TH5- The Practical Application of MDS (Minimum Data Set) and Other Available Data to Improve Site-Specific Quality Measure Performance

Thursday, March 22  
8:00 AM - 11:30 AM

Session Description

This session will present novel approaches to using a skilled nursing facility's own quality measure data to engage its medical director, unify its healthcare team, and improve quality measure performance.

Learning Objectives

- Determine how to use their Quality Measure data to engage the leadership and accountability of their Medical Director.
- Describe novel methods for creating high impact presentations of Quality Measure data.
- Use a SNF’s Quality Measure data to unify their healthcare team and motivate improved performance.
- Discuss the value of trending, tracking, and visualizing their Quality Measure data as a means to improve Quality Measure scores.

Presenter(s): Michelle Bellantoni, MD, CMD; Steven Fuller, DO, PhD, MS; Richard Feifer, MD, MPH; Ronald Crossno, MD, CMD; Emily Jaffe, MD

Presenter(s) Disclosures: All speakers have reported they have no relevant financial relationships to disclose.
The Practical Application of MDS (Minimum Data Set) and Other Available Data to Improve Site-Specific Quality Measure Performance

Introductory Remarks

Steven Fuller, PhD DO
Vice President and Corporate Medical Director
Presbyterian Senior Living

Episode of Care and the Data Continuum

<table>
<thead>
<tr>
<th>Hospital/Care Transitions</th>
<th>Skilled Nursing</th>
<th>Home Health</th>
<th>ACO Perspective</th>
<th>Payer Perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michele Bellantoni, MD</td>
<td>Steven Fuller, PhD DO</td>
<td>Ronald Crossno, MD</td>
<td>Richard Feifer, MD</td>
<td>Emily Jaffee, MD</td>
</tr>
<tr>
<td>Clinical Director, Geriatric Medicine and Gerontology</td>
<td>VP and Corporate Medical Director Presbyterian Senior Living</td>
<td>Vice President, Medical Affairs Chief Medical Officer Kindred at Home</td>
<td>Chief Medical Officer Genesis HealthCare</td>
<td>Vice President and Executive Medical Director Highmark Home and Community Services</td>
</tr>
</tbody>
</table>

Chapt. 1 | Chapt. 2 | Chapt. 3 | Chapt. 4 | Chapt. 5

No

5 Books

Yes

1 Book, 5 Chapters
Learning Objectives
By the end of the session, participants will be able to:

- identify opportunities to improve the clinical content and formatting of the Transfers in Care Documents prepared by referring hospital/emergency department providers
- analyze data on outcomes of hospital-SNF transfers to identify opportunities to improve practices
- strengthen the partnership among hospital and SNF providers to reduce complications, shorten convalescence, and lower health care costs.

Medication Reconciliation
Goals of Care
Treatment Plan
Warm Handoff
Hospital-SNF Provider

Standardized Clinical Assessments, Treatments, and Data Reported to SNF
Multi-disciplinary summary pre-populated with clinically important data fields, edited and signed by medical provider before discharge:

- Pharmacist certified Medication Reconciliation
- Nurse performed CAM Scores
- Rehab Services performed physical and functional scores
- Goals of Care field from Palliative Care Template
- Protocols for high risk treatments
71% (142/199) SNF admissions at least 1 med discrepancy

21% (495/2,319) medication discrepancies

50% discrepancies in medications with significant clinical impact: cardiac, opioids, neuropsychiatric, hypoglycemic, antibiotics, anticoagulants

150 patients
170 Pharmacist Intervention
2/3 clinical impact
41% discrepancies
59% drug-related problems

≥ 5 meds
Charleston Comorbidity Index ≥2
1 medication requiring therapeutic drug monitoring,
2 potential inappropriate medications for older adults,
3 problems related to drug administration/usage forms,
4 drug interactions,
5 slow or medications not suitable for renal or liver disease,
6 lack of indication for drug therapy,
7 appropriate length of therapy for temporarily used medications,
8 suboptimal treated or untreated diagnosis or symptoms,
9 medications causing adverse drug reactions or change in laboratory measures,
10 other needs for monitoring of treatments.
Assessment of Physical and Functional Status

Activity Measure for Post-Acute Care (AM-PAC) Instrument
Measures 3 functional domains
- Basic mobility
- Daily Activities
- Applied Cognition

