How are CMS's changes playing out?
(The three Rs Impacting SNFs)

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Three Rs Impacting SNFs

Reimbursement

- Hospital payments
  - HRRP, VBP & HAC
  - CJR (hip & Knee replacement)
  - Episodic payment
  - Bundle Payment demos
  - ACOs
- SNF
  - SNF PPS
  - SNF VBP (rehospitalization)
  - Bundle Payment demos

Reporting

- SNF QRP
- Payroll Based Journal (staffing)

Regulatory

- Requirements of Participation
- Emergency Preparedeness

Hospital Payment Systems

CMS HOSPITAL VBP IMPACT SNFs

- Hospitals are financially penalized up to 5.75% for quality
  - Hospital Readmission Reduction Program (HRRP) links 3% of payments to 30 day readmissions
  - Hospital VBP ties 1.75% of payments with composite quality score
  - Hospital Acquired Condition (HAC) links 1% of payments to composite adverse events score
  - Comprehensive Care for Joint Replacement (CJR) links a a payment cut or bonus to cost and quality targets

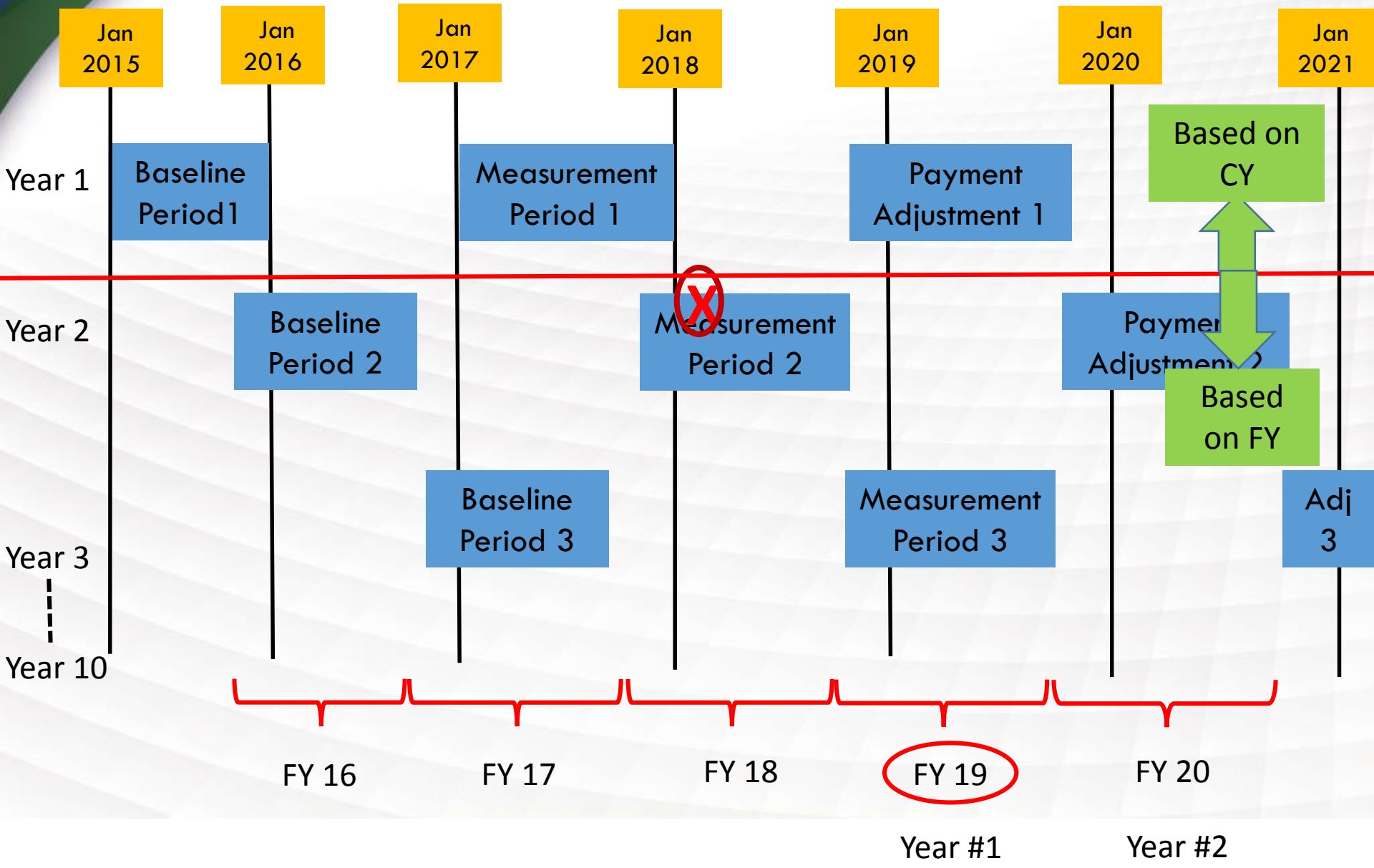
How to succeed with hospitals

- Improve your rates on the measures that count & **share** your performance with hospitals
  - Rehospitalization rate
  - Discharge to community rate
  - Length of Stay (LOS)
  - Improved function
  - Satisfaction score
- Develop a robust transitions of care program
  - Arrange follow-up and communicate with primary care MD
  - Do follow-up calls to discharges to community within 24 hours and 3-5 days later

SNF VBP

CMS SNF VBP program starts sooner than you think.

Timeline for SNF VBP



CMS SNF VBP Measures

	SNF RM	SNF PPR
Included Medicare FFS Part A beneficiaries	YES	YES
Includes other payors	NO	NO
Used data from Part A Medicare Claims	YES	YES
Used data from MDS	NO	NO
Readmission Diagnoses counted	All cause	Only Potentially Preventable
Time window is 30 days from SNF admission	YES	YES
Counts readmissions after SNF stay	YES	YES
Excludes elective admits	YES	YES
Excluded observation stays	YES	YES
Risk adjusted (Actual ÷ Predicted) x National Avg	YES	YES

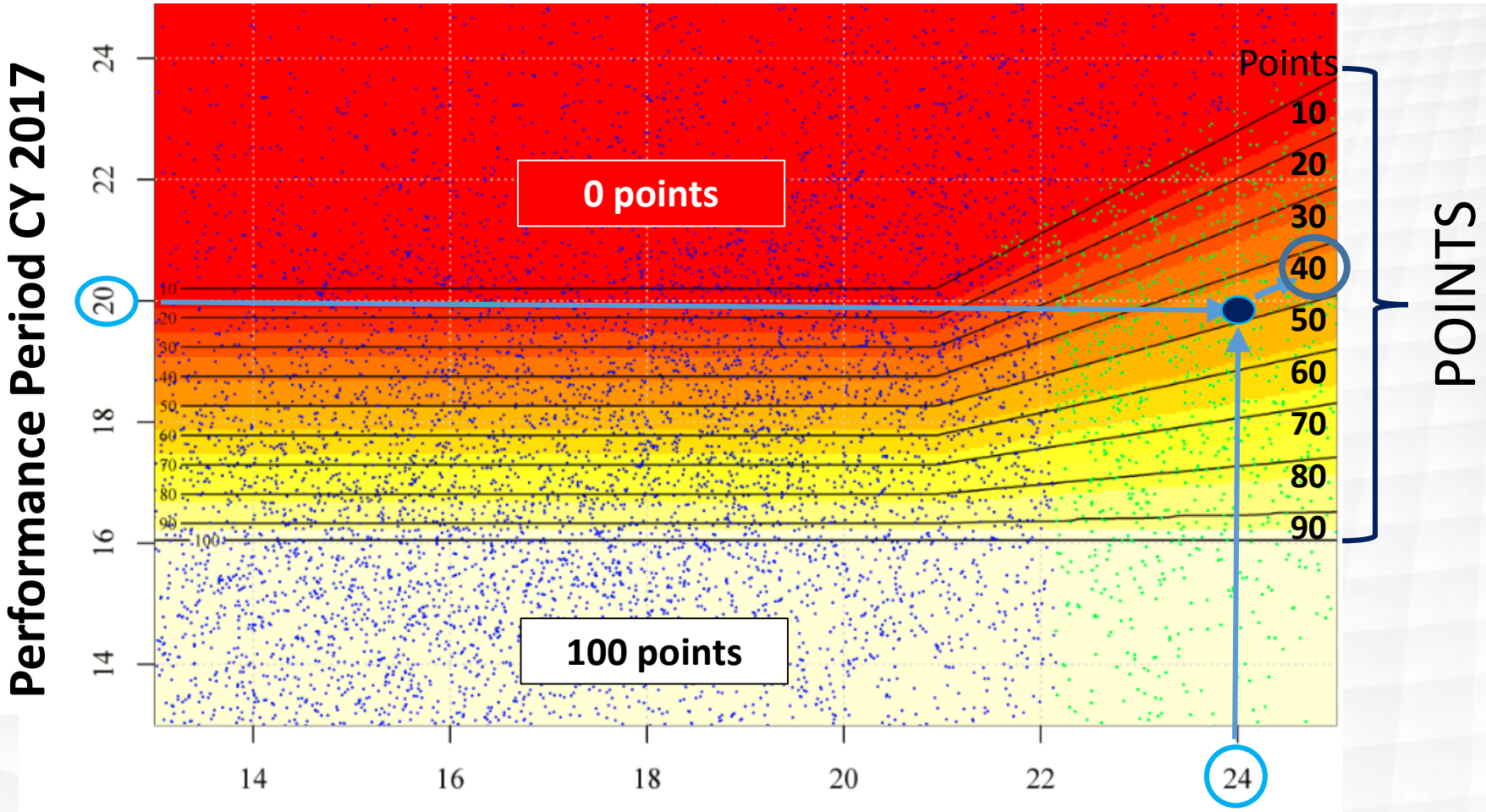
The Rehospitalization Score Yr 1

- Better of your achievement or improvement score
- Achievement score year 1:
  - If SNFRM rate **< 16.4%,** then achievement score is 100
  - If SNFRM rate **> 20.4%,** then achievement score is 0
  - Else: see formula
- Improvement score year 1:
  - If SNFRM rate < 16.4%, then improvement score is 90
  - If SNF RM CY2017 rate > CY2015 rate, then improvement score is 0
  - Else: see formula

