SNF Quality Reporting and Re-Admission Measures

Deborah Lake, RN, RAC-CT
Senior Managing Consultant
BKD, LLP

Agenda
- IMPACT Act – Overview
  - Quality Reporting
    - Falls with Major Injury
    - New or Worsened Pressure Ulcers
    - Functional QM
    - Future Measures
  - VBP Re-Admission Measures
    - QM/5-Star Re-hospitalization Measure
- Objectives
  - Understand components and requirements of the IMPACT Act and SNF Quality Reporting
  - Identify MDS 3.0 assessment changes that will require facility staff education and strategies for implementation
  - Be aware of specifics of the Quality Measure on Re-admissions that is being phased in for inclusion on 5-Star ratings
  - Understand upcoming Re-admissions measure established for Value Based Purchasing (VBP)

IMPACT ACT
- Improving Medicare Post-Acute Care Transformation (IMPACT) Act
  - Bipartisan bill passed on September 18, 2014 and signed into law on October 6, 2014
  - Required CMS to establish a SNF Quality Reporting Program (QRP)
  - Required CMS to make resident assessments and QM data standardized between post-acute care providers
    - Means of comparing, measuring outcomes
    - Systematic means of data collection of Medicare beneficiaries
  - Mandates QM data be implemented across 3 domains
    - Falls with major injury
    - New or worsened pressure ulcers
    - Assessment and care planning for functional status
IMPACT Act

- IMPACT Act QMs

| Falls | Skin Integrity | Function |

SNF Quality Reporting

- Reported separately with no overlap with Quality Measures (QMs) and Value Based Purchasing (VBPs)
- Public reporting will be separate from Nursing Home Compare
- For residents admitted on or after 10-1-16
- Stay driven ---- Not resident driven

For FY 2018 Payment Determination:

- CMS will start data collection on residents admitted to SNFs on and after October 1, 2016 and discharged from the SNF up to and including December 31, 2016
- SNFs must report all of the data necessary to calculate the quality measures on at least 80% of the MDS assessments they submit
- A measure cannot be calculated when there is use of a dash (-)

Penalty

- Beginning FY 2018, SNFs will have their annual payment update reduced by 2% if 80% of their Medicare assessments do not have 100% of data elements needed to calculate all 3 of the new QRP QMs
IMPACT Act

- Affects 4 post-acute care settings
  - Skilled Nursing Facilities (SNFs)
  - Long-term care Hospitals (LTCHs)
  - Inpatient Rehabilitation Facilities (IRFs)
  - Home Health Agencies

FALLS WITH MAJOR INJURY

Falls With Major Injury

- Medicare Part A residents experiencing one or more falls with major injury
  - Will use standardized MDS items J1800 & J1900C
  - Outcome measure

Falls With Major Injury

- Why Falls?????
  - 6% of medical expenses among adults 65 or older
  - 41% of accidental deaths annually
  - Accidental deaths from falls increases to 70% among adults 75 or older
  - 75% of nursing facility residents fall at least once a year
  - 10-25% of nursing facility resident falls result in fractures and/or hospital stays
Falls With Major Injury

- Fall (cont.):
  - Not a result of an overwhelming external force (e.g., resident pushed by another resident)
  - An intercepted fall occurs when the resident would have fallen if he or she had not caught themselves or had not been intercepted by another person – this is still considered a fall

Falls With Major Injury

- Injury Related to a Fall:
  - Any documented injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall
    - Injury (Except Major) – skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall related injury that causes the resident to complain of pain
    - Major Injury – bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Falls With Major Injury

- Clarification:
  - If the level of injury directly related to a fall that occurred during the look-back period is identified after the ARD and is at a different injury level than what was originally coded on an assessment that has been submitted to QIES ASAP, the assessment must be modified to update the level of injury that occurred with that fall

Falls With Major Injury

- Calculation of measure:
  - Numerator – Number of Medicare residents with one or more look-back scan assessments that indicate one or more major falls that resulting in a major injury
  - Denominator – Number of resident Medicare stays with one or more assessments that are eligible for a look-back scan except those with exclusions

