Practice Resource Documents for Home Health Therapists

Achieving OASIS-C Accuracy: Functional Scoring
Goal Writing Guidelines for Home Health Therapists
Fact Sheet for Documenting Therapy Services in the Home Health Setting
Achieving Skilled Therapy Documentation During Routine Treatment Visits

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Achieving OASIS-C Accuracy: Functional Scoring
Jonathan S. Talbot, PT, MS, COS-C; Diana Kornetti, PT, MA

A great challenge in the home health industry is training clinicians to accurately complete the Outcome and Assessment Information Set (OASIS). To further complicate this challenge, it has been determined that CMS has struggled to monitor accuracy. The February 2012 OIG report found that “states conducted limited … review of the accuracy of OASIS data” and that “CMS did not ensure the accuracy or completeness of OASIS data.” One might reasonably wonder how proposed reimbursement models (e.g. Pay for Performance) will legitimately rely on outcomes based upon OASIS data, if CMS can’t even validate the OASIS data as being accurate. This presents the physical therapy profession with a valuable opportunity to proactively pursue accuracy and proficiency with the OASIS in advance of CMS efforts to improve their ability to monitor it.

The purpose of this document is to promote the role of physical therapists in completing the OASIS tool accurately and appropriately, with emphasis on the functional mobility portion (M1800 – M1860). The unique training and experience of physical therapists qualifies them to be leaders in the industry with OASIS accuracy with these questions. With this said, there are some operational definitions within the OASIS instrument that differ from conventional physical therapy training and experience. Consequently, physical therapists are subject to errors resulting from responding to OASIS questions based solely upon their training, without due consideration to OASIS instructions. Failure to be aware of these differences can negatively impact OASIS accuracy.

BRIEF HISTORY OF OASIS

To achieve accuracy, it is helpful to understand the history and purpose of the OASIS instrument. The development of the OASIS instrument was born with the 1987 Omnibus Budget Reconciliation Act of 1987. In this Act, Congress mandated that “HCFA develop a standardized patient assessment instrument to assist in monitoring home health agencies.” Approximately a decade later, the Center for Health Services Research at the University of Colorado, under contract with CMS, produced the OASIS instrument. In January 1999, HCFA issued their final rule regarding the implementation of the OASIS instrument as part of comprehensive patient
assessments, and it has been entrenched in home health care ever since. The OASIS instrument has had some modifications over the years, with the most recent version, OASIS-C, being implemented in January 2010.

Clinicians should approach the OASIS instrument with the understanding that it is inherently a data collection tool, recognizing that there are specific instructions about the intent, scope, and the appropriate responses for each item. In the series of questions involving ADL’s and functional mobility, for example, the intent clearly states that the clinician should focus on the patient’s “ABILITY” (CMS capitalizes this word for emphasis) to safely perform the task, and to not merely focus on a patient’s performance. If these questions are scored according to this intent, then the intended purpose of the tool is fulfilled, and it serves as an effective instrument for measuring outcomes. However, if established conventions and instructions aren’t followed, the clinician is left to make assumptions, and the utility of the OASIS as an outcome measure is compromised.

Some physical therapists struggle with documenting evaluation findings that are consistent with their OASIS scores. For example, a physical therapist may document objective tests showing a high fall risk, multiple gait deviations, and a need for gait training 3x/week for 6 weeks, yet rate a patient as ambulating “independently” based upon M1860 scores of “0” or “1”. They may cite a rationale that these patients are walking around without anyone there to help them, because they live alone. This thought process makes it nearly impossible to rate any ambulatory patient who lives alone as anything less than independent. These patients may be “independent” if you define that word as doing things without assistance and leaving it at that. However, if you define “independent” as doing things safely without assistance, which is the definition utilized by the OASIS instrument, then the standard of independence for patients who live alone has measurably changed and OASIS scores should become more consistent with therapy evaluation findings.

Excessive concerns over unfounded “liability risks” may also contribute to inaccurate scoring. Some clinicians may feel reluctant to rate patients with unresolved safety concerns as being “unsafe” due to a fear of liability, should the patient suffer an injury while performing a task “unsafely.” This is particularly the case for patients who live alone. Instead of rating these patients as unsafe, they rate them as essentially safe on the OASIS and then proceed to arrange clinical services to address safety concerns that they identified during the therapy evaluation. This concern may result in part from prior clinician experience in inpatient settings where they are accustomed to all patients having a call light and thereby providing a safety measure in place for the clinician to leave the room. Nevertheless, this concern needs to be confronted in order to achieve accuracy.

It may help to remind clinicians who cite liability concerns to justify rating “unsafe” patients as “safe”, that the real liability concern has already been clearly identified by the United States Senate Committee on Finance.iii This investigation clearly identified a concern about the “gaming of Medicare” by therapists and home health agencies, by providing a level of services to patients for whom the evidence didn’t justify a skilled need. Consider how a plan of care for gait training for a
patient rated as independent on the OASIS item M1860 could justifiably raise legitimate concerns about inappropriate therapy utilization. It cannot be overstated that one of the key conventions of OASIS data collection is to rate a patient’s ability to *safely* perform a given task, whether human assistance is present or not. Clinicians cannot lose sight of the fact that if additional skilled teaching is needed to improve safety, then safety is indeed a problem that must be represented on the OASIS.

