

# Understanding The Quality Measures

Nursing Home Collaborative  
Workgroup Meeting

September 22, 2005

**Arizona**  
**Department of**  
**Health Services**



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Office of Long Term Care Licensing

# Presentation Topics

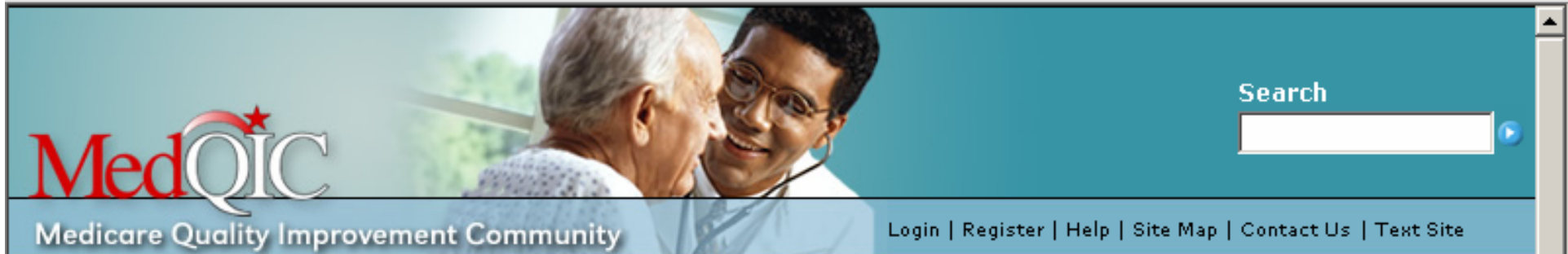
- The Quality Measure (QM) Resource Manual
- How the following QMs are calculated:
  - Chronic Care High-Risk Pressure Ulcers**
  - Restraints**
  - Depression**
  - Chronic Care Pain**



# The QM Resource Manual

- Found at <http://www.medqic.org> and <http://www.nhqi-star.org>
- Downloadable in PDF format by chapter
- Indicates which MDS questions trigger your QMs





- HOME
- RESOURCE CENTER
  - Improving Quality and Safety in Health Care
  - Physician Offices
  - Hospitals
  - Home Health Agencies
  - Nursing Homes**
  - Underserved Populations
  - Medicare Advantage
- SUPPORT CENTER
  - Find A Colleague
  - Community Forums
- ABOUT MedQIC
  - Background
  - QIO Listings
  - Content Contacts

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The Centers for Medicare & Medicaid Services (CMS) developed this comprehensive online resource of quality improvement information for Medicare's National Quality Improvement Priority Topics. [more](#)

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- HOME
- RESOURCE CENTER
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  - Physician Offices
  - Hospitals
  - Home Health Agencies
  - Nursing Homes** ▾
    - NHIFT
    - STAR
    - Activities of Daily Living
    - Bedfast or Chairfast
    - Delirium
    - Depression
    - Immunizations
    - Incontinence
    - Infections
    - Mobility

Home > Nursing Homes

## Nursing Homes

Nursing homes serve a vital role in the healthcare system by providing a wide range of personal care and health services to America's aging population. Elders residing in nursing homes generally are there because they can no longer care for themselves, and family and community support services are not adequate to ensure the elder's safety and quality of life. Nursing homes provide elders with 24-hour individualized support services. The differences in needs, characteristics, circumstances, expected outcomes, and long-term status of elders residing in nursing homes requires that staff employ a variety of techniques and strategies to provide quality care and ensure the quality of life for every resident.

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- ▶ [Links](#)
- ▶ [Measures](#)
- ▶ [Other Resources](#)

- Immunity
- Pain
- Physical Restraints
- Pressure Ulcers
- Urinary Catheters
- Urinary Tract Infections
- Walking Improvement
- Weight Loss

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- Background
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- ▶ [Pressure Ulcers](#)
- ▶ [Urinary Catheters](#)
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**Measure Resources**

- ▶ [Resources for Publicly Reported Measures](#)

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- HOME
- RESOURCE CENTER
  - Improving Quality and Safety in Health Care
  - Physician Offices
  - Hospitals
  - Home Health Agencies
  - Nursing Homes** ▾
    - NHIFT
    - STAR
    - Activities of Daily Living
    - Bedfast or Chairfast
    - Delirium
    - Depression
    - Immunizations
    - Incontinence
    - Infections
    - Mobility
    - Pain
    - Physical Restraints

