SA6- Beyond 5-Star Quality Rating System, A Guide to Survive the New Changes

Saturday, March 24
11:00 AM- 12:30 PM

Session Description

Centers for Medicare & Medicaid Services (CMS) has made several changes to the Quality Measure Domain (QM) of the 5-Star Quality Rating System, as well as the staffing data submission. The new quality measures are related to successful discharges to the community, emergency department visits, re-hospitalization, and improvement and maintenance of a resident's function. This session will primarily focus on the impact of the new changes in the overall star rating and its effect on the facilities, with a particular emphasis on practical approaches, case studies, and QAPI interventions to improve on the new quality measures.

Learning Objectives

Describe the 5-star quality rating system and its three domains.

Identify the new developments in staffing data submission- Payroll Based Journal (PBJ).

Explain the five new quality measures (QM), QAPI interventions to successfully improve quality and the new QM Metrix.

Presenter(s):  Ashkan Javaheri, MD, CMD; Irene Hamrick, MD; Sabine von Preyss-Friedman, MD, CMD

Presenter(s) Disclosures: All speakers have reported they have no relevant financial relationships to disclose.
Beyond 5- Star Quality Rating System; A Guide to Survive the New Changes

Ashkan Javaheri, MD, CMD, Mercy Medical Group, University of California, Davis
Irene Hamrick, MD, FAAFP, AGSF, University of Wisconsin, Madison
Sabine von Preyss-Friedman, MD, FACP, CMD, University of Washington, Seattle

Speaker Disclosures
Drs. Javaheri, Hamrick and von Preyss-Friedman have disclosed that they have no financial relationships related to this presentation.

Learning Objectives
By the end of the session, participants will be able to:
• Describe updates on CMS 5 Star Quality ratings for SNFs.
• Discuss new developments in staffing component.
• Discuss new Quality Measures and review existing Quality Measures.
• Explain the role of the Medical Director in the 5 Star system.

Updates to the 5 Star Skilled Nursing Facility Quality Rating System
Ashkan Javaheri, MD, CMD
Mercy Medical Group- Dignity Health Medical Foundation, Sacramento, CA
UC Davis School of Medicine
Ashkan.javaheri@dignityhealth.org

Consumers and Ratings

How the consumers get information about nursing home quality?
How 5 stars are assigned?

- **Step 1:** Start with the health inspection.
- **Step 2:** Add one star to the Step 1 result if staffing rating is 4 or 5-stars and greater than the health inspection rating; subtract one star if staffing is one star.
- **Step 3:** Add one star to the Step 2 result if the quality measure rating is 5-stars; subtract one star if quality measure rating is one star.
- **Step 4:** If the health inspection rating is one star, then the overall quality rating cannot be upgraded by more than one star based on the staffing and quality measure ratings.
- **Step 5:** If the nursing home is a Special Focus Facility (SFF) that has not graduated, the maximum overall quality rating is 3 stars.

The primary goal of Star-rating system

- To provide residents and their families with an easy way to understand assessment of nursing home quality, making meaningful distinctions between high and low.
  - From CMS Website

Public reporting supports key priorities for CMS

- Transparency
- Improved quality
- Informed decision making
- Assist with value based purchasing (VBP)
More than 50% of NHs became 4-5 star buildings in 4 years.

Star Rating! Is it perfect?

Some might argue that:
- Staffing and Quality Measures were based on self-reported data
- Questionable accuracy?
- Facilities might report higher staffing and/or manipulate the QMs to boost their star ratings
- It is possible that these changes reflect changes in reporting practices rather than real changes in quality

CMS 5 Star QRS Pros and Cons

Pros | Cons
---|---
Health Inspection | Comprehensive | Variation among states
Staffing | Adjusted for the population | Self-reported
Quality Measures | In-depth look | Few aspects of care

Better QM score = ↑ Health Inspection

Relationship between star rating and patient/family satisfaction

Not Statistically Significant
**Bottom Line**

- Facilities with higher staffing rate and higher QM score, do better on health inspection.
- However,
  - 50.5% of the facilities are 4-5 stars
  - 34.3% of the facilities are 4-5 stars on health inspection.
- 16% of the facilities have increased their ratings to 4-5 stars using staffing and QM scores

