What’s new in the world of MDS for 2017?

New MDS Items and New Quality Performance Measures
Tied to Value Based Purchasing

The IMPACT Act of 2014

Improving Medicare Post-Acute Care Transformation (IMPACT)

Purposes Include:
• Improvement of Medicare beneficiary outcomes
• Provider access to longitudinal information to facilitate coordinated care
• Enable comparable data and quality across PAC settings
• Improve hospital discharge planning
• Research
IMPACT and Data Standardization

• Requires Standardized Patient Assessment Data that will enable:
  • Data Element uniformity
  • Quality care and improved outcomes
  • Comparison of quality and data across post-acute care (PAC) settings
  • Improved discharge planning
  • Exchangeability of data
  • Coordinated care

• Paying for value rather than paying for volume.
Limitations and problems of current system

- PAC setting is often determined by the discharge planner rather than most appropriate setting
- Payments that are in excess of provider cost in many cases (10% over cost)
- Case mix system that doesn’t accurately reflect cost of care for many different types of residents
- Incentives that encourage over-utilization of therapy services
- Incentives that encourage shorter lengths of stay
  - Replace RU with RU if shorter length of stay
- Retroactive adjustments for accelerating minutes of therapy (COT)
- Payment for care regardless of outcomes or quality
PAC-PRD & the CARE Tool: Goals and Guiding Principles

Goals
- Fosters seamless care transitions
- Measures that can follow the patient
- Evaluation of longitudinal outcomes for patients that traverse settings
- Assessment of quality across settings
- Improved outcomes, and efficiency
- Reduction in provider burden

Data Uniformity
- Reusable
- Informative
- Increases reliability/validity
- Facilitates patient care coordination

Interoperability
- Data that can communicate in the same language across settings
- Data that can be transferable forward and backward to facilitate care coordination
- Follows the individual

What is Standardization?
Standardizing Function at the Item Level

Inpatient Rehabilitation Facilities - Patient Assessment Instrument (IRF-PAI)
Skilled Nursing Facilities - Minimum Data Set (MDS)
Home Health Agencies - Outcome & Assessment Information Set (OASIS)
Long-Term Care Hospitals - Continuity Assessment Record & Evaluation (CARE) Data Set (LCDS)

IRF-PAI
- Eating

MDS
- Eating

OASIS
- Eating

LCDS
- Eating
Standardized Assessment Data Elements

One Question: Much to Say → One Response: Many Uses

<table>
<thead>
<tr>
<th>GG0016: Functional Mobility (Complete during the 3-day assessment period)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code the patient’s usual performance using the 6-point scale below.</td>
</tr>
<tr>
<td>Enter Codes in boxes:</td>
</tr>
<tr>
<td>A. Roll left and right: The ability to roll from lying on back to left side, and not back to back.</td>
</tr>
<tr>
<td>B. Roll to lying: The ability to move from sitting on side of bed to lying flat on the back.</td>
</tr>
<tr>
<td>C. Lying to sitting on side of bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, no back support.</td>
</tr>
</tbody>
</table>

Data Element & Response Code

- Care Planning/Decision Support
- QL
- Quality Reporting
- Care Transitions

Self-Care GG0130

<table>
<thead>
<tr>
<th>Item</th>
<th>Item Description</th>
<th>Inpatient Rehabilitation Facility Patient Assessment Instrument (HRF-PAI) v1.0</th>
<th>Minimum Data Set (MDS) 3.0</th>
<th>Long-Term Care Hospital CARE Data Set v3.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Eating</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>B</td>
<td>Oral hygiene</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>C</td>
<td>Toileting hygiene</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>D</td>
<td>Wash upper body</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>E</td>
<td>Shower/bathe self</td>
<td>✓</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>F</td>
<td>Upper body dressing</td>
<td>✓</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>G</td>
<td>Lower body dressing</td>
<td>✓</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>H</td>
<td>Putting on/taking off footwear</td>
<td>✓</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>
IMPACT Act: Quality Measure Domains and Timelines

1. Functional status, cognitive function, and changes in function and cognitive function
   - SNF: October 1, 2016
   - IRF: October 1, 2016
   - LTCH: October 1, 2018
   - HHA: January 1, 2019

2. Skin integrity and changes in skin integrity
   - SNF: October 1, 2016
   - IRF: October 1, 2016
   - LTCH: October 1, 2018
   - HHA: January 1, 2017

