Nursing Home Resident Acute Care Readmissions

Mechanisms to Promote High Quality End of Life Care

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Factors
- Better quality of care would have prevented or decreased severity of acute change
- One physician visit could have avoided the transfer
- Better advance care planning would have prevented the transfer
- The same benefits could have been achieved at a lower level of care
- The resident’s overall condition limited his ability to benefit from the transfer

Resources Needed
- Physician or physician extender present in nursing home at least 3 days per week
- Exam by physician or physician extender within 24 hours
- Nurse practitioner involvement
- Registered nurse (as opposed to LPN or CNA) providing care
- Availability of lab tests within 3 hours
- Capability for intravenous fluid therapy

CMS Special Study Results
Ouslander et al: J Amer Ger Soc 58: 627-635, 2010
Drivers of Poor Transitions

**Low patient activation**
- Health literacy
- Self-management skills, tools
- Motivation; locus of control

**Lack of standardized, known process**
- Patient discharge, handover
- Internal workflow

**Inadequate cross-setting information transfer**
- Delays
- Inaccuracies
- Missing information

**Other potential drivers**
- Unavailable, inaccessible resources
- Lack of community identity; low cohesiveness

Mechanisms of Change

- Public reporting of quality measures
  - NH compare 5-star by Center for Medicaid CHIP and Survey (aka CMSO)
- Quality Improvement Organizations
  - Scopes of work (10th)
  - Advancing excellence
  - Special studies
- State Surveys
- Payment incentives
  - Pay for reporting, performance, value
- Conditions of participation
- Monitoring programmatic influence
PPACA: Quality

- Oct 1, 2011 publish **VBP plan** (Sec. 3006; SNF, HH)
- Oct 1, 2012 Secretary must publish **QMs and data requirement timeline** (Sec. 3004; hospice, LTCH, IRF)
  - Consensus endorsement QMs
  - QM data submission requirement with penalty - their market basket rate reduced by 2% for that FY.
- March, 2012 publish 10 or more patient **Outcomes** (Sec. 10302)
  - Prevalent & expensive conditions by 24 months
  - Primary & preventive care by 36 months

Quality includes Efficiency (Sec 10304)

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PPACA: Readmissions & Transitions

**3025 Hospital Readmission Reduction Program**
- Reduced payments for readmissions
  - high volume
  - high cost
  - ....

**3026 Community-based Care Transitions Program**
- Funding to “eligible entities” that provide improved care transition services to high-risk Medicare beneficiaries
  - High readmission rate hospitals
  - Community-based organizations
  - High risk = minimum hierarchical condition category score based on multiple chronic conditions or other risk factors associated with a readmission or substandard transition
Challenges

- Standardized data collection mechanism lacking
  - Hospice QAPI, PEACE/AIMs items require abstraction
  - MDS 3.0 Nursing home & SNFs
    - Exclude advance directives
  - OASIS C Home Health items
  - Hospital claims lag
- Infrastructure for electronic collection and reporting requires $
- Culture change

CARE
Continuity Assessment Record & Evaluation

- Common Set of Data Elements
  - Uniform
  - Standardized
- Major Domains
  - Administrative
  - Medical, Health Status
  - Cognitive, Mood, Pain
  - Impairments
  - Functional Status
  - Plan of Care
  - Discharge, Caregiver Needs
- Incorporate into Electronic Health Records
Deficit Reduction Act § 5008

- Develop standardized assessment instrument
- Medicare beneficiaries
- Uniformly measure, compare health, functional status
- Across care settings over time
  - +acute, IRFs, SNFs, HHA, LTCH
  - -hospice
- Test in payment demonstration 2008-2010
  - Post Acute Care Payment Reform Demonstration
- Report to Congress, Spring 2011

Questions

- What aspects of quality of care are meaningful & should be reported to the public?
  - Shaping behavior?
- What aspects of care are “valuable”?
  - Value perspective (patient, episode, trajectory?)
- What information is most critical to require @ and before points of transition?
Advance Care Directives in CARE

1. Have the patient (or rep) and the care team (or physician) documented agreed-upon care goals and expected dates of completion or re-evaluation?
   0= No, but this work is in process; 1=yes; 9=unclear/unknown

2. In anticipation of serious clinical complications, has the patient made care decisions which are documented in the medical record? (check all that apply)
   - 1. The patient has designated a decision-maker
   - 2. The patient (or surrogate) has made a decision to forgo resuscitation

Patient Prognosis in CARE

3. Which description best fits the patient’s overall status?
   A. Stable w/o risk for serious complications/death
   B. Temporarily facing high health risks but likely to return to stable w/o risk of serious complications & death
   C. Likely to remain in fragile health with ongoing high risks of serious complications & death
   D. Serious progressive conditions that could lead to death w/l 1 year
   E. Unknown or unclear
Opportunities

• CMS Technical Expert Panels
  • Summer, 2010 end-of-life data elements for CARE tool
  • ACA Section 3004 Quality measures for Hospice, LTCH, IRF
  • VBP plan for SNFs and HHAs
  • Outcomes
  • Efficiency

Thank you

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