**Quality and Payer mix**

- Do Medicaid patients receive worse quality care relative to private-paying patients?
  - No consistent finding of differential quality for Medicaid patients was found.
  - Medicaid patients are 27% more likely to be sent out to the hospital
    - Medical Care Research and Review, Oct 2011

**Does competition Matter?**

- There is very little evidence to suggest that the introduction of the NHQI report card measures led to increased patient demand or better long-stay quality.
- However, nursing homes residing in **more competitive markets improved** their reported quality more than facilities in less competitive markets.
  - Grabowski D, et al, Health Serv Res. 2011

**Who else might look at the star rating?**

- In addition to Patients/ Families (Consumers)
- Physicians and other healthcare providers
- Insurers: Several plans **will not include NH less than 3-star ratings** in their networks.
- ACOs: Waiver of 3-day qualifying stay by CMS requires NH with at least **3 star rating**.
- Regulators
- Lenders and investors

**Sample of payment model based on performance for commercial and Medicare HMO patients in Sacramento market**

- The Tier score is based on multiple factors reported on the ScoreCard for contracted facilities.
Temporary Freeze

- Temporary freeze of Health Inspection Five-Star Ratings beginning in 2018 for approximately 12 months – The health inspection conducted on or after November 28, 2017 will be frozen.
- 2-year cycle instead of 3-year cycle for health inspection will be used.

Health Inspection Survey

Objectives

- Identify the components of the CMS 5- Star Quality Rating System
- Understand the health inspection survey calculation of the star rating system
- Recognize the Medical Director’s role in the health inspection survey process

Citations

- F334 Infection Control - the cite addressed 2 residents who had not received all current adult immunizations
- Res. A lacked 23 valent pneumococcal immunization, Pneumovax. It took a week to gather information if he received it and was administered subsequent to survey.
- Res. B lacked PCV 13, Prevnar. He was admitted <30 days prior to survey for long term/terminal care. Consent for PCV 13 was not received until 30 days after admission (family issues). Administered the next day.
### 5 Star Rating

1. Health Inspection (State Inspection)
2. Staffing levels
3. QMs - Measures based on MDS quality measures

#### Dimensions of 5 Star Rating

<table>
<thead>
<tr>
<th>Health Inspection Results</th>
<th>Staffing</th>
<th>Quality Measure Data</th>
</tr>
</thead>
</table>

### Survey Result

- Patient should have been vaccinated immediately
- Citation: D
- F334 Influenza and Pneumococcal Immunization
- Section: 483.80(d)(1)(2) Influenza and Pneumococcal Immunizations

### Legal Information Institute

(d) Influenza and pneumococcal immunizations -

1. Influenza. The facility must develop policies and procedures to ensure that:
   - Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunizations;
   - Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
   - The resident or the resident's representative has the opportunity to

### Health Inspection

- Deficiencies
  - Number
  - Scope
  - Isolated
  - Pattern
  - Widespread
  - Severity

### CMS NH Compare

- Our facility had 3 star health survey rating before this incidence and received 3 star for this survey. But overall rating remained 5 star.
Revisits

- Surveyors revisit to ensure deficiencies are corrected
- More revisits are associated with more serious quality problems
- Surveyors can add new deficiencies if they see them but usually do not look for new ones.
- Surveyors return when there is a credible allegation of non-compliance by the facility if any of the F-tags cited are Substandard Quality of Care (SQC), or when tags are at the actual harm or immediate jeopardy levels.

National Deficiency Data

- In 2014 the average nursing home had:
  - 5.7 deficiencies
  - Only 10.2% facilities had none


State Specific, Federal Oversight

- State specific because of differences in:
  - Survey management: skill, supervision of surveyors and survey process
  - State licensure:
    - Facilities (certificate of need)
    - Staff (training hours, CEU)
    - Medicaid policy: eligibility rules, payment
  - Federal oversight and sample survey of 5% within 60 days of state survey

Survey Process Changes

- New Survey Process
  - 20% of facility census, max 35 residents: 70% from MDS, 30% surveyor selected on-site
  - Surveyors review Quality measures ahead of survey in Certification And Survey Provider Enhanced Reports (CASPER). MDS 3.0 QM 11-3. CASPER Reporting MDS
  - 8 hours on average for interviews, observations, and screening.

One Unified Nationwide Survey

Quality Improvement Strategy (QIS). QIS is a payment structure that provides increased reimbursement or other incentives to improve health outcomes, reduce hospital readmissions, improve patient safety and reduce medical errors, etc.

