NURSING HOME QUALITY INITIATIVE
QUALITY MEASURES RESOURCE MANUAL

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INTRODUCTION & OVERVIEW OF THE QUALITY MEASURES

This training guide contains information on the new set of quality measures that will be posted on the Medicare "Nursing Home Compare" (www.medicare.gov) web site for all nursing facilities beginning in the Fall of 2002. A brief introduction to the quality measures is listed here for informational purposes.

Ten quality measures were selected from a longer list of potential quality measures and recommended for use by the Centers for Medicare & Medicaid Services (CMS) for public reporting purposes. These measures address both the chronic and post acute resident populations served by nursing facilities.

The *chronic* population refers to those types of residents who typically enter a nursing facility because they are no longer able to care for themselves at home. These residents tend to remain in the nursing facility anywhere from several months to several years. Calculation of a chronic quality measure uses information on any resident with a full or quarterly OBRA MDS assessment in the "target" quarter. Target quarter refers to the period of time being used for calculation of a particular quality measure. The target quarter for measures being posted in October 2002 is the 2nd quarter (April, May, and June) of 2002.

The *post acute* population refers to those types of residents who are admitted to a facility and stay for a short period of time. These admissions typically follow an acute care hospitalization and involve high-intensity rehabilitation or clinically complex care. For the purposes of determining quality measures for these residents, calculations involve any residents with a 14-Day SNF PPS assessment in the target six-month period.

Six "chronic" care quality measures are being used for public reporting in October 2002:

1) Percent of Residents with Pain
2) Percent of Residents with Infections
3) Percent of Residents with Pressure Sores
4) Percent of Residents with Pressure Sores with an Additional Level of Risk Adjustment
5) Percent of Residents in Physical Restraints
6) Percent of Residents with Loss of Ability in Basic Daily Tasks

Four "post acute" care quality measures are being used for public reporting in October 2002:

1) Percent of Short-Stay Residents with Pain
2) Percent of Short-Stay Residents with Delirium
3) Percent of Short-Stay Residents with Delirium with an Additional Level of Risk Adjustment
4) Percent of Short-Stay Residents Who Walk as Well or Better on Day 14 as on Day 5 of Their Stay

Definitions for each of these quality measures are included in this manual. Numerators, denominators, exclusion criteria, resident level covariates, and facility level risk adjustments are described on the following pages. Also included in this manual is information regarding the criteria that are used to select MDS records to calculate the chronic and post acute quality measures. The updated CMS RAI Users Manual, September 2002, was used to provide instructions and examples for completing the MDS elements used in calculation of the quality measures.

Please note that the quality measures referenced in this manual are designed for use in the national rollout of the Nursing Home Quality Initiative, expected in the Fall of 2002. The pilot phase of this initiative ran from April to September 2002 and included a set of measures that was different than the set of measures being used by CMS for the national rollout. Additionally, these measures may change throughout the evolution of this quality initiative, as further research being conducted by organizations under contract with the Centers for Medicaid & Medicare Services yields new information.

WHAT IS A QUALITY MEASURE?

Quality Measures are related to specific clinical areas of care. The measures are derived from MDS data only. Quality Measures are intended to provide objective measures by which an individual may determine how well a nursing home staff is able to manage various aspects of care being provided to their residents.

When selecting a nursing home, these measures are intended to be used in conjunction with other variables often used to measure quality within a nursing home, such as resident and family satisfaction, staff interactions with the residents, level of staff knowledge in the area of geriatric medicine and care issues, and overall cleanliness and appearance of the facility.

An initial set of Quality Indicators (QIs) was developed by the Center for Health Systems Research and Analysis (CHSRA) at the University of Wisconsin-Madison under contract with Centers for Medicare & Medicaid Services (CMS). These indicators are currently used in nursing homes and are derived from information submitted by the nursing staff on the Minimum Data Set assessment (MDS).

The current quality indicators were intended to indicate areas of care that may be a potential concern within the facility. That is, these quality indicators were developed to point out the possibility of a problem with care. They were not intended to be an *absolute* statement of a problem, but rather to indicate a *potential* care problem that would require further investigation. State surveyors use current quality indicators to target residents for inclusion in a survey sample for annual state inspections and to provide feedback to nursing facilities for quality improvement.

The Centers for Medicare & Medicaid Services is very interested in supporting the ongoing process of quality improvement in nursing homes. As part of this effort, CMS contracted with health care research experts to review existing literature and identify a list of quality measures for further testing and analysis. As a result of this research, a “new” set of quality measures (termed the “Quality Measures”) has been developed for the dual purpose of public reporting and quality improvement in nursing facilities. It is important to note that these quality measures do NOT replace the current QIs that are used in the survey process and that are being used for quality improvement efforts in facilities at this time.

The measures chosen for public reporting include ten quality measures for two distinctive resident populations. The two resident populations include “post acute” residents that enter a nursing home for a short stay following an acute care hospitalization and “chronic care” residents that enter a nursing home for a long period of time, frequently because they are no longer capable of living on their own. The quality measures are risk adjusted to make them more appropriate as measures for public reporting purposes. See Chapter 4 for more information on risk adjustment.

The quality measures include the following:

Post Acute

Percent of Short-Stay Residents with Pain
Percent of Short-Stay Residents with Delirium
Percent of Short-Stay Residents with Delirium with an Additional Level of Risk Adjustment
Percent of Short-Stay Residents Who Walk as Well or Better on Day 14 as on Day 5 of Their Stay

Chronic

Percent of Residents with Pain
Percent of Residents with Infections
Percent of Residents with Pressure Sores
Percent of Residents with Pressure Sores with an Additional Level of Risk Adjustment
Percent of Residents in Physical Restraints
Percent of Residents with Loss of Ability in Basic Daily Tasks

NOTE: These ten measures are for use in all states during the Fall 2002 national rollout of the Nursing Home Quality Initiative (NHQI). It is possible that the measures may change during later phases of the quality initiative.

COMPARISON OF QUALITY MEASURES AND CURRENT QUALITY INDICATORS

A comparison of the quality measures and the current quality indicators shows a number of similarities as well as differences.

I. Dimensions of Care

Comparison of the set of quality measures (QMs) and the set of current quality indicators (QIs) show that while both sets of information address a number of similar clinical aspects of care, there are other aspects of care that are covered exclusively in the quality measure set (See Appendix A).

The QM set addresses a total of ten measures divided into two resident populations (chronic and post acute), while the current QI set is limited to the chronic population only and addresses a total number of 24 measures that are divided into 11 “domains” of care, with a range of one to four quality indicators per domain.

The QM set overlaps with several of the current QIs (ADL decline, percentage of pressure ulcers and use of physical restraints).

II. Risk Adjustment

The risk adjustment process differs between the quality measures and the current quality indicators. Briefly, several of the current QIs are risk-adjusted by separating residents into "high risk" and "low risk" groups based on the presence or absence of relevant risk factors. The QI is then computed separately for each group. This adjustment approach works well in the survey process, because it allows for determination of the relative sizes of the high and low risk populations for a facility. It also allows for identification of whether the facility has a potential care problem for either or both risk groups, as well as allowing for the setting of separate thresholds for the high and low risk groups.

Risk adjustment for the quality measures is done very differently than the risk adjustment process used in calculation of the current quality indicators. For one of the QMs (Delirium), the risk adjustment calculation takes into account variations between both resident level (covariate) and facility level (FAP) risk measures. For another two of the measures, (Improvement in Walking and Pressure Ulcers), the risk adjustment calculation takes into account only facility level risk measures. Chronic pain is risk adjusted at the resident level only. The quality measures are also standardized to national averages for comparison purposes. National figures were chosen as a standard so that facilities in different states can be fairly compared. The risk adjustment was adopted in order to allow for a fair comparison of facilities within states or in different states, as this is very important for publicly reported information.

III. Quality Measure Rates

It is important to note that the rates for the quality measures will likely differ somewhat from rates for the same current quality indicators on the current Monthly Quality Indicator Comparison Reports for your facility. This will happen because of differences in the record selection procedures, in the measure definitions, and in the risk adjustment process for the two sets of quality information.

RISK ADJUSTMENT

Risk adjustment is an important component in the calculation of quality measures. Without risk adjustment, a quality measure may not give a true and fair picture of clinical care being provided in the nursing facility. Facilities vary in the level of the overall health and functional impairment displayed by individual residents and in admission and discharge practices. It is important, therefore, to adjust for risk when computing the quality measures.

The new set of measures is risk adjusted in order to take into account differences that exist among residents in the nursing home setting. The methods of risk adjustment used for calculation of the quality measures involve use of resident information that is thought to be related to the triggering of individual quality measures but not reflective of care processes. This type of risk adjustment is meant to "level the playing field" when comparing quality measures between nursing facilities.

There are a number of different approaches to risk adjustment including determination of exclusion factors, regression analysis, and stratification (e.g., high/low risk). The set of quality measures uses the first two of these methods for the risk adjustment process.

Exclusion factors are used to limit the measures to the subset of residents who are at risk for a particular condition. For example, the late-loss ADL measure excludes comatose residents from consideration since ADL performance is obviously irrelevant for such residents. If comatose residents were included in this measure, then the number of comatose residents in a facility could affect that facility's reported score on the ADL measure, thereby making it difficult to compare it with other facilities (which might not have comatose residents).

The second general method of risk adjustment which is used in the quality measures is regression based. This involves using statistical methods to identify factors (such as resident characteristics) which are not related to quality of care but which are related to outcomes. The quality measures utilize two types of regression-based adjustments: resident and facility adjustments. These are explained in the following sections.

It is important to note that the measures and the risk adjustment methodology may change in later phases of the quality reporting initiative.

Resident Level Risk Adjustment

Individual residents face different levels of risk for particular measures due to personal variations in health and functional status. An individual resident may have a predisposing health condition that could increase the likelihood of that resident triggering a specific measure regardless of the quality of care provided by the nursing home. For example, accurate assessment of pain in a cognitively impaired resident may be more difficult due to the resident's inability to verbalize to nursing home staff. Furthermore, cognitively intact residents may choose to tolerate pain rather than take pain medication. Therefore the chronic quality measure for pain is risk adjusted using

data from item B4 on the MDS to take cognitive deficits into account as part of the QM calculation for pain in the chronic measure.

Two of the quality measures are risk adjusted at the resident level: delirium (for the post acute or PAC population) and pain (for the chronic population). These measures take into account various resident characteristics that may contribute to more negative health outcomes. (See Chapter 7 for more detailed information).

Facility Level Risk Adjustment

Some of the measures are adjusted at the facility level to account for differences in facility admitting and assessment practices. Facility level risk adjustment takes into account the fact that some nursing homes may admit frailer, sicker residents or may specialize in a particular area of care (e.g., pressure ulcers) that may account for a larger proportion of residents triggering on a particular quality indicator.

The facility level adjustments are made on the basis of the proportion of residents with admission assessments which meet certain conditions. This is called the "Facility Admission Profile" or FAP. The FAP adjustment affects three measures: pressure ulcers (for the chronic population) and delirium and walking (for the PAC population). The walking measure is always reported with the FAP adjustment. The other two measures are reported with and without the FAP adjustment. (See Chapter 7 for more detailed information).

Risk Adjustment Procedures

All of the QMs involve calculation of an observed score. Observed scores are obtained by looking at the numerator for a facility (the number of residents that have a particular condition) and the denominator (the number of residents that are at risk for having the condition). An observed QM score represents the number of residents in the facility that have triggered for a particular quality measure divided either by the overall number of residents in the facility or by a subset of residents in the facility that are at risk for triggering that same quality measure (after taking exclusions into account).

For QMs with resident-level risk adjustment, the appropriate resident measures are calculated (e.g., whether a particular resident is cognitively impaired). For QMs with the FAP adjustment, facility proportions are calculated for the appropriate measures (e.g., the proportion of a facility's residents who are admitted with pressure ulcers).

Once the resident measures and/or FAP proportions are calculated, expected scores are computed. The expected score for a facility represents the proportion of residents who would be expected to trigger a condition after taking resident and/or facility-level factors into account.

To compute the expected score, a formula which is derived from statistical analysis is applied to each resident's data. This formula uses the resident-level risk-adjustment factors and the respective facility proportions to compute the resident's expected score. Expected scores for all of the

residents in a facility are summed to produce the facility's expected score. (Note that if a QM has no resident or facility-level risk adjustment, the expected score is simply the national average of the observed QM scores for all facilities in the nation).

The final step in producing the reported measures is to calculate the adjusted score. The adjusted score is computed by dividing the observed score by the expected score, multiplying by the national average, and applying a mathematical transformation, which converts the resulting number into a score between 0 and 100. Because of the way this calculation is performed, a facility's adjusted score will be higher if its observed score is greater than its expected score. Conversely, its adjusted score will be lower if it observed score is less than its expected score.
Please note that some of the terms used in the preceding discussion are defined in Appendix B.

Understanding Your Risk Adjusted Score

It is important to understand the final adjusted score for each measure for your particular facility. The risk adjusted quality measure reflects the difference between the *expected* performance of a facility (compared to national averages) and the facility's *actual* observed performance on a particular quality measure. Facilities that are performing **better** than expected would have a *lower* adjusted score on the majority of the quality measures. Similarly, facilities that are performing **worse** than expected would have *higher* scores on the majority of the measures. One exception to this is the Walking Improvement quality measure where a higher score is reflective of better performance.

QUALITY MEASURES CALCULATION OVERVIEW

Introduction

The following flow charts illustrate the major steps involved in calculating and reporting the quality measures (QMs). Each major step is divided into several smaller steps, which are labeled with column headings along the top of the diagram.

STEP 1: CALCULATE RAW SCORES

Step 1 involves selecting assessments from the MDS data repository and using the selected assessments to compute raw scores.

Assessments. Three samples of assessments are selected from the MDS data repository: the chronic sample, the post-acute sample, and the FAP (facility admission profile) sample. Note that the chronic and PAC samples actually consist of several sub-samples (target assessments, prior assessments, etc.). However, in this discussion each of these sub-samples will be dealt with as a single sample.

Definitions. Definitions have been developed for each of the chronic and PAC QMs, for the covariates which are associated with certain chronic and PAC QMs, and for the FAPs which are associated with certain QMs. These definitions specify which types of assessments to use (admission, target, prior, etc.), whether certain assessments are excluded, and under what circumstances the measure is "triggered".

Resident level scores. Each set of definitions is applied to the selected assessments to produce resident level scores. One of three scores is possible for each resident in a particular sample: excluded from the measure, included but not triggered, or included and triggered.

Rollup. Resident level FAP scores are summarized or "rolled up" across residents within each facility.

Facility level scores. The FAP rollup procedure produces a FAP score for each FAP measure for each facility. This facility level FAP score represents the proportion of admissions which "triggered" each FAP measure within the facility.

STEP 2: CALCULATE EXPECTED SCORES

Step 2 involves using the raw scores from Step 1 to calculate expected scores for the risk adjusted QMs.

Prepare FAP scores. The regression models which are used to compute expected scores perform their calculations at the resident level. In the previous step, facility level FAP scores were computed. These scores are replicated or copied to the resident level within each facility. As a result, every resident within a given facility will have the same score (the facility's summarized score) for a given FAP measure.

Resident level input scores. The covariate scores from Step 1 comprise a set of resident level scores. These scores are used in the calculation procedure, which follows.

Calculation. For the QMs which use FAP and/or resident covariate risk adjustment, the resident level covariate scores and/or the resident level FAP scores are used as input in a set of logistic regression models. There is a separate logistic regression model for each risk adjusted QM. These models were developed using a national dataset, and the weights derived from these analyses are used to compute expected values. The models produce expected values for each resident for each of the QMs.

Resident level output scores. The logistic regression model produces resident-level expected scores for each QM.

STEP 3: REPORT OBSERVED AND ADJUSTED VALUES

Step 3 uses the results from the previous two steps to produce facility level reports.

Resident level scores. Two sets of resident level scores are used to produce the report: (1) Resident level chronic care and PAC QM observed scores (from Step 1), and (2) resident level expected scores (from Step 2) for the QMs which use resident covariate and/or FAP risk adjustment.

Rollup. Rollups are computed for all of the resident level scores. The expected values are rolled up to the facility level. The raw (observed) QM scores are rolled up to both the facility and the national level.

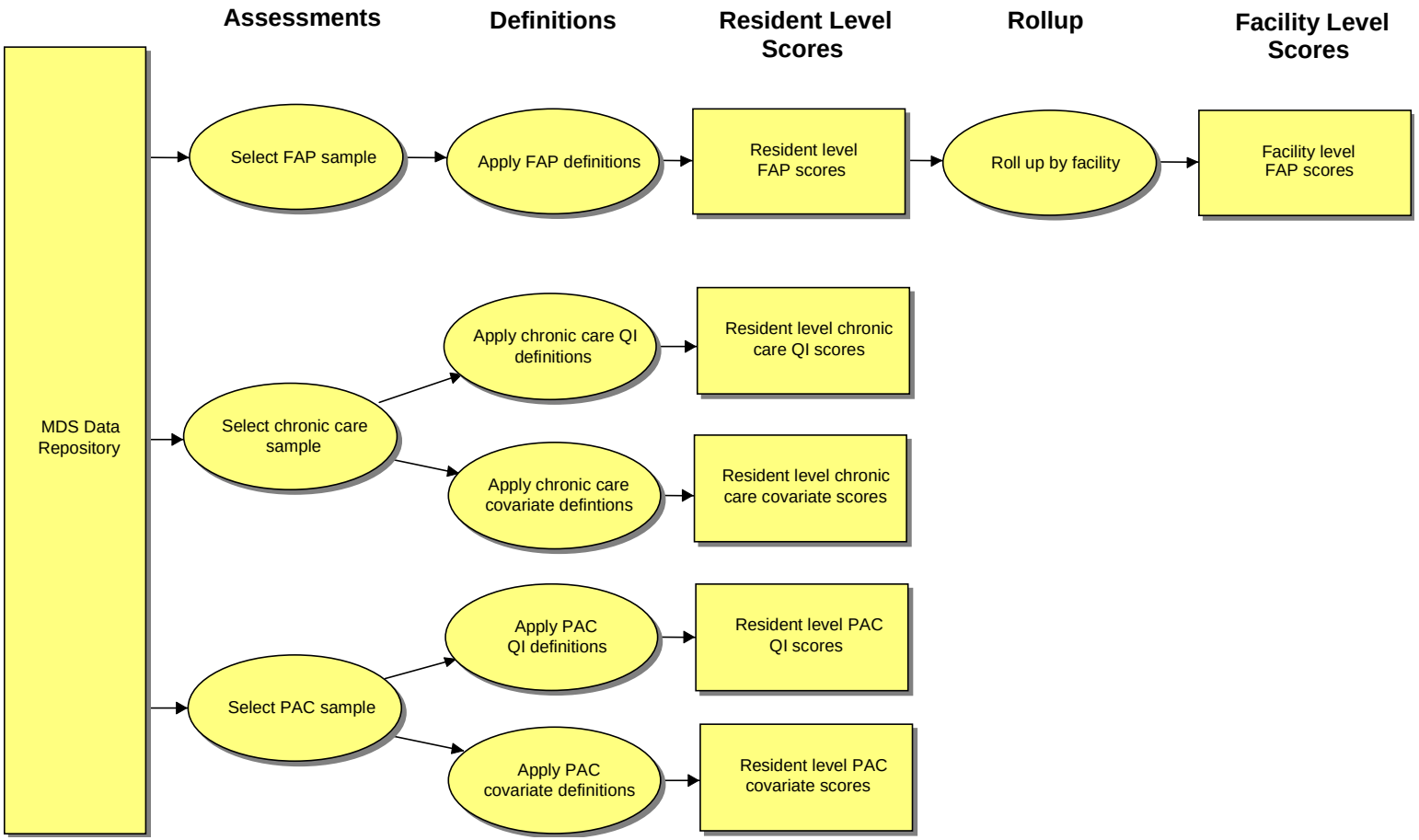
Unadjusted scores. Three sets of rolled up scores are produced: observed QM values, expected QM values, and national observed QM values. All three sets of values are used in the adjustment process.

Adjustment. The logit formula is a mathematical transformation, which uses each facility's observed, and expected value in conjunction with the national value to produce an adjusted score. The logit formula yields a higher score when a facility's observed value exceeds its expected value. Conversely, it yields a lower score when a facility's observed value is lower than its expected value.

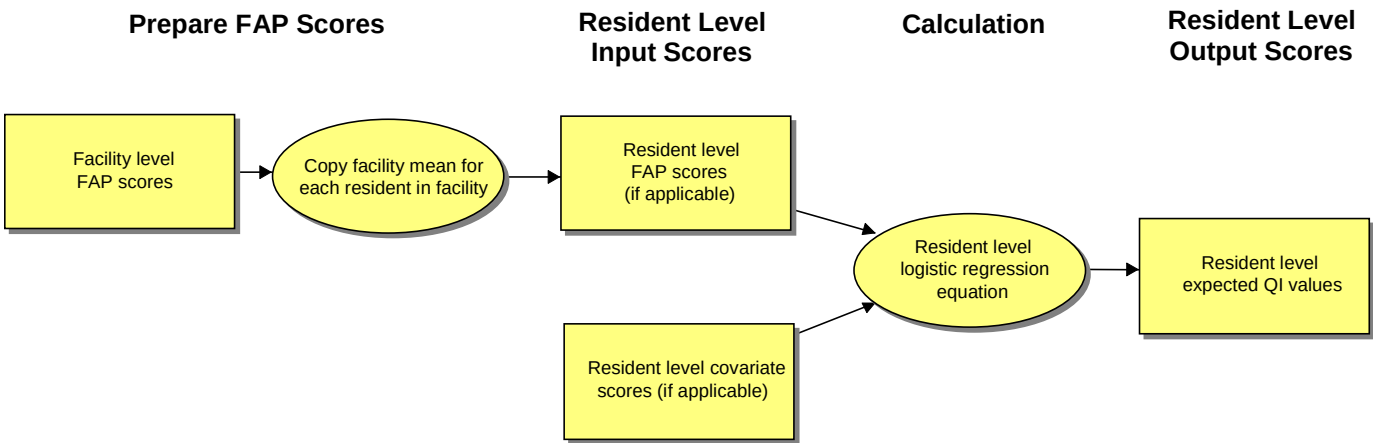
Adjusted scores. The adjustment process produces adjusted QM scores for each facility.

Report. The QM reports show the adjusted values for the three risk adjusted QMs, and the observed values for the remaining six QMs.

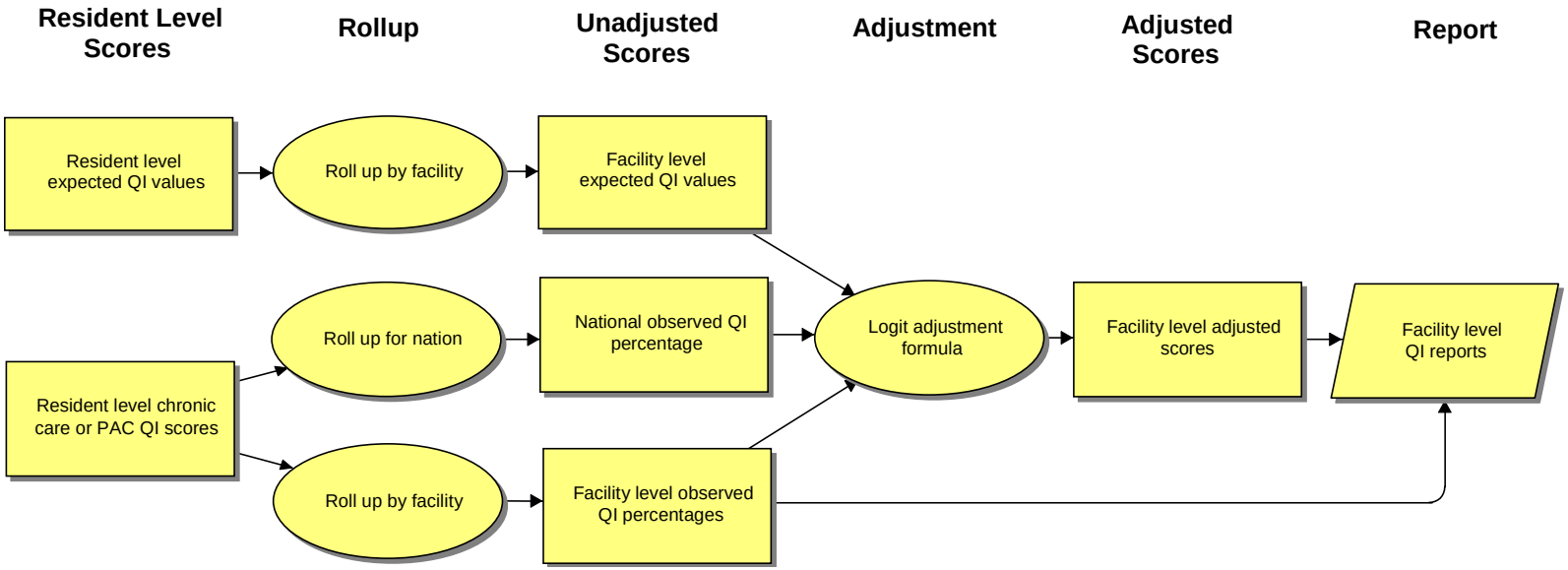
Quality Measure Calculations
Step1: Calculate Raw Scores



Quality Measure Calculations
Step 2: Calculate Expected



Quality Measure Calculations
Step 3: Report Observed and Adjusted



MDS RECORD SELECTION

To fully understand the quality measures, one must understand the methods used to select the assessment records that are used for calculation. This section will explain the various record selection methods used in the quality measure analysis.

Prior to understanding MDS record selection methodology, it is necessary to understand some basic terminology related to the two resident populations.

I. Chronic

a) **Target Assessment: [t][1]**
The target assessment is the most recent full (AA8a = 01, 02, 03, or 04) or quarterly (AA8a = 05 or 10) OBRA assessment that is available for the period of time in which the QM score was calculated. For example, if quality measure scores were to be calculated for the time period of April, May, and June of 2002, then each resident's most recent qualifying MDS assessments performed during that time frame would be referred to as a "target assessment". The time frame of April, May, and June of 2002 would be considered the "target quarter". The selected records are used for both prevalence and incidence measures. In order to be included in the calculation of a chronic QM, a resident must have a qualifying target assessment.

b) **Prior Assessment: [t-1][1]**
A prior assessment for the chronic population is the assessment that occurs in the most recent four months (46 to 165 days) preceding the *target* assessment. It is the normal OBRA assessment that occurs in the 4-month window ending 46 days before the target assessment. As you know, OBRA assessments are required every three months. The time period of four months is used to allow for inclusion of information coded on late assessments. Assessments conducted less than 45 days apart are not used in the calculations to insure that a sufficient span of time has passed to adequately measure any changes in the resident's condition. Time periods for selection of MDS records within the 4-month window are based on the assessment reference dates of the *target and the prior* assessment.

Selected prior MDS records are used in the calculation of incidence measures, which compare the resident's status at two points in time. In order to be included in the calculation of an incidence quality measure, a resident must have a qualifying target and prior assessment.

c) **Most Recent Full Assessment:**
This assessment is the most recent full assessment in the 17 months that precede the *target* assessment (item "a" above). For this selection, a normal OBRA full assessment (AA8a = 01, 02, 03, or 04) is used. If the target or prior assessments are quarterly assessments (AA8a = 05 or 10), an earlier full assessment will be selected. Data from such full assessments are used for quality measures that require information, which is not included on the shorter quarterly

[1] In Chapter 7 of this manual, the target assessment is referred to using the symbol, [t]. Prior assessments are sometimes referred to with use of the symbol [t-1].

form. A 17-month time period is used to allow for a full 12-month period before the prior assessment.

II. Post Acute

It is believed that early identification of clinical problems and prompt initiation of intervention result in better outcomes and higher quality of care. The post acute measures look at short-term changes in resident condition and function. To do so, the following records are selected for calculation:

a) **14- Day SNF PPS Assessment:**
While the chronic care QMs use a 3-month target period, the post acute QMs are based upon a 6-month time period. The post-acute sample includes 14-Day SNF PPS assessments (AA8b = 7) with reference dates during the 6-month target period. If a resident has more than one 14-Day SNF PPS assessment in the target period, then the latest assessment is used. To be included in the calculation of the post-acute QMs, a resident must have a qualifying 14-Day SNF PPS assessment.

b) **5- Day SNF PPS Assessment:**
The post acute sample also selects the SNF PPS 5-Day assessment (AA8b =1) that precedes the SNF PPS 14-Day assessment (AA8b = 7). The 5-Day SNF PPS assessment must have a reference date that is between 3 and 18 days prior to the reference date of the 14-Day SNF PPS assessment. This insures that it was performed in the proper time window. If there is more than one 5-Day SNF PPS assessment in this time period, the latest 5-Day SNF PPS assessment is selected. The 5-Day SNF PPS assessment is used in conjunction with a matching 14-Day SNF PPS assessment to measure a resident's change in status for incidence QMs.

c) **Recent MDS Admission Assessment:**
This assessment is the latest admission assessment within 50 days of a resident's admission to skilled care. The admission assessment is needed to capture information from the face sheet section that is completed upon admission. Using the 50-day time period insures that the admission assessment is part of the resident's SNF covered stay. This is based on that fact that the resident must be admitted to the SNF within 30 days of hospitalization and that the 14-Day SNF PPS assessment must be completed by day 19 of the SNF stay. This would be approximately a 50-day period and therefore this time frame is used for the selection period for this assessment.

III. FAP Sample

The facility admission profile (FAP) sample is used for risk adjustment for some of the QMs. The same sample is used for chronic care and post-acute care measures. The chronic care FAP sample consists of the latest admission assessment (AA8a = 01) for each resident with an assessment reference date during the 12 months ending with the end of the target period. The post-acute care FAP sample consists of the latest SNF PPS 5 Day assessment (AA8b = 1) which occurred within the last 12 month period.

Now that you have an understanding of the meaning for each of the terms associated with record selection, it is important to look at how each quality measure was calculated using these records. The record selection for each quality measure is listed in the MDS Coding section of this manual.

DIFFERENCES BETWEEN THE QMS & CURRENT QIS

As discussed previously, several of the quality measures employ resident level covariate and/or FAP risk adjustment. In contrast, the current QIs, some of which are risk adjusted, employ stratification (i.e., residents are grouped into high- and low-risk groups). This is the major difference between the two sets of measures. However, there are additional differences. For a measure that is included in both the QMs and the current QIs, there are differences in the way records are selected for QM/QI calculation. Additionally, there are some differences between the two sets of information in the specific definitions used for corresponding QMs and QIs.

This section presents the differences in the Record Selection Methods and the QM/QI definitions (triggering conditions and exclusions) for the comparable Chronic Care QMs and current QIs (the current QIs have no post-acute care measures).

