

Hospital Readmission Reduction Program



SETTING THE STAGE: WHY READMISSION?



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In Simple Terms

If you are a Medicare patient discharged from a hospital, the odds are about 1 in 5 that you'll end up back in the hospital within 30 days.



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MedPAC-Reported Hospital Readmission Rates

- 17.6% of hospital admissions resulted in readmission within 30 days of discharge
- 11.3% within 15 days of discharge
- 6.2% within 7 days of discharge
- Hospital and geographic variation

Medicare Payment Advisory Commission (MedPAC), Report to Congress:
Promoting Greater Efficiency in Medicare, June 2007, Chapter 5, Table 5-1



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MedPAC-Reported Potentially Preventable Hospital Readmission Rates

- 13.3% of hospital admissions resulted in readmission within 30 days of discharge
- 8.8% within 15 days of discharge
- 5.2% within 7 days of discharge

Medicare Payment Advisory Commission (MedPAC), Report to Congress: Promoting Greater Efficiency in Medicare, June 2007, Chapter 5, Table 5-2



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MedPAC-Reported Spending on Potentially Preventable Hospital Readmissions

- \$12 Billion for hospital admissions resulting in readmission within 30 days of discharge
- \$8 Billion for readmission within 15 days of discharge
- \$5 Billion for readmission within 7 days of discharge

Medicare Payment Advisory Commission (MedPAC), Report to Congress: Promoting Greater Efficiency in Medicare, June 2007, Chapter 5, Table 5-2



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Readmission Rates Reported in New England Journal of Medicine

- Medicare Fee for Service Beneficiaries
- 19.6% readmitted in 30 days
- 30.4% readmitted within 90 days
- 56.1% readmitted within year

Stephen F Jencks, M.D., Mark V. Williams, M.D. and Eric Coleman, M.D., M.P.H., "Rehospitalizations among Patients in the Medicare Fee for Service Program," New England Journal of Medicine, vol. 360 (April 2, 2009) pp. 1418-1428. Data year 2003-2004



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Medicare Spending Focus

- Medicare spending is projected to increase about 79% between 2010 and 2020
- Hospital readmission was identified as an opportunity to reduce Medicare Spending



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Congressional Action

- Efforts to contain Medicare spending have focused on Hospitals
- Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010
- Contains provision intended to reduce hospital readmissions (rehospitalization)



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Policy Perspective

- For certain types of services and procedures readmission and spending are too high
- Not all hospitalizations avoidable, but variation by hospital and geography suggest some readmissions are avoidable by improving quality
- Chronic illness targeted



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Fee For Service Incentivizes Higher Volume

“Medicare’s fee for service system, in which provider payments are made for each unit of service, provides incentives to hospitals, post-acute care providers, and others to increase volume of care rather than to reduce it.”

Medicare Hospital Readmissions: Issues, Policy Options and PPACA, Congressional Research Service, September 21, 2010, page 5



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Fee For Service Incentivizes Higher Volume

“Specifically, hospitals are paid for each discharge and thus have an incentive to maximize discharges. Thus hospitals could lose income by reducing admissions, as fewer rehospitalizations would result in fewer billable discharges.”

Medicare Hospital Readmissions: Issues, Policy Options and PPACA, Congressional Research Service, September 21, 2010, page 5



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Fee For Service Incentivizes Higher Volume

“Similarly, physicians and post-acute care providers are each paid separately and receive more reimbursement for a greater number of services, episodes of care, or admissions they provide.”

Medicare Hospital Readmissions: Issues, Policy Options and PPACA, Congressional Research Service, September 21, 2010



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Inpatient Prospective Payment System (IPPS)

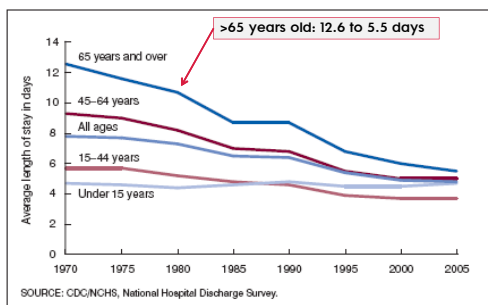
“Under IPPS, any differences between Medicare payments and hospitals’ costs are retained by the hospital. As a result, hospitals are financially rewarded for the efficient delivery of medical and surgical care and are more likely to discharge patients earlier.”

Medicare Payment Advisory Commission (MedPac), Report to Congress: Promoting Greater Efficiency in Medicare, June 2007, Chapter 5.



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Decline in Hospital Length of Stay



DeFrances et al, Adv data, 2007 Jul 12;(385):1-19



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Why Nursing Homes are Important in Reducing Readmission

Reason 1: Increasingly higher acuity hospital discharges are being admitted to SNFs



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Length of Stay

2011 Annual Quality Report, American Health Care and The Alliance for Quality Nursing Home Care

TABLE 3

DECREASING LENGTH OF ACUTE HOSPITAL LENGTH OF STAY IS ASSOCIATED WITH AN INCREASE IN SNF DISCHARGES AND AN INCREASE IN READMISSION RATE FOR HEART FAILURE

	Year		Net Change
	1992-94	2005-06	
Hospital Length of Stay (days)	8.5	8.4	-25.5%
SNF Discharges (%)	13.8	19.9	+43.7%
30-day Readmission Rate (%)	12.1	20.1	+66.1%
30-day Mortality (%)	12.8	10.7	-16.4%

Source: Smith et al. (2008) "Changes in Readmission Rates and Mortality Among Medicare Patients Hospitalized for Heart Failure 1992-2006." *Medical Care*, 46(10):1015-1024. doi:10.1016/j.jcline.2008.05.001. Copyright 2008 by Elsevier. All rights reserved. Reproduced with permission from Elsevier. All rights reserved. For more information, please visit: <http://www.elsevier.com/locate/medcare>

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The Result

- Hospitals historically have been focused on minimizing length of stay. With new policy efforts and legislative changes, focus will include reducing readmissions

➔ Hospital Readmissions Reduction Program

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HOSPITAL READMISSIONS REDUCTION PROGRAM

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Background

- Part of the 2012 IPPS rule that put in place the framework for the Medicare hospital inpatient readmissions payment policy established by the Affordable Care Act (ACA).
- This program is designed to reduce Medicare inpatient payments for acute care hospitals with higher than expected risk-adjusted readmission rates related to certain conditions.
- The penalty program will begin October 1, 2012 (FFY 2013).

