Quality Measure	QRP Type	Definition/Cause of Trigger/ and/or MDS Section	Risk Adjustments/ covariates	Interventions, Ideas and Approaches
Discharge to Community	Claims Based	Assesses successful discharge to the community from a Post Acute Care setting, with successful discharge to the community including no unplanned rehospitalizations and no death in the 31 days following discharge from SNF . Community, for this measure, is defined as home or self-care, with or without home health services, based on Patient Discharge Status Codes [01, 06, 81, 86] on the Medicare FFS claim .	Age/Gender Principal Dx(acute stay based) Ventilator Use in SNF Original Reason for Entitlement Surgical Categories based on Prior Acute Stay Dialysis (Acute Stay where End-Stage Renal Disease not Indicated) End-Stage Renal Disease Prior Acute Length of Stay Comorbidities Number of Hospital Stays in Past Year (Excluding Most Recent Stay)	Evaluation of barriers to DC upon admission Expand Social Services Resources and support in community Maximizing Functional Mobility and ADL Retraining to Prior Level of Function Fall Recovery Training Home assessment and environmental adaptation Proper assessment of barriers and support systems in the home that may lead to re-hospitalization Education on Medical condition and disease process and Education on signs of medical instability Medication Teaching/Training Reconciliation of Medication Care Navigation and management of Transitions Warm Hand offs to Home Care /Outpatient Consistent follow up calls, reporting, texts and visits
	DTC exclusions	*Under the age of 18 at start of stay *Was not discharge from an acute care facility within 30 days prior to SNF admission *Discharged from SNF AMA *Discharged from SNF to psychiatric hospital, another SNF, federal hospital, disaster alternative care site, or court/law enforcement *Had a long term nursing home stay in the 180 days preceding prior proximal hospitalization and not discharged to community from that stay	*Discharged from SNF to Hospice, or has a hospice benefit period that overlaps with the 31-day post SNF discharge window *Beneficiary was not continuously enrolled in Medicare Part A for at least 365 days prior to SNF admission and at least 31 days post SNF discharge *Discharge from acute care facility to SNF within 30 days but stay was for non-surgical treatment of cancer *SNF stays with problematic/incomplete data e.g. stays cannot be matched with Medicare enrollment data, claims with zero utilization days or if the beneficiary exhausted Medicare part A benefits during the stay	
Potentially Preventable <u>30-Day Post-Discharge</u> Readmission Measure	Claim Based	Reports a SNF's risk-standardized rate of Medicare FFS beneficiaries who are discharged following a SNF stay, bit experience a potentially preventable readmission to either an acute care hospital or long term care hospital in the 31 days following discharge.	Age/Gender Original Reason for Medicare Entitlement Surgery Category (if present) Dialysis (acute stay) Principal Dx (acute stay) Co-morbidities (acute stay) LOS prior hospitalization Prior Acute ICU/CCU days Number of Hospital Stays in Past Year (Excluding Most Recent Stay)	Evaluation of barriers to DC upon admission Expand Social Services Resources and support in community Maximizing Functional Mobility and ADL Retraining to Prior Level of Function Fall Recovery Training Home assessment and environmental adaptation Proper assessment of barriers and support systems in the home that may lead to re-hospitalization Education on Medical condition and disease process and Education on signs of medical instability Medication Teaching/Training Reconciliation of Medication Care Navigation and management of Transitions Warm Hand offs to Home Care /Outpatient Consistent follow up calls, reporting, texts and visits
	PPR-PD exclusions	*Under the age of 18 at start of stay *Was not discharge from an acute care facility within 30 days prior to SNF admission *Discharged from SNF AMA *Discharged from SNF to IP psychiatric hospital, short term ACH, LTCH, or a federal hospital	*Beneficiary was not continuously enrolled in Medicare Part A for at least 365 days prior to SNF admission and at least 31 days post SNF discharge *Discharge from acute care facility to SNF within 30 days but stay was for pregnancy or non-surgical treatment of cancer *Beneficiary died during the stay *SNF stays with problematic/incomplete data e.g. stays cannot be matched with Medicare enrollment data, claims with zero utilization days or if the beneficiary exhausted Medicare part A benefits during the stay	

