Nursing Home Resident Acute Care Readmissions

Mechanisms to Promote High Quality End of Life Care

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"Examining End of Life Care: Creating Sensible Policies for Patients, Providers, & Payers"

Robert Wood Johnson Foundation
Princeton, New Jersey

CMS Special Study Results

Ouslander et al: J Amer Ger Soc 58: 627-635, 2010

- Expert panel members rated improving quality of care for assessing acute changes, more involvement of primary care MDs and/or NPs/PAs, ability to do stat lab tests and IV fluids, improved advance care planning, and providing less futile care as important in reducing avoidable hospitalizations

Factors	Resources Needed
Better ***quality of care*** would have prevented or decreased severity of acute change	***Physician or physician extender*** present in nursing home at least 3 days per week
One ***physician visit*** could have avoided the transfer	Exam by ***physician or physician extender*** within 24 hours
Better **advance care planning** would have prevented the transfer	***Nurse practitioner*** involvement
The same ***benefits*** could have been achieved at a lower level of care	***Registered nurse*** (as opposed to LPN or CNA) providing care
The resident's overall condition limited his ability to ***benefit*** from the transfer	Availability of ***lab tests*** within 3 hours
	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 $
- Culture change

CARE

Continuity Assessment Record & Evaluation

- **Common Set of Data Elements**
  - Uniform
  - Standardized
- **Major Domains**
  - Administrative
  - Medical, Health Status
  - Cognitive, Mood, Pain
  - Impairments
  - Functional Status
  - Plan of Care
  - Discharge, Caregiver Needs
- **Incorporate into Electronic Health Records**

Deficit Reduction Act § 5008

- Develop standardized assessment instrument
- Medicare beneficiaries
- Uniformly measure, compare health, functional status
- Across care settings over time
  - +acute, IRFs, SNFs, HHA, LTCH
  - -hospice
- Test in payment demonstration 2008-2010
  - Post Acute Care Payment Reform Demonstration
- Report to Congress, Spring 2011

Questions

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

Advance Care Directives in CARE

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

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

2. In anticipation of serious clinical complications, has the patient made care decisions which are documented in the medical record? (check all that apply)
   - o 1. The patient has designated a decision-maker
   - o 2. The patient (or surrogate) has made a decision to forgo resuscitation

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/I 1 year
   - E. Unknown or unclear

Opportunities

- CMS Technical Expert Panels
  - Summer, 2010 end-of-life data elements for CARE tool
  - ACA Section 3004 Quality measures for Hospice, LTCH, IRF
  - VBP plan for SNFs and HHAs
  - Outcomes
  - Efficiency

Thank you

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