



INSIGHTS + PROGRESS

Quality Report on Skilled Nursing Facility Care

The
Alliance
For Quality Nursing Home Care





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Introduction

■ Our goal in preparing this report is to provide an objective national overview of Skilled Nursing Facility (SNF) patient care quality, pertinent quality trends, specific improvements, and areas of care requiring continued attention. Further, we seek to advance in the public arena the fundamental principle of transparency, and the ongoing self-directed SNF sector trend towards providing more data disclosure for consumers to evaluate, more accountability for results, and increased competition among facilities.

Overall, there has and always will be an immutable correlation among cumulative funding adequacy, workforce stability and nursing home care quality. If the federal budget and regulatory policies that have amassed more than \$65 billion in

cumulative Medicare funding reductions over the next ten years continue unabated – in lieu of significant structural post-acute care (PAC) payment reforms – the SNF sector will become unsustainable, to the detriment of elderly patients, the SNF workforce, and the entire U.S. healthcare system.

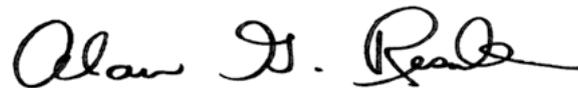
As the 2013 health policy debate unfolds, quality must continue to be a focal point in helping to transform the Medicare post-acute payment system, which should be more closely tied to patient need. More broadly, an historic opportunity for Medicare savings can be realized if the quality and cost advantages of SNFs are optimized by federal legislative and regulatory policies.

In addition to reporting Quality Measure

(QM) trends, this report examines rehospitalization trends, facility survey performance, and staffing patterns in U.S. SNFs. The top line findings of this report include:

- Short-stay Quality Measures (QMs), including pain and pressure ulcers, are steadily improving (trending improvement since 2003);
- A majority of long-stay QMs are improving;
- Standardized patient assessment and quality measurement across post-acute settings are necessary to improving patient-centered coordinated care and overall quality of care in our nation's healthcare delivery system.

Rigorous programs implemented over the past decade have improved quality of care and quality of life for SNF patients, and must continue in the years and decades ahead. There remains room for improvement. Today, however, there has never been a broader recognition by the SNF community about the seminal importance of quality in advancing key Medicare payment reforms, nor a broader commitment to work cooperatively with government, regulators and consumers to help drive ongoing, metrics-driven improvements.



Alan Rosenbloom

PRESIDENT

ALLIANCE FOR QUALITY NURSING HOME CARE



An Analysis of Quality in U.S. Nursing Homes

PointRight:

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A young woman with long brown hair, wearing a white lab coat over blue scrubs, is smiling and assisting an elderly woman. The elderly woman has short, wavy white hair and is wearing a white short-sleeved shirt. She is using a silver metal walker with blue handgrips. The background is a bright, out-of-focus indoor setting, likely a hospital or care facility.

Analyses of government data show measurable improvements in key short-stay, post-acute care and long-stay, chronic care quality measures as well as nursing facility survey performance.

Nursing Facility Quality Trends

■ The Centers for Medicare & Medicaid Services (CMS) publicly reports patient care outcomes for the nation's nursing facilities. These Quality Measures (QMs) are based on care items captured on the Minimum Data Set (MDS), the assessment tool used by nursing facility staff to assess individual care needs and plans for interventions.

A new MDS assessment tool, referred to as MDS 3.0, replaced the former 2.0 version and was introduced in nursing facilities on October 1, 2010. Substantial changes were made in the new 3.0 version of the MDS, which required development of new QMs.

Changes from the 2.0 to 3.0 QMs involved revisions to the MDS items themselves as well as coding instructions. Significant revisions were also made to the methodology or the selection of resident or patient samples (long-stay residents vs. short-stay patients) and to the types of MDS records used for calculating performance on the QMs.

Due to the breadth of changes made, it is impossible to directly compare the 2.0 QM rates to the 3.0 QM rates. Although the names of measures may sound similar, the 3.0 measures are not a continuation of the 2.0 measures. Rather, the 3.0 measures establish a new baseline for tracking and trending quality performance. See Appendix A for a table outlining differences between the MDS 2.0 and MDS 3.0 QMs discussed in this chapter.

Changes in Clinical Performance

■ This report reviews 15 of the MDS 2.0 QMs from the third quarter of fiscal year (FY) 2003 to the third quarter of FY 2010.* The following table shows trends for improvement or decline. Lower rates are better for all measures except for the influenza and pneumococcal immunization measures, where a

higher rate indicates better performance. Nursing facilities improved in all four short-stay, post-acute care (PAC) measures and eight long-stay, chronic care (CC) measures. Only three long-stay measures did not show improvement: urinary tract infection, incontinence, and influenza immunization.

Table 1: MDS 2.0 Quality Measures

Short-Stay				
Measure	Rate Q3 2003	Rate Q3 2010	Absolute Change†	Relative Change
Pain	23.0	19.1	-3.8%	-17%
Pressure Ulcers	20.4	11.8	-8.7%	-42%
Influenza Immunization	73.3 **	81.7	8.4%	11%
Pneumococcal Vaccination	67.8 **	78.6	10.8%	16%
Long-Stay				
Measure	Rate Q3 2003	Rate Q3 2010	Absolute Change†	Relative Change
Pain	6.7	3.2	-3.5%	-52%
High-Risk Pressure Ulcers	13.8	10.3	-3.5%	-25%
Urinary Tract Infection	8.4	9.0	0.6%	7%
Incontinence	46.3	51.7	5.3%	12%
Catheters	5.7	4.8	-0.8%	-14%
Restraints	8.0	2.6	-5.4%	-67%
ADL Decline	15.2	13.9	-1.3%	-9%
Weight Loss	9.6 *	7.4	-2.2%	-23%
Depression	14.6	14.1	-0.5%	-3%
Influenza Immunization	87.0 **	86.5	-0.5%	-1%
Pneumococcal Vaccination	75.3 **	84.8	9.5%	13%

 Trending Improvement  Trending Decline

■ Measures within the same clinical areas reviewed for the MDS 2.0 QMs shown in Table 1 were also reviewed for the MDS 3.0 QMs. The following table shows improvement in the PointRight Nation ** in 13 of 15 measures, nine of which showed a statistically significant change from the first quarter of

2011 to the second quarter of 2012. The long-stay incontinence and influenza immunization measures did not show improvement over the six quarters. This was similarly noted for the 2.0 QMs.

Table 2: MDS 3.0 Quality Measures

Short-Stay				
Measure	Rate Q3 2011	Rate Q3 2012	Absolute Change†	Relative Change
Pain	24.1	22.7	-1.5%†	-6%
Pressure Ulcers	2.1	1.4	-0.7%†	-34%
Influenza Immunization	80.8	81.3	0.5%†	1%
Pneumococcal Vaccination	79.4	79.7	0.4%†	0%
Long-Stay				
Measure	Rate Q3 2003	Rate Q3 2010	Absolute Change†	Relative Change
Pain	13.7	12.0	-1.7%†	-12%
High-Risk Pressure Ulcers	7.3	6.5	-0.7%†	-10%
Urinary Tract Infection	6.7	6.5	-0.2%	-3%
Incontinence	44.1	46.9	2.8%†	6%
Catheters	4.7	4.4	-0.3%	-6%
Restraints	2.0	1.8	-0.3%†	-14%
ADL Decline	20.1	17.1	-3.0%†	-15%
Weight Loss	7.5	7.1	-0.3%	-4%
Depression	6.3	6.0	-0.2%	-4%
Influenza Immunization	93.2	92.1	-1.1%	-1%
Pneumococcal Vaccination	91.5	92.6	1.1%†	1%

■ Trending Improvement ■ Trending Decline

† Statistically Significant Difference

* Nation- public database @15,900 facility average over time periods

** PointRight Nation - PointRight's national database (@ 2700 facility average over the specified time periods)

Trends in Key Quality Measures

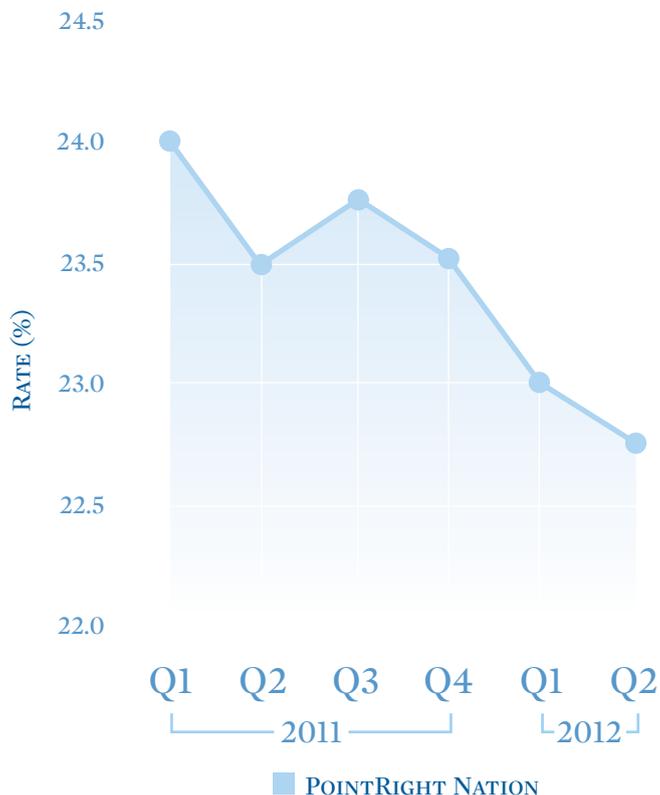
■ The QMs address performance within several areas of physical functioning and health status for nursing facility residents (long-stay) and patients (short-stay). Trends related to key areas are highlighted in the graphs below.

The management of pain in both post-acute patients and long-term residents has been viewed as an important outcome area for the past several years. The

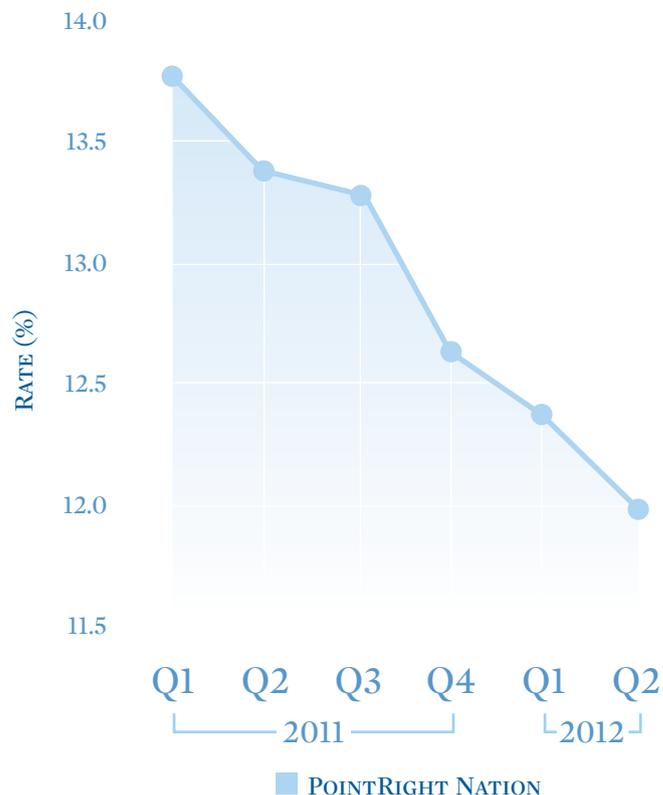
3.0 QMs use data from the new “Pain Assessment Interview” on the MDS 3.0 assessment tool; this allows for a standardized process that includes direct input from patients and residents.

The rates for both the short-stay and long-stay 3.0 pain QMs show improvement over the six quarters for the PointRight Nation. This clinical area also showed improvement for the Nation based on the 2.0 QMs.

Trends in 3.0 QM
Short-Stay Pain



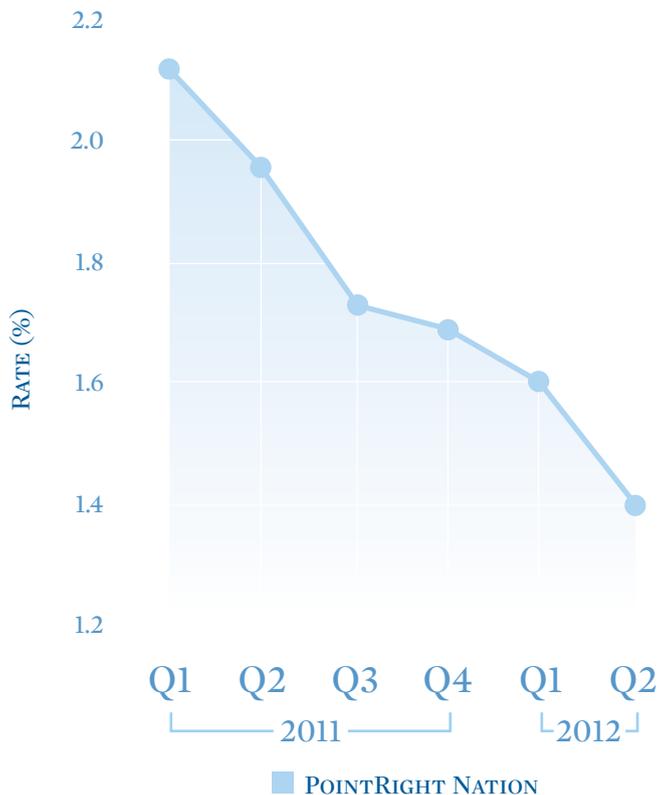
Trends in 3.0 QM
Long-Stay Pain



■ Prevention and treatment of pressure ulcers are high priorities in the care of frail, elderly, and disabled individuals in post-acute and long-term care facilities. The definition of the 3.0 short-stay and long-stay measures underwent changes from the 2.0 measures. The 3.0 measures no longer include Stage I pressure ulcers.

