

# DATA SPEAKS



## Data Speaks Course 3: What's my PDPM Primary Category? Does I0020B make sense for my residents?

### *Speakers:*

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EVP of Clinical Services Broad River Rehab*

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# Faculty Disclosure

- We have no financial relationships to disclose
- We have no conflicts of interests to disclose
- We will not promote any commercial products or services



# Requirements for Successful Completion

- 1.5 contact hours will be awarded for this continuing nursing education and administrator activity (NAB via BRR)
- Criteria for successful completion includes attendance for at least 80% of the entire event. Partial credit may not be awarded
- Approval of this continuing education activity does not imply endorsement by AAPACN or ANCC (American Nurses Credential Center) of any commercial products or services

American Association of Post-Acute Care Nursing (AAPACN) is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

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# What is DATA SPEAKS?

A collaborative learning series between AAPACN, ACHCA, and Broad River Rehab.

**Course 1: CMS Claims Data 101: How it is used and What you should track**

**Course 2: What is my niche? Data Driven Decision Making**

**Course 3: What's my PDPM Primary Category? Does I0020B make sense for my residents?**

**Course 4: How are my NTAs? A Nationwide look at where NTA Points Stack Up.**



# Series Overview

## Identified Gap(s):

Session will detail nationwide patient flow data to SNFs and what patterns have emerged as to the kinds of residents that SNFs are receiving.

## Description of current state:

Currently providers, beneficiaries and care teams have limited access to CMS data aside from what is analyzed internally within their communities and publicly reported on CMS.GOV and Nursing Home Compare.

## Description of desired/achievable state:

Attendees will achieve an increased understanding of national and regional based trends allowing for improved decision-making capabilities internally and for strategic partnerships with acute care hospitals and providers in their communities.

# Course Overview

- Session will highlight emerging data that can help facilities across the country evaluate whether they are selecting the most appropriate primary diagnosis at I0020B based on the types of residents they typically receive.



# Learner Objectives

Following this webinar, you will be able to:

- Explain current data metrics reported from CMS Research Data Assistance Center (ResDAC) for PDPM Case Mix group areas in 2019 and 2020 related to Primary Diagnosis
- Define how post-acute care communities can communicate with acute care hospitals and primary care physicians to identify specific clinical care needs and diagnoses
- Describe methods for auditing and monitoring data trends related to diagnostic categories



# Speaker: Dr. Kendall Brune

- **Dr. Kendall Brune, PhD, CHP, MBA, LNHA, FACHCA** has thirty plus years of experience in senior healthcare executive capacities in the development, construction and operation of ambulatory, pharmacy, senior housing, and care facilities. He currently owns, operates and manages facilities in MO, IL, TN and FL. Dr. Brune is an Adjunct Associate Professor in Family Medicine at Meharry Medical College. He also serves as the District 6 Governor for American College of Healthcare Administrators





# Speaker: Renee Kinder



**Renee Kinder, MS, CCC-SLP, RAC-CT** is Executive Vice President of Clinical Services for Broad River Rehab. Additionally, she authors McKnight's Long Term Care News Rehab Realities Blog, serves as Gerontology Professional Development Manager for the American Speech Language Hearing Association's (ASHA) gerontology special interest group, is the ASHA STAMP for Kentucky, a member of the University of Kentucky College of Medicine community faculty, and is an alternate advisor to the American Medical Association's Relative Value Update Committee (RUC) Health Care Professionals Advisory Committee (HCPAC)

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# Speaker: Wes Sperr

**Wes Sperr, MBA** has over thirty-four years of experience in senior housing and long term care management and over \$48M of building construction and project financing experience. His extensive experience in the management of all business activities concerning senior housing and long term care has been with a track record of professionalism, integrity and numerous accolades. His peers have noticed his achievements in both for-profit and not-for-profit organizations including, but not limited to, the American Retirement Corporation of Nashville, TN, BJC Health System, and Washington University School of Medicine, and many others.