PhysTherapy 2014;94:1252-1261

Predicting Discharge Disposition

AM-PAC "6-Clicks" Functional Assessment Scores Predict Acute Care Hospital Discharge Destination

From: Jette DU et al. Physical Therapy 2014;94:379-391

AM-PAC "6-Clicks" Basic Mobility Short Form

PhysTherapy 2014;94:1252-1261


Phys Ther | © 2014 American Physical Therapy Association

AM-PAC Scores by Discharge Setting

<table>
<thead>
<tr>
<th>Validation Sample</th>
<th>Daily Activity Score</th>
<th>Mobility Score</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>Positive Predictive Value</th>
<th>Negative Predictive Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobility Score</td>
<td>Daily Activity Score</td>
<td></td>
<td>82%</td>
<td>73%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Mobility Score</td>
<td>Daily Activity Score</td>
<td></td>
<td>72%</td>
<td>79%</td>
<td>75%</td>
<td>79%</td>
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</tbody>
</table>

Falls: AM-PAC “6-Clicks” Functional Assessment Scores Predict Acute Care Hospital Discharge Destination

Transition in Care Documentation of Physical and Functional Status

<table>
<thead>
<tr>
<th>Mobility Score</th>
<th>Daily Activity Score</th>
<th>Mobility Score</th>
<th>Daily Activity Score</th>
<th>Mobility Score</th>
<th>Daily Activity Score</th>
<th>Mobility Score</th>
<th>Daily Activity Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitivity</td>
<td>Specificity</td>
<td>Positive Predictive Value</td>
<td>Negative Predictive Value</td>
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<tr>
<td>82%</td>
<td>73%</td>
<td>80%</td>
<td>80%</td>
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<tr>
<td>72%</td>
<td>79%</td>
<td>75%</td>
<td>79%</td>
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</tbody>
</table>

Standardized Assessments of Cognition

<table>
<thead>
<tr>
<th>Date of Admission</th>
<th>Date of Discharge</th>
<th>Date of Admission</th>
<th>Date of Discharge</th>
<th>Date of Admission</th>
<th>Date of Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confusion Assessment (CAM)</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Montreal Cognitive Assessment (MOCA)</td>
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</tbody>
</table>

Johns Hopkins Medicine SNF Collaborative Transitions in Care Upgrades to Transfers Documents

- Upgrades to EPIC Transitions in Care Document
  - Addition of standardized assessments of physical, cognitive, and functional status
  - Documentation of Goals of Care, Social Support, and recommendations for next phase of medical care
  - Re-ordering of information: supporting diagnostics summarized at end of summary

Checklist for Transitions in Care Documents

- Hospital-SNF Provider Communications through HIPAA Compliant Smartphone Application

Checklist of Transfers in Care Documents

- Demographic Facesheet
- POLST: copy of Advance Directives, when available
- Discharge Summary
- Medication Administration Record: includes last dose of medication
- Case Management Summary/Interdisciplinary Rounds Tool
- Admission History and Physical
- Summary of Laboratory Data
- Summary of Radiology Data
- Rehab Services Initial and Discharge Consultation Notes: Physical Therapy, Occupational Therapy, Speech Therapy
- Box for personal items: dentures, glasses, hearing aids, documentation of ambulation devices

Johns Hopkins Medicine SNF Collaborative Transitions in Care Upgrades to Transfers Documents

- Technology Innovation Center:
  - https://www.johnshopkinsmedicine.org/technology_innovation/what_we_do/application_development.html
Goals for JHM SNF Collaborative

- Create a system-wide collaborative to improve quality and value of care for JHM patients
- Provide a model of collaboration for broader system change and coordination inclusive of hospitals, Accountable Care Organization, and Health Insurance Entities
- Understanding the great local efforts happening at each hospital/SNF; focus on supporting and collaborating with these efforts while building towards more system-level opportunities
- Harmonize/implement/share/scale best practices and other care interventions that have developed between hospitals, SNFs, Home Care Agencies, and providers
- Create common dashboards with agreed upon measures for included SNFs to serve JHM system-wide
- Prepare health system for care redesign and value-based payment models

CMS-funded Quality Improvement Organization Data for Hospital-SNF Transitions

Report Date: 03/27/2017
Report Source: JHM Hospitals Report from HQI
Report Timeframe: Q3 2014 to Q2 2017
This material was prepared by Health Quality Innovators (HQI), the Medicare Quality Innovation Network – Improvement Organization for Maryland and Virginia, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policies.

