SA2a- General Session II - The Society's Top Policy Issues 2018

Saturday, March 24

8:00 AM - 10:30 AM

Session Description

Learning Objectives

Updates on the top Society activity on policy issues including the following: legislative advocacy, communications with government agencies, updates on the health care reform implementation efforts, and on proposed changes to PA/LTC facilities requirement

List the Society’s top policy issues in 2018.

Discuss the Society’s advocacy on legislative initiatives, health care reform, and payment policy.

Anticipate upcoming changes in skilled nursing facility regulations.

Presenter(s): Karl Steinberg, MD, CMD; David Nace, MD, MPH, CMD; Alex Bardakh, MPP

Presenter(s) Disclosures: All speakers have reported they have no relevant financial relationships to disclose.
The Society’s Top Policy Issues 2018

- Karl Steinberg, MD, CMD, HMDC; Chair, Public Policy Committee;
- David Nace, MD, CMD; Vice Chair, Public Policy Committee;
- Alex Bardakh, MPP; Director, Public Policy and Advocacy

Speaker Disclosures

Drs. Steinberg and Nace, and Mr. Bardakh, have no relevant financial disclosures

Learning Objectives

By the end of the session, participants will be able to:

- Explain current Society public policy priorities, victories and major issues
- Describe the IMPACT Act and CMS’ Phase 2 implementation of the skilled nursing facility Requirements of Participation
- Discuss payment mechanisms of the Quality Payment Program (MIPS & APMs) and expected changes
- Prepare for Resident Classification System 1 (RCS1)

Political Update 2018

- Key Issues for the Year
  - Politics
    - Midterms for the party not in power: historical trends; presidential popularity
    - Midterm prospects for Congress; Senate more challenging
  - State Elections/Redistricting
  - The Economy: key trends include lower unemployment, wage increases, continued job insecurity and a volatile stock market.

Political Update 2018

- Policy
  - Trump First Year Accomplishments
  - Consensus Opportunities
  - Issues of Risk for Trump

Policy and Politics

- Trump Admin First Year Accomplishments
  - Tax Reform
  - Individual Mandate
  - Budget Deal
  - Gorsuch Confirmation (and circuit judges)
- Second Year Consensus Opportunities
  - Infrastructure
  - Opioids
  - Society working on position statement (based on 2017 HoD resolution)
- Will there be agreement on…
  - Immigration
  - Deficit
  - Entitlement Reform
Admin Goals in Regulatory Arena

- Patients over Paperwork Campaign
  - Reduce Admin Burden
  - Less time spent on things like EHR and Documentation
- Meaningful Measures
  - Too many measures across programs
  - Confusing and meaningless in terms of patient outcomes
  - Streamline measures and measure reporting
- Complete overhaul of Meaningful Use/ACI
- Overhaul of E&M Guidelines?

Society on the Hill

- Workforce – Geriatric Workforce Enhancement Program (GWEP)
- PA/RTC Role in Value-Based Medicine
- Advance Care Planning

Legislative Victories

- Permanent Repeal Therapy Caps – only 20+ years in the making
- Signed into Law: Recognize, Assist, Include, Support and Engage (RAISE) Family Caregivers Act (S. 1028), requires the development of a national strategy that would identify specific actions that government, communities, providers, employers, and others can take to recognize and support family caregivers.
- Passed out of committee: Good Samaritan Health Professional Act of 2017, a bill that protects health care professionals from being held liable for harm caused by providing health care services during a national or public health emergency, or a major disaster.
- Physician Payment Changes – reduction in MACRA penalty liability; physician payment protections

MACRA

Reminder – Two Pathways

- MIPS
- APM

Year 1 Submission is currently underway

- Visit qpp.cms.gov and look for the login icon at the top of the screen.
- Clinicians who participate in the Quality Payment Program have one place to submit all of their data eliminating the need for multiple visits to multiple websites.
Important Changes for Year 2

- Low-volume threshold
- Who is excluded?
- Cost category is back but SNF (POS 31) patients excluded!
  - 10% for 2018 Reporting Year
- Minimum performance threshold has changed!
  - Now need to report on more than one measure

MIPS Eligibility Year 2

- **Change to the Low-Volume Threshold for 2018.** Include MIPS eligible clinicians billing more than $90,000 a year in Medicare Part B allowed charges AND providing care for more than 200 Medicare patients a year.

