Judy Wilhide Brandt, RN, BA, RAC-MT,
RAC-MTA, QCP, CPC, DNS-CT
judy@judywilhide.com
909-800-9124
www.JudyWilhide.com

SNF QRP MDS-based Quality Measures
A deep dive into technical specifications
2023

WilhideConsulting
Respect the Aged

1

Agenda:

- Explain technical specifications of the MDS-based QRP Quality Measures
- Provide quick reference handouts with all QRP measures explained
- Define the MDS based QRP measures
- Explain “process” vs “outcome” measures
- Provide handouts with all non-QM MDS SPADEs for FY 2025

CMS QRP Website

2

3

- Task: Read and understand the logical specifications for MDS-based SNF QRP QMs.
- Knowledge required: Definitions used in the logical specification table.

Table 8-1
Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674) (CMS ID: S013.02)

Measure Description
This quality measure reports the percentage of Medicare Part A SNF Stays where one or more falls with major injury (defined as bone fractures, joint dislocations, closed head injuries with altered consciousness, or subdural hematoma) were reported during the SNF stay.
Measure Specifications[a]
If a resident has multiple Medicare Part A SNF Stays during the target 12 months, then all stays are included in this measure. ***Numerator*** The total number of Medicare Part A SNF Stays (Type 1 SNF Stays only) in the denominator with one or more look-back scan assessments that indicate one or more falls that resulted in major injury (J1900C = [1, 2]). ***Denominator*** The total number of Medicare Part A SNF Stays (Type 1 SNF Stays only) with one or more assessments that are eligible for a look-back scan[b] (except those with exclusions). ***Exclusions*** Medicare Part A SNF Stays are excluded if: 1. The number of falls with major injury was not coded; i.e., J1900C (Falls with Major Injury) = [-]. 2. The resident died during the SNF stay (i.e. Type 2 SNF Stays). a. Type 2 SNF Stays are SNF stays with a PPS 5-Day Assessment (A0310B = [01]) and a matched Death in Facility Tracking Record (A0310F = [12]).
Covariates
None.

4

General definitions that apply to entire manual

Specific definitions that only apply to MDS-based measures

QRP Reports available in CASPER

Specific MDS-based calculations

Logical specification table for each MDS-based QRP QM

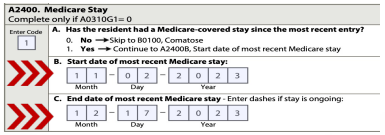
SKILLED NURSING FACILITY QUALITY REPORTING PROGRAM MEASURE CALCULATIONS AND REPORTING USER'S MANUAL VERSION 4.0

Table of Contents

5

SNF Stay Definitions

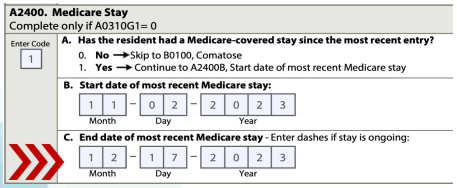
- **Medicare Part A Admission Record:** PPS 5-Day assessment (A0310B = [01])
  - *Nothing to do with an OBRA Admission Assessment (A0130A = 01)*
- **Medicare Part A Discharge Record:** Defined as a Part A PPS Discharge Assessment (A0310H = [1])
  - May or may not be combined with OBRA discharge.
- **Medicare Part A SNF Stay**: Consecutive time in the facility starting with the Medicare Part A start date on the *Admission Record* (PPS 5-Day assessment (A0310B = [01])) through the Medicare Part A end date on a Part A PPS Discharge Assessment (A0310H = [1])) or Death in Facility Tracking Record (A0310F = [12]); A Part A SNF Stay may include interrupted stays lasting 3 calendar days or less.
  - **Type 1 SNF Stay**: Stay with matched pair: PPS 5-Day Assessment (A0310B = [01]) and PPS Discharge Assessment (A0310H = [1]) and no Death in Facility Tracking Record (A0310F = [12]) within the SNF Stay.
  - **Type 2 SNF Stay**: Stay with a PPS 5-Day Assessment (A0310B = [01]) and a matched Death in Facility Tracking Record (A0310F = [12]).
- QRP Measures calculated per SNF *stay,* not per SNF *resident*



6

SNF Stay Definitions

- Target Period: The span of time that defines the Quality Measure Reporting Period (e.g., a 12-month calendar or fiscal year) for the SNF QRP quality measures.
  - *All MDS-Based QRP quality measures in SNF QRP use a 12-month calendar or fiscal year (4 quarters). They are refreshed on Care Compare quarterly using a rolling 4 quarters of data. Example on next slide*
- Stays included in target period are those that **ended** within the 12-month target period.
- A PPS stay ends with:
  - Part A PPS Discharge Assessment (using A2400C even when combined with OBRA discharge)
  - Death In Facility Tracking Record (while on a Part A stay as indicated in A2400C)
    - A PPS stay ending in death in facility is an exclusion for many SNF QRP MDS based QMs. Ensure you know the rules!



A2400. Medicare Stay
Complete only if A0310G1= 0

Enter Code: 1

A. Has the resident had a Medicare-covered stay since the most recent entry?
0. **No** → Skip to B0100, Comatose
1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay

B. Start date of most recent Medicare stay:
1 1 – 0 2 – 2 0 2 3
Month Day Year

C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:
1 2 – 1 7 – 2 0 2 3
Month Day Year

Reminder: No PPS DC with interrupted stay. If you do it anyway, you've created a false "SNF Stay" for QRP Purposes, and those QMs aren't going to look great. Same with a SNF stay ending in death. Never do a PPS DC with a death in facility tracking. Those really aren't going to look great.