3. Medication Reconciliation
   - HHA: January 1, 2017
   - SNF: October 1, 2018
   - IRF: October 1, 2018
   - LTCH: October 1, 2018

IMPACT Act: Quality Measure Domains and Timelines (continued)

4. Incidence of Major Falls
   - SNF: October 1, 2016
   - IRF: October 1, 2016
   - LTCH: October 1, 2018
   - HHA: January 1, 2019

5. Communicating the existence of and providing for the transfer of health information and care preferences
   - SNF: October 1, 2018
   - IRF: October 1, 2018
   - LTCH: October 1, 2018
   - HHA: January 1, 2019

Resource use and other measures will be specified for reporting:
- Total estimated Medicare spending per beneficiary
- Discharge to community
- Measures to reflect all-cause risk-adjusted potentially preventable hospital readmission rates

SNF: October 1, 2016
IRF: October 1, 2016
LTCH: October 1, 2016
HHA: January 1, 2017
What's new in the world of MDS and Medicare reimbursement...

...and what do we need to look at differently?
So many measures....

- We now will have different measures for all of the following:
  - Quality Measures on Nursing Home Compare
  - Five Star rating evaluation measures
  - Surveyor measures
  - Quality Reporting Program (QRP) measures for value-based purchasing

- And... in New York... Quality Pool measures...
### MDS Based Quality Measures
For SNF QRP Reporting – Oct 2016

<table>
<thead>
<tr>
<th>Metric</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRESSURE ULCERS</td>
<td>Percent of Residents/Patients with Pressure Ulcers That Are New Or Worsened (SNF QRP)</td>
</tr>
<tr>
<td>FALLS WITH MAJOR INJURY</td>
<td>Percent of Residents/Patients Experiencing One or More Falls with Major Injury (SNF QRP)</td>
</tr>
<tr>
<td>ADM/DISCH FUNCTION CP</td>
<td>Percent of Residents/Patients With an Admission and Discharge Functional Assessment and Care Plan That Addresses Function (SNF QRP)</td>
</tr>
</tbody>
</table>

### Claims Based Quality Measures
For SNF QRP Reporting – Oct 2017

<table>
<thead>
<tr>
<th>Metric</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICARE SPENDING</td>
<td>Medicare Spending per Beneficiary – Post-Acute Care (SNF QRP)</td>
</tr>
<tr>
<td>COMMUNITY DISCHARGE</td>
<td>Successful Discharge to Community (SNF QRP)</td>
</tr>
<tr>
<td>30-DAY READMISSION</td>
<td>Potentially Preventable 30-Day Post-Discharge Readmission Measure (SNF QRP)</td>
</tr>
</tbody>
</table>
Complying with “Reporting” Requirement

• Compliance with Reporting Requirements means...
  • Data submission starting in first quarter in FY 2017
  • 80% of all MDS assessments must contain 100% of the data elements required to calculate the measures (initially the 3 MDS Based QRP measures)
  • Need to consider all contributing data points for the measure
    • Target items
    • Covariates
    • Exclusions
    • Risk adjustments
  • NO DASHES in key MDS items

Can no longer just answer enough MDS questions to get the RUG score
Non-compliance with “Reporting” Requirement

• Penalty for non-compliance with reporting requirement
  • If 80% of MDS assessments submitted from Q1 2017 do not contain 100% of required data elements (more than 20% with errors/dashes)
  • 2% reduction in market basket update for all Medicare claims in FY 2018 starting October 1, 2017
  • There is no penalty at this time for outcome on measures
  • The penalty is for failure to report accurate data

MDS-Based Data Collection Penalty Phase-In Process

<table>
<thead>
<tr>
<th>DATA COLLECTION PERIOD</th>
<th>PENALTY PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 FY 2017</td>
<td>FY 2018</td>
</tr>
<tr>
<td>Q2, Q3, Q4 FY 2017</td>
<td>FY 2019</td>
</tr>
<tr>
<td>FY 2018</td>
<td>FY 2020</td>
</tr>
</tbody>
</table>

At full implementation of these measures in 2018, there will be a 2-year lag in the penalty period.
This is the first wave... there are more to come next year...

Data is collected on Medicare PPS 5-Day assessment and compared to the Medicare Part A PPS Discharge assessment for key indicators:

- New/Worsened Pressure Ulcers
- Functional Status Items

Also...

