DATA SPEAKS

Data Speaks Course 2: What is my niche? Data Driven Decision Making

AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

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Speakers:

Dr. Kendall Brune, PhD, CPH, MBA, LNHA, Fellow District 6 Governor, American College of Healthcare Administrators (ACHCA)

Renee Kinder MS, CCC-SLP, RAC-CT, EVP of Clinical Services Broad River Rehab

Joel VanEaton BSN, RN, RAC-CT, RAC-CTA, Master Teacher, EVP of Compliance and Regulatory Affairs Broad River Rehab

Faculty Disclosure

- I have no financial relationships to disclose
- I have no conflicts of interests to disclose
- I will not promote any commercial products or services

Requirements for Successful Completion

- 1.5 contact hours will be awarded for this continuing nursing education activity
- Criteria for successful completion includes attendance for at least 80% of the entire event. Partial credit may not be awarded
- Approval of this continuing education activity does not imply endorsement by AAPACN or ANCC (American Nurses Credential Center) of any commercial products or services

American Association of Post-Acute Care Nursing (AAPACN) is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

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What is DATA SPEAKS?

A collaborative learning series between AAPACN, ACHCA, and Broad River Rehab.

Course 1: CMS Claims Data 101: How it is used and What you should track

Course 2: What is my niche? Data Driven Decision Making

Course 3: What's my PDPM Primary Category? Does I0020B make sense for my residents?

Course 4: How are my NTAs? A Nationwide look at where NTA Points Stack Up.

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Course Overview

Identified Gap(s):

Session will detail nationwide patient flow data to SNFs and what patterns have emerged as to the kinds of residents that SNFs are receiving.

Description of current state:

Currently providers, beneficiaries and care teams have limited access to CMS data aside from what is analyzed internally within their communities and publicly reported on CMS.GOV and Nursing Home Compare.

Description of desired/achievable state:

Attendees will achieve an increased understanding of national and regional based trends allowing for improved decision-making capabilities internally and for strategic partnerships with acute care hospitals and providers in their communities.

Learner Objectives

1. Explain current data metrics used by CMS as reported by ResDAC for PDPM Case Mix group areas in 2019 and 2020.
2. Define how post-acute care communities can integrate hospital based DRG data to identify specific clinical care needs.
3. Describe variances present in current hospital and PAC data related to regional differences and how appreciation of these differences can guide care planning.

Speaker: Dr. Kendall Brune

- **Dr. Kendall Brune, PhD, CHP, MBA, LNHA, FACHCA** has thirty plus years of experience in senior healthcare executive capacities in the development, construction and operation of ambulatory, pharmacy, senior housing, and care facilities. He currently owns, operates and manages facilities in MO, IL, TN and FL. Dr. Brune is an Adjunct Associate Professor in Family Medicine at Meharry Medical College. He also serves as the District 6 Governor for American College of Healthcare Administrators

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Speaker: Renee Kinder

Renee Kinder, MS, CCC-SLP, RAC-CT is Executive Vice President of Clinical Services for Broad River Rehab. Additionally, she authors McKnight's Long Term Care News Rehab Realities Blog, serves as Gerontology Professional Development Manager for the American Speech Language Hearing Association's (ASHA) gerontology special interest group, is the ASHA STAMP for Kentucky, a member of the University of Kentucky College of Medicine community faculty, and is an alternate advisor to the American Medical Association's Relative Value Update Committee (RUC) Health Care Professionals Advisory Committee (HCPAC)

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Speaker: Joel VanEaton

Joel VanEaton, BSN, RN, RAC-CT, RAC-CTA, MT is Executive Vice President of Compliance and Regulatory Affairs for Broad River Rehab serving facilities in TN, KY, NC, SC, OH, MD and RI. Joel began his career in LTC as an MDS coordinator and worked for many years as the Director of Clinical Reimbursement and RAI for a group of nursing facilities in Tennessee and Kentucky. Joel has contributed to McKnight's LTC News and the AANAC LTC Leader. He currently serves as a board member on the AAPACN Education Foundation

