OASIS-D Update

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OASIS-D Update

LEARNING OBJECTIVES

- Identify the changes to Outcome and Assessment Information Set (OASIS) resulting from the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014
- Describe the major changes from OASIS-C2 to OASIS-D
- Understand OASIS M-item coding instructions to accurately code new and revised OASIS items
- Identify available resources for implementing OASIS-D

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Why OASIS-D?

IMPACT ACT OF 2014

- Improving Medicare Post-Acute Care Transformation Act of 2014
- Bipartisan bill signed into law by President Obama October 6, 2014
- Requires Post-Acute Care (PAC) providers to report ***standardized*** patient assessment data and quality measure data
  - Long Term Care Hospitals (LTCH)
  - Skilled Nursing Facilities (SNF)
  - Inpatient Rehabilitative Facility (IRF)
  - Home Health Agencies (HHA)
  - Hospices
- PAC Medicare spending $73.8 Billion.

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IMPACT ACT of 2014 Driving Forces

PURPOSE:
- ❑ Improve Medicare beneficiary outcomes
- ❑ Provide access to longitudinal data to facilitate coordinated care
- ❑ Enable comparable data and quality across PAC settings
- ❑ Improve hospital discharge planning
- ❑ Research

Why the attention on Post-Acute Care?
- ❑ Escalating cost associated with PAC
- ❑ Lack of data standards across PAC
- ❑ Goal of establishing payment rates according to the individual characteristics of the patient, not the care setting

Post Acute Care?

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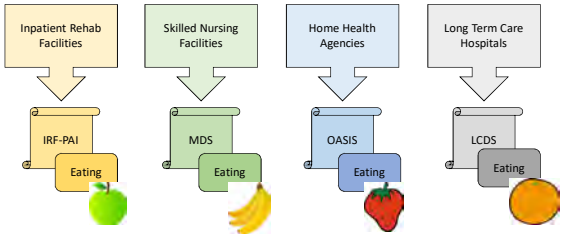
Why Standardization in PAC?



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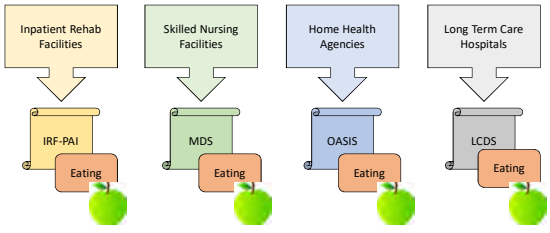
Why Standardization in PAC?



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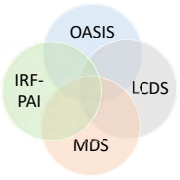
Standardized Patient Assessment Data Elements (SPADEs)



SPADEs:
- Questions and response options that are identical in all four PAC assessment instruments
- Identical standards and definitions apply

- The move toward standardized assessment data elements facilitates cross-setting data collection, quality measurement, outcome comparison, and interoperable data exchange

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Why is OASIS Being Updated Now?

IMPACT Act/ Standardization	Cross-Setting Alignment	Standardized Data Collection	Updates and Corrections
New Standardized Items • Section J: J1800 & J1900 • Section GG: GG0100, GG0110, GG0130, & GG0170	Alignment in content of items that support cross-setting measures • Drug Regimen Review • Pressure Ulcers • Active Diagnosis • Height & Weight	Reduction of burden • Quality measure changes • Survey and certification	General updates Corrections made as necessary

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WHAT'S NEW WITH THE OASIS-D ASSESSMENT INSTRUMENT?

- ✓New items are added
- ✓Different time point versions of some items
- ✓Removal of items
- ✓Revision of some items
- ✓Updated Skip Patterns

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WHAT'S NEW WITH THE OASIS-D GUIDANCE?

- ✓Chapter 3, two new sections of standard guidance added:
  - Section J – Health Conditions
  - Section GG – Functional Abilities and Goals
- ✓Chapter 4, Illustrative Examples are retired
- ✓Removal of many items and their corresponding guidance
- ✓Revisions to existing Guidance for some OASIS items to update or clarify information
- ✓Appendix F - sample reports are not included in this version. Users may refer to the Casper Reporting User Manual, Section 6, OASIS Quality Improvement Reports, located at: https://qtso.cms.gov/hhatrain.html

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OASIS-D Guidance Manual Changes

Guidance Manual Changes for 33 Items

M0080, M0090, M0102, M1021, M1023, M1046, M1056, M1060, M1307, M1332, M1334, M1342, M1610, M1730, M1800, M1810, M1820, M1830, M1840, M1845, M1850, M1860, M1870, M1910, M2001, M2003, M2005, M2010, M2016, M2020, M2030, M2301, M2401

OASIS-D Changes Effective January 1, 2019

For these 33 items, the Guidance Manual has been updated in one or more of the following sections:
- ✓ Item Intent
- ✓ Time Points Collected
- ✓ Response Specific Instructions
- ✓ Examples
- ✓ Data Sources and Resources

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OASIS-D New Items

Section J: Health Conditions (Falls)
- J1800: Any Falls Since SOC/ROC
- J1900: Number of Falls Since SOC/ROC

Section GG: Functional Abilities and Goals
- GG0100: Prior Functioning: Everyday Activities
- GG0110: Prior Device Use
- GG0130: Self-Care
- GG0170: Mobility

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OASIS-D Revised Items

Updated/ Revised

M1028	Active Diagnoses
M1306	Unhealed Pressure Ulcer/Injury at Stage 2 or Higher?
M1311	Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage
M1322	Current Number of Stage 1 Pressure Injuries
M1324	Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable
M2102	Types and Sources of Assistance
M2310	Reason for Emergent Care

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OASIS-D Revised Items

The 7 revised assessment items may have changes in one or more of the following areas:

- Time point versions
- Item text
- Response option(s)
- Use of the DASH (-) as a valid response
- Skip patterns

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Skip Pattern Changes

Skip pattern changes

M1000	Go To M1021 (M1017 item removed)
M1051	M1501 and M1230 items removed, New Go To Pattern
M1306	SOC/ROC/F-up Go To M1322, Discharge Go To M1324
M1311	New Time Point Versions, with specific Go To Patterns
M1340	M1350 item removed, New Go To Pattern
M1610	M1615 and M1620 items removed, No Go To Pattern needed
M2001	M2040 item removed, New Go To Pattern
M2410	M2430 and M0906 items removed, No Go To Pattern needed
M2420	M2430 item removed, No Go To Pattern needed

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OASIS Items Removed

28 Items Removed
- M0903, M1011, M1017, M1018, M1025, M1034, M1036, M1210, M1220, M1230, M1240, M1300, M1302, M1313, M1320, M1350, M1410, M1510, M1511, M1615, M1750, M1880, M1890, M1900, M2040, M2110, M2250, M2430

WHY?

OASIS Items were removed if they were not used to support:
- ✓ HH QRP measures
- ✓ HH Prospective Payment System (PPS)
- ✓ Survey process for Medicare certification
- ✓ HH Value-Based Purchasing (VBP) demonstration measures
- ✓ Critical risk-adjustment factors
- ✓ Conditions of Participation

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Updated One Clinician Rule

- Although one clinician must take responsibility for the comprehensive assessment, collaboration with the patient, caregivers, and other health care personnel, including the physician, pharmacist, and/or other agency staff is appropriate. For items requiring patient assessment, the collaborating healthcare providers must have had direct contact with the patient.
- Agencies may have the comprehensive assessment completed by one clinician. If collaboration with other health care personnel and/or agency staff is utilized, the agency is responsible for establishing policies and practices related to collaborative efforts, including how assessment information from multiple clinicians will be documented within the clinical record, ensuring compliance with applicable requirements, and accepted standards of practice.
- When collaboration is utilized, the M0090 Date assessment completed should reflect the last date the assessing clinician gathered or received any input used to complete the comprehensive assessment, including the OASIS items.
- When used, collaboration must occur within the appropriate timeframe and consistent with data collection guidance. Any exception to this general convention concerning collaboration is identified in item-specific guidance.

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Comprehensive Assessment Completion

- At the **start of care** time point, the comprehensive assessment should be completed within five days after the start of care date.
- At the **resumption of care**, the comprehensive assessment must be completed within 48 hours of return home after inpatient facility discharge, or within 48 hours of knowledge of a qualifying stay in an inpatient facility.
- A physician-ordered **resumption of care** (ROC) visit must be conducted on the physician-ordered ROC date.
- For the **transfer to inpatient facility, discharge from home care, death at home, and other follow-up**, the assessments must be completed on, or within 48 hours of becoming aware of the significant change in condition, transfer, discharge, or death date.

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M0080 Discipline of Person Conducting Assessment

Updated Guidance

(M0080) Discipline of Person Completing Assessment	
Enter Code ☐	1. RN 2. PT 3. SLP/ST 4. OT

ITEM INTENT
Specifies the discipline of the clinician completing the comprehensive assessment during an actual visit to the patient's home at the specified OASIS time point or the clinician reporting the transfer to an inpatient facility or death at home.

Response Specific Instructions
- While only the assessing clinician is responsible for accurately completing and signing a comprehensive assessment, he/she may collaborate to collect data for all OASIS items, if agency policy allows.

TIME POINTS ITEM(S) COMPLETED
- All

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M0090 Date Assessment Completed

Updated Guidance

(M0090) Date Assessment Completed

☐☐ / ☐☐ / ☐☐☐☐
month / day / year

ITEM INTENT
- Specifies the actual date the assessment is completed.

TIME POINTS ITEM(S) COMPLETED
- All

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M0102 Date of Physician-ordered Start of Care (Resumption of Care)

Updated Guidance

(M0102) Date of Physician-ordered Start of Care (Resumption of Care): If the physician indicated a specific start of care (resumption of care) date when the patient was referred form home health services, record the date specified.

☐☐ / ☐☐ / ☐☐☐☐
month / day / year

☐ NA - No Specific SOC date ordered by physician

ITEM INTENT
Specifies the date that home care services are ordered to begin or to resume following an inpatient stay of 24 hours or longer and for reasons other than diagnostic tests, if a SOC/ROC date was specified by the physician.
The item refers to the order to start home care services (that is, provide the first covered service), or resume home care services (that is provide the first visit following a qualifying inpatient stay) regardless of the type of services ordered (for example, therapy only).

TIME POINTS ITEM COMPLETED
- Start of care
- Resumption of care

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M1000 Which of the following Inpatient Facilities was Patient Discharged within past 14 Days?

(M1000) From which of the following **Inpatient Facilities** was the patient discharged within the past 14 days? **(Mark all that apply.)**

- ☐ 1 - Long-term nursing facility (NF)
- ☐ 2 - Skilled nursing facility (SNF/TCU)
- ☐ 3 - Short-stay acute hospital (IPPS)
- ☐ 4 - Long-term care hospital (LTCH)
- ☐ 5 - Inpatient rehabilitation hospital or unit (IRF)
- ☐ 6 - Psychiatric hospital or unit
- ☐ 7 - Other (specify) _____
- ☐ NA - Patient was not discharged from an inpatient facility *[Go to M1021]*

Skip pattern change due to item M1017 removed

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M1021 Primary Diagnosis / M1023 Other Diagnoses

RESPONSE SPECIFIC INSTRUCTIONS

Updated Guidance

- The assessing clinician is expected to complete the patient's comprehensive assessment and understand the patient's overall medical condition and care needs before selecting and assigning diagnoses and may elicit input from other agency staff that have had direct in-person contact with the patient, or have had some other means of gathering information to contribute to the OASIS data collection.

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M1028 Active Diagnoses

Revised Item

(M1028) Active Diagnoses – Comorbidities and Co-existing Conditions – Check all that apply
See OASIS Guidance Manual for a complete list of relevant ICD-10 codes.

- ☐ 1 - Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
- ☐ 2 - Diabetes Mellitus (DM)
- ☐ 3 - None of the above

ITEM INTENT
This item identifies whether two specific diagnoses are present and active. These diagnoses influence a patient's functional outcomes or increase a patient's risk for development or worsening of pressure ulcer(s).

TIME POINTS ITEM(S) COMPLETED
- Start of care
- Resumption of care

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CODING INSTRUCTIONS

M1028 Active Diagnoses

A **DASH** is a valid response for this item.

- **Code 1, Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD),** if the patient has an active diagnosis of Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD).
- **Code 2, Diabetes Mellitus (DM),** if the patient has an active diagnosis of Diabetes Mellitus (DM) indicated by any of the following diagnosis codes:
- **Code 3, None of the Above**, if the patient does not have any of the active diagnoses listed above.

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CODING TIPS

M1028 Active Diagnoses

- The physician (nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) may specifically indicate that a diagnosis is active.
- If there is documentation in the clinical record that a patient has diabetes mellitus, Select Response 2, Diabetes Mellitus (DM).
- If there is only documentation in the clinical record of a complication such as nephropathy or neuropathy and there is no documentation that the patient has diabetes, it should not be assumed the complication is associated with diabetes, and Response 2, Diabetes Mellitus, *should not* be checked.

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M1028 Active Diagnoses

EXAMPLE 1

- Mr. A is prescribed insulin for diabetes mellitus.
- He requires regular blood glucose monitoring to determine whether blood glucose goals are achieved by the current medication regimen.
- The physician progress note documents diabetes mellitus.

(M1028) Active Diagnoses – Comorbidities and Co-existing Conditions – Check all that apply
See OASIS Guidance Manual for a complete list of relevant ICD-10 codes.

- ☐ 1 - Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
- ☐ 2 - Diabetes Mellitus (DM)
- ☐ 3 - None of the above

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M1028 Active Diagnoses

EXAMPLE 2

- During the SOC/ROC assessment, Mrs. K told Nurse J, RN that she has had diabetes for 20 years.
- Nurse J reviewed the transfer documents from the acute care facility and all clinical records on the patient but was unable find a documented diagnosis of Diabetes Mellitus by physician, nurse practitioner, physician assistant or authorized licensed staff member in their state.
- There is no documented diagnosis of PVD or PAD.

(M1028) Active Diagnoses – Comorbidities and Co-existing Conditions – Check all that apply
See OASIS Guidance Manual for a complete list of relevant ICD-10 codes.

- ☐ 1 - Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
- ☐ 2 - Diabetes Mellitus (DM)
- ☐ 3 - None of the above

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M1046 Influenza Vaccine Received, and M1056 Reason Pneumococcal Vaccine not received

Updated Guidance

RESPONSE-SPECIFIC INSTRUCTIONS for M1046:

- Enter Response 5 if the influenza vaccine is contraindicated for medical reasons.
- Refer to the Centers for Disease Control and Prevention (CDC) website for information on contraindications for the influenza vaccine (See link in Chapter 5).