CMS combines strengths of the Traditional and QIS processes to establish a single nationwide survey. Balances structure (consistency) and surveyor autonomy.
Fines

- Minimum $25,000
- Maximum $100,000
- Health and Safety Code Section 1424.5 (a)(1)
- Money is used for:
  - Temporary managers to improve care
  - Quality assurance to improve care
  - Close facilities and transfer patients
  - [http://hfcis.cdph.ca.gov/faq/longtermcare.aspx](http://hfcis.cdph.ca.gov/faq/longtermcare.aspx)

How do we get out of this?

- Appeal
- Formal appeal
- Informal dispute resolution
- How to regain stars

Appeal

- Court
- Administrative hearing unit
- The outcome of the citation and collection of any fines assessed are not final until all appeals have been exhausted (Health and Safety Code Section 1428(b)).

Formal Dispute Resolution

- Formal appeals process, costly, cumbersome, and lengthy:
  1. Administrative law judge (ALJ)
     - court-like hearing, requiring extensive documentation, involving lawyers
  2. Departmental Appeals Board (DAB)
     - Department of Health and Human Services
  3. Litigated in the courts.


Informal Dispute Resolution

- Informal Dispute Resolution process
  - Administrative Dispute Resolution Act of 1990
  - Omnibus Budget Reconciliation Act of 1995
- Resolve disagreements with state surveyors prior to the formal appeal at the federal level


Informal Dispute Resolution

- Outcome possibilities:
  - Withdrawal of the deficiency
  - Changing its scope or severity
  - Withdrawing specific examples
  - No change

Informal Dispute Resolution

- Until resolved no:
  - Payment
  - Nursing home compare web
  - Online Survey, Certification and Reporting (OSCAR) recording
  - Still able to formally appeal

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3389192

Case

- F334 Infection Control
  - We requested and completed an Informal Dispute Resolution Conference which resulted in removal of one example; however the citation itself remains containing 1 example of 24 residents sampled.

Medical Director’s Role

- Provide medical perspective during survey
- Tracking old survey responses and processes
- Regular meetings with administrators
- Making sure administrators follow-through on deficiencies identified
- Involvement in Informal Dispute Resolution
- Establish connection with Surveyors
- Help initiate informal or formal dispute process
- QAPI involvement, Lead Quality Initiatives

QI Project

- Reviewed if current practice, policies, procedures etc were adequate or if change was required.
- Task forces were formed to revise various procedures, forms and processes.
- The teams met again after change was planned, communicated and implemented to critique the resulting process to determine outcomes met stated goals.
- Resulted in staffing changes, work flow change and additional attention to various routine tasks without the benefit of increased reimbursement.

Immunization Policy Updated

- All patients and staff are offered influenza vaccination
- May decline the vaccinations and must sign a form.
- Staff members who decline the influenza vaccination will be required to wear a protective respiratory mask throughout the influenza season.

Health Inspection

- 2 most recent surveys (complaint surveys added)
  - most recent period (cycle 1) is weighted 60%
  - Previous period (cycle 2) weighted 40%
**Last 2 Surveys Weighting**

- Weight
  - Last Survey 60%
  - Previous Survey 40%

[Diagram showing Last 2 Surveys Weighting]

**How Points are Translated into Stars**


**18 Month Moratorium on Certain F-Tags**

- 18-month moratorium on the
- Imposition of civil money penalties (CMPs)
- Discretionary denials of payment for new admissions (DPNAs)
- Discretionary termination where the remedy is based on a deficiency finding of one of the specified Phase 2 F-tags

- CMS Survey and Certification Group 18-04

**F-Tags included in 18 month Moratorium**

- F655 Baseline Care Plan
- F740 Behavioral Health Services
- F741 Sufficient/Competent Direct Care/Access Staff-Behavioral Health
- F758 Psychotropic Medications related to PRN Limitations
- F638 Facility Assessment
- F681 Antibiotic Stewardship Program
- F965 QAPI Program and Plan, related to the development of the QAPI Plan
- F926 Smoking Policies

**5 Star Rating**

1. Health Inspection (State Inspection)
2. Staffing levels
3. QMs - Measures based on MDS quality measures
Star Rating

- Based on Health Inspection (to avoid skewing by self-report domains)
- Can increase by max 1 star if Staffing or Quality are 4 or 5 stars
- Decrease by 1 star if other domains are 1 star
- If Health Inspection or Quality are 1 star, other domains can only raise rating by 1 star.