Record Selection Differences

Both the QMs and current QIs require selection of a Target Assessment, a Prior Assessment, and a Most Recent Full Assessment. The two systems use different rules for selection of each of these assessments. The selection methods are outlined below with the differences highlighted.

TARGET ASSESSMENT FOR CHRONIC QIS/QMS

Current QI Selection:
The most recent OBRA assessment, *excluding admission assessments*, (AA8a = 02, 03, 04, 05, or 10) with reference date (A3a) in the ***6-month*** period ending with the calculation "target date".

QM Selection:
The most recent OBRA assessment, *including admission assessments*, (AA8a = 01, 02, 03, 04, 05, or 10) with reference date (A3a) in the ***3-month*** period ending with the calculation "target date". Note that admission assessments are eligible for selection, but are excluded from the calculation of all but one (loss of ADLs) of the chronic care QMs.

PRIOR ASSESSMENT FOR CHRONIC QIS/QMS

Current QI Selection:
The most recent OBRA full (AA8a = 01, 02, 03 or 04) or quarterly assessment (05 or 10) with reference date (A3a) in the *6-month period ending* with the target assessment reference date.

QM Selection:
The most recent OBRA full (AA8a = 01, 02, 03 or 04) or quarterly assessment (05 or 10) with reference date (A3a) in *the window of 46 days to 165 days preceding* the target assessment reference date.

Current QI Selection:
The most recent OBRA full (AA8a = 01, 02, 03 or 04) assessment preceding the target assessment reference date, *with no time limit*.

QM Selection:
The most recent OBRA full (AA8a = 01, 02, 03 or 04) assessment preceding the target assessment reference date, but *within 17 months of that date*.

QM/QI Definition Differences

There are some general differences in defining quality measures. These general differences are discussed first followed by the list of differences for each QM.

GENERAL DIFFERENCES

1) **Missing data on exclusion conditions**

   Current QIs: A missing value on an exclusion condition allows the case to be included. The default is inclusion.

   QM: Cases are excluded if there is missing data on an exclusion condition. The default is exclusion.

2) **Exclusion of admission assessments**

   Current QIs: Admission assessments are excluded on all QMs.

   QM: Admission assessments are excluded on some QMs and not on others. The measures, which exclude admission assessments, are pain (chronic), pressure ulcers, restraints and infections.

3) **Treatment of ADL 8 codes (activity did not occur)**

   Current QIs: The 8 values (activity did not occur) on an ADL items are treated as missing in one case and as maximum dependence (equivalent to a code of 4) in others.

   QM: The use of the 8 values was standardized across all QMs, always recoding an 8 to a 4 (treating an 8 [activity did not occur] as being equivalent to a 4 [fully dependent]).

DIFFERENCES FOR EACH QM

CADL01 Percent of Residents with Loss of Ability in Basic Daily Tasks

1) **ADL trigger items**
   1.1) Current QIs: 8 value treated as missing.
   1.2) QM: 8 value recoded to 4.

2) **Exclusion because maximal ADL dependency precludes ADL decline**
   2.1) Current QI: Case is excluded only if there is maximal dependence (value 4 or 8) on all 10 ADLs from G1aA through G1jA.
   2.2) QM: Case is excluded if there is maximal dependence (value 4 or 8) on the 4 late-loss ADLs only (G1aA, G1Ba, G1hA, G1IA). The other ADLs are not considered.

3) **Exclusion of admission assessments**
   3.1) Current QIs: Excludes cases when the target assessment is an admission assessment.
   3.2) QM: Does not exclude admission assessments.

4) **Clinical exclusions**
   4.1) Current QIs: Only excludes residents who are comatose (B1) on the PRIOR assessment (target assessment not considered). Include residents with a missing value on comatose.
   4.2) QM: Excludes residents who are comatose (B1) or comatose item is missing, have end-stage disease (J5c) or end-stage disease item is missing, or are receiving hospice care (P1ao) or hospice care item is missing, ALL on the TARGET assessment (prior assessment not considered).

CPRU01 Percentage of Residents with Pressure Sores – Combined High/Low Risk Group

1) Current QIs use stratification for risk adjustment.
2) Quality measures do not include stratified risk adjustment.
3) QM's are reported with and without FAP adjustment. Current QIs do not include FAP adjustment.

CRES01 Percentage of Residents in Physical Restraints

There are no definitional differences.

MDS CODING INSTRUCTIONS FOR QUALITY MEASURES

POST ACUTE MEASURES

- Percent of Short-Stay Residents with Pain
- Percent of Short-Stay Residents with Delirium
- Percent of Short-Stay Residents with Delirium with an Additional Level of Risk Adjustment
- Percent of Short-Stay Residents Who Walk as Well or Better on Day 14 as on Day 5

PERCENT OF SHORT-STAY RESIDENTS WITH PAIN

QM Description

The percent of short stay residents who have moderate pain daily or excruciating pain at any time.

Rationale for Pain QM

Pain is a common experience with older people because the prevalence of musculoskeletal problems (e.g. arthritis, fractures) and other medical conditions such as peripheral vascular disease, wounds, neurological conditions and cancer diagnoses tend to increase with age. Studies have shown that pain is significantly underreported in nursing facilities especially amongst the oldest old, females, minorities and the cognitively impaired. Although pain can be relieved in up to 90% of cases, a significant number of residents receive inadequate or no treatment.

QM Category

Post-Acute Care Measure

MDS Assessments Used:

SNF PPS 14 Day Assessment (AA8b = 7).

QM Specifications:

NUMERATOR
The number of residents who experience moderate pain at least daily (J2a=2 and J2b=2) **OR** horrible/excruciating pain at any frequency (J2b=3) as noted on the SNF PPS 14-Day assessment.

DENOMINATOR
All residents with a valid SNF PPS 14-Day assessment (AA8b = 7).

RISK ADJUSTMENT

EXCLUSIONS

Residents satisfying any of the following conditions are excluded:

- The values of J2a or J2b are missing on the SNF PPS 14-Day assessment.
- The values of J2a and J2b are inconsistent on the SNF PPS 14-Day assessment. (An example of inconsistent coding would include the coding of pain frequency as "no pain" while intensity of pain is simultaneously coded as "moderate" pain).
- The resident is in a facility with a post acute care admission sample size of 0. The post acute care admission sample is 0 if there are no residents with a SNF PPS 5 day assessment (AA8b = 1) over the previous 12 month period.

Facility Admission Profile

- There is no facility level risk adjustment for this QM.

Covariates

- No covariates are used in the post-acute care Pain QM.

MDS Elements Related to QM:

J2A PAIN SYMPTOMS
Frequency with which resident complains or shows evidence of pain

J2B PAIN SYMPTOMS
Intensity of pain

MDS RAI Coding Instructions:

J2. PAIN SYMPTOMS (7-DAY LOOK BACK)

Intent: To record the **frequency** and **intensity** of signs and symptoms of pain. For care planning purposes this item can be used to identify indicators of pain as well as to monitor the resident's response to pain management interventions.

MDS 2.0 only captures pain symptoms. The **MDS 2.0 does not capture pain management/pain intervention data** (except by proxy in some residents, i.e., by capturing the pain became less severe with time or the decreasing frequency)**.** While we realize the frustration of staff providing pain relief measures, there is no place to code interventions for pain on the current MDS. Such documentation would be found elsewhere on the resident's record in the nurses' notes, progress notes, medication records, and care plan. This coding situation is often compared to the concept to allow users to code both swallowing problems (symptom) and feeding tube (intervention) but while pain (symptom) can be coded there is no place to code the intervention. CMS is working to update pain assessment and pain management data on the MDS 3.0 and is refining the draft pain RAP.

CMS anticipates that few residents on pain management measures will not have some level of breakthrough pain during the 7-day assessment period that should then be coded on the MDS. For example, if through assessment or clinical record review you note that the resident has received pain medications or other pain relief measures, investigate the pain need and capture the pain event on the MDS. However, if the resident does not experience ANY breakthrough pain in the 7-day assessment window, they would indeed code 0. Remember that the assessment covers a 7-day period and should reflect the highest level of pain recorded by any staff member, not just the assessment of the professional completing the MDS.

Definitions:

Pain - For MDS assessment purposes, pain refers to any type of physical pain or discomfort in any part of the body. Pain may be localized to one area, or may be more generalized. It may be acute or chronic, continuous or intermittent (comes and goes), or occur at rest or with movement. The pain experience is very subjective; pain is whatever the resident says it is.

Shows Evidence of Pain - Depends on the observation of others (i.e., cues), either because the resident does not verbally complain, or is unable to verbalize.

Process: Ask the resident if he or she has experienced any pain in the last seven days. Ask him/her to describe the pain. If the resident states he or she has pain, take his or her word for it. Pain is a subjective experience. Also observe the resident for indicators of pain. Indicators include moaning, crying, and other vocalizations; wincing or frowning and other facial expressions; or body posture such as

guarding/protecting an area of the body, or lying very still; or decrease in usual activities.

In some residents, the pain experience can be very hard to discern. For example, in residents who have dementia and cannot verbalize that they are feeling pain, symptoms of pain can be manifested by particular behaviors such as calling out for help, pained facial expressions, refusing to eat, or striking out at a nurse assistant who tries to move them or touch a body part. Although such behaviors may not be solely indicative of pain, but rather may be indicative of multiple problems, code for the frequency and intensity of symptoms if in your clinical judgment it is possible that the behavior could be caused by the resident experiencing pain.

Ask nurse assistants and therapists who work with the resident if the resident had complaints or indicators of pain the last week.

Coding: Code for the highest level of pain present in the last seven days. If the resident has no pain, code "0" (No pain) then skip to item J4.

a) **Frequency** - How often the resident complains or shows evidence of pain.

Codes:

0. **No pain (Skip to Item J4)**
1. **Pain less than daily**
2. **Pain daily**

b) **Intensity** - The severity of pain as described or manifested by the resident.

Codes:

1. **Mild Pain -** Although the resident experiences some ("a little") pain he or she is usually able to carry on with daily routines, socialization, or sleep.
2. **Moderate Pain -** Resident experiences "a medium" amount of pain.
3. **Times When Pain is Horrible or Excruciating -** Worst possible pain. Pain of this type usually interferes with daily routines, socialization and sleep.

Use your best clinical judgment when coding. If you have difficulty determining the exact frequency or intensity of pain, code for the more severe level of pain.

Rationale: Residents having pain will usually require further evaluation to determine the cause and to find interventions that promote comfort. You never want to miss an opportunity to relieve pain. Pain control often enables rehabilitation, greater socialization and activity involvement.

EXAMPLES	Pain Frequency	Pain Intensity
Mrs. G, a resident with poor short-and-long-term memory and moderately impaired cognitive function asked the charge nurse for "a pill to make my aches and pains go away" once a day during the last 7 days. The medication record shows that she received Tylenol every evening. The charge nurse states that Mrs. G usually rubs her left hip when she asks for a pill. However, when you ask her about pain, Mrs. G tells you that she is fine and never has pain. ***Rationale for coding*:** It appears that Mrs. G has forgotten that she has reported having pain during the last 7 days. Best clinical judgment calls for coding that reflects that Mrs. G has mild, daily pain.	2	1
Mr. T is cognitively intact. He is up and about and involved in self-care, social and recreational activities. During the last week he has been cheerful, engaging and active. When checked by staff at night, he appears to be sleeping. However, when you ask him how he's doing, he tells you that he has been having horrible cramps in his legs every night. He has only been resting, but feels tired upon arising. ***Rationale for coding*:** Although Mr. T may look comfortable to staff, he reports to you that he has terrible cramps. Best clinical judgment for coding this "screening" item for pain would be to record codes that reflect what Mr. T tells you. It is highly likely that Mr. T warrants a further evaluation.	2	3

J3. PAIN SITE (7-DAY LOOK BACK)

Intent: To record the location of physical pain as described by the resident, or discerned from objective physical and laboratory tests. Sometimes is difficult to pinpoint the exact site of pain, particularly if the resident is unable to describe the quality and location of pain in detail. Likewise, it will be difficult to pinpoint the exact site if the resident has not had physical or laboratory tests to evaluate the pain. In order to begin to develop a responsive care plan for promoting comfort, the intent of this item is to help residents and caregivers begin a pain evaluation by attempting to target the site of pain.

Definitions:

a) **Back Pain** - Localized or generalized pain in any part of the neck or back.

b) **Bone Pain** - Commonly occurs in metastatic disease. Pain is usually worse during movement but can be present at rest. May be localized and tender but may also be quite vague.

c) **Chest Pain While Doing Usual Activities** - The resident experiences any type of pain in the chest area, which may be described as burning, pressure, stabbing, vague discomfort, etc. "Usual activities" are those that the resident engages in normally. For example, the resident's usual activities may be limited to minor participation in dressing and grooming, short walks from chair to toilet room.

d) **Headache** - The resident regularly complains or shows evidence (clutching or rubbing the head) of headache.

e) **Hip Pain** - Pain localized to the hip area. May occur at rest or with physical movement.

f) **Incisional Pain** - The resident complains or shows evidence of pain at the site of a recent surgical incision.

g) **Joint Pain (Other Than Hip)** - The resident complains or shows evidence of discomfort in one or more joints either at rest or with physical movement.

h) **Soft Tissue Pain** - Superficial or deep pain in any muscle or non-bony tissue. Examples include abdominal cramping, rectal discomfort, calf pain, and wound pain.

i) **Stomach Pain** - The resident complains or shows evidence of pain or discomfort in the left upper quadrant of the abdomen.

j) **Other** - Includes either localized or diffuse pain of any other part of the body. Examples include general "aches and pains," etc.

Process: Ask the resident and observe for signs of pain. Consult staff members. Review the clinical record. Use your best clinical judgment.

Coding: Check all that apply during the last 7 days. If the resident has mouth pain check Item K1c in Section K, "Oral/Nutritional Status."

PERCENT OF SHORT-STAY RESIDENTS WITH DELIRIUM

QM Description:

This measure reflects the percentage of short-stay residents in the nursing home facility who have symptoms of delirium. Delirium is a stage of acute confusion that develops quickly and involves changes in awareness, attention, cognition (thinking and reasoning), and perception. An individual's degree of difficulty in these areas may be greater or less over the course of the day, but overall, delirium represents a sudden and significant decline from the previous level of functioning.

Rationale for Improvement and Management of Delirium QM:

Delirium is common among nursing home residents, especially those with preexisting cognitive impairment. Approximately 25% of residents admitted from acute care settings will have new or persistent delirium that restricts their success in rehabilitation and prolongs their stay in the nursing home. Delirium is not dementia and is never part of normal aging.

QM Category:

Post Acute Care Measure

MDS Assessments Used:

SNF PPS 14-Day Assessment (AA8b = 7).

QM Specifications:

NUMERATOR
The number of residents at SNF PPS 14-day assessment with at least one symptom of delirium that represents a departure from the usual functioning (i.e., at least one of the following is coded as "2": B5a, B5b, B5c, B5d, B5e, B5f).

DENOMINATOR
All residents with a valid SNF PPS 14-day assessment.

RISK ADJUSTMENT
EXCLUSIONS

Residents satisfying any of the following conditions:
- Comatose is indicated (B1=1) or comatose status is unknown (B1=missing) on the SNF PPS 14-day assessment.
- End-stage disease is indicated (J5c = checked) or end-stage disease status is unknown (J5c = missing) on the SNF PPS 14-day assessment.
- Hospice care is indicated (P1ao = checked) or hospice status is unknown (P1ao = missing) on the SNF PPS 14-day assessment.

- The QM did not trigger (resident is not included in the numerator) and there is a missing value on any of the items B5a through B5f on the SNF PPS 14-day assessment.
- The resident is in a facility with a post acute care admission sample size of 0. The post acute care admission sample is 0 if there are no residents with a SNF PPS 5 day assessment (AA8b = 1) over the previous 12-month period.

Facility Admission Profile

- There is no facility level risk adjustment for this measure.

Covariate

- There is one covariate for this QM. It is based on the most recent admission assessment (AA8a = 01) and includes:
    - No prior residential history (AB5a-AB5e not checked and AB5f is checked)**, AND**
    - There is an admission assessment (AA8a = 01) in 50-day period ending with the reference date on the SNF PPS 14-day assessment.

NOTE: If there is more than one admission assessment within the 50-day period, then the most recent admission assessment is selected. This assessment may be the same as the SNF PPS 14-day assessment.

If there is no recent admission assessment within the 50-day period ending with the reference date of the SNF PPS 14-day assessment, then it is assumed that the individual was a resident in the facility prior to the SNF stay. This would indicate that the resident does have a prior residential history.

MDS Elements Related to QM:

B5a Easily Distracted (e.g., Difficulty paying attention; gets sidetracked)

B5b Periods of Altered Perception or Awareness of Surroundings (e.g., moves lips or talks to someone not present; confuses night and day)

B5c Episodes of Disorganized Speech (e.g., speech is incoherent, nonsensical, irrelevant or rambling; loses train of thought)

B5d Periods of Restlessness (e.g. fidgeting or picking at skin, clothing, napkins, frequent position changes, calling out)

B5e Periods of Lethargy (e.g. sluggishness, staring into space, difficult to arouse, little body movement)

B5f Mental Function Varies Over the Course of the Day (e.g., sometimes better, sometimes worse)

B1 Comatose

J5c End Stage Disease

P1ao Hospice

AB5a-e Residential History

MDS RAI Coding Instructions:

SECTION B5-MEASURES OF DELIRIUM

The intent of Section B5 is to record behavioral signs that may indicate that delirium is present. Frequently, delirium is caused by a treatable illness such as infection or reaction to medications.

The characteristics of delirium are often manifested behaviorally and therefore can be observed. For example, disordered thinking may be manifested by rambling, irrelevant, or incoherent speech. Other behaviors are described in the definitions below.

A recent change (deterioration) in cognitive function is indicative of delirium (acute confusional state), which may be reversible if detected and treated in a timely fashion. Signs of delirium can be easier to detect in a person with intact cognitive function at baseline. However, when a resident has a pre-existing cognitive impairment or pre-existing behavior such as restlessness, calling out, etc., detecting signs of delirium is more difficult. Despite this difficulty, it is possible to detect signs of delirium in these residents by being attuned to recent changes in their usual functioning. For example, a resident who is usually noisy or belligerent may suddenly become quiet, lethargic, and inattentive. Or, conversely, one who is normally quiet and content may suddenly become restless and noisy. Or, one who is usually able to find his or her way around the unit may begin to get "lost".

Definitions:

a) **Easily distracted** (e.g., difficulty paying attention; gets sidetracked)

b) **Periods of altered perception or awareness of surroundings** (e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)

c) **Episodes of disorganized speech** (e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)

d) **Periods of restlessness** (e.g., fidgeting or picking at skin, clothing, napkins, etc.; frequent position changes; repetitive physical movements or calling out)

e) **Periods of lethargy** (e.g., sluggishness, staring into space; difficult to arouse; little body movement)

f) **Mental function varies over the course of the day** (e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

Coding:

Code for resident's behavior in the last seven days regardless of what you believe the cause to be — focusing on when the manifested behavior first occurred.

0. **Behavior not present**
1. **Behavior present, not of recent onset**
2. **Behavior present over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)**

CASE STUDY #1

EXAMPLES	Measures	Coding
Mrs. K is a 92 year old widow of 30 years who has severe functional dependency secondary to heart disease. Her primary nurse assistant has reported during the last two days that the resident has not "been herself". She has been napping more frequently and for longer periods during the day. The resident is difficult to arouse and has mumbling speech upon awakening. She also has difficulty paying attention to what she is doing. For example, at meals instead of eating as she usually does, she picks at her food as if she doesn't know what to do with the fork. She then stops and closes her eyes after a few minutes. Alternatively, Mrs. K has been waking up at night believing it to be daytime. She has been calling out to staff and demanding to be taken to see her husband (although he is deceased). On three occasions, Mrs. K was observed as she was attempting to climb out of bed over the foot of the bed.	a) Easily Distracted b) Periods of Altered Perception of Awareness of Surroundings c) Episodes of Disorganized Speech d) Periods of Restlessness e) Periods of Lethargy f) Mental Function Varies Over the Course of the Day	**2** (present, new) **2** (present, new) **2** (present, new) **2** (present, new) **2** (present, new)

CASE STUDY #2

EXAMPLES	Measures	Coding
Mr. D has a history of Alzheimer's disease. His skills for decision making have been poor for a long time. He often has difficulty paying attention to tasks and activities and usually wanders away from them. He rarely speaks to others, and when he does, his speech is garbled and nonsensical. He is often observed mumbling and moving his lips as if he is talking to someone. Although Mr. D is often restless and fidgety, this behavior is not new for him and it rarely interferes with a good sleep.	a) Easily Distracted	**1** (present, not new)
	b) Periods of Altered Perception of Awareness of Surroundings	**1** (present, not new)
	c) Episodes of Disorganized Speech	**1** (present, not new)
	d) Periods of Restlessness	**1** (present, not new)
	e) Periods of Lethargy	**0** (behavior not present)
	f) Mental Function Varies Over the Course of the Day	**1** (present, not new)

PERCENT OF SHORT-STAY RESIDENTS WITH DELIRIUM WITH AN ADDITIONAL LEVEL OF RISK ADJUSTMENT

QM Description:

This measure reflects the percentage of short-stay residents in the nursing facility who have symptoms of delirium. Delirium is a state of acute confusion that develops quickly and involves changes in awareness, attention, cognition (thinking and reasoning), and perception. An individual's degree of difficulty in these areas may be greater or less over the course of the day, but overall, delirium represents a sudden and significant decline from the previous level of functioning.

Rationale for Improvement and Management of Delirium QM:

Delirium is common among nursing home residents, especially those with preexisting cognitive impairment. Approximately 25% of residents admitted from acute care settings will have new or persistent delirium that restricts their success in rehabilitation and prolongs their stay in the nursing home. Delirium is not dementia and is never part of normal aging.

QM Category:

Post Acute Care Measure

MDS Assessments Used:

SNF PPS 14-Day Assessment (AA8b =7).

QM Specifications:

NUMERATOR
The number of residents at SNF PPS 14-day assessment with at least one symptom of delirium that represents a departure from the usual functioning (at least one of the following is coded as 2: B5a, B5b, B5c, B5d, B5e, B5f).

DENOMINATOR
All residents with a valid SNF PPS 14-day assessment.

RISK ADJUSTMENT
EXCLUSIONS

Residents satisfying any of the following conditions:

- Comatose is indicated (B1=1) or comatose status is unknown (B1=missing) on the SNF PPS 14-day assessment.
- End-stage disease is indicated (J5c = checked) or end-stage disease status is unknown (J5c = missing) on the SNF PPS 14-day assessment.
- Hospice care is indicated (P1ao = checked) or hospice status is unknown (P1ao = missing) on the SNF PPS 14-day assessment.
- The QM did not trigger (resident is not included in the numerator) and there is a missing value on any of the items B5a through B5f on the SNF PPS 14-day assessment.
- The resident is in a facility with a post acute care admission sample size of 0. The post acute care admission sample is 0 if there are no residents with a SNF PPS 5 day assessment (AA8b = 1) over the previous 12-month period.

Facility Admission Profile

Facility level adjustment considers the proportion of residents with at least one symptom of delirium that represents a departure from normal functioning (B5a through B5f=2) demonstrated on SNF PPS 5-day assessments (AA8b=1) over the previous 12 months (one or more of the following coded as 2: B5a through B5f).

Numerator:	SNF PPS 5-day assessments (AA8b = 1) with at least one or more of the following items coded as 2: B5a-B5f.
Denominator:	All SNF PPS 5-day assessments (AA8b = 1).
Exclusion:	SNF PPS 5-day assessments (AA8b = 1) that do not satisfy the numerator condition AND that have missing data on any item B5a through B5f.

Covariate

There is one covariate for this QM. It is based on the most recent admission assessment (AA8a = 01) and includes:

- No prior residential history (AB5a-AB5e not checked and AB5f is checked), **AND**
- There is an admission assessment (AA8a = 01) in 50-day period ending with the reference date on the SNF PPS 14-day assessment.

NOTE: If there is more than one admission assessment within the 50-day period, then the most recent admission assessment is selected. This assessment may be the same as the SNF PPS 14-day assessment.

If there is no recent admission assessment within the 50-day period ending with the reference date of the SNF PPS 14-day assessment, then it is assumed that the individual was a resident in the facility prior to the SNF stay. This would indicate that the resident does have a prior residential history.

MDS Elements Related to QM:

B5a Easily Distracted (e.g., Difficulty paying attention; gets sidetracked)

B5b Periods of Altered Perception or Awareness of Surroundings (e.g., moves lips or talks to someone not present; confuses night and day)

B5c Episodes of Disorganized Speech (e.g., speech is incoherent, nonsensical, irrelevant or rambling; loses train of thought)

B5d Periods of Restlessness (e.g. fidgeting or picking at skin, clothing, napkins, frequent position changes, calling out)

B5e Periods of Lethargy (e.g. sluggishness, staring into space, difficult to arouse, little body movement)

B5f Mental Function Varies Over the Course of the Day (e.g., sometimes better, sometimes worse)

B1 Comatose

J5c End Stage Disease

P1oa Hospice

AB5a-f Residential History

MDS RAI Coding Instructions:

SECTION B5-MEASURES OF DELIRIUM

The intent of Section B5 is to record behavioral signs that may indicate that delirium is present. Frequently, delirium is caused by a treatable illness such as infection or reaction to medications.

The characteristics of delirium are often manifested behaviorally and therefore can be observed. For example, disordered thinking may be manifested by rambling, irrelevant, or incoherent speech. Other behaviors are described in the definitions below.

A recent change (deterioration) in cognitive function is indicative of delirium (acute confusional state), which may be reversible if detected and treated in a timely fashion. Signs of delirium can be easier to detect in a person with intact cognitive function at baseline. However, when a resident has a pre-existing cognitive impairment or pre-existing behavior such as restlessness, calling out, etc., detecting signs of delirium is more difficult. Despite this difficulty, it is possible to detect signs of delirium in these residents by being attuned to recent changes in their usual functioning. For example, a resident who is usually noisy or belligerent may suddenly become quiet, lethargic, and inattentive. Or, conversely, one who is normally quiet and content may suddenly become restless and noisy. Or, one who is usually able to find his or her way around the unit may begin to get lost.

Definitions:

a) **Easily distracted** (e.g., difficulty paying attention; gets sidetracked)

b) **Periods of altered perception or awareness of surroundings** (e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)

c) **Episodes of disorganized speech** (e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)

d) **Periods of restlessness** (e.g., fidgeting or picking at skin, clothing, napkins, etc.; frequent position changes; repetitive physical movements or calling out)

e) **Periods of lethargy** (e.g., sluggishness, staring into space; difficult to arouse; little body movement)

f) **Mental function varies over the course of the day** (e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

Coding: Code for resident's behavior in the last seven days regardless of what you believe the cause to be — focusing on when the manifested behavior first occurred.

0. Behavior not present
1. Behavior present, not of recent onset
2. Behavior present over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

CASE STUDY #1

EXAMPLES	Measures	Coding
Mrs. K is a 92-year-old widow of 30 years who has severe functional dependency secondary to heart disease. Her primary nurse assistant has reported during the last two days that the resident has not "been herself". She has been napping more frequently and for longer periods during the day. The resident is difficult to arouse and has mumbling speech upon awakening. She also has difficulty paying attention to what she is doing. For example, at meals instead of eating as she usually does, she picks at her food as if she doesn't know what to do with the fork. She then stops and closes her eyes after a few minutes. Alternatively, Mrs. K has been waking up at night believing it to be daytime. She has been calling out to staff and demanding to be taken to see her husband (although he is deceased). On three occasions, Mrs. K was observed as she was attempting to climb out of bed over the foot of the bed.	a) Easily Distracted b) Periods of Altered Perception of Awareness of Surroundings c) Episodes of Disorganized Speech d) Periods of Restlessness e) Periods of Lethargy f) Mental Function Varies Over the Course of the Day	**2** (present, new) **2** (present, new) **2** (present, new) **2** (present, new) **2** (present, new) **2** (present, new)

CASE STUDY #2

EXAMPLES	Measures	Coding
Mr. D has a history of Alzheimer's disease. His skills for decision making have been poor for a long time. He often has difficulty paying attention to tasks and activities and usually wanders away from them. He rarely speaks to others, and when he does, his speech is garbled and nonsensical. He is often observed mumbling and moving his lips as if he is talking to someone. Although Mr. D is often restless and fidgety, this behavior is not new for him and it rarely interferes with a good sleep.	a) Easily Distracted	**1** (present, not new)
	b) Periods of Altered Perception of Awareness of Surroundings	**1** (present, not new)
	c) Episodes of Disorganized Speech	**1** (present, not new)
	d) Periods of Restlessness	**1** (present, not new)
	e) Periods of Lethargy	**0** (behavior not present)
	f) Mental Function Varies Over the Course of the Day	**1** (present, not new)

PERCENT OF RESIDENTS WHO WALK AS WELL OR BETTER ON DAY 14 AS ON DAY 5 OF THEIR STAY

QM Description:

The percent of short-stay residents whose ability to walk unassisted or with limited assistance has been maintained or improved. **Note that higher values on this quality measure imply good quality of care relative to ADL improvement.** This is different from most other quality measures where a high value implies the possibility of poorer care in that specific area.

Rationale for Improvement in Walking QM:

Walking plays a vital role in the ability to perform daily activities and maintain healthy lifestyles. As elderly individuals become more physically or psychologically impaired, their mobility performance and skills tend to decrease. Decreased mobility is caused by many factors, which may include change of medical condition, falls resulting in fractures or fear of falling, medication changes, decreased endurance due to acute illness, infections, or psychological changes. Further physical impairments such as muscle atrophy, loss of bone and muscle mass can often occur as a result of decreased mobility. If not assessed at the first signs of decline, difficulty with ambulation or immobilization are likely to occur.

QM Category:

Post-Acute Care Measure

MDS Assessments Used:

SNF PPS 14-Day Assessment (AA8b = 07) with a valid preceding 5-Day SNF PPS Assessment (AA8b = 01)

QM Specifications:

NUMERATOR

The number of SNF PPS residents who satisfy either of the following conditions:

- Independence in walking is maintained from the SNF PPS 5-day assessment to the SNF PPS 14-day assessment based on MDS values for "Walk in Room, Self-Performance," G1c(A) and "Walk in Corridor, Self-Performance," G1d(A):

  (G1c(A)[t-1]=0 AND G1d (A)[t-1]=0)
  AND
  (G1c (A)[t]=0 AND G1d (A)[t]=0).
  [t] = SNF PPS 14-day assessment; [t-1] = SNF PPS 5-day assessment

- Improvement in walking ability is evidenced from the SNF PPS 5-day assessment to the SNF PPS 14-day assessment based on MDS values for "Walk in Room, Self-Performance," G1c (A) and "Walk in Corridor, Self-Performance," G1d(A):

  (G1c (A)[t-1] + G1d (A)[t-1]) > (G1c (A)[t] + G1d (A)[t]).
  [t] = SNF PPS 14-day assessment; [t-1] = SNF PPS 5-day assessment.