The Rehospitalization Score Yr 2

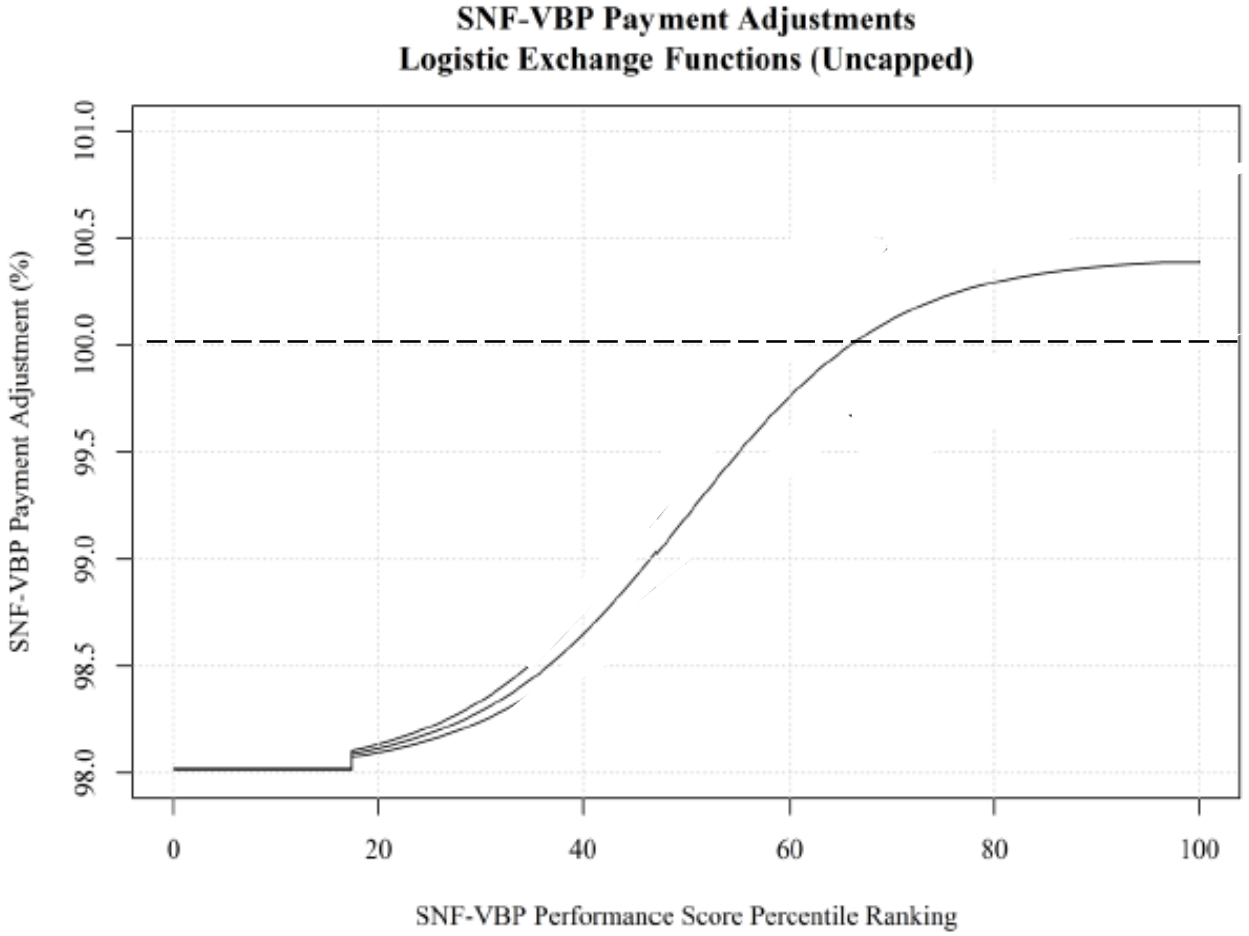
- Better of your achievement or improvement score
- Achievement score **year 2**:
  - If SNFRM rate < **16.3**%, then achievement score is 100
  - If SNFRM rate > **19.8**%, then achievement score is 0
  - Else: see formula
- Improvement score **year 2**:
  - If SNFRM rate < **16.3**%, then improvement score is 90
  - If SNF RM CY2017 rate > CY2015 rate, then improvement score is 0
  - Else: see formula

Scenario: Baseline rate is 24 and you improve to a performance rate of 20.
What is your rehospitalization score?
Plot baseline and performance rate; where they lines intersect ● you read the points.



Rehospitalization Score Nomogram

CMS Propose Exchange Function (Graph is representation: NOT exact)

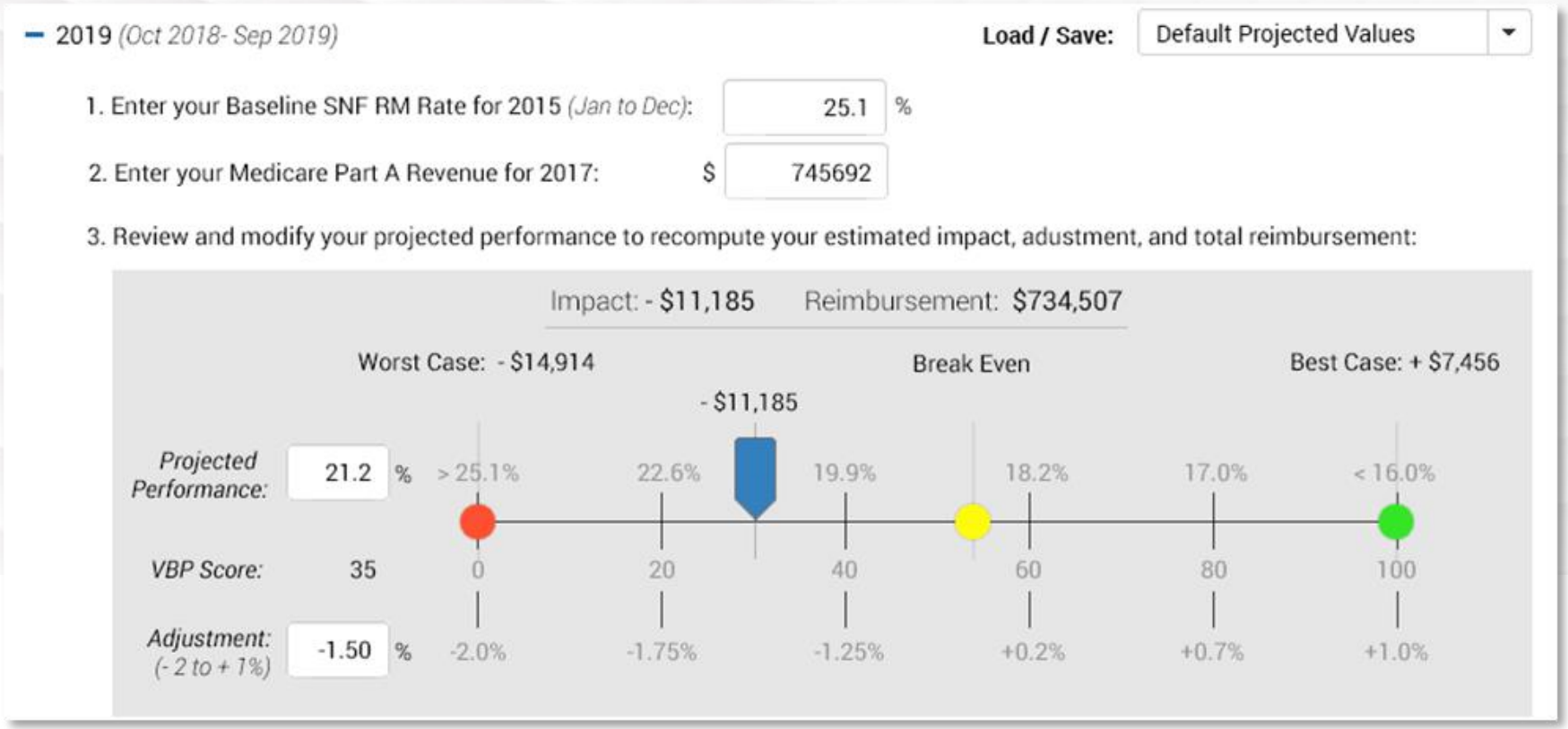


Note:

- formula is based on how large an incentive pool CMS has;
- Statute allows incentive to be between 50% to 70% of 2% estimated Total Part A payments for FY19
- Incentive pool is 60%

Know Your Payment Adjustment

- SNF VBP Predictor Tool planned for release in April 2018
- Tool will allow members to forecast their payment adjustment factor before CMS officially notifies providers in August



How can I get my Rehospitalization Rate?

SNF RM QIES Report

Your SNF's Performance on the Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) in 2015

Measure	Your SNF's Number of Eligible Stays	Your SNF's Number of Unplanned Readmissions*	Your SNF's Risk-Standardized Readmission Rate**	National Average Readmission Rate***
SNFRM	11	1	18.13%	19.00%

Source: Medicare claims and eligibility data from calendar year 2015.

* The number of stays at your SNF that were followed by an unplanned hospital readmission within 30 days of discharge from a prior proximal hospitalization.

** The risk-standardized readmission rate is your SNF's risk-adjusted rate of unplanned readmissions.

*** The national average readmission rate reported here is the average unadjusted unplanned readmission rate for all eligible SNF stays nationally.

QIES report also has ….

Tab 2. Facility Results

The second tab in the Supplemental Workbook (Facility Results) includes the following information calculated using index SNF stays with admission dates from January 1, 2015, through December 31, 2015.