- No risk adjustment

- Look-back scan

- Exclusion:
  - Excluded if none of the assessments that are included in the look-back scan has a usable response for items indicating the presence of a fall with major injury during the selected time window
  - J1900C = (-)
Falls With Major Injury

- Calculation of measure example:
  - A facility has a total of 250 SNF Part A stays during a 12 month period (denominator)
  - Of these stays, there were 10 documented falls with major injury reported in J1900C (numerator)
  - \( \frac{10}{250} \times 100 = 4\% \)

NEW OR WORSENED PRESSURE ULCERS

New/Worsened Pressure Ulcers

- Why pressure ulcers???
  - 2.2% to 23.9% incidence in SNFs
  - Cost of up to $19,000 to heal a Stage 4 ulcer
  - $18.8 million in cost/year

New/Worsened Pressure Ulcers

- Percent of residents with Stage 2-4 pressure ulcers that are new or worsened since admission to the SNF
- Determined by the following conditions on the target assessment (PPS Discharge Assessment)
  - Stage 2 (M0300B1) – (M0300B2) > 0
  - Stage 3 (M0300C1) – (M0300C2) > 0
  - Stage 4 (M0300D1) – (M0300D2) > 0

New/Worsened Pressure Ulcers

- Calculation of the measure:
  - Denominator – number of complete Part A stays (5-day PPS assessment and a PPS Discharge Assessment) ending during the selected time window, except those with exclusions
  - Numerator – number of complete Part A stays that end during the selected time window with one or more new or worsened Stage 2-4 pressure ulcers at the end of the stay
New/Worsened Pressure Ulcers

- Exclusions:
  - Data on new or worsened Stage 2, 3 or 4 pressure ulcers are missing at discharge
    - Dashes at M0300B1, M0300B2, M0300C1, M0300C2, M0300D1 or M0300D2
  - Resident died during SNF stay

Risk adjustment:

- Based on resident characteristics or covariates
- Characteristics or conditions that place a resident at increased risk for skin breakdown or impact their ability to heal on PPS 5-day assessment
  - Require limited or more assist in bed mobility
  - At least occasional bowel incontinence
  - Diagnosis of diabetes or PVD
  - Low body mass index (BMI) (Height and weight)

For accuracy in coding of M0300 remember the following:

- Definition of “worsened pressure ulcer”
  - Pressure ulcer must increase in numerical stage indicating a deeper level of tissue damage

Present on Admission:

- If a pressure ulcer increases in stage during a hospitalization it is considered “present on admission”
- If a pressure ulcer is acquired during a hospital stay, the stage should be coded on admission and is considered “present on admission”

Present on Admission (cont.)

- If a pressure ulcer was present on admission/entry or re-entry and subsequently increased in numerical stage during the stay, the ulcer is coded at that higher stage and is no longer “present on admission”
- If a pressure ulcer is unstageable on admission/entry or re-entry but later becomes stageable it is still “present on admission” at the stage at which it first becomes stageable
- If a pressure ulcer was acquired in a facility and the resident is hospitalized and returns to the facility with the same ulcer at the same stage the ulcer is not “present on admission”
- If a pressure ulcer is “present on admission” and the resident is hospitalized and returns with the same ulcer at the same stage, the ulcer is still “present on admission” as it was acquired outside of the facility
New/Worsened Pressure Ulcers

- Present on Admission (cont.)
  - If a resident with a pressure ulcer is hospitalized and the ulcer increases in stage during the hospitalization, it should be coded as “present on admission” upon return to the facility

FUNCTIONAL ASSESSMENT

IMPACT Act

- Standardized Data
  - Functional status - mobility and self care
  - Cognitive function – express ideas, understand, depression and dementia
  - Special services, treatments and interventions – ventilator use, dialysis, TPN, chemotherapy, etc.
  - Medical conditions and comorbidities
  - Impairments – incontinence, see, hear, swallow
  - Other categories as deemed necessary by CMS

Functional Assessment

- Percent of Patients, Residents and Persons With Admission and Discharge Functional Assessment and a Care Plan that Addresses Function
  - Data collection will begin October 1, 2016
  - Will measure the percent of residents with an Admission assessment (i.e. 5-day PPS) and a discharge functional assessment and a treatment goal that addresses function
  - Considered a process measure that looks at facility processes rather than a resident functional outcome measure
    - No impact on SNF reimbursement (RUG level)

Functional Assessment (cont.)

