive neurological patients including ALS, MS, Parkinson's, Alzheimer's, Dementia

Plan of Care Synopsis

(M2250) Plan of Care Synopsis: (Check only one box in each row.) Does the physician-ordered plan of care include the following:

Plan / Intervention	No	Yes	Not Applicable
a. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings	<input type="checkbox"/>	<input type="checkbox"/>	Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference
b. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	<input type="checkbox"/>	<input type="checkbox"/>	Patient is not diabetic or is bilateral amputee
c. Falls prevention interventions	<input type="checkbox"/>	<input type="checkbox"/>	Patient is not assessed to be at risk for falls
d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	<input type="checkbox"/>	<input type="checkbox"/>	Patient has no diagnosis or symptoms of depression
e. Intervention(s) to monitor and mitigate pain	<input type="checkbox"/>	<input type="checkbox"/>	No pain identified
f. Intervention(s) to prevent pressure ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Patient is not assessed to be at risk for pressure ulcers
g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician	<input type="checkbox"/>	<input type="checkbox"/>	Patient has no pressure ulcers with need for moist wound healing

M2250: Plan of Care Synopsis

- **Best Practices to be Reported on Home Care Compare**
- **Response Considerations**
 - **Yes indicates communication with physician regarding the Plan of Care**
 - **Collaboration with disciplines regarding appropriate Plan of Care items is acceptable**
 - **Plan of care interventions may be pharmacological and/or non pharmacological**
- **Depression**
 - **Diagnosis or screened for symptoms of depression**
 - **Medication monitoring; medication effectiveness; medication teaching; referrals (MSW or community referrals)**
- **Ulcer Treatments**
 - **Mark Yes if physician orders moist wound healing dressings OR NA if such orders have been requested from the physician with no agreement for orders OR no pressure ulcers with need for treatment**

OASIS-C Review: M2250

- 1. This item indicates the Plan of Care Synopsis at the completion of the OASIS-C assessment. The “physician ordered plan of care” means that the patient’s condition has been discussed and there is agreement as to the plan of care between the home health agency and the physician.
- Source: OASIS-C Final Guidance
 - Item Intent
 - Response- Specific Instructions
 - OASIS Q & A: Question 25 (1/2010)

More on Plan of Care Synopsis

- Does your agency have standardized clinical guidelines accessible for all care providers to reference?
 - Parameters may include:
 - Weights; vital signs; pain intensity ratings; blood sugar levels; wound measurements; intake and output; or other relevant measurements
- Plan of Care (485) must integrate these parameters if scoring “Yes” on patient-specific parameters
- Plan of Care must be in place in the 5 day SOC window and the 2 day ROC window in order to meet the measure definition
- Addenda and POC modifications may be indicated post initial assessment completion

OASIS-C Review: M2250

- 1. This item indicates the Plan of Care Synopsis at the completion of the OASIS-C assessment. Many of the areas in M2250 follow evidence based practices. Use of fall prevention interventions, instruction on proper foot care for diabetic patients, pressure ulcer prevention education, and ongoing pain assessment/monitoring are all good clinical practices that routinely implement without specific physician orders. Are we now required to obtain physician’s orders for these general care practices?
- If your agency wants credit for conducting this fall prevention intervention (Marking “yes” on M2250), you must have an order for fall prevention interventions.
- Source: OASIS Q & A: Question 24 (1/2010)

What Are Moist Wound Products?

- **WOCN Guidance**
 - Epithelial cells require moisture to move from the wound edges to re-epithelialize or close the wound
 - Moist wounds cells are able to migrate directly across the wound bed, and heal faster
- **Products**
 - Films
 - Alginates
 - Hydrocolloids
 - Hydrogels
 - Collagen
 - Una Boots
 - Medicate creams/ointments
- **www.convatec.com**

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Common M2250 Errors

- **Plan of Care Synopsis M2250 indicates “Yes” but**
 - Orders not in clinical record for specific intervention OR
 - Clinical record does not indicate patient has a specific risk or disease process
 - **Examples:** Diabetes; Risk for Pressure ulcers; Risk for Falls; Pain; Depression and/or a positive screen on the depression tool; Current Pressure ulcers
- **If the provider does not include these Best Practices in the Plan of Care (485) and/or orders, then the provider is not receive credit for performing these Best Practices**
 - Fall Prevention Interventions; Teach diabetic foot care

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A Quick Check: Process Items