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>BILLING &gt;$30,000 AND &gt;100</td>
<td>BILLING &gt;$90,000 AND &gt;200</td>
</tr>
</tbody>
</table>

MIPS Year 2 (2018) Performance Period

<table>
<thead>
<tr>
<th>Change: Instrument to Performance Period Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transition Years (2017) Final</strong></td>
</tr>
<tr>
<td><strong>Years (2018) Final</strong></td>
</tr>
<tr>
<td>Performance Period</td>
</tr>
<tr>
<td>Quality</td>
</tr>
<tr>
<td>Improvement Activities</td>
</tr>
<tr>
<td>Cost</td>
</tr>
<tr>
<td>Advancing Care Information</td>
</tr>
</tbody>
</table>

MIPS Performance Categories Year 2

- Comprised of four performance categories in 2018.
- 100 Possible Final Score Points

  - Quality: 50
  - Cost: 10
  - Improvement: 15
  - Advancing Care Information: 25

Cost Category in Year 2

- Change: Cost performance category weight is finalized at 10% for 2018.
- 10 episode-based measures adopted for the 2017 MIPS performance period will not be used.
- CMS is developing new episode-based measures with significant clinician input and are providing feedback on these measures the fall through field testing.
- This will allow clinicians to see their cost measure scores before the measures are potentially included in the MIPS program.
- CMS will propose new cost measures in future rulemaking.
- SNF (POS 31) excluded from cost measure attribution!

NEW: Virtual Groups in Year 2

- What is a virtual group?
  - A virtual group can be made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together “virtually” (no matter what specialty or location) to participate in MIPS for a performance period for a year.

  - To be eligible to join or form a virtual group, you would need to be a:
    - Solo practitioners who exceed the low-volume threshold individually, and are not a newly Medicare-enrolled eligible clinician, a Qualifying APM Participant (QP), or a Partial QP choosing not to participate in MIPS.
    - Group that has 10 or fewer eligible clinicians and exceeds the low-volume threshold at the group level.

  - **To be eligible to join a virtual group:**
    - Clinicians billing more than $90,000 in Medicare Part B allowed charges, AND providing care for more than 200 Medicare patients a year.
Performance Threshold Year 2

Change: Increase in Performance Threshold and Payment Adjustment

Transition Year 1 (2017) Final
- 3 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 4%

Year 2 (2018) Final
- 5 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 5%

How can I achieve 15 points?
- Report all required Improvement Activities.
- Meet the Advancing Care Information base score and submit 1 Quality measure that meets data completeness.
- Meet the Advancing Care Information base score, by reporting the 5 base measures, and submit one medium-weighted Improvement Activity.
- Submit 6 Quality measures that meet data completeness criteria.

3 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 4%

15 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 5%

Change: Increase in Performance Threshold and Payment Adjustment

Bonus Points for Complex Patients and Small Practices

- Up to 5 bonus points available for treating complex patients based on medical complexity.
  - As measured by Hierarchical Condition Category (HCC) risk score and a score based on the percentage of dual eligible beneficiaries.
- MIPS eligible clinicians or groups must submit data on at least 1 performance category in an applicable performance period.

- Exceptional performer set at 70 points
- Payment adjustment set at +/- 4%
- 3 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 4%

- Exceptional performer set at 70 points
- Payment adjustment set at +/- 5%
- 5 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 5%

- Exceptional performer set at 70 points
- Payment adjustment set at +/- 5%
- 15 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 5%

- Exceptional performer set at 70 points
- Payment adjustment set at +/- 5%
- 15 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 5%