Regaining Stars

- Medicare Compare
  [http://www.medicare.gov/nursinghomecompare/search.html](http://www.medicare.gov/nursinghomecompare/search.html)

Distribution of Stars based on Health Inspection

Within each State:
- Top 10% (lowest health inspection deficiency score) receive a 5 star rating.
- Middle 70% of facilities receive 2, 3 or 4 stars, equal number (~23.33 percent) in each category.
- Bottom 20% receive 1 star rating.

Staffing

- The rating for staffing is based on two case-mix adjusted measures
  - Total nursing (RN+ aids+ LPN) hours per resident day
  - RN hours per resident day
- The source data for the staffing measures is CMS form CMS-671 from CASPER report
- Resident census is based on the count of total residents from CMS form CMS-672
- RN hours: RN, RN director of nursing, and nurses with administrative duties
- LPN hours: Includes licensed practical/licensed vocational nurses
- Nurse aide hours: Includes certified nurse aides, aides in training, and medication aides/technicians
Data collection

- Each nursing home still reports its staffing hours to its state survey agency.
- These staffing hours are from a two-week period just before the state inspection.
- Staffing hours per resident per day is the total number of hours worked divided by the total number of residents.

Case-Mix is based on RUG reported on the last day of the month for the quarter.

Reported- Expected- Adjusted Staffing

Hours Adjusted = (Hours Reported / Hours Expected) * Hours National Average

Expected and Adjusted staffing levels

- **Expected staffing** levels based on the case-mix derived from MDS Resource Utilization Groups (RUGs), each of which is associated with an average “expected” amount of daily staff time for each of the three types of nursing staff.
- **Adjusted staffing** is then computed based on the relationship between reported and expected staffing.
- The Staffing ratings are based on total staffing, with RN staffing weighted more heavily than other types of staff.

Important to keep track of you staffing based on the number of residents

- Homemade formula
  - Total Medicare * 4.2 +
  - Total HMO * 4.0 +
  - Total Medicaid * 3.2

  \[ \frac{\text{A}}{\text{Census}} = \text{hours per resident per day} \]
Staffing and Quality

- Considerable evidence of a relationship between NH staffing levels, staffing stability, and resident outcomes.
- CMS Staffing Study found a clear association between nurse staffing ratios & NH quality of care:
  - Identified specific ratios of staff to residents below which residents are at substantially higher risk of quality problems.
- CNA turnover is also associated with higher resident behaviors deficiencies.
  - J Am Med Dir Assoc. 2014 Feb

Turnover is costly $$$

- Cost savings associated with a 10 percentage point increase in turnover for an average facility was $167,063 or 2.9% of annual total costs.
  - Based on a study in 900+ NHs in CA in 2005

Factors associated with staff turnover

<table>
<thead>
<tr>
<th>Higher turnover</th>
<th>Lower turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>For-profit and chain</td>
<td>None-for profit</td>
</tr>
<tr>
<td>Lower staffing rates</td>
<td>Training and supervision</td>
</tr>
<tr>
<td>Lower wages??</td>
<td>High unemployment rate in area</td>
</tr>
<tr>
<td>Higher work load</td>
<td>TEAM WORK</td>
</tr>
<tr>
<td>High bed number</td>
<td>REWARD EMPLOYEES</td>
</tr>
</tbody>
</table>

Factors associated with staff retention

- Involvement in interdisciplinary care plan meetings
- Length of experience and older workers (more stable family situations)
- Opportunities for professional growth
- Supervisory training and sufficient orientation
- Motivating positive feelings between aides and residents
- Perception of being valued
- Working as a team
- Positive relationships with coworkers
- Permanent assignments

Staffing “What’s New”

- In 2015 Congress passed “The Improving Medicare Post-Acute Care Transformation Act,” or IMPACT to increase transparency and reduce fraudulence reporting
- Section 6106 of the Affordable Care Act (ACA) requires facilities to electronically submit direct care staffing information
- Combined with census information
- Report on employee turnover and tenure
New Payroll-Based Journal

- CMS has developed a system for facilities to submit staffing and census information – Payroll-Based Journal (PBJ)

Payroll Base Journal (PBJ)

