Skilled Nursing Facility Quality Reporting Program (SNF QRP)

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Agenda

- Overview of IMPACT Act of 2014 and SNF QRP

- SNF QRP Policy Overview

- SNF QRP Quality Measures

- SNF QRP Resources

Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

- Bipartisan bill passed on September 18, 2014 and signed into law by President Obama on October 6, 2014

- Requires standardized patient assessment data across post-acute care (PAC) settings that will enable:
  - Quality care and improved outcomes
  - Data element uniformity
  - Comparison of quality and data across PAC settings
  - Improved, person-centered, goal-driven discharge planning
  - Exchangeability of data
  - Coordinated care

https://www.gpo.gov/fdsys/pkg/BILLS-113hr4994enr/pdf/BILLS-113hr4994enr.pdf

Driving Forces of the IMPACT Act

- **Purposes include:**
  - Improvement of Medicare beneficiary outcomes
  - Provider access to longitudinal information to facilitate coordinated care
  - Enable comparable data and quality across PAC settings
  - Improve hospital discharge planning
  - Research to enable payment models based on patient characteristics

- **Why the attention on Post-Acute Care:**
  - Escalating costs associated with PAC
  - Lack of data standards/interoperability across PAC settings
  - Goal of establishing payment rates according to the individual characteristics of the patient, not the care setting

Applicable PAC settings

Long-Term Care Hospital (LTCH)

Services provided: Inpatient services include rehabilitation, respiratory therapy, pain management, and head trauma treatment.

No. of Facilities: **420**	**LTCH CARE** – LTCH Continuity Assessment Record and Evaluation (CARE) Data Set submissions: **76K**
Average length of stay: **26** days	
No. of Beneficiaries: **124k**	Medicare spending: **$5.5** billion

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html

Inpatient Rehabilitation Facility (IRF)

Services provided: Intensive rehabilitation therapy including physical, occupational, and speech therapy.

No. of Facilities: **1,166**	**IRF-PAI** – IRF-Patient Assessment Instrument (PAI) submissions: **492k**
Average length of stay: **13** days	
No. of Beneficiaries: **373k**	Medicare spending: **$6.7** billion

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html

Home Health Agency (HHA)

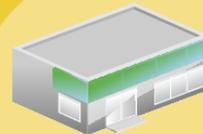**Services provided:** Skilled nursing or therapy services provided to Medicare beneficiaries who are homebound.

No. of Facilities: **12,311**	**OASIS:** Outcome and Assessment Information Set (OASIS) submissions: **35 million**
No. of Beneficiaries: **3.4** million	Medicare spending: **$18** billion

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html

Nursing Homes

Services provided: Short-term Skilled nursing and rehabilitation services to individuals whose health problems are too severe or complicated for home care or assisted living.

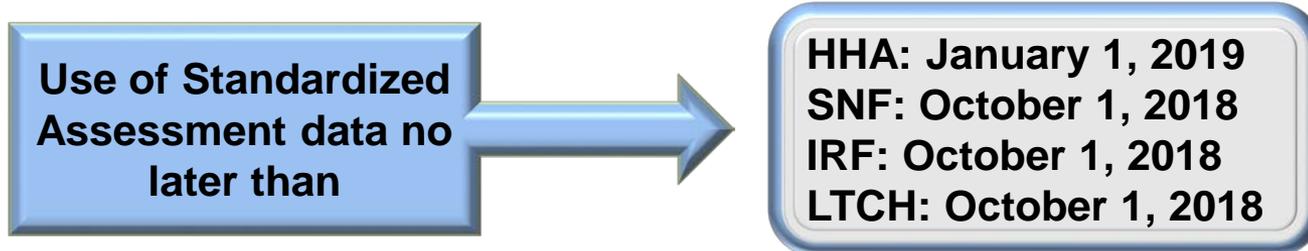|	
No. of Facilities: **15,000**	**MDS** – Minimum Data Set submissions: **20 million**
Average length of stay: **39** days	
Beneficiaries: **1.7** million	Medicare spending: **$28.7** billion

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html

IMPACT Act: Standardized Patient Assessment Data

- **Requirements for reporting assessment data:**
  - Providers must submit standardized assessment data through PAC assessment instruments under applicable reporting provisions
  - The data must be submitted with respect to admission and discharge for each resident, or more frequently as required