7

MDS based QRP QM Target Periods:

- Each quarter, MDS-based QRP QMs are refreshed using a rolling 12 months of data. When they refresh, the 12-month period is very old. Example:
- For refreshes in 2023:
  - January 2023 refresh target period: Q2 2021 – Q1 2022
  - April 2023 refresh target period: Q3 2021 – Q2 2022
  - July 2023 refresh target period: Q4 2021 – Q3 2022
  - October 2023 refresh target period: Q1 2022 – Q4 2022
    - This is the target period used for the 2% APU penalty for FY 2024, which starts Oct 1, 2023
    - (see "Intro to SNF QRP FY 2023: Avoid 2% APU penalty" recorded webinar for details)

8

https://www.medicare.gov/care-compare/

QRP QMs "additional quality measures" under Short Stay, *except one*

Colonial Health & Rehab Center, LLC

Quality measures

Learn more about quality measures

Find out why these short-stay measures are important

Find out why these long-stay measures are important

Get current data collection period

Click here for data collection period for currently reported QRP measures

Measures	Current data collection period
Additional quality measures - Short-stay residents	Measure Date Range
Percentage of SNF residents whose medications were reviewed and who received follow-up care when medication issues were identified.	01/01/2021 - 12/31/2021
Percentage of SNF residents who experience one or more falls with major injury during their SNF stay.	01/01/2021 - 12/31/2021
Percentage of SNF residents whose functional abilities were assessed and functional goals were included in their treatment plan.	01/01/2021 - 12/31/2021
Percentage of residents who are at or above an expected ability to care for themselves at discharge.	01/01/2021 - 12/31/2021
Percentage of residents who are at or above an expected ability to move around at discharge.	01/01/2021 - 12/31/2021

9

This is the list of QMs included in the Quality Measure Star Rating

This QRP measure used for 5 star and listed on Facility Level QM Report for QAPI/survey use Called "Changes in Skin Integrity Post Acute-Care" for QRP but same measure

Short-stay quality measures

★★☆☆☆

Below average

The short-stay quality measures rating reflects the average level of a nursing home's performance in certain areas of care for those who stayed in a nursing home for 100 days or less or are covered under the Medicare Part A Skilled Nursing Facility (SNF) benefit, and whose typical goal is to improve their health status so they can return to their previous setting, like their home.

Percentage of short-stay residents who were re-hospitalized after a nursing home admission *Lower percentages are better*	29.2%	National average: 22.1% Missouri average: 23.5%
Percentage of short-stay residents who have had an outpatient emergency department visit *Lower percentages are better*	10.5%	National average: 11.4% Missouri average: 11.6%
Percentage of short-stay residents who got antipsychotic medication for the first time *Lower percentages are better*	3.1%	National average: 1.8% Missouri average: 2.5%
Percentage of residents with pressure ulcers/pressure injuries that are new or worsened *Lower percentages are better*	5.3%	National average: 2.9%

Pressure ulcers can be painful and cause other complications, like a reduction in mobility and infections. SNFs can help prevent and treat pressure ulcers by understanding which residents are at higher risk, ensuring frequent changes in their position, providing proper nutrition, and using specialized beds to reduce pressure on the skin. This measure is also used in the Skilled Nursing Facility Quality Reporting Program (SNF QRP), other SNF QRP measures are listed in the "additional quality measures section."

10

handouts

Ten MDS Based Measures: 5 of 10 are from Section GG

Name of Measure	Name on Care Compare	Short Informal Description:	MDS items Used: Dashes in these times are "bad" dashes.
Admission and Discharge Functional Assessment and a Care Plan That Addresses Function	Percentage of SNF residents whose functional abilities were assessed and functional goals were included in their treatment plan.	Process Measure: Did you complete GG performance on PPS 5 & set at least one goal, and complete the Discharge GG functional status assessment when it was required? (Not required if "incomplete stay." (unplanned, or to hospital, or SNF stay less than 3 days, or death).	Section GG0130 & GG0170
Change in Self Care Score for Medical Rehabilitation Patients	Change in residents' ability to care for themselves	Sums Self Care Scores (GG0130) on PPS 5 day and PPS DC to get change in score. Numerator and denominator are risk adjusted. Excluded if no PT or OT during stay. Scores above 0 are better.	PPS 5 day: Column 1 Admit Performance: No dashes, to include Q1, RR1, SS1 (wheelchair questions). Column 2: Discharge Goal: at least one goal with two digit number, all bad dashes as long as one goal selected.
Change in Mobility Score for Medical Rehabilitation Patients	Change in residents' ability to move around	Sums Mobility Scores (GG0170) on PPS 5 day and PPS DC to get change in score. Numerator and denominator are risk adjusted. Excluded if no PT or OT during stay. Scores above 0 are better.	
Discharge Self-Care Score for Medical Rehabilitation Patients	Percentage of residents who are at or above an expected ability to care for themselves at discharge.	Estimates percentage of SNF stays that meet or exceed an expected discharge self-care score. Compares to national average. Higher is better.	PPS DC: (when required): Column 3, Discharge Performance: No dashes, to include Q3, RR3, SS3 (wheelchair questions)
Discharge Mobility Score for Medical Rehabilitation Patients	Percentage of residents who are at or above an expected ability to move around at discharge.	Estimates percentage of SNF stays that meet or exceed an expected mobility self-care score. Compares to national average. Higher is better.	

11

12

Percentage of SNF residents whose functional abilities were assessed and functional goals were included in their treatment plan

Higher percentages are better

96.1%

National average: 98.8%

Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

- Process Measure: Did you assess functional status upon SNF admission and discharge and set a care plan goal for functional status?
  - If no "bad dashes" you get 100%

- Process measures indicate what a provider does to maintain or improve health, either for healthy people or for those diagnosed with a health care condition. These measures typically reflect generally accepted recommendations for clinical practice.
- Process measures can inform consumers about medical care they may expect to receive for a given condition or disease, and can contribute toward improving health outcomes. The majority of health care quality measures used for public reporting are process measures.

AHRQ Agency for Healthcare Research and Quality

13

Percentage of SNF residents whose functional abilities were assessed and functional goals were included in their treatment plan

Higher percentages are better

96.1%

National average: 98.8%

Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

1. Admission Performance	2. Discharge Goal
Enter Codes In Boxes	
0 3	- -
0 2	0 6
0 3	- -
0 2	- -
0 3	- -

Complete Stay Must have: PPS 5 day with no dashes in Col 1 GG0130 & GG0170 and at least one goal in Col 2 . PPS DC Col 3 with no dashes

Incomplete stay must have: PPS 5 day with no dashes in Col 1 and at least one goal in Col 2

3. Discharge Performance
Enter Codes In Boxes
0 5
0 5
0 5
0 5
0 6

Q1. Does the resident use a wheelchair and/or scooter?
0. No → Skip to GG0130, Self Care (Discharge)
1. Yes → Continue to GG0170R, Wheel 50 feet with two turns.

R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability t two turns.