- Separate data collection for SNFs
  - Traditional Medicare SNF Part A stay
  - Addition of Item A0310H to Section A
  - Addition of Section GG to the MDS
  - Addition of End of Medicare Stay assessment (PPS Discharge Assessment)
Functional Assessment

- Start of Stay Assessment
  - 5-day assessment
  - Data collection is for Days 1-3 of the SNF PPS stay

**GG0130. Self Care (Assessment period: days 1 through 3 of the SNF PPS stay starting with A2400B)**

| Start with date in A2400B (start of most recent Medicare stay or Day 1 of stay) |

**Section GG - Assessment of resident’s admission performance and discharge goal**

- GG0130 – Self Care (3)
- GG0170 – Mobility (9)

---

### Self-care Items (3)

- Eating (does not include tube feeding)
- Oral Hygiene
- Toileting Hygiene

### Mobility Items (9)

- Sit to lying
- Lying to sitting on side of bed
- Sit to stand
- Chair/bed-to-chair transfer
- Toilet Transfer
- Walk 50 feet with 2 turns
- Walk 150 feet
- Wheel 50 feet with 2 turns
- Wheel 150 feet

### Key Definition: Helper

- Facility staff who are direct employees and facility contracted employees (rehab and agency staff)
- Does not include individuals hired, compensated or not, by individuals outside of the facility’s management and administration (hospice staff, private sitters, nursing/CNA students, etc.)
Functional Assessment

- **Helper Assistance:**
  - Required because the resident’s performance is unsafe or poor quality
  - Score according to amount of assistance provided
  - Activities may be completed with or without assistive devices

- **6-Level Rating Scale**
  - **01 = Dependent** – also includes 2 person assist
    - Helper does all of the effort
    - Resident does none of the effort to complete the activity
    - Includes assistance of 2 or more helper for resident to complete the activity (Helper follows with wheelchair while other helper does touch assist/holds gait belt)
  - **02 = Substantial/maximal assistance**
    - Helper does more than half the effort
    - Helper lifts or holds trunk or limbs

- **6-Point Rating Scale (cont.)**
  - **03 = Partial/moderate assistance**
    - Helper does less than half effort
    - Helper lifts, holds or supports trunk or limbs
  - **04 = Supervision or touching assistance**
    - Helper provides verbal cues or touching/steadying assist as resident completes activity
    - Assist may be provided throughout or intermittently

- **6 level Rating Scale (cont.)**
  - **05 = Set up or clean up assistance**
    - Resident completes activity
    - Helper sets up or cleans up (assists only prior to or following the activity)
  - **06 = Independent**
    - Resident completes activity by him/herself
    - No assistance from a helper
Functional Assessment

- Special codes to report why an activity was not attempted:
  - 07 = Resident refused to complete the activity
  - 09 = Not applicable (resident did not perform this activity prior to the current illness, exacerbation, or injury; consider prior level of function)
  - 88 = Not attempted due to medical condition or safety concerns

Functional Assessment (Self Care)

- Eating
  - Ability to use suitable utensils to bring food to the mouth and swallow once meal is presented on the table/tray
  - Includes modified food consistency

- Oral Hygiene
  - Ability to use suitable items to clean teeth (includes dentures)
  - The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them
  - Includes what the resident’s normal habits are (mouthwash, flossing, brushing, etc.)