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# Speaker: Joel VanEaton

**Joel VanEaton, BSN, RN, RAC-CT, RAC-CTA, MT** is Executive Vice President of Compliance and Regulatory Affairs for Broad River Rehab serving facilities in TN, KY, GA, NC, SC, OH, MD and RI. Joel began his career in LTC as an MDS coordinator and worked for many years as the Director of Clinical Reimbursement and RAI for a group of nursing facilities in Tennessee and Kentucky. Joel has contributed to McKnight's LTC News and the AANAC LTC Leader. He currently serves as a board member on the AAPACN Education Foundation



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# PDPM and MDS I0200B

- **Intent:** The items in this section are intended to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status.
- **Steps for Assessment:**
  - I0020 - Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay.
  - I0020B - Enter the International Classification of Diseases (ICD) code for that condition, including the decimal.

## I0020: Indicate the resident's primary medical condition category

### I0020. Indicate the resident's primary medical condition category

Complete only if A0310B = 01 or 08

Enter Code

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Indicate the resident's primary medical condition category that best describes the primary reason for admission

01. **Stroke**
02. **Non-Traumatic Brain Dysfunction**
03. **Traumatic Brain Dysfunction**
04. **Non-Traumatic Spinal Cord Dysfunction**
05. **Traumatic Spinal Cord Dysfunction**
06. **Progressive Neurological Conditions**
07. **Other Neurological Conditions**
08. **Amputation**
09. **Hip and Knee Replacement**
10. **Fractures and Other Multiple Trauma**
11. **Other Orthopedic Conditions**
12. **Debility, Cardiorespiratory Conditions**
13. **Medically Complex Conditions**

I0020B. ICD Code

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# ICD-10 and PDPM

- 2.1 How will ICD-10 codes be used under PDPM?
- There are two ways in which ICD-10 codes will be used under PDPM. First, providers will be required to report on the MDS the patient's primary diagnosis for the SNF stay. Each primary diagnosis is mapped to one of ten PDPM clinical categories, representing groups of similar diagnosis codes, which is then used as part of the patient's classification under the PT, OT, and SLP components. Second, ICD-10 codes are used to capture additional diagnoses and comorbidities that the patient has, which can factor into the SLP comorbidities that are part of classifying patients under the SLP component and the NTA comorbidity score that is used to classify patients under the NTA component.

# ICD-10 and PDPM

PT Clinical Categories	Section GG Function Score	PT Case-Mix Group	PT Case-Mix Index	Urban Rate	Rural Rate
<b><u>Major Joint Replacement or Spinal Surgery:</u></b> (Major Joint Replacement or Spinal Surgery)	0-5	TA	1.53	\$ 94.92	\$ 108.20
	6-9	TB	1.70	\$ 105.47	\$ 120.22
	10-23	TC	1.88	\$ 116.64	\$ 132.95
	24	TD	1.92	\$ 119.12	\$ 135.78
<b><u>Other Orthopedic:</u></b> (Non-Surgical Orthopedic/ Musculoskeletal, Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery))	0-5	TE	1.42	\$ 88.10	\$ 100.42
	6-9	TF	1.61	\$ 99.88	\$ 113.86
	10-23	TG	1.67	\$ 103.61	\$ 118.10
	24	TH	1.16	\$ 71.97	\$ 82.04
<b><u>Medical Management:</u></b> (Medical Management, Acute Infections, Cancer, Pulmonary, Cardiovascular and Coagulations)	0-5	TI	1.13	\$ 70.11	\$ 79.91
	6-9	TJ	1.42	\$ 88.10	\$ 100.42
	10-23	TK	1.52	\$ 94.30	\$ 107.49
	24	TL	1.09	\$ 67.62	\$ 77.08
<b><u>Non-Orthopedic Surgery And Acute Neurologic:</u></b> (Non-Orthopedic Surgery , Acute Neurologic)	0-5	TM	1.27	\$ 78.79	\$ 89.81
	6-9	TN	1.48	\$ 91.82	\$ 104.67
	10-23	TO	1.55	\$ 96.16	\$ 109.62
	24	TP	1.08	\$ 67.00	\$ 76.38