Johns Hopkins SNF Collaborative Team Members

Executive sponsors: P. Brown & R. Kasdin

- Jennifer Abol (JHM)
- Amy Deutschendorf (SHS)
- Michelle Bellantoni, MD (JHM/HCS)
- Scott Berlowitz, MD (MAF)
- Doreen Doyle, MD (JHH)
- Carol Sykerston (JHH/HCS)
- Lindsay Roberts (JMAF)
- Sarah Johnson-Cormack, MD (JMAP)

Additional participants include:

- Care Al-Amin (Suburban)
- Mohammad Ahmed, MD (HCGH)
- Alicia Arbage (JHH/HCS)
- Michael Albert, MD (JCP)
- Bob Bates (JCP)
- Edward Bessette (RRH)
- Arjun Chinnamus (JHH)
- Rachel Delgato (JHCO)
- Michael Finckham (JHH)
- [Other members listed]
Value Proposition for Patients, SNFs, Hospitals & Providers

**High Value SNF Network**
- Create a high value preferred SNF network which will be shared to help discharge planning decisions
- Review data and share experiences/best practices through a multi-stakeholder process to maximize value for all entities and payers

**Improve Transitions in Care**
- Improve collaboration with SNFs for better availability of SNF beds and improved lines of communication for follow-up inquiries
- Potential to predict post-procedure SNF discharge needs for patients, improving efficiency of transfers and hospital LOS

**Actionable Data/Dashboards**
- SNF-level and collaborative-level data with quality improvement support from local QIO and other forums for data review
- Focus on improved performance on quality, patient satisfaction and reduced unnecessary utilization

**System-level Collaboration**
- Leverage a system-level governing and multi-stakeholder structure that links JHM hospitals, JHHC, JMAP, among other entities
- Create a unified approach to transitions in care with partnering entities, as an initial phase towards broader post-acute care strategy

Procedures to Establish Hospital-SNF Collaborative

**Legal**
- Complete charter signatures for Quality Improvement Organization
- Complete collaborative agreement signatures (provider-level for data sharing)
- Receive consultant agreement (Site, Hospital, Regional Risk-adjusted Data)

**SNF Engagement**
- Invite SNFs and QIO to Broad Stakeholder Meeting
- Development of dashboard of quality measures

**Broad Marketing Campaign**
- Hospital/Health System Board of Governors, Physician Advisory Board, Nurse Staff Meeting, Nurse Staff Council, Staff Decision Committee in Minutes
- Multi-disciplinary meetings - Medicine, Nursing, Administration, Pharmacy, Allied Services, Case Management

**Data/Analytics**
- Scheduled update and dissemination of dashboard
- Return on investment analysis

**Transitions of Care**
- Standardized Assessments of Clinical Conditions, Treatments, Data Hospital/SNF data sharing: CMS-funded QIO, ACO, Consultant
- Hospital-SNF Collaborative multi-disciplinary meetings

Take Home Points

- **Standardized Assessments of Clinical Conditions, Treatments, Data**
- Hospital/SNF data sharing: CMS-funded QIO, ACO, Consultant
- Hospital-SNF Collaborative multi-disciplinary meetings
The Practical Application of MDS (Minimum Data Set) and Other Available Data to Improve Site-Specific Quality Measure Performance - Fuller

Learning Objectives
By the end of the session, participants will be able to:
- Determine how to use Quality Measure data to engage the leadership and accountability of Medical Directors.
- Describe novel methods for creating high impact presentations of Quality Measure data.
- Use a SNF’s Quality Measure data to unify their healthcare team and motivate improved performance.
- Discuss the value of trending, tracking, and visualizing Quality Measure data as a means to improve Quality Measure scores.

Data Sources
- MDS (Minimum Data Set)
- Electronic Health Record
- Pharmacy
- Radiology
- Vendors

Data Stories
- Quality Measures story
- Readmissions story
- Falls story
- Infections story
- Census story
Quality Measures Story

Readmissions Story

Readmissions – by month, day of week, time of day.
Data source = EHR

Readmissions – showing discharge diagnosis
Data Source = EHR
Falls Story

Don’t underestimate the impact of this metric.

“Estate of Oregon man seeks $2.3 million in negligence suit against home where he lived for 2 days.”

Nursing home to pay $250,000 in resident’s wheelchair death.”

This pervasive metric makes headlines more than any other quality measure, has huge financial and emotional impact.

