New SNF Quality Measures
Strategies to Boost your Facility Performance
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Objectives
• Understand the measure specifications for the new quality measures
• Identify ways for all staff to safely incorporate mobility programs into daily programming
• List critical ADL and discharge planning elements facilities should address to ensure safe and successful discharge to community

New Quality Measures
• Short-stay successfully discharged to the community
• Short-stay with OP ED visit
• Short-stay re-hospitalized after admit
• Short-stay who made improvements in function
• Long-stay whose ability to move independently worsened
• Long-stay receiving antianxiety or hypnotic
Benefits of New Measures

• Increased number of short-stay measures
• Address important domains not covered by other measures
• Claims-based measures may be more accurate than MDS-based measures

Five-Star Quality Ratings

• Five of the six new measures will be phased beginning 07.2016
  • Measure on anti-anxiety and hypnotic medication use will be left out
• July 2016: New measures have 50% the weight of the 11 measures used prior to July 2016
  • January 2017: New measures have same weight

Five-Star Quality Ratings

• Possible score ranges from 275 to 1,350 points (July 2016)
  • Between 325 and 1,600 (January 2017)

<table>
<thead>
<tr>
<th>QM Rating</th>
<th>Point Range July 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>★</td>
<td>275 – 669</td>
</tr>
<tr>
<td>★★</td>
<td>670 – 759</td>
</tr>
<tr>
<td>★★★</td>
<td>760 – 829</td>
</tr>
<tr>
<td>★★★★</td>
<td>830 – 904</td>
</tr>
<tr>
<td>★★★★★</td>
<td>905 – 1350</td>
</tr>
</tbody>
</table>
Claims Based Measures

- Measures use Medicare claims
- Include only Medicare fee-for-service beneficiaries
- Only include those admitted to SNF following IP/acute stay
- Measures are risk-adjusted

Short-Stay Residents Re-hospitalized After SNF Admission
- Includes observation stays
- Excludes planned readmissions and hospice

Short-Stay Residents Successfully Discharged to the Community
- DC within 100 days of admission
- Not hospitalized, readmitted to SNF, die in 3- days post DC

Short-Stay Residents With ED Visit
- Same 30-day timeframe as re-hospitalization measure
- All ED visits except those leading to IP admission

Measure Specifications

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
<th>Numerator Window</th>
<th>Denominator Window</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-Day All-Cause Readmissions</td>
<td>Part A claims to identify inpatient readmissions and Part B claims for observation stays. Claims and MDS are used for risk adjustment.</td>
<td>30 days after admission to a SNF following an inpatient hospitalization.</td>
<td>Patients must have been admitted to the nursing home following an inpatient hospitalization.</td>
</tr>
<tr>
<td>100-day Community Discharge Without Readmission</td>
<td>MDS to identify community discharges; claims to identify successful community discharges. Claims and MDS for risk-adjustment.</td>
<td>100 days after admission to a SNF following an inpatient hospitalization and 30 days following discharge.</td>
<td></td>
</tr>
<tr>
<td>30-Day Outpatient ED Visits</td>
<td>Part B Claims to identify outpatient ED visits. Claims and MDS for risk adjustment.</td>
<td>30 days after admission to a SNF following an inpatient hospitalization.</td>
<td></td>
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### Measure Specifications

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<thead>
<tr>
<th>Measure Specifications</th>
<th>30-Day All-Cause Readmissions</th>
<th>100-day Community Discharge Without Readmission</th>
<th>30-Day Outpatient ED Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator</strong></td>
<td>The number of SNF stays where there was a admitted to an acute care hospital within 30 days of SNF admission. Observation stays are included. Planned readmissions are excluded.</td>
<td>The number of SNF stays where there was a DC to the community (identified using MDS) within 100 days of admission who are not admitted to a hospital (IP or observation stay), a nursing home, or who die w/i 30 days of DC</td>
<td>The number of SNF stays where there was an outpatient ER visit not resulting in an inpatient stay or observation stay within 30 days of SNF admission.</td>
</tr>
<tr>
<td><strong>Exclusions</strong></td>
<td>Planned readmissions</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Measurement Period</strong></td>
<td>Rolling 12 months; updated every six months</td>
<td></td>
<td></td>
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<tr>
<td><strong>Denominator</strong></td>
<td>The denominator is the number of SNF stays that began within 1 day of discharge from a prior hospitalization at an acute care, CAH, or psychiatric hospital. Prior hospitalizations are identified using claims data.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusions</strong></td>
<td>Medicare Advantage enrollees</td>
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</tr>
<tr>
<td><strong>Risk Adjustment</strong></td>
<td>Logistic regression based on claims and MDS items found to be associated with readmission rates. Note that there are some differences in the MDS items used across the three measures. The risk-adjusted rate is calculated as the (actual rate/expected rate) x national average</td>
<td></td>
<td></td>
</tr>
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### MDS Measures

