CAH Swing Bed PI/QI Benchmarking Project

Updated Training Slides
September 8, 2019

West Virginia
CRITICAL ACCESS HOSPITAL NETWORK
Association

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Topics of discussion:

1) History/Purpose/Goal
2) CAH SB Benchmarking Project (2019-2020)
3) Data Collection Tool & Coding Instructions
4) Recommended process for data collection and reporting
5) Benchmarking measures and hospital SB PI/QI reporting
6) Review of staff training material available
7) Q&A

History / Purpose / Goal

- CAH quality of care is an important Medicare policy issue that has received little attention
- Being cost-based, concern has been raised about the cost of SB care in CAHs
- SB in CAHs have not been included in national efforts to address comparability of post-acute quality measures (e.g., IMPACT Act and NQF) because of the lack of mechanism to measure quality
  - Unlike SNFs and PPS SB, CAHs do not complete the MDS
- CAHs are not uniformly demonstrating the quality of care provided to their SB patients – we have nothing to compare with the SNFs
- Being high cost and inability to demonstrate SB quality limits CAHs' ability to rightfully promote their programs and participate in alternative payment model such as bundled payments

History / Purpose / Goal

- **CAHs have no quality measures to compare with others.**
- **We must develop ways to measure the quality of care in our swing bed programs**

- Advocates such as NRHA, FORH or AHA Rural have no SB quality data to share with CMS
- Goal is to have the measures endorsed by the National Quality Forum and used by CMS when assessing the value of SBs

History / Purpose / Goal

- The belief at the Federal Level is that CAHs' care and outcomes are poorer than SNFs and at a greater cost
- We need to have quality data to discuss with referring hospitals, payors, and our own communities
- We need to have a leg up on competition!

- Why wait until its mandated?
- You work hard for good outcomes
- Should we not be asking for a system to measure and compare

History / Purpose / Goal

- In 2018, Stroudwater and Mary Guyot Consulting joined with the University of Minnesota Rural Health Research Center to create a benchmarking pilot project for CAHs with outcomes to be shared with the Federal Office of Rural Health in hopes to increase their voices with the Feds when talking about SB quality in CAH hospitals

UNIVERSITY OF MINNESOTA
RURAL HEALTH
RESEARCH CENTER

Quality Measures for CAH Swing-Bed Patients

Michelle Casey, MS, Ira Moscovice PhD, Henry Stabler MPH

University of Minnesota Rural Health Research Center

November 2017

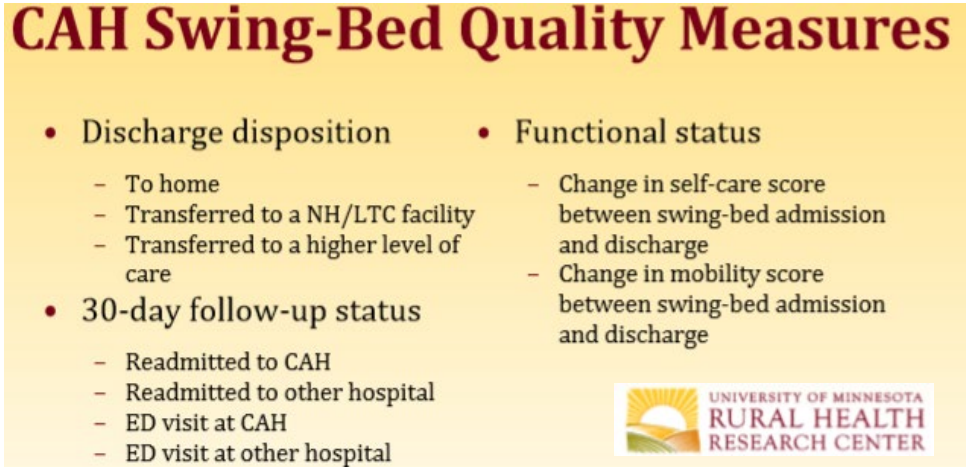
- The data for the pilot was collected from April 2018 thru March 2019 with the participation of 131 CAHs in 14 States (83 for 12 months and 48 for 6 months) – Final report to come out this Fall

- No longer a pilot project but Stroudwater is committed to continue offering the opportunity to CAH SB hospitals to participate in measuring and benchmarking data through SORHs or individual CAHs

History / Purpose / Goal

- The purpose of the pilot project was to identify quality measures that can be used to assess the quality of care provided to CAH SB patients, and implement a field test of these measures

- The goal was to benchmark the following quality measures which we did:



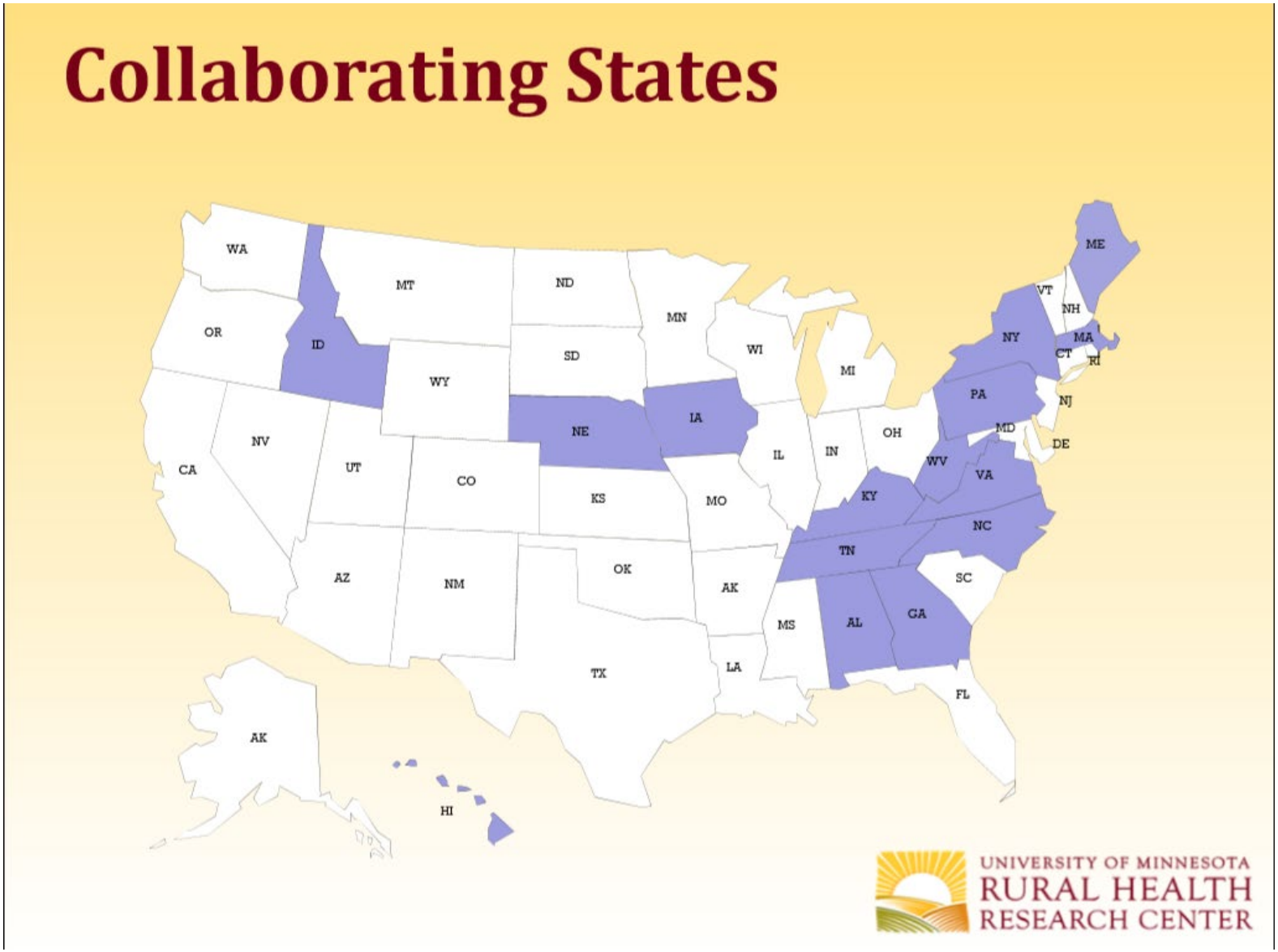
This project also benchmarks utilization total and by certain diagnosis grouping and ALOS

- With potential additional measures (based on Impact and what CMS measures for all other post-acute programs)

- Skin integrity (pressure ulcer status)
- Medication reconciliation
- Incidence of major falls
- Transfer of health information and care preferences when an individual transitions
- Healthcare associated infections

No new measures will be added until we can use same risk adjuster as CMS uses for SNFs and PPS SBs.

Participating Hospitals from States in the Pilot Project



Source: Stroudwater Swing Bed Portal 4/1/2018 to 7/8/2019

A CEO's Message as to Why Participate

So Why Participate in This Field Test?