Conclusion: Our current, case-by-case, root cause analysis, is no longer sufficient.

Falls by location

<table>
<thead>
<tr>
<th>Location</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room</td>
<td>62.7%</td>
</tr>
<tr>
<td>BR</td>
<td>10.5%</td>
</tr>
<tr>
<td>OTH</td>
<td>7.9%</td>
</tr>
<tr>
<td>Hall</td>
<td>7.3%</td>
</tr>
<tr>
<td>DR</td>
<td>5.6%</td>
</tr>
<tr>
<td>ACT</td>
<td>3.1%</td>
</tr>
<tr>
<td>Door</td>
<td>1.0%</td>
</tr>
<tr>
<td>Shower/Spa</td>
<td>0.4%</td>
</tr>
<tr>
<td>Rehab Gym</td>
<td>0.3%</td>
</tr>
<tr>
<td>Outside</td>
<td>0.3%</td>
</tr>
<tr>
<td>Well</td>
<td>0.1%</td>
</tr>
<tr>
<td>OffGrd</td>
<td>0.1%</td>
</tr>
<tr>
<td>IL</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

EHR Data

Some rooms have falls, some rooms don’t. Why?

High Risk vs. Low Risk Rooms

<table>
<thead>
<tr>
<th>FALL STRATEGY - Room Characteristics</th>
<th>FUP STRATEGY - Resident Characteristics</th>
<th>FUP STRATEGY - Functional Characteristics</th>
<th>FUP STRATEGY - Geographic Characteristics</th>
<th>FUP STRATEGY - Physical Room Characteristics</th>
<th>FUP STRATEGY - Operational Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Diseases? Medications?</td>
<td>ulary Care? Short term? Long Term?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Map layout, proximity to nursing station</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oversized furniture? Shelf location?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staffing availability – nurses, aids?</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Infections Story
Infections

• Better documentation
• Confirmed vs. suspected
• Facility vs. hospital acquired
• Better overall performance

Chronic Disease Management Story

Chronic Disease Profile

Pharmacy Story

Pharmacy Profile

12 SNFs

Pharmacy Cost
X-Ray Story

Census Story

Summary

Chapter 2: SNF

- Consider the position of your patients within the data continuum during an episode of care.
  - Hospital → Post-acute → Home
  - How do we tell our patient’s ‘Data Story?’

The End

Steven Fuller, PhD DO
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sfuller@psl.org
The Practical Application of MDS and Other Available Data to Improve Site-Specific Quality Measure Performance: A Homecare Perspective

Ronald J Crossno, MD CMD HMDC FAAFP FAAHPM
Chief Medical Officer for Kindred at Home
ronald.crossno@kindred.com

Learning Objectives
By the end of the session, participants will be able to:
• Describe general aspects of CMS-required data collection for the various home care settings.
• Discuss the CMS quality metrics for the various home care settings.
• Discuss the above measures regarding practical quality outcomes for patients and payors.

Overview of Homecare Settings
• Home Health
  • Primarily Medicare (Medicare Advantage is increasing rapidly)
  • Must be homebound and be certified as having skilled need
  • Mix of restorative (therapy) and clinical (nursing) services
• Hospice
  • >85% is Medicare (no Medicare Advantage)
  • Must be terminally ill and waive related non-hospice treatments
• Personal Care / Community Care
  • Primarily Medicaid population (many “dual-eligible”)
  • Non-skilled provider home care to forestall institutionalization

Demographics of Home Health Users

<table>
<thead>
<tr>
<th>Selected characteristics of Medicare HH users and All Medicare beneficiaries in 2013</th>
<th>All Medicare Home Health Users</th>
<th>All Medicare Beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 65+</td>
<td>24.0%</td>
<td>12.0%</td>
</tr>
<tr>
<td>Live alone</td>
<td>36.7%</td>
<td>28.8%</td>
</tr>
<tr>
<td>Have 3 or more chronic conditions</td>
<td>86.1%</td>
<td>62.9%</td>
</tr>
<tr>
<td>Have 2 or more ADL limitations</td>
<td>31.8%</td>
<td>12.9%</td>
</tr>
<tr>
<td>Report fair or poor health</td>
<td>48.7%</td>
<td>27.8%</td>
</tr>
<tr>
<td>Are in somewhat or much worse health than last year</td>
<td>41.9%</td>
<td>22.2%</td>
</tr>
<tr>
<td>Have incomes at or under 200% of the Federal Poverty Level (FPL)*</td>
<td>67.2%</td>
<td>52.1%</td>
</tr>
<tr>
<td>Have incomes under 100% of the Federal Poverty Level (FPL)**</td>
<td>31.2%</td>
<td>21.3%</td>
</tr>
</tbody>
</table>

