What I Hope You Leave With

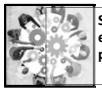
- Repositioning to Hospital Utilization vs. Rehospitalization
- The Metrics Available
- The Financial Implications
- An appreciation for the Bowtie

Why "Hospital Utilization" vs. "Rehospitalization"

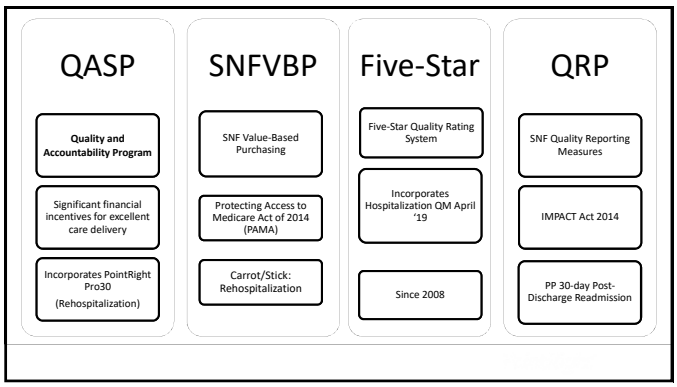

Broader more encompassing definition

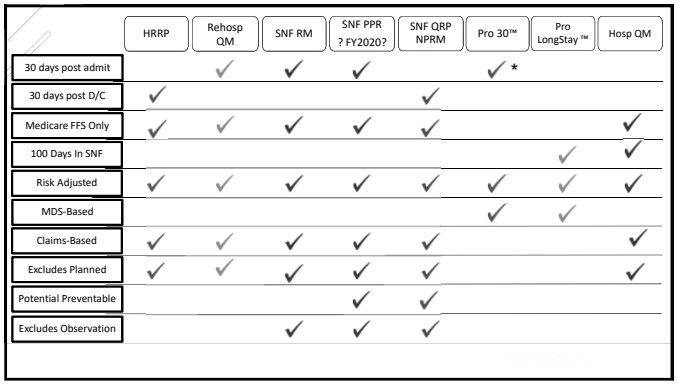

Has inherent success in various VBP/APM

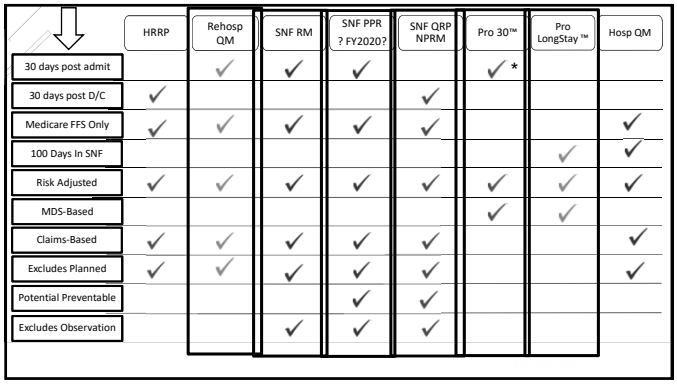

Develops all of the care team


Supports failure free environments & creative partnerships


Clear focus on patient/resident







3 Measures to Discuss

1. **PointRight Pro30**
   Rehospitalization within 30 days of discharge from hospital
2. **SNFPPR**
   Potentially Preventable Readmission within 30 days of discharge from hospital
3. **QRP: Potentially Preventable 30-day Post Discharge Readmission**
   Potentially Preventable Readmissions within 30 days post SNF discharge to the community

QASP and A Standard Rehospitalization Measure

- ✓ Pro30 is Part of QASP
- ✓ Endorsed by National Quality Forum (NQF)/Verified by Brown University
- ✓ Observed (actual) and case-mix adjusted rates
- ✓ From PointRight: Rates by low, medium, and high risk group
- ✓ Adopted by the American Health Care Association (AHCA)
- ✓ Medicare and All-Payer
- ✓ From PointRight: Rates by clinical cohorts – conditions that place SNF residents at increased risk for rehospitalization
- ✓ From PointRight: Resident risk alert for triggering