- CMS accepts XML file for PBJ reporting
- Reporting became mandatory effective July 1, 2016
- Providers require to file both staffing and census data no later than 45 days after the last day of each fiscal quarter

Reporting

- Exported file (XML) from automated systems (e.g., payroll, timekeeping)
- Manual entry directly through PBJ system, or
- Combination of XML and manual entry (merging data)

Staffing Hours Entry

- PBJ Staffing Data is now public
- In November 1, 2017, CMS posted a public use file containing PBJ staffing data submitted by long term care facilities.
- Including the hours nursing staff are paid to work each day, for each facility.
  - Director of nursing, registered nurses with administrative duties, registered nurses, licensed practical nurses with administrative duties, licensed practical nurses, certified nurse aides, medication aides, and nurse aides in training.

Report on PBJ

- Category of work (40 job title codes)
  - RN, LVN, LPN, CNA, therapist, ...
- Medical Director hours should be reported (not time spending seeing patients)
- Includes agencies and contract staff
- Resident census data
- Information on direct staff turnover and tenure
- Hours of care provided per category
- Auditable back to payroll data
- CMS will count “direct care” (hands-on care) only for 5-star QRS
- CMS has not disclosed how they will be auditing the data collected through the PBJ
Reporting Physician Hours in PBJ

- Number of hours spent on site conducting primary responsibilities as **MEDICAL DIRECTOR**
  - e.g. QA meetings, reviewing incident reports, …
- Hours for services performed that are billed to FFS Medicare or other payer, should not be reported
  - e.g. physician visits to residents, hospice staff, or private duty nurses

### Medical Director Hours Report Sample

<table>
<thead>
<tr>
<th>Service Rendered</th>
<th>Time Spent (Month)</th>
<th>Total Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Director</td>
<td></td>
<td></td>
</tr>
<tr>
<td>QA Meetings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incident Reports</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Responsibilities</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PT staff hours have been reported now on the CMS website and in the future might be part of the overall staffing. At this point, the staffing is based on:**

- Total nursing (RN+ aids+ LPN) hours per resident day

### Staffing report now and future

<table>
<thead>
<tr>
<th>Current Practices</th>
<th>Future Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collected annually during survey.</td>
<td>Quarterly electronic reporting.</td>
</tr>
<tr>
<td>Reported via 671 / 672.</td>
<td>Staff, contracted/agency employees, medical professionals.</td>
</tr>
<tr>
<td>Typically reported staff hours only</td>
<td>Auditable document trail</td>
</tr>
</tbody>
</table>

**Quality Metrix and Beyond**

Sabine von Preyss-Friedman, MD, FACP, CMD,

University of Washington, Seattle | CMO, Avalon Healthcare, Inc.
QM Objectives

• Understand the Basis for newest CMS Quality Metrix
• Understand Impact of Quality Measures
• Strategies for Quality Improvement
• The Role of the Medical Director

Medical Directors have to speak Quality and 5 Star

• Tightening networks for ACO’s and hospital systems
• Insurance selection and reimbursement
• Value-Based Purchasing for SNF’s
  • Medicaid Quality Incentives
  • Medicare VBP Rehospitalization

Coming to a SNF near you:
Value based Purchasing for SNF’s

Value-Based Purchasing (VBP)

• Linking provider payments to improved performance by health care providers.
• It attempts to reduce inappropriate care and to identify and reward the best-performing providers.

Value-Based Purchasing SNFs:

• Transforms payors (Medicare, Medicaid and others)
  • From passive payor of claims
  • To active purchasers of quality healthcare for its beneficiaries

Three Components of Value-Based Purchasing

1. Incentives
2. Performance measures
3. 2 benchmarks or targets

Three Components of Value-Based Purchasing

1. Incentives
2. Performance measures
3. 2 benchmarks or targets

Source: "Value-Based Payment in Nursing Facilities: Options and Lessons for States and Managed Care Plans," Jenna Libersky, Julie Stone, Leah Smith, James Verdier, and Debra Lipson, ICRC Technical Assistance Tool, November 2017
Value-Based Purchasing for SNF's

What is measured?