Alternative Payment Models (APMs) Quick Overview

- As defined by MACRA, APMs include CMS Innovation Center models (authorized under section 1115A, other than a Health Care Innovation Award), MSSP (Medicare Shared Savings Program), demonstrations under the Health Care Quality Demonstration Program, and demonstrations required by federal law.
- Advanced APMs are a subset of APMs. To be an Advanced APM, a model must meet the following three statutory requirements:
  - Requires participants to use certified EHR technology (CEHRT);
  - Provides payment for covered professional services based on quality measures comparable to those used in the MIPS quality performance category; and
  - Either: (1) is a Medical Home Model expanded under CMS Innovation Center authority OR (2) requires participants to bear a meaningful amount of financial risk.
- In order to achieve status as a Qualifying APM Participant (QP) and qualify for the 5% APM incentive payment for a year, eligible clinicians must meet a certain percentage of payments for covered professional services or see a certain percentage of patients through an Advanced APM during the associated performance period.

Alternative Payment Models

Advanced APMs in PA/LTC
- No available Advanced APMs for exclusive PA/LTC clinicians
- MIPS APMs available
- Could success of Initiative to Reduce Rehospitalizations Among Nursing Home Residents be scalable to Advanced APMs?
- Current submissions for PA/LTC being considered by PTAC

MIPS – Should I stay or should I go?
- MedPAC, President’s Budget and Health Affairs articles have all called for repeal of MIPS
- Specialty societies are so far not on board with the idea – continue work on simplification of reporting and scoring
- Something to monitor but continue to participate as if it’s sticking around!
Society Advocacy

- Simplify MIPS!
- Get credit in multiple categories
- Easier reporting options
- Flexibility in reweighting categories
- Create a “facility-based” eligible clinician definition

- Improve Risk Adjustment in Cost Measures
- I-SNP
- Johns Hopkins Model
- Others

Understanding the CMS ROPs &
New Survey Process

Three-Phase Implementation

- Phase 1:
  - Upon the effective date of the final rule (Nov 28, 2016)

- Phase 2:
  - 1 year following the effective date of the final rule (Nov 28, 2017)

- Phase 3:
  - 3 years following the effective date of the final rule (Nov 28, 2019)

Implementation Grid

<table>
<thead>
<tr>
<th>Implementation Date</th>
<th>Type of Change</th>
<th>Details of Change</th>
</tr>
</thead>
</table>
| Phase 1:
  - November 28, 2016 (imminent)
| Nursing Home Requirements for Participation | New Regulatory Language was uploaded to the Assessment Survey Processing Environment (ASPE)
| Phase 2: November 28, 2017 | I-SNP Implementation survey process | Revised I-SNP survey process
| Phase 3: November 28, 2019 | Requirements that need more time to implement | Requirements that need more time to implement

RoP Sections with Phase 2 Requirements

- Basis & Scope (§483.1)
- Definitions (§483.5)
- Resident rights (§483.10)
- Freedom from abuse, neglect, and exploitation (§483.12)
- Admission, transfer, and discharge rights (§483.15)
- Resident assessment (§483.20)
- Comprehensive person-centered care planning (§483.21)
- Quality of life (§483.24)
- Quality of care (§483.25)
- Physician services (§483.30)
- Nursing services (§483.35)
- Behavioral health services (§483.40)

RoP Sections with Phase 2 Requirements

- Pharmacy services (§483.45)
- Laboratory, radiology, and other diagnostic services (§483.50)
- Dental services (§483.55)
- Food and nutrition services (§483.60)
- Specialized rehabilitative services (§483.65)
- Administration (§483.70)
- Quality assurance and performance improvement (§483.75)
- Infection control (§483.80)
- Compliance and ethics program (§483.85)
- Physical environment (§483.90)
- Training requirements (§483.95)
F-tag Renumbering

- The image above is the F Tag Crosswalk showing:
  - The original regulatory grouping and the new associated grouping
  - The original regulation number and the new associated regulation number
  - The original F Tag and the associated new F Tag
- **Insert link to F-Tag crosswalk

What does this mean for me?