CMS has provided many resources to guide clinicians and improve scoring accuracy. These resources include the OASIS-C Guidance Manualiv, Quarterly Q&A’sv, and state OASIS Educational Coordinators.vi Other resources are also available to assist with accuracy, vii A dedicated pursuit of an adequate working knowledge of the instructions and conventions applicable to the OASIS assessment is essential to ensure that in practice it functions as the outcome and quality assessment instrument that it was meant to be. With all of these resources, we have every opportunity to enhance OASIS accuracy.

**OASIS DEFINITIONS VS. PHYSICAL THERAPY DEFINITIONS**

The OASIS instrument instructions have altered the definition of transfers and human assistance relative to the professional training and clinical experience of physical therapists. This difference has proven to be a source of confusion and inaccuracy for physical therapists who rely excessively on their training, in the absence of knowledge of OASIS instructions. Some examples involving M1840 and M1850 are useful to demonstrate this point.

First of all, on **M1840 Toilet Transferring**, most therapists would intuitively think of this as transferring on/off the toilet via either sit to stand or stand-pivot to/from a wheelchair. However, the wording of this item (see **Figure 1**) clearly demonstrates that the “ability to get to and from the toilet” (e.g. ambulation, wheelchair) should be considered as part of toilet transferring.

<table>
<thead>
<tr>
<th>OASIS ITEM</th>
</tr>
</thead>
<tbody>
<tr>
<td>(M1840) <strong>Toilet Transferring</strong>: Current ability to get to and from the toilet or bedside commode <em>safely</em> and transfer on and off toilet/commode.</td>
</tr>
<tr>
<td>□ 0 - Able to get to and from the toilet and transfer independently with or without a device.</td>
</tr>
<tr>
<td>□ 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.</td>
</tr>
<tr>
<td>□ 2 - Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).</td>
</tr>
<tr>
<td>□ 3 - Unable to get to and from the toilet or bedside commode but is able to use a bedside commode independently.</td>
</tr>
<tr>
<td>□ 4 - Is totally dependent in toileting.</td>
</tr>
</tbody>
</table>

**Figure 1.** **M1840 Toilet Transferring**, from CMS OASIS-C Guidance Manual, Dec. 2011, Ch. 3: K-3.
Meanwhile, the specific instructions for M1840 indicate that a patient who is independent with the actual transfer would still be rated no better than a “1” if the need for assistance or supervision is required during the mobility component of safely getting “to and from” the toilet (see Figure 2).

A second OASIS item that physical therapists must recognize as different from their historical training and understanding involves the term “minimal human assistance” as found in response “1” under item M1850 Transfers. For many therapists, this term suggests that hands-on assistance would be needed if the patient doesn’t use a device. OASIS instructions, however, redefine “minimal human assistance” to indicate hands-on assistance isn’t required (see Figure 3).

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**OASIS ITEM**

**M1850 Transferring**: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

- **0** - Able to independently transfer.
- **1** - Able to transfer with minimal human assistance or with use of an assistive device.
- **2** - Able to bear weight and pivot during the transfer process but unable to transfer self.
- **3** - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
- **4** - Bedfast, unable to transfer but is able to turn and position self in bed.
- **5** - Bedfast, unable to transfer and is unable to turn and position self.

- For response 1, “minimal human assistance” could include any combination of verbal cueing, environmental setup, and/or actual hands-on assistance.
- In order for the assistance to be considered minimal, it would mean the individual assisting the patient is contributing less than 25% of the total effort required to perform the transfer.

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Figure 2. M1840 Toilet Transferring, from CMS OASIS-C Guidance Manual, Dec. 2011, Ch. 3: K-8

It is imperative that physical therapists understand that for the purposes of accurately answering this OASIS item, the phrase “minimal human assistance” could equate to the patient requiring no more than standby assistance during a transfer (refer to Figure 3). Failure to apply these instructions can and does result in patients who require SBA with transfers being rated at “0” because the clinician feels they are much closer to being independent (e.g. patient lives alone and gets up and down on their own, albeit unsafely) than needing hands-on assistance. Unfortunately, the wording of response 2, which states “patient unable to transfer self”, conveys a meaning that the patient is physically unable to transfer without the therapist laying hands on them to assist with the transfer, leading many clinicians to avoid this response if the clinician is physically performing the transfer when the therapist isn’t there to assist. For accuracy, a clinician should jointly consider whether the patient transfers “safely” and whether the clinician plans to provide further teaching/treating to make the patient safer. If more teaching is needed to address safety concerns, and the patient should be using a device during transfers, then CMS has clearly indicated that response 2 is appropriate to describe this type of patient (see Figure 4).


Finally, specific instructions for M1850 Transferring demonstrate that the OASIS instrument includes a possible ambulation component within this item. Similar to the other examples, ambulation is not a component that physical therapists classically associate with transfers. With patients for whom the nearest sitting surface is not adjacent to their bed, their ability to ambulate safely to/from their chair and their bed will potentially impact the score for this item, even if the patient is independent with supine to sit and sit to stand. Figure 5 below shows the specific instructions in the OASIS-C Item Guidance manual that indicates that a bed to chair transfer could involve “a chair in another room” in cases where “there is no chair in the patient’s bedroom.”