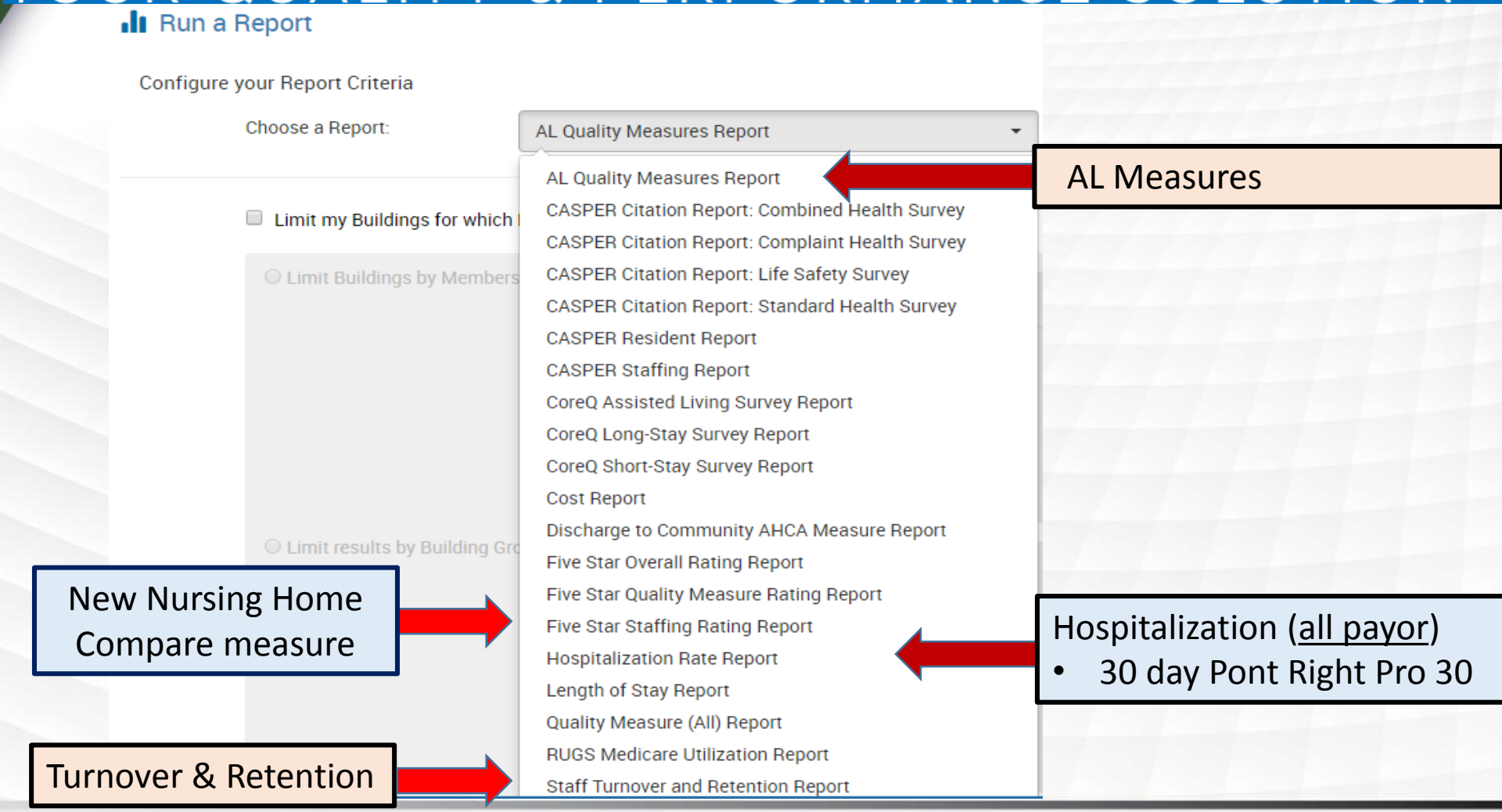
ROW NAME	DESCRIPTION
Your SNF's Number of Eligible Stays	The total number of SNF stays that met the inclusion criteria and were used to calculate your SNF's performance during this reporting period.
Your SNF's Number of Unplanned Readmissions	The total number of eligible SNF stays with an unplanned readmission during the 30-day readmission window.
Your SNF's Observed Readmission Rate	Your SNF's unadjusted rate of unplanned readmissions. This is calculated by dividing your SNF's total number of unplanned readmissions by your SNF's total number of eligible stays, and then multiplying by 100.
Your SNF's Predicted Number of Readmissions	The number of unplanned readmissions predicted based on your SNF's performance given your SNF's case mix.
Your SNF's Expected Number of Readmissions	The number of readmissions that would be expected if the patients at your SNF were treated at the average SNF.
Your SNF's Standardized Risk Ratio (SRR)	An indicator of your SNF's effect on readmission rates. It is calculated by dividing the predicted number of readmissions at your facility by the expected number of readmissions for the same patients if these patients had been treated at the average SNF. This is a ratio where values greater than 1.0 suggest a higher/worse than expected readmission rate and values less than 1.0 suggest a lower/better than expected readmission rate.
National Average Readmission Rate	The unadjusted readmission rate for all eligible SNF stays nationally. It is calculated by dividing the total number of unplanned readmissions for all SNFs by the total number of eligible stays for all SNFs, and then multiplying by 100.
Your SNF's Risk-Standardized Readmission Rate (RSRR)	Your SNF's risk-adjusted rate of unplanned readmissions. It accounts for patient-level risk factors such as clinical characteristics and comorbidities. It is calculated by multiplying your SNF's standardized risk ratio by the overall national raw readmission rate for all SNF stays.

But wait there is more…..

Tab 3. Eligible Stays

The third tab in the Supplemental Workbook (Eligible Stays) includes the following information for patients with index SNF stays who had admission dates from January 1, 2015, through December 31, 2015.

COLUMN	VARIABLE NAME	DESCRIPTION
Column B	ID Number	Unique identifier for each patient's SNF stay included in the worksheet. This is an arbitrary number generated strictly for the purposes of identifying SNF stays in the worksheet.
Column C	HICN	6- to 12-digit beneficiary Medicare health insurance claim (HIC) account number. Note: This is not the same as the Social Security Number.
Column D	Sex	The sex of the beneficiary.
Column E	Age	The age of the beneficiary at the time of SNF admission.
Column F	Admission Date of Index SNF Stay	Admission date for index SNF stay (DDMONYYYY).
Column G	Discharge Date of Index SNF Stay	Discharge date for index SNF stay (DDMONYYYY).
Column H	Index SNF Discharge Status Code	Destination to which the patient was discharged. See the ResDAC site for information regarding the coding of this variable: http://www.resdac.org/cms-data/variables/patient-discharge-status-code.
Column I	Prior Proximal Hospital CCN	CMS Certification Number (CCN) of the prior proximal hospital from which the SNF patient was discharged.
Column J	Admission Date of Prior Proximal Hospital Stay	Admission date for prior proximal hospital stay (DDMONYYYY).



AL Measures

New Nursing Home Compare measure

Hospitalization (all payor)
- 30 day Pont Right Pro 30

Turnover & Retention

New Survey & Regulations

What You need to know

- Lots of changes; no single big change
- Read the RoP - 22 pages in Federal register, or
  - redline version of RoPs from red book
- Review the tone and emphasis in your communication to Centers and staff
- Emphasize decrease in complexity and detail
  - Allow flexibility to implement
  - opportunity to simplify
- Prepare staff & residents to be observed and interviewed

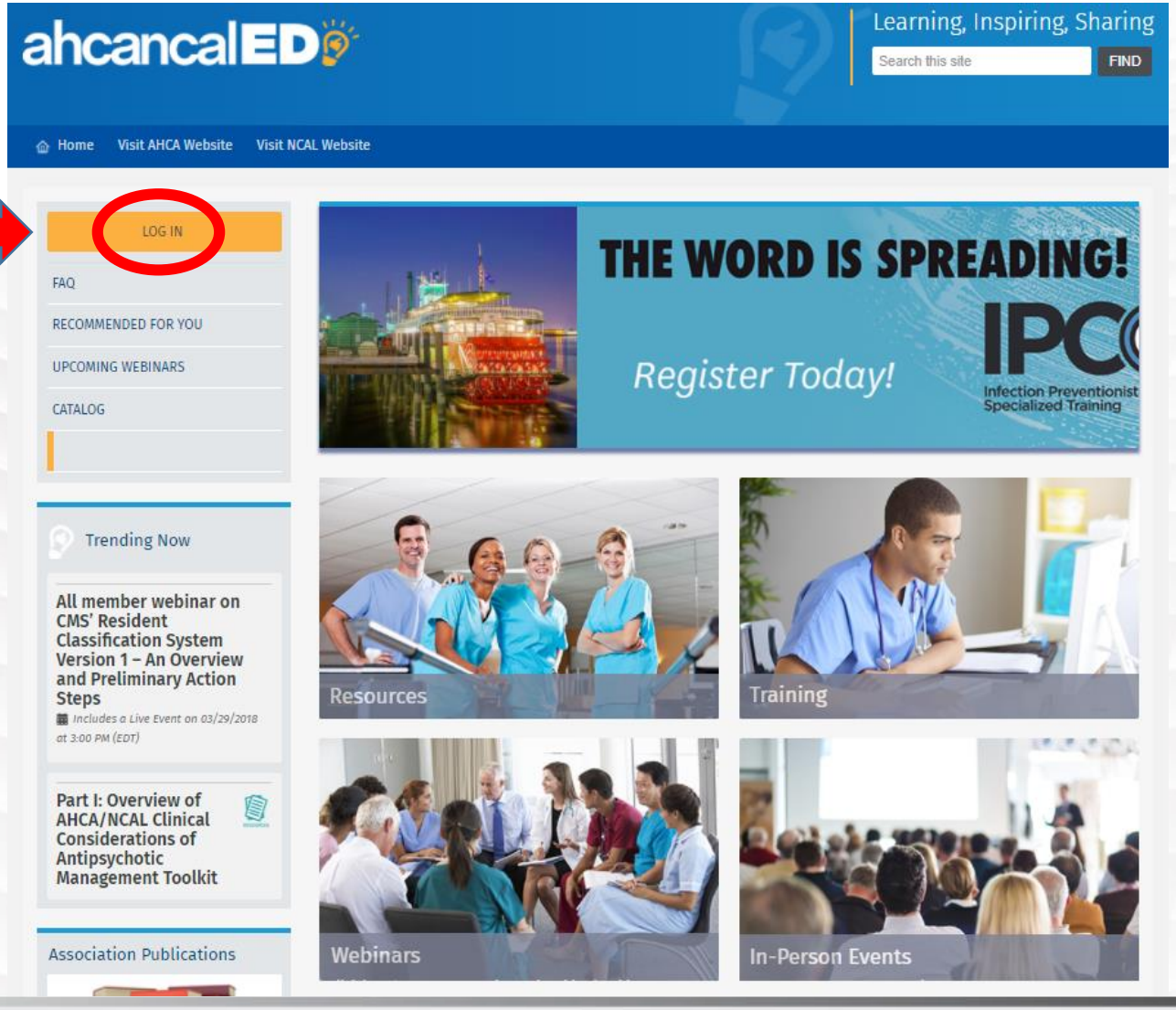
LTC Survey Subscription with Updates

Through November 2019

Order Now:

[AHCA Bookstore]

https://educate.ahcancal.org/



New Survey Process

- Modeled after QIS process with elements of traditional survey
- Based on new interpretive guidance in the SOM
- Emphasizes observation of care and resident interviews
- Relies on Critical Element Pathways
  - Computer- and software-based with investigative pathways updated with the new RoP

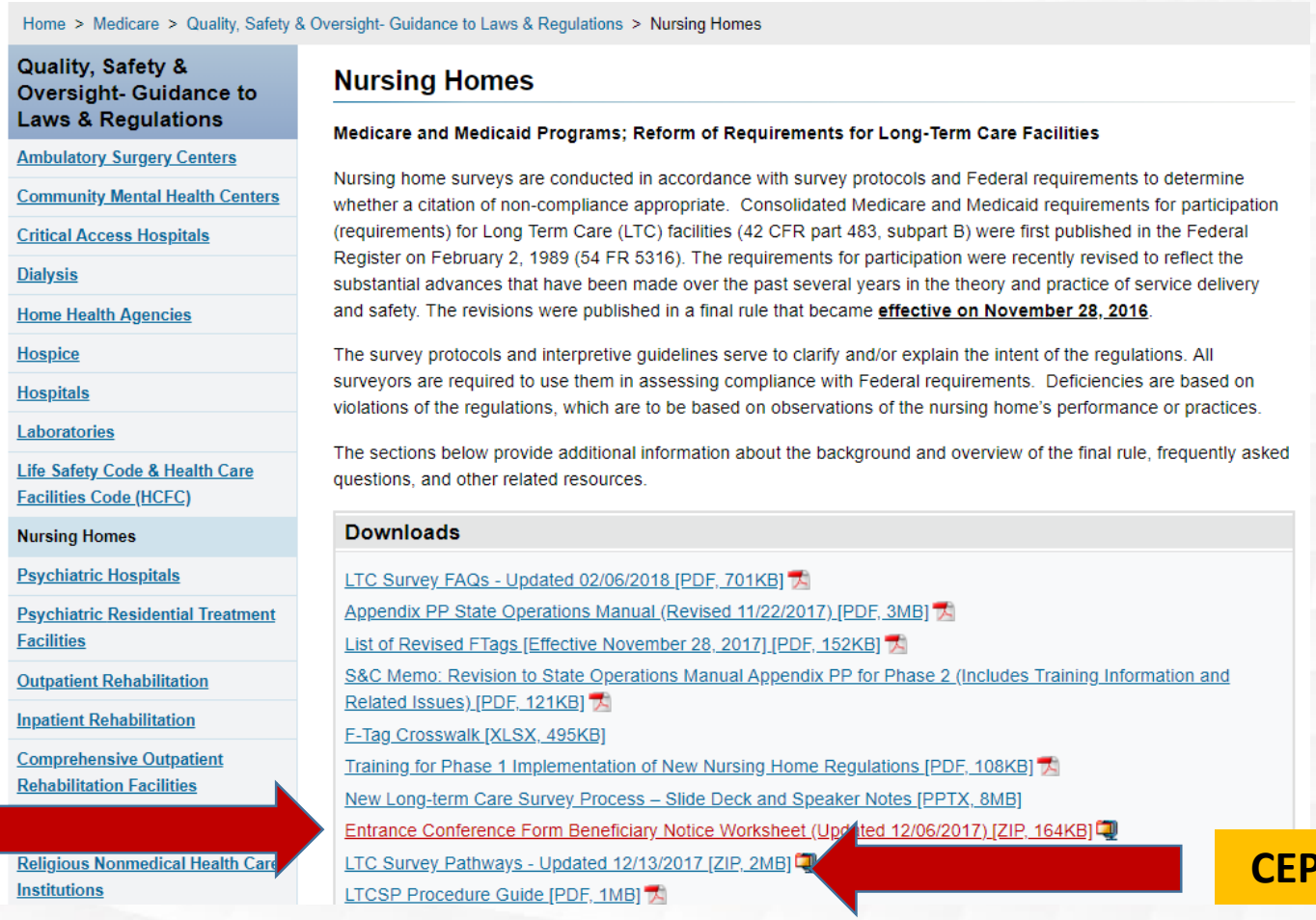
Mandatory CEPs

- Dining
- Infection Control
- SNF Beneficiary Protection Notification Review
- Kitchen Observation
- Medication Administration and Medication Storage
- Resident Council Meeting
- Sufficient and Competent Nurse Staffing Review
- Environment

Questions about new Survey process

- Do we have the information/documents needed to give surveyors upon entry, within 1 and 4 hours?
- How are we preparing staff to be observed providing care?
- How are we preparing staff to be interviewed about “how they do…”?
- Have we reviewed the CEPs the surveyors will use and updated out mock survey to be c/w the CEPs?
- Do the administrators have a copy of the regulations, IGs and CEPs handy to ask surveyors for clarification during the survey?

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html



Entrance Matrix

CEPs

Background Info Needed on Day #1

Material Needed within ONE Hour of Entrance

- Schedule of meal times
- Schedule of med administration times
- # & location of med storage rooms
- Actual work schedules of LPN & RNs

Material Needed within ONE Hour of Entrance

- List of key personnel, location and phone #
- If paid feeding assistants
  - 8 hours training by state approved program
  - Names of all staff completed training
  - List of residents who are eligible for FA

Material Needed within FOUR Hours of Entrance

- Complete Matrix of residents – new form
- Admission packet for new admissions
- Dialysis
  - Contracts, P&P about dialysis
  - List of qualified staff to perform dialysis
  - Transportation agreements to dialysis
  - Do you perform on-site dialysis

Material Needed within FOUR Hours of Entrance

- Hospice
  - agreements, P&P and
  - staff who oversees hospice contract
- Influenza/pnuemovax P&P
- Abuse Prohibition P&P

Material Needed within FOUR Hours of Entrance

- Infection Prevention Plan
- Facility assessment
- QAPI plan
- QAA committee
- Description of any experimental research occurring in the facility
- Nurse staffing waivers

Material Needed within FOUR Hours of Entrance

- List of rooms meeting any of the following:
  - Less than required square footage
  - More than four residents to room
  - Below ground level
  - No window to the outside
  - No direct access to an exit corridor

Materials Needed within 24 Hours of Entrance

- Form 671 – completed Medicare/Medicaid application
- Form 672 – completed census and condition information
- Beneficiary notice- residents discharged within the last six months

Trend in Citations

Top Tags in US :2007 – 2016

Year & % SNFs with tag	323	441	371	309	279	514	329	281	241
% SNF with tag	37.8	34.2	31.5	30.4	21.9	18.4	19.4	20.7	16.4
Avg rank	2	3	4	4	6	8	8	8	10
# times in top 10	10	10	10	10	10	10	9	7	6
# times in top 20	10	10	10	10	10	10	10	10	10

F-tag #	Description	F-tag #	Description
323	Facility free of Accidents (Falls)	514	Clinical records meet professional standards
441	**Infection control**	329	Free from unnecessary drugs
371	Sanitary food prep/distribution/storage	281	Services provided met professional stds
309	Necessary Care for Highest practical Well being	241	Dignity
279	Develop comprehensive care plan		

Since Nov 28th 2017

Tag #	Tag Description	Nation (N=15,677) # Citations	New Jersey (N=220) # Citations
F0880	Infection Prevention & Control	772	20
F0689	Free of Accident Hazards/Supervision/Devices	655	8
F0656	Develop/Implement Comprehensive Care Plan	618	19
F0812	Food Procurement, Store/Prepare/Serve Sanitary	517	18
F0684	Quality of Care	439	9
F0657	Care Plan Timing and Revision	396	9
F0761	Label/Store Drugs and Biologicals	367	8
F0550	Resident Rights/Exercise of Rights	335	8
F0686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	311	3
F0677	ADL Care Provided for Dependent Residents	304	1
F0641	Accuracy of Assessments	301	9
F0758	Free from Unnec Psychotropic Meds/PRN Use	293	7
F0755	Pharmacy Srvcs/Procedures/Pharmacist/Records	279	9
F0842	Resident Records - Identifiable Information	277	4
F0690	Bowel/Bladder Incontinence, Catheter, UTI	266	4
F0658	Services Provided Meet Professional Standards	252	22
F0584	Safe/Clean/Comfortable/Homelike Environment	232	6
F0609	Reporting of Alleged Violations	213	2
F0580	Notify of Changes (Injury/Decline/Room, etc.)	212	1
F0610	Investigate/Prevent/Correct Alleged Violation	193	3

Scope & Severity of Tags

Region	Deficiencies by Scope & Severity											
	B	C	D	E	F	G	H	I	J	K	L	Total
(I) Boston	51	19	759	223	62	64	4	0	16	4	0	1,202
(II) New York	34	10	736	191	34	11	0	0	3	0	0	1,019
New Jersey	25	1	332	93	26	3	0	0	2	0	0	482
New York	9	9	404	98	8	8	0	0	1	0	0	537
(III) Philadelphia	53	48	1,717	738	120	51	2	0	8	7	0	2,744
(IV) Atlanta	40	77	2,709	518	214	79	4	0	101	37	8	3,787
(V) Chicago	44	228	5,675	1,342	592	324	5	0	54	16	7	8,287
(VI) Dallas	69	66	577	2,277	525	63	24	0	38	101	31	3,771
(VII) Kansas City	16	53	1,344	654	203	97	3	0	21	6	5	2,402
(VIII) Denver	11	14	539	294	34	38	2	0	0	0	2	934
(IX) San Francisco	131	18	2,924	1,202	149	82	2	0	7	2	9	4,526
(X) Seattle	12	207	1,134	420	75	135	10	0	22	14	1	2,030
National Total	**461**	**740**	**18,114**	**7,859**	**2,008**	**944**	**56**	**0**	**270**	**187**	**63**	**30,702**

CMPs FY 2018

Year Type: Fiscal Year ▼ **Year:** 2018 ▼ C

Region	Total Number of CMPs	
	Per Diem	Per Instance
(I) Boston	10	23
(II) New York	3	10
New Jersey	2	7
New York	1	3
(III) Philadelphia	7	20
(IV) Atlanta	43	71
(V) Chicago	7	16
(VI) Dallas	32	90
(VII) Kansas City	9	38
(VIII) Denver	6	11
(IX) San Francisco	12	35
(X) Seattle	26	23
National Total	**155**	**337**

Infection Control

§ 483.80 Infection control

- Infection control program must have
  - A plan
  - Antibiotic stewardship program
  - Infection preventionist
  - A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility

Antibiotic Stewardship

Components of Antibiotic Use Protocols

- Correct antibiotic
  - antibiotic susceptibility patterns (i.e.: center antibiogram)
- Correct Indication for antibiotic
  - McGreer Criteria
- Antibiotic being monitored
  - Drug-drug interactions (e.g. Coumadin)
  - Drug levels
  - Side effects and allergic reactions

Monitoring isn't enough

"You can't fatten a cow by weighing it."*

--Ancient Proverb

McGeer Criteria for UTI (no catheter)

Both criteria 1 AND 2 must be present

1. At least 1 of the following sign or symptom subcriteria (a, b or c)
    a. Acute dysuria or acute pain, swelling, OR tenderness of the testes, epididymis, or prostate;
    b. Fever OR leukocytosis AND at least **1 of the following** localizing urinary tract subcriteria (b)
        i. Acute costovertebral angle pain or tenderness
        ii. Suprapubic pain
        iii. Gross hematuria
        iv. New or marked increase in incontinence
        v. New or marked increase in urgency
        vi. New or marked increase in frequency
    c. In the absence of fever or leukocytosis, then **2 or more** of the following localizing subcriteria
        i. Suprapubic pain
        ii. Gross hematuria
        iii. New or marked increase in incontinence
        iv. New or marked increase in urgency
        v. New or marked increase in frequency
2. One of the following microbiologic subcriteria
    a. At least 105 cfu/mL of no more than 2 species of microorganisms in a voided urine sample; OR
    b. At least 102 cfu/mL of any number of organisms in a specimen collected by in-and-out catheter.

Infect Control Hosp Epidemiol 2012;33(10):965-977

Resources for Antibiotic Stewardship Program

- Antibiotic Stewardship Fact Sheets for Residents & Families
  - https://www.cdc.gov/longtermcare/prevention/antibiotic-stewardship.html
- Creating a Culture to Improve Antibiotic Use in Nursing Homes
  - https://www.cdc.gov/longtermcare/pdfs/Factsheet-Core-Elements-Creating-Culture-Improve-Use.pdf
- Leadership – what can Medical Director, DON and Consultant Pharmacist do:
  - https://www.cdc.gov/longtermcare/pdfs/Factsheet-Core-Elements-Leading-Antibiotic-Stewardship.pdf

Care Plan Changes

48-Hour Baseline Care Plan

- Minimum of 6 key elements:
  - Initial goals based on admission orders
  - All physician orders, including medications and administration schedule
  - Dietary orders
  - Therapy services
  - Social services
  - PASARR recommendations, if PASARR completed
- Need to share a copy with resident & resident representative

Comprehensive Care Plan

- Content needs to include:
  - **measurable objectives and timeframes** to meet resident's needs (medical, nursing, mental and psychosocial) as identified in the comprehensive assessment
  - **Describe at a high level services to be provided as well as resident's goals and preferences**
  - Summary of
    - **Resident's strengths**
    - **Goals & desired outcomes**
    - **Life history**
    - **personal and cultural preferences**
    - **PASARR findings, and**
    - **specialized services needed**
- Needs to be consistent with the resident rights set forth in the RoPs (section 483.10(c))

SNF Quality Reporting Program (QRP)

PAC Transformation

IMPACT Act of 2014 has five parts :

1. Standardized assessment elements across PAC settings
2. Public reporting of common quality measures
3. Provide quality measures to consumers when transitioning to a PAC provider
4. HHS and MedPAC to conduct several studies & provide reports to Congress on linking payment to quality
5. $11 million in funding for SNF staffing data collection

Standardized measures from standardized data across PAC settings – SNF, IRF, LTCH, HH

SNF QRP Measures….

Measure Categories in Statute

- Rehospitalizations
- Discharge to community
- Pressure ulcers
- Medication reconciliation
- Incidence of major falls
- Functional Status
- Patient preferences
- Efficiency measure(s): Avg Total Medicare Spend per Beneficiary
- NQF Endorsement Required
  - Plus any other measures Secretary wants

Specified in FY 2016 & 2017 SNF PPS Final Rule

MDS based:

- New or worsening pressure ulcers
- Falls with injury
- Functional assessment at admission and discharge with goals
- Drug regimen review (10/1/18)

Claims based:

- SNF Potentially Preventable rehospitalization after SNF discharge
- Discharge to community
- Total Medicare Spend per beneficiary

SNF QRP Measures….

- Specified in FY 2018 SNF PPS Final Rule
  - Functional Outcome – MDS based (data collection begins 10/1/18)
    - Application of the Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)
    - Application of the Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)
    - Application of the Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (National Quality Forum [NQF] #2633)
    - Application of the Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)

SNF QRP Measures – Public Posting October 2018

*Anticipated on Nursing Home Compare

MDS-based quality measures:

- Pressure Ulcers That Are New or Worsened (Short Stay)
- Completion of Admission and Discharge Functional Assessment and a Care Plan that Addresses Function
- One or More Falls with Major Injury (Long Stay)

Claims-based quality measures:

- Total Estimated Medicare Spending Per Beneficiary (MSPB) Measure
- Discharge to Community-Post Acute Care– SNF QRP
- Potentially Preventable 30-Day Post Discharge Readmission Measure

Reporting Requirement & Penalty

- 80% of MDS assessments submitted during period must have 100% of the necessary data to calculate the SNF QRP measures
  - Specifications table: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-QRP-APU-Table-for-Assessment-Based-Measures-for-FY2019_8-18-17-FINAL.pdf
- If not, 2 percentage point reduction in the annual payment update (APU) for applicable Fiscal Year
  - FY 2018 (starting October 1, 2017) impact for Q416 data
  - FY 2019 (starting October 1, 2018) impact for Q117-Q417 data
  - May request for reconsideration

SNF QRP Measures – Submission Deadline

MDS-based quality measures:

- Data submission deadline for CY 2017 extended to 5/15/18
- If reporting threshold not met, 2 percentage point reduction in the annual payment update (APU) for FY19

- Review & Correct and Confidential feedback reports available now in CASPER for all SNF QRP measures
  - Use them to assist in your internal monitoring processes

Pay attention to Section GG

Ensure discharge MDS are submitted timely

SNF QRP Updates from CMS

- Check Spotlight & Announcements

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Spotlights-and-Announcements.html

CoreQ Overview

CMS Considering CoreQ

- CMS has indicated that they plan to add the collection of CoreQ in the future to SNF QRP.
  - Likely see in next years rule, requirements to collect and submit CoreQ data to CMS to be added to Nursing Home Compare

CoreQ Satisfaction

- AHCA/NCAL develop a short, reliable and valid questionnaire that could be added to existing survey instruments or used by itself to collect information to measure satisfaction
- The CoreQ measures were endorsed by the National Quality Forum (NQF)
- There are five center-level satisfaction measures
  - SNF short stay discharges
  - NF long stay residents
  - NF long stay family
  - Al residents
  - Al family

http://www.coreq.org/

Core questions

1. In recommending this facility to your friends and family, how would you rate it overall?
2. Overall, how would you rate the staff?
3. How would you rate the care you receive?

Additional question for:

- Short Stay: How would you rate how well your discharge needs were met?
- AL: How Overall, how would you rate the food?

- Likert scale (1-5): Poor, average, Good, Very Good, Excellent

http://www.coreq.org/

Vendors who use CoreQ

- Align
- Bivarus, Inc
- Brighton Consulting Group
- Cortex Health Inc.
- The Doug Williams Group, Inc. Healthcare Academy (ReadyQ)
- Holleran
- Lighthouse Care Updates
- inQ Experience Surveys
- Market Research Answers (CareSat)
- NRC
- Pinnacle
- Providigm/abaqis
- Sensight Surveys
- Service Trac

http://www.coreq.org/

Changes to Five Star

Changes in 2018

- Froze Survey Component for 12 months for any survey STARTED after Nov 28th, 2017.
  - Will update survey component in Spring of 2018 using only last two cycles
  - No freeze on staffing or quality measures component
- Will replace staffing measures with PBJ measures in Spring 2018.

Overall Scoring Methodology

Step 1: Initial star rating based on State ranking on your Survey Score

Step 2: Add or subtract one Star based on Staffing component

- ✓ Subtract 1 star if staffing rating is 1 star
- ✓ Add 1 star if staffing is 4 or 5 stars & > Survey rating

Step 3: Add or subtract 1 Star based on QM component

- ✓ Subtract 1 star if QM rating is 1 star
- ✓ Add 1 star if QM rating is 5 stars

