To Care is Human

2023 THCA/TNCAL CONVENTION & TRADE SHOW

BROAD RIVER REHAB

"A ***Knowledgeable*** and ***Compassionate*** partner"

Change is coming in SPADEs

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Learning Objectives

Change is coming in SPADEs

- Understand the importance of the IMPACT Act.
- Identify the SPADES that will be included with the revised MDS 3.0 v1.18.11
- Recognize the connection between the IMPACT Act/Spades and the SNF Quality Reporting Program
- Define the TOH QM
- Appreciate how the SPADEs are intended to engage the resident's quality experience.
- Recognize SNF QRP Compliance Pitfalls
- Understand the future of SPADEs

Skilled Nursing Facility Quality Reporting Program (SNF QRP) Resources

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- SNF QRP
- Reporting tables for FY 2024
- Reporting tables for FY 2025
- SNF QRP Technical Specifications and Addendum
- HAI Draft Specifications
- COVID-19 Vaccination Among HCP Specifications
- Influenza Vaccination Coverage Among HCP
- TOH Measures and SPADEs
- Claims Based Measures DTC and PPR
- MSPB
- Unified PAC Report to Congress
- CoreQ D/C Measure Manual
- Discharge Function Score measure
- MDS 3.0 v1.18.11

Change is coming in SPADEs

IMPACT Act

- On October 6, 2014, the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act) was signed into law.
- The Act requires the submission of standardized data by Long-Term Care Hospitals (LTCHs), **Skilled Nursing Facilities (SNFs)**, Home Health Agencies (HHAs) and Inpatient Rehabilitation Facilities (IRFs).
- Standardized data are to be collected by the commonly used assessment instruments: The Long-Term Care Hospital CARE Data Set (LCDS) for LTCHs, **the Minimum Data Set (MDS) for SNFs**, the Outcome and Assessment Information Set (OASIS) for HHAs, and the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF PAI) for IRFs.
- The IMPACT Act requires the reporting of standardized patient assessment data with regard to quality measures and standardized patient assessment data elements (SPADEs).
- The Act also requires the submission of data pertaining to measure domains pertaining to resource use, and other domains.
- In addition, the IMPACT Act requires assessment data to be standardized and interoperable to allow for exchange of the data among post-acute providers and other providers.
- The Act intends for standardized post-acute care data to improve Medicare beneficiary outcomes through shared-decision making, care coordination, and enhanced discharge planning.

Change is coming in SPADEs

Meaningful measures 2.0

- **Meaningful Measures 2.0 supports five interrelated goals.**
  - Empower consumers to make good health care choices through patient-directed quality measures and public transparency.
  - Leverage quality measures to promote health equity and close gaps in care.
  - Use the Meaningful Measures Initiative to streamline quality measurement.
  - Leverage measures to drive outcome improvement through public reporting and payment programs.
  - Improve quality measure efficiency by transitioning to digital measures and using advanced data analytics.

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- **CMS National Quality Strategy goals**
  - **Embed Quality into the Care Journey:** Incorporate quality as a foundational component to delivering value as a part of the overall care journey. Quality includes ensuring optimal care and best outcomes for individuals of all ages and backgrounds as well as across service delivery systems and settings. Quality also extends across payer types.
  - **Advance Health Equity:** Address the disparities that underlie our health system, both within and across settings, to ensure equitable access and care for all.
  - **Promote Safety:** Prevent harm or death from health care errors.
  - **Foster Engagement:** Increase engagement between individuals and their care teams to improve quality, establish trusting relationships, and bring the voices of people and caregivers to the forefront.
  - **Strengthen Resilience:** Ensure resilience in the health care system to prepare for, and adapt to, future challenges and emergencies.
  - **Embrace the Digital Age:** Ensure timely, secure, seamless communication and care coordination between providers, plans, payers, community organizations, and individuals through interoperable, shared, **and standardized digital data** across the care continuum.
  - **Incentivize Innovation & Technology:** Accelerate innovation in care delivery and incorporate technology enhancements (e.g. telehealth, machine learning, advanced analytics, new care advances) to transform the quality of care and advance value.
  - **Increase Alignment:** Develop a coordinated approach to **align performance metrics, programs, policy, and payment across CMS**, federal partners, and external stakeholders **to improve value**. Strive to create a simplified national picture of quality measurement that is comprehensible to individuals, their families, providers, and payers.