Additionally, coding on the MDS 3.0 assessment tool follows current clinical standards and no longer reverses stages for healing ulcers. Statistically significant improvement is noted for the PointRight Nation over the six quarters for both new measures. The Nation also showed improvement in these clinical areas based on the 2.0 measures.

Trends in 3.0 QM
Short-Stay Pressure Ulcers



Trends in 3.0 QM
Long-Stay High-Risk Pressure Ulcers

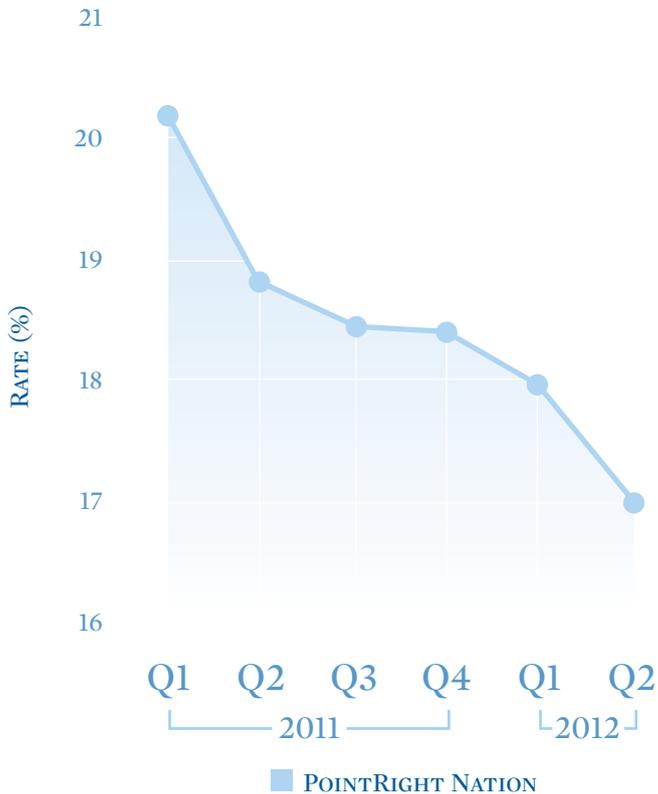


■ The 3.0 activities of daily living (ADL) decline measure shows improvement for the PointRight Nation. This measure reflects the percent of long-stay residents who experienced a decline in their ability to perform at least one of four late-loss ADLs: bed mobility, eating, transferring, and toileting.

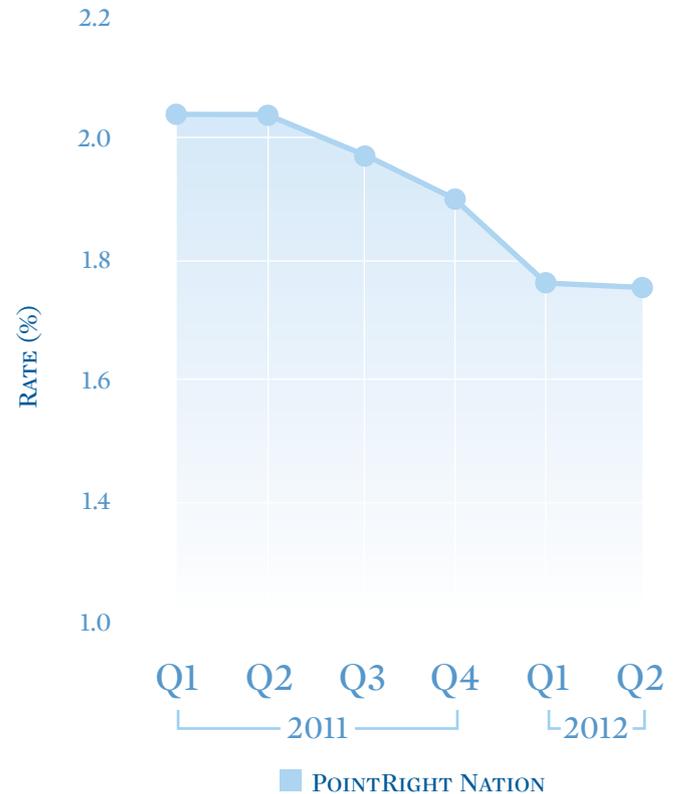
Another functional status area, the 3.0 restraint measure, indicating the percent of long-stay residents daily in physical restraints (trunk or limb restraint), shows a 15 percent relative improvement over six quarters for the PointRight Nation.

Similar 2.0 measures for these clinical areas showed improvement trends for the Nation.

Trends in 3.0 QM
Long-Stay ADL Decline



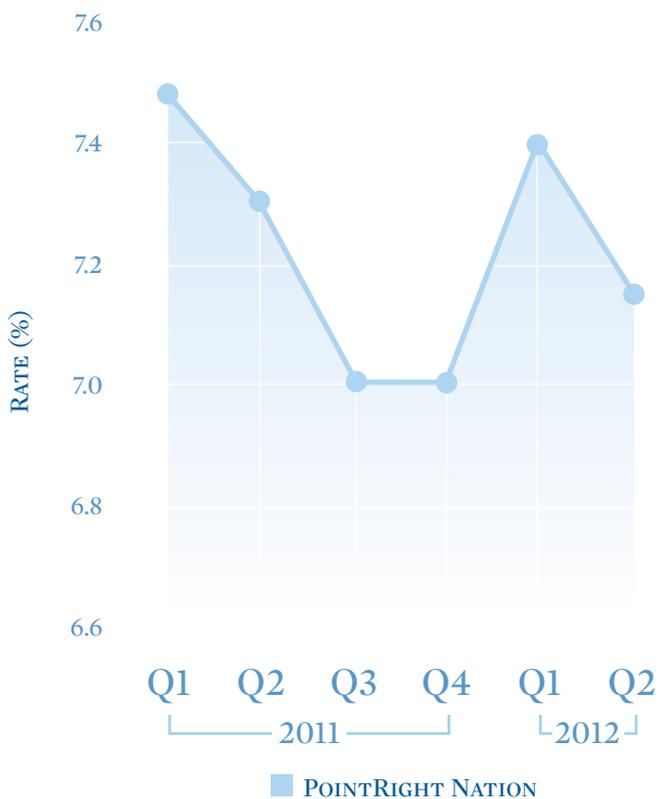
Trends in 3.0 QM
Long-Stay Restraints



■ Detecting and preventing inadequate nutrition and hydration, which can place residents and patients at higher risk for functional decline, are important outcome areas. The 3.0 weight-loss measure reflects the percent of long-stay residents who were not on a physician-prescribed weight-loss regimen and who

lost either five percent or more of their weight in one month or 10 percent in two consecutive quarters. An improvement trend is seen for the PointRight Nation for the 3.0 measure. The 2.0 measure in this clinical area, which was based on a slightly different definition, also showed improvement nationally.

Trends in 3.0 QM Long-Stay Weight Loss



Trends in Rehospitalization

■ Preventable rehospitalizations is a growing focus of policymakers and clinicians alike. PointRight's MDS database captures information on

whether post-acute skilled nursing patients return to the hospital within 30 days. The graph below shows some improvement since 2007.

Trend Analysis of Medicare 30-Day Rehospitalization Rate for PointRight National



The sample size for the 30-day rehospitalization rate is 2,450 facilities. To ensure valid calculation of the rehospitalization rate, Point Right excludes facilities with follow-up assessment rates of less than 90 percent.

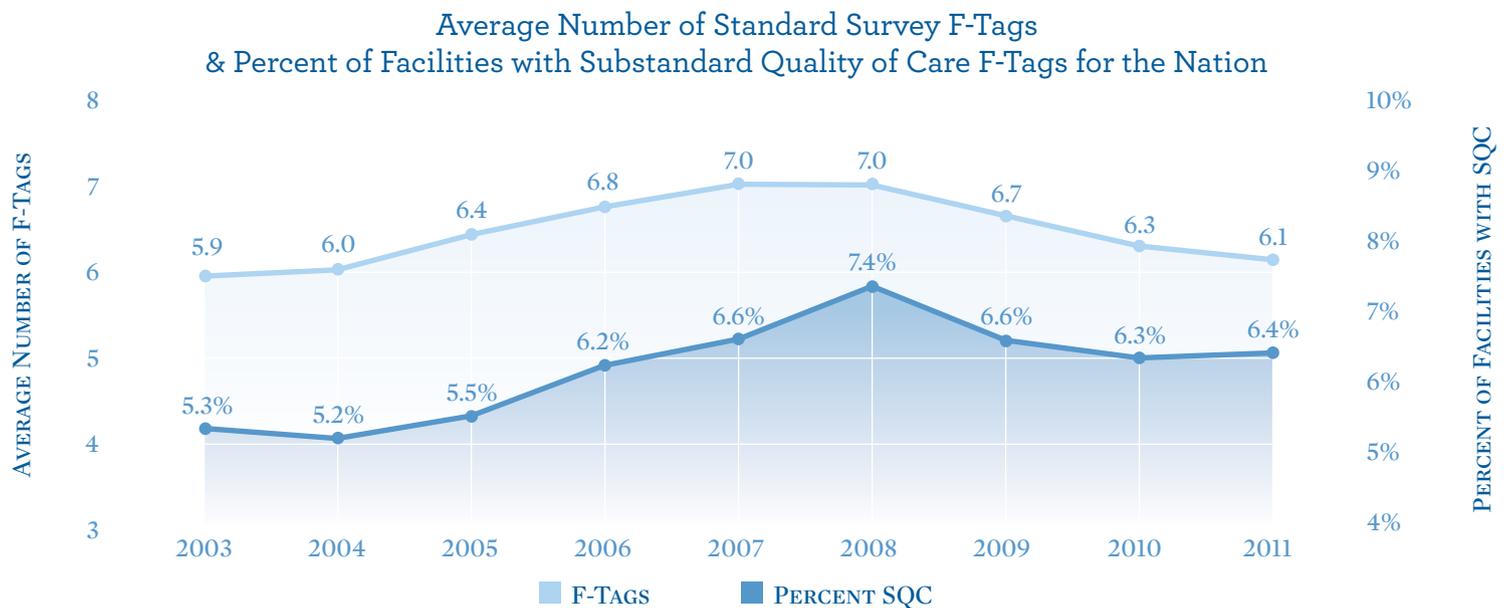
Trends in Survey Performance

■ To receive payment under the Medicare or Medicaid programs, nursing facilities are required to comply with federal requirements. Through an agreement with CMS, state government survey teams complete health and fire safety inspections of facilities and also investigate complaints.

Deficiencies, also known as F-Tags, are indicative of non-compliance with requirements and are based on the “scope and severity” of inspectors’ findings. Severity has four levels: no actual harm with potential for minimal harm; no actual harm with potential for more than minimal harm; actual harm; and immediate jeopardy to resident health or safety. The scope of deficiencies is designated as “isolated,” “pattern,” or “widespread.”

Substandard quality of care (SQ) refers to one or more deficiencies within the federal requirements related to resident or patient behavior and facility practices or quality of care, that would constitute immediate jeopardy to resident or patient health or safety; a pattern of harm or widespread actual harm; or a widespread potential for more than minimal harm. Inspection survey data obtained from the CMS public database was used to determine trends.

The average number of deficiencies and the percent of facilities with SQ show improvement beginning in 2009.



Staffing Trends

■ Staffing trends were explored using data from CMS' public database showing hours per resident day (HPRD). Total licensed nurse hours include registered nurse (RN) directors of nursing, nurses with administrative duties, RNs, and licensed practical/vocational nurses. Aide hours include certified nurse aides (CNAs), nurse aides in training, and

medication aides/technicians. "Percent of contract staff" hours includes these same nursing staff categories.

Average nurse aide and licensed nurse hours increased from 2003 to 2011, while the percent of contract staff decreased during this same period.

Trending Average Aide HPRD, Total Licensed Nurse HPRD and Percent of Contract Staff for the Nation







“This effort provides the foundation for uniform language across the continuum to describe the complexity of populations treated, regardless of setting. Having a uniform language, independent of clinical training, will be important to improving coordination of care and understanding differences in complexity of patients and their outcomes across the healthcare spectrum.”

Continuity Assessment Record and Evaluation (CARE): Developing Standardized Assessment Items for Post-Acute Care

Barbara Gage, Ph.D., M.P.A.

Summary of Findings



■ The national Post-Acute Care Payment Reform Demonstration (PAC PRD) mandated by Congress in the Deficit Reduction Act of 2005 and sponsored by The Centers for Medicare & Medicaid Services (CMS) tested a standardized set of assessment items for the Medicare program. The Continuity Assessment Record and Evaluation (CARE) items were tested in over 200 providers nationwide, including acute care hospitals, inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), skilled nursing facilities (SNFs), and home health agencies (HHAs). These items were selected from current assessment standards and were based on the latest scientific evidence. Results from the national demonstration showed the standardized items had high validity and reliability within and across these settings; the exceptions were certain instrumental activity of daily living items with low response rates. **Standardizing assessment items across the healthcare spectrum is an important step in improving communication, patient-centered coordinated care, quality of care, and developing a common language to describe patient complexity regardless of the setting in which the patient is treated.**

Why Standardize Items?