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Readmission: Who is Counted for this program?

- Patients age 65 or older
- Enrolled in traditional fee-for-service Medicare A & B at least 12 months prior to the date of admission
- Discharged from non-federal acute care hospital



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Readmission: Who is Counted?

- Principal diagnoses:
 - Acute Myocardial Infarction (AMI)
 - Heart Failure
 - Pneumonia



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General Readmission Characteristics

- Readmission to a hospital
- Within a certain time frame
- Following an original admission and discharge (indexing hospital)
- Readmission to same or different hospital
- Planned or unplanned surgical or medical treatment



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What Counts as a Readmission?

- Readmission to any acute care hospital
- Within 30 days of discharge from the indexing hospital
- For any reason ("all-cause readmission")



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Index Admission

- Index admission is one in which the 30 days after discharge is evaluated for a readmission
- The hospitalization considered for the readmission outcome determination

2011 Measures Maintenance Technical Report: Acute Myocardial Infarction, Heart Failure, and Pneumonia 30-Day Risk-Standardized Readmission Measures



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All-Cause Readmission

- Readmission for any reason
- Regardless of principal discharge diagnosis from the indexing hospital
- From the patient's perspective, any readmission for any cause is an adverse event



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Hospital Transfers

- Transfers between acute care hospitals
- Multiple contiguous hospitalizations considered a single acute episode of care
- Readmission attributed to the hospital that ultimately discharges to the post-acute setting

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Excluded Admissions

- In-hospital Death
- Without at least 30 days post discharge enrollment in Fee-For-Service Medicare
- Who were transferred to another acute care facility
- Who were discharged against medical advice



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Penalty for High Readmission Rates

- The program will begin October 1, 2012 (FFY 2013).
- In the 2012 IPPS Rule: "Specific information regarding the payment adjustment required under section 1886(q) of the Act will be proposed in next year's [2013] IPPS/LTCH PPS proposed rule."

Federal Register Volume 76, Number 160 (Thursday, August 18, 2011), Page 51661



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Penalty for High Readmission Rates

- In general, penalties (adjustments) of up to 1% will be imposed on hospitals in FY2013, related to higher than expected readmission rates
- These adjustments will be applied to some segment of hospital Medicare reimbursements



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Future Penalties

- More significant reductions – up to 2% in FY 2014 and up to 3% in FY 2015
- Additional conditions could be added including:
 - COPD
 - Cardiovascular surgical procedures
 - Vascular conditions

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READMISSION MEASURES



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Measure Characteristics

- Measures assess readmissions within a 30 day period from the date of discharge from an index hospital
- Outcome for each patient measured consistently
- Outcomes within 30 days of discharge can be strongly influenced by hospital care and the early transition to outpatient setting
- Clinically meaningful period

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Readmission Data Collection

CMS extracts and utilizes physician office, inpatient and institutional outpatient claims data from the year prior to the index hospitalization as well as claims data from the index hospitalizations to risk adjust the rates. CMS inpatient database is used to determine if a beneficiary has been readmitted within 30 days of discharge.

Specifications Manual for National Hospital Quality Measures



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Excess Readmission Ratio

- Hospital-specific ratio based on each applicable condition
- Defined by the Act as the ratio of risk-adjusted readmissions based on actual readmissions for an applicable hospital for each applicable condition, to the risk adjusted expected readmissions for the applicable hospital for the applicable condition



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Excess Readmission Ratio

Numerator- Predicted number of readmissions within 30 days on the basis of the hospital's performance with its observed case mix

Denominator- Number of readmissions expected on the basis of the nation's performance with that hospital's case mix

2011 Readmission Measures Maintenance Technical Report: Acute Myocardial Infarction, Heart Failure, and Pneumonia 30-Day Risk Standardized Readmission Measures, April 13, 2011



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Excess Readmission Ratio

$$\frac{\text{Predicted 30-day Readmission rate}}{\text{Expected 30-day Readmission Rate}} = \text{Excess Readmission Ratio}$$

Nursing Home Compare, www.hospitalcompare.com



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Predicted Readmission

- Predicted readmission is the number of readmissions (following discharge for heart attack, heart failure, or pneumonia) that would be anticipated in the particular hospital during the study period, given the patient case mix and the hospital's unique quality of care effect on readmission.

Nursing Home Compare, www.hospitalcompare.com



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Excess Readmission Ratio

$$\frac{\text{Predicted 30-day Readmission rate}}{\text{Expected 30-day Readmission Rate}} = \text{Excess Readmission Ratio}$$

Nursing Home Compare, www.hospitalcompare.com



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Expected Readmission

- Expected readmission is the number of readmissions (following discharge for heart attack, heart failure, or pneumonia) that would be expected if the same patients with the same characteristics had instead been treated at an "average" hospital, given the "average" hospital's quality of care effect on readmission for patients with that condition.

Nursing Home Compare, www.hospitalcompare.com



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Risk-Standardized Readmission Rate (RSRR)

Calculated as the ratio of the number of “adjusted actual” readmissions (predicted) to the number of “expected” readmissions at a given hospital, multiplied by the national unadjusted readmission rate.

