The IMPACT Act: Quality & Safety - The Final Rule

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**IMPACT ACT - Overview**

- **Decrease**: Decrease re-hospitalization rates through improved care coordination with other PAC providers & improved discharge planning for Residents/Patients during short term Sub-Acute Rehab and/or dually eligible long term stays.

- **Review and Revise**: Review and revise policies and practices to assure short term stay patients experience timely and safe discharge to the community.

- **Assure**: Assure patient care preferences are met as measured by standardized SAR patient satisfaction scores.

- **Improve**: Improve clinical quality measure scores in the following areas - pressure injury reduction, decrease falls with major injury reduction, and improve functional outcomes.
**Acronyms**

**IMPACT Act** - Improving Medicare Post-Acute Care Transformation Act

**SNF QRP** - Skilled Nursing Facility Quality Reporting Program

**APU** - Annual Payment Update

**QIES** - Quality Improvement and Evaluation System

**ASAP** - Assessment Submission and Processing system

**PCP** - Primary Care Practitioner

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**Bipartisan bill passed on September 18, 2014**

Signed into law by President Obama on October 6, 2014

- Requires Standardized Patient Assessment Data that will enable:
  - Data element uniformity
  - Quality care and improved outcomes
  - Comparison of quality and data across post-acute care (PAC) settings
  - Improved discharge planning
  - Exchangeability of data
  - Coordination of care

**IMPACT Act History**
Driving Forces of the IMPACT Act

**Purposes**
- Improvement of Medicare beneficiary outcomes
- Provider access to longitudinal information to facilitate coordinated care
- Enable comparable data and quality across PAC settings
- Improve hospital discharge planning
- Research to establish best practices

**Why the attention on Post-Acute Care?**
- Escalating costs associated with PAC
- Lack of data standards/interoperability across PAC settings
- Goal of establishing payment rates according to the individual characteristics of the patient, not the care setting

Five Elements of IMPACT Act

- **Standardized assessment tool** measuring quality metrics with data collected on admission & discharge:
  - Pressure ulcers, Functional status, Cognitive status, and Special Services.
- **Public reporting of quality measures** across PAC settings
  - Hospitalizations, rehospitalizations, readmissions after discharge from PAC, discharge to community, pressure ulcers, medication reconciliation, incidence of major falls, patient preferences, and average total Medicare cost per beneficiary
- **Hospitals and PAC providers to provide quality measures to consumers** when transitioning to a PAC provider
  - Conditions of participation are modified to incorporate Quality Measures (QMs) into the discharge planning process.
- **Market basket payment penalty of 2%** for failure to effectively collect and report data.
- **HHS and Med PAC to conduct studies** and reports to link payment to quality.
  - HHS and Med PAC must develop a plan to link Medicare PAC payment to quality of care, review current risk adjustment methodologies, and study the effect of beneficiaries' socioeconomic status on quality, resource use, and other measures.
- **Add $11M in funding** for CMS to use payroll data to measure staffing in SNF setting.
**Benefits of Standardized Data Elements**

- Supports coordination of care transitions
- Promotes care planning across settings
- Sets and justifies payment for services and reimbursement
- Establishes quality measure comparisons for key items
- Provides means for public reporting that can be used by consumers to compare providers across all PAC types when selecting PAC services

**Requirements for Reporting Assessment Data**

- Providers submitting standardized assessment data for PAC assessments – MDS data for SNF submission
- CMS to use standardized assessment data no later than October 1, 2018 – publicly report SNF quality data via the SNF QRP
- Data must be submitted for admission and discharge for each resident, or more frequently as required
- Data Categories
  - Functional and mental status,
  - Special services, treatments and interventions,
  - Medical conditions and comorbidities, Impairments,
  - Other categories required by the Secretary
Assuring Compliance...

First – initial admission clinical assessments MUST be completed correctly and accurately – establishes baseline for MDS coding

Second – All MDS assessments must be properly coded with backup to support coding

Third – MDS must be timely & accurate – cannot be late

Fourth – Care Plan must be individualized and focused on targeted areas: falls, pressure ulcers, functional ability, discharge planning

Non-Compliance Penalty

Beginning FY 2018 (October 2017) & each subsequent FY, the Secretary shall reduce the market basket update (also known as the Annual Payment Update, or APU) by 2 percentage points for any SNF that does not comply with the quality data submission requirements with respect to that FY.

