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COURAGE IGNITED

2024

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Cross-Continuum Collaboration

- A Key Driver for Success in Value-Based Care

Caryn Enderle, SLP
Director of Business Development
Concept Rehab & Engage Consulting

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OBJECTIVES

Understanding the role SNFs play in value-based care partnerships

Application of strategy to attract acute referral network partners

Fostering down-stream collaboration through strategic processes

Integrating therapy & nursing to enhance resident transitions

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VALUE-BASED CARE - DEFINITION

What is Value-Based Care?

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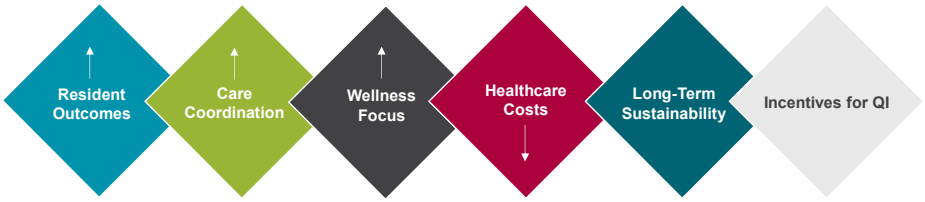
VALUE-BASED CARE – BENEFITS



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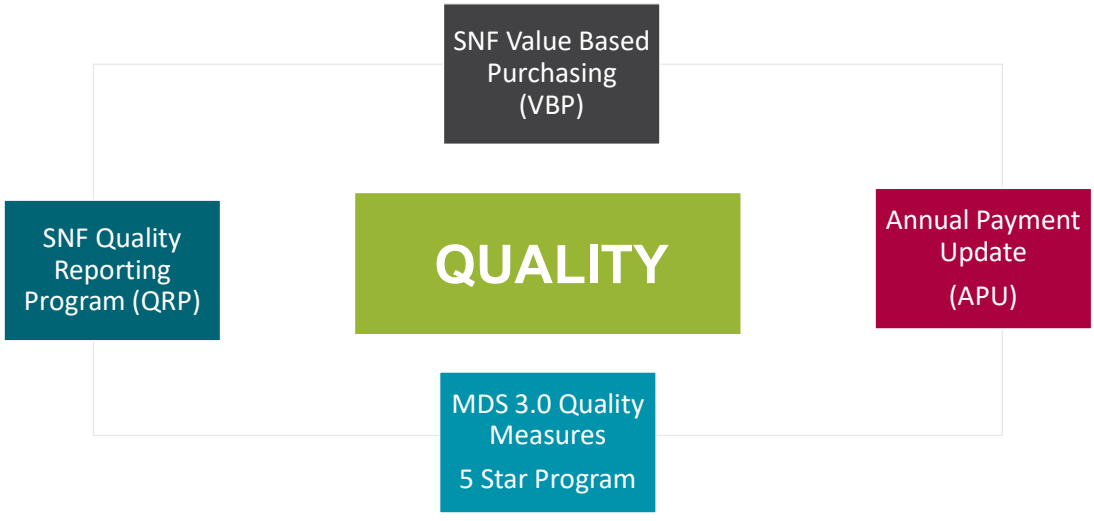
VALUE-BASED CARE – QUALITY IS KING!



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SNF QRP & VBP GUIDE

SNF QRP & VBP Guide

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SNF QRP Overview: The IMPACT Act of 2014 required that SNFs be required to submit data for public reporting. In response, CMS established the SNF QRP to include quality measures that relate to care provided by a SNF to be reported on Care Compare.

Reporting Insights: iQIES Reports to Review: SNF QRP Review and Correct Report, SNF QRP Annual Payment Update, SNF QRP Resident and Facility Level QM Report.