- A time of transition – within your centers (and for surveyors too)
- A time to reflect, self-assess, and prioritize your efforts
- A marathon, not a sprint

Overview of Phase 2 Requirements

Review of Phase 2 Requirements

- **Contact information** for State & local advocacy organizations, Medicare & Medicaid eligibility information, Aging & Disability Resources Center, and Medicaid Fraud Control Unit
- Document **transfer/discharge** in medical record and share information with receiving provider
- Develop **baseline care plan** within 48 hours of admission
- Include 6 key elements and share written copy

Phase 2 Requirements continued

- **Policies and procedures for reporting suspicion of crimes**
  - Within 2-hours if serious bodily injury; within 24 hours if no serious bodily injury
  - Focuses on INDIVIDUALS who are responsible for reporting
  - Ensure reporting of crimes by covered individuals
  - Annual reminder/re-education

Phase 2 Requirements continued

- **Policies and procedures for reporting suspicion of crimes**
  - Facility must educate covered individuals
  - Report to state and at least one law enforcement entity
  - No retaliation
  - Poster with employee rights (e.g. no retaliation for reporting)
Review of Phase 2 requirements cont’d

- **Pharmacy Services:**
  - Drug regimen review includes medical chart (not just MAR)
  - Limits on use of psychotropic drugs
  - Do not receive psychotropic drugs pursuant to PRN order unless necessary to treat condition as diagnoses & documented in medical record
  - PRN orders for psychotropic drugs are limited to 14 days unless physician or prescribing practitioner documents rationale

Review of Phase 2 requirements cont’d

- **Pharmacy Services:**
  - PRN orders for antipsychotic drugs are limited to 14 days and cannot be renewed unless physician or prescribing practitioner evaluates resident for appropriateness
  - Requires direct examination and documentation

Review of Phase 2 requirements cont’d

- **Dental services:** policy for when loss or damage of dentures is facility’s responsibility and prompt referral for dental services (within 3 days)
- **QAPI Plan**
- **Smoking policy**

Review of Phase 2 requirements cont’d

- **Complete facility assessment (FA)**
- **Sufficient and competent staffing** requirements tied to FA
- **Nursing services**
- **Food and nutrition services**
- **Behavioral health services**

Review of Phase 2 requirements cont’d

- **Behavioral health**
  - Care and services for residents with mental and psychosocial disorders as well as dementia – highest practicable
  - Implementing nonpharmacological interventions
  - Provide needed rehab services

Review of Phase 2 requirements cont’d

- **Infection prevention and control program**
  - System with key elements for preventing, identifying, reporting, investigating, and controlling – linked to facility assessment and national standards
- **Antibiotic stewardship program**
  - Antibiotic use protocols (to address prescribing practices) and system to monitor their use
Society Updated Synopsis of Federal Regs!
- Updated with all new F-Tags and Recommendations for Medical Directors and Clinicians!
- Thank you to Steve Levenson, Vicky Walker, Gaby Geise and the entire Clinical Issues Subcommittee!

Temporary Changes around Phase 2
- Star rating kept constant from Nov. 2017-2019
- CMP not being assessed for deficiencies in some of new Phase 2 regs
- Advocacy groups upset that nursing homes not being ‘punished’ appropriately

Other issues
- Non-f2f codes, ACP says full time required, in CPT?
- New(ish) codes cognitive, ACP, etc.

IMPACT Act of 2014
- Bi-partisan bill passed on September 18, 2014, and signed into law October 6, 2014

* The Act requires the submission of standardized patient assessment data elements by:
  - Long-Term Care Hospitals (LTCHs): LCDS
  - Skilled Nursing Facilities (SNFs): MDS
  - Home Health Agencies (HHAs): OASIS
  - Inpatient Rehabilitation Facilities (IRFs): IRF-PAI

* The Act specifies that data “…be standardized and interoperable so as to allow for the exchange of such data among such post-acute care providers and other providers and the use by such providers of such data that has been so exchanged, including by using common standards and definitions in order to provide access to longitudinal information to facilitate coordinated care and improved Medicare beneficiary outcomes.”

Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

IMPACT Act: Quality Measures

<table>
<thead>
<tr>
<th>Measure Domain</th>
<th>HHAs</th>
<th>SNFs</th>
<th>IRFs</th>
<th>LTCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional status</td>
<td>1/1/2019*</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2018</td>
</tr>
<tr>
<td>Skin integrity</td>
<td>1/1/2017</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
</tr>
<tr>
<td>Medication reconciliation</td>
<td>1/1/2017</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2018*</td>
</tr>
<tr>
<td>Incidence major falls</td>
<td>1/1/2016**</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
</tr>
<tr>
<td>Transfer of Health Information</td>
<td>1/1/2019**</td>
<td>10/1/2018**</td>
<td>10/1/2018**</td>
<td>10/1/2018**</td>
</tr>
<tr>
<td>Preventable UTI &amp; Other Measures Domain</td>
<td>HHAs</td>
<td>SNFs</td>
<td>IRFs</td>
<td>LTCH</td>
</tr>
<tr>
<td>Medicare Spending Per Beneficiary</td>
<td>1/1/2017</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
</tr>
<tr>
<td>Discharge to Community</td>
<td>1/1/2017</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
</tr>
<tr>
<td>Potentially Preventable Hospital Readmissions</td>
<td>1/1/2017</td>
<td>10/1/2015</td>
<td>10/1/2015</td>
<td>10/1/2016</td>
</tr>
</tbody>
</table>

* = implemented, but data collection has not begun
** = not implemented yet
IMPACT Act Measures Domains

- Functional status
- Mobility
- Ulcers
- Incontinence
- Delirium
- Improvement in functional status
- Medications
- Labs
- Chest X-Ray
- Equipment
- Area of interest for medication
- Area of interest for consultation
- Area of interest for education
- Area of interest for support
- Area of interest for discharge planning
- Area of interest for employment
- Area of interest for housing
- Area of interest for transportation
- Area of interest for social services
- Area of interest for another area

Statutory Timelines: Standardized Patient Assessment Data

- Providers must submit standardized assessment data through PAC assessment instruments under applicable reporting provisions
- The data must be submitted with respect to admission and discharge of each patient, or more frequently as required
- Data categories:
  - Functional status
  - Cognitive function and mental status
  - Special services, treatments, and interventions
  - Medical conditions and co-morbidities
  - Impairments
  - Other categories required by the Secretary

What is Standardization?

- Standardizing Function at the Item Level
- Achieving Standardization (i.e., Alignment) of Clinically Relevant Data Elements to Improve Care and Communication for Individuals Across the Continuum
- Enables shared understanding and use of clinical information;
- Enables the re-use of data elements (e.g., for transitions of care, care planning, referrals, decision support, quality measurement, payment reform, etc.);
- Supports the exchange of patient assessment data across providers;
- Influences and supports CMS and industry efforts to advance interoperable health information exchange (HIE) and care coordination in disparate settings.

Data Element Standardization

A NEW WAY?
RESIDENT CLASSIFICATION SYSTEM FOR SNF PAYMENT
RCS1 – Resident Classification System

- SNF Prospective Payment System in Place Since 1998 – Criticized Over Time
- CMS hired Acumen to develop a new payment system with 3 goals in mind
  - More accurately compensate SNFs
  - Reduce incentives for SNFs to deliver therapy based on financial considerations, rather than resident need
  - Maintain simplicity, to the extent possible
- CMS Held Expert Panels – AMDA was represented
- Would replace the current RUG based system

RCS 1 – What It Would Look Like

RCS1 – Resident Classification System

Area Case-mix adjustments

- Number of case-mix categories
- Maximum value
- Minimum value
- Functional status (3 ADLs: transfers, eating, toileting)
- Presence of cognitive impairment

RCS 1 – What It Would Look Like

RCS 1 – How It Would Work

To calculate the per day rate for a particular resident, RCS1 begins with unadjusted per diem rate for urban or rural.

RCS 1 Unadjusted Federal Rate Per Diem – Urban and Rural

The unadjusted federal per diem rates (urban or rural) are adjusted twice: first, to reflect the four case-mix categories (nursing, non-therapy ancillary services, physical and occupational therapy, and speech language pathology), and second, to account for declining payments under the variable per diem adjusted schedule. These case-mix adjusted rates, as reduced by the adjustment schedule, are added to the non-case-mix component to create a single, declining per day rate for each resident.