RESPONSE-SPECIFIC INSTRUCTIONS for M1056:

- Enter Response 2 if pneumococcal vaccine administration is contraindicated for this patient.
- Refer to the Centers for Disease Control and Prevention (CDC) website for information on contraindications for the pneumococcal vaccine (See link in Chapter 5).

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M1051 Pneumococcal Vaccine

(M1051) Pneumococcal Vaccine: Has the patient ever received the pneumococcal vaccination (for example, pneumovax)?	
Enter Code ☐	1. No 2. Yes *[Go to M2005 at TRN, Go to M1242 at DC]*

Skip pattern change due to removal of M1501 & M1230

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M1060 Height and Weight

Updated Guidance

(M1060) Height and Weight – While measuring, if the number is X.1-X.4 round down; X.5 or greater round up

□□ inches

a. Height (in inches). Record most recent height measure since the most recent SOC/ROC

□□□ pounds

b. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard agency practice (for example, in a.m. after voiding, before meal, with shoes off, etc.

ITEM INTENT

- These items support calculation of the patient's body mass index (BMI) using the patient's height and weight.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care

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M1060 Height and Weight

CODING INSTRUCTIONS HEIGHT

- Measure height in accordance with the agency's policies and procedures.
- Measure and record the patient's height to the nearest whole inch.
- Use mathematical rounding (i.e., if height measurement is X.5 inches or greater, round height upward to the nearest whole inch. If height measurement number is X.1 to X.4 inches, round down to the nearest whole inch). For example, a height of 62.5 inches would be rounded to 63 inches, and a height of 62.4 inches would be rounded to 62 inches.
- Only enter a height that has been directly measured by agency staff. Do not enter a height that is self-reported or derived from documentation from another provider setting.

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M1060 Height and Weight

CODING INSTRUCTIONS WEIGHT

- Weight should be measured in accordance with the agency's policies and procedures.
- Measure and record the patient's weight in pounds.
- Use mathematical rounding (e.g., if weight is X.5 pounds [lbs.] or more, round weight upward to the nearest whole pound. If weight is X.1 to X.4 lbs., round down to the nearest whole pound). For example, a weight of 152.5 lbs. would be rounded to 153 lbs. and a weight of 152.4 lbs. would be rounded to 152 lbs.
- If agency staff weighs the patient multiple times during the assessment period, use the first weight.
- Only enter a weight that has been directly measured by agency staff. Do not enter a weight that is self-reported or derived from documentation from another provider setting.

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CODING TIPS

M1060 Height and Weight

A **DASH** is a valid response for this item.

- When reporting height for a patient with bilateral lower extremity amputation, measure and record the patient's current height (i.e., height after bilateral amputation).
- If a patient cannot be weighed, for example, because of extreme pain, immobility, or risk of pathological fractures, the use of a dash (–) is appropriate. Document the rationale on the patient's medical record.
- When there is an unsuccessful attempt to measure a patient's height or weight, at SOC/ROC, and there is a documented agency-obtained height or weight from one or more previous home health visits, an agency-obtained height or weight from a documented visit conducted within the previous 30-day window may be used to complete M1060 for this SOC/ROC assessment.
- Whenever possible, a current height and weight should be obtained by the agency as part of the SOC/ROC assessment.

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Pressure Ulcer / Injury Review

Deleted Items

M1300 & M1302
Pressure Ulcer Risk
M1313
Worsening of Pressure Ulcer Status
M1320
Status of Most Problematic Pressure Ulcer
M1350
Other Skin Lesions

Remaining Items

M1306
Unhealed Pressure Ulcer/Injury at Stage 2 of Higher or Unstageable
M1307
Oldest Stage 2 Pressure Ulcer
M1311
Current Number Unhealed Pressure Ulcers/Injuries at Each Stage
M1322
Current Number of Stage 1 Pressure Injuries
M1324
Most Problematic Pressure Ulcer/Injury Stage

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Pressure Ulcer / Injury Terminology

Stage 1	Now called Pressure Injury
Stage 2,3 & 4	Now called Pressure Ulcer
DTI	Deep Tissue Injury
Unstageable	Unstageable due to Slough/Eschar – Pressure Ulcer
	Unstageable due to Non-removable Dressing/Device – Pressure Ulcer/Injury

Pressure Ulcer that was staged and now has a "scab" indicates it is healing and therefore staging does not change.

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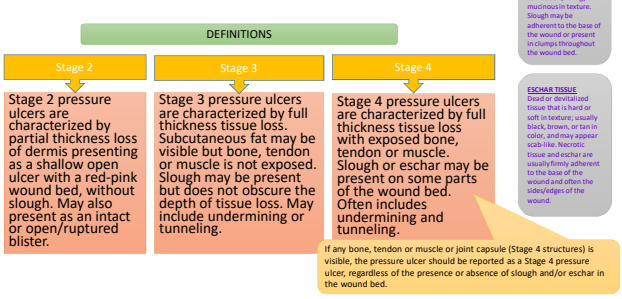
Pressure Ulcers/Injuries at Each Stage



Pressure Ulcer / Injury Guidance

- Skin assessment should be completed as close to that actual time of the SOC/ROC as possible
  - Report pressure ulcer/injury stage (or whether unstageable) based on the first skin assessment
  - Do Not change OASIS coding if the ulcer/injury increases in numerical stage (worsens) or becomes stageable or unstageable within the assessment time period
- Once a Stage 2, 3, or 4 pressure ulcer is completely covered with new epithelial tissue, it is considered healed and no longer reported as a pressure ulcer
- A pressure ulcer treated with a skin graft is a surgical wound until the graft edges are completely healed

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Pressure Ulcer / Injury Guidance

- Pressure ulcers/injuries that are known to be present but that are unobservable due to a dressing/device, such as a cast, that cannot be removed to assess the skin underneath. "Known" refers to when documentation is available that states a pressure ulcer/injury exists under the non-removable dressing/device.
- Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green or brown) tissue present such that the anatomic depth of soft tissue damage cannot be visualized in the wound bed, should be classified as unstageable. If the wound bed is only partially covered by eschar or slough, and the anatomical depth of tissue damage can be visualized, numerically stage the ulcer, and do not code this as unstageable.
- Pressure ulcers that are covered with slough and/or eschar, and the wound bed cannot be visualized, should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore stage) cannot be determined. Only until enough slough and/or eschar is removed to expose the anatomic depth of soft tissue damage involved, can the stage of the wound be determined.

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Revised Item

M1306 Unhealed PU/Injury at Stage 2 or Higher

(M1306)	Does this patient have at least one **Unhealed Pressure Ulcer/Injury at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure injuries and all healed pressure ulcers/injuries)
Enter Code ☐	0 No *[Go to M1322 at SOC/ROC/FU; Go to M1324 at DC]* 1 Yes

Skip pattern change added "Go to M1324 at Discharge"

Incorporated National Pressure Ulcer Advisory Panel (NPUAP) terminology updates to align with other PAC instruments.

Item text revised:
- Replaced "excludes….healed **Stage 2** pressure ulcers" with "excludes….**all** healed pressure ulcers"
- Added Pressure ulcer/injuries

ITEM INTENT
Identifies the presence or absence of Unhealed Stage 2 or higher or Unstageable pressure ulcers/injuries only.

TIME POINTS ITEM(S) COMPLETED
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency – not to inpatient facility

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Updated Guidance

M1307 Oldest Stage 2 Pressure Ulcer

(M1307)	The **Oldest Stage 2 Pressure Ulcer** that is present at discharge: (Excludes healed Stage 2 pressure ulcers)
Enter Code ☐	1 Was present at the most recent SOC/ROC assessment 2 Developed since the most recent SOC/ROC assessment. Record date pressure ulcer first identified: ☐☐ Month ☐☐ Day ☐☐☐☐ Year NA No Stage 2 pressure ulcers are present at discharge

ITEM INTENT
- The intent of this item is to a) identify the oldest Stage 2 pressure ulcer that is present at the time of discharge and is not fully epithelialized (healed), b) assess the length of time this ulcer remained unhealed while the patient received care from the home health agency and c) identify patients who develop Stage 2 pressure ulcers while under the care of the agency.

TIME POINTS ITEM(S) COMPLETED
Discharge from agency – not to inpatient facility

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M1311 Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Revised Item

M1311 updated and changed:
- Now shows *time point versions* for each time point an assessment is completed
- For SOC/ROC and Follow-up OASIS assessments
  - Shows A1 to F1
- For Discharge OASIS assessment
  - Shows A1, A2, B1, B2, to F1, F2
- SOC/ROC and Discharge information used to calculate revised pressure ulcer measure
- Alignment with other PAC instruments
  - Incorporated NPUAP terminology updates
  - Skip pattern language and directions modified

Skip pattern changes due to new time point versions

A **Dash** is a valid response for **DISCHARGE ONLY.**

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M1311 Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Revised Item

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage *(SOC/ROC)*		Enter Number
A1.	**Stage 2:** Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers**	☐
B1.	**Stage 3:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers**	☐
C1.	**Stage 4:** Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. **Number of Stage 4 pressure ulcers**	☐
D1.	**Unstageable: Non-removable dressing/device:** Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device**	☐
E1.	**Unstageable: Slough and/or eschar:** Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar**	☐
F1.	**Unstageable: Deep tissue injury** **Number of unstageable pressure injuries presenting as deep tissue injury**	☐

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage (Discharge)	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 – Go to M1311B1, Stage 3] **A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐ ☐
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers** [If 0 – Go to M1311C1, Stage 4] **B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐ ☐
C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. **Number of Stage 4 pressure ulcers** [If 0 – Go to M1311D1, Unstageable: Non-removable dressing/device] **C2. Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐ ☐
D1. Unstageable: Non-removable dressing/device: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device** [If 0 – Go to M1311E1, Unstageable: Slough and/or eschar] **D2. Number of these unstageable pressure ulcers/injuries that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐ ☐
E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** [If 0 – Go to M1311F1, Unstageable: Deep tissue injury] **E2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐ ☐
F1. Unstageable: Deep tissue injury Number of unstageable pressure injuries presenting as deep tissue injury [If 0 – Go to M1324] **F2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐ ☐

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M1311 Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

ITEM INTENT

- This item identifies the number of pressure ulcers/injuries at each stage (Stage 2, 3, and 4) and designated as Unstageable, that are observed on assessment.
- At discharge, this item also identifies if each pressure ulcer/injury present on the discharge assessment was observed ***at the same stage*** at the time of the most recent SOC/ROC.
- Stage 1 pressure injuries and all healed pressure ulcers/injuries are not reported in this item.

TIME POINTS ITEMS COMPLETED

- Start of Care
- Resumption of Care
- Follow-up
- Discharge from agency – not to inpatient facility

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M1311 Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Determining "Present at the most recent SOC/ROC" to answer M1311

- For each pressure ulcer/injury observed and coded in items M1311A1-F1 on Discharge, determine whether that pressure ulcer/injury was observed ***at the same stage*** at the time of the most recent SOC/ROC, and did not form during this home health quality episode.
- If the pressure ulcer/injury was unstageable at SOC/ROC, but becomes numerically stageable later, when completing the Discharge assessment, its "Present at the most recent SOC/ROC" stage should be considered the stage at which it first becomes numerically stageable.
- If it subsequently increases in numerical stage, do not report the higher stage ulcer as being "present at the most recent SOC/ROC" when completing the Discharge assessment.
- The general standard of practice for patients starting or resuming care is that patient assessments are completed as close to the actual time of the SOC/ROC as possible.
  - For example, if a pressure ulcer/injury that is identified on the SOC date increases in numerical stage within the assessment time frame, the stage of the pressure ulcer/injury at the first skin assessment completed would be reported in M1311X1 at the SOC.

M1311 Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

EXAMPLE 1

The RN assesses Mr. J's skin at the SOC and identifies a DTI with intact skin on his left heel.

This DTI remains unchanged until the RN skin assessment 10 days later, which reveals open skin presenting as a Stage 3 pressure ulcer.

The pressure ulcer does not change for the remainder of the episode. At the discharge (DC) skin assessment, the ulcer remains a Stage 3.

(In this example, there are no other pressure ulcers/injuries at the SOC assessment, during the episode or at DC).

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(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 – Go to M1311B1, Stage 3]	☐
A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers** [If 0 – Go to M1311C1, Stage 4]	☐
B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. **Number of Stage 4 pressure ulcers** [If 0 – Go to M1311D1, Unstageable: Non-removable dressing/device]	☐
C2. Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
D1. Unstageable: Non-removable dressing/device: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device** [If 0 – Go to M1311E1, Unstageable: Slough and/or eschar]	☐
D2. Number of these unstageable pressure ulcers/injuries that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** [If 0 – Go to M1311F1, Unstageable: Deep tissue injury]	☐
E2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
F1. Unstageable: Deep tissue injury Number of unstageable pressure injuries presenting as deep tissue injury [If 0 – Go to M1324]	☐
F2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐

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M1311 Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

EXAMPLE 2

The RN completes a skin assessment during the SOC visit for Mrs. K, and identifies a right hip DTI with intact skin.

This DTI is first numerically stageable 10 days later as a Stage 3 pressure ulcer and increases in numerical stage five days after that, to a Stage 4 pressure ulcer.

The pressure ulcer remains a Stage 4 at DC.

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M1311 Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

EXAMPLE 3

The RN assesses Mr. L's skin during the assessment timeframe for the SOC, and identifies a DTI with intact skin on his right heel.

This DTI first becomes numerically stageable at the third home visit, as a Stage 3 pressure ulcer.

At the DC skin assessment, this pressure ulcer is unstageable due to slough and eschar.

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Revised Item

M1322 Current Number of Stage 1 Pressure Injuries

(M1322)	**Current Number of Stage 1 Pressure Injuries:** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.
Enter Code ☐	0 1 2 3 4 or more

ITEM INTENT
Identifies the presence and number of Stage 1 pressure injuries.

TIME POINTS ITEM(S) COMPLETED
- Start of care
- Resumption of care
- Follow-up

Removed Discharge from Agency – Not to Inpatient Facility

51

M1324 Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable

Revised Item

(M1324)	**Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable:** (Excludes pressure ulcer/injury that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or deep tissue injury.)
Enter Code ☐	1 Stage 1 2 Stage 2 3 Stage 3 4 Stage 4 NA Patient has no pressure ulcers/injuries or no stageable pressure ulcer/injuries

ITEM INTENT
- Identifies the stage of the most problematic stageable pressure ulcer/injury.
- Please note; pressure ulcers/injuries that have healed are not considered for this item.