✓ Note: If you are one star on the survey component; you can only add 1 star

Survey Component of Five Star

Survey Component Methodology

Step 1: Calculate weighted 3 year average survey score

Step 2: Rank all centers within each state based on their scores

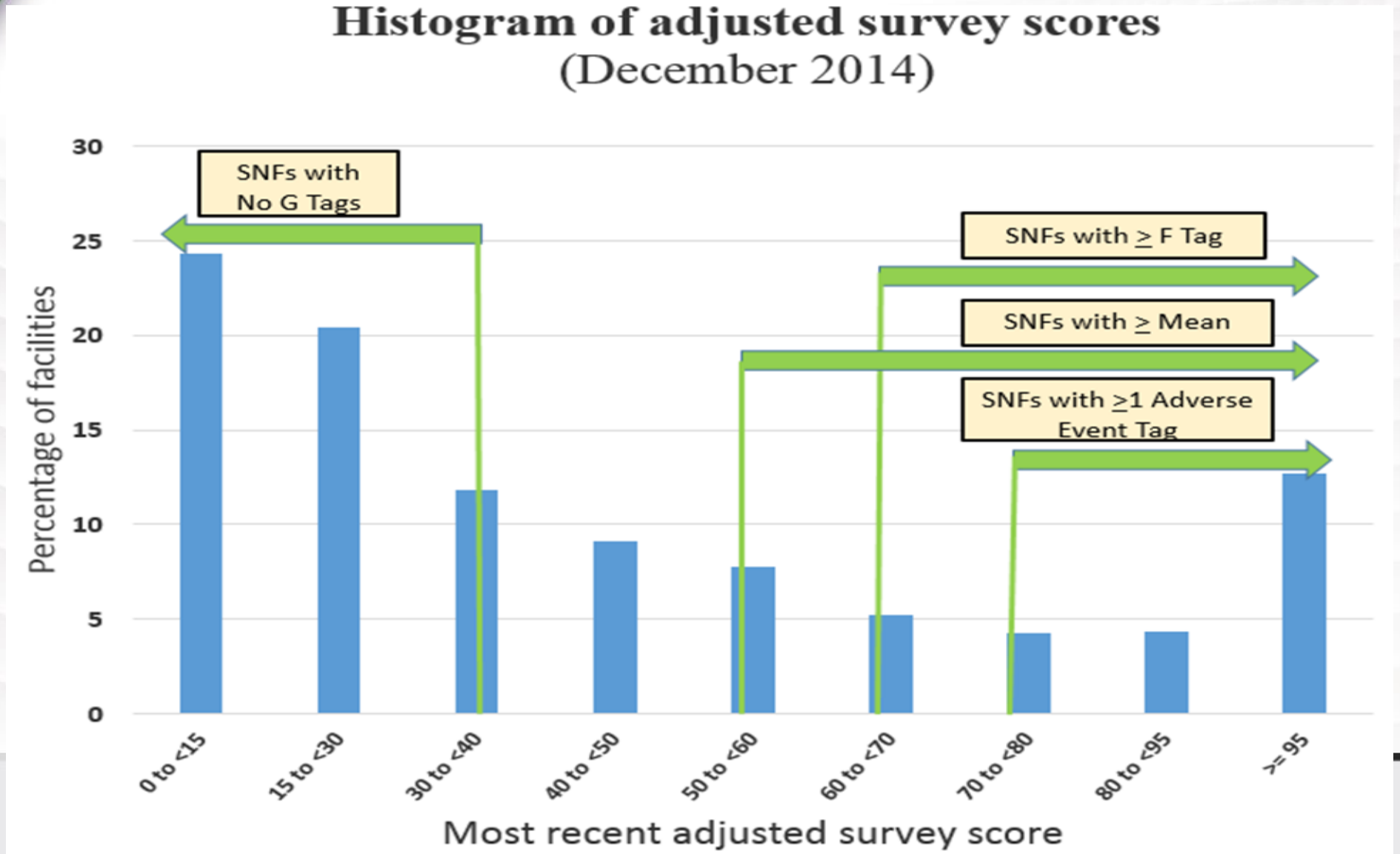
Step 3: Assign one to five stars based on forced distribution of ranking within each state because variation between states is so large and unrelated to quality.

How is Survey Score Calculated?

Table 1
Health Inspection Score: Weights for Different Types of Deficiencies

Severity	Scope		
	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	**J** 50 points* (75 points)	**K** 100 points* (125 points)	**L** 150 points* (175 points)
Actual harm that is not immediate jeopardy	**G** 20 points	**H** 35 points (40 points)	**I** 45 points (50 points)
No actual harm with potential for more than minimal harm that is not immediate jeopardy	**D** 4 points	**E** 8 points	**F** 16 points (20 points)
No actual harm with potential for minimal harm	**A** 0 point	**B** 0 points	**C** 0 points

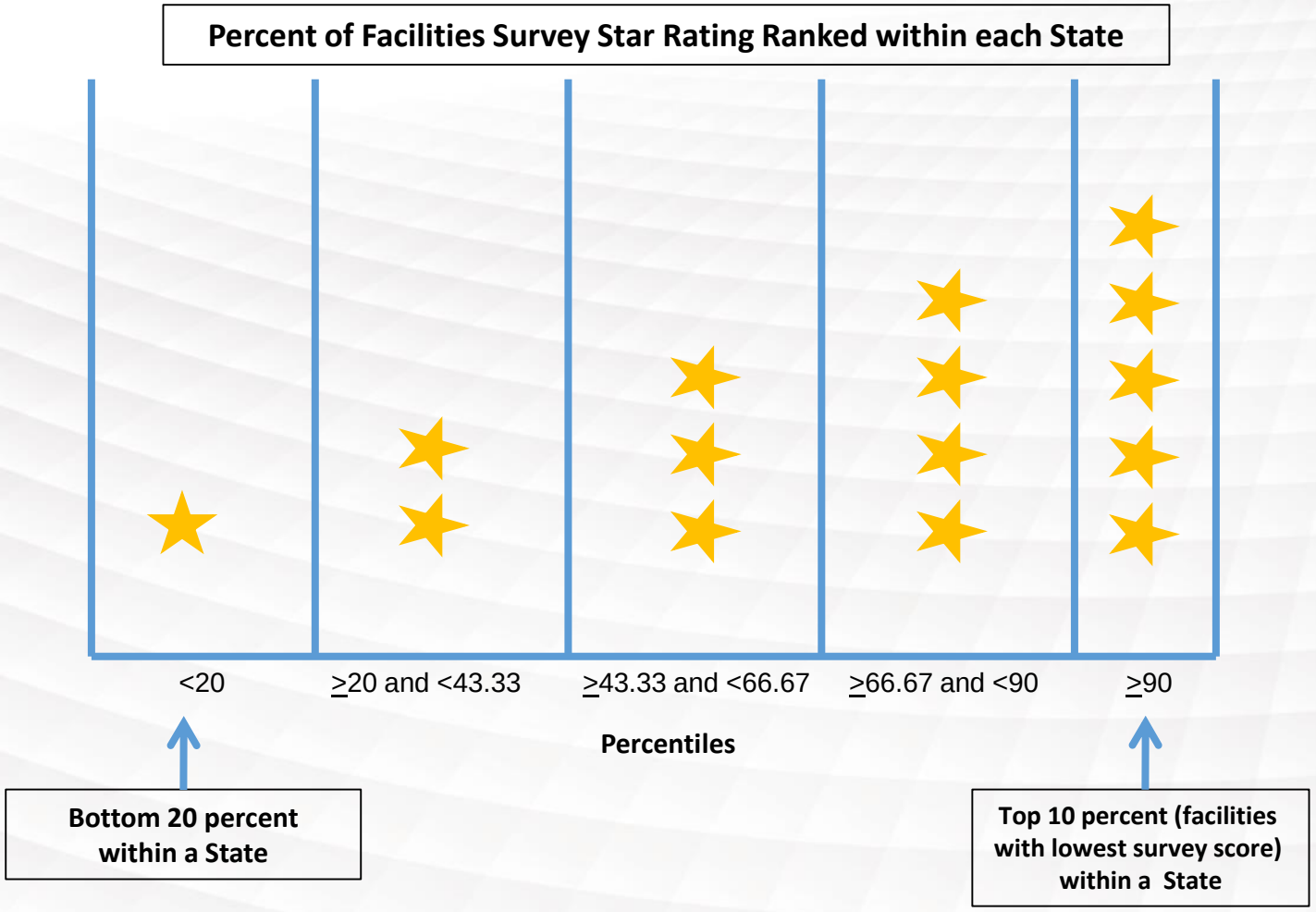
Distribution of Member's Survey Scores



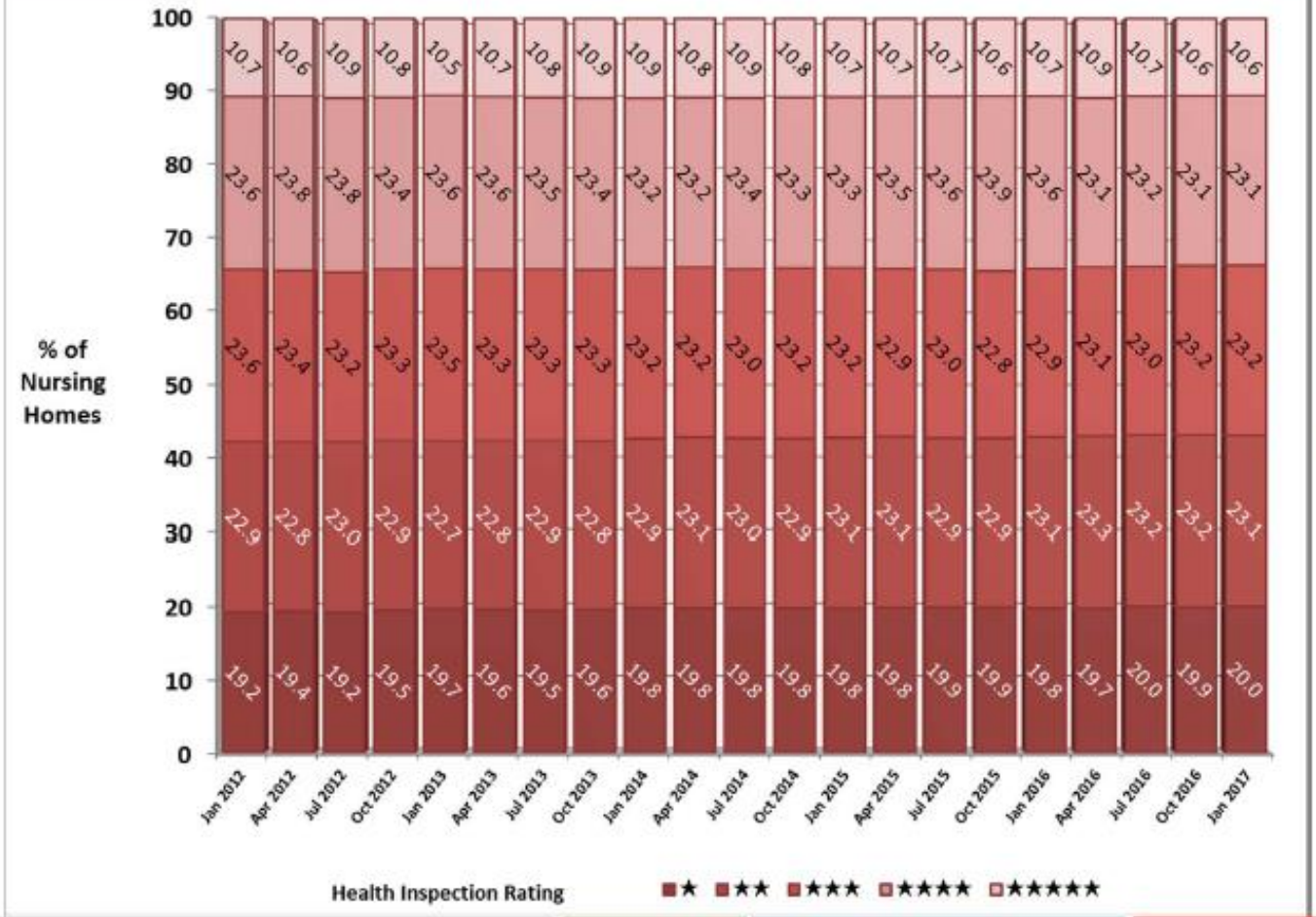
Survey Score

		Weighting Current	Weighting March 2018
▪ Cycle 1	Most recent standard survey + All complaint surveys in prior (1-12 months)	50%	60%
▪ Cycle 2	Prior standard survey + All complaint surveys in prior (13 - 24 months)	33%	40%
▪ Cycle 3	Prior to cycle 2 standard survey + All complaint surveys in prior (25 - 36 months)	12.5%	0%

Survey Component Star Rating



Distribution of Health Inspection Ratings: 2012-2017



Note: By design, the distribution of health inspection ratings is fixed.