**Figure 5. M1850 Transferring**, from CMS OASIS-C Guidance Manual, Dec. 2011, Ch. 3: K-12.

An area of inconsistency found to be a problem for some agencies is that of clinicians documenting patients as being “bedfast” on M1850 and “chairfast” on M1860. Clinicians must
appreciate the definitions of “bedfast” and “chairfast” as provided by CMS. Specifically, CMS defines a “bedfast” individual as someone who is “unable to tolerate being out of bed.” Clearly a chairfast patient doesn’t meet this definition. There are few automatics in the OASIS assessment, but in this case, patients rated as “bedfast” on M1850 (response 4 or 5) should automatically be rated no better than “bedfast” on M1860 (response 6). Some clinicians have found it helpful to compare M1850 and M1860 responses in a side-by-side table, providing a visual reminder of the need to be consistent (see Appendix-3).

In summary, both M1840 Toilet Transferring and M1850 Transferring may include an ambulation/mobility component and the phrase “minimal human assistance” as found in M1850 is defined to include merely supervision. These definitions are different than traditional physical therapy definitions for these words and must be considered for accurate scoring. A crosswalk for physical therapists has been prepared to illustrate how some common physical therapist interpretations of OASIS items differ from the instructions and definitions associated with the OASIS document (see Appendix-1). Clinicians who fail to accept these definitions for the purpose of completing the OASIS assessment will continue to struggle with accuracy, which in turn will negatively impact their agency outcomes, risk adjustment, and case mix scores.

**OASIS ASSESSMENT STRATEGIES TO IMPROVE ACCURACY**

One statement that is pervasive throughout the OASIS-C Item Guidance manual is that “a combined observation/interview approach with a patient or caregiver is required to determine the most accurate response for this item.” This approach is best practice and most home health clinicians are largely aware of the importance of performing the assessment this way. Unfortunately, due to time constraints and/or lack of sufficient training, some clinicians may be reluctant to routinely observe the patient performing the functional tasks required for accurate OASIS scoring. A more consistent approach for evaluating patients with combined observation/interview is essential, and can be best achieved by conducting a room-by-room assessment, focusing on safety, and maintaining the proper perspective.

**Conducting a Room-by-Room Assessment:**

Many clinicians, particularly non-therapists, may feel like they don’t really know how to conduct a functional assessment. With this in mind, a tool has been prepared to create more consistency with the assessment (see Appendix-2, *Room by Room Assessment of Functional OASIS Items*). This tool highlights a consistent approach for asking patients to “show” the clinician what they need to see, as well as where in the home the clinician should observe the task. This tool also prompts the clinician to observe and take note of any safety concerns or equipment utilized, which may affect the OASIS score. Without conducting the room-by-room assessment, it can be difficult to accurately rate the OASIS items M1800 – M1890.
Focus on Safety:
In order to be consistent with the purpose and intent of the OASIS instrument, it is critical to remember that a patient’s ability to safely perform functional tasks is the primary consideration. Patients who live alone are all too often being inappropriately rated as “independent” with tasks that they are performing unsafely on their own, out of necessity. The irony is that in many cases, the clinicians who rate these patients as “independent” with OASIS items simultaneously document in their therapy evaluation that the patient requires standby or contact-guard assistance with those tasks. From a physical therapy standpoint, this means they are not safe and require skilled therapy to achieve independence. If that is true, then how can they be “independent” on the corresponding OASIS item? We can’t have it both ways. In order to fully justify a plan of care, the clinician has a responsibility to ensure that the safety concerns represented in their physical therapy documentation are consistent with the safety concerns represented in the OASIS scores.

Maintaining the Proper Perspective:
Clinicians must consistently strive to align their perspective with the instructions provided by CMS. Relying too much on personal interpretations, getting distracted by rumored liability concerns, and losing sight of the fact that the OASIS is a data collection instrument can all contribute to inaccuracies. Following the instructions provided by CMS will bring clinicians closer to accurate OASIS assessments more than any other approach. The OASIS simply asks that a patient’s ability to safely perform various tasks be rated over a specified timeframe (typically the time of the visit and the prior 24 hours).

The following questions may prove helpful for maintaining a perspective that is compatible with consistently answering the OASIS items accurately:

1) Are my therapy evaluations and plans of care consistent with my OASIS scores?

2) When my evaluation of a patient indicates that services are needed to address safety concerns and mobility deficits, do my OASIS scores demonstrate that need as well?
   a. Do I rate patients as “independent” with ambulation on M1860 with a “0” or “1” response, and include Gait Training in my plan of care?
   b. Do I rate patients as “independent” with transfers on M1850 with a “0” or “1” response (using a device for “1”), and include Transfer Training in my plan of care?

3) If a patient is rated as independent with managing a task on any OASIS question, how is it possible to justify skilled services to train an independent patient to be safer with that task?

4) Is it appropriate to document that a patient has a known high risk for falls, based upon evidence-based testing, and then rate them as independent with ambulation on the OASIS?
5) Is it appropriate to rate all patients who live alone as “safe” and “independent” on the OASIS items, since many of these patients somehow get dressed, perform transfers, and ambulate with no one there to help them? If so, then why does safety matter?