- **If a provider does not have orders for Fall Prevention Interventions, but provides this care, they can still receive outcome credit for Fall Risk Prevention**
 - True
 - False
- **If a patient has a diagnosis of depression, but does not score a 3 or higher on the PHQ2 then the clinician scores an NA on M2250**
 - True
 - False

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More Common Audit Findings

- Diabetes listed in diagnosis, but “NA” for DM foot care in M2250 (Agency requires DM Foot Care)
- Diabetic foot care is scored “Yes”, but no orders for diabetic foot care OR no diagnosis for Diabetes
- Depression listed as a diagnosis, but “NA” for Depression interventions
- Fall Risk Assessment is High, and “Yes” is scored on M2250, but no orders for Fall Prevention Interventions
- Patient at risk for pressure ulcers by Braden score, and M2250 is scored “Yes” for Pressure ulcer Prevention, but no orders for Pressure ulcer preventions
- Patient screened “no risk” for symptoms of depression, and no Depression dx, but Depression M2250 is scored “Yes”

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The Discharge Process

- Completion of the Discharge OASIS requires a review of the previous OASIS & the care provided during this episode
 - How will discharging clinicians complete this OASIS?
 - What tracking tools or processes are available to quickly respond to these items?
- Does your agency have a Pre-Discharge Protocol to identify further care interventions prior to discharge?
 - Risk Interventions (Fall; Integument)
 - Quality Interventions (Pain; Depression; Medications)

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Intervention Items: “Look Back”

(M2400) **Intervention Synopsis:** (Check only one box in each row.) Since the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

Plan / Intervention	No	Yes	Not Applicable
a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Patient is not diabetic or is bilateral amputee
b. Falls prevention interventions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Formal multi-factor Fall Risk Assessment indicates the patient was not at risk for falls since the last OASIS assessment
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Formal assessment indicates patient did not meet criteria for depression AND patient did not have diagnosis of depression since the last OASIS assessment
d. Intervention(s) to monitor and mitigate pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Formal assessment did not indicate pain since the last OASIS assessment
e. Intervention(s) to prevent pressure ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Formal assessment indicates the patient was not at risk of pressure ulcers since the last OASIS assessment
f. Pressure ulcer treatment based on principles of moist wound healing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Dressings that support the principles of moist wound healing not indicated for this patient's pressure ulcers <u>OR</u> patient has no pressure ulcers with need for moist wound healing

What Process Items Come from M2400?

- **Diabetic Foot Care**
 - Check POC; orders
 - How about visit notes
 - Document return demonstrations
 - Continue to perform foot & skin scans
- **Pain Intervention**
 - Check POC; orders
 - How about visit notes
 - Do orders & visit notes indicate monitoring AND mitigating pain?
- **Pressure Ulcer Treatment Based on Moist Wound Healing (Check orders; visit notes; other)**

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M2400: Intervention Synopsis

- **Response Considerations**
 - Specific interventions were both included on the physician Plan of Care (485) AND implemented as part of care since the previous OASIS
 - Includes Resumption of Care (ROC's)
 - Clinical record indicates specific care has been provided
 - Visit notes; Case management; Other to indicate the provision of services; Communication logs
 - Mark N/A if patient did not meet that criteria
 - Not a diabetic for diabetic foot care
 - Patient does not have pressure ulcers
- **To Score an NA means a *formal assessment* must have been performed as defined in the relevant OASIS items**
 - Depression
 - Mark N/A if patient did not screen positive for symptoms of depression; and does not have a diagnosis of depression

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What Are Agency Protocols.....

- **For review of M2400 one week prior to Discharge?**
 - How Do You Track POC Interventions?
 - How Do You Ensure Per Diem Staff Implement Specific POC Interventions?
 - Tracking Protocols?
- **What Are the Agency's Risks if These Items are Scored "No"**
 - Survey Focus (Distant and/or On Site)
 - Quality Issues
 - Reimbursement Issues
- **Considerations Then**
 - Case Management Oversight; Case Conference; Other

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More Quick Checks: M2400

- Mrs. Wells plan of care included orders for diabetic foot care including assessment and patient/caregiver education on proper foot care. Agency clinical record indicates weekly foot scans, but Mrs. Wells and her caregiver refused diabetic foot care teaching, stating they knew everything there was to know about caring for her feet since she has been a diabetic for 17 years. How would you score M2400 (a) for diabetic foot care?
 - No
 - Yes
 - NA
 - Item would be skipped

Common M2400 Errors

- Discharge indicates the Plan of Care and interventions were performed during this episode of care but
 - Orders not in clinical record for specific intervention OR
 - Clinical notes (or OASIS) do not indicate the intervention was performed
 - Examples: Diabetic foot care; Pressure ulcer prevention; Pain monitoring and mitigation; Fall Prevention; Depression monitoring and/or interventions
- If the provider does not include these Best Practices in the Plan of Care (485) and/or orders, then the provider is not receive credit for performing these Best Practices

How About Rehab Risks?

