Fall Risk Assessment:
Am I Meeting M1910 Criteria

Presented By:

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President - Home Health Section APTA

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Introduction of the Speaker

Cindy Krafft MS PT, COS-C is the Assistant Director of Operational Consulting for Fazzi Associates. She has been in home health for 14 years in a variety of capacities from PRN clinician to the Director of Rehabilitation for a six agency home care system. She is currently working with agencies to develop their rehabilitation programs, helping them to achieve their highest potential both clinically and financially. She has been a well received speaker at both the state and national levels on the topics of documentation, program development, therapy utilization and recruitment. She is the newly elected President of the Home Health Section of the American Physical Therapy Association and the Chair of the NAHC Therapy Advisory Committee.
Instructions and Handouts for: Fall Risk Assessment

It is very important that you have these materials printed and ready to use prior to the start of the training.

In order to participate in this training you will need to do the following:

1. Dial 1 (877) 615-4339 at least 10 minutes prior to the start of the webinar.
2. When asked, enter Conference ID 8160290#.
3. Give your agency’s name.
4. At this time you will be entered into the call and in “listen mode.”
5. If at any time you need assistance you may press *0 for the operator.
6. There will be a Q & A period toward the end of the session. Questions will be answered in the order in which they are received. To ask a question, press *1. You will have the opportunity to ask your question and then be returned to “listen mode.” Do not press *1 prior to this time.
7. To view the presentation online you must click on the link sent to you from GoToWebinar.

Nurses Only: Directions to receive contact hours for the training.

1. Each participant must complete an evaluation in order to receive contact hours. Click on the following link in order to access the online evaluation form: https://www.surveymonkey.com/s/PG9W8GV.

*Please allow four weeks for processing.

Therapists Only: Directions to receive contact hours for the training.

The process for therapy CEUs varies state to state. In order to assist therapists with getting a session approved, we have provided material that can be submitted to the state licensing board. Please check with your individual state for more specific information as to the process.

More information on APTA Guide to Practice can be found at the following websites:
www.cms.gov
www.medicare.com
http://oig.hhs.org
Objectives

• Discuss the impact of OASIS item M1910 on Fall Risk Assessment practices.
• Identify tools for effective capture of fall risks.
• Discuss an interdisciplinary approach to fall prevention to drive positive clinical outcomes.

Shift in OASIS Data Collection

• OASIS B1 = tell me about the patient.
• OASIS-C = and tell me what your team:
  – Plans to do (SOC/ROC)
  – Completed during the episode (TF/DC)

Why Assess Fall Risk?

• Driver of rehospitalization rates.
• Safety concern for caregivers.
• Cost of care across multiple settings.
• Prevention as opposed to fire fighting.
• Not addressed the same way for each patient.
M1032 Risk for Hospitalization

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

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

In the professional judgment of the assessor, impact ability to remain safely in the home. Recent decline = past year. Frailty can also include things like slower movements, declining function, etc.

M2310 Reasons for Emergent Care

(M2310) Reason for Emergent Care: For what reason(s) did the patient receive emergent care (with or without hospitalization)? (Mark all that apply.)

- 1 – Impaired medication administration, medication side effects, toxicity, anaphylaxis
- 2 – Injury caused by fall
- 3 – Respiratory infection (e.g., pneumonia, bronchitis)
- 4 – Other respiratory problems
- 5 – Heart failure (e.g., fluid overload)
- 6 – Congestive heart failure (congestive heart failure)
- 7 – Hypertension or stroke
- 8 – Other heart disease
- 9 – Diabetes (2K) or 2A3
- 10 – Hyperglycemia, diabetes out of control
- 11 – Kidney failure, obstruction, complication
- 12 – Depression, suicide attempt
- 13 – Urinary tract infection
- 14 – Injuries related to dialysis or transplantation
- 15 – Injurious incident or obstruction
- 16 – Choked
- 17 – Nervous system abnormality
- 18 – Deep vein thrombosis, pulmonary embolism
- 19 – Other transportation
- 20 – Repeated patient

M2430 Reasons for Hospitalization

(M2430) Reason for Hospitalization: For what reason(s) did the patient require hospitalization? (Mark all that apply.)