6) If a therapy evaluation indicates the need for several weeks of gait training to address a known fall risk for a patient who lives alone, which OASIS score would be more likely to trigger regulatory questions about the medical necessity of a plan of care?
   a. Rating this patient as safe to “walk alone” or “independent” with ambulation (because there is no one there to walk with them “at all times”), **OR**
   b. Rating this patient as being at a level of requiring “assistance of another person at all times” to be made safe.

7) Do I rate patients as “independent” or “safe” based upon how I found them during the OASIS assessment visit, or based upon how I left them after providing necessary teaching/training during that visit? Am I considering that the OASIS instructions expect me to consider whether they can safely perform the task during more than 50% of the time period under consideration (the time of the visit and the preceding 24 hours)?

8) Am I utilizing available resources for accuracy? (e.g. OASIS-C Item Guidance, OASIS Quarterly Q&A, OASIS Educational Coordinators)

**PHYSICAL THERAPY, OASIS, AND APTA’s VISION 2020**

Physical therapists should first and foremost recognize that a professional commitment to perform quality comprehensive OASIS assessments will promote the achievement of APTA’s Vision 2020. viii Performing the comprehensive assessment associated with the OASIS allows physical therapists to demonstrate the ability to develop and coordinate the implementation of an effective plan of care to improve the health of the patients they serve. Isn’t this what doctoring professions do? Physical therapists should seize this opportunity to lead the way with a level of professionalism that patients expect.

The clinical assessment associated with the OASIS instrument involves a more comprehensive evaluation than many physical therapists may be accustomed to performing, so clinicians need to get up to speed with the comprehensive physical therapy evaluation skills that are taught in physical therapy curriculum. For instance, checking multiple vital signs (including temperature), evaluating for deficits associated with heart failure, performing pulmonary auscultation, testing for peripheral neuropathy, checking medications for polypharmacy, assessing the vestibular system, and monitoring for skin breakdown are valued clinical assessment skills for best practice in homecare.
As noted above, the performance of a comprehensive OASIS assessment by a physical therapist is consistent with the future of physical therapy practice as described by APTA’s Vision 2020 which includes the following elements:

- Autonomous Physical Therapist Practice
- Direct Access
- Doctor of Physical Therapy and Lifelong Education
- Evidence-based practice
- Practitioner of Choice
- Professionalism

With the exception of Direct Access, all of the above elements are accounted for when performing an OASIS assessment. Direct Access is currently outside the control of the physical therapy profession, because CMS requires a physician referral for admission to home health physical therapy services.

For a variety of reasons, some physical therapists struggle to accept the challenge of becoming proficient with performing quality OASIS assessments. Some comment that it takes too much time and isn’t worth the effort. Others excuse themselves by stating that they don’t feel their clinical training has been adequate to perform the OASIS assessment properly. The answer to these concerns is the same answer that one would offer to a physical therapist who says they never learned how to measure range of motion in school. *Take responsibility to learn what you need to know to do your job effectively.* Physical therapists pursuing work in the home health setting should aggressively pursue this knowledge and training as a professional responsibility for that setting.

For those physical therapists new to home care, the process of becoming proficient with the OASIS instrument is both challenging and professionally rewarding. Similar to physical therapists in sub acute and inpatient settings who require training to accurately complete FIM scoring, home health clinicians may require a significant amount of training to attain proficiency with the OASIS instrument. Clinicians seeking this training should read the OASIS Item Guidance carefully and stay up to date with OASIS Quarterly Q&A’s. Although home health agencies can facilitate this training, the burden of this training lies with the physical therapist professional. It is certainly in the best interest of home health physical therapists to strive for OASIS proficiency without waiting to be compelled to do so.

Physical therapists that attain proficiency with quality OASIS assessments and regularly develop comprehensive, team-oriented plans of care are a driving force for helping to make Vision 2020 become a reality. The home health industry needs more physical therapists that are dedicated to responsible and quality care. Regulatory changes will continue to occur. By demonstrating a more consistent level of professionalism and better clinical outcomes via OASIS accuracy, the physical therapy profession can be positioned to more strongly influence the direction of regulatory changes towards Vision 2020.
APPENDIX