- Patient complexity does NOT indicate need for therapy or high level of therapy
- OASIS assessment does NOT support therapy needs
- OASIS & therapy evaluations do NOT indicate consistency in assessments and POC
- Therapy notes do NOT indicate reasonable and medical necessity
- Therapy disciplines overlap in goals and interventions are considered duplicitous by your MAC

Therapy Utilization M2200

- **Looking Past the “Diagnosis” to OASIS-C Scores**
 - Diagnosis alone does not warrant a therapy intervention
 - Impairments, function limitations, & disability are the keys to appropriate therapy referrals
- **Disability**
 - Behaviors that occur over a period of time because of persistent functional limitations
 - Inability to effectively care for oneself
 - Inability to effectively participate in social roles
 - Indication in quality of life measures

Where It All Begins

- **Collaboration between assessing clinicians and their documentation**
 - Consistent, integrated clinical documentation
 - OASIS M items as “therapy flags”
 - Functional Domains
 - Clinical Domains
 - OASIS M items support data for therapy evaluations
- **Common Language**
 - Standardized Measures
 - Berg; TUG; Gait velocity; Tinetti
 - MMT; Borg; MMSE
 - Moderate; Minimal; Maximal; modified independent

Therapy Evaluation Musts

- **Is the Therapy Evaluation consistent with the OASIS-C Data?**
 - Prior Level of Function
 - ADL Capacities
 - Pertinent Medical History
 - Number of Falls
 - Rehab Potential
 - Equipment Needs
 - Other
- **Other Critical Metrics**
 - Clinical measurements
 - Fine motor; Gait Analysis; Edema; Endurance

Does Relevant Data Impact Goals?

- **Subjective data impact goals**
 - Pain level
 - Sensory/Neurological Deficits
 - Functional Deficits
 - Responses to treatment
 - Caregiver availability/willingness
 - Other
- **Objective Data Consistent with Goals**
 - Balance score
 - Fall Risk Assessment
 - Vital signs – protocols
 - Treatments

More on Consistency

- **Conflicting Documentation**
 - Do therapists review the OASIS-C functional items?
 - Does nursing assessment and documentation support therapy services?
- **Untreated Abnormal Findings**
 - Do therapists notify nurses regarding abnormal vital signs, pain or other findings for follow-up?
 - What are required therapy interventions?
- **Communication Between Disciplines**
 - Is *critical* to coordinate multidisciplinary care
 - Where is care communication documented?

Therapy Documentation

- **MUST REFLECT**
- *Prior level of function*
- *Current deficits*
- *Progress toward goals*
- *Restoration to a previous level*
- *Goals – MUST be tied to function*
- **Medical review is often performed by non therapists**
 - **Document deficits**
 - **Modify goals**



Tips to Improve Documentation

- **Clearly identify goals and goal progression in objective & quantifiable terms**
 - Discuss during team conferences; logs
- **Indicate necessity of skills services each visit**
 - Every clinical note is a stand alone document
- **Chart *Negatively* – Specific patient deficits**
- **Participate in agency clinical record audits**
 - SOC/ROC
 - Rehab Only
- **Track & monitor downcodes & denials by team and therapist**
- **Update therapy protocols and/or standards**



What Are Your Agency's Risks with C?

- **Not Accurately Representing Patient Complexity on Diagnosis Items**
- **Inconsistent Use of Risk Assessments?**
 - Wound assessment measurements
 - Risk assessments (Falls)
 - Standardized assessment tools (Pain; Integument)
- **Lack of Follow-Up on the POC for High Risk Patients?**
- **Lack of Agency Protocols for Process Items?**
 - Medications; Pain; Integument; Falls
- **Inability to Track POC (During Episode & D/C)**
 - Implementation of POC
 - Change POC if indicated



Tips to Enhance Risk Management

- **Ensure clinicians have the designated agency best practice tools readily accessible**
 - Reference Cards with Bags (Pain Tools; Med Education)
- **Perform OASIS-C Joint Visits (IRR Tool)**
 - Observe the use of Best Practice Tools
 - Question staff on the interpretation of Best Practice Risk Assessment Tools
- **Track Audits to Provide Specific Clinician Feedback**
 - All “No’s” need a narrative
 - All “yes” Risk assessment items need tool & score details
- **Standardize Clinician Education Tools**
 - High Risk Medications; Falls Prevention; Pressure Ulcer Prevention; Pain Diary