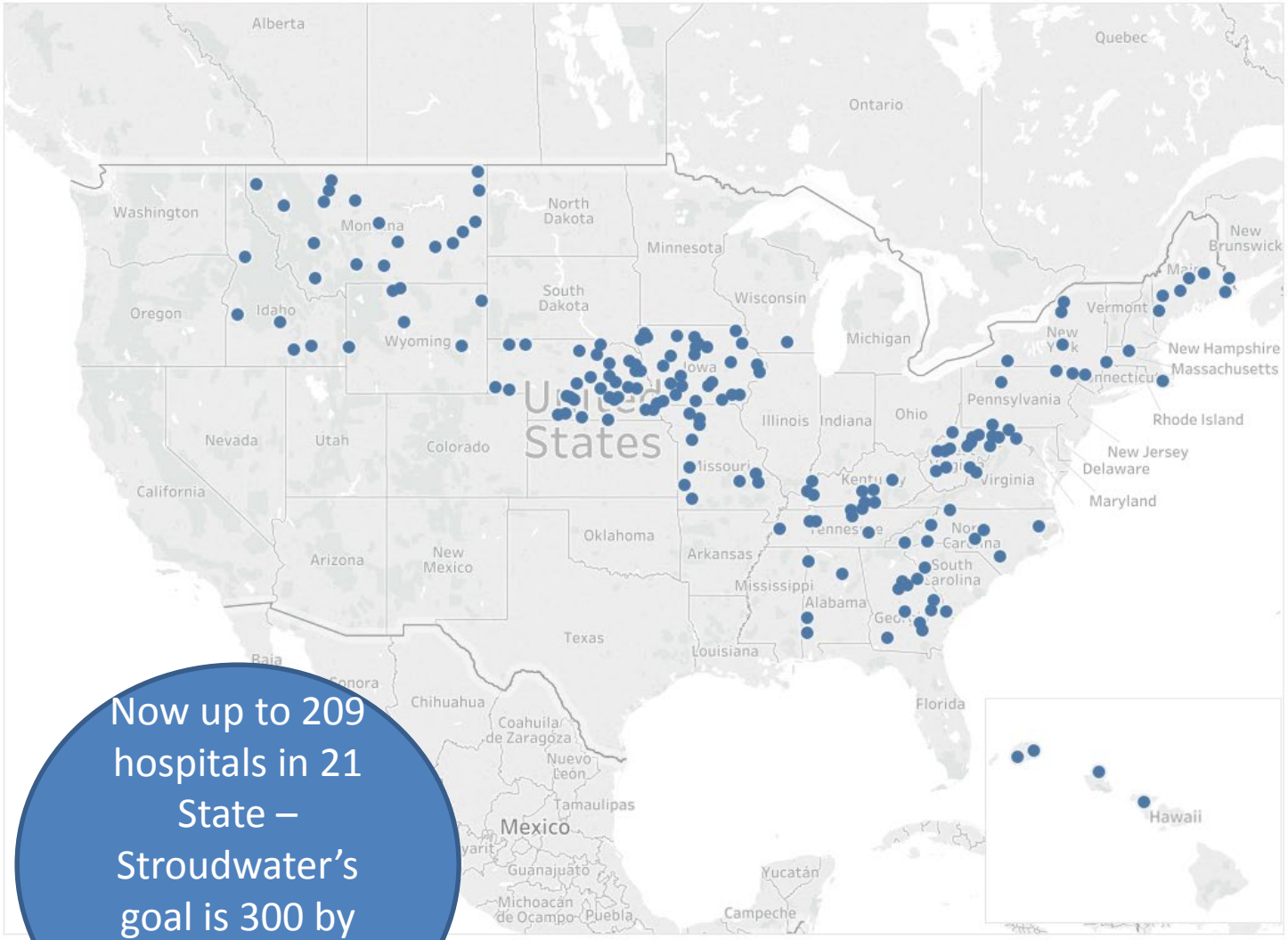
- Want timely rural-relevant data
- Want to make the best possible decisions
- Want to provide value to all stakeholders (patients, payees, partners)
- Want a successful hospital
- Want the community to thrive

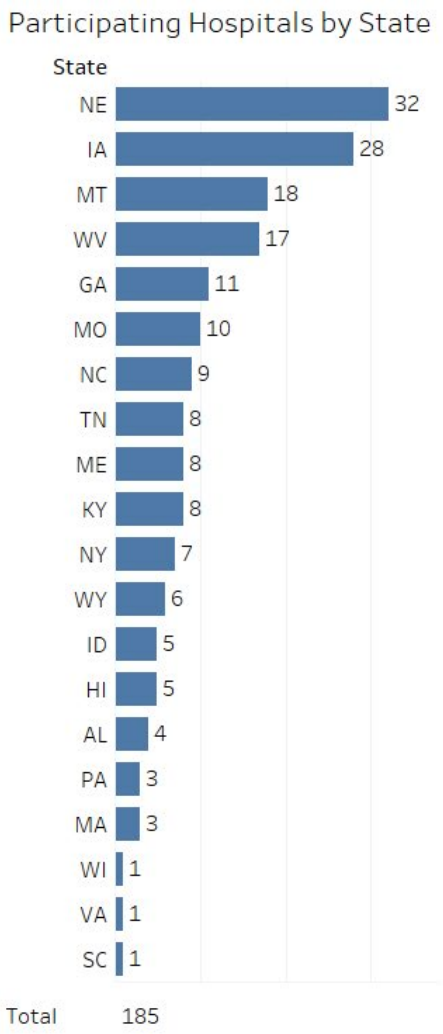
Leslie Marsh, CEO
Lexington Regional Health Center
Lexington, NE

UNIVERSITY OF MINNESOTA
RURAL HEALTH
RESEARCH CENTER

Source: Stroudwater Swing Bed Portal 4/1/2018 to 7/8/2019

Participating Hospitals as of July 2019





Now up to 209 hospitals in 21 State – Stroudwater's goal is 300 by the end of the year

Source: Stroudwater Swing Bed Portal 4/1/2018 to 7/8/2019

CAH SB Benchmarking Project (2019-2020) – No longer a Pilot

- Stroudwater continues providing the data inputting and reporting portal
- Data is no longer going to the University of Minnesota
- Mary Guyot Consulting continues to support the project as a SB/SNF expert
- CEOs must have signed a Subscription Agreement with Stroudwater Associates in order for hospitals to access the data portal
- Hospitals must identify 2-3 people (referred to as end-users) who are or will be trained by Stroudwater to enter data in their tool and pull reports for the hospital SB PI/QI. (old and new hospitals)
  - End-users must have registered with Stroudwater (special form to complete) to have access to the website for the data portal)
- WV and AL contracts with Mary Guyot Consulting to provide the hospitals clinical training, facilitate meetings, analyze and present the benchmarked data as well as discuss best practice and provide SB program education regarding utilization and quality
- Those using the portal will be notified of quarterly webinars from Stroudwater where anybody from your hospital can call in. Depending on the topic you may or may not participate since we cover a lot of the material in quarterly meetings ourselves when lessons learned are shared with you all.

CAH SB Benchmarking Project (2019-2020)

- If you are a new CAH such as Tanner Medical Center/East Alabama or the hospital is new to the project, you must participate in an IRR process with an open-book test before you start – I will work with you on this.
- AL has quarterly meetings ideally attended by the SB Coordinator, therapy, hospital PI/QI Dir., nursing rep and end-users (most often the same as one of the above positions)
- The October 2019 benchmarking kick-off will be a webinar (DTBD)
- Meetings for 2020 are from 9:00 AM to 2:30 PM on the following dates: Jan 30, April 23 & July 30 at the AlaHA Board Room
- The benchmarking data will be sent to you ahead of the meeting by Bethany Gamma to discuss with your SB team (preferably as a group) and come prepared to explain what you did to improve or what are the issues with lower scores.
- After the meeting you will be forwarded the full set of slides which includes benchmarking and continuing education
- Those present are asked to go back and share the information as well as agree on an action plan based on data or program issues which you are expected to report on during the following meeting giving you 3 months to improve

CAH SB Benchmarking Project (2019-2020)

- If you are a new CAH such as Summersville or new to the project, you have to participate in an IRR process with an open-book test before you start – I will work with you on this.
- WV has quarterly meetings ideally attended by the SB Coordinator, therapy, hospital PI/QI Dir., nursing rep and end-users (most often the same as one of the above positions)
- Meetings for 2019-2020 are from 9:00 AM to 2:30 PM on the following dates: Oct. 31, 2019 (yes, feel free to dress up for Halloween) & Jan 29, April 22 & July 29, 2020 at the Bridgeport Convention Center, Bridgeport WV
- The benchmarking data will be sent to you ahead of the meeting by Dianna Iobst to discuss with your SB team (preferably as a group) and come prepared to explain what you did to improve or what are the issues with lower scores.
- After the meeting you will be forwarded the full set of slides which includes benchmarking and continuing education
- Those present are asked to go back and share the information as well as agree on an action plan based on data or program issues which you are expected to report on during the following meeting giving you 3 months to improve

Data Collection Tool and Coding Instructions

Coding Review and Q&A (10:15 – 11:00)

Swing Bed Pilot Project Data Collection Form

Unique Patient Identifier

A1900: Swing Bed Admission Date		
Month	Day	Year
		20

A0900: Patient Date of Birth		
Month	Day	Year

Patient's residence prior to the inpatient admission that preceded swing bed stay		
Choose one		
	01. Community	
Where in community		a. Private home/apartment
		b. Board/care
		c. Assisted living
		d. Group home
	02. Nursing home/SNF	
	04. Psychiatric hospital	
	05. Inpatient rehabilitation facility	
	06. ID/DD Facility	For persons w/intellectual disability
	07. Hospice	Hospice facility or Home with hospice
	09. Long Term Care Hospital (LTCH)	
	99. Other	

1. Unique Patient Identifier as decided by hospital such as act. # or something totally different but you must have a system where you would remember how to access the info and look back at the chart if needed

2. DOB and SB Adm. Date is self-explanatory

Note:

Most likely, your SB patient will come from your or a referring hospital but the question is asking " residence prior to the Inpatient Admission that preceded the swing bed stay" CMS did change this from the MDS but we will continue asking it like this because its more relevant to our hospitals.

But, if they came to the hospital as a patient from any of those other places, then code 02 to 09 which ever applies

99 = not any of the above (ie: prison)

Payor

Expected primary payer source for swing bed stay	
Choose one	
	01. Medicare
	02. Medicare Advantage
	03. Medicaid
	04. Commercial Insurance (includes Blue Cross)
	05. Self-pay
	06. Other Such as: VA, Prison

1. Medicare = generic/general
2. Medicare Advantage such as HMO/PPO
3. Medicaid – only applies if primary (generic or managed care) – not to be used for Medicare/Medicaid – in this case you would choose Medicare
4. Commercial – all other insurance
5. Self-pay – self-explanatory
6. Other = VA, Prison etc…

The questions is: what will be the **primary payor**?

