

# Final Specifications for HH QRP Quality Measures and Standardized Patient Assessment Data Elements

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## SECTION 1

### CROSS-SETTING MEASURES DEVELOPMENT WORK: AN INTRODUCTION

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), enacted Oct. 6, 2014, directs the Secretary of Health and Human Services to “specify quality measures on which Post-Acute Care (PAC) providers are required under the applicable reporting provisions to submit standardized patient assessment data” in several domains, including functional status, skin integrity, and incidence of major falls. The IMPACT Act requires the implementation of measures to address these measure domains in home health agencies (HHAs), skilled nursing facilities (SNFs), long-term care hospitals (LTCHs), and inpatient rehabilitation facilities (IRFs).

The IMPACT Act also requires, to the extent possible, the submission of such quality measure data through the use of a PAC assessment instrument and the modification of such instrument as necessary to enable such use. For HHAs, the Outcome and Assessment Information Set (OASIS) will be used.

The reporting of quality data by HHAs is mandated by Section 1895(b)(3)(B)(v)(II) of the Social Security Act (“the Act”). For more information on the statutory history of the HH Quality Reporting Program (QRP), please refer to <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Requirements.html>. More information on the IMPACT Act is available at <https://www.govtrack.us/congress/bills/113/hr4994>.

In this document, we present specifications for the following three (3) measures proposed for adoption for the Final Specifications for HH QRP Quality Measures and Standardized Patient Assessment Data Elements:

1. 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)
2. Application of Percent of Residents Experiencing One or More Falls with Major Injury (NQF #0674)
3. Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury

**SECTION 2**  
**MEASURES AFFECTING THE CY 2020 PAYMENT DETERMINATION AND**  
**SUBSEQUENT YEARS**

**2.1 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)**

**2.1.1 Measure Description**

The cross-setting function quality measure is a process measure that is an application of the quality measure Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631). This quality measure reports the percent of episodes with a Start of Care (SOC) /Resumption of Care (ROC) and a discharge functional assessment and a treatment goal that addresses function. The treatment goal provides evidence that a care plan with a goal has been established for the patient.

This process quality measure requires the collection of SOC/ROC and discharge functional status data by clinicians using standardized clinical assessment items or data elements that assess specific functional activities, that is, self-care and mobility activities. The self-care and mobility function items are coded using a 6-level rating scale that indicates the patient's level of independence with the activity. A higher score indicates greater independence. If an activity is not attempted, the reason that the activity did not occur is coded. For this quality measure, documentation of a goal for one of the function items reflects that the patient's care plan addresses function. The functional goal is recorded at start or resumption of care for at least one of the standardized self-care or mobility function items using the 6-level rating scale. Subsequent to the SOC/ROC assessment, goal setting and establishment of a care plan to achieve the goal, at the time of discharge the self-care and mobility functional performance is reassessed using the same 6-level rating scale, enabling the ability to re-assess the patient's functional abilities. This quality measure will be calculated using data from the Outcome and Assessment Information Set (OASIS).

**2.1.2 Purpose/Rationale for the Measure**

The National Committee on Vital and Health Statistics, Subcommittee on Health<sup>1</sup> noted: “[i]nformation on functional status is becoming increasingly essential for fostering healthy people and a healthy population. Achieving optimal health and well-being for Americans requires an understanding across the life span of the effects of people's health conditions on their ability to do basic activities and participate in life situations, that is, their functional status.” This statement is supported by research showing that patient functioning is associated with important patient outcomes such as discharge destination and length of stay in inpatient settings<sup>2</sup> as well as

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<sup>1</sup> Subcommittee on Health National Committee on Vital and Health Statistics, “Classifying and Reporting Functional Status” (2001).

<sup>2</sup> Reistetter T. A., Graham J. E., Granger C. V., Deutsch A, Ottenbacher K. J. (2010). Utility of Functional Status for Classifying Community Versus Institutional Discharges after Inpatient Rehabilitation for Stroke. Archives of Physical Medicine and Rehabilitation; 91:345-350.

risk of nursing home placement and hospitalization of older adults living the in community.<sup>3</sup> Functioning is important to patients and their family members.<sup>4 5 6</sup>

The primary goal of home care is to provide restorative care where improvement is expected, maintain function and health status when improvement is not expected, and/or facilitate transition to end-of-life care when appropriate.<sup>7</sup> Many patients who receive post-acute care (PAC) services, such as care provided by home health agencies (HHAs), have functional limitations and are at risk for further decline in function due to limited mobility and ambulation.<sup>8</sup>

Given the variation in patient populations across the PAC providers, the functional activities that are typically assessed by clinicians for each type of PAC provider may vary. For example, the activity of rolling left and right in bed is an example of a functional activity that may be most relevant for low-functioning patients who are chronically critically ill. However, certain functional activities, such as eating, oral hygiene, lying to sitting on the side of the bed, toilet transfers, and walking or wheelchair mobility, are important activities for patients/residents in each PAC setting. These activities are included in the cross-setting measure. The patient populations treated by home health agencies (HHAs) vary in their functional abilities at the time of the home health (HH) admission and their goals of care. For HH patients who are home-bound, achieving independence within the living environment and promoting community mobility may be the goal of care. For other HH patients, the goal of care may be to slow the rate of functional decline to avoid institutionalization.<sup>9</sup> The clinical practice guideline, Assessment of Physical Function,<sup>10</sup> recommends that clinicians document functional status at baseline and over time to validate capacity, decline, or progress. These quality measures will inform HH providers about opportunities to improve care in the area of self-care and function and strengthen incentives for quality improvement related to patient function.

Although functional assessment data are currently collected in HH, this data collection has employed different assessment instruments, scales, and items relative to other PAC providers. The data collected cover similar topics, but are not standardized across PAC settings. Further, the different sets of functional assessment items are coupled with different rating scales, making communication about patient functioning challenging when patients/residents transition from one type of provider to another. Collection of standardized functional assessment data across all PAC settings, using standardized data items, would establish a common language for patient/resident functioning, which may facilitate communication and care coordination as patients/residents transition from one type of provider to another. The collection of standardized

<sup>3</sup> Miller E.A., Weissert W. G. (2000) Predicting Elderly People's Risk for Nursing Home Placement, Hospitalization, Functional Impairment, and Mortality: A Synthesis. *Medical Care Research and Review*, 57; 3: 259-297.

<sup>4</sup> Kurz, A. E., Saint-Louis, N., Burke, J. P., & Stineman, M. G. (2008). Exploring the personal reality of disability and recovery: a tool for empowering the rehabilitation process. *Qual Health Res*, 18(1), 90-105.

<sup>5</sup> Kramer, A. M. (1997). Rehabilitation care and outcomes from the patient's perspective. *Med Care*, 35(6 Suppl), JS48-57.

<sup>6</sup> Stineman, M. G., Rist, P. M., Kurichi, J. E., & Maislin, G. (2009). Disability meanings according to patients and clinicians: imagined recovery choice pathways. *Quality of Life Research*, 18(3), 389-398.

<sup>7</sup> Riggs, J. S. & Madigan, E. A. (2012). Describing variation in home health care episodes for patients with heart failure. *Home Health Care Management and Practice*, 24(3): 146-152.

<sup>8</sup> Kortebein P, Ferrando A, Lombebeida J, Wolfe R, Evans WJ (2007). Effect of 10 days of bed rest on skeletal muscle in health adults. *JAMA*; 297(16):1772-4.

<sup>9</sup> Ellenbecker CH, Samia L, Cushman MJ, Alster K (2008). Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr. Chapter 13.

<sup>10</sup> Kresevic DM. Assessment of physical function. In: Boltz M, Capezuti E, Fulmer T, Zwicker D, editor(s). (2012). Evidence-based geriatric nursing protocols for best practice. 4th ed. New York (NY): Springer Publishing Company, p. 89-103.

functional status data may also help improve patient/resident functioning during an episode of care by ensuring that basic daily activities are assessed at the start and end of each episode of care with the aim of determining whether at least one functional goal is established.

The functional assessment items included in the functional status quality measure were originally developed and tested as part of the Post-Acute Care Payment Reform Demonstration (PAC PRD) version of the Continuity Assessment Record and Evaluation (CARE) Item Set, which was designed to standardize assessment of patient's/resident's status across acute and post-acute providers, including skilled nursing facilities (SNFs), HHAs, long-term care hospitals (LTCHs), and inpatient rehabilitation facilities (IRFs). The functional status items on the CARE Item Set are daily activities that clinicians typically assess at the time of admission and/or discharge to determine patients'/residents' needs, evaluate patient/resident progress and prepare patients/residents and families for a transition to home or to another provider.