Easy Money for CMS

- **Compliance Issues**
 - Orders; RAPS's & Final Claims
 - Verbal orders prior to RAP
 - CoP's
 - Timeliness; DRR; Physician orders
- **Survey Issues**
 - Care Planning
 - Addresses every identified risk or potential risk
 - Look Back Documentation
 - Have you implemented the POC?
- **MAC Issues**
 - OASIS-C supports medical necessity & services
 - OASIS-C supports therapy utilization
 - Consistent clinical documentation
- **Quality & Reimbursement Issues: More To Come**

What Processes Support Risk Management?

- **Standardized Best Practice Tools**
 - All agency identified risk assessments
 - All agency patient education tools
- **Revised Audit Processes: SOC; Transfer/Discharge**
 - Individual staff feedback & education
 - Track & trend results for staff meeting & education updates
- **Revised Case Management Processes (See Tool)**
 - Who performs multi-disciplinary functions?
 - Fall Prevention Interventions?
 - OASIS-C focused education updates
- **Pre-Discharge Process**
 - Proactive Plan of Care Review
 - Look Back Parameters
- **Agency Surveillance Processes: Report Tracking; Other**

Resource Web Site



- **CMS OASIS Web Page**
 - www.cms.hhs.gov/oasis
- **CDC**
 - www.cdc.gov
- **CMS Medicare Learning Network (MLN) Website**
 - www.cms.hhs.gov/MLNGeninfo/
- **Office of Inspector General (OIG)**
 - www.oig.hhs.gov
- **CHAMP**
 - www.champ-program.org
- **Center for Excellence for Fall Prevention**
 - www.stopfalls.org

Timed Up & Go (TUG) Directions

Timed Up and Go Test

Overview:

The Timed Up and Go (TUG) test measures, in seconds, the time taken by an individual to stand up from a standard arm chair (approximate seat height of 46 cm [18in], arm height 65 cm [25.6 in]), walk a distance of 3 meters (118 inches, approximately 10 feet), turn, walk back to the chair, and sit down. The subject wears his/her regular footwear and uses his/her customary walking aid (cane, walker, etc.). No physical assistance is given. The subject starts with his/her back against the chair, his/her arms resting on the armrests, and walking aid at hand. The subject is instructed that, on the word “**go**” he/she is to get up and walk at a comfortable and safe pace to a line on the floor 3 meters away, turn, return to the chair and sit down again. *The subject walks through the test **once** before being timed in order to become familiar with the test.*

Use either a stopwatch or wristwatch with a second hand to time the test. If using a stopwatch, start the time once the subject is standing and stop the time once the subject is seated.

Instructions to the patient:

“When I say ‘go’ I want you to stand up and walk to the line, turn and then walk back to the chair and sit down again. Walk at your normal pace.”

Scoring:

TUG Score _____sec.

Walking aid used? Type of aid: _____

Older adults (age 65+) who took 13.5 seconds or longer to perform the TUG¹ were classified as fallers with an overall correct prediction rate of 90%².

¹ Podsiadlo, D., & Richardson, S. (1991). The timed “up & go”: A test of basic functional mobility for frail elderly persons. *Journal of the American Geriatrics Society*, 39, 142-148.

² Shumway-Cook A, Baldwin M, Polissar NL, Gruber W. Predicting the probability for falls in community-dwelling older adults. *Phys Ther*. 1997;77:812

CARE MANAGEMENT

(M2100) Types and Sources of Assistance: Determine the level of caregiver ability and willingness to provide assistance for the following activities, if assistance is needed. (Check only **one** box in each row.)

Type of Assistance	No assistance needed in this area	Caregiver(s) currently provide assistance	Caregiver(s) need training/ supportive services to provide assistance	Caregiver(s) <u>not likely</u> to provide assistance	Unclear if Caregiver(s) will provide assistance	Assistance needed, but no Caregiver(s) available
a. ADL assistance (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
b. IADL assistance (e.g., meals, housekeeping, laundry, telephone, shopping, finances)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
c. Medication administration (e.g., oral, inhaled or injectable)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
d. Medical procedures/ treatments (e.g., changing wound dressing)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
e. Management of Equipment (includes oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
f. Supervision and safety (e.g., due to cognitive impairment)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
g. Advocacy or facilitation of patient's participation in appropriate medical care (includes transportation to or from appointments)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5