Use of Standardized Assessment data no later than	→	HHA: January 1, 2019 SNF: October 1, 2018 IRF: October 1, 2018 LTCH: October 1, 2018

- **Data categories:**
  - Functional status, Cognitive function and mental status, Special services, treatments, and interventions, Medical conditions and co-morbidities, Impairments, Other categories required by the Secretary

IMPACT Act Quality Measure Domains

- Functional status, cognitive function, and changes in function and cognitive function

- Skin integrity and changes in skin integrity

- Medication reconciliation

- Incidence of major falls

- Communicating the existence of and providing for the transfer of health information and care preferences

IMPACT Act Resource Use and Other Measures

- Resource use and other measures will be specified for reporting, which may include standardized assessment data in addition to claims data.

- Resource use and other measure domains include:
  - Total estimated Medicare spending per beneficiary
  - Discharge to community
  - Measures to reflect all-condition risk-adjusted potentially preventable hospital readmission rates

SNF Quality Reporting Program

- In response to the reporting requirements under the Act, CMS established the SNF Quality Reporting Program (QRP) and its quality reporting requirements in the FY 2016 SNF Prospective Payment System (PPS) final rule.
- Per the statute, SNFs that do not submit the required quality measures data may receive a two percentage point reduction to their annual payment update (APU) for the applicable payment year.
- **This program is effective October 1, 2016**.
- For more information regarding the SNF QRP, please visit our page under construction:
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html

SNF QRP Policy Overview

Sharon Lash, CMS

SNF QRP Policies Finalized in SNF PPS FY 2016 Final Rule

1. Participation/timing for new SNFs

2. Data collection timelines and requirements for the FY 2018 payment determination and subsequent years

3. Data completion threshold

4. Exception and Extension requirements

5. Reconsideration and Appeals procedures

6. Public display of quality data

SNF QRP Policies Finalized in SNF PPS FY 2016 Final Rule (continued)

1. **Participation/Timing for New SNFs**

    - A new SNF would be required to begin reporting data on any quality measures finalized for that program year by no later than the first day of the calendar quarter subsequent to 30 days after the date on its CMS Certification Number (CCN) notification letter.

    - For example, if a SNF received its CCN on August 28, 2016, and 30 days are added (for example, August 28 + 30 days = September 27), the SNF would be required to submit data for residents who are admitted beginning on October 1, 2016.

SNF QRP Policies Finalized in SNF PPS FY 2016 Final Rule (continued)

2. **Data collection timelines and requirements for the FY 2018 payment determination and subsequent years**

   - FY 2018 payment determination will be based on one quarter of data from 10/1/16 to 12/31/16.

Payment Determination Affected	Data Collection Period	Data Submission Deadline
FY 2018	10/1/16-12/31/16	5/15/17

SNF QRP Policies Finalized in SNF PPS FY 2016 Final Rule (continued)

2. **Data collection timelines and requirements for the FY 2018 payment determination and subsequent years** (continued)

    - SNFs currently submit MDS 3.0 data to CMS through the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system.

    - The October 1, 2016 implementation of the SNF QRP will **not** change the process of MDS 3.0 data submission through QIES.

SNF QRP Policies Finalized in SNF PPS FY 2016 Final Rule (continued)

2. **Data collection timelines and requirements for the FY 2018 payment determination and subsequent years** (continued)

- However, there are two major changes to the MDS 3.0 effective October 1, 2016:

  – Additional MDS submission**,** the **Part A PPS Discharge Assessment**

  – Addition of **Section GG**

SNF Part A PPS Discharge Assessment

- The Part A PPS Discharge assessment is a Discharge assessment developed to inform current and future SNF QRP measures and the calculation of these measures.

- It consists of demographic, administrative, and clinical items.

- The Part A PPS Discharge assessment is completed when a resident's Medicare Part A stay ends, but the resident remains in the facility (i.e., is not physically discharged from the facility).

- If the Medicare Part A stay ends on the day of or one day before the date of physical discharge, the OBRA Discharge assessment and Part A PPS Discharge assessment are both required and may be combined.