Primary Medical Condition/Reason for SB Admission

Note: PRIMARY medical condition category **documented by the provider**

Intent: The items in this section are intended to code diseases that have a direct relationship to the patient's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions is to generate an updated, accurate picture of the patient's current health status.

I0020. Primary Medical Condition: Indicate the patient's primary medical condition category included in provider's documentation

Indicate the patient's primary medical condition category that best describes the primary reason for admission

Enter Code

01. Stroke
02. Non-Traumatic Brain Dysfunction
03. Traumatic Brain Dysfunction
04. Non-Traumatic Spinal Cord Dysfunction
05. Traumatic Spinal Cord Dysfunction
06. Progressive Neurological Condition
07. Other Neurological Conditions
08. Amputation
09. Hip and Knee Replacement
10. Fractures and Other Multiple Trauma
11. Other Orthopedic Conditions
12. Debility, Cardiorespiratory Conditions
13. Medically Complex Conditions
14. Other Medical Conditions

This allows to compare utilization by groups

1. These are for grouping purpose only – we don't admit for a stroke but s/p stroke so any type of stroke and sequelae would be "01"
2. Pay attention to hip & knee replacement vs FX and other multiple trauma - Note: if the hip and knee replacement is secondary to a hip fracture, code as 10, Fractures and Other Multiple Trauma. Example include hip fracture, pelvic fracture, and fracture of tibia and fibula
3. See future slides for more specific descriptions to help you code in the correct medical condition

Primary Medical Condition/Reason for SB Admission (cont')

❖ Steps for Assessment

- Review the documentation in the medical record to identify the patient's primary medical condition associated with admission to the facility.
- Medical record sources for physician diagnoses include the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available.
- Care managers – do not be afraid to discuss with the provider if you do not have all the info you need documented - Providers to update documentation if necessary
- Do not hesitate to discuss with your coders
- Consider making a list for the provider to check off but remember that is not sufficient - documentation must support the grouping checked off with further documentation on the specific one or more conditions that got them into that grouping
- Also remember that these conditions from acute must be something that is still impacting the care in SB

❖ Coding Instructions

- Enter the code that represents the primary medical condition that resulted in the patient's admission – see next 3 slides for coding descriptions. Consider laminating this info to be used as a resource.
- If codes 1–13 do not apply, use code 14, "Other Medical Condition," and proceed. Code 14 usage should be very limited

Primary Medical Condition/Reason for SB Admission (cont')

❖ Medical Condition/Reason – Definitions

- **Code 01**, Stroke = if the patient's primary medical condition category is due to stroke. Examples include ischemic stroke, subarachnoid hemorrhage, cerebral vascular accident (CVA), and other cerebrovascular disease.

- **Code 02**, Non - Traumatic Brain Dysfunction = if the patient's primary medical condition category is non-traumatic brain dysfunction. Examples include Alzheimer's disease, dementia with or without behavioral disturbance, malignant neoplasm of brain, and anoxic brain damage.

- **Code 03**, Traumatic Brain Dysfunction = if the patient's primary medical condition category is traumatic brain dysfunction. Examples include traumatic brain injury, severe concussion, and cerebral laceration and contusion.

- **Code 04,** Non - Traumatic Spinal Cord Dysfunction = if the patient's primary medical condition category is non-traumatic spinal cord injury. Examples include spondylosis with myelopathy, transverse myelitis, spinal cord lesion due to spinal stenosis, and spinal cord lesion due to dissection of aorta.

- **Code 05**, Traumatic Spinal Cord Dysfunction = if the patient's primary medical condition category is due to traumatic spinal cord dysfunction. Examples include paraplegia and quadriplegia following trauma.

Primary Medical Condition/Reason for SB Admission (cont')

❖ Medical Condition/Reason – Definitions (cont')

- **Code 06,** Progressive Neurological Conditions = if the patient's primary medical condition category is a progressive neurological condition. Examples include multiple sclerosis and Parkinson's disease.

- **Code 07,** Other Neurological Conditions = if the patient's primary medical condition category is other neurological condition. Examples include cerebral palsy, polyneuropathy, and myasthenia gravis.

- **Code 08,** Amputation = if the patient's primary medical condition category is an amputation. An example is acquired absence of limb.

- **Code 09,** Hip and Knee Replacement = if the patient's primary medical condition category is due to a hip or knee replacement. An example is total knee replacement. If hip replacement is secondary to hip fracture, code as fracture.

- **Code 10,** Fractures and Other Multiple Trauma , if the patient's primary medical condition category is fractures and other multiple trauma. Examples include hip fracture, pelvic fracture, and fracture of tibia and fibula.

Primary Medical Condition/Reason for SB Admission (cont')

❖ Medical Condition/Reason – Definitions (cont')

- **Code 11,** Other Orthopedic Conditions = if the patient's primary medical condition category is other orthopedic condition. An example is unspecified disorders of joint.

- **Code 12**, Debility, Cardiorespiratory Conditions = if the patient's primary medical condition category is debility or a cardiorespiratory condition. Examples include chronic obstructive pulmonary disease (COPD), asthma, and other malaise and fatigue.

- **Code 13**, Medically Complex Conditions = if the patient's primary medical condition category is a medically complex condition. Examples include diabetes, pneumonia, chronic kidney disease, open wounds, pressure ulcer/injury, infection, and disorders of fluid, electrolyte, and acid-base balance.

- **Code 14**, Other Medical Condition = if the patient's primary medical condition category is not one of the listed categories.

Examples of Primary Medical Condition/Reason for SB Admission

1) **Ms. K** is a 67-year-old female with a history of Alzheimer's dementia and diabetes who is admitted after a stroke. The diagnosis of stroke, as well as the history of Alzheimer's dementia and diabetes, is documented in Ms. K's history and physical by the admitting physician.
   - **Coding:** Would be coded 01, Stroke. I0020B would be coded as I63.411 (Cerebral infarction due to embolism of the right middle cerebral artery).
   - **Rationale:** The physician's history and physical documents the diagnosis stroke as the reason for Ms. K's admission. The ICD-10 code provided in I0020B above is only an example of an appropriate code for this condition category.

2) **Mrs. E** is an 82-year-old female who was hospitalized for a hip fracture with subsequent total hip replacement and is admitted for rehabilitation. The admitting physician documents Mrs. E's primary medical condition as total hip replacement (THR) in her medical record. The hip fracture resulting in the total hip replacement is also documented in the medical record in the discharge summary from the acute care hospital.
   - **Coding:** Would be coded 10, Fractures and Other Multiple Trauma. I0020B would be coded as S72.062 (Displaced articular fracture of the head of the left femur).
   - **Rationale:** Medical record documentation demonstrates that Mrs. E had a total hip replacement due to a hip fracture and required rehabilitation. Because she was admitted for rehabilitation as a result of the hip fracture and total hip replacement, Mrs. E's primary medical condition category is 10, Fractures and Other Multiple Trauma. The ICD-10 code provided in I0020B above is only an example of an appropriate code for this condition category.

Examples of Primary Medical Condition/Reason for SB Admission

3) **Mrs. H** is a 78-year-old female with a history of hypertension and a hip replacement 2 years ago. She was admitted to an extended hospitalization for pancreatitis. She had a central line placed during the hospitalization so she could receive TPN (total parenteral nutrition). She also received regular blood glucose monitoring and treatment with insulin when she became hyperglycemic. During her SNF stay, she is being transitioned from being NPO (nothing by mouth) and receiving her nutrition parenterally to being able to tolerate oral nutrition. The hospital discharge diagnoses of pancreatitis, hypertension, and malnutrition were incorporated into Mrs. H's SNF medical record.
   - **Coding:** Would be coded 13, Medically Complex Conditions would be coded as K85.00 (Idiopathic acute pancreatitis without necrosis or infection).
   - **Rationale:** Mrs. H had hospital care for pancreatitis immediately prior to her SNF stay. Her principal diagnosis of pancreatitis was included in the summary from the hospital. The surgical placement of her central line does not change her care to a surgical category because it is not considered to be a major surgery.

Prior Surgery within the last 100 Days

J2000. Prior Surgery: Indicate if patient has had prior surgery (inpatient)	
Enter Code ☐	Did the patient have major surgery during the **100 days prior to admission?** 0. **No** 1. **Yes** 8. **Unknown**

CMS had clarified Criteria for major surgery in the MDS instructions as follows: – must meet all 3:

1. patient was an inpatient in an acute care hospital for at least one day in the 100 days prior to admission to the skilled nursing facility (SNF) (Note – if patient had hip replacement as a SDS (more frequent now) then for some reason had to be admitted soon thereafter for 3 days – we would consider this as meeting the criteria for major surgery

2. patient had general anesthesia during the procedure, and

3. Surgery carried some degree of risk to the patient's life or the potential for severe disability

Prior Functioning – Before Hospital Admission

Risk Adjustment Elements: Prior Functioning

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 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 a 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

Record the patient's usual ability to perform self-care, indoor mobility (ambulation), stairs, and functional cognition prior to the current illness, exacerbation, or injury.

a. (3) - Independent – **NO Assistance** from a helper
b. (2) Needed **some help** – self-explanatory
c. (1) Dependent – **a helper is a must**
d. (8) Unknown – **only to be used if** the patient cannot say and there are no family/friends… who can inform us and the medical record does not have the information
e. **Not applicable** – one would expect that you would have a code 1, 2 or 3 for (A) self-care because that is a must but feasible that you would have N/A for ambulation and stairs if the patient does not do that. Same goes for functional cognition – so, If the patient was unable to do the everyday activity prior to admission to acute, code as 9, Not Applicable