Home > Nursing Homes > Measures > Measure Detail

## Resources for Publicly Reported Measures

- [Quality Measure Resource Manual](#)  
~~This Quality Measures Resource Manual~~ contains detailed information on the enhanced set of quality measures that are being implemented by the Centers for Medicare & Medicaid Services (CMS) as part of the Nursing Home Quality Initiative (NHQI).
- [How to Access Your Quality Measure Report in the Minimum Data Set \(MDS\) Quality Improvement Evaluation System \(QIES\)](#)
- [Tips on Checking the Accuracy of Your Quality Measures - Including Frequently Asked Questions \(FAQs\)](#)
- [Example Calculation of Chronic Care Pressure Ulcer Quality Measure](#)
- [Screening, Assessing, and Monitoring Overview](#)
- [Minimum Data Set \(MDS\)](#)
- [Nursing Home Compare](#)  
Provides detailed information about the past performance of every Medicare and Medicaid certified nursing home in the country



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- HOME
- RESOURCE CENTER
- Improving Quality and Safety in Health Care
- Physician Offices
- Hospitals
- Home Health Agencies
- Nursing Homes** ▾
- NHIFT
- STAR
- Activities of Daily Living
- Bedfast or Chairfast
- Delirium
- Depression
- Immunizations
- Incontinence
- Infections
- Mobility
- Pain
- Physical Restraints

Home > Nursing Homes > Other Resource Detail

**Other Resource:**  
**Quality Measures Resource Manual**








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**Table of Contents:**  
 Chapter 1: Overview of the Quality Measures  
 Chapter 2: What is a CMS NHQI Quality Measure?  
 Chapter 3: Resident MDS Assessment Selection for Measures Calculation  
 Chapter 4: Risk Adjustment  
 Chapter 5: Quality Measures Calculation Overview  
 Chapter 6: Quality Measure Definitions and MDS Coding Instructions

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# Nursing Home STAR Site

Setting Targets - Achieving Results

- Public QM Data
- How to Set Targets
- My Target Setting
- Create an Account
- Related Links**

Quarter 1 2005 QM scores are now available in STAR. Reminder: Targets entered before the start of the 4th quarter (October 1, 2005) can be edited until October 1, their effective start date.

## Welcome

Welcome to the nursing home Setting Targets-Achieving Results (STAR) site! This site allows you to set targets for the following quality measures: physical restraints, high risk pressure ulcers, depression, and chronic care pain. Registered nursing homes can view their quality measure scores, select appropriate targets, and track their progress over time. Using the nursing home STAR site, your nursing home can become a 'star' performer.

Site created by:



Registration on this site is free and available to all Medicare and/or Medicaid certified nursing homes.

To register for the nursing home STAR site, please click [Create an Account](#). Please have your Medicare/Medicaid provider number available when creating an account. If you are already registered, please click [Login](#) to sign into your account and begin using the STAR site.

For instructions and other electronic resources, please click on [Help](#).

### [Centers for Medicare & Medicaid Services](#)

The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program and works in partnership with the States to administer Medicaid, the State Children's Health Insurance Program, and health insurance portability standards. In addition to these programs, CMS has other responsibilities, including the administrative simplifications standards from the Health Insurance Portability and Accountability Act of 1996, quality standards in health care facilities through its survey and certification activity, and clinical laboratory quality standards.

### [Enhanced Set of Quality Measures Resource Manual](#)

~~This Quality Measures Resource Manual contains detailed information on the enhanced set of quality measures that are being implemented by the Centers for Medicare & Medicaid Services (CMS) as part of the Nursing Home Quality Initiative (NHQI).~~

### [MedQIC](#)

The Centers for Medicare & Medicaid Services (CMS) has created this comprehensive online resource of quality improvement information for Medicare's National Quality Improvement Priority Topics. The purpose of MedQIC is to support Quality Improvement Organizations and providers of services to Medicare beneficiaries in finding, using, and sharing quality improvement resources. Information on MedQIC is organized by settings and clinical topics and includes resources for each Priority Topic. You may also search the entire database for literature, tools, and other information related to improving quality of care.

### [MedQIC - Improving Care in Nursing Homes](#)

The differences in needs, characteristics, circumstances, expected outcomes, and long-term status of elders residing in nursing homes requires that staff employ a variety of techniques and strategies to provide quality care and ensure the quality of life for every resident.