SNF QRP Policies Finalized in SNF PPS FY 2016 Final Rule (continued)

3. **Data completion threshold**

    - Beginning with the FY 2018 payment determination, SNFs must report all of the data necessary to calculate the quality measures on at least 80% of the MDS assessments that they submit.

    - A SNF is compliant with the QRP if all of the data necessary to calculate the measures has been submitted to fully calculate the quality measures.

    - A measure cannot be calculated, for example, when the use of a dash [-], indicates that the SNF was unable to perform a pressure ulcer assessment.

SNF QRP Policies Finalized in SNF PPS FY 2016 Final Rule (continued)

4. **Exception and Extension requirements**

    - Our experience with other QRPs has shown that there are times when providers are unable to submit quality data due to extraordinary circumstances beyond their control (for example, natural, or man-made disasters).

    - A SNF may request an exception or extension for the SNF QRP within 90 days of the date that the extraordinary circumstances occurred.

SNF QRP Policies Finalized in SNF PPS FY 2016 Final Rule (continued)

4. **Exception and Extension requirements** (continued)

- The SNF may request an exception or extension by submitting a written request to CMS via email to the SNF Reconsideration mailbox. This mailbox will be activated when the QRP is implemented: SNFQRPReconsiderations@cms.hhs.gov.

- Information to include in these request can be found:

  https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-QR-Reconsideration-and-Exception-and-Extension.html

SNF QRP Policies Finalized in SNF PPS FY 2016 Final Rule (continued)

5. **Reconsideration and Appeals procedures**

    - If a SNF is found noncompliant with FY 2018 requirements, they can request reconsideration.

    - SNFs may file for reconsideration if they believe that the finding of noncompliance is in error.

SNF QRP Policies Finalized in SNF PPS FY 2016 Final Rule (continued)

5. **Reconsideration and Appeals procedures** (continued)

- The SNF may request reconsideration by submitting a written request to CMS via email to the SNF Reconsideration mailbox. This mailbox will be activated when the QRP is implemented: SNFQRPReconsiderations@cms.hhs.gov.

- Information to include in these request can be found:

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-QR-Reconsideration-and-Exception-and-Extension.html

SNF QRP Policies Finalized in SNF PPS FY 2016 Final Rule (continued)

6. **Public display of quality data**

    - Public reporting of SNF QRP quality data is scheduled to begin in fall 2018 per the IMPACT Act, Section 1899B(g)(1).

    - Public reporting will include a period for review and correction of quality data prior to the public display of SNF performance data.

SNF QRP Quality Measures

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SNF QRP Quality Measures Overview

- In the FY 2016 SNF PPS final rule, 3 quality measures affecting FY 2018 payment determination were finalized for adoption into the SNF QRP.

- All 3 of these quality measures use assessment data from the MDS.

- The following slides present basic information about the specifications for these quality measures. Information about item coding is not included in this presentation.

SNF QRP Quality Measures Overview

- For more information about quality measure (QM) calculation and MDS items included in calculation, see the document titled, *SNF QRP- Specifications for the Quality Measures Adopted through the FY 2016 Final Rule*

  https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-QRP-Measure-Specifications_August-2015R.pdf

Application of Percent of Residents Experiencing One of More Falls with Major Injury (Long Stay) (NQF #0674)

MLN Connects®

Application of Percent of Residents Experiencing One of More Falls with Major Injury (Long Stay)

- This QM is intended for use as a cross-setting measure to meet the requirements of the IMPACT Act of 2014 addressing the domain of major falls.

- This QM reports the percentage of resident Medicare Part A stays where one or more falls with major injury (defined as bone fractures, joint dislocations, closed head injuries with altered consciousness, or subdural hematoma) occurred during the SNF stay.

Application of Percent of Residents Experiencing One of More Falls with Major Injury (Long Stay)

- **Medicare Part A Stay:** The period of time between the start of a resident's Medicare Part A covered stay defined by a start date (A2400B) and an end date (A2400C).
  - The stay is identified by a 5-day PPS assessment and an associated discharge (which may be standalone SNF Part A PPS Discharge or a Part A PPS Discharge combined with an OBRA Discharge).

