Team Approach With Rehab Is a Stepping Stone For Hospital Partnerships

PRESENTERS:

- Robin L Boyle, PT
  rboyle@embracepremier.com

- Julia L Bellucci, MS, CCC-SLP
  jbellucci@embracepremier.com
OBJECTIVES:

- Upon completion, participants will be able to describe the prevalence of re-admissions as well as the targeted diagnoses.
- Upon completion, participants will identify the potential roles that therapy plays in reducing re-admissions, improving quality, and achieving preferred provider status.
- Upon completion, participants will describe the structure of a comprehensive program that identifies risk, utilizes root cause analysis and determines an individualized, person-centered plan to address issues.

PARTNERSHIP

What are the hospital expectations of a preferred provider?

- We understand payment models, (ex., what is measured on hospital PEPPER)
  - 3 day Skilled Nursing Facility qualifying admission - % that are skilled
  - 30 day readmission to the same hospital or elsewhere
  - 30 day readmission to same hospital
- We understand effect of readmission rates, hospital quality reporting, and meaningful use of EHR
- We know their clinical specialties, clinical pathways/protocols and we can service them
  - i.e. Cardiac, Neuro, Orthopedic, trach/vent
- Experts from existing staff that will work as liaisons with hospital case managers
SHIFT IN HEALTH CARE DELIVERY

- Decreased Admissions
  - Increased time in observation

- Shorter Lengths of Stay
  - Hospitals holding on to low complexity patients – keeping in affiliated care environments
    - Able to control outcomes and costs
    - Able to reduce re-admissions
    - Allow for outpatient procedures at lesser cost

- Pushes the more ill and complex patient to PAC environments including SNFs
  - SNFs need to be prepared to take more expensive patients requiring vent/trach, parenteral nutrition, antibiotic therapy, wound care, and chemotherapy

https://ncbi.nlm.nih.gov/books/NBK232671

PARTNERSHIP

CMS's- ACO's Pearls of Wisdom

- Identify and build on your organization’s strengths
- Set clear priorities for performance year 1
- Select committed and mission-driven partners
- Understand your patient population
- Set short-and long-term quality improvement goals
- Promote transparency and good communication
- Engage physicians and clinic staff

**PARTNERSHIP**

**What are the Hospital Expectations of SNFs?**

- Low Readmission Rates
- Nursing Home Compare (5 Star Rating)
  - QMs, Staffing, Survey
- Good Quality/Outcomes – Low Cost
- Episode Cost- LOS
- Patient/Family Satisfaction
- Comprehensive Transitional Care
- Continuum of Care
  - Home Health/AL/IL/Outpatient Therapy
- Facilities capabilities that align with patient needs
  - Respiratory Services
  - Cardio/Pulmonologist
  - Psychiatric Care

---

**IMPROVED QUALITY**

+ **REDUCED COST**

**SUCCESS**
CMS QUALITY STRATEGY

- Improving Health Care Delivery Vision
  - Better
  - Smarter
  - Healthier

- Focuses on:
  - Using incentives to improve care
  - Tying payment to value through new payment models, and...

CMS QUALITY STRATEGY

- Changing how care is given through:
  - Better teamwork
  - Better coordination across care settings
  - More attention to population health
  - Putting the power of healthcare information to work

CMS.gov
CMS QUALITY STRATEGY

- Implemented to reward providers with incentive payments for the quality of care that they give to people with Medicare

Goal:

- Make care safer by reducing harm, inappropriate and unnecessary care

- Help patients and their families be involved as partners in their care

- Promote effective communication and coordination of care
CMS QUALITY STRATEGY

Goals (con’t):

- Promote effective prevention and treatment of chronic disease
- Work with communities to help people live healthy
- Make care affordable

REWARDING QUALITY CARE ➔ VALUE BASED PROGRAMS

- ACA required Secretary to implement a VBP and submit plan to Congress
- VBP – Reward providers with incentive payments for quality of care

Three-Part Aim:
- Better care for individual
- Better health for populations
- Lower cost
VALUE BASED PROGRAMS

Administration’s goals for health care payment reform:

- **30% of Medicare payments tied to quality or value through alternative payment models** by the end of 2016, and 50% by the end of 2018

- **85% of all Medicare FFS payments are tied to quality or value** by the end of 2016, and **90% by the end of 2018**

  - [https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html)