NOTE: All MDS scores of "8" (activity did not occur) are converted to "4" (total dependence) on G1c (A) and G1d (A) for comparison purposes on this measure.

DENOMINATOR
All residents with a valid SNF PPS 14-day assessment and a valid preceding SNF PPS 5-day assessment.

RISK ADJUSTMENT
EXCLUSIONS

Residents satisfying any of the following conditions:
- End-stage disease is indicated (J5c=checked) or end-stage disease status unknown (J5c= missing) on the SNF PPS 14-day assessment.
- Comatose is indicated (B1=1) or comatose status unknown (B1=missing) on the SNF PPS 14-day assessment.
- Hospice care is indicated (P1ao=checked) or hospice status is unknown (P1ao=missing) on the SNF PPS 14-day assessment.
- Ventilator dependence is indicated (P1al=checked) or ventilator status is unknown (P1al=missing) on the SNF PPS 14-day assessment.
- Quadriplegia is indicated (I1z=checked) or quadriplegic status is unknown (I1z=missing) on the SNF PPS 14-day assessment.
- Paraplegia is indicated (I1x=checked) or paraplegic status is unknown (I1x=missing) on the SNF PPS 14-day assessment.
- The values for Walk in Room, Self-Performance, G1c (A), or Walk in Facility, Self-Performance, G1d (A) are missing on either the 5-day or 14-day assessment.
- The resident is in a facility with a post acute care admission sample size of 0. The post acute care admission sample is 0 if there are no residents with a SNF PPS 5-day assessment (AA8b = 1) over the previous 12-month period.

FACILITY ADMISSION PROFILE
Facility level adjustment considers the mean sum of walking in room (G1c (A)) and walking in corridor (G1d (A)) among SNF PPS 5-day assessments (AA8b = 1) over previous 12 months.

NOTE: Convert 8s (activity did not occur) to 4s (total dependence) on G1d (A) and G1c (A) before summing these items.

Exclusions: SNF PPS 5-day assessments (AA8b = 1) with a missing value on G1c (A) or G1d (A).

Covariates
No covariates are used in the Walk as well or better QM.

MDS Elements Related to QM:

G1c (A) Walk in Room Self-Performance
How resident walks between locations in his/her room

G1d (A) Walk in Corridor Self-Performance
How resident walks in corridor on unit

B1 Comatose
P1ao Hospice
J5c End Stage Disease
P1al Ventilator Dependant
I1z Quadriplegic
I1x Paraplegic

MDS RAI Coding Instructions:

G1. (A) ACTIVITIES OF DAILY LIVING (ADL) SELF-PERFORMANCE

Intent: To record the resident's self-care performance in activities of daily living (i.e., what the resident actually did for himself or herself and/or how much verbal or physical help was required by staff members) during the **last seven days**.

Definition: **ADL SELF-PERFORMANCE** - Measures what the resident **actually did** (not what he or she might be capable of doing) within each ADL category over the last seven days according to a performance-based scale.

Walk in Room - How resident walks between locations in his/her room.

Walk in Corridor - How resident walks in corridor on unit.

Process:

In order to be able to promote the highest level of functioning among residents, clinical staff must first identify what the resident actually does for himself or herself, noting when assistance is received and clarifying the types of assistance provided (verbal cueing, physical support, etc.)

A resident's ADL self-performance may vary from day to day, shift to shift, or within shifts. There are many possible reasons for these variations, including mood, medical condition, relationship issues (e.g., willing to perform for a nurse assistant he or she likes), and medications. The responsibility of the person completing the assessment, therefore, is to capture the total picture of the resident's ADL self-performance over the seven-day period, 24 hours a day - i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.

In order to accomplish this, it is necessary to gather information from multiple sources - i.e., interviews/discussion with the resident and direct care staff on all three shifts, including weekends and review of documentation used to communicate with staff across shifts. Ask questions pertaining to all aspects of the ADL activity definitions. For example, when discussing Bed Mobility with a nurse assistant, be sure to inquire specifically how the resident moves to and from a lying position, how the resident turns from side to side, and how the resident positions himself or herself while in bed. A resident can be independent in one aspect of Bed Mobility yet require extensive assistance in another aspect. Since accurate coding is important as a basis for making decisions on the type and amount of care to be provided, be sure to consider each activity definition fully.

The wording used in each coding option is intended to reflect real-world situations where slight variations are common. Where variations occur, the coding ensures that the resident is not assigned to an excessively independent or dependent category. For example, by definition, codes 0, 1, 2, and 3 (Independent, Supervision, Limited Assistance, and Extensive Assistance) permit one or two exceptions for the provision of heavier care. This is clinically useful and increases

the likelihood that staff will code ADL Self-Performance items consistently and accurately.

Because this section involves a two-part evaluation (Item G1A, ADL Self-Performance and Item G1B, ADL Support), each using its own scale, it is recommended that you complete the Self-Performance evaluation for all ADL Self-Performance activities before beginning the ADL Support evaluation.

To evaluate a resident's ADL Self-Performance, begin by reviewing the documentation in the clinical record. Talk with clinical staff from each shift to ascertain what the resident does for himself or herself in each ADL activity as well as the type and level of staff assistance being provided. As previously noted, be alert to differences in resident performance from shift to shift, and apply the ADL codes that capture these differences. For example, a resident may be independent in Toilet Use during daylight hours but receive non-weight bearing physical assistance every evening. In this case, the resident would be coded as a "2" (Limited Assistance) in Toilet Use.

The following chart provides general guidelines for recording accurate ADL Self-Performance and ADL Support assessments.

GUIDELINES FOR ASSESSING ADL SELF-PERFORMANCE AND ADL SUPPORT

The scales in Items G1A, and G1B, are used to record the resident's actual level of involvement in self-care and the type and amount of support actually received during the last seven days.

Do not record your assessment of the resident's capacity for involvement in self-care - i.e., what you believe the resident might be able to do for himself or herself based on demonstrated skills or physical attributes. For nursing facilities, an assessment of potential capability is covered in Item G8 ("ADL Functional Rehabilitation Potential"). For swing bed facilities, the potential capability should be considered during care planning.

Do not record the type and level of assistance that the resident "should" be receiving according to the written plan of care. The type and level of assistance actually provided might be quite different from what is indicated in the plan. Record what is actually happening.

Engage direct care staff, from all shifts, who have cared for the resident over the last seven days in discussions regarding the resident's ADL functional performance. Remind staff that the focus is on the last seven days only. To clarify your own understanding and observations about each ADL activity (bed mobility, locomotion, transfer, etc.), ask probing questions, beginning with the general and proceeding to the more specific.

Coding: For each ADL category, code the appropriate response for the resident's actual performance during the past seven days. Enter the code in column (A), labeled "SELF-PERF." Consider the resident's performance during all shifts, as functionality may vary. In the pages that follow two types of supplemental instructional material are presented to assist you in learning how to use this code: a schematic flow chart for scoring ADL Self Performance and a series of case examples for each ADL.

In your evaluations, you will also need to consider the type of assistance known as "set-up help" (e.g., comb, brush, toothbrush, toothpaste have been laid out at the bathroom sink by the nurse assistant). Set-up help is recorded under ADL Support Provided (Item G1B). But in evaluating the resident's ADL Self-Performance, include set-up help within the context of the "0" (Independent) code. For example: If a resident grooms independently once grooming items are set up for him, code "0" (Independent) in Personal Hygiene.

0. Independent - No help or staff oversight -OR- Staff help/oversight provided only one or two times during the last seven days.

1. Supervision - Oversight, encouragement, or cueing provided three or more times during last seven days -OR- Supervision (3 or more times) plus physical assistance provided only one or two times during last seven days.

2. Limited Assistance - Resident highly involved in activity, received physical help in guided maneuvering of limbs or other non weight-bearing assistance on three or more occasions -OR- limited assistance (3 or more times) plus more help provided only one or two times during last seven days.

3. Extensive Assistance - While the resident performed part of activity over last seven days, help of following type(s) was provided three or more times:

- Weight-bearing support provided three or more times;
- Full staff performance of activity (3 or more times) during part (but not all) of last seven days.

4. Total Dependence - Full staff performance of the activity during entire seven-day period. Complete non-participation by the resident in all aspects of the ADL definition.

For example: For a resident to be coded as totally dependent in eating, he or she would be fed all food and liquids at all meals and snacks (including tube feeding delivered totally by staff), and never initiate any subtask of eating (e.g., picking up finger foods, giving self tube feeding or assisting with procedure) at any meal.

8. Activity Did Not Occur During the Entire 7-Day Period - Over the last seven days, the ADL activity was not performed by the resident or staff. In other words, the particular activity did not occur at all.

For example: A resident who was restricted to bed for the entire seven-day period and was never transferred from bed would receive a code of "8" for Transfer.

However, do not confuse a resident who is totally dependent in an ADL activity (code 4 - Total Dependence) with the activity itself not occurring. For example: Even a resident who receives tube feedings and no food or fluids by mouth is engaged in eating (receiving nourishment), and must be evaluated under the Eating category for his or her level of assistance in the process. A resident who is highly involved in giving himself a tube feeding is not totally dependent and should not be coded as "4".

Each of these ADL Self-Performance codes is exclusive; there is no overlap between categories. Changing from one self-performance category to another demands an increase or decrease in the number of times that help is provided. Thus, to move from Independent to Supervision to Limited Assistance, non weight-bearing supervision or physical assistance must increase from one or two times up to three or more times during the last seven days.

There will be times when no one type or level of assistance is provided to the resident 3 or more times during a 7-day period. However, the sum total of support of various types will be provided 3 or more times. In this case, code for the least dependent self-performance category where the resident received that level or more dependent support 3 or more times during the 7-day period.

EXAMPLES

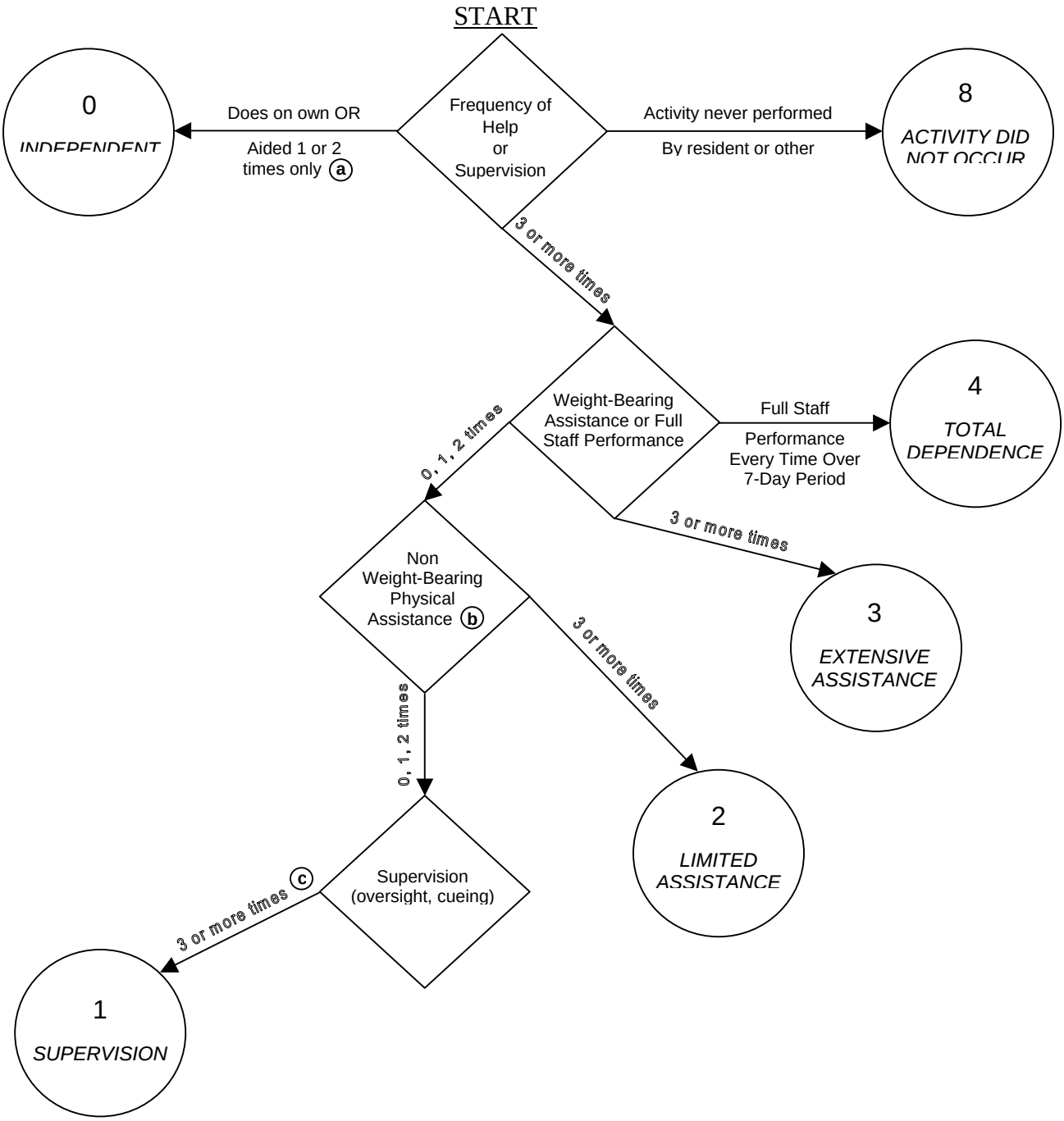
The resident received supervision for walking in the corridor on two occasions and non weight-bearing assistance on two occasions. **Code "1" for Supervision in Walking in Corridor.**

Rationale: Supervision is the least dependent category.

The resident received supervision in dressing on one occasion, non weight-bearing assistance (i.e., putting a hat on resident's head) on two occasions, and weight-bearing assistance (i.e., lifting resident's arm into a sleeve) on one occasion during the last 7 days. **Code "2" for Limited Assistance in Dressing.**

Rationale: There were 3 episodes of physical assistance in the last 7 days: 2 non-weight-bearing episodes, and 1 weight-bearing episode. Limited Assistance is the correct code because it reflects the least dependent support category that encompasses 3 or more activities that were at least at that level of support.

SCORING ADL SELF PERFORMANCE



a) Can include one or two events where received supervision, non weight-bearing assistance, or weight-bearing assistance.

b) Can include one or two episodes of weight-bearing assistance, e.g., two events with non weight-bearing assistance plus two of weight-bearing assistance would be coded as a "2".

c) Can include one or two episodes where physical help received, e.g., two episodes of supervision, one of weight-bearing assistance and one of non weight-bearing assistance would be coded as a "1".

G1. (B) ADL SUPPORT PROVIDED

Intent: To record the type and highest level of support the resident received in each ADL activity over the last seven days.

Definitions:

a) **ADL Support Provided:** Measures the highest level of support provided by staff over the last seven days, even if that level of support only occurred once. **This is a different scale, and is entirely separate from the ADL Self-Performance assessment.**

b) **Set-Up Help:** The type of help characterized by providing the resident with articles, devices or preparation necessary for greater resident self-performance in an activity. This can include giving or holding out an item that the resident takes from the caregiver.

EXAMPLES OF SETUP HELP

- **For bed mobility** - handing the resident the bar on a trapeze, staff applies ½ rails and then provides no further help.
- **For transfer** - giving the resident a transfer board or locking the wheels on a wheelchair for safe transfer.
- **For locomotion:**
    - **Walking** - handing the resident a walker or cane.
    - **Wheeling** - unlocking the brakes on the wheelchair or adjusting foot pedals to facilitate foot motion while wheeling.
- **For dressing** - retrieving clothes from closet and laying out on the resident's bed; handing the resident a shirt.
- **For eating** - cutting meat and opening containers at meals; giving one food category at a time.
- **For toilet use** - handing the resident a bedpan or placing articles necessary for changing ostomy appliance within reach.
- **For personal hygiene** - providing a washbasin and grooming articles.
- **For bathing** - placing bathing articles at tub side within the resident's reach; handing the resident a towel upon completion of bath.

Process: For each ADL category, code the maximum amount of support the resident received over the last seven days irrespective of frequency, and enter in the "SUPPORT" column. Be sure your evaluation considers all nursing shifts, 24 hours per day, including weekends. Code independently of the resident's Self-Performance evaluation. For example, a resident could have been Independent in ADL Self-Performance in Transfer but received a one-person physical assist one or two times during the seven-day period. Therefore, the ADL Self-Performance Coding for Transfer would be "0" (Independent), and the ADL Support coding "2" (One person physical assist).

Coding: **NOTE:** The highest code of physical assistance in this category (other than the "8" code) is a code of "**3**" not "4" as in Self-Performance.

0. No Setup or Physical Help from Staff

1. Setup Help Only - The resident is provided with materials or devices necessary to perform the activity of daily living independently.

2. One Person Physical Assist

3. Two+ Persons Physical Assist

8. ADL Activity Itself Did Not Occur During the Entire 7 Days - When an "8" code is entered for an ADL Support Provided category, enter an "8" code for ADL Self-Performance in the same category.

For example: If a resident never left the unit during the assessment period, code "8" for locomotion off unit. The activity did not occur, there was no help provided.

Clarifications:

- The ADL coding was created to reflect real situations where small variations in performance are common. For example, in scoring a resident as independent in ADL self-performance, there can be 1 or 2 exceptions. As soon as there are 3 exceptions, the resident is not independent and you need to consider another code. Staff members who are new to conducting MDS assessments need to become familiar with the coding structure and how exceptions are handled. Codes of 0, 1, 2, and 3 (Independent, Supervision, Limited Assistance, and Extensive Assistance) have been designed to allow one or two exceptions for the provision of assistance from the staff helper.

- Because of the differences in the scales used to score these two columns, data reliability is considerably improved by completing the Self-Performance column first for all items and then returning to the top and completing the Support column.

- For a resident to have a code of totally dependent for ADLs, the resident had to be totally dependent each time the activity occurred. As soon as the resident did some part of the activity, the resident was not totally dependent.

For all other categories, the clinician is reviewing for the most dependent activity that occurred at least 3 times in the last 7 days. Knowing the total number of times the activity occurred is not necessary for scoring accuracy. Knowing whether the activity occurred 3 or more times in the last 7 days is key to ADL coding accuracy.

- When considering toilet use, do not limit your assessment to bathroom use. Elimination may occur in the toilet room, commode, in the bedroom on a bedpan, or urinal. It includes transferring on/off the toilet, cleansing, changing pads, managing an ostomy or catheter, and clothing adjustment.

- General supervision of a dining room is not the same as individual supervision of a resident. If the resident ate independently, then MDS Item G1h is coded as "0" (Independent). If the individual resident needed oversight, encouragement, or cueing during the last 7 days, the item is coded as a "1" (Supervision). For a resident who has received oversight, encouragement, or cueing and also received more help, such as physical assistance provided one or two times during the 7-day assessment period, the resident would still be coded as a "1" (Supervision). Residents who are in "feeding" or "eating" groups and who are individually supervised during the meal would be coded as "1" (Supervision) for Self Performance in Eating.

- The key to the differentiation between guided maneuvering and weight-bearing assistance is determining *who* is supporting the weight of the resident's hand. If the staff member supports some of the weight of the resident's hand while helping the resident to eat (e.g., lifting a spoon or a cup to mouth), this is "weight-bearing" assistance for this activity. If the resident can lift the utensil or cup, but staff assistance is needed to guide the resident's hand to his/her mouth, this is guided maneuvering.

- If therapists are involved with the resident, their input should be included either by way of an interview or by the assessor reviewing the therapy documentation. The resident may perform differently in therapy than on the unit. Also focus on occurrences of exceptions in the resident's performance. When discussing a resident's ADL performance with a therapist, make sure the therapist's information can be expressed in MDS terminology.

- If staff performed an activity for the resident during the entire observation period, but the resident is able to do part of that activity, it would not be coded as "4" (total dependence). These situations would be when the resident is able to assist in dressing, but the staff puts on the shoes, socks or TED stockings.

CLARIFICATIONS USING THE CODE "8" (ACTIVITY DID NOT OCCUR)

- If the resident is bed bound and does not walk and there was no locomotion via bed, wheelchair or other means, then you would code an "8". However, if the bed is moved in order to provide locomotion on or off the unit, then you would code according to the definitions provided in Section G., 1A & B.
- For example, use code 8 when the resident did not walk in the past seven days, (in room/in corridor), for both the self-performance and the support columns.
- A resident who has not been out of bed in the past seven days could be coded 8 for (A) & (B) in MDS Sections G1b-f, unless the bed was moved (locomotion on/off unit). Other ADLs are considered individually.
- The eating item for G1h is a little more complex. If in the past seven days the resident truly did not receive any nourishment, the item would be coded 8. It should go without saying that this is a serious issue. Be careful not to confuse total dependence with eating (code 4) with the activity itself (in this case, receiving nourishment and fluids). Keep in mind that a resident who is fed via tube, and manages the tube feeding independently is coded as independent (code 0). G1h includes receiving IV fluids. For a resident who is receiving fluids for hydration, and is totally dependent, this is coded as 4, rather than 8.
- Toilet use focuses on whether elimination occurs, rather than the process. The elimination may be in the toilet room, commode, in the bedroom on a bedpan or urinal. It includes transferring on/off the toilet, cleansing, changing pads, managing an ostomy or catheter and clothing adjustment. The "8" code is rarely used in this section, as it would indicate that elimination did not occur.

The examples that follow clarify coding for both Self-Performance and Support. The answers appear to the right of the resident descriptions. Cover the answers, read and score the example, then compare your answers with those provided.

EXAMPLES: ADL SELF-PERFORMANCE AND SUPPORT	Self-Perf.	Support
Walk in room		
Resident walked in his/her room while holding on to furniture for support.	0	0
Resident walked independently during the day and received non-weight bearing physical help of 1 person for getting to the bathroom in room at night.	2	2
Resident received non-weight bearing physical assistance of one person for all walking in own room.	2	2
Resident did not walk but wheeled self independently in own room.	8	8
Walk in corridor		
A timid, fearful resident is usually physically independent in walking. During the last week she was very anxious and fearful of falling, and therefore received reassurance and encouragement from someone walking next to her while walking back to her room from meals in the unit dining room.	1	0
A resident with memory loss ambulated independently on the unit corridor albeit with a walker. Several times a day she left her walker in the bathroom, in the dining room, etc., necessitating that someone return it to her and offer her reminders to use it for safety.	1	1
Resident walked in corridor on unit by supporting self on one side with the handrail along the wall and receiving verbal cues from another person.	1	0
Resident walked twice daily 4-6 feet in the corridor outside his room. He received weight-bearing assistance of 1 person for each walk.	3	2
Resident walked in room for short distances with heavy assistance of 2 persons but traveled independently in corridor on unit by wheelchair.	8	8

EXAMPLES: ADL SELF-PERFORMANCE AND SUPPORT	Self-Perf.	Support
Locomotion on unit		
Resident ambulated slowly on unit pushing a wheelchair for support, stopping to rest every 15 - 20 feet. She has good safety awareness and has never fallen. Staff felt she was reliable enough to be on her own.	0	0
A resident with a history of falling and an unsteady gait always received physical guidance (non-weight-bearing) of one person for all ambulation. Two nights last week the resident was found in his bathroom after getting out of bed and walking independently.	2	2
Resident ambulated independently around the unit "ad lib," socializing with others and attending activities during the day. Loves dancing and yoga. Because she can become afraid at night, she received contact guard of one person to walk her to the bathroom at least twice every night.	2	2
During last week resident was learning to walk short distances with new leg prosthesis with heavy partial weight-bearing assistance of two persons. He refuses to ride in a wheelchair.	3	3
Locomotion off unit		
Resident independently walked with a cane to all meals in the Main Dining Room (off the unit) and social and recreational activities in the nearby hobby shop. Received no set-up or physical help during the assessment period.	0	0
Resident walked independently to the off unit dining room for all meals. For one visit to a clinic held at the opposite end of the building, she was given a ride in a wheelchair by a volunteer. She was wheeled to the clinic and after her session, she was wheeled back to her unit.	0	2
Resident is independent in walking about her residential unit. She does get lost and has difficulty finding her room but enjoys stopping to chat with others. Because she would get lost, she was always accompanied by a staff member for her daily walks around the facility.	1	0

Coding:

For each ADL category, code the appropriate response for the resident's actual performance during the past seven days. Enter the code in column (A), labeled "SELF-PERF." Consider the resident's performance during all shifts, as

functionality may vary. In the pages that follow two types of supplemental instructional material are presented to assist you in learning how to use this code: a schematic flow chart for scoring ADL Self Performance and a series of case examples for each ADL.

In your evaluations, you will also need to consider the type of assistance known as "set-up help" (e.g., comb, brush, toothbrush, toothpaste have been laid out at the bathroom sink by the nurse assistant). Set-up help is recorded under ADL Support Provided (Item G1B). But in evaluating the resident's ADL Self-Performance, include set-up help within the context of the "0" (Independent) code. For example: If a resident grooms independently once grooming items are set up for him, code "0" (Independent) in Personal Hygiene.

0. **Independent** - No help or staff oversight -OR- Staff help/oversight provided only one or two times during the last seven days.

1. **Supervision** - Oversight, encouragement, or cueing provided three or more times during last seven days -OR- Supervision (3 or more times) plus physical assistance provided only one or two times during last seven days.

2. **Limited Assistance** - Resident highly involved in activity, received physical help in guided maneuvering of limbs or other non weight-bearing assistance on three or more occasions -OR- limited assistance (3 or more times) plus more help provided only one or two times during last seven days.

3. **Extensive Assistance** - While the resident performed part of activity over last seven days, help of following type(s) was provided three or more times:

    - Weight-bearing support provided three or more times.
    - Full staff performance of activity (3 or more times) during part (but not all) of last seven days.

4. **Total Dependence** - Full staff performance of the activity during entire seven-day period. Complete non-participation by the resident in all aspects of the ADL definition.

For example: For a resident to be coded as totally dependent in eating, he or she would be fed all food and liquids at all meals and snacks (including tube feeding delivered totally by staff), and never initiate any subtask of eating (e.g., picking up finger foods, giving self tube feeding or assisting with procedure) at any meal.

8. **Activity Did Not Occur During the Entire 7-Day Period** - Over the last seven days, the ADL activity was not performed by the resident or staff. In other words, the particular activity did not occur at all.

For example: A resident who was restricted to bed for the entire seven-day period and was never transferred from bed would receive a code of "8" for Transfer.

However, do not confuse a resident who is totally dependent in an ADL activity (code 4 - Total Dependence) with the activity itself not occurring. **For example:** Even a resident who receives tube feedings and no food or fluids by mouth is engaged in eating (receiving nourishment), and must be evaluated under the Eating category for his or her level of assistance in the process. A resident who is highly involved in giving himself a tube feeding is not totally dependent and should not be coded as "4".

Each of these ADL Self-Performance codes is exclusive; there is no overlap between categories. Changing from one self-performance category to another demands an increase or decrease in the number of times that help is provided. Thus, to move from Independent to Supervision to Limited Assistance, non weight-bearing supervision or physical assistance must increase from one or two times up to three or more times during the last seven days.

There will be times when no one type or level of assistance is provided to the resident 3 or more times during a 7-day period. However, the sum total of support of various types will be provided 3 or more times. In this case, code for the least dependent self-performance category where the resident received that level or more dependent support 3 or more times during the 7-day period.

EXAMPLES

The resident received supervision for walking in the corridor on two occasions and non weight-bearing assistance on two occasions. **Code "1" for Supervision in Walking in Corridor.** ***Rationale:*** Supervision is the least dependent category.

The resident received supervision in dressing on one occasion, non weight-bearing assistance (i.e., putting a hat on resident's head) on two occasions, and weight-bearing assistance (i.e., lifting resident's arm into a sleeve) on one occasion during the last 7 days. **Code "2" for Limited Assistance in Dressing.**
Rationale: There were 3 episodes of physical assistance in the last 7 days: 2 non-weight-bearing episodes, and 1 weight-bearing episode. Limited Assistance is the correct code because it reflects the least dependent support category that encompasses 3 or more activities that were at least at that level of support.

G1. (B) ADL SUPPORT PROVIDED

Intent: To record the type and highest level of support the resident received in each ADL activity over the last seven days.

Definitions:

a) **ADL Support Provided:** Measures the highest level of support provided by staff over the last seven days, even if that level of support only occurred once. **This is a different scale, and is entirely separate from the ADL Self-Performance assessment.**

b) **Set-Up Help:** The type of help characterized by providing the resident with articles, devices or preparation necessary for greater resident self-performance in an activity. This can include giving or holding out an item that the resident takes from the caregiver.

EXAMPLES OF SETUP HELP

- **For bed mobility** - handing the resident the bar on a trapeze, staff applies ½ rails and then provides no further help.
- **For transfer** - giving the resident a transfer board or locking the wheels on a wheelchair for safe transfer.
- **For locomotion:**
  - **Walking** - handing the resident a walker or cane.
  - **Wheeling** - unlocking the brakes on the wheelchair or adjusting foot pedals to facilitate foot motion while wheeling.
- **For dressing** - retrieving clothes from closet and laying out on the resident's bed; handing the resident a shirt.
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- **For toilet use** - handing the resident a bedpan or placing articles necessary for changing ostomy appliance within reach.
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- **For bathing** - placing bathing articles at tub side within the resident's reach; handing the resident a towel upon completion of bath.

Process:

For each ADL category, code the maximum amount of support the resident received over the last seven days irrespective of frequency, and enter in the "SUPPORT" column. Be sure your evaluation considers all nursing shifts, 24 hours per day, including weekends. Code independently of the resident's Self-Performance evaluation. For example, a resident could have been Independent in ADL Self-Performance in Transfer but received a one-person physical assist one or two times during the seven-day period. Therefore, the ADL Self-Performance Coding for Transfer would be "0" (Independent), and the ADL Support coding "2" (One person physical assist).

Coding:

NOTE: The highest code of physical assistance in this category (other than the "8" code) is a code of "**3**" not "4" as in Self-Performance.

0. No Setup or Physical Help from Staff

1. Setup Help Only - The resident is provided with materials or devices necessary to perform the activity of daily living independently.

2. One Person Physical Assist

3. Two+ Persons Physical Assist

8. ADL Activity Itself Did Not Occur During the Entire 7 Days - When an "8" code is entered for an ADL Support Provided category, enter an "8" code for ADL Self-Performance in the same category.

For example: If a resident never left the unit during the assessment period, code "8" for locomotion off unit. The activity did not occur, there was no help provided.