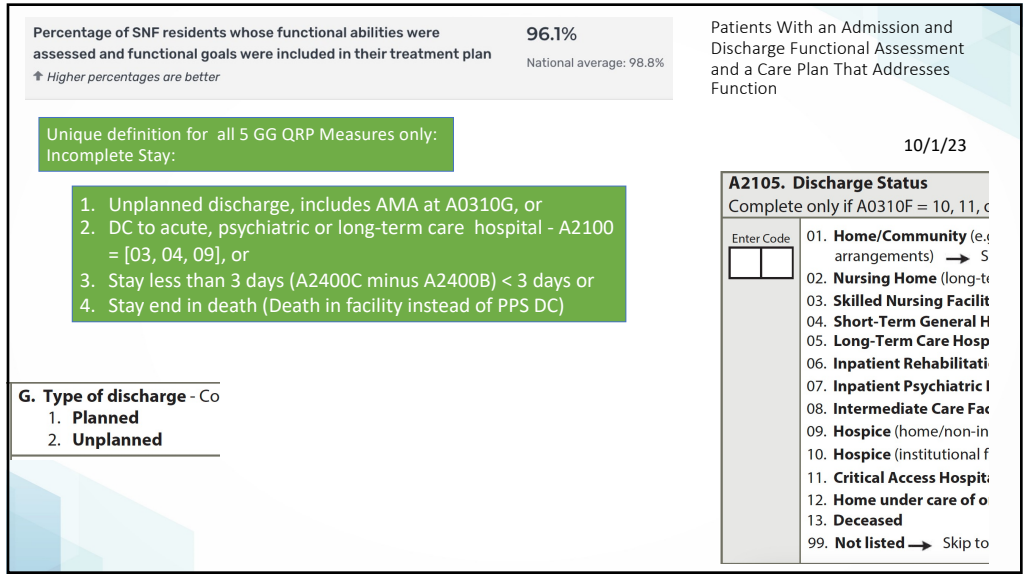
RR1. Indicate the type of wheelchair or scooter used.
1. Manual
2. Motorized

S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at leas space.

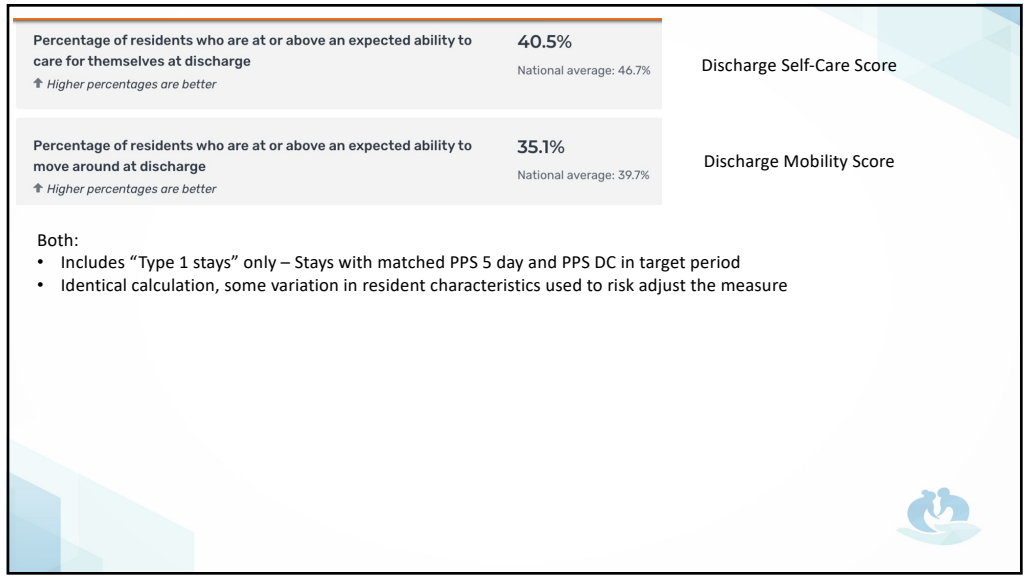
SS1. Indicate the type of wheelchair or scooter used.
1. Manual
2. Motorized

Note! These questions are considered "Column 1". & "bad dashes" for APU penalty

14


Percentage of SNF residents whose functional abilities were assessed and functional goals were included in their treatment plan
96.1%
National average: 98.8%
Higher percentages are better
Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
Unique definition for all 5 GG QRP Measures only:
Incomplete Stay:
1. Unplanned discharge, includes AMA at A0310G, or
2. DC to acute, psychiatric or long-term care hospital - A2100 = [03, 04, 09], or
3. Stay less than 3 days (A2400C minus A2400B) < 3 days or
4. Stay end in death (Death in facility instead of PPS DC)
10/1/23
G. Type of discharge - Co
1. Planned
2. Unplanned
A2105. Discharge Status
Complete only if A0310F = 10, 11,
Enter Code
01. Home/Community (e.
arrangements) → S
02. Nursing Home (long-t
03. Skilled Nursing Facilit
04. Short-Term General H
05. Long-Term Care Hosp
06. Inpatient Rehabilitati
07. Inpatient Psychiatric I
08. Intermediate Care Fac
09. Hospice (home/non-in
10. Hospice (institutional f
11. Critical Access Hospit
12. Home under care of o
13. Deceased
99. Not listed → Skip to

15


Percentage of residents who are at or above an expected ability to care for themselves at discharge
40.5%
National average: 46.7%
Higher percentages are better
Discharge Self-Care Score
Percentage of residents who are at or above an expected ability to move around at discharge
35.1%
National average: 39.7%
Higher percentages are better
Discharge Mobility Score
Both:
• Includes "Type 1 stays" only – Stays with matched PPS 5 day and PPS DC in target period
• Identical calculation, some variation in resident characteristics used to risk adjust the measure

16

Discharge ***Self-Care*** Score

Exclusions
Medicare Part A SNF Stays are excluded if:

1. Incomplete stay: defined on previous slide
2. Diagnoses on PPS 5 day: B0100 = 1 Coma or PVS or designated ICD-10 CM codes in I0020b or I8000
3. Age less than 18
4. DC to hospice (A2100 = 07) or hospice while resident (O0100K2)
5. No PT or OT on PPS 5 day: O0400B and O0400C therapy minutes = 0

Table A-3
Primary Medical Condition Category (I0020B) and Active Diagnosis in the Last 7 days (I8000A through I8000J) – ICD-10-CM Codes

Primary Medical Condition Category (Item I0020B and I8000A through I8000J)	ICD-10-CM Codes			
Severe brain damage	G93.9			
Complete tetraplegia	G82.51, G82.53, S14.111A, S14.111D, S14.111S, S14.112A, S14.112D, S14.112S,	S14.113A, S14.113D, S14.113S, S14.114A, S14.114D, S14.114S, S14.115A, S14.115D,	S14.115S, S14.116A, S14.116D, S14.116S, S14.117A, S14.117D, S14.117S,	S14.118A, S14.118D, S14.118S, S14.119A, S14.119D, S14.119S
Locked-in state	G83.5			
Severe anoxic brain damage, edema or compression	G93.1, G93.5, G93.6			