2011 Readmission Measures Maintenance Technical Report: Acute Myocardial Infarction, Heart Failure, and Pneumonia 30-Day Risk Standardized Readmission Measures, April 13, 2011



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Risk-Standardized Readmission Rate (RSRR) Calculation

$$\left[\begin{array}{c} \text{Excess} \\ \text{Readmission} \\ \text{Ratio} \end{array} \right] \times \left[\begin{array}{c} \text{U.S. National} \\ \text{Readmission} \\ \text{Rate} \end{array} \right] = \text{Risk-Standardized Readmission Rate}$$

Nursing Home Compare, www.hospitalcompare.com



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An Indication of Quality

- The higher a hospital's predicted 30-day readmission rate, relative to expected readmission for the hospital's particular case mix of patients, the higher its adjusted readmission rate will be. Hospitals with better quality will have lower rates.

Nursing Home Compare, www.hospitalcompare.com



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Hospital Readmission Example

- Suppose the model predicts that 10 of Hospital A's heart attack admissions would be readmitted within 30 days of discharge in a given year, based on their age, gender, and pre-existing health conditions, and based on the estimate of the hospital's specific quality of care.

Nursing Home Compare, www.hospitalcompare.com



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Hospital Readmission Example

- Then, suppose that the expected number of 30-day readmissions for those same patients were higher – say, 15 – if they had instead been treated at an "average" U.S. hospital.

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Example 1: Excess Readmission Ratio

$$\frac{10 \text{ Predicted}}{15 \text{ Expected}} = .667 \quad \text{Excess Readmission Ratio}$$



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Hospital Readmission Example

- If the actual readmission rate for the study period for all heart attack admissions in all hospitals in the U.S. is 12 percent, then the hospital's 30-day risk-standardized readmission rate would be 8 percent.

Nursing Home Compare, www.hospitalcompare.com



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Example 1: Risk-Standardized Readmission Rate (RSRR)

$$\left[\begin{array}{c} \text{Excess} \\ \text{Readmission} \\ \text{Ratio} \end{array} \right] \times \left[\begin{array}{c} \text{U.S. National} \\ \text{Readmission} \\ \text{Rate} \end{array} \right] = \text{Risk-Standardized Readmission Rate}$$

$$.667 \quad \times \quad 12.0\% \quad = \quad 8.0\%$$



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Hospital Readmission Example

- If, instead, 9 of these patients would be expected to have been readmitted if treated at the “average” hospital, then the hospital’s 30-day risk-standardized readmission rate would be 13.3 percent.

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Example 2: Excess Readmission Ratio

$$\frac{10 \text{ Predicted}}{9 \text{ Expected}} = 1.11 \quad \text{Excess Readmission Ratio}$$



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Example 2: Risk-Standardized Readmission Rate (RSRR)

$$\left[\begin{array}{c} \text{Excess} \\ \text{Readmission} \\ \text{Ratio} \end{array} \right] \times \left[\begin{array}{c} \text{U.S. National} \\ \text{Readmission} \\ \text{Rate} \end{array} \right] = \text{Risk-Standardized Readmission Rate}$$

$$1.11 \quad \times \quad 12.0\% \quad = \quad 13.3\%$$



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Hospital Readmission Example

- In the first case, the hospital performed better than the national average and had a relatively low risk-standardized readmission rate (8 percent); in the second case, it performed worse and had a relatively high rate (13.3 percent).

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RISK ADJUSTMENT



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Risk Adjustment Definition

- A statistical process used to identify and adjust for variation in patient outcomes that may be due to differences in patient characteristics, or risk factors, across health care facilities.

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Risk Adjustment Concept

- Conceptually allows for a comparison of a particular hospital's performance given it's case mix to an average hospital's performance with that same case mix.

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Hospital Case Mix

- Hospitals with relatively low-risk patients whose predicted readmission is the same as the expected readmission for the average hospital for the same group of low-risk patients would have an adjusted readmission rate equal to the national rate (12 percent in the prior example).

Nursing Home Compare, www.hospitalcompare.com



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Hospital Case Mix

- Similarly, hospitals with high-risk patients whose predicted readmission is the same as the expected readmission for the average hospital for the same group of high-risk patients would also have an adjusted readmission rate equal to the national rate of 12 percent.

Nursing Home Compare, www.hospitalcompare.com



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Risk Adjustment Impact

- Reduces hospital incentive to selectively admit lower risk residents as a strategy to reduce readmissions

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Risk Adjustment Variables

- CMS Readmission measures adjust for key variables
- Co-variables obtained from Medicare administrative claims data 12 months prior to and including the index admission
- Adjust for case-mix based on clinical status (e.g. demographic factors comorbid diseases and indicators of frailty)

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Non Risk-Adjusted Variables

- Admission source
- Discharge disposition
- Socioeconomic status

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Appropriate Exclusions

- Measures contain exclusions appropriate to the condition. For example:
 - The Acute MI measure does not count planned readmission for revascularization
 - Conceptually a continuation of care for the index admission

2011 Measures Maintenance Technical Report: Acute Myocardial Infarction, Heart Failure, and Pneumonia 30-Day Risk-Standardized Readmission Measures



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PUBLIC REPORTING OF HOSPITAL PERFORMANCE



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Hospital Compare

- 30 day readmission rates listed by hospitals nationwide
- Specific rates for heart attack, heart failure and pneumonia
- Compared with national and state average
- What is your referring hospital's status?