Clarifications:

- The ADL coding was created to reflect real situations where small variations in performance are common. For example, in scoring a resident as independent in ADL self-performance, there can be 1 or 2 exceptions. As soon as there are 3 exceptions, the resident is not independent and you need to consider another code. Staff members who are new to conducting MDS assessments need to become familiar with the coding structure and how exceptions are handled. Codes of 0, 1, 2, and 3 (Independent, Supervision, Limited Assistance, and Extensive Assistance) have been designed to allow one or two exceptions for the provision of assistance from the staff helper.

- Because of the differences in the scales used to score these two columns, data reliability is considerably improved by completing the Self Performance column first for all items and then returning to the top and completing the Support column.

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other categories, the clinician is reviewing for the most dependent activity that occurred at least 3 times in the last 7 days. Knowing the total number of times the activity occurred is not necessary for scoring accuracy. Knowing whether the activity occurred 3 or more times in the last 7 days is key to ADL coding accuracy.

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- General supervision of a dining room is not the same as individual supervision of a resident. If the resident ate independently, then MDS Item G1h is coded as "0" (Independent). If the individual resident needed oversight, encouragement, or cueing during the last 7 days, the item is coded as a "1" (Supervision). For a resident who has received oversight, encouragement, or cueing and also received more help, such as physical assistance provided one or two times during the 7-day assessment period, the resident would still be coded as a "1" (Supervision). Residents who are in "feeding" or "eating" groups and who are individually supervised during the meal would be coded as "1" (Supervision) for Self Performance in Eating.

- The key to the differentiation between guided maneuvering and weight-bearing assistance is determining *who* is supporting the weight of the resident's hand. If the staff member supports some of the weight of the resident's hand while helping the resident to eat (e.g., lifting a spoon or a cup to mouth), this is "weight-bearing" assistance for this activity. If the resident can lift the utensil or cup, but staff assistance is needed to guide the resident's hand to his/her mouth, this is guided maneuvering.

- If therapists are involved with the resident, their input should be included either by way of an interview or by the assessor reviewing the therapy documentation. The resident may perform differently in therapy than on the unit. Also focus on occurrences of exceptions in the resident's performance. When discussing a resident's ADL performance with a therapist, make sure the therapist's information can be expressed in MDS terminology.

- If staff performed an activity for the resident during the entire observation period, but the resident is able to do part of that activity, it would not be coded as "4" (total dependence). These situations would be when the resident is able to assist in dressing, but the staff puts on the shoes, socks or TED stockings.

CLARIFICATIONS USING THE CODE "8" (ACTIVITY DID NOT OCCUR)

- If the resident is bed bound and does not walk and there was no locomotion via bed, wheelchair or other means, then you would code an "8". However, if the bed is moved in order to provide locomotion on or off the unit, then you would code according to the definitions provided in Section G., 1A & B.
- For example, use code 8 when the resident did not walk in the past seven days, (in room/in corridor), for both the self-performance and the support columns.
- A resident who has not been out of bed in the past seven days could be coded 8 for (A) & (B) in MDS Sections G1b-f, unless the bed was moved (locomotion on/off unit). Other ADLs are considered individually.
- The eating item for G1h is a little more complex. If in the past seven days the resident truly did not receive any nourishment, the item would be coded 8. It should go without saying that this is a serious issue. Be careful not to confuse total dependence with eating (code 4) with the activity itself (in this case, receiving nourishment and fluids). Keep in mind that a resident who is fed via tube, and manages the tube feeding independently is coded as independent (code 0). G1h includes receiving IV fluids. For a resident who is receiving fluids for hydration, and is totally dependent, this is coded as 4, rather than 8.
- Toilet use focuses on whether elimination occurs, rather than the process. The elimination may be in the toilet room, commode, in the bedroom on a bedpan or urinal. It includes transferring on/off the toilet, cleansing, changing pads, managing an ostomy or catheter and clothing adjustment. The "8" code is rarely used in this section, as it would indicate that elimination did not occur.

The examples that follow clarify coding for both Self-Performance and Support. The answers appear to the right of the resident descriptions. Cover the answers, read and score the example, then compare your answers with those provided.

EXAMPLES: ADL SELF-PERFORMANCE AND SUPPORT	Self-Perf.	Support
Walk in room		
Resident walked in his/her room while holding on to furniture for support.	0	0
Resident walked independently during the day and received non-weight bearing physical help of 1 person for getting to the bathroom in room at night.	2	2
Resident received non-weight bearing physical assistance of one person for all walking in own room.	2	2
Resident did not walk but wheeled self independently in own room.	8	8
Walk in corridor		
A timid, fearful resident is usually physically independent in walking. During the last week she was very anxious and fearful of falling, and therefore received reassurance and encouragement from someone walking next to her while walking back to her room from meals in the unit dining room.	1	0
A resident with memory loss ambulated independently on the unit corridor albeit with a walker. Several times a day she left her walker in the bathroom, in the dining room, etc., necessitating that someone return it to her and offer her reminders to use it for safety.	1	1
Resident walked in corridor on unit by supporting self on one side with the handrail along the wall and receiving verbal cues from another person.	1	0
Resident walked twice daily 4-6 feet in the corridor outside his room. He received weight bearing assistance of 1 person for each walk.	3	2
Resident walked in room for short distances with heavy assistance of 2 persons but traveled independently in corridor on unit by wheelchair.	8	8

CHRONIC MEASURES

Percent of Residents with Pain
Percent of Residents with Infections
Percent of Residents with Pressure Sores
Percent of Residents with Pressure Sores with an Additional Level of Risk Adjustment
Percent of Residents in Physical Restraints
Percent of Residents with Loss of Ability in Basic Daily Tasks

PERCENT OF RESIDENTS WITH PAIN

QM Description:

The percent of residents with either a moderate level of pain occurring every day or excruciating pain at any frequency on the target assessment.

Rationale for Pain QM:

Pain is a common experience with older people because the prevalence of musculoskeletal problems (e.g. arthritis, fractures) and other medical conditions such as peripheral vascular disease, wounds, neurological conditions and cancer diagnoses which tend to increase with age. Studies have shown that pain is significantly underreported in nursing facilities especially amongst the oldest old, females, minorities and the cognitively impaired. Although pain can be relieved in up to 90% of cases, a significant number of residents receive inadequate or no treatment.

QM Category:

Chronic Care Measure

MDS Assessments Used:

OBRA Full (AA8a = 01, 02, 03, or 04) or Quarterly Assessment (AA8a = 05 or 10)

QM Specifications:

NUMERATOR
The number of residents who experience moderate pain at least daily (J2a=2 and J2b=2) OR horrible/excruciating pain at any frequency (J2b=3) as noted on the OBRA Full or Quarterly Assessment.

DENOMINATOR
All residents with a valid Full (AA8a= 01, 02, 03, or 04) or OBRA Quarterly (AA8a = 05 or 10) Assessment.

RISK ADJUSTMENT
EXCLUSIONS

Residents satisfying any of the following conditions are excluded:

- Most recent OBRA assessment is the admission assessment (AA8a = 01)
- The values of J2a or J2b are missing on the OBRA assessment
- The values of J2a and J2b are inconsistent on the OBRA assessment
  (An example of inconsistent coding would include the coding of pain frequency as "no pain" while intensity of pain is simultaneously coded as "moderate" pain.)
- The resident is in a facility with a chronic care admission sample size of 0. The chronic care admission sample is 0 if there are no residents with a non-PPS admission assessment (AA8a = 01 and AA8b = blank or 6) over the previous 12-months.

- **Facility Admission Profile**

There is no facility level adjustment for this QM.

- **Covariates**

There is one covariate for this Quality Measure:

- Indicator of independence or modified independence in daily decision making on the prior assessment:

  Covariate = 1 if B4 = 0 or 1
  Covariate = 0 if B4 = 2 or 3

  Rationale: Accurate assessment of pain may be more difficult in cognitively impaired residents versus cognitively intact residents.

MDS Elements Related To QM:

J2a Pain Symptoms
Frequency with which resident complains or shows evidence of pain

J2b Pain Symptoms
Intensity of pain

B4 Decision Making
Level of impairment in daily decision making

MDS RAI Coding Instructions:

J2. PAIN SYMPTOMS (7-DAY LOOK BACK)

Intent: To record the **frequency** and **intensity** of signs and symptoms of pain. For care planning purposes this item can be used to identify indicators of pain as well as to monitor the resident's response to pain management interventions.

MDS 2.0 only captures pain symptoms. The **MDS 2.0 does not capture pain management/pain intervention data** (except by proxy in some residents, i.e., by capturing the pain became less severe with time or the decreasing frequency). While we realize the frustration of staff providing pain relief measures, there is no place to code interventions for pain on the current MDS. Such documentation would be found elsewhere on the resident's record in the nurses' notes, progress notes, medication records, and care plan. This coding situation is often compared to the concept to allow users to code both swallowing problems (symptom) and feeding tube (intervention) but while pain (symptom) can be coded there is no place to code the intervention. CMS is working to update pain assessment and pain management data on the MDS 3.0 and is refining the draft pain RAP.

CMS anticipates that few residents on pain management measures will *not* have some level of breakthrough pain during the 7-day assessment period that should then be coded on the MDS. For example, if through assessment or clinical record review you note that the resident has received pain medications or other pain relief measures, investigate the pain need and capture the pain event on the MDS. However, if the resident does not experience ANY breakthrough pain in the 7-day assessment window, they would indeed code 0. Remember that the assessment covers a 7-day period and should reflect the highest level of pain recorded by any staff member, not just the assessment of the professional completing the MDS.

Definitions:

a) **Pain** - For MDS assessment purposes, pain refers to any type of physical pain or discomfort in any part of the body. Pain may be localized to one area, or may be more generalized. It may be acute or chronic, continuous or intermittent (comes and goes), or occur at rest or with movement. The pain experience is very subjective; pain is whatever the resident says it is.

b) **Shows Evidence of Pain** - Depends on the observation of others (i.e., cues), either because the resident does not verbally complain, or is unable to verbalize.

Process:

Ask the resident if he or she has experienced any pain in the last seven days. Ask him/her to describe the pain. If the resident states he or she has pain, take his or her word for it. Pain is a subjective experience. Also observe the resident for indicators of pain. Indicators include moaning, crying, and other vocalizations; wincing or frowning and other facial expressions; or body posture such as guarding/protecting an area of the body, or lying very still; or decrease in usual activities.

In some residents, the pain experience can be very hard to discern. For example, in residents who have dementia and cannot verbalize that they are feeling pain, symptoms of pain can be manifested by particular behaviors such as calling out for help, pained facial expressions, refusing to eat, or striking out at a nurse assistant who tries to move them or touch a body part. Although such behaviors may not be solely indicative of pain, but rather may be indicative of multiple problems, code for the frequency and intensity of symptoms if in your clinical judgment it is possible that the behavior could be caused by the resident experiencing pain.

Ask nurse assistants and therapists who work with the resident if the resident had complaints or indicators of pain the last week.

Coding:

Code for the highest level of pain present in the last seven days. If the resident has no pain, code "0" (No pain) then skip to item J4.

a) **Frequency** - How often the resident complains or shows evidence of pain.

Codes:

0. **No pain (Skip to Item J4)**
1. **Pain less than daily**
2. **Pain daily**

b) **Intensity** - The severity of pain as described or manifested by the resident.

Codes:

1. **Mild Pain** - Although the resident experiences some ("a little") pain he or she is usually able to carry on with daily routines, socialization, or sleep.
2. **Moderate Pain** - Resident experiences "a medium" amount of pain.
3. **Times When Pain is Horrible or Excruciating** - Worst possible pain. Pain of this type usually interferes with daily routines, socialization and sleep.

Use your best clinical judgment when coding. If you have difficulty determining the exact frequency or intensity of pain, code for the more severe level of pain.
Rationale: Residents having pain will usually require further evaluation to determine the cause and to find interventions that promote comfort. You never want to miss an opportunity to relieve pain. Pain control often enables rehabilitation, greater socialization and activity involvement.

EXAMPLES	Pain Frequency	Pain Intensity
Mrs. G, a resident with poor short-and-long-term memory and moderately impaired cognitive function asked the charge nurse for "a pill to make my aches and pains go away" once a day during the last 7 days. The medication record shows that she received Tylenol every evening. The charge nurse states that Mrs. G usually rubs her left hip when she asks for a pill. However, when you ask her about pain, Mrs. G tells you that she is fine and never has pain. ***Rationale for coding*:** It appears that Mrs. G has forgotten that she has reported having pain during the last 7 days. Best clinical judgment calls for coding that reflects that Mrs. G has mild, daily pain.	2	1
Mr. T is cognitively intact. He is up and about and involved in self-care, social and recreational activities. During the last week he has been cheerful, engaging and active. When checked by staff at night, he appears to be sleeping. However, when you ask him how he's doing, he tells you that he has been having horrible cramps in his legs every night. He has only been resting, but feels tired upon arising. ***Rationale for coding*:** Although Mr. T may look comfortable to staff, he reports to you that he has terrible cramps. Best clinical judgment for coding this "screening" item for pain would be to record codes that reflect what Mr. T tells you. It is highly likely that Mr. T warrants a further evaluation.	2	3

J3. PAIN SITE (7-DAY LOOK BACK)

Intent: To record the location of physical pain as described by the resident, or discerned from objective physical and laboratory tests. Sometimes is difficult to pinpoint the exact site of pain, particularly if the resident is unable to describe the quality and location of pain in detail. Likewise, it will be difficult to pinpoint the exact site if the resident has not had physical or laboratory tests to evaluate the pain. In order to begin to develop a responsive care plan for promoting comfort, the intent of this item is to help residents and caregivers begin a pain evaluation by attempting to target the site of pain.

Definitions:

a. **Back Pain** - Localized or generalized pain in any part of the neck or back.

b. **Bone Pain** - Commonly occurs in metastatic disease. Pain is usually worse during movement but can be present at rest. May be localized and tender but may also be quite vague.

c. **Chest Pain While Doing Usual Activities** - The resident experiences any type of pain in the chest area, which may be described as burning, pressure, stabbing, vague discomfort, etc. "Usual activities" are those that the resident engages in normally. For example, the resident's usual activities may be limited to minor participation in dressing and grooming, short walks from chair to toilet room.

d. **Headache** - The resident regularly complains or shows evidence (clutching or rubbing the head) of headache.

e. **Hip Pain** - Pain localized to the hip area. May occur at rest or with physical movement.

f. **Incisional Pain** - The resident complains or shows evidence of pain at the site of a recent surgical incision.

g. **Joint Pain (Other Than Hip)** - The resident complains or shows evidence of discomfort in one or more joints either at rest or with physical movement.

h. **Soft Tissue Pain** - Superficial or deep pain in any muscle or non-bony tissue. Examples include abdominal cramping, rectal discomfort, calf pain, and wound pain.

i. **Stomach Pain** - The resident complains or shows evidence of pain or discomfort in the left upper quadrant of the abdomen.

j. **Other** - Includes either localized or diffuse pain of any other part of the body. Examples include general "aches and pains," etc.

Process: Ask the resident and observe for signs of pain. Consult staff members. Review the clinical record. Use your best clinical judgment.

Coding: Check all that apply during the last 7 days. If the resident has mouth pain check Item K1c in Section K, "Oral/Nutritional Status."

PERCENT OF RESIDENTS WITH INFECTIONS

QM Description:

The percent of residents with a new infection such as pneumonia, respiratory infection, septicemia, viral hepatitis, fever, recurrent lung aspiration, urinary tract infection, or infection of a wound since being admitted to the facility.

Rationale for Infection QM:

Infections are common in the long-term care setting. Major areas of concern are endemic infections, outbreaks, and colonization and infection of residents with antimicrobial-drug resistant microorganisms. The most frequent endemic infections are respiratory tract, urinary tract, skin and soft tissue, and gastrointestinal infections. Pneumonia and septicemia are the only infections in this setting that are often fatal. Urinary tract infections are generally the most prevalent. (Nicolle LE, "Preventing Infections in Non-Hospital Settings: Long-Term Care". *Emerging Infectious Diseases*. Vol 7, No.2, 2001; 205-206.)

QM Category:

Chronic Care Measure

MDS Assessments Used:

OBRA Full (AA8a = 01, 02, 03, or 04) or Quarterly Assessment (AA8a = 05 or 10) with carry-forward of information from most recent full assessment.

QM Specifications:

NUMERATOR

Residents with any of the following infections or health conditions noted on the target or most recent full assessment (only if the most recent full assessment is a non-admission assessment with AA8a = 02, 03, or 04):

- **Pneumonia (I2e=checked)** on the target assessment or most recent full assessment (if the most recent full is a non-admission assessment),
- **Respiratory infection (I2f=checked)** on the target assessment or most recent full assessment (if the most recent full is a non-admission assessment),
- **Septicemia (I2g=checked)** on the target assessment or most recent full assessment (if the most recent full is a non-admission assessment),
- **Urinary tract infection (I2j=checked)** on the target assessment only,
- **Viral hepatitis (I2k=checked)** on the target assessment or most recent full assessment (if the most recent full is a non-admission assessment),
- **Wound infection (I2l=checked)** on the target assessment or most recent full assessment (if the most recent full is a non-admission assessment),
- **Fever (J1h=checked)** on the target assessment or most recent full assessment (if the most recent full is a non-admission assessment), or

- **Recurrent lung aspiration (J1k=checked)** on the target assessment or most recent full assessment (if the most recent full is a non-admission assessment).

DENOMINATOR

All residents with a valid OBRA full or quarterly assessment (AA8a = 05 or 10).

RISK ADJUSTMENT
EXCLUSIONS

Residents satisfying any of the following conditions are excluded:

- The target assessment is an admission (AA8a = 01) assessment.
- The QM did not trigger (resident is not included in the QM numerator) AND the urinary tract infection item (I2j) is missing on the target assessment.
- The QM did not trigger and the value of any of the other infections or health conditions (I2e, I2f, I2g, I2k, I2l, J1h, or J1k) selected from the target assessments or most recent full assessment is missing.
- The resident has end-stage disease (J5c = checked) or status is unknown (J5c = missing) on the target assessment.
- The resident is receiving hospice care (P1ao = checked) or hospice status is unknown (P1ao = missing) on the target assessment or the most recent full assessment.
- The resident is in a facility with a Chronic Care Admission Sample size of 0. The chronic care admission sample is 0 if there are no residents with a non-PPS admission assessment (AA8a = 01 and AA8b = blank or 6) over the previous 12-months.

- **Facility Admission Profile**

There is no facility level risk adjustment for this QM.

- **Covariates**

No covariates used in the Infection QM.

NOTE: For some states which use a shorter version of the quarterly assessment, values for MDS items (I2e, I2f, I2g, I2k, I2I, J1h, or J1k) may not be available for calculation. In these instances, values for these MDS items will be "carried forward" from the most recent full assessment which occurred in the 17 months preceding the reference date of the target OBRA Quarterly (AA8a = 05 or 10) assessment.

States have the option to choose one of four forms to do their resident's quarterly assessments. Three of these forms collect data on multiple infections necessary to calculate the quality measure (pneumonia, respiratory infections, septicemia, wound infections, hepatitis, and urinary tract infections). However, if a state uses the form called a "2-page quarterly", the only infection collected is urinary tract infections. Since the MDS quarterly data is used to calculate the quality measures, there is variation in the types of data being collected in different states. For comparison purposes, the facility data is best compared to the state's data and not the national average since everyone in the state will be using the same quarterly form.

The 19 states/territories using the 2-page quarterly (only counting urinary tract infections) are:

Alaska, Alabama, California, Connecticut, District of Columbia, Delaware, Hawaii, Massachusetts, Maryland, Michigan, New Mexico, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Wisconsin, Wyoming, and the Virgin Islands.

Even though some states collect different data, CMS has chosen to report the infection quality measure because it is so important to prevent and treat infections in nursing home residents.

MDS Elements Related to QM:

I2e-Pneumonia

I2f- Respiratory Infection

I2g-Septicemia

I2j-Urinary Tract Infection

I2k-Viral Hepatitis

I2i-Wound Infection

J1h-Fever

J1k-Recurrent Lung Aspiration(s) in the last 90 days

J5c End Stage Disease

P1ao Hospice

MDS RAI Coding Instructions:

SECTION I. DISEASE DIAGNOSES

Intent: To document the presence of diseases which have a relationship to the resident's current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring or risk of death. In general, these are conditions that drive the current care plan.

The disease conditions in this section require a physician-documented diagnosis in the clinical record. It is good clinical practice to have the resident's physician provide supporting documentation for any diagnosis.

Do not include conditions that have been resolved or no longer affect the resident's functioning or care plan. In many facilities, clinical staff and physicians neglect to update the list of resident's "active" diagnoses. There may also be a tendency to continue old diagnoses that are either resolved or no longer relevant to the resident's plan of care. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's health status.

Definition: **Nursing Monitoring** - Includes clinical monitoring by a licensed nurse (e.g., serial blood pressure evaluations, medication management, etc.)

I1. DISEASES (7-DAY LOOK BACK)

Definitions:

ENDOCRINE/METABOLIC/NUTRITIONAL

▲ **a. Diabetes Mellitus** - Includes insulin-dependent diabetes mellitus (IDDM) and diet-controlled diabetes mellitus (NIDDM or AODM).

b. Hyperthyroidism

c. Hypothyroidism

HEART/CIRCULATION

☆ **d. Arteriosclerotic Heart Disease (ASHD)**

e. Cardiac Dysrhythmias - Disorder of heart rate or heart rhythm.

☆ **f. Congestive Heart Failure**

g. Deep Vein Thrombosis

h. Hypertension

Key: ▲ **Full MDS, MPAF and SB-MDS Items**
☆ **Full MDS and MPAF Items**

i. Hypotension

✯ **j. Peripheral Vascular Disease** - Vascular disease of the lower extremities that can be of venous and/or arterial origin.

k. Other cardiovascular disease

MUSCULOSKELETAL

l. Arthritis - Includes degenerative joint disease (DJD), osteoarthritis (OA), and rheumatoid arthritis (RA). Record more specific forms of arthritis (e.g., Sjogren's syndrome; gouty arthritis) in Item I3 (with ICD-9-CM code).

✯ **m. Hip Fracture** - Includes any hip fracture that occurred at any time that continues to have a relationship to current status, treatments, monitoring, etc. Hip fracture diagnoses also include femoral neck fractures, fractures of the trochanter, and subcapital fractures.

n. Missing Limb (e.g., Amputation) - Includes loss of any part of any upper or lower extremity.

o. Osteoporosis

p. Pathological Bone Fracture - Fracture of any bone due to weakening of the bone, usually as a result of a cancerous process.

NEUROLOGICAL

q. Alzheimer's Disease

▲ **r. Aphasia** - A speech or language disorder caused by disease or injury to the brain resulting in difficulty expressing thoughts (i.e., speaking, writing), or understanding spoken or written language.

▲ **s. Cerebral Palsy** - Paralysis related to developmental brain defects or birth trauma. Includes spastic quadraplegia secondary to cerebral palsy.

✯ **t. Cerebrovascular Accident (CVA/Stroke)** - A vascular insult to the brain that may be caused by intracranial bleeding, cerebral thromboses, infarcts, and emboli.

u. Dementia Other Than Alzheimer's - Includes diagnoses of organic brain syndrome (OBS) or chronic brain syndrome (CBS), senility, senile dementia, multi-infarct dementia, and dementia related to neurologic diseases other than Alzheimer's (e.g., Picks, Creutzfeld-Jacob, Huntington's disease, etc.).

Key: ▲ **Full MDS, MPAF and SB-MDS Items**

✯ **Full MDS and MPAF Items**

▲ **v.** **Hemiplegia/Hemiparesis** - Paralysis/partial paralysis (temporary or permanent impairment of sensation, function, motion) of both limbs on one side of the body. Usually caused by cerebral hemorrhage, thrombosis, embolism, or tumor. There must be a diagnosis of hemiplegia or hemiparesis in the resident's record.

▲ **w.** **Multiple Sclerosis** – Chronic disease affecting the central nervous system with remissions and relapses of weakness, incoordination, paresthesis, speech disturbances and visual disturbances.

✯ **x.** **Paraplegia** - Paralysis (temporary or permanent impairment of sensation, function, motion) of the lower part of the body, including both legs. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury. There must be a diagnosis of paraplegia in the resident's record.

y. **Parkinson's Disease**

▲ **z.** **Quadriplegia** - Paralysis (temporary or permanent impairment of sensation, function, motion) of all four limbs. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury. There must be a diagnosis of quadriplegia in the resident's record. (Spastic quadriplegia, secondary to cerebral palsy, should not be coded as quadriplegia.)

aa. **Seizure Disorder**

bb. **Transient Ischemia Attack (TIA)** - A sudden, temporary, inadequate supply of blood to a localized area of the brain. Often recurrent.

cc. **Traumatic Brain Injury** - Damage to the brain as a result of physical injury to the head.

Key: **▲ Full MDS, MPAF and SB-MDS Items**
✯ Full MDS and MPAF Items

PSYCHIATRIC/MOOD

dd. Anxiety Disorder

✯ **ee. Depression**

✯ **ff. Manic Depressive (Bipolar Disease)** - Includes documentation of clinical diagnoses of either manic depression or bipolar disorder. "Bipolar disorder" is the current term for manic-depressive illness.

✯ **gg. Schizophrenia**

PULMONARY

✯ **hh. Asthma**

✯ **ii. Emphysema/COPD** - Includes COPD (chronic obstructive pulmonary disease) or COLD (chronic obstructive lung disease), and chronic restrictive lung diseases such as asbestosis and chronic bronchitis.

SENSORY

jj. Cataracts

kk. Diabetic Retinopathy

ll. Glaucoma

mm. Macular Degeneration

OTHER

nn. Allergies - Any hypersensitivity caused by exposure to a particular allergen. Includes agents (natural and artificial) to which the resident is susceptible for an allergic reaction, not only those to which he or she currently reacted to in the last seven days. This item includes allergies to drugs (e.g., aspirin, antibiotics), foods (e.g., eggs, wheat, strawberries, shellfish, milk), environmental substances (e.g., dust, pollen), animals (e.g., dogs, birds, cats), and cleaning products (e.g., soap, laundry detergent), etc. Hypersensitivity reactions include but are not limited to, itchy eyes, runny nose, sneezing, contact dermatitis, etc.

oo. Anemia - Includes anemia of any etiology.

pp. Cancer

Key: ▲ **Full MDS, MPAF and SB-MDS Items**

✯ **Full MDS and MPAF Items**

qq. Renal Failure

rr. *NONE OF ABOVE*

Process:

Consult transfer documentation and medical record (including current physician treatment orders and nursing care plans). If the resident was admitted from an acute care or rehabilitation hospital, the discharge forms often list diagnoses and corresponding ICD-9-CM codes that were current during the hospital stay. If these diagnoses are still active, record them on the MDS form. Also, accept statements by the resident that seem to have clinical validity. Consult with physician for confirmation and initiate necessary physician documentation of current diagnoses in the clinical record.

Physician involvement in this part of the assessment process is crucial. The physician should be asked to review the items in Section I closest to the scheduled MDS assessment. Use this scheduled visit as an opportunity to ensure that active diagnoses are noted and "inactive" diagnoses are designated as resolved. This is also an important opportunity to share the entire MDS assessment with the physician. In many nursing facilities physicians are not brought into the MDS review and assessment process. It is the responsibility of facility staff to aggressively solicit physician input. Inaccurate or missed diagnoses can be a serious impediment to care planning. Thus, you should share this section of the MDS with the physician and ask for his or her input. Physicians completing a portion of the MDS assessment should sign in Item R2 (Signatures of Those Completing the Assessment).

Full physician review of the most recent MDS assessment or ongoing input into the assessment currently being completed can be very useful. For the physician, the MDS assessment completed by facility staff can provide insights that would have otherwise not been possible. For staff, the informed comments of the physician may suggest new avenues of inquiry, or help to confirm existing observations, or suggest the need for additional follow-up.

Check a disease item only if the disease has a relationship to current ADL status, cognitive status, behavior status, medical treatment, nursing monitoring, or risk of death. For example, it is not necessary to check "hypertension" if one episode occurred several years ago unless the hypertension is either currently being controlled with medications, diet, biofeedback, etc., or is being regularly monitored to prevent a recurrence.

Coding:

Do not record any conditions that have been resolved and no longer affect the resident's functional status or care plan.

Check all that apply. If none of the conditions apply, check *NONE OF ABOVE*. ***If you have more detailed information available in the clinical record for a more definitive diagnosis than is provided in the list in Section I1, check the more***

general diagnosis in I1 and then enter the more detailed diagnosis (with ICD-9-CM code) under I3.

For example: If the record reveals that the resident has "Osteoarthritis" you check Item I1l (Arthritis) and record "Osteoarthritis" with 1CD-9-CM Code 715.00 in Section I3.

Consult the resident's transfer documentation (in the case of new admissions or re-admissions) and current medical record including current nursing care plans. There will be times when a particular diagnosis will not be documented in the medical record. If that is the case, as indicated above, accept statements by the resident that seem to have clinical validity, consult with the physician for confirmation, and initiate necessary physician documentation.

For example: If a new resident says he or she had a severe depression and was seeing a private psychiatrist in the community, this information may have been missed if the information was not carried forward in records accompanying the resident from an acute care hospital to the nursing facility.

The following chart of ICD-9-CM codes for diseases listed in Item I1 is intended to clarify the level of specificity represented when the disease item is checked. This is also the list to use in computer applications of the MDS.

Clarifications:

- Residents with communication problems as a result of Alzheimer's, Parkinson's or multi-infarct dementia need to be carefully assessed. These diagnoses may result in impairment in the ability to comprehend or express language that may affect some or all channels of communication, including listening, reading, speaking, writing and gesturing.

- Depression secondary to Alzheimer's disease should be coded **only** if there is physician documentation in clinical record to support the diagnoses.

  If the resident with a diagnosis of Alzheimer's disease has expressions/features defined in Section E, Mood and Behavior Patterns, code accordingly. The resident's diagnosis of depression should have physician's documentation supporting the diagnosis. In addition, staff should address the resident's mood and behavior in the resident's record.

  In situations such as this, always ask the resident's physician to provide clarification to assure proper coding of the disease or condition.