17

Discharge Status A2100/A2105

Now

A2100. Discharge Status
Complete only if A0310F = 10, 11, or 12

Enter Code

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
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**

Stay tuned for technical spec revisions, but ***pay attention now to correct DC status***

10/1/23

A2105. Discharge Status
Complete only if A0310F = 10, 11, c

Enter Code

01. **Home/Community** (e.
arrangements) → S
02. **Nursing Home** (long-t
03. **Skilled Nursing Facilit**
04. **Short-Term General H**
05. **Long-Term Care Hosp**
06. **Inpatient Rehabilitati**
07. **Inpatient Psychiatric I**
08. **Intermediate Care Fac**
09. **Hospice** (home/non-in
10. **Hospice** (institutional f
11. **Critical Access Hospit**
12. **Home under care of o**
13. **Deceased**
99. **Not listed** → Skip to

18

Discharge Self-Care Score

GG0130 on Part A PPS DC:

3. Discharge Performance Enter Codes in Boxes ↓	
0 6	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
0 4	**B. Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
0 3	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
0 2	**E. Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
0 2	**F. Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
0 2	**G. Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
0 3	**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.

21

1. Add scores in GG0130 on PPS DC for all stays in target period.
   - 07, 09, 10, 88, dash use value 01
- Compare DC self-care score to this resident's expected self-care score, if at or better, you trigger. Triggering is good.

19

Expected self - care discharge scores:

- Resident risk factors from the PPS 5 day MDS are used to calculate an expected self - care discharge score for each resident stay
- Examples of risk factors include:
  - Age
  - Prior functioning
  - Primary medical condition
  - Comorbidities
- Each resident stay's observed discharge self - care score is compared to the expected discharge self - care score, except those stays that are excluded.
- If the observed score is equal to or greater than the expected discharge score, the stay is in the numerator.

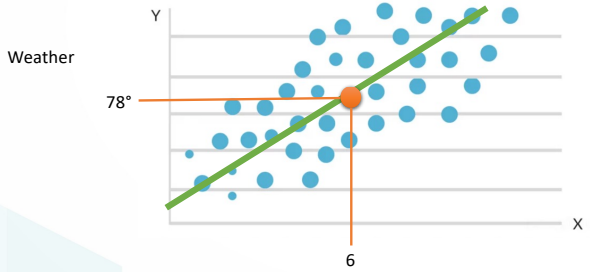
20

How do that know what was expected? Generalized Linear Model regression analysis

- Generalized Linear Model regression analysis: A statistically valid way to predict stuff, based on multiple variables.

Example simple linear regression:

- A car dealership wants to understand when they can expect to sell the most cars based on weather. They hire a statistician. They want to know how many sales they can expect as the weather changes.
- They take the sales history for a year: Each car sold and weather at time of sale. Based on the regression below, they can expect to sell 6 cars when it's 78°



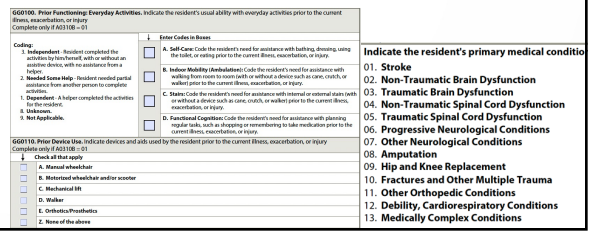
- Simple linear regression: Just a few factors
- Generalized Linear Model regression: Can use multiple factors, more useful to predict things. For these QMs, they use many resident characteristics to predict a discharge score. Not a simple straight line through some dots, but same idea.

21

Characteristics (risk—adjustment **covariates**) used to predict expected discharge score from the PPS 5 Day MDS

- Age (the older the more likely to have a lower discharge score
- Admit GG self-care scores (more dependent more likely to have lower DC score)
- Certain Primary medical condition categories and their relation to admission self-care score
- Prior surgery in J2000
- Prior functioning (GG0100): Self care, indoor ambulation
- Prior mobility device use (GG0110): walker, wheelchair, mechanical lift, orthotics/prosthetics
- Pressure Ulcer
- Cognitive level (BIMS, items from staff assessment, B0700 makes self understood, B0800 ability to understand others
- Continence (urinary and bowel)
- IV feeding while resident

There is a reason for every box on a PPS MDS

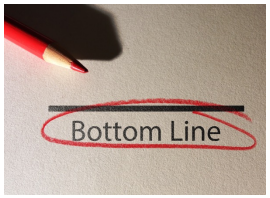


22

Characteristics (risk—adjustment covariates) used to predict expected discharge score from the PPS 5 Day MDS

- Section I checkboxes and diagnosis codes
  - Septicemia, sepsis, SIRS:
  - Lymphoma and other cancers
  - Diabetes with/without complications
  - Certain endocrine and metabolic disorders
  - Dementia
  - Paraplegia, hemiplegia, tetraplegia
  - MS
  - Parkinson's
  - Huntington's
  - Angina pectoris, cardiorespiratory conditions category
  - Pneumonia, lung infections
  - Dialysis, CKD
  - Amputations and complications

- Bottom line: The older, frailer, more complex on the PPS 5 day, the lower their expected DC Self-Care score
- Second bottom line: MDS accuracy is critically important.



23

Discharge Mobility Score

3. Discharge Performance Enter Codes in Boxes ↓	
0 6	**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.
0 5	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
0 5	**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.
0 6	**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.
0 4	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
0 4	**F. Toilet transfer:** The ability to get on and off a toilet or commode.
8 8	**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.
0 6	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
0 6	**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
0 6	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
0 6	**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.
0 6	**M. 1 step (curb):** The ability to go up and down a curb and/or up and down one step. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
0 6	**N. 4 steps:** The ability to go up and down four steps with or without a rail. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
0 6	**O. 12 steps:** The ability to go up and down 12 steps with or without a rail.
0 6	**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.

79

Doesn't use wheelchair items

Expected DC Mobility score calculated the same as Expected DC Self-Care with some variation in MDS data and diagnoses used as covariates.

