

CMS Special Study Results Ouslander et al: J Amer Ger Soc 58: 627-635, 2010 Expert panel members rated improving quality of care for assessing acute changes, more involvement of primary care MDs and/or NPs/PAs, ability to do stat lab tests and IV fluids, improved advance care planning, and providing less futile care as important in reducing avoidable hospitalizations **Factors Resources Needed Physician or physician extender** present in nursing home at least 3 days per week Better quality of care would have prevented or decreased severity of acute change One physician visit could have avoided the Exam by physician or physician extender within transfer Better advance care planning would have prevented the transfer Nurse practitioner involvement The same **benefits** could have been achieved at a **Registered nurse** (as opposed to LPN or CNA) lower level of care providing care The resident's overall condition limited his ability to Availability of lab tests within 3 hours benefit from the transfer Capability for intravenous fluid therapy

Drivers of Poor Transitions

Low patient activation

- Health literacy
- Self-management skills, tools
- Motivation; locus of control

Lack of standardized, known process

- Patient discharge, handover
- Internal workflow

Inadequate cross-setting information transfer

- Delays
- Inaccuracies
- · Missing information

Other potential drivers

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





Mechanisms of Change

- Public reporting of quality measures
 - NH compare 5-star by Center for Medicaid CHIP and Survey (aka CMSO)
 - Quality Improvement Organizations
 - Scopes of work (10th)
 - Advancing excellence
 - Special studies
- State Surveys
- · Payment incentives
 - Pay for reporting, performance, value
- · Conditions of participation
- Monitoring programmatic influence





PPACA: Quality

Oct 1, 2011 publish **VBP plan** (Sec. 3006; SNF, HH)
Oct 1, 2012 Secretary must publish **QM**s and data requirement timeline (Sec. 3004; hospice, LTCH, IRF)

- Consensus endorsement QMs
- QM data submission requirement with penalty their market basket rate reduced by 2% for that FY.

March, 2012 publish 10 or more patient **Outcomes** (Sec. 10302)

- Prevalent & expensive conditions by 24 months
- Primary & preventive care by 36 months

Quality includes Efficiency (Sec 10304)





PPACA: Readmissions & Transitions

3025 Hospital Readmission Reduction Program

- Reduced payments for readmissions
 - high volume
 - high cost
 - ...

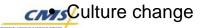
3026 Community-based Care Transitions Program

- Funding to "eligible entities" that provide improved care transition services to high-risk Medicare beneficiaries
 - High readmission rate hospitals
 - Community-based organizations
 - High risk = minimum hierarchical condition category score based on multiple chronic conditions or other risk factors associated with a readmission or substandard transition



Challenges

- Standardized data collection mechanism lacking
 - Hospice QAPI, PEACE/AIMs items require abstraction
 - MDS 3.0 Nursing home & SNFs
 - Exclude advance directives
 - OASIS C Home Health items
 - Hospital claims lag
- Infrastructure for electronic collection and reporting requires \$



CARE

Continuity Assessment Record & Evaluation



- Uniform
- Standardized

Major Domains

- Administrative
- Medical, Health Status
- Cognitive, Mood, Pain
- Impairments
- Functional Status
- Plan of Care
- Discharge, Caregiver Needs

Incorporate into Electronic Health Records





Deficit Reduction Act § 5008

- Develop standardized assessment instrument
- Medicare beneficiaries
- Uniformly measure, compare health, functional status
- Across care settings over time
 - +acute, IRFs, SNFs, HHA, LTCH
 - -hospice

CNIS!

- Test in payment demonstration 2008-2010
 - Post Acute Care Payment Reform Demonstration
- Report to Congress, Spring 2011



Questions

- What aspects of quality of care are meaningful & should be reported to the public?
 - Shaping behavior?
- · What aspects of care are "valuable"?
 - Value perspective (patient, episode, trajectory?
- What information is most critical to require
 - @ and before points of transition?



Advance Care Directives in CARE

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

0= No, but this work is in process; 1=yes; 9=unclear/unknown

- In anticipation of serious clinical complications, has the patient made care decisions which are documented in the medical record? (check all that apply)
 - o 1. The patient has designated a decision-maker
 - The patient (or surrogate) has made a decision to forgoresuscitation



Patient Prognosis in CARE

- 3. Which description best fits the patient's overall status?
 - A. Stable w/o risk for serious complications/death
 - B. Temporarily facing high health risks but likely to return to stable w/o risk of serious complications & death
 - C. Likely to remain in fragile health with ongoing high risks of serious complications & death
 - D. Serious progressive conditions that could lead to death w/l 1 year
 - E. Unknown or unclear