MEASURE	MEASURE DESCRIPTION	MEASURE IMPACT
Medicare Claims-Based Measures: Data for these measures are collected from claims, and no additional data need to be submitted by the SNF.		
Potentially Preventable 30-Day Post Discharge Readmission Measure	Estimates the risk-standardized rate of unplanned, potentially preventable readmissions for residents who receive services in SNF.	SNF QRP
Discharge to Community (DTC)	Reports risk-standardized rate of Medicare residents who are DC'd to community following SNF stay and do not have an unplanned readmission to hospital in the 31 days following discharge and remain alive.	Five-Star, SNF QRP, SNF VBP (2027)
Medicare Spending Per Beneficiary (MSPB)	Evaluates SNF providers' resource use relative to the use of national median SNF provider regarding the cost to Medicare for services performed by the SNF.	SNF QRP
SNF Healthcare-Associated Infections (HAI) Requiring Hospitalization	Estimates the risk-standardized rate HAIs that are acquired during SNF care and result in hospitalizations (Day 4 or after SNF admission and within 3 days from SNF DC).	SNF QRP, SNF VBP (2026)
MDS-Based QRP Measures: Data collected using the MDS 3.0 and submitted to CMS via iQIES		
Residents Experiencing One or More Falls with Major Injury	Medicare A SNF stays where one or more falls with major injury were reported during the SNF stay.	SNF QRP
Drug Regimen Review Conducted With Follow-Up for Identified Issues	Medicare A SNF stays in which a drug regimen review was conducted at the time of admission and timely follow-up with a physician occurred each time potential clinically significant medication issues were identified throughout stay.	SNF QRP
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	Medicare A SNF stays with Stage 2-4 pressure ulcers, unstageable pressure ulcers, non-removable dressing/device, or deep tissue injury, that are new or worsened since admission.	QM, Five-Star, SNF QRP
Discharge Self-Care Score for Medical Rehabilitation Patients	Estimates the percentage of Medicare A SNF stays that meet or exceed an expected discharge self-care score. (Utilizes GG Self-Care items).	SNF QRP
Discharge Mobility Score for Medical Rehabilitation Patients	Estimates the percentage of Medicare A SNF stays that meet or exceed an expected discharge mobility score. (Utilizes GG Mobility items).	SNF QRP
Discharge Function Score	Estimates the percentage of Medicare A SNF stays that meet or exceed an expected discharge function score. (Utilizes a combo of GG mobility and self-care items. Score range from 10-60 points). Data collection began 10/1/23.	QM, Five-Star, SNF QRP, SNF VBP (2027)
Transfer of Health (TOH) Information to the Provider Post-Acute Care	Reports the percentage of SNF stays indicating a current reconciled medication list was transferred to the subsequent provider at the time of discharge.	SNF QRP
Transfer of Health (TOH) Information to the Patient Post-Acute Care	Reports the percentage of SNF stays indicating a current reconciled medication list was transferred to the resident, family and/or caregiver at the time of discharge.	SNF QRP
NHSN Measures: Data for these measures are submitted via the CDC National Healthcare Safety Network (NHSN)		
COVID-19 Vaccination Coverage among Healthcare Personnel	Process measure where SNFs submit data to NHSN on the number of staff "up-to-date" with COVID-19 vaccination.	SNF QRP
Influenza Vaccination Coverage among Healthcare Personnel	Process measure where SNFs submit data to NHSN on the number of staff who received the influenza vaccination during the October 1 through March 31st time period.	SNF QRP
Annual Payment Update (APU): SNFS are subject to a 2% reduction in annual payment update (APU) if reporting requirements are not met:		
1. 90% of MDS assessments have 100% required data reported. 2. 100% of data measures submitted using CDC NHSN (COVID-19 and influenza HCP vaccination measures)		

SNF VBP Overview: CMS awards incentive payments to SNFs through the SNF VBP Program to encourage SNFs to improve the quality of care they provide to patients. CMS withholds 2% of Medicare FFS Part A payments to fund the program, then redistributes between 50% to 70% of this withhold to SNFs as incentive payments.

Reporting Insights: iQIES Reports to Review: CMS provides confidential feedback reports to SNFs on a quarterly basis through iQIES.