24

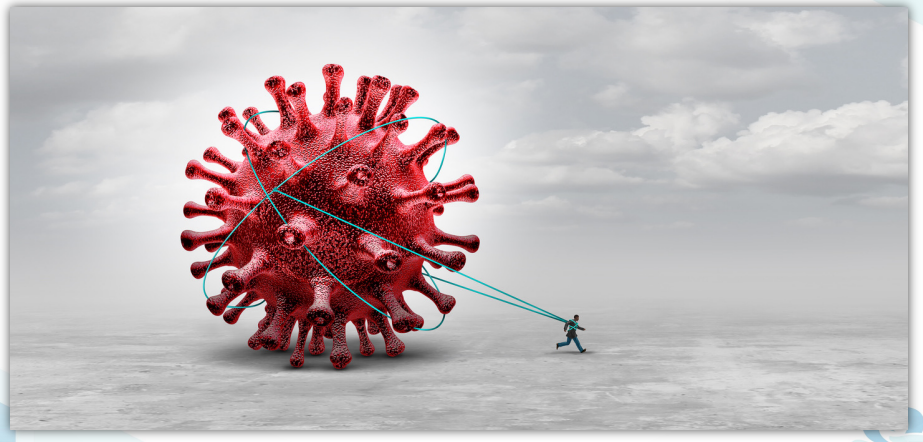
Percentage of residents who are at or above an expected ability to care for themselves at discharge *Higher percentages are better*	40.5% National average: 46.7%
Percentage of residents who are at or above an expected ability to move around at discharge *Higher percentages are better*	35.1% National average: 39.7%

Less than half of the entire country are at/above expected score at discharge. Why?

- Why do you think the national averages are so low? Speculation:
  - Regression model using characteristics that aren't predictive (faulty analysis: *Correlation does not imply causation*)
  - We're blowing off some of the risk adjustment items (Prior functioning and prior device use – does anyone really care?)
  - General focus on payment items and less on risk adjustment items on PPS 5 day
  - Accuracy issues in PPS 5 day and PPS DC GG items (Do we give both the same focus?)
  - This data is calendar year 2021

25

Calendar Year 2021 in USA Nursing Homes



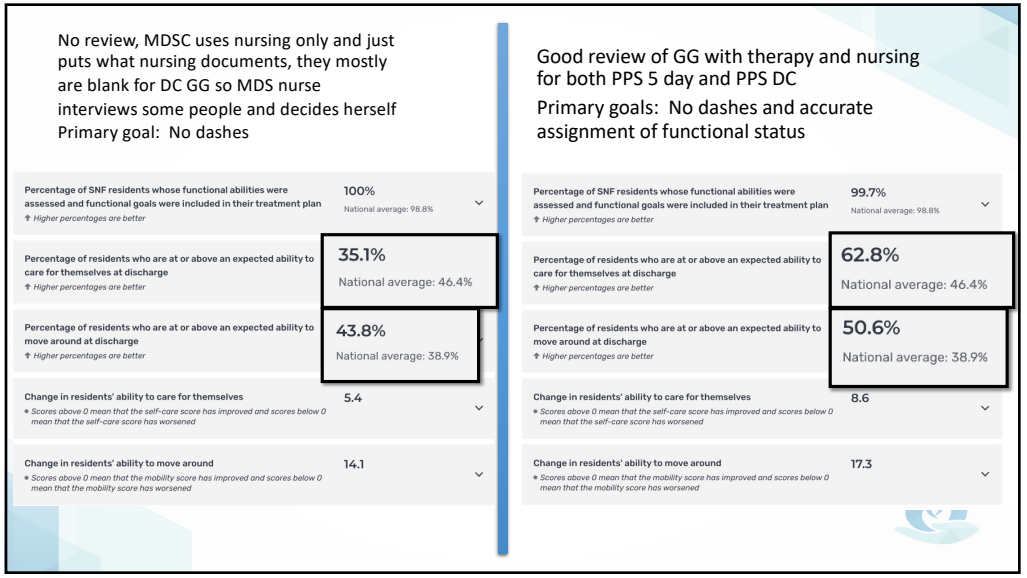
Data does not define who we are

26

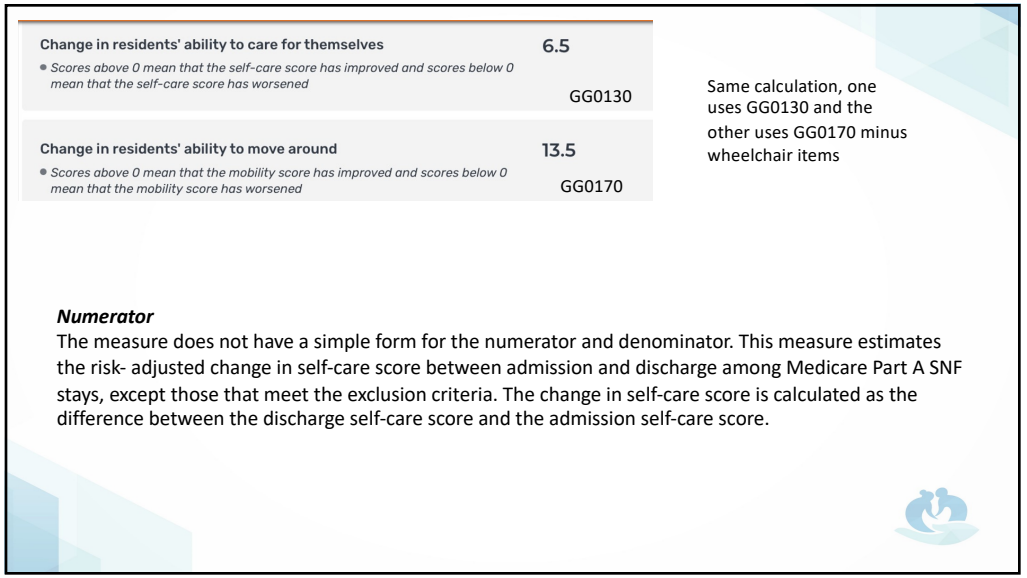
No review, MDSC uses nursing only and just puts what nursing documents, they mostly are blank for DC GG so MDS nurse interviews some people and decides herself
Primary goal: No dashes

Good review of GG with therapy and nursing for both PPS 5 day and PPS DC

Primary goals: No dashes and accurate assignment of functional status



27



Same calculation, one uses GG0130 and the other uses GG0170 minus wheelchair items

Numerator

The measure does not have a simple form for the numerator and denominator. This measure estimates the risk- adjusted change in self-care score between admission and discharge among Medicare Part A SNF stays, except those that meet the exclusion criteria. The change in self-care score is calculated as the difference between the discharge self-care score and the admission self-care score.

28

Change in Self-Care Score

PPS 5 Day

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

19

PPS DC

1. Discharge Performance Enter Codes in Boxes
0 6
0 4
0 3
0 2
0 2
0 2
0 3

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

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

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

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

F. **Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.

G. **Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.

H. **Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

22

Numerator

The measure does not have a simple form for the numerator and denominator. This measure estimates the risk-adjusted change in self-care score between admission and discharge among Medicare Part A SNF stays, except those that meet the exclusion criteria. The change in self-care score is calculated as the difference between the discharge self-care score and the admission self-care score.