- Toileting Hygiene
  - Ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan or urinal
  - If managing an ostomy, include wiping the opening but not managing equipment
  - Includes 3 tasks:
    - Adjustment of clothing before elimination
    - Perineal hygiene
    - Adjustment of clothing after elimination
**Functional Assessment (Mobility)**

- **Sit to Lying**
  - Ability to move from sitting on the side of the bed to lying flat on the bed
- **Lying to sitting on side of bed**
  - Ability to safely move from lying on the back to sitting on the side of the bed
  - Feet flat on the floor and no back support

- **Sit to stand**
  - Ability to safely come to a standing position from sitting in a chair or on the side of the bed
- **Chair/bed-to-chair transfer**
  - Ability to transfer to and from a bed to a chair (or wheelchair)

- **Toilet transfer**
  - Ability to safely get on and off a toilet or commode

- **Question H – Does the resident walk?**
  - **No, and walking is not clinically indicated**
    - Skip to GG0170Q1 (Does resident use a wheelchair/scooter?)
  - **No, and walking is clinically indicated**
    - Code discharge goals for GG0170J and GG0170K
  - **Yes**
    - Continue to GG0170J (Walk 50 feet with 2 turns)

- **Walk 50 feet with 2 turns**
  - Once standing, the ability to walk at least 50 feet and make 2 turns
- **Walk 150 feet**
  - Once standing, the ability to walk at least 150 feet in a corridor or similar space
  - Note: Turns include a 90 degree change in direction

- **Question Q1 – Does the resident use a wheelchair/scooter? (Q3 on Discharge)**
  - **No – Skip to GG0130 Self Care**
    - If Discharge assessment skip to H0100, Appliances
  - **Yes – Continue on to GG0170R (Wheel 50 feet with 2 turns)**
Functional Assessment (Mobility)

- Wheel 50 feet with 2 turns
  - Once seated in a wheelchair/scooter, can wheel at least 50 feet and make 2 turns

- Question RR1 – Indicate type of wheelchair/scooter used (RR3 on Discharge)
  - Manual or motorized

- Wheel 150 feet
  - Once seated in wheelchair/scooter, can wheel 150 feet in a corridor or similar space

- Question SS1 – Indicate the type of wheelchair/scooter used (SS3 on Discharge assessment)
  - Manual or motorized

Functional Assessment

- Section G
  - All assessments – except End of Medicare assessment
  - 7-day look back period
  - “Rule of 3” coding for most dependent status
  - 5-point coding system
    - Higher – more dependent

- Section GG
  - 5-day and End of Medicare assessments only
  - Based on first and last 3 days of Medicare stay
  - Coding based on “usual” performance
  - 6-point coding system
    - Higher – more independent

Functional Assessment (Mobility) (cont.)

- Resident Performance (cont.)
  - Score based on assist provided
  - Record the resident’s usual or baseline status – not the resident’s best of worst performance
  - Do not code staff’s assessment of the resident’s capability to perform the task
  - If the resident does not attempt the task and a helper does not complete the task, code the reason why the activity as not attempted

- Use of a dash (-) indicates “No information” and should be rarely used
- If 2 or more helpers are required to assist the resident with task – Code dependent
- Helper assist is needed d/t unsafe or poor quality performance
Section GG completed today. Based on chart review, direct observation and discussion with direct care staff, patient and family over the 3 day observation period the following have been determined to be the usual performance of this resident’s self-care and mobility:

- -------- is the usual performance for eating
- -------- is the usual performance for oral hygiene

Due to ________ the following self-care and/or mobility items were unable to be assessed.
Functional Assessment (Goals)

- **Discharge Goals**
  - A minimum of 1 self-care or mobility function goal must be coded to meet measure
    - Goal can be to maintain, increase or decrease function
  - Use of same 6-point scale
  - Options of 07, 88 and 09 are not to be used when coding discharge goals
  - If a goal is not required for a certain task enter a dash (-)

Functional Assessment (Goals)

- **Discharge Goals (cont.)**
  - Licensed clinicians can establish discharge goals at the time of admission
  - Goals should be established as part of the resident’s care plan