MEASURE	MEASURE DESCRIPTION	MEASURE IMPACT
Medicare Claims-Based Measures: Data for these measures are collected from claims, and no additional data need to be submitted by the SNF.		
Number of Hospitalizations per 1,000 Long-Stay Resident Days	Number of unplanned inpatient admissions or outpatient observation for long-stay residents that occurred during a one-year period	Five-Star, SNF VBP (2027)
Discharge to Community (DTC)	Reports risk-standardized rate of Medicare residents who are DC'd to community following SNF stay and do not have an unplanned readmission to hospital in the 31 days following discharge and remain alive.	SNF QRP, SNF VBP (2027)
SNF Healthcare-Associated Infections (HAI) Requiring Hospitalization	Estimates the risk-standardized rate HAIs that are acquired during SNF care and result in hospitalizations (Day 4 or after SNF admission and within 3 days from SNF DC).	SNF QRP, SNF VBP (2026)
SNF 30-Day All-Cause Readmission Measure	Estimates the risk-standardized rate of all-cause, unplanned hospital readmissions for SNF beneficiaries within 30 days of discharge from a prior hospitalization. (Will be replaced in FY 2028 with "SNF Within-Stay Potentially Preventable Readmissions)	SNF VBP
MDS-Based QRP Measures: Data collected using the MDS 3.0 and submitted to CMS via iQIES		
Residents Experiencing One or More Falls with Major Injury	Reports percentage of residents experiencing one or more falls with major injury reported (long-stay)	QM, Five-Star, SNF VBP (2027)
Discharge Function Score	Estimates the percentage of Medicare A SNF stays that meet or exceed an expected discharge function score. (Utilizes a combo of GG mobility and self-care items. Score range from 10-60 points).	QM, Five-Star, SNF QRP, SNF VBP (2027)
Measures		
Total Nurse Staffing Hours Per Resident Day	Utilizes PBJ data to calculate the total nursing hours per resident day, is case-mix adjusted, and includes the total nursing hours including RN, LPN and nurse aide hours.	SNF VBP (2026)
Total Nursing Staff Turnover	Utilizes six consecutive quarters PBJ data to define annual turnover of nursing staff and includes RN, LPN and nurse aide turnover.	SNF VBP (2026)

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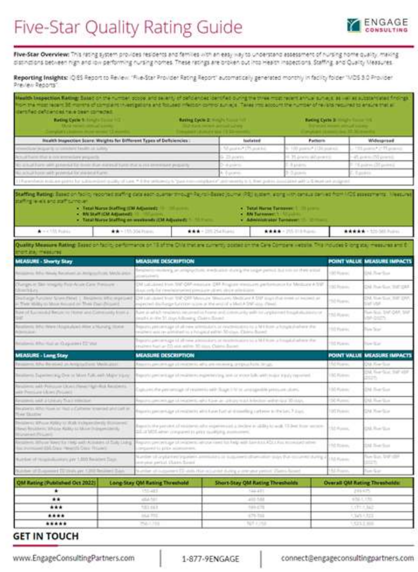
FIVE STAR QUALITY RATING GUIDE



Five-Star Quality Rating Guide

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Five-Star Overview: This rating system provides residents and families with an easy way to understand assessment of nursing home quality, making distinctions between high and low performing nursing homes. These ratings are broken out into Health Inspections, Staffing, and Quality Measures.

Reporting Insights: iQIES Report to Review: "Five-Star Provider Rating Report" automatically generated monthly in facility folder "MDS 3.0 Provider Preview Reports".

Health Inspection Rating:

Rating Cycle 1: | **Rating Cycle 2:** | **Rating Cycle 3:**

Health Inspection Score: Weights for Different Types of Deficiencies	Isolated	Pattern	Widespread

Staffing Rating:

- **Total Nurse Staffing (CM Adjusted):**
- **RN Staff (CM Adjusted):**
- **Total Nurse Staffing on weekends (CM Adjusted):**
- **Total Nurse Turnover:**
- **RN Turnover:**
- **Administrator Turnover:**

Quality Measure Rating:

MEASURE - Shorty Stay	MEASURE DESCRIPTION	POINT VALUE	MEASURE IMPACTS

MEASURE - Long Stay	MEASURE DESCRIPTION	POINT VALUE	MEASURE IMPACTS

QM Rating (Published Oct 2022)	Long-Stay QM Rating Threshold	Short-Stay QM Rating Thresholds	Overall QM Rating Thresholds
★			
★★			
★★★			
★★★★			
★★★★★			