Application of Percent of Residents Experiencing One of More Falls with Major Injury (Long Stay)

Numerator

Denominator

=

The number of resident Medicare Part A stays with one or more look-back scan assessments that indicate one or more falls that resulted in major injury (J1900C=[1,2])

The number of resident Medicare Part A stays with one or more assessments that are eligible for a look-back scan except those with exclusions

Application of Percent of Residents Experiencing One of More Falls with Major Injury (Long Stay)

- Assessments eligible for inclusion in the look-back scan:
    - OBRA Discharge
    - PPS 5-, 14-, 30-, 60-, 90-day
    - SNF Part A PPS Discharge assessment
    - OBRA Admission, Quarterly, Annual, or Significant Change/Correction assessments

Application of Percent of Residents Experiencing One of More Falls with Major Injury (Long Stay)

- **SNF Denominator Exclusions:** Resident Medicare Part A stay is excluded if none of the assessments that are included in the look-back scan has a usable response for items indicating the presence of a fall with major injury during the selected time window (i.e., information on falls with major injury is missing [J1900C = (-)] on all assessments used during a resident's stay during the selected time window).

- **SNF Risk Adjustment:** This measure is not risk-adjusted or stratified.

Percent of Patients or Residents with Pressure Ulcers that are New or Worsened (NQF #0678)

Percent of Patients or Residents with Pressure Ulcers That Are New or Worsened

- This QM is adopted as a cross-setting measure to meet the requirements of the IMPACT Act of 2014 addressing the domain of skin integrity and changes in skin integrity.

- This measure is intended to encourage PAC providers to prevent pressure ulcer development or worsening, and to closely monitor and appropriately treat existing pressure ulcers.

Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (continued)

Numerator

Denominator

$=$

The number of short-stay residents with an MDS 3.0 Assessment during the selected time window who have one or more Stage 2–4 pressure ulcers that are new or worsened

The number of short-stay residents with one or more MDS 3.0 Assessments that are eligible for a look-back scan (except those with exclusions)
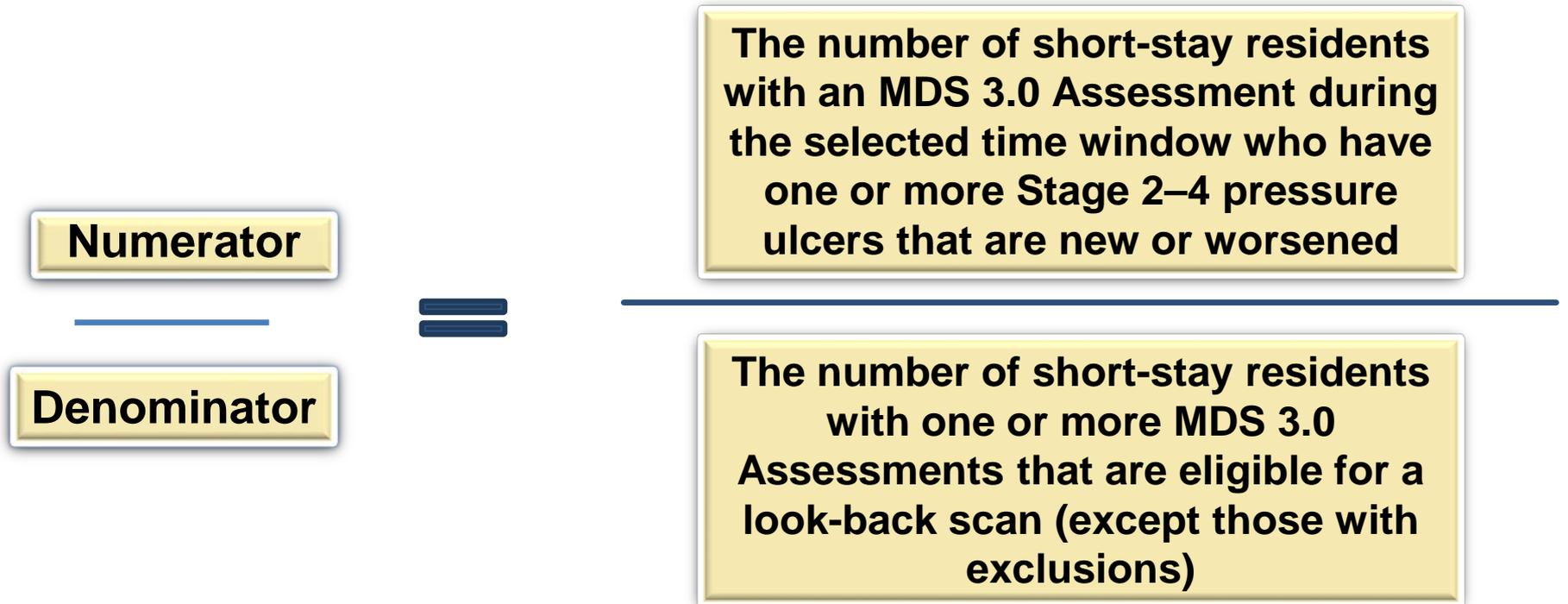
Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (continued)