Change is coming in SPADEs

IMPACT Act

- There are 16 quality measures that have been developed for SNFs as a result with more to come, some filtered through the Meaningful Measures Framework, with multiple of Standardized Patient Assessment Data Elements or SPADES in MDS 3.0 v1.18.11.
- The SNF QRP is currently driven by 14 quality measures. 8 of these measures derive from the Minimum Data Set, 4 from Medicare claims and 2 are reported through NHSN. Only 2 of these measures currently affect a facility's 5-star rating.
- **Quality Measure Domains:** - Skin integrity and changes in skin integrity; - Functional status, cognitive function, and changes in function and cognitive function; - Medication reconciliation; - Incidence of major falls; - Transfer of health information and care preferences when an individual transitions;
- **Resource Use and Other Measure Domains**: - Resource use measures, including total estimated Medicare spending per beneficiary; - Discharge to community; and All-condition risk-adjusted potentially preventable hospital readmissions rates.
- **SNF QRP compliance thresholds** are 100% of MDS data elements **(including SPADEs)** on at least 80% of MDS submissions **and** 100% of NHSN data submission requirements. Noncompliance with either threshold equals a 2% reduction to the Market Basket Update.

Change is coming in SPADEs

IMPACT Act Quality Measures

IMPACT Act Domain	IMPACT Act Measure	Source	PAC Setting Adopted
Skin Integrity and Changes in Skin Integrity	Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) replaced with Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.	Assessment	IRF, LTCH, SNF, HH
Functional Status, Cognitive Function, and Changes in Function and Cognitive Functiony	Application of Percent of LTCH Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function	Assessment	IRF, LTCH, SNF, HH
	Change in Self-Care Score for Medical Rehabilitation Patients	Assessment	IRF, SNF
	Change in Mobility Score for Medical Rehabilitation Patients	Assessment	IRF, SNF
	Change in Discharge Self-Care Score for Medical Rehabilitation Patients	Assessment	IRF, SNF
	Change in Discharge Mobility Score for Medical Rehabilitation Patients	Assessment	IRF, SNF
Medication Reconciliation	Drug Regimen Review	Assessment	IRF, LTCH, SNF, HH
Incidence of Major Falls	Application of the Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	Assessment	IRF, LTCH, SNF, HH
Transfer of Health Information and Care Preferences when an Individual Transitions	Transfet of Health Information to Provider Transfer of health Information to Patient	Assessment Assessment	IRF, LTCH, SNF, HH
Resource Use Measures, including Total Estimated Medicare Spending Per Beneficiary	Medicare Spending Per Beneficiary	Claims	IRF, LTCH, SNF, HH
Discharge to Community	Discharge to Community	Claims	IRF, LTCH, SNF, HH
All-Condition Risk-Adjusted Potentially Preventable Hospital Readmissions Rates	Potentially Preventable 30-Day Post-Discharge Readmission	Claims	IRF, LTCH, SNF, HH
Meaningful Measure Domain	**IMPACT Act Measure**		**PAC Setting Adopted**
Patient Safety (Meaningful Measures 2.0)	SNF Healthcare Associated infections	Claims	SNF
Patient Safety (Meaningful Measures 2.0)	Influenza vaccination HCP	NHSN	IRF, LTCH, SNF
Patient Safety (Meaningful Measures 2.0)	COVID-19 Vaccination HCP	NHSN	IRF, LTCH, SNF

Change is coming in SPADEs

IMPACT Act

- The Improving Post-Acute Care Transformation (IMPACT) Act of 2014 also requires a report to Congress on unified payment for Medicare post-acute care (PAC).
- Medicare PAC services are provided to beneficiaries by PAC providers defined as skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), and home health agencies (HHAs).
- Each PAC provider setting has a separate Medicare fee-for-service (FFS) prospective payment system (PPS).
- A goal of unified PAC payment is to base the payment on patient characteristics instead of the PAC setting.
- This framework applies a uniform approach to case-mix adjustment across Medicare beneficiaries receiving PAC services for different types of PAC providers while accounting for factors independent of patient need that are important drivers of cost across PAC providers.
- The unified approach to case-mix adjustment includes standardized patient assessment data collected by the four PAC providers.