- 1 – Impaired medication administration, medication side effects, toxicity, anaphylaxis
- 2 – Injury caused by fall
- 3 – Respiratory infection (e.g., pneumonia, bronchitis)
- 4 – Other respiratory problems
- 5 – Heart failure (e.g., fluid overload)
- 6 – Congestive heart failure (congestive heart failure)
- 7 – Hypertension or stroke
- 8 – Other heart disease
- 9 – Diabetes (2K) or 2A3
- 10 – Hyperglycemia, diabetes out of control
- 11 – Kidney failure, obstruction, complication
- 12 – Depression, suicide attempt
- 13 – Urinary tract infection
- 14 – Injuries related to dialysis or transplantation
- 15 – Injurious incident or obstruction
- 16 – Choked
- 17 – Nervous system abnormality
- 18 – Deep vein thrombosis, pulmonary embolism
- 19 – Other transportation
- 20 – Repeated patient
Has this patient had a multi-factor Fall Risk Assessment (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)?

- 0 – No multi-factor falls risks assessment conducted
- 1 – Yes, and it does not indicate a risk for falls
- 2 – Yes, and it indicates a risk for falls

Key Words: Standardized, Multifactoral, Validated.
Multifactor assessment must include at least one standardized and validated test and scale. Use scoring parameters of the tool.
Response 1: No, low, or minimal risk.
Response 2: Greater than low/minimal risk.

Validated Options

- Timed Up and Go
- Tinetti
- Berg
- Functional Reach
- Others...

TUG Overview

- The Timed Up and Go (TUG) test measures, in seconds, the time taken by an individual to stand up from a standard arm chair (approximate seat height of 46 cm [18in], arm height 65 cm [25.6 in]), walk a distance of 3 meters (118 inches, approximately 10 feet), turn, walk back to the chair, and sit down. The subject wears his/her regular footwear and uses his/her customary walking aid (cane, walker, etc.). No physical assistance is given.
TUG Overview
(Example Continued)

• The subject starts with his/her back against the chair, his/her arms resting on the armrests, and walking aid at hand. The subject is instructed that, on the word “go” he/she is to get up and walk at a comfortable and safe pace to a line on the floor 3 meters away, turn, return to the chair and sit down again.

TUG Overview
• The subject walks through the test once before being timed in order to become familiar with the test.
• Use either a stopwatch or wristwatch with a second hand to time the test:
  – If using a stopwatch, start the time once the subject is standing and stop the time once the subject is seated

Interpreting the TUG
Older adults (age 65+) who took 13.5 seconds or longer to perform the TUG 1 were classified as fallers with an overall correct prediction rate of 90%.
Multifactoral Options

- OASIS Items
- Home grown tools
- Vendor tools
- Missouri Alliance
- Other...

Risk Factors

- Age
- Gender
- Fall history
- Environmental:
  - Interaction with not just inventory
  - Medications
  - Gait/Balance deficits
  - Vision
  - Incontinence
  - Cognition

M1200 Vision

(M1200) Vision (with corrective lenses if the patient usually wears them):

- 0 – Normal Vision: sees adequately in most situations; can see medication labels, newsprint
- 1 – Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm’s length
- 2 – Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive

Captures ability to see and visually manage (function) with corrective lenses if usually worn.
Corrective lenses includes grocery store reading glasses.
Excludes magnifying glass.
M1615 When Urinary Incontinence Occurs

(M1615) When does Urinary Incontinence occur?

- 0 – Timed-voiding defers incontinence
- 1 – Occasional stress incontinence NEW
- 2 – During the night only
- 3 – During the day only NEW
- 4 – During the day and night

Response 0: Schedules toileting to prevent episodes of incontinence and it works.
Response 1: Inability to prevent the escape of urine during stress (laughing, coughing, sudden movement, lifting, etc.).
Select 2, 3 or 4 if incontinence happens with regularity or for reasons other than “stress.”

M1700 Cognitive Functioning

(M1700) Cognitive Functioning: Patient’s current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

- 0 – Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
- 1 – Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.
- 2 – Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.
- 3 – Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- 4 – Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

Day of Assessment: Time of assessment and 24 hrs preceding.

M2000 Drug Regimen Review SOC/ROC

(M2000) Drug Regimen Review: Does a complete drug regimen review indicate potential clinically significant medication issues, e.g., drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance?

- 0 – Not assessed/reviewed [Go to M2010]
- 1 – No problems found during review [Go to M2010]
- 2 – Problems found during review
- NA – Patient is not taking any medications [Go to M2040]

Best Practice review includes all meds, prescribed and over the counter; administered by any route; completed in assessment time frames (SOC 5 days, ROC 2 days); required by Medicare COP 42 CFR 484.55(c).

Potentially clinically significant “problems” - Actual/ potential threat to safety and well being based on assessing clinician’s judgment. As identified in the item description.
Alert! Office-based staff may collaborate and must communicate findings to the assessor. May change M0090 assessment completed date.
M2015 Drug Education Intervention TIF/DC

(M2015) Patient/Caregiver Drug Education Intervention: Since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, drug reactions, and side effects, and how and when to report problems that may occur?

