Advisory Board

For U.S. health care providers

Hospital Scorecards for Skilled Nursing Facilities

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Introduction

Scorecard methodology

This document is an explanatory scorecard—providing suggested metrics for meaningfully evaluating SNFs' potential to support system accountable care goals, along with a rationale explaining the importance of each metric.

Researchers drew from the following sources to select these metrics:

- Scorecards and performance metrics used by peer institutions nationwide
- Clinical literature on criteria impacting quality and efficiency of care for SNF patients and residents
- Post-Acute Care Collaborative expert knowledge of the capabilities and services necessary for SNFs to successfully support accountable care goals

This scorecard is available in excel form on advisory.com to directly input and track data in one convenient location. This dynamic scorecard can be easily customized to include metrics optimal for a given system.

Guidance on maximizing this scorecard

Organization: For ease of use, the scorecard is divided into several categories of metrics— the provider profile, clinical metrics, operational metrics, strategic metrics, and Covid-19 metrics. These categories were selected to align with the key areas indicating a SNF's potential as a successful partner—quality, efficiency, and alignment with system-specific goals.

Data Source Identification: The scorecard identifies metrics for which data can be collected from Medicare data sets, which can be accessed through CMS's Nursing Home Compare, and Advisory Board's Post-Acute Pathways Explorer. For other metrics, hospitals and SNFs should populate the data via internal tracking capabilities, or via qualitative discussion for more abstract metrics.

Customization: **This scorecard is designed to be a picklist of relevant metrics, not a list of all the metrics every provider should include. Must-use metrics are flagged at the beginning of each section with a red asterisk (*). Providers should choose from the other metrics in each category to align with their health system's needs.**

Read on to view the metrics.

Table of contents

Source: Advisory Board interviews and analysis.

Provider profile

Before evaluating specific metrics, hospitals and SNFs should establish a clear background understanding of the SNFs being reviewed. This information helps hospital leaders understand the types of patients each SNF serves and contextualize metrics in the scorecard. For example, a SNF's readmission rate should be considered in the context of its diagnosis mix.

Additionally, these metrics can inform the type of partnership which makes the most sense to form. For example, a smaller facility may warrant a different type of partnership than a large facility, as there is a difference in potential hospital census that can be sent to the facility.

Key background considerations to understand a SNF's profile are listed below.

Metric	Rationale	Data source
Number of certified beds*	Number of certified beds and average daily census serve as an indicator of how many patients the SNF is equipped to care for and helps the hospital right-size the volume of patients referred.	Post-Acute Pathways Explorer, Market Compare: SNF
• **Diagnosis mix*** (% of patient population by discharge) • **HCC[1] score mix*** (% of patient population by discharge)	Diagnosis and HCC score mix help identify the patient populations the SNF is best able to serve and contextualizes outcomes metrics. • SNFs treating more challenging patient diagnoses are more likely to have higher readmission rates, due to the nature of their patient mix. • HCC scores are used by CMS to measure patient risk. A patient with a higher HCC score indicates a higher risk for health care utilization and cost.	• Post-Acute Pathways Explorer, Patient Transitions Report; Internal SNF data
• **Located within a hospital?** (yes/no) • **In a Continuing Care Retirement Community?**	Sites of care co-located with a SNF may suggest more coordinated care between such sites, which can be beneficial during patient transitions.	Nursing Home Compare
Tax status (non-profit/for profit)	Partnership vehicles may need to be structured differently based on the tax status of participants.	Nursing Home Compare

Source: National Hospice and Palliative Care Organization, "NHPCO's Facts and Figures: Hospice Care in America," October 2013, http://www.nhpco.org/hospice-statistics-research-press-room/facts-hospice-and-palliative-care; "The Debate in Hospice Care," Journal of Oncology Practice, 4, no. 3 (2008): 153-157, http://jop.ascopubs.org/content/4/3/153.full.