Looking into the future

- Think big picture
- Role of Preferred Provider Networks (are you seeing this in your market??)
- Predictive Analytics – PointRight, NaviHealth etc, have platforms to help with SNF selection
- Health IT – do you have a strategy for billing, reporting, and tracking performance?
- Foundation for PA/LTC partnered with HIMSS conduct a major PA/LTC IT readiness study. More to come!
- How do you leverage your clinical expertise in PA/LTC population in value-based environment when others don’t understand what you do?

QUESTIONS?
SA2b - General Session II - Who Will Care for me When I am Old and Frail?

Saturday, March 24
8:00 AM - 10:30 AM

Session Description

Each day, 10,000 people turn 65. They are faced with a final phase of life that can include multimorbidity, prolonged period of functional impairment, and health care transitions from hospital to PA/LTC settings. Physicians have increasingly focused their practice on one setting of care much like the rapid growth of hospitalists, physicians who focus solely on the care of hospitalized patients. Similar trends are occurring in the PA/LTC sector. In this lecture, the temporal trends in the care of frail older people in the hospital and PA/LTC settings, such as nursing facilities, will be characterized. The implications of these temporal trends and need for future research will be discussed.

Learning Objectives

- Describe demographic changes of frail, older persons and who provides their care.
- Examine the evidence of the effectiveness of physicians who specialize in hospital care or PA/LTC settings, such as nursing facilities.
- Identify the future research agenda to address key questions regarding trends in who is providing care of frail, older people.

Presenter(s): Joan Teno, MD, MS

Presenter(s) Disclosures: All speakers have reported they have no relevant financial relationships to disclose.
Who Will Care for Me When I am Old and Frail?

Joan M. Teno MD, MS
Date: March, 2018

Disclosure

- This research was funded by a grant from the National Institute of Health and the Robert Wood Johnson Foundation Health Policy Investigator Award.

Objectives

1. Demographic changes
2. Evidence of health care provider specialization by setting of care
3. Key questions and future research

Demography

Baby Boomers Retire

As the year 2014 began, 7,600,000 people who were born between 1946 and 1964 reached age 65. If current trends continue, nearly 60,000,000 Americans will reach age 65 by 2030, when over 20% of the population will be aged 65 or older. The Census Bureau projects that by 2030, 23% of the population will be aged 65 or older.

Disability in the Last Two Years of Life

Figure 2: Prevalence of multiple chronic conditions among US adults aged 18 to 44 years, 45 to 64 years, and 65 years or older, National Health Interview Survey for 2001 through 2010.

Source: Ward, BW Prev Chronic Dis; 2013

Multimorbidity

Figure 2: Prevalence of multiple chronic conditions among US adults aged 18 to 44 years, 45 to 64 years, and 65 years or older, National Health Interview Survey for 2001 through 2010.

Source: Ward MM Prev Chronic Dis; 2013
Changes in Physician Practice

Changing Landscape

• Historically, a primary care physician saw you across settings of care. Persons now encounter multiple types of physicians with “ist” who are increasingly specialized in one setting of care.

• For persons with advanced dementia, we document changes in the type of physicians caring for these persons and continuity of care from the nursing home to the acute care hospital.

Methods

• Prospective cohort of hospitalized persons with MDS assessment completed 120 days or less prior to that hospital admission.

• All persons had CPS >=5 and 4 or more ADL impairments with a dementia diagnosis

• Using 20% Part B Medicare claims between 2000 and 2010, we classified each physician caring for hospitalized dementia patients as either a hospitalist, primary care physician (PCP), or specialist.
Change in Type of Physician 2000-2010

<table>
<thead>
<tr>
<th></th>
<th>Year 2000</th>
<th>Year 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Provider</td>
<td>45%</td>
<td>15%</td>
</tr>
<tr>
<td>Hospitalist</td>
<td>10%</td>
<td>18%</td>
</tr>
<tr>
<td>PCP sees patient in the hospital</td>
<td>45%</td>
<td>32%</td>
</tr>
<tr>
<td>PCP sees patient post-hospitalization</td>
<td>30%</td>
<td>21%</td>
</tr>
</tbody>
</table>

But What About Nursing Home Care?