# ICD-10 and PDPM

1. Presence of Acute Neurologic Condition (ICD-10), 2. SLP-Related Comorbidity (MDS Section I and O), or 3. Cognitive Impairment (CFS Table)	1. Mechanically Altered Diet (K0510C2) or 2. Swallowing Disorder (K0100A - K0100D)	SLP Case-Mix Group	SLP Case-Mix Group	SLP Case-Mix Index	Urban Rate	Rural Rate
None	Neither	SA/A	SA	0.68	\$ 15.75	\$ 19.84
None	Either	SB/B	SB	1.82	\$ 42.15	\$ 53.11
None	Both	SC/C	SC	2.67	\$ 61.84	\$ 77.91
Any One	Neither	SD/D	SD	1.46	\$ 33.81	\$ 42.60
Any One	Either	SE/E	SE	2.34	\$ 54.19	\$ 68.28
Any One	Both	SF/F	SF	2.98	\$ 69.02	\$ 86.96
Any Two	Neither	SG/G	SG	2.04	\$ 47.25	\$ 59.53
Any Two	Either	SH/H	SH	2.86	\$ 66.24	\$ 83.45
Any Two	Both	SI/I	SI	3.53	\$ 81.75	\$ 103.01
All Three	Neither	SJ/J	SJ	2.99	\$ 69.25	\$ 87.25
All Three	Either	SK/K	SK	3.7	\$ 85.69	\$ 107.97
All Three	Both	SL/L	SL	4.21	\$ 97.50	\$ 122.85



# I0020B Coding Case Study

Ms. K is a 67-year-old female with a history of Alzheimer's dementia and diabetes who is admitted after a stroke. The diagnosis of stroke, as well as the history of Alzheimer's dementia and diabetes, is documented in Ms. K's history and physical by the admitting physician.

**Coding:** I0020 would be coded 01, Stroke. I0020B would be coded as I69.051 (Hemiplegia and hemiparesis following non-traumatic subarachnoid hemorrhage).

**Rationale:** The physician's history and physical documents the diagnosis stroke as the reason for Ms. K's admission. The ICD-10 code provided in I0020B above is only an example of an appropriate code for this condition category

# I0020B Coding Case Study

Mrs. E is an 82-year-old female who was hospitalized for a hip fracture with subsequent total hip replacement and is admitted for rehabilitation. The admitting physician documents Mrs. E's primary medical condition as total hip replacement (THR) in her medical record. The hip fracture resulting in the total hip replacement is also documented in the medical record in the discharge summary from the acute care hospital.

**Coding:** I0020 would be coded 10, Fractures and Other Multiple Trauma. I0020B would be coded as S72.062D (Displaced articular fracture of the head of the left femur).

**Rationale:** Medical record documentation demonstrates that Mrs. E had a total hip replacement due to a hip fracture and required rehabilitation. Because she was admitted for rehabilitation as a result of the hip fracture and total hip replacement, Mrs. E's primary medical condition category is 10, Fractures and Other Multiple Trauma. The ICD-10 code provided in I0020B above is only an example of an appropriate code for this condition category



### ***Your source for CMS data support***

The Research Data Assistance Center (ResDAC) provides free assistance to academic and non-profit researchers interested in using Medicare, Medicaid, SCHIP, and Medicare Current Beneficiary Survey (MCBS) data for research. Primary funding for ResDAC comes from a CMS research contract. ResDAC is a consortium of faculty and staff from the University of Minnesota, Boston University, Dartmouth Medical School, and the Morehouse School of Medicine.

ResDAC offers a number of services for researchers with all levels of experience using or planning to use CMS data. Services include technical data assistance, information on available data resources, and training

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# I0020B and CMS FAQs

## 1.7 Will providers still report the patient HIPPS code in the same way on the UB-04?

Yes, SNF billing practices related to the use of the HIPPS code and revenue codes remain the same under PDPM.

## 1.8 Is it required that the principal diagnosis on the SNF claim match the primary diagnosis coded in item I0020B?

While we expect that these diagnoses should match, there is no claims edit that will enforce such a requirement.

## 1.9 Is it required that the SNF primary diagnosis match the primary diagnosis reported for the qualifying hospital stay?

No, the primary diagnosis for the SNF stay may differ from the primary diagnosis reported for the hospital stay that serves as the qualifying hospital stay necessary for SNF coverage.

# SNF Primary Diagnosis

**CMS 100-2 Ch. 8 clarifies that,** “To be covered the extended care services must have been for the treatment of a condition for which the beneficiary was receiving inpatient hospital services (including services of an emergency hospital) or a condition which arose while in the SNF for treatment of a condition for which the beneficiary was previously hospitalized. In this context, the applicable hospital condition need not have been the principal diagnosis that actually precipitated the beneficiary’s admission to the hospital, but could be any one of the conditions present during the qualifying hospital stay.”