Prior Device Use – Before Hospital Admission

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 and/or scooter
☐	C. Mechanical lift — Any mechanical, sit-to-stand, stand assist, full body lifts , chair lift, stair chair
☐	D. Walker — Any type – does not include canes
☐	E. Orthotics/Prosthetics
☐	Z. None of the above

Note: Devices & aids that the patient used **prior to being admitted** to acute for the current illness/medical condition

If patient was not using a device prior to hospitalization but was given a walker or w/c during the acute stay for his/her ambulation – the answer would be “Z” none of the above

If the patient was using a walking cane, then check “Z” – none of the above

Unhealed Pressure Ulcer/Injury

M0210. Patient had one or more unhealed pressure ulcers/injuries at swing-bed admission	
☐	0. No (Skip to next section)
	1. Yes (Answer question below)
⬇	**M0300: Number of pressure ulcers/injuries**
☐	One or more Stage 1 pressure ulcers/injuries
☐	One or more Stage 2 pressure ulcers/injuries
☐	One or more Stage 3 pressure ulcers/injuries
☐	One or more Stage 4 pressure ulcers/injuries
☐	One or more unstageable pressure ulcers/injuries due to non-removable dressing, slough and/or eschar, or deep tissue injury

Reference from MDS the manual

- Stage 1 and deep tissue injuries are called “pressure injuries because wounds are closed”
- Stage 2, 3, or 4 or unstageable due to slough or eschar are termed “pressure ulcers” since they are usually open wounds
- Unstageable due to non-removable dressing or device use “pressure ulcer/injury” since could be open or closed

Note: all refers to deep tissue injury so a skin tear would not constitute a pressure ulcer/injury

Understand/Understood

B0700. Makes self understood: Ability of patient to express ideas and wants, consider both verbal and non-verbal expression	
Choose one	
☐	0. Understood
	1. Usually understood - difficulty communicating some words or thoughts but is able if prompted or given time
	2. Sometimes understood - ability is limited to making concrete requests
	3. Rarely/never understood
B0800. Ability to understand others: Ability of patient in understanding verbal content	
Choose one	
☐	0. Understands
	1. Usually understands - misses some part/intent of message but comprehends most
	2. Sometimes understands - responds adequately to simple, direct communication only
	3. Rarely/never understands

which includes writing, pointing, sign language, and cue cards.

Note: clearly read the definitions – this is not assessing speaking, language or hearing – for instance, the patient does not have to be able to speak everything to be understood or usually understood if they can sign or point and/or write or need a translator.

Falls

J1700. History of Falls: Did the patient have a fall anytime in the six (6) months prior to admission?	
Choose one	
☐	1. Yes
	0. No

Falls could have occurred at home, community, NH, etc or while an IP in acute.

DEFINITION

FALL

Unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground. Falls include any fall, no matter whether it occurred at home, while out in the community, in an acute hospital or a nursing home. Falls are not a result of an overwhelming external force (e.g., a resident pushes another resident).

An intercepted fall occurs when the resident would have fallen if he or she had not caught him/herself or had not been intercepted by another person – this is still considered a fall.

CMS understands that challenging a resident'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.

Have we updated our "Fall description" to reflect CMS' definition

Cognitive

- **Note**: BIMS (Brief Interview for Mental Status) should be attempted on all patients except those who are never/rarely understood
  - Staff must follow instructions exactly as on the tool reflects to administer BIMS
  - **Skip to Memory/Recall only if** patient cannot do BIMS
  - **Memory/Recall section is skipped if** BIMS was administered

Brief Interview for Mental Status (BIMS)

C0100. Should Brief Interview for Mental Status be Conducted? Attempt to conduct interview with all patients

Enter code ☐

0. **No** (patient is rarely/never understood). **Go to Memory/Recall Ability section below**
1. **Yes**, continue to Repetition of Three Words below

C0200. Repetition of Three Words

Enter code ☐

Ask patient: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: **sock, blue,** and **bed**. Now tell me the three words."*

Number of words repeated after first attempt

0. **None**
1. **One**
2. **Two**
3. **Three**

After the patient's first attempt, repeat the words using cues *("sock, something to wear; blue, a color; bed, a piece of furniture")*. You may repeat the words up to two more times.

C0300. Temporal Orientation (orientation to year, month, and day)

Enter code ☐

Ask patient: *"Please tell me what year it is right now."*

A. Able to report correct year

0. **Missed by >5 years** or no answer
1. **Missed by 2-5 years**
2. **Missed by 1 year**
3. **Correct**

Enter code ☐

Ask patient: *"What month are we in right now."*

B. Able to report correct month

0. **Missed by >1 month** or no answer
1. **Missed by 6 days to 1 month**
2. **Accurate within 5 days**

Enter code ☐

Ask patient: *"What day of the week is today?"*

C. Able to report correct day of the week

0. **Incorrect** or no answer
1. **Correct**

C0400. Recall

Enter code ☐

Ask patient: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"* If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

A. Able to recall "sock"

0. **No** - could not recall
1. **Yes, after cueing** ("something to wear")
2. **Yes, no cue required**

Enter code ☐

B. Able to recall "blue"

0. **No** - could not recall
1. **Yes, after cueing** ("a color")
2. **Yes, no cue required**

Enter code ☐

C. Able to recall "bed"

0. **No** - could not recall
1. **Yes, after cueing** ("a piece of furniture")
2. **Yes, no cue required**

Enter code ☐☐

C0500. What was the patient's BIMS Summary Score from questions above?

Values should be 00 to 15

Cognitive (cont')

C0100: Should Brief Interview for Mental Status Be Conducted?

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?
Attempt to conduct interview with all residents

Enter Code ☐

0. **No** (resident is rarely/never understood) → Skip to and complete C0700-C1000, Staff Assessment for Mental Status
1. **Yes** → Continue to C0200, Repetition of Three Words

- The items in this section are intended to determine the patient's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions.
- This information identifies if the interview will be attempted.
- Most patients are able to attempt the Brief Interview for Mental Status (BIMS).
- A structured cognitive test is more accurate and reliable than observation alone for observing cognitive performance.
- Without an attempted structured cognitive interview, a patient might be mislabeled based on his or her appearance or assumed diagnosis.
- Structured interviews will efficiently provide insight into the patient's current condition that will enhance good care.

Cognitive (cont')

- **Steps for Assessment**

1) Who ever does the BIMS assessment MUST be trained whether it is the D/C planner, SLP or patient's nurse

2) Interact with the patient using his or her preferred language. Be sure he or she can hear you and/or has access to his or her preferred method for communication. If the patient appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards.

3) Determine if the patient needs or wants an interpreter. • If so, complete the interview with an interpreter.

4) Determine if the patient is rarely/never understood verbally, in writing, or using another method. If rarely/never understood, skip to C0900 – Memory / Recall

5) **Coding Tips** • Attempt to conduct the interview with ALL patients. This interview is preferably conducted after at least a few days in SB to make sure it does not reflect remnants of the IP acute stay affected by the recent surgery or the transfer which is most likely short term.

Cognitive (cont')

C0200-C0500: Brief Interview for Mental Status (BIMS)

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Enter Code ☐

Ask resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed.*** *Now tell me the three words."*

Number of words repeated after first attempt

0. **None**
1. **One**
2. **Two**
3. **Three**

After the resident's first attempt, repeat the words using cues ("*sock, something to wear; blue, a color; bed, a piece of furniture*"). You may repeat the words up to two more times.

C0300. Temporal Orientation (orientation to year, month, and day)

Enter Code ☐

Ask resident: "*Please tell me what year it is right now.*"

A. Able to report correct year

0. **Missed by > 5 years or no answer**
1. **Missed by 2-5 years**
2. **Missed by 1 year**
3. **Correct**

Enter Code ☐

Ask resident: "*What month are we in right now?*"

B. Able to report correct month

0. **Missed by > 1 month** or no answer
1. **Missed by 6 days to 1 month**
2. **Accurate within 5 days**

Enter Code ☐

Ask resident: "*What day of the week is today?*"

C. Able to report correct day of the week

0. **Incorrect** or no answer
1. **Correct**

DEFINITION

CATEGORY CUE

Phrase that puts a word in context to help with learning and to serve as a hint that helps prompt the resident. The category cue for sock is "something to wear." The category cue for blue is "a color." For bed, the category cue is "a piece of furniture."

- The items in this section are intended to determine the patient's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions.

Cognitive (cont')

- **Steps for BIMS Assessment – MUST BE FOLLOWED**

1) Ask the patient each of the 3 questions in Item C0300 separately.

2) Say to the patient: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed." Interviewers need to use the words and related category cues as indicated. If the interview is being conducted with an interpreter present, the interpreter should use the equivalent words and similar, relevant prompts for category cues.

3) Immediately after presenting the three words, say to the patient: "Now please tell me the three words." - If the patient specifically asks for clues, respond by saying, "I need to know if you can answer this question without any help from me."