1. OASIS-C Crosswalk for Therapists

2. Room-by-Room Assessment of Functional OASIS-C Items

3. M1850 and M1860 Side by Side View for Consistency
<table>
<thead>
<tr>
<th>OASIS TERMINOLOGY</th>
<th>COMMON PHYSICAL THERAPIST INTERPRETATION</th>
<th>OASIS-C INSTRUCTIONS</th>
<th>APPLICABLE OASIS ITEM(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Assistance”</td>
<td>Usually quantified as either standby, contact-guard, minimal, moderate, or maximal assistance.</td>
<td>Requires human assistance and includes: 1) Verbal cueing, OR 2) Supervision/standby assist/spotting, OR 3) Physical assistance</td>
<td>All OASIS items</td>
</tr>
<tr>
<td>“Independently”</td>
<td>Patient performs task by themselves, with or without equipment.</td>
<td>Patient performs the task safely, requiring no human “assistance” and no further instruction or training.</td>
<td>All OASIS items</td>
</tr>
<tr>
<td>“Routine”</td>
<td>What an average person should be able to do.</td>
<td>What the evaluating clinician considers being routine for a specific patient’s needs and circumstances.</td>
<td>M1810 M1820</td>
</tr>
<tr>
<td>“Minimal human assistance”</td>
<td>The patient requires approximately 25% physical assistance to perform the task.</td>
<td>Requires human assistance and includes: 1) Verbal cueing, OR 2) Environmental set-up, OR 3) Actual hands-on assistance</td>
<td>M1850</td>
</tr>
<tr>
<td>“Someone must help the patient”</td>
<td>The patient requires physical assistance to accomplish the task.</td>
<td>Includes: 1) Verbal cueing, OR 2) Supervision/standby assist/spotting, OR 3) Physical assistance</td>
<td>M1800 M1810 M1820</td>
</tr>
<tr>
<td>“Toilet Transfer”</td>
<td>Getting on and off the toilet</td>
<td>Includes: 1. Getting on and off the toilet, AND 2. Getting to and from the toilet</td>
<td>M1840</td>
</tr>
<tr>
<td>“Bed to chair transfer”</td>
<td>Stand/pivot transfer to/from bed and chair. Chair is generally adjacent to bed.</td>
<td>Ability to safely move from the bed to the nearest sitting surface. Consider safety with ambulation if the nearest sitting surface is not adjacent to the bed.</td>
<td>M1850</td>
</tr>
<tr>
<td>“Assistance of another person at all times.”</td>
<td>The patient lives with someone who is able to walk with them.</td>
<td>The patient is unsafe with walking on all surfaces and requires “assistance” (e.g. SBA, CGA, Min Assist) to be safe. May be living alone, with unsafe gait.</td>
<td>M1860</td>
</tr>
<tr>
<td>“Variety of surfaces”</td>
<td>Ability to safely navigate all possible surfaces (e.g. level, unlevel, slopes, and stairs)</td>
<td>Ability to safely navigate on surfaces that a patient would “routinely encounter in his/her environment, and may vary based on the individual residence.”</td>
<td>M1860</td>
</tr>
</tbody>
</table>
M1800 – Grooming
“Where do you keep grooming supplies?
“Can you get them out for me?”
* Observe items located out of safe reach.

M1820-Lower Body Dressing
“Show me how you get pants out of your dresser.”
“Show me how you take off your shoes and socks. I need to check your feet.”
* Note use of dressing aids and balance.

M1810-Upper Body Dressing
“Show me how you get a shirt out of the closet.”
* Note use of dressing aids and balance.

M1800-Grooming
“Where do you keep grooming supplies?
“Can you get them out for me?”
* Observe items located out of safe reach.

M1830-Bathing
“Show me how you get into your tub/shower.”
* Note presence of grab bars, hand-held shower head, and shower seat.
* Observe incorrect use of fixtures, towel rack, shower door/frame, or curtain rod.

M1840-Toilet Transferring
“Show me how you get to the bathroom from other rooms.”
“Show me how you get on/off the toilet.”
* Note presence of raised commode seat, toilet frame, and/or grab bars.
* Observe unsafe use of toilet roll holder, towel rack, or sink countertop.

M1870 - Feeding or Eating
M1880 - Ability to Plan and Prepare Light Meals
M1890 - Ability to Use Telephone

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<table>
<thead>
<tr>
<th>OASIS RESPONSE</th>
<th>M1850 – TRANSFERRING</th>
<th>M1860 – AMBULATION/LOCOMOTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>INDEPENDENT</td>
<td>INDEPENDENT</td>
</tr>
<tr>
<td></td>
<td>• Transfers safely supine to sit, sit to stand, and bed to chair (Independent bed mobility and transfers)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Safely ambulates to nearest sitting surface (if not adjacent to the bed)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• No device or human assistance needed with all of the above.</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>INDEPENDENT WITH DEVICE OR MINIMAL HUMAN ASSISTANCE</td>
<td>INDEPENDENT WITH SINGLE-HANDED DEVICE</td>
</tr>
<tr>
<td></td>
<td>• Independent/safe with device, and no assistance needed, OR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• &lt;25% assistance, and no device needed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• “Minimal human assistance” includes verbal cueing, supervision, &amp; set-up</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>ASSISTANCE REQUIRED FOR SAFETY</td>
<td>INTERMITTENT ASSISTANCE REQUIRED</td>
</tr>
<tr>
<td></td>
<td>• Able to bear weight AND pivot</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Requires assistance (which may be only verbal cueing) AND a device</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• If no device, requires &gt; 25% assistance</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>UNABLE TO BEAR WEIGHT OR PIVOT</td>
<td>CONTINUOUS ASSISTANCE REQUIRED</td>
</tr>
<tr>
<td></td>
<td>• Non-ambulating</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Not bedfast (able to tolerate being out of bed)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Likely a CHAIRFAST patient</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>BEDFAST</td>
<td>CHAIRFAST</td>
</tr>
<tr>
<td></td>
<td>• Unable to tolerate being out of bed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Independent bed mobility</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Able to turn/position self</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>BEDFAST</td>
<td>CHAIRFAST</td>
</tr>
<tr>
<td></td>
<td>• Unable to tolerate being out of bed</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>N/A</td>
<td>BEDFAST</td>
</tr>
<tr>
<td></td>
<td>• Unable to tolerate being out of bed</td>
<td></td>
</tr>
</tbody>
</table>