■ **About one in five Medicare beneficiaries is admitted to the hospital each year. Almost 40 percent of these patients will be discharged to one of four Post-Acute Care (PAC) settings**, including skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), and home health agencies (HHA) for additional nursing or therapy treatments (Gage et al, 2012a). **Skilled nursing facilities typically admit the largest share of these PAC cases** (Gage, 1999; Gage et al., 2005; Gage et al, 2009; Gage et al, 2012 PAC PRD) followed by HHAs (37 percent), IRFs (9 percent), ambulatory therapy providers (such as hospital outpatient departments, clinics, and therapists offices) (9 percent) and LTCHs (2 percent). And many of these PAC patients are discharged to at least a second PAC provider during their episode of care, particularly those discharged from SNFs and LTCHs (Gage et al, 2012a). About two-thirds of the PAC cases discharged to SNFs received additional services. Almost a quarter

of the SNF cases were transferred back to the acute hospital in 2008 (23.1 percent). Another third (32.7 percent) were discharged from the SNF to a HHA. Among patients with the acute-SNF-HHA pattern, another 20 percent returned to the acute hospital within 30 days of discharge from the HHA (Gage et al, 2012a).

In general, the four PAC settings are assumed to differ in the type and intensity of services provided, effectively providing a “continuum of care.” But these providers’ services are not mutually exclusive; each of the three inpatient PAC settings (LTCHs, IRFs, and SNFs) provide 24-hour nursing, and all four settings provide physical, occupational, and speech pathology services to some extent. Past research has shown that the types of patients treated in these settings appear to overlap (Gage et al, 2009, Gage et al, 1999). **Communicating across settings in a consistent language is key to improving care coordination and patient outcomes.**

The CARE Item Set

Development of the CARE Item Set

■ CMS awarded a contract to Dr. Gage and her team at RTI, International to develop a standardized set of items for use across acute and PAC settings.¹ The standardized CARE items were built on the current state of the science in each of the medical communities, the existing assessment tools which had each been developed at different times and by different research teams, and stakeholder input. Input was provided by representatives from each of the five levels of care (acute hospitals and the four PAC settings) and clinicians from each of the various disciplinary areas, including nursing, therapy, case management, and physicians. Collaborators included practicing geriatricians and physiatrists, as well as experts in the MDS, the IRF-PAI, and the OASIS tools. Stakeholder input was collected through a

variety of mechanisms, including CMS-sponsored Open Door Forums, Technical Expert Panels, professional meetings, and on-going e-mail solicitation of input. **Over 25 associations were involved in identifying the assessment domains needed to differentiate health status complexity among Medicare beneficiary populations.** Experts familiar with the assessment items currently used in the acute and PAC settings also participated to discuss the implications of selecting items originally tested in different settings.² These provider associations and the clinical and measurement experts provided valuable input regarding the types of concepts needed to measure differences in severity and the best items to measure those concepts across all settings.

¹ The CARE team included collaborators from the University of Pennsylvania, the Rehabilitation Institute of Chicago, UCLA, Visiting Nurse Services of New York, Case Western, and several pilot site participants, including RML Hospital, Edward Hospital, Alexian Hospital, and the VNA of Fox Valley.

² Stakeholder input was critical to the CARE development process. The conceptual domains and specific items were selected by the major stakeholders and subject matter experts including clinicians, policymakers, providers, and national professional and provider associations. Some of the participating associations included American Health Care Association, American Hospital Association, Acute Long-Term Hospital Association, the National Association of Long-Term Hospitals, the American Medical Rehabilitation Providers Association, Commission on the Accreditation of Rehabilitation Facilities, The Joint Commission, Leading Age (formerly American Association of Homes and Services for the Aging), National Association for Home Care, and the Visiting Nurse Association of America. Additional input was provided throughout the process by several clinical communities, including the National Pressure Ulcer Advisory Panel, the Association of Rehabilitation Nurses, the American Physical Therapy Association, the American Occupational Therapy Association, the American Speech-Language-Hearing Association, the American Medical Directors Association, and the American Academy of Physical Medicine and Rehabilitation, among others.

The CARE Tool Items

■ The stakeholders identified four clinical domains that were important in measuring patient complexity and some of the factors affecting treatment options. These areas are all typically assessed today,

either formally with a standardized item within a setting or informally in chart notes. These include the following (a complete set of standardized items can be found at www.pacdemo.rti.org):

Medical Status/Clinical Complexity — These items measure patient medical status and define complexity in terms of medical diagnoses, comorbid conditions, major treatments received during stay (e.g., ventilator weaning, hemodialysis), medications, skin integrity (number and size of pressure ulcers and locations and presence of other wounds), and physiologic factors (e.g., vital signs, laboratory results, blood gases, pulmonary function). Some of these items may be irrelevant for a healthier patient but including them provides a standard measurement when needed.

Functional Status — These items include screening items on impairments (e.g., bladder, bowel, swallowing, vision, hearing, weight-bearing, grip strength, respiratory status, and endurance), as well as measures of self-care, mobility, and safety-related functions (medication management, phone management) and other independent activities of daily living items relevant to less impaired populations.

Cognitive Status — These items target memory/ recall ability; delirium/confusion (some of which may be short-term related to current medications or longer term, which may complicate rehabilitation therapy); behavioral symptoms, including those that are self-injurious (pulling IV lines) or directed toward others; signs of depression or sadness; and presence of pain, which may affect patients' engagement and outcomes.

Social Support Factors — These items target social support issues, including information on structural barriers in the home, living situations, caregiver availability, and the need for assistance, as well as issues related to discharge complications.

These four domains are typically collected in all of the settings although the information may be collected informally in some settings, as in chart notes, and the item used and type of professional assessing each factor may vary by setting. For healthier patients, fewer

items are relevant. For the more complex patients, the CARE items offer standardized versions of information already typically collected on those types of patients (Gage et al, 2012b).

Item Selection Considerations

■ Final item selection was based on the input of clinicians from each of the different levels of care and the different clinical disciplines, including nursing, therapy, case management, psychology, and physicians. Four workgroups were formed to provide appropriate clinical input for each of the four domains. The three federally mandated assessment tools were reviewed for items currently measuring these concepts, as were items currently used in other systems, such as in the acute and LTCH hospitals, Veterans Administration, and past research efforts (See Gage et al, 2012b for a complete discussion of the item selection process.) The workgroups considered item applicability across all the populations and took into account certain overriding considerations, such as ceiling and floor effects, specificity/granularity, and burden on clinicians to collect data.

A review of the **three federally mandated tools used in 2006 showed they all measured similar concepts**, but they used different clinical items, timeframes for data collection, and measurement scales (Gage and Greene, 2006).² For example, each of the three tools measured skin integrity, but the IRF-PAI and OASIS used the PUSH tool items while

the MDS used a set of items more closely related to the current recommendations of the National Pressure Ulcer Advisory Panel. Measures of function also differed across each of the tools. Each had measures of activities of daily living and mobility. **However, the item definitions and the measurement scales varied, making it difficult to compare the self care or mobility status of a patient in one setting with that of a patient in another setting.** These differences affected items in all the domains, including even the identification of the medical condition where most tools used ICD-9 codes but the MDS used check-off boxes identifying broad groups of conditions. Though these differences permit good measurement within each setting, they fail to allow patient-centered, cross-setting considerations of quality and outcomes.

The selected items also needed to minimize floor and ceiling effects. Certain items in the existing tools were limited in their ability to measure acuity for the very sickest (floor effects) and the very healthiest patients (ceiling effects) and thus in their ability to explain variation across patients having a broad range of severity across an episode of care as found

in the PAC populations. CARE items and scales were selected to reduce those limitations in the current tools yet still have the granularity needed to measure individual patients.

Assessment windows also varied across settings making it difficult to compare the patients' health status at the same point in time,

such as at admission. Patients in the LTCH are typically assessed throughout the stay, including within the first 24 hours of admission; IRF admissions data reflect the first 72 hours of the stay; SNFs collect data reflecting the first five days of the admission; and HHAs submit initial assessment data related to the first visit, which is tied to the physician's ordered start date or within the first 48 hours of referral or return home although HHA staff have five days to complete the comprehensive assessment. These differences make it difficult to compare patient severity at the same point in time across providers. A standardized set of assessment items and rules is needed to allow a common language for communicating across settings. Data collection burden was another key consideration in selecting items. Items were restricted to the type already being

collected in each setting, although not necessarily in each assessment tool. Some items, such as vision and hearing limitations, were noted in charts and discharge summaries but not consistently collected or measured. To avoid undue burden, the standardized items were broken into two types – a small subset of core items for collection on all patients and a supplemental set of items selectively used to define severity of a condition when a condition was present. **Few items apply to all patients, but the CARE items provide standardized items to use when needed.**

Item validity and reliability was another important consideration. Items included in the federal set needed to be valid measures of the concepts they were intended to measure and be reliable across assessors. Most CARE items had already been tested in at least one population but it was important to measure reliability in all the settings in which the item would be used. Extensive testing of the reliability and validity of the items was conducted to determine whether the standardized version in the CARE tool was as reliable and valid as the item in the original source.

² The MDS 2.0 and OASIS-B were in use at the time of the CARE development. CARE items were coordinated with MDS 3.0 and, OASIS-C development.

Item Validity & Reliability Tests

■ The CARE tool items were extensively pilot-tested during the development process. Reliability and validity were tested during the demonstration. Practicing clinicians in each setting were trained on the standardized item set prior to their use. These clinicians were asked to provide continuous feedback on the uses of items with different types of patients in their respective settings. This was helpful for soliciting practicing clinicians' input on the applicability of each item to the types of patient they were treating. Helpful comments were provided, including requests for some of the cognitive measures to be applied at both admission and discharge, instead of just PAC admission. Positive feedback from the trainings focused on two areas in particular: Nursing staff across the settings appreciated the input of the leading scientific communities in recommending standard approaches for measuring pressure ulcers and other factors. Second, SNF and HHA therapy staff appreciated the more specific functional status measures included in the CARE tool. They felt

the items better reflected the complexity of their cases and the improvements achieved through their treatments Gage et al, 2012b).

More formal analysis of validity was also conducted using statistical methods. **Factor analysis was used to test domain identifications by examining intercorrelations among variables within a common domain.** For example, the CARE item set included 34 function items. However, the factor analysis illustrated the presence of three subscales among them – self-care (9 items), mobility (15 items), and instrumental activities of daily living (10 items). The subscale identification is important for grouping items into concise, conceptual measure areas. In addition, the validity of CARE items was assessed relative to existing items in the legacy tools (MDS, OASIS, and IRF-PAI). Differences were expected in the rating of patients using the legacy and CARE items given that the definitions of items and scales differed across each tool (see Gage et al, 2012b for a complete discussion).

■ Two formal types of reliability tests were conducted. The first used a traditional inter-rater reliability study approach to measure the reliability of the standardized items when applied to populations in settings other than those for whom the items were originally validated. The second type of test, where assessors in different settings rated uniform “hypothetical” patients, examined the degree of agreement when items were used by different disciplines in different settings. Overall, the results showed very good agreement on most items. The reliability results were consistent with those achieved in earlier tests of the MDS, OASIS, and IRF-PAI (Gage et al, 2012b). This suggests the standardized items can reliably replace items in the current legacy tools. Across all 146 items tested, only 17 percent had a rating lower than 0.60, including both the unweighted and weighted kappas and in samples with and without missing values included. These kappa values are equal or exceeding the reliability of the current tools (Ibid.).

Defining the Subscales

Self Care

Eating, oral hygiene, toilet hygiene, dressing upper body, dressing lower body, footwear, washing upper body, showering/bathing self

Mobility

Lying to sitting on side of bed, sit to stand, chair/bed-chair transfer, toilet transfer, car transfer, rolling left and right, sit to lying, picking up objects, 1 step curb, 4 stairs, 12 stairs, walking/wheeling distances (in room once standing, 50 feet, 100 feet, 150 feet), walking 10 feet on uneven surfaces, walking 50 feet with two turns, wheeling long/short ramps

IADL

Telephone answering, telephone calling, medication management (oral, inhalant/mist, injectable), make light meal, wipe down surface, light shopping, laundry, use public transportation

Key findings from the reliability test showed the following:

- All five settings were able to collect information in a reliable, consistent, and comprehensive manner for their Medicare populations.
- Participant feedback on CARE items was generally positive. Clinicians in all five settings appreciated the use of standard items for measuring pressure ulcers and other medical factors that affect staffing intensity. Therapists consistently commented that the CARE items were easier to use and provided greater specificity for measuring severity and change in function than the items that had been in the MDS 2.0 and OASIS-B in use at the time of the demonstration. They also commented positively about the coding approach of determining whether a patient could do at least half the task or not, and if they could, whether they could safely leave the patient to complete the task without supervision. The LTCH staff appreciated being able to note small changes in a patient moving from complete dependence to being able to complete a task with much assistance (over half the task was completed by the helper), particularly for the most impaired populations.
- Reliability testing for CARE showed positive results that are consistent with reliability standards used for previous CMS-mandated patient assessment instruments, suggesting that these items can be used in each setting and be reliable enough for payment and quality monitoring purposes.
- Overall, the inter-rater reliability results showed very good agreement on most items. These results suggest that most of the standardized versions of the assessment items have strong reliability within and across settings. Differences across settings were present, but each setting still had acceptable levels of reliability within settings, suggesting that these items could be used to measure a patient's progress in a standardized way across an episode of care.
- Items with poorer agreement among the samples (less than 0.60) tended to be items with fewer responses (e.g., items where the response code was “other” or “tube feeding” and “comatose,” for which few cases were included). A few items with reasonable sample sizes appeared to be less reliable, such as certain components of the swallowing item (“complaints of difficulty or pain when swallowing,” “holding food or liquid,” and “loss of liquid when swallowing”). These lower reliability ratings were offset in the swallowing domain by high reliability in the less discretionary components, such as “no intake by mouth” (NPO; 0.97) and “no impairments” (0.84). Other poor-scoring items included “light shopping,” and “laundry.”