TIME POINTS ITEM(S) COMPLETED
- Start of Care
- Resumption of Care
- Follow-up
- Discharge from agency – not to an inpatient facility

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Pressure Ulcer / Injury Resources

- The National Pressure Ulcer Advisory Panel – NPUAP: Educational and Clinical Resources
  - http://www.npuap.org/resources/educational-and-clinical-resources/
- International Skin Tear Advisory Panel (ISTAP)
  - http://www.skintears.org/education/tools/
- Wound, Ostomy and Continence Nurses Society's Guidance on OASIS-C2 Integumentary Items: Best Practice for Clinicians
  - http://c.ymcdn.com/sites/www.wocn.org/resource/resmgr/publications/WOCN_Guidance_on_OASIS-C2_In.pdf

53

M1332 Current Number of Stasis Ulcer(s) that are Observable

Updated Guidance

(M1332)	**Current Number of Stasis Ulcer(s) that are Observable:**
Enter Code ☐	1 One 2 Two 3 Three 4 Four or more

ITEM INTENT
- Identifies the number of visible (observable) stasis ulcers.

RESPONSE SPECIFIC INSTRUCTIONS
- All stasis ulcers except those that are covered by a non-removable dressing/device, such as a cast or Unna boot, are considered observable.

TIME POINTS ITEM(S) COMPLETED
- Start of care
- Resumption of care
- Follow-up

Removed Discharge from Agency – Not to Inpatient Facility

54

M1334 Status of Most Problematic Stasis Ulcer that is Observable

Updated Guidance

(M1334) Status of Most Problematic Stasis Ulcer that is Observable:	
Enter Code ☐	1. Fully granulating 2. Early/partial granulation 3. Not healing

ITEM INTENT
- Identifies the degree of healing present in the most problematic, observable stasis ulcer. The "most problematic" ulcer may be the largest, the most resistant to treatment, an ulcer that is infected, etc., depending on the specific situation.

TIME POINTS ITEM(S) COMPLETED
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency – not to inpatient facility

RESPONSE SPECIFIC INSTRUCTIONS

- Determine status of the most problematic stasis ulcer that is observable using healing status definitions developed by the Wound Ostomy and Continence Nurses (WOCN) Society.

55

M1340 Does the patient have a Surgical Wound?

M1340 Does this patient have a Surgical Wound?	
Enter Code ☐	0 No *[Go to M1400]* 1 Yes, patient has at least one observable surgical wound 2 Surgical wound known but not observable due to non-removable dressing/device *[Go to M1400]*

Skip pattern change due to removal of M1350

56

M1342 Status of Most Problematic Surgical Wound that is Observable

Updated Guidance

(M1342) Status of Most Problematic Surgical Wound that is Observable	
Enter Code ☐	0 Newly epithelialized 1 Fully granulating 2 Early/partial granulation 3 Not healing

ITEM INTENT
- Identifies the degree of healing present in the most problematic, observable surgical wound.

TIME POINTS ITEM(S) COMPLETED
- Start of Care
- Resumption of Care
- Follow-up
- Discharge from agency – not to an inpatient facility

- Determine status of the most problematic surgical wound using healing status definitions developed by the Wound Ostomy and Continence Nurses (WOCN) Society. The clinician must first assess if the wound is healing entirely by primary intention (well-approximated with no dehiscence), or if there is a portion healing by secondary intention, (due to dehiscence, interruption of the incision, or intentional secondary healing).

57

M1610 Urinary Incontinence or Urinary Catheter Presence

Updated Guidance

No skip pattern removed M1615

(M1610)	Urinary Incontinence or Urinary Catheter Presence:
Enter Code ☐	0 No incontinence or catheter (includes anuria or ostomy for urinary drainage) 1 Patient is incontinent 2 Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic)

ITEM INTENT
- Identifies presence of urinary incontinence or condition that requires urinary catheterization of any type, including intermittent or indwelling. The etiology (cause) of incontinence is not addressed in this item.

TIME POINTS ITEM(S) COMPLETED
- Start of care
- Resumption of care
- Follow-up

Removed Discharge from Agency – Not to Inpatient Facility

58

M1730 Depression Screening

Updated Guidance

(M1730)	Depression Screening: Has the patient been screened for depression, using a standardized, validated depression screening tool?
Enter Code ☐	0 No 1 Yes, patient was screened using the PHQ-2© scale. Instructions for this two-question tool: Ask patient "Over the last two weeks, how often have you been bothered by any of the following problems?"

PHQ-2 ©	Not at all 0-1 day	Several days 2-6 days	More than half of the days 7-11 days	Nearly every day 12-14 days	NA Unable to respond
	☐ 0	☐ 1	☐ 2	☐ 3	☐ NA
	☐ 0	☐ 1	☐ 2	☐ 3	☐ NA

ITEM INTENT
- Identifies if the home health agency screened the patient for depression using a standardized, validated depression-screening tool.
- CMS does not mandate that clinicians conduct depression screening for all patients, nor is there a mandate for the use of the PHQ-2© or any other particular standardized, validated tool. The best practices stated in the item are not necessarily required in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED
- Start of care
- Resumption of care

Deleted Sentence:
This item is used to calculate process measures to capture the agency's use of best practices following completion of the comprehensive assessment.

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M1730 Depression Screening

RESPONSE SPECIFIC INSTRUCTIONS

- In order to enter Response 1, 2 or 3, the standardized, validated depression screening must be completed during the time frame specified by CMS for completion of the assessment (specifically, within five days of SOC or within two days of inpatient facility discharge at ROC, or on the physician-ordered ROC date.
- A clinician other than the assessing clinician may complete the standardized, validated depression screening for consideration by the assessing clinician.

60

Expansion of the One Clinician Rule M1800 to M1870

Updated Guidance

RESPONSE SPECIFIC INSTRUCTIONS

- When coding this item, the assessing clinician may consider available input from other agency staff who have had direct patient contact. Refer to Chapter 1 for additional details on this and other OASIS conventions.

- M1800 Grooming
- M1810 Dress Upper Body
- M1820 Dress Lower Body
- M1830 Bathing
- M1840 Toilet Transferring
- M1845 Toileting Hygiene
- M1850 Transferring
- M1860 Ambulation/Locomotion
- M1870 Feeding or Eating

61

Updated Guidance

M1910 Falls Risk Assessment

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

ITEM INTENT

- Identifies whether the home health agency has assessed the patient and home environment for characteristics that place the patient at risk for falls. The multi-factor falls risk assessment must include at least one standardized, validated tool that 1) has been scientifically tested in a population with characteristics similar to that of the patient being assessed (for example, community-dwelling elders, noninstitutionalized adults with disabilities, etc.) and shown to be effective in identifying people at risk for falls; and 2) includes a standard response scale. The standardized, validated tool must be both appropriate for the patient based on their cognitive and physical status and appropriately administered per the tool's instructions.
- The best practices stated in the item are not necessarily required in the Conditions of Participation.

Deleted Sentence:

This item is used to calculate process measures to capture the agency's use of best practices following completion of the comprehensive assessment.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care

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RESPONSE SPECIFIC INSTRUCTIONS

M1910 Falls Risk Assessment

- CMS does not mandate that clinicians conduct falls risk screening for all patients, nor is there a mandate for the use of a specific tool.

- A clinician other than the assessing clinician may complete the standardized, validated fall risk screening for consideration by the assessing clinician.

63

Drug Regimen Review

- There are no new or updated Drug Regimen Review items for 2019
- The Drug Regimen Review items were first introduced to home health in 2010 and revised in January 1, 2017 (OASIS-C2)
  - During 2018, the Drug Regimen Review items are being implemented in IRF, LTCH, and SNF
    - Inpatient Rehabilitation Facilities
    - Long Term Care Hospitals
    - Skilled Nursing Facilities
- Changes to the Drug Regimen Review items for home health in 2019 are limited to guidance refinement to promote cross-setting alignment

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Updated Guidance

M2001 Drug Regimen Review

(M2001)	**Drug Regimen Review:** Did a complete drug regimen review identify clinically significant medication issues?
Enter Code ☐	0 No – No issues found during review *[Go to M2010]* 1 Yes – Issues found during review 9 NA – Patient is not taking any medications *[Go to M2102]*

Skip pattern change due to removal of M2040

ITEM INTENT
- Identifies if review of the patient's medications indicated any potential or *actual* clinically significant medication issues.

TIME POINTS ITEM(S) COMPLETED
- Start of care
- Resumption of care

65

Updated Guidance

M2003 Medication Follow-up

(M2003)	**Medication Follow-up**: Did the agency contact the physician (or physician designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?
Enter Code ☐	0 No 1 Yes

ITEM INTENT
- Identifies if potential or actual clinically significant medication issues identified through the drug regimen review were communicated to the physician (or physician-designee) and to the extent possible, prescribed/recommended actions were completed by midnight of the next calendar day following their identification.

TIME POINTS ITEM(S) COMPLETED
- Start of care
- Resumption of care

66

M2005 Medication Intervention

Updated Guidance

(M2005)	**Medication Intervention:** Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?
Enter Code ☐	0. No 1. Yes 9. NA-There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications

ITEM INTENT
Identifies if potential or actual clinically significant medication issues identified at the time of or at any time since the most recent SOC/ROC were communicated to the physician (or physician-designee) and to the extent possible, prescribed/recommended actions were completed by midnight of the next calendar day following their identification.

TIME POINTS ITEM(S) COMPLETED
- Transfer to an inpatient facility
- Death at home
- Discharge from agency – not to an inpatient facility

67

M2005 Medication Intervention

(M2001)	**Drug Regimen Review:** Did a complete drug regimen review identify potential clinically significant medication issues?
Enter Code ☐	0 No – No issues found during review [Go to M2010] 1 Yes – Issues found during review 9 NA – Patient is not taking any medications [Go to M2102]

(M2003)	**Medication Follow-up:** Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?
Enter Code ☐	0. No 1. Yes

(M2005)	**Medication Intervention:** Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?
Enter Code ☐	0. No 1. Yes 9. NA-There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications

68

M2010 Patient/Caregiver High-Risk Drug Education

Updated Guidance

(M2010)	**Patient/Caregiver High-Risk Drug Education:** Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?
Enter Code ☐	0. No 1. Yes 9. NA-There were no potential clinically significant medication issues identified sine SOC/ROC or patient is not taking any medications

ITEM INTENT
- Identifies if clinicians instructed the patient and/or caregiver about all high-risk medications the patient takes. High-risk medications are those identified by an authoritative source, such as the Institute for Safe Medication Practices as having considerable potential for causing significant patient harm when they are used erroneously.
- This item is targeted to high-risk medications as it may be unrealistic to expect that patient education on all medications occur on admission and failure to provide patient education on high-risk medications such as hypoglycemics and anticoagulants (and others) at SOC/ROC could have severe negative impacts on patient safety and health.
- The best practices stated in the item are not necessarily required in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED
- Start of care
- Resumption of care

69

M2016 Patient/Caregiver Drug Education Intervention

Updated Guidance

(M2016)	**Patient/Caregiver Drug Education Intervention:** At the time of, or at any time since the most recent SOC/ROC assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur?
Enter Code ☐	0. No 1. Yes 9. NA-Patient not taking any drugs

ITEM INTENT
Identifies if agency staff and/or other health care providers, such as pharmacists, instructed the patient/caregiver about how to manage all medications effectively and safely within the time period under consideration, including instruction related to monitoring the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur.
The best practices stated in the item are not necessarily required in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED
- Transfer to an inpatient facility
- Discharge from agency – not to an inpatient facility

70

M2020 Management of Oral Medications

(M2020)	**Management of Oral Medications:** Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**
Enter Code ☐	0. Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times. 1. Able to take medication(s) a the correct times if: (a) Individual dosages are prepared in advance by another person; OR (b) Another person develops a drug diary or chart. 2. Able to take medication(s) at the correct times if given reminders by another person at the appropriate times. 3. Unable to take medication unless administered by another person. NA No oral medications prescribed.

Updated Guidance

ITEM INTENT
This item is intended to identify the patient's ability to take all oral (p.o.) medications reliably and safely on the day of assessment.

The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely take oral medications, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform medication management. Ability can be temporarily or permanently limited by:
- Physical impairments (for example, limited manual dexterity);
- Emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear);
- Sensory impairments (for example, impaired vision, pain);
- Environmental barriers (for example, access to kitchen or medication storage area, stairs, narrow doorways).

TIME POINTS ITEM(S) COMPLETED
- Start of care
- Resumption of care
- Discharge from agency – not to an inpatient facility

71

Updated Guidance

M2030 Management of Injectable Medications

(M2030)	**Management of Injectable Medications:** Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**
Enter Code ☐	0. Able to independently take the correct medication(s) and proper dosage(s) at the correct times. 1. Able to take injectable medication(s) at the correct times if: (a) Individual syringes are prepared in advance by another person; OR (b) Another person develops a drug diary or chart. 2. Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection. 3. Unable to take injectable medication unless administered by another person NA No injectable medications prescribed

ITEM INTENT
This item is intended to assess the patient's ability to take all injectable medications reliably and safely at on day of assessment.
The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely manage injectable medications, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform medication management. Ability can be temporarily or permanently limited by:
- Physical impairments (for example, limited manual dexterity);
- Emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear);
- Sensory impairments (for example, impaired vision, pain);
- Environmental barriers (for example, access to kitchen or medication storage area, stairs, narrow doorway.

TIME POINTS ITEM(S) COMPLETED
- Start of care
- Resumption of care
- Follow-up
- *Removed - Discharge from agency – not to an inpatient facility*

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Revised Item

M2102 Types and Sources of Assistance (SOC/ROC)

(M2102)	**Types and Sources of Assistance:** Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.
Enter Code ☐	f. **Supervision and safety** (for example, due to cognitive impairment) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available

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Revised Item

M2102 Types and Sources of Assistance (Discharge)

(M2102)	**Types and Sources of Assistance:** Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.
Enter Code ☐	a. **ADL assistance** (for example, transfer/ ambulation, bathing, dressing, toileting, eating/feeding) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	c. **Medication administration** (for example, oral, inhaled or injectable) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	d. **Medical procedures/ treatments** (for example, changing wound dressing, home exercise program) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	f. **Supervision and safety** (for example, due to cognitive impairment) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available

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Revised Item

M2301 Emergent Care

Updated Guidance

(M2301)	**Emergent Care:** At the time of or at any time since the most recent SOC/ROC assessment has the patient utilized a hospital emergency department (includes holding/observation status)?
Enter Code ☐	0 No ***[Go to M2401]*** 1 Yes, used hospital emergency department WITHOUT hospital admission 2 Yes, used hospital emergency department WITH hospital admission UK Unknown ***[Go to M2410]***

ITEM INTENT

- Identifies whether the patient was seen in a hospital emergency department. Responses to this item include the entire period at or since the most recent SOC/ROC assessment, including use of hospital emergency department that results in a qualifying hospital admission, necessitating Transfer OASIS data collection. This item includes current events.

