Rod Baird, Marc D. Rothman, MD, CMD, and Paul Katz, MD, CMD, are jointly present- ing a talk entitled “Skilled Nursing Facility (SNF) Physician Quality Data: Peril or Promise?” at AMDA’s annual conference later this month. The presentation objectives are to cover the principles of LTC quality improvement, the expectations of a large PA/LTC facility group, and the reporting needs of an LTC medical group.

This column, which coincides with the conference presentation, discusses “twofers”—activities that serve more than one objective, such as documenting clinical data, or recycling a PowerPoint slide deck—and identifying and tracking PA/LTC “twoper” quality measures, as well as identifying timely and universally recognized measures that benefit patients.

Every January, medical groups and their electronic health record vendors are challenged to introduce that year’s quality reporting strategy to their cli- nicians. Each year, this gets more diffi- cult. How do you craft a strategy that pleases the practitioners and satisfies the performance specifications for PQRS reporting, value-based purchasing quality tiering, and EHR meaningful use?

To illustrate the challenge, this list identifies the audience for the physi- cians’ “quality” activities.

▶ Clinician: An individual and group’s professional objectives. What do I/we do each day that creates value?
▶ Patient: The individual whose clinical and human needs we serve. How do we improve the quality of life for the patients and their families?
▶ Facility: The customer and its needs and expectations. What do the LTC facilities we cover expect from a medi- cal group to satisfy their needs?
▶ Health system: The environment in which we perform our duties and to which we are accountable. What do health sys- tems, accountable care organizations, and other community organizations expect from us as LTC medical groups?
▶ Third party payer: Regulators, third party payers, and their requirements. How do I successfully meet/exceed the mandates for reporting compliant behavior?

What makes a good quality measure? Practically speaking, it should have cer- tain characteristics:

▶ Meaningful: The measure should assess something that is important, preferably to multiple parties, and par- ticularly for the individual subject to the measure (e.g., does this patient need an antipsychotic medication?).
▶ Measurable: The activity should be capable of being measured objectively. Some of the most important com- ponents of quality are very difficult to standardize and quantify, particu- larly attitude and behavior. Others are quantifiable but very difficult to bench- mark across settings.
▶ Controllable: The individual being measured (prescribing physician/NPP) should be the person in control of the decision.
▶ Achievable: By their nature, quality measures have performance objectives. It should be objectively possible for the typical individual or group to achieve the measures’ benchmark.
▶ Feedback: Timely reporting on the measure given to the individual or group. The purpose of quality measures should be to continuously improve pro- cesses or outcomes of care. Usually, the shorter the delay in providing feedback, the quicker the desired response (pro- cess quality control – point of service measurement). The flip side of point-of-service measurement is clinical deci- sion support—in which the individual performing the measured activity (e.g., prescribing an antipsychotic) is alerted as they select the medication of possible treatment alternatives.
▶ In PA/LTC, who measures quality—the physician or the facility? That’s a challenge; quality measures require signifi cant volume to achieve statistical significance. Some are quite difficult to track. For example, how does the physi- cian monitor average lengths of stay, or 30-day rehospitalization rates? It is pos- sible, but quite difficult, without facility data. Physician groups only get feed- back from the Centers for Medicare & Medicaid Services 9 months after the close of the calendar year.

In our conference presentation, Dr. Rothman, Dr. Katz, and I will discuss a different area of quality measurement:

▶ Dr. Katz – Physician-initiated quality initiatives that do the most to improve LTC patient care processes and outcomes.
▶ Dr. Rothman – Physician-influenced care processes and results that have the greatest impact on the SNF/NF and their patients.
▶ My talk – The intersection between LTC medicine’s economics and the menu of CMS-approved physician quality measures.

As presenters, we want to advance a framework for a defi nition of quali- ty that is shared between the SNF and attending physicians. When I had the opportunity to review the programs of my co-presenters, two distinct thoughts arose. Each of us shared the same goal—developing high value strategies to improve patient care for PA/LTC patients. It was also obvious that few, if any, of our shared goals could be used to satisfy more than two audiences at once; twofers are hard, three or more nearly impossible. That is the crux of our collective PA/LTC quality measure- ment problem.

SNF Physician Quality Data: Peril or Promise?

Goal Examples

Let’s examine two quality goals that Dr. Katz proposed to illustrate the challenge.

Facility/physician goal 1: Physicians respond to “acute change in condition alerts” within 1 hour. This is a possible twopler.

Medical group strategic alignment: This was the first standardized quality mea- sure our medical group developed and tracked in 2004. Our medical directors decided it was important to measure response times to “on-call” messages. We began with mailed surveys to facilities. Those surveys were far from scientific, with low response rates and subjective measurements. They did establish the signifi cance facility leaders placed on timely responses (24/7).

How we tracked performance: Creating a practice wide “on-call” performance plan became our fi rst formal quality project. (Note to facilities – this process is analogous to what is now called QAPI [quality assurance and performance improve- ment]). Shortly afterward, we purchased a computer-controlled telephone system that logged our call activity. After many months of work fl ow and system analy- sis, we ended up with a monthly on-call performance report that is distributed the following month to all physicians by email. Anyone in the practice can see who covered calls by the day, the call vol- ume, and percentage of calls answered.