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    - NHIFT
    - STAR
    - Activities of Daily Living
    - Bedfast or Chairfast
    - Delirium
    - Depression
    - Immunizations
    - Incontinence
    - Infections
    - Mobility
    - Pain
    - Physical Restraints

Home > Nursing Homes > Measures > Measure Detail

## Resources for Publicly Reported Measures

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  - Nursing Homes** ▾
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    - Bedfast or Chairfast
    - Delirium
    - Depression
    - Immunizations
    - Incontinence
    - Infections
    - Mobility
    - Pain
    - Physical Restraints

Home > Nursing Homes > Other Resource Detail

## Other Resource: Quality Measures Resource Manual

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  - [Chapter 5](#)  
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# The Chronic Care High-Risk Pressure Ulcer Quality Measure



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# MDS Assessments Used

## Target Assessment:

OBRA Full (AA8a = 01, 02, 03, or 04) or Quarterly Assessment (AA8a = 05 or 10). Latest assessment with assessment reference date (A3a) within the 3-month target period. Note that admission assessments (AA8a = 01) are excluded from measure calculations.





# QM Specifications

## Numerator:

- Residents with pressure sores (Stage 1–4) on the target assessment (M2a > 0 OR I3a-I3e = 707.0).



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# QM Specifications (Continued)

## High-Risk Denominator:

- Impaired in bed mobility or transfer on the target assessment as indicated by G1a(A) = 3, 4, or 8 OR G1b(A) = 3, 4, or 8.
- Comatose on the target assessment as indicated by B1=1.
- Suffer malnutrition on the target assessment as indicated by I3a through I3e = 260, 261, 262, 263.0, 263.1, 263.2, 263.8, or 263.9.







		<b>OF DISTRESS</b>		complaints—e.g., persistently seeks medical attention, obsessive concern with body functions	
		a. Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die"		i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues	
		b. Repetitive questions—e.g., "Where do I go; What do I do?"		<b>SLEEP-CYCLE ISSUES</b>	
		c. Repetitive verbalizations—e.g., calling out for help, ("God help me")		j. Unpleasant mood in morning	
		d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home, anger at care received		k. Insomnia/change in usual sleep pattern	
		e. Self deprecation—e.g., "I am nothing; I am of no use to anyone"		<b>SAD, APATHETIC, ANXIOUS APPEARANCE</b>	
		f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others		l. Sad, pained, worried facial expressions—e.g., furrowed brows	
		g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack		m. Crying, tearfulness	
				n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking	
				<b>LOSS OF INTEREST</b>	
				o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends	
				p. Reduced social interaction	
2.	<b>MOOD PERSISTENCE</b>	One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered			
3.	<b>CHANGE IN MOOD</b>	Resident's mood status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated			
4.	<b>BEHAVIORAL SYMPTOMS</b>	(A) Behavioral symptom frequency in last 7 days 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 days in last 7 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily  (B) Behavioral symptom alterability in last 7 days 0. Behavior not present OR behavior was easily altered 1. Behavior was not easily altered	(A) (B)		

Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community	b.
NONE OF ABOVE	c.
	d.

<b>SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS</b>		
1. (A) ADL SELF-PERFORMANCE—(Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup)		
0. INDEPENDENT—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days		
1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last 7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days		
2. LIMITED ASSISTANCE—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days		
3. EXTENSIVE ASSISTANCE—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times: —Weight-bearing support — Full staff performance during part (but not all) of last 7 days		
4. TOTAL DEPENDENCE—Full staff performance of activity during entire 7 days		
8. ACTIVITY DID NOT OCCUR during entire 7 days		
(B) ADL SUPPORT PROVIDED—(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)		
0. No setup or physical help from staff		(A) (B)
1. Setup help only		SELF-PERF SUPPORT
2. One person physical assist		
3. Two+ persons physical assist	8. ADL activity itself did not occur during entire 7 days	
a. MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed	
b. TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)	
c. WALK IN ROOM	How resident walks between locations in his/her room	
d. WALK IN CORRIDOR	How resident walks in corridor on unit	
e. LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	
f. LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	
g. DRESSING	How resident puts on, fastens, and takes off all items of street	



	or reentry assessment, only a limited subset of MDS items need be completed]	7. Discharged—return anticipated 8. Discharged prior to completing Initial assessment 9. Reentry 10. Significant correction of prior quarterly assessment 0. NONE OF ABOVE b. Codes for assessments required for Medicare PPS or the State 1. Medicare 5 day assessment 2. Medicare 30 day assessment 3. Medicare 60 day assessment 4. Medicare 90 day assessment 5. Medicare readmission/return assessment 6. Other state required assessment 7. Medicare 14 day assessment 8. Other Medicare required assessment	
9.	RESPONSIBILITY/LEGAL GUARDIAN	(Check all that apply) Durable power attorney/financial Legal guardian Other legal oversight Durable power of attorney/health care Family member responsible Patient responsible for self NONE OF ABOVE	d. e. f. g.
10.	ADVANCED DIRECTIVES	(For those items with supporting documentation in the medical record, check all that apply) Living will Do not resuscitate Do not hospitalize Organ donation Autopsy request Feeding restrictions Medication restrictions Other treatment restrictions NONE OF ABOVE	f. g. h. i.

