Quality Measurement in Post-Acute Settings

Presentation to the State Quality Advisory Committee

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Roadmap

- Care transitions as priority system transformation domain
- Care transitions: opportunity and context in MA
- Current measures relating to care transitions in post acute care settings
- Gaps in measurement; limitations of existing measures
- Recommendations & discussion

Care Transitions

- National mobilization of effort to improve care transitions
  - Reduce avoidable rehospitalizations & avoidable NH hospitalizations
  - Improve care across settings: promote desirable system-ness
- Partnership for Patients (US DHHS; CMS)
  - Reduce avoidable 30-day readmissions by 20%
  - Reduce inpatient harm (falls, infections, medications, pressure ulcers)
- Affordable Care Act
  - $10B in funding to promote delivery system transformation
  - Majority cite reduce readmissions, improving care coordination, communication, providing enhanced care outside hospitals

Care Transitions – key facts

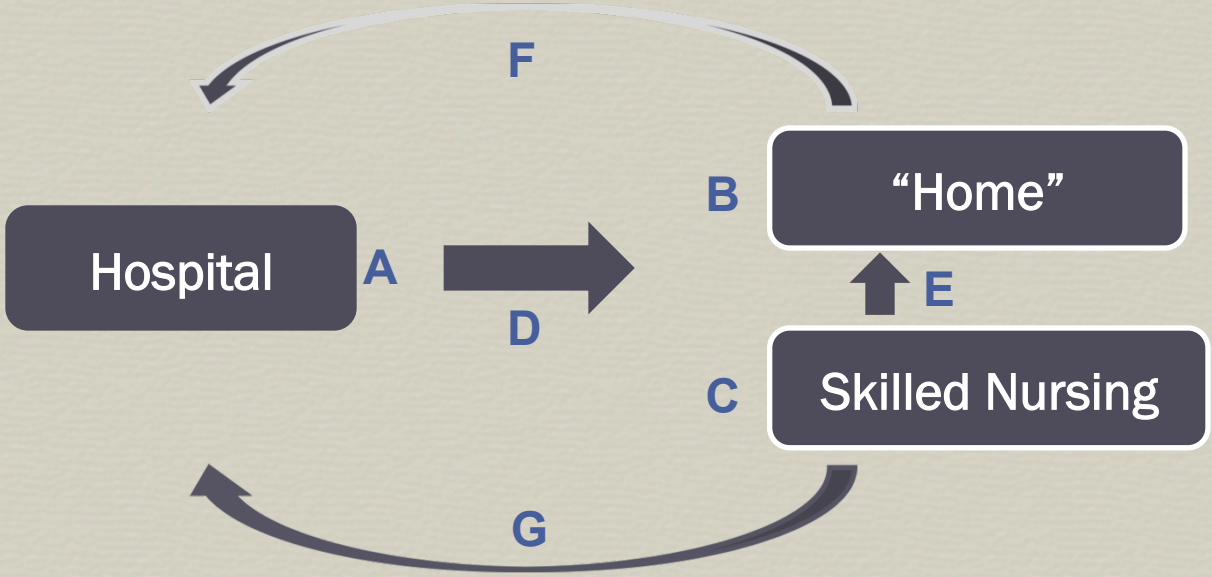
- Abundant evidence that preparation for post-hospitalization care is inadequate (education, follow up plans, medication management, information transfer)
- One result of poor transition is avoidable re-hospitalization
- Re-hospitalizations are:
  - Frequent: 1 in 5 Medicare at 30d; 377,000 bed days in MA
  - Costly: $18B Medicare; $577 million in MA (all payer)
  - Variable: rates vary 2-fold nationally (13-26%) and >4x intra-state
  - Amenable to improvement: numerous multi-part strategies have reduced readmission rates 20-65%

Numerous opportunities for improvement

- Conduct an enhanced assessment of individuals' ongoing care needs
- Employ "teach back" and improved education strategies
- Provide a personalized plan of care; ensure patient/family are involved in developing and understanding the plan
- Ensure timely transfer of information to next provider
- Establish an early post-discharge point of contact
- Provide enhanced medication review and confirmation
- …and others

None of these processes are uniformly measured in the post-acute setting

Landscape of complementary efforts



Transforming care across settings

- Improving the discharge process:
  - STAAR, Community-based Care Transitions Program (CCTP)
- Improving quality of NH and HH care:
  - INTERACT, HH BPIP
- Transitional care between settings:
  - CCTP, STAAR cross-continuum teams; IMPACT (electronic information transfer)
- Enhanced ongoing management for very high risk:
  - Medical Home, ACO, PACE/SNP/SCO, MOLST
- Linkage to community-based supports and services
  - CCTP, ASAPs, ADRCs