- Overall, the number of physicians billing in a nursing home (NH) has decreased from 13.7% to 9.8%
- The number of physicians, NPs, or PAs billing exclusively in the NH setting increased by 48% for physicians and nearly doubled for NP/PAs.
- In 2007, health care professionals that billed exclusively in the NH accounted for 22% of total billing. This increased to 31.5% in 2014

State Variation

2014 Variation Among Nursing Homes

- 25% 0
- 50% 7.4
- 75% 40.2
- 99% 97.1%

Limitations

- Reflects billing by fee-for-service Medicare given that Medicare Advantage E&M encounters are not required.
- Potentially, the PCP could not bill for a visit or communicated with the hospitalist via phone.

Conclusion

- Increasingly, continuity of care is lacking for persons with advanced dementia.
- Care in the nursing home is increasingly provided by NPs or PAs whose practice is focused on NH, but this varies by state.
- Future research should examine the impact on care quality.
This lack of continuity potentially impacts ...

- Medical errors
- Lack of coordination of treatment plan
- Burdensome transitions
- Hospital readmissions
- Perceptions of quality of care

Results

<table>
<thead>
<tr>
<th>Frequency, %</th>
<th>Adjusted Odds Ratio* (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Late transition</td>
<td>No late transition</td>
</tr>
<tr>
<td>Quality of care rated excellent</td>
<td>45.5 (34.2 – 57.0)</td>
</tr>
<tr>
<td>Unmet needs for spiritual support</td>
<td>14.9 (2.0 – 17.6)</td>
</tr>
<tr>
<td>Not always treated with respect</td>
<td>12.2 (10.3 – 14.0)</td>
</tr>
<tr>
<td>Care not consistent with goals</td>
<td>12.5 (10.3 – 14.8)</td>
</tr>
<tr>
<td>Inadequate communication about care decisions</td>
<td>13.5 (11.4 – 15.7)</td>
</tr>
</tbody>
</table>

Table 1. Associations Between Markers of Quality of Care and Presence of a Late Transition in the Last Three Days of Life

Summary

- 18% (weighted 843,724) of decedents experienced a late transition
- Those with late transitions were less likely to rate care as excellent, more likely to be treated without respect, had more unmet spiritual needs, and experienced worse communication
- For NH to hospital transitions, opportunities to improve quality of end-of-life care are more pronounced

Tradeoff

- Experience vs. Continuity/knowledge of care
- Meltzer argues that handoffs cost $$ and that for a potential group of persons that benefit from enhance continuity of care
- Ownership and the child’s game of “hot potato”
Why did we move to health care providers focusing on one site of care?

- DRG – quicker and sicker
- Efficiency – if PCP uses hospitalist, they can see 9 more patients per week – that would free up 7000 FTE of PCP effort nationwide
- Practice makes perfect
- Increased physician presence in NHs is associated with increased detection of infection

Evercare Demonstration (2)

Table 1. Rates of Preventable Hospital Admissions

<table>
<thead>
<tr>
<th>Rate/Month</th>
<th>Evercare</th>
<th>Control In</th>
<th>Control Out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average no.</td>
<td>1,472</td>
<td>831</td>
<td>1,310</td>
</tr>
<tr>
<td>Average no. of hospital admissions/100 enrollees</td>
<td>0.35</td>
<td>0.89***</td>
<td>1.06***</td>
</tr>
<tr>
<td>Average no. of ISU admissions/100 enrollees</td>
<td>0.52</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average no. of events (hospital and ISU admissions)/100 enrollees</td>
<td>0.87</td>
<td>0.89</td>
<td>1.06</td>
</tr>
</tbody>
</table>

Note: ISU = Intensive Service Unit. 
***p < .001, **p < .01.