ICD-9-CM CODES FOR DISEASES LISTED IN SECTION I1

ICD-9-CM CODE	DISEASE CONDITION
ENDOCRINE/METABOLIC/NUTRITIONAL	
250.00	Diabetes mellitus
242.9[0 or1]	Hyperthyroidism
244.9	Hypothyroidism
HEART/CIRCULATION	
414.00 through 414.03	Arteriosclerotic heart disease (ASHD)
427.9	Cardiac dysrhythmia
428.0	Congestive heart failure
453.8	Deep vein thrombosis
401.9	Hypertension (unspecified)
458.9	Hypotension (unspecified)
443.9	Peripheral vascular disease (unspecified)
429.2	Other cardiovascular disease
MUSCULOSKELETAL	
716.90	Arthritis (unspecified site)
820.9	Hip fracture (unspecified site or NOS [not otherwise specified])
736.89	Missing limb (e.g., amputation)
733.00	Osteoporosis (unspecified)
733.10	Pathological bone fracture (unspecified sites)

(continued on next page)

ICD-9-CM CODES FOR DISEASES LISTED IN SECTION I1 (CONTINUED)

ICD-9-CM CODE	DISEASE CONDITION
NEUROLOGICAL	
331.0	Alzheimer's disease
784.3	Aphasia
343.00 through 343.90	Cerebral palsy (unspecified)
436	Cerebrovascular accident (stroke) (NOS acute)
290.0	Dementia other than Alzheimer's (Senile Dementia, NOS)
342.90 through 342.92	Hemiplegia/Hemiparesis
340	Multiple sclerosis (NOS)
344.1	Paraplegia
332.0	Parkinson's disease
344.00 through 344.09	Quadriplegia
780.3	Seizure disorder
435.9	Transient ischemic attack (TIA) (unspecified)
854.00	Traumatic brain injury (unspecified)
PSYCHIATRIC/MOOD	
300.00	Anxiety disorder (unspecified)
311	Depression
296.8	Manic depression (bipolar disease)
295.90	Schizophrenia (unspecified)
PULMONARY	
493.90	Asthma (unspecified)
492.8	Emphysema
496	COPD
SENSORY	
366.9	Cataracts (unspecified)
362.01, 362.02 and 250.50 through 250.53	Diabetic retinopathy
365.9	Glaucoma (unspecified)
362.50	Macular degeneration (unspecified)
OTHER	
995.3	Allergies (unspecified)
285.9	Anemia
199.1	Cancer (unspecified as to site or stage)
586	Renal failure (unspecified)

ICD-9-CM: The International Classification of Diseases – 9th Revision - Clinical Modification. Ann Arbor, Michigan: Edward Brothers, Inc., October 1989.

I2. INFECTIONS (7-DAY LOOK BACK)

Definitions:

✯ **a. Antibiotic Resistant Infection (e.g., Methicillin resistant Staph)** - An infection in which bacteria have developed a resistance to the effective actions of an antibiotic. Check this item only if there is supporting documentation in the clinical record (including transmittal records of new admissions and recent transfers from other institutions).

✯ **b. Clostridium Difficile (C.diff)** - Diarrheal infection caused by the Clostridium difficile bacteria. Check this item only if there is supporting documentation in the clinical record of new admissions and recent transfers (e.g., hospital referral or discharge summary, laboratory report).

✯ **c. Conjunctivitis** - Inflammation of the mucous membranes lining the eyelids. May be of bacterial, viral, allergic, or traumatic origin.

✯ **d. HIV Infection** - Check this item only if there is supporting documentation or the resident (or surrogate decision-maker) informs you of the presence of a positive blood test result for the Human Immunodeficiency Virus or diagnosis of AIDS. If a State has a policy to omit transmission of HIV information, the State policy supercedes the MDS requirement.

▲ **e. Pneumonia** - Inflammation of the lungs; most commonly of bacterial or viral origin.

✯ **f. Respiratory Infection** - Any upper or lower (e.g., bronchitis) respiratory infection other than pneumonia.

▲ **g. Septicemia** - Morbid condition associated with bacterial growth in the blood. Septicemia can be indicated once a blood culture has been ordered and drawn. A physician's working diagnosis of septicemia can be accepted, provided the physician has documented the septicemia diagnosis in the resident's clinical record.

✯ **h. Sexually Transmitted Diseases** - Check this item only if there is supporting documentation of a current diagnosis of gonorrhea, or syphilis. DO NOT include HIV in this category. If a State has established statutory or regulatory privacy policies precluding transmission of sexually transmitted diseases information, the State policy supercedes the MDS requirement.

Key: ▲ Full MDS, MPAF and SB-MDS Items

✯ Full MDS and MPAF Items

✯ **i. Tuberculosis** - Includes residents with active tuberculosis or those who have converted to PPD positive tuberculin status and are currently receiving drug treatment (e.g., isoniazid (INH), ethambutol, rifampin, cycloserine) for tuberculosis.

✯ **j. Urinary Tract Infection** - Includes chronic and acute symptomatic infection(s) in the last 30 days. Check this item only if there is current supporting documentation and significant laboratory findings in the clinical record.

Once a urine culture has been done, a physician's working diagnosis of UTI provides sufficient documentation to code the UTI at Item I2j. The diagnosis of UTI, along with lab results when available, must be documented in the resident's clinical record.

In response to questions regarding the resident with colonized MRSA, we consulted with the Centers for Disease Control (CDC) who provided the following information:

A physician often prescribes empiric antimicrobial therapy for a suspected infection **after a culture is obtained, but prior to receiving the culture results**. The confirmed diagnosis of UTI will depend on the culture results and other clinical assessment to determine appropriateness and continuation of antimicrobial therapy. This should not be any different, even if the resident is known to be colonized with an antibiotic resistant organism. An appropriate culture will help to ensure the diagnosis of infection is correct, and the appropriate antimicrobial is prescribed to treat the infection. The CDC does not recommend routine antimicrobial treatment for the purposes of attempting to eradicate colonization of MRSA or any other antimicrobial resistant organism.

✯ **k. Viral Hepatitis** - Inflammation of the liver of viral origin. This category includes diagnoses of hepatitis A, hepatitis B, hepatitis non-A non-B, and hepatitis C.

✯ **l. Wound infection** - Infection of any type of wound (e.g., surgical; traumatic; pressure) on any part of the body.

m. NONE OF ABOVE

Process:

Consult transfer documentation and the resident's clinical record (including current physician treatment orders and nursing care plans). Accept statements by the resident that seem to have clinical validity. Consult with physician for confirmation and initiate necessary physician documentation.

Key: ▲ Full MDS, MPAF and SB-MDS Items

✯ Full MDS and MPAF Items

Physician involvement in this part of the assessment process is crucial.

Coding:

Check an item only if the infection has a relationship to current ADL status, cognitive status, mood and behavior status, medical treatment, nursing monitoring, or risk of death. Do not record any conditions that have been resolved and no longer affect the resident's functional status or care plan. For example, do not check "tuberculosis" if the resident had TB several years ago unless the TB is either currently being controlled with medications or is being regularly monitored to detect a recurrence.

Check all that apply. If none of the conditions apply, check **NONE OF ABOVE**. If you have more detailed information available in the clinical record for a more definitive diagnosis than is provided in the list in Section I2 check the appropriate box in I2 and enter the more detailed information (with ICD-9-CM code) under I3.

ICD-9-CM CODES FOR DISEASES LISTED IN SECTION I2

CD-9-CM CODE	DISEASE CONDITION
INFECTION	
041.9, 041.11, 041.19	Antibiotic resistant infection (e.g., methicillin resistant staph)
040.0	Clostridium difficile (C.diff)
372.30	Conjunctivitis
042	HIV infection
486	Pneumonia (organism unspecified)
038.9	Septicemia (not otherwise specified)
099.9	Sexually transmitted diseases (Venereal diseases) (unspecified)
011.90	Tuberculosis (pulmonary unspecified)
599.0	Urinary tract infection (site not specified)
070.9	Viral hepatitis (unspecified, without mention of hepatic coma)
958.3, 998.5	Wound infection

ICD-9-CM: The International Classification of Diseases - 9th Revision - Clinical Modification. Ann Arbor, Michigan: Edward Brothers, Inc., October 1989.

PERCENT OF RESIDENTS WITH PRESSURE SORES

QM Description:

The percent of residents who are reported to have one or more pressure sores on the OBRA full or quarterly assessment.

Rationale for Pressure Ulcer QM:

Between 3% and 5% (or more) of residents in nursing facilities have pressure ulcers, (aka pressure sores or bed sores.) Sixty percent or more of residents will typically be at risk of pressure ulcer development. Pressure ulcers can have serious consequences for the elderly and are costly and time consuming to treat. However, they are one of the most common, preventable and treatable conditions among the elderly who have restricted mobility. Successful outcomes can be expected with preventive and treatment programs. Assessment goals are: 1) to ensure that a treatment plan is in place for residents with pressure ulcers; and (2) to identify residents at risk for developing a pressure ulcer who are not currently receiving some type of preventive care program.

QM Category:

Chronic Care Measure

MDS Assessments Used:

OBRA Full (AA8a = 01, 02, 03, or 04) or Quarterly Assessment (AA8a = 05 or 10)

QM Specifications:

NUMERATOR
The number of residents with pressure ulcers (Stage 1-4) on the OBRA Full or Quarterly Assessment (M2a>0 or I3a-e=707.0).

DENOMINATOR
All residents with a valid OBRA Full (AA8a = 01, 02, 03 or 04) or Quarterly (AA8a = 05 or 10) Assessment.

RISK ADJUSTMENT
EXCLUSIONS

Residents satisfying any of the following conditions are excluded:
- Most recent OBRA assessment is the admission assessment (AA8a=01).
- The QM did not trigger (resident is not included in the QM numerator) AND the value of M2a is missing on the target assessment.

- The resident is in a facility with a chronic care admission sample size of 0. The chronic care admission sample is 0 if there are no residents with a non-PPS admission assessment (AA8a = 01 and AA8b = blank or 6) over the previous 12-months.

Facility Risk Adjustment
There is no facility level adjustment for this QM.
(See Percentage of Residents with Pressure (Bed) Sores with FAP in following section)

Covariates
No covariates used in the Pressure (Bed) Sores QM.

MDS Elements Related to QM:

M2a Type of Ulcer
Presence of Stage 1-4 pressure ulcer

I3a-e Other Current or More Detailed Diagnoses and ICD-9 Codes
Diagnosis of pressure ulcer is coded

MDS RAI Coding Instructions:

SECTION M. SKIN CONDITION

To determine the condition of the resident's skin, identify the presence, stage, type, and number of ulcers, and document other problematic skin conditions. Additionally, to document any skin treatments for active conditions as well as any protective or preventive skin or foot care treatments the resident has received in the last seven days.

M1. ULCERS (DUE TO ANY CAUSE) (7-DAY LOOK BACK)

Intent: To record the number of ulcers, of any type at each ulcer stage, on any part of the body.

Definitions: A skin ulcer can be defined as a local loss of epidermis and variable levels of dermis and subcutaneous tissue, or in the case of Stage I pressure ulcers, persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. Open lesions/sores are skin ulcers that may develop because of injury, circulatory problems, pressure, or in association with other diseases such as syphilis. Rashes without open areas, burns, desensitized skin and surgical wounds are **NOT** coded here, but are included in Item M4.

a) **Stage 1.** A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.

b) **Stage 2.** A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.

c) **Stage 3.** A full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue.

d) **Stage 4.** A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

Process:

Review the resident's record and consult with the nurse assistant about the presence of an ulcer. Examine the resident and determine the stage and number of any ulcers present. Without a full body check, an ulcer can be missed.

Assessing a Stage 1 ulcer requires a specially focused assessment for residents with darker skin tones to take into account variations in ebony-colored skin. To recognize Stage 1 ulcers in ebony complexions, look for the following:

1) any change in the feel of the tissue in a high-risk area,
2) any change in the appearance of the skin in high-risk areas, such as the "orange-peel" look,
3) a subtle purplish hue, and
4) extremely dry, crust-like areas that, upon closer examination, are found to cover a tissue break.

Coding:

All skin ulcers should be coded in this item. Record the number of ulcers at each stage on the resident's body, in the last 7 days, regardless of the ulcer cause. If necrotic eschar is present, prohibiting accurate staging, code the ulcer as Stage "4" until the eschar has been debrided (surgically or mechanically) to allow staging. If there are no ulcers at a particular stage, record "0" (zero) in the box provided. If there are more than 9 ulcers at any one stage, enter a "9" in the appropriate box.

Clarifications:

- All problems and lesions present during the current observation period should be documented on the MDS assessment. These items refer to the objective presence of problems or lesions, as observed during the assessment period.

- CMS acknowledges that the National Pressure Ulcer Advisory Panel (NPUAP) has published guidelines for pressure ulcer stages and is considering changes to the existing MDS coding procedures for the future. For the present, staff should code the MDS using a reverse staging protocol. For the MDS assessment, code the ulcer in terms of what you see (i.e., visible tissue). For example, a healing Stage 3 pressure ulcer that has the appearance (i.e., presence of granulation tissue, size, depth, and color) of a stage 2 ulcer must be coded as a "2".

- Debridement of an ulcer merely removes necrotic and decayed tissue to promote healing. The ulcer still exists and may or may not be at the same stage as it was prior to debridement. Good clinical practice dictates that the ulcer be re-examined and re-staged after debridement. Also code treatments as appropriate in Item M5, (Skin Treatments).

- If a skin shear or tear occurs on a pressure point (e.g., a resident has a skin tear on her sacrum while being pulled up in bed), it should be coded as a Stage II ulcer (M1). Determining whether the Stage II ulcer on a pressure point is the result of pressure may require a determination by the clinician based on an assessment. The determination that an ulcer is the result of pressure cannot be made based merely on its location over a pressure point. From this example, on one hand, it may be determined that because the resident cannot reposition herself while on her back in bed, that indeed pressure on the sacrum contributed to the formation of the ulcer, i.e., the resident cannot move on her own to relieve the pressure. On the other hand, if the shear or tear occurred over a pressure point, on a resident who is able to reposition herself, the determination is less likely that pressure on that point was the cause of the ulcer.

EXAMPLE

Mrs. L has end-stage metastatic cancer and weighs 75 pounds. She has a Stage 3 ulcer over her sacrum and two Stage 1 ulcers over her heels.

Items M1, Ulcers (due to any cause)	Stage	Code
	a) 1	2
	b) 2	0
	c) 3	1
	d) 4	0

Mr. Alaska has five open wounds as a result of frostbite that are not pressure or venous stasis ulcers. Upon examination, these wounds meet the criteria provided in Item M1 (Ulcers) coding definitions: 4 ulcers are consistent with Stage 2 ulcer staging and 1 ulcer appears to be at Stage 3. Assuming that the resident in this scenario has no pressure ulcers, code the resident's condition as follows:

Items M1, Ulcers (due to any cause)	Stage	Code
	a) 1	0
	b) 2	4
	c) 3	1
	d) 4	0

Items M2, Type of Ulcer:

Code "0" (highest stage ulcer is not a pressure ulcer)

Items M4, Other Skin Problems or Lesions Present:

Code Item M4c unless the frostbite wounds are to the foot, then code M6.

Include coding for treatments provided in Items M5 (Skin Treatments) and M6, (Foot Problems and Care) as appropriate.

M2 TYPE OF ULCER (7-DAY LOOK BACK)

Intent: To record the highest stage for two types of ulcers, Pressure and Stasis, that was present in the last 7 days.

Definitions:

▲ **a. Pressure Ulcer** - Any lesion caused by pressure resulting in damage of underlying tissues. Other terms used to indicate this condition include bedsores and decubitus ulcers.

✯ **b. Stasis Ulcer** - An open lesion, usually in the lower extremities, caused by decreased blood flow from chronic venous insufficiency; also referred to as a venous ulcer or ulcer related to peripheral vascular disease (PVD).

Process: Review the resident's record. Consult with the physician regarding the cause of the ulcer(s).

Coding: Using the ulcer staging scale in Item M1, record the highest ulcer stage for pressure and stasis ulcers present in the last 7 days. Remember that there are other types of ulcers than the two listed in this item (e.g., ischemic ulcers). An ulcer recorded in Item M1, may not necessarily be recorded in Item M2 (see last example below).

More definitive information concerning pressure ulcers is provided in the AHCPR Guidelines for pressure ulcers in adults.

www.ahrq.gov/consumer/bodysys/edbody6.htm

Key: ▲ Full MDS, MPAF and SB-MDS Items

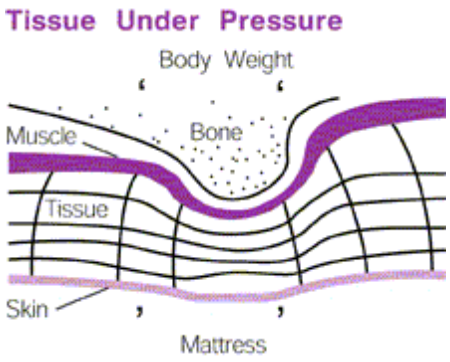
✯ Full MDS and MPAF Items

What are Pressure Ulcers?

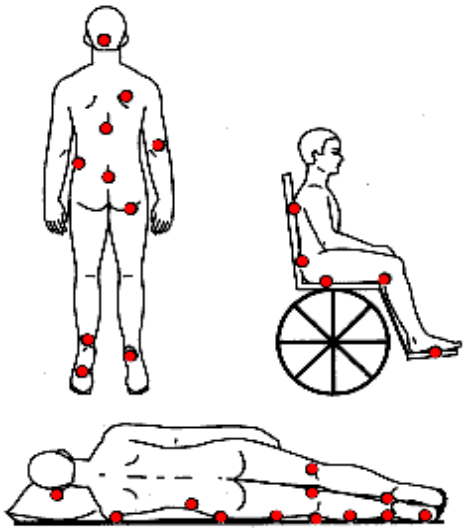
A pressure ulcer is an injury usually caused by unrelieved pressure that damages the skin and underlying tissue. Pressure ulcers are also called decubitus ulcers or bedsores and range in severity from mild (minor skin reddening) to severe (deep craters down to muscle and bone).

Unrelieved pressure on the skin squeezes tiny blood vessels, which supply the skin with nutrients and oxygen. When skin is starved of nutrients and oxygen for too long, the tissue dies and a pressure ulcer forms. The affected area may feel warmer than surrounding tissue. Skin reddening that disappears after pressure is removed is normal and not a pressure ulcer.

Other factors cause pressure ulcers, too. If a person slides down in the bed or chair, blood vessels can stretch or bend and cause pressure ulcers. Even slight rubbing or friction on the skin may cause minor pressure ulcers.



Where Pressure Ulcers Form



Pressure ulcers form where bone causes the greatest force on the skin and tissue, and squeezes them against an outside surface. This may be where bony parts of the body press against other body parts, a mattress, or a chair. In persons who must stay in bed, most pressure ulcers form on the lower back below the waist (sacrum), the hip bone (trochanter), and on the heels. In people in chairs or wheelchairs, the exact spot where pressure ulcers form depends on the sitting position. Pressure ulcers can also form on the knees, ankles, shoulder blades, back of the head, and spine.

Nerves normally tell the body when to move to relieve pressure on the skin. Persons in bed who are unable to move may get pressure ulcers after as little as 1-2 hours. Persons who sit in chairs and who cannot move can get pressure ulcers in even less time because the force on the skin is greater.

The full AHCRP guideline for clinicians can be found at:
http://www.ahcpr.gov/clinic/cpgonline.htm

Clarifications:

- In order to code Pressure Ulcers in the case of a blister, the key is to determine if there was a source of pressure that caused the blister. In the presence of moisture, less pressure may be required to develop a pressure ulcer. If, for example, a blister was found in the area of the incontinence brief waist or leg band, pressure from the band is a likely cause of the blister and the assessor would record the blister as a pressure ulcer. If no source of pressure could be identified, the blister may be evidence of perineal dermatitis caused by excessive urine or stool eroding the epidermis. No pressure is required for perineal dermatitis to occur. If this were the case, the blister would not be recorded as a pressure ulcer, but would be considered a rash. For additional information, refer to: Lyder, C. (1997). Perineal dermatitis in the elderly: A critical review of the literature. Journal of Gerontological Nursing 23(12), 5-10.

- If there is persistent redness without a break in the skin that does not disappear when pressure is relieved, the problem should be recorded as a Stage 1 ulcer (M1). Less pressure is needed for a pressure ulcer to form when the skin is soiled with urine and/or feces. **If the resident is unable to move, or does not move to relieve pressure on the skin, then pressure is very likely to have helped form the ulcer.** Item M1a should be coded as "1" and M2a should be coded for the highest stage. In addition, if this is a situation where there is redness from pressure in combination with a contact rash from incontinence,

especially if the resident was wet long enough to develop the rash, code Item M2a, pressure ulcer for the highest stage. If the resident's mobility status is not impaired (i.e., they can move to relieve pressure on the skin) and the redness is not likely due to pressure, do not code Item M2a. Code the condition in M4, Other Skin Problems or Lesions Present.

EXAMPLE

Mr. C has diabetes and poor circulation to his lower extremities. Last month Mr. C spent 2 weeks in the hospital where he had a left below the knee amputation (BKA) for treatment of a gangrenous foot. His hospital course was complicated by delirium (acute confusion) and he spent most of his time on bed rest. Nurses remarked that he would only stay lying on his back. He had only an egg crate mattress on his bed to relieve pressure. A water mattress and air mattress were both tried but aggravated his agitation. He was readmitted to the nursing facility 3 days ago with a Stage II pressure ulcer over his sacrum and a Stage I pressure ulcer over his right heel and both elbows. No other ulcers were present.

Items M1 or SB-MDS 31, Ulcers (due to any cause)	**Code (# at stage)**
a) Stage 1	3
b) Stage 2	1
c) Stage 3	0
d) Stage 4	0

Items M2 or SB-MDS 32, Type of Ulcer	**Code (highest stage)**
a) Pressure Ulcer	2
b) Stasis Ulcer	0

***Rationale for coding*:** Mr. C has 4 pressure ulcers, the highest stage of which is Stage 2.

Mrs. B has a blockage in the arteries of her right leg causing impaired arterial circulation to her right foot (ischemia). She has 1 ulcer, a Stage 3 ulcer on the dorsal surface (top) of her right foot.

Items M1 or SB-MDS 31, Ulcer (due to any cause)	**Code (# at Stage)**
a) Stage 1	0
b) Stage 2	0
c) Stage 3	1
d) Stage 4	0

Items M2 or SB-MDS 32, Type of Ulcer	**Code (highest stage)**
a) Pressure ulcer	0
b) Stasis ulcer	0

Items M4 or SB-MDS 33, Other Skin Problems or Lesions Present

a) Open lesions other than pressure or stasis ulcers, rashes, cuts (e.g., cancer lesions)

***Rationale for coding*:** Mrs. B's ulcer is an ischemic ulcer rather than caused by pressure or venous stasis.

PERCENT OF RESIDENTS WITH PRESSURE SORES WITH AN ADDITIONAL LEVEL OF RISK ADJUSTMENT

QM Description:

The percent of residents who are reported to have one or more pressure sores on the OBRA Full or Quarterly Assessment.

Rationale for Pressure Ulcer QM:

Between 3% and 5% (or more) of residents in nursing facilities have pressure ulcers (aka pressures sores or bed sores.) Sixty percent or more of residents will typically be at risk of pressure ulcer development. Pressure ulcers can have serious consequences for the elderly and are costly and time consuming to treat. However, they are one of the most common, preventable and treatable conditions among the elderly who have restricted mobility. Successful outcomes can be expected with preventive and treatment programs. Assessment goals are: 1) to ensure that a treatment plan is in place for residents with pressure ulcers; and (2) to identify residents at risk for developing a pressure ulcer who are not currently receiving some type of preventive care program.

QM Category:

Chronic Care Measure

MDS Assessments Used:

OBRA Full (AA8a = 01, 02, 03, or 04) or Quarterly Assessment (AA8a = 05 or 10)

QM Specifications:

NUMERATOR
The number of residents with pressure ulcers (Stage 1-4) on the OBRA Full or Quarterly Assessment (M2a>0 or I3a-e=707.0).

DENOMINATOR
All residents with a valid OBRA Full (AA8a = 01, 02, 03 or 04) or Quarterly (AA8a = 05 or 10) Assessment.

RISK ADJUSTMENT
EXCLUSIONS

Residents satisfying any of the following conditions are excluded:

- Most recent OBRA assessment is the admission assessment (AA8a=01).

- The QM did not trigger (resident is not included in the QM numerator) AND the value of M2a is missing on the target assessment.
- The resident is in a facility with a chronic care admission sample size of 0. The chronic care admission sample is 0 if there are no residents with a non-PPS admission assessment (AA8a = 01 and AA8b = blank or 6) over the previous 12-months.

FACILITY ADMISSION PROFILE

Facility level risk adjustment considers the prevalence of stage 1-4 pressure ulcers (M2a >0 OR I3a-e = 707.0) among admissions (AA8a = 01) occurring over previous 12-months.

Numerator:	Admission assessments (AA8a = 01) with M2a > 0 **OR** I3a-e = 707.0
Denominator:	All admission assessments (AA8a = 01)
Exclusions:	Admission assessments (AA8a = 01) that do not satisfy the numerator condition **AND** that have missing data on M2a

Covariates

No covariates used in the Pressure Sores QM.

MDS Elements Related to QM:

M2a Type of Ulcer

Presence of Stage 1-4 pressure ulcer

I3a-e Other Current or More Detailed Diagnoses and ICD-9 Codes

Diagnosis of pressure ulcer is coded

MDS RAI Coding Instructions:

SECTION M. SKIN CONDITION

To determine the condition of the resident's skin, identify the presence, stage, type, and number of ulcers, and document other problematic skin conditions. Additionally, to document any skin treatments for active conditions as well as any protective or preventive skin or foot care treatments the resident has received in the last seven days.

M1. ULCERS (DUE TO ANY CAUSE) (7-DAY LOOK BACK))

Intent: To record the number of ulcers, of any type at each ulcer stage, on any part of the body.

Definitions: A skin ulcer can be defined as a local loss of epidermis and variable levels of dermis and subcutaneous tissue, or in the case of Stage I pressure ulcers, persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. Open lesions/sores are skin ulcers that may develop because of injury, circulatory problems, pressure, or in association with other diseases such as syphilis. Rashes without open areas, burns, desensitized skin and surgical wounds are **NOT** coded here, but are included in Item M4.

a) **Stage 1.** A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.

b) **Stage 2.** A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.

c) **Stage 3.** A full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue.

d) **Stage 4.** A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

Process:

Review the resident's record and consult with the nurse assistant about the presence of an ulcer. Examine the resident and determine the stage and number of any ulcers present. Without a full body check, an ulcer can be missed.

Assessing a Stage 1 ulcer requires a specially focused assessment for residents with darker skin tones to take into account variations in ebony-colored skin. To recognize Stage 1 ulcers in ebony complexions, look for the following:

1) any change in the feel of the tissue in a high-risk area,
2) any change in the appearance of the skin in high-risk areas, such as the "orange-peel" look,
3) a subtle purplish hue, and
4) extremely dry, crust-like areas that, upon closer examination, are found to cover a tissue break.

Coding:

All skin ulcers should be coded in this item. Record the number of ulcers at each stage on the resident's body, in the last 7 days, regardless of the ulcer cause. If necrotic eschar is present, prohibiting accurate staging, code the ulcer as Stage "4" until the eschar has been debrided (surgically or mechanically) to allow staging. If there are no ulcers at a particular stage, record "0" (zero) in the box provided. If there are more than 9 ulcers at any one stage, enter a "9" in the appropriate box.

Clarifications:

- All problems and lesions present during the current observation period should be documented on the MDS assessment. These items refer to the objective presence of problems or lesions, as observed during the assessment period.

- CMS acknowledges that the National Pressure Ulcer Advisory Panel (NPUAP) has published guidelines for pressure ulcer stages and is considering changes to the existing MDS coding procedures for the future. For the present, staff should code the MDS using a reverse staging protocol. For the MDS assessment, code the ulcer in terms of what you see (i.e., visible tissue). For example, a healing Stage 3 pressure ulcer that has the appearance (i.e., presence of granulation tissue, size, depth, and color) of a stage 2 ulcer must be coded as a "2".

- Debridement of an ulcer merely removes necrotic and decayed tissue to promote healing. The ulcer still exists and may or may not be at the same stage as it was prior to debridement. Good clinical practice dictates that the ulcer be re-examined and re-staged after debridement. Also code treatments as appropriate in Item M5 (Skin Treatments).

- If a skin shear or tear occurs on a pressure point (e.g., a resident has a skin tear on her sacrum while being pulled up in bed), it should be coded as a Stage II ulcer (M1). Determining whether the Stage II ulcer on a pressure point is the result of pressure may require a determination by the clinician based on an assessment. The determination that an ulcer is the result of pressure cannot be made based merely on its location over a pressure point. From this example, on one hand, it may be determined that because the resident cannot reposition herself while on her back in bed, that indeed pressure on the sacrum contributed to the formation of the ulcer, i.e., the resident cannot move on her own to relieve the pressure. On the other hand, if the shear or tear occurred over a pressure point, on a resident who is able to reposition herself, the determination is less likely that pressure on that point was the cause of the ulcer.

EXAMPLE

Mrs. L has end-stage metastatic cancer and weighs 75 pounds. She has a Stage 3 ulcer over her sacrum and two Stage 1 ulcers over her heels.

Items M1 or SB-MDS 31, Ulcers (due to any cause)	Stage	Code
	a) 1	2
	b) 2	0
	c) 3	1
	d) 4	0

Mr. Alaska has five open wounds as a result of frostbite that are not pressure or venous stasis ulcers. Upon examination, these wounds meet the criteria provided in Item M1 (Ulcers) coding definitions: 4 ulcers are consistent with Stage 2 ulcer staging and 1 ulcer appears to be at Stage 3. Assuming that the resident in this scenario has no pressure ulcers, code the resident's condition as follows:

Items M1 or SB-MDS 31, Ulcers (due to any cause)	Stage	Code
	a) 1	0
	b) 2	4
	c) 3	1
	d) 4	0

Items M2 or SB-MDS 32, Type of Ulcer:

Code "0" (highest stage ulcer is not a pressure ulcer)

Items M4 or SB-MDS 33, Other Skin Problems or Lesions Present:

Code Item M4c unless the frostbite wounds are to the foot, then code M6.

Include coding for treatments provided in Items M5 (Skin Treatments) and M6, (Foot Problems and Care) as appropriate.

M2 TYPE OF ULCER (7-DAY LOOK BACK)

Intent: To record the highest stage for two types of ulcers, Pressure and Stasis, that was present in the last 7 days.

Definitions:

▲ **a. Pressure Ulcer** - Any lesion caused by pressure resulting in damage of underlying tissues. Other terms used to indicate this condition include bedsores and decubitus ulcers.

✯ **b. Stasis Ulcer** - An open lesion, usually in the lower extremities, caused by decreased blood flow from chronic venous insufficiency; also referred to as a venous ulcer or ulcer related to peripheral vascular disease (PVD).

Process: Review the resident's record. Consult with the physician regarding the cause of the ulcer(s).

Coding: Using the ulcer staging scale in Item M1, record the highest ulcer stage for pressure and stasis ulcers present in the last 7 days. Remember that there are other types of ulcers than the two listed in this item (e.g., ischemic ulcers). An ulcer recorded in Item M1, may not necessarily be recorded in Item M2, (see last example below).

