

STRIVE

Staff Time and Resource Intensity Verification

Technical Expert Panel Meeting

December 1, 2005

STRIVE@IFMC.ORG

Welcome & Introductions

- Jean Eby, Director,
Iowa Foundation for Medical Care
- Kathy Langenberg, R.N.,
STRIVE Operations Manager,
Iowa Foundation for Medical Care
- Dane Pelfrey, STRIVE Project Manager,
Iowa Foundation for Medical Care

Welcome & Introductions

- Bob Burke, Ph.D.,
STRIVE Project Director,
The George Washington University
- Brant Fries, Ph.D., STRIVE Analytic Task Lead,
University of Michigan
- Bob Godbout, Ph.D.,
STRIVE Survey Design Consultant, Stepwise
- Dave Malitz, Ph.D.,
STRIVE Survey Design Consultant, Stepwise
- Dave Oatway, R.N., M.P.H.,
STRIVE Database Manager, CareTrack

Geographic Distribution of Project Team

- IFMC is based in West Des Moines, Iowa with offices in Owings Mills, MD
- George Washington University, Washington, DC
- University of Michigan, Ann Arbor, MI
- CareTrack Systems, Key West, FL
- Stepwise Systems, Austin, TX

Welcome & Introductions

- TEP Participant Introductions
- Procedures for the day
- Format
- Amenities
- Phones – place on vibrate
- End at 4:00 p.m.
- Contact – STRIVE@IFMC.ORG

STRIVE Goals

- Enhance efficiency and accuracy of the RUGs system
- Reflect changes in health care practices since implementation of SNF PPS
- Design payment to promote quality

TEP Objectives

- Understand scope of STRIVE Project
- Obtain Stakeholder Input:
 - Project Goals
 - Critical Issues
 - Technical Issues

Agenda

- ✓ Welcome & Introductions
- Study Design / Overview
 - TEP Discussion – Study Design
- Data Collection / Facility Recruitment
 - TEP Discussion –
Data Collection / Facility Recruitment
- Lunch / Data Collection Demonstration
- Analysis & Sampling Plans
 - TEP Discussion – Analysis & Sampling Plans

Agenda, continued

- Special Populations & Supplemental Data Items
 - TEP Discussion –
Special Populations & Supplemental Data Items
- Observer Comment Period
- Adjourn

Historical Background

- Omnibus Budget Reconciliation Act of 1987
 - Development of uniform assessment instrument, based on a minimum data set to improve facility care planning and resident outcomes
- Balanced Budget Act of 1997
 - SNF moves to PPS system in 1998, many states use the case-mix payment system for Medicaid reimbursement

Historical Background

- The case mix system at the core of the Medicare SNF PPS consists of three components:
 - Staff time measures (STM)
 - Resident assessments
 - Cost calculations of resources
- Resource Utilization Groups
 - RUG-III
 - Each group represents a level of resource utilization and is quantified with a case mix index score
 - Links resource utilization to payment rates

Historical Background

- RUG-III classification system was designed by relating resident characteristics to wage-weighted staff time
- Information regarding a resident's characteristics was derived from the MDS resident assessment instrument

Historical Background

- Nearly 50 percent of states use a version of the RUG classification system to pay for Medicaid nursing home care
- Both the Federal and state systems are based on staff time measurement data collected in 1990, 1995, and 1997

Historical Background

- No national time study has taken place since 1997

STRIVE

- On September 30, 2005, CMS awarded a contract to Iowa Foundation for Medical Care (IFMC) and its partners to conduct this study

Scope of Work

- STRIVE project team will implement and manage CMS's multi-state STM study including the following tasks:
 - Establish TEP
 - Recruit nursing homes, state agencies, and volunteers to participate
 - Provide hardware, software, and training to obtain the data in a useable form
 - Coordinate data collection through pilot test and national time study
 - Analyze data

Analytic Approaches

- Resource use for Medicare and Medicaid
- Resource use for special populations
 - e.g., ventilator
- Ancillary costs
 - e.g., drug costs
- Alternative items and measures
 - e.g., MDS 3.0, MDS-PAC
- Skilled service patterns
 - e.g., IV meds, therapy patterns
- Potential collaboration with other studies
 - DVA, Canada

Sampling Approaches

- Large nationally representative sample (about 12,000 residents)
- Stratified random sample of facilities within state
- Medicare and special population strata
- Facility screening based on survey deficiencies and QI/QM measures

Data Collection State / Facility Roles

Dave Oatway, R.N., M.P.H.