SNF 30-Day All Cause Readmission Measure (SNFRM)
- Risk-standardized rate of all-cause, unplanned hospital readmissions of Medicare SNF beneficiaries
- Within 30 days of discharge from their prior proximal acute hospitalization
- Regardless of whether the beneficiary is readmitted to the hospital directly from the SNF or has been discharged from the SNF
- Identified through Medicare claims

Value-based Purchasing for SNF’s

Incentives
- 2% of Medicare Payments are withheld from all SNF’s
- 60% of the withheld payments are used for incentive payments (Medicare keeps 40%)
- Top tier SNF’s receive incentive payment
- Lower tier SNF’s loose up to 2% of revenue

Value-Based Purchasing SNFs:

- VBP SNF Rehospitalizations – Medicare patients:
  - Adding first payment adjustment October 1, 2018 (FY 2019)
  - Performance is based on Calendar Year 2017
  - Payment adjustment October 1, 2019 (FY 2020)
  - Performance is based on Fiscal Year 2018 (NOW)

Value-Based Purchasing for SNF’s

Benchmarks?
SNFs are assigned SNF VBP Performance Scores
- SNF VBP Performance Scores range from 0 to 100 points
- Based on their readmissions during:
  - Baseline period (CY 2015)
  - Performance period (CY 2017)
- SNFs are assigned values for both
  - Their improvement from the baseline year to the performance year (max 90pts)
  - Their achievement in the performance period (max 100 pts)
- Whichever score is the highest

What will VBP payments look like?

Example of hypothetical performance scores and incentive multipliers

What do we know?
Baseline Performance Data are published
- https://www.medicare.gov/nursinghomecompare/search.html
Currently published Data

States and VBP Examples
Some are aligned with CMS 5 Star Rating

Medicaid Quality Incentive Payments
Several states have Medicaid Quality Incentive Payments that are based on select QM performance
- Example: State of Washington
  - Antipsych Meds (S)
  - Falls w/Maj Injury (L)
  - Hi-Risk PU (L)
  - UTI (L)
  - As of 2017: Employee Turnover
  - Full WA Incentive Payment $7.69/MDCD day

Quality Measures Domain
Reach for the Stars!
- Only 5 Star Rating will affect Overall CMS 5 Star Rating
- HOWEVER, specific measures may effect Value Based Purchasing

New Quality Measures 2016
Short Stay Measures
- Percentage of residents who were re-hospitalized (claims-based)
- Percentage of residents who were successfully discharged to the community (claims-based)
- Percentage of residents who have had an emergency department visit (claims-based)
- Percentage of residents who made improvements in function from admission to discharge (MDS-based)

Long Stay Measures
- Percentage of residents whose ability to move independently worsened (MDS-based)
11 Ongoing Quality Measures:

<table>
<thead>
<tr>
<th>Long Stay Residents (&gt;100 cumulative days in facility/episode)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Percent of residents whose need for help with activities of daily living has increased</td>
</tr>
<tr>
<td>2) Percent of high risk residents with pressure sores</td>
</tr>
<tr>
<td>3) Percent of residents who have/had a catheter inserted and left in their bladder</td>
</tr>
<tr>
<td>4) Percent of residents who were physically restrained</td>
</tr>
<tr>
<td>5) Percent of residents with a urinary tract infection</td>
</tr>
<tr>
<td>6) Percent of residents who self-report moderate to severe pain</td>
</tr>
<tr>
<td>7) Percent of residents experiencing one or more falls with major injury</td>
</tr>
<tr>
<td>8) Percent of residents who received an antipsychotic medication</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Short-Stay Residents (&lt;100 cumulative days in facility/episode)</th>
</tr>
</thead>
<tbody>
<tr>
<td>9) Percent of residents with pressure ulcers (sores) that are new or worsened</td>
</tr>
<tr>
<td>10) Percent of residents who self-report moderate to severe pain</td>
</tr>
<tr>
<td>11) Percent of residents who received an antipsychotic medication newly started</td>
</tr>
</tbody>
</table>

Data Time Frames: New QMs

- **3 Claims-Based** short stay measures period:
  - Rolling 12 months report starting in 2016
- **MDS-Based**:
  - 4 QTR average method, starting 5 quarters back, now 10/1/16-9/31/2017

Risk Adjustments: Refine QM’s

- **Exclusions**: Outcomes that are not under facility control
- **Covariates**: Characteristics, conditions or diagnoses that increase the resident’s risk for triggering in a Quality Measure

Percentage of Short Stay Patients Rehospitalized after a NH Admission

- Number of nursing home stays
- **Unplanned** readmission to hospital
- Within 30 days of admission to SNF
  - Includes discharged patients
  - Inpatient stay or observation stay

