The Relationship Between Functional Performance Outcomes, Rehabilitation Intensity, and the Potential Effect of PDPM on Skilled Nursing Facilities

By

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Abstract

Objective: This study utilized Section GG's functional performance measures to evaluate correlations between rehab intensity, patient self-care, and mobility outcomes to ensure patients are receiving sufficient amounts of therapy in post-acute care settings.

Methods: SPSS Statistics 27.0 was used to conduct a secondary analysis of a medical data set collected from 93 skilled nursing facilities in the midwest region (N = 1352).

Results: The study identified relationships between insurance type, length of treatment, and diagnostic category in a SNF based on Medicare beneficiaries. There was a significant positive relationship between insurance and length of treatment, where beneficiaries with Medicare were found to have longer stays (avg. days 31) than those with Medicare Advantage Plans (avg. days 17). A limited positive correlation was found between length of stay and functional outcomes measured in self-care and mobility items (p = 0.01).

Conclusions: The shift from volume to value-based reimbursement for rehabilitation services in PAC settings created questions surrounding the relationship between the amount of therapy provided and patient functional outcomes. Functional outcomes were found to be higher in Medicare beneficiaries as measured by standardized Section GG measurements in PAC when their insurance coverage allowed for longer stays versus Medicare Advantage Plans.
Keywords: section GG; occupational therapy; medicare

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Within the past decade, policymakers created an initiative known as the Triple Aim to evaluate current healthcare practices and optimize three critical components of the United States' healthcare system: improve the quality of health services provided, improve the health and wellness of the United States' population, and decrease the cost of healthcare (Berwick et al., 2008; Sandhu et al., 2018). Medicare is a federal health insurance program in the United States for people ages 65 and over, regardless of income, medical history, or health status (Centers of Medicare and Medicaid Services, 2019b). Currently, Medicare plays a critical role in providing health and financial security to 50 million people (Centers of Medicare and Medicaid Services, 2019a). Medicare insures various medical services, including Part A services that cover inpatient hospital stays, skilled nursing facility (SNF) stays, home health visits, and hospice care. Over the past decade, healthcare costs covered by Medicare grew by 34.3% and rose an additional 3.2% between 2018 and 2019 (U. S. Census Bureau, 2020). This increase in healthcare costs covered by Medicare is partly due to the 65+ population utilizing more services (Cubanski et al., 2019).

Medicare Advantage Plans (MGA) were first introduced in 2003 in response to a need for additional coverage for Medicare beneficiaries, specifically regarding prescription drug coverage (Jacobson, 2015). Advantage plans are healthcare insurance coverage plans facilitated through government-contracted private companies that provide a continuum of coverage options with lower out-of-pocket costs for beneficiaries with various medical needs compared to traditional medicare plans. Between 2008 and 2018, the number of beneficiaries enrolled in an MGA plan extended from 22% to 34% (Cubanski et al., 2019). Following these policy changes, the number of beneficiaries choosing private plans grew partly to lower out-of-pocket costs (Jacobson,

2015). However, these out-of-pocket costs are variable between private companies and private insurers contracted through Medicare and must follow the rules set by Medicare to ensure reimbursement of services covered through MGA (Medicare, 2022).

Since 2000, the passing of the Affordable Care Act (ACA), 24 U.S.C. § 157 (2010) and the Improving Medicare Post-Acute Care Transformation (IMPACT) Act, 24 U.S.C. § 1395 (2014) included mandates and significant changes to reduce the cost of services, improve the quality of care for Medicare Part A recipients, and implement the Triple Aim initiative (Sandhu et al., 2018). Based on these mandates, the Center for Medicare and Medicaid Services (CMS) transitioned in October 2019 from a volume to a value-based system called a Patient-Driven Payment Model (PDPM) that focuses on patient characteristics and the quality of healthcare service, replacing the former system based on the amount of services provided. The PDPM changed reimbursement methods by creating a standardized number of therapy minutes per diagnosis, a change that was meant to deter SNF rehabilitation services from inappropriately administering costly therapy minutes. CMS initiated the shift in payment models in anticipation that it would reduce the rate of readmissions and improve the health of Medicare beneficiaries (Kroll & Fisher, 2019).