- SNF Primary versus UB-04 versus I0020B, clinical decision making.
- Why would there be a discrepancy?
- Could there be differences in the DRG from the acute care stay; UB-04 and I0020B?

# ICD-10 Updates with COVID-19

Late in December 2020, CMS made changes to the ICD010 CM mapping associated with the PDPM clinical categories for PT and OT as well as NTA comorbidities.

These changes were made regarding new ICD-10-CM codes that the CMS and the CDC approved for certain conditions associated with COVID-19.

Changes were noted in a [CDC memo](#) dated Dec. 3, 2020, **with an effective date of January 1, 2021.**

The FY 2021 PDPM ICD-10 Mappings (ZIP) on [CMS' PDPM website](#) have an effective date of 1/1/2021 and the update notes inside the mapping tool itself indicate an effective date of January 1<sup>st</sup>, 2021.

# ICD-10 Updates with COVID-19

The CDC memo indicates that, “As a result of the ongoing COVID-19 public health emergency, the Centers for Disease Control and Prevention’s National Center for Health Statistics (CDC/NCHS) is implementing additional codes into the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) for reporting to include:

- Encounter for screening for COVID-19 (Z11.52)
- Contact with and (suspected) exposure to COVID-19 (Z20.822)
- Personal history of COVID-19 (Z86.16)
- Multisystem inflammatory syndrome (MIS) (M35.81)
- Other specified systemic involvement of connective tissue (M35.89)
- Pneumonia due to coronavirus disease 2019 (J12.82)



# ICD-10 Updates with COVID-19

From the list of new codes, all but Multisystem inflammatory syndrome (MIS) (M35.81) and Other specified systemic involvement of connective tissue (M35.89) map to return to provider not to any clinical category. For M35.81 and M35.89. the following revisions apply.

- ICD-10-CM code, (M35.8) Other specified systemic involvement of connective tissue, has been removed from both the clinical category Mapping and NTA comorbidities and replaced by M35.81 and M35.89.
- These new codes map to Non-Surgical Orthopedic/Musculoskeletal for the PT and OT categories and Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies for the NTA category.