### SECTION B. COGNITIVE PATTERNS

1.	COMATOSE	(Persistent vegetative state/no discernible consciousness) 0. No 1. Yes (If yes, skip to Section G)	
2.	MEMORY	(Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem b. Long-term memory OK—seems/appears to recall long past 0. Memory OK 1. Memory problem	

### SECTION C. COMMUNICATION/HEARING PATTERNS

1.	HEARING	(With hearing appliance, if used) 0. HEARS ADEQUATELY—normal talk, TV, phone 1. MINIMAL DIFFICULTY when not in quiet setting 2. HEARS IN SPECIAL SITUATIONS ONLY—speaker has to adjust tonal quality and speak distinctly 3. HIGHLY IMPAIRED/absence of useful hearing	
2.	COMMUNICATION DEVICES/TECHNIQUES	(Check all that apply during last 7 days) Hearing aid, present and used Hearing aid, present and not used regularly Other receptive comm. techniques used (e.g., lip reading) NONE OF ABOVE	a. b. c. d.
3.	MODES OF EXPRESSION	(Check all used by resident to make needs known) Speech Writing messages to express or clarify needs American sign language or Braille Signs/gestures/sounds Communication board Other NONE OF ABOVE	a. b. c. d. e. f. g.
4.	MAKING SELF UNDERSTOOD	(Expressing information content—however able) 0. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests 3. RARELY/NEVER UNDERSTOOD	
5.	SPEECH CLARITY	(Code for speech in the last 7 days) 0. CLEAR SPEECH—distinct, intelligible words 1. UNCLEAR SPEECH—slurred, mumbled words 2. NO SPEECH—absence of spoken words	
6.	ABILITY TO UNDERSTAND OTHERS	(Understanding verbal information content—however able) 0. UNDERSTANDS 1. USUALLY UNDERSTANDS—may miss some part/intent of message 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication 3. RARELY/NEVER UNDERSTANDS	
7.	CHANGE IN COMMUNICATION/HEARING	Resident's ability to express, understand, or hear information has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	



# QM Specifications (Continued)

## Exclusions:

- The target assessment is an admission (AA8a = 01) assessment.
- 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 does not qualify as high-risk AND the value of G1a(A) or G1b(A) is missing on the target assessment.
- The resident does not qualify as high-risk AND the value of B1 is missing on the target assessment.



# 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 with ICD-9 Code 707.0.

## **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, in a recliner, or other type of furniture the resident sleeps in, rather than a bed.



# MDS Elements Related to QM

(Continued)

## **G1b (A) Transfer Self-Performance:**

How the resident moves between surfaces—i.e., to/from: bed, chair, wheelchair, standing position. Exclude from this definition movement to/from bath or toilet, which is covered under Toilet Use and Bathing.

## **B1 Comatose:**

The resident has been diagnosed as comatose or in a persistent vegetative state.



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# MDS Elements Related to QM

(Continued)

## **Nutritional Deficiencies ICD-9 Codes:**

- 260 Kwashiorkor
- 261 Nutritional marasmus
- 262 Other severe, protein-calorie malnutrition
- 263.0 Malnutrition of moderate degree
- 263.1 Malnutrition of mild degree
- 263.2 Arrested development following protein-calorie malnutrition
- 263.8 Other protein-calorie malnutrition
- 263.9 Unspecified protein-calorie malnutrition



# The Restraints Quality Measure



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# MDS Assessments Used

## Target Assessment:

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

Latest assessment with assessment reference  
date (A3a) within the 3-month target period.

Note that admission assessments (AA8a = 01)  
are excluded from measure calculations.



# QM Specifications

## **Numerator:**

Residents who were physically restrained daily (P4c or P4d or P4e = 2) on the target assessment.

## **Denominator:**

All residents with a valid target assessment after exclusions are applied.



# QM Specifications (Continued)

## Exclusions:

- The target assessment is an admission (AA8a = 01) assessment.
- The QM did not trigger (resident is not included in the QM numerator) AND P4c or P4d or P4e is missing on the target assessment.



# MDS Elements Related to QM

## **Devices and Restraints Used In the Last 7 days:**

### **P4c Trunk Restraint:**

Includes any device, equipment, or material that the resident cannot easily remove (i.e., vest or waist restraint, belts used in wheelchairs).