Additionally, this change in reimbursement may influence treatment plan decisions for patients and impact reimbursement for therapy services related to patient outcome measurements from standardized data collection across post-acute care (PAC) settings (Sandhu et al., 2018). Currently, there is no standardized amount of therapy per day in rehabilitation services in Skilled Nursing Facilities (Jette et al., 2005). Identifying a method to quantify rehabilitation intensity can help refine the value of therapy services for Medicare beneficiaries and improve the value-based care payment model.

Within each PAC setting, functional outcomes were measured using individual assessment tools. However, the assessments did not include the same standardized items across settings. The development of a new tool in PAC was the precursor to change in reimbursement allowing for the feasibility of implementation across settings and comparing functional outcomes (Deutsch et al., 2022). The CMS created and implemented the Continuity Assessment Record and Evaluation (CARE) tool (Sandhu et al., 2018) which collects standardized data regarding the functional status of Medicare beneficiaries on admission to a PAC facility. Section GG is an excerpt from the CARE tool consisting of self-care and mobility scales assessed at admission and discharge and is now the assessment of function tool used across PAC settings (Sandhu et al., 2018).

The creation of Section GG eliminated a barrier for researchers to determine meaningful comparisons of functional outcomes; before the CARE tool, relationships between functional outcomes and rehabilitation intensity could not be explored (Kroll & Fisher, 2019). For clinicians to use Section GG scales, self-care and mobility, independently from the CARE tool, a team of expert personnel in their respective fields tested individual items within the CARE tool to confirm the validity and reliability of the measures across various PAC settings (Gage et al., 2012). These pilot tests revealed that individual items within the CARE tool showed high interrater reliability between healthcare professionals and demonstrated face validity compared to assessment tools testing similar items (Gage et al., 2012).

In a study by Cogan et al. (2020), researchers found that functional outcomes from mobility and self-care scales of the Functional Independence Measure (FIM) had a positive correlation with length of stay (LOS) and rate of recovery (Cogan et al., 2020). Similarly, we want to utilize Section GG's functional performance measures to evaluate correlations between

rehab intensity and patient self-care and mobility outcomes. The items from Section GG aid in determining the quality measures of rehabilitation services provided regarding the new PDPM reimbursement model for SNFs and other PAC facilities. Similar to previous studies, we will be defining rehabilitation intensity calculated by dividing the total time spent in rehabilitation treatment by the length of stay [RI=Time (min)/LOT(min)] (Jette et al., 2005; Mallinson et al., 2014). Understanding this relationship may facilitate an agreement between medical professionals and Medicare policymakers on evidence-based practice decisions that best support patients in PAC settings.

Methods

Study Design

This study was a secondary analysis of a medical data set collected from a therapy company that provides care in skilled nursing facilities. Medical system data was retrieved from 93 SNFs located in two midwestern states in the United States. The data analyzed was for one fiscal year from October 1st, 2020, to September 31st, 2021. Demographic and health information was collected for a total of 1352 participants in addition to the functional measures assessed through Section GG as part of the Minimum Data Set (MDS) for Medicare programs (Centers of Medicare and Medicaid Services, 2019a). Data was pulled from 2020 to 2021 to include patients seen under the external circumstances of COVID-19- and one-year post-implementation of the Medicare Patient-Driven Payment Model (PDPM). The current study is considered exempt from review by the University of Indianapolis institutional review board as the medical data set has been deidentified and poses less than minimal risk to participants. This report follows the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guideline (Elm et al., 2008).

Inclusion Criteria

Participants were included based on the following inclusion criteria: 1) admission to a skilled nursing facility following a hospital stay, 2) age 65 years and older, 3) received rehabilitation services, 4) primary payer source documented as Medicare Part A or Medicare Advantage, 5) diagnosed with a medically complex (multiple/complex morbidities) or orthopedic conditions (hip or other), 6) discharged to the community, and 7) had complete admission and discharge records. Demographic information collected included sex and age. Since not all Medicare Beneficiaries are over the age of 65, those under the age of 65 were excluded to reduce the risk of bias due to age stratification. Any erroneous data from the data set, such as data outside reporting parameters, were also excluded.

Clean and Excluded Data

Data extracted from the medical data set from 93 SNFs was organized by the researchers based on if the participant had completed both the mobility and self-care sections, just the mobility section, or just the self-care section of the Section GG tool.