CMS Rehospitalization: **Exclusions**

- Only fee for service Medicare
  - Not Medicare Advantage Plans
  - Not residents who do not have both Med A & B
- Hospice Patients
  - “From” and “Thru” dates overlap with NH stay
- Comatose based on MDS

Risk Adjustment: Your SNF population

<table>
<thead>
<tr>
<th>MDS BASED COVARIATES</th>
<th>CLAIMS BASED COVARIATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional Status</td>
<td>Cormorbidity Index</td>
</tr>
<tr>
<td>Clinical Conditions</td>
<td>Hospital LOS/# Hosp.</td>
</tr>
<tr>
<td>Clinical Treatments</td>
<td>ICU/ESRD</td>
</tr>
<tr>
<td>Clinical Diagnosis</td>
<td></td>
</tr>
</tbody>
</table>
Facility Expected Rate

- Average probability across all SNF stays for 1 year

Measure Calculation

- **Expected Rate:**
  - Average probability of rehospitalization at that SNF in the past year, updated every 12 months
  - QM star based on Risk Standardized rate
  - Rolling 12 months rehospitalization rate
  - Measure updated every 6 months
    - April and October, lags 9 months behind

Rehospitalization:

**What should your goal be?**

- Hospitalization at the **right time for the right condition**
- Know your rate and state/national rate
- National rate 2014/2015: 21.1%
- WA rate: 16.7%
- Hospital and insurance networks expectation: Significantly below, often < 12%

Percentage of short stay patients who had an outpatient ER visit

- All NEW admission and readmissions
- ED visits within 30 day of SNF entry
- Includes discharged patients
- Claims based

Exclusions

- ED visits resulting in inpatient stay
- Only Medicare FFS patients
- Hospice enrolled
Facility Expected Rate

- Average probability across all stays for the past year

Measure Calculation

- Rolling 12 month ED visit rate
- Measure updated every 6 months, April and October
- Expected rate updated every 12 months

Medical Director Interventions

- Know your hospital transfer rate
- Integrate Interact Program
- Interact Rehospitalization Review
- High Presence Provider Models
- Initial visit by provider within 72 hours
- Focus on rehospitalizations:
  - Hospital Transfer Committee

Hospital Transfer Committee

- **Suggested composition:**
  - Medical Director
  - Director of Nursing
  - Administrator
  - Charge Nurse

- Meet at least monthly
- Review Completed Interact QI Tool
- Identify trends that lead to hospital transfers
- Answer question: How could our care be improved?
- Don’t be satisfied with avoidable/unavoidable

QI Improvement Tool for Rehospitalization

- Utilize for unplanned rehospitalizations
Medical Director

Review the following team practices:
- Medication reconciliation and teaching processes
- Family engagement in discharge
- Condition specific teaching (i.e. Zone tools for CHF)
- PCP notification of return to community
- PCP appointment and clarify transport to PCP
- HH follow-up and their quality metric
- Follow-up telephone calls (3 days, 2 weeks, 4 weeks)

Hospital Transfers: Other Considerations

- MDS accuracy is key (Covariates!)
- Integrate hospice and end of life discussions as early as necessary
- Initiate SNF follow-up from hospital palliative care services
- Work with hospitals on transfer processes and improve timeliness and safety of transfers

Percentage of Short Stay Residents: Successfully discharged to the community

- Percentage of all new admissions
- Discharged to the community within 100 calendar days
  - For 30 subsequent days
  - Not re-admitted to hospital or SNF within 30 days
  - Did not die within 30 days

Percentage of Short Stay Residents: Successfully discharged to the community

- Exclusions
  - Only Medicare FFS
  - Comatose
  - Hospice
  - Did not have initial MDS

Community Discharge Covariates

- Claims based covariates:
  - Number of previous rehospitalizations
  - ICU stay
  - Disability coverage
- MDS based covariates:
  - Fairly extensive, especially in functional area

Measure Calculation

- Expected Rate: Calculates the probability for this outcome for your facility case mix for a year
  - Measure updated quarterly
  - Expected Rate updated every 12 months

- Observed Rate $\times$ National Rate = Risk Standardized Rate
### Percentage of Short Stay Residents: Who made Improvements in Function