FY 2018 compliance determination is based on data submitted for admissions to the SNF on and after October 1, 2016, and discharged from the SNF up to and including December 31, 2016.

Period for correction of data for FY2018 submission ended May of 2017.
Avoiding Non-Compliance Issues

The use of Dashes on MDS is what causes non-compliance.

Dashes signify no information – this must be extremely limited if used at all.

MDS Coordinators must review all validation reports immediately for any errors and make corrections as needed and resubmit files timely.

MDS Coordinator must review all SNF QRP Quarterly Review & Correct reports.

Staff must understand the impact on reimbursement for non-compliance.

Notification of Non-Compliance Letter

- Notification will be sent via CASPER
- MDS coordinators must check CASPER for information
- If found noncompliant with FY 2018 requirements, may request reconsideration of the finding
- SNFs may file for reconsideration if they believe the finding of noncompliance is in error
- Reconsideration requests are submitted by email to CMS containing all the requirements listed on the Reconsideration Requests portion of the SNF QRP webpage.
- Please note that a SNF cannot request reconsideration until notified by CMS of a finding of noncompliance with FY 2018 requirements
CMS makes accommodations in the event SNF is unable to submit quality data due to extraordinary circumstances beyond their control (e.g., natural or man-made disasters) or when a systemic problem with data collection systems directly affected the ability to submit data.

SNF affected by an extraordinary circumstance can submit an exception or extension request to CMS.

SNFs should submit a request via email within 90 calendar days of the occurrence of the extraordinary circumstance.

The Extensions and Exception Requests portion of the SNF QRP webpage provides more information about this process.

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2018 QRP Quality Measures – MDS Based Finalized in 2016

1. Application of Percent of Patients or Residents Experiencing One or More Falls with Major Injury (Long Stay)
2. Percent of Patients or Residents with Pressure Ulcers that are New or Worsened
3. Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function
2018 QRP Quality Measures – Claims Based
Finalized in 2017

1. Discharge to Community - Post Acute Care (PAC) SNF QRP
2. Potentially Preventable 30-Days Post-Discharge Readmission Measure for SNF QRP
3. Medicare Spending Per Beneficiary - Post-Acute Care (PAC) Skilled Nursing Facility Measure
4. Drug Regimen Review Conducted With Follow-Up for Identified Issues - Post Acute Care (PAC) SNF QRP

Quality Tracking Strategies

- Establishment of Quality tracking processes that can be used to improve QM domain scores in the clinical areas of:
  - Pressure Injury Reduction,
  - Decrease falls with major injuries
  - Improve functional outcomes – change in self-care & mobility
Falls since admission/prior assessment with major injury
Coded on discharge MDS

MDS Items Related to Falls with Major Injury

Decreasing Falls with Major Injury

Root: Root cause analysis to determine cause(s) of falls
Trend: Trend analysis of all falls by individual resident as well as facility-wide
Don’t Fall: Don’t fall into the fall trap – no pun intended
Look: Look at environmental risk factors – gap analysis
Reconsider: Reconsider use of side rails and bed and chair alarms
Pressure Injury Reduction

- Weekly wound rounds by qualified wound care nurse and physician
- Utilization of a standardized tool based on current definitions and standards of practice
- Proper identification and staging of pressure injuries
- Daily skin checks by aides during care
- See something say something culture
- QAPI Performance Improvement Project – engaging line staff
- Identification of pressure reduction techniques and devices

MDS Items Related to Pressure Injuries

- Bowel Continence
- Peripheral Vascular Disease
- Diabetes Mellitus
- Bed Mobility Self Performance
- Height & Weight
- Stage 2 Pressure Injuries 5 day PPS & Discharge
- Stage 3 Pressure Injuries 5 day PPS & Discharge
- Stage 4 Pressure Injuries 5 day PPS & Discharge
Functional Assessment & Care Plan: Self-Care

- Eating - 5 day PPS & Discharge
- Oral hygiene - 5 day PPS & Discharge
- Toileting - 5 day PPS & Discharge

Functional Assessment & Care Plan: Mobility

**Comparison of 5 day PPS and Discharge MDS Codes**

- Sit to lying
- Lying to sit on bedside
- Sit to stand
- Chair/bed to chair transfer
- Toilet transfer
- Walking
- Walk 50 feet two turns
- Walk 150 feet
- Uses wheelchair or scooter
- Wheels 50 feet with two turns
Review all policies and practices that ensure:

- Short term stay patients experience timely and safe discharge to the community
- Patient care preferences are met using a standardized satisfaction tool - Core Q

Discharge Planning Practices

- Starts on day of admission
- Initial discharge discussion starts immediately
- IDC team meeting within five days of admission
- Discharge care plan developed on day of admission
- Coordination of discharge services early in stay to assure safe discharge & prevent rehospitalization
- Medication reconciliation with PCP on admission and discharge
- Clear written discharge instructions with follow up appointments
- Written patient education materials
- Follow up phone call post discharge to assure all services in place, medications obtained and to answer any questions
Medication Reconciliation Practices

- Utilize EPIC reviews for all new and readmissions to avoid incompatible or duplicative therapy
- Reconcile medication on day of admission against hospital discharge orders, PCP recommendations and attending physician
- Have two nurses review medication reconciliation to prevent errors
- Reconcile all discharge medications with PCP
- Provide patient teaching with each med pass
- Provide family teaching regarding medications and side effects
- Include written instructions for all medications on discharge
- Ensure all prescriptions have been called into the patient’s pharmacy on day of discharge

Decreasing Rehospitalization Rates

- Administration & clinical techniques to decrease re-hospitalization rates through:
  - Enhanced care coordination with other PAC providers
  - Modifying discharge planning for SAR Patients
  - Medication reconciliation
Patient Care Satisfaction

- Measurement of the care experience must include the four Core Q questions:
  - Rating of care
  - Rating of staff
  - Would you recommend this facility to family/friends
  - Rating how well discharge needs were met

Quick Planning Task

How is your management team tracking current quality measures used in the SNF quality reporting system to ensure compliance and improve the patient experience of care in our facility?
Person-Centered Care Plan Development

The Must Haves of Care Planning

- Person centered - generic is not allowed
- SMART goals - specific, measurable, attainable, results oriented, time framed
- The focus is not what the staff will do it is what the resident feels should be done
- Resident evaluation of success is what is key - not staff evaluation
- Discharge planning starts on day one
- Functional outcomes are key - goal for SNF stay is improvement
- Baseline care plan within 48 hours of time of admission
- Resident & family input critical
- Care team must include food service, social worker and nursing assistant

Meet Mary O’Hara

- My name is Mary O’Hara and I was born in Ireland in 1930. I grew up in the countryside outside of Donegal and love flowers especially wild Irish roses. I cherish my family especially my two children, four grandchildren, and three great grandchildren. I am Roman Catholic and take time each day to pray. Sometimes you may find me crying since I often miss my husband Patrick who is in heaven, we were married for 65 wonderful years.

- Since my stroke five years ago I need help at times with walking, dressing, & bathing. I prefer to have a shower every other day in the morning around 8:30am since this helps with my arthritis and improves my mobility. I am slower in the morning and hope you will have patience with me. I get up at 8am and I must brush my teeth, style my hair and get dressed before going for breakfast.

- I like a short nap after lunch, like dinner around 6pm, watch TV or listen to music and then go back to bed around 10pm to watch the news and doze off. I keep my TV timer set in case I fall asleep without turning it off. Keeping to my usual schedule makes me feel safe and decreases my anxiety.
### My Concerns, Needs, Likes, Hopes

