Nursing Home Resident Acute Care Readmissions

Mechanisms to Promote High Quality End of Life Care

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May 19, 2010 17th annual Princeton Conference 'Examining End of Life Care: Creating Sensible Policies for Patients, Providers, & Payers"

> Robert Wood Johnson Foundation Princeton, New Jersey





CMS Special Study Results

Ouslander et al: J Amer Ger Soc 58: 627-635, 2010

Expert panel members rated improving quality of care for assessing acute changes, more involvement of primary care MDs and/or NPs/PAs, ability to do stat lab tests and IV fluids, improved advance care planning, and providing less futile care as important in reducing avoidable hospitalizations

Factors	Resources Needed
Better quality of care would have prevented or decreased severity of acute change	Physician or physician extender present in nursing home at least 3 days per week
One physician visit could have avoided the transfer	Exam by physician or physician extender within 24 hours
Better advance care planning would have prevented the transfer	Nurse practitioner involvement
The same benefits could have been achieved at a lower level of care	Registered nurse (as opposed to LPN or CNA) providing care
The resident's overall condition limited his ability to benefit from the transfer	Availability of lab tests within 3 hours
	Capability for <i>intravenous fluid</i> therapy
MS/	



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

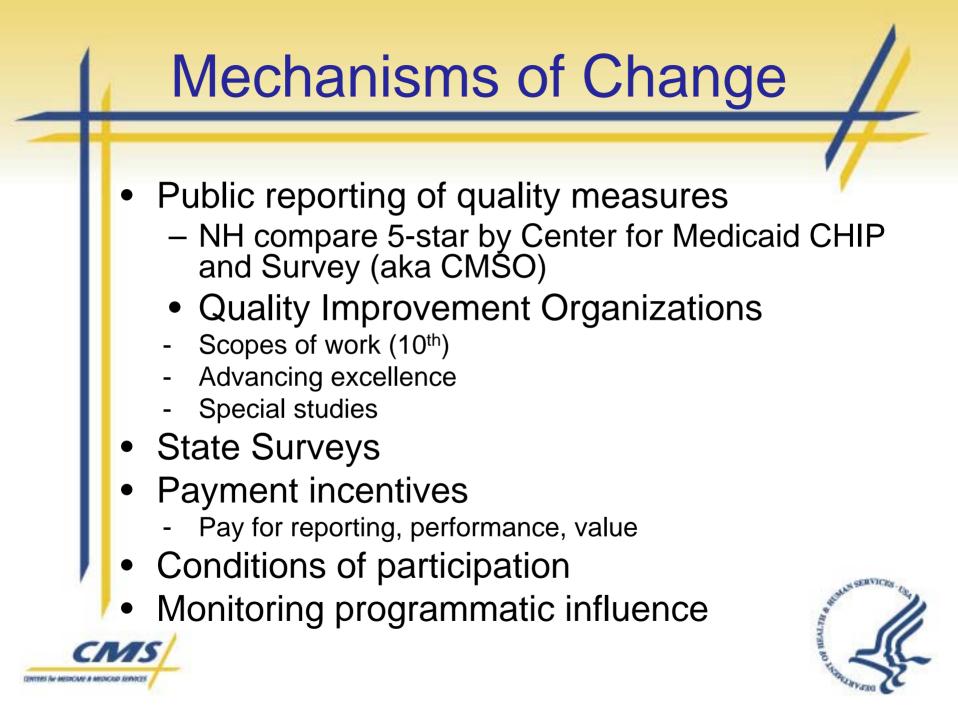
- Delays
- Inaccuracies
- Missing information

Other potential drivers

- Unavailable, inaccessible resources
- Lack of community identity; low cohesiveness







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)