1. Hierarchical Condition Category.

Clinical criteria

Metric	Rationale	Data source
30-day, all-cause, all-DRG readmission rate*	Readmissions serve as a proxy measure for care quality and coordination. While risk-adjusted readmission rates are a more meaningful measure, they are difficult to calculate; however, select third-party data vendors offer this capability.	Post-Acute Pathways Explorer, Patient Outcomes Report
Average length of stay* (in days; for high-volume, high-variance diagnoses; short-stay patients only)[1]	An unnecessarily long length of stay significantly increases episode costs. However, average length of stay should be viewed in the context of the complexity and acuity of the provider's patient population; we recommend that hospitals consider ALOS for individual diagnoses, focusing on the highest-volume diagnoses with the greatest ALOS variation across providers.	Post-Acute Pathways Explorer, Patient Outcomes Report
Rate of Functional Improvement* (% of stays showing improvement in ADL score—specifically, using three measures of mobility: bed mobility, transfer, and ambulation—from first to last MDS assessment)[1]	Significant functional improvement during a patient's stay demonstrates high-quality, effective care and appropriate utilization. Given the increase in therapy provided in SNFs over time and the large contribution of these therapy costs to total costs, MedPAC recommends measuring ability of SNFs to improve or maintain the functional status of their beneficiaries.	Internal SNF data
Does medication reconciliation occur upon admission? (% admissions, yes/no)	Prescription errors are especially prevalent in older patients who are more likely to take multiple medications and whose ability to absorb, process, and respond to drugs has been altered by the aging process. These errors can often cause rehospitalizations.	Internal SNF data
Percentage of short-stay residents who got antipsychotic medication for the first time	Inappropriate use of antipsychotics frequently leads to negative outcomes for elderly patients—for example, elderly dementia patients taking an antipsychotic have a 1.6 times greater mortality risk than those not receiving an antipsychotic. Therefore, antipsychotics should be used appropriately, only after lower-risk interventions have been attempted. Yet studies have found that 83% of antipsychotics administered to elderly nursing facility residents were prescribed for off-label uses, and 17% of nursing facility patients receiving antipsychotics were given the drugs at a level which exceeded recommended daily dosage.	Post-Acute Pathways Explorer, Market Compare: SNF

1. Providers may group patients either by the primary diagnosis/condition they are assigned upon arrival at the SNF, or by their hospital discharge MS-DRG. We recommend grouping current data by primary diagnosis/condition as that data element should be easily available. However, where possible it will also be valuable to group historical data by discharge MS-DRG. Hospitals can more easily interpret length of stay in terms of discharge MS-DRG (perhaps organized to inpatient service lines), since it reflects the patient classification system they are most familiar with. However, because the discharge MS-DRG provided to SNFs upon a patient's arrival is only provisional (it is not verified or finalized until claims are processed), SNFs usually do not know the final discharge MS-DRG upon patient arrival. Advisory Board tools draw on claims data and therefore do have the ability to track length of stay by final discharge MS-DRG, but this data often has a substantial time lag. SNFs' information on patient primary diagnosis/condition, on the other hand, should be easily accessible and up-to-date.

Source: Paula Rochon, "Drug Prescribing for Older Adults," www.uptodate.com; Value of Insight, "The Utilization Plateau," www.cdn.com; Food and Drug Administration, "Public Health Advisory: Deaths with Antipsychotics in Elderly Patients with Behavioral Disturbances," www.fda.gov; Department of Health and Human Services Office of the Inspector General, "Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents," www.oig.hhs.gov; Centers for Medicare and Medicaid Services, "New data show antipsychotic drug use is down in nursing homes nationwide," www.cms.gov; Hill A-M, et al., "Circumstances of fall sand falls-related injuries in a cohort of older patients following hospital discharge," Clin Interv Aging, 8 (2013): 765-774, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3699056/; Medicare Payment Advisory Commission, "March 2014 Report to the Congress: Medicare Payment Policy," 190, http://www.medpac.gov/documents/reports/mar14_entirereport.pdf?sfvrsn=0; Allman RM, "Pressure ulcer prevalence, incidence, risk factors, and impact," Clin Geriatr Med, 13, no. 3 (1997): 421-36, http://www.ncbi.nlm.nih.gov/pubmed/9227937; Advisory Board interviews and analysis.