Source: Avalere – Ref #1

Home Health Data Collection & Reporting
• Outcome and Assessment Information Set (OASIS)
  • Used to develop treatment plans (analogous to MDS)
  • Used to determine Case Mix Weight (CMW) ⇒ payment rate
  • Assessments done at start and end of episode (typically 60d)
• Other CMS reports
  • Program for Evaluating Payment Patterns Electronic Report (PEPPER)
  • Annualized comparison to other agencies in state
  • Certification and Survey Provider Enhanced Reports (CASPER)
The Practical Application of MDS and Other Available Data to Improve Site-Specific Quality Measure Performance – A Homecare Perspective - Crossno

HH CMS Star Quality Rating System
- Quality Measures assessed (derived from OASIS)
  - Ability to ambulate
  - Assistance with bathing
  - Shortness of breath
  - Provision of medication education
  - Flu vaccination rates*
  - 60-day hospitalization rate * being removed from list in 2018
- Reported in ½-star increments
- Reported quarterly with
  - 3-mo preview lag (to correct errors) & 6-mo comparison lag
  - Reported as a 12-month rolling average

Home Health Consumer Assessment of Healthcare Providers and Systems (HH-CAHPS)
- Patient experience rating survey sent to random selection of patients 45-60 days after start of episode
- Composite of 5 HH-CAHPS results
  - Perception of patient care
  - Adequacy of communication
  - Any specific care issues
  - % who rate care 9 or 10
  - % who would recommend agency
- Report in whole-integer star ratings
- Reported quarterly with a 6-month comparison lag, reporting a 12-month rolling average

Home Health Compare
- Medicare.gov Home Health Compare website
  - [https://www.medicare.gov/homehealthcompare/search.html](https://www.medicare.gov/homehealthcompare/search.html)
  - Went live in 2015
  - Includes both Star Ratings (Quality & HH-CAHPS)
  - Also displays several other quality measures not included in the either Star Rating methodologies
- Additional features
  - Comparison between agencies and state & national averages
  - Entire database is available for download

Value-Based Purchasing
- CMS-mandated “demonstration” project in 9 states
  - AZ, FL, IA, MA, MD, NC, NE, TN, WA
- Composite of some Star Quality Measures, HH-CAHPS measures, and several other OASIS measures
- Used to stack-rank providers within a single state
- Payment penalty / bonus applied to bottom / top quartiles
  - Applied state by state
  - 2-yr lag between reporting year and financial application
  - ±2% first year (FY 2018), increasing annually to ±9% by 2022
  - Plans to expand into more states are unclear

Other Home Health Setting Considerations
- Payors (commercial & Medicare Advantage) often will limit contract discussions to only higher ranked agencies
- Many hospitals only offer preferred status to agencies
  - With higher star-ratings, and/or
  - With lower 30-day return-to-acute (RTA) rates
- Data on patient outcomes
  - Quality ratings vs. patient outcomes (e.g. mortality) is lacking
  - Earlier HH visits (with medication reconciliation) ↓ RTA rates Ref #2
  - Mixed data regarding lower RTA and mortality rates Ref #3 & #4

Outcomes for Major Joint Readmissions Among Post-Acute Care Users
- 30-day Readmission Rates for major joint replacement of lower extremity w/ major complication
- Data on Home Health Agencies, Inpatient Rehabilitation Facilities, Skilled Nursing Facilities

Source: Avalere – Ref #5

Ref #1 - [Avalere](https://www.medicare.gov/homehealthcompare/search.html)
Ref #2 - [Avalere](https://www.medicare.gov/homehealthcompare/search.html)
Ref #3 - [Avalere](https://www.medicare.gov/homehealthcompare/search.html)
Ref #4 - [Avalere](https://www.medicare.gov/homehealthcompare/search.html)
Ref #5 - [Avalere](https://www.medicare.gov/homehealthcompare/search.html)
Outcomes for Major Joint Readmissions Among Post-Acute Care Users

30-day Readmission Rates for major joint replacement of lower extremity w/o major complication

- 8.1% in 2009
- 7.3% in 2010
- 6.0% in 2011
- 7.3% in 2012
- 7.1% in 2013
- 7.5% in 2014
- 6.8% in 2015