The development of the CARE Item Set and a description and rationale for each item is described in a report entitled "The Development and Testing of the Continuity Assessment Record and Evaluation (CARE) Item Set: Final Report on the Development of the CARE Item Set: Volume 1 of 3."<sup>11</sup> Reliability and validity testing were conducted as part of CMS' Post-Acute Care Payment Reform Demonstration, and we concluded that the functional status items have acceptable reliability and validity. A description of the testing methodology and results are available in several reports, including the report entitled "The Development and Testing of the Continuity Assessment Record And Evaluation (CARE) Item Set: Final Report On Reliability Testing: Volume 2 of 3"<sup>12</sup> and the report entitled "The Development and Testing of The Continuity Assessment Record And Evaluation (CARE) Item Set: Final Report on Care Item Set and Current Assessment Comparisons: Volume 3 of 3."<sup>13</sup> The reports are available on CMS' Post-Acute Care Quality Initiatives webpage at: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/CARE-Item-Set-and-B-CARE.html>.

### **2.1.3 Denominator Statement**

Number of Medicare/Medicaid (including Advantage programs) covered home health episodes of care for patients who are at least 18 years of age, ending during the reporting period that do not meet the generic exclusions described below.

### **2.1.4 Denominator Details**

All home health episodes of care, defined as a start/resumption of care assessment (OASIS item M0100) (Reason for Assessment) = 1 (Start of care) or 3 (Resumption of care)) paired with a corresponding discharge/transfer/death assessment (M0100 (Reason for Assessment) = 6 (Transfer to inpatient facility – not discharged), 7 (Transfer to inpatient facility

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<sup>11</sup> Research Triangle International. The Development and Testing of the Continuity Assessment Record and Evaluation (CARE) Item Set: Final Report on the Development of the CARE Item Set (Contract HHSM-500-2005-00291) 2012, August.

<sup>12</sup> *IBID*

<sup>13</sup> *IBID*

– discharged), 8 (Death at home), or 9 (Discharge from agency)), other than those covered by generic and measure-specific denominator exclusions.

### **2.1.5 Numerator Statement**

The numerator for this quality measure is the number of home health quality episodes with functional assessment data for each self-care and mobility activity and at least one self-care or mobility goal.

### **2.1.6 Numerator Details**

All three of the following are required for the patient to be counted in the numerator:

1. A valid numeric score indicating the patient’s functional status, or a valid code indicating the activity was not attempted or could not be assessed for each of the functional assessment items on the SOC/ROC assessment;
2. A valid numeric score, which is a discharge goal indicating the patient’s expected level of independence, for at least one self-care or mobility item on the SOC/ROC assessment; and
3. A valid numeric score indicating the patient’s functional status, or a valid code indicating the activity was not attempted or could not be assessed, for each of the functional assessment items on the discharge assessment.

### **2.1.7 Incomplete Episode**

For home health episodes ending in a qualifying admission to an inpatient facility [Transfer], or a Death at Home, the discharge functional status data would not be required for the episode to be included in the numerator. For episodes ending in transfer or death at home, the following are required for these patients to be counted in the numerator:

1. A valid numeric score indicating the patient’s functional status, or a valid code indicating the activity was not attempted or could not be assessed for each of the functional assessment items on the SOC/ROC assessment; and
2. A valid numeric score, which is a discharge goal indicating the patient’s expected level of independence, for at least one self-care or mobility item on the SOC/ROC assessment.

### **2.1.8 Items Included in the Quality Measure**

An important consideration when measuring functional status is that certain activities may not be relevant or feasible to assess for all home health patients. For example, walking may not occur at the start or resumption of care because it is not safe for a patient to ambulate. In this situation, a clinician would code that a functional activity was not attempted because it was not safe or feasible for the patient to perform the activity.

**The following functional status items are included in this measure:**

**Self-Care Items**

**Eating (GG0130A):** 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.

**Oral hygiene (GG0130B):** 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.]

**Toileting hygiene (GG0130C):** 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.

**Mobility Items**

**Sit to lying (GG0170B):** The ability to move from sitting on side of bed to lying flat on the bed.

**Lying to sitting on side of bed (GG0170C):** 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.

**Sit to stand (GG0170D):** The ability to safely come to a standing position from sitting in a chair or on the side of the bed.

**Chair/bed-to-chair transfer (GG0170E):** The ability to safely transfer to and from a bed to a chair (or wheelchair).

**Toilet transfer (GG0170F):** The ability to safely get on and off a toilet or commode.

*For patients/residents who are walking, complete the following items:*

**Walk 50 feet with two turns (GG0170J):** Once standing, the ability to walk at least 50 feet and make two turns.

**Walk 150 feet (GG0170K):** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

*For patients/residents who use a wheelchair, complete the following items:*

**Wheel 50 feet with two turns (GG0170R):** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.

**Indicate the type of wheelchair/scooter used (GG0170RR).**

- 1. Manual**
- 2. Motorized**

**Wheel 150 feet (GG0170S):** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.

**Indicate the type of wheelchair/scooter used (GG0170SS).**

- 1. Manual**
- 2. Motorized**

### **Self-Care and Mobility Rating Scale: Codes and Code Definitions**

- 6. Independent** – Patient/resident completes the activity by him/herself with no assistance from a helper.
- 5. Setup or clean-up assistance** – Helper SETS UP or CLEANS UP; patient/resident completes activity. Helper assists only prior to or following the activity.
- 4. Supervision or touching assistance** – Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient/resident completes activity. Assistance may be provided throughout the activity or intermittently.
- 3. 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.
- 2. Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts, holds or supports trunk or limbs and provides more than half the effort.
- 1. Dependent** – Helper does ALL of the effort. Patient/resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the patient/resident to complete the activity.

*If activity was not attempted, code reason:*

- 07. Patient/resident refused**
- 09. Not applicable** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
- 10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)**
- 88. Not attempted due to medical condition or safety concerns**

#### **2.1.9 Risk Adjustment**

This is a process measure and not risk-adjusted

#### **2.1.10 Quality Measure Calculation Algorithm**

1. For each provider, the records of patients meeting the inclusion criteria (i.e., denominator) discharged during the 12 month target time period are identified and counted. This count is the denominator.
3. The records of patients not transferred to an inpatient facility or who did not die at home are identified and the number of these episodes with complete SOC/ROC functional assessment data (codes 1 through 6 or 7, 9, 10 or 88) AND at least one

- self-care or mobility goal (codes 1 through 6) AND complete discharge functional assessment data (codes 1 through 6 or 7, 9,10 or 88) is counted.
4. The records of patients who are transferred to an inpatient facility or who died at home are identified, and the number of these patient records with complete SOC/ROC functional status data (codes 1 through 6 or 7, 9,10 or 88) AND at least one self-care or mobility goal (codes 1 through 6) is counted.
  5. The counts from step 2 and step 3 are summed. The sum is the numerator count.
  6. The numerator count is divided by the denominator count to calculate this quality measure, and converted to a percent value by multiplying by 100.

#### **2.1.11 Denominator Exclusions**

There are no measure-specific exclusions.

#### **2.1.12 Numerator Exclusions**

Medicare-certified home health agencies are currently required to collect and submit OASIS data only for adult (aged 18 and over), non-maternity Medicare and Medicaid patients (who are receiving skilled home health care). Therefore, maternity patients, patients less than 18 years of age, non-Medicare/Medicaid patients, and patients who are not receiving skilled home services are all excluded from the measure calculation. However, the OASIS items and related measures could potentially be used for other adult patients receiving services in a community setting, ideally with further testing. Publicly reported data for HHAs on CMS's Home Health Compare Web site require that the HHA have at least 20 observations for the quality measure and that the HHA has been in operation at least six months.

## **2.2 Application of Percent of Residents Experiencing One or More Falls with Major Injury (NQF #0674)**

### **2.2.1 Measure Description**

The quality measure addressing the incidence of major falls is an Application of the NQF-endorsed Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674). This quality measure reports the percentage of quality episodes in which the patient experiences one or more falls with major injury (defined as bone fractures, joint dislocations, and closed-head injuries with altered consciousness, or subdural hematoma) during the home health episode.