Use of the Standardized CARE Items in Medicare's Quality Monitoring Process

The CARE items are currently being used to develop setting-agnostic measures of quality in the Medicare program. As required in Section 3004 of the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) is required to establish quality reporting programs for inpatient rehabilitation facilities, long-term care hospitals, and hospices. These efforts complement CMS' extant quality measurement programs: Hospital Inpatient Quality Reporting System (Hospital IQR), Hospital Outpatient Quality Reporting (Hospital OQR), Physician Quality Reporting System (PQRS), Nursing Home (NH), Home Health (HH), End-Stage Renal Disease (ESRD), Medicare Part C (Part C), and Medicare Part D (Part D).

As part of this process, CMS is developing patient-centered, cross-setting measures that are independent of the setting of care. For example, in the last year, CMS proposed a uniform measure of pressure ulcers that could apply across all settings. This builds on the premise that pressure ulcer severity is independent of setting; the severity of the ulcer may vary by setting, but this should be due to patient complexity in each setting, not setting-specific factors. Recognizing this

allows use of the same items and scales across settings to measure severity of a pressure ulcer. Additional risk factors may be needed to adjust for expected differences in patient severity at each level of care, but the items to measure those differences can be consistently measured. As part of this effort, the same core set of items can be found in the MDS 3.0, the OASIS-C, the IRF-PAI and the new LTCH- CARE assessment tool. All measures are submitted to the National Quality Forum for endorsement.³

Patient-centered approaches reflect the national strategy of improving population health, regardless of the setting of care. As noted earlier, Medicare beneficiaries use a range of services during an episode of care.

The CARE items provide standardized approaches for developing cross-setting measures that assess the severity of a patient's condition, regardless of whether the condition is a primary concern or a comorbid condition complicating their treatment.

Additional work remains to be done before standardized items are in place across the Medicare program but this work shows it is feasible. The standardized

versions of the items are reliable when applied to the acute and PAC populations. They are being used in the Medicare program quality measures to measure common conditions, such as pressure ulcers, and are being considered for functional status outcomes. For additional information, see <http://www.cms.gov/Center/Special-Topic/Quality-of-Care-Center.html>. These efforts will continue over the next few years as CMS moves to more uniform measurement approaches across an episode of care.

This effort provides the foundation for uniform language across the continuum to describe the complexity of populations treated, regardless of setting. Clinical staff in particular found this approach useful as patients are transferred across settings into their care. **Having a uniform language, independent of clinical training, will be important in improving coordination of care and understanding differences in complexity of patients and their outcomes across the health-care spectrum.**

Questions about this article can be directed to Barbara Gage, Ph.D., Fellow and Managing Director, The Engelberg Center for Health Care Reform at the Brookings Institution, bgage@brookings.edu or 202-238-3571.

3 CMS contracts with the National Quality Forum as the consensus-based entity responsible for convening multi-stakeholder groups (the Measures Application Partnership or MAP) to provide input to HHS on the identification of the best available performance measures and the selection of these measures for use in the programs listed in Section 1890(b)(7)(B)(i)(I) of the Act.

“Nearly nine out of 10 residents and their families – a full 88 percent – have high overall satisfaction levels and would recommend to others the facility in which they or their loved one resides.”



Consumer and Employee Satisfaction: An Important Measure of Care and Caring

*The data in this report present insights gathered from residents, families, and employees in surveys administered by **National Research Corporation** through its My InnerView subsidiary. **National Research Corporation** maintains the largest database of experience, satisfaction, and commitment data across all long-term care settings, but this report is limited to data collected on skilled nursing facilities.*

Overview



■ The demographic make-up of nursing facilities participating in the My InnerView surveys through the National Research Corporation (NRC) database is close to the national profile of nursing facilities in two key areas: number of licensed beds and profit status. The organizations participating in the NRC database have a slightly higher representation of 80-150 beds (51% vs. 48% nationally) and slightly higher representation for for-profit facilities (72% vs. 69% nationally). The NRC data differ from the national profile in one other way: 84% of nursing facilities included in this analysis were part of a multi-facility organization versus 55% nationally.

This report includes responses from:

- 85,770 family members from 2,651 nursing facilities
- 63,502 residents from 2,566 nursing facilities
- 219,268 employees from 2,369 nursing facilities

The Surveys

■ Satisfaction surveys are designed to assess more than basic levels of resident or patient satisfaction. Surveys are designed to collect information to support important facility initiatives on quality assurance, customer engagement, employee program development, performance improvement, referral source management, and community outreach. The My InnerView Customer Survey, reported on in this chapter, asked residents and families to review 22 nursing facility experiences across three broad areas:

- 1. Quality of life** – How do residents and families rate facility and staff performance on matters of safety, privacy, dignity, choice, and other aspects of individual well-being?
- 2. Quality of care** – How do residents and families rate staff and care practices, including competence and caring attitude?
- 3. Quality of services** – How satisfied are residents and families with meals, laundry, facility maintenance, and other core facility services?

■ Differences between the short-stay and long-stay versions of the survey were designed to evaluate issues that are more pertinent to each group. For example, the short-stay patient survey includes questions about the discharge process and progress toward discharge goals. Because there is a high correlation between consumer satisfaction and workforce satisfaction, My InnerView launched the Workforce Satisfaction and Commitment Surveys, which measure staff experiences within the facility context – with the goal of providing managers and leaders perspective on three key questions:

- 1. Resources** – Do employees have the tools, training, equipment, feedback, and other necessary resources to ensure successful caregiving?
- 2. Relationships** – Do team members, supervisors, and managers interact on a daily basis in ways that support employees' ability to provide quality care and services?
- 3. Commitment** – Does the employee feel aligned with and effectively integrated into the facility staff?

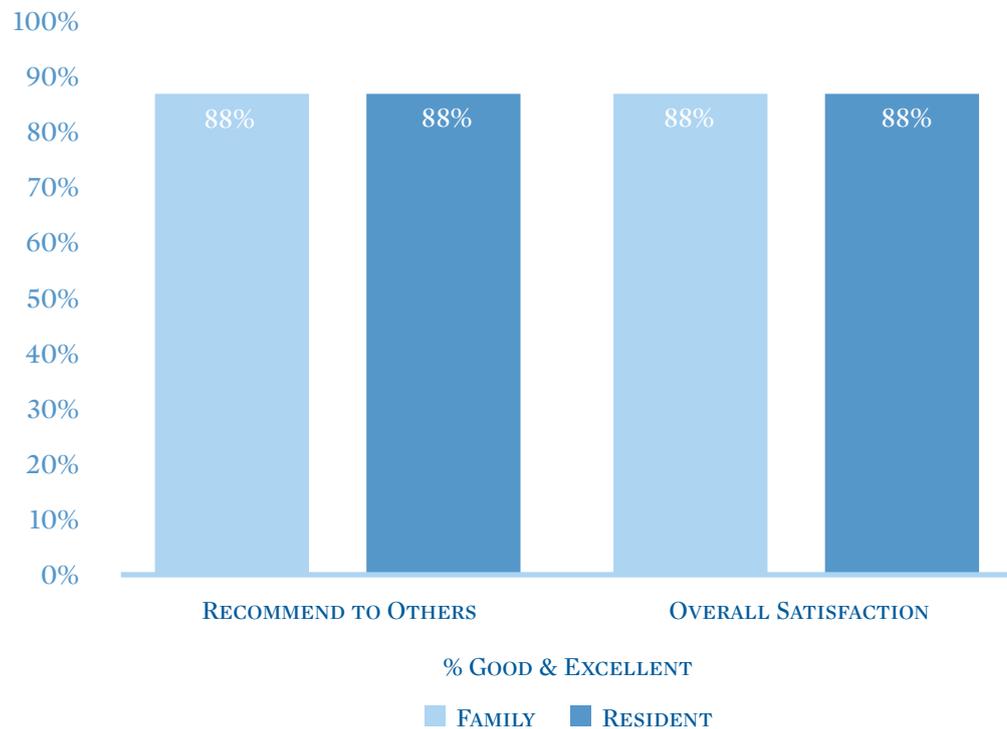
Consumer Satisfaction



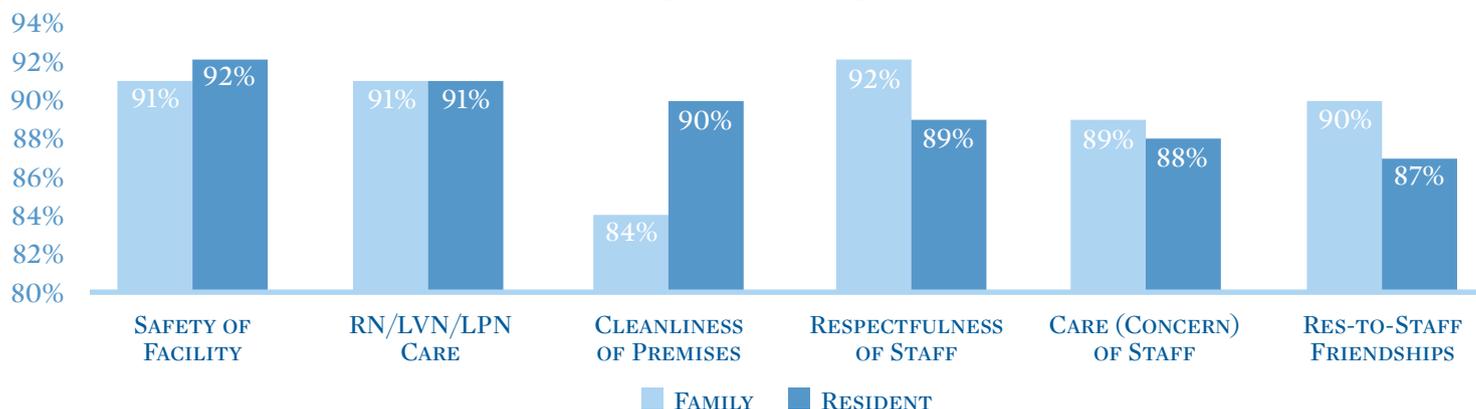
■ The general image of nursing facilities may not be entirely positive, yet nearly nine out of 10 residents and their families – a full 88 percent – have high overall satisfaction levels and would recommend to others the

facility in which they or their loved one resides. A consumer's willingness to provide a positive recommendation for a service or product is closely tied to the highest levels of satisfaction.

Overall Customer Satisfaction Ratings



Five Highest Scoring Measures



■ Satisfaction rates over the past five years have seen sustained, if gradual, improvement. In 2006, 83 percent of families said they would recommend their facility as an “excellent” or “good” place to receive care. That percentage increased to 88 percent in 2011-2012. Similarly, 85 percent of residents said they would recommend their facility as “excellent” or “good” in 2006 compared to 88 percent in 2011-2012.

Families’ and residents’ areas of both “excellent” and positive (“excellent” or “good”) satisfaction include the quality of meals or dining experience and the safety of personal belongings.

Analysis of the relationship between specific areas of satisfaction and an individual’s willingness to recommend a facility helps identify important areas of performance. The top two drivers of satisfaction – and willingness to recommend – for both residents and families are care (concern) of staff and competency of staff. These areas receive high satisfaction scores. The third driver of residents’ willingness to recommend is choices/preferences, while the third driver for families is responsiveness of facility management.

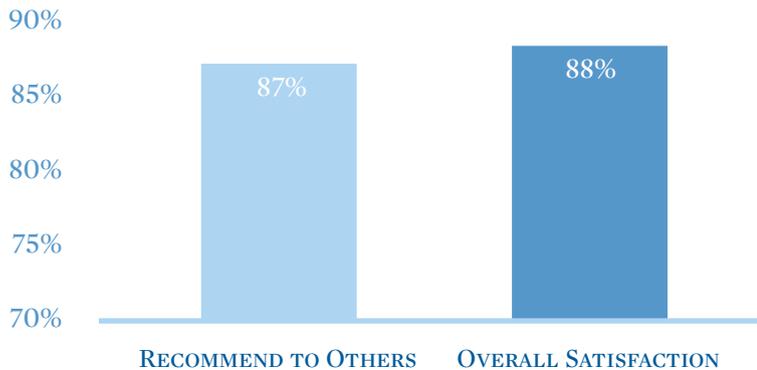
Trends in Willingness to Recommend Facility





Satisfaction of Short-Stay Patients

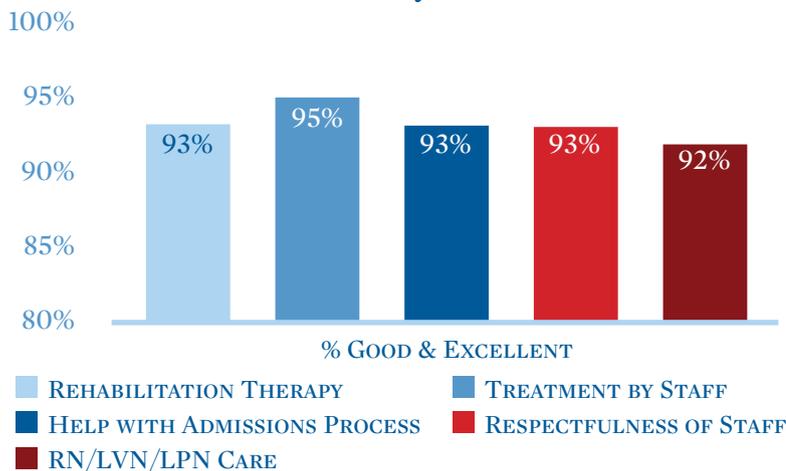
Short-Stay Satisfaction



■ The “short-stay” patient survey was designed to be administered primarily to post-acute Medicare beneficiaries who, for the most part, receive facility-based rehabilitation for fewer than 30 days.