29

Exclusions

1. Incomplete stay (as identified earlier in presentation)
2. All seven self-care items on PPS 5 day are coded 06 independent
3. Diagnoses on PPS 5 day: B0100 = 1 Coma or PVS or designated ICD-10 CM codes in I0020b or I8000
4. Age less than 18
5. DC to hospice (A2100 = 07) or hospice while resident (O0100K2)
6. No PT or OT on PPS 5 day: O0400B and O0400C therapy minutes = 0

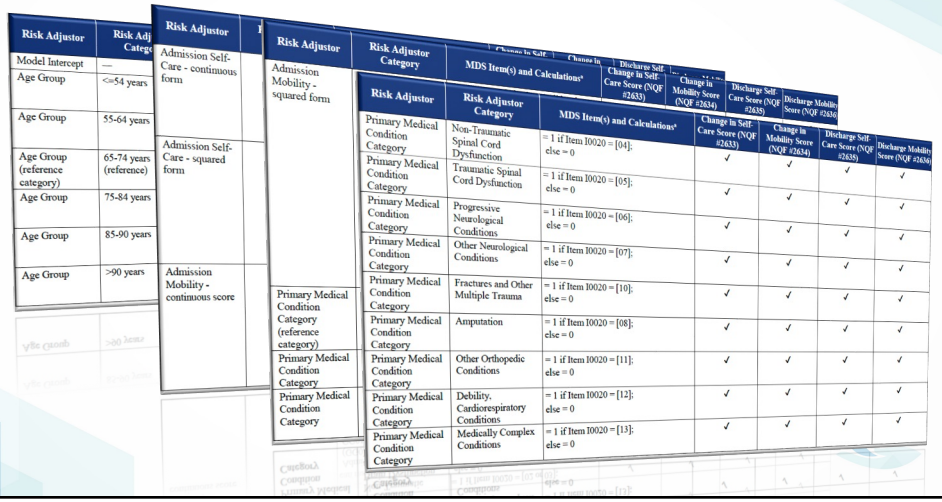
30

Covariates for generalized linear regression

- Age group
- Admission self-care score – continuous score
- Admission self-care score – squared form
- Primary medical condition category
- Prior surgery
- Prior functioning: self-care
- Prior functioning: indoor mobility (ambulation)
- Prior mobility device use
- Stage 2 pressure ulcer
- Stage 3, 4, or unstageable pressure ulcer/injury
- Cognitive abilities
- Communication impairment
- Urinary Continence
- Bowel Continence
- Tube feeding or total parenteral nutrition
- Comorbidities

31

Table A-4: SNF QRP Measure Calculations and Reporting User's Manual V4.0 – Effective October 1, 2022
Multiple pages with covariates used for all four GG outcomes measures



32

Ten MDS Based Measures:

Name of Measure	Name on Care Compare	Short Informal Description:	MDS items Used: Dashes in these times are "bad" dashes.
One or More Falls With Major Injury	Percentage of SNF residents who experience one or more falls with major injury during their SNF stay.	J1900C: Fall Major Injury ≠ 0 on any OBRA, PPS 5 day, OBRA DC, PPS DC in Medicare stay.	Note: Only dashes in J1900C on PPS 5 day or PPS DC count as "bad" dashes
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	Percentage of SNF residents with pressure ulcers that are new or worsened.	On a PPS DC: Number "present" > number "present on admission" for Stage 2,3,4, unstageable due to non-removable device, slough/Eschar or DTI. Risk adjusted using elements on PPS 5 day: GG0170C1, Lying to sitting, H0400: bowel continence, I0900: PVD/PAD, I2900: DM, K0200A: Height, K0200B: Weight	PPS 5 day(risk adjustments): GG0170C1, H0400, I0900, I2900, K0200A, K0200B PPS DC (triggers) M0300B1, B2, C1, C2, D1, D2, E1, E2, F1, F2, G1, G2
Drug Regimen Review Conducted With Follow-Up for Identified Issues	Percentage of SNF residents whose medications were reviewed and who received follow-up care when medication issues were identified.	Process Measure: On PPS 5 day: Did you complete N2001. Drug Regimen Review, N2003. Medication Follow-up with no dashes? On PPS DC: Did you complete N2005: Medication Intervention with no dashes?	PPS 5 day: N2001, N2003. PPS DC: N2005
Transfer of Health Information to Provider (begin collection 10/1/23)	Percentage of SNF stays with PPS DC assmt indicating a current reconciled medication list was provided to the subsequent provider at DC	Process measure: Did you fill out A2105, DC status, A2121 & A2122 on PPS DC with no dashes when DC status in A2015 is: 02,03,04,05,06,07,08,09,10,11,12 (MDS V1.18.11 10/1/23)	Part A PPS DC: A2105, A2121, A2122
Transfer of Health Information to Patient (begin collection 10/1/23)	Percentage of SNF stays with PPS DC assmt indicating a current reconciled medication list was provided to the patient at DC	Process measure: Did you fill out A2105, DC status, A2123 & A2124 on PPS DC with no dashes when DC status in A2015 is 01 (MDS V1.18.11 10/1/23)	Part A PPS DC: A2105, A2123, A2124

Begin collection 10/1/23

33

Percentage of residents whose medications were reviewed and who received follow-up care when medication issues were identified

Higher percentages are better

60.3%

National average: 91.1%

Process measures, 100% if no dashes in any boxes

N2001. Drug Regimen Review - Complete only if A0310B = 01

Enter Code ☐ **Did a complete drug regimen review identify potential clinically significant medication issues?** 5 day
0. **No** - No issues found during review
1. **Yes** - Issues found during review
9. **NA** - Resident is not taking any medications

N2003. Medication Follow-up - Complete only if N2001 =1

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

N2005. Medication Intervention - Complete only if A0310H = 1

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

Excluded if SNF stay ended in death.

N2005. Medication Intervention - Complete only if A0310H = 1

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

34

Percentage of SNF residents who experience one or more falls with major injury during their SNF stay

Lower percentages are better

0%

National average: 1%

J1900. Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is m

↓ Enter Codes in Boxes

Coding:
0. None
1. One
2. Two or more

☐	**A. No injury** - no evidence of any injury is noted on physical assessment by the nurse care clinician; no complaints of pain or injury by the resident; no change in the resid behavior is noted after the fall
☐	**B. Injury (except major)** - skin tears, abrasions, lacerations, superficial bruises, hemat sprains; or any fall-related injury that causes the resident to complain of pain
1	**C. Major injury** - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Numerator: Total number of Part A F Stays (Type 1 SNF Stays only) in the denominator with one or more look-back scan assessments that indicate one or more falls that resulted in major injury (J1900C = [1, 2]).