Change is coming in SPADEs

- **Additional MDS Based QMs**
  - Transfer of Health Information to the Provider–Post-Acute Care (PAC): This measure assesses for and reports on the timely transfer of health information, specifically transfer of a reconciled medication list.
  - This measure evaluates for the transfer of information when a patient/resident is transferred or discharged from their current setting to a subsequent provider.
  - For this measure, the subsequent provider is defined as a **short-term general hospital, a SNF, intermediate care, home under care of an organized home health service organization or hospice, hospice in an institutional facility, an IRF, an LTCH, a Medicaid nursing facility, an inpatient psychiatric facility, or a critical access hospital.**
  - Transfer of Health Information to the Patient–Post-Acute Care (PAC): This measure, the Transfer of Health Information to the Patient, assesses for and reports on the timely transfer of health information, specifically transfer of a medication list.
  - This measure evaluates for the transfer of information when a patient/resident is discharged from their current setting of PAC to a **private home/apartment, board and care home, assisted living, group home, transitional living or other residential care arrangements.**
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Change is coming in SPADEs

- The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires CMS to develop, implement, and maintain standardized patient assessment data elements (SPADEs) for PAC settings (SNF, HH, LTCH, IRF).
- The goals of implementing cross-setting SPADEs are to facilitate care coordination and interoperability and to improve Medicare beneficiary outcomes.
- The IMPACT Act further requires that the assessment instruments for each PAC setting (MDS, OASIS, LCDS, IRF PAI) be modified to include core data elements on health assessment categories and that such data be standardized and interoperable. HH, IFF and LTCH tools have already been modified to report these SPADEs. **MDS 3.0 v1.18.11 contains the data elements necessary to comply with this mandate.**
- CMS has adopted SPADEs for five categories specified in the IMPACT Act:
  - **Cognitive function** (e.g., able to express ideas and to understand normal speech) and mental status (e.g., depression and dementia)
  - **Special services, treatments, and interventions** (e.g., need for ventilator, dialysis, chemotherapy, and total parenteral nutrition)
  - **Medical conditions and comorbidities** (e.g., diabetes, heart failure, and pressure ulcers)
  - **Impairments** (e.g., incontinence; impaired ability to hear, see, or swallow)
  - **Other categories** as deemed necessary by the Secretary (Social Determents of Health)

Change is coming in SPADEs

Cognitive Function

- Impairments in cognitive function can result from many underlying conditions, including dementia, Alzheimer's Disease, stroke, brain injury, side effects of medication, metabolic and endocrine imbalances, and delirium.
- Cognitive impairments may affect a patient or resident's ability to recover from illness or injury, or they may be a sign of an acute condition (e.g., hypoxia) that requires immediate intervention.
- Cognitive impairment that manifests with behavioral symptoms—or that impairs a patient's ability to communicate, prompting behavioral disturbances—may put the patient or resident or others in the care setting at risk for injury or assault, or may signal unmet patient or resident needs (e.g., pain management).
- Screening for the presence of impairment can help ensure appropriate and timely intervention.
- CMS has identified several data elements as applicable for cross-setting use in standardized assessment of cognitive impairment.

Change is coming in SPADEs

Cognitive Function

- BIMS: The BIMS is a performance-based cognitive assessment developed to be a brief cognition screener with a focus on learning and memory. The BIMS evaluates repetition, recall with and without prompting, and temporal orientation.
- As a screening tool, the BIMS has been shown to accurately predict formal diagnoses of impaired cognitive function in nursing homes.
- The assessment of cognitive function in SNF residents is essential due to the substantial number of residents affected by cognitive impairments and its **potential to impact care, health, and cost outcomes**.
- BIMS data show that approximately **33 percent of Medicare FFS SNF residents** are moderately to severely cognitively impaired.
- Results of the BIMS' screening for cognitive impairment can be used to initiate appropriate therapy in a timely fashion, to establish a baseline for identifying changes in cognitive function over time, and to inform staff about a resident's ability to understand and participate in treatments during their stay and about what supports and services will likely be needed at the time of discharge.
- The standardized assessment of cognitive function using the BIMS data elements would provide important information for care planning, care transitions, patient safety, and resource use in SNFs.