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Hospital Compare



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Hospital Compare – Outcome Measures

Hospital Readmission Rates Outcome of Care Measures

"30-Day Readmission" is when patients who have had a recent hospital stay need to go back into a hospital again within 30 days of their discharge. Below, the rates of readmission for each hospital are compared to the U.S. National Rate. The rates take into account how sick patients were before they were admitted to the hospital. [Read more information about Hospital Readmission Measures.](#)

[View Graphs](#)

[View Tables](#)

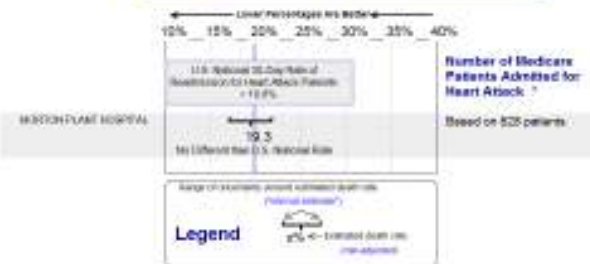
	HEASC HOSPITAL SHREVEPORT	SHREVEPORT HOSPITAL
	460 HIGH STREET SHREVEPORT, LA 70569 (504) 733-5555	360 ONEILL ST CLEARWATER, FL 33758 (727) 463-7669
	Add to My Favorites	Add to My Favorites
Rate of Readmission for Heart Attack Patients	No Different than U.S. National Rate	No Different than U.S. National Rate
Rate of Readmission for Heart Failure Patients	No Different than U.S. National Rate	No Different than U.S. National Rate
Rate of Readmission for Pneumonia Patients	No Different than U.S. National Rate	No Different than U.S. National Rate



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Hospital Compare - Graphs

Rate of Readmission for Heart Attack Patients



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Hospital Compare Website

www.hospitalcompare.hhs.gov



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NURSING HOME READMISSION RATES



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Measurement

- The same rigor as applied in hospitals has to be applied to measurement of readmissions from nursing homes.
- The measures are different from the nursing home perspective

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Hospital vs. Nursing Home Measures

- Because nursing home care and hospitalization of nursing home residents is often unrelated to a resident's primary diagnosis, disease-specific hospitalization measures defined by the hospital discharge diagnosis or primary admitting diagnosis to the nursing home are less appropriate



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Short Stay Measure

- For the purposes of new Medicare policy, the short-stay measure is 30 days.
- Some studies and stakeholders believe it makes sense to measure the rate at which patient stays end in an admission to a hospital over the total number of admissions, within the first 100 days



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Long Stay Measure

- Once the rate of hospital admissions becomes fairly steady at about 100 days, then the risk of admission is relatively constant for each day.
- For long-term residents of nursing homes, therefore, the more logical hospital admission measure is the number of admissions to hospital per nursing home day, pooling days across residents.



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Rate of Readmission

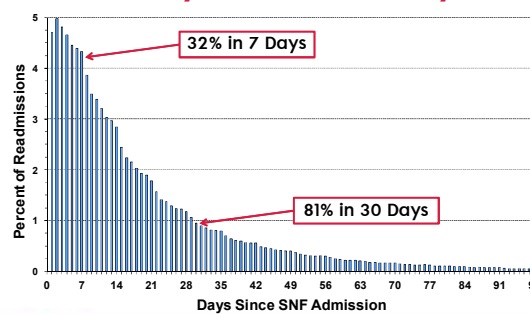
- Nursing home admissions are highest in the first weeks after start of nursing home care
- Gradual decrease until 90-100 days when rate of readmission steady
- Denominator for nursing home rate is nursing home admissions, not discharges (corresponds to time of Hospital Discharge)

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Most Hospital Readmissions Occur Early in the SNF Stay



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Nursing Home Readmission Rate

of residents readmitted to hospital within 30 days of NH admission, for other than planned elective surgery

of NH admissions with at least 30 days since the date of their admission to the nursing home

= Nursing Home All-cause Readmission Rate



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Challenges

- Reduce readmissions to the hospital for short-stay patients
- Demonstration of performance by use of measurement
- Competing for patients from hospitals, ACO's and other referral sources

Medicare Hospital Readmissions: Issues, Policy Options and PPACA, Congressional Research Service, September 21, 2010



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Hospital Imperative

“With the rising rate of hospital discharges to SNFs and the increasing complexity of SNF admissions, readmissions to hospital from nursing homes is a major issue for hospitals. The result is that preventing hospital readmissions is becoming a major focus of nursing home performance efforts.”

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Why is this Important to SNFs?

- Hospitals are increasingly seeking post-acute providers that can help them manage readmissions by:
 - Implementing systems to track and analyzing reasons for readmission (QA)
 - Develop appropriate improvement efforts to reduce readmission rates (PI)



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REDUCING AVOIDABLE
HOSPITAL ADMISSIONS FROM
THE NURSING HOME



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How Many are Avoidable?

- According MedPAC, for Medicare beneficiaries hospitalized in 2005, more than three-quarters of 30-day and 15 day readmissions, and 84% of 7-day readmissions, were potentially preventable.

Medicare Payment Advisory Commission (MedPAC), Report to Congress: Promoting Greater Efficiency in Medicare, June 2007, Chapter 5



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SNF Admissions

In 2008, 50% of patients receiving post-acute care were admitted to SNF's

American Health Care Association and Alliance for Quality Nursing Home Care. 2010 Annual Quality Report



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SNF Admissions

"Pneumonia and Heart Failure were two of the most prevalent admitting diagnoses to SNFs representing 3.6 percent and 4.0 percent, respectively, of SNF admissions in 2008."

American Health Care Association and Alliance for Quality Nursing Home Care. 2010 Annual Quality Report



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Reducing Avoidable Readmissions

- **Determine:**
 - How to define avoidable admissions
 - If there are avoidable readmissions that can be acted upon
 - How to prevent avoidable admissions that have been identified

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Study on Nursing Home to Hospital Transfers

- Study of nursing home to hospital transfer and ER visit "appropriateness"
- Chart review conducted
- Rated transfer or admission appropriateness
- **Conclusion: 40% of hospital transfers were "inappropriate"**

Saliba, D, Kingston, J, Buchannon et al. "Appropriateness of the Decision to Transfer Nursing Facility Residents to Hospital." *Journal of the American Geriatric Society*



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Potentially Avoidable Hospital Readmissions From Nursing Homes

- A larger research study shows 67% of hospitalizations were “potentially avoidable”
- Retrospective assessment different than clinical decision making in real time and does not infer unnecessary hospitalization

Ouslander et al “Potentially Avoidable Hospitalizations of Nursing Home Residents: Frequency, Causes, and Costs”. *Journal of the American Geriatric Society* 58:627-635, 2010.