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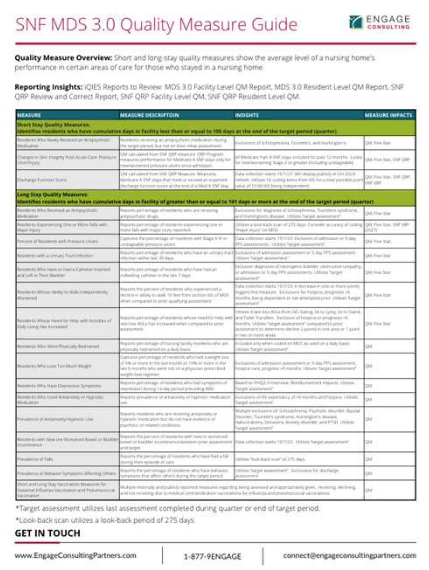
SNF MDS 3.0 QUALITY MEASURE GUIDE



SNF MDS 3.0 Quality Measure Guide

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Quality Measure Overview: Short and long-stay quality measures show the average level of a nursing home's performance in certain areas of care for those who stayed in a nursing home.

Reporting Insights: iQIES Reports to Review: MDS 3.0 Facility Level QM Report, MDS 3.0 Resident Level QM Report, SNF QRP Review and Correct Report, SNF QRP Facility Level QM, SNF QRP Resident Level QM.

MEASURE	MEASURE DESCRIPTOIN	INSIGHTS	MEASURE IMPACTS
Short Stay Quality Measures: Identifies residents who have cumulative days in facility less than or equal to 100 days at the end of the target period (quarter)			
Long Stay Quality Measures: Identifies residents who have cumulative days in facility of greater than or equal to 101 days or more at the end of the target period (quarter)			

*Target assessment utilizes last assessment completed during quarter or end of target period.

*Look-back scan utilizes a look-back period of 275 days.

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CROSS – CONTINUUM COLLABORATION

What is Cross-Continuum Collaboration?

80%

of Medical Errors

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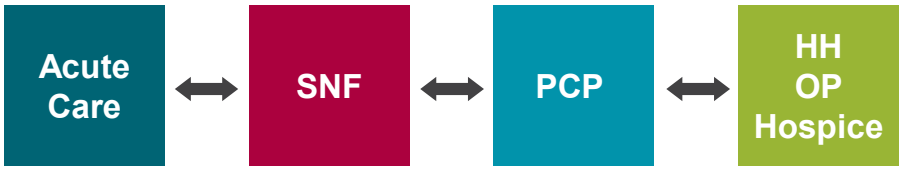
ACUTE TO POST-ACUTE CARE CONTINUUM



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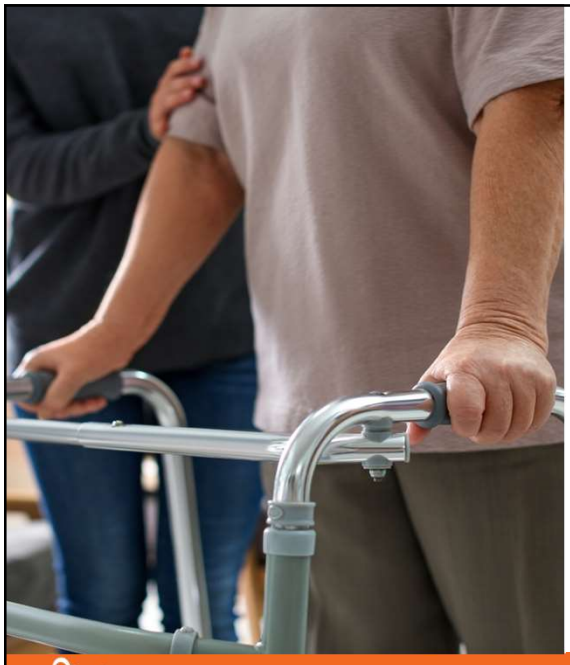

CHALLENGES SNFS FACE

- Care Coordination
- Fragmentation
- Outcomes

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SNF FOCUS – CARE & TRANSITIONS UNDER VBC

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BENEFITS OF COLLABORATION BETWEEN ACUTE & SNF

- Improved Care Coordination = Higher Quality Care = Better Outcomes
- Enhanced Patients Experience
- Reduced Spend per Episode