VALUE BASED PERFORMANCE

Linking Medicare Payments to Performance:

- Performance standards on Quality Measures include both achievement and improvement
- SNF Performance Score must include a ranking of SNFs from low to high
- 2% of Medicare payments will be withheld to fund incentive payments
- Incentive payments must total 50-70% of amount withheld
HOSPITAL ACCOUNTABILITY

- Hospital Readmission Measures
- Bundled Payments (BPCI)
- CJR

HOSPITAL READMISSION MEASURES

CMS targeted diagnoses:

- FY 2012 CHF, Pneumonia, Acute Myocardial Infarction
- FY 2014 COPD; total hip arthroplasty (THA) and total knee arthroplasty (TKA).
- FY 2015 finalized the expansion of the applicable conditions beginning with the FY2017 program to coronary artery bypass graft (CABG) surgery.
- FY 2016 finalized an update to the pneumonia readmission measure additional pneumonia diagnoses: (i) patients with aspiration pneumonia; and (ii) sepsis patients coded with pneumonia present on admission (but not including severe sepsis).

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HRRP/Hospital-Readmission-Reduction-Program.html
**THE GOAL OF ACA**

- Hospitals will receive bundled payments covering not just the hospitalization, but the care after the hospitalization.

- Hospitals with high rate of readmission will be paid less if patients are readmitted to the hospital within the same 30-day period with those targeted diagnoses.

**HOSPITAL RE-ADMISSION STANDINGS**

- The benefits of the reduction program have slowed and experts are recommending that the program be retired. Spending on readmissions fell by 9 billion by 2014, and rates have decreased to 22% (CHF patients)

- Analysis through 2016 shows a further drop of .1%

- 75% of hospitals are being penalized due to the measure.

- Experts feel that too many variable contribute to readmissions outside of hospital/SNF control.
PAMA 2014

Protecting Access to Medicare Act

- VBP for SNF
- 30 day all cause, all condition readmission measure

SKILLED NURSING FACILITY VALUE-BASED PURCHASING PROGRAM (SNFVBP)

- **What:** Rewards skilled nursing facilities with incentive payments for the quality of care they give to people with Medicare.

- **When:** Starts in fiscal year 2019.

- **Why:** Promotes better clinical outcomes for skilled nursing facility patients and makes their care experience better during skilled nursing facility stays.

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html
DATA COLLECTION FOR SNFVBP

- CMS has established SNF baselines for readmissions from 2015 data collection

- Feedback reports for each facility started in October 2016 through CASPER system

- Performance Period (Comparison data) starts January 1, 2017

CONFIDENTIAL FEEDBACK REPORT

DATA – SNF VBP

- Performance data on readmissions on Nursing Home Compare website by October 2017

- Effective October 2018 (FY 2019) SNF payments will be reduced by 2%

SNF VBP MEASURE - SNFRM

SNFRM estimates risk-standardized rate of all-cause, unplanned hospital readmissions of Medicare SNF beneficiaries within 30 days of discharge from their prior proximal acute hospitalization

- Hospital readmissions are identified through Medicare claims
- Tracks readmissions within 30-days after discharge from a prior hospitalization, not d/c from a SNF.
- Readmissions within 30-day window counted regardless of whether the beneficiary is readmitted directly from SNF or had been discharged from SNF
SNFRM

- Includes all Medicare Fee For Service patients
- Risk-adjusted based on patient demographics, principal diagnosis in prior hospitalization, co-morbidities, and other health status variables that affect probability of readmission
- Excludes planned readmissions since these are not indicative of poor quality
- The FY2019 SNFRM will be in use for the first year of the program

SNFRM EXCLUSIONS

- Anyone less than 18 years
- SNF stays with a gap of greater than 1 day between discharge from the prior hospitalization proximal hospitalization and the SNF admission
- SNF stays where the resident was discharged from the SNF against medical advice
- SNF stays in which the principal dx for prior proximal hospitalizations was for the medical treatment of cancer or pregnancy
SNFRM

- Will form the basis for the SNF performance on the measure and value-based incentive payments will be determined by comparing all SNFs’ performance scores

- Will be replaced by the SNFPPR in future rulemaking

SUCCESSFUL HOSPITAL PARTNERSHIP BEGINS WITH:

Early Identification of Risks
EPISODE COSTS PER BENEFICIARY

Page X out of X

Casper Report
LTCH QIP Facility-Level Quality Measure Report

CCN: 989950059
Provider Name: CASPER LONG-TERM CARE HOSPITAL
City/State: WALNUTH MA

Report Period: 04/01/2015 – 12/31/2015
Date was calculated on: 04/16/2015
Report from Date: 09/28/2017
Report Version Number: 1.00

Table Legend:
[1] The treatment period is the time during which the patient receives care services from the attributed LTCH, and includes Part A, Part B, and End-Stage Renal Disease (ESRD) services.
[2] The specified services period is the time during which any Medicare Part A and Part B services other than those in the treatment period are counted towards the episode spending.

