The Illinois Quality Improvement Program

Presented by:

The Health Care Council of Illinois

The Illinois Quality Improvement Program

Two Aspects:

- Restorative Philosophy vs RUGs
- Quality Performance Incentives

Restorative Philosophy vs RUGs

Resource Utilizations Groups (RUGs):

- Statistical, acuity-based, diagnosis-driven
- Measures what is, not what we want
- Ideal for replacing flat-rate systems that create costly hospital backlogs
- Used nationally for short-stay, post-acute, Medicare rehab and recovery patients

RUGs: Medicare vs Medicaid

Relative Case Mix Index established through time studies:

- Fries Medicare Time Studies: 1990 and 95-97
- Robert Kane Medicaid Studies in four states (CO, IN, MI, MN) 1998-2004, published in Health Services Research 42:2 April 2007, "Explaining Direct Care Resources Use of Nursing Home Residents: Findings from Times Studies in Four States."

RUGs: Medicare vs Medicaid

Kane Conclusions:

- Fries CMI weighted toward high acuity Medicare patients; underweights resource utilization for Medicaid patients
- Unlike Medicare, restorative programs DO make a resource utilization difference for Medicaid patients
- Greater resource utilization on Alzheimer's Units

Restorative Philosophy vs RUGs

Of the 28 states that use RUGs for its Medicaid program, 26 have felt the need to either:

- add additional clinical areas for access, and/or
- incentivize quality performance measures

Medicaid clinical additions to RUGs

- AIDS Special Care Units (NY, ID, OH)
- Traumatic Brain Injury (NY, ID, KY, ME, NB, NH, NC, ND, OH, OR, VA)
- Ventilator Care or Units (NY, ID, IN, KS, NE, NH, NC, ND, OH, OR, SD, TX)
- Tracheostomy Care (ID, OR)
- Behaviorally Complex (NY, ID, UT, DE, WI)
- Special Care Alzheimer's Units (IN, IA, MS)
- Early dementia add-on (NY - $8)
- End Stage dementia (OH)
- Moderate/severe cognitive impairment (GA, WI)
- Bariatric Care (NY - $17)
- Rehab/restorative/prevention programs (DE – +25%, ND, WA)
- Prevention of pressure ulcers (GA, SD, VT)
- Restraint reduction (GA)
- Management of Severe Pain (GA)
- Specialty Equipment and Supplies (ID, PA, UT)
- Parenteral Nutrition (ND)

Does this list seem to be at all familiar to anyone in Illinois?

Restorative Philosophy vs RUGs

- With the exception of the AIDS Special Care Unit, all of these conditions that other states feel are needed to augment RUGs are already covered in the Illinois MDS reimbursement system.
- And Illinois does not have access problems or costly hospital backlogs with any of these conditions.

Restorative Philosophy vs RUGs

Illinois' Restorative Philosophy:

- Improve ADL Functioning and Independence
- Prevent Deterioration
- Prevent Pressure Ulcers
- Reduce Pain
- Decrease depression and increase emotional health, quality of life and satisfaction

Restorative Philosophy vs RUGs

As of March 31, 2010, out of 47,516 Medicaid residents in Illinois nursing homes:

- 44,598 were receiving fall prevention services *
- 37,091 were receiving pressure ulcer prevention services
- 31,018 receiving memory assistance services for cognitive impairment *
- 27,854 mobility restorative programs
- 14,394 residents were receiving services for pain management
- 11,510 were receiving continence restorative services *
- 2,490 receiving services in Special Care Alzheimer's Units
- 662 were receiving discharge planning services for discharge in the next three months
- 190 were receiving services for traumatic brain injury
- 306 receiving ventilator services
- 35 who had been successfully weaned from a vent in the past three months

* The three most frequent reasons for non-Medicare nursing home admissions

Restorative Philosophy vs RUGs

RUGs was developed in the 1980s:

- Modeled after DRGs in hospitals
- Diagnosis drives the care plan and resource utilization in an acute-care hospital

Is that true for a post-acute nursing home or home care population?

Restorative Philosophy vs RUGs

Ask a Nurse:

How would you allocate resources for cerebral palsy or multiple sclerosis (RUGs Special Care category)?

Answer:

Don't know. Depends:

Restorative Philosophy vs RUGs

- First Resource Question: What is the level of ADL need? Then:
- What about cognitive impairment?
- What about continence?
- What is the restorative and therapy potential?

- After that, diagnosis adds little in determining resource allocation

Restorative Philosophy vs RUGs

The current Illinois Restorative system:

- Developed collaboratively by clinicians, not mathematicians
- Follows an individualized clinical assessment model, not statistical groupings
- Embraces a restorative and prevention philosophy
- Based on care we want, not just a measurement of what is
- Recognizes many of the new high-tech developments of the past ten years
- Results in earlier release from high-cost hospitals and earlier discharge into the community
- Last year, 39,000 nursing home residents went home in less than 3 months

Restorative Philosophy vs RUGs

Illinois, along with four other states (Maryland, Arizona, Delaware, Mass), uses an MDS-based, case-mix system based on ADL need, with additional resources based on individualized assessment information.

- Same thought process as Illinois home care assessment
- Illinois reimbursement system thinks more like a nurse and less like a mathematician
- More than a year ago, provider clinicians offered a revised MDS Medicaid reimbursement system based on the new MDS 3.0

Quality Performance Incentives

In addition to supplementing clinical conditions not covered under RUGS, the Medicaid RUGs states also add other incentives for quality management practices and quality outcomes, including:

Quality Performance Incentives

- Higher than average staffing (IA, ME, MN, NJ, OH, TX)
- Higher than average staff retention (GA, IA, KS, ME, MN, NJ, OH)
- Lower Use of Contract Staff (IA)
- One-on-one coverage (ID, SC)
- ADL Improvement (MD)
- Use of Independent Satisfaction surveys (GA, IA, MN, OH, UT)
- IMD or MR/DD (KY, MA)
- Private room for Medicaid (LA)
- Above average Quality Indicators (MN, TX)
- High Medicaid Census (NE, OH, PA)
- Incentives for Health Information Technology (NJ)
- Good survey outcomes (OH, TX, UT)

Quality Performance Incentives

What do we want for Illinois nursing home residents?

What programs encourage quality outcomes and cost-efficiency?

Influenced by developments of the past year:

- National Healthcare Reform Act
- Media Spotlights
- Illinois Nursing Home Safety Act

Some initial thought-provoking suggestions for Illinois (not exclusive, not exhaustive):

Quality Performance Incentives

- Prevention of ER visits and re-hospitalizations (OIG: falls, pneumonia, diabetes, asthma, heart disease and mental illness); Also YHP/McKesson focus
- Community integration after 3 months
- Aftercare: still in the community after 6 months
- HEALED Pressure ulcers
- Improved ADLs
- Decrease in Pain
- Lack of dehydration
- Lack of infections
- Restorative Care
- Psychosocial programs
- Therapeutic activities
- Staffing Stability/Retention
- Independent Resident Sensitivity and Abuse Prevention Training
- Private room rates
- Higher Medicaid Occupancy
- Incentives for Health Information Technology
- Customer satisfaction

Quality Performance Incentives

- Reduced hospitalizations
- Increased, quicker and effective community discharges
- Improved sentinel event medical care
- Better quality of life
- Emotional health
- Resident Satisfaction
- Employee empowerment

Isn't that what we all want to see?

Let's do it together.