Source: Avanta - Self MRe

Hospice Data Collection & Reporting

- No standardized reporting tool
- Hospice Item Set (HIS) began in 2014 from claims data
- CMS proposal to add formal tool to Hospice Quality Reporting Program (HQRP)
- Other CMS reports
  - Program for Evaluating Payment Patterns Electronic Report (PEPPER)
  - Annualized comparison to other agencies in state
  - Certification and Survey Provider Enhanced Reports (CASPERS)

Hospice Item Set (HIS)

- Currently eight HIS measures
  - Treatment preferences documented
  - Beliefs & values addressed
  - Pain screening
  - Pain assessment
  - Dyspnea screening
  - Dyspnea treatment
  - Bowel regimen present with opioids
  - Weighted composite score of other 7
- Star system not yet implemented
- Reported quarterly with unclear lag
- Infrequent reporting by CMS to date of national averages

Hospice Consumer Assessment of Healthcare Providers and Systems (H-CAHPS)

- Patient experience survey sent to random selection of designated caregivers 45+ days after patient death
- Currently eight H-CAHPS measures
  - Hospice team communication
  - Getting timely care
  - Treating family member with respect
  - Getting emotional & religious support
  - Getting help for symptoms
  - Getting hospice care training
  - % rating care as 9 or 10
  - % who would recommend this hospice
- No composite score
- First public reporting began Q1 2018

Hospice Compare

- Medicare.gov Hospice Compare website
  - https://www.medicare.gov/hospicecompare/
  - Went live in late 2017
  - Includes only HIS measures; H-CAHPS just added
- Additional considerations
  - Item comparisons between agencies and national averages
  - CMS has reported ongoing data inconsistencies and errors at the time this presentation was composed
  - No proposals to date regarding value-based purchasing

Other Hospice Setting Considerations

- Electing Medicare Hospice Benefit removes beneficiary from Medicare Advantage for hospice-related care
- Little incentive for Medicare Advantage providers to contract
- Hospital considerations
  - Data shows hospice clearly reduces RTA
  - Only beneficial to hospital for clearly end-stage disease
  - Multiple studies have shown improved
  - Patient/caregiver satisfaction (e.g. ↑ quality of life)
  - Patient outcomes (e.g. ↓ pain, ↓ distressing symptoms)
  - System outcomes (e.g. ↓ costs, ↑ provider satisfaction)
Personal Assistance / Community Care

- No standardized reporting except
  - Hours worked
  - Type of care provided (e.g. personal hygiene, household chores)
  - Therefore no quality data reported
- State funding is predicated on lower LTCF placement
  - Perception that such care saves the state money
  - Published data is minimal

Integration of Data

- CMS is striving to make data accessible on its website
  - Limitation: only includes Medicare beneficiary data
- Otherwise, none of these systems intercommunicate
  - Data translators in development, often with specific aim (e.g. screening OASIS data for potentially hospice-qualified patients)
- Many data measures are setting specific
  - (e.g. HH: 60-day hospitalization, HP: beliefs & values addressed)
- Some important data is not systematically collected
  - (e.g. RTA which affects hospital penalties)

Home Care Setting: Challenges

- Quality Measures for CMS has limitations
  - Required to be a National Quality Forum endorsed measure
  - NQF measures were developed primarily for research
  - Only home-setting tool with history of long use is OASIS
  - QMs for other home-care settings are in relative infancy
- Use of QMs for determining quality outcomes is evolving
  - Heightened interest by patient advocates, policy-makers, and payors to actually measure improved patient outcomes

Bibliography

Practical Application of Data to Improve Quality and Performance

Richard Feifer, MD, MPH, FACP
Chief Medical Officer
Genesis HealthCare

Speaker Disclosure

Dr. Feifer is employed by Genesis HealthCare. He has no other financial relationships to disclose.

Genesis Overview

Key Facts:
- 450+ facilities across 30 states
- ~60,000 beds
- ~80,000 dedicated employees
- 200+ clinical specialty units.
- 550+ Genesis physicians and physician assistants.
- Genesis also supplies contract rehabilitation services to approx. 1,700 locations across 46 states.