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CMS Defining Quality

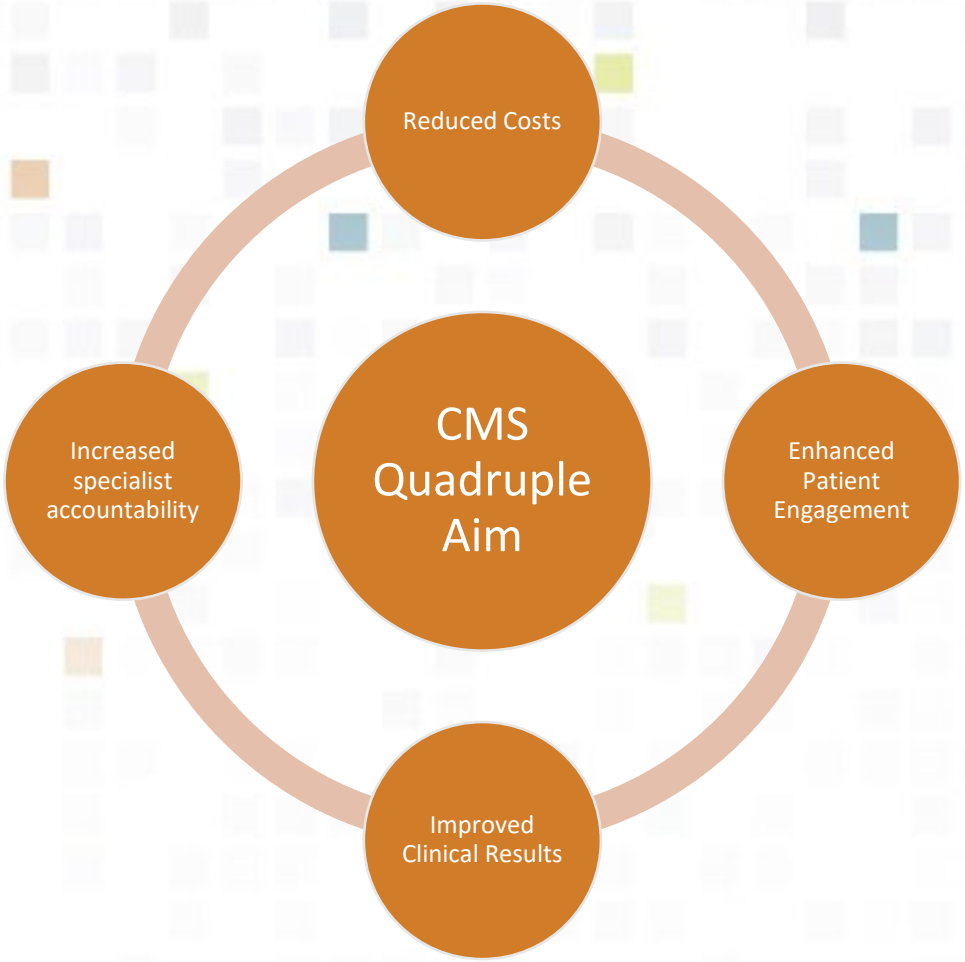
CMS Quality Strategy

Better Care: Improve the overall quality of care by making health care more person-centered, reliable, accessible, and safe.

Smarter Spending: Reduce the cost of quality health care for individuals, families, employers, government, and communities.

Healthier People, Healthier Communities: Improve the health of Americans by supporting proven interventions to address behavioral, social, and environmental determinants of health, and deliver higher-quality care.

CMS Quadruple Aim



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ResDAC

RESEARCH DATA ASSISTANCE CENTER

Your source for CMS data support

The Research Data Assistance Center (ResDAC) provides free assistance to academic and non-profit researchers interested in using Medicare, Medicaid, SCHIP, and Medicare Current Beneficiary Survey (MCBS) data for research. Primary funding for ResDAC comes from a CMS research contract. ResDAC is a consortium of faculty and staff from the University of Minnesota, Boston University, Dartmouth Medical School, and the Morehouse School of Medicine.

ResDAC offers a number of services for researchers with all levels of experience using or planning to use CMS data. Services include technical data assistance, information on available data resources, and training

Acute Care (hospital) DRGs

Currently, cases are classified into Medicare Severity Diagnosis Related Groups (MS-DRGs) for payment under the IPPS based on the following information reported by the hospital: the principal diagnosis, up to 24 additional diagnoses, and up to 25 procedures performed during the stay. In a small number of MS-DRGs, classification is also based on the age, sex, and discharge status of the patient. Effective October 1, 2015, the diagnosis and procedure information is reported by the hospital using codes from the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS).

Jan 2021 DRG Updates: COVID

Diagnosis Code	Description	CC	MDC	MS-DRG
J12.82	Pneumonia due to coronavirus disease 2019	MCC	04	193, 194, 195
			25	974, 975, 976
M35.81	Multisystem inflammatory syndrome	CC	08	545, 546, 547
M35.89	Other specified systemic involvement of connective tissue	CC	08	545, 546, 547
Z11.52	Encounter for screening for COVID-19	N	23	951
Z20.822	Contact with and (suspected) exposure to COVID-19	N	23	951
Z86.16	Personal history of COVID-19	N	23	951

If diagnosis code M35.81 or M35.89 is reported as a principal diagnosis, they will exclude the following diagnoses from acting as a CC under the CC Exclusions List

Principal Diagnosis Code	Exclude Secondary Diagnosis	Description
M35.81 or M35.89	M35.1	Other overlap syndromes
	M35.5	Multifocal fibrosclerosis
	M35.81	Multisystem inflammatory syndrome
	M35.89	Other specified systemic involvement of connective tissue

The ICD-10 MS-DRG V38.1 Grouper Software, Definitions Manual Table of Contents and the Definitions of Medicare Code Edits V38.1 manual will be available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software

[1] The Index and Tabular Addenda for the new diagnosis codes will be made available via the CDC website at: https://www.cdc.gov/nchs/icd/icd10cm.htm

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ICD-10 Updates with COVID-19

Late in December 2020, CMS made changes to the ICD010 CM mapping associated with the PDPM clinical categories for PT and OT as well as NTA comorbidities.