PointRight Pro30

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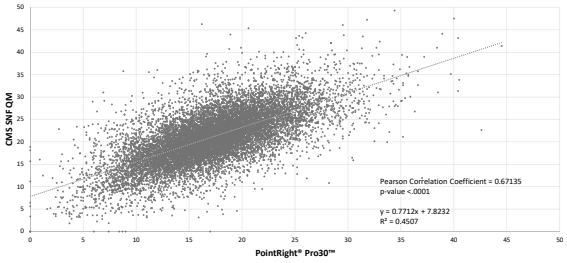
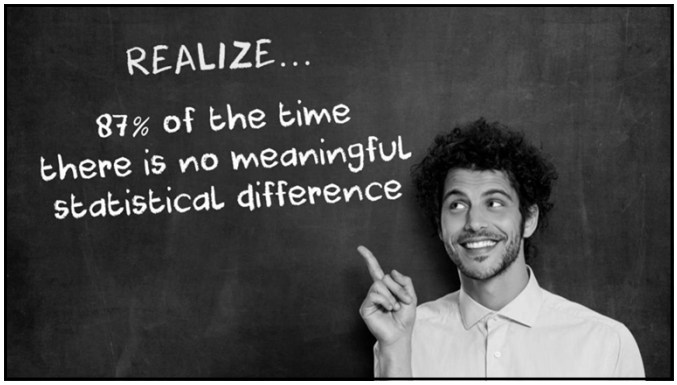
CMS SNF QM and PointRight® Pro30™





Comment: Some commenters expressed concern that SNFs will not have access to the data used to calculate the SNFRM, and will therefore **not be able to validate CMS's calculations.**

Response: While we intend to make as much information related to SNFRM performance as possible available **to SNFs through confidential quarterly feedback reports** required under section 1888(g)(5) of the Act, **we understand that claims based quality measurement is difficult for providers to replicate. It would require familiarity with a number of data sources that are used to develop the risk-adjustment model for SNFRM in order to account for variation across SNFs in case-mix and patient characteristics predictive of readmission** (including the MedPAR, Medicare Enrollment Database (EDB), Medicare Denominator files, Agency for Healthcare Research & Quality (AHRQ)'s Clinical Classification Software (CCS) groupings of ICD-9 codes, and CMS's hierarchical condition category (HCC) mappings of ICD-9 codes). We view this as a necessary compromise to minimize reporting burden on participating SNFs by using claims data while ensuring that we obtain timely data for quality measurement.

Pro 30® vs. CMS SNF QM: What it Means

		PointRight® Pro 30®	
		Low	**High**
CMS SNF QM	**HIGH**	Rehosp occurs post SNF discharge	What the What? X
	LOW	You're Awesome ✓	More rehosp than others Planned readmissions may play a role

Understanding SNF **VBP** in Detail.

Register Today at
https://educate.ahcancal.org/p/snfvbp

ahcancalED

FROM REHOSPITALIZATION TO HOSPITALIZATION

McKnight's
LONG-TERM CARE NEWS

September 05, 2016
Pursuing excellence

Long-stay measures

Change is in the wind. The National Quality Forum has recommended for endorsement a new metric that measures a skilled nursing facility's ability to manage the long-stay population, specifically in terms of hospitalization prevention.

To date, similar measures have focused exclusively on the first 30 days after an acute hospital stay, a very different cohort. This new metric is important, considering that over 60% of SNF residents are long-stay patients, many of whom are at end of life, with a terminal illness or heightened frailty. Hospitalization of this population is often associated with negative consequences; in 2015 the national average of long-stay hospitalization was 14.15%, with performance ranging from 0% to 20.26%.

Steven Littlehale, EVP and Chief Clinical Officer, PointRight Inc.

Long-Stay Resident Hospitalization

Over 65% of Skilled Nursing Facility "patients" are actually long-stay residents, not intending to go home.

15%	National rate for Long-stay residents hospitalization.
30%	SNFs in which short-stay rehospitalization aligns with long-stay hospitalization performance.

PointRight Pro Long Stay

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Long-Stay Resident Hospitalization

Over 65% of Skilled Nursing Facility "patients" are actually long-stay residents, not intending to go home.