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References


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Goal Writing Guidelines for Home Health Therapists

by Dee Kornetti, PT, MA, HCS-D, COS-C, Ken Miller, PT, DPT and Jonathan Talbot, PT, MS

Introduction

With new Centers for Medicare & Medicaid Services (CMS) regulations, increased governmental oversight, audits and expanded medical review of health care providers; add in the movement from current payment models to value-based, pay for performance payment models, it is crucial for therapists to improve home care practice and focus on proper goal setting to meet the standards. The changes to the payment model will be geared at improving outcomes and base payment on these outcomes. Setting objective goals based on assessment tools then comparing these measures at specific time points during episodes of care are now the new standard and requirement by CMS. Evaluating the effectiveness of interventions will be absolutely critical for home care providers to survive in the new model.

Many therapists see the CMS final rule 2011 regulations as annoying, obtrusive, and time-consuming. However, these regulations now mandate a necessary change in therapist practice in home care. Ultimately, these changes will improve professionalism and truly improve therapists’ practice. The days of “poor, fair and good” grading of balance and endurance will be a memory.

Therapists should embrace the push toward improving care and these guidelines serve as a framework for therapists to create goals that meet the new regulations. These guidelines are not exhaustive and should be considered a starting point for goal setting. There are five necessary elements that all goals should include: 1. who the goal pertains to, 2. objective measure, 3. score interpretation, 4. functional improvement, and 5. time frame.

Element 1. Who? Does the goal pertain to the patient/client or to the caregiver? Sometimes patients may need ongoing assistance even after discharge from therapy and the goal of therapy may be to improve the caregiver’s care of the patient. For example, a patient with dementia may need ongoing assistance with ambulating in the home environment and the therapist intervention may be more geared to caregiver training in patient management.

Element 2. Objective measure. Standardized tests and objective measures should be used to assess the status of a patient’s strength, balance, falls risk, endurance, etc. These standardized test measures need to be documented in the goal to demonstrate progress throughout the episode of care. For example: a goal of improving balance from “Fair” to “Fair +” is meaningless because it doesn’t include objective measurement. Using a measure such as gait speed is objective, measureable, and repeatable as there are standardized testing protocols available. Documenting that the patient will improve comfortable gait speed from 1.6 feet/second to 2 feet/second is an objective goal.

Element 3. Score interpretation. There needs to be a conclusion or opinion drawn from the result of the test measure, demonstrating the professional skills of a therapist. Being able to draw conclusions, predictions and opinions based on objective test measures are what separate therapists from technicians. The therapist needs to give the objective goal in element 2 a meaningful interpretation by stating how, for example, improved gait speed from 1.6 feet/second to 2.0 feet/second will reduce the patient’s risk of falling. It’s helpful and important to cite evidence to support the therapist’s conclusion in element 3. Example: “Based on Harada’s work, gait speeds of less than 1.86 ft/second have show an increased risk of falling.”
Element 4. Functional improvement. Showing a reduced risk of falling only paints part of the picture. This element ties the objective test and score interpretation into something functional and meaningful for the patient and reviewer. For example, stating that the improved comfortable gait speed will allow the patient to return to ambulating safely and independently in his/her home environment provides information about how reaching the goal will meaningfully improve the patient’s self-sufficiency.

Element 5. Time frame. The last element needs to document how much time the therapist believes is needed to reach the goal. This element is important during re-assessments to determine if present interventions are effective in working toward attainment of goals or if the interventions and/or goals need to be modified. Perhaps the goal is unrealistic or the intervention is ineffective. Both of these reasons necessitate modifications to the plan of care.

EXAMPLES OF GOAL WRITING USING TABLE FORMAT

Example 1: During evaluation, balance was measured using the Berg Balance Test (BBT), and score interpretation revealed patient to have balance impairment with (+) falls risk (BBT score = 37/56). The evaluating therapist determined through assessment and report of prior level of functioning, that the patient has recently been restricting her normal activities of daily living (ADLs) due to feeling unstable on her feet and verbalizing reduced balance confidence.

<table>
<thead>
<tr>
<th>To whom does goal apply?</th>
<th>Objective Measure</th>
<th>Target Score</th>
<th>Score Interpretation</th>
<th>Expected Functional Improvement</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client</td>
<td>Berg Balance Test</td>
<td>≥ 48/56</td>
<td>Reduce fall risk</td>
<td>Improve safety with tub/shower transfers</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Client</td>
<td>Activities-Specific Balance Confidence Scale (ABC)</td>
<td>≥ 80%</td>
<td>Improve balance confidence</td>
<td>Improve safety during ADL’s</td>
<td>6 weeks</td>
</tr>
</tbody>
</table>

Example 2: During evaluation, muscle testing (MMT) values for LE plantarflexors, hip flexors and knee extensors were abnormal. Plantarflexor strength = 3/5; hip flexor strength = 3+/5; knee extensor strength = 4-/5. The patient demonstrated functional limitations in gait, stair climbing and balance/stability, requiring him to use a single-point cane to walk on uneven surfaces/out of doors.

