In an effort to reduce the national average, additional impetus, especially in those states where pressure ulcer rates exceed the national average is needed. To assist us in our efforts, CMS developed tables containing the current GPRA measures for each region, a target, and a stretch goal equal to the average percent reduction submitted by the QIOs. These goals will help us measure the success of their efforts to improve these two care issues.

Reduce Pressure Ulcers— Over the last several years, CMS, SAs, Advancing Excellence in America's Nursing Homes and QIOs have worked with long-term care facilities to improve performance with respect to pressure ulcer prevention.

Regional Follow-up and Data Analysis (2003-2007)— While pressure ulcer rates had been steadily increasing for years, CMS now has preliminary data indicating a decline in the rate of pressure ulcers. Between the **third quarter of 2003** and the third quarter of 2008, the prevalence of pressure ulcers declined from 8.9% to 8.0%. Using a new quality measure for high risk pressure ulcers, over the same time period, the rate dropped from 13.8% to 11.4%, a relative improvement of about 17%. There are even more encouraging results from those nursing homes recently working closely with their QIOs. Their high risk pressure ulcer measure decreased from 13.4% in the second quarter of 2004 to 11.9% in the first quarter of 2007—a relative improvement of 11%.

In 2009, CMS, through the QIO program in its 9th Scope of Work, continued to improve quality of care and services in nursing homes by targeting improvements in pressure ulcers. The CMS published a list of 4,000 nursing homes that have a higher than expected pressure ulcer rate. Each QIO worked with some of the homes in each state to improve care in this area.

QIO Initiatives with Nursing Homes in Need (NHIN): In the 9th SOW contract, every QIO participated in the NHIN task that incorporated objectives related to CMS's Special Focus Facilities (SFF) activities. SFFs are nursing homes that have performed poorly on recent standardized surveys overseen by CMS' Survey and Certification Division. QIOs were assigned a NHIN with whom it conducted in-depth analysis and developed a plan for improvement.

B. Implementation and Maintenance of MDS 3.0

Background

The statutory authority for the RAI is found in Section 1819(f)(6)(A-B) for Medicare and Section 1919 (f)(6)(A-B) for Medicaid, of the Social Security Act (SSA), as amended by the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). These sections of the SSA require the Secretary of the Department of Health and Human Services (the Secretary) to specify a Minimum Data Set (MDS) of core elements for use in conducting assessments of nursing home residents. It furthermore requires the Secretary to designate one or more resident assessment instruments based on the MDS.
The OBRA regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents. The Resident Assessment Instrument (RAI) process the basis for the accurate assessment of each nursing home resident consists of 3 basic components:

- Minimum Data Set Version 3.0
- Care Area Assessment (CAA) process
- Utilization Guidelines

While its primary purpose as an assessment tool is used to identify resident care problems that are addressed in an individualized care plan, data collected from MDS assessments is also used for the Medicare reimbursement Prospective Payment System (PPS), many state Medicaid reimbursement systems, and monitoring the quality of care provided to nursing home residents.

MDS assessment data are also used to monitor the quality of care in the nation's nursing homes. MDS-based quality measures (QMs) were developed by researchers to assist: (1) State Survey and Certifications staff in identifying potential care problems in a nursing home; (2) nursing home providers with quality improvement activities/efforts; (3) nursing home consumers in understanding the quality of care provided by a nursing home; and (4) CMS with long-term quality monitoring and program planning. CMS continuously evaluates the usefulness of the QMs, which may be modified in the future to enhance their effectiveness. In keeping with the objectives set forth in the Institute of Medicine (IOM) study completed in 1986 (Committee on Nursing Home Regulation, IOM) that made recommendations to improve the quality of care in nursing homes, the RAI provides each resident with a standardized, comprehensive and reproducible assessment.