Note: Claims-based measures are included in CASPER Patient-Level Quality Measure reports.

Table: Medicare Fee-for-Service Claims and Eligibility File

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>CMS Measure ID</th>
<th>Number of Eligible Episodes</th>
<th>Average Spending Per Episode</th>
<th>MPR Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Spending During Treatment Period</td>
<td>Spending During Non-Episode Period</td>
<td>Total Spending During Episode</td>
</tr>
<tr>
<td>Medicare Spending Per Beneficiary (MSF) /Post-Acute Care Long-Term Care Hospital Quality Reporting Program</td>
<td>MPR-14.01</td>
<td>24</td>
<td>$11,296</td>
<td>$5,150</td>
</tr>
<tr>
<td>Medicare Spending Per Beneficiary (MSF) /Post-Acute Care Long-Term Care Hospital Quality Reporting Program</td>
<td>MPR-15.01</td>
<td>4,200,000</td>
<td>$15,086</td>
<td>$6,146</td>
</tr>
</tbody>
</table>

RISK IDENTIFICATION & MANAGEMENT

Purpose: To identify potential risks for each resident through an ID approach, evaluate and analyze risk effectively, implement interventions, and monitor outcomes to prevent and reduce risk.

Prevention: Residents identified as being at risk of injury require interventions and monitoring to prevent harm.

Procedure:
1. Residents identified as being at risk of injury are referred to the Provider's designated professional.
2. All residents are screened for injuries, and referrals are made to the appropriate professional.
3. The provider's designated professional will review the risk of injury and determine the appropriate intervention.
BEGINNS AT ADMISSION - RESIDENT SNAPSHOT

Snapshot Risk Identification Form

- Eating - indicates risk of poor nutrition or assist needed
- Swallowing - can indicate any choking or aspiration risks
- Description of appetite
- Specialized diet
- Dressing - indicates what level of independence resident may be
- Circulation or skin related problems
- Ambulation/Transfers/Fall Risk - indicates possible balance problems or fall risk
BEGIN AT ADMISSION

- Bathing/Bathroom use - indicates level of independence
- Continent of bowel and bladder
- Cognition - indicates possible safety concerns
- Behavioral/Psychological/Elopement issues
- Pain presence
- Sleep patterns
- Functional decline/Falls - if falling at home more likely to fall in facility
- Previous therapy in present year - could indicate ongoing problem
- Medication review - can indicate side effects or poor adjustment to new medications

TRIGGER TO ACTION

- Add patients who trigger upon admission either from Resident Snapshot - PLOF/Health Profile, trigger on MDS assessments, therapy assessments and other referrals to Action List

- Review these patients at the morning meeting or UR with IDT
TRIGGERS FOR ACTION:

1. Referral from Snapshot
2. Fall history
3. Reduced intake by mouth/altered diet
4. Changes/High number of medications/antipsychotics
5. Unstable or changes in vitals
6. Fluctuating functional status
7. Behavior changes/Impaired cognition
8. Pain
9. Skin issues
10. Decreased mobility/ADLS
11. Bowel/Bladder issues
12. Poor sleep patterns

Pay particular attention to targeted HRR diagnosis.

ACTION LIST
RISK ACTION MEETING

- Facility to determine the most appropriate setting to discuss residents
- Can be morning stand up, UR, or IDT meeting
- Complete comprehensive review of all risk factors
- Can use Pause, What is Root Cause to determine cause and appropriate referrals (can be used during meeting or as part of comprehensive evals)
- Track referrals using assignment sheets are completed.

MEDICAL NECESSITY FORM
PAUSE: WHAT IS THE ROOT CAUSE?