These changes were made regarding new ICD-10-CM codes that the CMS and the CDC approved for certain conditions associated with COVID-19.

Changes were noted in a CDC memo dated Dec. 3, 2020, **with an effective date of January 1, 2021.**

The FY 2021 PDPM ICD-10 Mappings (ZIP) on CMS' PDPM website have an effective date of 1/1/2021 and the update notes inside the mapping tool itself indicate an effective date of January 1st, 2021.

ICD-10 Updates with COVID-19

The CDC memo indicates that, “As a result of the ongoing COVID-19 public health emergency, the Centers for Disease Control and Prevention’s National Center for Health Statistics (CDC/NCHS) is implementing additional codes into the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) for reporting to include:

- Encounter for screening for COVID-19 (Z11.52)
- Contact with and (suspected) exposure to COVID-19 (Z20.822)
- Personal history of COVID-19 (Z86.16)
- Multisystem inflammatory syndrome (MIS) (M35.81)
- Other specified systemic involvement of connective tissue (M35.89)
- Pneumonia due to coronavirus disease 2019 (J12.82)

ICD-10 Updates with COVID-19

From the list of new codes, all but Multisystem inflammatory syndrome (MIS) (M35.81) and Other specified systemic involvement of connective tissue (M35.89) map to return to provider not to any clinical category. For M35.81 and M35.89. the following revisions apply.

- ICD-10-CM code, (M35.8) Other specified systemic involvement of connective tissue, has been removed from both the clinical category Mapping and NTA comorbidities and replaced by M35.81 and M35.89.
- These new codes map to Non-Surgical Orthopedic/Musculoskeletal for the PT and OT categories and Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies for the NTA category.

Administrators Strategic Role with DRG

- Clinical Care Path Engagement prior to facility admission and during the post acute phase
- Appreciating the role of the care continuum
- What is the ultimate goal and outcome of the multi-disciplinary team?

CMS- How is data used?

CMS and Shared Data

IMPACT Act

Payment Reform

Care Compare

PEPPER Reports

CPT Code Updates

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IMPACT Act

The Improving Medicare Post-Acute Care Transformation Act of 2014

The IMPACT Act is an attempt to address the PAC information gap and would require collection and analyses of data that will enable Medicare to:

- Compare quality across PAC settings;
- Improve hospital and PAC discharge planning; and
- Use this information to reform PAC payments (via site neutral or bundled payments, for example) while ensuring continued beneficiary access to the most appropriate setting of care.

IMPACT Act Requirements

Requires Post-Acute Providers to Report Standardized Assessment Data –Builds on existing PAC assessment tools, and requires the reporting of common data across PAC providers for purposes of:

- Patient assessment,
- Quality comparisons,
- Resource use measurement, and
- Payment reform, i.e. establishing payment rates according to the individual characteristics of the patient, not the care setting

IMPACT Act

Provides Congress with New Payment Models to Consider for Future Reforms –Requires reports to Congress from Med PAC and the Department of Health and Human Services that will utilize the PAC assessment data to:

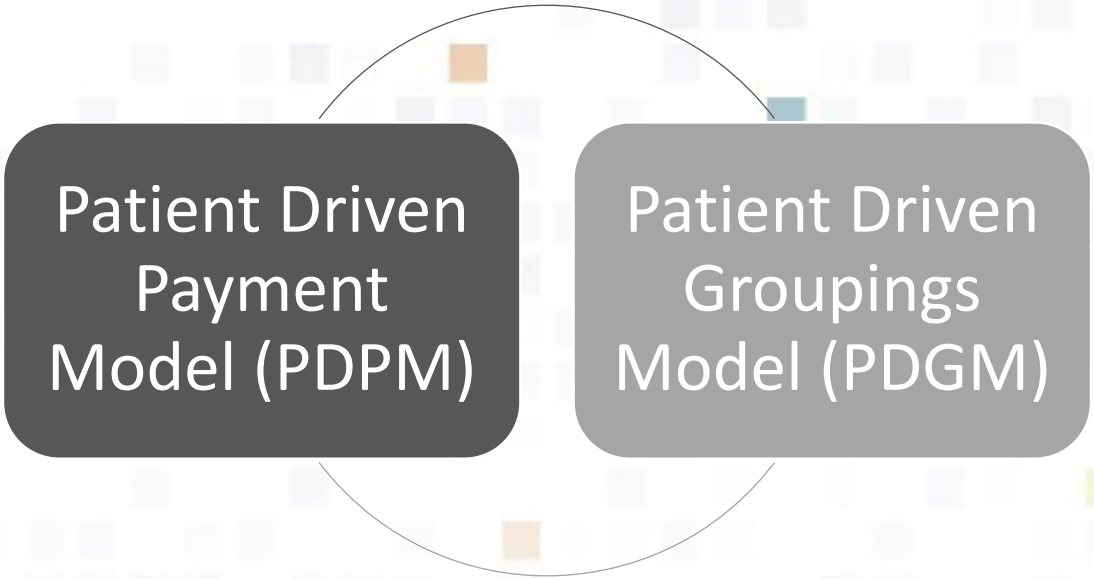
- Build actual payment prototypes that,
- Congress can use to consider for future PAC payment reforms (ex. PDPM, PDGM).