CMS' original RAI was published in 1990 and implemented in all States by 1991. CMS subsequently undertook a collaborative process to revise the RAI, which culminated in the release of MDS version 2.0 (MDS 2.0) in 1995. In response to changes in nursing home care, resident characteristics, advances in resident assessment methods, and provider and consumer concerns about the performance of the MDS 2.0, CMS contracted with the RAND Corporation and Harvard University to draft revisions and nationally test MDS 3.0.

MDS Version 3.0 was implemented in October 2010 with goals to introduce advances in assessment measures, increase clinical relevance of items, improve the accuracy and validity of the tool, increase user satisfaction, and increase the resident's voice by introducing more resident interview items.

C. Culture Change

Background

The CMS began efforts to improve the quality of care and quality of life in nursing homes with the passage of OBRA '87. This law included new mandates for quality of life, quality of care, and resident rights. To further the CMS' work to implement these important aspects of the law and regulations, CMS have become a part of a national movement known as "culture change" (other terms for culture change may include "resident-directed care," "person-centered care," and "individualized care.") Culture change principles echo OBRA '87 principles of knowing and respecting each nursing home resident in order to provide individualized care that best enhances each person's quality of life. The OBRA '87 regulations support culture change principles as an optimum implementation of the law that mandates resident dignity, autonomy, and quality of life. The concept of culture change encourages facilities to examine and update their practices and policies to ensure resident choice and promote resident-centered care. CMS is engaged with ongoing work with the Eden Alternative/Wellspring, Pioneer Network, and Greenhouse ProjectTM to identify potential future projects related to culture change.

The CMS has participated in several initiatives and projects to advance the concept of culture change including:

- A 2002 satellite broadcast that introduced culture change principles to surveyors
- A joint project with QIOs to teach nursing homes about these principles
- A new self-assessment tool for nursing homes in 2006: Artifacts of Culture Change
- A series of satellite broadcasts in FY2007 on various aspects of culture change
- A national symposium in April 2008 titled *Creating Home in the Nursing Home: A National Symposium on Culture Change and the Environment Requirements*
- A 2010 national stakeholder workshop on dining practices with Food and Drug Administration and Centers for Disease Control and Prevention (CDC)
- A 1.5 year national task force convened by the Pioneer Network made recommendations for changes in the Life Safety Code (LSC) that were just adopted by the National Fire Protection Association for their 2012 Code.

D. Quality Assurance and Performance Improvement (QAPI) Initiative

Overview

The CMS has undertaken a bold initiative to broaden quality activities in nursing homes. The Provisions set forth at section 1128I (c) of the Social Security Act, as added by Section 6102 of the Affordable Act provide the opportunity for CMS to mobilize some of the best practices in nursing home quality and to identify technical assistance needs in advance of a new quality assurance performance improvement (QAPI) regulation. The provision states that the Secretary (delegated to CMS) shall establish and implement a QAPI program for facilities that includes development of standards (regulations) and provision of technical assistance on the development of best practices in order to meet regulation standards. This new provision significantly expands the level and scope of required activities currently described in the existing Quality Assessment and Assurance (QAA) provision at 42 CFR, Part

483.75(o), to ensure that facilities continuously identify and correct quality deficiencies as well as promote and sustain performance improvement.

Results

With the passing of the Affordable Care Act, CMS embarked on a twenty-month mission to develop a QAPI program by December 31, 2011. During the demonstration phase, CMS and its contractors:

- Reviewed existing tools that are available to help manage QAPI processes in nursing homes
- Established a Technical Expert Panel (TEP) to assist CMS contractors in developing and applying a QAPI prototype based on existing literature and practice
- Launched a demonstration project in September 2011 in 17 homes across four states to test implementation strategies and effectiveness of QAPI tools and resources
- Engaged stakeholders in a dialogue around dissemination strategies for national rollout. These active discussions continue on a frequent basis with multiple stakeholders from around the country)
- Appointed onsite technical assistance liaisons to visit each nursing home in the demonstration and provide them with individualized technical assistance.
- Approved curricula for learning collaboratives, a forum for information exchange among the demonstration homes that is facilitated by the liaisons. This support group during implementation provides feedback to CMS on the effectiveness of the materials that have

been developed and leads to ongoing revisions and improvement to the tools and resources as needed.