14%	California rate for Long-stay residents hospitalization.
14%	Hospitalized long-stay residents were at end of life

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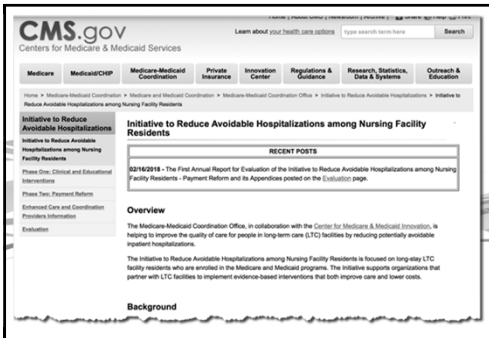

July 2018 to confidential "Nursing Home Compare Five-Star Ratings of Nursing Homes Provider Rating Report."

October 2018, the long-stay hospitalization measure was posted on the Nursing Home Compare website as a long-stay quality measure."

Spring 2019, this quality measure was included in the Five Star Quality Rating System.

NUMBER OF HOSPITALIZATIONS PER 1,000 LONG-STAY RESIDENT DAYS

Measure Name

The measure name is Number of Hospitalizations per 1,000 Long-Stay Resident Days.

Purpose of Measure

If a nursing home sends many residents back to the hospital, it may indicate that the nursing home is not properly assessing or taking care of its residents who are admitted to the nursing home from a hospital.

This claims-based quality measure will be reported on Nursing Home Compare starting in October 2018, and integrated into the Five-Star Quality Rating System in April 2019. It reports the ratio of unplanned hospitalizations per 1,000 long-stay resident days. This document describes the specifications for this measure.

Measure Description and Specifications

The long-stay hospitalizations measure determines the number of unplanned inpatient admissions or outpatient observation stays that occurred among permanent (i.e. long-stay) residents of a nursing home during a one-year period, expressed as the number of unplanned hospitalizations for every 1,000 days that the long-stay residents were admitted to the facility (i.e. "long-stay resident days"). Higher values of the long-stay hospitalizations measure indicate worse performance on the measure. See Table 4 for detailed specifications for the measure.

Numerator: The numerator for the measure is the number of admissions to an acute care or critical access hospital, for an inpatient or outpatient observation stay, occurring while the individual is a long-term nursing home resident

- CMS number of hospitalizations per 1,000 long-stay resident days
- Residents >100 days
- Claims-based
- MDS used for case-mix adjustment
- Key exclusions, such as hospice
- Includes observation stay

PointRight® Pro Long Stay™ Hospitalization

A Standard Hospitalization Measure

- ✓ Verified by Brown University
- ✓ Endorsed by National Quality Forum (NQF)
- ✓ Observed (actual) and case-mix adjusted rates
- ✓ Adopted by the American Health Care Association (AHCA)
- ✓ National Benchmarks

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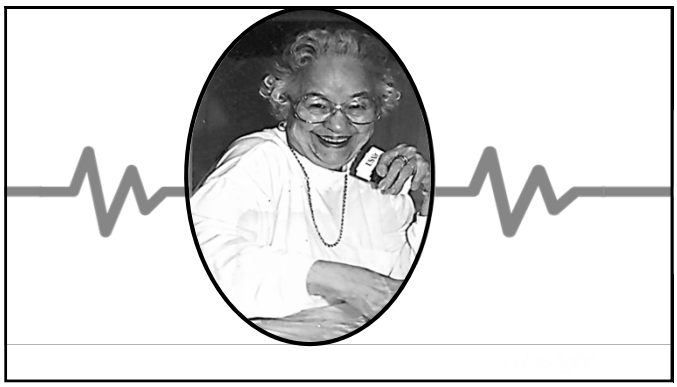
Connect.

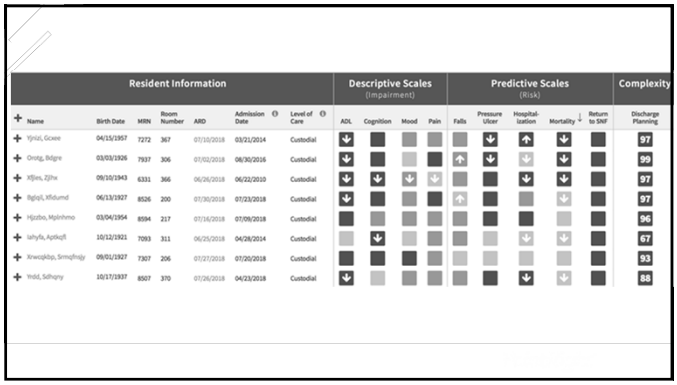
Putting the pieces together for a better outcome