Therapy Measures and Functional Outcomes

The primary outcomes assessed were the Section GG scores included in the Minimum Data Set (MDS), the length of treatment, and the amount of therapy (i.e., Occupational and Physical) provided during the SNF stay. Occupational therapists scored participants on self-care items while the physical therapists scored the mobility items. Within three days of admission and by the last three days prior to discharge, the scores were recorded and identified as pre-and post-rehabilitative scores. The scores represent a continuum of dependence with self-care and mobility tasks where a score of one is the max dependency needed to complete the task and a score of six for complete independence. Additional scores include a 07 (refusal), 09 (not

applicable), 10 (not attempted due to environmental limitation), and 88 (not attempted due to medical condition/safety), which were not included in the analysis.

Statistical Analysis

Data analyses of the medical data set were conducted using SPSS Statistics 27.0 (*SPSS Statistics*, 2020). Descriptive statistics were analyzed for all variables (Table 1). The length of treatment variable was positively skewed to the right, so a log-10 transformation was completed. Linear regressions for PTLOT and OTLOT based on (a) RI and insurance, and (b) RI and dxcat. Linear regressions were also run for the average change in SC and average change in MO based on (a) dxcat & LOT, (b) dxcat & time; (c) dxcat, insurance, and RI, (d) dxcat, insurance, beginning SC/MO, and LOT; and (e) dxcat, insurance, beginning SC/MO, and time. Two-tailed T-tests were conducted to evaluate the means of individual items in the Section GG MO and SC sections to determine if there were relationships between the variables.

Results

The data consisted of participants classified by outcome groups: participants with MO and SC data (n=824), participants with just SC data (n=322), and participants with just MO data (n=383). The researchers excluded participants based on their age (below 65 or above 120), any erroneous information (scores higher than 6), and unidentified or missing insurance information. A total of (n=177) participants were excluded (68 participants after no insurance, 33 participants after erroneous data, and 76 participants after age), leaving 1352 participants remaining.

Insurance

Out of the 1352 participants, 63.6% of the participants had Medicare while 36.4% of the participants had Medicare Advantage. Of the Medicare participants, 64% had a diagnosis of medically complex, 16% had ortho-hip, and 20% had ortho-other. Of the Medicare Advantage

participants, 61% had a diagnosis of medically complex, 18% had ortho-hip, and 21% had ortho-other. Results found that people with MCA tend to have longer stays and had higher improvements in self-care and mobility scores than people with MGA (see Figures 1 and 2). The type of insurance the participant had was significant to the LOT, which then led to a significance in the time. Participants with MCA had a longer LOT and had an increase in time compared to participants with MGA.

Diagnostic Categories

We compared the links between (PT/OT)Time, insurance, diagnostic category, and (PT/OT)LOT. Results showed that the relationship between insurance and PT LOT is strongest for patients with medically complex diagnoses. On the opposite end, the relationship between insurance and PTLOT is weakest when looking at patients with the diagnosis of ortho-other. The same results were found when comparing the relationship between insurance and (PT/OT)Time. When analyzing the relationship between insurance type and (PT/OT)LOT, the relationship was strongest for patients with medically complex diagnoses and similar for both ortho diagnosis categories.

Rehab Intensity

Due to (PT/OT)LOT and (PT/OT)Time having the same relationship within diagnoses and with insurance, we looked at the relationship between LOT, time, and RI. In this test, we saw that (PT/OT)Time and (PT/OT)LOT are strongly correlated. Patients with MCA had an average of 42 mins/session, while patients with MGA had an average of 44 mins/session. Results indicate that RI decreases with an increase in LOT for both PT/OT and that MGA patients had much less variability and shorter stays. Patients with MCA had an average LOT of 27 days, while patients with MGA had an average LOT of 16 days.

Predicting LOT

Regressions were run to predict how long a person will be allowed to remain in therapy (PT or OT LOT) as a function of their insurance and RI. For both PT and OT, results showed that patients were significantly likely to have less rehab intensity the longer they are in rehab and that they were significantly likely to have more time in rehab if they have MCA rather than MGA insurance.

To predict how long a person will be allowed to remain in therapy (PT or OT LOT) as a function of their diagnosis and rehab intensity, results showed that patients were significantly likely to have less rehab intensity the longer they are in rehab. They were significantly likely to have more time in rehab if they have a diagnosis of Ortho-Hip rather than Medically complex, and Ortho-Other had a marginally significant likelihood of more time in rehab than did Medically complex.

