MDS 3.0 Quality Measures

USER'S MANUAL

APPENDIX F

Specifications for Facility Characteristics Report (V10.0 10-15-2012)

(to accompany User's Manual V6.0 09-17-2012)

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Specifications for Facility Characteristics Report

Selection

The Facility Characteristic Report is populated using data from records selected using the standard QM episode and record selection logic as given in the QM User's Manual. The Facility Characteristics measures can be processed with the QM measures. Each Facility Characteristic measure is computed for both short-stay and long-stay residents.

Most of the Facility Characteristic measures are populated using data from a look-back scan of the assessment records selected for each resident. For each resident, the look-back scan begins with the target assessment selected for QM processing. The resident's records are scanned in reverse chronological order (by ARD) and all data items required for the Facility Characteristics report are populated from data that are available from each assessment. As assessments are scanned, each required item is initially populated with the item value from the target assessment. If the value from the target assessment is a valid (non-missing) value, then the scan for that item stops. If the value for the target assessment is not a valid value (a missing value), then the scan continues with the earlier assessments in reverse chronological order. Once a valid value is found for an item, that value is used for the report (i.e., the value is not changed if additional values are present in earlier records).

A "valid value" is any value that is one of the "normal" responses to an item. Except for the diagnosis codes in items I8000A through I8000J, missing non-valid values are:

1. A dash ("-") indicating that the item was not assessed.
2. A caret ("^") indicating that the item was skipped.
3. A null (.) indicating that the item is inactive.

Note that scanning works differently for diagnosis codes that are contained in items I8000A through I8000J. For these items, the scanning procedure populates the report values with values from the latest assessment where the I8000 items are active (not null). Thus, as scanning occurs, identify the first (chronologically latest) assessment where the I8000 values for that assessment are valid (not null). I8000 values that are contained on any earlier assessments are not used.

For each resident, the look-back scan (for all of the report items, including diagnosis codes) continues until any of the following conditions is satisfied:

- All required items have been populated with valid values, as defined above, OR
- All selected records for a resident have been scanned.

Note that scanning stops for a resident as soon as ***either*** of these conditions is satisfied.

Measure Specifications

The definitions in the following table are applied to a look-back scan of the records selected for a resident as described in the prior section on *Record Selection*. Counts of the number of residents within each facility that meet the numerator criteria for each measure below are used as the numerator to produce facility percentages for the report.

The denominator used to produce the facility percentages in the report will vary for different measures, depending on missing data. If missing data precludes determination of the status for a measure as indicated in the "Exclusions" section, then the resident is excluded from both the numerator and denominator in the facility percentage.

MEASURE	DESCRIPTION AND DEFINITION
Gender	
Male	**Description:** Resident is included if Item A0800 (Gender) is equal to **1** (Male). Records with dashes (not assessed) in A0800 are excluded from the male/female counts. **Numerator:** A0800 = 1 (Male). **Exclusions:** A0800 missing
Female	**Description:** Resident is included if Item A0800 (Gender) is equal to **2** (Female). Records with dashes (not assessed) in A0800 are excluded from the male/female counts. **Numerator:** A0800 = 2 (Female). **Exclusions:** A0800 missing
Age	
	Calculation of Age, based on Items A0900 (Birth Date) and A2300 (Assessment Reference Date ARD): IF (MONTH(A0900) > MONTH(A2300)) OR (MONTH(A0900) = MONTH(A2300) AND DAY(A0900) >= DAY(A2300)) THEN Age = YEAR(A2300)-YEAR(A0900) ELSE Age = YEAR(A2300)-YEAR(A0900)-1
<25 years old	**Description:** Age less than 25 years old. **Numerator:** Record triggers if age < 25.
25-54 years old	**Description:** Age of 25 through 54 years old. **Numerator:** Record triggers if age >= 25 and <= 54.
55-64 years old	**Description:** Age of 55 through 64 years old. **Numerator:** Record triggers if age >= 55 and <= 64.
65-74 years old	**Description:** Age of 65 to 74 years old. **Numerator:** Record triggers if age >= 65 and <= 74.
75-84 years old	**Description:** Age of 75 through 84 years old. **Numerator:** Record triggers if age >= 75 and <= 84.
85+ years old	**Description:** Age of 85 years of age or older. **Numerator:** Record triggers if age >= 85.

