Nursing Home Resident Acute Care Readmissions

Mechanisms to Promote High Quality End of Life Care

Shari M. Ling, MD
Medical Officer
Division of Chronic & Post-acute Care,
Quality Measurement & Health Assessment Group
Office of Clinical Standards and Quality

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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

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

shari.ling@cms.hhs.gov