REMOVED FROM INTENT

- Identifies whether the patient was seen in a hospital emergency department *at the time of or at any time since the most recent SOC/ROC assessment.*

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Revised Item

M2310 Reason for Emergency Care

(M2102) **Reason for Emergent Care:** For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)? **(Mark all that apply.)**

- ❑ 1 Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
- ❑ 10 Hypo/Hyperglycemia, diabetes out of control
- ❑ 19 Other than above reasons
- ❑ UK Reason Unknown

ITEM INTENT

- Identifies the reasons for which the patient sought and/or received care in a hospital emergency department.

TIME POINTS ITEM(S) COMPLETED

- Transfer to an inpatient facility
- Discharge from agency – not to an inpatient facility

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RESPONSE SPECIFIC INSTRUCTIONS

M2310 Reason for Emergency Care

- This item excludes urgent care services not provided in a hospital emergency department, including care provided in a doctor's office, care provided by an ambulance crew, or care received in urgent care facilities.
- If more than one reason contributed to the hospital emergency department visit, mark all appropriate responses. For example, if a patient received care for a fall at home and was found to have medication side effects, mark both Response 19, Other than above reasons (for the fall), and Response 1 (for the medication side effects).
- If a patient seeks care in a hospital emergency department for a specific suspected condition, report that condition, even if the suspected condition was ruled out (for example, patient was sent to ED for suspected DVT but diagnostic testing and evaluation were negative for DVT – select Response 19 – Other than above reasons).
- If the reason is not included in the choices, select Response 19 - Other than above reasons.
- If the patient has received emergent care in a hospital emergency department multiple times since the most recent SOC/ROC, include the reasons for all visits.

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Updated Guidance

M2401 Intervention Synopsis

(M2401)	**Intervention Synopsis:** (Check only one box in each row.) At the time of or at any time since the most recent SOC/ROC 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	☐ 0	☐ 1	☐ NA — Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
b.	Falls prevention interventions	☐ 0	☐ 1	☐ NA — Every standardized, validated multi-factor fall risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no risk for falls.
c.	Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	☐ 0	☐ 1	☐ NA — Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the most recent SOC/ROC assessment indicates the patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.
d.	Intervention(s) to monitor and mitigate pain	☐ 0	☐ 1	☐ NA — Every standardized, validated pain assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no pain.
e.	Intervention(s) to prevent pressure ulcers	☐ 0	☐ 1	☐ NA — Every standardized, validated pressure ulcer risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient is not at risk of developing pressure ulcers.
f.	Pressure ulcer treatment based on principles of moist wound healing	☐ 0	☐ 1	☐ NA — Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

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M2401 Intervention Synopsis

Updated/ Revised

ITEM INTENT

- Identifies if specific interventions focused on specific problems were both included on the physician-ordered home health Plan of Care AND implemented as part of care provided ***at the time of or at any time since the most recent SOC/ROC assessment***. "Included in the physician-ordered Plan of Care" means that the patient condition was discussed and there was agreement as to the Plan of Care between the home health agency staff and the patient's physician.
- The problem-specific interventions referenced in the item may or may not directly correlate to stated requirements in the Conditions of Participation

TIME POINTS ITEM(S) COMPLETED

- Transfer to an inpatient facility
- Discharge from agency – not to an inpatient facility

- ✓ Deleted "during the home health care episode"
- ✓ Also, Removed statement related to Process Measure

79

M2410 Inpatient Facility & M2420 Discharge Disposition

Skip patterns no longer required due to removal of M2430 and M0960

(M2410)	To which **Inpatient Facility** has the patient been admitted?
Enter Code ☐	1. Hospital 2. Rehabilitation facility 3. Nursing home 4. Hospice NA No inpatient facility admission ***[Omit "NA" option on TRN]***

(M2420)	**Discharge Disposition**: Where is the patient after discharge from your agency? (Choose only one answer.)
Enter Code ☐	1. Patient remained in the community (without formal assistive services) 2. Patient remained in the community (with formal assistive services) 3. Patient transferred to a non-institutional hospice 4. Unknown because patient moved to a geographic location not served by this agency UK Other unknown

80

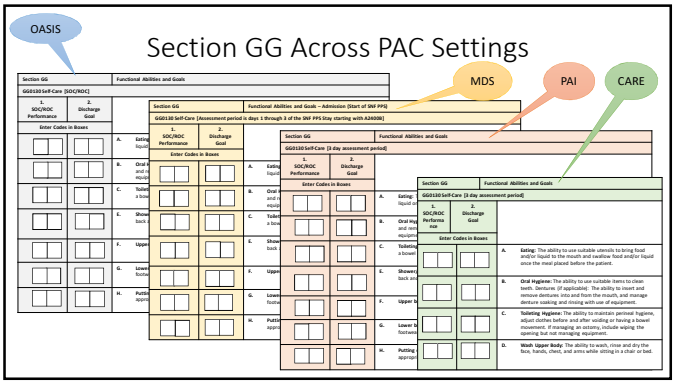
SECTION GG: FUNCTIONAL ABILITIES AND GOALS

- New items added to continue implementation of IMPACT ACT with the goal of standardization across Post Acute Care (PAC) settings
- This move towards standardized assessment of some data items facilitates cross-setting
  - Data collection
  - Quality measurement
  - Outcome comparison
  - Interoperable data exchange

- SNF • Minimum Data Set (MDS)
- LTCH • Community Assessment Record & Evaluation (CARE)
- HH • Outcome & Assessment Information Set (OASIS)
- IRF • Patient Assessment Instrument (IRF-PAI)

81

Section GG Across PAC Settings



SECTION GG: FUNCTIONAL ABILITIES AND GOALS

How will Section GG items be used?

- GG items will be used to calculate the cross-setting quality process measure "Percent of Home Health Episodes with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function"

Reports the percent of patients with a SOC/ROC and a discharge functional assessment and a treatment goal that addresses function

83

SECTION GG: FUNCTIONAL ABILITIES AND GOALS

Differences between Section GG and M-Items

- GG items are not intended to be exactly the same as M-items
- Important to understand inclusions/exclusions
- Coding scales are different for GG items

84

Data Collection Conventions for GG Items

- **OBSERVE**-Assess patient's status based upon direct observation

- **LISTEN**-Consider reports by patient/family/caregiver

- **PROMOTE GREATEST SAFE INDEPENDENCE**-Provide the opportunity to perform the activity as independently as possible, while remaining safe

85

Data Collection Conventions for GG Items

- **CONSIDER REQUIRED ASSISTANCE**-If caregiver assistance is required, code according to amount of assistance needed for safety

- **DEVICE USE DOESN'T REQUIRE DOWNCODING**-If the patient is able to safely get and use a device to complete the task with no help, code Independent

- **DETERMINE USUAL STATUS**-If performance varies during the assessment time frame, report the usual status

86

GG0100: Prior Functioning: Everyday Activities

GG0100. Prior Functioning: Everyday Activities: Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury.

Coding:
3. Independent – Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.
2. Needed Some Help – Patient needed partial assistance from another person to complete activities.
1. Dependent – A helper completed the activities for the patient.
8. Unknown
9. Not Applicable

New Item

↓Enter Codes in Boxes

☐	**A. Self Care**: Code the patient's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury
☐	**B. Indoor Mobility (Ambulation):** Code the patient's need for assistance with walking from room to room (with or without a device such as cane, crutch or walker) prior to the current illness, exacerbation, or injury.
☐	**C. Stairs**: Code the patient's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation or injury.
☐	**D. Functional Cognition**: Code the patient's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

87

GG0100 Prior Functioning: Everyday Activities

ITEM INTENT

- This item identifies the patient's usual ability with everyday activities, prior to the current illness, exacerbation or injury.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care

New Item

88

GG0100 Prior Functioning: Everyday Activities

RESPONSE SPECIFIC INSTRUCTIONS

- Interview patient or family or review patient's clinical records describing patient's prior functioning with everyday activities.

89

GG0100 Prior Functioning: Everyday Activities

CODING INSTRUCTIONS

A **DASH** is a valid response for this item.

- **Code 3, Independent**, if the patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.
- **Code 2, Needed Some Help**, if the patient needed partial assistance from another person to complete activities.
- **Code 1, Dependent**, if the helper completed the activities for the patient.
- **Code 8, Unknown**, if the patient's usual ability prior to the current illness, exacerbation or injury is unknown.
- **Code 9, Not Applicable**, if the activity was not applicable to the patient prior the current illness, exacerbation or injury.

CODING TIP

If no information about the patient's ability is available after attempt to interview patient or family and after reviewing patient's clinical record, **Code 8, Unknown**.

90

GG0100 Prior Functioning: Everyday Activities

EXAMPLE 1

Mr. and Mrs. Sells tell you, that Mr. Sells was able to do his own self cares prior to his hospitalization. Mr. Sells confirms he was able to take his own shower and complete ADLs, including grooming, dressing and eating before he was hospitalized.

Mr. Sells also tells the nurse he was ambulating with a walker around his home, and used a stair lift to negotiate the stairs to the second floor, where his bedroom is located.

The nurse assesses Mr. Sells to be alert, oriented and confirms he is able to take his medications correctly, and this was the same prior to hospitalization.

91

GG0100. Prior Functioning: Everyday Activities: Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury.

Coding:	Enter Codes in Boxes	
3. Independent – Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper. **2. Needed Some Help** – Patient needed partial assistance from another person to complete activities. **1. Dependent** – A helper completed the activities for the patient. **8. Unknown** **9. Not Applicable**	☐	**A. Self Care**: Code the patient's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury
	☐	**B. Indoor Mobility (Ambulation):** Code the patient's need for assistance with walking from room to room (with or without a device such as cane, crutch or walker) prior to the current illness, exacerbation, or injury.
	☐	**C. Stairs**: Code the patient's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation or injury.
	☐	**D. Functional Cognition**: Code the patient's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

92

GG0100 Prior Functioning: Everyday Activities

EXAMPLE 2

Mrs. Able tells you, she is a retired nurse and she broke her hip recently and just returned home from Rehab at a SNF. She says she has always been very independent and was able to do all her own self cares including all ADLs, shopping and medication management prior to the incident.

The nurse observes Mrs. Able's house is a one story, but noticed there are 4 steps going into the family room, from a remodel of the garage. Mrs. Able tells the nurse, she walked independently prior to her incident. She currently is using a walker to ambulate in the home.

Mrs. Able appears to be alert, oriented and has a medication planner (pill box) on the kitchen table, which she says is filled once a week.

93

GG0100. Prior Functioning: Everyday Activities: Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury.

Coding:
3. Independent – Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.
2. Needed Some Help – Patient needed partial assistance from another person to complete activities.
1. Dependent – A helper completed the activities for the patient.
8. Unknown
9. Not Applicable

↓ Enter Codes in Boxes

☐	**A. Self Care**: Code the patient's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury
☐	**B. Indoor Mobility (Ambulation):** Code the patient's need for assistance with walking from room to room (with or without a device such as cane, crutch or walker) prior to the current illness, exacerbation, or injury.
☐	**C. Stairs**: Code the patient's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation or injury.
☐	**D. Functional Cognition**: Code the patient's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

94

GG0100 Prior Functioning: Everyday Activities

EXAMPLE 2

Mrs. Able's daughter arrives to check on her mother and tells you, she checks on her mother daily and did this prior to her hip fracture. The daughter states she helped her mother into and out of the shower, due to safety concerns and brought groceries and provided supper daily (prior to current injury).

The nurse ask if Mrs. Able was able to ambulate independently prior to her hip fracture, the daughter tells you she sometimes used a cane, but was mostly independent. She was able to climb up and down stairs to the family room using the hand rail.

The daughter also states she filled Mrs. Able's medication planner weekly and checked each day to make sure she is taking her medications appropriately.

95

GG0100. Prior Functioning: Everyday Activities: Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury.

Coding:
3. Independent – Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.
2. Needed Some Help – Patient needed partial assistance from another person to complete activities.
1. Dependent – A helper completed the activities for the patient.
8. Unknown
9. Not Applicable

↓ Enter Codes in Boxes

☐	**A. Self Care**: Code the patient's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury
☐	**B. Indoor Mobility (Ambulation):** Code the patient's need for assistance with walking from room to room (with or without a device such as cane, crutch or walker) prior to the current illness, exacerbation, or injury.
☐	**C. Stairs**: Code the patient's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation or injury.
☐	**D. Functional Cognition**: Code the patient's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

96

GG0110 Prior Device Use

GG0110. Prior Device Use. Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury.	
↓ Check all that apply	
☐	**A. Manual wheelchair**
☐	**B. Motorized wheelchair**
☐	**C. Mechanical lift**
☐	**D. Walker**
☐	**E. Orthotics/Prosthetics**
☐	**Z. None of the above**

New Item

97

GG0110 Prior Device Use

ITEM INTENT

- This item identifies the patient's use of devices and aids immediately prior to the current illness, exacerbation, or injury to align treatment goals.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care

New Item

98

GG0110 Prior Device Use

RESPONSE SPECIFIC INSTRUCTIONS

- Interview patient or family or review the patient's clinical record describing the patient's use of prior devices and aids.



99

CODING INSTRUCTIONS

GG0110 Prior Device Use

- **Check all devices that apply.**
- **GG0110C - Mechanical lift**, any device a patient or caregiver requires for lifting or supporting the patient's bodyweight. Examples include, but are not limited to:
  - Stair lift
  - Hoyer lift
  - Bath tub lift
- **GG0110D - Walker**, ***All*** types of walkers. Examples include, but are not limited to:
  - Pick-up walker
  - Hemi-walker
  - Rolling walker
  - Platform walker
- **Check Z, None of the Above**, if the patient did not use any of the listed devices or aids immediately prior to the current illness, exacerbation or injury.

100

GG0110 Prior Device Use

Example 1

Mrs. M is a bilateral lower extremity amputee and has multiple diagnoses including diabetes, obesity and peripheral vascular disease.

She is unable to walk and did not walk prior to the current episode of care that started due to a pressure ulcer and respiratory infection.

She used a motorized wheelchair to mobilize.

101

GG0110 Prior Device Use

GG0110. Prior Device Use. Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury.	
↓ Check all that apply	
☐	**A. Manual wheelchair**
☐	**B. Motorized wheelchair**
☐	**C. Mechanical lift**
☐	**D. Walker**
☐	**E. Orthotics/Prosthetics**
☐	**Z. None of the above**

102

GG0110 Prior Device Use

Example 2

Mr. C has bilateral lower extremity neuropathy secondary to his diabetes.