More definitive information concerning pressure ulcers is provided in the AHCPR Guidelines for pressure ulcers in adults.

www.ahrq.gov/consumer/bodysys/edbody6.htm

Key: ▲ Full MDS, MPAF and SB-MDS Items

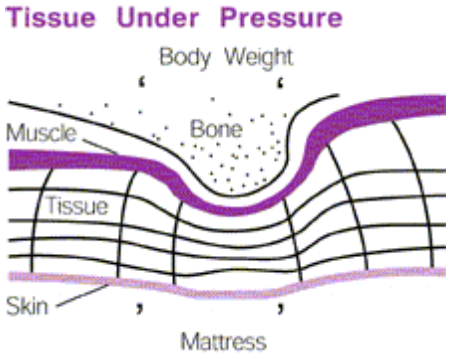
✯ Full MDS and MPAF Items

What are Pressure Ulcers?

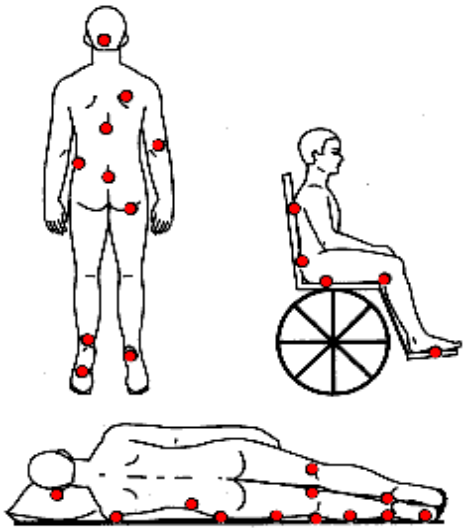
A pressure ulcer is an injury usually caused by unrelieved pressure that damages the skin and underlying tissue. Pressure ulcers are also called decubitus ulcers or bedsores and range in severity from mild (minor skin reddening) to severe (deep craters down to muscle and bone).

Unrelieved pressure on the skin squeezes tiny blood vessels, which supply the skin with nutrients and oxygen. When skin is starved of nutrients and oxygen for too long, the tissue dies and a pressure ulcer forms. The affected area may feel warmer than surrounding tissue. Skin reddening that disappears after pressure is removed is normal and not a pressure ulcer.

Other factors cause pressure ulcers, too. If a person slides down in the bed or chair, blood vessels can stretch or bend and cause pressure ulcers. Even slight rubbing or friction on the skin may cause minor pressure ulcers.



Where Pressure Ulcers Form



Pressure ulcers form where bone causes the greatest force on the skin and tissue, and squeezes them against an outside surface. This may be where bony parts of the body press against other body parts, a mattress, or a chair. In persons who must stay in bed, most pressure ulcers form on the lower back below the waist (sacrum), the hip bone (trochanter), and on the heels. In people in chairs or wheelchairs, the exact spot where pressure ulcers form depends on the sitting position. Pressure ulcers can also form on the knees, ankles, shoulder blades, back of the head, and spine.

Nerves normally tell the body when to move to relieve pressure on the skin. Persons in bed who are unable to move may get pressure ulcers after as little as 1-2 hours. Persons who sit in chairs and who cannot move can get pressure ulcers in even less time because the force on the skin is greater.

The full AHCRP guideline for clinicians can be found at:
http://www.ahcpr.gov/clinic/cpgonline.htm

Clarifications:

- In order to code Pressure Ulcers in the case of a blister, the key is to determine if there was a source of pressure that caused the blister. In the presence of moisture, less pressure may be required to develop a pressure ulcer. If, for example, a blister was found in the area of the incontinence brief waist or leg band, pressure from the band is a likely cause of the blister and the assessor would record the blister as a pressure ulcer. If no source of pressure could be identified, the blister may be evidence of perineal dermatitis caused by excessive urine or stool eroding the epidermis. No pressure is required for perineal dermatitis to occur. If this were the case, the blister would not be recorded as a pressure ulcer, but would be considered a rash. For additional information, refer to: Lyder, C. (1997). Perineal dermatitis in the elderly: A critical review of the literature. Journal of Gerontological Nursing 23(12), 5-10.

- If there is persistent redness without a break in the skin that does not disappear when pressure is relieved, the problem should be recorded as a Stage 1 ulcer (M1). Less pressure is needed for a pressure ulcer to form when the skin is soiled with urine and/or feces. **If the resident is unable to move, or does not move to relieve pressure on the skin, then pressure is very likely to have helped form the ulcer.** Item M1a should be coded as "1" and M2a should be coded for the highest stage. In addition, if this is a situation where there is redness from pressure in combination with a contact rash from incontinence, especially if the resident was wet long enough to develop the rash, code Item M2a, (pressure ulcer for the highest stage).

If the resident's mobility status is not impaired (i.e., they can move to relieve pressure on the skin) and the redness is not likely due to pressure, do not code Item M2a. Code the condition in M4, Other Skin Problems or Lesions Present.

EXAMPLE

Mr. C has diabetes and poor circulation to his lower extremities. Last month Mr. C spent 2 weeks in the hospital where he had a left below the knee amputation (BKA) for treatment of a gangrenous foot. His hospital course was complicated by delirium (acute confusion) and he spent most of his time on bed rest. Nurses remarked that he would only stay lying on his back. He had only an egg crate mattress on his bed to relieve pressure. A water mattress and air mattress were both tried but aggravated his agitation. He was readmitted to the nursing facility 3 days ago with a Stage II pressure ulcer over his sacrum and a Stage I pressure ulcer over his right heel and both elbows. No other ulcers were present.

Items M1 or SB-MDS 31, Ulcers (due to any cause)	**Code (# at stage)**
a) Stage 1	3
b) Stage 2	1
c) Stage 3	0
d) Stage 4	0

Items M2 or SB-MDS 32, Type of Ulcer	**Code (highest stage)**
a) Pressure Ulcer	2
b) Stasis Ulcer	0

***Rationale for coding*:** Mr. C has 4 pressure ulcers, the highest stage of which is Stage 2.

Mrs. B has a blockage in the arteries of her right leg causing impaired arterial circulation to her right foot (ischemia). She has 1 ulcer, a Stage 3 ulcer on the dorsal surface (top) of her right foot.

Items M1 or SB-MDS 31, Ulcer (due to any cause)	**Code (# at Stage)**
a) Stage 1	0
b) Stage 2	0
c) Stage 3	1
d) Stage 4	0

Items M2 or SB-MDS 32, Type of Ulcer	**Code (highest stage)**
a) Pressure ulcer	0
b) Stasis ulcer	0

Items M4 or SB-MDS 33, Other Skin Problems or Lesions Present

a) Open lesions other than pressure or stasis ulcers, rashes, cuts (e.g., cancer lesions)

***Rationale for coding*:** Mrs. B's ulcer is an ischemic ulcer rather than caused by pressure or venous stasis.

PERCENT OF RESIDENTS IN PHYSICAL RESTRAINTS

QM Description

The percent of residents who are restrained daily.

Rationale for Restraint QM:

Research and standards of practice show that the belief that restraints ensure safety is often unfounded. In practice, restraints have many negative side effects and risks that, in some cases, far outweigh any possible benefit that can be derived from their use. Restraints not only may not prevent falls, but can cause greater harm including strangulation, loss of muscle tone, decreased bone density (with greater susceptibility for fractures), pressure sores, decreased mobility, depression, agitation, loss of dignity, incontinence, constipation, and in some cases, resident death. Benefits of refraining from the use of physical restraints have been well-documented in long-term care literature; they include improvement in residents' quality of life, greater autonomy, use of fewer anti-psychotic medications, less skin breakdown, and fewer serious injuries due to falls. CMS remains committed to protecting the health and safety of nursing home residents and carrying out the statutory mandates to preserve the resident's right to be free from the inappropriate use of restraints.

NOTE: This measures does not include bed or side rails.

QM Category:

Chronic Care Measure

MDS Assessments Used:

OBRA Full (AA8a = 01, 02, 03, or 04) or Quarterly Assessment (AA8a = 05 or 10)

QM Specifications:

NUMERATOR
The number of residents who were physically restrained daily (P4c, P4d, or P4e = 2) on the most recent OBRA Full (AA8a = 01, 02, 03 or 04) or Quarterly (AA8a = 05 or 10) Assessment.

DENOMINATOR
All residents with a valid Full (AA8a = 01, 02, 03 or 04) or Quarterly (AA8a = 05 or 10) Assessment.

RISK ADJUSTMENT
EXCLUSIONS

Residents satisfying the following condition(s):

- The target assessment is an admission (AA8a = 01) assessment.
- The QM is not triggered (numerator condition not satisfied) AND P4c, P4d, or P4e has a missing value.
- The resident is in a facility with a Chronic Care Admission Sample size of 0. The chronic care admission sample is 0 if there are no residents with a non-PPS admission assessment (AA8a = 01 and AA8b = blank or 6) over the previous 12 months.

Facility Admission Profile

There is no facility level risk adjustment for this QM.

Covariates

No covariates used in the Restraint QM.

MDS Elements Related to QM:

P4c Trunk Restraint

P4d Limb Restraint

P4e Chair Prevents Rising

Devices and Restraints Used In the Last 7 days.

MDS RAI Coding Instructions:

SECTION P4-DEVICES AND RESTRAINTS

P4. PHYSICAL RESTRAINTS (7-DAY LOOK BACK)

Intent: To record the frequency, over the last seven days, with which the resident was restrained by any of the devices listed below at any time during the day or night. The intent is to evaluate as part of the assessment process whether a device meets the definition of a physical restraint, and then to code only those devices categorized in section P4 that have the effect of restraining the resident.

Definitions: **Physical restraints** are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.

a) **Full Bed Rails** - Full rails may be one or more rails along both sides of the resident's bed that block three-quarters to the whole length of the mattress from top to bottom. This definition also includes beds with one side placed against the wall (prohibiting the resident from entering and exiting on that side) and the other side blocked by a full rail (one or more rails). Include in this category veil screens (used in pediatric units) and enclosed bed systems.

b) **Other Types of Bed Rails Used** - Any combination of partial rails (e.g., 1/4, 1/3, 1/2, 3/4, etc.) or combination of partial and full rails not covered by the above "full bed rail" category (e.g., one-side half rail, one-side full rail, two-sided half rails, etc.)

c) **Trunk Restraint** - Includes any device or equipment or material that the resident cannot easily remove (e.g., vest or waist restraint, belts used in wheelchairs).

d) **Limb Restraint** - Includes any device or equipment or material that the resident cannot easily remove, that restricts movement of any part of an upper extremity (i.e., hand, arm) or lower extremity (i.e., foot, leg). Include in this category mittens.

e) **Chair Prevents Rising** - Any type of chair with locked lap board or chair that places resident in a recumbent position that restricts rising or a chair that is soft and low to the floor. Include in this category enclosed framed wheeled walkers with or without a posterior seat and lap cushions.

Process:

Check the resident's clinical records and restraint flow sheets. Consult nursing staff. Observe the resident. The assessor should not focus on the intent or reason behind the use of the device, but on the effect the device has on the resident. Does the device, material, or equipment meet the definition of a physical restraint? If so, code the item in the appropriate category.

Coding:

For each device type, enter:

0. Not used in last 7 days
1. Used, but used less than daily in last 7 days
2. Used on a daily basis in last 7 days

Because the coding categories are limited, we have given some direction on which category to code particular devices. While the device may not be completely representative of the category description, follow the coding instruction as given. There may be devices that we have not given coding instruction and that there is not a category that is representative of the device. For those devices, do not code at this time, but note that in subsequent versions of the MDS, CMS will include an "other" category that would be an appropriate place to code these devices.

Exclude from this P4 section items that are typically used in the provision of medical care, such as catheters, drainage tubes, casts, traction, leg, arm, neck or back braces, and bandages that are serving in their usual capacity to meet medical need.

Clarifications:

- Cognitively impaired residents are at a higher risk of entrapment and injury or death caused by restraints. It is vital that restraints used on this population be carefully considered and monitored. In some cases the risk of using the device may be greater than the risk of not using the device.

- As will be set forth in the guidance to surveyors, the Merry Walker® Ambulation Device and similar devices should not be categorically classified as a restraint. The following coding information provides further detailed guidance on how to code utilization of the device that might for a particular resident be considered a restraint. If these devices assist ambulation for a particular resident, they should be coded as a cane/walker/crutch, whether or not they are coded as a restraint.

1) **Coding When Not a Restraint**

If a resident is able to easily open the front gate and exit the device, the device should **NOT** be coded as a restraint for this particular resident. It would be coded at Item G5a as a cane/walker/crutch.

2) **Coding When a Restraint**

a) Only if the device has the effect of restricting the resident's freedom of movement, should the device be considered a restraint. If the resident's freedom of movement is restricted because the resident cannot open the front gate and exit the device (due to cognitive or physical limitations that prevents him or her from exiting the device), then the device should be classified as a restraint in section P4 of the MDS.

b) The current version of the MDS (Version 2.0) does not contain a category for a restraint in which this device obviously falls. We understand that these devices do not prevent a resident from standing. Nevertheless, until CMS releases the next version of the MDS, when the device restricts freedom of movement, code the device at Item P4e, Chair Prevents Rising, with either a "1" Used less than daily, or a "2" Used daily. In subsequent versions of the MDS, CMS will include an "other" category, which would be an appropriate place to code this type of device.

c) Coding the device at section P4e does not preclude the facility from also coding the device at G5a "cane/walker/crutch" if the resident used the device to walk during the last 7 days.

Request for Restraints:

While a resident, family member, legal representative or surrogate may request that a restraint be used, the facility has the responsibility to evaluate the appropriateness of that request, as they would a request for any type of medical treatment. As with other medical treatments, such as the use of prescription drugs, a resident, family member, legal representative or surrogate has the right to refuse treatment, but not to demand its use when it is not deemed medically necessary. According to the Code of Federal Regulation (CFR) at 42 CFR 483.13(a), "The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms." CMS expects that no resident will be restrained for discipline or convenience. Prior to employing any restraint, the nursing facility must perform a prescribed resident assessment to properly identify the resident's needs and the medical symptom the restraint is being employed to address. The guidelines in the State Operations Manual (SOM) state, "...the legal surrogate or representative cannot give permission to use restraints for the sake of discipline or convenience or when the restraint is not necessary to treat the resident's medical symptoms." That is, the facility may not use restraints in violation of regulation solely based on a legal surrogate or a representative's request or approval. The

SOM goes on to state, "While Federal regulations affirm a resident's right to participate in care planning and to refuse treatment, the regulations do not create the right for a resident, legal surrogate or representative to demand that the facility use specific medical interventions or treatments that the facility deems inappropriate." Statutory requirements hold the facility ultimately accountable for the resident's care and safety, including clinical decisions.

Are Restraints Prohibited?

The regulations and CMS' guidelines do not prohibit the use of restraints in nursing facilities, except when they are imposed for discipline or convenience and not required to treat the resident's medical symptoms. The regulation states, "The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms" (42 CFR 483.13(a)). Research and standards of practice show that the belief that restraints ensure safety is often unfounded. In practice, restraints have many negative side effects and risks that, in some cases, far outweigh any possible benefit that can be derived from their use. Prior to using any restraint, the facility must assess the resident to properly identify the resident's needs and the medical symptom that the restraint is being employed to address. If a restraint is needed to treat the resident's medical symptom, the facility is responsible to assess the appropriateness of that restraint. When the decision is made to use a restraint, CMS encourages, to the extent possible, gradual restraint reduction because there are many negative outcomes associated with restraint use. While a restraint-free environment is not a Federal requirement, the use of restraints should be the exception, not the rule.

Bed Rails Used as Positioning Devices:

In classifying any device as a restraint, the assessor must consider the **effect** the device has on the individual, not the purpose or intent of its use. It is possible for a device to improve the resident's mobility and also have the effect of restraining the individual. If the side rail has the effect of restraining the resident, the facility is responsible to assess the appropriateness of that restraint. Prior to employing any restraint, the facility must assess the resident to properly identify the resident's needs and the medical symptom the restraint is being employed to address. When the facility decides that a restraint is needed to treat the resident's medical symptom, CMS encourages, to the extent possible, gradual restraint reduction because of the many negative outcomes associated with restraint use. While bed rails may serve more than one function, the assessor should code P4a or P4b when the bed rails meet the definition of a restraint. When a bed rail is *both* a restraint *and* a transfer or mobility aid, it should be coded at MDS Item P4 (a or b, as appropriate) *and* at MDS Item G6b (Bedrails used for mobility or transfer).

Devices Used with Immobile Residents

Side Rails - Physical restraints are defined as "any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily that restricts freedom of movement or normal access to one's body." If the resident is immobile and can not voluntarily get out of bed due to a physical limitation and not due to a restraining device or because proper assistive devices were not present, the bed rails do not meet the definition of a restraint.

For residents who have no voluntary movement, staff needs to determine if there is any appropriate use of bed rails. Bed rails may create a visual barrier and deter physical contact from others. Some residents have no ability to carry out voluntary movements, yet they exhibit involuntary movements. Involuntary movements, resident weight, and gravity's effects may lead to the resident's body toward the edge of the bed. For this type of resident, clinical evaluation of alternatives (e.g., a concave mattress to keep the resident from going over the edge of the bed), coupled with frequent monitoring of the resident's position, should be considered. While the bed rails may not constitute a restraint, they may affect the resident's quality of life and create an accident hazard.

Geriatric Chairs - For a resident who has no voluntary or involuntary movement, the geriatric chair does not meet the definition of a restraint and should not be coded at Item P4e. If the resident has the ability to transfer from other chairs, but cannot transfer from a geriatric chair, a geriatric chair is a restraint to that individual, and should be coded at Item P4e. If the resident has no ability to transfer independently, then the geriatric chair does not meet the definition of a restraint, and should not be coded at Item P4e.

EXAMPLES

Mrs. D, an insulin-dependent diabetic, was admitted to the nursing facility yesterday from her own home. At home she had been having a lot of difficulty with insulin regulation since developing an ulcer on her left foot six weeks ago. During the last 90 days prior to admission, Mrs. D had two hospitalizations, for 3 and 5 days respectively. Code "2" for two hospital admissions in the last 90 days.

Mr. W has been a resident of the nursing facility for two years. He has a blood dyscrasia and receives transfusions at the local emergency room twice monthly. In the last month, Mr. W was admitted to the hospital for 2 days after developing a fever during his blood transfusion. Code "1" for one hospital admission in the last 90 days.

PERCENT OF RESIDENTS WITH LOSS OF ABILITY IN BASIC DAILY TASKS

QM Description:

The percent of residents who are worsening in their ability to perform at least one of four late loss activities of daily living (ADLs). Activities of daily living are the activities people must perform daily to function independently. The ADLs measured in this item are level of independence in eating, ability to move in bed, ability to move from one chair to another, and ability to go to the bathroom independently.

Rationale for ADL QM:

Personal mastery of Activities of Daily Living and mobility are as crucial to human existence in the nursing home as they are in the community. The nursing home is unique only in that most residents require help with self-care functions. ADL dependence can lead to intense personal distress -- invalidism, isolation, diminished self-worth, and a loss of control over one's destiny. As inactivity increases, complications such as pressure ulcers, falls, contractures, and muscle wasting can be expected.

QM Category:

Chronic Care Measure

MDS Assessments Used:

OBRA Full (AA8a = 01, 02, 03, or 04) or Quarterly Assessment (AA8a = 05 or 10)

QM Specifications:

NUMERATOR

- The number of residents with worsening (increasing item score) in self-performance of four Late-Loss ADLs as compared to prior assessment. Late-loss ADL item values of "8" (activity did not occur) are recoded to "4" (total dependence) for evaluation of the change.

  The four ADLs are:
  1) Bed Mobility (G1aA)
  2) Transfer (G1bA)
  3) Eating (G1hA)
  4) Toilet Use (G1iA)

- Residents meet the definition of this quality measure when at least *two* of the following are true. ([t] = target assessment; [t-1] = prior assessment):

    1) G1a(A)[t]-G1a(A)[t-1] > 0, or
    2) G1b(A)[t]-G1b(A)[t-1] > 0, or
    3) G1h(A)[t]-G1h(A)[t-1] > 0, or
    4) G1i(A)[t]-G1i(A)[t-1] > 0,

    OR at least *one* of the following is true:

    1) G1a(A)[t]-G1a(A)[t-1] > 1, or
    2) G1b(A)[t]-G1b(A)[t-1] > 1, or
    3) G1h(A)[t]-G1h(A)[t-1] > 1, or
    4) G1i(A)[t]-G1i(A)[t-1]>1.

DENOMINATOR
All residents with a valid OBRA Full (AA8a = 01, 02, 03 or 04) or Quarterly Assessment (AA8a = 05 or 10) and a valid prior assessment.

RISK ADJUSTMENT
EXCLUSIONS

- None of the four Late-Loss ADLs (Bed Mobility Self-Performance G1a (A), Transfer Self-Performance G1b (A), Eating Self-Performance G1h (A), and Toilet Use Self-Performance G1i (A)) can show decline because all four each have a value of 4 (total dependence) or a value 8 (activity did not occur) on the prior assessment.
- The QM did not trigger (resident not included in the numerator) AND there is missing data on any one of the four Late-Loss ADLs on the most recent OBRA Full or Quarterly Assessment or prior assessment.
- The resident is comatose (B1=checked) or comatose status is unknown (B1= missing) on the most recent OBRA Full or Quarterly Assessment.
- The resident has end-stage disease (J5c=checked) or end-stage status is unknown (J5c= missing) on the most recent OBRA Full or Quarterly Assessment.
- The resident is receiving hospice care (P1ao=checked) or hospice status is unknown (P1ao= missing) on the most recent OBRA Full or Quarterly Assessment.
- The resident is in a facility with a chronic care admission sample size of 0. The chronic care admission sample is 0 if there are no residents with a non-PPS admission assessment (AA8a = 01 and AA8b = blank or 6) over the previous 12 months.

NOTE: Values for the MDS item, P1ao may not be available for calculation using the shorter quarterly assessment form. In these instances, values for this MDS item will be "carried forward" from the most recent full assessment, which occurred in the 13 months proceeding the reference date on the target (OBRA Quarterly) assessment.

Facility Admission Profile
There is no facility level risk adjustment for this measure.

Covariates
There are no covariates for the Late-Loss ADL Worsening QM.

MDS Elements Related to QM:

G1a (A) Bed Mobility Self-Performance
How the resident moves to and from lying position, turns side to side, and positions body while in bed

G1b (A) Transfer Self-Performance
How resident moves between surfaces-to/from: bed, chair, wheelchair, standing position

G1h (A) Eating Self-Performance
How resident eats and drinks

G1i (A) Toilet Use Self-Performance
How resident uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes

B1 Comatose
J5c End Stage Disease
P1ao Hospice

MDS RAI Coding Instructions

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS (7-DAY LOOK BACK)

Most nursing facility residents and swing bed patients are at risk of physical decline. Most long-term and many short-term residents also have multiple chronic illnesses and are subject to a variety of other factors that can severely impact self-sufficiency. For example, cognitive deficits can limit ability or willingness to initiate or participate in self-care or constrict understanding of the tasks required to complete ADLs. A wide range of physical and neurological illnesses can adversely affect physical factors important to self-care such as stamina, muscle tone, balance, and bone strength. Side effects of medications and other treatments can also contribute to needless loss of self-sufficiency.

Due to these many, possibly adverse influences, a resident's potential for maximum functionality is often greatly underestimated by family, staff, and the resident himself or herself. Thus, all residents are candidates for nursing-based rehabilitative care that focuses on maintaining and expanding self-involvement in ADLs. Individualized plans of care can be successfully developed only when the resident's self-performance has been accurately assessed and the amount and type of support being provided to the resident by others has been evaluated. See Section 1.11 on the use of an interdisciplinary team to provide the most accurate assessment of each resident.

G1. (A) ACTIVITIES OF DAILY LIVING (ADL) SELF-PERFORMANCE

Intent: To record the resident's self-care performance in activities of daily living (i.e., what the resident actually did for himself or herself and/or how much verbal or physical help was required by staff members) during the **last seven days**.

Definition: **ADL SELF-PERFORMANCE** - Measures what the resident **actually did** (not what he or she might be capable of doing) within each ADL category over the last seven days according to a performance-based scale.

Walk in Room - How resident walks between locations in his/her room.

Walk in Corridor - How resident walks in corridor on unit.

Process:

In order to be able to promote the highest level of functioning among residents, clinical staff must first identify what the resident actually does for himself or herself, noting when assistance is received and clarifying the types of assistance provided (verbal cueing, physical support, etc.)

A resident's ADL self-performance may vary from day to day, shift to shift, or within shifts. There are many possible reasons for these variations, including mood, medical condition, relationship issues (e.g., willing to perform for a nurse assistant he or she likes), and medications. The responsibility of the person completing the assessment, therefore, is to capture the total picture of the resident's ADL self-performance over the seven-day period, 24 hours a day - i.e.,

not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.

In order to accomplish this, it is necessary to gather information from multiple sources - i.e., interviews/discussion with the resident and direct care staff on all three shifts, including weekends and review of documentation used to communicate with staff across shifts. Ask questions pertaining to all aspects of the ADL activity definitions. For example, when discussing Bed Mobility with a nurse assistant, be sure to inquire specifically how the resident moves to and from a lying position, how the resident turns from side to side, and how the resident positions himself or herself while in bed. A resident can be independent in one aspect of Bed Mobility yet require extensive assistance in another aspect. Since accurate coding is important as a basis for making decisions on the type and amount of care to be provided, be sure to consider each activity definition fully.

The wording used in each coding option is intended to reflect real-world situations where slight variations are common. Where variations occur, the coding ensures that the resident is not assigned to an excessively independent or dependent category. For example, by definition, codes 0, 1, 2, and 3 (Independent, Supervision, Limited Assistance, and Extensive Assistance) permit one or two exceptions for the provision of heavier care. This is clinically useful and increases the likelihood that staff will code ADL Self-Performance items consistently and accurately.

Because this section involves a two-part evaluation (Item G1A, ADL Self-Performance and Item G1B, ADL Support), each using its own scale, it is recommended that you complete the Self-Performance evaluation for all ADL Self-Performance activities before beginning the ADL Support evaluation.

To evaluate a resident's ADL Self-Performance, begin by reviewing the documentation in the clinical record. Talk with clinical staff from each shift to ascertain what the resident does for himself or herself in each ADL activity as well as the type and level of staff assistance being provided. As previously noted, be alert to differences in resident performance from shift to shift, and apply the ADL codes that capture these differences. For example, a resident may be independent in Toilet Use during daylight hours but receive non-weight bearing physical assistance every evening. In this case, the resident would be coded as a "2" (Limited Assistance) in Toilet Use.

The following chart provides general guidelines for recording accurate ADL Self-Performance and ADL Support assessments.

GUIDELINES FOR ASSESSING ADL SELF-PERFORMANCE AND ADL SUPPORT

The scales in Items G1A and G1B are used to record the resident's actual level of involvement in self-care and the type and amount of support actually received during the last seven days.

Do not record your assessment of the resident's capacity for involvement in self-care - i.e., what you believe the resident might be able to do for himself or herself based on demonstrated skills or physical attributes. For nursing facilities, an assessment of potential capability is covered in Item G8 (AADL Functional Rehabilitation Potential"). For swing bed facilities, the potential capability should be considered during care planning.

Do not record the type and level of assistance that the resident "should" be receiving according to the written plan of care. The type and level of assistance actually provided might be quite different from what is indicated in the plan. Record what is actually happening.

Engage direct care staff, from all shifts, who have cared for the resident over the last seven days in discussions regarding the resident's ADL functional performance. Remind staff that the focus is on the last seven days only. To clarify your own understanding and observations about each ADL activity (bed mobility, locomotion, transfer, etc.), ask probing questions, beginning with the general and proceeding to the more specific.

Coding:

For each ADL category, code the appropriate response for the resident's actual performance during the past seven days. Enter the code in column (A), labeled "SELF-PERF." Consider the resident's performance during all shifts, as functionality may vary. In the pages that follow two types of supplemental instructional material are presented to assist you in learning how to use this code: a schematic flow chart for scoring ADL Self-Performance and a series of case examples for each ADL.

In your evaluations, you will also need to consider the type of assistance known as "set-up help" (e.g., comb, brush, toothbrush, toothpaste have been laid out at the bathroom sink by the nurse assistant). Set-up help is recorded under ADL Support Provided (Item G1B). But in evaluating the resident's ADL Self-Performance, include set-up help within the context of the "0" (Independent) code. **For example:** If a resident grooms independently once grooming items are set up for him, code "0" (Independent) in Personal Hygiene.

0. Independent - No help or staff oversight -OR- Staff help/oversight provided only one or two times during the last seven days.

1. Supervision - Oversight, encouragement, or cueing provided three or more times during last seven days -OR- Supervision (3 or more times) plus physical assistance provided only one or two times during last seven days.

2. Limited Assistance - Resident highly involved in activity, received physical help in guided maneuvering of limbs or other non weight-bearing assistance on three or more occasions -OR- limited assistance (3 or more times) plus more help provided only one or two times during last seven days.

3. Extensive Assistance - While the resident performed part of activity over last seven days, help of the following type(s) was provided three or more times:

- Weight-bearing support provided three or more times
- Full staff performance of activity (3 or more times) during part (but not all) of last seven days

4. Total Dependence - Full staff performance of the activity during entire seven-day period. Complete non-participation by the resident in all aspects of the ADL definition.

For example: For a resident to be coded as totally dependent in eating, he or she would be fed all food and liquids at all meals and snacks (including tube feeding delivered totally by staff), and never initiate any subtask of eating (e.g., picking up finger foods, giving self tube feeding or assisting with procedure) at any meal.

8. Activity Did Not Occur During the Entire 7-Day Period - Over the last seven days, the ADL activity was not performed by the resident or staff. In other words, the particular activity did not occur at all.

For example: A resident who was restricted to bed for the entire seven-day period and was never transferred from bed would receive a code of "8" for Transfer.

However, do not confuse a resident who is totally dependent in an ADL activity (code 4 - Total Dependence) with the activity itself not occurring. For example: Even a resident who receives tube feedings and no food or fluids by mouth is engaged in eating (receiving nourishment), and must be evaluated under the Eating category for his or her level of assistance in the process. A resident who is highly involved in giving himself a tube feeding is not totally dependent and should not be coded as "4".

Each of these ADL Self-Performance codes is exclusive; there is no overlap between categories. Changing from one self-performance category to another demands an increase or decrease in the number of times that help is provided. Thus, to move from Independent to Supervision to Limited Assistance, non weight-bearing supervision or physical assistance must increase from one or two times up to three or more times during the last seven days.

There will be times when no one type or level of assistance is provided to the resident 3 or more times during a 7-day period. However, the sum total of support of various types will be provided 3 or more times. In this case, code for the least dependent self-performance category where the resident received that level or more dependent support 3 or more times during the 7-day period.