Functional Assessment (Goals)

- Based on review of resident’s performance, the IDT has determined that as resident stabilizes from ________, they are expected to make gains in function by discharge in the following areas:
  - Increase to supervision or touch assistance in eating
  - Increase to partial/moderate assistance in toilet transfers

Functional Assessment (Discharge)

- **End of SNF PPS Stay Assessment (PPS Discharge Assessment)**
  - Newly added
  - Will be required when a resident discharges from traditional Medicare Part A
  - Data collection period is the last 3 days of the SNF PPS Stay
  - Ends with the date in A2400C (end date of most recent Medicare stay)
Functional Assessment (Discharge)

- Part A End of Stay Assessment is completed when all of the following occur:
  - Planned discharge (A0310G is coded as 1)
  - Resident is not coded as being discharged to acute care hospital in A2100, Discharge status
  - Discharge occurs on or after the 4th day of the Medicare stay

- Part A planned discharge from facility

- Medicare coverage ends and resident remains in facility
  - Nursing Home and Swing Bed PPS Part A Discharge

- Minimum Data Set (MDS) - Version 3.0
  - Resident Assessment and Care Screening
  - Nursing Home and Swing Bed PPS Part A Discharge (End of Stay) (INF/ES6) Item Set

- New PPS Part A End of Stay Assessment/Item Set
  - 12 pages to include:
    - Section A
    - Section GG
    - Same coding conventions
    - One column coding for discharge performance
    - Based on last 3 days of stay
    - Section J - Falls (J1800 and J1900)
    - Section M - Unhealed ulcers (M0210, M0300 and M0800)
    - Section X
    - Section Z
Functional Assessment (Discharge)

- Contains data elements used to calculate current and future SNF QRP measures
  - Section A, GG, J and M
- Completed on planned discharges:
  - Part A stay ends but resident remains in the facility
    - Done as a standalone assessment
  - Part A stay ends and resident is discharged from the facility
    - May be combined with an OBRA Discharge assessment when the resident discharge occurs on the day of or on day after the End Date of the Most Recent Medicare Stay (A2400C)
    - When combined the ARD (A2300) and Discharge Date (A2000) must be equal

Functional Assessment (Discharge)

- If the last day of the Medicare stay (A2400C) is earlier than the actual Discharge date (A2000) from the facility, the Part A Discharge assessment is required.

- If the last day of the Medicare stay occurs on the day of or one day before the Discharge date from the facility, the OBRA Discharge and Part A Discharge assessment are both required and may be combined.

Functional Assessment (Discharge)

- If the last day of the Medicare stay occurs on the same day that the resident dies, a Death in Facility Tracking Record is completed. A Part A Discharge assessment would not be required.

- For a standalone Part A PPS Discharge assessment the last day of the Medicare stay (A2400C), the ARD (A2300)

Functional Status QM

- Purpose: To determine the percent of residents who have their functional status assessed upon admission and discharge and have a care plan addressing function
  - No risk adjustment
  - Process measure – Want high percent for measure
  - Implemented October 1, 2016 thru December 31, 2016 for FY 2018 payment

Calculations:

\[
\text{Residents who meet criteria (Complete or Incomplete Stay)} \times \frac{100}{\text{Total # of Part A stays}}
\]
Functional Status QM

- Complete Stay
  - Valid score indicating functional status or valid code why activity was not attempted on each functional item on admission and discharge to Part A
  - At least one self-care and/or mobility goal

- Incomplete Stay
  - Valid score indicating functional status or valid code why activity was not attempted on each functional item on admission to Part A
  - At least one self-care and/or mobility goal
  - Unplanned discharge to hospital, AMA or death
  - Discharge data not required

Functional Status QM

- Calculation of measure example:
  - A facility has a total of 225 SNF Part A resident stays that meet the inclusion criteria during a 12 month period (denominator)
  - Of these stays, there were 175 with complete stays of which 165 had complete functional status data on admission and discharge
  - There were 50 residents with incomplete stays of which 45 had complete admission functional status data