Prior to this current episode, he used a cane.

Today, he is using a walker.

103

GG0110 Prior Device Use

GG0110. Prior Device Use. Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury.	
↓ Check all that apply	
☐	**A. Manual wheelchair**
☐	**B. Motorized wheelchair**
☐	**C. Mechanical lift**
☐	**D. Walker**
☐	**E. Orthotics/Prosthetics**
☐	**Z. None of the above**

104

GG0110 Prior Device Use

Example 3

Mrs. Smith is a paraplegic and has used a manual wheelchair for a number of years now.

She has a mechanical lift to assist with transfers to the bed.

105

GG0110 Prior Device Use

GG0110. Prior Device Use. Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury.	
↓ Check all that apply	
☐	**A. Manual wheelchair**
☐	**B. Motorized wheelchair**
☐	**C. Mechanical lift**
☐	**D. Walker**
☐	**E. Orthotics/Prosthetics**
☐	**Z. None of the above**

106

GG0130 Self-Care
GG0170 Mobility

GG0130

ITEM INTENT
- This item identifies the patient's ability to perform the listed self-care activities, and discharge goal(s).

TIME POINTS ITEM(S) COMPLETED
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency – not to an inpatient facility

New Item

GG0170

ITEM INTENT
- This item identifies the patient's ability to perform the listed mobility activities, and discharge goal(s).

TIME POINTS ITEM(S) COMPLETED
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency – not to an inpatient facility

New Item

107

GG0130 Self-Care [SOC/ROC]

1. SOC/ROC Performance ↓ Enter Codes in Boxes	2. Discharge Goal ↓	
☐☐	☐☐	A. **Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal placed before the patient.

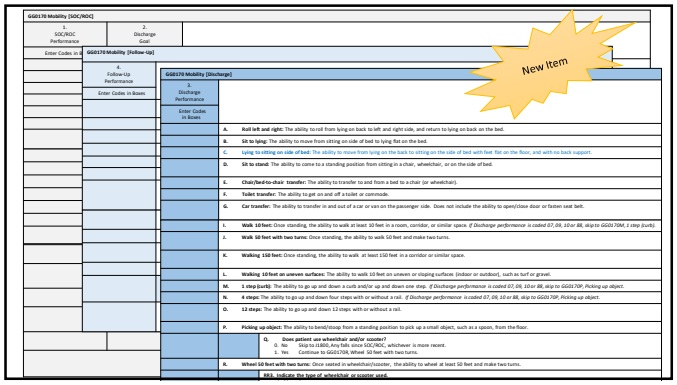
New Item

GG0130 Self-Care [Follow-Up]

4. Follow-Up Performance Enter Codes in Boxes	
☐☐	A.
☐☐	B.
☐☐	C.

GG0130 Self-Care [Discharge]

3. Discharge Performance Enter Codes in Boxes	
☐☐	A. **Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal placed before the patient.
☐☐	B. **Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	C. **Toileting Hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	E. **Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
☐☐	F. **Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
☐☐	G. **Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	H. **Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.



CODING INSTRUCTIONS for:
- SOC/ROC
- Follow-Up
- Discharge

GG0130 Self-Care
GG0170 Mobility

A **DASH** is a valid response for this item.

Activities may be completed with or without assistive devices.

06. Independent – Patient completes the activity by him/herself with no assistance from a helper.

05. Setup or clean-up assistance – Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.

04. Supervision or touching assistance – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.

03. Partial/moderate assistance – Helper does ***LESS THAN HALF*** the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.

02. Substantial/maximal assistance – Helper does ***MORE THAN HALF*** the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

01. Dependent – Helper does ***ALL*** of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

07. Patient refused

09. Not applicable – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.

10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)

88. Not attempted due to medical conditions or safety concerns

Safety and Quality of Performance – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

110

GG0130 Self-Care & GG0170 Mobility

DEFINITIONS

ASSESSMENT TIMEFRAME
The assessment timeframe is the maximum number of days within which to complete the comprehensive assessment.

TIME PERIOD UNDER CONSIDERATION
The time period under consideration is the span of time for data collection and assessment. For most OASIS items this is the day of assessment. For other items, item wording or related guidance will specify the time period under consideration, such as, since the most recent SOC/ROC.

USUAL PERFORMANCE, ABILITY
A patient's usual performance is his/her ability greater than 50% of the assessment timeframe.

111

RESPONSE SPECIFIC INSTRUCTIONS for:
- SOC/ROC
- Follow-Up
- Discharge

GG0130 Self-Care
GG0170 Mobility

1. Licensed clinicians may assess the patient's performance based on:

Direct observation (preferred) OR Reports from the patient, clinicians, care staff, and/or family.

112

RESPONSE SPECIFIC INSTRUCTIONS for:
- SOC/ROC
- Follow-Up
- Discharge

GG0130 Self-Care
GG0170 Mobility

2. Patients should be allowed to perform activities as **independently as possible**, *as long as they are safe*.

- If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.
- Activities may be completed with or without assistive device(s).
- ***Use of assistive device(s) to complete an activity should not affect coding of the activity.***

113

RESPONSE SPECIFIC INSTRUCTIONS for:
- SOC/ROC
- Follow-Up
- Discharge

GG0130 Self-Care
GG0170 Mobility

3. Patients with cognitive impairments/limitations may need physical and/or verbal assistance when completing an activity.
4. Code based on the patient's need for assistance to perform the activity safely

EXAMPLES GG0130

- Choking Risk due to rate of eating
- Choking Risk due to amount of food placed in mouth
- Fall Risk due to unsteady ambulation

EXAMPLES GG0170

114

RESPONSE SPECIFIC INSTRUCTIONS for:
- SOC/ROC

GG0130 Self-Care
GG0170 Mobility

1. Code the patient's functional status based on a functional assessment that occurs at or soon after the patient's SOC/ROC.
2. The SOC/ROC function scores are to reflect the patient's SOC/ROC baseline status and are to be based on observation of activities, to the extent possible.
3. When possible, the assessment should occur prior to the start of therapy services to capture the patient's true baseline status.

This is because therapy interventions can affect the patient's functional status.

115

RESPONSE SPECIFIC INSTRUCTIONS for:
- SOC/ROC

GG0130 Self-Care
GG0170 Mobility

4. A patient's functional ability can be impacted by the environment or situations encountered in the home.
5. Observing the patient in different locations and circumstances within the home is important for a comprehensive understanding of the patient's functional status.

If the patient's ability varies during the **assessment timeframe**, record their ***usual ability*** to perform each activity.

REMEMBER

Do not record the patient's best performance and do not record the patient's worst performance, but rather the patient's usual performance; ***what is true greater than 50% of the assessment timeframe***.

116

RESPONSE SPECIFIC INSTRUCTIONS for:
- SOC/ROC Discharge Goals

GG0130 Self-Care
GG0170 Mobility

Use a **DASH** for any remaining self-care or mobility goals that were not coded.

1. Code the patient's discharge goal(s) using the 6-point scale.
2. Use of the activity not attempted codes (07, 09, 10 or 88) is permissible to code discharge goal(s).

Activities may be completed with or without assistive devices.
06. Independent – Patient completes the activity by him/herself with no assistance from a helper.
05. Setup or clean-up assistance – Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04. Supervision or touching assistance – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. Partial/moderate assistance – Helper does ***LESS THAN HALF*** the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. Substantial/maximal assistance – Helper does ***MORE THAN HALF*** the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. Dependent – Helper does ***ALL*** of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:
07. Patient refused
09. Not applicable – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)
88. Not attempted due to medical conditions or safety concerns

RESPONSE SPECIFIC INSTRUCTIONS for:
- SOC/ROC Discharge Goals

GG0130 Self-Care
GG0170 Mobility

3. Discharge goal(s) may be coded:

- Same as SOC/ROC performance
- Higher than SOC/ROC performance
- Lower than SOC/ROC performance

118

RESPONSE SPECIFIC INSTRUCTIONS for:
- SOC/ROC Discharge

GG0130 Self Care
GG0170 Mobility

4. If the SOC/ROC performance of an activity was coded using one of the activity not attempted codes (07, 09, 10 or 88) a discharge goal may be submitted using the 6-point scale if the patient is expected to be able to perform the activity by discharge.

119

RESPONSE SPECIFIC INSTRUCTIONS for:
- SOC/ROC Discharge

GG0130 Self-Care
GG0170 Mobility

5. Licensed clinicians can establish a patient's discharge goal(s) at the time of SOC/ROC based on:

- ✓ The patient's prior medical condition
- ✓ SOC/ROC assessment
- ✓ Self-care and mobility status
- ✓ Discussions with the patient and family
- ✓ Professional judgment

- ✓ The profession's practice standards
- ✓ Expected treatments
- ✓ Patient motivation to improve
- ✓ Anticipated length of stay
- ✓ The discharge plan

6. Goals should be established as part of the patient's care plan.

120

RESPONSE SPECIFIC INSTRUCTIONS for:
- Follow-Up
- Discharge

GG0130 Self-Care
GG 0170 Mobility

TIME PERIOD UNDER CONSIDERATION
The time period under consideration is the span of time for data collection and assessment. For most OASIS items this is the day of assessment. For other items, item wording or related guidance will specify the time period under consideration, such as, since the most recent SOC/ROC.

Follow-up Performance: Clinicians should code the patient's functional status based on a functional assessment that occurs within the assessment timeframe.

Discharge Performance: The discharge *time period under consideration* includes the last 5 days of care. This includes the date of the discharge visit plus the four preceding calendar days. Code the patient's functional status based on a functional assessment that occurs at or close to the time of discharge.

121

GG0130 Self-Care [SOC/ROC]

1. SOC/ROC Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal placed before the patient.
☐☐	☐☐	**B. Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	☐☐	**C. Toileting Hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	☐☐	**E. Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
☐☐	☐☐	**F. Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
☐☐	☐☐	**G. Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	☐☐	**H. Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

CODING INSTRUCTIONS for:
- SOC/ROC
- Follow-Up
- Discharge

GG0130 Self-Care
GG0170 Mobility

A **DASH** is a valid response for this item.

Activities may be completed with or without assistive devices.
06. Independent – Patient completes the activity by him/herself with no assistance from a helper.
05. Setup or clean-up assistance – Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04. Supervision or touching assistance – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. Partial/moderate assistance – Helper does ***LESS THAN HALF*** the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. Substantial/maximal assistance – Helper does ***MORE THAN HALF*** the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. Dependent – Helper does ***ALL*** of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:
07. Patient refused
09. Not applicable – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)
88. Not attempted due to medical conditions or safety concerns

Safety and Quality of Performance – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

123

CODING TIPS for:
❖ GG130A Eating.

GG0130 Self-Care

Patient uses a gastrostomy tube (G-Tube) or total parenteral nutrition (TPN):
1. Assistance with tube feedings or TPN is not considered when coding the item eating.

Code GG0130A as:
88, Not attempted due to medical condition or safety concerns.

If the patient does not eat or drink by mouth and relies ***solely*** on nutrition and liquids through tube feedings or TPN due to a ***new (recent-onset) medical condition***,

Code GG0130A as:
09, Not applicable

If the patient ***does not*** eat or drink by mouth at the time of the assessment, and the patient did not eat or drink by mouth ***prior to*** the current illness, injury or exacerbation

Code eating based on the amount of assistance the patient requires to eat and drink by mouth.

If the patient eats and drinks by mouth, ***and relies partially*** on obtaining nutrition and liquids via tube feedings or TPN

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CODING TIPS for:
❖ GG130B Oral Hygiene

GG0130 Self Care

- If a patient does not perform oral hygiene during home visit, determine the patient's abilities based on the patient's performance of similar activities during the assessment, or on patient and/or caregiver report.


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GG0130 Self-Care

EXAMPLE 1
- Mrs. H does not have any food consistency restrictions, but often needs to swallow two or three times so that the food clears her throat due to difficulty with pharyngeal peristalsis.
- She requires verbal cues to use the compensatory strategy of extra swallows to clear the food.

EXAMPLE 2
- Mrs. V has difficulty seeing on her left side since her stroke.
- During meals, a helper must remind her to scan the entire plate to ensure she has seen all the food.

EXAMPLE 3
- Mr. R is unable to eat or drink by mouth since he had a stroke 1 week ago.
- He receives nutrition and hydration through a G-tube, which is administered by a helper.

☐☐	☐☐	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal placed before the patient.

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GG0130 Self-Care

EXAMPLE 4

- Ms. J cannot swallow any food or liquids secondary to ALS.
- She has a J-tube and has been on tube feedings for several years.
- She is being admitted to skilled home health care for treatment of a sacral pressure injury.
- Her treatment includes TPN to support wound healing.

EXAMPLE 5

- Mr. B has been prescribed bowel rest for pancreatitis, and he is not to eat or drink anything for one week, after which the home health nurse will support advancing back to a regular diet.
- TPN has been prescribed, and he is being admitted to home care for TPN teaching and management.

☐☐	☐☐	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal placed before the patient.

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GG0130 Self-Care

EXAMPLE 6

- The helper provides steadying assistance to Mr. S as he walks to the bathroom.
- The helper applies toothpaste onto Mr. S's toothbrush.
- Mr. S then brushes his teeth at the sink in the bathroom without physical assistance or supervision.
- Once Mr. S is done brushing his teeth and washing his hands and face, the helper returns and provides steadying assistance as the patient walks back to his bed.

☐☐	☐☐	**B. Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.

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GG0130 Self-Care

EXAMPLE 7

- During the SOC/ROC assessment, Mrs. E states she prefers to participate in her oral hygiene twice daily.
- On assessment, the clinician identifies that Mrs. E's caregiver completes more than half of this activity.
- Mrs. E has severe arthritis, Parkinson's disease, diabetic neuropathy, and renal failure. These conditions result in multiple impairments, including limited endurance, weak hand grasp, slow movements and tremors.
- The assessing clinician, using professional judgment, all available information and collaboration as allowed, determines that Mrs. E is not expected to progress to a higher level of functioning during the episode of care.
- However, the clinician anticipates that Mrs. E will be able to maintain her SOC/ROC performance level.
- The clinician discusses functional goals with Mrs. E and they agree maintaining functioning is a reasonable goal.

☐☐	☐☐	**B. Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.

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GG0130 Self-Care

EXAMPLE 8

- Mrs. T has a progressive neurological illness that affects her strength, coordination, and endurance.
- Mrs. T prefers to use the bedside commode for as long as possible rather than using incontinence undergarments.
- The helper currently supports Mrs. T while she is standing so that Mrs. T can pull down her underwear before sitting onto the bedside commode.
- When Mrs. T has finished voiding, she wipes her perineal area.
- Mrs. T then requires the helper to support her trunk while Mrs. T pulls up her underwear.
- The assessing clinician, using professional judgment, all available information and collaboration as allowed anticipates that Mrs. T will weaken further by discharge, and while she will still be able to use the bedside commode, she will need the helper to assist with all toileting hygiene.