ASSIGNMENT SHEET

<table>
<thead>
<tr>
<th>Issue Identified</th>
<th>Recommended Solution</th>
<th>Responsible Person</th>
<th>Date to Be Completed</th>
<th>Corrective Action Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RE: Resistant __________________ To be turned in to __________________
**PATH TO SUCCESS**

- Document/execute all care plans/interventions
- Revise as needed until successful
- Review/Revise Assignment sheets weekly to hold staff accountable

**COMMUNICATION AND TRAINING**

- Once the end result is achieved, communicate to all care staff and make sure all training is complete
- Competency staff, ensure they can return demonstrate effectively – accessibility of care plan
- Use sign off sheets during training with dates completed, who attended and who instructed
COMMUNICATION AND TRAINING

- Nursing will follow for next two weeks for carryover

- Nursing should write a note on carryover and positive impact to function and quality of life for resident

COMMUNICATION AND TRAINING

- Team will recommend discharge from Action List

- Written status/adaptation should be present in a private place, so care staff can access it easily during care

- Residents will be reviewed quarterly
DAILY/WEEKLY MONITORING

- Each resident will continue to be monitored and his/her progress and status of plan reported in morning meeting.

- Assignment sheets will be reviewed in weekly meetings, and modifications may be made by IDT.

INTERACT 4.0

- INTERACT stands for Interventions to Reduce Acute Care Transfers.

- It is a quality improvement program to improve the identification, evaluation, and communication about changes in the residents' status.

- The program is comprised of communication, care paths, clinical and advanced-care planning tools for care teams and tracking systems to use to reduce unnecessary readmissions to the hospital.

Source: INTERACT website: http://interact.fau.edu
Several of the tools can be utilized for at-risk quality improvement and tracking programs:

- Stop and Watch Tool
- SBAR Form
- Hospitalizations Tracking Tool
- Quality Improvement Tool

You may use any of the resources from the website free of charge but cannot modify them in anyway.
Review of Discharge Checklist by the IDT will be completed prior to discharge

All training of care staff and families must be done prior to discharge from program

Updates are given at the morning meeting and the resident is removed from Action List

This person, unless discharged to another environment, would be reviewed quarterly upon clinical rounds to make sure plan still appropriate or if a comprehensive assessment is needed again.
WHAT ROLE CAN THERAPY PLAY IN REDUCING READMISSIONS?

- Complete comprehensive assessment with the appropriate plan of care and possible recommendations/referrals to other IDT members
  - Tracking Systems for outcomes: Therapute, Weekly UR review
  - Include environmental modification
  - Include vital signs in Plan of Care if appropriate
  - Behavioral modification
  - Patient centered staff training
  - Adaptive equipment
  - Functional maintenance programs
- Be an extra watchdog for changes in vital signs
WHAT ROLE CAN THERAPY PLAY?

- Timely communication of change in status to proper team members to address and possibly involve a physician early in process (written communication)

- Stop and Watch

- Get residents moving or in better positions to reduce risk of pneumonia, infection, or falls

- Participate in Falls, Wounds, and Pain programs consistently

WHAT ROLE CAN THERAPY PLAY? (CON’T.)

- Educating resident and caregivers, so they understand their risks, helps to control disease a safer and higher functional level

- Communicate to home health agencies and other discharge settings/caregivers re: equipment, care plan, the discharge plans/needs to help resident return to a safe environment
**WHAT ROLE CAN THERAPY PLAY? (CON’T.)**

- 7 day a week staffing
- Therapy educated on specialization populations – hospital/SNF niche
- Facility education/competencies for conditions/complexities – including CMS focuses
- Marketing with Facility to hospital discharge planners and physicians
  - Look at Me Now!
- Offer Satisfaction Survey prior to discharge from therapy

**TRANSITIONAL CARE CONSIDERATIONS**

- Need to know discharge plans early on in episode of care to better establish plan of care
- Involve families/next care providers in treatment sessions/weekly meetings
- Utilize discharge or transitional care checklist to monitor all is addressed prior to discharge
- Need to have medication reconciliation process with nursing, physician and pharmacy - including confirming orders confirming comprehension of caregivers and patient for medication regime
TRANSPORTIAL CARE CONSIDERATIONS

- Perform home assessment at least 3 days prior to d/c with family/caregivers included - Could do virtual home visit if live not appropriate

- Clearly state and give written follow up with appointments and next care providers

- Make sure all can return demonstrate or repeat instructions before discharge (medication self-management)