CMS is pleased to report that the national QAPI rollout is currently underway and advancing. QAPI tools, resources, and technical assistance currently being tested in the demonstration will be available to all nursing homes by Summer 2012. Developed materials will assist nursing homes in improving their current quality programs using best practices and local learning collaboratives.

E. Care Transitions

Background

A care transition can be defined as the transfer of a person from one setting or one set of providers to another. Recent data from scientific studies, including randomized controlled trials, suggest that adverse events such as medication errors, missed follow up appointments, unnecessary re-hospitalizations and other adverse events occur more frequently due to poor handoffs during care transitions. These problems are further complicated by the "silos" within our health care system; critical information often is not communicated from one set of providers (the "senders") to the next set of providers (the "receivers") during a care transition. More importantly, consumers and their families are often not included or engaged in the process to ensure that essential data are transferred during these care transitions.

Efforts are underway in several states to analyze and evaluate the reasons for substandard care during care transitions. National groups such as the National Transitions of Care Coalition (www.NTOCC.org), American Board of Internal Medicine (ABIM), Institute for Healthcare Improvement, CMS and many others are bringing together groups of consumers, providers, professionals, government agencies, insurers and purchasers of healthcare to address the need to ensure safe, timely, person-centered care across settings.

The CMS is participating in a number of care transitions initiatives, including work led by the 14 QIOs that have contracts to improve care transitions as well as initiatives through the Center for Medicare and Medicaid Innovation and the Center for Strategic Planning that are providing grants through Section 3026 of the Affordable Care Act, which authorizes the funding of the Communitybased Care Transitions Program (CCTP) The goals of the CTTP are to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high risk beneficiaries, and to document measurable savings to the Medicare program. In addition, the PfP program includes the goal of 20% reduction in 30-day readmissions by the end of 2013. The Hospital Engagement Networks and other private and public partners involved in PfP are directly focusing on achieving this goal, utilizing the resources available to hospitals and communities to accelerate the adoption and spread of best- practices that have been shown to reduce readmissions. The CMS is developing draft interpretive guidance for surveyors related to the evaluation of care transitions when a resident goes from the nursing home to the emergency department or acute care setting, or home (alone or with home health services). Additionally, CMS is developing similar interpretive guidance for hospitals to evaluate care transitions when patients go home or to a post-acute care setting.

The CMS will continue to work with other agencies such as the Office of the National Coordinator to develop and evaluate standardized forms and processes that include the essential data elements that should always be communicated when a person transfers from one setting of care to another. In addition to paper or electronic forms that provide this information, systems to communicate and update those caring for the individual must be implemented across settings in every community (e.g., physician-to-physician telephone calls on complex patients or post-discharge telephone follow-up calls by the hospital or nursing home within 48 hours). This requires health care organizations (e.g., hospitals, nursing homes, home care agencies, physician office practices, clinics, hospices and others) to collaborate on the development of systems for communication that will ensure the effective transfer of critical information in a timely manner. New regulations that address minimum standards for each healthcare setting and across healthcare settings are evolving and are under consideration.

F. Health Care Acquired Infections (HAIs) in Long-Term Care

Background

Healthcare-acquired infections are mostly preventable, but occur far too often in nursing homes. The high incidence of HAIs in nursing homes is due to multiple factors including, but not limited to understaffed facilities, staff without the appropriate training or time to identify infections early,

overtreatment with antibiotics, the increasing clinical complexity of the average nursing home resident, and frequent transitions between care settings that lead to person-person transmission of HAIs. Additionally, nursing homes frequently lack a systematic approach to prevent and identify HAIs.