- **New or worsened pressure ulcers** are determined based on examination of all assessments in a resident's episode for reports of Stage 2–4 pressure ulcers that were not present or were at a lesser stage on admission

Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (continued)

SNF Denominator Exclusions

1. If missing data on items used to calculate the measure
2. If there is no initial assessment available to derive data for risk adjustment (covariates).

Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (continued)

SNF Risk Adjustment

- Is used to account for the medical and functional complexity of the residents.
- Based on resident characteristics or covariates
- Characteristics or conditions were selected that put residents at increased risk for skin breakdown or impact ability to heal

Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (continued)

SNF Risk Adjustment Covariates:

1. Limited or more assistance in bed mobility self-performance dependence on the initial assessment.
2. Bowel incontinence at least occasionally on the initial assessment.
3. Have diabetes or peripheral vascular disease on initial assessment.
4. Low Body Mass Index (BMI)

Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631)

Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function

- CMS has adopted this measure to satisfy the IMPACT Act requirements for CMS to specify QMs and PAC providers to report standardized data regarding functional status, cognitive function, and changes in function and cognitive function.

- This QM reports the percent of residents with an admission and a discharge functional assessment and at least one goal that addresses function.

Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function

Numerator

Denominator

=

The number of Medicare Part A covered resident stays with functional assessment data for each self-care and mobility activity and at least one self-care or mobility goal

The number of Medicare Part A covered resident stays
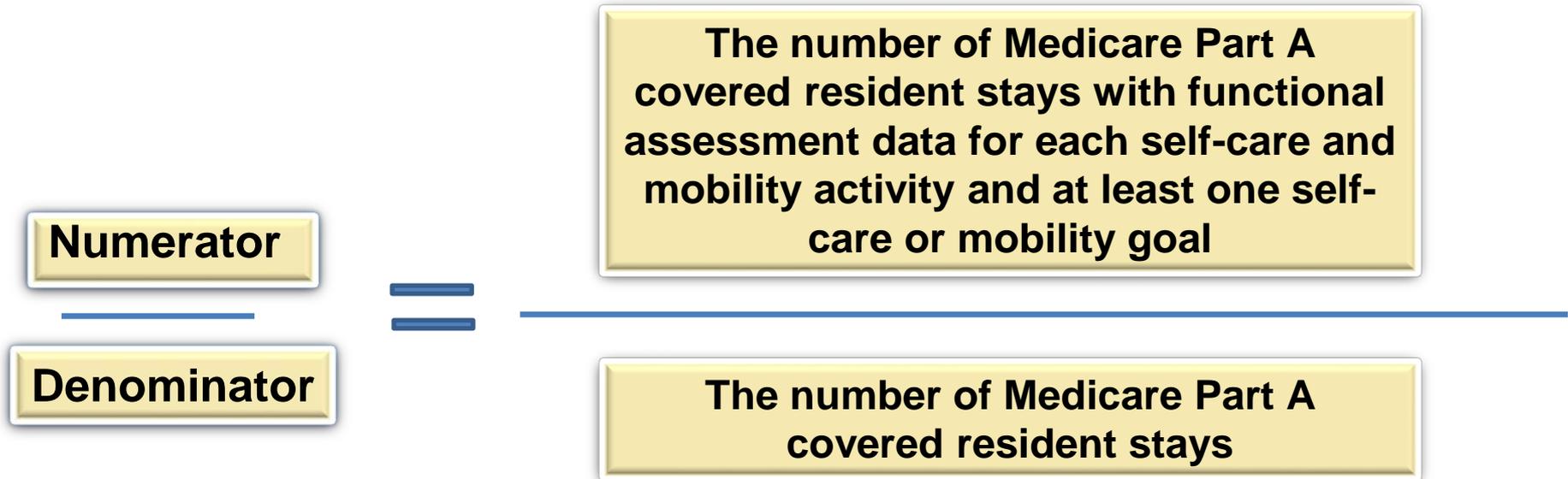
Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function