Care Transitions- MA Context

Post Acute Care Measurement Systems (CMS)

- Home Health: OASIS (97)
  - Subset publically reported on Home Health Compare (23)
- Home Health: HHCAHPS
  - Publically reported on Home Health Compare, May 2012
- Short- and Long-Stay Nursing Facilities: MDS
  - Subset publically reported on Nursing Home Compare (18)
- Inpatient Rehabilitation & Long Term Acute Care Hospital
  - IRF-PAI (for determining payment only)

NQF Measurement Domains for PAC

Highest-Leverage Areas for Performance Measurement	Core Measure Concepts
Function	• Functional and cognitive status assessment • Mental health
Goal Attainment	• Establishment of patient/family/caregiver goals • Advanced care planning and treatment
Patient Engagement	• Experience of care • Shared decision-making
Care Coordination	• Transition planning
Safety	• Falls • Pressure ulcers • Adverse drug events
Cost/Access	• Inappropriate medicine use • Infection rates • Avoidable admissions

Source: National Quality Forum, 2011

Home Health measures that are currently publicly reported

Clinical and Functional Status	Process[22]	Utilization	Patient Experience
Improvement in Bathing	Influenza Immunization Received for Current Flu Season	Acute Care Hospitalization	Patient Care (Composite Measure)
Improvement in Ambulation-Locomotion	Pneumococcal Vaccine Ever Received	Emergency Department Use without Hospitalization[23]	Communication (Composite Measure)
Improvement in Bed Transferring	Timely Initiation of Care		Specific Care Issues (Composite Measure)
Improvement in Management of Oral Medication	Depression Assessment Conducted		Overall Rating
Improvement in Dyspnea	Multifactor Fall Risk Assessment Conducted for Patients 65 and Over		Willingness to Recommend
Improvement in Pain Interfering with Activity	Pain Assessment Conducted		
Improvement in Status of Surgical Wounds	Pressure Ulcer Prevention in Plan of Care		
	Pressure Ulcer Prevention Implemented in Short Term Episodes		
	Pain Interventions Implemented During Short Term Episodes		
	Drug Education Implementation in Short Term Episodes		
	Diabetic Foot Care Implemented in Short Term Episodes		
	Heart Failure Symptoms Addressed During Short Term Episodes		

NQF-endorsed measures for Short and Long-Stay Nursing Facilities

- Physical therapy or nursing rehabilitation/restorative care for long-stay patients with new balance problem (RAND)
- Percent of residents experiencing one or more falls with major injury (long stay) (CMS)
- The percentage of residents on a scheduled pain medication regimen on admission who report a decrease in pain (short)
- Percent of residents who self-report moderate to severe pain (short stay) (CMS)
- Percent of residents who self-report moderate to severe pain (long stay) (CMS)
- Percent of residents with pressure ulcers that are new or worsened (short stay) (CMS)
- Percent of high-risk residents with pressure ulcers (long stay) (CMS)
- Percent of residents assessed and appropriately given the seasonal influenza vaccine during the flu season (short stay)
- Percent of residents assessed and appropriately given the seasonal influenza vaccine (long stay) (CMS)
- Percent of residents assessed and appropriately given the pneumococcal vaccine (short stay) (CMS)
- Percent of residents assessed and appropriately given the pneumococcal vaccine (long stay) (CMS)
- Percent of residents with a urinary tract infection (long stay) (CMS)
- Percent of low-risk residents who lose control of their bowels or bladder (long stay) (CMS)
- Percent of residents who have/had a catheter inserted and left in their bladder (long stay) (CMS)
- Percent of residents who were physically restrained (long stay) (CMS)
- Percent of residents whose need for help with activities of daily living has increased (long stay) (CMS)
- Percent of residents who lose too much weight (long stay) (CMS)
- Percent of residents who have depressive symptoms (long stay) (CMS)
- Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Discharged Resident Instrument
- Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-Stay Resident Instrument
- Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Family Member Instrument

Measures relating to second national priority domain of reducing harm

Patient Centered Measures

- Home Health CAPHS (required, reported)
  - Did someone ask you about all the… medications you take?
  - Did someone look at all the ….medications you take?
  - Did someone tell you about the services you would receive?
- Nursing Home CAPHS (available, not required)
- Care Transitions Measure-3 (not validated in non-hospital settings, work in progress, will be included in CCTP) (available, not required)