### **P4d Limb Restraint:**

Includes any device, 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).



# MDS Elements Related to QM

(Continued)

## **P4e 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.



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Resident \_\_\_\_\_

Numeric Identifier \_\_\_\_\_

5. PREFERENCES CHANGE IN DAILY ROUTINE	Code for resident preferences in daily routines 0. No change      1. Slight change      2. Major change	
	a. Type of activities in which resident is currently involved	
	b. Extent of resident involvement in activities	

**SECTION O. MEDICATIONS**

1. NUMBER OF MEDICATIONS	(Record the number of different medications used in the last 7 days; enter "0" if none used)	
2. NEW MEDICATIONS	(Resident currently receiving medications that were initiated during the last 90 days) 0. No      1. Yes	
3. INJECTIONS	(Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)	
4. DAYS RECEIVED THE FOLLOWING MEDICATION	a. Antipsychotic	
	b. Antianxiety	
	c. Antidepressant	
	d. Hypnotic	
	e. Diuretic	

**SECTION P. SPECIAL TREATMENTS AND PROCEDURES**

1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS	a. SPECIAL CARE—Check treatments or programs received during the last 14 days	
	TREATMENTS	
	Chemotherapy	a. Ventilator or respirator
	Dialysis	b. Alcohol/drug treatment program
	IV medication	c. Alzheimer's/dementia special care unit
	Intake/output	d. Hospice care
	Monitoring acute medical condition	e. Pediatric unit
	Ostomy care	f. Respite care
	Oxygen therapy	g. Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs)
	Radiation	h. NONE OF ABOVE
	Suctioning	
	Tracheostomy care	
	Transfusions	

4. DEVICES AND RESTRAINTS	(Use the following codes for last 7 days:) 0. Not used 1. Used less than daily 2. Used daily	
	Bed rails	
	a. — Full bed rails on all open sides of bed	
	b. — Other types of side rails used (e.g., half rail, one side)	
	c. Trunk restraint	
	d. Limb restraint	
	e. Chair prevents rising	
5. HOSPITAL STAY(S)	Record number of times resident was admitted to hospital with an overnight stay in last 90 days (or since last assessment if less than 90 days). (Enter 0 if no hospital admissions)	
6. EMERGENCY ROOM (ER) VISIT(S)	Record number of times resident visited ER without an overnight stay in last 90 days (or since last assessment if less than 90 days). (Enter 0 if no ER visits)	
7. PHYSICIAN VISITS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (Enter 0 if none)	
8. PHYSICIAN ORDERS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? Do not include order renewals without change. (Enter 0 if none)	
9. ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the last 90 days (or since admission)? 0. No      1. Yes	

**SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS**

1. DISCHARGE POTENTIAL	a. Resident expresses/indicates preference to return to the community 0. No      1. Yes	
	b. Resident has a support person who is positive towards discharge 0. No      1. Yes	
	c. Stay projected to be of a short duration—discharge projected within 90 days (do not include expected discharge due to death) 0. No      1. Within 30 days      2. Within 31-90 days      3. Discharge status uncertain	
2. OVERALL CHANGE IN CARE NEEDS	Resident's overall self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change    1. Improved—receives fewer    2. Deteriorated—receives	



# The Depression Quality Measure



*Arizona Department of Health Services*  
Division of Licensing Services

# MDS Assessments Used

## **Target Assessment:**

OBRA Full (AA8a = 01, 02, 03, or 04) or Quarterly Assessment (AA8a = 05 or 10). Latest assessment with assessment reference date (A3a) within the 3-month target period.

## **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.



# QM Specifications

## **Numerator:**

Residents whose Mood Scale scores are greater on target assessment relative to prior assessment (Mood Scale score [t] > Mood Scale score [t-1]).

## **Denominator:**

All residents with a valid target assessment and a valid prior assessment, after exclusions are applied.



# QM Specifications (Continued)

## Exclusions:

- The Mood Scale score is missing on the target assessment [t].
- The Mood Scale score is missing on the prior assessment [t-1] and the Mood Scale score indicates symptoms present on the target assessment (Mood Scale [t] > 0).
- The Mood Scale score is at a maximum (value 8) on the prior assessment.
- The resident is comatose (B1 = 1) or comatose status is unknown (B1 = missing) on the target assessment.