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SNF's ROLE – CARE COORDINATION

Care Coordination -

- Ensuring each resident receives the appropriate care, based on clinical needs and resident preference
- Communication of the residents needs and preferences before care transitions to the next setting
- The information is then used to guide the delivery of safe, appropriate and effective care

https://www.ahrq.gov/ncepcr/care/coordination.html

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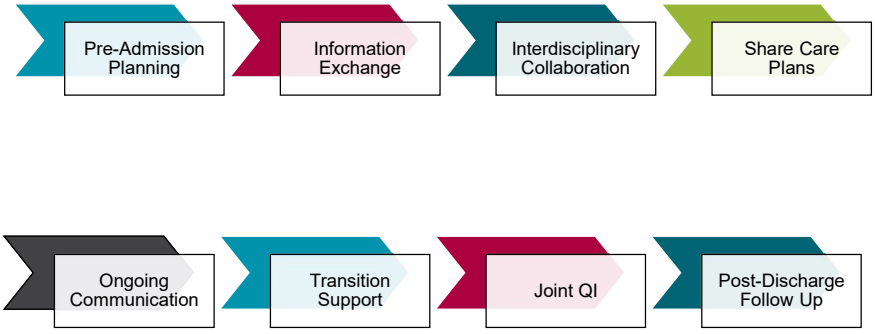
SNF's ROLE – ENHANCING CARE COORDINATION



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SNF TO ACUTE – PRE-ADMISSION PLANNING/COMMUNICATION

PRE-ADMISSION PLANNING

Pre-Admission Care Coordination
- As early as possible
- SNF response timely
  (Bed availability, Pt eligibility)
- Comprehensive orders/Information exchange

Resident & Family Engagement
- About transition plan
- About care options
- What to expect upon admission
- Active participation, preferences

Documentation & Communication
- Care plan
- Medication Reconciliation
- Comprehensive medical record shared
- Continued communication post-transfer

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SNF TO ACUTE – PRE/POST TRANSITION COMMUNICATION

Information Type	Study Finding	Impact on Transition?
Behavioral Status	Missing 67.7% of the time	Yes
Complete Documentation	11% of Opportunities	Yes
Mental Status	Missing 44.1% of the time	Yes
Functional Status/Level of Ind.	Missing 35.8% of the time	Yes

SNF avg Hours Spent to Obtain Information from Hospital **= 8.2 Hours/Week**

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SNF TO ACUTE – PRE/POST TRANSITION COMMUNICATION

Strategies to Enhance and Facilitate Communication

- Work collaboratively on standardized discharge summary templates that meet both needs (Hospital Work with EHR for certification criteria)
- Collaborate on process for how to share lab results or other records that may be returned at the hospital level after discharge (who would the hospital contact after hours or on weekend)
- Identify if a SNFist model is possible – their role is to improve care continuity and information sharing
- Shared ownership Hospital/SNF
- Shared IT

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SNF TO ACUTE – ESTABLISH JOINT QI PROGRAMS

JOINT QI INITIATIVES

How to Develop Joint QI Programs
- Identify the team
- Foster a culture of communication & collaboration
- Recognize common objectives
- Determine baseline measures
- Define performance goals
- Action Plan development
- Begin performance improvement

Joint Monitoring of Performance
- Shared accountability
- Track performance
- Regular Meetings

Ongoing
- Review results
- Celebrate achievements
- Assess and modify
- Share best practices

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SNF/ACUTE – JOINT QI

Health Services Research Study
Collaboration Between Hospitals & SNFs and the Impact on Resident Outcomes

- ✓ 138 Staff Interviews
- ✓ 16 Hospitals
- ✓ 25 SNFs
- ✓ 8 Unique Markets

…"Although collaboration with SNFs requires significant administrative and clinical time investment, it is associated with positive patient outcomes."