- Written instructions and orders for medication, appointments and continued care given to physician, caregivers/next providers and patient

- Give instructions if problem arises and contact information of pertinent personnel

- Telephone or Skype session 2-3 business days later and a weekend day to follow up with progress, medication management and any questions

- Talk to both patient and caregivers

- Try to not discharge on Friday - give them early in week discharges to allow home health or core staff time with patient

- Perform Patient/Family Satisfaction Survey
  - use part of QAPI
  - can be given a week before discharge from facility
TRANSITIONAL CARE MANAGEMENT SERVICES

Effective January 1, 2013, under the Physician Fee Schedule Medicare pays for two CPT codes (99495 and 99496) that are used to report physician or qualifying non-physician practitioner (NPP) care management services for a patient following a discharge from:

- an Inpatient Acute Care Hospital
- Inpatient Psychiatric Hospital
- Long Term Care Facility
- Inpatient Rehabilitation Facility
- Hospital outpatient observation or Partial hospitalization, or
- Stay at Community Mental Health Center


TRANSITIONAL CARE REQUIREMENTS

- Services are required by the beneficiary for a smooth transition to community setting
- The health care professional accepts care of the beneficiary post-discharge from the facility setting without a gap
- The health care professional takes responsibility for beneficiary's care
- The beneficiary has medical and/or psychosocial problems that require moderate or high complexity medical decision making
- The 30-day Transition Care period begins on date the beneficiary is discharged from inpatient hospital setting to community and continues for next 29 days
TRANSITIONAL CARE SERVICES

- The beneficiary must be returned to his or her community setting

- During the 30 days beginning on the date the beneficiary is discharged from an inpatient setting, 3 components must be furnished:
  1. An interactive contact
  2. Non face-to-face services
  3. A face-to-face visit

TRANSITION CARE COMPONENTS

Interactive Contact

- Made with beneficiary and/or caregiver within 2 business days following discharge to community setting
- The contact can be a phone call, email or face-to-face

- Can be physician or clinical staff member supervised by physician that can determine patient's status and needs

- Held to certain requirements to be considered timely contact (see guidelines)
TRANSITION CARE COMPONENTS

Non Face-to-Face Services

- Must furnish unless physician determines that they are not medically indicated or needed
- Clinical Staff under physician supervision can provide some services
- Physician or NPP can provide:
  - Review discharge information
  - Review need for or follow up on pending diagnostic tests or treatments
  - Interact with other health care professional involved in care
  - Education to beneficiary or caregivers
  - Assist in scheduling follow up services

TRANSITIONAL CARE COMPONENTS

Clinical staff can provide with Physician/NPP supervision: *(State Practice Laws apply)*

- Communication with community service personnel
- Education to patient and/or caregivers to support self-management, ADLs, etc.
- Assess and support compliance and management of recommended treatment or medication regime
- Identify community and health resources
- Assist beneficiary in accessing care and services needed
TRANSITIONAL CARE COMPONENTS

Face-to-Face Visit

- Face-to-face visit for a moderate medical decision complexity within 14 days of discharge (CPT code 99495)

- Face-to-face visit for a high medical decision complexity within 7 days of discharge (CPT code 99496)

Note: These 3 components must be done within the timeframes and supervision requirements outlined to bill one of the appropriate codes

TELEHEALTH SERVICES

- Effective for services furnished on or after January 1, 2014, the TCM service CPT codes can be billed for Telehealth services

- All requirements and State Practice Laws apply

- There is a medication reconciliation and management requirement that must be met no later than the date which a face-to-face visit is furnished
TRANSITION CASE MANAGER

- Liaison with the hospital
- Works with IDT in SNF to coordinate after care and follow up calls to patient and families
- Coordinates equipment and environmental modifications
- In place to reduce risk of re-hospitalizations and will set SNFs apart from a hospital’s perspective


SUCCESSFUL PARTNERSHIP – NEXT STEPS

Therapy can positively impact

- Quality Measures
- Survey
- Staffing
CMS' KEYS TO QUALITY IMPROVEMENT

- At the global level, **awareness and education** across a broad spectrum of healthcare workers is necessary, while at the local level, each facility **must attack the problem individually**.

- At the core of each of these initiatives, improvement requires a facility to **examine existing practices** and update as necessary, **perform root cause analysis**, offer consistent and **up-to-date staff education**, and have reference tools available to support staff.