# CMS and Shared Data

IMPACT  
Act

Payment  
Reform

Care  
Compare

PEPPER  
Reports

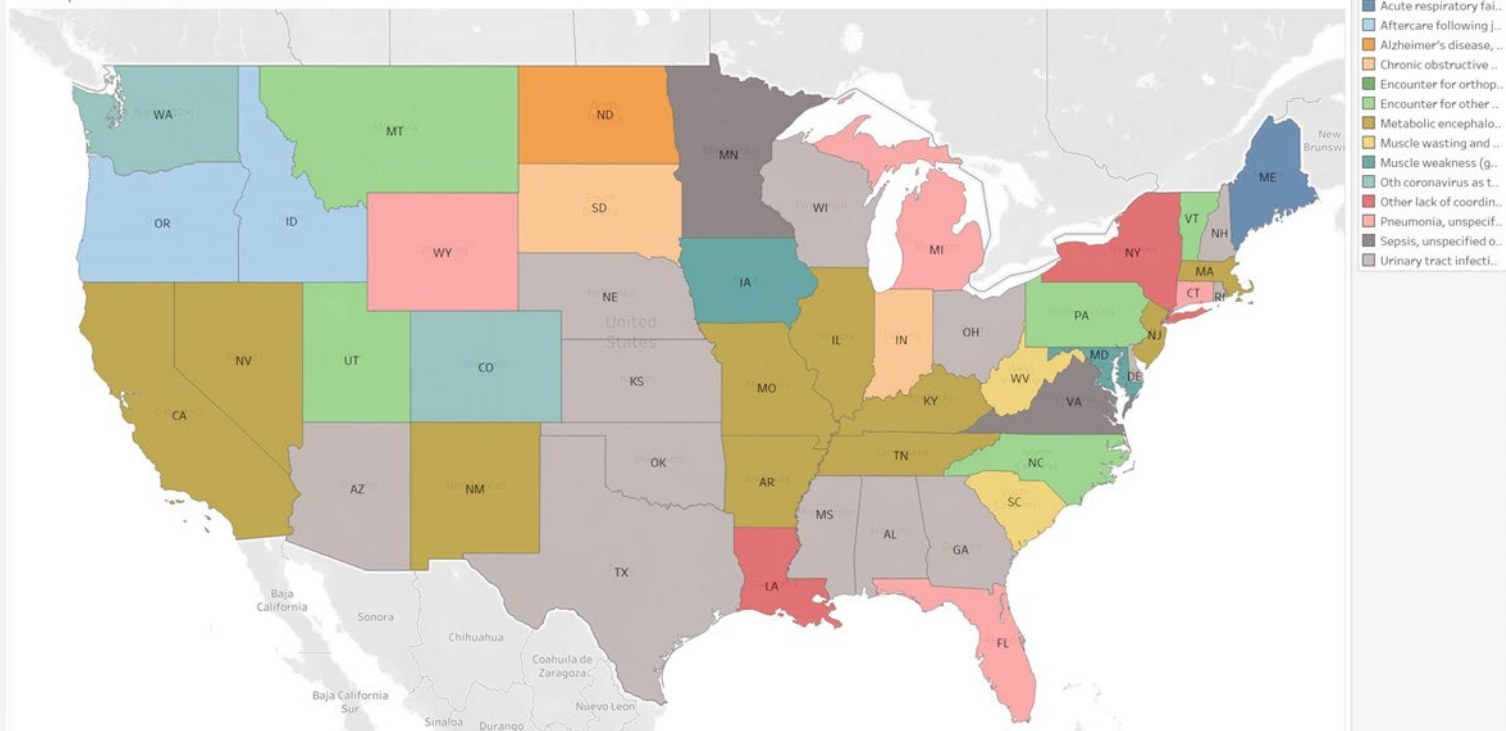
CPT Code  
Updates

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# ResDAC SNF Principle Dx

Nationwide, Metabolic Encephalopathy is the most used SNF Principle Dx.

Principle DX on Part A SNF Claims



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# ResDAC SNF Principle Dx by County