The data for the measure would be submitted via the OASIS for home health patients. New OASIS items would need to be added. This quality measure is based on data reported for two items (See Appendix A). The first item (J1800) is a gateway item that asks whether the patient has experienced any falls since start of care (SOC)/resumption of care (ROC). Because the home health measure is based on episode-level data reported at discharge, the item (J1800) for the OASIS asks whether the patient has experienced any falls since SOC/ROC. If the answer to J1800 is no, the next item (J1900) is skipped. If the answer to J1800 is yes, the next item (J1900) asks for the number of falls with a) no injury, b) injury (except major), and c) major injury. The measure is calculated using data reported for J1900C (number of falls with major injury).

### **2.2.2 Denominator Statement**

All quality episodes that are eligible except those that meet the exclusions.

### **2.2.3 Denominator Details**

All home health episodes of care, defined as a start/resumption of care assessment (OASIS item M0100) (Reason for Assessment) = 1 (Start of care) or 3 (Resumption of care)) paired with a corresponding discharge/transfer assessment (M0100 (Reason for Assessment) = 6 (Transfer to inpatient facility – not discharged), 7 (Transfer to inpatient facility – discharged), 8 (Death at home), or 9 (Discharge from agency)), other than those covered by generic and measure-specific denominator exclusions.

### **2.2.4 Numerator Statement**

The numerator for this quality measure is the number of quality episodes in which the patient experienced one or more falls that resulted in major injury during the episode of care.

### **2.2.5 Numerator Details**

Quality episodes in which the patients had an assessment that indicated one or more falls that resulted in major injury (J1900C = [Coding 1, 2]).

## 2.2.6 Items Included in the Quality Measure

The items used for this measure (See Appendix A) collect data that indicates whether or not a fall took place (J1800), and if so, the number of falls in each of the following categories (J1900):

**Injury Related to Fall:** Any documented injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after as, the fall and attributed to the fall.

**Injury (Except Major):** Includes skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the patient to complain of pain.

**Major Injury:** Defined as a bone fracture, joint dislocation, closed-head injury with altered consciousness, or subdural hematoma.

Only the data on number of falls resulting in major injury are included to calculate this measure.

The item (J1900C) would assess whether patient had one or more falls that resulted in major injury since the time of admission to home health.

## 2.2.7 Risk Adjustment

This measure is not risk-adjusted.

## 2.2.8 Quality Measure Calculation Algorithm

The following steps would be used to calculate the measure. Since this measure is not risk-adjusted, only the agency observed score is computed.

### *Calculate the facility observed score (steps 1 through 3)*

**Step 1.** Calculate the denominator count:

Calculate the number of quality episodes, except for those who meet the exclusion criteria.

**Step 2.** Calculate the numerator count:

Calculate the number of quality episodes during the selected time window for those who experienced one or more falls that resulted in major injury during the episode of care.

**Step 3.** Calculate the agency's observed score:

Divide the agency's numerator count by its denominator count to obtain the agency's observed score; that is, divide the result of step 2 by the result of step 1.

### **2.2.9 Denominator Exclusions**

The quality episode is excluded if one of the following is true for all of the look-back scan assessments:

1. The occurrence of falls was not assessed OR
2. The assessment indicates that a fall occurred AND the number of falls with major injury was not assessed.

### **2.2.10 Numerator Exclusions**

Medicare-certified home health agencies are currently required to collect and submit OASIS data only for adult (aged 18 and over), non-maternity Medicare and Medicaid patients who are receiving skilled home health care. Therefore, maternity patients, patients less than 18 years of age, non-Medicare/Medicaid patients, and patients who are not receiving skilled home services are all excluded from the measure calculation. However, the OASIS items and related measures could potentially be used for other adult patients receiving services in a community setting, ideally with further testing. Publicly reported data for HHAs on CMS's Home Health Compare Web site require that the HHA have at least 20 observations for the quality measure and that the HHA has been in operation at least six months.

## 2.3 Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury

### 2.3.1 Quality Measure Description

This proposed quality measure reports the percent of quality episodes in which the patient has one or more Stage 2-4 pressure ulcers, or an unstageable ulcer, present at discharge that are new or worsened since the beginning of the quality episode.<sup>14</sup> The measure is calculated using data from the OASIS. For home health patients, this measure reports the percent of quality episodes with reports of Stage 2-4 pressure ulcers, or unstageable pressure ulcers due to slough/eschar, non-removable dressing/device, or deep tissue injury, that were not present or were at a lesser stage on admission.

### 2.3.2 Purpose/Rationale for Quality Measure

This quality measure is proposed to replace the current pressure ulcer measure, Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678), in the HH QRP measure set beginning with the CY 2020 HH QRP. The change in the measure name is to reduce confusion about the new modified measure. The modified version differs from the current version of the measure because it includes new or worsened unstageable pressure ulcers, including deep tissue injuries (DTIs), in the measure numerator. The proposed modified version of the measure also contains updated specifications intended to eliminate redundancies in the assessment items needed for its calculation and to reduce the potential for underestimating the frequency of pressure ulcers. The modified version of the measure would satisfy the IMPACT Act domain of “Skin integrity and changes in skin integrity.” In order to recommendations provided by a cross-setting pressure ulcer Technical Expert Panel (TEP) and supported by the National Pressure Ulcer Advisory Panel (NPUAP), the current quality measure has been modified in two ways. First, the measure has been modified to incorporate the addition of unstageable pressure ulcers due to slough or eschar, unstageable pressure ulcers due to non-removable dressing or device, and unstageable pressure ulcers presenting as deep tissue injuries in the numerator. This measure is being proposed across PAC settings, including HH, IRF, SNF, and LTCH settings.

Second, the measure calculation has been amended to include M1311 items instead of M1313 items for the HH QRP. This item calculation modification is intended to reduce redundancies in assessment items. To reflect these two changes, the measure is being proposed for CY 2018 federal rulemaking as: Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.

Regardless of setting or provider type, pressure ulcers are recognized as a serious medical condition. Considerable evidence exists regarding the seriousness of pressure ulcers, and the relationship between pressure ulcers and pain, decreased quality of life, and increased mortality in aging populations.<sup>15 16 17 18</sup> Pressure ulcers interfere with activities of daily living and

<sup>14</sup> For the purposes of payment determination in the Home Health Quality Reporting Program, quality episodes are defined by pairing a SOC/ROC assessment with an end of care (EOC) assessment. EOC assessments include Discharge from Agency, Transfer to an Inpatient Facility and Death at Home.

<sup>15</sup> Casey, G. (2013). “Pressure ulcers reflect quality of nursing care.” *Nurs N Z* 19(10): 20-24.

<sup>16</sup> Gorzoni, M. L. and S. L. Pires (2011). “Deaths in nursing homes.” *Rev Assoc Med Bras* 57(3): 327-331.

<sup>17</sup> Thomas, J. M., et al. (2013). “Systematic review: health-related characteristics of elderly hospitalized adults and nursing home residents associated with short-term mortality.” *J Am Geriatr Soc* 61(6): 902-911.

functional gains made during rehabilitation, predispose patients to osteomyelitis and septicemia, and are strongly associated with longer hospital stays, longer IRF stays, and mortality.<sup>19 20 21</sup> Additionally, patients with acute care hospitalizations related to pressure ulcers are more likely to be discharged to long-term care facilities (e.g., a nursing facility, an intermediate care facility, or a nursing home) than hospitalizations for all other conditions.<sup>22 23</sup>

Pressure ulcers typically result from prolonged periods of uninterrupted pressure on the skin, soft tissue, muscle, or bone.<sup>5 9 24</sup> Elderly individuals receiving home health care have a wide range of impairments and/or medical conditions that increase their risk of developing pressure ulcers, including but not limited to, impaired mobility or sensation, malnutrition or under-nutrition, obesity, stroke, diabetes, dementia, cognitive impairments, circulatory diseases, and dehydration. The use of wheelchairs and medical devices (e.g., hearing aid, feeding tubes, tracheostomies), a history of pressure ulcers, or presence of a pressure ulcer at admission are additional factors that increase pressure ulcer risk in elderly patients.<sup>1 5 6 8 25 26 27 28 29 30 31</sup>

Pressure ulcers are high-cost adverse events across the spectrum of health care settings, from acute hospitals to home health.<sup>5 8 10</sup> Pressure ulcer incidence rates vary considerably by clinical setting, ranging from 0.4% to 38% in acute care, 2.2% to 23.9% in skilled nursing facilities [SNFs] and nursing homes [NHs], and 0% to 17% in home health.<sup>8 9</sup> As reported in the Federal Register, in 2006 the average cost for a hospital stay related to pressure ulcers was \$40,381.<sup>32</sup> The Advancing Excellence in America's Nursing Homes Campaign reported that it