**Exclusions**
- Comatose
- Life Expectancy < 6 months
- Hospice
- No ADL impairment on admission
- Target period is end of calendar quarter
- Data updated every quarter

**Comparison of function:**
- From initial/5 day assessment to discharge assessment
- **ADL’s**
  - Transfer
  - Locomotion on unit
  - Walk in corridor

**Triggers if:**
- Change of Performance Score in ADL areas
- \([\text{Discharge ADL Score}] - [5\text{ day ADL Score}] < 0\)

**Covariates**
- Based on resident status prior to admission (5 day assessment)
- Age/Gender
- Severe cognitive impairment
- Heart failure
- CVA/TIA
- Hip fracture
- Other fracture
- Long-form ADL score
New Long-Stay Measure, MDS Based

New Long Stay Measure: LS residents whose ability to move independently has worsened

- Decline in independence in locomotion on unit, self-performance
  - Includes the ability to move about independently, whether a person’s typical mode of movement is by walking or by using a wheelchair
- Target assessment compared to prior MDS assessment
- Increase in 1 or more points on that descriptor (7.8 recoded to 4)

**EXCLUSIONS**
- Comatose
- Prognosis < 6 months
- Hospice
- Totally dependent

**RISK ADJUSTMENTS**
- Based on ADL’s on prior assessments

Scoring Rules: QM Domain

- For each measure 1 – 100 points are assigned
  - 0% percentile = 100 pts
  - 99% percentile = 20 pts

New Quality Measures 2016

**Short Stay Measures**

- Percentage of residents who were re-hospitalized (claims-based)
- Percentage of residents who were successfully discharged to the community (claims-based)
- Percentage of residents who have had an emergency department visit (claims-based)
- Percentage of residents who made improvements in function from admission to discharge (MDS-based)

**Long Stay Measures**

- Percentage of residents whose ability to move independently worsened (MDS-based)
11 Ongoing Quality Measures:

**Long Stay Residents (＞100 cumulative days in facility/episode):**
1. Percent of residents whose need for help with activities of daily living has increased
2. Percent of high risk residents with pressure sores
3. Percent of residents who have had a catheter inserted and left in their bladder
4. Percent of residents who were physically restrained
5. Percent of residents with a urinary tract infection
6. Percent of residents who self-report moderate to severe pain
7. Percent of residents experiencing one or more falls with major injury
8. Percent of residents who received an antipsychotic medication

**Short Stay Residents (＜100 cumulative days in facility/episode):**
9. Percent of residents with pressure ulcers (sores) that are new or worsened
10. Percent of residents who self-report moderate to severe pain
11. Percent of residents who received an antipsychotic medication newly started

---

Star Cut points for quality measures, January 2017

<table>
<thead>
<tr>
<th>Star Level</th>
<th>Percent</th>
<th>Point Range July 2016</th>
<th>Point Range January 2017</th>
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<tbody>
<tr>
<td>★</td>
<td>75%</td>
<td>275 - 689</td>
<td>325 - 789</td>
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<tr>
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<td>60%</td>
<td>570 - 759</td>
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<td>45%</td>
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<td>30%</td>
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<td>930 - 1054</td>
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<td>★★★★★</td>
<td>25%</td>
<td>905 - 1350</td>
<td>1055 - 1460</td>
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Point Calculators – Trend Tracker

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<thead>
<tr>
<th>Category</th>
<th>Current</th>
<th>Last 12 Months</th>
<th>Last 24 Months</th>
<th>Last 36 Months</th>
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<td>9.7%</td>
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<td>Pressure Ulcers (New)</td>
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<tr>
<td>PAD</td>
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<td>7.4%</td>
<td>7.0%</td>
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<td>3.7%</td>
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<td>0.1%</td>
<td>0.0%</td>
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<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

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Overall Nursing Home Rating (STARS)

1. Start with Health Inspection rating
2. Add one star to the Step 1 result if staffing rating is four or five stars and greater than the health inspection rating
3. Subtract one star if staffing is one star

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VBP: What can the Medical Director do?

- Know your facility’s rehospitalization data, be instrumental in:
  - QAPI, root cause, and goal setting
  - Education
- Know your state’s Medicaid (and other stakeholders) incentive payment plans

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Will there be a Medical Director 5 Star Rating?

- What have you done to bring Value to your facility?
References

- "Quality Measures 2016", A Buerhaus, Dir Quality Management, EmpRes Healthcare