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MSPB (Medicare Spending Per Beneficiary)	Claims Based	Evaluates SNF resource use relative to the resource use of the national median of all SNF providers. Specifically, the measure assesses the Medicare spending performed by the SNF provider and other healthcare providers during a Medicare Spending Per Beneficiary (MSPB) - Post-Acute Care episode during SNF stay and 30 days post SNF discharge (Med A and Med B)	HCC Codes Age ESRD Clinical Complexity (CMI) during recent acute stay Hospice utilization during episode LOS prior hospitalization Prior Acute ICU/CCU days	Medication Cost Review prior to Admission Review of Consults during stay Review of Medication Cost during stay Utilization Review discussion Treat in Place Protocol
	MSPB exclusions	*planned hospital admissions *routine management of certain preexisting chronic conditions (e.g. dialysis for ESRD, tx for preexisting cancer) *Some Routine screening and healthcare maintenance (colonoscopies and mammograms)	*any episode where beneficiary has primary payor other than Medicare for any part of 90-day look back period plus episode window *immune-modulating medications (e.g. immunosuppressants for organ transplant or RA)	
SNF Healthcare-Associated Infections (SNF-HAI)	Claims Based Outcome Measure	Facility level, one-year outcomes that measure that estimate the risk-standardized rates of HAIs that are acquired during SNF care and result in hospitalization. Reports a variety of HAI as a singular rate with infection severity indicated by infections that require hospitalization. Identified using principal diagnosis of Medicare inpatient claims Incubation period: HAI must occur during period beginning on day 4 after SNF admission and within three days of SNF discharge	Age/Gender Original reason form Medicare entitlement IP stay surgery category IP stay dialysis treatment (excludes ESRD) IP stay principal diagnosis category IP LOS Comorbidities IP stay utilization of ICU/CCU Number of IP stays within 365 day look back	Stop and watch Early detection Treat in Place Protocols Clinical Reports (CNA to CNA, CNA to nurse, Nurse to nurse) for changes in condition Routine Education UR Discussion
	SNF-HAI exclusions	*Emergency room visits *Observation stays * SNF LOS shorter than 4 days *Beneficiary under 18 years of age at start of stay *14 day repeat infection timeframe to exclude infections preexisting to SNF stay	*Beneficiary was not continuously enrolled in Medicare Part A for at least 365 days prior to measure period, and three days after end of SNF stay *Beneficiary did not have a Part A short-term ACH stay within 30 days riot to the SNF admission date *Medicare did not pay for SNF stay	

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Falls with Major Injury	Assessment Based	Percentage of patient/resident stays of Medicare Part A stays where one or more falls with major injury were reported during the SNF stay. Includes at least 1 fall with: - Bone fracture - Joint dislocation - Closed head injury with altered consciousness - Subdural hematoma (J1900C= 1,2)	***Exclusions*** J1800 = [-] The assessment indicated that a fall occurred; J1800 = [1] AND the number of falls with major injury was not assessed; i.e., J1900C = [-] **Covariates:** None	Assessment for at risk Assessment of Medical Condition/ and vitals Pain Management Behavior/Cognitive Management Sensation/Vision/Hearing treatment Toileting and Incontinence Management Proper Environmental Adaptation- Modification of Room to allow resident to be independent and set up with the safest solution Preventative intervention review Recreation Programming SimpleLTC Analytics and Analyzer Review SNF QRP Quality measure resident level characteristics & Verify triggering residents
Changes in Skin Integrity: Pressure Ulcer/Injury	Assessment Based	Percentage of Medicare Part A SNF Stays with Stage 2-4 pressure ulcers, or unstageable pressure ulcers due to slough/eschar, non-removable dressing/device, or deep tissue injury, that werenot present or at a lesser stage at the time of admission as indicated on end of pps MDS.	***Exclusions*** 1. Data on new or worsened Stage 2, 3, 4, and unstageable pressure ulcers, including deep tissue injuries, are missing [-] at discharge, i.e.: (M0300) 2. The resident died during the SNF Part A stay **Covariates** 1. Functional Mobility Admission Performance: 2. Bowel Incontinence: 3. Peripheral Vascular Disease / Peripheral Arterial Disease or Diabetes Mellitus 4. Low body mass index, based on height and weight	Identification of at risk MD Consult Accurate Wound Staging upon admission Effective Wound Treatment and timely changes Interdisciplinary wound rounds Preventative measures day 1 of admission: appropriate mattress, positioning and devices Moisture Barriers Nutrition and Hydration Management Bowel and Bladder Training and Toileting Schedules PT/OT Referral Modality Treatment- ACP Consistent body audit procedure for early intervention of reddened areas- color, temperature and sensation assessment SimpleLTC Analytics and Analyzer Review SNF QRP Quality measure resident level characteristics & Verify triggering residents
Transfer of Health information to Provider	Assessment Based	The percentage of Medicare Part A stays indicating a current reconciled medication list was transferred to the subsequent provider at the time of discharge. For residents with multiple stays during the reporting period, each stay is eligible for inclusion. MDS section A2121	***Exclusions:*** Type 2 SNF Stay (PPS 5-day with a matched DIF record)	Review of facility processes for transfer of reconciled medication list for both planned and unplanned discharges Review of SNF Facility level QRP report QAPI/PIP Validation of MDS coding