HAIs reduce nursing home residents' quality of life; increase the risks for acute hospitalizations (with their associated negative sequelae), morbidity, and mortality; and further strain the limited resources of the provider community. Reducing HAIs, therefore, is an important goal for the Division of Nursing Homes (DNH). We will accomplish this strategic objective through multiple projects (described below), many of which are currently underway, using all the tools and levers we have available while enlisting the help from our partners in the payer and provider communities.

Partnership with HHS agencies and providers

The DNH is currently working with federal partners on projects to reduce the incidence of HAIs in nursing homes. For instance, the DNH is helping to coordinate an HHS interagency working group that will provide to the HHS Secretary a new chapter on reducing HAIs in the long-term care environment. This chapter will add to the *National Action Plan to Prevent Healthcare Associated Infections: Roadmap to Elimination* (the National Action Plan). As part of this work we are proposing metrics that will capture the rate of high frequency and high cost HAIs, such as C.difficile infection, urinary tract infections (both non-catheter and catheter-associated), catheter care processes, and the vaccination rates of both residents and staff for influenza and pneumonia. This will help to establish robust baseline estimates of the burden of HAIs in nursing homes (mostly by utilizing the nursing home module of the National Health Safety Network surveillance tool), and to track the progress of HAI reduction initiatives. Simultaneously, the DNH is developing a study with the Centers for Disease Control and Prevention (CDC) to evaluate state action plans to address HAIs in nursing homes. This work is two-fold. First, we will be conducting an environmental scan

of all state survey agencies or departments of health to determine what actions they are taking to reduce HAIs in nursing homes. Second, we will be conducting an in-depth analysis of selected states that are farther along in this process, so that we can use the lessons learned from individual state's experiences to better train nursing home surveyors to identify potential risk for HAIs.

Ongoing Survey and Certification Work Related to HAIs

Recently we have worked with the CDC and other partners in a number of policy areas, including combining several tags into one infection control tag at F441 and expanding the interpretive guidance from 8 to 38 pages. In addition to the policy change, train-the-trainer sessions were held jointly by CMS and the CDC to heighten awareness of infection control issues and increase surveyor confidence in citing these deficiencies. We will be analyzing these citation data to monitor trends in infection control (IC) citations, and also to act on increased numbers of IC deficiencies in the CMS regions. We may, in the future, also be able to analyze the text from the Statement of Deficiencies (CMS FORM 2567) that is created for facilities being cited for specific F-tags. This will provide us with an opportunity to more systematically analyze the qualitative data related to IC deficiencies.

The MDS version 3.0 contains a wealth of information on HAIs that we will be analyzing as part of our own internal analyses and for public reporting practices. In April we will begin posting on the Nursing Home Compare website the new set of quality measures based on the MDS 3.0 instrument. Some of these measures address HAI-related domains such as resident vaccinations, urinary tract infections, and catheterization. Additionally, we will be able to analyze data from the MDS related to multi-drug resistant organisms (MDROs). We will also explore analyses that link the nursing home residents with acute care hospitalizations for infections as either the primary or secondary diagnoses.

G. Inappropriate Use of Antipsychotic Medications in Nursing Homes

Antipsychotic medications are frequently prescribed off label to residents with dementia related behavioral and psychological symptoms (BPSD).1,2 This has led to increased attention to the behavioral health management of nursing home residents and the potentially inappropriate use of antipsychotics in this population. Evidence suggests that antipsychotics have limited benefits in this population, and the potential for adverse consequences such as the risk of movement disorders, falls, hip fractures, cerebrovascular accidents, and death. 3,4,5,6 Additionally, nursing home residents are medically complex and take multiple medications that increase their risk of adverse effects and drug interactions.7

Based on continued evidence that nursing home residents are at risk for adverse events due to polypharmacy and overuse of many different types of medications, CMS has undertaken a national initiative with several internal and external partners. This initiative will focus initially on one particular class of medications, antipsychotics, in an effort to reduce the overall use of these agents in nursing homes. However, as outlined in F329, CMS still expects surveyors to evaluate other important classes of medications for unnecessary use, such as antibiotics, anticoagulants, proton pump inhibitors and others (F329 focuses on the importance of looking at all medications as well as implementation of non-pharmacological approaches to optimize the care of residents in nursing homes). The CMS is taking a multidimensional approach to the problem of inappropriate use of antipsychotic medications in nursing homes.