QUALITY MEASURES

<table>
<thead>
<tr>
<th>Quality Measures: Long-stay Residents</th>
<th>Therapy Can Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of long-stay residents experiencing one or more falls with major injury</td>
<td>✔</td>
</tr>
<tr>
<td>Percentage of long-stay residents with a urinary tract infection</td>
<td>✔</td>
</tr>
<tr>
<td>Percentage of long-stay residents who self-report moderate to severe pain</td>
<td>✔</td>
</tr>
<tr>
<td>Percentage of long-stay high-risk residents with pressure ulcers</td>
<td>✔</td>
</tr>
<tr>
<td>Percentage of long-stay low-risk residents who lose control of their bowels or bladder</td>
<td>✔</td>
</tr>
<tr>
<td>Percentage of long-stay residents who have/had a catheter inserted and left in their bladder</td>
<td>✔</td>
</tr>
<tr>
<td>Percentage of long-stay residents who were physically restrained</td>
<td>✔</td>
</tr>
<tr>
<td>Percentage of long-stay residents whose ability to move independently worsened</td>
<td>✔</td>
</tr>
<tr>
<td>Percentage of long-stay residents whose need for help with daily activities has increased</td>
<td>✔</td>
</tr>
<tr>
<td>Percentage of long-stay residents who lose too much weight</td>
<td>✔</td>
</tr>
<tr>
<td>Percentage of long-stay residents who have depressive symptoms</td>
<td>✔</td>
</tr>
<tr>
<td>Percentage of long-stay residents who received an antianxiety or hypnotic medication</td>
<td>✔</td>
</tr>
<tr>
<td>Percentage of long-stay residents assessed and given, appropriately, the seasonal influenza vaccine</td>
<td>✔</td>
</tr>
<tr>
<td>Percentage of long-stay residents assessed and given, appropriately, the pneumococcal vaccine</td>
<td>✔</td>
</tr>
<tr>
<td>Percent of long-stay residents who got an antipsychotic medication</td>
<td>✔</td>
</tr>
</tbody>
</table>
QUALITY MEASURES

<table>
<thead>
<tr>
<th>Quality Measures: Short-stay Residents</th>
<th>Therapy Can Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of short-stay residents who made improvements in function</td>
<td>✔</td>
</tr>
<tr>
<td>Percentage of short-stay residents who were re-hospitalized after a nursing home admission</td>
<td>✔</td>
</tr>
<tr>
<td>Percentage of short-stay residents who have had an outpatient emergency department visit</td>
<td>✔</td>
</tr>
<tr>
<td>Percentage of short-stay residents who were successfully discharged to the community</td>
<td>✔</td>
</tr>
<tr>
<td>Percentage of short-stay residents who self-report moderate to severe pain</td>
<td>✔</td>
</tr>
<tr>
<td>Percentage of short-stay residents with pressure ulcers that are new or worsened</td>
<td>✔</td>
</tr>
<tr>
<td>Percentage of short-stay residents assessed and given, appropriately, the seasonal influenza vaccine</td>
<td>✔</td>
</tr>
<tr>
<td>Percentage of short-stay residents assessed and given, appropriately, the pneumococcal vaccine</td>
<td>✔</td>
</tr>
<tr>
<td>Percentage of short-stay residents who are newly administered antipsychotic medications</td>
<td>✔</td>
</tr>
</tbody>
</table>

NEW QUALITY MEASURES ADDED IN NURSING HOME COMPARE

- Percentage of short-stay residents who were successfully discharged to the community (claims-based)
- Percentage of short-stay residents who have had an outpatient emergency department visit (claims-based)
- Percentage of short-stay residents who were re-hospitalized after a nursing home admission (claims-based)
- Percentage of short-stay residents who made improvements in function (MDS-based)
- Percentage of long-stay residents whose ability to move independently worsened (MDS-based)
- Percentage of long-stay residents who received an anti-anxiety or hypnotic medication (MDS-based)
  - Not included in 5 star rating
NEW QUALITY MEASURES

- In FY 2018 final rule, CMS is finalizing its replacement of the current pressure ulcer measure and four new measures.