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General Readmission Improvement Strategies

- Greater availability of physicians, NPs and PAs for onsite acute change in status assessment
- Need to improve overall care quality for resident with acute change in condition
- Ability to obtain diagnostic tests and administer IVs
- Reduce amount of futile care and improve advance care planning

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Nursing Home Performance

- As these factors are under the influence of the nursing home, the case can be made that hospital admission rates can be viewed as a performance measure for nursing homes.

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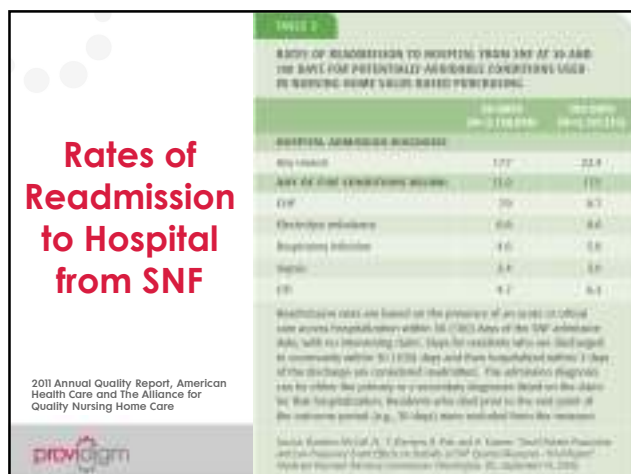
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Potentially Avoidable Conditions

- Based on literature related specifically to nursing home residents, five conditions were identified as “potentially avoidable” hospitalizations
- These five conditions include hospitalizations for a primary or secondary diagnosis of: heart failure, respiratory infection, urinary tract infection, sepsis, and/or electrolyte imbalance



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Not 100% Avoidable

- From a clinical perspective, potentially avoidable hospitalizations defined in this manner were never intended to mean that no hospitalizations should occur from nursing homes for these conditions

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A Good Start

- Hospitalizations from these conditions are just more likely to be avoidable than hospitalizations for many other conditions
- Interventions aimed at reducing hospitalizations for these conditions make sense as a starting place for nursing homes that are trying to reduce hospitalization rates

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Strategies for Reducing Avoidable Hospitalizations

- Targeted Strategies
 - Assessing Patient Risk for Readmission
 - Disease management programs for ACA conditions frequently discharged to SNFs (e.g. heart failure and pneumonia)
 - Increasing Advanced Care Planning (e.g. MAPP) for those with high mortality risk

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Strategies for Reducing Avoidable Hospitalizations

- Global Strategies
 - Measuring and Monitoring Risk-Adjusted Rates
 - Intervention Toolbox (e.g. Interact II)
 - Advance Practice Nurses/Physician Assistants
 - Dedicated Physician Coverage Aimed at Managing Acute Decline

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What does this mean to your hospital and managed care partners?

- They are going to be looking very carefully at which nursing homes they partner with.
- They want to partner with facilities that are tracking and managing readmissions.



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What does this mean to you?

- You will need to be able to market yourself to hospitals and managed care partners and show:
 - Your risk-adjusted readmission rate
 - What you are doing to track and reduce readmissions
 - That you utilize a comprehensive Quality Management system that helps you monitor all areas of care



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Why are Managed Care Organizations looking at readmissions?

- Because of the way they are paid, managed care organizations are incentivized to avoid readmission of their patients.
 - Hospital readmissions mean extra days in the hospital, which are very costly.
 - Payors want to provide care for the least amount of money in order to profit from their capped fees.



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HOSPITAL AND NURSING HOME PARTNERSHIP



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Readmission Prevention

- Preventing readmission from nursing homes requires solutions designed for the SNF population and the nursing home environment



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Three Reasons Why SNFs Have a Critical Role to Play in Reducing Readmissions



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Reason 1: Increasingly higher acuity hospital discharges are being admitted to SNFs



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TABLE 1

DECREASING LENGTH OF ACUTE HOSPITAL LENGTH OF STAY IS ASSOCIATED WITH AN INCREASE IN SNF DISCHARGES AND AN INCREASE IN READMISSION RATE FOR HEART FAILURE

	Year		%Change
	1993-94	2003-04	
Hospital Length of Stay (days)	8.6	6.4	-25.5%
SNF Discharges (%)	13.0	19.9	+53.1%
30-day Readmission Rate (%)	17.5	20.1	+16.1%
30-day Mortality (%)	12.8	10.7	-16.4%

Source: Trends in Length of Stay and Short-term Outcomes Among Medicare Patients Hospitalized for Heart Failure, 1993-2006. Héctor Riera, Joseph S. Ross, Yuen Wang, Jesse Chen, Maria T. Velazquez, Sharon-Jae T. Normand, Nathan P. Curtis, Elizabeth E. Drye, Judith H. Lichtman, Patricia S. Kramon, Michael Goodwood, Mark A. Krumholz. JAMA 303(27): 2541-2547, 2010.