**Short-Stay Residents With Improvements in Function**
- Self-performance in transfer, locomotion on unit, walk in corridor
- Improvement from the 5-day assessment to the Discharge assessment

**Long-Stay Residents Whose Ability to Move Independently Worsened**
- Defined based on locomotion on unit
- Walking or wheelchair

**Long-Stay Residents who Received an Antianxiety or Hypnotic Medication**
- Reexamine prescribing patterns
### Measure Specifications

<table>
<thead>
<tr>
<th>Description</th>
<th>Percent of short-stay nursing home residents who make functional improvements on mid-loss ADLs during episode of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source</td>
<td>MDS</td>
</tr>
<tr>
<td>Numerator Window</td>
<td>Based on change in status between the 5-day assessment and DC assessment</td>
</tr>
<tr>
<td>Measurement Period</td>
<td>Updated quarterly</td>
</tr>
</tbody>
</table>

**Mobility Decline**

- The percent of long-stay nursing home residents who experienced a decline in their ability to move about their room and adjacent corridors since their prior assessment

- Based on change in status between prior and target assessments
- Based on the target assessment

**Antianxiety/ Hypnotic Use**

- Percent of long-stay nursing home residents who receive antianxiety or hypnotic medications

**Risk Adjustment**

- Risk adjusted based on ADLs from prior assessment (eating, toileting, transfer, and walking in corridor)
- None

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<tr>
<th>Description</th>
<th>Short-stay residents with negative MDADL change score. Sum of self-performance locomotion on unit, transfer, walk in corridor (7 or 8 recoded to 4)</th>
</tr>
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<tbody>
<tr>
<td>Denominator Window</td>
<td>Residents must have a valid Discharge (return not anticipated) assessment and a valid preceding 5-day assessment</td>
</tr>
<tr>
<td>Data Source</td>
<td>MDS</td>
</tr>
<tr>
<td>Numerator</td>
<td>Short-stay residents with decline in locomotion since prior assessment. Defined as an increase in locomotion on unit self-performance points since prior assessment (7 or 8 recoded to 4)</td>
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**Antianxiety/ Hypnotic Use**

- The number of long-stay residents who received any number of antianxiety medications or hypnotic medications

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<th>Description</th>
<th>Long-stay residents with qualifying MDS target assessment that is not an Admission or 5-day assessment accompanied by at least one qualifying prior assessment</th>
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<td>Denominator Window</td>
<td>Long-stay residents must have a qualifying MDS target assessment that is not an Admission or 5-day assessment accompanied by at least one qualifying prior assessment</td>
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<td>Numerator Exclusions</td>
<td>None</td>
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<td>Denominator</td>
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<td>Risk Adjustment</td>
<td>All long-stay residents with a selected target assessment</td>
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<td>Risk Adjusted</td>
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**Antianxiety/ Hypnotic Use**