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- <sup>18</sup> White-Chu, E. F., et al. (2011). "Pressure ulcers in long-term care." *Clin Geriatr Med* 27(2): 241-258.
- <sup>19</sup> Bates-Jensen BM. Quality indicators for prevention and management of pressure ulcers in vulnerable elders. *Ann Int Med*. 2001;135 (8 Part 2), 744-51.
- <sup>20</sup> Park-Lee E, Caffrey C. Pressure ulcers among nursing home residents: United States, 2004 (NCHS Data Brief No. 14). Hyattsville, MD: National Center for Health Statistics, 2009. Available from <http://www.cdc.gov/nchs/data/databriefs/db14.htm>.
- <sup>21</sup> Wang, H., et al. (2014). "Impact of pressure ulcers on outcomes in inpatient rehabilitation facilities." *Am J Phys Med Rehabil* 93(3): 207-216.
- <sup>22</sup> Hurd D, Moore T, Radley D, Williams C. Pressure ulcer prevalence and incidence across post-acute care settings. Home Health Quality Measures & Data Analysis Project, Report of Findings, prepared for CMS/OCSQ, Baltimore, MD, under Contract No. 500-2005-000181 TO 0002. 2010.
- <sup>23</sup> Institute for Healthcare Improvement (IHI). Relieve the pressure and reduce harm. May 21, 2007. Available from <http://www.ihl.org/IHI/Topics/PatientSafety/SafetyGeneral/ImprovementStories/FSRelievethePressureandReduceHarm.htm>.
- <sup>24</sup> Russo CA, Steiner C, Spector W. Hospitalizations related to pressure ulcers among adults 18 years and older, 2006 (Healthcare Cost and Utilization Project Statistical Brief No. 64). December 2008. Available from <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb64.pdf>.
- <sup>25</sup> Agency for Healthcare Research and Quality (AHRQ). Agency news and notes: pressure ulcers are increasing among hospital patients. January 2009. Available from <http://www.ahrq.gov/research/jan09/0109RA22.htm>.
- <sup>26</sup> Cai, S., et al. (2013). "Obesity and pressure ulcers among nursing home residents." *Med Care* 51(6): 478-486.
- <sup>27</sup> DeJong, G., et al. (2014). "Factors Associated with Pressure Ulcer Risk in Spinal Cord Injury Rehabilitation." *Am J Phys Med Rehabil*. 2014 May 29. [Epub ahead of print]
- <sup>28</sup> MacLean DS. Preventing & managing pressure sores. *Caring for the Ages*. March 2003;4(3):34-7. Available from <http://www.amda.com/publications/caring/march2003/policies.cfm>.
- <sup>29</sup> Michel, J. M., et al. (2012). "As of 2012, what are the key predictive risk factors for pressure ulcers? Developing French guidelines for clinical practice." *Ann Phys Rehabil Med* 55(7): 454-465.
- <sup>30</sup> National Pressure Ulcer Advisory Panel (NPUAP) Board of Directors; Cuddigan J, Berlowitz DR, Ayello EA (Eds). Pressure ulcers in America: prevalence, incidence, and implications for the future. An executive summary of the National Pressure Ulcer Advisory Panel Monograph. *Adv Skin Wound Care*. 2001;14(4):208-15.
- <sup>31</sup> Reddy, M. (2011). "Pressure ulcers." *Clin Evid (Online)* 2011.
- <sup>32</sup> Centers for Medicare & Medicaid Services (CMS). Medicare program; changes to the hospital inpatient prospective payment system and fiscal year 2008 rates. *Fed Register*. August 22, 2007;72(162):47205.

can cost as much as \$19,000 to treat a single Stage 4 pressure ulcer.<sup>33</sup> Using data from 2009 and 2010, severe (Stage 3 and 4) pressure ulcers acquired during a hospital stay were estimated to have increased CMS payments across 90-day episodes of care by at least \$18.8 million a year.<sup>34</sup>

The terminology and definitions developed by the National Pressure Ulcer Advisory Panel (NPUAP) for the care of pressure ulcers are often used to inform the PAC patient and resident assessment instruments and corresponding assessment manuals, specifically the IRF-PAI, the LTCH CARE Data Set, the MDS for SNFs, and the OASIS for HHAs. Considering the recent updates made by the NPUAP to their Pressure Ulcer Staging System, CMS intends to continue the adaptation of NPUAP terminology for coding the patient and resident assessment instruments. CMS will provide guidance which emphasizes that terminology related to these wounds may include injuries, as well as pressure ulcers, while retaining current holistic assessment instructions definitions and terminology. Further guidance and information on adaptation of the NPUAP guidelines, and definitions, and terminology, via assessment manuals and assessment instruments will be posted on the Web site at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-PAI-and-IRF-QRP-Manual.html>.

### **2.3.3 Denominator**

The denominator is the number of quality episodes, except those that meet the exclusion criteria. HH quality episodes are defined by pairing assessments completed at the start or resumption of care with assessments completed at discharge.

### **2.3.4 Denominator Exclusions**

1. Episodes that end in a death at home or transfer to an inpatient facility are excluded from this measure as OASIS data collection that occurs at these time points does not contain the items needed to compute this measure.
2. Episodes without an assessment completed at the start or resumption of care and an assessment completed at discharge are excluded.
3. Episodes are excluded if the discharge assessment does not have a usable response for M1311a, M1311b, M1311c, M1311d, M1311e or M1311f.

### **2.3.5 Numerator**

The numerator is the number of completed quality episodes for patients whose assessment at discharge indicates one or more new or worsened Stage 2-4 or unstageable pressure ulcers compared to the start or resumption of care assessment.

Where on any discharge assessment:

1. Stage 2 (M1311A1) - (M1311A2) > 0, OR

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<sup>33</sup> Advancing Excellence in America's Nursing Homes (AEANH). Explore our goals. n.d. Available from <https://www.nhqualitycampaign.org/goals.aspx>.

<sup>34</sup> Kandilov AMG, Coomer NM, Dalton K. (2014) The impact of hospital-acquired conditions on Medicare program payments. MMRR 4(4): E1-E23

2. Stage 3 (M1311B1) - (M1311B2) > 0, OR
3. Stage 4 (M1311C1) - (M1311C2) > 0, OR
4. Unstageable – Non-removable dressing/device (M1311D1) - (M1311D2) > 0, OR
5. Unstageable – Slough and/or eschar (M1311E1) - (M1311E2) > 0, OR
6. Unstageable – Deep tissue injury (M1311F1) - (M1311F2) > 0

### 2.3.6 Items Included in the Quality Measure

- **M1311A1.** Number of Stage 2 pressure ulcers, **M1311A2.** Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC
- **M1311B1.** Number of Stage 3 pressure ulcers, **M1311B2.** Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC
- **M1311C1.** Number of Stage 4 pressure ulcers, **M1311C2.** Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC
- **M1311D1.** Number of unstageable pressure ulcers/injuries due to non-removable dressing/device, **M1311D2.** Number of these unstageable pressure ulcers/injuries that were present at most recent SOC/ROC
- **M1311E1.** Unstageable: Slough and/or eschar, **M1311E2.** Number of these unstageable pressure ulcers that were present at most recent SOC/ROC
- **M1311F1.** Unstageable: Deep tissue injury, **M1311F2.** Number of these unstageable pressure injuries that were present at most recent SOC/ROC

### 2.3.7 Risk Adjustment Factors

This measure will be risk-adjusted based on an evaluation of potential risk factors and their statistically significant impact on the outcome. Proposed risk factor covariates include:

1. Indicator of supervision/touching assistance or more at SOC/ROC for functional mobility item Lying to Sitting on Side of Bed (GG0170C):  
Covariate = [1] (yes) if GG0170C = [01, 02, 03, 04, 07, 09, 88]  
Covariate = [0] (no) if GG0170C = [05, 06, -]
2. Indicator of bowel incontinence at least occasionally at SOC/ROC (M1620):  
Covariate = [1] if M1620 = [2, 3, 4, 5]  
Covariate = [0] if M1620 = [0, 1, NA, UK]
3. Have diabetes mellitus, peripheral vascular disease or peripheral arterial disease:  
Covariate = [1] (yes) if any of the following are true at SOC/ROC: M1028 = [1] (checked) or M1028 = [2] (checked)  
Covariate = [0] (no) if M1028 = [3] (checked)
4. Indicator of Low Body Mass Index, based on Height (M1060a) and Weight (M1060b) at SOC/ROC  
Covariate = [1] (yes) if BMI ≥ [12.0] AND ≤ [19.0]  
Covariate = [0] (no) if BMI > [19.0]

Covariate = [0] (no) if M1060a = [-] OR M1060b = [-] OR BMI < [12.0], ('-'= No response available)

Where: BMI = (weight \* 703 / height<sup>2</sup>) = ((M1060b) \* 703) / (M1060a<sup>2</sup>) and the resulting value is rounded to one decimal.