- Falls with Major Injury – (all assessment in look-back scan)

This is for traditional Medicare Part A
*Does not include Medicare Advantage or HMO

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### Pressure Ulcers

#### Percent of Residents/Patients with Pressure Ulcers That Are New Or Worsened (SNF QRP)

**Numerator**
- Number of complete resident Medicare Part A stays that end during the selected time window with one or more new or worsened Stage 2-4 pressure ulcers at the end of the stay.
  - Determine on Part A PPS assessment: Stage 2, 3, 4 coded at M0300 (NOT M0800)

**Denominator**
- Number of complete resident Medicare Part A stays ending during the selected time window, except those that meet exception criteria.
  - (Complete = NO Unplanned discharges)

**Exclusions**
- Stay is excluded if data is missing at Pressure Ulcer staging for Stage 2, 3, 4 at M0300 –
  - Dashes are considered missing data
  - Stay is excluded if death in facility

**Risk Adjustment**
- Covariates – (adjust the percentage – do not exclude records)
  - Bed Mobility ≥ 2
  - Bowel incontinence ≥ occasionally
  - Low BMI < 19
  - Diabetes or PVD

These conditions need to be on initial assessment.

**Timeframe**
- Rolling 12 months of data

**For residents with multiple stays, each stay is eligible.**

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Dash in any of these items coded on the MDS will be considered an error.
Considerations for New/Worsened PU

- Rolling 12 month of data = current quarter and 3 prior quarters
- Starts with stays beginning October 1, 2016
- Qualifying stay = PPS Discharge
- Be sure to check coding of ALL triggers, exclusions, and risk adjusters
- If pressure ulcer develops after admission, but heals by discharge, it is not counted against facility.
- Don’t under-stage pressure ulcers – take the higher stage initially
- Coding is for actual PU with a 7 day look-back
- Healed during look-back period = not coded as a current PU

### FALLS WITH MAJOR INJURY

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
<th>Exclusions</th>
<th>Risk adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of residents with one or more assessments in the look-back scan containing a fall with major injury coded at J1900C</td>
<td>All long-stay nursing home residents with a one or more look-back scan assessments except those with exclusions</td>
<td>Missing data (dashes)</td>
<td>None</td>
</tr>
</tbody>
</table>

Resident is excluded if one of the following is true for all of the look-back scan assessments: 1. The occurrence of falls was not assessed (J1800 = [-]), or 2. The assessment indicates that a fall occurred (J1800 = [1]) and the number of falls with major injury was not assessed (J1900C = [-]).
Considerations for Falls with Major Injury

- Only code falls that meet the definition of a major injury
- Educate nurses in anatomy and physiology related to definitions
- All falls while still a resident count (LOA, in hospital, etc)
- New rule: Any documented injury that occurred as a result of, or was recognized within a short period of time (hours to few days) after the fall and is attributed to the fall is coded for the time of the fall.
  - Example: resident discharged to hospital with pain, later facility is notified of fracture, must code discharge as a fall with major injury
### ADM/DISCH FUNCTION CP

#### Percent of Residents/Patients With an Admission and Discharge Functional Assessment and Care Plan That Addresses Function (SNF QRP)

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
<th>Exclusions</th>
<th>Risk adjustment</th>
</tr>
</thead>
</table>
| Number of stays with data for each self-care and mobility activity and at least one self-care goal. | Number of Part A covered stays | For incomplete stay: Admission data and at least one goal required. Discharge data would not be required.  
- Acute medical emergency  
- AMA discharge  
- Death on Part A stay | None |

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### Section GG

**Functional Abilities and Goals - Admission (Start of SNF PPS Stay)**

**GG0130. Self-Care (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B)**

Complete only if A2400B = 01

- **Code the resident's usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale.** If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goals(s) using the 6-point scale. Do not use codes 07, 08, or 88 to code end of SNF PPS stay (discharge) goals.

- **Coding:**
  - **Safety and Quality of Performance:** If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided. Activities may be completed with or without assistive devices.
  - **00:** Independent - Resident completes the activity by himself/herself with no assistance from a helper.
  - **01:** Setup or clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
  - **02:** Supervision or touching assistance - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident 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.
  - **04:** Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

- **05:** **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity.