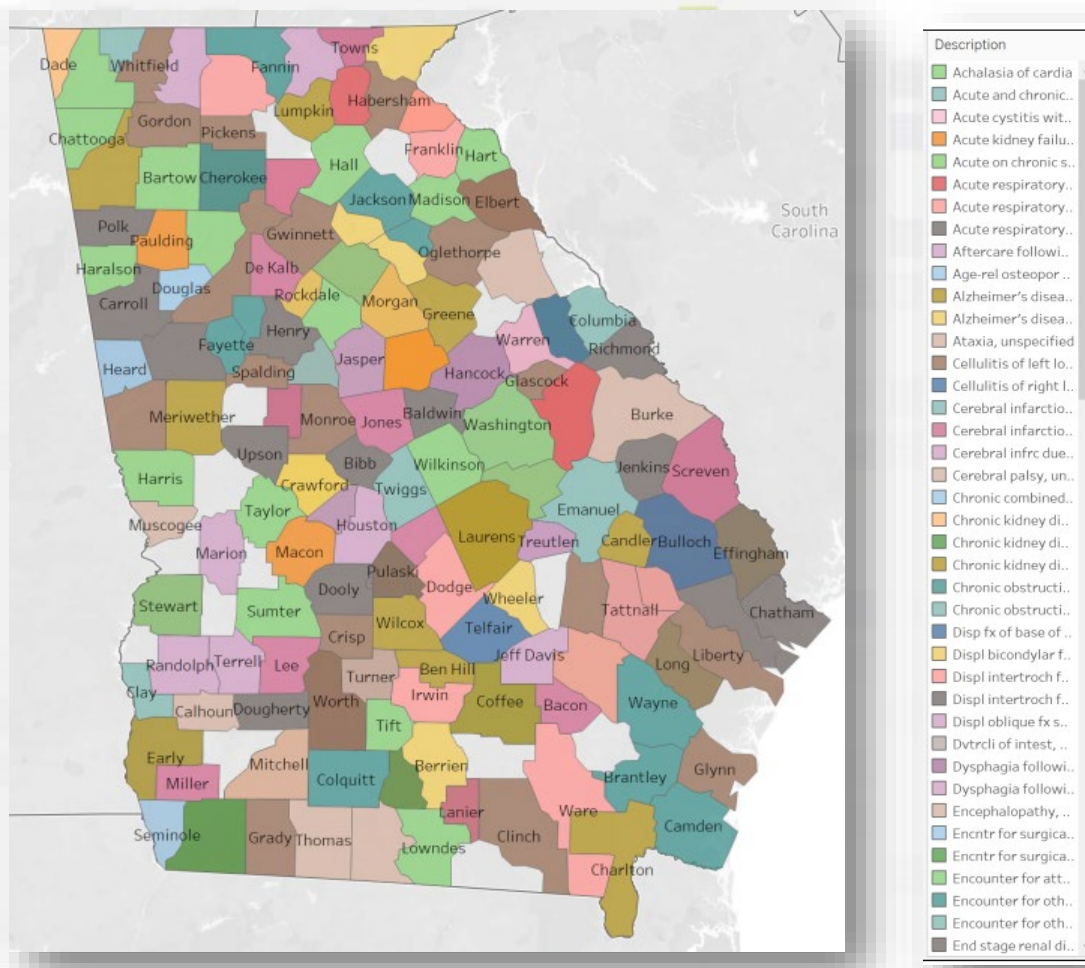
State Example: Tennessee



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# ResDAC SNF Principle Dx. by County

State Example: Georgia



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# ResDAC SNF Principle Dx. by County

State Example: Hawaii



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# Administrators Take Away Points

- Understanding Primary Diagnoses and Residuals
- Appreciating the importance of chronic care management
- Common sense approaches to care
- Taking time to review the literature and research



# Chronic Care the IDT and COVID-19 Considerations

- Evidenced Based Review of the following systems:
  - Pulmonary
  - Neurologic
  - Hematologic
  - Renal
  - Skin
  - Liver
  - Mobility Considerations

American Congress of Rehab Medicine, What Now for Rehabilitation Specialists? Coronavirus Disease 2019 Questions and Answers, derived from: [www.archives-pmr.org](http://www.archives-pmr.org)





# Pulmonary

- The lung damage of COVID-19 leads to an impairment of gas exchange, with potential for
- impaired pulmonary function.
- As a result, many patients report prolonged dyspnea and chest tightness, although the dyspnea may not be commensurate with the degree of hypoxia.
- **Pulmonary fibrosis is another factor that may affect long-term lung function**



# Cardiac

- Complications can include hypotension, arrhythmia, reduced ejection fraction, and myocarditis.
- Left ventricular dysfunction in the acute phase may be attributed to markedly increased cytokine levels.
- Activation or enhanced release of inflammatory cytokines can lead to necrosis of myocardial cells and exacerbations of coronary atherosclerotic plaques, making them prone to rupture.
- An intense inflammatory response superimposed on preexisting cardiovascular disease may precipitate cardiac injury.
- **Myocardial damage might result in long-term dysfunction and must be taken into consideration for patients entering rehabilitation.**
- Although most patients develop persistent tachycardia, it has been found to be relatively benign and self-limiting.

# Neurologic

- Acutely, 36% of patients with COVID-19 develop neurologic symptoms, including headaches, altered consciousness, seizures, absence of smell and taste, paresthesias, and stroke.
- Posterior reversible encephalopathy syndrome, which causes headache, confusion, seizures, and visual loss can be a complication.
- COVID-19 has been associated viral encephalitis has also been rarely reported.
- Patients are found to have very high D-dimer levels and hypercoagulability, in turn potentially increasing the risk of acute cerebrovascular events.
- As with many viral syndromes, Guillain-Barre' syndrome, acute demyelinating encephalopathy, acute necrotizing hemorrhagic encephalopathy, and acute transverse myelitis have also been rarely reported.
- Myopathy with severe muscular symptoms is commonly observed among moderate and severe cases.

# Hematologic

- Patients severely affected by COVID-19 are at high risk for a hypercoagulable state, characterized by very high D-dimer levels, thrombo-embolism, and stroke.
- In one review, thromboembolism was documented in as many as 1 in 5 patients and strokes occurred in 3%.
- Thromboembolic events occur despite prophylactic use of anticoagulants, and both venous and arterial thrombosis occurs.
- In addition, severe COVID-19 infection appears to be associated with bleeding complications, an increased risk for intracranial hemorrhage, and, in some instances, disseminated intravascular coagulation.