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Reason 2: The frailest hospitalized Medicare patients are discharged to SNFs

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SNF Stroke Admissions Are More Functionally and Cognitively Impaired

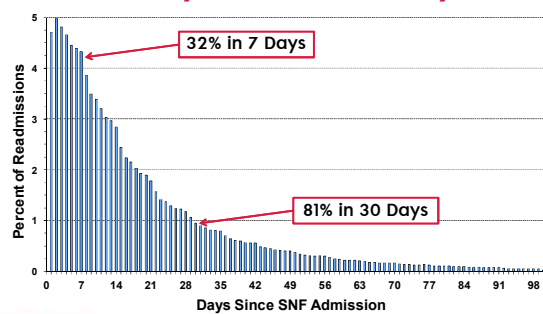
	SNF	IRF	Home Health
Function (0-90)	34	40	64
Cognition (MMSE 0-30)	19	23	25
Aphasia (%)	45	21	19

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Reason 3: SNFs can intervene when hospital discharges are at highest risk for readmission

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Most Hospital Readmissions Occur Early in the SNF Stay



previ^oign

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How SNFs Can Reduce Hospital Readmission

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First, You Have to Measure Your Readmission Rate

of residents readmitted to hospital within 30 days of NH admission, for other than planned elective surgery

of NH admissions with at least 30 days since the date of their admission to the nursing home

= All-cause Readmission Rate (as calculated in QIS Admission Sample Record Review)

previ^oign

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abaqis[®] Facility Readmission Rates From 686 SNFs with 25 or more admissions (57,276 admissions from Jan – Dec 2011)

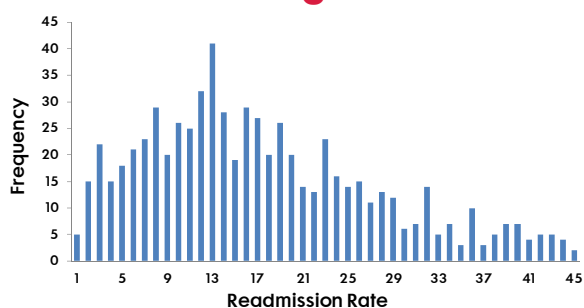
Mean	17.4%
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Minimum	1%
25 th Percentile	10%
Median	16%
75 th Percentile	24%
Maximum	45%

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Raw Readmission Rates Vary Among SNFs



previQm

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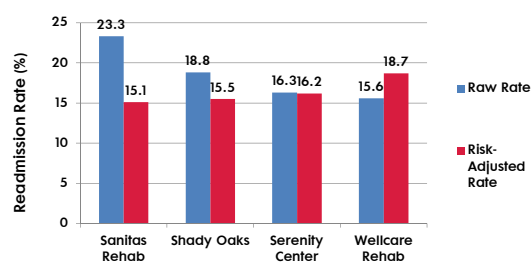
Second, Adjust for Resident Risk of Readmission

- Because not all residents have the same risk for hospitalization
- For comparing rates across nursing homes or groups of nursing homes
- For tracking or monitoring rates over time in a nursing home
- Risk adjustment models can identify residents at highest risk for hospitalizations

previQm

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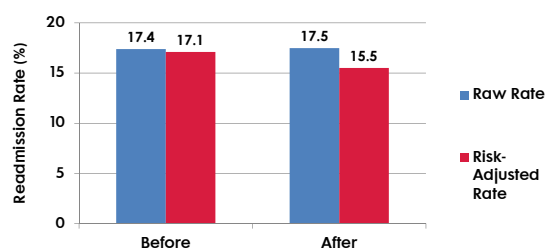
Effect of Risk Adjustment on Readmission Rate (based on actual facility rates)



previQm

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Risk Adjustment is Necessary to Measure Performance Improvement



previQm

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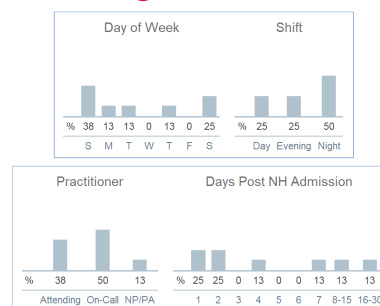
Important Risk Adjusters

- Co-morbidity Index
- Function (ADLs, etc.)
- Special Care
- Admission Conditions
- Geography



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Third, Evaluate Potential Care Management Issues



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Fourth, Intervene and Measure Impact as part of QAPI Cycle

- Performance Improvement Intervention – Identify aims for improving rates, implement changes
- Repeat Measurement of Readmission Rate – Risk adjustment is necessary for comparing rates over time because facility case mix can change



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Fifth, Partner With Referring Entities

- Discharging Hospitals
- Payers (e.g. Medicare Advantage Program, Medicare FFS)
- Physicians

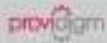


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Providigm's Basic QIS Overview



QIS Developed under CMS

- 1992-1997:** Preliminary tests of a staged survey
(University of Colorado)
- 1998-2005:** QIS Development Contract
(University of Colorado, led by Dr. Andrew Kramer, University of Wisconsin, Maverick Systems, Alpine Systems, under subcontract to RTI)
- 2005-2007:** Demonstration/refinement in CT, KS, OH, LA, CA, followed by statewide expansion in FL, CT, KS
(University of Colorado)
- 2007-2009:** Development and refinement
(University of Colorado)
- 2007-2011:** National Training Contractor
(Providigm, formerly Nursing Home Quality, LLC, is awarded the CMS Training Contract for National QIS Rollout)

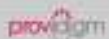


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QIS Implementation

- CMS identifies states in order of bands, S & C letter 09-50
- Within bands of states CMS and State Agency determine order (July to July bands)
- Alpine Technology Group provides tech/computer set up training.
- CMS and NHQ have a stakeholder call with the State to discuss training logistics (equipment, dates, locations etc.)
- State selects initial team(s) to be trained
- The initial round of training takes 4-6 weeks depending on State schedule

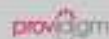


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Surveyor Training

- 1 week of classroom training (week 1)
- Observed Mock Survey (week 2)
- Observed Survey of Record and evaluate
- Compliance (week 3)
- Second Survey of Record observed to finish compliance testing (week 4) and recommend any needed remediation.