Provider benchmarking
Incentive compensation metrics and targets

Incentive Compensation Alignment Model

<table>
<thead>
<tr>
<th>Key Domain</th>
<th>Medical Director</th>
<th>NPs, PAs</th>
<th>Full-Time Attending Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Productivity</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Population Health, Clinical Quality, &amp; 5-Star Quality Measures</td>
<td>N/A</td>
<td>N/A</td>
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<td>Medication Safety (CTR)</td>
<td>N/A</td>
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<tr>
<td>Genesis Center Performance</td>
<td>N/A</td>
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<td>N/A</td>
</tr>
</tbody>
</table>

Example of Medical Director Targets

Hospice optimization

Duration of Hospice Utilization

Utilization Of Hospice for Deaths on Hospice Apr 2016 - Mar 2017. Only patients with a single continuous hospice utilization are included. Both short stay and long stay patients are included.

Duration of Hospice Utilization

Utilization Of Hospice for LTC Deaths on Hospice Apr 2016 - Mar 2017. LTC is defined as > 100 SNF days. Hospice utilization is truncated at 180 days. Patients with multiple hospice stays are included, with all hospice days summed together.
**TH5 - Practical Application of Data to Improve Quality and Performance - Feifer**

### Distribution of Hospice Utilization

<table>
<thead>
<tr>
<th>Percentile</th>
<th>Hospice Days Prior to Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>90%</td>
<td>361</td>
</tr>
<tr>
<td>79%</td>
<td>185</td>
</tr>
<tr>
<td>70%</td>
<td>114</td>
</tr>
<tr>
<td>60%</td>
<td>69</td>
</tr>
<tr>
<td>50%</td>
<td>38</td>
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<tr>
<td>40%</td>
<td>20</td>
</tr>
<tr>
<td>30%</td>
<td>11</td>
</tr>
<tr>
<td>20%</td>
<td>6</td>
</tr>
<tr>
<td>10%</td>
<td>3</td>
</tr>
</tbody>
</table>

### ACO data and analytics

- **ACO QM Dashboard – Provider View**
- **ACO QM Dashboard – Administrative View**

### ACO Weekly Physician Report

### Flacker Score

- **Risk assessment for dying within one year**
  - Readily available inputs from MDS
  - Functional ability
  - Weight loss
  - Shortness of breath
  - Swallowing problems
  - Male gender
  - Body mass index
  - Congestive heart failure
  - Age > 88
TH5 - Practical Application of Data to Improve Quality and Performance - Feifer
TH5: The Practical Application of MDS (Minimum Data Set) and Other Available Data to Improve Site-Specific Quality Measure Performance - Jaffee

Speaker Disclosures

Dr. Jaffe has no financial relationship(s).

Learning Objectives

By the end of the session, participants will be able to:
• Review current state and need for PAC data
• Describe one insurance providers solution to PAC variation
• Review data available to payers to help manage patient populations
• Limitations of claims data
• Future state for IFDS

Current state

• 42% Medicare hospital discharges requiring Post-acute care
• 43.5% post-acute spend of total 30-day hospital/post-acute care episode for Medicare
• 73% variation in Medicare spending due to post-acute care in the US
• 8800 number of unique clinical pathways after a hospitalization

Environment

• Increased cost pressures and high variation in post-acute spending
• Managed care organizations are increasingly offloading risk to providers through value-based reimbursement strategies
• Early stage bundles demonstrations showcased the effect post-acute can have on overall spend

HM Home and Community Services

• Post acute solution
• Structure
• Goals
5 Pillars to achieve outcomes

- Performance dashboards
- High performing networks
- Clinical services
- Value based contracts
- Innovations

HM Home and Community Services

- Network Management
- Home Health
- Skilled Nursing Facility
- Inpatient Rehabilitation
- LTACH

Home Health

- Network Performance Managers
- Care pathways
- Claims data
- Clinical data

SNF

- Network Performance Manager
- Utilization Management
- Care pathways
- Claims data

Limitations

Data transparency and insight is a key first step
Clinical structure is designed to test and implement solutions that specifically address transitions, patient activation and goals of care. The guiding aim is to deliver efficient and effective services, typically provided in the highest acuity settings, in the less restrictive and safe environment.

**Care pathways**
- Stroke
- Heart care
- COPD
- Behavioral Health
- Palliative Care

**Quality Initiatives**
- Clinical data
- Clinical councils
- Weighted rankings
- Specialized networks
- Detailed specialists and providers

**Next steps**
- Clinical data
- Clinical councils
- Weighted rankings
- Specialized networks
- Detailed specialists and providers

**Questions**