# MDS Elements Related to QM

**E1a Indicators of Depression, Anxiety, or Sad Mood:**  
Resident-made negative statements.

**E1c Indicators of Depression, Anxiety, or Sad Mood:**  
Repetitive verbalizations.

**E1e Indicators of Depression, Anxiety, or Sad Mood:**  
Self deprecation.



# MDS Elements Related to QM

(Continued)

**E1f Indicators of Depression, Anxiety, or Sad Mood:**  
Expressions of what appear to be unrealistic fears.

**E1g Indicators of Depression, Anxiety, or Sad Mood:**  
Recurrent statements that something terrible is about to happen.

**E1h Indicators of Depression, Anxiety, or Sad Mood:**  
Repetitive health complaints.



# MDS Elements Related to QM

(Continued)

**E1m Indicators of Depression, Anxiety, or Sad Mood:**

Crying, tearfulness.

**E1n Indicators of Depression, Anxiety, or Sad Mood:**

Repetitive physical movements.

**E2 Mood Persistence:**

One or more indicators of depressed, sad, or anxious mood were not easily altered by attempts to “cheer up”, console, or reassure the resident over the last seven days.



*Arizona Department of Health Services*  
Division of Licensing Services

# MDS Elements Related to QM

## (Continued)

### **K4c Nutritional Problems:**

Leaves 25% or more of food uneaten at most meals.

### **B1 Comatose:**

The resident has been diagnosed as comatose or in a persistent vegetative state.



**SECTION E. MOOD AND BEHAVIOR PATTERNS**

1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	(Code for indicators observed in last 30 days, irrespective of the assumed cause)	
	0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to five days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)	
2. MOOD PERSISTENCE	One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days	
	0. No mood indicators	1. Indicators present, easily altered
	2. Indicators present, not easily altered	
	3. Indicators present, not easily altered	
	4. Indicators present, not easily altered	
	5. Indicators present, not easily altered	
	6. Indicators present, not easily altered	
3. CHANGE IN MOOD	Resident's mood status has changed as compared to status of 90 days ago (or since last assessment, if less than 90 days)	
	0. No change	1. Improved 2. Deteriorated
4. BEHAVIORAL SYMPTOMS	(A) Behavioral symptom frequency in last 7 days	
	0. Behavior not exhibited in last 7 days	

**VERBAL EXPRESSIONS OF DISTRESS**

- a. Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die"
- b. Repetitive questions—e.g., "Where do I go; What do I do?"
- c. Repetitive verbalizations—e.g., calling out for help, ("God help me")
- d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home, anger at care received
- e. Self deprecation—e.g., "I am nothing; I am of no use to anyone"
- f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others
- g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack

**SLEEP-CYCLE ISSUES**

- h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions
- i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues
- j. Unpleasant mood in morning
- k. Insomnia/change in usual sleep pattern

**SAD, APATHETIC, ANXIOUS APPEARANCE**

- l. Sad, pained, worried facial expressions—e.g., furrowed brows
- m. Crying, tearfulness
- n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking

**LOSS OF INTEREST**

- o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends
- p. Reduced social interaction

3. PAST ROLES	Absence of personal contact with family/friends	e.
	Recent loss of close family member/friend	f.
	Does not adjust easily to change in routines	g.
NONE OF ABOVE		h.
3. PAST ROLES	Strong identification with past roles and life status	a.
	Expresses sadness/anger/empty feeling over lost roles/status	b.
	Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community	c.
	NONE OF ABOVE	d.

**SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS**

1. (A) ADL SELF-PERFORMANCE—(Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup)			
0. INDEPENDENT—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days			
1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last 7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days			
2. LIMITED ASSISTANCE—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days			
3. EXTENSIVE ASSISTANCE—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times: —Weight-bearing support — Full staff performance during part (but not all) of last 7 days			
4. TOTAL DEPENDENCE—Full staff performance of activity during entire 7 days			
8. ACTIVITY DID NOT OCCUR during entire 7 days			
(B) ADL SUPPORT PROVIDED—(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)		(A)	(B)
0. No setup or physical help from staff			
1. Setup help only			
2. One person physical assist			
3. Two+ persons physical assist			
8. ADL activity itself did not occur during entire 7 days			
a. BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b. TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c. WALK IN ROOM	How resident walks between locations in his/her room		
d. WALK IN CORRIDOR	How resident walks in corridor on unit		
e. LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency in moving chair		



UP CONDITIONS	patients unstable—(including, precarious, or deteriorating)	a.
	Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem	b.
	End-stage disease, 6 or fewer months to live	c.
	NONE OF ABOVE	d.