# Renal

- Patients severely affected by COVID-19 are more likely to have acute kidney injury.
- Studies have shown that among those with normal creatinine levels on admission, most will recover from an acute kidney injury. However, proteinuria and hematuria can be prolonged.
- **It is recommended that patients with acute kidney injury be regularly assessed for 3-6 months after discharge.**

# Skin

- COVID-19 has been associated skin lesions include (from most common to least common) maculopapular eruptions, urticarial, acral erythema with vesicles or pustules (pseudo-chilblains), vesicular eruptions, and livedo reticularis.
- Frank necrosis, secondary to vasculopathy, can also occur and may result in limb loss.
- Because of prone positioning, facial wounds may occur among survivors and could be problematic because of secondary infections and necrosis.

# Liver

- COVID-19 related liver dysfunction with abnormal liver enzymes (mainly elevated serum prominences in those patients who spend significant amounts of time in prone position.
- Frequent changes in position and the use of supports to float the bony prominences are required.
- **Interdisciplinary collaboration between the rehabilitation team, nursing, and respiratory therapy is crucial to provide frequent pressure relief. Prone teams that include physical or occupational therapists and are available 24 hours per day 7 days per week may be helpful in reinforcing proper technique to minimize injuries.**

# Administrators Take Away Points

- How can you include meaningful activity into daily care?
- Understand the interest of those you serve daily
- Accountability as a provider



# Meaningful Engagement in Therapy

- Interdisciplinary collaboration between the rehabilitation team, nursing, and respiratory therapy is crucial to provide frequent pressure relief. Prone teams that include physical or occupational therapists and are available 24 hours per day 7 days per week may be helpful in reinforcing proper technique to minimize injuries.
- For noncritically ill inpatients, daily out-of-bed mobility and participation in activities of daily living (ADL) helps to promote functional recovery and improve delirium.
- Interdisciplinary collaboration between the rehabilitation team, nursing team, and physicians to bundle care and promote mobility activities is recommended to reduce immobility-related harm while ensuring efficient use of resources.
- Rehabilitation team members play a crucial role in educating nursing and other team members on the safe progression of patient mobility. Education about engaging patients in daily therapeutic exercises, ADLs, and cognitive stimulation tasks is recommended for carry over from therapy sessions to amplify functional recovery.

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# Chronic Condition and Ventilation

- Survivors of acute respiratory distress syndrome with mechanical ventilation are reported to have complications such as laryngeal injury, tracheal stenosis, heterotopic ossification, contractures, adhesive capsulitis, decubitus ulcers, dysphonia, dysphagia, sensorineural hearing loss, brachial plexus injuries, and peripheral neuropathies (peroneal and ulnar).

# Chronic Condition and ICU Weakness

- Weakness and decreased exercise capacity are the most common symptoms after prolonged ICU stay and immobility.
- Critical illness polyneuropathy (CIP), critical illness myopathy (CIM), and muscle atrophy are major causes of functional impairment related to COVID-19. CIP and CIM are characterized by generalized and symmetrical weakness, atrophy, and decreased or absent deep tendon reflexes and can cause difficulty weaning from mechanical ventilation because of associated respiratory muscle weakness.
- CIP and/or CIM co-occur with other symptoms or complications, including pain, reduced range of motion, fatigue, incontinence, and dysphagia.
- **Many of these secondary complications are preventable if appropriate rehabilitation is provided early in the disease course**

# Chronic Condition and Cognition

- COVID-19 can produce prolonged hypoxia that may lead to both acute and long-term neuropsychological dysfunction.
- The further elements of prolonged ventilation, use of sedatives, prone positioning, human isolation, and extended time away from social contacts may contribute to severe delirium.
- All components of cognition can be affected, including attention, visual-spatial abilities, memory, and higher order executive functions.
- Common adverse psychological effects include posttraumatic stress disorder, insomnia, depression, and general anxiety, and they can be exacerbated by fear, stigma, and isolation.