0 – No
1 – Yes
NA – Patient not taking any drugs

Captures Best Practice during quality episode (at time of or since previous assessment >TIF or DC) for general medication instruction.

Instructions include: Precautions for taking, how to monitor for side effects and adverse effects, and when, who, and how to contact health care provider.

M1860 Ambulation

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

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

M2020 Management of Oral Meds

(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 the ability, not compliance or willingness.)

0 – Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times
1 – Able to take medication(s) at the correct times if: NEW (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 NEW another person at the appropriate times
3 – Unable to take medication unless administered by another person
4 – No oral medications prescribed

Reminders by a device, chart or diary that a patient can independently manage are not considered in person assistance or “reminders” – score as independent.
M1800 Grooming

(M1800) Grooming: Current ability to tend safely to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care).

- 0 – Able to groom self unaided, with or without the use of assistive devices or adaptive methods
- 1 – Grooming utensils must be placed within reach before able to complete grooming activities
- 2 – Someone must assist the patient to groom self
- 3 – Patient depends entirely upon someone else for grooming needs

Includes gathering of supplies.

Response 2 includes standby assist and verbal cueing (in person assistance of any kind).

Majority of TASKS - If varying ability on day of assessment…level of ability to perform the majority and/or more frequently performed grooming tasks.

M1810 Ability to Dress Upper Body

(M1810) Current Ability to Dress Upper Body safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

- 0 – Able to obtain, put on, and remove clothing and shoes without assistance
- 1 – Able to dress upper body without assistance if clothing and shoes are laid out or handed to the patient
- 2 – Someone must help the patient put on upper body clothing
- 3 – Patient depends entirely upon another person to dress upper body

Includes getting clothing from storage location.

Consider upper extremity prosthetic, orthotic or other supportive devices.

Majority of Items - If varying ability on day of assessment…level of ability to manage the majority of the clothing items.

M1820 Ability to Dress Lower Body

(M1820) Current Ability to Dress Lower Body safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

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

Includes getting clothing from storage location.

Consider lower extremity prosthetic, orthotic or other supportive devices.

Majority of Items - If varying ability on day of assessment…level of ability to manage the majority of the clothing items.
M1830 Bathing

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

- 0 – Able to bathe self in shower or tub independently, including getting in and out of tub/shower
- 1 – With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower. **Ex** Responses 0 or 1: Patient must also be independent with the transfer
- 2 – Able to bathe in shower or tub with the intermittent assistance of another person: (a) for intermittent supervision or encouragement or reminders, OR (b) to get in and out of the shower to tub, OR (c) for washing difficult to reach areas. Needs intermittent assistance of another person
- 3 – Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance. Needs presence of another person.
- 4 – Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode. Responses 4 & 5 – Includes non-functional tub/shower.
- 5 – Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person throughout the bath.
- 6 – Unable to participate effectively in bathing and is bathed totally by another person: Totally Dependent.

M1840 Toilet Transferring

(M1840) Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.

- 0 – Able to get to and from the toilet and transfer independently with or without a device
- 1 – When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer
- 2 – Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance)
- 3 – Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently
- 4 – Is totally dependent on toileting

Convenience is not an ability issue.

Response 1 - Needs assistance with access to and/or transfer on/off bathroom toilet.

M1845 Toilet Hygiene

(M1845) Toilet Hygiene: Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.

- 0 – Able to get to manage toileting hygiene and clothing management without assistance
- 1 – Able to manage toileting hygiene and clothing management without assistance if supplies/implments are laid out for the patient
- 2 – Someone must help the patient to maintain toileting hygiene and/or adjust clothing
- 3 – Patient depends entirely upon another person to maintain toileting hygiene

*Assistance* = in person assistance of any kind.

Majority of TIME - If varying ability on day of assessment…level of ability more than 50% of this day of assessment.
M1880 Ability to Plan and Prepare Light Meals

Current Ability to Plan and Prepare Light Meals (e.g., cereal, sandwich) or reheat delivered meals safely:

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

Any prescribed diet requirements should be considered.

Don’t forget “compliance vs. willingness.”

With enteral feedings, exclude set up, monitoring, and changing the equipment.

M2100 Types and Sources of Assistance

SOC/ROC/DC

Types and Sources of Assistance:

Determine the level of caregiver ability and willingness to provide assistance for the following activities, if assistance is needed.