- When a resident has an incomplete stay, collection of discharge functional status data might not be feasible.

- For residents with incomplete stays, admission functional status data and at least one treatment goal would be required, discharge functional status data would not be required to be reported.

Incomplete and Complete Stays

- Residents who have **incomplete stays** are defined as those residents:
  - With incomplete stays due to a medical emergency,
  - Who leave the SNF against medical advice, or
  - Who die while in the SNF.
- All residents not meeting the criteria for incomplete stays will be considered **complete stays**.

Risk Adjustment

- This measure is not risk adjusted.

Section GG

- The IMPACT Act requires that CMS implement cross-setting quality measures, and the Section GG items which are used to calculate this measure were developed and tested for use in PAC settings.

- These items assess the need for assistance with self-care and mobility activities.

- Items focus on resident's self-care and mobility:
  - Admission performance
  - Discharge (end of SNF stay) goals
  - Discharge (end of SNF stay) performance

Section GG Items- Rationale

- **GG0130. Self-Care:** During a Medicare Part A stay, residents may have self-care limitations on admission. In addition, residents may be at risk of further functional decline during their stay in the SNF.

- **GG0170. Mobility:** Residents in Medicare Part A stays may have mobility limitations on admission. In addition, residents may be at risk of further functional decline during their stay in the SNF.

GG0130. Self-Care- Admission (Start of SNF PPS Stay)

GG0130. Self-Care (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B)
Complete only if A0310B = 01

Code the resident's usual performance at the start of the SNF PPS stay for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay, code the reason. Code the patient's end of SNF PPS stay goal(s) using the 6-point scale.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.

05. **Setup or clean-up assistance** - Helper SET~~~~ ~S UP; resident com~~~~tes activity. He~

assist~~~~ ~following t~

If activity was not attempted, code reason:

07. **Resident refused.**

09. **Not applicable.**

Not attempted due t~ ~dical

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
▢▢	▢▢	**A. Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.
▢▢	▢▢	**B. Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]
▢▢	▢▢	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. If managing an ostomy, include wiping the opening but not managing equipment.

GG0130. Self-Care- Discharge (End of SNF PPS Stay)

GG0130. Self-Care (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C)
Complete only if A0310G is not = 2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2100 is not = 03

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

Coding:

Safety and **Quality of Performance** - If helper ass̶~~red because resid~~ performance ~~~~ ~~~~ity was not attempt~~ ~~de

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

GG0130 – Admission or Discharge Performance Coding Instructions

01. **Dependent**

Code the resident's usual performance at the start of the SNF PPS stay for each activity [obscured] not attempted at the start of the SNF PPS stay, code the reason. Code the patient's end of SNF PPS stay goal(s) using the 6-point scale.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided. *Activities may be completed with or without assistive devices.* 06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper. 05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity. 04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. 03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. 02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity.	**If activity was not attempted, code reason:** 07. **Resident refused.** 09. **Not applicable.** 88. Not attempted due to **medical condition or safety concerns.**

Discharge Goal: Coding Tips

- Use the 6-point scale to code the resident's discharge goal(s). Do not use codes 07, 09, or 88 to code discharge goal(s).

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

- Clinicians may code one goal for each self-care and mobility item included in Section GG at the time of the 5-day PPS assessment.

- A minimum of one self-care or mobility goal must be coded per resident stay on the 5-day PPS assessment.

GG0170. Mobility – Admission (Start of SNF PPS Stay)

Code the resident's usual performance at the start of the SNF PPS stay for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay, code the reason. Code the patient's end of SNF PPS stay goal(s) using the 6-point scale.