4) After the patient's first attempt to repeat the items:
   - If the patient correctly stated all three words, say, "That's right, the words are sock, something to wear; blue, a color; and bed, a piece of furniture" [category cues].
     - Category cues serve as a hint that helps prompt patients' recall ability. Putting words in context stimulates learning and fosters memory of the words that patients will be asked to recall in item C0400, even among patients able to repeat the words immediately.
   - If the patient recalled two or fewer words, say to the patient: "Let me say the three words again. They are sock, something to wear; blue, a color; and bed, a piece of furniture. Now tell me the three words." If the patient still does not recall all three words correctly, you may repeat the words and category cues one more time.
   - If the patient does not repeat all three words after three attempts, re-assess ability to hear. If the patient can hear, move on to the next question. If he or she is unable to hear, attempt to maximize hearing (alter environment, use hearing amplifier) before proceeding

Cognitive (cont')

C0300. Temporal Orientation (orientation to year, month, and day)

Enter Code ☐

Ask resident: "*Please tell me what year it is right now.*"

A. Able to report correct year

0. **Missed by > 5 years** or no answer
1. **Missed by 2-5 years**
2. **Missed by 1 year**
3. **Correct**

Enter Code ☐

Ask resident: "*What month are we in right now?*"

B. Able to report correct month

0. **Missed by > 1 month** or no answer
1. **Missed by 6 days to 1 month**
2. **Accurate within 5 days**

Enter Code ☐

Ask resident: "*What day of the week is today?*"

C. Able to report correct day of the week

0. **Incorrect** or no answer
1. **Correct**

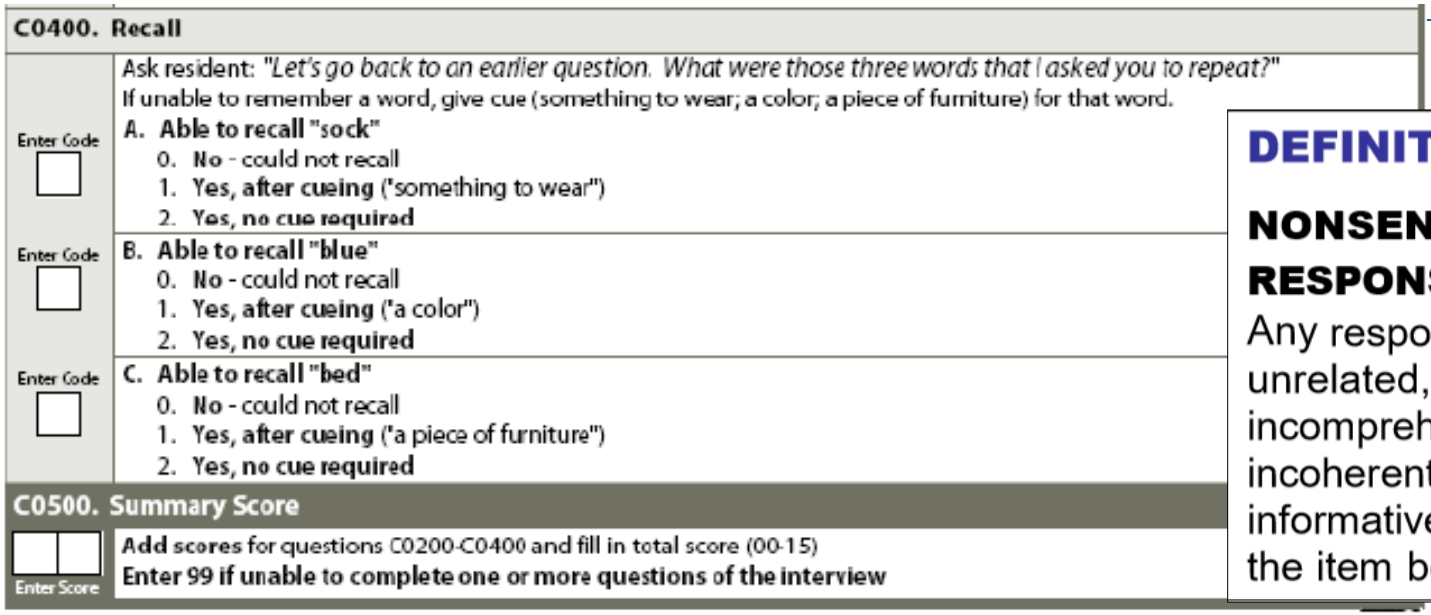
DEFINITION

TEMPORAL ORIENTATION

In general, the ability to place oneself in correct time. For the BIMS, it is the ability to indicate the correct date in current surroundings.

1. Ask the patient each of the 3 questions in Item C0300 separately.
2. Allow the patient up to 30 seconds for each answer and do not provide clues.
3. If the patient specifically asks for clues (e.g., "is it bingo day?") respond by saying, "I need to know if you can answer this question without any help from me."
4. Use Flash Cards from the tool kit as necessary

Cognitive (cont')



C0400. Recall

Ask resident: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"*
If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

Enter Code

A. **Able to recall "sock"**
0. **No** - could not recall
1. **Yes, after cueing** ("something to wear")
2. **Yes, no cue required**

Enter Code

B. **Able to recall "blue"**
0. **No** - could not recall
1. **Yes, after cueing** ("a color")
2. **Yes, no cue required**

Enter Code

C. **Able to recall "bed"**
0. **No** - could not recall
1. **Yes, after cueing** ("a piece of furniture")
2. **Yes, no cue required**

C0500. Summary Score

Enter Score

Add scores for questions C0200-C0400 and fill in total score (00-15)
Enter 99 if unable to complete one or more questions of the interview

DEFINITION

NONSENSICAL RESPONSE

Any response that is unrelated, incomprehensible, or incoherent; it is not informative with respect to the item being rated.

1. Ask the patient the following: "Let's go back to an earlier question. What were those three words that I asked you to repeat?"
2. Allow up to 5 seconds for spontaneous recall of each word.
3. For any word that is not correctly recalled after 5 seconds, provide a category cue. Category cues should be used only after the patient is unable to recall one or more of the three words.
4. Allow up to 5 seconds after category cueing for each missed word to be recalled.
5. If on the first try (without cueing), the patient names multiple items in a category, one of which is correct, they should be coded as correct for that item.
6. If, however, the interviewer gives the patient the cue and the patient then names multiple items in that category, the item is coded as could not recall, even if the correct item was in the list.

Cognitive (cont')

C0900. Memory/Recall Ability: please complete the below. Check all that patient is able to recall correctly if not able to perform BIMS.			
☐	Current season	☐	That he or she is in a hospital swing bed
☐	Location of own room	☐	None of the above were recalled
☐	Staff names and faces		

Steps for Assessment

1. This section is completed only if the patient was not able to take the BIMS test
2. Ask the patient about each item. For example,
   - "What is the current season? Is it fall, winter, spring, or summer?"
   - "What is the name of this place?"
   - If the patient is not in his or her room, ask, "Will you show me to your room?" Observe the patient's ability to find the way.
3. For patients with limited communication skills, in order to determine the most representative level of function, ask direct care staff across all shifts and family or significant other about recall ability.
4. Ask whether the patient gave indications of recalling these subjects or recognizing them during the look-back period.
5. Observations should be made by staff across all shifts and departments and others with close contact with the patient.
6. Review the medical record for indications of the patient's recall of these subjects during the look-back period

Cognitive (cont')

Coding Instructions for Memory/Recall

1. For each item that the patient recalls, check the corresponding answer box. If the patient recalls none, check none of above.

2. Check current season: if patient is able to identify the current season (e.g., correctly refers to weather for the time of year, legal holidays, religious celebrations, etc.).

3. Check location of own room: if patient is able to locate and recognize own room. It is not necessary for the patient to know the room number, but he or she should be able to find the way to the room.

4. Check staff names and faces: if patient is able to distinguish staff members from family members, strangers, visitors, and other patients. It is not necessary for the patient to know the staff member's name, but he or she should recognize that the person is a staff member and not the patient's son or daughter, etc.

5. Check that he or she is in a hospital swing bed: if patient is able to determine that he or she is currently at the hospital for something describe as rehab, a bed at the hospital to work on getting better before going home etc.. , in skilled care, in a swing bed etc..

6. Check none of above was recalled if that is the case

Urinary/Bowel Incontinence – TPN/Tube Feeding

H0300. Urinary Continence	
Choose one	
☐	0. Always Continent
	1. Occasionally incontinent
	2. Frequently incontinent
	3. Always incontinent
	9. Not rated, pt had catheter, ostomy, or no urine output

H0400. Bowel Continence	
Choose one	
☐	0. Always Continent
	1. Occasionally incontinent
	2. Frequently incontinent
	3. Always incontinent
	9. Not rated, pt had ostomy or did not have bowel movement

K0510A. Total parenteral nutrition	
Choose one	
☐	1. Yes
	0. No

K0150B. Tube Feeding	
Choose one	
☐	1. Yes
	0. No

Note:

1. Urinary/Bowel section may need all 3 days to assess – may not be able to determine in 1 or 2 days.

2. TPN and Tube feeding only applies if present or initiated during the SB stay – not to be counted if discontinued before SB admission

Comorbidities

Comorbidities: Indicate the patient's comorbidities included in provider's documentation	
Check all that apply	
☐	**Major infections:** Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock; and Other Infectious Diseases
☐	**Metastatic Cancer** and **Acute Leukemia**
☐	**Diabetes:** Diabetes with Chronic Complications; Diabetes without Complication; Type I Diabetes Mellitus
☐	**Other Significant Endocrine and Metabolic Disorders**
☐	**Delirium and Encephalopathy**
☐	**Dementia:** Dementia with Complications; Dementia without Complications
☐	**Tetraplegia** (excluding complete tetraplegia) and **Paraplegia**
☐	**Multiple Sclerosis**
☐	**Parkinson's** and **Huntington's Diseases**
☐	**Angina Pectoris**
☐	**Coronary Atherosclerosis/Other Chronic Ischemic Heart Disease**
☐	**Hemiplegia, Other Late Effects of Cerebrovascular Accident:** Hemiplegia/Hemiparesis; Late Effects of Cerebrovascular Disease, Except Paralysis
☐	**Dialysis Status and Chronic Kidney Disease - Stage 5**
☐	**Urinary Obstruction and Retention**
☐	**Amputations:** Traumatic Amputations and Complications; Amputation Status, Lower Limb/Amputation Complications; Amputation Status, Upper Limb

Note:

1. Comorbidities documented by the provider in H&P or progress notes

2. **Must be active** – hx of if not impacting the treatment plan is not to be checked off

3. Ok to discuss with the provider if obvious comorbidity but provider did not document

Exceptions to Full Assessment

- **Self Care & Mobility Data** will be completed for all payors minus the following **exceptions:**

If any of the following apply, skip to Discharge and 30-day Follow-Up	
Check all that Apply	
☐	Died while in Swing Bed
☐	Left the swing bed program against medical advice
☐	Discharged to hospice care — Regardless of hospice facility, unit, bed, home with hospice
☐	Unexpectedly discharged to a short-stay acute hospital/CAH
☐	Length of stay of less than 3 days
☐	Independent with all self-care activities at the time of admission
☐	Patient with any of the following medical conditions: coma/persistent vegetative state; complete tetraplegia; locked-in syndrome; severe anoxic brain damage, cerebral edema, or compression of brain
☐	Younger than 21 years old
☐	Not receiving Physical Therapy or Occupational Therapy

If none of the above applies then complete the self care & mobility assessments

Still an exception if receiving PT for wound debridement only!