Clinical criteria continued

Metric	Rationale	Data source
Frequency of medication review (number of occurrences during one month; long-stay patients only)	Providers should regularly review continued appropriateness of medication—particularly antipsychotics—to ensure that a temporary disturbance does not result in unnecessary long-term use.	Internal SNF data
Percentage of short-stay residents who experience one or more falls with major injury during their SNF stay	Falls should be avoidable in most cases with proper patient segmentation, care planning, and preventive measures. However, in the six months after hospital discharge, up to 40% of elderly patients fall in the six months and up to 15% of unplanned hospital readmissions are due to a fall.	Post-Acute Pathways Explorer, Market Compare: SNF
Rate of healthcare-acquired infections and conditions (UTIs, pressure ulcers)	Proper care protocols should keep patients from developing these avoidable conditions—which often have severe consequences for the elderly. For example, UTIs are one of the top five preventable conditions causing readmissions from SNFs, and pressure ulcers cause pain, infectious complications, prolonged and expensive hospitalization, and increased risk of death.	Post-Acute Pathways Explorer, Market Compare: SNF
Are universal mental health screenings conducted? (yes/no)	Many individuals with chronic illnesses also have co-morbid mental health concerns that significantly impact their health outcomes and quality of life. Mental health screenings allow providers to either address the psychosocial aspects of care or link patients to appropriate services.	Internal SNF data

1. For additional detail on suggested methodology, please see p. 192-193 of the Medicare Payment Advisory Commission report cited on this page.

Source: Centers for Disease Control and Prevention, "What You Should Know and Do this Flu Season If You are 65 Years and Older," http://www.cdc.gov/flu/about/disease/high_risk.htm; Chan TC, et al., "Effectiveness of influenza vaccination in institutionalized older adults," J Am Med Dir Assoc, 15, no. 3 (2014) http://www.ncbi.nlm.nih.gov/pubmed/24321878; Biscevic-Tokick J, et al., "Pneumonia as the most common lower respiratory tract infection," Med Arch, 67, no. 6 (2013), 442445, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4272454/; Medicare Payment Advisory Commission, "March 2014 Report to the Congress: Medicare Payment Policy," 190, http://www.medpac.gov/documents/reports/mar14_entirereport.pdf?sfvrsn=0; Advisory Board interviews and analysis.

Operational criteria

Metric	Rationale	Data source
Average response time to referrals* (in hours)	For a safe and efficient transfer, SNFs must be able to accept referrals as soon as possible after the patient is ready for discharge from the hospital. Hospitals should be sure to specifically ask about admissions availability after hours and on weekends.	Internal hospital data
Medicare spending per beneficiary* (displayed as a ratio)	This measure shows whether Medicare spends more, less or about the same on an episode of care for a Medicare resident treated in a specific SNF compared to how much Medicare spends on an episode of care across all SNFs nationally. A lower MSPB may indicate an efficient provider. However, hospitals should ensure that it is not accompanied by poor outcomes.	Post-Acute Pathways Explorer, Market Compare: SNF
Hospital patient acceptance rate	SNFs that readily accept a high number of a hospital's patients generally have the clinical capability to handle the full range of acuity seen in the hospitals' patient panel and are more likely to align with the hospital's initiatives.	Internal hospital data
Patient/caregiver satisfaction score (% rating facility as "excellent" or "good")	Higher patient and caregiver satisfaction scores indicate the quality of the care team. Additionally, satisfied patients are more likely to have a positive impression of their entire care episode, including care received in the hospital itself. SNFs should routinely survey patients on their satisfaction with the facility's environment, staff, administration, activities, meals and dining, and social services.	Internal SNF data
Annual staff turnover Rate (%)	High staff turnover is associated with both higher costs and poorer quality of care. Turnover disrupts patients' continuity of care and reduces the amount of time a staff member may spend caring for each patient. Furthermore, it incurs costs due to recruitment, selection, and training of new staff and reduced efficiency of new staff.	Internal SNF data
Total licensed nurse staff hours per resident day (RN and LPN)	Nursing staff hours directly measure the amount of daily interaction between patients and nurses.	Post-Acute Pathways Explorer, Market Compare: SNF
24/7 RN presence (yes/no)	Higher levels of RN staffing are positively associated with quality.	Internal SNF data
Use of staffing agency nurses (% of agency staffing hours relative to total staffing hours in one month)	Increased staffing agency use is associated with decreased quality.	Internal SNF data

Source: Stone RI, Department of Health and Human Services, "Who Will Care For Us? Addressing the Long-Term Care Workforce Crisis," 2001, http://aspe.hhs.gov/daltcp/reports/ltcwf.htm; Scanlon WJ, Government Accounting Office, "Nursing workforce: Recruitment and retention of nurses and nurse aides is a growing concern," 2001, GAO-01-750T; Castle NG, et al., "Caregiver Staffing in Nursing Homes and Their Influence on Quality of Care," FAAN, 49, no. 6 (2011), 545–552; Advisory Board interviews and analysis.