- On the assistance of 2 or more helpers is required for the resident to complete the activity.

- **If activity was not attempted, code reason:**
  - **07:** Resident refused.
  - **09:** Not applicable.
  - **88:** Not attempted due to medical condition or safety concerns.

#### Admission Performance

1. [ ]
2. [ ]

#### Discharge Goal

1. [ ]  A. **Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.
2. [ ]  B. **Oral hygiene:** The ability to use suitable items to clean teeth. (Dentures if applicable) The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.
3. [ ]  C. **Tubbling hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinary. If managing an ostomy, include wiping the opening but not managing equipment.
### Self-care measures

<table>
<thead>
<tr>
<th>Mobility measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Admission</strong></td>
</tr>
<tr>
<td><strong>2. Discharge</strong></td>
</tr>
<tr>
<td><strong>Discharge</strong></td>
</tr>
<tr>
<td><strong>Exits</strong></td>
</tr>
<tr>
<td>Codes in Boxes</td>
</tr>
<tr>
<td>Codes in Boxes</td>
</tr>
<tr>
<td>Codes in Boxes</td>
</tr>
</tbody>
</table>

**A. Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.

**B. Oral hygiene:** The ability to use suitable items to clean teeth. (Dentures if applicable) The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.

**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. If managing an ostomy, include wiping the opening but not managing equipment.
# Mobility Part 1 - Transfer measures

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>B.</td>
<td>Sit to lying:</td>
<td>The ability to move from sitting on side of bed to lying flat on the bed.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>C.</td>
<td>Lying to sitting on side of bed:</td>
<td>The ability to safely 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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>D.</td>
<td>Sit to stand:</td>
<td>The ability to safely come to a standing position from sitting in a chair or on the side of the bed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E.</td>
<td>Chair/bed-to-chair transfer:</td>
<td>The ability to safely transfer to and from a bed to a chair (or wheelchair).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>F.</td>
<td>Toilet transfer:</td>
<td>The ability to safely get on and off a toilet or commode.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

# Mobility Part 2 - Walking and Wheeling

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>H3.</td>
<td>Does the resident walk?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. No → Skip to GG0170Q3. Does the resident use a wheelchair/scooter?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Yes → Continue to GG0170R. Walk 50 feet with two turns</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J.</td>
<td>Walk 50 feet with two turns:</td>
<td>Once standing, the ability to walk at least 50 feet and make two turns.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K.</td>
<td>Walk 150 feet:</td>
<td>Once standing, the ability to walk at least 150 feet in a corridor or similar space.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q3.</td>
<td>Does the resident use a wheelchair/scooter?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Yes → Continue to GG0170R. Wheel 50 feet with two turns</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R.</td>
<td>Wheel 50 feet with two turns:</td>
<td>Once seated in wheelchair/scooter, can walk at least 50 feet and make two turns.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RR3.</td>
<td>Indicate the type of wheelchair/scooter used.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Manual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Motorized</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S.</td>
<td>Wheel 150 feet:</td>
<td>Once seated in wheelchair/scooter, can wheel at least 150 feet in a corridor or similar space.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SS3.</td>
<td>Indicate the type of wheelchair/scooter used.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Manual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Motorized</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Challenges...

- Some New functional items to assess
- Some are the same functional items with different definitions
- New performance scale
- New terminology
- Shortened time frame to assess on admit (Days 1-3)
- Need to plan to assess function last 3 days
- Usual performance vs. algorithm for coding

Learning a new way to look at performance...

<table>
<thead>
<tr>
<th>Current Section G</th>
<th>New Section GG</th>
</tr>
</thead>
</table>
| • Weight bearing assistance  
  • Limited assist  
  • Extensive assist  
  • Totally Dependence  
  • Total assist EVERY time | • More than half the time vs. Less than half the time  
  • Partial/moderate assist  
  • Substantial maximum assist  
  • Dependent  
  • Helper does all the effort  
  • OR assistance of 2 helpers is required for the resident to complete the activity |
Learning a new way to look at performance...