<table>
<thead>
<tr>
<th>Type of Assistance</th>
<th>No assistance needed in this area</th>
<th>Caregiver(s) currently provide assistance</th>
<th>Caregiver(s) need training to provide assistance</th>
<th>Caregiver(s) will provide assistance</th>
<th>Unclear if caregiver(s) will provide assistance</th>
<th>Assistance needed (but not described above)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervision and safety (e.g., fall or cognitive impairment)</td>
<td>Row 1 – Supervision and safety includes needs related to the ability of the patient to safely remain in the home. This category of assistance needs includes a wide range of activities that may be necessary due to cognitive, functional, or other health deficits. Such assistance may range from calls to remind the patient to take medications, to in-person visits to ensure that the home environment is safely maintained, to the need for the physical presence of another person in the home to ensure that the patient doesn’t wander, fall, or for other safety reasons (i.e., leaving the stove burner on).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Now What?

Identification of risk(s) is meant to drive active care planning that has specific focus and measureable outcomes.
M1100 Living Situation

(M1100) Patient Living Situation: Which of the following best describes the patient’s residential circumstance and availability of assistance? (Check one box only.)

<table>
<thead>
<tr>
<th>Living Arrangement</th>
<th>Availability of Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Around the clock</td>
</tr>
<tr>
<td>a. Patient lives alone</td>
<td>01</td>
</tr>
<tr>
<td>b. Patient lives with other person(s) in the home</td>
<td>06</td>
</tr>
<tr>
<td>c. Patient lives ingregate situation (e.g. assisted living)</td>
<td>11</td>
</tr>
</tbody>
</table>

Captures living situation and usual availability of “in person” assistance for ADL and IADL. If living situation has recently changed, report the usual arrangement unless the new circumstance is expected to be permanent.

Impact on the Care Plan

- Identification of issues is the starting point.
- Connecting the issue to functional areas and safety is key.
- Goals and interventions should be in the proper context.
- Documentation implications for visits.

M2250 Plan of Care Synopsis SOC/ROC

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

<table>
<thead>
<tr>
<th>Plan / Intervention</th>
<th>Yes</th>
<th>No</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings</td>
<td>☒</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>b. Physician’s orders on treatment for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>c. Falls prevention interventions</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>e. Intervention(s) to monitor and eliminate pain</td>
<td>☒</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>f. Intervention(s) to prevent pressure ulcers</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>g. Pressure ulcer treatment based on principles of moist wound healing, OR, for treatment based on moist wound healing (MWH), as requested by physician</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Captures use of Best Practice. Select “NO” and “N/A” carefully.
M2400 Intervention Synopsis TIF/DC

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

Captures best practices during quality episode.

Select "NO" and "N/A" carefully!

Plan: Interventions

1. Diabetic foot care including monitoring for the presence of blisters or the lower extremities and ulcer/change in wound status?

2. Falls prevention interventions

3. Depression interventions such as medication, referral for other treatment, or a monitoring plan for current treatment?

4. Incontinence to monitor and mitigate pain?

5. Interventions to prevent pressure ulcers

6. Pressure ulcer treatment based on principles of wound healing

Care Management-Home Care

Comprehensive Assessment

Plan of Care

Care Coordination

Home

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800 · 379 · 0361
The process for therapy CEUs varies state to state. In order to assist therapists with getting a session approved, we have provided material that can be submitted to the state licensing board. Please check with your individual state for more specific information as to the process.

**EDUCATIONAL ACTIVITY CONTENT OUTLINE**

**Title of Activity:** Fall Risk Assessment: Am I meeting M1910 Criteria?  
**Date:** May 27, 2010

**Purpose/Goal:** To provide best practice strategies in identifying fall risk assessment tools that drive interdisciplinary care delivery and dispel the idea that therapy is the only service involved in fall prevention.

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>CONTENT (Topics)</th>
<th>TIME FRAME</th>
<th>PRESENTER</th>
<th>TEACHING METHODS</th>
</tr>
</thead>
</table>
| 1.         | Discuss the impact of OASIS item M1910 on Fall Risk Assessment practices.  
Examination of the current status of a “validated” risk assessment and options agencies have been using to meet the standard. | 25 mins | Cindy Krafft MS PT, COS-C | Lecture, power point |
| 2.         | Identify tools for effective capture of fall risks.  
Explore Tinetti, Berg, Functional Reach, TUG, and areas needed to attain “multifactoral” status. | 25 mins | Cindy Krafft MS PT, COS-C | Lecture, power point |
| 3.         | Discuss an interdisciplinary approach to fall prevention to drive positive clinical outcomes.  
Utilization of OASIS data to determine contributory factors to fall risk and connect discipline teams to address. | 25 mins | Cindy Krafft MS PT, COS-C | Lecture, power point |
| 4.         | Questions and answers. | 15 mins | Cindy Krafft MS PT, COS-C | Question and Answer |