Kathy Langenberg, R.N.

Bob Burke, Ph. D.

Goals of Data Collection

- Accurate resource use data
 - Collect time data with most current and tested technology
 - Use normal staff levels and resident loads
 - Reflect current practices
- Accurate assessment data
 - Reflect current resident characteristics

Data Collection

- Types of data to be collected
 - Time data from staff
 - Additional resources used for resident care
 - Drugs/Medications
 - Supplies
 - Services
 - Resident Characteristics
 - MDS 2.0
 - Supplemental items

Privacy

- Resident level data not shared or available outside of the project
- Study conducted in compliance with HIPAA standards
- Staff data not shared with facility
- Data protected

Time Data Collection

- Collect time from all direct care staff
 - PocketPC running the CareTrack Staff Time software
 - Paper backup available for technical problems
 - Individual and group times
- PocketPC time data collection is very easy to learn and use, and is reliable and accurate



Resident Specific Time

- Resident Specific Time (RST)
 - Time staff members spend with or on behalf of a resident
 - Therapists identify the modality by selecting HCPCS code

Non-Resident Specific Time

- Non-Resident Specific Time (NRST)
 - Time staff members spend supporting the delivery of care
 - Administrative duties
 - Cleaning
 - Training
 - Corporate activities

Meals and Breaks

- Meals and Breaks
 - Time staff member's spend on personal meals and breaks

Additional Resources Used to Care for Residents

- Identify and Document
 - Drugs/Medications
 - Supplies
 - Services

Resident Assessment

- Complete/update hardcopy MDS 2.0 with an assessment reference date during the time study
- Collect supplemental assessment items on paper
- Send to IFMC for data entry

Facility Characteristics

- Demographics
- Administration, ownership
- Names, types, sizes of nursing units
- Staffing levels

Data Collection Roles

Dave Oatway, R.N., M.P.H.

State Roles

- Designates state project lead
- Recruits facilities
- Recruits staff for on-site data collection and monitoring
- Trains staff
- Schedules facilities and staff
- Monitors data collection
- *Support provided by IFMC*

Stakeholder Roles

- Supports study goals
- Encourages study participation
- Communicates issues and concerns
- Provides volunteers for data collection

Facility Roles

- Participates in study
- Prepares staff for study
- Provides staff and resident rosters
- Collects staff time and resource data
- Collects assessment data
- Provides work space as needed

IFMC Roles

- Overall STRIVE lead
- Supports State Recruitment
 - Trains state project staff
 - Provides sample facility list
 - Supplies recruitment materials and protocols
 - Maintains recruitment information
 - Assists in recruitment as needed
- Supports State Study
 - Supplies study materials and protocols
 - Supplies laptops and PocketPCs
 - Provides help line and study support

Data Collection Summary

- Data collection performed by states, with assistance provided by IFMC
- Fully trained volunteers create partnerships and keep the process transparent to the stakeholders