Protects Beneficiary Choice and Access to Care –Directs the Secretary to develop regulations:

- That encourages the use of quality data in patient discharge planning while continuing to take into account patient preferences.
- That Provide for collection of comparable information across PAC settings so that any future PAC payment reforms have the data needed to identify and ensure continued patient access to appropriate settings of care.

IMPACT Act

- The Act requires that CMS make ***interoperable standardized patient assessment and quality measures data, and data on resource use and other measures to allow for the exchange of data among PAC and other providers to facilitate coordinated care and improved outcomes***
- Achieving standardization (i.e., alignment/harmonization) of clinically relevant data elements improves care and communication for individuals across the continuum: ***Enables shared understanding and use of clinical information.***
- ***Enables the re-use of data elements*** (e.g., for transitions of care, care planning, referrals, decision support, quality measurement, payment reform, etc.)
- Supports the ***exchange of patient assessment data across providers*** (ex. Care Compare)
- Influences and supports CMS and industry efforts to advance ***interoperable health information exchange and care coordination***
- SNF QRP - CMS believes that the QRP will, ***"…promote higher quality and more efficient health care for Medicare Beneficiaries"***



CMS- How is data used to shape PAC Models?

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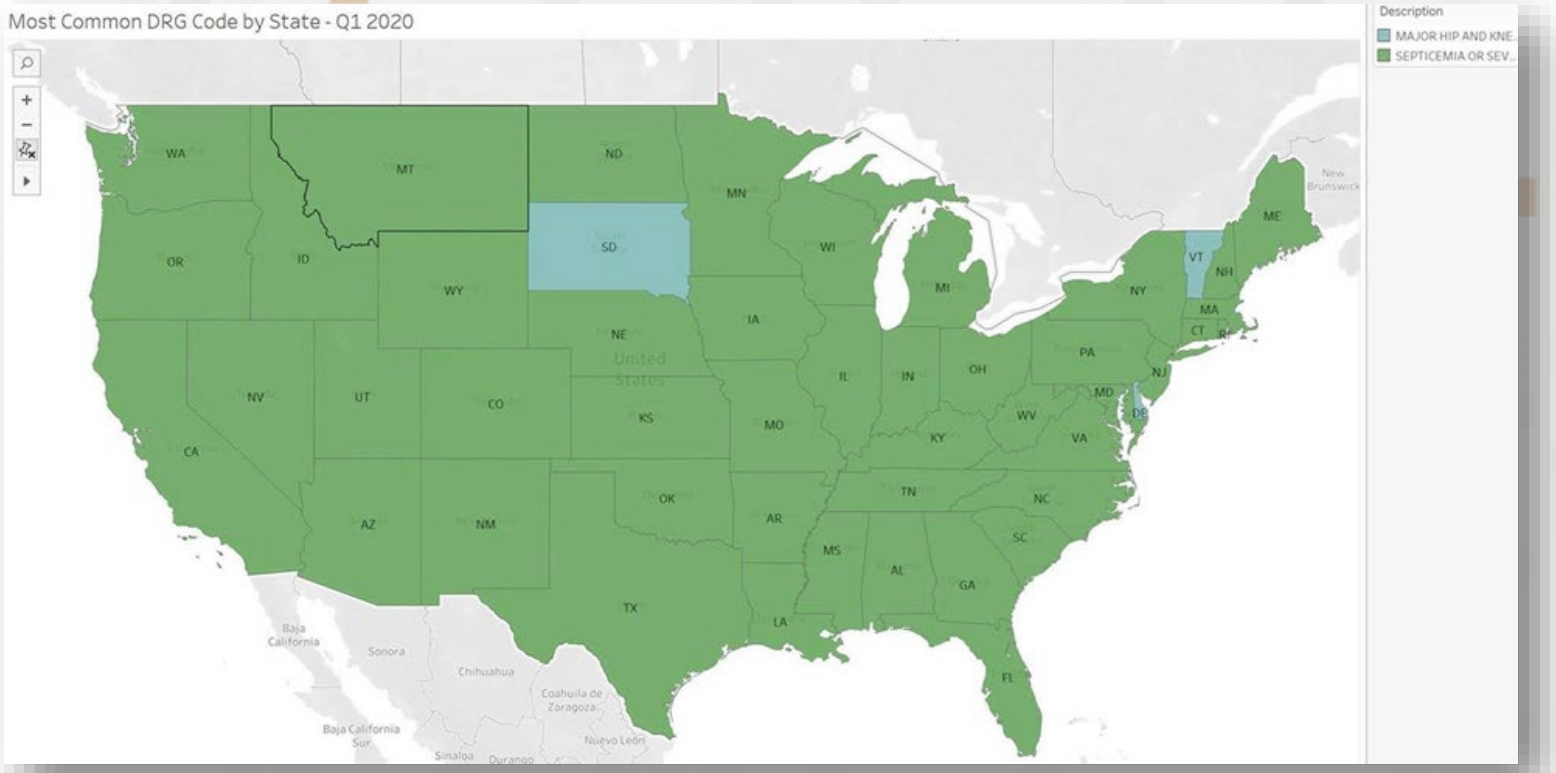
Hospital Relationships and DRGs

- A DRG, or diagnostic related group, is how Medicare and some health insurance companies categorize hospitalization costs and determine how much to pay for a patient's hospital stay.
- Rather than paying the hospital for each specific service that was provided, Medicare or a private insurer will pay the hospital a predetermined amount based on the patient's Diagnostic Related Group.
- This encompasses a variety of metrics designed to classify the resources needed to care for a given patient based on diagnosis, prognosis, and various other factors.