### 2.3.8 Quality Measure Calculation Algorithm

The following steps are used to calculate the measure:

#### A. Calculate the agency observed score (steps 1 through 3)

**Step 1.** Calculate the denominator count:

Calculate the total number of quality episodes with a selected target OASIS assessment in the measure time window that do not meet the exclusion criteria.

**Step 2.** Calculate the numerator count:

Calculate the total number of quality episodes in the denominator whose OASIS assessments indicates one or more new or worsened pressure ulcers at discharge compared to start or resumption of care.

**Step 3.** Calculate the agency's observed rate:

Divide the agency's numerator count by its denominator count to obtain the agency's observed rate; that is, divide the result of step 2 by the result of step 1.

#### B. Calculate the predicted rate for each quality episode (steps 4 and 5)

**Step 4.** Determine presence or absence of the pressure ulcer risk factors for each patient:

If dichotomous risk factor covariates are used, assign covariate values, either '0' for covariate condition not present or '1' for covariate condition present, for each quality episode for each of the covariates as reported at SOC/ROC, as described in the section above. In some cases the actual values for a risk factor covariate may be used, e.g., the number of pressure ulcers present at each level at SOC/ROC or the total number of pressure ulcers present across all levels or the number of unstageable pressure ulcers.

**Step 5.** Calculate the predicted rate for each quality episode with the following formula:

$$[1] \text{ Episode-level predicted QM rate} = 1 / [1 + e^{-x}]$$

Where e is the base of natural logarithms and X is a linear combination of the constant and the logistic regression coefficients times the covariate scores (from Formula [2], below).

$$[2] \text{ QM triggered (yes=1, no=0)} = B_0 + B_1 * COVA + B_2 * COVB + \dots B_N * COVN$$

Where B<sub>0</sub> is the logistic regression constant, B<sub>1</sub> is the logistic regression coefficient for the first covariate (where applicable), COVA is the episode-level rate for the first covariate, B<sub>2</sub> is the logistic regression coefficient for the second covariate, and COVB is the episode-level rate for the second covariate (where applicable), etc. The

regression constant and regression coefficients\* are numbers obtained through statistical logistic regression analysis.

\* Regression coefficients and constants are updated each reporting period.

C. Calculate the agency predicted rate (step 6)

**Step 6.** Once a predicted QM rate has been calculated for all quality episodes, calculate the mean agency-level predicted QM rate by averaging all episode-level predicted values for that agency.

D. Calculate national predicted rate (step 7)

**Step 7.** Calculate the national predicted rate:

Once a predicted QM value has been calculated for all episodes, calculate the mean national-level predicted QM rate by averaging all episode-level predicted values. Note that the sample will include only those quality episodes with non-missing data for the component covariates.

E. Calculate the agency's risk-adjusted rate (step 8)

**Step 8.** Calculate the agency-level risk-adjusted rate based on the:

agency-level observed QM rate (step 3),

agency-level mean predicted QM rate (step 6), and

\*national mean predicted QM rate (step 7), using the following formula:

agency risk adjusted rate = agency observed rate + national predicted rate – agency predicted rate

*\*The national predicted QM rates are updated each reporting period.*

## SECTION 3 STANDARDIZED PATIENT ASSESSMENT DATA ELEMENTS

### 3.1 Standardized Patient Assessment Data Element Work: An Introduction

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires CMS to develop, implement, and maintain standardized patient assessment data elements for PAC settings. The goals of implementing cross-setting standardized patient assessment data elements are to facilitate care coordination, interoperability, and improve outcomes of Medicare beneficiaries and other patients receiving post-acute care. Existing PAC assessment instruments (i.e., Outcome and Assessment Information Set (OASIS) for HHAs, Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) for IRFs, LTCH CARE Data Set (LCDS) for LTCHs, and the Minimum Data Set (MDS) for SNFs) often collect data items pertaining to similar concepts, but the individual data elements -- questions and response options -- vary by assessment instrument. With a few exceptions, the data elements collected in these assessment instruments are not currently standardized or interoperable, therefore, patient responses across the assessment instruments cannot be compared easily. The IMPACT Act further requires that the assessment instruments described above be modified to include core data elements on health assessment categories and that such data be standardized and interoperable. Implementation of a core set of standardized assessment items across PAC settings has important implications for Medicare beneficiaries and other patients receiving post-acute care, families, providers, and policymakers. These categories specified in the IMPACT Act are:

1. Functional status, such as mobility and self-care
2. Cognitive function (e.g., able to express ideas and to understand normal speech) and mental status (e.g., depression and dementia)
3. Special services, treatments, and interventions (e.g., need for ventilator, dialysis, chemotherapy, and total parenteral nutrition)
4. Medical conditions and co-morbidities (e.g., diabetes, heart failure, and pressure ulcers)
5. Impairments (e.g., incontinence; impaired ability to hear, see, or swallow)

In the following sections, we present specifications and evidence of support for the standardized patient assessment data elements finalized in the HH QRP. We are finalizing the standardized patient assessment data elements that we proposed to adopt for the IMPACT Act categories of Functional Status and Medical Conditions and Co-Morbidities. The standardized patient assessment data that we proposed for these clinical categories are collected and used to calculate the Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678) measure and the 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) measure.

We will not finalize the standardized patient assessment data element proposals due to the substantial comments requesting the delay for standardized patient assessment data element implementation coupled with extensive comments on the increase in burden the proposed standardized patient assessment data element policy would impose on facilities, and the need for

time to prepare and implement training, manuals, and reports. We intend to propose standardized patient assessment data elements for the three categories of Cognitive Function and Mental Status; Special Services, Treatments, and Interventions; and Impairments no later than in the CY 2020 HH PPS proposed rule.

## 3.2 Functional Status

Beginning with the CY 2020 HH QRP, we are finalizing that the submission of the admission and discharge performance data used in the measure, 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), that we finalized in this CY 2018 HH PPS final rule also meets the requirement for the collection of standardized patient assessment data in the area of Functional Status. This process measure has been finalized in the FY 2016 IRF PPS final rule (80 FR 47100 through 47111) for the IRF QRP, the FY 2016 SNF PPS final rule (80 FR 46444 through 46453) for the SNF QRP, and the FY 2016 IPPS/LTCH PPS final rule (80 FR 49739 through 49747) for the LTCH QRP.

This cross-setting function process measure requires the collection of admission and discharge functional status data using standardized clinical assessment items, or data elements, which assess specific functional activities, that is, 3 self-care and 9 mobility activities. These activities are coded using a 6-level rating scale that indicates the patient's level of independence with the activity; higher scores indicate more independence. For more information about this quality measure, we refer readers to Section 2 of this document.

A table showing the functional status data elements for the measure, 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), included in the MDS 3.0, IRF-PAI 2.0 and LCDS 4.00 is provided in Appendix 1, Table 1.

### **3.3 Medical Condition and Comorbidity Data**

Standardized patient assessment data elements to satisfy the IMPACT Act category of Medical Conditions and Comorbidities are already submitted for calculation of the measure the Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678), which was finalized for adoption into the HH QRP in the CY 2016 HH PPS final rule, and for the other PAC quality reporting programs in the FY 2016 SNF PPS final rule, the FY 2014 IRF PPS final rule, and the FY 2014 IPPS/LTCH PPS final rule. The standardized patient assessment data elements used to calculate and risk adjust this measure fall under the IMPACT Act category “medical conditions and comorbidities,” listed in section 1899B(b)(1)(B) of the Act, which includes pressure ulcers and diabetes. The data elements used to calculate the finalized measure, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury, are also related to the category of medical conditions and comorbidities, and are described in Section 2 of this document.

**APPENDIX 1:  
FUNCTION ITEMS INCLUDED IN THE PROCESS FUNCTION QUALITY MEASURE  
FOR HH, IRF, SNF, AND LTCH QUALITY REPORTING PROGRAMS**

**Table 1** shows the items included in the function quality measures that are process measures. For the HH, IRF, SNF and LTCH settings, the cross-setting measure, an *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; endorsed), is listed.