Current Section G

- Independent: No help or staff
- Supervision: Oversight, encouragement
- Limited assistance: Resident helps
- Extensive assistance: Resident
- Total dependence: Full staff presence

New Section GG

- Independent: Resident completes the activity
- Setup or clean-up assistance: Helper assists only prior to or following the activity
- Supervision or touching assistance: Helper assists as resident completes activity
- Partial/mild assistance: Helper supports trunk or limbs, but provides less than half
- Substantial/maximal assistance: Helper does trunk or limbs and provides more than half
- Dependent: Helper does all of the effort, or the assistance of 2 or more helpers is required

WHAT DO WE DO WITH SECTION GG?

Determine usual performance in functional status on GG during the first 3 days of the PPS Stay

Set at least one goal on the PPS 5-day assessment

Determine usual performance during the last 3 days of a complete PPS Stay

Days 1-3 starting with date at A2400B

Last 3 days ending with date at A2400C
Discharge assessment completed for PLANNED DISCHARGES only

Planned vs. Unplanned Discharge

- Measures calculate on planned discharges only
- Incomplete stays do not allow the facility an opportunity to finish progress toward goals
- PPS discharges are completed when resident comes off from MCR A and stay in the facility also

Part A PPS Discharge Assessment (A0310H)[PPSDC]

- Must be completed when Medicare Part A stay ends, but resident remains in the facility
- Must not be completed when Part A stay ends with death in facility or on LOA
- If planned physical discharge is the day of or one day after End of Medicare Stay (A2400C) may combine PPSDC with OBRA DCRA or DCRNA
- If unplanned OBRA DC is day of or one day after A2400C, DO NOT COMPLETE PPSDC AT ALL.

SNF-QRP will calculate Each. Separate. Stay. unless “unplanned”

Admission Entry Tracking

1. Stay 1
   - DCRA or RNA Unplanned
   - SNF-QRP Measures Not Calculated

2. Stay 2
   - DCRA or RNA Planned
   - SNF-QRP Measures Calculated

PPS DC stay in SNF

3. Stay 3
   - SNF-QRP Measures Calculated

Enter Code

1. Planned
2. Unplanned

H. Is this a SNF Part A PPS Discharge Assessment?

0. No
1. Yes
A2300. Assessment Reference Date

Observation end date: 

Month   Day   Year

A2400. Medicare Stay

A. Has the resident had a Medicare-covered stay since the most recent entry?
   0. No  → Skip to GG0130, Self Care
   1. Yes  → Continue to A2400B, Start date of most recent Medicare stay

B. Start date of most recent Medicare stay:

   Month   Day   Year

C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:

   Month   Day   Year

Traditional Medicare Only

Start and End of Medicare Stay

Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS stay, code the reason.
### Different Definitions for Self-Care Activities

<table>
<thead>
<tr>
<th>Eating (GG)</th>
<th>Eating (G)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Use suitable utensils</td>
<td>• How resident eats and drinks</td>
</tr>
<tr>
<td>• Bring food to mouth</td>
<td>• Includes IV/TG</td>
</tr>
<tr>
<td>• Swallow food</td>
<td></td>
</tr>
</tbody>
</table>

### Different Definitions for Self-Care Activities

<table>
<thead>
<tr>
<th>Oral Hygiene (GG)</th>
<th>Personal Hygiene (G)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Use suitable items to clean teeth</td>
<td>• Combing hair</td>
</tr>
<tr>
<td>• Remove dentures</td>
<td>• Brushing teeth</td>
</tr>
<tr>
<td>• Replace dentures</td>
<td>• Shaving</td>
</tr>
<tr>
<td>• Manage equipment for soaking</td>
<td>• Applying makeup</td>
</tr>
<tr>
<td>• Manage equipment for rinsing</td>
<td>• Washing and drying face and hand</td>
</tr>
</tbody>
</table>

**Note:**
- **Eating (GG)**: Focuses on the physical act of eating, using utensils, bringing food to the mouth, and swallowing food.
- **Eating (G)**: Involves how residents eat and drink, including intravenous/tube feeding (IV/TG).
- **Oral Hygiene (GG)**: Includes various tasks such as cleaning teeth, managing dentures, and equipment.
- **Personal Hygiene (G)**: Covers activities like combing hair, brushing teeth, applying makeup, and personal washing.