- All long-stay residents with a selected target assessment

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<th>Functional Improvement</th>
<th>Mobility Decline</th>
<th>Antianxiety/Hypnotic Use</th>
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<tr>
<td>Comatose on the 5-day assessment</td>
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<td>Comatose or missing data at prior assessment</td>
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</tr>
<tr>
<td>Prognosis of &lt;6 months on 5-day assessment</td>
<td>Prognosis of &lt;6 months on 5-day assessment</td>
<td>Prognosis of &lt;6 months at prior assessment</td>
<td>Prognosis of &lt;6 months at prior assessment</td>
</tr>
<tr>
<td>No MLADL Impairment (MLADL=0) on the 5-day assessment</td>
<td>Missing data on any of the three MLADL items on the discharge or 5-day assessments</td>
<td>Resident totally dependent during locomotion on prior assessment</td>
<td>Missing data on locomotion on target or prior assessment, or no prior assessment available to assess prior function</td>
</tr>
<tr>
<td>Missing data on locomotion on prior assessment, or no prior assessment available to assess prior function</td>
<td>Hospice on the 5-day assessment</td>
<td>Hospice care while a resident</td>
<td>Hospice care while a resident</td>
</tr>
<tr>
<td>Hospice on the 5-day assessment</td>
<td>Prior assessment is discharge assessment with or without return anticipated</td>
<td></td>
<td></td>
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Power of Purpose

Why is 5-Star Important?

- Bundled Payment Waivers (CJR)
  - Waives 3-day qualifying hospital stay
  - Performance year 2
  - Transferred to SNFs rated 3-stars or higher for at least 7 of the previous 12 months

What Does this Mean for Us?

- Address transfers, locomotion, walking in corridor
- Relate to highest self-performance in ADL and mobility
  - For a facility to achieve a high quality rating, **entire IDT** must be prepared to emphasize these elements during care
- Prepare client for successful discharge
What Can You Do?

- Transfer and Mobility Programs
  - Identify residents with a change in function and notify therapy
  - Therapy screen and evaluation
  - Discharge planning for carryover
  - Mobility clinics
  - Walk to Dine; Happy Feet
  - Restorative programming
  - Consider skilled maintenance

Facility Considerations

- Impact of no lift policies
- Using gait belts
- Training all staff for proper techniques
  - Ex. weight bearing restrictions, transfer techniques, guarding
- Instruction in body mechanics and proper lifting techniques
  - Employee wellness

Maintenance and Equipment

- Wheelchair brakes in good working order?
- Walker/canes fit to the resident?
- Enough assistive devices?
- Locks on beds in working order?
- DME in bathrooms for transfer?
- Corridors free from clutter?
- Wheelchair positioning and assistive devices in place?
Preparing for Successful Discharge

Protocols!

• Full team including SW, nursing, therapy
• To ensure that all critical elements are addressed
• Addressing high risk re-admissions (e.g., AMI, COPD, CHF)

Preparing for Successful Discharge

• ADL Programs to ensure highest level of function
  • OT, nursing, and restorative
• Medication management and understanding
• Caregiver training
  • Ensure return demonstration
• Home programs
• Home assessment (consider “telehealth” i.e., technology)

Preparing for Successful Discharge

• Engage the resident and family in a partnership to create the POC
  • Assess desires and understanding of the POC
  • Reconcile the care plan developed collaboratively with the resident and family caregivers
Early Engagement with PAC Providers

- Was DME ordered?
- Home care or OP ordered?
- Follow-up appointments made?
- Medications ordered?
- Services of HHA? Appropriate for client?

Prevent ER Visits and Readmissions

- Ensure SNF staff are ready and capable to care for the resident
  - Confirm understanding of resident’s care needs (hospital transfer forms)
  - Resolve any questions to ensure a good fit between resident and SNF
    - Consider your capabilities and where gaps, provide training to staff
    - Plans to address high risk transfers

Decision Support Tools

- Change in Condition Cards
  - Help determine whether to report specific symptoms, signs, and lab results immediately, vs. non-immediately

- Care Paths
  - Decision support tools providing guidance on recognition, evaluation, management of conditions that commonly cause hospital transfers
Prevent ER Visits and Readmissions

- Reconcile the treatment plan and proactively plan for condition changes
  - Re-evaluate status post-transfer
  - Reconcile treatment plan and medication list
  - Timely consultation for condition changes (STOP AND WATCH Tools)
  - Detailed MD communication (SBAR)

Prevent Readmissions Post-DC

- How can/will you continue to work with the client after discharge?
  - Client advocate for the episode of care
- How can you make technology work for you?
  - Web-based home programs, exercises, vital sign monitoring

Prevent Readmissions Post-DC

- Who addresses the “social” side of discharge?
  - Were medications delivered timely?
  - Is DME/AE in place?
  - Did the client see MD for follow up?
- One person to coordinate and place phone calls