**Table 1  
Function Items Included in the Process Function Quality Measures for HH, IRF, SNF, and  
LTCH QRPs**

Item Identifier	Item Name	HH QRP	IRF QRP	SNF QRP	LTCH QRP	
		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; endorsed)	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; endorsed)	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; endorsed)	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; endorsed)	Percent of long-term care hospital patients with an admission and discharge functional assessment and a care plan that addresses function (NQF #2631; endorsed)*
<b>SELF-CARE GG0130</b>						
<b>A</b>	Eating	✓	✓	✓	✓	✓
<b>B</b>	Oral hygiene	✓	✓	✓	✓	✓
<b>C</b>	Toileting hygiene	✓	✓	✓	✓	✓
<b>D</b>	Wash upper body	—	—	—	—	✓
<b>E</b>	Shower/bathe self	—	—	—	—	—
<b>F</b>	Upper body dressing	—	—	—	—	—
<b>G</b>	Lower body dressing	—	—	—	—	—

(continued)

**Table 1 (continued)**  
**Function Items Included in the Process Function Quality Measures for HH, IRF, SNF, and LTCH QRPs**

Item Identifier	Item Name	HH QRP	IRF QRP	SNF QRP	LTCH QRP	
		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; endorsed)	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; endorsed)	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; endorsed)	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; endorsed)	Percent of long-term care hospital patients with an admission and discharge functional assessment and a care plan that addresses function (NQF #2631; endorsed)*
<b>H</b>	Putting on/taking off footwear	—	—	—	—	—
<b>MOBILITY GG0170</b>						
<b>A</b>	Roll left and right	—	—	—	—	✓
<b>B</b>	Sit to lying	✓	✓	✓	✓	✓
<b>C</b>	Lying to sitting on side of bed	✓	✓	✓	✓	✓
<b>D</b>	Sit to stand	✓	✓	✓	✓	✓
<b>E</b>	Chair/bed-to-chair transfer	✓	✓	✓	✓	✓
<b>F</b>	Toilet transfer	✓	✓	✓	✓	✓
<b>G</b>	Car transfer	—	—	—	—	—
<b>I</b>	Walk 10 feet	—	—	—	—	✓
<b>J</b>	Walk 50 feet with two turns	✓	✓	✓	✓	✓
<b>K</b>	Walk 150 feet	✓	✓	✓	✓	✓
<b>L</b>	Walking 10 feet on uneven surface	—	—	—	—	—

(continued)

**Table 1 (continued)**  
**Function Items Included in the Process Function Quality Measures for HH, IRF, SNF, and LTCH QRPs**

Item Identifier	Item Name	HH QRP	IRF QRP	SNF QRP	LTCH QRP	
		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; endorsed)	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; endorsed)	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; endorsed)	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; endorsed)	Percent of long-term care hospital patients with an admission and discharge functional assessment and a care plan that addresses function (NQF #2631; endorsed)*
<b>M</b>	1 step (curb)	—	—	—	—	—
<b>N</b>	4 steps	—	—	—	—	—
<b>O</b>	12 steps	—	—	—	—	—
<b>P</b>	Picking up object	—	—	—	—	—
<b>Q</b>	<i>Does patient use wheelchair/scooter?</i>	✓	✓	✓	✓	✓
<b>R</b>	Wheel 50 feet with two turns	✓	✓	✓	✓	✓
<b>RR</b>	Type of wheelchair/scooter	✓	✓	✓	✓	✓
<b>S</b>	Wheel 150 feet	✓	✓	✓	✓	✓
<b>SS</b>	Type of wheelchair/scooter	✓	✓	✓	✓	✓

NOTES:

✓ = Item is included in the quality measure.

— = Item is not included in the quality measure.

\* This process measure was adopted for the LTCH QRP through the FY 2015 IPPS/LTCH PPS final rule (79 FR 50298 through 50301).

**APPENDIX 2:**  
**SUPPLEMENTAL INFORMATION TO THE ASSESSMENT ITEMS USED TO  
CALCULATE THE ADOPTED HH FUNCTION QUALITY MEASURES**

Standardized functional assessment items are included in the *Section GG* of the Quality Indicator section of the Outcome and Assessment Information Set (OASIS) proposed for implementation starting January 1, 2019. These standardized items are used to collect data to calculate the adopted quality measures intended to meet the IMPACT Act requirement for measure domain: functional status, cognitive function, and changes in function and cognitive function. The quality measure Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631) rely on the collection of data using these standardized items derived from the Continuity Assessment Record and Evaluation (CARE) Item Set. The standardized items used to calculate the adopted quality measures will enable CMS to assess functional change in an IRF care setting.

The standardized items included within the OASIS do not duplicate existing items on the OASIS currently in use for data collection on functional assessment. While many of the standardized items have labels that are similar to existing items on the OASIS, there are several key differences between the two sets that may result in variation in the patient assessment results. Key differences include: (1) the data collection and associated data collection instructions; (2) the rating scales used to score a patient’s level of independence; and (3) the item definitions.

Supplemental information discussing the standardized items used to calculate the adopted function quality measures is listed below.

1. Data Collection and Data Collection Instructions for the Standardized Function Items:

- The breath of the standardized items used to assess function reflects the intent to measure function with greater precision for low-functioning patients as well as high-functioning patients.
- For the standardized items, function is assessed based on a patient’s usual performance. When patient functioning varies, the patient’s *usual* performance (rather than *most dependent*) will be reported on the standardized items included in the OASIS. Standardized functional assessment items are also included in Section GG of the MDS 3.0, IRF PAI, and the LTCH CARE Data Set.
- The standardized function items reflect best practice clinical assessment of daily activities that occur as part of the start of care (SOC) /resumption of care (ROC) and/or discharge assessment workflow.
  - Activities assessed at admission occur in order to set discharge goals and activities are assessed at discharge in order to optimize a safe transition to home or the next care setting.
  - Examples include: “Sit to stand” and “Roll left and right” are bed mobility activities that are often assessed at SOC/ROC in most HHAs. “Car transfers,” “Walking 10 feet on an uneven surface” and “Picking up an object from a standing position” are activities that are often assessed at discharge.

## 2. Rating Scales Used to Assess Functional Activities:

- The standardized items include 7 self-care activities and 17 mobility activities that are rated on a 6-level rating scale ranging from “6” meaning “Independent” to “1” that refers to dependent (Figure 1).
- A higher score on the rating scale means greater independence.
- Four special codes (07, 09, 10, 88) are available to report that a patient did not attempt an activity and to identify the rationale for why a patient did not attempt an activity (e.g., safety concerns, patient refused), which is important information when examining patient outcomes.
- Supervision and touching assistance with *no lifting* assistance is coded at a level 4 on the rating scale. Supervision assistance is coded at a level of 4 to reflect the supervision that is often needed during the entire time of completing an activity.
- The level titled “Dependent” is defined to include only patients who are completely dependent. That is, if a patient is coded “Dependent,” then that patient does not assist with completing an activity.

**Figure 1.**  
**Rating Scale for Standardized Functional Assessment Items**

**Coding:**

**Safety and Quality of Performance** – If helper assistance is required because patient’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 – Patient completes the activity by him/herself with no assistance from a helper.
- 05. Setup or clean-up assistance – Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
- 04. Supervision or touching assistance – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient 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. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

**If activity was not attempted, code reason:**

- 07. Patient refused
- 09. Not applicable – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
- 10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)
- 88. Not attempted due to medical conditions or safety concerns

## 3. Definitions for the Standardized Items:

- The standardized items include assessment and scoring methods to allow for variation. For example, a score is reported for four walking items with different distances (10, 50 and 150 feet) and different types of surfaces (even and uneven surfaces) and includes the capacity for coding two wheelchair items, if applicable.

- The standardized items have specified definitions. For example, the standardized function item for assessing “Eating” does not include tube feeding administration. If an individual is solely receiving nutrition by tube feeding and the staff administers his tube feedings and he does not eat by mouth, the standardized “Eating” item would be coded as the “Activity was not attempted due to medical condition or safety concerns” (code = 88).
- For personal hygiene, one standardized item focuses on a single activity, “Oral hygiene,” which is not intermixed with other personal hygiene activities. The focus of this item enables the ability to identify activity-specific limitations, areas requiring clinical focus, and set activity-specific goals.