Change is coming in SPADEs

Cognitive Function: Brief Interview for Mental Status (BIMS)

- The following MD items have been retained in MDS 3.0v1.18.11 to assess for cognitive function.
  - **C0100 Should Brief Interview for Mental Status (C0200-C0500) be Conducted?**
  - **C0200 Repetition of Three Words**
  - **C0300 Temporal Orientation**
  - **C0400 Recall**
  - **C0500 BIMS Summary Score**

Change is coming in SPADEs

- **Cognitive Function** (cont.)
  - **Confusion Assessment Method (CAM©)**: The CAM is a widely used delirium screening tool. Delirium, when undetected or untreated, can increase the likelihood of complications, rehospitalization, and death relative to patients/residents without delirium.
  - The CAM allows trained facility staff to identify delirium with sensitivity and specificity, even in populations with a high prevalence of dementia.
  - Assessing mental status of SNF residents has several benefits, including establishing a baseline for recognizing changes in mental status, highlighting threats to patient safety (e.g., risk of falls), and helping clinicians identify appropriate treatment and supports to be incorporated into care plans.
  - **SNF residents with delirium are more likely to experience new complications and be re-hospitalized**, and less likely to be discharged to the community within 30 days.
  - The standardized assessment of cognitive impairment, including delirium and reversible confusion using the Short CAM data elements, provide important information for care planning, care transitions, patient safety, and **resource use in SNFs**.

Change is coming in SPADEs

- **Cognitive Function** (cont.)
  - **Confusion Assessment Method (CAM©)**: The following items have been retained in MDS v1.18.11 to assess delirium.
    - **C1310 Signs and Symptoms of Delirium (from CAM©)**
    - **C1310 A. Acute Onset Mental Status Change**
    - **C1310 B. Inattention**
    - **C1310 C. Disorganized Thinking**
    - **C1310 A. Altered Level of Consciousness**

Change is coming in SPADEs

- **Cognitive Function** (cont.)
  - **Depression** is the most common mental health condition in older adults, yet underrecognized and thus undertreated. Existing data show that depressed mood is relatively common in patients and residents receiving PAC services.
  - Older adults with depression may exhibit different symptoms than younger adults, including **fatigue, insomnia, irritable mood, confusion, and lack of focus**. Some **medications and medical conditions, such as heart disease, stroke, or cancer**, may also cause depressive symptoms in older adults. Diagnosis and treatment of depression can lead to significant improvement of symptoms, as measured on depression assessment scales.
  - Assessments of the signs and symptoms of depression help PAC providers better understand the needs of their patients and residents by prompting further evaluation (i.e., to establish a diagnosis of depression); elucidating the patient's or resident's ability to participate in therapies for conditions other than depression during their stay; and identifying appropriate ongoing treatment and support needs at the time of discharge.
  - The standardized assessment of depression among PAC patients and residents **supports clinical decision making, early clinical intervention, person-centered care, and improved care continuity and coordination**. The use of valid and reliable standardized assessments can aid in the communication of information within and across providers, further enabling the transfer of accurate health information.

Change is coming in SPADEs

- **Cognitive Function** (cont.)
  - **Patient Healthcare Questionnaire (PHQ-2 to 9)**: The PHQ-2 to 9 data elements use a summed-item scoring approach to first screen for signs and symptoms of depressed mood in patients and residents by assessing the two cardinal criteria for depression: depressed mood and anhedonia (inability to feel pleasure).
  - At least one of the two must be present for a determination of probable depression, which signals the need for continued assessment of the additional seven PHQ symptoms. Specifically,
    - If both D0150A1 and D0150B1 are coded 9, OR both D0150A2 and D0150B2 are coded 0 (Never or 1 day) or 1 (2-6 days), END the PHQ interview.
  - The following MDS items have been revised on MDS 3.0v1.18.11 to accommodate this data
    - **D0150 Resident Mood Interview (PHQ-2 to 9)** (Replaces D0200)
    - **D0160. Total Severity Score** (Replaces D0300)

Change is coming in SPADEs

- **Special Services, Treatments, and Interventions (Including Nutritional Approaches)**
  - Some medical conditions require complex clinical care, consisting of special services, treatments, and interventions. The implementation of these interventions typically indicates conditions of a more serious nature and can be life-sustaining.
  - Patients and residents who need them may have few clinical alternatives. Conditions requiring the use of special services, treatments, and interventions can have a profound effect on an individual's health status, self-image, and quality of life.
  - Providers should be aware of the patient or resident's clinical needs to plan the provision of these important therapies, ensure the continued **appropriateness of care and resource use, and support care transitions**.
  - The assessment of special services, treatments, and interventions may also help identify **resource use intensity** by capturing the medical complexity of patients/residents.
  - CMS has identified data elements for cross-setting standardization of assessment for special services, treatments, and interventions in the areas of cancer, respiratory, and other treatments, as well as nutritional approaches and high-risk medications.