Plus, the average/median/maximum elapsed time to clear voice mail messages is displayed by individual and for the group. Every 6 months, we analyze call frequency per patient and group this by facility. Facilities or physicians with high call frequencies per patient may trigger additional analysis.

Challenge: Although this is a superb per- formance measure for both physicians and facilities, it is almost impossible to standardize. Our group had to invent a series of rules to create standard measures of performance. We began by creating an “on-call” number for each medical group so that we could begin classifying the purpose of a call. Without a fl exible tele- phone system, this would be impossible. Now we could measure the percentage of on-call calls that were answered immedi- ately (our goal was 85%).

Next, we built rules that defined what was meant by “response time to voice mail”; these provide a measure of how long it takes to clear that message. All of these measures are now benchmarked, but they are only relevant to our own metrics. When we share data with facili- ties, their interest is simply that their attending physicians and on-call cover- age staff think response time is so impor- tant that it is measured. The facility, or another medical group, could establish the same measure and get very different statistics based on the tools employed.

Qualitatively, we are measuring the same thing, but our results are based on different systems of measurement.

Performance monitoring and effectiveness: This measure is important to patients and facilities; tracking it helps physicians improve process quality. Unfortunately, it is not suitable for quantitative compari- son across disparate groups/facilities in the absence of standard metrics.

Facility/physician goal 2: A complete ini- tial clinical encounter from the physician is on patient chart in a timely manner. Facility staff needs the physician assess- ment as the basis for many care planning tasks. This, too, is a possible twopler!

When our medical group fi rst devel- oped an EHR, we automated the deliv- ery of notes to the facility as soon as they were electronically signed. We believed our notes added value to patient care. Our facility liaisons were surprised when some facilities continued to complain about missing notes after EHR imple- mentation. During a root cause analysis, staff discovered that some physicians weren’t fi nishing their encounter notes for several days. They would start the encounter at the facility, but keep paper crib notes to use as a guide for compos- ing a fi nal note after rounding. Being human, some of those notes remained incomplete for days on end. Our solu- tion was to create unsigned note reports from the EHR that were published for all to see.

Result: The unsigned note report signifi cantly lowered the frequency of open notes remaining open past midnight. We can demonstrate that more than 98% of all notes are signed and delivered on the day of the visit. (Dr. Rothman has an analogous quality metric—the physician performs and documents a complete face-to-face admission visit by day 2 of the patient’s stay.)

Challenge: How does a physician track performance if he/she doesn’t know the patient’s admitted diagnosis? Administrative- ly, we have to rely on someone manually entering the facility admission date into each patient encounter. In our medical group, we have successfully negotiated a loop system that links the admit time to the chart in our EHR, thus allowing the entering physician to be automatically notified of an admitted patient’s status. Once again, Dr. Rothman developed rules to de- fine what constitutes an admission to the facility. Our medical directors, with help from our facilities, determined that a patient who does not answer the “Are you admitted?” question is not an admitted patient. Our system attempts to send the admitting physician an alert to enter admission data into the EHR so that the patient’s visit is registered.

Quality Tip

“Skilled Nursing Facility (SNF) Physician Quality Data: Peril or Promise” will describe data collec- tion, review and dissemination of SNF physician data, as well as barriers to physician engagement and solu- tions for collaboration. Dr. Rothman, Dr. Katz, and Mr. Baird will be presenting on Saturday, March 21, 4:00-5:30 p.m. at the AMDA annual conference, Louisville, KY. To regis- ter, visit www.paltcmedicine.org.
Diabetes in Midlife Raises Dementia Risk

BY NICOLA GARRETT

Adults with type 2 diabetes or prediabetes in midlife had greater cognitive decline over the next 20 years than did people without diabetes, according to the findings from a large prospective cohort study. The Atherosclerosis Risk in Communities (ARIC) study of 13,351 adults aged 48-67 years found those with diabetes in midlife had a 19% greater cognitive decline over a 20-year period than did people without diabetes (adjusted global z-score difference, -0.15 [95% CI, -0.22 to -0.08]), according to the findings published in Annals of Internal Medicine (Ann Intern Med 2014;161:785-93).

The investigators used three neuropsychological tests to assess cognitive function: the delayed word recall test, the digit symbol substitution test of the Wechsler Adult Intelligence Scale-Revised, and the word fluency test.

Cognitive decline was significantly greater in people with prediabetes (HbA1C level of 5.7%-6.4%), compared with those with an HbA1C level lower than 5.7%, reported the study authors, led by Andreea M. Rawlings of the Johns Hopkins Bloomberg School of Public Health in Baltimore.

People with poorly controlled diabetes (HbA1C ≥ 7%) had greater cognitive decline than did people with better-controlled disease (adjusted global z-score difference, -0.16; P = .071). The association with cognitive decline was stronger for longer-duration diabetes (P < .001), and the findings were similar for black and white adults (P = .44). Maintaining cognitive function is a critical aspect of successful aging and ensuring a high quality of life, the study authors said.

“Diabetes and glucose control are potentially modifiable and may offer an important opportunity for the prevention of cognitive decline, thus delaying progression to dementia,” they wrote. At the population level, delaying the onset of dementia by even a couple of years could reduce its prevalence by more than 20% over the next 30 years, according to the investigators. Diabetes was assessed at baseline, and cognitive function was assessed at baseline and periodically during the 20-year follow-up.

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