Quality Measure	QRP Type	Definition/Cause of Trigger/ and/or MDS Section	Risk Adjustments/ covariates	Interventions, Ideas and Approaches
Transfer of Health Information to Patient	Assessment Based	The percentage of Medicare Part A SNF stays indicating a current reconciled medication list was transferred to the resident/family, and or caregiver at the time of discharge. For residents with multiple stays during the reporting period, each stay is eligible for inclusion. MDS section A2123	***Exclusions:*** Type 2 SNF Stay (PPS 5-day with a matched DIF record)	Review of facility processes for transfer of reconciled medication list Review of SNF Facility level QRP report QAPI/PIP Validation of MDS coding
Drug Regimen Review	Assessment Based	Percentage of Medicare Part A SNF Stays in which a drug regimen review was conducted at the time of admission and timely follow-up with a physician occurred each time potential clinically significant medication issues were identified throughout the stay. N2001, N2003, & N2005	DIF during Skilled stay (5D pps with a matched DIF)	SimpleLTC Analytics and Analyzer Review SNF QRP Quality measure resident level characteristics & Verify triggering residents Casper report: assessment with error # 3897 Consistent documentation of reviews and results
Covid-19 Vaccine: Percent of Patients who are up to date	Assessment Based	The Percentage of Medicare Part A SNF Stays in which residents are "up to date" with their Covid-19 vaccinations per the CDC's latest guidance. *The definition of up to date" may change based on the CDC's latest guidance. MDS Section O0350	None	Review of facility process for obtaining vaccination information on admission Review of SNF QRP Facility Level Report Educate and encourage Vaccination flyers Vaccination discussions Involve PCP

Quality Measure	QRP Type	Definition/Cause of Trigger/ and/or MDS Section	Risk Adjustments/ covariates	Interventions, Ideas and Approaches
Discharge Mobility Score	Assessment Based	Estimates the percentage of Medicare Part A SNF Stays that meet or exceed an expected discharge mobility score. GG items Utilized: Roll left and right, Sit to lying, Lying to sitting on side of bed, sit to stand, chair/bed to chair transfer, toilet transfer, car transfer, walk 10 feet walk 50 feet with 2 turns, walk 150 feet, walking 10 feet on uneven surfaces, 1 step (curb), 4 steps, 12 steps, picking up object, *wheel 50 feet with 2 turns and wheel 150 feet if walk 10 feet on admit and d/c is ANA	**Exclusions** 1.The Medicare Part A SNF Stay was an incomplete stay 2. The resident has the following medical conditions: a. Coma, persistent vegetative state, complete tetraplegia, locked-in syndrome, severe anoxic brain damage, cerebral edema or compression of brain. 3. The resident is younger than age18 4. The resident is discharged to hospice or received hospice while a resident: **Covariates:** 1. Age group 2. Admission mobility score – continuous score 3. Admission mobility score – squared form 4. Primary medical condition category 5. Interaction between primary medical condition category and admission mobility score 6. Prior surgery 7. Prior functioning: indoor mobility (ambulation) 8. Prior functioning: stairs 9. Prior functioning: functional cognition 10. Prior mobility device use 11. Stage 2 pressure ulcer 12. Stage 3, 4, or unstageable pressure ulcer/injury 13. Cognitive abilities 14. Communication impairment 15. Urinary Continence 16. Bowel Continence 17. Tube feeding or total parenteral nutrition 18. History of falls 19. Comorbidities	PT/OT/SLP services Additional RNA/FMP Programming Care giver training Home Exercise Program Training to complete in Room Education of staff to encourage independence with ADLs and mobility with self-care and mobility Recreation Programming with emphasis on return to home skills and physical exercise Review of Section GG Utilization Review discussions Review of clinical factors e.g. pain, depression