Change is coming in SPADEs

- **Special Services, Treatments, and Interventions (Including Nutritional Approaches) (cont.)**
- MDS item **O0110 Special Treatments, Procedures, and Programs**, has been added to MDS 3.0 v1.18.11. This is a significant revision to O0100. Multiple items for the following are now required to be coded on admission (column a Days 1-3 of stay), while a resident (column b last 14 days) and at discharge (column c last 3 days of stay). **Note** that the column, "While NOT a Resident", has been removed.
  - **A1. Chemotherapy (A2. IV, A3. Oral, A10. Other),**
  - **B1. Radiation,**
  - **C1. Oxygen therapy (C2. Continuous, C3. Intermittent, C4. High-concentration oxygen delivery system)**
  - **D1. Suctioning (D2. Scheduled, D3. As needed),**
  - **E1. Tracheostomy Care,**
  - **F1. Invasive mechanical ventilator**
  - **G1. Non-invasive mechanical ventilator (G2. BiPAP, G3. CPAP)**
  - **H1. IV medications (H2. vasoactive medications, H3. antibiotics, H4. anticoagulants, H5. other)**
  - **I1. Transfusions**
  - **J1. Dialysis (J2. hemodialysis, J3. peritoneal dialysis)**
  - **O1. IV access (O2. peripheral IV, O3. midline, O4. central line)**

Change is coming in SPADEs

- **Special Services, Treatments, and Interventions (Including Nutritional Approaches) (cont.)**
- **MDS item K0520, Nutritional Approaches,** has been added to MDS 3.0v1.18.11. This is a revision to K0510. MDS items for the following are now required to be coded on admission (3-day window days 1-3 of the stay), while not a resident (last 7 days), while a resident (last 7 days) and at discharge (3-day window last 3 days of the stay).
  - **A. Parenteral/IV feeding**
  - **B. Feeding tube**
  - **C. Mechanically altered diet** (not coded while not a resident)
  - **D. Therapeutic diet** (not coded while not a resident)

Change is coming in SPADEs

- **Special Services, Treatments, and Interventions (Including Nutritional Approaches) (cont.)**
- **MDS item N0415, High-risk drug classes: use and indication**, has been added to MDS 3.0v1.18.11. This is a significant revision to N0410. MDS items for the following are now required to be coded when taken (Column 1) and that there is an indication for use (Column 2) **See page N-11 for example of Indication for use**.
- Assessing use of high-risk medications by SNF residents and indications for each medication would provide important information related to resident safety in SNFs and care transitions between SNFs and other settings
  - **A. Antipsychotic**
  - **B. Antianxiety**
  - **C. Antidepressant**
  - **D. Hypnotic**
  - **E. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin)**
  - **F. Antibiotic**
  - **G. Diuretic**
  - **H. Opioid**
  - **I. Antiplatelet (new item)**
  - **J. Hypoglycemic (including insulin) (new item).**

Change is coming in SPADEs

- **Medical Conditions and Co-Morbidities**
- **Pain Interference**: A substantial percentage of older adults receiving services in a PAC setting experience pain.
  - Pain in older adults can be treated with medications, complementary and alternative approaches, or physical therapy.
  - Treatment of pain in older adults may be complicated by factors such as dementia; high rates of polypharmacy; end-of-life care; and patient expectations, attitudes, and fears related to pain treatment.
  - Untreated pain is an often-debilitating condition that is associated with a host of adverse physical consequences, including **loss of function, poor quality of life, disruption of sleep and appetite, inactivity, and weakness, as well as psychological effects such as depression, anxiety, fear, and anger.**
  - Pain among SNF residents can interfere with rehabilitation and has potential secondary complications. The potential effects of pain on resident health are myriad, and it is critical to assess pain during hospitalization and after discharge.
  - Assessing pain in in SNF residents during their stay can lead **to appropriate treatment and improved quality of life, reduce complications associated with immobility such as skin breakdown and infection, and facilitate rehabilitation efforts and returning to community settings.**
  - Pain assessment post-discharge can also be used to plan appropriate treatment and may reduce readmissions.