**Footer:**
- **PROCARE**
- **Providing the solutions you need...for the values you work...
## Different Definitions for Self-Care Activities

### Toileting Hygiene (GG)
- Perineal hygiene
- Adjust clothes before
- Adjust clothes after
- Wiping opening of ostomy
- Positioning/removing bedpan or urinal

### Toileting (G)
- Uses toilet room, commode, bedpan, urinal
- Transfers on/off
- Cleanses self
- Changes pad
- Manages ostomy or catheter
- Adjusts clothes

### Transfer (GG)
- Sit to lying
- Lying to sitting on side of bed
- Sit to stand
- Chair/bed-to-chair transfer
- Toilet transfer

### Transfer (G)
- How resident moves between surfaces
  - Bed, chair, w/c, standing
  - Excludes toilet
Different Definitions for Self-Care Activities

<table>
<thead>
<tr>
<th>Walk/Wheel (GG)</th>
<th>Walk/Locomotion (G)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Walk 50 feet with 2 turns</td>
<td>• Walk in room</td>
</tr>
<tr>
<td>• Walk 150 feet</td>
<td>• Walk in corridor</td>
</tr>
<tr>
<td>• Wheel 50 feet with 2 turns</td>
<td>• Locomotion on unit</td>
</tr>
<tr>
<td>• Wheel 150 feet</td>
<td>• Locomotion off unit</td>
</tr>
</tbody>
</table>

Example: Eating Days 1-3

DAY 1
• Very tired and weak, drank some juice, didn’t want to eat anything that evening
07: Resident refused

DAY 2
• Weak during breakfast. Ate a few bites using her fork, drifted off to sleep. CNA fed her about 75% of her meal. For lunch, the CAN fed about 25%, resident fed the rest. For the evening meal she fed herself after set-up

DAY 3
• CNA fed about half of breakfast, but by lunch she was more alert, feeling stronger, and only needed supervision and cueing to eat using utensils. At the evening meal, she felt strong enough to go to the dining room. When eating with other residents, she fed herself using suitable utensils without cueing by staff.

What is her “Usual Performance”? 03: Partial/Mod Assist

07: Resident refused
04: Supervision/Touching
02: Substantial/Max assist
03: Partial/Mod assist
05: Set-up/ Clean up
Coding Guidance

• **Ways to perform assessment**
  - Direct observation
  - Documentation collection
  - Documentation review
  - Helper = facility employed or contracted staff
    • No volunteers, family, Hospice
  - Use of assistive devices is permitted

• **Coding USUAL PERFORMANCE**
  - Not the best
  - Not the worse
  - If hard to choose between two levels, aim low on initial assessment
  - Intent is to measure progress
  - At some time this will be publically reported based on data being collected now

Goal Setting for Functional Status

• Licensed clinicians can establish a resident’s discharge goal(s) at the time of admission based on the 5-Day PPS assessment, discussions with the resident and family, professional judgement, and the professional’s standard of practice.
  - Goals should be established as part of the resident’s plan of care.

• Must have at least one goal per resident stay
• May code one for each self-care and mobility item, but only one is required.
• The goal can be to improve, decline, or remain the same
• For therapy residents, should not be to decline
• Do not use codes 07, 09, or 88
Complete Stay – Compliant Submission

Need performance score for all functional activities (self-care and mobility sections)

Discharge performance for each functional activity

At least ONE GOAL

Documentation Tools

- Some organizations have developed tools that are free to members
- Some software companies have developed tools
- Tools are not required
- Tools are not necessary
- There is no algorithm
- There is no counting required
- It is a judgement call on what the usual performance is for the resident in the first 3 days.
It takes a team....

- Who is the best one to complete section GG?
- The therapist?
- The nurse manager?
- The MDS nurse?

- The best answer.... THE TEAM!

Sy ner. gy (def)

The interaction of two or more agents or forces so that their combined effect is greater than the sum of their individual effects.

Other SNF QRP measures coming next year for VBP
**Potentially Preventable 30-Day Post Discharge Readmission Measure for SNF QRP**

- No simple numerator/denominator
- Numerator is risk adjusted estimate of the number of unplanned hospital readmissions that occurred within 30 days of PAC discharge
  - Risk adjusted for patient/resident characteristics
  - ICD-10 codes from hospital claims
- Potentially preventable:
  - Management of infections (i.e. Pneumonia, UTI, C-Diff, Cellulitis)
  - Management of chronic conditions (i.e. CHF, COPD, Diabetes)
  - Inadequate prevention of other events (i.e. accidents, injury)