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SNF's ROLE – ADDITIONAL PERFORMANCE MEASURES

5 Key Metrics for SNF Performance

Average Length of Stay

30-Day Readmissions

Specialty Care Programs

Response Time for Referrals

Cost per SNF Episode

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SNF's ROLE – ADDITIONAL PERFORMANCE MEASURES

Name	Distance	Amt Paid to SNF	# Discharg	% Discharg	# Distinct Patients	SNF ALOS	Re-Admit I	Overall Rating	Health Inspect	Quality I	Staffing Rating
Regency At Shelby Township	3.8	$958,914	108	12.20%	96	19.5	32.30%	2	2	4	3
Pomeroy Living Sterling Skille	5	$698,326	94	10.60%	82	16.2	37.70%	4	4	4	2
Shelby Crossing Health Campi	5.4	$770,421	84	9.50%	80	18	23.50%	5	5	5	4
Pomeroy Living Rochester Ski	5.6	$652,760	74	8.30%	66	15.5	23.10%	2	2	4	3
Shelby Health And Rehabilitat	5.3	$816,711	73	8.20%	67	24.6	17.00%	3	2	5	2
Promedica Skilled Nsg & Reha	2.8	$557,651	69	7.80%	64	20	19.60%	2	1	5	4
Wellbridge Of Rochester Hills	3.8	$416,260	57	6.40%	54	16.3	31.90%	4	4	4	2
Promedica Skilled Nsg & Reha	6.1	$428,884	51	5.70%	48	20.1	25.00%	3	2	5	3
Orchard Grove Health Campu	14.8	$528,702	41	4.60%	36	24.8	21.90%	5	5	5	3
Wellbridge Of Romeo, Llc	13	$352,237	38	4.30%	30	24.1	20.00%	5	4	5	3
Bellbrook	4.3	$333,807	37	4.20%	29	20.3	24.10%	4	4	4	4
Wellbridge Of Clarkston	17.2	$227,873	23	2.60%	22	25.1	6.70%	4	3	5	3
Woodward Hills Health And R	7.9	$107,654	14	1.60%	12	17.2	50.00%	2	1	5	2
Fraser Villa	8.9	$94,465	12	1.40%	<11	18.7	33.30%	5	5	5	3
Shorepointe Nursing Center	14	$105,374	<11	N/A	<11	27.1	N/A	2	2	4	3
Lake Orion Nursing Center	13.5	$98,759	<11	N/A	<11	21.9	N/A	3	4	4	1
Courtney Manor	82.1	$95,126	<11	N/A	<11	35.3	N/A	4	3	5	3
The Village Of East Harbor	17.1	$67,314	<11	N/A	<11	17.3	N/A	3	3	4	4
West Bloomfield Health And	16.4	$56,226	<11	N/A	<11	24.3	N/A	4	3	4	5
Regency Manor Nursing & Re	3	$55,534	<11	N/A	<11	32.3	N/A	3	3	3	3
Mission Point Nsg & Phy Reha	6.3	$30,958	<11	N/A	<11	28	N/A	1	1	4	1
Medilodge Of Rochester Hills	5.6	$28,078	<11	N/A	<11	16.3	N/A	2	2	4	4
Skld Bloomfield Hills	7.1	$27,780	<11	N/A	<11	21	N/A	1	1	3	3
Medilodge Of Southfield	10.7	N/A	<11	N/A	<11	N/A	N/A	1	1	4	4
Medilodge Of Richmond	21.2	N/A	<11	N/A	<11	N/A	N/A	3	3	3	4
The Orchards At Armada	18.5	N/A	<11	N/A	<11	N/A	N/A	4	4	4	2
The Oaks At Woodfield	31.6	N/A	<11	N/A	<11	N/A	N/A	5	4	5	4

Beaumont Hospital, Troy Dischar

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SNF's ROLE – CAPITATING COSTS IN THE SNF STAY

Reduce LOS, Decrease Risk of Readmission, Avoid Duplication

- Admissions collaboration
- Sharing care capabilities
- Effective pre-auth process
- Therapy integration
- Resident and caregiver participation

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Downstream Partnership Coordination and Collaboration