Coding:

1. Admission Performance ↓ Enter Codes in Boxes ↓	2. Discharge Goal	
☐☐	☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	☐☐	**C. Lying to sitting on side of bed:** The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
☐☐	☐☐	**D. Sit to stand:** The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
☐☐	☐☐	**E. Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair).
☐☐	☐☐	**F. Toilet transfer:** The ability to safely get on and off a toilet or commode.
☐		**H1. Does the resident walk?** 0. **No,** and walking goal is <u>not</u> clinically indicated → Skip to GG0170Q1, Does the resident use a wheelchair/scooter? 1. **No,** and walking goal <u>is</u> clinically indicated → Code the resident's discharge goal(s) for items GG0170J and GG0170K 2. **Yes** → Continue to GG0170J, Walk 50 feet with two turns
☐☐	☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	☐☐	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
☐		**Q1. Does the resident use a wheelchair/scooter?** 0. **No** → Skip to GG0130, Self Care 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐	☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, can wheel at least 50 feet and make two turns.
☐		**RR1. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**
☐☐	☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, can wheel at least 150 feet in a corridor or similar space.
☐		**SS1. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**

GG0170. Mobility – Discharge (End of SNF PPS Stay)

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

Coding:

3. Discharge Performance Enter Codes in Boxes	
☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	**C. Lying to sitting on side of bed:** The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
☐☐	**D. Sit to stand:** The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
☐☐	**E. Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair).
☐☐	**F. Toilet transfer:** The ability to safely get on and off a toilet or commode.
☐	**H3. Does the resident walk?** 0. **No** → Skip to GG0170Q3, Does the resident use a wheelchair/scooter? 2. **Yes** → Continue to GG0170J, Walk 50 feet with two turns
☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
☐	**Q3. Does the resident use a wheelchair/scooter?** 0. **No** → Skip to H0100, Appliances 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, can wheel at least 50 feet and make two turns.
☐	**RR3. Indicate the type of wheelchair/scooter used.** 1. Manual 2. Motorized
☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, can wheel at least 150 feet in a corridor or similar space.
☐	**SS3. Indicate the type of wheelchair/scooter used.** 1. Manual 2. Motorized

GG0170 – Admission or Discharge Performance Coding Instructions

Complete only if A0310B = 01, PPS 5-day assessment or A0310G = 1, Planned and A0310H = 1, Part A PPS Discharge.

Code the resident's usual performance at the end of the SNF PPS stay for each activity. If activity was not attempted at the end of the SNF PPS stay, code the reason.

| 06. Independent |

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.

05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity.

04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.

03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.

02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused.**

09. **Not applicable.**

88. Not attempted due to **medical condition or safety concerns.**

SNF QRP Resources

- **SNF QRP Webpage**: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-IMPACT-Act-2014.html
  - Information about SNF QRP measures and requirements
  - Important updates and announcements
  - Training materials, fact sheets, and other resources for providers

- **SNF QRP Help Desk:** SNFQualityQuestions@cms.hhs.gov
  - For general questions about the SNF QRP, reporting requirements, reporting deadlines, and SNF QRP quality measures

Question & Answer Session

Acronyms in this Presentation

- APU: Annual Payment Update
- BMI: Body Mass Index
- CCN: CMS Certification Number
- FY: Fiscal Year
- HHA: Home Health Agency
- IMPACT Act: Improving Medicare Post-Acute Care Transformation Act
- IRF: Inpatient Rehabilitation Facility
- IRF-PAI: IRF- Patient Assessment Instrument
- LTCH: Long-term Care Hospital
- LTCH-CARE Data Set: LTCH- Continuity Assessment Record and Evaluation Data Set

- MDS: Minimum Data Set
- NQF: National Quality Forum
- OASIS: Outcome and Assessment Information Set
- OBRA: Omnibus Budget Reconciliation Act
- PAC: Post-Acute Care
- PPS: Prospective Payment System
- QIES ASAP: Quality Improvement and Evaluation System Assessment Submission and Processing
- QM: Quality Measure
- QRP: Quality Reporting Program
- SNF: Skilled Nursing Facility

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