Predicting Functional Outcomes

Since the RI is too small for meaningful linear regression analysis, 2-tailed T-tests were conducted to evaluate the means of various individual items in the Section GG MO and SC sections to determine if there is a relationship between the variables. Table 2 demonstrates a broad correlation between Section GG MO items, change in status and the treatment provided. For Table 3, overall, we found that 2-tailed T-tests demonstrated correlations (p=.01) between Section GG MO and SC items based on the treatment provided as measured by length of stay in rehabilitation (LOT) and the time (minutes provided) and number of therapy sessions provided. However, one item in MO (Sit < >Ly) and two items in SC (Eat and TH) correlated with RI at a higher level (p=0.05), refer to Tables 2 and 3.

Discussion

This study evaluated correlations between rehab intensity, patient self-care, and mobility outcomes as measured using Section GG's functional performance tool. While the researchers predicted there would be a significant relationship between RI and LOT using the calculation RI=Time (min)/LOT(min), this yielded a numerical value too small to derive significant correlations above the $p=.01$ level. Previous studies using this RI calculation found significant correlations (Jette et al., 2004, 2005; O'Brien & Zhang, 2018; Prusynski et al., 2021). However, these were performed under the RUG system, where the present study is amongst the first to measure RI under the PDPM payment model (Kroll & Fisher, 2019).

Under the RUG system, SNFs were incentivized to provide higher amounts of therapy for the greatest financial return from reimbursement (Prusynski et al., 2021). When CMS enforced the new PDPM payment model, these incentives were reduced, creating an overall reduction in the amount of rehabilitation provided to beneficiaries (Chen et al., 2021). For example, researchers in Cogan et al. (2021) found that patients grouped in high and medium levels of therapy received 130 minutes or more per day. Whereas, this study found average therapy minutes per treatment at 82.5 minutes, for both MCA and MGA. Evaluating the effect of reduced therapy minutes on patient outcomes is important to ensure that an overcorrection in cost-effective healthcare practices does not exist.

While this study aimed to find evidentiary support for the effect RI has on patient outcomes under the PDPM payment model, researchers determined that a different calculation is necessary to determine RI correlations. However, the researchers found that LOT and Time may be better predictors of improvement, with findings that show a significant relationship between

LOT, the type of insurance covering Medicare beneficiaries' SNF stay, medical conditions of Medicare beneficiaries, and their functional outcomes.

In this study, patients who experienced the most improvement from admission to discharge had a medically complex diagnosis; this positive relationship applies to both OT and PT LOT. Ortho-hip and ortho-other diagnoses also showed functional increases, however the correlation between these outcomes and LOT were weaker in comparison to medically complex patients. These results provide a unique insight to the type of Medicare beneficiary that benefits most from longer lengths of stay.

Past studies have evaluated the relationships between the amount of therapy received and functional improvements through readmission rates and functional outcomes, reporting results that are different than those discovered in the present study (Jette et al., 2005; Chen et al., 2012). First, Jette et al. (2005) researchers found that rehabilitation intensity at higher dosages contributed increased functional independence and minimized need for longer length of stay. It is important to recognize that the changes in policy from a fee-for-service to a PDPM model affects the therapy dosage that Medicare beneficiaries receive. Reimbursement changes affect providers and how they choose to manage therapy services and may lead to changes in the length of stay; in this case, the length of stay beneficiaries receive becomes increasingly vital to support improved functional outcomes.

Researchers in Chen et al. (2021) using a Skilled Nursing Facility Utilization and Payment Public Use File which provided information on Medicare beneficiaries' stays in the year 2016 under the FFS payment model found a positive relationship between higher amounts of rehabilitation administered and rates of readmission. Chen et al. (2021) found that some SNFs provided more therapy related; however, this resulted in individuals who received more therapy

and a longer LOS yet yielded higher rates of readmission and associated costs of care. These findings suggest two important concepts. One, under the previous payment model, therapists may have been able to supply excess amounts of therapy without regard to patient outcomes. Second, in conjunction with the present study findings, the differences of severity in patient conditions impacts how much time with therapy is necessary to maximize patient outcomes, and should be considered in regards to healthcare policy to support patients who would benefit from more therapy.