ResDAC Hospital DRG

Nationwide, Septicemia is the number 1 hospital recorded DRG



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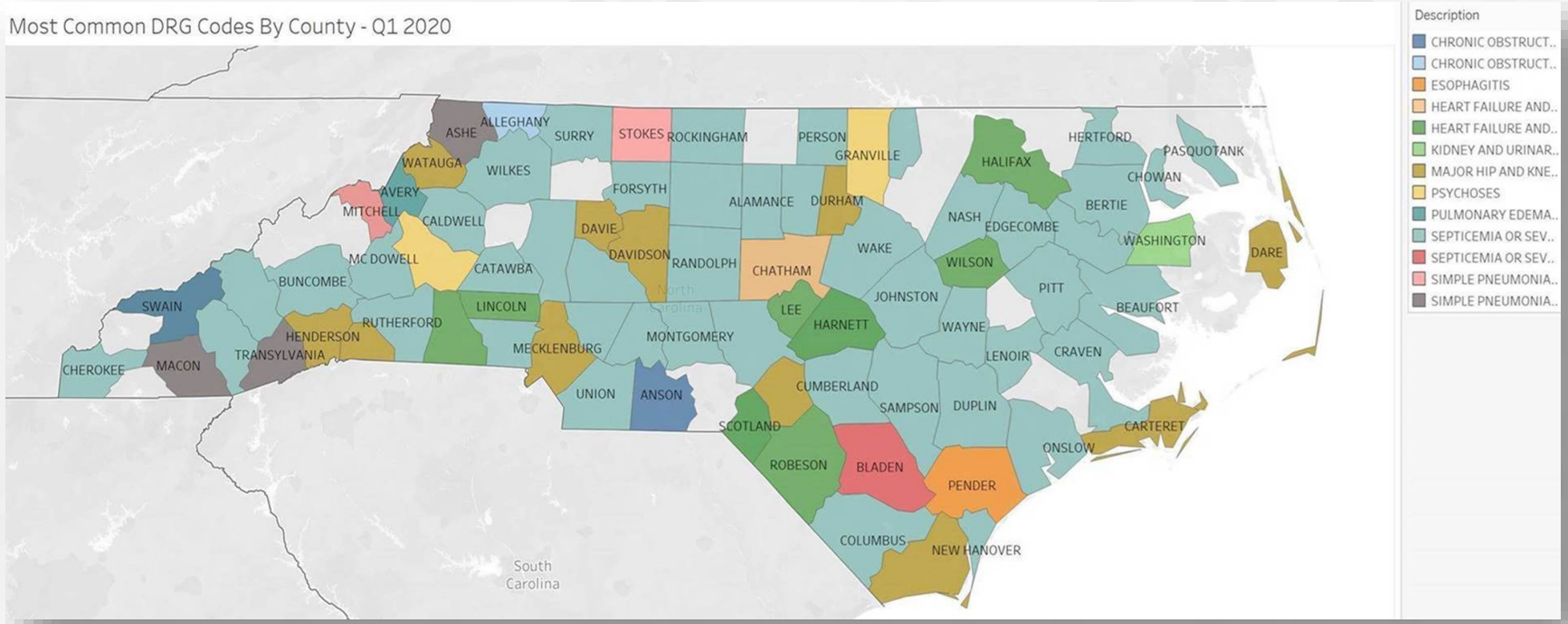
ResDAC Hospital DRG