- Reminder: Type 1 stay: Matched pair PPS 5 day + PPS DC

Look-back scan assessment:
- Any OBRA (A0310A = 01, 02, 03, 04, 05, 06)
- PPS 5 day (A0310B – 01)
- OBRA Discharge (A0310F = 19, 11
- PPS DC: A0310H = 1

Exclusions:
- Dash in J1900C
- Type 2 stay (SNF stay ended in death)

35

Percentage of residents with pressure ulcers/pressure injuries that are new or worsened

Lower percentages are better

1.7%

M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister

1. **Number of Stage 2 pressure ulcers** - If 0 → Skip to M0300C, Stage 3
2. **Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at

C. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling

Enter Number 1

Enter Number 0

1. **Number of Stage 3 pressure ulcers** - If 0 → Skip to M0300D, Stage 4
2. **Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling

1. **Number of Stage 4 pressure ulcers** - If 0 → Skip to M0300E, Unstageable - Non-removable dressing/device
2. **Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

E. Unstageable - Non-removable dressing/device: Known but not stageable due to non-removable dressing/device

1. **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device** - If 0 → Skip to M0300F, Unstageable - Slough and/or eschar
2. **Number of these unstageable pressure ulcers/injuries that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar

1. **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** - If 0 → Skip to M0300G, Unstageable - Deep tissue injury
2. **Number of these unstageable pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

G. Unstageable - Deep tissue injury:

1. **Number of unstageable pressure injuries presenting as deep tissue injury** - If 0 → Skip to N2005, Medication Intervention
2. **Number of these unstageable pressure injuries that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

PPS DC: For any pressure ulcer, number present > number present on admission. Reported facility score is risk-adjusted

Exclusions:
- Dash in M0300
- Type 2 stay (SNF stay ended in death)

36

Risk adjustment for Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury

- The risk-adjusted quality measure score can be thought of as an estimate of what the SNF's quality measure rate would be if the facility had residents who were of average risk.
- The facility-level risk-adjusted score is calculated on the basis of:
  - The facility-level observed quality measure score;
  - The facility-level expected quality measure score; and
  - The national average observed quality measure score.

37

Percentage of residents with pressure ulcers/pressure injuries that are new or worsened

Lower percentages are better

1.7%

National average: 2.9%

As number of covariates increase, facility score is adjusted lower, making you look better

- Covariates on PPS 5 day that help overall adjusted score:
- Lying to sitting on side of bed (GG0170C) coded:
  - 01 Dependent
  - 02 Substantial max Assist
  - 07 Resident refused
  - 09 Not applicable
  - 10 Not attempted due to environmental limitations
  - 88 Not attempted due to medical condition or safety concern
- Bowel Incontinence: Bowel Continence (H0400) coded anything other than 0: Continent
- I0900: Peripheral Vascular Disease / Peripheral Arterial Disease
- I2900: Diabetes Mellitus
- Low body mass index (BMI), based on height (K0200A) and weight (K0200B): BMI less than 19.0
  - BMI = (weight * 703 / height^2) = ([K0200B] * 703) / (K0200A^2)

38

1. Transfer of Health Information to Provider
2. Transfer of Health Information to Patient

Two new QRP process measures begin collection 10/1/23
Not risk-adjusted

Completed when Part A PPS DC is combined with OBRA Discharge

A2105. Discharge Status
Complete only if A0310F = 10, 11, or 12

Enter Code

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge
02. **Nursing Home** (long-term care facility)
03. **Skilled Nursing Facility** (SNF, swing beds)
04. **Short-Term General Hospital** (acute hospital, IPPS)
05. **Long-Term Care Hospital** (LTCH)
06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
08. **Intermediate Care Facility** (ID/DD facility)
09. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**
13. **Deceased**
99. **Not listed** → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge
Complete only if A0310H = 1 and A2105 = 02-12

Enter Code

At the time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the subsequent provider?
0. **No** - Current reconciled medication list not provided to the subsequent provider → Skip to A2300, Assessment Reference Date
1. **Yes** - Current reconciled medication list provided to the subsequent provider

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider
Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.
Complete only if A2121 = 1

Check all that apply	Route of Transmission
☐	**A. Electronic Health Record**
☐	**B. Health Information Exchange**
☐	**C. Verbal** (e.g., in-person, telephone, video conferencing)
☐	**D. Paper-based** (e.g., fax, copies, printouts)
☐	**E. Other methods** (e.g., texting, email, CDs)

A2123. Provision of Current Reconciled Medication List to Resident at Discharge
Complete only if A0310H = 1 and A2105 = 01, 99

Enter Code

At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver?
0. **No** - Current reconciled medication list not provided to the resident, family and/or caregiver → Skip to A2300, Assessment Reference Date
1. **Yes** - Current reconciled medication list provided to the resident, family and/or caregiver

A2124. Route of Current Reconciled Medication List Transmission to Resident
Indicate the route(s) of transmission of the current reconciled medication list to the resident/family/caregiver.
Complete only if A2123 = 1

Check all that apply	Route of Transmission
☐	**A. Electronic Health Record** (e.g., electronic access to patient portal)
☐	**B. Health Information Exchange**
☐	**C. Verbal** (e.g., in-person, telephone, video conferencing)
☐	**D. Paper-based** (e.g., fax, copies, printouts)
☐	**E. Other methods** (e.g., texting, email, CDs)

"To Provider" required with DC status 2 – 12
"To resident" required with DC status 01 or 99

39

The Reconciled Medication List

The Transfer of Health Information measures serve as a check to ensure that a reconciled medication list is provided as the patient changes care settings at discharge. Defining the completeness of that medication list is left to the discretion of the providers and patient who are coordinating this care.

An example of items that could be on a reconciled medication list can be but are not limited to a list of the current prescribed and over-the-counter medications, nutritional supplements, vitamins, and/or homeopathic and herbal products administered by any route at the time of discharge or transfer. A reconciled medication could also include important information about: (1) the patient/resident, including their name, date of birth, active diagnoses, known medication and other allergies, and known drug sensitivities and reactions; and (2) each medication, including the name, strength, dose, route of medication administration, frequency or timing, purpose/indication, and/or any special instructions. However, this information serves as guidance and as stated prior, the completeness of the medication list is left to the discretion of the providers and patient.

Documentation sources for reconciled medication list information include electronic and/or paper records. Some examples of such records are discharge summary records, a Medication Administration Record, an Intravenous Medication Administration Record, a home medication list, and physician orders.