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Client</td>
<td>Ankle Plantarflexor Manual Muscle Test (MMT)</td>
<td>Gain of ≥1 MMT grade</td>
<td>Increase calf strength</td>
<td>Normalized gait pattern and enable safe ambulation without device.</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Client</td>
<td>Hip Flexor and Knee Extensor strength</td>
<td>Gain of ≥1 MMT grade</td>
<td>Increase LE strength</td>
<td>Safe/independent stair climbing, improved balance, and safe ambulation with single-point cane on uneven surfaces</td>
<td>6 weeks</td>
</tr>
</tbody>
</table>

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Fact Sheet for Documenting Therapy Services in the Home Health Setting
by Ken Miller, PT, DPT

Target Audience: Clinicians (Physical Therapists and Physical Therapist Assistants); Agency Owners/Administrators; Paper and Electronic Medical Record designers/vendors; third party insurance payers; governmental agencies such as Health and Human Services Agency, Centers for Medicare and Medicaid Services and national/state home health care associations.

Purpose: This document serves to highlight the Code of Ethics for the Physical Therapist [Adopted by the APTA House of Delegates, in 2009 and Effective in 2010] and the Guide for Professional Conduct [Amended by the Ethics and Judicial Committee of the APTA, in 2010] with regard to physical therapists’ documentation and compliance with Centers for Medicare and Medicaid Services’ (CMS) Prospective Payment System (PPS) 2011 Final Rule Therapy regulations in both paper and electronic medical records (EMR).

CMS PPS 2011 Final Rule (Therapy regulations): The Medicare Benefit Policy Manual Chapter 7 contains CMS’ coverage requirements and regulations for home health services. Section 40.2 pertains to the requirements for skilled therapy services. “As described in section 40.2.1(b), at defined points during a course of therapy, the qualified physical therapist (instead of an assistant) must perform the ordered therapy service visit, assess the patient’s function using a method which allows for objective measurement of function and comparison of successive measurements, and document the results of the assessments, corresponding measurements, and effectiveness of the therapy in the patient’s clinical record.” The CMS requirement of including objective measurement of function and the repetition of the same objective measurements at specific time points during the episode of care is a new rule implemented in 2011. Documenting effectiveness of POC towards goal attainment is another new requirement from the PPS 2011 Final rule; section 40.2.1.b.1.ii and 40.2.1.b.1.iii state that the qualified therapist must determine the effectiveness of the plan of care, or lack thereof.

Health Insurance Portability and Accountability Act (HIPAA) of 1996: The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) called for the establishment of standards and requirements for transmitting certain health information to improve the efficiency and effectiveness of the health care system while protecting patient privacy. HIPAA requirements initiated movement towards establishment and standardization of an electronic medical health record and electronic transactions related to billing.

Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009: The HITECH Act of 2009 provided for further promotion of the use of electronic medical record documentation with the establishment of incentive programs and included standardization of the EMR and the players involved in the process. The HITECH Act further clarifies the protection of health information that is addressed in the HIPAA Act. The Act defined the term, “Health Information Technology” which means hardware, software, integrated technologies or related licenses, intellectual property, upgrades, or packaged solutions sold as services that are designed for or support the use by
health care entities or patients for the electronic creation, maintenance, access, or exchange of health information. The term "enterprise integration" means the electronic linkage of health care providers, health plans, the government, and other interested parties, to enable the electronic exchange and use of health information among all the components in the health care infrastructure in accordance with applicable law, and such term includes related application protocols and other related standards.

Section 3001 of the Act established within the Department of Health and Human Services an Office of the National Coordinator for Health Information Technology. The National Coordinator performs the duties under subsection (c) in a manner consistent with the development of a nationwide health information technology infrastructure that allows for the electronic use and exchange of information and that—“(1) ensures that each patient’s health information is secure and protected, in accordance with applicable law; “(2) improves health care quality, reduces medical errors, reduces health disparities, and advances the delivery of patient-centered medical care; “(3) reduces health care costs resulting from inefficiency, medical errors, inappropriate care, duplicative care, and incomplete information; (4) provides appropriate information to help guide medical decisions at the time and place of care; (5) ensures the inclusion of meaningful public input in such development of such infrastructure; (6) improves the coordination of care and information among hospitals, laboratories, physician offices, and other entities through an effective infrastructure for the secure and authorized exchange of health care information; (7) improves public health activities and facilitates the early identification and rapid response to public health threats and emergencies, including bioterror events and infectious disease outbreaks; (8) facilitates health and clinical research and health care quality; (9) promotes early detection, prevention, and management of chronic diseases; (10) promotes a more effective marketplace, greater competition, greater systems analysis, increased consumer choice, and improved outcomes in health care services; and (11) improves efforts to reduce health disparities.”

Item #3 above regarding incomplete information; item #4 regarding the provision of appropriate information to help guide medical decisions, and items #8-11 all pertain to the PPS 2011 requirement of objective measurements and use of these measurements to determine effectiveness or lack thereof of the plan of care in decision making.