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Surveyor Training

- Surveyors are "Registered QIS Surveyors" if training successfully completed
- State Agency determines QIS Trainer candidates
- Trainer candidates complete a minimum of 6 QIS surveys (2 completed during training plus 4 more independently)
- State schedules T3 or QIS trainer training



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Train the Trainer

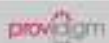
- Trainer workshop for trainer candidates (material review, teaching skills) (week 1)
- Compliance candidates during classroom training of State Surveyors (week 2)
- Compliance candidates during a Mock Survey (week 3)
- Compliance candidates during the Survey of Record (week 4) and suggest remediation as needed.
- Trainer Candidates become Certified QIS Trainers



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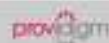
DESCRIPTION OF THE QUALITY INDICATOR SURVEY PROCESS



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QIS Objectives

- Greater Consistency
- More Comprehensive
- Enhanced Documentation
- Target Survey Resources



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Stage 1 Samples

- **Census Sample** - random sample of current residents (n = 40)
- **Admission Sample** - random sample of new admissions (n = 30)
- **MDS Sample** - all residents with an MDS within the prior six months of the survey

Advantages of Three Samples

- **Census Sample** emphasizes long-stay residents residing in the facility
- **Admission Sample** captures the SNF post-acute residents and long-stay residents at critical point (e.g. re-hospitalization, rehabilitation, weight loss)
- **MDS Sample** covers all residents (except very recent) and is facility-reported information

Surveyor Initiated

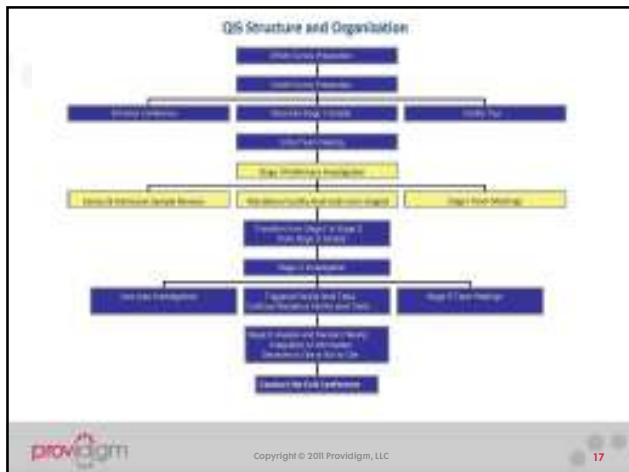
- At any time in the process, surveyors can initiate investigation of care issues for any resident. Because of the large QIS samples, surveyor initiated investigations are a minor part of the process.



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Stage 1 Preliminary Investigation

- **Census Sample**
 - Resident Interviews
 - Resident Observations
 - Family Interviews
 - Staff Interviews
 - Clinical Record Reviews
- **Admission Sample**
 - Clinical Record Reviews

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Mandatory Facility Tasks

- Liability Notice and Beneficiary Appeal Rights
- Dining Observation
- Infection Control & Immunization
- Kitchen/Food Service Observation
- Medication Administration
- Medication Storage
- Quality Assessment and Assurance (QA&A)
- Resident Council President/Representative Interview

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Transition From Stage 1 to Stage 2

- On-site and MDS data combined to create outcome and process indicators.
- 109 resident-centered Quality of Care and Quality of Life indicators (QCLIs). This number does not currently include MDS indicators.
- QCLI rates compared with thresholds to identify “triggers” for Stage 2 review or investigation.

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Small and Not Small Sample Thresholds

- Census Sample
 - Small- 35 or fewer in the Census Sample
 - Not Small- 36 or more in Census Sample
 - Family Interview- one threshold regardless of sample size



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Small and Not Small Sample Thresholds

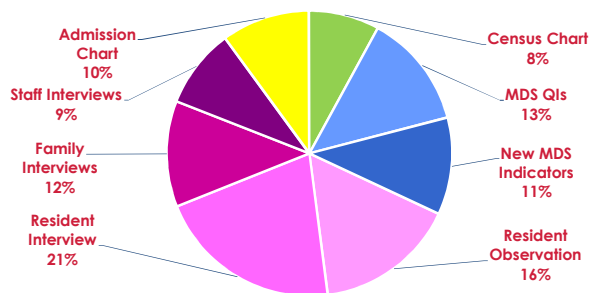
- Admission Sample
 - Small- 9 or fewer residents in Admission Sample
 - Not Small- 10 or more residents in the Admission Sample



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QIS Triggers for Stage 2 Investigation



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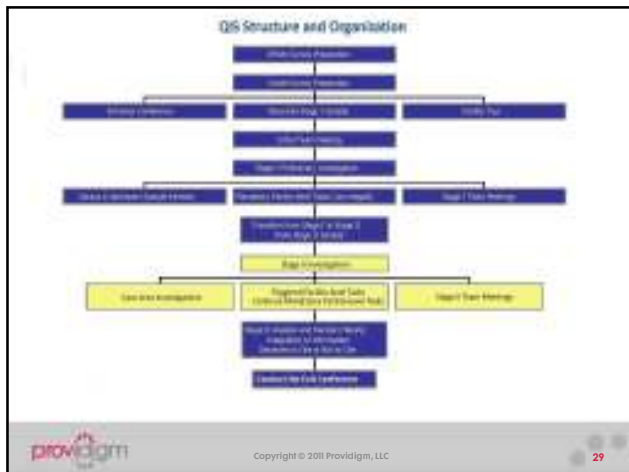
Transition From Stage 1 to Stage 2 (continued)

- Computer selects Stage 2 sample to include all triggered Care Areas
- Review list of dialysis, hospice, PASRR and ventilator residents



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Care Areas

- A component of nursing home care that is related to one or more Quality of Care and Life Indicators (QCLIs).
- There are 56 Care Areas in QIS.