☐☐	☐☐	**C. Toileting Hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.

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GG0130 Self-Care

EXAMPLE 9

During SOC/ROC functional assessment, Mr. M states he prefers to bathe himself rather than depending on helpers or his wife to perform this activity.

The clinician assesses Mr. M's SOC/ROC performance for Shower/Bathe self, and determines the helper performs more than half the effort.

The assessing clinician, using professional judgement, available information and collaboration as allowed anticipates that by discharge Mr. M will require a helper for less than half of the activity Shower/Bathe self.

☐☐	☐☐	**E. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.**

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GG0130 Self-Care

EXAMPLE 10

Mrs. D has been unable to eat or drink by mouth for several weeks, due to a large, cancerous lesion on the soft palate.

A week ago, the lesion worsened becoming very painful and required surgical removal.

At the SOC, she remains restricted from any oral intake, with the expected goal of progressing to small sips of water and soft foods by mouth with supervision by discharge from home health.

☐☐	☐☐	**B. Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.

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GG0130 Self-Care

EXAMPLE 11

Mr. James has a history of CHF and COPD with dyspnea. He is being admitted for after care following a right arm fracture with cast from a recent fall at home. Prior to his fall he was independent with self-cares.

He needs set-up assistance from caregiver to eat due to cast. He is able to eat and drink with left hand once food is set up and has no problems swallowing.

He has dentures and is able to remove and replace them, but is unable to manage the necessary equipment/supplies to soak dentures.

He also needs assistance with toileting, showering, and dressing but is expected to make a full recovery to his prior level of functioning.

He needs total assistance with socks and shoes.

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GG0130 Self-Care [SOC/ROC]

1. SOC/ROC Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
0 3	0 6	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal placed before the patient.
0 2	0 6	**B. Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
0 1	0 6	**C. Toileting Hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
0 2	0 6	**E. Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
0 2	0 6	**F. Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
0 2	0 6	**G. Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
0 1	0 6	**H. Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

GG0130 Self-Care

EXAMPLE 11

Mr. James is being recertified due to complications. He now has the right arm in a sling, but very little ROM due to the sling and edema.

He continues to need set-up assistance from caregiver to eat. He is able to eat and drink with left hand once food is set up and has no problems swallowing.

He has dentures and is able to remove and replace them, but is unable to manage the necessary equipment/supplies to soak dentures.

He continues to need assistance with toileting.

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GG0130 Self-Care

GG0130 Self-Care [Follow-Up]	
4. Follow-Up Performance Enter Codes in Boxes	
0 3	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal placed before the patient.
0 2	**B. Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
0 1	**C. Toileting Hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.

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GG0130 Self-Care

EXAMPLE 11

Mr. James is being discharged and has returned to his previous state of health.

He is now independent with eating, oral hygiene, toileting, bathing, and dressing including putting on and taking off footwear.

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GG0130 Self-Care [Discharge]	
3. Discharge Performance Enter Codes in Boxes	
0 6	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal placed before the patient.
0 6	**B. Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
0 6	**C. Toileting Hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
0 6	**E. Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
0 6	**F. Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
0 6	**G. Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
0 6	**H. Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

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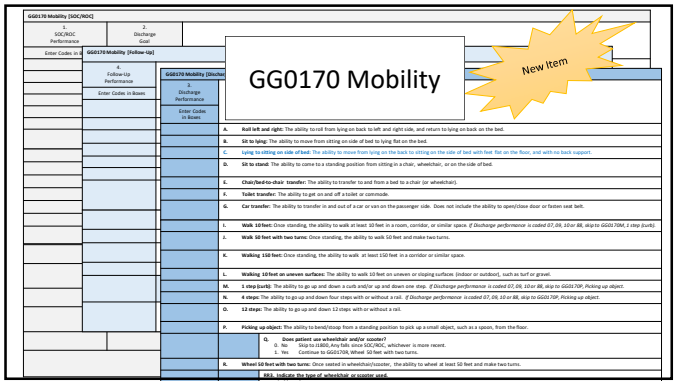
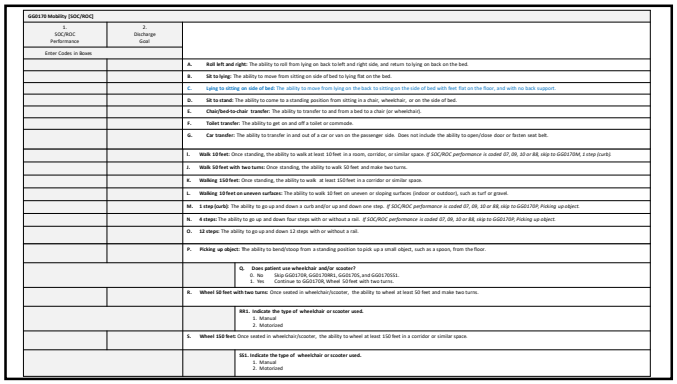
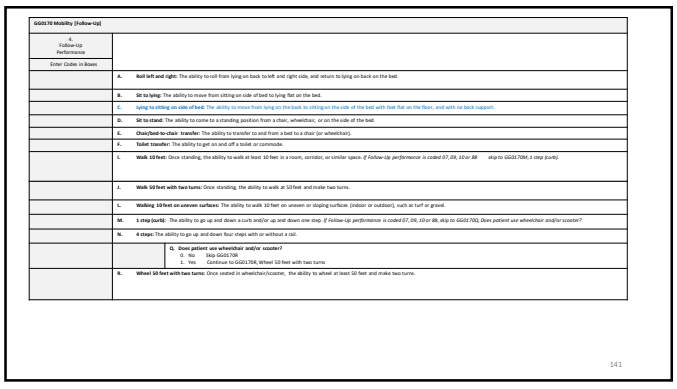

GG0170 Mobility
New Item




141

GG0170 Mobility (Discharge)		
3. Discharge Performance Enter Codes in Boxes		
	A.	**Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
	B.	**Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
	C.	**Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of bed with feet flat on the floor, and with no back support.
	D.	**Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of bed.
	E.	**Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
	F.	**Toilet transfer:** The ability to get on and off a toilet or commode.
	G.	**Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
	I.	**Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If Discharge performance is coded 07, 09, 10 or 88, skip to GG0170M, 1 step (curb).*
	J.	**Walk 50 feet with two turns:** Once standing, the ability to walk 50 feet and make two turns.
	K.	**Walking 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
	L.	**Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
	M.	**1 step (curb):** The ability to go up and down a curb and/or up and down one step. *If Discharge performance is coded 07, 09, 10 or 88, skip to GG0170P, Picking up object.*
	N.	**4 steps:** The ability to go up and down four steps with or without a rail. *If Discharge performance is coded 07, 09, 10 or 88, skip to GG0170P, Picking up object.*
	O.	**12 steps:** The ability to go up and down 12 steps with or without a rail.
	P.	**Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
	Q.	**Does patient use wheelchair and/or scooter?** 0. No Skip to J1800, Any falls since SOC/ROC, whichever is more recent. 1. Yes Continue to GG0170R, Wheel 50 feet with two turns.
	R.	**Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
		RR3. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized
	S.	**Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
		SS3. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized

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GG0170 Mobility

Does the patient complete the activity by him/herself with **NO ASSISTANCE**? *(no physical, verbal/nonverbal cueing, set-up/cleanup assistance needed)*	Yes → Code 06 Independent
Does the patient complete the activity with *ONLY Setup or clean-up assistance from 1 helper?*	Yes → Code 05 Setup or Clean-up assistance
Does the patient complete the activity with **ONLY** *verbal/nonverbal cueing or touching/steadying/contact guard assistance from 1 helper?*	Yes → Code 04 Supervision or touching assistance
Does the patient complete the activity with *Physical assistance from one helper with the helper providing* ***less than half the effort****?*	Yes → Code 03 Partial/moderate assistance
Does the patient complete the activity with *Physical assistance from one helper with the helper providing* ***more that half the effort****?*	Yes → Code 02 Substantial/maximal assistance
Does the helper provide ***all of the effort*** to complete the activity? OR Is the activity completed with the *assistance of 2 or more helpers*?	Yes → Code 01 Dependent

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CODING TIPS

GG0170 Mobility

- If a patient:
  - Does not attempt the activity, and;
  - A helper does not complete the activity, and;
  - The patient's usual status cannot be determined based on patient or caregiver report.

Code the reason the activity was not attempted:

- ❑ **Code 07** if the patient refused to attempt the activity
- ❑ **Code 10** if the activity was not attempted due to environmental limitations
- ❑ **Code 09** if the patient could not perform an activity at the time of assessment, and also could not perform the activity prior to the current illness, exacerbation or injury
- ❑ **Code 88** if the patient could not perform an activity at the time of the assessment, but could perform the activity prior to the current illness, exacerbation or injury

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GG0170 Mobility

CODING TIPS

- If the only help a patient needs to complete an activity is:
  - A helper to retrieve an assistive device or adaptive equipment,
    - Such as a cane for walking, or
    - A tub bench for bathing

Then → **Code 05,** Set up or clean-up assistance

If two or more helpers are required to assist the patient to complete the activity.

Then → **Code 01,** Dependent

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GG0170 Mobility

CODING TIPS

A DASH (–) indicates "No information."

Do not use a **DASH** if the reason that the item was not assessed was because:

- ✓The patient refused (code 07);
- ✓The item is not applicable (code 09);
- ✓The activity was not attempted due to environmental limitations (code 10); or;
- ✓The activity was not attempted due to medical condition or safety concerns (code 88).

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GG0170 Mobility

CODING TIPS for:
GG0170A, Roll Left and Right
GG0170B, Sit to Lying
GG0170C, Lying to Sitting on Side of Bed

		A. **Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
		B. **Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
		C. **Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of bed with feet flat on the floor, and with no back support.

- ❑ If at the time of the assessment the patient is *unable to lie flat due to medical conditions or restrictions*,
- ❑ But **could** perform this activity prior to the current illness, exacerbation or injury.

Then → **Code 88, Not Attempted** Due to medical condition or safety concerns

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CODING TIPS for:
GG0170A, Roll Left and Right
GG0170B, Sit to Lying
GG0170C, Lying to Sitting on Side of Bed

GG0170 Mobility

		A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
		B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
		C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of bed with feet flat on the floor, and with no back support.

- If at the time of the assessment the patient is unable to lie flat due to medical conditions or restrictions, *and*;
- Could not perform the activity prior to the current illness, exacerbation or injury

Then

Code 09,
Not applicable.

CLINICAL JUDGMENT should be used to determine what is considered a "lying" position for the patient. For example, a clinician could determine that a patient's preferred slightly elevated resting position is "lying" for that patient.

GG0170 Mobility

EXAMPLE 1

At SOC, the physical therapist helps Mr. R turn onto his right side by instructing him to bend his left leg and roll to his right side.

He then instructs him how to position his limbs to return to lying on his back and then to repeat a similar process for rolling onto his left side and then return to lying on his back.

Mr. R completes the activity without physical assistance from a helper.

Mr. R was moving about in bed without difficulty prior to hospitalization.

The therapist expects Mr. R will roll left and right by himself by discharge.

		A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.

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GG0170 Mobility

EXAMPLE 2

- Mr. A suffered multiple vertebral fractures due to a fall off a ladder.
- At SOC, he requires assistance from a therapist to get from a sitting position to lying flat on the bed because of significant pain in his lower back.
- The therapist supports his trunk and lifts both legs to assist Mr. A from sitting at the side of the bed to lying flat on the bed.
- Mr. A assists himself a small amount by raising one leg onto the bed and then bending both knees while transitioning into a lying position.

		B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.

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GG0170 Mobility

EXAMPLE 3

- At SOC, Mrs. H requires assistance from two helpers to transfer from sitting at the edge of the bed to lying flat on the bed due to paralysis on her right side, obesity, and cognitive limitations.
- One of the helpers explains to Mrs. H each step of the sitting to lying activity.
- Mrs. H is then fully assisted to get from sitting to a lying position on the bed.
- Mrs. H makes no attempt to assist when asked to perform the incremental steps of the activity.

☐☐	☐☐	B. **Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.

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GG0170 Mobility

CODING TIPS for: GG0170C, Lying to Sitting on Side of Bed

☐☐	☐☐	C. **Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of bed with feet flat on the floor, and with no back support.

1. If a patient's feet do not reach the floor upon lying to sitting, the clinician will determine if a bed height adjustment (if applicable), or a foot stool is required to accommodate foot placement on the floor/footstool.
2. Back support refers to an object or person providing support of the patient's back.

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GG0170 Mobility

EXAMPLE 4

- Ms. H is recovering from a spinal fusion.
- At SOC, she rolls to her right side and pushes herself up from the bed to get from a lying to a seated position.
- The therapist provides needed verbal cues to guide Ms. H as she safely uses her hands and arms to support her trunk and avoid twisting as she raises herself from the bed.
- Ms. H then safely maneuvers to the edge of the bed, finally lowering her feet to the floor to complete the activity without hands-on assistance.

☐☐	☐☐	C. **Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of bed with feet flat on the floor, and with no back support.

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GG0170 Mobility

CODING TIPS for: GG0170D, Sit to Stand

☐☐	☐☐	D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of bed.

If the only help a patient needs to complete the sit to stand activity is for a helper to retrieve an assistive device or adaptive equipment; such as a walker or ankle foot orthosis.

Then

Code 05, Setup or Clean-up Assistance.

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GG0170 Mobility

EXAMPLE 5

- Mr. B is being admitted to home health for pressure ulcer care.
- He has complete tetraplegia from an injury one year ago and has been unable to bear weight in standing since the injury.
- At SOC, using a patient lift that does not require him to come to standing, he is transferred from his bed into a wheelchair with assistance.

☐☐	☐☐	D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of bed.

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GG0170 Mobility

CODING TIPS for: GG0170E, Chair/Bed-to-Chair Transfer

☐☐	☐☐	E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).

Sit to lying and lying to sitting are not assessed as part of GG0170E.

1. The activity begins with the patient sitting (in a chair, wheelchair, or at the edge of the bed) and transferring to sitting in a chair, wheelchair, or at the edge of the bed.
2. If a mechanical lift is used to assist in transferring a patient for a chair/bed-to-chair transfer and *two helpers* are needed to assist with a mechanical lift transfer, then **Code 01, Dependent**, even if the patient assists with any part of the chair/bed-to-chair transfer.