### SECTION K. ORAL/NUTRITIONAL STATUS

1.	ORAL PROBLEMS	Chewing problem Swallowing problem Mouth pain NONE OF ABOVE	a. b. c. d.
2.	HEIGHT AND WEIGHT	Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in last 30 days; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes  a. HT (in.) <input type="text"/> <input type="text"/> <input type="text"/> b. WT (lb.) <input type="text"/> <input type="text"/> <input type="text"/>	
3.	WEIGHT CHANGE	a. Weight loss—5 % or more in last 30 days; or 10 % or more in last 180 days 0. No 1. Yes b. Weight gain—5 % or more in last 30 days; or 10 % or more in last 180 days 0. No 1. Yes	
4.	NUTRITIONAL PROBLEMS	Complains about the taste of many foods Regular or repetitive complaints of hunger Leaves 25% or more of food uneaten at most meals NONE OF ABOVE	a. b. c. d.
5.	NUTRITIONAL APPROACHES	(Check all that apply in last 7 days) Parenteral/IV Feeding tube Mechanically altered diet Syringe (oral feeding) Therapeutic diet Dietary supplement between meals Plate guard, stabilized built-up utensil, etc. On a planned weight change program NONE OF ABOVE	a. b. c. d. e. f. g. h. i.
6.	PARENTERAL OR ENTERAL INTAKE	(Skip to Section L if neither 5a nor 5b is checked) a. Code the proportion of total calories the resident received through parenteral or tube feedings in the last 7 days	

4.	ULCERS	(U. 1, U2)	1. Yes	
	OTHER SKIN PROBLEMS OR LESIONS PRESENT	(Check all that apply during last 7 days) Abrasions, bruises Burns (second or third degree) Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions) Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster Skin desensitized to pain or pressure Skin tears or cuts (other than surgery) Surgical wounds NONE OF ABOVE	a. b. c. d. e. f. g. h.	
5.	SKIN TREATMENTS	(Check all that apply during last 7 days) Pressure relieving device(s) for chair Pressure relieving device(s) for bed Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE	a. b. c. d. e. f. g. h. i. j.	
6.	FOOT PROBLEMS AND CARE	(Check all that apply during last 7 days) Resident has one or more foot problems—e.g., corns, calluses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE	a. b. c. d. e. f. g.	

### SECTION N. ACTIVITY PURSUIT PATTERNS

1.	TIME PERIOD	(Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., awake no more than one hour	
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# The Chronic Care Pain Quality Measure



*Arizona Department of Health Services*  
Division of Licensing Services

# MDS Assessments Used

## **Target Assessment:**

OBRA Full (AA8a = 01, 02, 03, or 04) or Quarterly Assessment (AA8a = 05 or 10). Latest assessment with assessment reference date (A3a) within the 3-month target period. Note that admission assessments (AA8a = 01) are excluded from measure calculations.

## **Prior Assessment:**

OBRA Full (AA8a = 01, 02, 03, or 04) or Quarterly Assessment (AA8a = 05 or 10). Assessment reference date (A3a) must be in the window of 46 days to 165 days preceding the target assessment reference date. Prior assessments are used for covariate calculations.



# QM Specifications

## **Numerator:**

Residents with pain occurring daily, reaching a moderate level at least once during the assessment period (J2a = 2 and J2b = 2) OR horrible/excruciating pain at any frequency (J2b = 3) on the target assessment.

## **Denominator:**

All residents with a valid target assessment after exclusions are applied.



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# 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 Cognitive Skills for Daily Decision-Making:**

Resident's actual performance in making everyday decisions about tasks or activities of daily living.



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2. OCCASIONALLY INCONTINENT—BLADDER, 2 or more times a week but not daily; BOWEL, once a week			
3. FREQUENTLY INCONTINENT—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week			
4. INCONTINENT—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time			
a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed	
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed	
2.	BOWEL ELIMINATION PATTERN	Bowel elimination pattern regular—at least one movement every three days	
		a. Diarrhea	a.
		b. Fecal impaction	d.
		Constipation	b.
		NONE OF ABOVE	e.