Change is coming in SPADEs

- **Medical Conditions and Co-Morbidities (cont.)**
- **Pain Interference (Cont.)**
- **J0400 Pain Frequency** is now numbered J0410
- The following MDS Items have been added to MDS 3.0v1.18.11(Revised J0500) to address pain in PAC settings
  - **J0510. Pain Effect on Sleep**
  - **J0520. Pain Interference with Therapy Activities**
  - **J0530. Pain Interference with Day-to-Day Activities**
- The order of the frequency intervals for all pain items (Rarely, Occasionally, Frequently and Almost Constantly) have been reversed.

Change is coming in SPADEs

- **Impairments**
  - **Hearing and Vision Impairments**: Hearing and vision impairments are common conditions that, if unaddressed, affect patients' and residents' **activities of daily living, communication, physical functioning, rehabilitation outcomes, and overall quality of life.**
  - Sensory limitations can lead **to confusion in new settings, increase isolation**, contribute to **mood disorders, and impede accurate assessment of other medical conditions, such as cognition**.
  - Hearing impairments may cause difficulty in communication of important information concerning the patient's or resident's condition, preferences, and care transitions;
  - Vision impairments have been associated with **increased risk of falls**.
  - Both types of impairment can also interfere with comprehension of and adherence to discharge plans Assessments pertaining to sensory status aid PAC providers in
    - Understanding the needs of their patients and residents by establishing a diagnosis of hearing or vision impairment,
    - Elucidating the patients' and residents' ability and willingness to participate in treatments or use assistive devices during their stays, and
    - Identifying appropriate ongoing therapy and support needs at the time of discharge.

Change is coming in SPADEs

- **Impairments**
  - **Hearing and Vision Impairments** (cont.)
  - The following MDS items have been retained in MDS 3.0v1.18.11 to address impairments
    - **B0200 Hearing**
    - **B1000 Vision**

Change is coming in SPADEs

- **New Category: Social Determinants of Health**
  - CMS has identified data elements for cross-setting standardization of assessment for seven social determinants of health (SDOH).
  - **Healthy People 2020 defines SDOH** as, *"…the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."*
  - **World Health Organization** – *"Social determinants of health (SDH) are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems. The SDH have an important influence on Health Inequities - the unfair and avoidable differences in health status seen within and between countries. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health."*
  - *Examples of the social determinants of health, which can influence health equity in positive and negative ways: - Income and social protection – Education - Unemployment and job insecurity – Working life conditions - Food insecurity – Housing, basic amenities and the environment - Early childhood development - Social inclusion and non-discrimination - Structural conflict - Access to affordable health services of decent quality.*

Change is coming in SPADEs

- **New Category: Social Determinants of Health (cont.)**
- MDS items have been added and or revised to assess for SDOH:
  - **Ethnicity – MDS item A1005**
  - **Race – MDS item A1010**
  - **Preferred Language – MDS item A1110**
  - **Interpreter Services – MDS item A1110**
  - **Transportation – MDS item A1250**
  - **Health Literacy – MDS item B1300**
  - **Social Isolation – MDS item D0700**

Change is coming in SPADEs

- **Health Equity Update (SNF PPS FY 2024)**
- In the FY 2023 SNF PPS proposed rule CMS included an RFI entitled “Overarching Principles for Measuring Equity and Healthcare Quality Disparities Across CMS Quality Programs.
- CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by CMS’ programs and models, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that beneficiaries need to thrive.
- This initiative is guided by 5 priorities
- **Priority 1:** Expand the Collection, Reporting and Analysis of Standardized Data
- **Priority 2:** Assess Causes of Disparities Within CMS Programs, and Address Inequities in Policies and Operations to Close Gaps
- **Priority 3:** Build Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities
- **Priority 4: Advance Language Access, Health Literacy** and the Provision of Culturally Tailored Services
- **Priority 5:** Increase All Forms of Accessibility to Health Care Services and Coverage

Change is coming in SPADEs

- **Health Equity Update (SNF PPS FY 2024 cont.)**
- CMS' **National Quality Strategy** identifies a wide range of potential quality levers that can support CMS' advancement of equity, including:
- (1) establishing a **standardized approach** for resident-reported data and stratification;
- (2) employing quality and **value-based programs** to address closing **equity gaps**; and
- (3) developing **equity-focused** data collections, analysis, regulations, oversight strategies, and quality improvement initiatives.