Evercare Demonstration (3)

- No difference in quality
- $88,000 savings per 1 NP FTE

History

- Wasson RCT in VA
  - Found that complex patients randomized to continuity of primary care physicians had 38% fewer hospitalization and 74% fewer ICU stays
• “It is imperative that we first understand ‘who’ is delivering care in nursing homes before asking the question, ‘What difference does it make?’”

- Paul Katz

Katz AMA 1991 study

- 77% of physicians spent no time in NH
- Among those in physicians that went to NH, average time was 2 hours per week
- Only 3.1% spent substantial time in NH

Trends in E&M Billing

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians, Np</td>
<td>204</td>
<td>233</td>
<td>269</td>
</tr>
<tr>
<td>Non-billing or NF Eq. Req.</td>
<td>58 (14.9%)</td>
<td>104 (11.1%)</td>
<td>107 (10.9%)</td>
</tr>
<tr>
<td>Billing reffs or NE Eq. Req.</td>
<td>3,194 (83.8%)</td>
<td>3,067 (33.8%)</td>
<td>3,005 (29.8%)</td>
</tr>
<tr>
<td>Nonphysicians or physician assistants, Np</td>
<td>84 (2.1%)</td>
<td>80 (2.1%)</td>
<td>131 (12.6%)</td>
</tr>
<tr>
<td>Non-billing or NF Eq. Req.</td>
<td>7,590 (71.7%)</td>
<td>8,199 (91.0%)</td>
<td>9,179 (91.3%)</td>
</tr>
<tr>
<td>Billing reffs or NE Eq. Req.</td>
<td>2,338 (15.3%)</td>
<td>2,333 (16.0%)</td>
<td>3,412 (31.3%)</td>
</tr>
<tr>
<td>Reduction and management codes, Np</td>
<td>4,112 (17%)</td>
<td>5,108 (6.1%)</td>
<td>5,208 (6.0%)</td>
</tr>
<tr>
<td>Nonphysicians or physician assistants, reduction and management codes</td>
<td>539 (12.2%)</td>
<td>528 (13.3%)</td>
<td>747 (13.3%)</td>
</tr>
<tr>
<td>Physician billing (5% or Np, Eq. Req.</td>
<td>48 (1.1%)</td>
<td>81 (1.1%)</td>
<td>137 (1.3%)</td>
</tr>
</tbody>
</table>

Abbreviations: NH, nursing home; E&M, Evaluation and Management; NP, Nurse Practitioner; PA, Physician Assistant


Interventions and Effects on Care of Patients

1. Key Interventions and Effective Care for Patients

- Educational interventions: Reaching and engaging primary care providers through educational outreach and community awareness
- Development of electronic health records and information systems for providers and patients
- Financial incentives: Providing financial incentives to providers for high-quality care
- Policy initiatives: Developing policies to support high-quality care

2. Effectiveness of Interventions

- N Engl J Med 2017;376:1078-1082

Single focused interventions will fail

- Understand, and embrace complexity
- Studying board certification, whether there is NP or PA is ignoring the multiple changes that are needed to improve care
- Education is important, but not sufficient if the economic incentives are not aligned with high-quality care
Research questions

• What is the impact on quality of care with adoption of new model’s health care provider practice?
• How does the implementation vary? E.g., what is right mix? It is probably not 90% but mix of two sites of care
• What are key intervention’s components to improve care of seriously ill persons?
• Identify the denominator?
• Efficiency?

Hypothesis

• The seriously ill population, where the goals of care are either unclear or the person stills want to pursue treatment focusing on extending life if possible, will benefit from an enhanced approach with continuity of care by health care providers that see the patient across settings of care.
• Not just continuity, but set of interventions that are part of intervention

Potential next steps

1. Observational fixed effect, Diff –n-Diff, X temporal matching to understand impact of specialization
2. Identify the denominator of persons more likely to benefit
3. Study variation in implementation through mixed method study
4. Pragmatic trail of enhanced benefit that focuses on continuity of care among persons using post-acute services

Change the Culture

• The world as we have created it is a process of our thinking. It cannot be changed without changing our thinking.

- Albert Einstein

Thank you............. Teno@ohsu.edu