Overall, short-stay patients provide slightly more positive feedback than their long-stay counterparts. Nearly 90 percent of patients rate their facility as excellent or good, with 87 percent willing to recommend the facility to others.

Short-Stay Satisfaction



Post-acute, short-stay patients are most satisfied with treatment of staff, quality of rehabilitation therapy, licensed nursing care, help with admissions, and respectfulness of staff.

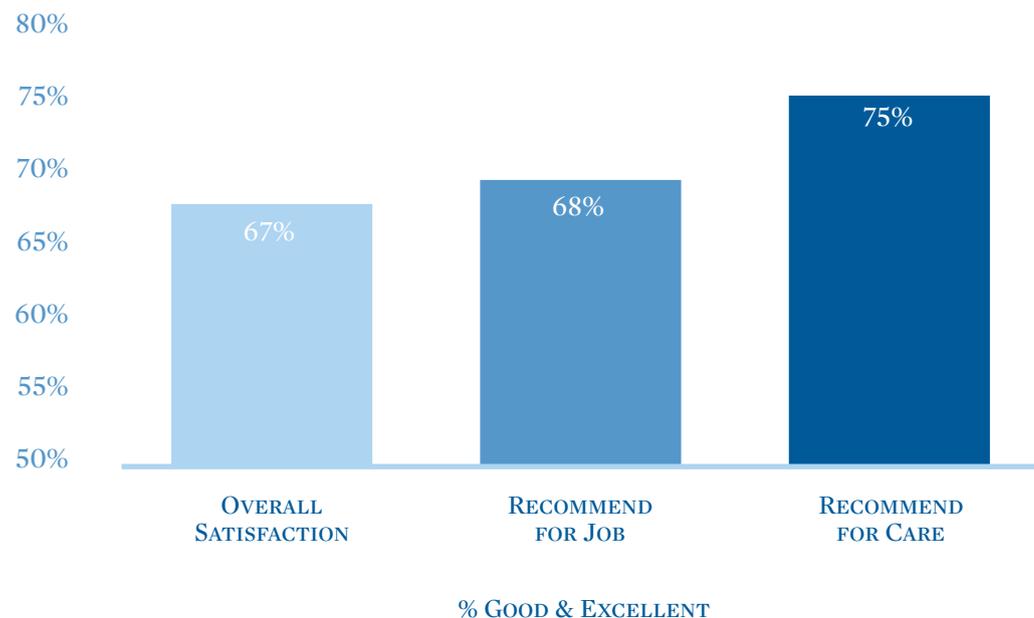
Employee Satisfaction



■ Facilities with higher workforce satisfaction also have higher resident and family satisfaction, making workforce satisfaction an important facility metric and an overall driver of quality care. An effective strategy for quality improvement must include

an intense and sustained focus on the skills, commitment and satisfaction of the workforce, particularly the frontline caregiving staff who directly care for residents and communicate with family members.

Employee Satisfaction



■ Employees of nursing facilities also provide valuable feedback about the facility both as a place of work and a place to receive care.

In 2011, three out of four nursing facility employees would recommend their facility as a place to receive care. Approximately two out of every three employees would recommend their facility as a place to work.

Employees were asked to rate their satisfaction with various aspects of their work in the facility. Sense of accomplishment was the top rated aspect of the work performed by nursing facility employees.



Conclusion

■ Resident, family, and employee satisfaction scores provide critical insights into the consumer and employee experience. Not only do the scores provide a blueprint for improving the care experience

of residents and their families, survey results also assist managers in building a stronger, more capable and satisfied workforce that is dedicated to assuring the delivery of quality care.



Quality Initiatives: Spotlights on Success

■ In 2002, the Alliance for Quality Nursing Home Care and other leaders in the skilled nursing facility (SNF) community launched Quality First, a sector-wide initiative in which providers promised to promote a dynamic workplace for employees, advance the development of key quality measures, and publicly report the results of our quality performance. Since that time, SNF providers have initiated successful quality improvement efforts that have achieved positive results in a variety of key areas.

With nine million people discharged from

acute care to post-acute care settings each year, the role of the SNF sector has grown considerably to meet the needs of this patient population. The post-acute care patients that SNFs care for require specialized medical and rehabilitative care in order to recover and regain function for an independent, active, and safe lifestyle. Programs have been designed to help patients meet the challenges of returning to community life after discharge, while minimizing the risk of the patient returning to the hospital.

■ Alliance member companies have em-



Overview

“Despite significant budgetary and regulatory changes that are making it increasingly difficult for SNFs to invest in new quality initiatives, enhanced staffing levels, or innovative technologies, SNFs have achieved positive trends in quality over the past decade and remain committed to sustaining that improvement.”

braced their role in post-acute care as evidenced by the development of new clinical specialty programs and best practice initiatives to ensure the best possible care for patients. While numerous successful quality initiatives have been put in place involving staffing improvements, SNFs as a whole have experienced a decline in workforce totals in recent years. According to the Bureau of Labor Statistics at the U.S. Department of Labor, the number of nursing facility employees is on the decline due in large part to significant funding reductions in the Medicare and Medicaid programs, which fund care for three out of every four patients. Between September 2011 and September 2012, the total number of SNF employees dropped by 11,200 (1,671,400 in 2011 to 1,660,200 in 2012). The most significant contraction occurred between October and November 2011, immediately following an 11.1 percent reduction in Medicare payments to SNFs.

Despite significant budgetary and regulatory changes that are making it increasingly difficult for SNFs to invest in new quality initiatives, enhanced staffing levels, or innovative technologies, SNFs have achieved positive trends in quality over the past decade and remain committed to sustaining that improvement.

In this chapter, three Alliance member companies detail quality improvement programs that have moved the needle and achieved measurable results in key quality improvement areas. The results of these programs offer objective evidence of SNF commitment to providing the highest possible quality of care and quality of life to patients in several important areas:

- Discharging more patients home
- Reducing average length of stay
- Reducing rehospitalization rates
- Expanding rehabilitation and therapy services

Through the specialized programs discussed in the following pages, and through similar programs throughout the country, SNFs reaffirm their commitment to continuous quality improvement by putting quality first.

Kindred Healthcare

Innovations in Reduced Lengths of Stay & Hospital Rehospitalizations



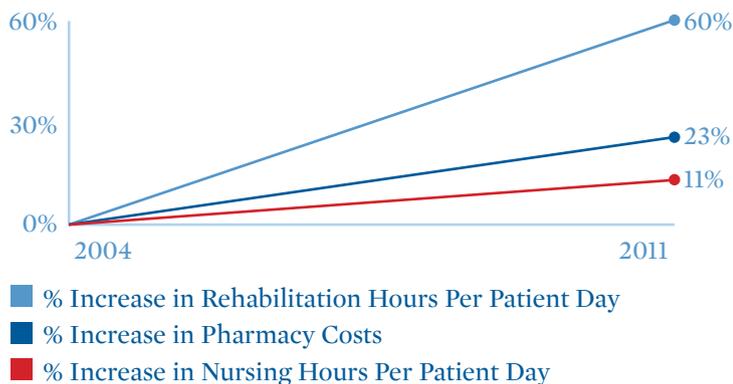
■ It is widely recognized that rehospitalizations are expensive and preventable. The

Centers for Medicare & Medicaid Services (CMS) estimates that costs associated with preventable readmissions throughout the entire healthcare continuum exceed \$17 billion each year. Specific to nursing facility care, reports estimate that an average of one in four patients are readmitted to a hospital within 30 days.

In line with the Medicare program's emphasis on reducing rehospitalizations Kindred Healthcare has put increased focus in recent years on sending patients home quickly and safely with fewer hospital readmissions. Despite challenging reimbursement and regulatory pressures, Kindred invested additional clinical resources in efforts to reduce readmissions, including an 11 percent increase in nursing hours per patient day since 2004. This investment resulted in an increase in the number of patients discharged home, a decrease in the average length of stay, and a reduction of hospital readmissions.

Kindred Investments In Clinical Resources

Increases in Rehab Hours,
Pharmacy Costs & Nursing Hours



Source: Kindred Internal Data

■ During that same period, Kindred has increased the number of rehabilitation hours per patient day by 60 percent in order to enable faster recovery and return home, as well as to prevent costly rehospitalizations – with both outcomes providing significant savings to the nation's Medicare system. Savings were generated by significantly reducing the average length of stay for patients in Kindred nursing centers – a 27 percent reduction since 2008 – with stronger functional status and increased rates of discharge home, rather than discharge to another care setting.

Expansion in Clinical Capabilities

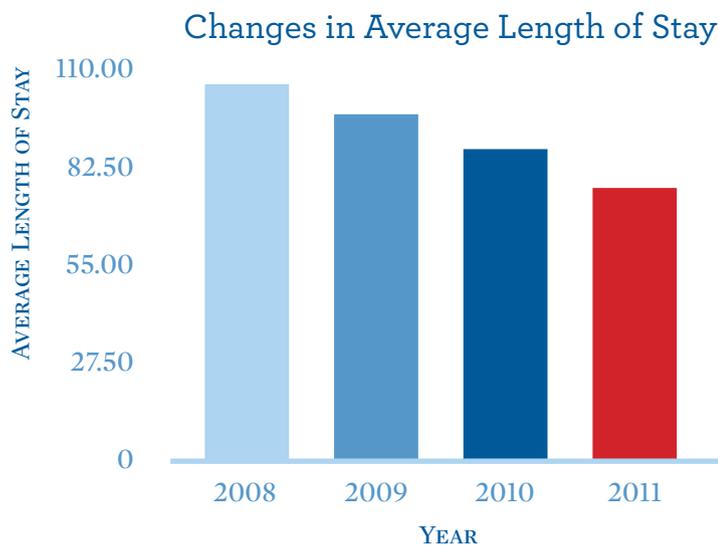
■ Kindred nursing and rehabilitation centers are treating an increasing number of medically and clinically complex patients with growing nursing and therapy needs. To meet their ultimate goal of preparing patients to return home – and stay home – Kindred has expanded its clinical capabilities in areas of cardiac, pulmonary, renal, orthopedic, stroke recovery and wound care.

Kindred recognizes the critical role rehabilitative therapies play in preventing hospitalizations, as evidenced by research showing that higher-intensity therapy interventions result in shorter lengths of stay in post-acute care settings and improved recovery. Not only can appropriate therapy facilitate recovery from an injury or surgical intervention, therapy also

contributes greatly to identifying and intervening when risk is identified through programs that address falls management and cognitive retraining.

Kindred's focus on innovative strategies to reduce rehospitalizations from post-acute care settings includes a series of market-specific pilot initiatives. For example:

- Centralized admissions for all post-acute settings help discharge planners determine the appropriate care setting based on clinical criteria and patient need.
- Clinical programs are tailored to meet the needs of acute hospitals in the given market to promote coordinated care. Drawing upon clinical criteria, and partnerships with other care settings, Kindred professionals determine when patients are ready to transition into a SNF for nursing and rehabilitative care, and when to discharge to home or a lower setting of care without increasing the risk of quality problems or rehospitalization.
- Transitional care nurses are being integrated into nursing centers in order to facilitate patient transfers between care settings and provide patient advocacy, education, and support for disease management, medication management, and patient-centered goals.



Measuring Functional Outcomes

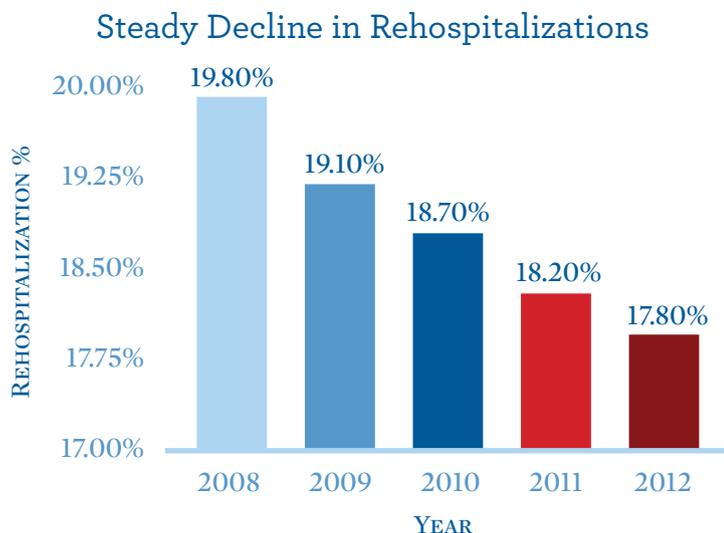
■ In order to effectively measure the impact that all therapy modalities – physical, occupational, and speech language pathology – Kindred uses internal data to measure modified “functional outcomes measures” (FOMs). Tools to track patient outcomes aid in a clinically driven course of therapy and better enable therapists to track recovery. Research indicates that tracking FOMs provides valuable data for assessing the effectiveness of rehab interventions. In 2011, the rehabilitation provided by Kindred’s

RehabCare therapists enabled patients and residents to regain 76.5 percent of their function as compared to what they were able to do prior to illness or injury. Additionally, from 2011 to 2012 therapists were able to deliver an even greater improvement in the increase in FOMs scores from admission to discharge at its nursing centers for all patient conditions – including stroke, wounds, neurological and orthopedic diagnoses, and pulmonary/cardiac conditions.

Changes in Rehospitalization

■ Kindred’s increased focus on reducing rehospitalizations through increased clinical capabilities, expanded staffing and streamlined

transition of care processes, Kindred nursing and rehabilitation centers have reduced rehospitalizations by 10 percent from 2008 through the first half of 2012.



■ Kindred further demonstrates its commitment to quality care and performance improvement through outcomes data that is reported publicly at www.kindredhealthcare.com/our-company/our-quality. Kindred provides robust reports on rehospitalization rates, length of stay, discharge disposition and functional outcome measures. These reports are used to improve quality and build post-acute care relationships to establish patient goals and plan for a successful return home.