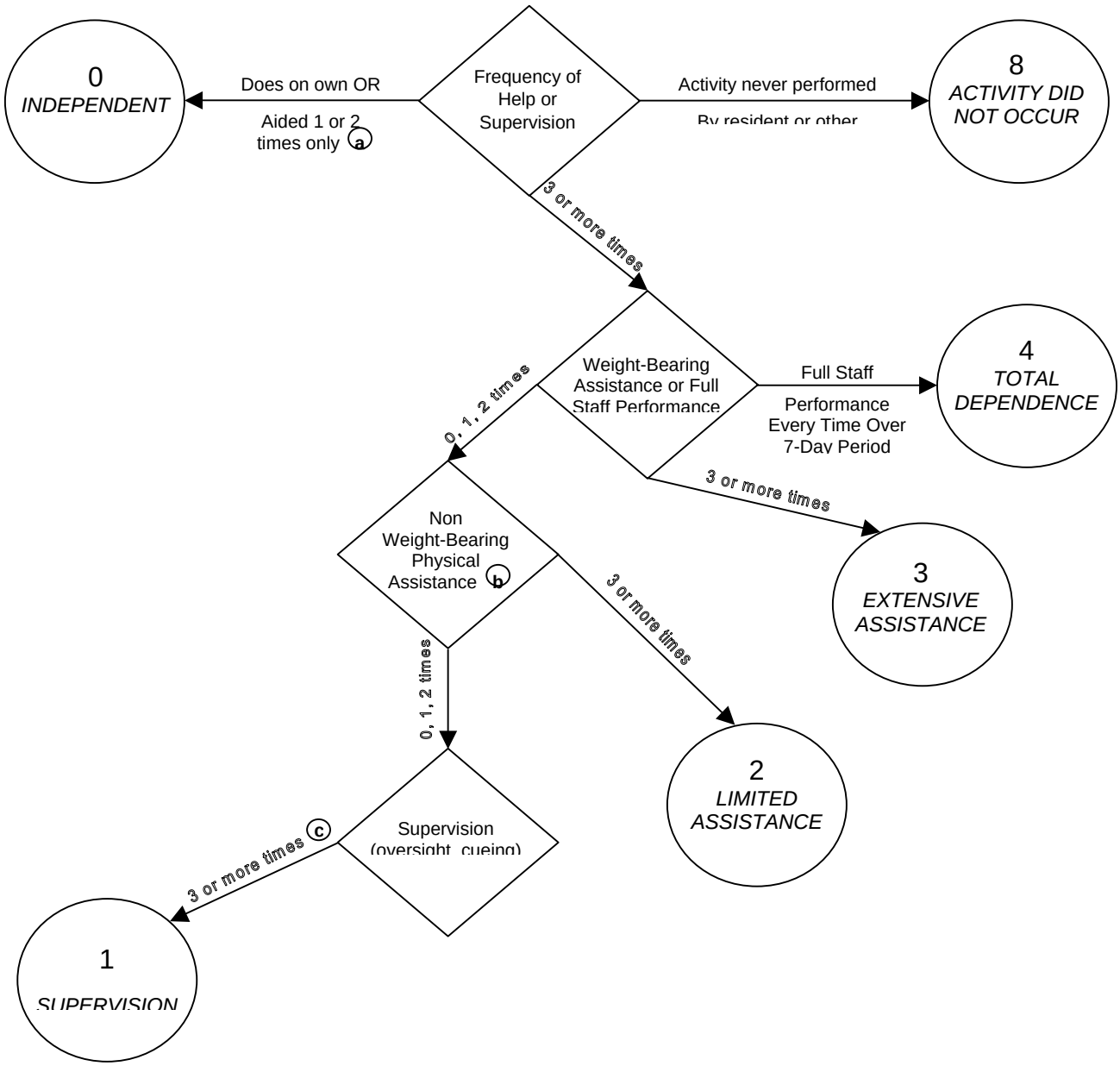
EXAMPLES

The resident received supervision for walking in the corridor on two occasions and non weight-bearing assistance on two occasions. **Code "1" for Supervision in Walking in Corridor.** ***Rationale:*** Supervision is the least dependent category.

The resident received supervision in dressing on one occasion, non weight-bearing assistance (i.e., putting a hat on resident's head) on two occasions, and weight-bearing assistance (i.e., lifting resident's arm into a sleeve) on one occasion during the last 7 days. **Code "2" for Limited Assistance in Dressing.**
Rationale: There were 3 episodes of physical assistance in the last 7 days: 2 non-weight-bearing episodes, and 1 weight-bearing episode. Limited Assistance is the correct code because it reflects the least dependent support category that encompasses 3 or more activities that were at least at that level of support.

SCORING ADL SELF PERFORMANCE

START



a) Can include one or two events where received supervision, non weight-bearing assistance, or weight-bearing assistance.

b) Can include one or two episodes of weight-bearing assistance, e.g., two events with non weight-bearing assistance plus two of weight-bearing assistance would be coded as a "2".

c) Can include one or two episodes where physical help received, e.g., two episodes of supervision, one of weight-bearing assistance and one of non weight-bearing assistance would be coded as a "1".

G1. (B) ADL SUPPORT PROVIDED

Intent: To record the type and highest level of support the resident received in each ADL activity over the last seven days.

Definitions:

a) **ADL Support Provided:** Measures the highest level of support provided by staff over the last seven days, even if that level of support only occurred once. **This is a different scale, and is entirely separate from the ADL Self-Performance assessment.**

b) **Set-Up Help:** The type of help characterized by providing the resident with articles, devices or preparation necessary for greater resident self-performance in an activity. This can include giving or holding out an item that the resident takes from the caregiver.

EXAMPLES OF SETUP HELP

- **For bed mobility** - handing the resident the bar on a trapeze, staff applies ½ rails and then provides no further help.
- **For transfer** - giving the resident a transfer board or locking the wheels on a wheelchair for safe transfer.
- **For locomotion:**
    - **Walking** - handing the resident a walker or cane.
    - **Wheeling** - unlocking the brakes on the wheelchair or adjusting foot pedals to facilitate foot motion while wheeling.
- **For dressing** - retrieving clothes from closet and laying out on the resident's bed; handing the resident a shirt.
- **For eating** - cutting meat and opening containers at meals; giving one food category at a time.
- **For toilet use** - handing the resident a bedpan or placing articles necessary for changing ostomy appliance within reach.
- **For personal hygiene** - providing a washbasin and grooming articles.
- **For bathing** - placing bathing articles at tub side within the resident's reach; handing the resident a towel upon completion of bath.

Process:

For each ADL category, code the maximum amount of support the resident received over the last seven days irrespective of frequency, and enter in the "SUPPORT" column. Be sure your evaluation considers all nursing shifts, 24 hours per day, including weekends. Code independently of the resident's Self-Performance evaluation. For example, a resident could have been Independent in ADL Self-Performance in Transfer but received a one-person physical assist one or two times during the seven-day period. Therefore, the ADL Self-Performance Coding for Transfer would be "0" (Independent), and the ADL Support coding "2" (One person physical assist).

Coding:

NOTE: The highest code of physical assistance in this category (other than the "8" code) is a code of "**3**" not "4" as in Self-Performance.

0. No Setup or Physical Help from Staff

1. Setup Help Only - The resident is provided with materials or devices necessary to perform the activity of daily living independently.

2. One Person Physical Assist

3. Two+ Persons Physical Assist

8. ADL Activity Itself Did Not Occur During the Entire 7 Days - When an "8" code is entered for an ADL Support Provided category, enter an "8" code for ADL Self-Performance in the same category.

For example: If a resident never left the unit during the assessment period, code "8" for locomotion off unit. The activity did not occur, there was no help provided.

Clarifications:

- The ADL coding was created to reflect real situations where small variations in performance are common. For example, in scoring a resident as independent in ADL self-performance, there can be 1 or 2 exceptions. As soon as there are 3 exceptions, the resident is not independent and you need to consider another code. Staff members who are new to conducting MDS assessments need to become familiar with the coding structure and how exceptions are handled. Codes of 0, 1, 2, and 3 (Independent, Supervision, Limited Assistance, and Extensive Assistance) have been designed to allow one or two exceptions for the provision of assistance from the staff helper.
- Because of the differences in the scales used to score these two columns, data reliability is considerably improved by completing the Self-Performance column first for all items and then returning to the top and completing the Support column.
- For a resident to have a code of totally dependent for ADLs, the resident had to be totally dependent each time the activity occurred. As soon as the

resident did some part of the activity, the resident was not totally dependent. For all other categories, the clinician is reviewing for the most dependent activity that occurred at least 3 times in the last 7 days. Knowing the total number of times the activity occurred is not necessary for scoring accuracy. Knowing whether the activity occurred 3 or more times in the last 7 days is key to ADL coding accuracy.

- When considering toilet use, do not limit your assessment to bathroom use. Elimination may occur in the toilet room, commode, in the bedroom on a bedpan, or urinal. It includes transferring on/off the toilet, cleansing, changing pads, managing an ostomy or catheter, and clothing adjustment.
- General supervision of a dining room is not the same as individual supervision of a resident. If the resident ate independently, then MDS Item G1h is coded as "0" (Independent). If the individual resident needed oversight, encouragement, or cueing during the last 7 days, the item is coded as a "1" (Supervision). For a resident who has received oversight, encouragement, or cueing and also received more help, such as physical assistance provided one or two times during the 7-day assessment period, the resident would still be coded as a "1" (Supervision). Residents who are in "feeding" or "eating" groups and who are individually supervised during the meal would be coded as "1" (Supervision) for Self-Performance in Eating.
- The key to the differentiation between guided maneuvering and weight-bearing assistance is determining *who* is supporting the weight of the resident's hand. If the staff member supports some of the weight of the resident's hand while helping the resident to eat (e.g., lifting a spoon or a cup to mouth), this is "weight-bearing" assistance for this activity. If the resident can lift the utensil or cup, but staff assistance is needed to guide the resident's hand to his/her mouth, this is guided maneuvering.
- If therapists are involved with the resident, their input should be included either by way of an interview or by the assessor reviewing the therapy documentation. The resident may perform differently in therapy than on the unit. Also focus on occurrences of exceptions in the resident's performance. When discussing a resident's ADL performance with a therapist, make sure the therapist's information can be expressed in MDS terminology.
- If staff performed an activity for the resident during the entire observation period, but the resident is able to do part of that activity, it would not be coded as "4" (total dependence). These situations would be when the resident is able to assist in dressing, but the staff puts on the shoes, socks or TED stockings.

CLARIFICATIONS USING THE CODE "8" (ACTIVITY DID NOT OCCUR)

- If the resident is bed bound and does not walk and there was no locomotion via bed, wheelchair or other means, then you would code an "8". However, if the bed is moved in order to provide locomotion on or off the unit, then you would code according to the definitions provided in Section G., 1A & B.
- For example, use code 8 when the resident did not walk in the past seven days, (in room/in corridor), for both the self-performance and the support columns.
- A resident who has not been out of bed in the past seven days could be coded 8 for (A) & (B) in MDS Sections G1b-f, unless the bed was moved (locomotion on/off unit). Other ADLs are considered individually.
- The eating item for G1h is a little more complex. If in the past seven days the resident truly did not receive any nourishment, the item would be coded 8. It should go without saying that this is a serious issue. Be careful not to confuse total dependence with eating (code 4) with the activity itself (in this case, receiving nourishment and fluids). Keep in mind that a resident who is fed via tube, and manages the tube feeding independently is coded as independent (code 0). G1h includes receiving IV fluids. For a resident who is receiving fluids for hydration, and is totally dependent, this is coded as 4, rather than 8.
- Toilet use focuses on whether elimination occurs, rather than the process. The elimination may be in the toilet room, commode, in the bedroom on a bedpan or urinal. It includes transferring on/off the toilet, cleansing, changing pads, managing an ostomy or catheter and clothing adjustment. The "8" code is rarely used in this section, as it would indicate that elimination did not occur.

The examples that follow clarify coding for both Self-Performance and Support. The answers appear to the right of the resident descriptions. Cover the answers, read and score the example, then compare your answers with those provided.

EXAMPLES: ADL SELF-PERFORMANCE AND SUPPORT	Self-Perf.	Support
Bed Mobility		
Resident was physically able to reposition self in bed but had a tendency to favor and remain on his left side. He received frequent reminders and monitoring to reposition self while in bed.	1	0
Resident received supervision and verbal cueing for using a trapeze for all bed mobility. On two occasions when arms were fatigued, he received heavier physical assistance of two persons.	1	3
Resident usually repositioned himself in bed. However, because he sleeps with the head of the bed raised 30 degrees, he occasionally slides down towards the foot of the bed. On 3 occasions the night nurse assistant helped him to reposition by providing weight-bearing support as he bent his knees and pushed up off the footboard.	3	2
To turn over, the resident always began by reaching for a side rail for support. He received physical assistance of one person to guide his legs into position and complete the turn by guiding him with a turn sheet (using weight-bearing assistance).	3	2
Resident independently turned on his left side whenever he wanted. Because of left-sided weakness he received physical weight bearing help of 1-2 persons to turn to his right side or sit up in bed.	3	3
Because of severe, painful joint deformities, resident was totally dependent on two persons for all bed mobility. Although unable to contribute physically to positioning process, she was able to cue staff for the position she wanted to assume and at what point she felt comfortable.	4	3

EXAMPLES: ADL SELF-PERFORMANCE AND SUPPORT	Self-Perf.	Support
Transfer		
Despite bilateral above-the-knee amputations, resident almost always moved independently from bed to wheelchair (and back to bed) using a transfer board he retrieves independently from his bedside table. On one occasion in the past week, staff had to remind resident to retrieve the transfer board. On one other occasion, the resident was lifted, by a staff member, from the wheelchair back into the bed.	0	2
Resident was physically independent for all transfers. However, he would not get up in the morning until the nurse assistant rearranged his bed covers and released the half side rail on his bed.	0	1
Once someone correctly positioned the wheelchair in place and locked the wheels, the resident transferred independently to and from the bed.	0	1
Resident moved independently in and out of armchairs but always received light physical guidance of one person to get in and out of bed safely.	2	2
Transferring ability varied throughout each day. Resident received no assistance at some times and heavy weight-bearing assistance of one person at other times.	3	2

EXAMPLES: ADL SELF-PERFORMANCE AND SUPPORT	Self-Perf.	Support
Walk in room		
Resident walked in his/her room while holding on to furniture for support.	0	0
Resident walked independently during the day and received non-weight bearing physical help of 1 person for getting to the bathroom in room at night.	2	2
Resident received non-weight bearing physical assistance of one person for all walking in own room.	2	2
Resident did not walk but wheeled self independently in own room.	8	8
Walk in corridor		
A timid, fearful resident is usually physically independent in walking. During the last week she was very anxious and fearful of falling, and therefore received reassurance and encouragement from someone walking next to her while walking back to her room from meals in the unit dining room.	1	0
A resident with memory loss ambulated independently on the unit corridor albeit with a walker. Several times a day she left her walker in the bathroom, in the dining room, etc., necessitating that someone return it to her and offer her reminders to use it for safety.	1	1
Resident walked in corridor on unit by supporting self on one side with the handrail along the wall and receiving verbal cues from another person.	1	0
Resident walked twice daily 4-6 feet in the corridor outside his room. He received weight-bearing assistance of 1 person for each walk.	3	2
Resident walked in room for short distances with heavy assistance of 2 persons but traveled independently in corridor on unit by wheelchair.	8	8

EXAMPLES: ADL SELF-PERFORMANCE AND SUPPORT	Self-Perf.	Support
Locomotion on unit		
Resident ambulated slowly on unit pushing a wheelchair for support, stopping to rest every 15 - 20 feet. She has good safety awareness and has never fallen. Staff felt she was reliable enough to be on her own.	0	0
A resident with a history of falling and an unsteady gait always received physical guidance (non-weight-bearing) of one person for all ambulation. Two nights last week the resident was found in his bathroom after getting out of bed and walking independently.	2	2
Resident ambulated independently around the unit "ad lib," socializing with others and attending activities during the day. Loves dancing and yoga. Because she can become afraid at night, she received contact guard of one person to walk her to the bathroom at least twice every night.	2	2
During last week a resident was learning to walk short distances with a new leg prosthesis with heavy partial weight-bearing assistance of two persons. He refuses to ride in a wheelchair.	3	3
Locomotion off unit		
Resident independently walked with a cane to all meals in the Main Dining Room (off the unit) and social and recreational activities in the nearby hobby shop. Received no set-up or physical help during the assessment period.	0	0
Resident walked independently to the off unit dining room for all meals. For one visit to a clinic held at the opposite end of the building, she was given a ride in a wheelchair by a volunteer. She was wheeled to the clinic and after her session, she was wheeled back to her unit.	0	2
Resident is independent in walking about her residential unit. She does get lost and has difficulty finding her room but enjoys stopping to chat with others. Because she would get lost, she was always accompanied by a staff member for her daily walks around the facility.	1	0
Resident did not leave the residential unit during the 7-day assessment period.	8	8

EXAMPLES: ADL SELF-PERFORMANCE AND SUPPORT	Self-Perf.	Support
Dressing		
Resident usually dressed self. After a seizure, she received total help from several staff members once during the week.	0	3
Resident is totally independent in dressing herself except for donning and removing TED stockings. Nurse assistant applied the TED stockings each AM and removed them at bedtime.	3	2
Nurse assistant provided physical weight-bearing help with dressing every morning. Later each day, as resident felt better (joints were more flexible), she required staff assistance only to undo buttons and guide her arms in/out of sleeves every pm.	3	2
A 325 lb. resident received total care by two persons in dressing. He did not participate by putting arms through sleeves, lifting legs into shoes, etc.	4	3
Eating		
Resident arose daily after 9:00 am, preferring to skip breakfast and just munch on fresh fruit later in the morning. She ate lunch and dinner independently in the facility's main dining room.	0	0
Resident on long standing tube feedings via gastrostomy tube was completely independent in self-administration including self-medication via the tube once set up by staff.	0	1
Resident with a history of dysphagia and choking, ate independently as long as a staff member sat with him during every meal (stand-by assistance if necessary).	1	0
Resident is blind and confused. He ate independently once staff oriented him to types and whereabouts of food on his tray and instructed him to eat.	1	1
Cognitively impaired resident ate independently when given one food item at a time and monitored to assure adequate intake of each item.	1	1
Resident fed self-solid foods independently at all meals and snacks. Self-administered all fluids and medications via G-tube with supervision once set up appropriately.	1	1
Resident, with difficulty initiating activity, always ate independently after someone guided her hand with the first few bites and then offered encouragement to continue.	3	2

EXAMPLES: ADL SELF-PERFORMANCE AND SUPPORT	Self-Perf.	Support
Eating (continued)		
Resident with fine motor tremors fed self finger foods (e.g., sandwiches, raw vegetables and fruit slices, crackers) but always received supervision and total physical assistance with liquids and foods requiring utensils.	3	2
Resident fed self with staff monitoring at breakfast and lunch but tired later in day. She was fed totally by nursing assistant at supper meal.	3	2
Resident who was being weaned from gastrostomy tube feedings continued to receive total care for twice daily tube feedings. Additionally, she ate small amounts of food by mouth with staff supervision.	3	2
Resident received tube feedings via a jejunostomy for all nutritional intake. Feedings were given by a nurse.	4	2
Toileting Use		
Resident used bathroom independently once up in a wheelchair; used bedpan independently at night after it was set up on bedside table.	0	1
In the toilet room resident is independent. As a safety measure, the nurse assistant stays just outside the door, checking with her periodically.	1	0
Resident uses the toilet independently but occasionally required minor physical assistance for hygiene and straightening clothes afterwards. She received such help twice during the last week.	0	2
When awake, resident was toileted every two hours with minor assistance of one person for all toileting activities (e.g., contact guard for transfers to/from toilet, drying hands, zipping/buttoning pants). She required total care of one person several times each night after incontinence episodes.	3	2
Resident received heavy assistance of two persons to transfer on/off toilet. He was able to bear weight partially, and required only standby assistance with hygiene (e.g., being handed toilet tissue or incontinence pads).	3	3
Obese, severely physically and cognitively impaired resident receives a hoyer lift for all transfers to and from her bed. It is impossible to toilet her and she is incontinent. 2 persons provide complete personal hygiene at least every 2 hours.	4	3

EXAMPLES: ADL SELF-PERFORMANCE AND SUPPORT	Self-Perf.	Support
Personal Hygiene		
New resident, in nursing facility adjustment phase, liked to sleep in his clothes in case of fire. He remained in the same clothes for 2 - 3 days at a time. He cleaned his hands and face independently and would not let others help with any personal hygiene activities.	0	0
Once grooming articles were laid out and arranged by staff, resident regularly performed the tasks of personal hygiene by receiving verbal directions from one person throughout each task.	1	1
Resident carried out personal hygiene but was not motivated. She received daily cueing and positive feedback from nursing staff to keep self clean and neat. Once started, she could be left alone to complete tasks successfully.	1	0
Resident shaves self with an electric razor, washes his face and hands, brushes his teeth, and combs his hair. Because he is losing his sight, staff stand-by to hand grooming articles to the resident and return articles to their proper location.	1	1
Resident performed all tasks of personal hygiene except shaving. The facility barber visited him on the unit three times a week to shave his thick beard.	3	2
Resident required total daily help combing her long hair and arranging it in a bun. Otherwise she was independent in personal hygiene.	3	2

APPENDICES

APPENDIX A: COMPARISON OF CURRENT QUALITY INDICATORS (QIS) & PUBLICLY REPORTED QUALITY MEASURES (QMS)

Table A1: Overview of QMs and CHSRA Quality Indicators

QM MEASURE	Corresponding CHSRA QI?	Corresponding Page #s
Chronic Care Measures		
The Percentage of Residents with Loss of Ability in Basic Daily Tasks	Yes	2 - 3
The Percentage of Residents With Infections	Yes*	4 - 5
The Percentage of Residents With Pain	No	6
The Percentage of Residents With Pressure Sores	Yes	7 – 8
The Percentage of Residents in Physical Restraints	Yes	9
Post-Acute Care (PAC) Measures		
The Percentage of Short-Stay Residents With Delirium	No	10 – 11
The Percentage of Short-Stay Residents With Pain	No	12
The Percentage of Short-Stay Residents Who Walk as Well or Better on Day 14 as on Day 5 of their stay	No	13 - 14

* The QM related to infections assesses a spectrum of infections; the corresponding CHSRA QI includes only urinary tract infections (UTIs).

Chronic Care

Table A2: ADL Decline	
Publicly Reported Quality Measure	**Corresponding CHSRA QI**
Title: **The Percentage of Residents with Loss of Ability in Basic Daily Tasks**	*Title:* **Incidence of Decline in Late Loss ADLs.**
Assessments Used: • **Target assessment:** AA8a = 01, 02, 03, 04, 05, or 10. Assessment reference date (A3a) must be within 3 months of the end of the target date. • **Prior assessment:** AA8a = 01, 02, 03, 04, 05, or 10. Assessment reference date (A3a) must be in the window of 46 days to 165 days preceding the target assessment reference date.	*Assessments Used:* • **Target assessment:** AA8a = 02, 03, 04, 05, or 10. Assessment reference date (A3a) must be in the specified target period (default target period is six months). Note that admissions assessments (AA8a = 01) are not eligible for measure calculation. • **Prior assessment:** AA8a = 01, 02, 03, 04, 05, or 10. Assessment reference date (A3a) can be any time prior to the target assessment reference date.
Numerator: Residents meet the definition of Late-Loss ADL worsening when at least two of the following are true: 1. G1a(A)[t] - G1a(A)[t-1] > 0, or 2. G1b(A)[t] - G1b(A)[t-1] > 0, or 3. G1h(A)[t] - G1h(A)[t-1] > 0, or 4. G1i(A)[t] - G1i(A)[t-1] > 0, OR at least one of the following is true: 1. G1a(A)[t] - G1a(A)[t-1] > 1, or 2. G1b(A)[t] - G1b(A)[t-1] > 1, or 3. G1h(A)[t] - G1h(A)[t-1] > 1, or 4. G1i(A)[t] - G1i(A)[t-1] > 1. <u>Notes:</u> • [t] refers to target assessment, [t-1] refers to prior assessment. • Late-Loss ADL items values of 8 are recoded to 4 for evaluation of change.	*Numerator:* Residents meet the definition of Late-Loss ADL worsening when at least two of the following are true: 1. G1a(A)[t] - G1a(A)[t-1] > 0, or 2. G1b(A)[t] - G1b(A)[t-1] > 0, or 3. G1h(A)[t] - G1h(A)[t-1] > 0, or 4. G1i(A)[t] - G1i(A)[t-1] > 0, OR at least one of the following is true: 1. G1a(A)[t] - G1a(A)[t-1] > 1, or 2. G1b(A)[t] - G1b(A)[t-1] > 1, or 3. G1h(A)[t] - G1h(A)[t-1] > 1, or 4. G1i(A)[t] - G1i(A)[t-1] > 1. <u>Notes:</u> • [t] refers to target assessment, [t-1] refers to prior assessment

Table A2: ADL Decline	
Publicly Reported Quality Measure	**Corresponding CHSRA QI**
Title: **The Percentage of Residents with Loss of Ability in Basic Daily Tasks**	*Title:* **Incidence of Decline in Late Loss ADLs.**
	assessment. •Late-Loss ADL items values of 8 are considered missing for evaluation of change.
Denominator: All residents with a target and a prior assessment (after exclusions are applied).	*Denominator:* All residents with a target and a prior assessment (after exclusions are applied).
Risk adjustment strategies used: Exclusion.....Yes Stratification ..... No Regression..... No	*Risk adjustment strategies used:* Exclusion.....Yes Stratification ..... No Regression..... No
Exclusions: Residents meeting any of the following conditions: 1. None of the four Late-Loss ADLs (G1a(A), G1b(A), G1h(A), and G1i(A)) can show decline because each of the four have a value of 4 (total dependence) or a value 8 (activity did not occur) on the prior assessment [t-1]. 2. The QM did not trigger (resident not included in the numerator) AND there is missing data on any one of the four Late-Loss ADLs (G1a(A), G1b(A), G1h(A), or G1i(A)) on the target assessment [t] or prior assessment [t-1]. 3. The resident is comatose (B1 = 1) or comatose status is unknown (B1 = missing) on the target assessment. 4. The resident has end-stage disease (J5c = checked) or end-stage disease status is unknown (J5c =	*Exclusions:* Residents meeting any of the following conditions: 1. All of the ADLs (G1a(A) through G1j(A)) have a value of 4 (total dependence) or a value 8 (activity did not occur) on the prior assessment [t-1]. 2. The QI did not trigger (resident not included in the numerator) AND there is missing data on any one of the four Late-Loss ADLs (G1a(A), G1b(A), G1h(A), or G1i(A)) on the target assessment [t] or prior assessment [t-1]. 3. The resident is comatose (B1 = 1) on the prior assessment.

Table A2: ADL Decline	
Publicly Reported Quality Measure	**Corresponding CHSRA QI**
Title: **The Percentage of Residents with Loss of Ability in Basic Daily Tasks**	*Title:* **Incidence of Decline in Late Loss ADLs.**
missing) on the target assessment. 5. The resident is receiving hospice care (P1ao = checked) or hospice status is unknown (P1ao = missing) on the target assessment or the most recent full assessment. 6. All residents in a facility with a Chronic Care Admission Sample size of 0. The Chronic Care Admission Sample is 0 if there are no residents with a non-PPS admission assessment (AA8a=01 and AA8b=blank or 6) over the previous 12 months.	
Stratification procedure: None	*Stratification procedure:* None
Regression procedure: FAP ..... None Clinical covariates .... None	*Regression procedure:* None

Chronic Care

Table A3: Infections	
Publicly Reported Quality Measure	**Corresponding CHSRA QI**
Title: **The Percentage of Residents With Infections**	*Title:* **Prevalence of UTIs**
Assessments Used: • **Target assessment:** AA8a = 01, 02, 03, 04, 05, or 10. Assessment reference date (A3a) must be within 3 months of the end of the target date. Note that admissions assessments (AA8a = 01) are excluded from measure calculations. • **Most recent full assessment:** AA8a = 01, 02, 03, or 04. Assessment reference date (A3a) must be within 17 months preceding the target assessment reference date. The most recent full assessment is used, if necessary, to fill in data items which may not be collected on the target assessment.	*Assessments Used:* • **Target assessment:** AA8a = 02, 03, 04, 05, or 10. Assessment reference date (A3a) must be in the specified target period (default target period is six months). Note that admissions assessments (AA8a = 01) are not eligible for measure calculation.
Numerator: Residents with any of the following infections or health conditions noted on the target or most recent full assessment only if the most recent full assessment is a non-admission assessment with AA8a = 02, 03, or 04. 1. Pneumonia (I2e = checked) on the target assessment or most recent full assessment (if the most recent full is a non-admission assessment), 2. Respiratory infection (I2f = checked) on the target assessment or most recent full assessment (if the most recent full is a non-admission assessment),	*Numerator:* Urinary tract infection (I2j) is checked.