From "finalized' data specs in 2019: Wait to see RAI manual definition of "reconciled med list"

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/Final-Specifications-for-SNF-QRP-Quality-Measures-and-SPADEs.pdf

40

SPADES: Start collection 10/1/23 for penalty 10/1/24 (FY 2025)

Handout lists all non-QM MDS SPADE items

Note: Part A PPS Discharge will have 84 ***new*** items

MDS Data Element	PPS 5-day (A0310B = 01)	Part A PPS DC (A0310H = 1)
J0530: Pain interfere activities	x	x
K0520A1: IV feeding on admission	x	
K0520AA: IV feeding at discharge		x
K0520B1: Feeding tube on admission	x	
K0520B4: Feeding tube at discharge		x
K0520C1: Mechanically altered diet on admission	x	
K0520C4: Mechanically altered diet at discharge		x
K0520D1: Therapeutic diet on admission	x	
K0520D4: Therapeutic diet at discharge		x
K0520Z1: None of the above on admission	x	
K0520Z4: None of the above at discharge		x
N0415A1: Antipsychotic is taking	x	x
N0415A2: Antipsychotic indication	x	x
N0415E1: Anticoagulant is taking	x	x
N0415E2: Anticoagulant indication	x	x
N0415F1: Antibiotic is taking	x	x
N0415F2: Antibiotic indication	x	x
N0415H1: Opioid is taking	x	x
N0415H2: Opioid indication	x	x
N0415I1: Antiplatelet is taking	x	x
N0415I2: Antiplatelet indication	x	x
N0415J1: Hypoglycemic is taking	x	x
N0415J2: Hypoglycemic indication	x	x
N0415Z1: Is taking none of the above	x	x
O0110A1a: Chemotherapy on admission	x	
O0110A1c: Chemotherapy at discharge		x
O0110A2a: IV on admission	x	
O0110A2c: IV at discharge		x
O0110A3a: Oral on admission	x	
O0110A3c: Oral at discharge		x
O0110A3Oa: Other on admission	x	
O0110A3Oc: Other at discharge		x
O0110B1a: Radiation on admission	x	
O0110B1c: Radiation at discharge		x
O0110C1a: Oxygen on admission	x	
O0110C1c: Oxygen at discharge		x
O0110C2a: Continuous on admission	x	
O0110C2c: Continuous at discharge		x
O0110C3a: Intermittent on admission	x	
O0110C3c: Intermittent at discharge		x
O0110C4a: High-concentration on admission	x	
O0110C4c: High-concentration at discharge		x
O0110D1a: Suctioning on admission	x	
O0110D1c: Suctioning at discharge		x

MDS Data Element	PPS 5-day (A0310B = 01)	Part A PPS DC (A0310H = 1)
A1005 Ethnicity	x	
A1010 Race	x	
A1110A Preferred language	x	
A1110B Interpreter	x	
A1250 Transportation	x	x
A2105 Discharge Status		x
B0200 Hearing	x	
B1000 Vision	x	
B1300 Health literacy	x	x
C0100: Should BIMS be conducted	x	x
C0200: Repeat 3 words	x	x
C0300A: Year	x	x
C0300B: Month	x	x
C0300C: Day	x	x
C0500: BIMS Score	x	x
C1310A: Mental Status Change	x	x
C1310B: Inattention	x	x
C1310C: Disorganized thinking	x	x
C1310D: Altered LOC	x	x
D0150A1: Presence - Little interest	x	x
D0150A2: Frequency - Little interest	x	x
D0150B1: Presence - down,depressed	x	x
D0150B2: Frequency - down,depressed	x	x
D0150C1: Presence - Sleep trouble	x	x
D0150C2: Frequency - Sleep trouble	x	x
D0150D1: Presence - Tired	x	x
D0150D2: Frequency - Tired	x	x
D0150E1: Presence - Appetite	x	x
D0150E2: Frequency - Appetite	x	x
D0150F1: Presence - Feel bad about self	x	x
D0150F2: Frequency - Feel bad about self	x	x
D0150G1: Presence - Trouble concentrating	x	x
D0150G2: Frequency - Trouble concentrating	x	x
D0150H1: Presence - Move/speak slow	x	x
D0150H2: Frequency - Move/speak slow	x	x
D0150I1: Presence- Better off dead	x	x
D0150I2: Frequency- Better off dead	x	x
D0160: PHQ-9 Score	x	x
D0700: Social isolation	x	x
J0530: Pain effect sleep	x	x
J0520: Pain interfere therapy	x	x

MDS Data Element	PPS 5-day (A0310B = 01)	Part A PPS DC (A0310H = 1)
O0110D2a: Scheduled on admission	x	
O0110D2c: Scheduled at discharge		x
O0110D3a: As needed on admission	x	
O0110D3c: As needed at discharge		x
O0110E1a: Tracheostomy on admission	x	
O0110E1c: Tracheostomy at discharge		x
O0110F1a: Invasive mechanical ventilator on admission	x	
O0110F1c: Invasive mechanical ventilator at discharge		x
O0110G1a: Non-invasive mechanical ventilator on admission	x	
O0110G1c: Non-invasive mechanical ventilator at discharge		x
O0110G2a: BIPAP on admission	x	
O0110G2c: BIPAP at discharge		x
O0110G3a: CPAP on admission	x	
O0110G3c: CPAP at discharge		x
O0110H1a: IV med on admission	x	
O0110H1c: IV med at discharge		x
O0110H2a: Vasoactive med on admission	x	
O0110H2c: Vasoactive med at discharge		x
O0110H3a: Antibiotics on admission	x	
O0110H3c: Antibiotics at discharge		x
O0110H4a: Anticoagulation on admission	x	
O0110H4c: Anticoagulation at discharge		x
O0110H10a: Other on admission	x	
O0110H10c: Other at discharge		x
O0110I1a: Transfusions on admission	x	
O0110I1c: Transfusions at discharge		x
O0110J1a: Dialysis on admission	x	
O0110J1c: Dialysis at discharge		x
O0110J2a: Hemodialysis on admission	x	
O0110J2c: Hemodialysis at discharge		x
O0110J3a: Peritoneal dialysis on admission	x	
O0110J3c: Peritoneal dialysis at discharge		x
O0110K1a: IV access on admission	x	
O0110K1c: IV access at discharge		x
O0110K2a: Peripheral on admission	x	
O0110K2c: Peripheral at discharge		x
O0110K3a: Midline on admission	x	
O0110K3c: Midline at discharge		x
O0110K4a: Central on admission	x	
O0110K4c: Central at discharge		x
O0110Z1a: None of the above on admission	x	
O0110Z1c: None of the above at discharge		x

41

42