State Example: North Carolina



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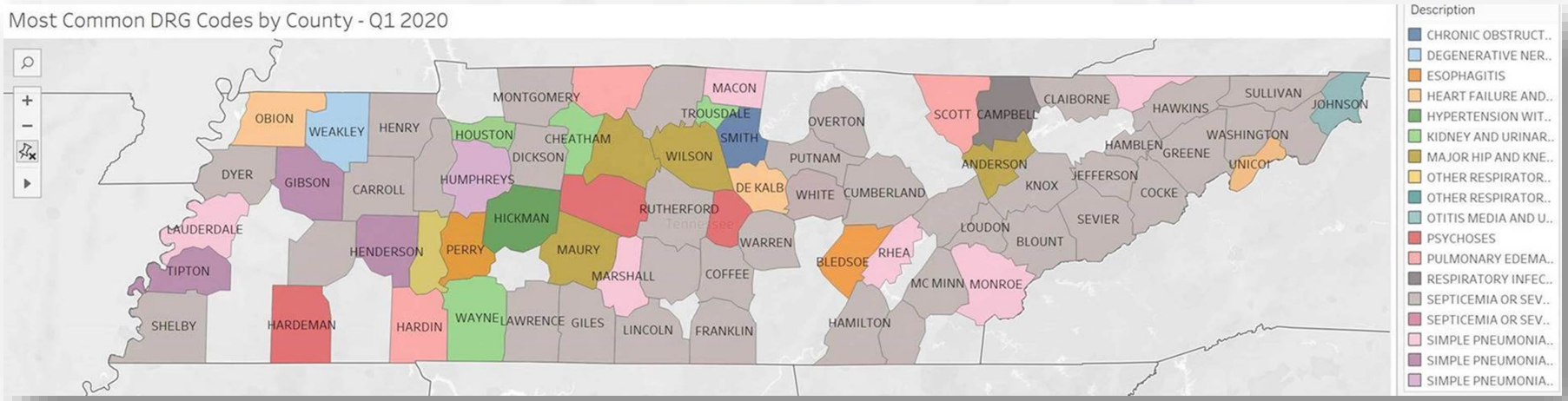
ResDAC Hospital DRG



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ResDAC DRG and Re-admissions

Interesting from ResDAC:

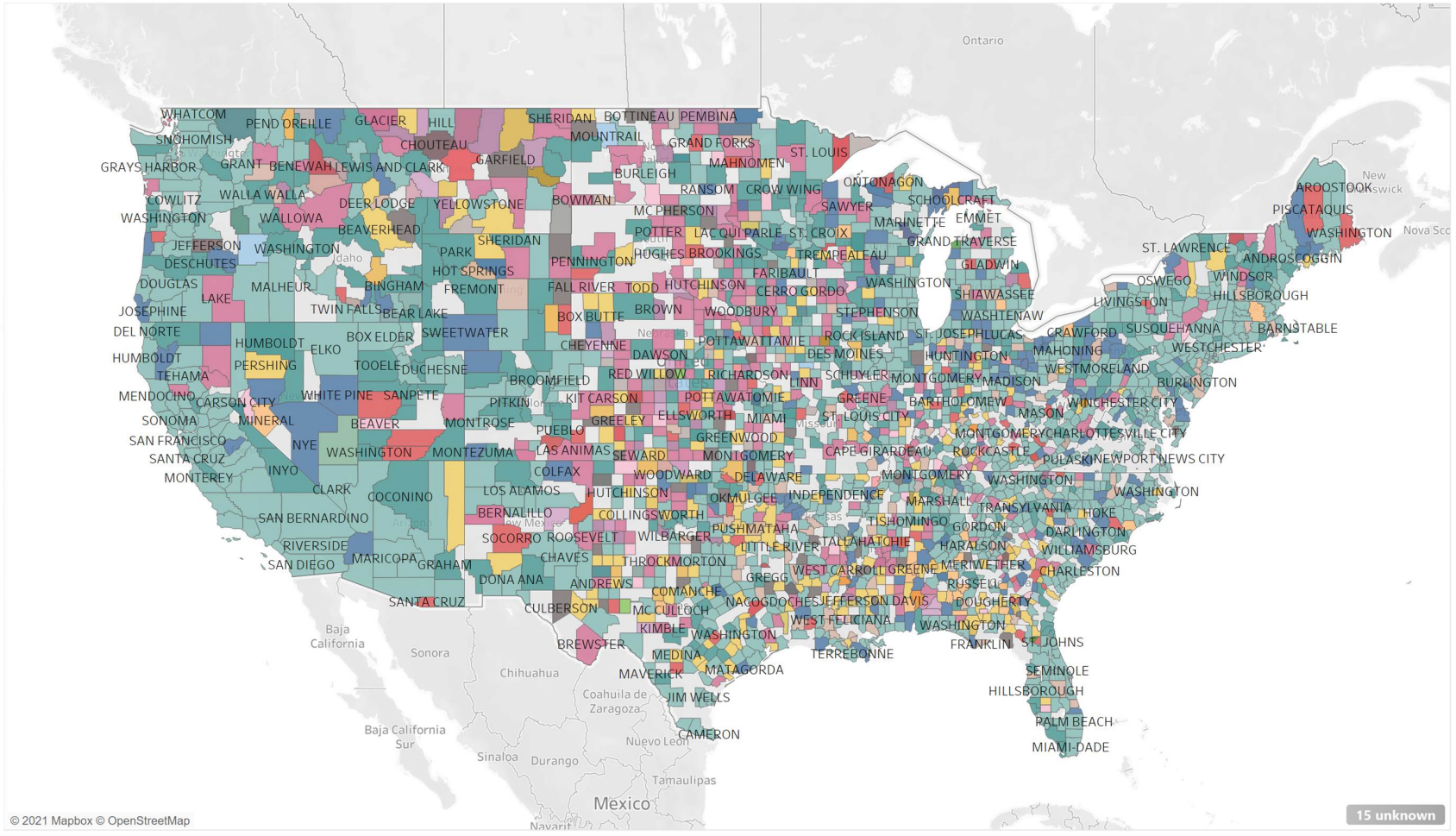
- Nationally for residents that were admitted to SNFs, after a hospital stay for any diagnosis other than septicemia, and then readmitted to a hospital in that same episode with a diagnosis of septicemia;
  - In the top 25% of SNF primary diagnosis 13% were respiratory related, 6% were Renal Related, 4% were related to encephalopathy, 1% were surgical related and 1% related to arterial occlusion.
- Facilities can use this data to facilitate processes to prevent residents from developing septicemia and partner with hospitals to create care flow pathways that help residents achieve their goals while limiting Healthcare-Acquired Infections and rehospitalizations.