The potential overuse of antipsychotic agents is a symptom of a much larger problem – namely that many nursing facilities may not have a systematic plan to provide comprehensive behavioral health management to residents with diagnoses such as dementia and BPSD. The CMS believes that the intent of OBRA '87 and current regulations already support a number of essential elements that must be in place in order for facilities to be in compliance with federal regulations on quality of care and quality of life related to behavioral health.

4. Create Strategic Approaches through Partnerships

Effective quality assurance in nursing homes is best achieved through the combined, motivated, and coordinated approach by many stakeholders in the health care system, including:

- Consumers, their families, and their friends
- Providers
- Purchasers, including CMS, states, private and public health plans, and individual purchasers or policy-holders
- Professionals, professional associations, workers of all types
- Survey and Certification agencies (states and CMS)
- Quality Improvement Organizations
- Universities and other educational and research organizations
- Legal rights organizations, including advocacy groups such as the AARP, State Ombudsmen, and law enforcement.

Although each entity within the system may have different roles and responsibilities, the goal of quality care is advanced when an increasing number of entities in the system can act synergistically. When such a concerted action is achieved, the total can indeed become greater than "the sum of its parts." Therefore, it is CMS' mission to encourage collaboration among the principal individuals and organizations that are responsible for ensuring quality.

A. **Collaboration between SAs and QIOs** – QIOs are contractors for CMS, located in every state and U.S. territory. QIOs provide free assistance to hospitals, nursing homes and other providers of care for Medicare beneficiaries to address issues related to better clinical outcomes for patients, program efficiencies, and cost savings to the Medicare Trust Fund. QIOs operate under three-year contract cycles; most contracts are held by non-profit community-based organizations. The most recent contract extends from August 1, 2011–July 31, 2011 and is referred to as the 10th Scope of Work (SOW). Under this contract, there are several opportunities for QIOs to work with the nursing home community. QIOs are working with CMS identified providers to positively impact nursing home care by focusing on the reduction of pressure ulcers (811 nursing homes) and the use of physical restraints (1004 nursing homes); 133 of those facilities are working on both measures.

Additionally, QIOs are working to reduce the occurrence of adverse drug events by participating in a Patient Safety and Clinical Pharmacy Services (PSPC) Breakthrough Collaborative. Some QIOs have recruited nursing homes as part of their learning collaborative.

Beginning in Fall of 2012, CMS will launch a National Nursing Home Collaborative that focuses on preventable healthcare acquired conditions (HACs). As part of that initiative, the QIOs and their nursing home partners will work to strengthen the building blocks of change in order to help nursing homes make meaningful gains in the residents' quality of life and clinical outcomes.

These building blocks may include but are not limited to staffing, operations, finance, and leadership. The CMS fully supports the QIOs in this endeavor and will continue to strengthen our partnership by aligning resources, encouraging collaborative participation of all nursing homes and ensuring that each SA is a collaborative partner.

B. Quarterly Meetings with the States— The CMS will continue to meet with the Association of Health Facility Survey Agencies (the national organization representing SAs) four times a year, two of which are in person. CMS also works with States on new policies and procedures, frequently seeking their review and comment on relevant topics.

C. Leadership Summit—The CMS will sponsor the eighth annual joint meeting with SAs in Spring 2013 in the Baltimore, Maryland area, to build better communication and strengthen understanding of program initiatives. Although the agenda covers all providers and suppliers in the survey and certification program, nursing homes will be a strong emphasis.