Function/Mobility Sections

1. Admission assessment must be completed within 3 calendar days of admission (including day of admission)

2. Coding on admission should reflect the person's baseline admission functional status and is based on a clinical assessment.

3. The admission functional assessment, when possible, should be conducted **prior to the person benefitting from treatment** interventions in order to determine a true baseline functional status on admission.

4. Treatment should not be withheld in order to conduct the functional assessment.

5. Activities may be completed **with (if they usually use a device or safer attempted with a device) or without assistive device(s)**. Coding is not based on devices.

6. Patients with cognitive impairments/limitations may need physical and/or verbal assistance when completing an activity. Code based on the patient's need for assistance to perform the activity safely (for example, choking risk due to rate of eating, amount of food placed into mouth, risk of falling). These are at the very lease not independent – will be coded a 5 (supervision/set up) or lower

Function/Mobility Sections

7. If the patient performs the activity more than once during the assessment period and the **patient's performance varies**, **coding should be based on the patient's "usual performance," which is identified as the patient's usual activity/performance for any of the Self-Care or Mobility activities, not the most independent or dependent performance over the assessment period.**

8. A provider may need to use the entire 3-day assessment period to obtain the patient's usual performance for all measures ie: patient too tired to complete the assessment on day 1 or weather is bad, and you do not have a car simulator…

9. Assess the patient's self-care status based on:
   - direct observation,
   - the patient's self-report,
   - family reports, and
   - direct care staff reports documented in the patient's medical record during the assessment period

10. CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the patient during the three-day assessment period
    - CMS defines "Qualified Clinician" as Healthcare professionals practicing within their scope of practice and consistent with Federal, State, local law and regulations"

Function/Mobility Sections (cont')

11. This should not be a therapy only assessment – should be what the patient's usual performance is since admission on all shifts – not just what they did with therapy

12. Ideally this is a stand-up meeting the day after all admission assessments have been completed - with SB Coordinator, nursing and therapy rep that know the patients at which time each item is discussed, and levels agreed to. Night shift should include patient's functional status at the morning report to get the full picture

13. Read the description of the items to be coded very carefully – do not read into it more than its asking (see later examples) **– Must be able to perform all aspects of the described items to be considered Independent.**

14. Carefully read the coding key descriptions and choose what best fits the patient – always look at the descriptions before and after the one you think it is to make sure you have the correct one

15. All assessment items must be attempted to be coded – otherwise a reason for no attempt must be coded (see slides on "Exceptions")

16. See attachments for Coding Examples, Probing Question Examples etc…

Basic CMS Guidelines to Coding Function & Mobility

- When coding the patient's usual performance, **"effort"** refers to the type and amount of assistance the helper provides in order for the activity to be completed. The 6-point rating scale definitions include the following types of assistance: setup/cleanup, touching assistance, verbal cueing, and lifting assistance.

- **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**

Basic CMS Guidelines to Coding Function & Mobility

- **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

Self Care & Mobility Items To Be Coded

☐☐	**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 is 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 the 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 Tips

❑ Coding Tips for – Eating

- Assesses eating and drinking by mouth only
- Assistance with tube feedings or TPN is not considered when coding Eating.
- If the patient does not eat or drink by mouth and relies solely on nutrition and liquids through tube feedings or TPN because of a new (recent-onset) medical condition but with plans to D/C at a point, code as 88, Not attempted due to medical condition or safety concerns.
- If the patient did not eat or drink by mouth prior to the current illness, injury, or exacerbation, code eating as 09, Not applicable
- For patients who have a combination of oral and tube feeding, eating should be coded on the amount of assistance the patient requires to eat and drink by mouth
- If the patient eats finger foods with his or her hands, code based upon the amount of assistance provided

Coding Tips

❑ Coding Tips for – Toileting Hygiene

- This item pertains to both voiding and/or having a bowel movement
- Toileting hygiene includes managing undergarments, clothing, and incontinence products and performing perineal cleansing before and after voiding or having a bowel movement.
- Hygiene tasks can take place before and after use of the toilet, commode, bedpan, or urinal
- If the patient does not usually use undergarments, then assess the patient's need for assistance to manage lower-body clothing and perineal hygiene.
- If the patient has indwelling catheter and has bowel movements, code the toileting hygiene based on the assistance needed by the patient when moving his or her bowels
- If the patient completes a bladder or bowel in bed, code Toileting hygiene based on the patient's need for assistance in managing clothing and perineal cleansing.

Coding Tips

❑ Coding Tips for – Shower/Bath Self

- Assessment can take place in a shower or bath, at a sink, or at the bedside (i.e., full body sponge bath)
- Shower/bathe self includes the ability to wash, rinse, and dry the face, upper and lower body, perineal area, and feet. Do not include washing, rinsing, and drying the patient's back or hair.
- Shower/bathe self does not include transferring in/out of a tub/shower.
- If the patient bathes himself or herself and a helper sets up materials for bathing/showering, then code as 05, Setup or clean-up assistance.
- If the patient cannot bathe his or her entire body because of a medical condition, then code Shower/bathe self based on the amount of assistance needed to complete the activity

Coding Tips

❑ Coding Tips for – Upper & Lower Body Dressing

- The following items are considered a piece of clothing when coding the dressing items:
  - **Other upper body dressing examples**: thoracic-lumbar-sacrum orthosis (TLSO), abdominal binder, back brace, stump sock/shrinker, upper body support device, neck support, hand or arm prosthetic/orthotic.

  - **Other lower body dressing examples**: knee brace, elastic bandage, stump sock/shrinker, lower-limb prosthesis. o Footwear examples: ankle-foot orthosis (AFO), elastic bandages, foot orthotics, orthopedic walking boots, compression stockings (considered footwear because of dressing don/doff over foot).

Coding Tips

❑ Coding Tips for – Upper Body Dressing

- Includes bra, undershirt, button-down shirt, pullover shirt, dresses, sweatshirt, sweater, nightgown **(NOT hospital gown),** and pajama top
- If the patient dresses himself or herself and a helper retrieves or puts away the patient's clothing, then code 05, Setup or clean-up assistance.
- Helper assistance with buttons and/or fasteners is considered touching assistance = 04
- For both upper & lower - If donning and doffing an elastic bandage, elastic stockings, or an orthosis or prosthesis occurs while the patient is dressing/undressing, then count the elastic bandage/elastic stocking/orthotic/prosthesis as a piece of clothing when determining the amount of assistance the patient needs when coding the dressing item.

Coding Tips

❑ Coding Tips for – Lower Body Dressing

- Helper assistance with buttons and/or fasteners is considered touching assistance = 04
- Includes underwear, incontinence brief, slacks, short, capri pants, pajama bottoms, and skirts
    - Other examples: knee brace, elastic bandage, stump sock/shrinker, lower-limb prosthesis

Coding Tips

❑ Coding Tips - Putting on/taking off Footwear

- Includes socks, shoes, boots, and running shoes
  - Other examples: ankle-foot orthosis (AFO), elastic bandages, foot orthotics, orthopedic walking shoes, compression stocking (on and off over foot) – Amputees may not have footwear as shoe attached

- **For patients with bilateral lower extremity amputations** with or without use of prostheses, the activity of putting on/taking off footwear may not occur. For example, the socks and shoes may be attached to the prosthesis associated with the upper or lower leg.
  - If the patient performed the activity of putting on/taking off footwear immediately prior to the current illness, exacerbation, or injury, code as 88, Not attempted due to medical condition or safety concerns.
  - If the patient did not perform the activity of putting on/taking off footwear immediately prior to the current illness, exacerbation, or injury because the patient had bilateral lower-extremity amputations and the activity of putting on/taking off footwear was not performed during the assessment period, code as 09, Not applicable

- **For patients with a single lower extremity amputation** with or without use of a prosthesis, the activity of putting on/taking off footwear could apply to the intact limb or both the limb with the prosthesis and the intact limb.
  - If the patient performed the activity of putting on/taking off footwear for the intact limb only, then code based upon the amount of assistance needed to complete the activity.
  - If the patient performed the activity of putting on/taking off footwear for both the intact limb and the prosthetic limb, then code based upon the amount of assistance needed to complete the activity.

Self Care & Mobility Items To Be Coded (cont')

Admission 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 the 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 the 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
	J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns
	K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space

Lying flat on bed normal for that pt.