Hospital Relationships with Admin

- DRG versus Re-admission potential
- Be aware of risks for penalty to the hospital
- Consider partnership specific to clinical characteristics
- What is the clinical care path of the hospital?
  - Where are your staff in their clinical care path and their accessibility

KEY NEXT SLIDE

Most Used DRG Codes By County



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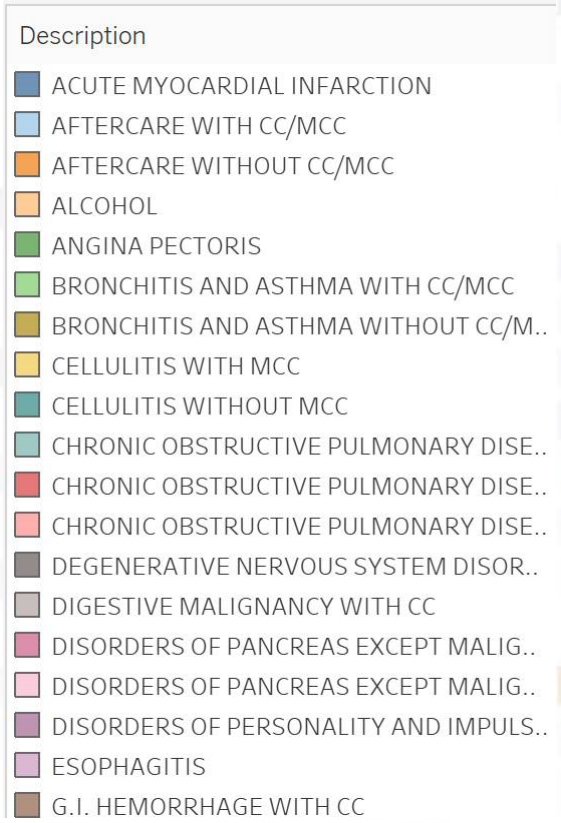

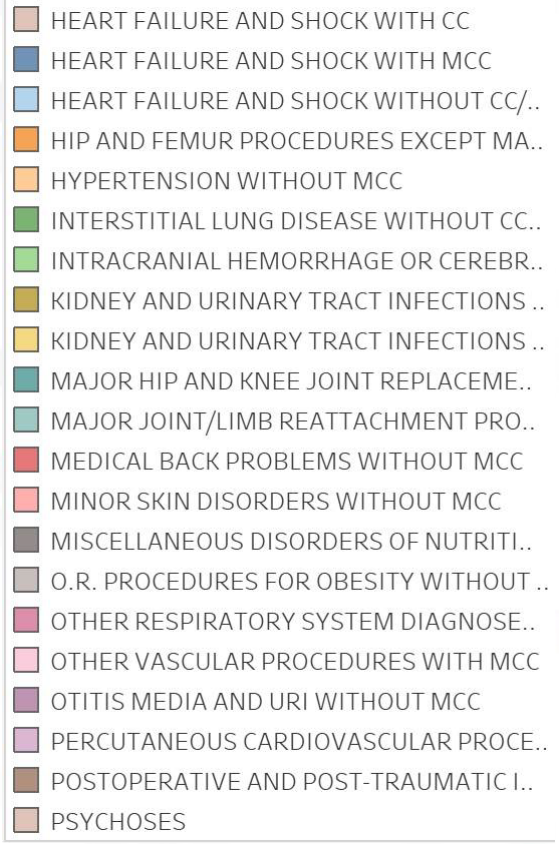

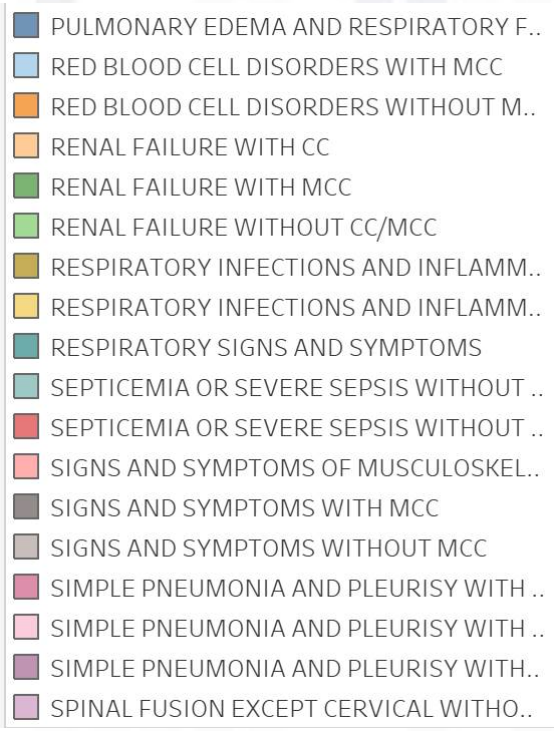

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Clinical Pathways & Regional Trends