D. Communicating with other Stakeholders— The CMS presents annually at national training conferences for several national associations such as the American Health Care Association and the LeadingAge, as well as interim meetings with the regulatory subcommittee and the legislative training session held in Washington, D.C., each year. The CMS also holds stakeholder meetings periodically on various topics of interest and meet with consumer advocates such as The Consumer Voice (formerly NCCNHR) and AARP for purposes of exchanging information.

E. Advancing Excellence in America's Nursing Homes Campaign— CMS collaborates with 30 national organizations to facilitate a national nursing home quality campaign entitled *Advancing Excellence in America's Nursing Homes* (www.nhqualitycampaign.org). The unprecedented, collaborative campaign, which began in 2006, seeks to dramatically advance the quality of care and quality of life for those living or recuperating in America's 15,800 nursing homes. The *Advancing Excellence in America's Nursing Homes Campaign* is helping nursing homes and others coordinate their energy and resources to build upon current initiatives such as the CMS QIO 10th Statement of Work, CMS GPRA goals, Quality First, the Campaign for Quality Care, and the culture change movement.

The national campaign has focused on the following actionable goals and demonstrated that nursing homes that select a goal and work on do, in fact, improve at a rate faster than others:

Goal 1: Reducing Staff Turnover
Goal 2: Consistent Assignment
Goal 3: Reducing the use of restraints
Goal 4: Reducing the incidence and prevalence of pressure ulcers
Goal 5: Improving pain management
Goal 6: Developing advance care planning
Goal 7: Increasing resident/family satisfaction
Goal 8: Raising staff satisfaction

The Campaign is expected to change its goals in 2012 and will include Appropriate Use of Medications, Increasing Resident Mobility, Safely Avoiding Hospitalizations, Prevention of

Infections, Better Person-centered Care Planning, Reduction of Pressure Ulcers and pain Management. The Campaign was launched at a National Nursing Home Quality Summit meeting in Washington, DC on September 29, 2006. As of November 2011, more than 7,600 facilities had joined the Campaign, committing to work on at least three of the campaign's eight measurable goals to improve their quality of care.

This represents more than 50% of all nursing homes in the United States based on the latest available count of Medicare/Medicaid nursing homes. In addition, more than 3100 consumers have joined the Campaign.

Participating consumers are promoting the Campaign by encouraging nursing homes to sign onto the campaign, and asking nursing home administrators if they are participating and which goals they have chosen. One of the resources of the Campaign is the use of Local Area Networks for Excellence (LANEs) as facilitators in the success of the campaign objectives. LANEs are stakeholders at the state level that come together for the purpose of supporting providers and consumers in achieving the campaign goals.

A State LANE:

- Serves as the central organization to ensure the intra-state success of the Campaign
- Recruits participating providers and consumers
- Promotes the campaign
- Provides access to local education
- Fosters constructive relationships among stakeholders
- Identifies evidenced-based protocols.

The Campaign has demonstrated progress in meeting its goals. For example, the goal to lower restraints to less than 5% nationally was met and reset to less than 3% nationally. The CMS meets regularly with the Campaign Board of Directors to evaluate progress and to determine areas in nursing home care that will benefit from quality improvement. Progress toward the goals will be posted on the campaign's website quarterly at: www.nhqualitycampaign.org.

The Campaign also is working with CMS on its national initiatives to reduce use of antipsychotic medications in nursing homes and to initiate Quality Assurance/Performance Improvement Programs (QAPI)

F. Long Term Care Rebalancing — The CMS awarded a total of $764 million in competitive grants to states over five years to help shift Medicaid from its historical emphasis on institutional long term care services to a system that offers more choices (including home- and community-based services for seniors and persons with disabilities from all age groups). This *Money Follows the Person* (MFP) "rebalancing" initiative was included in the Deficit Reduction Act of 2005 (DRA) with an appropriation of $1.75 billion. Demonstration grants were awarded to 30 States and the District of Columbia in January 2007 and May 2008. The Affordable Care Act (ACA) extended the program five more years with grant expenditures authorized through fiscal year 2020. The ACA also increased the DRA appropriation another $2.25 billion making the total appropriation for MFP $4 billion. In February 2011 CMS awarded MFP grants to 13 additional States. In February 2012 CMS released a solicitation to invite the seven remaining non-

participating States to apply for an MFP grant. As of June 30, 2011, almost 16,000 individuals have transitioned from institutional settings including nursing homes.