SECTION J. HEALTH CONDITIONS			
1.	PROBLEM CONDITIONS	(Check all problems present in last 7 days unless other time frame is indicated)	
	INDICATORS OF FLUID STATUS	Dizziness/Vertigo	t.
		Edema	g.
		Fever	h.
		Hallucinations	i.
		Internal bleeding	j.
		Recurent lung aspirations in last 90 days	k.
		Shortness of breath	l.
		Syncope (fainting)	m.
		Unsteady gait	n.
		Vomiting	o.
		NONE OF ABOVE	p.
	OTHER		
	Delusions		

MDS 2.0 September, 2000

Resident \_\_\_\_\_

2.	PAIN SYMPTOMS	(Code the highest level of pain present in the last 7 days)	
	a. FREQUENCY with which resident complains or shows evidence of pain		b. INTENSITY of pain
	0. No pain (skip to J4)		1. Mild pain
	1. Pain less than daily		2. Moderate pain
	2. Pain daily		3. Times when pain is horrible or excruciating
3.	PAIN SITE	(If pain present, check all sites that apply in last 7 days)	
	Back pain	a.	Incisional pain
	Bone pain	b.	Joint pain (other than hip)
	Chest pain while doing usual activities	c.	Soft tissue pain (e.g., lesion, muscle)
	Headache	d.	Stomach pain
	Hip pain	e.	Other
4.	ACCIDENTS	(Check all that apply)	
	Fell in past 30 days	a.	Hip fracture in last 180 days
	Fell in past 31-180 days	b.	Other fracture in last 180 days
			NONE OF ABOVE
5.	STABILITY OF CONDITIONS	Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable—(fluctuating, precarious, or deteriorating)	a.
		Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem	b.
		End-stage disease, 6 or fewer months to live	c.
		NONE OF ABOVE	d.

Numeric Identifier \_\_\_\_\_

### SECTION M. SKIN CONDITION

1.	ULCERS	(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9 = 9 or more.) [Requires full body exam.]	Number at Stage
	(Due to any cause)		
	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.		
2.	TYPE OF ULCER	(For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4)	
	a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue		
	b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities		
3.	HISTORY OF RESOLVED ULCERS	Resident had an ulcer that was resolved or cured in LAST 90 DAYS	
		0. No 1. Yes	
4.	OTHER SKIN PROBLEMS OR LESIONS PRESENT	(Check all that apply during last 7 days)	
	Abrasions, bruises		a.
	Burns (second or third degree)		b.
	Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions)		c.

Resident \_\_\_\_\_

Numeric Identifier \_\_\_\_\_

## MINIMUM DATA SET (MDS) — VERSION 2.0 FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING FULL ASSESSMENT FORM

(Status in last 7 days, unless other time frame indicated)

### SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1.	<b>RESIDENT NAME</b>				
		a. (First)	b. (Middle Initial)	c. (Last)	d. (Jr/Sr)
2.	<b>ROOM NUMBER</b>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>			
3.	<b>ASSESSMENT REFERENCE DATE</b>	a. Last day of MDS observation period <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/>  Month                 </div> <div style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/>  Day                 </div> <div style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>  Year                 </div> </div> b. Original (0) or corrected copy of form (enter number of correction)			
4a.	<b>DATE OF REENTRY</b>	Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days)  <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/>  Month                 </div> <div style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/>  Day                 </div> <div style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>  Year                 </div> </div>			
5.	<b>MARITAL STATUS</b>	1. Never married      3. Widowed      5. Divorced 2. Married              4. Separated			
6.	<b>MEDICAL RECORD NO.</b>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>			
7.	<b>CURRENT PAYMENT SOURCES FOR N.H. STAY</b>	(Billing Office to indicate; check all that apply in last 30 days)			
	Medicaid per diem	a.	VA per diem	t.	
	Medicare per diem	b.	Self or family pays for full per diem	g.	
	Medicare ancillary part A	c.	Medicaid resident liability or Medicare co-payment	h.	

3.	<b>MEMORY/ RECALL ABILITY</b>	(Check all that resident was normally able to recall during last 7 days) Current season: <input style="width: 20px; height: 20px;" type="text"/> a. Location of own room: <input style="width: 20px; height: 20px;" type="text"/> b. Staff names/faces: <input style="width: 20px; height: 20px;" type="text"/> c.					
		That he/she is in a nursing home NONE OF ABOVE are recalled			d.	e.	f.
4.	<b>COGNITIVE SKILLS FOR DAILY DECISION-MAKING</b>	(Made decisions regarding tasks of daily life) 0. INDEPENDENT—decisions consistent/reasonable 1. MODIFIED INDEPENDENCE—some difficulty in new situations only 2. MODERATELY IMPAIRED—decisions poor; cues/supervision required 3. SEVERELY IMPAIRED—never/rarely made decisions					
5.	<b>INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/AWARENESS</b>	(Code for behavior in the last 7 days. [Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time].) 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)					
		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)					



# Contact Information

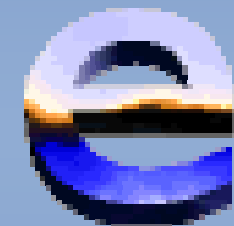
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