- Sepsis
- Mental Health
- Respiratory
- Residual from COVID

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Clinical Pathway: Areas to Consider

Polypharmacy	Risk factors impacting minority populations	PT, OT, SLP, RT considerations.	Dialing in the person centeredness
How can we engage technology	Education and teaching and training protocols	Proactively id risk factors that are signs for re-admission?	Impacts of having multiple co-morbidities

Common sense tools- Pulse ox, natural diet and vitamins

The Future: Quality Metrics

- In early December, CMS posted a memo QSO 21-06-NH that reversed a prior decision by the agency to postpone substantial refreshes to the 5-star ratings until the COVID waiver data freeze had a chance to catch up. This memo indicated a restart of the health inspection and quality measure portions of the 5-star rating starting with the January Care Compare Refresh.
- On Friday January 15th, as promised in the December memo, CMS posted the revised 5-Star User's guide with full details of what to expect with the January refresh of Care Compare.
- On Tuesday January 19th, CMS posted 5-Star preview reports in facility CASPER folders in QIES.
- Care Compare will be refreshed with this updated data on or around January 27th.

The Future: Quality Metrics

What Changed with the Quality Measure Rating

- Quarterly updates of most of the quality measures (QMs) posted on Care Compare and used in the Five-Star Quality Rating System will resume with the January 2021 refresh.
- For the January 2021 update, CMS used data for July 2019- June 2020 for all of the measures that were updated.
- The two QMs that are part of the Skilled Nursing Facility Quality Reporting Program will not be updated in January 2021. Data used for these two measures will be as follows;
  - Rate of successful return to home and community from a SNF – 10/01/17 – 09/30/19
  - Percentage of SNF residents with pressure ulcers/pressure injuries that are new or worsened, now Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury – 01/01/19 – 12/31/19

The Future: Quality Metrics

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
MUC20-0002	Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization	This measure will estimate the risk-adjusted rate of healthcare-associated infections (HAIs) that are acquired during skilled nursing facility (SNF) care and result in hospitalizations. The measure is risk adjusted to "level the playing field" and to allow comparison of measure performance based on residents with similar characteristics between SNFs. It is important to recognize that HAIs in SNFs are not considered "never-events." The goal of this risk-adjusted measure is to identify SNFs that have notably higher rates of HAIs that are acquired during SNF care and result in hospitalization, when compared to their peers.	Outcome	Centers for Medicare & Medicaid Services	SNF QRP
MUC20-0044	SARS-CoV-2 Vaccination Coverage among Healthcare Personnel	This measure tracks SARS-CoV-2 vaccination coverage among healthcare personnel (HCP) in IPPS hospitals, inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), inpatient psychiatric facilities, ESRD facilities, ambulatory surgical centers, hospital outpatient departments, skilled nursing facilities, and PPS-exempt cancer hospitals.	Process	Centers for Disease Control & Prevention	ASCQR; ESRD QIP; Hospital IQR Program; Hospital OQR Program; IPFQR; IRF QRP; LTCH QRP; PCHQR; SNF QRP

"To increase incentives to vaccinate Medicare beneficiaries, CMS will evaluate how to incorporate quality measures for COVID-19 immunizations into its value-based purchasing programs, including Medicare Advantage Star-Ratings, the physician quality payment program, and accountable care programs." McKnight's LTC News 1/25/21

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The Future: Quality Metrics

New QRP Measures	Revised MDS Section A
Transfer of Health Information to the Provider–Post-Acute Care (PAC); assesses for the timely transfer of health information, specifically a reconciled medication list. This measure evaluates for the transfer of information when a patient is transferred or discharged from their current setting to a subsequent provider	New items at A1805, A2105, A2121, A2122 have been added to accommodate this QRP measure.
Transfer of Health Information to the Patient–Post-Acute Care (PAC). This proposed measure assesses for and reports on the timely transfer of health information, i.e., a current reconciled medication list, to the patient/resident when discharged from their current setting of post-acute care	New items at A1805, A2105, A2121, A2123, 2124 have been added to accommodate this QRP measure.

The Future: Administrators and TeleMedicine

- COVID-19 has increased need for care at bedside for nursing teams and physicians
- Practical solutions:
  - Embrace the change which allows for increased access to MDs, orders and meeting patient need.
  - SMART TV, and access to Internet
  - Reduces risks associated with leaving the facility for care
  - Wearables- Ask what is the device you need, what is the tech communication back to care provider?

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- Broad River Rehab Reflections are the third Thursday of each month. February 2021 topic - **Part I of Series: Introduction to Quality Measurement**

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