Specifically, the demonstrations support state efforts to:

- Rebalance their long term care support system so that individuals have a choice of where they live and receive services
- Transition individuals from institutions who want to live in the community
- Promote a strategic approach to develop and implement a quality management strategy that ensures the provision and improvement of services in community- based settings. The strategy must ensure the health and safety of demonstration participants during, and after transition to the community

Included in the MFP Demonstration project was a directive by Congress that CMS provide technical assistance and oversight to the MFP demonstration states, for the purpose of improving state quality management systems under Medicaid Home- and Community- Based Service waivers. These funds, which CMS has awarded to a technical assistance provider, will be available throughout the duration of the demonstration.

The MFP demonstration also includes a requirement that states demonstrate a thorough plan of engagement of institutional providers as well as other stakeholders to maximize the effectiveness of the demonstration. Successfully rebalancing a state's long-term care system to favor home- and community-based services is best achieved through engagement of the institutional providers as well as other stakeholders in the state.

Lastly, as part of the work discussed in item 3.B., Development and Validation of MDS 3.0, CMS changed an item in the MDS to elicit interest in and support for community- based options. For the first time, residents of nursing homes will be asked directly if they would like to learn about options for returning to the community. The CMS is currently working with stakeholders to refine processes to make referrals for information regarding community-based options.

5. Advancing Quality through Innovation and Demonstration

CMS' demonstration projects foster health care transformation by finding new ways to pay for and deliver care that improve care and health while lowering costs. These projects include Medicare's current Nursing Home Value-Based Purchasing (NHVBP) Demonstration, which aims to promote high-quality care and prevent costly, potentially avoidable hospitalizations and develop plans to implement VBP programs for payments under the Medicare program for both Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs).

The Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents was developed jointly by the CMS' Center for Medicare and Medicaid Innovation (Innovation Center) and the Medicare-Medicaid Coordination Office (MMCO). Through this initiative, CMS will partner with organizations to implement evidence-based interventions that reduce avoidable hospitalizations. These organizations will collaborate with States and nursing facilities, with each

enhanced care and coordination provider implementing its intervention in at least 15 partnering nursing facilities.

A. Nursing Home Value-Based Purchasing (NHVBP) Demonstration

The CMS views value-based purchasing (VBP) as an important step in revamping how Medicare pays for health care services, moving the program toward rewarding better value, outcomes, and innovation instead of the volume of services provided. The Agency seeks continuous improvement through ongoing quality incentive program and newly developed programs. These efforts include Medicare's current Nursing Home Value-Based Purchasing (NHVBP) Demonstration, which aims to promote high-quality care and prevent costly, potentially avoidable hospitalizations and develop
plans to implement VBP programs for payments under the Medicare program for both Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs).

Under this initiative, CMS assesses the performance of nursing homes based on selected measures of quality of care. The categories (or domains) for the potential measures include nurse staffing avoidable hospitalizations, resident outcomes, and survey deficiencies. The nurse staffing measures (including staffing levels and turnover) are derived from payroll data and resident census data collected from the participants on a quarterly basis. The avoidable hospitalization measure is a risk adjusted measure that is derived from the claims data and the Minimum Data Set. The survey measures and the outcome measures are similar to those utilized on the Nursing Home Compare website. The four domains are combined into a composite measure of which each facility is relatively ranked to each other for each state. The demonstration includes all Medicare-eligible beneficiaries residing in nursing homes (i.e., those receiving Part A benefits as well as those that receive only Part B benefits). The CMS expects that improvements in quality may result in avoidance of some unnecessary hospitalizations, yielding savings to Medicare. These savings will be shared with nursing homes that either improve quality or maintain high quality of care.