Core Measure Concepts	Nursing Home Compare Measures	Home Health Compare Measures
Establishment and attainment of patient/ family/caregiver goals		
Advanced care planning and treatment		
Experience of care		• Home Health Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Shared decision-making		
Transition planning		• Timely initiation of care
Falls	• Percent of residents experiencing one or more falls with major injury (long stay)	• Multifactor fall risk assessment conducted for patients 65 and over
Pressure ulcers	• Percent of residents with pressure ulcers that are new or worsened (short-stay) • Percent of high risk residents with pressure ulcers (long-stay)	• Pressure ulcer prevention in plan of care • Pressure ulcer risk assessment conducted • Pressure ulcer prevention implemented
Adverse drug events		• Drug education on all medications provided to patient/caregiver during short term episodes of care • Improvement in management of oral medications
Inappropriate medication use		
Infection rates	• Percent of residents who have/had a catheter inserted and left in their bladder (long-stay) • Percent of residents with a urinary tract infection (long-stay)	
Avoidable admissions		• Acute care hospitalization • Emergency department use without hospitalization

Care Coordination Performance Measures Across Settings

	Clinician	Hospital	Post-Acute Care/Long-Term Care
Care Transitions	Support CTM-3 (NQF #0228) if successfully developed, tested, and endorsed at the clinician level	Support immediate inclusion of CTM-3 measure and urge for it to be included in the existing HCAHPS survey Support several discharge planning measures (i.e., NQF #0338, 0557, 0558)	Support CTM-3 if successfully developed, tested, and endorsed in PAC-LTC settings Identified specific measure for further exploration for its use in PAC/LTC settings (i.e., NQF #0326, 0647)
Readmissions	Readmission measures are a priority measure gap and serve as a proxy for care coordination	Support the inclusion of both a readmission measure that crosses conditions and readmission measures that are condition-specific	Identified avoidable admissions/readmissions (both hospital and ED) as priority measure gaps
Medication Reconciliation	Support inclusion of measures that can be utilized in an HIT environment including medication reconciliation measure (i.e., NQF #0097)	Recognize the importance of medication reconciliation upon both admission and discharge, particularly with the dual eligible beneficiaries and psychiatric populations	Identified potential measures for further exploration for use across all PAC/LTC settings (i.e., NQF #0097)

Currently Reported Nursing Facility Measures Relating to Care Transitions

None

- No NQF measures
- No NH Compare measures
- NQF found that none of the Nursing Home Compare measures addressed care coordination, patient/family centered care

Currently Reported Performance Measurement from Inpatient Rehabilitation Facilities and LTAC

None; however, these facilities will be required to do so in FY14

Gaps in Current Measurement in PAC

- Effective care coordination and communication across settings
- Establishment and attainment of patient family/caregiver goals, including advanced care planning
- Adverse drug events; medication reconciliation across settings
- "Avoidable" admissions, observation stays and ED use
- Lack of measures for special populations to track disparities

Limitations in Measurement of Transitions in Post-Acute Care Settings

- Constructs of "avoidable" and "preventable" were developed in younger populations
- No measure captures accountability for the decision to hospitalize
- Inadequate measurement of end of life care, preferences
- Measurement of "readmissions/admissions" fails to capture increasingly frequent observation stays
- Risk adjustment methods include many patient factors that have been shown to be associated with hospitalization, including comorbidities, prior hospitalizations, and functional status

Measures for Future Consideration: Communication at Time of Transitions

Transition record given to discharged patients and Transition record received by next provider within 24h* Patients or caregivers who received a transition record at the time of discharge including at a minimum:

- Reason for admission
- Major tests and procedures and the results
- Principal diagnosis at discharge
- Current medication list
- Studies pending at discharge
- Patient instructions
- Advanced care plan

*Source NQF: developed by the AMA Physician Consortium for Performance Improvement

Opportunities for Post-Acute Care/Care Transitions Measurement in SQMS

1. *Align SQMS with national priorities* to improve care transitions and leverage state mobilization toward that aim
2. Select a suite of *complementary measures across settings* (hospitals, short and long-stay nursing facilities, home health)
3. *Adopt existing measures* in home health and nursing facilities
4. *Use existing data resources* to provide additional insight
5. *Consider new measures that fill gaps* that will promote progress on unified performance goals

Recommendations

1. Align the measures in the State Quality Measurement Set with the national priority of improving care transitions and the state-wide mobilization of acute and post-acute provider efforts to do so.

2. Care Transitions: Include 3 existing measures from post-acute settings that relate to care transitions:

   - 3 existing Home Health measures: timeliness; acute hospitalization; ED use without hospitalization

   - Consider 2 new measures from nursing facilities and inpatient rehabilitation facilities measuring 30-day hospitalization/ED use (to parallel home health)

3. Nursing Facility Quality: Include 2 existing measures that relate to the presence of pressure ulcers to align with national "iapatient" patient quality/safety goals

4. Consider 2 new measures for information transfer once state-wide electronic transitional information transfer is feasible (IMPACT and DPH project)

5. Encourage the DHCFP to make available all cause unadjusted 30-day readmission/ observation/ED visit data reports for quality improvement

Thank you