Table A3: Infections	
Publicly Reported Quality Measure	**Corresponding CHSRA QI**
Title: **The Percentage of Residents With Infections**	*Title:* **Prevalence of UTIs**
3. Septicemia (I2g = checked) on the target assessment or most recent full assessment (if the most recent full is a non-admission assessment), 4. Urinary tract infection (I2j = checked) on the target assessment only, 5. Viral hepatitis (I2k = checked) on the target assessment or most recent full assessment (if the most recent full is a non-admission assessment), 6. Wound infection (I2l = checked) on the target assessment or most recent full assessment (if the most recent full is a non-admission assessment), 7. Fever (J1h = checked) on the target assessment or most recent full assessment (if the most recent full is a non-admission assessment), 8. Recurrent lung aspiration (J1k = checked) on the target assessment or most recent full assessment (if the most recent full is a non-admission assessment).	
Denominator: All residents with a target assessment (after exclusions are applied).	*Denominator:* All residents with a target assessment (after exclusions are applied).
Risk adjustment strategies used: Exclusion..... Yes Stratification ..... No Regression..... No	*Risk adjustment strategies used:* Exclusion..... No Stratification ..... No Regression..... No
Exclusions: Residents satisfying any of the following conditions: 1. The target assessment is an admission	*Exclusions:* None

Table A3: Infections	
Publicly Reported Quality Measure	**Corresponding CHSRA QI**
Title: **The Percentage of Residents With Infections**	*Title:* **Prevalence of UTIs**
assessment (AA8a = 01). 2. The QM did not trigger (resident is not included in the QM numerator) AND the urinary tract infection item (I2j) is missing on the target assessment. 3. The QM did not trigger and the value of any of the other infections or health conditions (I2e, I2f, I2g, I2k, I2l, J1h, or J1k) selected from the target assessments or most recent full assessment is missing. 4. The resident has end-stage disease (J5c = checked) or status is unknown (J5c = missing) on the target assessment. 5. The resident is receiving hospice care (P1ao = checked) or hospice status is unknown (P1ao = missing) on the target assessment or the most recent full assessment. 6. All residents in a facility with a Chronic Care Admission Sample size of 0. The Chronic Care Admission Sample is 0 if there are no residents with a non-PPS admission assessment (AA8a=01 and AA8b=blank or 6) over the previous 12 months.	
Stratification procedure: None	*Stratification procedure:* None
Regression procedure: FAP ..... None Clinical covariates .... None	*Regression procedure:* None

Chronic Care

Table A4: Pain (Chronic Care)	
Publicly Reported Quality Measure	**Corresponding CHSRA QI**
TITLE: **The Percentage of Residents With Pain (Chronic Care)**	*Title:* **No comparable QI**
Assessments Used: • **Target assessment:** AA8a = 01, 02, 03, 04, 05, or 10. Assessment reference date (A3a) must be within 3 months of the end of the target date. Note that admissions assessments (AA8a = 01) are excluded from measure calculations.	*Assessments Used:*
Numerator: Residents with moderate pain at least daily (J2a = 2 AND J2b = 2) OR horrible/excruciating pain at any frequency (J2b = 3) on the target assessment.	*Numerator:*
Denominator: All residents with a target assessment (after exclusions are applied).	*Denominator:*
Risk adjustment strategies used: Exclusion.....Yes Stratification ..... No Regression.....Yes	*Risk adjustment strategies used:*
Exclusions: Residents meeting any of the following conditions: 1. The target assessment is an admission assessment (AA8a = 01). 2. Either J2a or J2b is missing on the target assessment. 3. The values of J2a and J2b are inconsistent on the target assessment. (An example of inconsistent coding would include the coding of pain frequency as “no pain” while intensity of pain is simultaneously coded as “moderate”	*Exclusions:*

Table A4: Pain (Chronic Care)	
Publicly Reported Quality Measure	**Corresponding CHSRA QI**
TITLE: **The Percentage of Residents With Pain (Chronic Care)**	*Title:* **No comparable QI**
pain.) 4. All residents in a facility with a Chronic Care Admission Sample size of 0. The Chronic Care Admission Sample is 0 if there are no residents with a non-PPS admission assessment (AA8a=01 and AA8b=blank or 6) over the previous 12 months.	
Stratification procedure: None	*Stratification procedure:*
Regression procedure: **Facility Admission Profile:** None **Clinical covariate:** Indicator of independence or modified independence in daily decision making on the prior assessment if B4 = 0 or 1.	*Regression procedure:*

Chronic Care

Table A5: Pressure Sores	
Publicly Reported Quality Measure	**Corresponding CHSRA QI**
Title: **The Percentage of Residents With Pressure Sores***	*Title:* **Prevalence of Stage 1-4 Pressure Ulcers**
Assessments Used: • **Target assessment:** AA8a = 01, 02, 03, 04, 05, or 10. Assessment reference date (A3a) must be within 3 months of the end of the target date. Note that admissions assessments (AA8a = 01) are excluded from measure calculations. • **FAP assessment:** AA8a/AA8b = 01/blank or 01/6. Assessment reference date (A3a) must be in the 12 months preceding the end of the target date.	*Assessments Used:* • **Target assessment:** AA8a = 02, 03, 04, 05, or 10. Assessment reference date (A3a) must be in the specified target period (default target period is six months). Note that admissions assessments (AA8a = 01) are not eligible for measure calculation.
Numerator: Residents with pressure sores (Stage 1-4) on target assessment (M2a > 0 OR I3a-e = 707.0).	*Numerator:* Residents with pressure ulcers (Stage 1-4) on target assessment (M2a > 0 OR I3a-e = 707.0).
Denominator: All residents with a target assessment (after exclusions are applied).	*Denominator:* All residents with a target assessment (after exclusions are applied).
Risk adjustment strategies used: Exclusion.....Yes Stratification ..... No Regression* .....Yes	*Risk adjustment strategies used:* Exclusion.....Yes Stratification .....Yes Regression..... No
Exclusions: Residents meeting any of the following conditions: 1. The target assessment is an admission (AA8a = 01) assessment. 2. The QM did not trigger (resident is not included in	*Exclusions:* 1. The QI did not trigger (resident is not included in the QI numerator) AND the value of M2a is missing on the target assessment.

Table A5: Pressure Sores	
Publicly Reported Quality Measure	**Corresponding CHSRA QI**
Title: **The Percentage of Residents With Pressure Sores***	*Title:* **Prevalence of Stage 1-4 Pressure Ulcers**
the QM numerator) AND the value of M2a is missing on the target assessment. 3. All residents in a facility with a Chronic Care Admission Sample size of 0. The Chronic Care Admission Sample is 0 if there are no residents with a non-PPS admission assessment (AA8a=01 and AA8b=blank or 6) over the previous 12 months.	

*Note: This QM is reported both with an additional level of risk adjustment (i.e. with and without the FAP adjustments).

Table A5: Pressure Sores	
Publicly Reported Quality Measure	**Corresponding CHSRA QI**
Title: **The Percentage of Residents With Pressure Sores**	*Title:* **Prevalence of Stage 1-4 Pressure Ulcers**
Stratification procedure: None	*Stratification procedure:* • **High risk** Impaired transfer of bed mobility (G1a(A) or G1b(B) = 3 or 4 OR Comatose (B1 = 1) OR Malnutrition I3 = ICD-9 CM 260, 261, 262, 263.0, 263.1, 263.2, 263.8, or 263.9 OR End stage disease (J5c = 1). • **Low risk:** All other residents with a target assessment. Note: This QI is reported without risk adjustment (i.e., for all residents with a target assessment) and for high- and low-risk groups separately.
Regression procedure: **Facility admission profile*:** Prevalence of stage1-4 pressure sores (M2a > 0 OR I3a-e = 707.0) among admissions (AA8a = 01) occurring over previous 12 months. • **Numerator:** Admission assessments (AA8a = 01) with M2a > 0 OR I3a-e = 707.0. • **Denominator:** All admission assessments (AA8a = 01).	*Regression procedure:* None

Table A5: Pressure Sores	
Publicly Reported Quality Measure	**Corresponding CHSRA QI**
Title: **The Percentage of Residents With Pressure Sores**	*Title:* **Prevalence of Stage 1-4 Pressure Ulcers**
• **Exclusions:** Admission assessments (AA8a = 01) that do not satisfy the numerator condition AND that have missing data on M2a. **Clinical covariates:** None	

*Note: This QM is reported both with an additional level of risk adjustment (i.e. with and without the FAP adjustments).

Chronic Care

Table A6: Restraints	
Publicly Reported Quality Measure	**Corresponding CHSRA QI**
Title: **The Percentage of Residents in Physical Restraints**	*Title:* **Prevalence of Daily Physical Restraints**
Assessments Used: • **Target assessment:** AA8a = 01, 02, 03, 04, 05, or 10. Assessment reference date (A3a) must be within 3 months of the end of the target date. Note that admissions assessments (AA8a = 01) are excluded from measure calculations.	*Assessments Used:* • **Target assessment:** AA8a = 02, 03, 04, 05, or 10. Assessment reference date (A3a) must be in the specified target period (default target period is six months). Note that admissions assessments (AA8a = 01) are not eligible for measure calculation.
Numerator: Residents who were physically restrained daily (P4c or P4d or P4e = 2) on target assessment.	*Numerator:* Residents who were physically restrained daily (P4c or P4d or P4e = 2) on target assessment.
Denominator: All residents with a target assessment (after exclusions are applied).	*Denominator:* All residents with a target assessment (after exclusions are applied).
Risk adjustment strategies used: Exclusion.....Yes Stratification ..... No Regression..... No	*Risk adjustment strategies used:* Exclusion.....Yes Stratification ..... No Regression..... No
Exclusions: Residents meeting any of the following conditions: 1. The target assessment is an admission (AA8a = 01) assessment. 2. The QM is not triggered (numerator condition not satisfied) AND P4c, P4d, or P4e has a missing value. 3. All residents in a facility with a Chronic Care	*Exclusions:* Residents meeting any of the following conditions: 1. The QI is not triggered (numerator condition not satisfied) AND P4c, P4d, or P4e has a missing value.

Table A6: Restraints	
Publicly Reported Quality Measure	**Corresponding CHSRA QI**
Title: **The Percentage of Residents in Physical Restraints**	*Title:* **Prevalence of Daily Physical Restraints**
Admission Sample size of 0. The Chronic Care Admission Sample is 0 if there are no residents with a non-PPS admission assessment (AA8a=01 and AA8b=blank or 6) over the previous 12 months.	
Stratification procedure: None	*Stratification procedure:* None
Regression procedure: FAP ..... None Clinical covariates .... None	*Regression procedure:* None

Post-Acute Care

Table A7: Short-Stay Delirium	
Publicly Reported Quality Measure	**Corresponding CHSRA QI**
TITLE: **The Percentage of Short-Stay Residents With Delirium***	*Title:* **No comparable QI**
Assessments Used: • **SNF PPS 14-Day assessment:** AA8b = 7. Assessment reference date (A3a) must be within 6 months of the end of the target date. • **SNF PPS 5-Day assessment:** AA8b = 1. Assessment reference date (A3a) must be in the window of 3 days to 18 days prior to the selected 14-day assessment (may be used for covariate calculations). • **FAP Assessment:** SNF PPS 5-Day assessment: AA8b = 1 and reference date (A3a) must be in the 12 months preceding the end of the target period.	*Assessments Used:*
Numerator: Residents at SNF PPS 14-day assessment with at least one symptom of delirium that represents a departure from usual functioning (at least one B5a through B5f = 2).	*Numerator:*
Denominator: All residents with an SNF PPS 14-day assessment (AA8b = 7) (after exclusions are applied).	*Denominator:*
Risk adjustment strategies used: Exclusion.....Yes Stratification ..... No Regression* .....Yes	*Risk adjustment strategies used:*

Table A7: Short-Stay Delirium	
Publicly Reported Quality Measure	**Corresponding CHSRA QI**
TITLE: **The Percentage of Short-Stay Residents With Delirium***	*Title:* **No comparable QI**
Exclusions: Residents satisfying any of the following conditions: 1. Comatose (B1 = 1) or comatose status unknown (B1 = missing) on the SNF PPS 14-day assessment. 2. Residents with end-stage disease (J5c = checked (value 1)) or end-stage disease status unknown (J5c = missing) on the SNF PPS 14-day assessment. 3. Resident is receiving hospice care (P1ao = checked) or hospice status is unknown (P1ao = missing) on the SNF PPS 14-day assessment. 4. The QM did not trigger (resident not included in the numerator) and there is a missing value on any of the items B5a through B5f on the SNF PPS 14-day assessment. 5. All residents in a facility with a Post Acute Care Admission Sample size of 0. The Post Acute Care Admission Sample is 0 if there are no residents with PPS 5-day assessment (AA8b = 1) over previous 12 months.	*Exclusions:*
Stratification procedure: None	*Stratification procedure:*
Regression procedure: **Facility admission profile*:** Proportion of residents with at least one symptom of delirium that represents a departure from normal functioning demonstrated on SNF PPS 5-day assessments (AA8b = 1) over previous 12 months (one or more of the items B5a through B5f = 2).	*Regression procedure:*

Table A7: Short-Stay Delirium	
Publicly Reported Quality Measure	**Corresponding CHSRA QI**
TITLE: **The Percentage of Short-Stay Residents With Delirium***	*Title:* **No comparable QI**
• **Numerator:** SNF PPS 5-day assessments (AA8b = 1) with at least one B5a through B5f = 2. • **Denominator:** All SNF PPS 5-day assessments (AA8b = 1). • **Exclusion:** SNF PPS 5-day assessments (AA8b = 1) that do not satisfy the numerator condition AND that have missing data on any item B5a through B5f. **Clinical covariate:** Indicator of NO prior residential history preceding the current SNF stay for the resident if the following condition is satisfied: • There is a recent admission assessment (AA8a = 01) available for the resident AND AB5a through AB5e are not checked (value 0) and AB5f is checked (value 1) on that assessment.	

*Note: This QM is reported both with an additional level of risk adjustment (i.e. with and without the FAP adjustments).

Post-Acute Care

Table A8: Short-Stay Pain	
Publicly Reported Quality Measure	**Corresponding CHSRA QI**
TITLE: **The Percentage of Short-Stay Residents With Pain**	*Title:* **No comparable QI**
Assessments Used: • **SNF PPS 14-Day assessment:** AA8b = 7. Assessment reference date (A3a) must be within 6 months of the end of the target date.	*Assessments Used:*
Numerator: Residents at SNF PPS 14-day assessment with moderate pain at least daily (J2a = 2 AND J2b = 2) OR horrible/excruciating pain at any frequency (J2b = 3).	*Numerator:*
Denominator: All residents with an SNF PPS 14-day assessment (AA8b = 7) (after exclusions are applied).	*Denominator:*
Risk adjustment strategies used: Exclusion.....Yes Stratification ..... No Regression..... No	*Risk adjustment strategies used:*
Exclusions: Residents satisfying any of the following conditions: 1. Either J2a or J2b is missing on the 14-day assessment. 2. The values of J2a and J2b are inconsistent on the 14-day assessment. 3. All residents in a facility with a Post Acute Care	*Exclusions:*

Table A8: Short-Stay Pain	
Publicly Reported Quality Measure	**Corresponding CHSRA QI**
TITLE: **The Percentage of Short-Stay Residents With Pain**	*Title:* **No comparable QI**
Admission Sample size of 0. The Post Acute Care Admission Sample is 0 if there are no residents with a SNF PPS 5-day assessment (AA8b = 1) over previous 12 months.	
Stratification procedure: None	*Stratification procedure:*
Regression procedure: FAP ..... None Clinical covariates .... None	*Regression procedure:*

Post-Acute Care

Table A9: Short Stay Walking Improvement	
Publicly Reported Quality Measure	**Corresponding CHSRA QI**
TITLE: **The Percentage of Short-Stay Residents Who Walk as Well or Better on day 14 as on day 5 of their stay**	*Title:* **No comparable QI**
Assessments Used: • **SNF PPS 14-Day assessment:** AA8b = 7. Assessment reference date (A3a) must be within 6 months of the end of the target date. • **SNF PPS 5-Day assessment:** AA8b = 1. Assessment reference date (A3a) must be in the window of 3 days to 18 days prior to the selected 14-day assessment. • **FAP Assessment:** SNF PPS 5-Day assessment: AA8b = 1 and reference date (A3a) must be in the 12 months preceding the end of the target period.	*Assessments Used:*
Numerator: SNF PPS residents who satisfy either of the following conditions: 1) Independence in walking is maintained from the SNF PPS 5-day assessment to the SNF PPS 14-day assessment. (G1c(A)[t-1] = 0 AND G1d(A)[t-1] = 0) AND G1c(A)[t] = 0 AND G1d(A)[t] = 0. **OR** 2) Improvement in walking ability is evidenced from the SNF PPS 5-day assessment to the SNF PPS 14-day assessment:	*Numerator:*

Table A9: Short Stay Walking Improvement	
Publicly Reported Quality Measure	**Corresponding CHSRA QI**
TITLE: **The Percentage of Short-Stay Residents Who Walk as Well or Better on day 14 as on day 5 of their stay**	*Title:* **No comparable QI**
(G1c(A)[t-1] + G1d(A)[t-1] > G1c(A)[t] + G1d(A)[t]. Note: Values of 8s (activity did not occur) are converted to 4s (total independence) on G1d(A) and G1c(A) for this comparison.	
Denominator: All residents with a SNF PPS 14-day assessment (AA8b = 7) and a preceding SNF PPS 5-day assessment (AA8b = 1) (after exclusions are applied).	*Denominator:*
Risk adjustment strategies used: Exclusion.....Yes Stratification ..... No Regression.....Yes	*Risk adjustment strategies used:*
Exclusions: Residents satisfying any of the following conditions: 1. Comatose (B1 = 1) or comatose status unknown (B1 = missing) on the SNF PPS 14-day assessment. 2. End-stage disease (J5c = checked (value 1)) or end-stage disease status unknown (J5c = missing) on the SNF PPS 14-day assessment. 3. Resident is receiving hospice care (P1ao = checked) or hospice status is unknown (P1ao=missing) on the SNF PPS 14-day assessment. 4. Ventilator dependent (P1a1 checked (value 1)) or ventilator status is unknown (P1a1 = missing) on the	*Exclusions:*

Table A9: Short Stay Walking Improvement	
Publicly Reported Quality Measure	**Corresponding CHSRA QI**
TITLE: **The Percentage of Short-Stay Residents Who Walk as Well or Better on day 14 as on day 5 of their stay**	*Title:* **No comparable QI**
SNF PPS 14-day assessment. 5. Quadriplegic (I1z = checked (value 1)) or quadriplegic status is unknown (I1z = missing) on the SNF PPS 14-day assessment. 6. Paraplegic (I1x = checked (value 1)) or paraplegic status is unknown (I1x = missing) on the SNF PPS 14-day assessment. 7. G1c(A) or G1d(A) is missing on either the 5-day or 14-day assessment 8. All residents in a facility with a Post Acute Care Admission Sample size of 0. The Post Acute Care Admission Sample is 0 if there are no residents with a PPS 5-day assessment (AA8b = 1) over previous 12 months.	
Stratification procedure: None	*Stratification procedure:*
Regression procedure: **Facility admission profile:** Mean sum of walking in room (G1c(A)) and walking in corridor (G1d(A)) among PPS 5-day assessments (AA8b = 1) over previous 12 months. Note: Values of 8s (activity did not occur) are converted to 4s (total dependence) on G1d(A) and G1c(A) before summing these items. • **Exclusion:** PPS 5-day assessments (AA8b = 1) with a missing value on G1c(A) or G1d(A).	*Regression procedure:*

APPENDIX B: GLOSSARY

Adjusted Score: Reflection of the difference between the expected performance of a facility (compared to the national average) and the facility's actual observed performance on a particular quality measure.

Chronic (long stay): These residents tend to remain in the nursing facility anywhere from several months to several years. Calculation of quality measures for the chronic population includes all residents with a valid OBRA assessment in the "target" quarter or quarter of interest.

Covariate: Individual resident characteristics that may contribute to worse outcomes for a particular quality measure (e.g., effect of a residents ability to make decisions on pain measures).

Denominator: Number of residents in the facility or group of residents in a facility that are at risk for a particular condition of interest.

Exclusions: Residents that are taken out of consideration for a quality measures due to an admission date, diagnosis or other condition.

Incidence: A change in status in a resident's health condition over a period of time. This measure looks at information on the most recent assessment and compares it to information coded on prior assessments.

Numerator: Number of residents in the facility that has the condition of interest and therefore, the number of residents who has triggered for a particular quality measure.

Observed score: Ratio from the calculation of the numerator divided by the denominator.

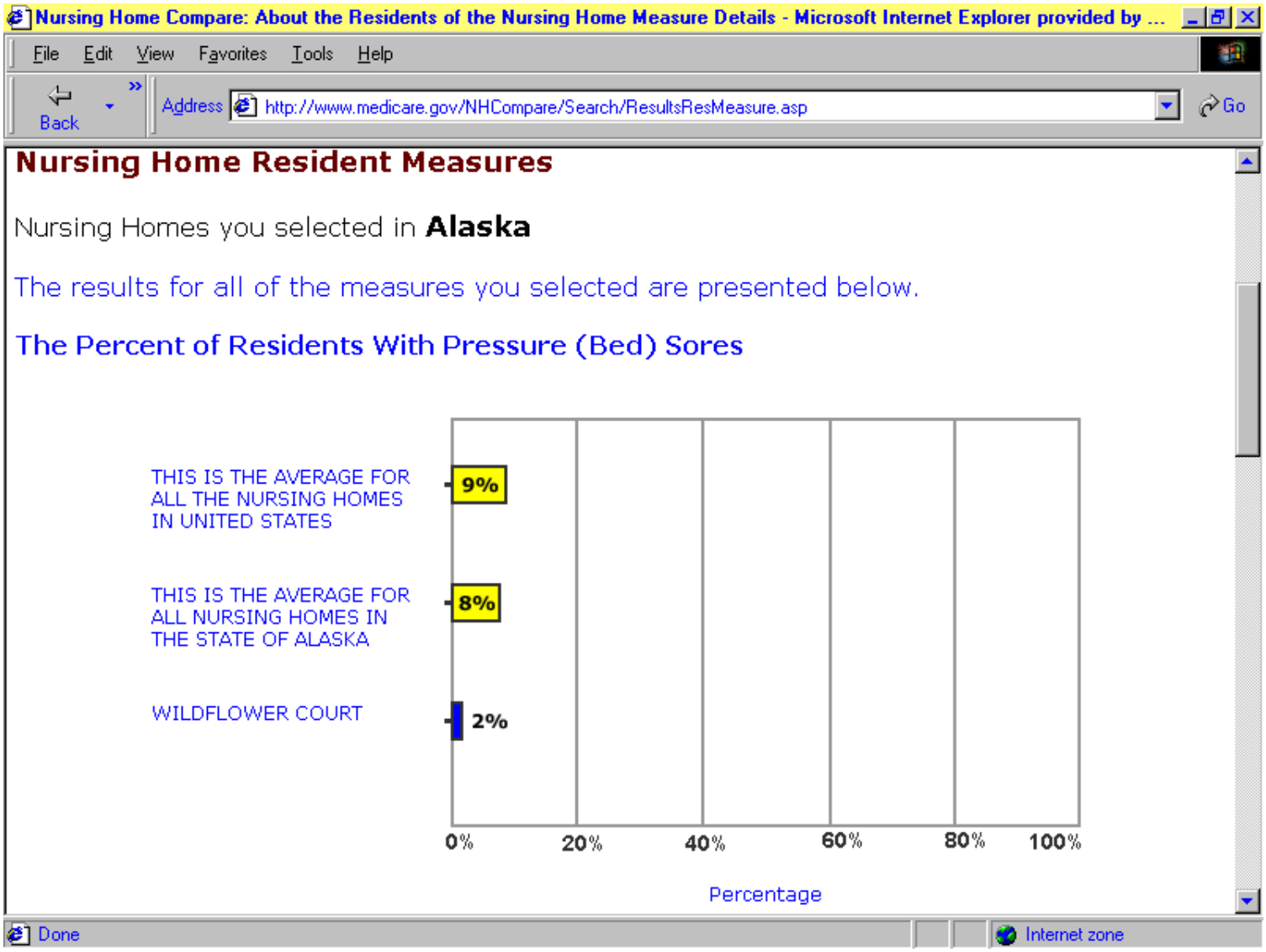
Post acute (short stay): The Post Acute population refers to those types of residents who are admitted to a facility and stay for a short period of time. These admissions typically follow an acute care hospitalization and involve high-intensity rehabilitation or clinically complex care. For the purposes of determining quality measures for these residents, calculations involve any residents with a 14-Day SNF PPS assessment in the target (most recent) six-month period.

Prevalence: The status of a resident's health condition at one particular point in time. This measure looks at only the most recent assessment.

Prior Assessment [t-1]: Assessment which occurs prior to the target assessment.

Target Assessment [t]: Target assessment refers to the assessment that occurs during the period of time being looked at for calculation of a particular quality measure. For example, measures being posted in the Fall of 2002 include calculation of data from the 2nd quarter (April to June) of 2002. Therefore, the target assessment is the assessment that occurred within that time period.

APPENDIX C: NURSING HOME COMPARE WEBSITE



APPENDIX D: MDS RESOURCES

Centers for Medicare & Medicaid Services (CMS)
Formerly the Health Care Financing Administration

7500 Security Boulevard
Baltimore, Maryland 21244
Phone: 410-786-3000
www.cms.hhs.gov

The Centers for Medicare & Medicaid Services (CMS) is a federal agency within the U.S. Department of Health and Human Services. The website includes information for consumers and health care professionals regarding health care programs and services including survey and certification Federal Regulations and Guidance to Surveyors. The "gold standard" instruction for completion of the MDS is always the CMS RAI User's Manual and the subsequent Questions and Answers (Q&As) posted on the CMS website at http://www.cms.hhs.gov/medicaid/mds20/default.htm. The most recent version of the CMS Q&As serves as the standard and may supercede past CMS Q&As.

ADDITIONAL ORGANIZATIONS/WEB SITES/EDUCATIONAL MATERIALS

CMS does not endorse nor accept responsibility for the accuracy of content included in any of the following references. They are provided as additional resources but are not a comprehensive list. These resources do not supercede the CMS RAI Users' Manual and the subsequent Q&As posted on the CMS website.

PROFESSIONAL ORGANIZATIONS

American Association of Nurse Assessment Coordinators (AANAC)
1780 S. Bellaire St., Ste. 150
Denver, CO 80222-4307
Phone: 303-758-3588
http://www.aanac.org

AANAC is a non-profit professional association representing Nurse Assessment Coordinators and all members of the Interdisciplinary Team involved in resident assessment using the Resident Assessment Instrument (RAI)/Minimum Data Set. The website provides easy access to accurate and timely information on clinical assessment, regulatory requirements, reimbursement, computer automation, research and the law.

American Association of Homes and Services for the Aging
901 E street, NW, Suite 500
Washington, DC 20004
Phone: 202-508-9450
http://www.aahsa.com

The American Association of Homes and Services for the Aging (AAHSA) association represents 5,600 not-for-profit nursing homes, continuing care retirement communities, assisted living and senior housing facilities, and community service organizations. AAHSA serves its members by representing the concerns of not-for-profit organizations that serve the elderly through interaction with Congress and federal agencies. It also strives to enhance the professionalism of practitioners and facilities through educational conferences and programs, and publications representing current thinking in the long-term care and retirement housing fields.

American Health Care Association
1201 L Street, NW
Washington, DC 20005
Phone: 202-898-6307
http://www.ahca.org

The American Health Care Association (AHCA) is a federation of state health organizations, together representing nearly 12,000 non-profit and for-profit assisted living, nursing facility, residential services for persons with mental retardation and developmental disabilities, and subacute care providers. AHCA represents the long term care community to the nation at large -- to government, business leaders, and the general public. It also serves as a force for change within the long term care field, providing information, education, and administrative tools that enhance quality at every level.

American Medical Directors Association
10480 Little Patuxent Pkwy, Suite 760
Columbia, MD 21044
Phone: 800-876-2632
http://www.amda.com

The American Medical Directors Association is the national professional association committed to the continuous improvement of the quality of patient care by providing education, advocacy, information, and professional development for medical directors and other physicians who practice in the long term care continuum. AMDA currently has over 7,000 members and a database of over 2,000 attending physicians.

National Citizens Coalition for Nursing Home Reform
1424 16th Street NW, Suite 202
Washington DC 20036
Phone: 202-332-2275
http://www.nccnhr.com

The National Citizens' Coalition for Nursing Home Reform (NCCNHR) was formed because of public concern about substandard care in nursing homes. NCCNHR currently has two hundred member groups with a growing individual membership of over 1,000. Members and subscribers to NCCNHR's information resources from 42 states comprise a diverse and caring coalition of: local citizen action groups, state and local long-term care ombudsmen, legal services programs, religious organizations, professional groups, nursing home employees' unions, concerned providers, national organizations, and growing numbers of family and resident councils. NCCNHR provides information and leadership on federal and state regulatory and legislative policy development and models and strategies to improve care and life for residents of nursing homes and other long term care facilities.

Health Care Quality Alliance
4938 Hampden Lane, #201
Bethesda, Maryland 20814
Phone: 202-905-3535
http://www.healthquality.org

The Health Care Quality Alliance unites 97 diverse, national health-related organizations with a common commitment to preserving and enhancing the quality of health care made available to the American public. The Health Care Quality Alliance serves as a unique, cross-disciplinary forum for examining critical and timely public policy issues that influence the delivery and financing of quality health care. The Alliance promotes working relationships among its diverse member organizations in order to discover and defend mutual quality concerns.

American Hospital Association
One North Franklin,
Chicago, IL 60606-3421
Phone: 312-422-3000
http://www.aha.org

The American Hospital Association (AHA) is the national organization that represents and serves all types of hospitals, health care networks, and their patients and communities. Close to 5,000 hospitals, health care systems, networks, other providers of care and 37,000 individual members come together to form the AHA. The mission of AHA is to advance the health of individuals and communities. AHA leads, represents, and serves health care provider organizations that are accountable to the community and committed to health improvement.

AARP
601 E St., NW
Washington, DC 20049
Phone: 800-424-3410
http://www.aarp.org

AARP is a nonprofit, nonpartisan membership organization for people 50 and over. The organization provides information and resources; advocates on legislative, consumer, and legal issues; assists members to serve their communities; and offers a wide range of unique benefits, special products, and services for members.

American Health Management Information Association
233 N. Michigan Avenue, Suite 2150
Chicago, IL 60601-5800
Main Number: 312-233-1100
Product Orders Fax: 312-233-1500
General E-mail: info@ahima.org
http://www.ahima.org

OTHER RESOURCES

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Center for Health Sciences Research (CHSRA)
University of Wisconsin at Madison
11th floor WARF Bldg.
610 Walnut Street
Madison, WI 53705-2397
Phone: 608/263-5722
http://chsra.wisc.edu

At the Center for Health Systems Research and Analysis (CHSRA) at the University of Wisconsin-Madison researchers seek to improve long-term care and health systems by creating performance measures and developing information and decision support systems. A common theme among CHSRA projects is the application of decision theory and other engineering principles to long-term care and health care systems in the United States and other countries. Employing state-of-the-art technology, CHSRA researchers: develop and evaluate long-term care performance measures and quality assurance and reimbursement systems; develop health information systems and databases for use in policy analysis and epidemiologic studies; and, develop and evaluate information systems to support health education and promotion programs.

HCPro
200 Hoods Lane
Marblehead, MA 01945, USA
Phone: 800/650-6787
www.snfinfo.com

HCPro and its wholly owned subsidiaries, Opus Communications, The Greeley Company, and The Greeley Education Company, constitute a multidisciplinary, service-based organization focusing exclusively on the healthcare industry. SNFInfo.com is known as the "Long-Term Care Information Supersite." Extensive information is available to providers including survey and certification updates, Medicare/PPS billing information, publications and newsletters. Additional training materials, books, and publications can be purchased on the site.

Heaton Resources
A Division of MED-PASS, Inc.
10800 Industry Lane
Miamisburg, OH 45342
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Phone: (800) 221-2469
(800) 438-8884
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LTCQ, Inc.
135 South Road
Bedford, MA 01730
Phone: (781) 275-4567
http://www.LTCQ.com

LTCQ's mission is to improve quality throughout long term care by providing innovative information analysis and reporting products that help health care providers: identify areas of concern (patients at risk, process problems, poor performance), understand why they are occurring, learn how to correct them, and maintain excellent operations and processes. LTCQ, Inc. provides products and services that improve clinical and financial performance while decreasing risk. These offerings can be incorporated into existing quality improvement activities, corporate compliance plans, and corporate integrity agreements or as an integral part of pre-acquisition assessments.