# Diabetes

The world is currently grappling with a dual pandemic of diabetes and coronavirus disease 2019 (COVID-19). Several articles published in the recent issues of Diabetes, Obesity and Metabolism and elsewhere have raised concerns about a bi-directional relationship between these two health conditions. It is now undoubtedly proven that diabetes is associated with a poor prognosis of COVID-19. On the other hand, COVID-19 patients with diabetes frequently experience uncontrolled hyperglycemia and episodes of acute hyperglycemic crisis, requiring exceptionally high doses of insulin. **More intriguingly, recent reports show that newly diagnosed diabetes is commonly observed in COVID-19 patients.** [\*Diabetes Obesity and Metabolism, November 27, 2020\*](#)

# Reminder: Trauma Informed Care

## F699

*(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)*

### *§483.25(m) Trauma-informed care*

*The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.*

*[§483.25(m) will be implemented beginning November 28, 2019 (Phase 3)]*

# The Future: Quality Metrics

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
MUC20-0002	<b>Skilled Nursing Facility</b> Healthcare-Associated Infections Requiring Hospitalization	This measure will estimate the risk-adjusted rate of healthcare-associated infections (HAIs) that are acquired during skilled nursing facility (SNF) care and result in hospitalizations. The measure is risk adjusted to “level the playing field” and to allow comparison of measure performance based on residents with similar characteristics between SNFs. It is important to recognize that HAIs in SNFs are not considered “never-events.” The goal of this risk-adjusted measure is to identify SNFs that have notably higher rates of HAIs that are acquired during SNF care and result in hospitalization, when compared to their peers.	Outcome	Centers for Medicare & Medicaid Services	<b>SNF QRP</b>
MUC20-0044	SARS-CoV-2 Vaccination Coverage among Healthcare Personnel	This measure tracks SARS-CoV-2 vaccination coverage among healthcare personnel (HCP) in IPPS hospitals, inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), inpatient psychiatric facilities, ESRD facilities, ambulatory surgical centers, hospital outpatient departments, <b>skilled nursing facilities</b> , and PPS-exempt cancer hospitals.	Process	Centers for Disease Control & Prevention	ASCQR; ESRD QIP; Hospital IQR Program; Hospital OQR Program; IPFQR; IRF QRP; LTCH QRP; PCHQR; <b>SNF QRP</b>

“To increase incentives to vaccinate Medicare beneficiaries, CMS will evaluate how to incorporate quality measures for COVID-19 immunizations into its value-based purchasing programs, including Medicare Advantage Star-Ratings, the physician quality payment program, and accountable care programs.” McKnight’s LTC News 1/25/21



# The Future: Quality Metrics

Don't forget the QRP measure and SPADES that were to begin reporting Oct. 2020 but have been delayed due to the delay in RAI Manual and MDS 3.0 Revisions.

- **Transfer of Health Information to the Provider–Post-Acute Care (PAC)**; assesses for the timely transfer of health information, specifically a reconciled medication list. This measure evaluates for the transfer of information when a patient is transferred or discharged from their current setting to a subsequent provider. \*
- **Transfer of Health Information to the Patient–Post-Acute Care (PAC)**. This proposed measure assesses for and reports on the timely transfer of health information, i.e., a current reconciled medication list, to the patient/resident when discharged from their current setting of post-acute care. \*



# The Future: Quality Metrics

- 3 SPADEs for Cognitive Function. \*
- 15 SPADEs to Assess for Special Services, Treatments, and Interventions. \*
- 1 SPADE to Assess for Medical Conditions and Co-Morbidities. \*
- 2 SPADEs to Assess for Impairments
- 5 SPADEs to assess for a new category: Social Determinants of Health. \*

\* New MDS items



# Administrators Take Away Points

- Understand importance of communication with care givers at the next level of care
- Consider need for patient education prior to discharge for areas associated with medication and chronic care conditions
- Role play to practice transfer of “work” process

# CEU Reminders

- *This educational activity is provided jointly by AAPACN and Broad River Rehab. If you would like to receive proof of ANCC continuing education credits earned for viewing this webinar, complete the [verification form](#) and return it to AAPACN f*
- *Please allow 3-5 business days for AAPACN to process your verification form. Once your completion of the webinar is verified, you will receive a confirmation email directing you to the My Continuing Education page on [www.AANAC.org](http://www.AANAC.org) or [www.AADNS-LTC.org](http://www.AADNS-LTC.org), where you can access, download, and print your certificate.*
- *NAB Credits will be awarded by Broad River Rehab. Please allow 3-5 business days for receipt of certificate.*



# Want to Know More?

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