In light of recent trends which show an exponential number of traditional Medicare (MCA) beneficiaries are opting for Medicare Advantage (MGA) plans, it is important to evaluate how these changes in coverage affect treatment outcomes (Damico et al., 2022). This study identified significant relationships between traditional Medicare (MCA) and Medicare Advantage (MGA) plans and length of a Medicare part A stay in a SNF (LOT), which were also evaluated in terms of patients' diagnostic category (Ortho-hip, Ortho-other, and Medically Complex). The LOT was found to have a significant relationship with insurance, where beneficiaries with traditional Medicare plans were found to have longer stays compared to those with Medicare Advantage.

Before healthcare reform, reimbursement incentivized PAC companies under the FFS reimbursement model to maximize rehab minutes and beneficiary length of stay regardless of frailty, medical necessity, or insurance type (Angelelli et al., 2000). Under the new PDPM, researchers in this study found that regardless of insurance type, the average therapy minutes were similar between disciplines but was significantly less than the time provided under the FFS model (82.5 minutes v. 130 minutes). In contrast, there was more variability in length of stay coverage regardless of diagnosis category where MGA patients had shorter stays in an SNF due

to the cuts in rehab reimbursement compared to MCA beneficiaries. Specifically, patients with MCA had on average longer stays (27 days v. 16 days), which were positively correlated with better functional outcomes. This suggests that some insurance types support appropriate amounts of medically necessary services, which are correlated with longer stays, and thus show better functional outcomes. However, if beneficiaries with a higher frailty status are prematurely discharged due to lack of insurance coverage, the length of treatment may not be enough to address their functional deficits, resulting in lower functional outcomes .

Transitioning to the PDPM greatly influenced the amount of therapy patients are able to receive and how long they are able to receive therapy services. While it is important to minimize excessive therapy dosage, policymakers should be aware of the effect that changes in policy have on the functional outcomes of beneficiaries. This study provides insight to how functional outcomes as measured by Section GG are impacted by payment model shifts. Length of treatment was found to be positively significant when correlated with functional outcomes, which demonstrates the importance of finding a balance between safeguarding therapy resources that maximize beneficiaries' functional outcomes while encouraging facilities to make treatment decisions that are cost-effective.

Future Research

Future researchers should consider how the different insurance plans and LOT have the potential to affect the amount of readmissions to acute and post-acute care facilities following discharge from a post-acute care setting. Other researchers could also investigate the functional outcomes of patients once discharged to the community and if their length of stay provided by insurances in a PAC impacted the success patients had in the community, including readmission rates to hospitals (within 30 days of hospital and SNF stay). Due to limited time and resources,

our study did not delve into the possible impact COVID-19 had on functional outcomes, admission to post-acute care settings, and length of stay. Future research can focus on the effect COVID-19 had in post-acute care settings. In addition, further research should be conducted with a national dataset to add clarity to the relationship of the functional outcome measures to the amount of therapy provided with more diagnostic groups and diversified demographic populations.

Study Limitations

There are several study limitations that should be acknowledged. In this study, we focused the analysis only on Medicare beneficiaries aged 65 years and older. Due to this, findings can not be generalized to patients younger than the age of 65 years who receive therapy services in post-acute care. It is also unknown if the therapy sessions were group or individual sessions or what type of treatment interventions the patients received that could be associated with better mobility or self-care patient outcomes. Additionally, our data only included the diagnostic categories of medically complex, ortho-hip, and ortho-other. There may have been other conditions the patients had that could have influenced therapy minutes or length of treatment.

Conclusions

Implementation from a volume to value-based payment model for health care services has not considered the relationship between the amount of therapy provided to patients needed for functional outcomes. The findings of this study suggest that Medicare beneficiaries show better functional outcomes as measured by standardized Section GG measurements in PAC when their insurance coverage allows for longer stays. Insurance that allows for variability in length of stay is more supportive of improvement in functional outcomes compared to insurance options

that limit occupational and physical therapy minutes in an SNF. If patients are discharged too early, they may not receive the volume of rehabilitation services needed to maximize functional performance outcomes, which could lead to hospital readmissions. The implications of these findings on payment model changes suggest potential hindrance of functional outcomes, posing a risk to insurance companies and PAC facilities in the form of costly rates of readmission.

Data Availability Statement

Data is available from the corresponding author.

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Disclosure

The authors report that there are no competing interests to declare.