GG0170 Mobility

EXAMPLE 6

- Mr. L had a stroke and uses a wheelchair for mobility.
- When Mr. L gets out of bed at SOC, the therapist moves the wheelchair into the correct position and locks the brakes so that Mr. L can transfer into the wheelchair safely.
- Mr. L transfers into the wheelchair by himself without the need for supervision or assistance during the transfer.
- The family reports that Mr. L does transfer safely without the need for supervision, once the wheelchair is placed and locked.
- The nurse does not expect Mr. L's mobility status to change by discharge.

☐☐	☐☐	**E.** Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).

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CODING TIPS for: GG0170F, Toilet Transfer

GG0170 Mobility

☐☐	☐☐	**F.** Toilet transfer: The ability to get on and off a toilet or commode.

1. Use of assistive device(s) and adaptive equipment (for instance a grab bar or elevated toilet) required to complete the toilet transfer should not affect coding of the activity.
2. If the only help a patient needs to complete the toilet transfer activity is for a helper to retrieve and place the toilet seat riser, and remove it after patient use, then enter code 05, Setup or clean-up assistance.
3. Toileting hygiene and clothing management are not considered part of the toilet transferring activity.
4. If the patient requires *assistance from two or more helpers* to get on and off the toilet or commode, then enter **Code 01, Dependent.**

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GG0170 Mobility

EXAMPLE 7

- The assessing clinician notes that the home health aide visit note (documented on the afternoon visit on the SOC date) stated that the aide needed to steady Mrs. Z with a light contact when the patient lowers her underwear and then transfers onto the toilet.
- After voiding, Mrs. Z cleanses herself. She then stands up supporting her own weight as the aide steadies her.
- Mrs. Z pulls up her underwear as the aide steadies her to ensure Mrs. Z does not lose her balance.

☐☐	☐☐	**F.** Toilet transfer: The ability to get on and off a toilet or commode.

159

GG0170 Mobility

EXAMPLE 8

At SOC, Mrs. S is on bedrest due to a new medical complication. She uses a bedpan for bladder and bowel management.

The assessing clinician expects the patient will return to independent use of the bathroom toilet once the current condition resolves.

☐☐	☐☐	F. Toilet transfer: The ability to get on and off a toilet or commode.

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GG0170 Mobility

CODING TIPS for: GG0170G, Car Transfer

☐☐	☐☐	G. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.

1. If the patient is *not able to attempt car transfers* (for example because no car is available, or there are weather or other environmental constraints), and the patient's usual status cannot be determined based on patient or caregiver report.

THEN → Code 10, Not Attempted due to environmental limitations.

2. If at the time of the assessment the patient is unable to attempt car transfers, and could not perform the car transfers prior to the current illness, exacerbation or injury.

THEN → Code 09, Not Applicable

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GG0170 Mobility

EXAMPLE 9

- Mrs. W uses a wheelchair and ambulates for only short distances.
- At SOC, Mrs. W requires the physical therapist to lift most of her weight to get from a seated position in the wheelchair to a standing position.
- The therapist provides trunk support when Mrs. W takes several steps during the transfer turn.
- Mrs. W lowers herself into the car seat with steadying assistance from the therapist.
- Mrs. W moves her legs into the car as the therapist lifts the weight of her legs from the ground.

☐☐	☐☐	G. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.

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GG0170 Mobility

EXAMPLE 10

- The day after being admitted to home health, Mrs. N works with an occupational therapist on transfers in and out of the passenger side of a car.
- When reviewing the therapist's evaluation, the assessing clinician reads that when performing car transfers, Mrs. N required verbal reminders for safety and contact guarding assistance from the OT for guidance and direction.
- The therapist instructed the patient on strategic hand placement while Mrs. N transitioned to sitting into the car seat.
- Documentation showed that the therapist opened and closed the car door.

☐☐	☐☐	G. **Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.**

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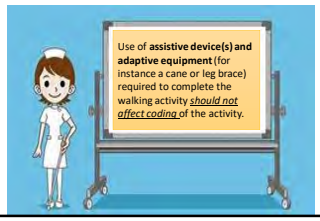
GG0170 Mobility

CODING TIPS for: GG0170I, Walk 10 Feet

☐☐	☐☐	I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170M, 1 step (curb).*



If the only help a patient needs to complete the walking activity is for a helper to retrieve and place the walker and/or put it away after patient use, then enter

Code 05, Setup or clean-up assistance.

164

GG0170 Mobility

EXAMPLE 11

- Mr. L had bilateral amputations 3 years ago, and prior to this HH admission he used a wheelchair and did not walk.
- At SOC, Mr. L does not use prosthetic devices and only uses a wheelchair for mobility.
- Mr. L's care plan includes assisting with fitting and use of bilateral lower extremity prostheses.
- The therapist's care plan goal is for Mr. L to walk distances of 30 feet with supervision within his home and then discharge to outpatient therapy.

☐☐	☐☐	I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170M, 1 step (curb).*

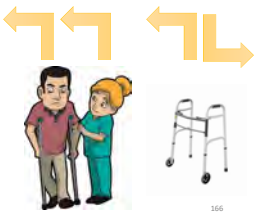
165

CODING TIPS for: **GG0170J**, Walk 50 feet with two turns

GG0170 Mobility

☐☐	☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk 50 feet and make two turns.

1. The turns are 90 degree turns and may be in the same direction or may be in different directions.
2. The 90 degree turns should occur at the patient's ability level (i.e., not jeopardizing patient safety), and can include the use of an assistive device without affecting coding of the activity.



166

GG0170 Mobility

EXAMPLE 12

- At SOC, Mr. B is recovering from a recent stroke and now has difficulty walking. Even with assistance, he is able to walk only 30 feet.
- Mr. B's care plan includes muscle strengthening and gait training.
- The therapist expects Mr. B will be able to walk 50 feet with two turns safely with the assistance of a caregiver for verbal cues and contact guard for steadying on the turns at discharge.

☐☐	☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk 50 feet and make two turns.

167

CODING TIPS for: **GG0170K**, Walk 150 Feet

GG0170 Mobility

☐☐	☐☐	**K. Walking 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

1. *If the patient's environment does not accommodate a walk of 150 feet without turns,* but the patient demonstrates the ability to walk with or without assistance 150 feet with turns without jeopardizing the patient's safety, code using the 6-point scale.
2. Use of assistive device(s) and adaptive equipment (for instance a rolling walker or quad cane) required to complete the walking activity should not affect coding of the activity.

If the only help a patient needs to complete the walking activity is for a helper to retrieve and place the walker and/or put it away after patient use, then enter

Code 05, Setup or clean-up assistance.

168

GG0170 Mobility

EXAMPLE 13

- Mr. R has recent endurance limitations due to an exacerbation of heart failure and is only walking about 30 feet before he tires, loses strength and must sit and rest.
- He reports he was walking 150 feet or more with his cane prior to this exacerbation of his heart failure.

☐☐	☐☐	K. **Walking 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

169

GG0170 Mobility

CODING TIPS for: GG0170L, Walk 10 Feet on Uneven Surfaces

☐☐	☐☐	L. **Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.

If the patient is not able to attempt walking on uneven surfaces

AND

The patient's usual status for walking 10 feet on uneven surfaces cannot be determined based on patient or caregiver report

THEN

Code 10, Not Attempted due to environmental limitations

Remember

Use of assistive device(s) and adaptive equipment (for instance a rolling walker or quad cane) required to complete the walking activity *should not* affect coding of the activity.

170

GG0170 Mobility

EXAMPLE 14

- Mrs. N has severe joint degenerative disease and is recovering from sepsis.
- When walking on the uneven driveway was attempted yesterday when Mrs. N came home from the hospital, she reports that her neighbor had to hold her belt and help lift her a little during a few steps.
- The neighbor also provided help to advance the walker across the gravel driveway as the patient walked.

☐☐	☐☐	L. **Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.

171

CODING TIPS for: **GG0170M**, 1 Step (curb)

GG0170 Mobility

☐☐	☐☐	**M. 1 step (curb): The ability to go up and down a curb and/or up and down one step.** *If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170P, Picking up object.*

Use of assistive device(s) and adaptive equipment (for instance a railing or cane) required to complete the activity ***should not*** affect coding of the activity.

172

GG0170 Mobility

EXAMPLE 15

- Mrs. Z had a stroke and needs to learn how to step up and down one step to enter and exit her home.
- At SOC, the physical therapist provides needed verbal cueing as Mrs. Z uses her quad cane to aid her balance in stepping up and back down one step.
- The therapist does not provide any physical assistance.

☐☐	☐☐	**M. 1 step (curb): The ability to go up and down a curb and/or up and down one step.** *If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170P, Picking up object.*

173

CODING TIPS for: **GG0170N**, 4 Steps

GG0170 Mobility

Use of assistive device(s) and adaptive equipment (for instance a railing or cane) required to complete the activity ***should not*** affect coding of the activity.

☐☐	☐☐	**N. 4 steps:** The ability to go up and down four steps with or without a rail. *If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170P, Picking up object.*

If at the time of the assessment the patient is unable to complete the activity due to a physician prescribed restriction
BUT
The patient could perform this activity prior to the current illness, exacerbation or injury.

THEN

Code 88, Not Attempted, due to medical condition or safety concern.

174

GG0170 Mobility

EXAMPLE 16

- At SOC, Mr. J has lower body weakness and the physical therapist provides light touching assistance when he ascends 4 steps.
- While descending 4 steps, the physical therapist faces the patient and descends the stairs providing minimal trunk support, with one hand on the patient's hip and the other holding the gait belt, as Mr. J holds the stair railing.

☐☐	☐☐	**N. 4 steps:** The ability to go up and down four steps with or without a rail. *If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170P, Picking up object.*

175

GG0170 Mobility

CODING TIPS for: GG0170O, 12 Steps

Use of assistive device(s) and adaptive equipment (for instance a railing or cane) required to complete the activity *should not* affect coding of the activity.

☐☐	☐☐	**O. 12 steps: The ability to** go up and down 12 steps with or without a rail.

If at the time of the assessment the patient is unable to complete the activity due to a physician prescribed restriction
BUT
could perform this activity prior to the current illness, exacerbation or injury.

THEN

Code 88, Not Attempted due to medical condition or safety concern

176

GG0170 Mobility

EXAMPLE 17

- At SOC, Ms. Y is recovering from a stroke and has 12 stairs with a railing and she needs to use these stairs to enter and exit her home.
- The physical therapist uses a gait belt around her trunk and at times is required to support much of the patient's weight as Ms. Y ascends and then descends 12 stairs.

EXAMPLE 18

- Mrs. D is returning home after a hip replacement.
- She is restricted from stair climbing until she is seen for her follow-up MD appointment.
- Just prior to her surgery, she was able to climb her flight of 12 stairs with stand-by assist of her niece.

☐☐	☐☐	**O. 12 steps: The ability to** go up and down 12 steps with or without a rail.

177

CODING TIPS for: GG0170P, Picking up Object

GG0170 Mobility

☐☐	☐☐	**P. Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.

If at the time of the assessment the patient is unable to complete the activity (for instance is unable to stand), **AND** *could not* stand to perform this activity prior to the current illness, exacerbation or injury.

THEN → **Code 09**, Not Applicable

Use of assistive device(s) and adaptive equipment (for instance a cane to support balance and a reacher to pick up the object) required to complete the activity *should not* affect coding of the activity.

178

GG0170 Mobility

EXAMPLE 19

- Mr. P has a neurologic condition that has resulted in coordination and balance problems.
- At SOC, he reports he and his wife worked with the OT in the SNF on picking things off the floor.
- He demonstrates how he stoops to pick up a pencil from the floor as his wife provides the right amount of verbal cues for safety and stands by, ready to help in case he loses his balance.

EXAMPLE 20

- Ms. C has recently undergone a hip replacement. At SOC, she walks with a walker without assistance.
- When she drops a hair brush from her walker basket, she asks her daughter to locate her long-handled reacher and bring it to her.
- Using the reacher, Mrs. C is able to bend slightly, and safely pick up the hair brush with the reacher, without need of additional assistance or verbal cues.

☐☐	☐☐	**P. Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.

179

CODING TIPS for: GG0170Q, Does the patient use a wheelchair and/or scooter?

GG0170 Mobility

☐	**Q. Does patient use wheelchair and/or scooter?** 0. No Skip GG0170R, GG0170RR1, GG0170S, and GG0170SS1. 1. Yes Continue to GG0170R, Wheel 50 feet with two turns.

The intent of the wheelchair mobility item is to assess the ability of patients who are learning how to self-mobilize using a wheelchair or patients who used a wheelchair prior to admission.

Use **clinical judgment** to determine if the patient's use of a wheelchair is for self-mobilization due to the patient's medical condition or safety.

If the patient is ambulatory and is not learning how to mobilize in a wheelchair, and only uses a wheelchair for transport within a larger living facility (assisted living facility or apartment complex), or for community mobility outside the home (for instance to a physician appointment or to dialysis).

THEN → **Code 0**, No

180

CODING TIPS for:
GG0170R, Wheel 50 feet with two turns
GG0170RR1, Type of Wheelchair/Scooter

GG0170 Mobility

	R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
	RR1. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized

1. Indicate whether the wheelchair or scooter used is **manual** or **motorized**.
2. The turns are 90 degree *turns and may be in the same direction* (two 90 degree turns to the right or two 90 degree turns to the left) or *may be in different directions* (one 90 degree turn to the right and one 90 degree turn to the left).

The 90 degree turns should occur at the patient's ability level (i.e., not jeopardizing patient safety).

#1 PATIENT SAFETY

181

GG0170 Mobility

EXAMPLE 21

- At SOC, Mrs. M is unable to bear any weight on her right leg due to a recent fracture.
- The nurse observes as the certified nursing assistant in the assisted living facility provides steadying assistance when transferring Mrs. M from the bed into her motorized wheelchair.
- Once in her wheelchair, Mrs. M propels herself safely about 60 feet down the hall and safely makes two turns without any necessary physical assistance or supervision.

EXAMPLE 22

- Once seated in the manual wheelchair, Ms. R wheels about 10 feet, including around one corner to the hallway.
- Due to shoulder pain, she asks her son to push the wheelchair the additional 40 feet around another corner and into her bathroom.

	R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
	RR1. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized

182

CODING TIPS for:
GG0170S, Wheel 150 feet
GG0170SS1, Type of Wheelchair/Scooter

GG0170 Mobility

	S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
	SS1. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized

If the patient's environment does not accommodate wheelchair/scooter use of 150 feet without turns, but the patient demonstrates the ability to mobilize the wheelchair/scooter with or without assistance 150 feet with turns without jeopardizing the patient's safety, code using the 6-point scale.