Analysis Plan and Sampling Plan

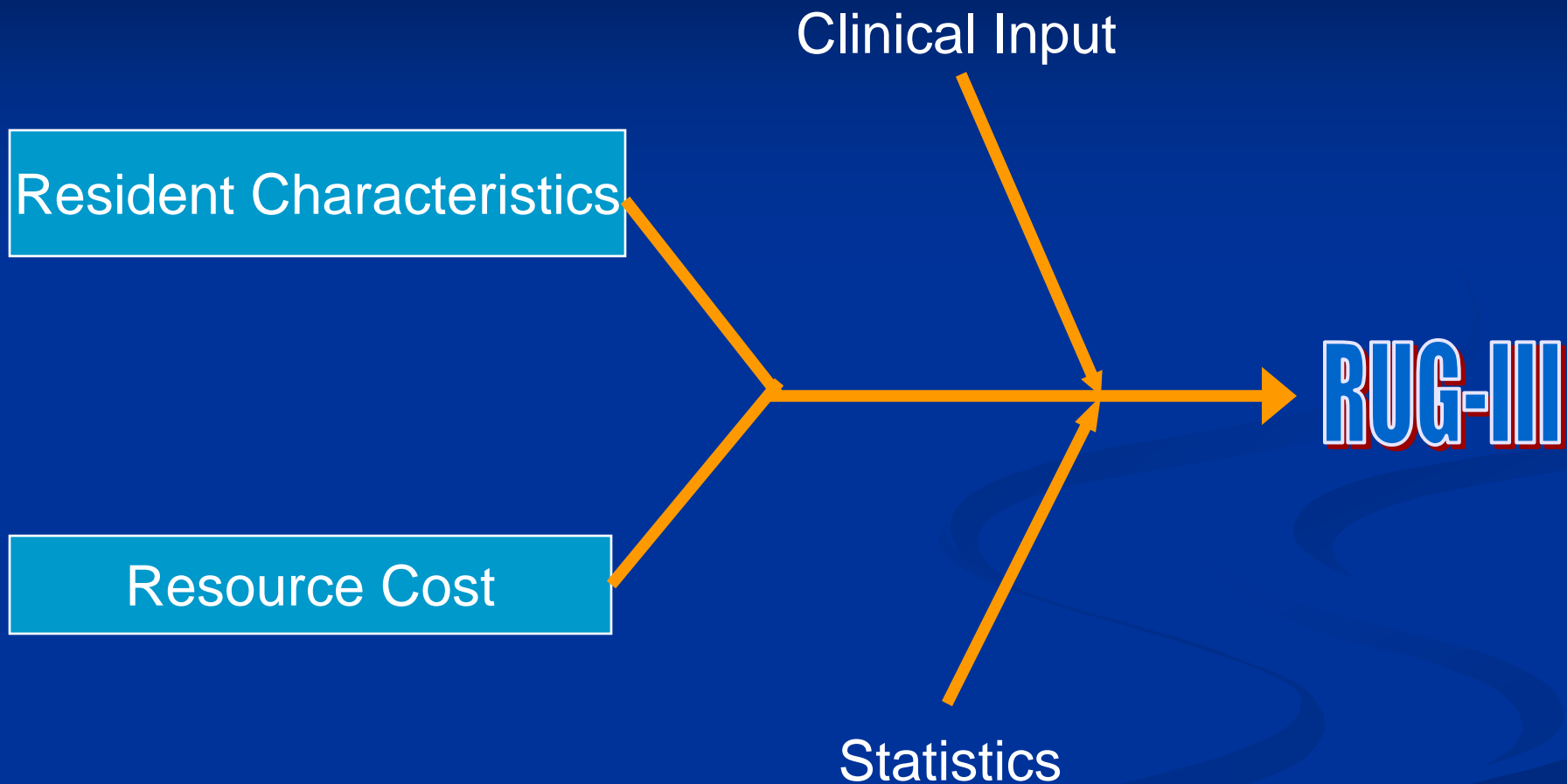
Brant Fries, Ph.D.

David Malitz, Ph.D.

Analytic Goals

- Recalibrate CMI for current RUG-III Systems
 - Use full sample (N=12,000)
 - 34, 44, 53 group systems
 - Possibly several CMIs:
Medicare, Medicaid, DVA

Analytic Approach



Analytic Goals

- Test RUG-III modifications
 - Structure of RUG-III
 - e.g., “Rehab+Extensive”
 - e.g., “leafy-end splits”
 - Classification of special populations
 - e.g., ventilator/respirator
 - Effect of changing RUG-III criteria
 - e.g., use of known scales
 - e.g., IV medications before/after NH admission
 - e.g., additional qualifiers
 - Incorporation of new assessment items

Analytic Goals

- Test RUG-III modifications (cont.)
 - Update RUG-III service-based measures
 - e.g., physician orders/visits
 - Effect of assessment schedule
 - Effect of additional cost measures

Analytic Goals

- Other issues:
 - Reliability of any new assessment items
 - Skilled service patterns
- Potential collaboration with DVA
- Potential collaboration with Canadian study

Sampling Design

- Stratified, random sample of facilities within volunteer states
- Stratification will insure adequate representation
 - Medicare residents
 - Special populations
 - Hospital-based facilities
- Facility exclusions
 - Poor quality
 - Unable to participate
 - e.g., emergencies, legal action

Sampling Plan

- Sample size
 - Target: 15 states, 240 facilities, 12,000 residents
 - Selected facilities will include all units (except large facilities)

Stratification of Facilities



Sampling Methodology

- **Step 1.** Data-based exclusions using administrative data
 - OSCAR deficiencies
 - Quality Indicators (QIs) and Quality Measures (QMs)
- **Step 2.** Select sample from remaining facilities (over-sample)
- **Step 3.** Stakeholder exclusions from list of sampled facilities

Facility Exclusions

- Development of data-based exclusions
 - Discussions with QI/QM experts
 - Measures to include
 - Combining measures
 - CMS algorithm for scoring survey and complaint deficiency history
- Stakeholder exclusions

Analysis Plan and Sampling Plan

TEP Discussion

Special Populations and Supplemental Data Items

Bob Godbout, Ph.D.