Functional Status QM

- Calculation of measure example:
  - Denominator = 225
  - Numerator = 165 + 45 = 210
  - \( \frac{210}{225} = 0.933 \times 100 = 93.3\% \)

Functional Assessment

- Prep for Implementation
  - "Draft" RAI manual with Section GG instructions
  - Review Section GG – become familiar with ADL functional items and definitions
  - Participate in CMS/Industry training that become available
  - Begin discussions between therapy and nursing on processes for coding, data collection and care planning
    - Combination
    - Nursing only
    - Therapy only

Functional Assessment

- Prep for Implementation (cont.)
  - Ensure prompt and effective communication with rehab staff
  - IDT Collaboration
    - Nursing
    - Direct Care
    - Rehab
    - Social Services

Functional Assessment

- Prep for Implementation (cont.)
  - Determine needs for changes in current documentation
    - What is the best way to get it
  - Check with software vendors on whether or not they will have documentation capabilities (nursing and therapy)
  - Education of staff
    - Coding requirements
    - Use of therapy department to assist nursing staff understand differences in coding options
  - Begin practice coding before "Go Live" date of October 1, 2016
Quality Reporting Program

Finalized for FY 2018 (Claims based)
- Medicare spending per beneficiary (MSPB)
- Discharge to community
- Potentially preventable 30-day post discharge readmission (PPRM)

Finalized for FY 2020 (MDS Based)
- Drug Regimen Review Conducted with Follow-Up for Identified Issues

Quality Reporting Program

Medicare Spending per Beneficiary (MSPB)
- To encourage accountability between providers
- Medicare A and B claims
- Episode based measure based on care in SNF and defined period after end of SNF treatment
- 20 minimum episodes
- Admitted to facility within 30 days of hospital discharge
- Treatment period starts on admission to SNF

Quality Reporting Program

Medicare Spending Per Beneficiary (cont.)
- Associated service period ends 30 days after treatment period ends
- Excludes clinically unrelated services
- Risk adjusted using claims from 60 days prior
- Initial feedback for CY 2016 discharges
- Public reporting for CY 2017

Quality Reporting Program

Discharge to Community
- Residents successfully discharged to community 31 day following discharge
  - No unplanned hospital admit or death
  - Will be taken from claims
  - Patient Status Code of 01, 06, 81 or 86
- Minimum of 25 eligible stays
- Facility feedback for CY 2016
- Public reporting for CY 2017

Quality Reporting Program

Discharge to Community (cont.)
- Will have risk adjustment based on age, sex, diagnosis, ventilator status, ESRD, dialysis and other co-morbidities
- Will exclude residents sent to home based hospice

Quality Reporting Program

Potentially Preventable 30-Day Discharge Readmission Measure (PPRM)
- 30-day window starting 2 days after SNF discharge
- Must have been admitted to the SNF within 30 days of hospital discharge
- Admitted to LTCH or acute care hospital with a diagnosis considered to be unplanned and potentially preventable
- Re-admission for which the probability of occurrence could have been avoided with planned, explained and implemented post discharge instruction
### Quality Reporting Program

#### Potentially Preventable 30-Day Discharge Readmission Measure (cont.)
- Inadequate management of:
  - Chronic conditions
  - Infections
  - Other planned events
- Risk adjustment for age, sex, hospital diagnosis, hospital LOS, ICU stay, renal status, hospital stays in prior year, etc.
- 25 minimum eligible stays

#### Drug Regimen Review Conducted with Follow Up or Identified Issues
- Review of all medications to identify any potentially clinically significant issues
- Does not specify what clinical professional is required to perform review
- Identify medication issues, communicate with physician and have resolution within a rapid period of time (midnight of the next calendar day)
- Reported on admission and on discharge with look back thru entire stay

#### Drug Regimen Review Conducted with Follow Up or Identified Issues (cont.)
- No risk adjustment
- Will require modification of MDS for 10-1-18 for reporting
- Included in CASPER reporting in 2020
- Confidential feedback in October, 2019