**Code of Ethics for the Physical Therapist and the APTA Guide for Professional Conduct:**
The APTA Guide for Professional Conduct states, “The Code and the Guide apply to all physical therapists.” Given this definitive statement, all physical therapists are mandated to abide by the ethical code that was adopted in 2009. The Code and Guide serve to provide a framework by which physical therapists may determine the propriety of their conduct. The Code of Ethics contains 8 principles physical therapists must adhere to however, principles 3, 4, 5, and 7 are applicable to proper documentation and conformance to the PPS 2011 regulations.1, 2
Principle #3: Physical therapists shall be accountable for making sound professional judgments.
It is the ethical responsibility of physical therapists to follow principle #3 and use sound judgment when documenting in the clinical record. It is not reasonable to cite principle #3 in order to argue that physical therapists “do not need to comply with the inclusion of objective test measures and adherence to the multiple reassessment time points and content” if the paper or electronic medical record system templates do not include these required elements. The purpose of using objective measurements successively through the home care episode is to determine the efficacy of the interventions being provided and assists for making sound professional judgments.

Principle #4: Physical therapists shall demonstrate integrity in their relationships with patients/clients, families, colleagues, students, research participants, other health care providers, employers, payers, and the public.
The Home Health Section realizes that CMS regulations may change annually and understands that all parties involved in the provision of home care have challenges to maintain compliance with regulatory changes. Physical therapists, home health agencies, and Paper/EMR designers/software vendors alike need to demonstrate integrity in their relationships between and amongst themselves. Integrity is paramount within the relationship in order to ensure regulatory compliance. Where physical therapists are bound by the Code of Ethics, home health agencies and paper/EMR designers/software vendors are bound by their respective mission/vision statements.

Principle #5: Physical therapists shall fulfill their legal and professional obligations.
The Home Health Section believes that physical therapists are mandated to comply with CMS PPS 2011 requirements to follow their legal and professional obligation to practice physical therapy.

Principle #7: Physical therapists shall promote organizational behaviors and business practices that benefit patients/clients and society.
The Home Health Section believes that physical therapists should work together with home health agencies and paper/EMR designers/software vendors and other organizations involved in the home health industry for the purpose of promoting practices that benefit patients/clients and society. Organizational behaviors and business practices that focus on the best care of patients/clients and society as a whole is congruent with and mandated by principle #7.

Conclusion: All entities involved in the delivery of home health services are mandated by federal law [HIPAA, HITECH Acts, CMS PPS 2011, etc.]; state law [State Health Department] and are obligated to follow their respective accreditation agencies [The Joint Commissions], the Code of Ethics and Mission/Vision Statements. The Home Health Section seeks to be a home health industry leader to assist physical therapists, home health agencies and paper/EMR designers/software vendors and others in regulatory compliance. Specifically, the Section strives to assist physical therapists in complying with the documentation requirements of CMS’ Prospective Payment System (PPS) 2011 Final Rule with regard to both paper and electronic medical records (EMR). We believe that collaboration between physical therapists, agencies, and others is critical for best practice and in the best interest of our patients/clients and society as a whole.

References:
Achieving Skilled Therapy Documentation during Routine Treatment Visits

by Jonathan S. Talbot, PT, MS

The vast majority of visits provided by physical therapists and physical therapist assistants are routine treatment visits. Achieving consistency in documenting skilled therapy during these visits will have a significant impact on the justification of services provided and the receipt of appropriate reimbursement for those services. The key to meeting the skilled therapy standard lies with how specific interventions are documented.

**Intervention Documentation**

Documentation of skilled care is greatly enhanced by recording answers to the following questions for each intervention provided:

1) **What did the therapist teach?**
   - What instructions were given to enhance the effectiveness of the intervention? (i.e. quality, speed, frequency)
   - What instructions were given regarding safety? (i.e. positioning, breathing)
   - What instructions were given about the purpose the intervention? (i.e. relationship to functional deficits)

2) **What did the client do?**
   - This should include a detailed description of the intervention provided (client positioning, resistance, reps, distance, time, etc)
   - Description should be specific enough to enable another clinician to easily reproduce the same intervention during a subsequent visit.

3) **How did the client respond?**
   - % verbal cueing
   - Pain level pre and post-intervention
   - Performance limitations (e.g. pain, fatigue, shortness of breath)
   - Vital signs pre- and post-activity

**Therapist Assessment/Plan**

A quality therapist assessment regarding the client's benefit from the therapy interventions should include comparative statements that answer questions such as the following:

- How did the amount of teaching compare with the prior visit (i.e. % verbal cueing)?
- How much did the client do today compared to the prior visit?
- What problems did the client have today compared to the prior visit?
- What do the comparisons suggest about the client’s progress toward his/her functional goals?

Documenting “tolerated treatment well” suggests an inadequate assessment of the client's benefit from services and is generally the result of insufficient objective data being recorded during the visit. The plan for the next visit should attempt to facilitate efficient progression toward functional goals. For example, documenting “Gait train x200’ with emphasis on equalizing step length” or “Attempt balance training on foam pad with feet together and eyes open” will focus the clinician during the next visit on planned intervention progressions. Merely documenting “Continue POC” is too general, and is often associated with inadequate activity progression during the course of treatment.