- Beginning in FY 2020, the changes in measures will be:
  - Changes in skin integrity Post Acute Care: Pressure Ulcer/Injury
  - Four outcomes based functional measures on Resident Functional Status:
    - Change in Self Care Score for Medical Rehab Pt.
    - Change in Mobility Score for Medical Rehab Pt.
    - Discharge Self Care Score for Medical Rehab Pt.
    - Discharge Mobility Score for Medical Rehab Pt.
FURTHER CONSIDERATIONS TO IMPROVE QUALITY

- Monitor QM scoring monthly through facility level reports
- Address 5 star reports frequently in formal IDT meetings
- Identify Risk areas
- Root Cause Analysis on poor outcomes and set plan in place


IMPROVE QUALITY

- Once Root Cause is determined educate and change practice to not have it happen again
- Assign responsibilities to IDT members and follow up weekly in UR or morning meeting to make sure plan is completed and effective

IMPROVE QUALITY

• Stay current to all regulations and performance expectations through CMS sources, consultants, webinars and conferences

• QAPI approach with IDT members to all risk areas

Reginald M. Hislop III, PhD., Maureen McCarthy, R.N., BS., RAC-MT, CQP, 

IMPROVE QUALITY

• Know your reports and review often
  • PEPPEr
  • CASPER-QIES portal
  • Nursing Home Compare data
  • MDS Assessments
  • Facility level reports

• Starting in November 2017, facilities will need to provide surveyors their QAPI plans to satisfy ROP
IMPROVE QUALITY

Surveyors are looking for Performance Improvement Plans for QMs or other areas to see that a facility is dedicated to improving their overall quality of services

THERAPY PRACTICES

Have they changed with the times?
- Has their mindset evolved with decreased LOS
  - Therapy availability
  - Practice standards
PREPARATION FOR SURVEY

Goes beyond – Are your employee files up to date and is your filing done?

- Does your therapy staff understand risk as it applies to Survey
  - IJ - Non-compliance with ROPs which has caused, or is likely to cause, serious injury, harm, impairment, or death of a resident

- Equipment issues
  - Maintenance
  - Cleaning
  - Calibration
  - Following Manufacturer’s Guidelines

SURVEY

- Staff competency with
  - Equipment
  - Patient Populations
  - Conditions

- Staff knowledge of all risk policies and procedures both general and patient specific
  - Dietary Guidelines
  - Orders
  - Infection/Isolation

- Staff knowledge of documentation risk areas
SURVEY READY

- Does therapy manager check on those therapists who may document “unreasonable” expectations/orders
- “Supervision” – documentation
- How are recommendations made/communicated?
- How is front line staff educated? Where is it documented?
- Do therapists know how to communicate with the survey team?

DOES YOUR THERAPY DEPARTMENT CONDUCT A SATISFACTION SURVEY?

- Focuses on Resident/Family Satisfaction
- Help gauge Ohio QI scores for survey and enables needed changes to be made
- Areas in need of improvement can be part of QAPI program
- Indirectly could help in transition planning therefore ↓readmissions
- Referrals
SUCCESSFUL PARTNERSHIP

How are you being measured – hospital expectations?

- Therapy Length of Stay
  - cost per Episode

- Quality Outcomes (QMs)
  - patient outcomes

- Re-admission Rate – Yours? And how you help the hospital with theirs

- Nursing Home Compare
  - Survey
  - QMs
  - Staffing
OBJECTIVES REVIEWED

- Upon completion, participants will be able to describe the prevalence of re-admissions as well as the targeted diagnoses.

- Upon completion, participants will identify the potential roles that therapy plays in reducing re-admissions, improving quality, and achieving preferred provider status.

- Upon completion, participants will describe the structure of a comprehensive program that identifies risk, utilizes root cause analysis and determines an individualized plan to address issues.

FINAL THOUGHTS

Alternative Payment Systems are not going away

- Must adapt and change

- Educate all staff on focuses including therapy regarding current standing on all measures

- Establish goals, plan and monitor outcomes
  - Including Early Risk Identification

- Know your data and know how to defend it
FINAL THOUGHTS

Culture Change: SNFs are no longer an island, facility and therapy staff must integrate and be a part of the change. Must adapt – keep quality and efficiency top of mind. Use therapy as a stepping stone to support facility as a preferred provider.

IMPROVED QUALITY + REDUCED COST = SUCCESSFUL HOSPITAL PARTNERSHIP

REFERENCES

- www.nhqualitycampaign.org
- Readmissions Reduction Program (HRRP) https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html
REFERENCES

- Value Based Programs, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html
- SNFVBP https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html