Change is coming in SPADEs

- **Health Equity Update (SNF PPS FY 2024 cont.)**
- CMS is committed to developing approaches to meaningfully incorporate the advancement of health equity into the SNF QRP. One option we are considering is including **social determinants of health (SDOH) as part of new quality measures**.
- CMS is considering whether health equity measures we have adopted for other settings, such as hospitals, could be adopted in post-acute care settings.
- CMS is exploring ways to incorporate SDOH elements into the measure specifications. For example, CMS is considering **a future health equity measure like screening for social needs and interventions**.
- **With 30 percent to 55 percent of health outcomes attributed to SDOH**, a measure capturing and addressing SDOH could encourage SNFs to identify residents' specific needs and connect them with the community resources necessary to overcome social barriers to their wellness.

Change is coming in SPADEs

- **Health Equity Update (SNF PPS FY 2024 cont.)**
  - In a recent McKnight's column, it was noted that, "According to the Centers for Disease Control and Prevention"
  - "social isolation can increase a person's risk of premature death from all causes and increases the risk of dementia by 50%."
  - "Social isolation is a lack of social connections. Social isolation can lead to loneliness in some people, while others can feel lonely without being socially isolated."
  - **"Health Risks of Loneliness:** Although it's hard to measure social isolation and loneliness precisely, there is strong evidence that many adults aged 50 and older are socially isolated or lonely in ways that put their health at risk. Recent studies found that:
    - Social isolation **significantly increased a person's risk of premature death** from all causes, a risk that may rival those of smoking, obesity, and physical inactivity.[1]
    - Social isolation was associated with about a **50% increased risk of dementia**.[1]
    - Poor social relationships (characterized by social isolation or loneliness) was associated with a **29% increased risk of heart disease** and a **32% increased risk of stroke**.[1]
    - Loneliness was **associated with higher rates of depression, anxiety, and suicide**.
    - Loneliness among heart failure patients was **associated with a nearly 4 times increased risk of death, 68% increased risk of hospitalization, and 57% increased risk of emergency department visits**.[1]

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Change is coming in SPADEs

- **Health Equity Update (SNF PPS FY 2024 cont.)**
- CMS could specify a health equity measure using the same SDOH data items that we currently collect as standardized patient assessment data elements under the SNF.
- These SDOH data items assess health literacy, social isolation, transportation problems, and preferred language (including need or want of an interpreter).
- CMS also sees value in aligning SDOH data items across all care settings as we develop future health equity quality measures under our SNF QRP statutory authority.
- This would further the NQS to align quality measures across our programs as part of the **Universal Foundation**.

FY 2024 Changes to the Skilled Nursing Facility Quality Reporting Program (SNF QRP)

Change is coming in SPADEs

- CMS is:
  - Adopting three measures in the SNF QRP,
  - Removing three measures from the SNF QRP, and
  - Modifying one measure in the SNF QRP. In addition,
  - Making policy changes to the SNF QRP, and
  - Publishing a timeline for reporting of new measures.

FY 2024 New QRP Measures

Change is coming in SPADEs

- CMS is adopting the **Discharge Function Score (DC Function) measure** beginning with the FY 2025 SNF QRP.
- This measure assesses functional status by assessing the percentage of SNF residents who meet or exceed an expected discharge function score and uses mobility and self-care items already collected on the Minimum Data Set (MDS).
- This measure will replace the topped-out process measure – the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment/a Care Plan That Addresses Function (Application of Functional Assessment/Care Plan) measure.

FY 2024 New QRP Measures

Change is coming in SPADEs

- CMS is adopting the **COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date (Patient/Resident COVID-19 Vaccine) measure** beginning with the FY 2026 SNF QRP.
- This measure reports the percentage of stays in which residents in an SNF are up to date with recommended COVID-19 vaccinations in accordance with the Centers for Disease Control and Prevention's (CDC's) most recent guidance.
- Data will be collected using a new standardized item on the MDS (initial reporting through NHSN).