Quality Measure	QRP Type	Definition/Cause of Trigger/ and/or MDS Section	Risk Adjustments/ covariates	Interventions, Ideas and Approaches
Discharge Self Care Score	Assessment Based	Estimates the percentage of Medicare Part A SNF Stays that meet or exceed an expected discharge self-care score MDS GG Self care items: Eating, Oral Hygiene, Toileting Hygiene, Shower/Bathe Self, Upper Body Dressing, Lower Body Dressing, Putting on/taking off footwear	**Exclusions** 1.The Medicare Part A SNF Stay was an incomplete stay 2. The resident has the following medical conditions: a. Coma, persistent vegetative state, complete tetraplegia, locked-in syndrome, severe anoxic brain damage, cerebral edema or compression of brain. 3. The resident is younger than age 18 4. The resident is discharged to hospice or received hospice while a resident **Covariates:** 1. Age group 2. Admission self-care score – continuous score 3. Admission self-care score – squared form 4. Primary medical condition category 5. Interaction between primary medical condition category and admission self-care score 6. Prior surgery 7. Prior functioning: self-care 8. Prior functioning: indoor mobility (ambulation) 9. Prior mobility device use 10. Stage 2 pressure ulcer 11. Stage 3, 4, or unstageable pressure ulcer/injury 12. Cognitive abilities 13. Communication Impairment 14. Urinary Continence 15. Bowel Continence 16. Tube feeding or total parenteral nutrition 17. Comorbidities	PT/OT/SLP services Additional RNA/FMP Programming Care giver training Home Exercise Program Training to complete in Room Education of staff to encourage independence with ADLs and mobility with self-care and mobility Recreation Programming with emphasis on return to home skills and physical exercise Review of Section GG Utilization Review discussions Review of clinical factors e.g. pain, depression

Quality Measure	QRP Type	Definition/Cause of Trigger/ and/or MDS Section	Risk Adjustments/ covariates	Interventions, Ideas and Approaches
Discharge Function Score		The Percentage of Medicare Part A SNF Stays that meet or exceed an expected discharge function score. If multiple Part A stays during the target 12 months, then all stays are included. GG items used for calculations: Eating Oral Hygiene Toileting Hygiene Roll left and right Lying to sitting on side of bed Sit to stand Chair/bed to chair transfer Toilet transfer Walk 10 feet* Walk 50 feet with 2 turns* Wheel 50 feet with 2 turns* *Count wheel 50 feet with 2 turns value twice if Walk 10 feet is activity not attempted code on both admission and discharge.	**Exclusions** 1.The Medicare Part A SNF Stay was an incomplete stay (unplanned discharge, stay less than 3 days, DIF) 2. The resident has the following medical conditions: a. Coma, persistent vegetative state, complete tetraplegia, locked-in syndrome, severe anoxic brain damage, cerebral edema or compression of brain. 3. The resident is younger than age 18 4. The resident is discharged to hospice or received hospice while a resident **Covariates:** 1. Age group 2. Admission function – continuous score 3. Admission function – squared form 4. Primary medical condition category 5. Interaction between primary medical condition category and admission function 6. Prior surgery 7. Prior functioning: self-care 8. Prior functioning: indoor mobility (ambulation) 9. Prior function: stairs 10. Prior functioning: functional cognition 11. Prior mobility device use 12. Stage 2 pressure ulcer 13. Stage 3, 4, or unstageable pressure ulcer/injury 14. Cognitive abilities 15. Communication Impairment 16. Urinary Continence 17. Bowel Continence 18. History of falls 19. Nutritional approaches 20. High BMI 21. Low BMI 22: Comorbidities 23. no PT or OT at admission	PT/OT/SLP services Additional RNA/FMP Programming Care giver training Home Exercise Program Training to complete in Room Education of staff to encourage independence with ADLs and mobility with self-care and mobility Recreation Programming with emphasis on return to home skills and physical exercise Review of Section GG Utilization Review discussions Review of clinical factors e.g. pain, depression Communication of expected discharge function score Facility process for updating of tasks during stay

Quality Measure	QRP Type	Definition/Cause of Trigger/ and/or MDS Section	Risk Adjustments/ covariates	Interventions, Ideas and Approaches
Influenza Vaccination Coverage among Healthcare Personnel	NHSN process measure	Identifies the percentage of HCP who receive the influenza vaccination among the total number of HCP in the facility for at least one working day between 10/1 and 3/31 of the following year, regardless of clinical responsibility or patient contact. Summary in NHSN MUST be completed and submitted annually by May 15	none	Ensure annual submission is completed Have a back up plan for submission Educate and encourage Vaccination flyers Vaccination discussions Confirm data submission
Covid-19 Vaccination Coverage among Healthcare Personnel	NHSN process measure	Identifies the percentage of HCP eligible to work in the SNF setting for at least one day during the reporting period, who are considered up to date, regardless of clinical responsibility or patient contact. Weekly reporting	HCP who were determined to have a medical contraindication	Ensure submission weekly Have a back up plan for submission Educate and encourage Be aware of what Up to date means Vaccination flyers Vaccination discussions