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Table 1. Variable List

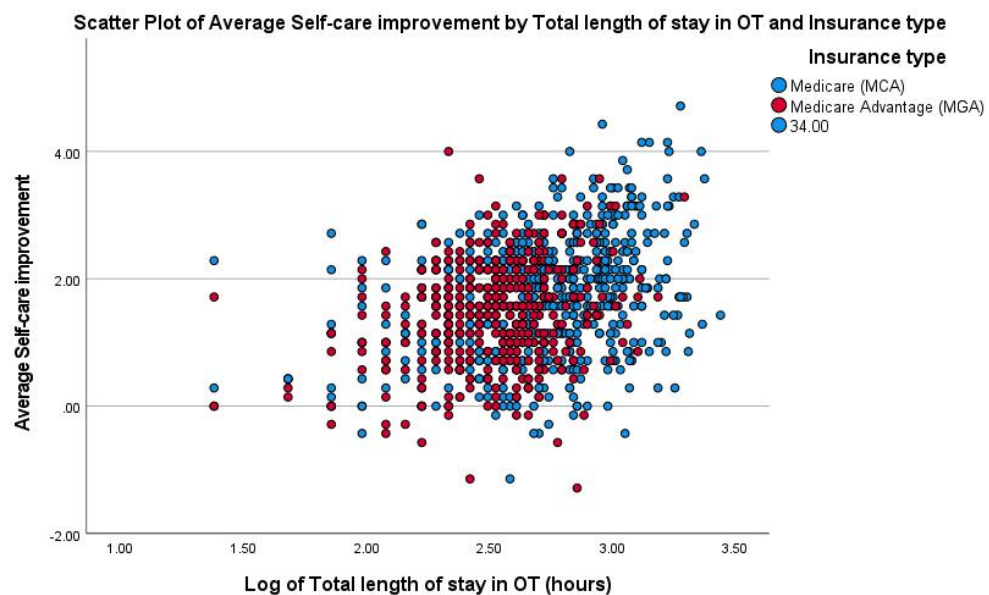| Variable Labels	Variable Abbreviations
Medicare	MCA
Medicare Advantage Plans	MGA
Physical Therapy Length of Treatment	PTLOT
Occupational Therapy Length of Treatment	OTLOT
Physical Therapy Time in Minutes	PTTime
Occupational Therapy Time in Minutes	OTTime
Rehab Intensity	RI
Diagnostic Category	dxcat
Self-care score improvements	SC
Mobility score improvements	MO

Figure 1. Scatter Plot of SC Impr., OTLOT, and Insurance
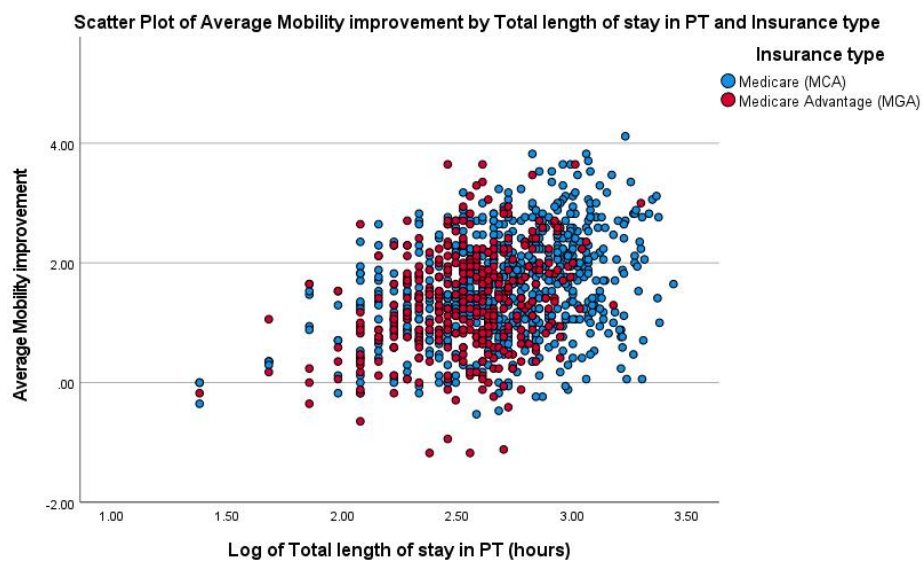