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 \$

cnasculture 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

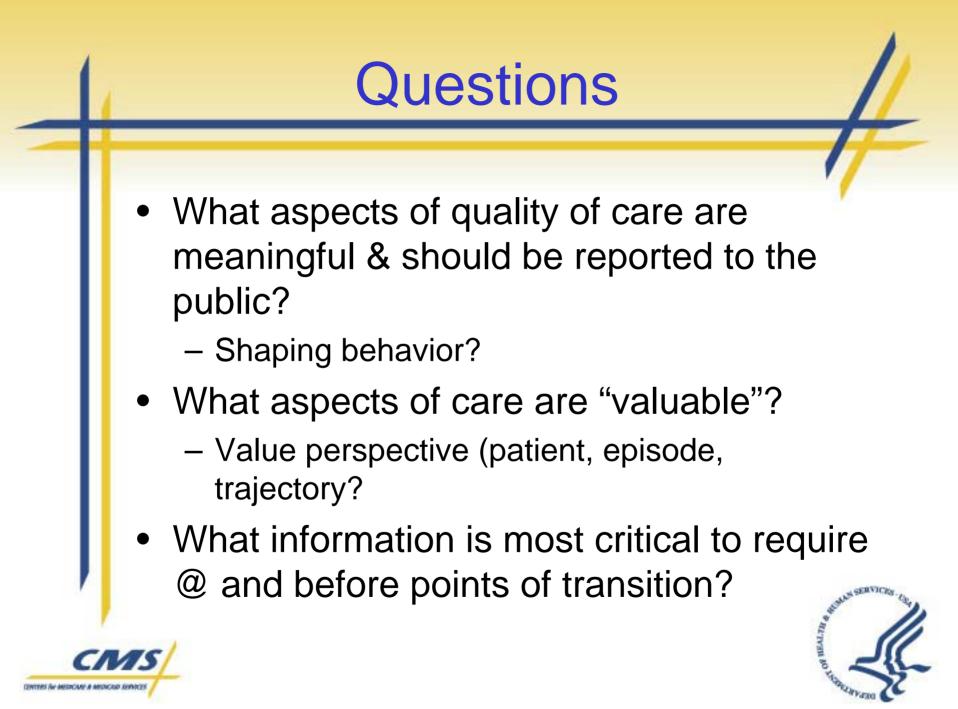




Deficit Reduction Act § 5008

- 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





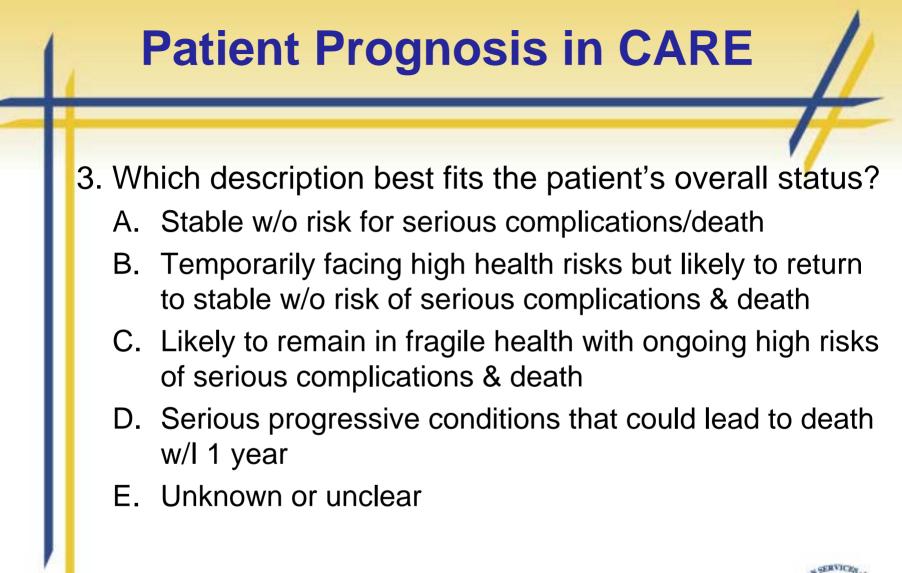
Advance Care Directives in CARE

 Have the patient (or rep) and the care team (or physician) documented agreed-upon care goals and expected dates of completion or reevaluation?

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)
 - o 1. The patient has designated a decision-maker
 - 2. The patient (or surrogate) has made a decision to forgo resuscitation









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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