### SNF VBP

#### Skilled Nursing Facility Value-Based Purchasing (SNF VBP)
- 2014 Protecting Access to Medicare Act (PAMA)
- Rewards facilities with incentive payments for the quality of care they give to Medicare beneficiaries
  - Promotes better clinical outcomes
  - Makes care experience better
- 2% of SNF payments will be withheld to fund incentive payments in program
- Incentive payments must total 50-70% of amount withheld

### VBP RE-ADMISSION MEASURES

#### Skilled Nursing Facility Value-Based Purchasing (SNF VBP)
- Requires that VBP apply to payments for services furnished in FY 2019
- Fee for service Medicare beneficiaries who were inpatients at PPS, critical access or psychiatric hospitals
- SNFs can earn back 2% withhold based on re-hospitalization score – better of achievement or improvement score
  - Achievement score based on ranking of rate
  - Improvement score based on improvement over 2 years
SNF VBP

- Skilled Nursing Facility Value-Based Purchasing (SNF VBP)
  - Facility scores will be based on performance on the measure
    - Available through confidential quarterly feedback reports starting 10-1-16 (CASPER)
    - Tracks hospital re-admissions thru Medicare claims
    - Adjusted to account for patient differences when comparing facility re-admission rates

SNF VBP

- SNF 30-Day All-Cause Readmission Measure (SNFRM)
  - Estimates the risk standardized rate of unexpected readmissions within 30 days of hospital discharge
    - 30-days after discharge from a prior hospitalization
    - Rate of re-admission for SNF residents to hospital before or after discharge from the SNF
    - Excludes planned readmissions
    - Risk adjusted based on demographics, hospital diagnosis, comorbidities, etc.

SNF VBP

- VBP incentive payments will be determined by comparing all SNF performance scores
  - Adjusted to account for patient differences when comparing facility re-admission rates
  - All condition, unplanned inpatient hospital re-admissions

SNF VBP

- SNF 30-Day Potentially Preventable Readmission Measure (SNFPPR)
  - Estimates the risk standardized rate of unexpected, potentially preventable readmissions within 30 days of hospital discharge
    - Beginning FY 2019 – CY 2015 claims as baseline period
    - SNF admission must take place within one day of hospital discharge
    - Based on SNF admissions – Beneficiary could be included multiple times a year

SNF VBP

- SNF 30-Day Potentially Preventable Readmission Measure (cont.)
  - 2 types of re-admissions
    - Within stay
    - Post-SNF discharge period
  - Within stay re-admission
    - Inadequate management of chronic condition, infections, unplanned events and injury prevention
  - Post-SNF discharge re-admission
    - Inadequate management of chronic conditions, infections or unplanned events
  - Risk adjustment for age, sex, hospital diagnosis, hospital LOS, ICU stay, renal status, hospital stays in prior year, etc.
  - No minimum eligible stays
5-STAR/QM RE-ADMISSION MEASURE

Re-hospitalization Measure

- Short Stay Residents Who Were Re-hospitalized After a Nursing Home Admission
  - FFS Medicare beneficiaries
  - Re-hospitalization for any reason to any hospital within 30 days of admission to a SNF from a hospital
  - Medicare A and B claims too determine re-hospitalization or observation admissions
  - Excludes:
    - Planned re-admissions
    - Hospice enrollment
    - Admissions to SNF not from hospital

Re-hospitalization Measure

- Short Stay Residents who Were Re-hospitalized After a Nursing Home Admission
  - Risk adjusted
    - Actual rate/expected rate X national average
  - Rolling 12 month window — Updated semi-annually

Re-Hospitalizations

- Do you:
  - Have adequate staff training
  - Have consistent/reliable medical support
  - Use INTERACT or a similar tool
  - Review all readmissions to the hospital
    - When, why, who ……..
  - Track rates of re-admissions
  - Have good discharge planning and tracking

THANK YOU!!!

ddiake@bd.com