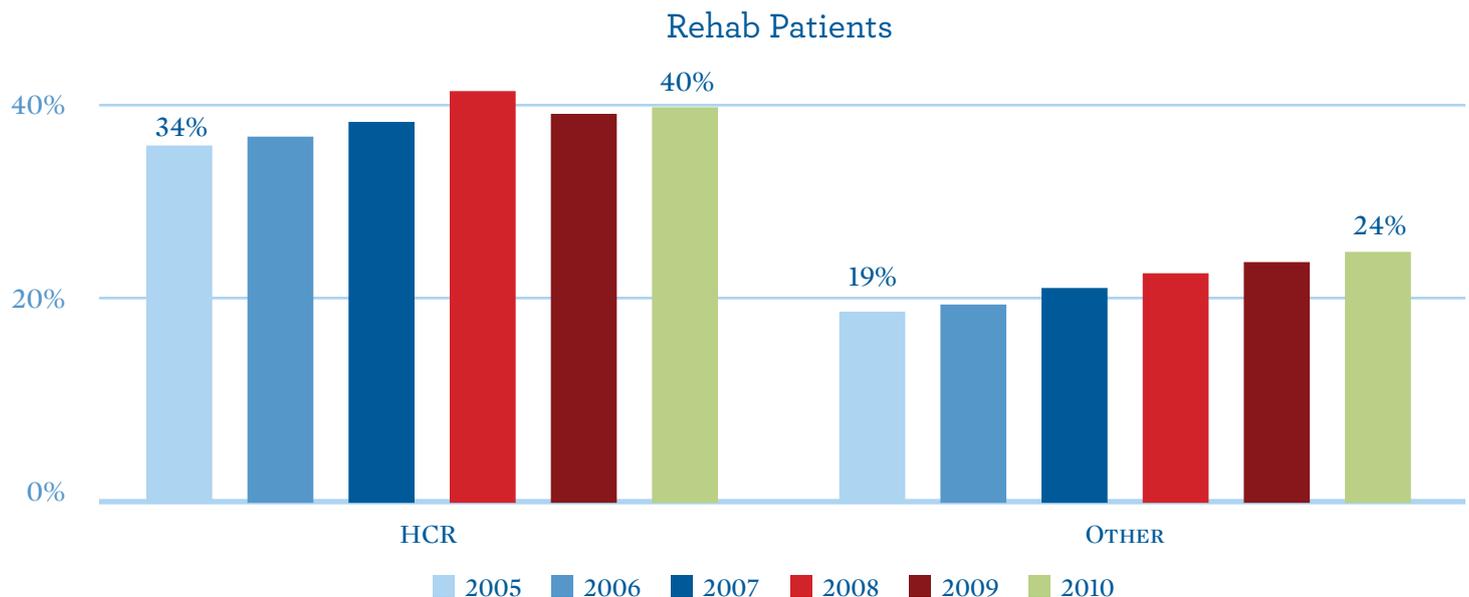
HCR ManorCare

Center-Based Medical Practice Nurse Practitioner Program



■ As the clinical complexity of post-acute care patients increases, HCR ManorCare has embraced a new role as a care provider capable of treating patients with hospital-level acuity, and offering patients a combination of clinical excellence and rehabilitation sophistication. On average, the patient population at HCR

ManorCare centers is more clinically complex than the patients treated in other skilled nursing facilities across the United States. This is particularly true among the percentage of residents receiving rehabilitative care. The HCR ManorCare average for patients requiring rehabilitation in 2010 was 40 percent, 16 percentage points higher than the other providers.¹



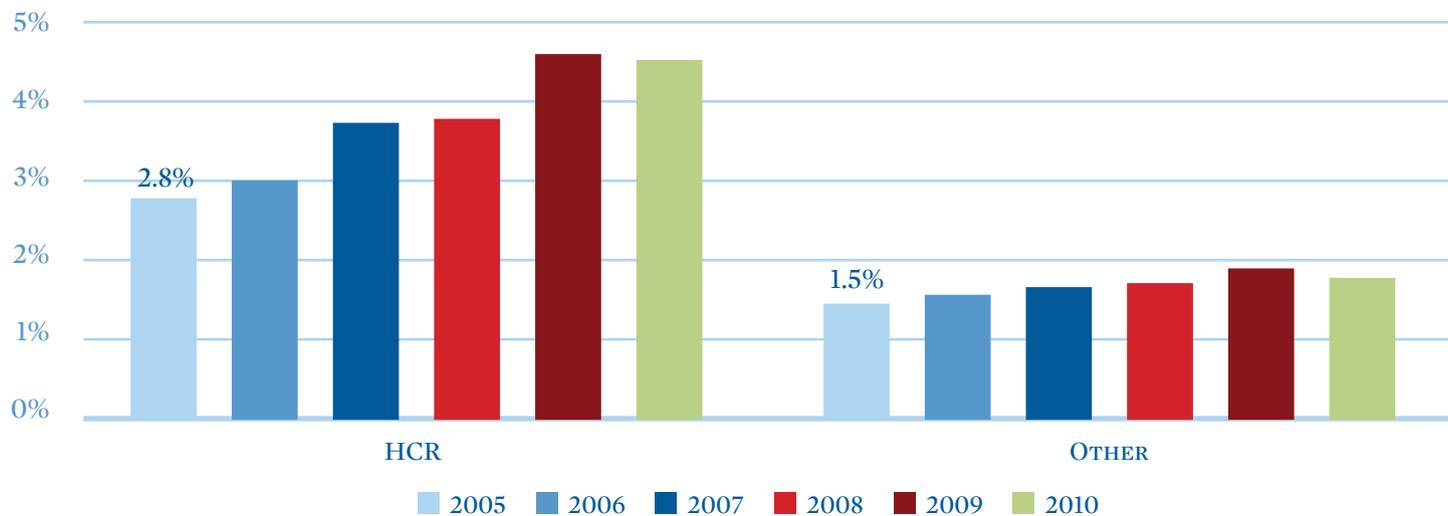
¹ Complexity of Care in HCR ManorCare Facilities. Team TSI Corporation, February 2011.
Composed using the CMS CASPER (OSCAR) database.

In terms of medical complexity, HCR ManorCare facilities care for much higher levels of patients requiring IV therapy, tracheotomy care, ostomy care, and dialysis care, among others. The data below also show the increased percentage of patients receiving these services at HCR ManorCare over a six-year time period (2005-2010):

- Rehabilitation therapy increased by 16 percent;
- IV therapy increased by 61 percent;
- Tracheotomy services increased by 45 percent;
- Ostomy care increased by 50 percent; and
- Dialysis care by 22 percent.²

The data seen in the charts below show that the complexity of patients cared for at HCR ManorCare exceeds the complexity found at other skilled nursing facilities in all four areas.

IV Therapy

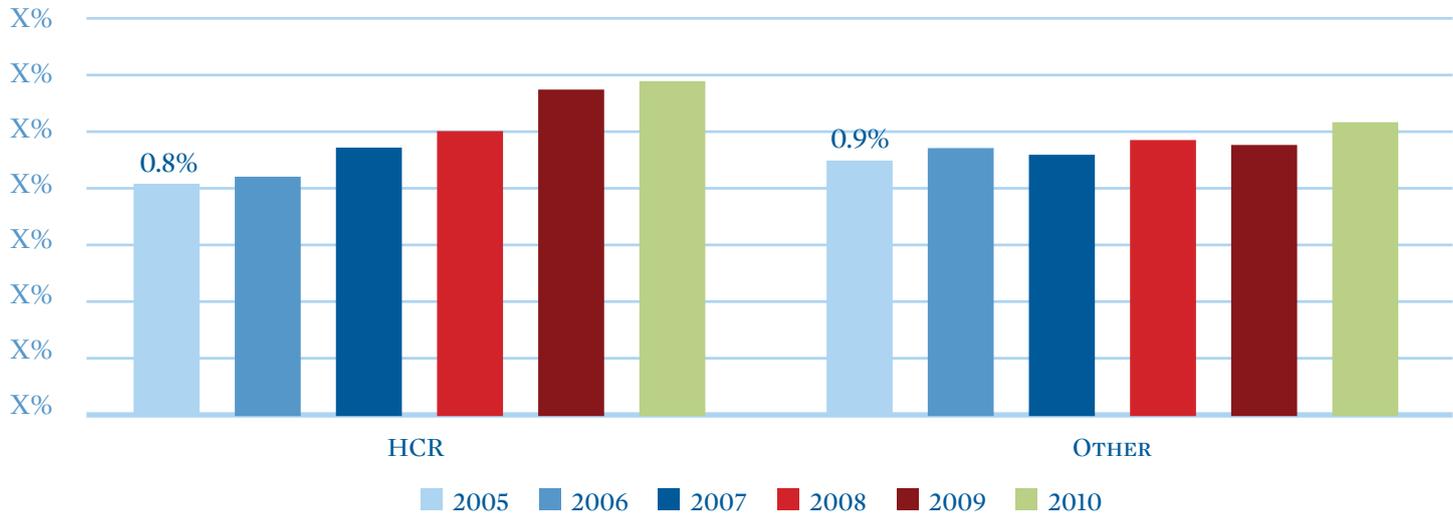


² Ibid.

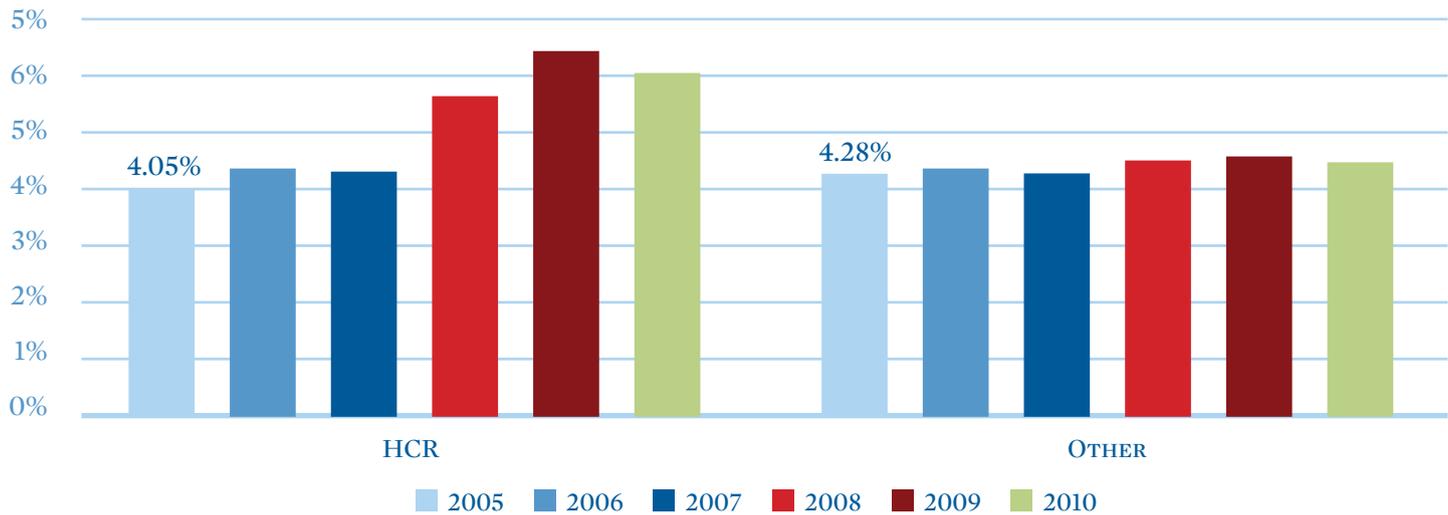
■ To address changes in patient acuity, HCR ManorCare has made considerable investments in professional staff to meet the requirements of patients

who have more complex needs than a traditional nursing center's long-term residents.

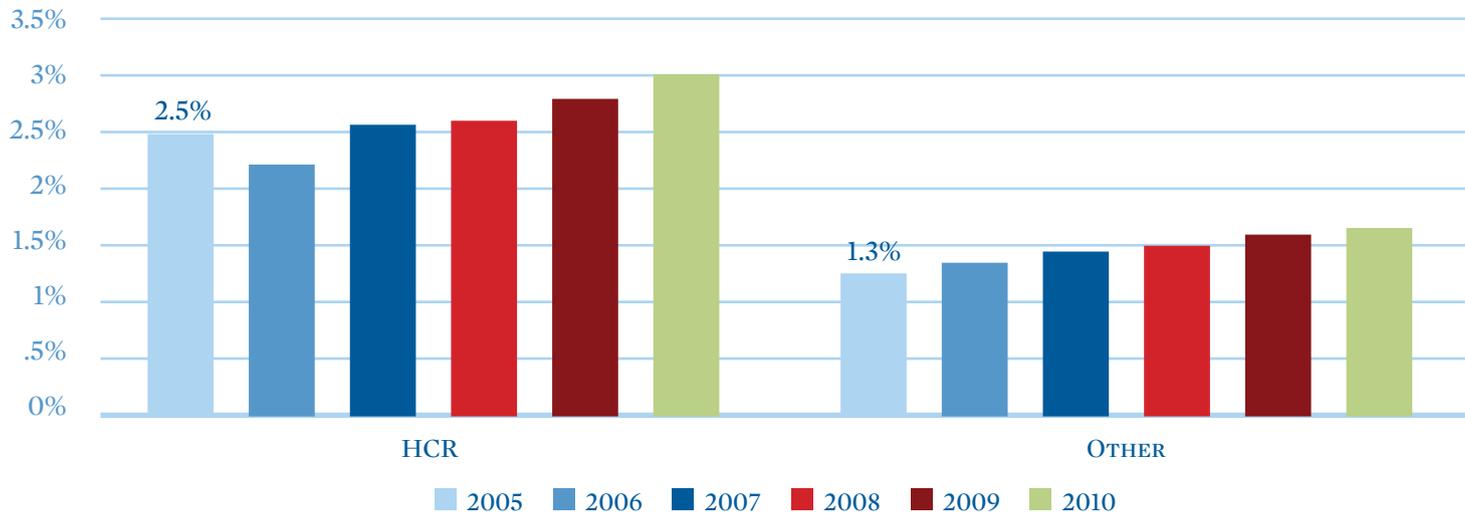
Tracheotomy



Ostomy



Dialysis



Center-Based Medical Practice Nurse Practitioner Program

■ The care and services given to a higher-acuity patient population necessitate employing a greater number of specialized professionals to efficiently guide progress, manage discharge planning, and reduce the probability of the patient going back to an acute-care setting.