MEASURE	DESCRIPTION AND DEFINITION
Diagnostic characteristics	
Psychiatric diagnosis	**Description:** Resident is included as having a psychiatric diagnosis if any of the following is true: • any psychiatric mood disorders are checked in items I5700 through I6100, OR • item I5350 (Tourette's Syndrome) is checked, OR • item I5250 (Huntington's Disease) is checked, OR • ICD-9 codes in items I8000A through I8000J are between 295.00 and 298.99, inclusive (indicating "other psychoses"). **Numerator:** • Any of the following items are checked: I5250, I5350, I5700 through I6100; OR • 18000A through J has ICD-9 codes between 295.00 and 298.99, inclusive. **Exclusions:** No value I5250, I5350, I5700 through I6100 = 1 and any value I5250, I5350, I5700 through I6100 missing
Intellectual Disability (ID) (Mental retardation as defined at 483.45(a)) or Developmental Disability (DD)	**Description:** Resident is counted as having ID/DD if any of the following items are checked: • A1550A (Down syndrome) • A1550B (Autism) • A1550C (Epilepsy) • A1550D (Other organic condition related to ID/DD) • A1550E (ID/DD with no organic condition) **Numerator:** A1550A, B, C, D, or E is checked. **Exclusions:** No value A1550A, B, C, D, or E = 1 and any value A1550A, B, C, D, or E missing
Hospice	**Description:** Resident is included if Item O0100K2 (Hospice care) is checked. **Numerator:** O0100K2 is checked. **Exclusions:** O0100K2 missing
Prognosis	
Life expectancy of less than 6 months	**Description:** Resident is included if item J1400 (Prognosis) is coded **1** (Yes). **Numerator:** J1400 = 1 (Yes). **Exclusions:** J1400 missing
Discharge Plan	
Discharge planning IS NOT already occurring for the resident to return to the community.	**Description:** Resident is included if Item Q0400A (Discharge Plan) is coded **0** (No). **Numerator:** Q0400A = 0 (No). **Exclusions:** Q0400A missing
Discharge planning IS already occurring for the resident to return to the community.	**Description:** Resident is included if Item Q0400A (Discharge Plan) is coded **1** (Yes). **Numerator:** Q0400A = 1 (Yes). **Exclusions:** Q0400A missing

MEASURE	DESCRIPTION AND DEFINITION
Referral	
Referral not needed.	**Description:** Resident is included if Item Q0600 (Referral) is coded **0** (No - Referral not needed). **Numerator:** Q0600 = 0 (No - Referral not needed). **Exclusions:** Q0600 missing
Referral is or may be needed, but has not been made.	**Description:** Resident is included if Item Q0600 (Referral) is coded **1** (Yes – Referral is or may be needed). **Numerator:** Q0600 = 1 (Yes - Referral is or may be needed). **Exclusions:** Q0600 missing
Referral has been made.	**Description:** Resident is included if Item Q0600 (Referral) is coded **2** (Yes - Referral made). **Numerator:** Q0600 = 2 (Yes - Referral made). **Exclusions:** Q0600 missing
Type of Entry	
Admission	**Description:** Resident is included if Item A1700 (Type of Entry) is coded **1**, (Admission). **Numerator:** A1700 = 1 (Admission). **Exclusions:** A1700 missing
Reentry	**Description:** Resident is included if Item A1700 (Type of Entry) is coded **2**, (Reentry). **Numerator:** A1700 = 2 (Reentry). **Exclusions:** A1700 missing
Entered Facility From	
Community (private home/apartment board/care, assisted living, group home)	**Description:** Resident is included if Item A1800 (Entered From) is coded **01** (Community). **Numerator:** A1800 = 01 (Community). **Exclusions:** A1800 missing
Another nursing home or swing bed	**Description:** Resident is included if Item A1800 (Entered From) is coded **02** (Another nursing home or swing bed). **Numerator:** A1800 = 02 (Another nursing home or swing bed). **Exclusions:** A1800 missing
Acute hospital	**Description:** Resident is included if Item A1800 (Entered From) is coded **03** (Acute hospital). **Numerator:** A1800 = 03 (Acute hospital). **Exclusions:** A1800 missing
Psychiatric hospital	**Description:** Resident is included if Item A1800 (Entered From) is coded **04** (Psychiatric hospital). **Numerator:** A1800 = 04 (Psychiatric hospital). **Exclusions:** A1800 missing
Inpatient rehabilitation facility	**Description:** Resident is included if Item A1800 (Entered From) is coded **05** (Inpatient rehabilitation facility). **Numerator:** A1800 = 05 (Inpatient rehabilitation facility). **Exclusions:** A1800 missing

MEASURE	DESCRIPTION AND DEFINITION
Entered Facility From (cont.)	
ID/DD facility	**Description:** Resident is included if Item A1800 (Entered From) is coded **06** (ID/DD facility). **Numerator:** A1800 = 06 (ID/DD facility). **Exclusions:** A1800 missing
Hospice	**Description:** Resident is included if Item A1800 (Entered From) is coded **07** (Hospice). **Numerator:** A1800 = 07 (Hospice). **Exclusions:** A1800 missing
Long Term Care Hospital (LTCH)	**Description:** Resident is included if Item A1800 (Entered From) is coded **09** (Long Term Care Hospital (LTCH)). **Numerator:** A1800 = 09 (Long Term Care Hospital (LTCH)). **Exclusions:** A1800 missing
Other	**Description:** Resident is included if Item A1800 (Entered From) is coded **99** (Other). **Numerator:** A1800 = 99 (Other). **Exclusions:** A1800 missing