The Big So What

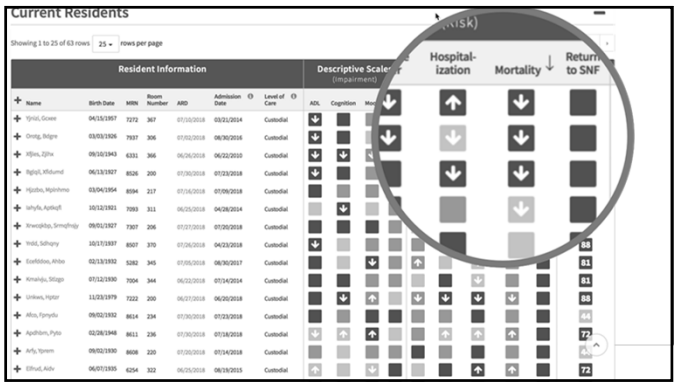
Facility Information	Observed Pro30 Rehospitalization Impact		Adjusted ProLong Stay Impact	
County Name	Market's Median Observed Rehospitalization (Pro30)	Additional Annual Admissions if Improve Below Median (per 100 beds)	Market's Median Hospitalization (ProLong Stay)	Additional Admissions if Improve Below Median (per 100 beds)
Stanislaus	14.9%	176	15.2%	
Los Angeles	19.0%	105	19.0%	86
Merced	14.9%	176	15.2%	
Madera	14.9%	176	15.2%	
Orange	14.3%	149	15.5%	150
San Diego	14.5%	145	14.7%	196
Tulare	19.5%	162	16.9%	
Kern	19.5%	162	16.9%	
Del Norte	11.7%	169	11.6%	
Sonoma	11.8%	238	8.4%	
Imperial	14.5%	145	14.7%	196

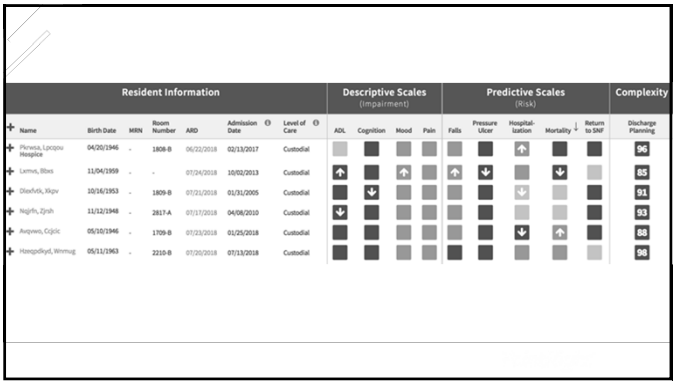
A Business Case for Doing the Right Thing





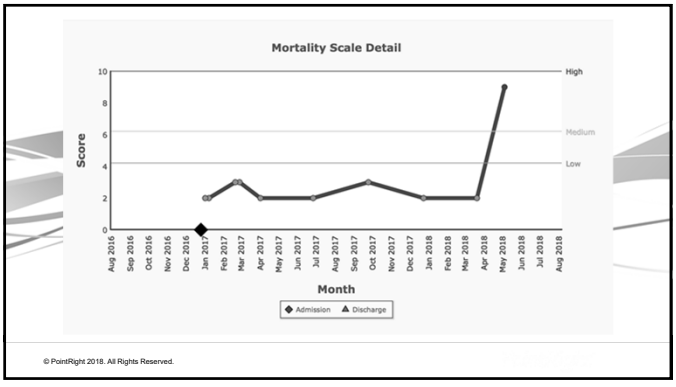
Resident Information							Descriptive Scales (Impairment)				Predictive Scales (Risk)					Complexity
Name	Birth Date	MRN	Room Number	ARD	Admission Date	Level of Care	ADL	Cognition	Mood	Pain	Falls	Pressure Ulcer	Hospital-ization	Mortality ↓	Return to SNF	Discharge Planning
Yjnjzl, Gcaee	04/15/1957	7272	367	07/10/2018	03/21/2014	Custodial										97
Orotg, Bdgre	03/03/1926	7937	306	07/02/2018	08/30/2016	Custodial										99
Xfjes, Zjlhx	09/10/1943	6331	366	06/26/2018	06/22/2010	Custodial										97
Bglql, Xfidumd	06/13/1927	8526	200	07/30/2018	07/23/2018	Custodial										97
Hjzzbo, Mplnhmo	03/04/1954	8594	217	07/16/2018	07/09/2018	Custodial										96
Iehyfa, Aptkqfl	10/12/1921	7093	311	06/25/2018	04/28/2014	Custodial										67
Krwcqkbp, Srmqfnjjy	09/01/1927	7307	206	07/27/2018	07/20/2018	Custodial										93
Yrdd, Sdhqny	10/17/1937	8507	370	07/26/2018	04/23/2018	Custodial										88