Brant Fries, Ph.D.

Special Populations

- Criteria for inclusion on list
 - Group is of high interest
 - Practice patterns have changed
 - Strengthens model
 - Group is rare (prevalence <0.5%)
- Special Population Matrix

Ancillary Cost Measures

- Some measures collected directly, some as part of assessment
- Bundled vs. unbundled service
- Examples
 - IV drugs/ IV medications
 - Hyperbaric oxygen
 - Barium swallows

Issues in Collecting Drug Data

- Bundled only for Medicare Part A stays
- With NDC codes, can attach price/cost per dose (need advice)
- HIPAA & privacy concerns
- Costly to collect

Issues in Collecting Drug Data

- Collect what is:
 - Ordered?
 - Dispensed?
 - Taken?
- Data collection options:
 - Medicare / Medicaid bills
 - High cost drugs
 - All drugs
 - All drugs for a sample of residents

Issues in Collecting Drug Data

- Collection Approach: Medicare bills
 - Identify bills related to drugs, link to other cost data
 - Pros:
 - Does not require primary data collection
 - Cons:
 - Drugs not identified
 - Only possible for Medicare residents
 - Difficult to identify appropriate bills (time frame)
 - Delay in getting complete bills

Issues in Collecting Drug Data

- Collection Approach: High cost drugs
 - Locate database with daily cost by drug, pick drugs in top % (e.g., 2%)
 - Facility or STRIVE project staff code drug/frequency/dose received by resident
 - Pros:
 - Focus on drugs most likely at issue
 - Reduces data collection effort (few residents receive)
 - Cons:
 - List of high-daily-cost drugs could be very long
 - Need to find database to identify high-daily-cost drugs
 - High-daily-cost drugs may be used infrequent High cost drugs change over time
 - Time consuming to check list

Issues in Collecting Drug Data

- Collection Approach: All drugs for Medicare A
 - Alternative approaches:
 - Staff enter drug data directly into database (with lookup)
 - Printout sent to IFMC for entry
 - Drug database sent from facility/pharmacy to IFMC
 - Need NDC codes
 - Pros:
 - Have all drugs, can do any analysis needed
 - Cons:
 - Each alternative data collection/coding method is time-consuming

Issues in Collecting Drug Data

- Collection Approach: All drugs for sample of Medicare A residents
 - Collect in facilities where data are available
 - Methods similar to “All drugs”
 - Pros:
 - Same as before
 - Less expensive, as only doing for part of sample
 - Cons:
 - Same as before
 - Facilities with this capability may create a biased sample
 - May not have sufficient sample size for some analyses

Other Cost Data Issues

- Collection of some supplies/services straightforward
 - Collect selected items as part of assessment (include volume)
- Similar collection issues for some other high-cost supplies
- What is daily cost for a supply with no specified time period
 - e.g., pressure-relieving bed

Supplemental Assessment Items

- Sources:
 - Refine MDS 2.0 items
 - e.g., IV medications
 - Other MDS instruments
 - e.g., MDS V3.0, MDS-PAC
 - Other assessment systems

Supplemental Assessment Items

- Criteria for choosing
 - Expected influence on case mix
 - Cannot be “gamed”
 - Can be audited
 - Quality of item
(specification, training material)
 - Difficulty to obtain data
 - Existing reliability study

Reliability Studies

- New assessment items
 - Standard inter-rater reliability approach
 - Limited to new untested items
- Reliability of ancillary cost measures

Skilled Service Patterns

- Services before or after SNF admission
 - e.g., IV medications, suctioning
- Therapy patterns and RUG break points
- Therapy modalities

Special Populations and Supplemental Data Items

TEP Discussion

STRIVE TEP - Next Steps

- TEP slides posted on CMS Website
 - www.cms.hhs.gov/providers/snfpps
(available later this month)
- TEP comments due by 12/22/05
 - Strive@ifmc.org
- Participate in follow-up teleconferences

Open Discussion - Observers

- Please take a position in line near the front table
- Please limit questions and comments to 2 minutes

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**Thank you
for your
participation
&
attendance**