**APPENDIX 3:  
DATA ELEMENTS USED IN CALCULATION OF CHANGES IN SKIN INTEGRITY  
POST-ACUTE CARE: PRESSURE ULCER/INJURY QM**

SNF		IRF		LTCH		HH	
<b>M0300/M1311 – Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage</b>							
<b>B. Stage 2:</b> Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister.		<b>B. Stage 2:</b> Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister.		<b>B. Stage 2:</b> Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister.		<b>A1. Stage 2:</b> Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister.	
Enter number <input type="text"/>	1: Number of Stage 2 pressure ulcers. If 0 skip to M0300C, Stage 3	Enter number <input type="text"/>	1: Number of Stage 2 pressure ulcers. If 0 skip to M0300C, Stage 3	Enter number <input type="text"/>	1: Number of Stage 2 pressure ulcers. If 0 skip to M0300C, Stage 3	Enter number <input type="text"/>	1: Number of Stage 2 pressure ulcers. If 0 skip to M1311B1, Stage 3
Enter number <input type="text"/>	2: Number of <u>these</u> Stage 2 pressure ulcers that were present upon admission/ entry or reentry. Enter how many were noted at the time of admission/ entry or reentry.	Enter number <input type="text"/>	2: Number of <u>these</u> Stage 2 pressure ulcers that were present upon admission. Enter how many were noted at the time of admission.	Enter number <input type="text"/>	2: Number of <u>these</u> Stage 2 pressure ulcers that were present upon admission. Enter how many were noted at the time of admission.	Enter number <input type="text"/>	2: Number of <u>these</u> Stage 2 pressure ulcers that were present at most recent SOC/ROC. Enter how many were noted at the time of most recent SOC/ROC.
<b>C. Stage 3:</b> Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.		<b>C. Stage 3:</b> Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.		<b>C. Stage 3:</b> Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.		<b>B1. Stage 3:</b> Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.	
Enter number <input type="text"/>	1: Number of Stage 3 pressure ulcers. If 0 skip to M0300D, Stage 4.	Enter number <input type="text"/>	1: Number of Stage 3 pressure ulcers. If 0 skip to M0300D, Stage 4.	Enter number <input type="text"/>	1: Number of Stage 3 pressure ulcers. If 0 skip to M0300D, Stage 4.	Enter number <input type="text"/>	1: Number of Stage 3 pressure ulcers. If 0 skip to M1311C1, Stage 4.
Enter number <input type="text"/>	2: Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission/ entry or reentry. Enter how many were noted at the time of admission / entry or reentry	Enter number <input type="text"/>	2: Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission. Enter how many were noted at the time of admission.	Enter number <input type="text"/>	2: Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission. Enter how many were noted at the time of admission.	Enter number <input type="text"/>	2: Number of <u>these</u> Stage 3 pressure ulcers that were present at most recent SOC/ROC. Enter how many were noted at the time of most recent SOC/ROC.

SNF		IRF		LTCH		HH	
<b>D. Stage 4:</b> Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.		<b>D. Stage 4:</b> Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.		<b>D. Stage 4:</b> Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.		<b>C1. Stage 4:</b> Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.	
Enter number <input type="text"/>	1: Number of Stage 4 pressure ulcers. If 0 skip to M0300E, Unstageable non-removable dressing/device.	Enter number <input type="text"/>	1: Number of Stage 4 pressure ulcers. If 0 skip to M0300E, Unstageable non-removable dressing/device.	Enter number <input type="text"/>	1: Number of Stage 4 pressure ulcers. If 0 skip to M0300E, Unstageable non-removable dressing/device.	Enter number <input type="text"/>	1: Number of Stage 4 pressure ulcers. If 0 skip to M1311D1, Unstageable non-removable dressing/device.
Enter number <input type="text"/>	2: Number of <u>these</u> Stage 4 pressure ulcers that were present upon admission/ entry or reentry. Enter how many were noted at the time of admission / entry or reentry.	Enter number <input type="text"/>	2: Number of <u>these</u> Stage 4 pressure ulcers that were present upon admission. Enter how many were noted at the time of admission.	Enter number <input type="text"/>	2: Number of <u>these</u> Stage 4 pressure ulcers that were present upon admission. Enter how many were noted at the time of admission.	Enter number <input type="text"/>	2: Number of <u>these</u> Stage 4 pressure ulcers that were present at most recent SOC/ROC. Enter how many were noted at the time of most recent SOC/ROC.
<b>E. Unstageable</b> – Non-removable dressing/device: Known but not stageable due to non-removable dressing/device.		<b>E. Unstageable</b> – Non-removable dressing/device: Known but not stageable due to non-removable dressing/device.		<b>E. Unstageable</b> – Non-removable dressing/device: Known but not stageable due to non-removable dressing/device.		<b>D1. Unstageable</b> – Non-removable dressing/device: Known but not stageable due to non-removable dressing/device.	
Enter number <input type="text"/>	1: Number of unstageable pressure ulcers/injuries non-removable dressing/device. If 0 skip to M0300F, Unstageable – Slough and/or eschar.	Enter number <input type="text"/>	1: Number of unstageable pressure ulcers/injuries non-removable dressing/device. If 0 skip to M0300F, Unstageable – Slough and/or eschar.	Enter number <input type="text"/>	1: Number of unstageable pressure ulcers/injuries non-removable dressing/device. If 0 skip to M0300F, Unstageable – Slough and/or eschar.	Enter number <input type="text"/>	1: Number of unstageable pressure ulcers/injuries non-removable dressing/device. If 0 skip to M1311E1, Unstageable – Slough and/or eschar.
Enter number <input type="text"/>	2: Number of <u>these</u> unstageable pressure ulcers/injuries that were present upon admission/ entry or reentry. Enter how many were noted at the time of admission / entry or reentry.	Enter number <input type="text"/>	2: Number of <u>these</u> unstageable pressure ulcers/injuries that were present upon admission. Enter how many were noted at the time of admission.	Enter number <input type="text"/>	2: Number of <u>these</u> unstageable pressure ulcers/injuries that were present upon admission. Enter how many were noted at the time of admission.	Enter number <input type="text"/>	2: Number of <u>these</u> unstageable pressure ulcers/injuries that were present at most recent SOC/ROC. Enter how many were noted at the time of most recent SOC/ROC.

SNF		IRF		LTCH		HH	
<b>F. Unstageable</b> – slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar.		<b>F. Unstageable</b> – slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar.		<b>F. Unstageable</b> – slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar.		<b>E1. Unstageable</b> – slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar.	
Enter number <input type="text"/>	1: Number of unstageable pressure ulcers due to coverage of the wound bed by slough and/or eschar. If 0 skip to M0300G, Unstageable – Deep tissue injury.	Enter number <input type="text"/>	1: Number of unstageable pressure ulcers due to coverage of the wound bed by slough and/or eschar. If 0 skip to M0300G, Unstageable – Deep tissue injury.	Enter number <input type="text"/>	1: Number of unstageable pressure ulcers due to coverage of the wound bed by slough and/or eschar. If 0 skip to M0300G, Unstageable – Deep tissue injury.	Enter number <input type="text"/>	1: Number of unstageable pressure ulcers due to coverage of the wound bed by slough and/or eschar. If 0 skip to M1311F1, Unstageable – Deep tissue injury.
Enter number <input type="text"/>	2: Number of <u>these</u> unstageable pressure ulcers that were present upon admission/ entry or reentry. Enter how many were noted at the time of admission / entry or reentry.	Enter number <input type="text"/>	2: Number of <u>these</u> unstageable pressure ulcers that were present upon admission. Enter how many were noted at the time of admission.	Enter number <input type="text"/>	2: Number of <u>these</u> unstageable pressure ulcers that were present upon admission. Enter how many were noted at the time of admission.	Enter number <input type="text"/>	2: Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC. Enter how many were noted at the time of most recent SOC/ROC.
<b>G. Unstageable</b> – Deep tissue injury:		<b>G. Unstageable</b> – Deep tissue injury:		<b>G. Unstageable</b> – Deep tissue injury:		<b>F1. Unstageable</b> – Deep tissue injury:	
Enter number <input type="text"/>	1. Number of unstageable pressure injuries presenting as deep tissue injury. If 0 skip to M1030, Number of Venous and Arterial Ulcers.	Enter number <input type="text"/>	1. Number of unstageable pressure injuries presenting as deep tissue injury. If 0 skip to N2005, Medication Intervention.	Enter number <input type="text"/>	1: Number of unstageable pressure injuries presenting as deep tissue injury. If 0 skip to N2005, Medication Intervention.	Enter number <input type="text"/>	1: Number of unstageable pressure injuries presenting as deep tissue injury. If 0 skip to M1322
Enter number <input type="text"/>	2. Number of <u>these</u> unstageable pressure injuries that were present upon admission/ entry or reentry. Enter how many were noted at the time of admission / entry or reentry.	Enter number <input type="text"/>	2. Number of <u>these</u> unstageable pressure injuries that were present upon admission. Enter how many were noted at the time of admission.	Enter number <input type="text"/>	2: Number of <u>these</u> unstageable pressure injuries that were present upon admission. Enter how many were noted at the time of admission.	Enter number <input type="text"/>	2: Number of <u>these</u> unstageable pressure injuries that were present at most recent SOC/ROC. Enter how many were noted at the time of most recent SOC/ROC.