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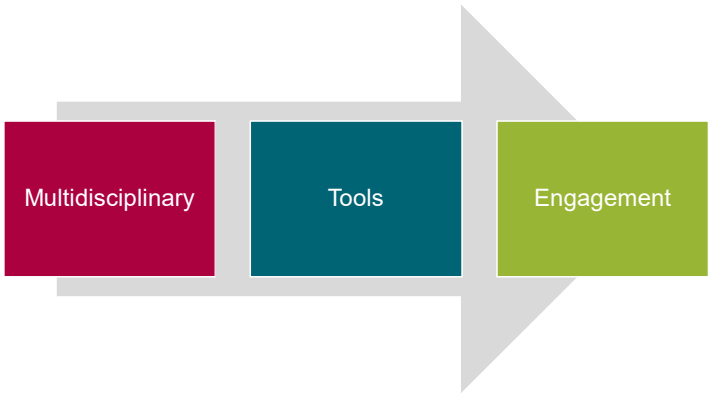
STRATEGIES FOR DOWNSTREAM TRANSITIONS



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DOWNSTREAM STRATEGY – MULTIDISCIPLINARY APPROACH

- NURSING
- PHYSICIAN TEAM
- THERAPY
- SOCIAL WORK/CASE MANAGEMENT/DISCHARGE PLANNERS
- HOME HEALTH TEAM/HOSPICE/OUTPATIENT REHAB
- RESIDENT & FAMILY

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NURSING'S ROLE – CONTINUUM COLLABORATION

- Medication management
- Care coordination in the SNF & setting up success
- D/C planning

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DOWNSTREAM STRATEGY – CARE COORDINATION TOOLS

Tools to Enhance Care Coordination Downstream

- HER – Electronic documentation sharing, access to relevant and timely clinical information
- Interoperable HIE – Secure exchange of information across the continuum, share data and clinical results to decrease duplication and costs
- Telehealth/Remote Monitoring –
- Discharge Planning Referral Management Systems-
- Apps for care coordination (or portals) -
- Checklists and Protocols -

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DOWNSTREAM STRATEGY – PATIENT & FAMILY ENGAGEMENT

- Shared decision Making
- Open communication
- Collaboration
- Return demonstration
- Competencies
- Transition Support

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Leveraging Therapy Collaboration for Successful Continuum Transitions

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THERAPY's ROLE – CONTINUUM COLLABORATION

- Care planning and goal assessment
- Resident & family engagement
- Rehabilitation implementation
- Interdisciplinary transition planning

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THERAPY'S ROLE – CARE PLANNING & GOAL ASSESSMENT

- Function, mobility, cognition, communication assessments
- Interdisciplinary collaboration - identify needs/goals to prepare for next care setting
- Resident preferences and abilities
- Prepare for next level only

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THERAPY'S ROLE – RESIDENT & FAMILY ENGAGEMENT

- Goal setting
- Ongoing progress
- Home Safety Evaluation
- Return Demonstration

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THERAPY'S ROLE – INTERDISCIPLINARY TRANSITION PLANNING

- Resident & Family – Education, planning, modifications, exercises
- Nursing – Med Management, equipment, clinical, timely referrals
- Physicians – Orders, follow-up PCP
- HH/Hospice/OP – Goals, risks, refer back

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THERAPY'S ROLE – CLINICAL REIMBURSEMENT COLLABORATION

- Interdisciplinary Team integration
- MDS + Rehab Director daily!
- Speech Therapy – BIMS, cognition, swallowing, communication
- Depression capture
- NTA capture
- Clinical and specialty programs – QM, Five Star, VBP

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INNOVATIONS IN CONTINUUM PARTNERSHIPS

- Upstream to downstream Care Coordination Teams
- Technology - for communication, coordination, data sharing, referrals, community services
- Expanding Telehealth
- SNFist – Acute to SNF
- Transportation Solutions
- Innovative SNF Programming

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CALL TO ACTION

What can you go back to your SNF **tomorrow** and do as a result of our time today??

IMMEDIATELY- Identify changes needed through evaluation- Communication, collaboration, admission process, QI initiatives, clinical programs, metrics (LOS, HRR, Cost, response time, duplication), integrating therapy, resident and family engagement

Identify Priorities – to achieve excellent outcomes for residents, high performance on measures and capitation of costs

Create a Work Plan with Teams & Timelines – With upstream/Downstream partners involved and active
Implement, track data, make changes, accountability, SUCCESS

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QUESTIONS?

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Thank You!

Caryn Enderle
MA, CCC/SLP - L
Director of Business Development
614-570-2404
caryne@conceptrehab.com

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RESOURCES & REFERENCES

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