**Potentially Preventable 30-Day Post Discharge Readmission Measure for SNF QRP**

- Exclusions:
  - Under 18 years
  - Discharge AMA (status code on UB-04)
  - Not continuously enrolled in Part A 12 months prior to SNF stay or 30 days after
  - Prior hospitalization for non-surgical treatment of cancer
  - Transferred to federal hospital (DoD, VA, Prison)
  - Problematic data
**Discharge to Community – Post Acute Care**

**SNF QRP**

- Assesses successful discharge to the community
- Successful community discharge has achieved significant savings where capitated payments are in place
- Ability to care for long-term disability patients in the community vs. institution creates significant savings

“Community”: Defined by codes on bill

* Discharge status codes 01 Home, 06 self-care, 81 with home health, 86 without home health

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**Discharge to Community – Post Acute Care**

**SNF QRP**

- Successful community discharge:
  - No unplanned hospitalizations (Acute of LTCH)
  - No death
  - From any cause... Within 31 days of discharge

- Exclusions:
  - Hospice, other adjustments similar to previous claims-based measures
  - Discharge to psych hospital
  - Discharge to law enforcement/court
  - Medicare benefit exhausts
Medicare Spending Per Beneficiary
SNF QRP

• Used for benchmarking provider to “expected spending”
• Not just a simple sum of costs – some exclusions apply
• Begins upon admission to SNF
• Ends 30 days after SNF discharge (includes associated services)
• Mirrors hospital Medicare Spending Per Beneficiary measure

Drug Regimen Review Conducted with Follow-Up for Identified Issues
SNF QRP

• Begins October FY 2018
• MDS-Based measure
• Will be new part of MDS assessment in Section N to record if Drug Regimen Review was conducted and if follow-up was completed for any identified areas of concern.
One other preview...

- **PROPOSED MEASURE – Pay For Performance**
  - Would not directly impact 2017 reimbursement, however, 2017 data would be used and would impact 2019 reimbursement

- SNF 30-Day Potentially Preventable Re-Admission Measure (SNF PPR)
  - Part of PAMA (Protecting Access to Medicare Act)
  - Reward providers who decrease hospitalizations
  - Planned start in 2019 using data from 2017

- SNF VBP: One Measure only
  - First year: Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFMR NQF #2510)
  - To be replaced by:
  - FY 17 Proposed Measure: SNF 30-Day Potentially Preventable Readmission Measure (SNFPPR)

- 2% of Medicare claims off the top
- Can earn back up to 50-70%
- 30-50% CMS will keep (trust fund)
List is several pages long of potentially preventable conditions.

Table 2-1. List of Conditions for Defining Potentially Preventable Hospital Readmissions for 30-Days Post-PAC Discharge with ICD-9 Codes

Note: These conditions will be used for the post-PAC discharge measures.

<table>
<thead>
<tr>
<th>Conditions</th>
<th>Diagnosis</th>
<th>ICD-9. CM</th>
<th>30 day post-PAC discharge</th>
<th>Clinical Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult asthma*</td>
<td></td>
<td></td>
<td>X</td>
<td>Inadequate management of chronic conditions</td>
</tr>
<tr>
<td>*Extrinsic asthma NOS</td>
<td></td>
<td>493.00</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>*Extrinsic asthma w/ status asth</td>
<td></td>
<td>493.01</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>*Extrinsic asthma w/acute exac</td>
<td></td>
<td>493.02</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>*Intrinsic asthma NOS</td>
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<td>493.10</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>*Intrinsic asthma w/ status asth</td>
<td></td>
<td>493.11</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>*Inf asthma w/ status asth</td>
<td></td>
<td>493.12</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>*Inf asthma w/ (ac) exac</td>
<td></td>
<td>493.20</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>*Chob asthma w/ status asth</td>
<td></td>
<td>493.21</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>*Chob asthma w/ (ac) exac</td>
<td></td>
<td>493.22</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>*Exercise induced bronchospasm</td>
<td></td>
<td>493.81</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>*Cough variunt asthma</td>
<td></td>
<td>493.82</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>*Asthma NOS</td>
<td></td>
<td>493.90</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>*Asthma w/ status asth mut</td>
<td></td>
<td>493.91</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>*Asthma NOS w/ (ac) exac</td>
<td></td>
<td>493.92</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

QUESTIONS?

Michelle Synakowski, Director of ProCare
LeadingAge New York
msynakowski@leadingageny.org
518-867-8850