Figure 2. Scatter Plot of MO Impr., PTLOT, and Insurance

Table 2. 2-Tailed T-Tests for MO Improvement

Correlations																	
	1 step impr.	12 step impr.	4 step impr.	Car T/F impr.	Ch <> Bd T/F impr.	Ly > EOB impr.	PU Obj. impr.	Roll L< >R impr.	Sit < >Ly impr.	Sit < >Std impr.	TO T/F impr.	Amb 10 impr.	Amb 150 impr.	Amb 150 +2 impr.	Amb 10 US impr.	W/C 150 impr.	W/C 50 +2 impr.
Mobility impr.	.546**	.297**	.481**	.488**	.713**	.665**	.513**	.582**	.657**	.714**	.710**	.661**	.541**	.659**	.480**	.247**	.183**
PT Time	0.056	0.031	0.056	.141**	.222**	.210**	.093**	.183**	.210**	.199**	.208**	.231**	0.052	.128**	0.036	.173**	.148**
PT LOT	0.022	0.027	0.037	.072*	.277**	.281**	.075*	.237**	.274**	.249**	.264**	.273**	.081**	.169**	0.052	.203**	.179**
Rehab Intensity - Physical Therapy	0.034	-0.005	0.039	.089**	-0.050	-.080**	-0.015	-0.054	-.060*	-0.043	-0.049	-0.028	-0.033	-0.014	0.001	-0.003	-0.026
**. Correlation is significant at the 0.01 level (2-tailed).																	
*. Correlation is significant at the 0.05 level (2-tailed).																	

Note: Refer to Table 4 for Mobility Section GG Items

Table 3. 2-Tailed T-Tests for SC Improvement

Correlations							
	Eat impr.	LBD impr.	OH impr.	Footwear impr.	Bathe impr.	TH impr.	UBD impr.
Self-care improvement	.413**	.869**	.611**	.817**	.691**	.817**	.734**
Time in Occupational Therapy	.136**	.171**	.146**	.163**	.090**	.205**	.241**
OT LOT	.216**	.246**	.227**	.238**	.103**	.294**	.307**
Rehab Intensity - Occupational Therapy	-.069*	-0.049	-.094**	-0.038	-0.009	-.071*	-0.040
**. Correlation is significant at the 0.01 level (2-tailed).							
*. Correlation is significant at the 0.05 level (2-tailed).							

Note: Refer to Table 5 for Self-Care Section GG Items

Table 4

Mobility Section GG Items	Mobility Section GG Abbreviations	Mobility Section GG Description
1 step (curb)	1 step	Ability to go up and down a curb/step
12 steps	12 step	Ability to go up and down 12 steps with/without railing
4 steps	4 step	Ability to go up and down 4 steps with/without railing
Car transfer	Car T/F	Ability to transfer in and out of car on passenger side
Chair/bed-to-chair transfer	Ch < > Bd T/F	Ability to transfer to and from a bed to a chair
Lying to sitting on side of bed	Ly > EOB	Ability to move from lying on back to sitting edge of bed with feet on floor and no back support
Picking up object	PU Obj.	Ability to bend from standing to pick up small object off floor
Roll left and right	Roll L< >R	Ability to roll from lying on back to left and right and return to back
Sit to lying	Sit < >Ly	Ability to move from sitting edge of bed to lying flat on bed
Sit to stand	Sit < >Std	Ability to stand from sitting in bed/chair
Toilet Transfer	TO T/F	Ability to get on/off toilet/commode
Walk 10 feet	Amb 10	Ability to walk 10 feet in a room
Walk 150 feet	Amb 150	Ability to walk 150 feet in a room
Walk 150 feet with two turns	Amb 150 +2	Ability to walk 150 feet with two turns
Walk 10 feet on uneven surfaces	Amb 10 US	Ability to walk 10 feet on uneven or sloping surfaces

Wheel 150 feet	W/C 150	Ability to wheel 150 feet in a room
Wheel 50 feet with two turns	W/C 50 +2	Ability to wheel 50 feet with two turns

Table 5

Self-Care Section GG Items	Self-Care Section GG Abbreviations	Self-Care Section GG Description
Eating	Eat	Ability to use suitable utensils, bring food to mouth, and swallow food presented
Lower Body Dressing	LBD	Ability to dress/undress below the waist including fasteners
Oral Hygiene	OH	Ability to use suitable items to clean teeth/dentures
Putting on/taking off footwear	Footwear	Ability to take on/off appropriate footwear, socks, or shoes
Shower/bathe self	Bathe	Ability to bathe self in shower/tub including washing, rinsing, and drying
Toileting hygiene	TH	Maintain hygiene and manage clothes before/after using toilet/commode
Upper body dressing	UBD	Ability to dress/undress above the waist including fasteners