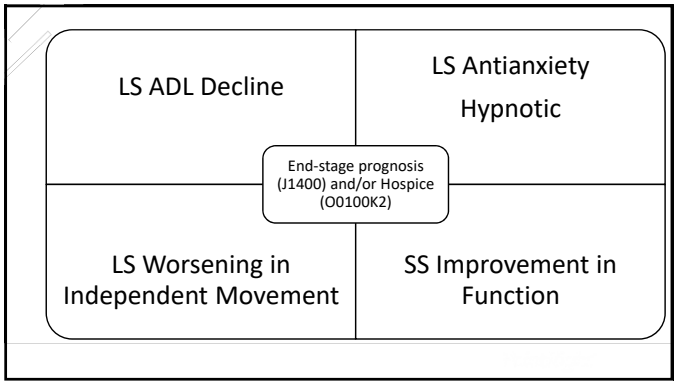
Resident Information							Descriptive Scales (Impairment)				Predictive Scales (Risk)					Complexity
Name	Birth Date	MRN	Room Number	ARD	Admission Date	Level of Care	ADL	Cognition	Mood	Pain	Falls	Pressure Ulcer	Hospital-ization	Mortality	Return to SNF	Discharge Planning
Pkrwsa, Lpcqou Hospice	04/20/1946	-	1808-B	06/22/2018	02/13/2017	Custodial										96
Lxmvs, Blbxs	11/04/1959	-	-	07/24/2018	10/02/2013	Custodial										85
Dlevfvtk, Xkpv	10/16/1953	-	1809-B	07/21/2018	01/31/2005	Custodial										91
Ngjrfn, Zjrsh	11/12/1948	-	2817-A	07/17/2018	04/08/2010	Custodial										93
Avqvwo, Ccjcic	05/10/1946	-	1709-B	07/23/2018	01/25/2018	Custodial										88
Hzeqpdkyd, Wnmug	05/11/1963	-	2210-B	07/20/2018	07/13/2018	Custodial										98

Power of Prediction:
Mortality – the items



Model Validation: Mortality "Frailty" Model

Model score Rank	5- day Assessment		14 - day Assessment		30 - day Assessment		60 - day Assessment	
	Predicted Prob	Actual Rate	Predicted Prob	Actual Rate	Predicted Prob	Actual Rate	Predicted Prob	Actual Rate
10	68.71%	70.14%	62.58%	68.18%	58.07%	68.33%	69.54%	69.35%
9	51.71%	54.35%	49.79%	54.10%	48.86%	54.04%	50.00%	54.15%
8	42.29%	44.33%	40.97%	44.20%	39.35%	44.11%	40.18%	44.11%
7	33.80%	34.35%	33.66%	34.25%	30.76%	34.12%	31.36%	34.08%
6	27.91%	27.32%	27.82%	27.30%	26.47%	27.26%	25.02%	27.26%
5	23.18%	22.31%	23.54%	22.27%	22.30%	22.24%	20.42%	22.24%
4	17.95%	17.30%	18.76%	17.24%	16.95%	17.22%	16.13%	17.26%
3	12.43%	12.26%	12.97%	12.20%	12.09%	12.18%	10.70%	12.18%
2	6.72%	7.65%	7.06%	7.27%	6.61%	7.21%	6.01%	7.21%
1	3.82%	4.73%	3.31%	4.30%	3.02%	4.24%	3.12%	4.22%



Hospice (O0100K2) is an exclusion

Are You...

Utilizing and Leveraging Your Data?

The PDPM Tie In

- Rehospitalization may impact your PDPM Rate
- All reported hospitalization utilization measures remain intact
- The value of untethered therapy and ancillaries in preventing rehospitalization

QUESTIONS

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Thank You!

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