183

GG0170 Mobility

EXAMPLE 23

- Mr. N uses a below-the-knee prosthetic limb.
- Mr. N has peripheral neuropathy and limited vision due to complications of diabetes.
- Via observation and patient report, the assessing clinician determines that Mr. N's usual performance is that a helper is needed to provide verbal cues for safety due to vision deficits, and the patient mobilizes his manual wheelchair a distance of 150 within his home.

☐☐	☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
	☐	**SS1. Indicate the type of wheelchair or scooter used.** 1. Manual 2. Motorized

184

Section J: Health Conditions

J1800 Any Falls Since SOC/ROC, whichever is more recent	
Enter Code ☐	Has the patient had any falls since SOC/ROC, whichever is more recent? 0. No → Skip J1900 1. Yes → Continue to J1900, Number of Falls since SOC/ROC, whichever is more recent.
J1900. Number of Falls Since the SOC/ROC, whichever is more recent.	
CODING: 0. None 1. One 2. Two or more	↓ Enter Codes in Boxes
☐	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
☐	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
☐	**C. Major injury:** Bone **fractures**, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

J1800 Any Falls Since SOC/ROC, whichever is more recent

J1800 Any Falls Since SOC/ROC, whichever is more recent	
Enter Code ☐	Has the patient had any falls since SOC/ROC, whichever is more recent? 0. No → Skip J1900 1. Yes → Continue to J1900, Number of Falls since SOC/ROC, whichever is more recent.

ITEM INTENT
This item identifies if the patient had any witnessed or unwitnessed falls since the most recent SOC/ROC.

TIME POINTS ITEM(S) COMPLETED
- Transfer to an inpatient facility
- Death at home
- Discharge from agency – not to an inpatient facility

New Item

186

Definitions related to Falls

FALL

- Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (such as a bed or chair).
- The fall may be witnessed or unwitnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground.
- Falls are not a result of an overwhelming external force (such as, a person pushes a patient).

187

Definitions related to Falls

REMEMBER
An intercepted fall is considered a fall.

INTERCEPTED FALL

- An **intercepted fall** occurs when the patient would have fallen if he or she had not caught him/herself or had not been intercepted by another person.

188

Definitions related to Falls

CHALLENGING A PATIENT'S BALANCE

- CMS understands that **challenging a patient's balance** and training him/her to recover from a loss of balance is an intentional therapeutic intervention and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls.

189

J1800 Any Falls Since SOC/ROC, whichever is more recent

RESPONSE-SPECIFIC INSTRUCTIONS

- Review home health clinical record, incident reports and any other relevant clinical documentation (for example, fall logs)
- Interview patient and/or caregiver about occurrence of falls

190

J1800 Any Falls Since SOC/ROC, whichever is more recent

A **DASH** is a valid response for this item.

J1800 Any Falls Since SOC/ROC, whichever is more recent	
Enter Code ☐	Has the patient had any falls since SOC/ROC, whichever is more recent? 0. No → Skip J1900 1. Yes → Continue to J1900, Number of Falls since SOC/ROC, whichever is more recent.

CODING INSTRUCTIONS

- **Code 0, No**, if the patient has not had any fall since the most recent SOC/ROC.
- **Code 1, Yes**, if the patient has fallen since the most recent SOC/ROC.

191

J1800 Any Falls Since SOC/ROC, whichever is more recent

EXAMPLE 1

- The discharging RN reviews the clinical record and interviews the patient and caregiver, Mrs. K and her daughter Susan, determining that a single fall occurred since the most recent SOC/ROC.
- The fall is documented on a clinical note from an RN home visit in which Susan reported her mother slipped from her wheelchair to the floor the previous day.

EXAMPLE 2

- An incident report describes an event in which Mr. S appeared to slip on a wet spot on the floor during a home health aide bath visit.
- He lost his balance and bumped into the wall, but was able to steady himself and remain standing.

J1800 Any Falls Since SOC/ROC, whichever is more recent	
Enter Code ☐	Has the patient had any falls since SOC/ROC, whichever is more recent? 0. No → Skip J1900 1. Yes → Continue to J1900, Number of Falls since SOC/ROC, whichever is more recent.

192

J1800 Any Falls Since SOC/ROC, whichever is more recent

EXAMPLE 3

- A patient is participating in balance retraining activities during a therapy visit.
- The therapist is intentionally challenging patient's balance, anticipating a loss of balance.
- The patient has a loss of balance to the left due to hemiplegia and the physical therapist provides minimal assistance to allow the patient to maintain standing.

EXAMPLE 4

- A patient is ambulating with a walker with the help of the physical therapist.
- The patient stumbles and the therapist has to bear some of the patient's weight in order to prevent a fall.

J1800 Any Falls Since SOC/ROC, whichever is more recent	
Enter Code ☐	Has the patient had any falls since SOC/ROC, whichever is more recent? 0. No → Skip J1900 1. Yes → Continue to J1900, Number of Falls since SOC/ROC, whichever is more recent.

193

J1900 Number of Falls Since SOC/ROC, whichever is more recent

New item

J1900. Number of Falls Since the SOC/ROC, whichever is more recent.		
CODING: 0. None 1. One 2. Two or more	↓ Enter Codes in Boxes	
	☐	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	☐	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	☐	**C. Major injury:** Bone **fractures**, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

ITEM INTENT
This item identifies the number of falls a patient had since the most recent SOC/ROC, and fall-related injury.

TIME POINTS ITEM(S) COMPLETED
Transfer to an inpatient facility
Death at home
Discharge from agency – not to an inpatient facility

194

Definitions related to Fall Injuries

INJURY RELATED TO A FALL
Any documented or reported injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall.

NO INJURY
No evidence of any injury noted on assessment; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall.

195

Definitions related to Fall Injuries

INJURY (EXCEPT MAJOR)
Includes:
- Skin tears,
- Abrasions,
- Lacerations,
- Superficial bruises,
- Hematomas, and
- Sprains; or
- Any fall-related injury that causes the patient to complain of pain.

MAJOR INJURY
Includes:
- Bone fractures,
- Joint dislocations,
- Closed head injuries with altered consciousness, and
- Subdural hematoma.

196

J1900 Number of Falls Since SOC/ROC, whichever is more recent

RESPONSE-SPECIFIC INSTRUCTIONS

- ***Review*** the home health clinical record, incident reports and any other relevant clinical documentation, such as fall logs.

- ***Interview*** the patient and/or caregiver about occurrence of falls.

- ***Determine*** the number of falls that occurred since the most recent SOC/ROC, and, code the level of fall-related injury for each.

197

J1900 Number of Falls Since SOC/ROC, whichever is more recent

- ***Code*** falls no matter where the fall occurred.
- ***Code*** each fall only once.

If the patient has multiple injuries in a single fall, code the fall for the highest level of injury.

198

J1900 Number of Falls Since SOC/ROC, whichever is more recent

CODING INSTRUCTIONS for:
❖ **J1900A. No Injury**

A **DASH** is a valid response for this item.

- **Code 0, None**, if the patient had *no injurious falls* since the most recent SOC/ROC.
- **Code 1, One**, if the patient had *one non-injurious fall* since the most recent SOC/ROC.
- **Code 2, Two or more**, if the patient had *two or more non-injurious* falls since the most recent SOC/ROC.

J1900. Number of Falls Since the SOC/ROC, whichever is more recent.	
CODING: 0. None 1. One 2. Two or more	Enter Codes in Boxes
☐	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
☐	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
☐	**C. Major injury:** Bone **fractures**, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

199

J1900 Number of Falls Since SOC/ROC, whichever is more recent

Coding Instructions for:
❖ **J1900B. Injury, Except Major**

A **DASH** is a valid response for this item.

- **Code 0, None**, if the patient had *no falls with injury, except major*, since the most recent SOC/ROC.
- **Code 1, One**, if the patient had *one fall with injury, except major*, since the most recent SOC/ROC.
- **Code 2, Two or more**, if the patient had *two or more falls with injury*, except major, since the most recent SOC/ROC.

J1900. Number of Falls Since the SOC/ROC, whichever is more recent.	
CODING: 0. None 1. One 2. Two or more	Enter Codes in Boxes
☐	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
☐	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
☐	**C. Major injury:** Bone **fractures**, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

200

J1900 Number of Falls Since SOC/ROC, whichever is more recent

Coding Instructions for:
❖ **J1900C. Major Injury**

A **DASH** is a valid response for this item.

- **Code 0, None**, if the patient had no falls with *major injury* since the most recent SOC/ROC.
- **Code 1, One,** if the patient had one fall with *major injury* since the most recent SOC/ROC.
- **Code 2, Two or more**, if the patient had two or more falls with *major injury* since the most recent SOC/ROC.

J1900. Number of Falls Since the SOC/ROC, whichever is more recent.	
CODING: 0. None 1. One 2. Two or more	Enter Codes in Boxes
☐	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
☐	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
☐	**C. Major injury:** Bone **fractures**, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

201

J1900 Number of Falls Since SOC/ROC, whichever is more recent

EXAMPLE 1

- The discharging RN reviews the clinical record and interviews Mrs. K and her daughter Susan, the patient and caregiver, determining that a single fall occurred since the most recent SOC/ROC.
- The fall is documented on a clinical note from an RN home visit in which Susan reported that her mother slipped from her wheelchair to the floor the previous day.
- Susan contacted the EMTs for help returning Mrs. K to her wheelchair; the EMT assessment at that time identified no injury.
- Documentation of the RN assessment during the home visit details no injury identified related to the fall.

J1900. Number of Falls Since the SOC/ROC, whichever is more recent.		
CODING: 0. None 1. One 2. Two or more	Enter Codes in Boxes	
	☐	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	☐	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	☐	**C. Major injury:** Bone **fractures**, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

202

J1900 Number of Falls Since SOC/ROC, whichever is more recent

EXAMPLE 2

- Review of the clinical record and incident reports, and, patient / caregiver report, identify that a single fall occurred since the most recent SOC/ROC.
- The fall is documented on a clinical note from an RN home visit that describes the patient Mr. R's report of a fall that occurred between visits, in which he tripped on the dog, fell against the wall and banged his elbow, sustaining a skin tear that he treated himself.
- Documentation of the RN assessment during the home visit details the healing skin tear, and no other injury or symptom identified related to the fall.

J1900. Number of Falls Since the SOC/ROC, whichever is more recent.		
CODING: 0. None 1. One 2. Two or more	Enter Codes in Boxes	
	☐	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	☐	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	☐	**C. Major injury:** Bone **fractures**, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

203

J1900 Number of Falls Since SOC/ROC, whichever is more recent

EXAMPLE 3

- Review of the patient record and incident reports, and, patient / caregiver report identify that a single fall occurred since the most recent SOC/ROC.
- The fall is documented on an incident report that describes a telephone call received from the patient, Mrs. B's, daughter Mary, in which Mary reported Mrs. B fell at home and hit her head, and was transported via ambulance to the emergency room.
- Examination and testing revealed a subdural hematoma.
- Mrs. B was held in observation stay and received treatment, returning home in stable condition after 48 hours.

J1900. Number of Falls Since the SOC/ROC, whichever is more recent.		
CODING: 0. None 1. One 2. Two or more	Enter Codes in Boxes	
	☐	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	☐	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	☐	**C. Major injury:** Bone **fractures**, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

204

J1900 Number of Falls Since SOC/ROC, whichever is more recent

EXAMPLE 4

- Review of the patient record, incident reports and patient/caregiver report identify that two falls occurred since the most recent SOC/ROC.
- The falls are documented on clinical notes.
- The first describes an event during which Mr. G tripped on the bathroom rug and almost fell, but caught himself against the sink.
- The RN assessment identified no injury.
- The second describes an event during which Mr. G, while coming up the basement stairs with the laundry, fell against the stair and sustained a bruise and laceration on his left knee.

J1900. Number of Falls Since the SOC/ROC, whichever is more recent.		
CODING: 0. None 1. One 2. Two or more	Enter Codes in Boxes	
	☐	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	☐	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	☐	**C. Major injury:** Bone **fractures**, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

205

J1900 Number of Falls Since SOC/ROC, whichever is more recent

EXAMPLE 5

- Review of the patient record, incident reports and patient / caregiver report identify that a single fall occurred since the most recent SOC/ROC.
- The fall is documented on an incident report, which describes an event during which Mrs. J fell while walking from her bedroom to the bathroom and was transported to the emergency room via ambulance.
- Examination and testing revealed a skin tear on Mrs. J's left hand, bruising on both knees, and a fractured left hip.

J1900. Number of Falls Since the SOC/ROC, whichever is more recent.		
CODING: 0. None 1. One 2. Two or more	Enter Codes in Boxes	
	☐	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	☐	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	☐	**C. Major injury:** Bone **fractures**, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

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Section J: Highlights

- **J1800**: Any Falls Since SOC/ROC and **J1900**: Number of Falls Since SOC/ROC, are completed at:
  - Transfer
  - Discharge-not to an Inpatient Facility
  - Death at Home
- An ***intercepted fall*** is considered a fall.
- CMS does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls.
- There are three levels of fall-related injury:
  - No Injury
  - Injury (Except Major)
  - Major Injury

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Summary

- OASIS-D to be implemented with all assessments with a M0090 Date Assessment Completed date of January 1, 2019, or later
- Changes to OASIS-D include:
  - **New** standardized patient assessment data elements
  - Alignment in content of items that support cross-setting measures **(revised)**
  - Comprehensive Item Use Evaluation, resulting in reduction of burden and quality measure changes **(removal)**
  - Updates and corrections to guidance

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Summary

- Revisions to OASIS-D involve either:
  - Changes in the assessment item and related guidance
  - Revisions to the Guidance Manual
- Some response options have been removed to reduce provider burden
- Different time point versions created for some items
- Incorporated NPUAP terminology updates
- Revised language to align with other PAC settings
- Consult the OASIS-D Guidance Manual for specific direction

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Resources

- CMS QTSO website: https://qtso.cms.gov
- BHRS website: https://health.mo.gov/safety/homecare/
- BHCR list serve
- Suzi.hamlet@health.mo.gov

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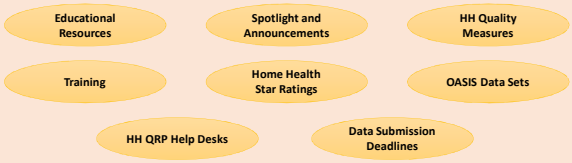
HH QRP Website

CMS Home Health Quality Reporting Program Website

- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html



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CMS Training Information and Updates

- Spotlight and Announcements
- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Spotlight-and-Announcements.html

- Home Health Quality Reporting Training
- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Training.html

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Questions

Thank you for your commitment to OASIS accuracy!

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