Staffing Component of Five Star

Rating Methodology – Staffing Component

Step 1: Calculate risk adjusted staffing based on RN and total Direct Care Staff (DCS) levels

Step 2: Compare to risk adjusted cut-points to assign stars for RN and for DCS

Step 3: Compare the RN and DCS staff ratings to assign a Staffing component star rating

Staffing Scoring Matrix

Staffing Points and Rating (updated February 2015)

RN rating and hours		Total nurse staffing rating and hours (RN, LPN and nurse aide)				
		1	2	3	4	5
		<3.262	3.262 – 3.660	3.661 – 4.172	4.173 – 4.417	≥4.418
1	<0.283	★	★	★★	★★	★★★
2	0.283 – 0.378	★	★★	★★★	★★★	★★★
3	0.379 – 0.512	★★	★★★	★★★	★★★★	★★★★
4	0.513 – 0.709	★★	★★★	★★★★	★★★★	★★★★
5	≥0.710	★★★	★★★	★★★★	★★★★	★★★★★

Loose 1 Star

Add 1 Star

PBJ Measures

- RN HPPD – Nurse RN Hours Per Patient Day
- Total Nurse HPPD - Total Nurse Staffing (RN, LPN & CNA) Hours Per Patient Day
- PT HPPD – Physical therapist Hours Per Patient Day

PBJ Measure Methodology

- Calculate Average Staff Hours
  - Sum hours paid each day and divide by total # of days
- Calculate Average Census
  - Sum daily Census for each day and divide by total # days
- Calculate HPPD
  - Divide Avg Staff Hours by Avg Daily Census
- Risk Adjust
  - Compare Measured HPPD vs the expected HPPD

Data Errors Impacting PBJ

- Census is off
  - Based on admission and discharge MDS
- Hours reported incorrectly for a day
  - Zero hours
  - Outside national range (<1.5 and > 14 HPPD)

Potential Penalties

CMS will force your Staff Star Rating to ONE star IF:

- Fail to submit ANY data for quarter
- ZERO RN hours for >7 days in the quarter

Quality Measure Component of Five Star

Rating Methodology – QM Component

Step 1: Assign 20, 40, 60, 80 or 100 points for each QM based on QM rate against a set of threshold cut-points

Step 2: Add up points for all 16 QMs

Step 3: Compare Aggregate score of 16 QMs against threshold cut-points to assign Stars

QM Rates and Points

Measures		QM Rates to Achieve Points				
		100	80	60	40	20
Short Stay	Pain	< 7%	< 13%	< 19%	< 26%	>26%
	Pressure Ulcers[1]	0%	< 0.7%	< 1.6%	>1.6%	
	Antipsychotic Meds	0%	< 1%	< 2%	< 3.5%	>3.5%
	Functional Improvement	> 82%	> 71%	> 63%	> 52%	>52%
	Rehospitalization	< 14%	< 19%	< 22%	< 26%	>26%
	ED Visits	< 5%	< 9%	< 12%	< 16%	>16%
	Community Discharge	> 66%	> 60 %	> 55%	> 48%	<48%
Long Stay	ADL Decline	< 10%	< 13%	< 17%	< 21%	>21
	Pain	< 2%	< 5%	< 8%	< 13%	>13%
	Pressure Ulcers	< 3%	< 4%	< 6%	< 9%	>9%
	Catheter	< 1%	< 2%	< 3%	< 5%	>5%
	UTI	< 2%	< 3%	< 5%	< 8%	>8%
	Restraints[2]	0%	< 1%		>1%	
	Falls	< 1%	< 2%	< 4%	< 5%	>5%
	Antipsychotic Meds	< 7%	< 13%	< 17%	< 24%	>24%
	Mobility Decline	< 8%	<14%	< 19%	< 25%	>25%

[1] SS pressure ulcers points have only 4 categories 100, 75, 50 and 25

[2] LS restraints points have only 3 categories 100, 60,20

QM Rates and Points

Measures		QM Rates to Achieve Points				
		100	80	60	40	20
SS	Pain	< 7%	< 13%	< 19%	< 26%	>26%
	Pressure Ulcers[1]	0%	< 0.7%	< 1.6%	>1.6%	
	Antipsychotic Meds	0%	< 1%	< 2%	< 3.5%	>3.5%
LS	Pain	< 7%	< 13%	< 17%	< 24%	>24%
	Pressure Ulcers[1]	0%	< 0.7%	< 1.6%	>1.6%	
	Restraints[2]	0%	< 1%	< 2%	>2%	
	Antipsychotic Meds	< 7%	< 13%	< 17%	< 24%	>24%
	Mobility Decline	< 8%	<14%	< 19%	< 25%	>25%

[1] SS pressure ulcers points have only 4 categories 100, 75, 50 and 25

[2] LS restraints points have only 3 categories 100, 60,20

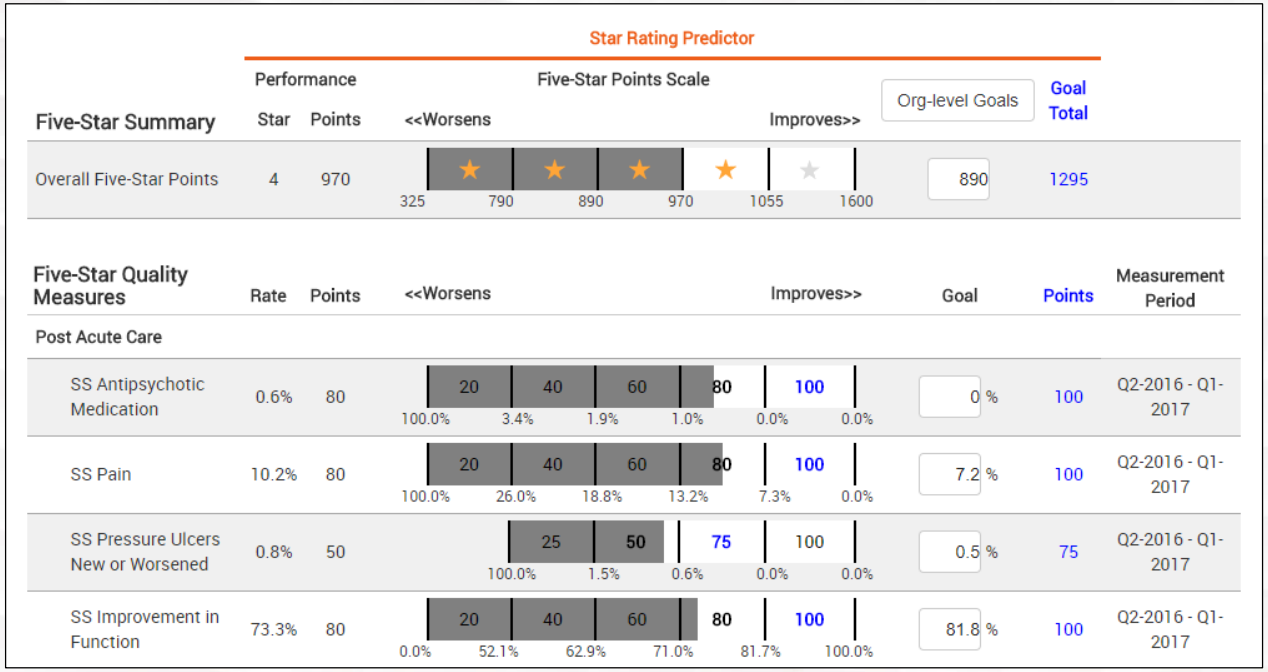
Table 2. Quality Measure Five Star Rating

STARS	POINTS to Achieve Star	Avg Points per QM
*	325 to 789	NA
**	790 to 889	49
***	890 to 969	56
****	970 to 1054	61
*****	1055 to 1600	66

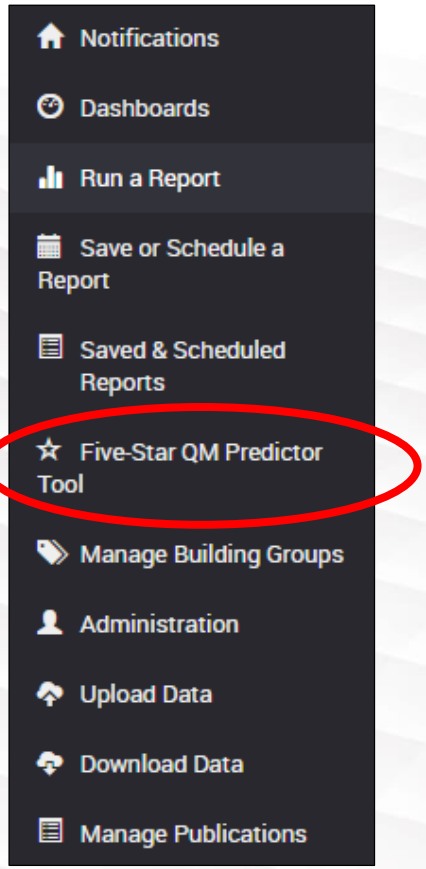
Five-Star Quality Measure Predictor Tool

LTC Trend Tracker: Five-Star Quality Measure (QM) Predictor Tool

- This online tool helps you see how close you are to gaining or losing points on each measure and model various scenarios

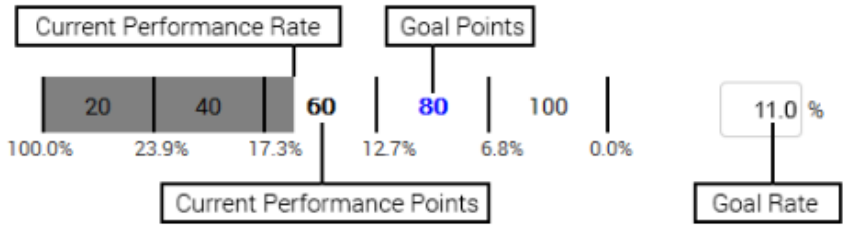


LTC Trend Tracker: Five-Star QM Predictor Tool



How to read this table:

The example LS Antipsychotic performance rate is currently 17.0% (indicated by the horizontal bar), which contributes 60 points to the total QM domain score (indicated by bold font). The percentages listed between point categories are the rate cut-points defined for that measure. When a goal rate is set for a measure, the corresponding points will be indicated by blue text. The example LS Antipsychotic goal was set to 11.0%, which would contribute 80 points to the total QM domain score.