Figure 1.3: Draft COVID-19 Vaccination Item for MDS

Q1. Resident's[33] COVID-19 vaccination is up to date.
0. No, resident is not up to date
1. Yes, resident is up to date

FY 2024 Modified QRP Measures

Change is coming in SPADEs

- CMS is modifying the **COVID-19 Vaccination Coverage among Healthcare Personnel (HCP COVID-19 Vaccine) measure** beginning with the FY 2025 SNF QRP.
- This measure tracks the percentage of healthcare personnel (HCP) working in SNFs who are considered up to date with recommended COVID-19 vaccination in accordance with the CDC's most recent guidance.
- The current version of this measure reports only on whether HCP had received the primary vaccination series for COVID-19.
- This modification will require SNFs to report the **cumulative number of HCP who are up to date with recommended COVID-19 vaccinations** in accordance with the CDC's most recent guidance

FY 2024 Removed QRP Measures

Change is coming in SPADEs

- CMS removing the **Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (Application of Functional Assessment/Care Plan) measure** beginning with the FY 2025 SNF QRP.
- CMS is removing this measure for two reasons.
  - **First**, the Application of Functional Assessment/Care Plan measure meets the conditions for measure removal factor one: measure performance among SNFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.
  - **Second**, this measure meets the conditions for measure removal factor six: there is an available measure (the DC Function measure) that is more strongly associated with desired resident functional outcomes.

FY 2024 Removed QRP Measures

Change is coming in SPADEs

- CMS is removing the **Application of the IRF Functional Outcome Measures: Change in Self-Care Score for Medical Rehabilitation Patients (Change in Self-Care Score) measure; and the Change in Mobility Score for Medical Rehabilitation Patients (Change in Mobility Score)** measure beginning with the FY 2025 SNF QRP.
- CMS is removing these two measures because these measures meet the condition for measure removal factor eight: the costs associated with a measure outweigh the benefits of its use in the program.
- Additionally, these measures are similar or duplicative of other measures within the SNF QRP.

Change is coming in SPADEs

- **FY 2024 SNF PPS Final Rule Updates to SNF QRP**
  - **Changes to the Skilled Nursing Facility Quality Reporting Program (SNF QRP): MDS Reporting Requirements**
    - CMS will increase the SNF QRP Data Completion thresholds for the Minimum Data Set (MDS) Data Items beginning with the FY 2026 SNF QRP.
    - SNFs will need to report **100%** of the required quality measure data and standardized resident assessment data collected using the MDS on at least **90%** of the assessments they submit to CMS.
    - Starting with data collected in CY 2024, any SNF that does not meet the requirement that 90% of all MDS assessments submitted contain 100% of required data items, **will be subject to a reduction of 2 percentage points to the applicable FY annual payment update beginning with FY 2026**.

Change is coming in SPADEs

- **FY 2024 SNF PPS Final Rule Updates to SNF QRP**
  - **Changes to the Skilled Nursing Facility Quality Reporting Program (SNF QRP): Public Reporting**
    - CMS will begin the public reporting of the Transfer of Health Information to the Provider—PAC Measure and the Transfer of Health Information to the Patient—PAC Measure beginning with the October 2025 Care Compare refresh or as soon as technically feasible.
    - CMS will begin publicly displaying data for the DC Function measure beginning with the October 2024 refresh of Care Compare using data collected from January 1, 2023 through December 31, 2023 (Quarter 1 2023 through Quarter 4 2023).
    - CMS will begin publicly displaying data for the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure beginning with the October 2025 refresh of Care Compare or as soon as technically feasible with a data collection period of Q4 2024 (October 1, 2024 through December 31, 2024).

Change is coming in SPADEs

Conclusions:

- SPADEs are here to stay for both QRP, VBP and Payment (UPAC)
- Don’t procrastinate your engagement of these concepts
- MDS Accuracy is PARAMOUNT! Future QMs and Payment are at stake.
- Engage the updated MDS and RAI Manual as if you never read it before. It’s that important!
- Have a resource library (Slide 5). Essential documents necessary for engagement and Understanding are crucial to have at your fingertips.
- Resident centered care is always the end goal.

QUESTIONS?