<table>
<thead>
<tr>
<th>What I Wish</th>
<th>How You Can Help</th>
<th>Who Can Help</th>
</tr>
</thead>
<tbody>
<tr>
<td>I miss my husband and sometimes get sad and cry when I think about him.</td>
<td>1. Just sit with me and talk or hold my hand.</td>
<td>Anyone who I am friends with and the staff that care for me</td>
</tr>
<tr>
<td>Sometimes I may refuse to eat or just want to stay in bed and not get up.</td>
<td>2. When I refuse care remind me Patrick liked to see me looking pretty. Ask about our trips.</td>
<td>My family when they visit</td>
</tr>
<tr>
<td></td>
<td>3. Ask if it would like to Skype with my family</td>
<td>My caregivers</td>
</tr>
<tr>
<td></td>
<td>4. Remind me to feed &amp; water my roses &amp; ask me to tell you my wild Irish Rose stories</td>
<td>My family when they visit</td>
</tr>
<tr>
<td></td>
<td>5. Sit with me in the garden with a cup of tea and biscuits and let me listen to my Irish music.</td>
<td>My caregivers</td>
</tr>
<tr>
<td>I have trouble walking since my stroke and need to use a walker but want to use the bathroom alone even though I know I could fall and get hurt.</td>
<td>1. Help me by keeping my walker close by and if I forget to use it please remind me.</td>
<td>My caregivers</td>
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<td></td>
<td>2. Ask if I need help but don't get upset if I say no.</td>
<td>My caregivers</td>
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<td></td>
<td>3. I need help putting on my shoes and stockings since I sometimes get dizzy when I bend over.</td>
<td>My caregivers</td>
</tr>
<tr>
<td></td>
<td>4. Make sure my tea is always served in my Wild Irish Rose &quot;to go&quot; cup with the handle. Let my daughter know new ones are needed. I keep extras in my closet.</td>
<td>My caregivers</td>
</tr>
<tr>
<td></td>
<td>5. Maurice &amp; Kira like to help me when I walk - it's ok.</td>
<td>All my wonderful caregivers</td>
</tr>
<tr>
<td>I like to sleep until 8am and take a shower before breakfast. I nap around 2pm for about a half hour. I go to bed at night around 10pm. I have lost so much weight and want to look nice when I look in the mirror – it makes me feel better.</td>
<td>1. It is okay to gently wake me with a nice cup of fresh brewed hot tea around 8am.</td>
<td>My family when they visit</td>
</tr>
<tr>
<td></td>
<td>2. I am not a big breakfast person – tea, Irish soda bread &amp; scones are what I enjoy.</td>
<td>My family when they visit</td>
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<td></td>
<td>3. I like to brush my teeth, wash my face and brush my hair before breakfast or I won't eat.</td>
<td>My family when they visit</td>
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<td>4. Offer to help me get my clothes from the closet</td>
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### What I Wish

- If I sometimes pace or get upset I might be missing Patrick. If you remind me to tell you about our honeymoon and show me his picture, I will feel better. Patrick and I loved to travel and I still enjoy looking at the pictures we took, talking about the countries we visited and the memories we shared.
- I eat very little for breakfast – tea and toast. I enjoy my main meal around noon, have a cup of tea and biscuits at 3pm and prefer a light supper - soup, sandwiches, salads. I love sweets even though I am not supposed to eat too many due to sugar problems. I also love chocolates – especially Godiva.
- I love gardening, looking at gardening magazines, visiting the botanical gardens, planting seedlings, and decorating my house with flowers and garden scenes. I like to draw or paint flowers. I like fresh flowers in my room - this always makes me feel better. Oh since I enjoy sitting outside every day, be sure I wear my hat to protect my skin.
- If I forget I can't do everything like I used to please sit with me and explain that you care about me and don't want me to get hurt and then offer to help me. I am a good listener. I like a good joke and smiles.
- I worry about losing my ability to feed myself. Even though I know I could fall and get hurt, I don't want me to get hurt and then offer to help me. I am a good listener. I like a good joke and smiles.
- I have trouble walking since my stroke and need to use a walker but want to use the bathroom alone even though I know I could fall and get hurt. I worry about losing my ability to feed myself. I worry that the doctor may get upset with me if my sugar goes up, but having a sweet treat each day is one of the few pleasures I have left.
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Person-centered care is at core of all CMS initiatives and really is the heart of what we do day to day!

Helpful Resources

- Castle, Nicholas George castlen@pitt.edu – CORE Q satisfaction surveys
- Help@qtso.com or 1-877-201-4721 (QIES Help Desk): For questions about MDS record completion and submission processes, or for technical questions. This group also handles questions related to MDS/CASPER login IDs/passwords and jRAVEN software.
- SNFQRPR reconsiderations@cms.hhs.gov (Reconsideration Help Desk): For reconsideration requests and follow-up questions if your facility has received a CMS determination of noncompliance letter.
- Subscribe to this listserv for the latest SNF QRP information including but not limited to training, stakeholder engagement opportunities, and general updates about reporting requirements, quality measures, and reporting deadlines: https://public-dc2.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_12265
More Helpful Resources

- **SNFQualityQuestions@cms.hhs.gov** (QRP Help Desk): For general questions about the SNF QRP, reporting requirements, reporting deadlines, and SNF QRP quality measures.
- **BetterCare@cms.hhs.gov** or 1-800-839-9290: For questions related to Nursing Home Compare and the Five-Star Quality Rating System.
- 1-888-238-2122 (CMSNet Help Desk): For assistance with your CMSNet login ID/password.

I’ve Still Got a Lot of Life to Live!

Thanks for the help!
Thank You for Being a Great Audience