Flat on floor or on stool if bed cannot be adjusted

Coding Tips

Coding Tips for – Rolling Left and Right

- Patient demonstrates being able to lie on back and turn left, return to back and turn to right then return to the back – must be able to do both w/out assistance – if he can do 1 side but not the other, level at how much assistance did you have to give.
- If can go one side but not the other due to pain or tubes etc then put 88

Coding Tips for – Sitting to Lying Flat

- Lying Flat = to what is usual for that patient – if they need bed up at 30 % due to breathing issues then that is "their flat"

Coding Tips for - Lying to Sitting on Side of Bed

- Lying to sitting on side of bed, indicates that the patient transitions from lying on his/her back to sitting on the side of the bed with feet flat on the floor and sitting upright on the bed without back support.
- The clinician is to assess the patient's ability to perform each of the tasks within this activity and determine how much support the patient requires to complete the activity.
- Clinical judgment should be used to determine what is considered a "lying" position for that patient.
- If the patient's feet do not reach the floor upon lying to sitting, the clinician will determine if a bed height adjustment or a foot stool is required to accommodate foot placement on the floor/footstool.
- Back support refers to an object or person providing support of the patient's back.

Coding Tips (cont')

❑ Coding Tips for – Chair/Bed-to-Chair

- Chair/bed-to-chair transfer, begins with the patient sitting in a chair or wheelchair or sitting upright at the edge of the bed and returning to sitting in a chair or wheelchair or sitting upright at the edge of the bed.

- The activities of "Sit to lying" and "Lying to sitting" on the side of the bed are two separate activities that are not assessed as part of "Chair/Bed-to-Chair"

- 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 by holding the railing etc….

Coding Tips (cont')

❑ Coding Tips for Car Transfers

- The Car transfer item includes the patient's ability to transfer in and out of the passenger seat of a car or car simulator.

- For item regarding car transfer, use of an indoor car can be used to simulate outdoor car transfers.
    - These half or full cars would need to have similar physical features of a real car for the purpose of simulating a car transfer, that is, a car seat within a car cabin.

- The Car transfer item does not include transfers into the driver's seat, opening/closing the car door, fastening/unfastening the seat belt.

- In the event of inclement weather or if an indoor car simulator or outdoor car is not available during the entire 3-day assessment period, then use code 10, Not attempted due to environmental limitations.

- 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, code 09, Not applicable. But, if the patient could get in and out of a car prior to the hospitalization but unsafe to try now due to mobility limitation, then cade "88" - unsafe

Items To Be Coded (cont')

❑ Coding Tips for Walking

- Walking activities do not need to occur during one session.
- Allowing a patient to rest between activities or completing activities at different times during the day or on different days may facilitate completion of the activities.
- When coding walking items, do not consider the patient's mobility performance when using parallel bars.
  - Parallel bars are not a portable assistive device.
- If safe, assess and code walking using a portable walking device when needed.
- The turns are 90-degree turns.
  - The turns 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 left and one 90-degree turn to the right).
  - The 90-degree turn should occur at the person's ability level and can include use of an assistive device (for example, cane).

Coding Tips

- **Walk 10 feet**: Once standing, the ability to walk at least **10 feet in a room, corridor, or similar space**
  - **Note:** Does the patient walk? Mr. Z currently does not walk, but a walking goal is clinically indicated.
  - Coding: 88 due to clinically unsafe on admission
  - But it would be 09 N/A if he did not walk prior to his acute admission stay. Same goes to walking 50 ft and 150 ft.

- If unsafe to walk 10 ft. on admission (88) then code the same for 50 ft with 2 turns and 150 ft.

- If able to walk 10 ft then attempt 50 ft to code unless its clear that 10 ft is the max to be walked safely and put 88 for the next 2 levels

- **Walk 50 feet with two turns**: Once standing, the ability to walk a total of at least 50 feet (1 way or go and return) and make two turns (left and right or 2 lefts and 2 rights)

- **Walk 150 feet**: Once standing, the ability to walk at least 150 feet in a corridor or similar space (again 1 way or go and return)

Coding Tips (cont')

☐☐	**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 See note below
☐☐	**M. 1 step (curb):** The ability to go up and down a curb and/or up and down one step
☐☐	**N. 4 steps:** The ability to go up and down four steps with or without a rail
☐☐	**O. 12 steps:** The ability to go up and down 12 steps with or without a rail May use a step of 4 x 3
☐☐	**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 Also applies to picking up from a wheelchair
	☐ **P1. Does the patient use a wheelchair and/or scooter?** **0. No ➟ Skip rest of questions** **1. Yes ➟ Continue to 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
	☐ **RR1. 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
	☐ **SS1. Indicate the type of wheelchair or scooter used** 1. **Manual** 2. **Motorized**

Items To Be Coded (cont')

- **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

- **1 step (curb):** The ability to go up and down a curb and/or up and down one step

- **4 steps:** The ability to go up and down four steps with or without a rail

- **12 steps**: The ability to go up and down 12 steps with or without a rail – reportedly CMS noted that a 4-step x 3 up and down will pass for a 12 step

- **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 – may be picking object from a W/C if the patient is W/C bound – remember that it is ok if they need a reacher to pick up the object – we are not measuring the need for device or not

- **Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns (see description of 90 degree turn on previous slide)

- **Wheel 150 feet**: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space

Coding Tips (cont')

- The **intention of the wheelchair items** is to assess the patient's use of a wheelchair for self-mobilization at admission and discharge when appropriate.

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

- If the patient walks and is not learning how to mobilize in a wheelchair, and only uses a wheelchair for transport between locations within the facility, code the wheelchair/scooter gateway items at admission and/or discharge items as follows: Does the patient use a wheelchair/scooter = 0 for No.
  - Answering the question in this way invokes a skip pattern which will skip all remaining wheelchair questions.

- Otherwise said, only code wheelchair mobility based on an assessment of the patient's need and ability to mobilize in the wheelchair.

- Remember that it is very possible that the patient starts with a wheelchair but no longer is the case on discharge – only walking will apply at discharge.

Coding Function & Mobility - Exceptions

- **All functions must be attempted unless there is a reason why not as follows:** **Note:** It is expected that the documentation in the chart supports reasons for not assessing all items. So, when using any of these exception code, there should be documented to back up the reason for not assessing.

  - **07 - Patient refused** – do all possible to convince them to participate

  - **09 - Not applicable** - **Not attempted** and **the patient did not perform this activity prior to the current illness**, exacerbation, or injury – for instance, if patient was not doing stairs before then its NA, if patient does not ambulate or uses w/c in community then those items are NA etc…

  - **10 - Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints) – for example, there are no 12-step stairs in the hospital (gym or stairs between hospital floors etc… Remember that if the weather is not good to test outdoors on day 1, do not use "not attempted due to environmental limitations" unless the weather does not change for all 3 days

  - **88 - Not attempted due to medical condition or safety concerns** – for instance you may not be able to assess stairs within the 1st 3 days for post stroke, or maybe their medical issues are still not sufficiently stable to attempt some of the testing

Function/Mobility Sections (Discharge)

1. Same items will be tested on **discharge**

2. Must be completed within 3 calendar days of discharge including the day of discharge
   - For the Discharge assessment, code the patient's discharge functional status, based on a clinical assessment of the patient's performance that occurs as close to the time of the patient's discharge as possible to capture all areas of improvement possible

3. Usually done the day prior or day of the discharge at a stand-up mtg

4. Same coding principles apply to discharge assessments

5. Again, all assessment items must be attempted to be coded – otherwise a reason for no attempt must be coded

6. Patients should be allowed to perform activities as independently as possible for both admission and discharge, as long as they are safe for both admission & discharge assessments.

7. Remember that even if patient was coded on admission as 07 (refused) or 10 (environmental issue) does not mean it is automatically the same at discharge

Discharge Data

A2000. Swing Bed Discharge Date		
Month	Day	Year
		20

Self explanatory but make sure you have a good system to enter this info for instance both D/C to home and Home with HH would be coded 01

Be sure to close a record by discharging them if they are returned to acute from SB. So, if returned to SB after acute – you should have 2 D/C record on this one patient.

Patient's Discharge Status		
Choose one		
	01. Community	
	Where in community	a. Private home/apartment
		b. Board/care
		c. Assisted living
		d. Group home
	02. Nursing home/SNF	
	03. Acute hospital	
	04. Psychiatric hospital	
	05. Inpatient rehabilitation facility	
	06. ID/DD facility	
	07. Hospice	
	08. Deceased	
	09. Long Term Care Hospital (LTCH)	
	99. Other	

30-Day Follow-up Status

30-Day Follow-Up Status	
Choose one	
	00. No Attempt to Contact Patient/Family
	01. Contact with Patient/Family Attempted 3 times, no Response
	02. Patient Reached but Readmission/ Observation to Another Facility Unknown
	03. Patient not Readmitted to any Facility
	04. Patient received care at Acute, Swing Bed, Observation or ED
	05. Deceased

Not only is having a follow-up call system the right thing to do to prevent readmissions but demonstrating a low readmission rate after SB vs SNF will help to make a "decreased cost" point.

- We understand that getting information regarding a hospital use other than yours may be difficult to get information from the patient hence all the choices on the next Slide. – We do expect that you will be able to get info from HIM for patients who used your CAH at a minimum

- Managing care from acute or post-acute requires follow-up calls done within 24-72 hrs post discharge based on condition, then weekly or more if issues were identified but no less than 30 days post discharge for the 30 day post discharge window closing and data collection
  - Does require having good processes in place informing the patient/family of the follow-up call, ensuring we have the correct # to call and preferred times including what # they should expect would show up on their phone

Who Should We Conduct Follow-Up Calls For?