Recognizing this shift in patient acuity, HCR ManorCare has added nurse practitioners (NP) to the professional care teams at high-acuity centers across the country. While HCR ManorCare has employed NPs in their centers for more than a dozen years, they determined that utilizing NPs with a higher level of medical expertise through a Center-Based Medical Practice Model would allow them to provide higher quality care to more complex patients. The center-

based NP works with the medical director and/or designated attending physicians to establish a medical practice within the center through an independent but collaborative relationship.

Centers targeted for this program include those serving a patient population with at least 40 percent short-stay residents (lengths of stay less than 28 days) and discharge to SNF immediately following hospitalization. Further, centers accepting higher volumes of patients with shorter average hospital lengths of stay (3-6 days) were chosen for the program to more effectively meet the needs of patients requiring higher levels of care and allow HCR to accept more challenging patients.

The Role of the Nurse Practitioner

■ NPs with an established medical practice are permitted to provide comprehensive evaluations of new admissions either prior to or following the initial assessment by the patient's attending physician, which generally includes a brief examination of the patient's medical history and physical condition. The comprehensive evaluation completed by the NP is a thorough review — taking an average of 45 minutes per patient.

To foster improved processes at their centers, HCR ManorCare has established thresholds for medical practice NPs to ensure timely assessment of new admissions — at least 70 percent of new admissions must be seen within 48 hours of admission — and further follow up must be completed on days 3, 10 and 28 of the patient's SNF visit. Additionally, if a patient has a primary diagnosis on admission of congestive heart failure, acute myocardial infarction, or pneumonia, they are seen daily for seven days and then a minimum of weekly thereafter for the first 30 days.

Measuring Success of the Center-Based Nurse Practitioner Program

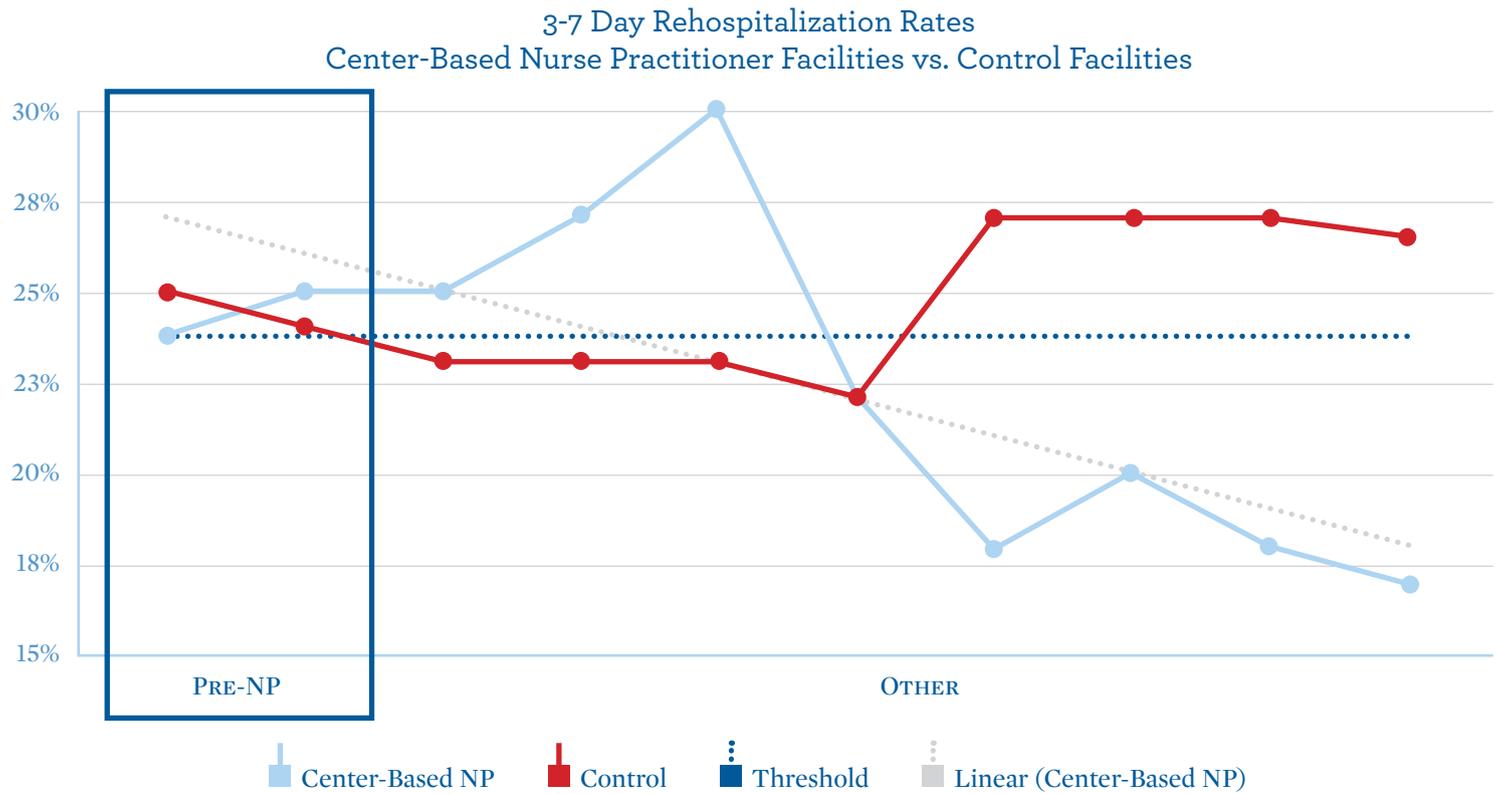
■ As a preventative intervention program, success can be difficult to measure. However, HCR ManorCare has found that centers participating in the Center-Based Medical Practice Nurse Practitioner Program have improved medical, clinical, and administrative operations and significantly reduced rates for readmission to the acute-care setting.

High-acuity centers with medical practice NPs are successfully managing complex cases by reducing preventable and unnecessary readmissions to the hospital and avoiding a gap in the continuum of medical care provided when a patient transitions from the acute to the post-acute care setting. The Center-Based Medical Practice Nurse Practitioner program has been particu-

larly instrumental in reducing rehospitalization rates within the critical 3-7 day admission window by 30 to 40 percent.

Exhibit 1 below shows that over a 10-month time period following the initial 6-month period of the medical practice NP entering a center, the 3-7 day rehospitalization rate dropped from 25 to 17 percent of the total 30-day rehospitalization percent. When compared with the control group of centers without a medical practice NP, centers experienced 37 percent fewer hospital readmissions (27% vs. 17%) within the 3-7 day window.

EXHIBIT 1: Center-Based Nurse Practitioner vs. Control Group Rehospitalization Rates



■ HCR ManorCare currently has 82 full-time center-based medical practice NPs in 86 of its skilled nursing centers nationwide. Because of the success HCR has

seen in streamlining assessment processes and reducing rehospitalizations, the program is being gradually extended.

Genesis HealthCare

Focus on Short-Term, Post-Acute Rehabilitation



Genesis HealthCareSM

■ Skilled nursing facilities are an essential part of the healthcare delivery system. Of the 40 percent of Medicare hospital discharge patients requiring post-acute care and rehabilitation services, nearly half are now discharged to a skilled nursing facility (SNF).

In response to this increased demand for skilled nursing care among older Americans, Genesis introduced a series of quality improvement efforts to offer increased clinical capabilities for patients seeking short-term skilled nursing and rehabilitative care in 2011. Genesis short-stay centers throughout the country provide new options for post-acute care and specialty programs such as cardiac and pulmonary management for all short-stay centers.

The Genesis PowerBack Program

■ Genesis introduced the PowerBack Rehabilitation model in 2011. PowerBack Rehabilitation was designed to intensify therapy and medical services with the goal of allowing patients to move

Clinical improvements and capital investments have been made to increase capabilities for treating short-stay patients with the goal of regaining their strength for discharge home. From expert specialists in medical and therapeutic disciplines to the most advanced technologies and equipment, Genesis' clinical teams develop highly personalized plans designed to get patients home quickly after a hospital stay.

While the environment is medically intensive, Genesis skilled nursing centers are utilizing evidence-based delivery care models, increased patient education initiatives and specialized rehabilitation equipment to improve patients' outcomes. Further emphasis has been placed on rapid recovery situations to help Genesis patients optimize rehabilitation.

through the rehabilitation process efficiently, safely, and rapidly. The program also focuses on educating patients after discharge and following up with them regarding appropriate post-acute care.

Genesis now has seven PowerBack Rehabilitation locations in the eastern United States. The first PowerBack Rehabilitation location, launched at Brightwood Campus in Lutherville, Timonium, Maryland, has achieved

measurable results in several quality areas. Since January 2012, PowerBack at Brightwood has increased its volume of high-acuity patients from 100 admissions per month to 150 admissions per month.

Measuring Powerback Success

■ Genesis uses Functional Independence Measures (FIM) to uniformly assess the severity of patient disability as well as the functional outcomes of medical rehabilitation. Since 1994, a version specific to skilled nursing centers and sub-acute providers has been available (FIM-PAI). The tool is composed of 18 items: 13 motor tasks and 5 cognitive assessments. These items are rated on a 7 point-ordinal scale ranging from total assistance (or complete dependence) to complete independence, resulting in a range of possible scores of 18 to 126.

Typically the FIM results are gathered at admission and at discharge and the reporting compares a single provider's results to national averages. Additionally, the reports define these gains in particular diagnostic groups such as Orthopedic Disorders or Neurologic Conditions. The average discharge FIM score will reveal the average level of disability of patients discharged after an episode of care in a post-acute setting. The FIM reporting also provides the average change in the FIM score, which defines the amount of functional gain occurred during the episode of care. The FIM

scores gathered for Genesis PowerBack Rehabilitation (PBR) patients at Brightwood Campus demonstrate that :

- The average length of stay (LOS) of a PowerBack patient declined by one day since March 2010, from 15 days to 14 days, and is 8 days shorter than the average LOS among all SNFs. The goal of efficient rehabilitation is to maximize physical function in the shortest amount of time.
- The average discharge FIM score is 12 points higher at Powerback Rehabilitation when compared with the national average (higher Average Discharge FIM scores are better). This means that patients cared for at PowerBack exceeded the national average in how much functional improvement they attained during their stay.
- The average discharge to community scores for PowerBack are 9 percentage points higher than the national average. This rate reports the percentage of patients who left the facility and were discharged to a location in the community.

Brightwood's FIM Data

	Apr 2009-Mar 2010	Apr 2011 – Mar 2012
Average LOS PBR	15	14
Average LOS US	18	22
Average Discharge FIM PBR	114.7	112
Average Discharge FIM US	102.6	100
Discharge to Community PBR	100%	95%
Discharge to Community US	87%	86%

**FIM data not available April 2010 to March 2011*

PowerBack Quality Measures Data

■ Further, publicly reported Quality Measures (QM) data for PowerBack Rehabilitation at Brightwood illustrates that, on average, pa-

tients within this program are performing better when compared to national short-stay patients.

EXHIBIT 1: Short-Stay Residents With New or Worsening Pressure Ulcers (PowerBack vs. National Average)

■ For example, as seen in Exhibit 1 at right, the percent of PowerBack patients with pressure ulcers that are new or worsened (short-stay) remains below the national average. While the pre-PowerBack vs. PowerBack QM rate remains steady, the new and worsening pressure ulcer rate at PowerBack, Brightwood is 0.3 percent lower than the national SNF average.

Short-Stay Worsening/New PU Quality Measures

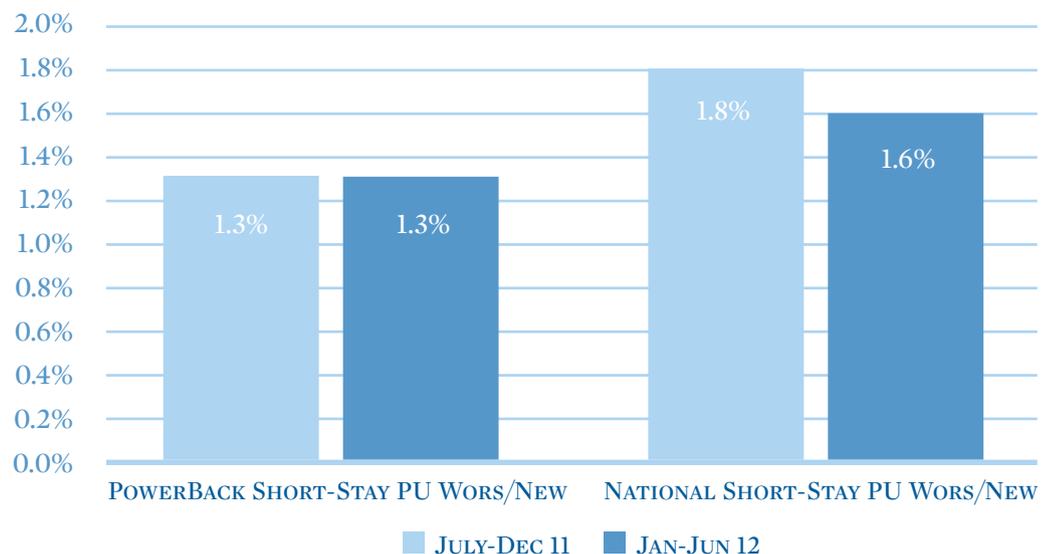


EXHIBIT 2: Short-Stay Residents With Influenza Immunization and Pneumonia Vaccination (PowerBack vs. National Average)

■ Data shown in Exhibit 2 below demonstrates that PowerBack short-stay patients at Brightwood are far exceeding national rates for both influenza immunizations and pneumonia vaccinations. Furthermore, Genesis has seen a considerable improvement in both

Short-stay QMs since the PowerBack program was introduced at Brightwood in January 2012, experiencing an improvement of 7 percent in short-stay flu immunizations and a .5 percent improvement in short-stay pneumonia vaccinations from December 2011.