This 3-year demonstration began on July 1, 2009 in three States: Arizona, New York and Wisconsin. As of June 30, 2010, there were 38 nursing homes participating in the demonstration in Arizona; 78 in New York; and 61 in Wisconsin. In 2011, The CMS calculated the performance of the participants for the base year (i.e., the year just before the demonstration began) and for year 1 for several domains of quality. The CMS then reconciled the performance calculation to determine each participating nursing homes' level of quality and level of improvement under the demonstration. As a result, 30 nursing homes in Wisconsin and Arizona were awarded incentive payments totaling over 3.2 million dollars. The CMS is currently in the process of making performance calculations for year 2 of the demonstration and intends to announce the year 2 results by the end of the summer 2012.

<u>Reports to Congress</u>: <u>Plans for a Value-Based Purchasing Program for SNFs and HHAs</u>

Sections 3006(a) and (b) of the Affordable Care Act, requires the Secretary of Health and Human Services to develop plans to implement VBP programs for payments under the Medicare program for SNFs and HHAs. The Reports to Congress discuss the elements required by the statute,

examine the quality framework and lessons learned to date under relevant demonstrations, and seeks input from stakeholders.

B. Implement Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents

Background

Nursing facility residents often experience potentially avoidable inpatient hospitalizations. These hospitalizations are expensive, disruptive and disorienting for frail elders and people with disabilities. Nursing facility residents are especially vulnerable to the risks that accompany hospital stays and transitions between nursing facilities and hospitals, including medication errors and hospital-acquired infections.

Many nursing facility residents are enrolled in both the Medicare and Medicaid programs (Medicare-Medicaid enrollees). CMS research on Medicare-Medicaid enrollees in nursing facilities
found that approximately 45% of hospital admissions among those receiving either Medicare skilled nursing facility services or Medicaid nursing facility services could have been avoided, accounting for 314,000 potentially avoidable hospitalizations and $2.6 billion in Medicare expenditures in 2005.

Implement Initiative

Through this initiative, CMS will partner with eligible, independent, non-nursing facility organizations (referred to as "enhanced care & coordination providers") to implement evidence-based interventions that reduce avoidable hospitalizations. Eligible organizations can include

physician practices, care management organizations, and other public, for-profit and not-for-profit entities. The enhanced care & coordination providers will collaborate with States and nursing facilities, with each enhanced care & coordination provider implementing its intervention in at least 15 partnering nursing facilities. CMS expects to fund approximately seven enhanced care & coordination providers who will implement their proposed interventions in a total of approximately 150 nursing facilities.

The goal of these interventions is to improve the health and health care among nursing facility residents and ultimately reduce avoidable inpatient hospital admissions. Successful applicants will implement such interventions that will have the following objectives:

- Reduce the frequency of avoidable hospital admissions and readmissions;
- Improve resident health outcomes;
- Improve the process of transitioning between inpatient hospitals and nursing facilities; an
- Reduce overall health care spending without restricting access to care or choice of providers.

CMS is not prescribing any specific clinical model; it is allowing applicants to propose interventions to meet the initiative's objectives. However, all interventions must include the following activities:

- Hire staff who maintain a physical presence at nursing facilities and partner with nursing facility staff to implement preventive services;
- Work in cooperation with existing providers;
- Facilitate residents' transitions to and from inpatient hospitals and nursing facilities;
- Provide support for improved communication and coordination among existing providers; and
- Coordinate and improve management and monitoring of prescription drugs, including psychotropic drugs.

Interventions will be evaluated for their effectiveness in meeting the objectives and providing residents with a better care experience. This initiative is expected to last for four years from August 2012 to August 2016.

Resource: Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of Clinical Standards and Quality 2012

"This course was developed from the public domain document: Improving Nursing Home Quality 3-Part Action Plan – Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of Clinical Standards and Quality 2012)."