Strategic criteria

Metric	Rationale	Data source
• **Volume of the hospital's patients treated by the SNF*** • **Strong relationship with hospital** (ranked on a scale of strength of 1-10)	An existing strong relationship between hospital and SNF is an indicator of partnership viability. Specific indicators may vary, based on the hospital's goals for the partnership. Some potential indicators include: • Patient volumes from the hospital • Use of the hospital's medical director • Use of the hospital's physicians • Existing partnership initiatives, such as joint pathways	• Post-Acute Pathways Explorer, Patient Outcomes Report • Post-Acute Pathways Explorer, Patient Outcomes Report; Internal Hospital/SNF data
Existence of aligned specialty program (ranked on importance to the hospital on a scale of 1-10)	A health system may strategically choose a SNF partner based on clinical capabilities that align with the health system's patient population.	Internal Hospital/SNF data
Collaboration with other providers (ranked on a scale of strength of 1-10)	SNFs with strong up- and/or downstream relationships can better manage safe transitions and right-size utilization of each setting.	Internal SNF data

Source: Advisory Board interviews and analysis.

Covid-19 pandemic criteria

Metric	Rationale	Data source
• **Rate of staff Covid-19 vaccination*** • **Rate of patient Covid-19 vaccination***	High rates of Covid-19 vaccination are important for stopping the spread of the virus and protecting staff and patients alike.	Internal SNF data
• **Existence of separate quarantine unit(s) for Covid-19 patients*** (yes/no) • **Access to adequate PPE to last at least next two weeks** (yes/no) • **Adherence to CDC, state, and local Covid-19 guidance** (yes/no)	These infection control measures promote the safety of staff and patients alike.	Internal SNF data
• **Total Covid-19 cases** • **Total Covid-19 deaths as a percentage of confirmed cases**	These data points are meant to give the hospital an idea of how the SNF fared during the Covid-19 pandemic. However, it is important to contextualize this data with the below listed data points.	Covid-19 Nursing Home Data
• **Community Covid-19 spread** • **Urban location** (yes/no) • **Number of certified beds**	These data points are meant to contextualize the above data regarding Covid-19 cases and deaths. The risk factors most associated with high Covid-19 cases and deaths in SNFs are outside the control of SNFs, such as community spread, urban location, and large bed count. Therefore, when judging SNF quality based on Covid-19 performance, SNFs must be looked at in the context of their surroundings.	• Local data • SNF website • Post-Acute Pathways Explorer, Market Compare: SNF
CMS star rating for staffing	While studies have failed to find correlations between overall CMS star rating and Covid-19 performance, three out of four studies done on the relationship between CMS star rating for staffing and Covid-19 performance have found a relationship between better staffing star rating and fewer cases and deaths.	Post-Acute Pathways Explorer, Market Compare: SNF
Rate of staff working at more than one facility	The more shared workers a nursing home has, the more likely it is to have a higher number of Covid-19 infections.	Internal SNF data
Relationship with hospital during Covid-19 pandemic (on a scale of 1-10)	The Covid-19 pandemic has necessitated greater care coordination between hospitals and SNFs. Additionally, hospitals and SNFs have partnered to secure PPE, implement infection control measures, and even influence state legislation. A SNF that was a willing and enthusiastic partner with the hospital during the pandemic may be a good fit for long-term partnership.	Internal hospital data

Source: Ochieng, N, et al., Kaiser Family Foundation, "Factors Associated With COVID-19 Cases and Deaths in Long-Term Care Facilities: Findings from a Literature Review," 2021, https://www.kff.org/coronavirus-covid-19/issue-brief/factors-associated-with-covid-19-cases-and-deaths-in-long-term-care-facilities-findings-from-a-literature-review/; Fortier, J, NPR, "They Work In Several Nursing Homes To Eke Out A Living, And That May Spread The Virus," https://www.npr.org/sections/health-shots/2020/10/26/927841874/they-work-in-several-nursing-homes-to-eke-out-a-living-and-that-spreads-the-viru; Advisory Board interviews and analysis.

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