- A post-discharge for this project should be done for every discharges including:
  - Those who left the SB AMA (against medical advice)
  - SB LOS less than 3 days
  - Independent with all self-care activities at the time of admission
  - Regardless of whether they received PT and/or OT
  - Those discharged to a nursing home (we need to know the outcome of those patients also)

- Post-discharge for this project will not be called if the following exceptions exist:
  - Died while on the unit or you are aware that they passed after being discharged
  - Discharged to hospice care
  - Unexpected D/C to a short-stay acute hospital/CAH because the hospital may do their own follow-up
  - Patients in coma/persistent vegetative state etc (as per exception list)

30-Day Follow-up Status

	30 Day Follow Up Description
☐	Readmitted to Our Facility Acute Same or Related Condition as the Swing Bed stay
☐	Readmitted to Our Facility Acute New Condition Different from the Swing Bed Stay
☐	Readmitted to Our Facility Swing Bed Same or Related Condition as the Swing Bed stay
☐	Readmitted to Our Facility Swing Bed New Condition Different from the Swing Bed Stay
☐	ED Visit at Our Facility Same or Related Condition as the Swing Bed stay
☐	ED Visit at Our Facility New Condition Different from the Swing Bed Stay
☐	Observation Stay at Our Facility Same or Related Condition as the Swing Bed stay
☐	Observation Stay at Our Facility New Condition Different from the Swing Bed Stay
☐	Readmitted to Acute or Placed on Observation at Other Facility Same or Related Condition as the Swing Bed stay
☐	Readmitted to Acute or Placed on Observation at Other Facility New Condition Different from the Swing Bed Stay
☐	Readmitted to Acute or Placed on Observation at Other Facility Unknown
☐	Readmitted to Other Facility (Swing Bed/SNF) Same or Related Condition as the Swing Bed stay
☐	Readmitted to Other Facility (Swing Bed/SNF) New Condition Different from the Swing Bed Stay
☐	Readmitted to Other Facility (Swing Bed/SNF) Unknown
☐	ED Visit at Other Facility Same or Related Condition as the Swing Bed stay
☐	ED Visit at Other Facility New Condition Different from the Swing Bed Stay
☐	ED Visit at Other Facility Unknown

Check **all** that applies

Take the time to read every options

We hope to make this list less cumbersome for the next update.

Coding Q&A?

Q: Do we have to have data on every admissions?

A: Yes, every admissions must be entered and all sections of the assessment to be coded up to the part of Exclusions. If exclusions apply, then skip to D/C and Follow-up items.

****

Q: What if the patient was discharged unexpectedly and we only had time to do 4 of the sections?

A: Complete what you can based on documentation including the Exception section.

****

Q: What if a patient had therapy but it only started on day 4 or 5, how do I document the admission Functional Assessment

A: Team members who worked with the patient such as nurses and SB Coordinator must complete the Functional Assessment by the end of Day 3

There may be more "88" then if therapy was involved because nursing does not feel comfortable assessing and may be a reason why therapy was requested.

****

Coding Q&A?

Q: What if we did the admission functional assessment and entered the data in the system but the patient dies on day 5 which now puts him on the exclusion list – do I erase the functional data

A: No need to go back and erase – complete the Exception list – the program will ignore the functional data already inputted

****

Q: Patient is nourished 100% via g-tube but the plan is to work with him to have at least partial oral feeding or removal of the g-tube by discharge

A: Code as 88 = unsafe and code status on discharge

Q: What if the patient is 50% g-tube and 50% oral?

A: Code based on the 50% oral intake

****

Q: Patient has had a stroke and can barely walk for a few steps safely, but the plan is to work with him to walk before D/C – do I code 88 (unsafe) or 1 (dependent) for 10 ft, 50 ft and 150 ft

A: Code 88 unless safe enough to complete 10 ft with max-assist of 1 or 2 staff in which case you would code level 1 or 2

Coding Q&A?

Q: How do I code if the patient was able to do 10 ft with a staff member by his side and another following with a w/c in case he needs to sit down, how do I code "walk 10 ft"

A: Code as 01 = Dependent (because 2 staff members were needed)

****

Q: Patient has significant SOB but able to walk up to 10 feet with helper doing more than ½ of the effort – how do I code walk 10, 50 ft and 150 feet?

A: Code 10 ft as 02 = Substantial/Maximum Assist
Code 50 ft and 150 ft as 88

****

Q: We have a patient status post car accident who has a lot of pain when turning in bed. When assessing 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) The patient needs max assist of 1 to turn to the left but has too much pain to be turned to his right side. Do we code this measure a "2" – max assist?

A: No, code as 88 – you were not able to complete the full assessment

Coding Q&A?

Q: A patient is receiving medical care and rehab until day 8 at which time the therapy staff discharges the patient from their services since he has met his rehab goals but remains on the unit until day 13 to complete IV antibiotic. When is the D/C assessment completed? Based on day 6-7-8 or 11-12-13 functional level?

A: Based on day 11-12-13 (preferably measured on day 12 or 13)

****

Q: A patient is admitted late Friday pm for medical issues and rehab. There are no therapists working on the weekend hence patient will have been in the program for 3 days (Fri-Sat-Sun) before a therapy assessment. Do we still code the admission assessment, or do we take the info from Monday's therapy assessment?

A: Nursing will be responsible to do the admission functional assessment – If you wait for Monday am for the SB Coord to coordinate, base info on admission status but definitely not using info pass 3 days – again may be more "88" (unsafe to assess) – Therapy and nursing will be involved in the D/C assessment

Coding Q&A?

Q: Patient is admitted for medical issues/treatments and the need for skilled therapy was not identified until day 4 or 5 or, the patient was too sick to initiate therapy from day 1. How do we code the admission assessment – do we base it on the first 3 days or from the time therapy was requested?

A: As above, nursing will code the admission functional assessment

****

Q: During the 3 days for assessment, the PT noted the patient to be a level 3 (mod assist – less than ½ performed by helper) for chair/bed-to-chair transfer but the rest of the time the patient is reported to require max assist where the nursing staff must perform more than ½ of the effort as helpers. Do we code chair/bed-to-chair as 2 or 3

A: Code as 2 (max assist) since this what the patient looks like on the average

****

Q: A patient had his 3-day assessment but was transferred back to acute care on day 5 with an expected return to SB when stable. We discharged the patient to acute on day 5 therefore this patient will be an exception, so we do not complete the discharge self-care and mobility assessment. After 3 days in acute, he is returned to SB as planned. Do we go from where we left of?

A: We start over since in SB it is considered a new admission

Coding Q&A?

Q: A patient was discharge to acute and did not return to SB. Do we complete a 30-day follow-up?

A: No

****

Q: A patient was discharged from acute to SB with a fresh trach and 2 weeks rest from chemo and radiation therapy with a plan to then be readmitted to acute for neck surgery. Do I report this as a readmission to acute though it was planned?

A: No since the planned readmission was documented – the next tool update should include a box to identify "planned readmission"

****

Q: A patient was admitted to acute care from an Assisted Living. After the acute care he was discharged to a Transitional Care Unit at that hospital and now he is being transferred to your SB program. How do I code his residence prior to acute?

A: Assisted Living

****

Q: Our patient was discharged home with Hospice provided by the local home health, do I code 01 – community or 07 – Hospice?

A: 07 - Hospice

Coding Q&A?

Q: Should I be doing a 30-day follow-up with hospice patients discharged to a hospital, at home or in a facility/unit or NH bed for hospice?

A: No

****

Q: Do I do follow-up with patients D/C'ed AMA or < than 3 day stays

A: Yes

****

Q: Do we need to complete a 30-day follow up call to patients who were discharged to home (community) but with Home Health?

A: Yes

****

Coding Q&A?

Q: A patient was discharged from acute to SB with a fresh trach and 2 weeks rest from chemo and radiation therapy with a plan to then be readmitted to acute for neck surgery. Do I report this as a readmission to acute though it was planned?

A: No – we will need to differentiate on the next version of the data collection to match what CMS measures

****

Q: **P**atient had his 3-day assessment but was transferred back to acute care on day 5 with an expected return to SB when stable. We discharged the patient to acute on day 5 therefore this patient will be an exception hence we do not complete the discharge assessment. After 3 days in acute, he is returned to SB as planned. Do we go from where we left of?

A: The 2nd admission is a new admission and treated as such. Requires all data to be completed again including a new 3-day assessment and all the other questions.

****

Coding Q&A?

Q: Coding data was reported to Stroudwater under a wrong account # - had used the acute act. # vs the SB act. # but I can't change it. What do I do to correct this

A: Contact Paula Knowlton (pknowlton@Stroudwater.com) at Stroudwater and they will make the correction for you.

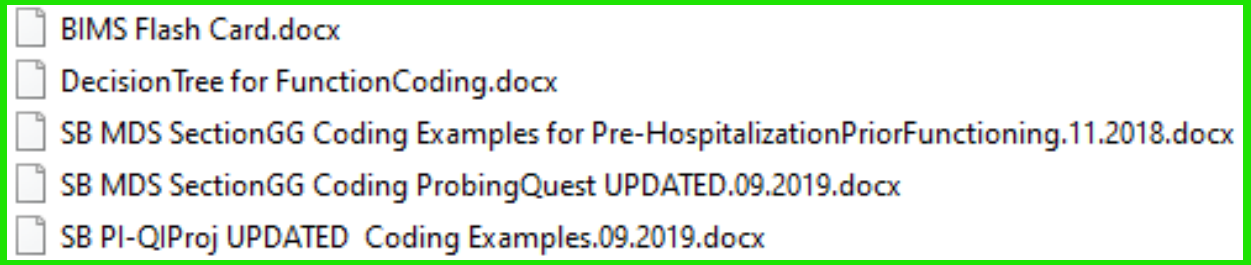
****

Q: Is there a deadline as to when admissions and discharges must be entered in the web-based system?

A: **D**eadline is by the 10th of the month following the quarter but recommend by day-5 to give Stroudwater an opportunity to benchmark data, followed by clinical analysis in order to share with participating hospitals.
Ideally records are completed no later than the week of discharge (except follow-up data) in order to have on-going up to date access to data reporting and making the project more manageable. Never put off tomorrow what you can do today – one never knows what will happen on the last day to enter data!

Examples on How to Code & Other Tools

1) In addition, review the following updated WORD documents and discuss with staff before they start coding:



2) Keep this PP presentation and attached documents in the same folder for future staff training needs


QUESTIONS?
COMMENTS?
CONCERNS?