Short-Stay Vaccination QMs

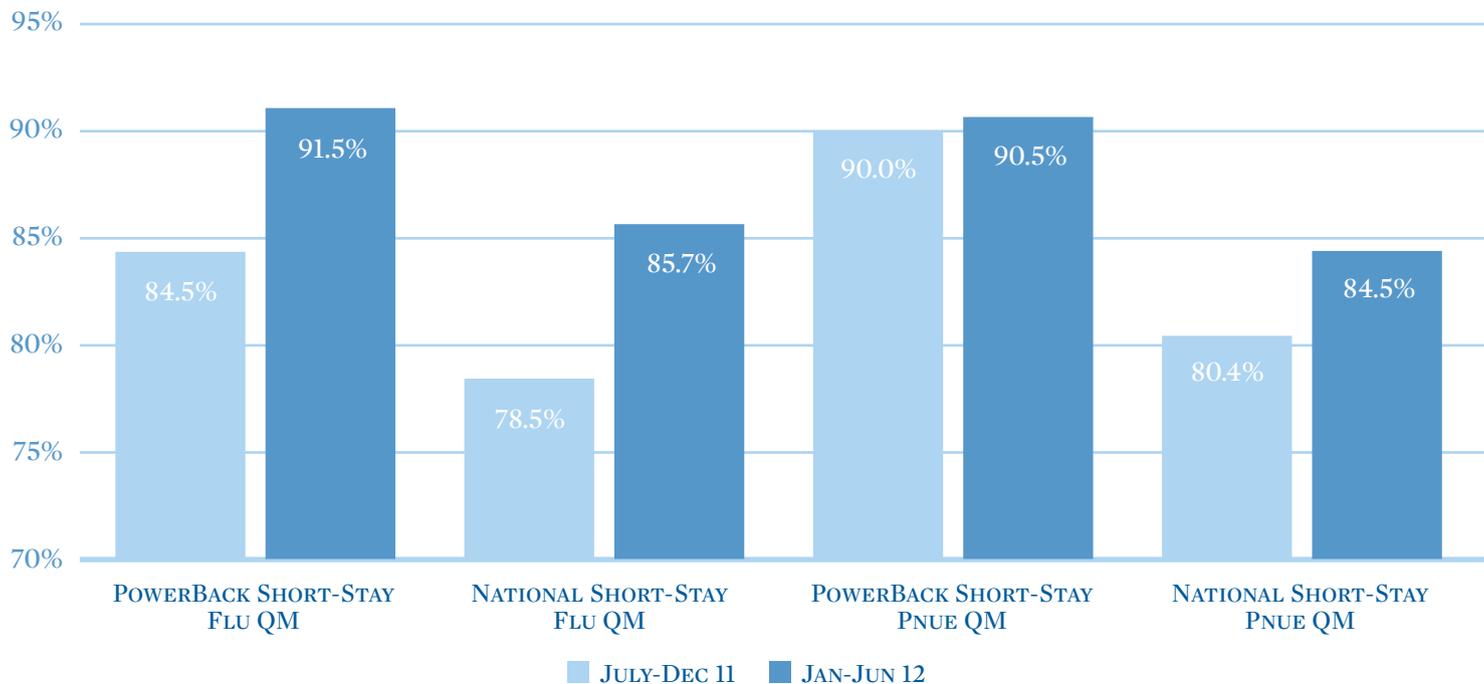
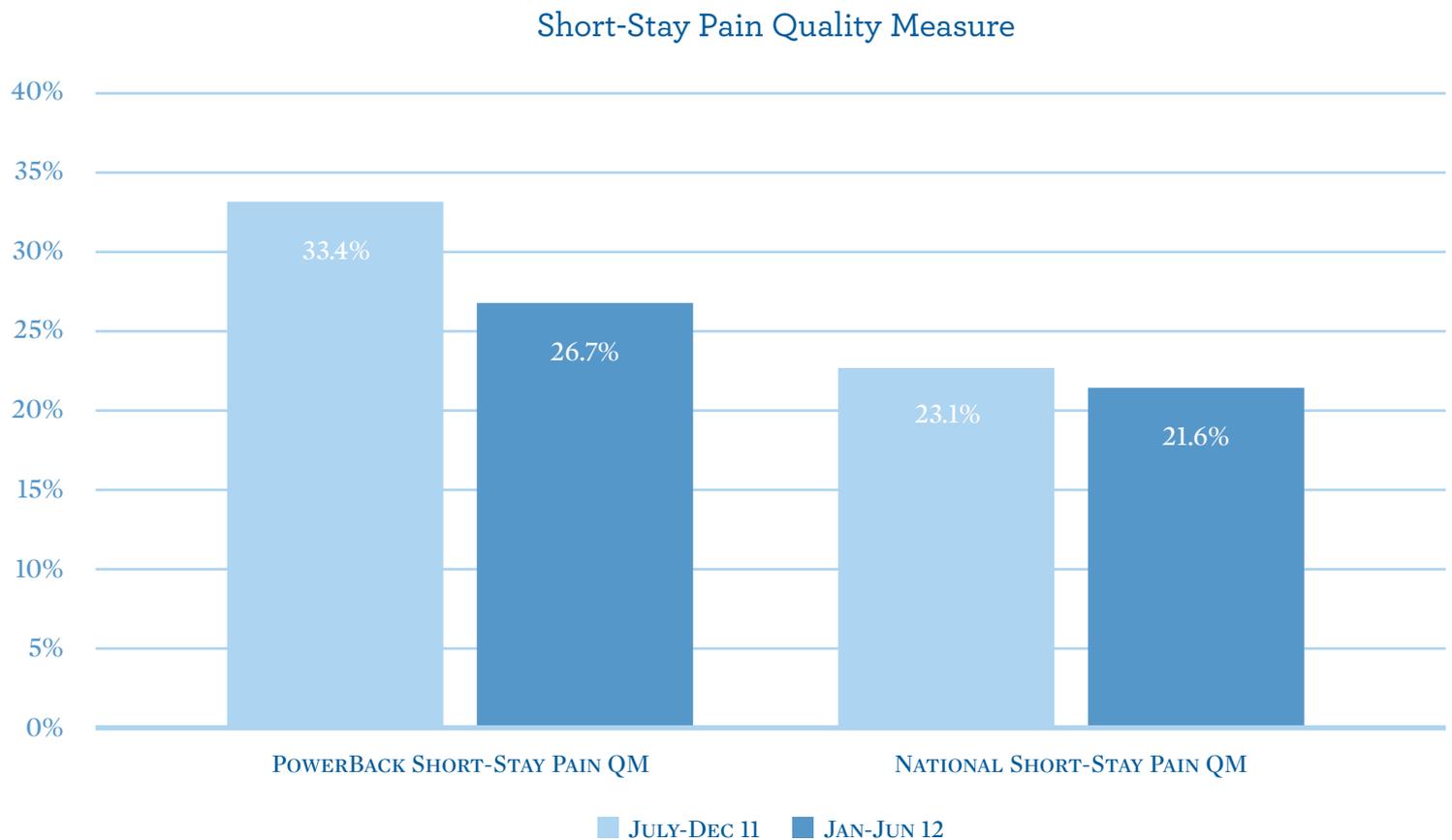


EXHIBIT 3: Short-Stay Residents With Pain (PowerBack vs. National Average)



■ Exhibit 3 shows the short-stay pain QM data for PowerBack patients, for which Genesis has seen a 6.7 percent improvement since the program was introduced at Brightwood, however the QM rate remains slightly higher than the national average. While this

rate was expected to be higher than the national average because the facility cares for a 100 percent short-stay population with higher acuity patients, pain among PowerBack patient is continuing to decline.



Appendix A – Quality Measures: Changes from MDS 2.0 to MDS 3.0

	MDS 2.0 Quality Measures	MDS 3.0 Quality Measures	Differences
	<p>SS (PAC)measure used only 5 and 14 day PPS;</p> <p>LS (CC)measures used OBRA assessments; 14-day look-back for most MDS items</p> <p>*= used in Five-Star Quality Domain</p>	<p>Uses all PPS and OBRA assessments for both SS and LS measures including a Discharge Assessment which was not available with 2.0 QMs; based on resident episodes; 7-day look-back for most MDS items</p>	<p>MDS 2.0 and 3.0 QMs use completely different resident sample and assessment selection methodologies and cannot be directly compared; SS includes residents with episodes \leq 100 days; LS includes residents with episodes $>$100 days</p>
Pain SS	Percent of residents who had moderate to severe pain-PAC*	SS Measure (#0676): Percent of Residents Who Self-Report Moderate to Severe Pain*	MDS 3.0 QM uses direct resident interview and industry standard pain scales.
Pressure Ulcers SS	Percent of residents with pressure ulcers (sores)-PAC*	SS Measure (#0678): Percent of Residents with New or Worsening Stage II-IV Pressure Ulcers*	MDS 3.0 QM does not capture Stage I PUs as did MDS 2.0 QM; MDS 3.0 no longer “reverse stages”
Flu Vaccine SS & LS	Percent of residents given influenza vaccination during the flu season—short-stay (PAC) and long-stay (CC)	SS Measure (#0680), LS Measure (#0681): Percent of Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine	MDS 3.0 includes offered and declined the vaccine, and ineligible due to contraindications
Pneumococcal Vaccine SS & LS	Percent of residents who were assessed and given pneumococcal vaccination—short-stay (PAC) and long-stay (CC)	SS Measure (#0682), LS Measure (#0683): Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine	MDS 3.0 includes offered and declined the vaccine, and ineligible due to contraindications
Pain LS	Percent of long-stay residents who have moderate to severe pain (CC)*	LS Measure (#0677): Percent of Residents Who Self-Report Moderate to Severe Pain*	MDS 3.0 QM uses direct resident interview and industry standard pain scales
Pressure Ulcers LS	Percent of long-stay high-risk residents who have pressure ulcers (CC)*	LS Measure (#0679): Percent of High-Risk Residents With Stage II- IV Pressure Ulcers*	MDS 3.0 QM does not capture Stage I PUs as did MDS 2.0 QM. MDS 3.0 no longer “reverse stages”

	MDS 2.0 Quality Measures	MDS 3.0 Quality Measures*	Differences
	<p>SS measure used only 5 and 14 day PPS</p> <p>LS measures used OBRA assessments</p> <p>* = Used in Five-Star Quality Domain</p>	<p>Uses all PPS and OBRA assessments for both SS and LS measures including a Discharge Assessment which was not available with 2.0 QMs; based on resident episodes</p>	<p>MDS 2.0 and 3.0 QMs use completely different resident sample and assessment selection methodologies and cannot be directly compared</p>
Infections LS	<p>Percent of long-stay residents who had a urinary tract infection (CC)*</p>	<p>LS Measure (#0684): Percent of Residents with a Urinary Tract Infection*</p>	<p>Item 12300 used in 3.0 QM has specific criteria to follow for coding UTI</p>
Incontinence LS	<p>Percent of long-stay residents who lose control of their bowels or bladder (CC)</p>	<p>LS Measure (#0685): Percent of Low Risk Residents Who Lose Control of Their Bowel or Bladder</p>	<p>3.0 QM uses the BIMS score to determine severe cognitive impairment</p>
Catheter LS	<p>Percent of long-stay residents who have/had a catheter inserted and left in their bladder (CC)*</p>	<p>LS Measure (#0686): Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder*</p>	<p>3.0 QM adds exclusions for neurogenic bladder and obstructive uropathy</p>
Restraints LS	<p>Percent of long-stay residents who were physically restrained (CC)*</p>	<p>LS Measure (#0687): Percent of Residents Who Were Physically Restrained*</p>	<p>Similar</p>
ADLs LS	<p>Percent of long-stay residents whose need for help with daily activities has increased (CC)*</p>	<p>LS Measure (#0688): Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased*</p>	<p>"MDS 3.0 measure interprets a code of "7" or "8" in section G- ADLs as a "4" for purposes of calculating the measure"</p>
Weight Loss LS	<p>Percent of long-stay residents who lose too much weight (CC)</p>	<p>LS Measure (#0689): Percent of Residents Who Lose Too much Weight</p>	<p>MDS 3.0 measure pertains to residents who were not on a physician prescribed weight-loss regimen</p>
Depression LS	<p>Percent of long-stay residents who are more depressed or anxious (CC)</p>	<p>LS Measure (#0690): Percent of Residents Who Have Depressive Symptoms</p>	<p>MDS 3.0 measures uses standardized scales PHQ-9 © and PHQ-9OV© items + scores</p>

Appendix B – Chapter 2 Reference List

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