**APPENDIX 4:  
RISK ADJUSTMENT COVARIATES USED IN CALCULATION OF CHANGES IN  
SKIN INTEGRITY POST-ACUTE CARE: PRESSURE ULCER/INJURY QM**

SNF Risk Adjustment Covariates	IRF Risk Adjustment Covariates	LTCH Risk Adjustment Covariates	HH Risk Adjustment Covariates
<b>Functional Mobility Admission Performance</b>			
<b>GG0170C. Mobility: Lying to Sitting on Side of Bed:</b> The ability to 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. 06. Independent 05. Setup or clean-up assistance 04. Supervision or touching assistance 03. Partial/moderate assistance 02. Substantial/maximal assistance 01. Dependent If activity was not attempted, code reason: 07. Resident refused 09. Not applicable 10. Not attempted due to environmental limitations 88. Not attempted due to medical condition or safety concerns	<b>GG0170C. Mobility: Lying to Sitting on Side of Bed:</b> The ability to 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. 06. Independent 05. Setup or clean-up assistance 04. Supervision or touching assistance 03. Partial/moderate assistance 02. Substantial/maximal assistance 01. Dependent If activity was not attempted, code reason: 07. Patient refused 09. Not applicable 10. Not attempted due to environmental limitations 88. Not attempted due to medical condition or safety concerns	<b>GG0170C. Mobility: Lying to Sitting on Side of Bed:</b> The ability to 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. 06. Independent 05. Setup or clean-up assistance 04. Supervision or touching assistance 03. Partial/moderate assistance 02. Substantial/maximal assistance 01. Dependent If activity was not attempted, code reason: 07. Patient refused 09. Not applicable 10. Not attempted due to environmental limitations 88. Not attempted due to medical condition or safety concerns	<b>GG0170C. Mobility: Lying to Sitting on Side of Bed:</b> The ability to 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. 06. Independent 05. Setup or clean-up assistance 04. Supervision or touching assistance 03. Partial/moderate assistance 02. Substantial/maximal assistance 01. Dependent If activity was not attempted, code reason: 07. Patient refused 09. Not applicable 10. Not attempted due to environmental limitations 88. Not attempted due to medical condition or safety concerns

SNF Risk Adjustment Covariates	IRF Risk Adjustment Covariates	LTCH Risk Adjustment Covariates	HH Risk Adjustment Covariates
<b>Bowel Continence</b>			
<b>H0400. Bowel Continence</b> 0. Always continent 1. Occasionally incontinent 2. Frequently incontinent 3. Always incontinent 9. Not rated	<b>H0400. Bowel Continence</b> 0. Always continent 1. Occasionally incontinent 2. Frequently incontinent 3. Always incontinent 9. Not rated	<b>H0400. Bowel Continence</b> 0. Always continent 1. Occasionally incontinent (one episode of bowel incontinence) 2. Frequently incontinent (2 or more episodes of bowel incontinence, but at least one continent bowel movement) 3. Always incontinent (no episodes of continent bowel movements) 4. Not rated, patient had an ostomy or did not have a bowel movement for the entire 3 days	<b>M1620. Bowel Incontinence</b> 0. Very rarely or never has bowel incontinence 1. Less than once weekly 2. One to three times weekly 3. Four to six times weekly 4. On a daily basis 5. More often than once daily NA. Patient has ostomy for bowel elimination

SNF Risk Adjustment Covariates	IRF Risk Adjustment Covariates	LTCH Risk Adjustment Covariates	HH Risk Adjustment Covariates
<b>Peripheral Vascular Disease (PVD) / Peripheral Arterial Disease (PAD) or Diabetes</b>			
<p><b>I0900. Peripheral Vascular Disease (PVD) /Peripheral Arterial Disease (PAD)</b></p> <p>0. Did not have PVD or PAD in the last 7 days</p> <p>1. Had PVD or PAD in the last 7 days</p> <p><b>I2900 Diabetes Mellitus (DM)</b></p> <p>0. Did not have DM in the last 7 days</p> <p>1. Had DM in the last 7 days</p>	<p><b>I0900. Peripheral Vascular Disease (PVD) /Peripheral Arterial Disease (PAD)</b></p> <p>0. Does not have PVD or PAD</p> <p>1. Have PVD or PAD</p> <p><b>I2900 Diabetes Mellitus (DM)</b></p> <p>0. Does not have DM</p> <p>1. Has DM</p>	<p><b>I0900. Peripheral Vascular Disease (PVD) / Peripheral Arterial Disease (PAD)</b></p> <p>0. Does not have PVD or PAD</p> <p>1. Have PVD or PAD</p> <p><b>I2900. Diabetes Mellitus (DM)</b></p> <p>0. Does not have DM</p> <p>1. Has DM</p>	<p><b>I0900. Peripheral Vascular Disease (PVD) / Peripheral Arterial Disease (PAD)</b></p> <p>2. Does not have PVD or PAD</p> <p>3. Have PVD or PAD</p> <p><b>I2900. Diabetes Mellitus (DM)</b></p> <p>1. Does not have DM</p> <p>2. Has DM</p>
<b>Height and Weight (Low Body Mass Index)</b>			
<p><b>K0200A (Height); and K0200B (Weight).</b></p>	<p><b>25A (Height); and 26A (Weight).</b></p>	<p><b>K0200A (Height); and K0200B (Weight).</b></p>	<p><b>(M1060) Height and Weight</b></p> <p>a. Height (in inches). Record most recent height measure since the most recent SOC/ROC</p> <p>b. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard agency practice</p>

**APPENDIX 5:  
PRESSURE ULCER QUALITY MEASURE ITEM STANDARDIZATION: DATA  
ELEMENTS COLLECTED FOR CALCULATION OF QUALITY MEASURES USED IN  
HH, SNF, LTCH, AND IRF QUALITY REPORTING PROGRAMS**

**SNF, LTCH, IRF and HH PAC Settings: Items Collected at Discharge**

<b>Item</b>	<b>Item Description</b>	<b>Proposed MDS (effective 10/1/2018)</b>	<b>Proposed LTCH CARE Data Set (effective 4/1/2018)</b>	<b>Proposed IRF-PAI (effective 10/1/2018)</b>	<b>Proposed OASIS (effective 01/01/2019)</b>
<b>M0300/ M1311</b>	<b>Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage</b>				
<i>A/(M1322)</i>	Number of Stage 1 pressure ulcers	X	X	X	X
<i>B1/A1</i>	Number of Stage 2 pressure ulcers	X	X	X	X
<i>B2/A2</i>	Number of these Stage 2 pressure ulcers that were present upon admission/at the time of most recent SOC/ROC	X	X	X	X
<i>C1/B1</i>	Number of Stage 3 pressure ulcers	X	X	X	X
<i>C2/B2</i>	Number of these Stage 3 pressure ulcers that were present upon admission/at the time of most recent SOC/ROC	X	X	X	X
<i>D1/C1</i>	Number of Stage 4 pressure ulcers	X	X	X	X
<i>D2/C2</i>	Number of these Stage 4 pressure ulcers that were present upon admission/at the time of most recent SOC/ROC	X	X	X	X
<i>E1/D1</i>	Number of unstageable pressure ulcers/injuries due to non-removable dressing/device	X	X	X	X
<i>E2/D2</i>	Number of these unstageable pressure ulcers/injuries that were present upon admission/at the time of most recent SOC/ROC	X	X	X	X
<i>F1/E1</i>	Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar	X	X	X	X
<i>F2/E2</i>	Number of these unstageable pressure ulcers that were present upon admission/at the time of most recent SOC/ROC	X	X	X	X
<i>G1/F1</i>	Number of unstageable pressure injuries presenting as deep tissue injury	X	X	X	X
<i>G2/F2</i>	Number of these unstageable pressure injuries that were present upon admission/at the time of most recent SOC/ROC	X	X	X	X

X = Item is present