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Care Area Investigations

- Specific Critical Element Pathways
- General Critical Element Pathway
- Guidance to Surveyors from State Operations Manual
- Triggered Facility Tasks

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Care Area Investigations

- Investigate both resident-level and facility-wide issues
- Integrate information from multiple sources
- Rate severity for each resident where deficient practice is found

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Stage 2 Sample Selection

- All surveyor-initiated residents
- Minimum of 3 residents from each triggered Care Area
- Priority is residents currently residing in the facility
- Includes closed record reviews
- All residents with positive response for abuse will be investigated

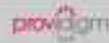


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Critical Element (CE) Pathways

- Used in Stage 2
- Guide investigation
- Assist in evaluating compliance with regulatory requirements
- Provide consistent, organized and systematic review of triggered Care Area

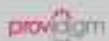


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Critical Element Pathways

- Determine if Critical Elements of Care are met:
 - Comprehensive Assessment (F272)
 - Care Planning (F279)
 - Care Plan Implementation by Qualified Persons (in accordance with Plan of Care) (F282)
 - Care Plan Revision (F280)
 - Provision of Care and Services? (variable)



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Care Areas with Specific CE Pathways

- | | |
|-------------------------------|---------------------------------------|
| • Activities | • Physical Restraints |
| • ADLs and ROM | • Pressure Ulcers |
| • Behavior & Emotional Status | • Psychoactive Medications |
| • Communication/Sensory | • Tube Feeding |
| • Dental | • PASRR |
| • Dialysis | • Rehab/Community Discharge |
| • Hospice and Palliative Care | • Urinary Incontinence, Catheter, UTI |
| • Hospitalization or Death | • Unnecessary Medication |
| • Hydration | • Ventilator |
| • Pain | |



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Specialized Care Areas with Specific CE Pathways

- Ventilator
- Dialysis
- Hospice/Palliative Care
- PASRR
- One resident from each area is surveyor initiated



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General CE Pathway

- Used for selected Care Areas without a Specific CE Pathway:
 - Fecal Impaction
 - Skin Conditions other than Pressure Ulcers
 - Infections other than UTI
 - Accidents no longer uses general pathway



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Guidance to Surveyors

- Guidance to Surveyors is used for some Care Areas that do not have a specific CE pathway:
 - Abuse
 - Accidents
 - Choices
 - Dignity
 - Privacy
 - Social Services
 - Food Quality
 - Foot Care
 - Notification of Change
 - Personal Property
 - Participation in Care Plan



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Triggered Facility Tasks

- Abuse Prohibition
- Admission, Transfer, and Discharge
- Environmental Observations
- Personal Funds
- Sufficient Nursing Staff
- QIS Extended Survey



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Unnecessary Medication Review

- Although not a Mandatory Task; conducted in every survey
- 10 residents
- Record and review all ordered medications
- Use the SOM to direct decisions regarding drug irregularities



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Stage 2 Analysis and Decision-Making

- Combine Stage 2 findings across residents by F tag
- Integrate survey team findings into single statement
- Review regulation and guidance
- Identify deficiencies and determine severity and scope

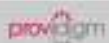


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Complaint Investigation

- Initiate residents and specified care areas into Stage 2 Sample
- Investigate using same procedures as triggered Stage 2 activities

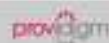


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Exit Conference

- No different than exit conference in traditional survey process
- State procedures may vary
- Share the team's preliminary deficiency findings



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RESOURCES

QIS Resources

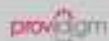
- [Current Quality Indicator Survey \(QIS\) Electronic Forms and Worksheets](#)
- [Quality of Care and Quality of Life Indicator \(QCL\) Dictionary](#)

AHCA 2011 Quality Report

- [Hospitalization of Nursing Home Residents](#) – Dr. Andrew Kramer
- [Focus on Rehabilitation Measures](#) – Dr. Andrew Kramer

Articles by [Dr. Andrew Kramer](#) published in [Provider Magazine](#)

- [QIS System Addresses Hospital Readmissions](#) – June 2011
- [Why The Deficiency Variation In Facilities?](#) – April 2011



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Home About QIA QIS QISD Solutions QIS Links Education BAYEN MSL PAI JAVEN MSL 3.0 MSL 3.0 GASCO JAVEN L JAVEN BAYEN Solina, BSC Solina, BSC STAYAC Time, Share Providers Vendors Payment Protection Status	QIS Review QIS Information QIS Guides QIS Real Time Analysis QIS Information Resources QIS Checklist (updated 11/05/2011) 508 Compliant QIS Survey Forms Offline Preparation Forms User Admission Information (PDF 12 KB) (updated 01/11/2011) Offline Preparation Worksheet (PDF 15 KB) (updated 01/11/2011) Entrance Conference Entrance Conference Worksheet (QIS Facility Copy) (PDF 41 KB) (updated 01/11/2011) Entrance Conference Worksheet (QIS Team Copy) (PDF 20 KB) (updated 01/11/2011) Mandatory Facility Task Forms Medication Administration Observation (PDF 20 KB) (updated 01/11/2011) Inspection Checklist: Physical Environment Observation (PDF 20 KB) (updated 01/11/2011) Quality Assurance and Compliance Checklist (PDF 21 KB) (updated 01/11/2011) Medication Administration (PDF 17 KB) (updated 01/11/2011) Health History & Assessment, Patient Rights, Rights (PDF 30 KB) (updated 01/11/2011) Quality Observation (PDF 15 KB) (updated 01/11/2011) Medical Records & Communication (PDF 40 KB) (updated 01/11/2011) Staffing and Resource Observation (PDF 30 KB) (updated 01/11/2011)
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