Quality Initiative

Quality Initiative 2.0

	% of Members Achieving Goal		
	2015Q4	2016Q1	2017Q3
Organizational			
▪ Satisfaction[3]	5.6%	9.7%	18.7%
▪ Staff turnover over (<40% or -15)	5.3%	5.3%	8.1%
▪ Unintended healthcare Outcomes	--	--	--
Short Stay			
▪ Rehospitalization (<10% or -30%)[1,2]	19.0%	19.6%	22.2%
▪ DC to Community (>70% or -15%)[2]	28.6%	33.9%	39.2%
▪ Functional Improvement[2] (>75% or +10%)	--	--	54.5%
Long Stay			
▪ Hospitalization[4] (<10% or -15%)	36.1%	38.0%	37.9%
▪ Antipsychotic Use (-30%)	50.5%	52.6%	56.8%

TXT = included in Five Star
TXT = included in PBJ
TXT = included in new RoPs

[1] included in SNF VBP
[2] included in SNF QRP
[3] included in Hospital VBP
[4] MedPAC recommends adding to Five Star and SNF VBP

Members notified of their progress and
High achievers will be recognized at 2018 Quality Summit

AHCA Quality Initiative 3.0

- Announce at Quality Summit in March 2018

Goal	Measure	Where Available
Reduce Hospitalization	Pro30 for Short-Stay ProLS for Long-Stay	LTC Trend Tracker
Increase Customer Satisfaction	Core Q for Short-Stay Core Q for Long-Stay	LTC Trend Tracker
Reduce Off-Label use of Antipsychotics	Anti-Psychotic QM SS Anti-Psychotic QM LS	Nursing Home Compare/ LTC Trend Tracker
Improve Functional Improvement (Self-Care and Mobility)	AHCA Functional Improvement Measure (Self-Care and Mobility)	LTC Trend Tracker

Pursue AHCA/NCAL Quality Award Program

4 out of 10 Members Recognized

Totals From The Quality Award Program 2007-2016

BRONZE

Commitment to Quality

3,721 *total awards*

SILVER

Achievement in Quality

512 *total awards*

GOLD

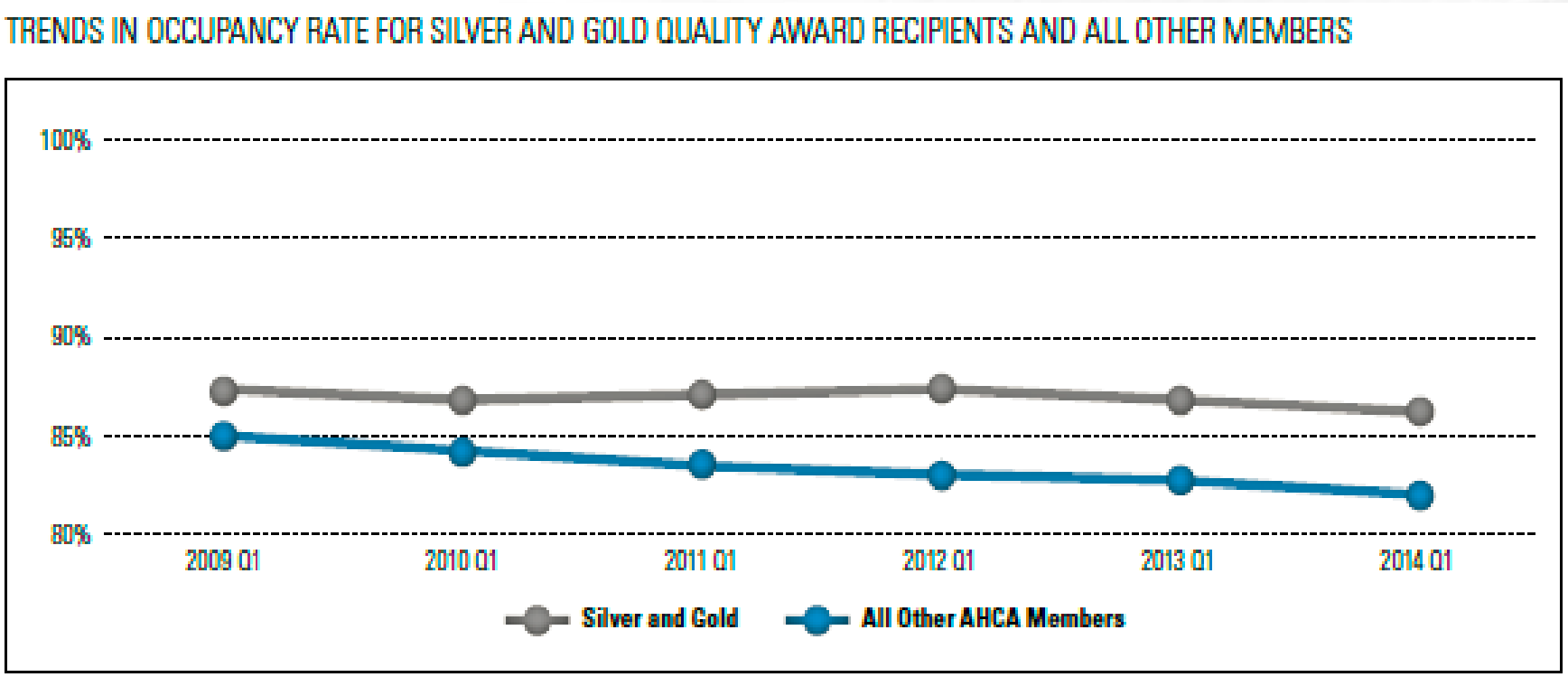
Excellence in Quality

28 *total awards*

Business Advantage for Silver & Gold

iii. Financial data from FY2015 CMS Cost Reports. Operating Margin = (Operating Revenue – Operating Expenses) / Operating Revenue x 100. Bad Debt = Total Liabilities / Total Assets X 100. Occupancy Rate = Total Patient Days / Total Available Bed Days X 100. Performance diff¬erence is statistically significant ($p<0.05$) for all measures.

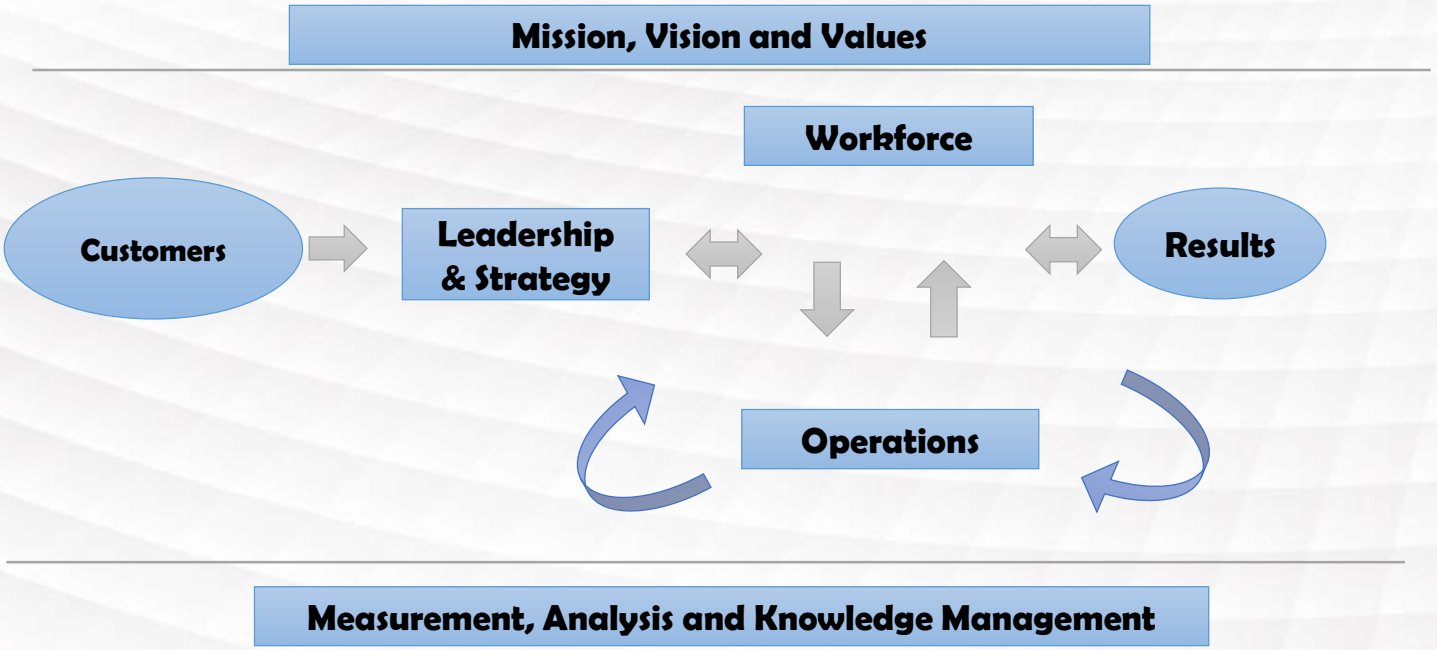
Occupancy Higher in Silver & Gold



States Recognizing QA recipients

- Medicaid VBP program
  - Florida
  - Utah
  - Tennessee
- State Quality Improvement requirements
  - Ohio

Integrated Management System
(Framework for Performance Excellence)



Dates and Deadlines

- August: Applications Published
- November: ITA Deadline
- Jan-Feb: Application Deadline
- Early Summer: Gold Site Visits
- Summer: Notification
- October: Recognition at AHCA/NCAL Convention

Quality Award Website

- All applicants should start with the Quality Award website: www.ahcancal.org/qualityaward
- Distinct websites for Bronze, Silver and Gold
- Contain application packet and resources
- All users need a log-in and password
  - Don't have one? Having trouble accessing the website? Email us at qualityaward@ahca.org.