



Improving Nursing Home Quality



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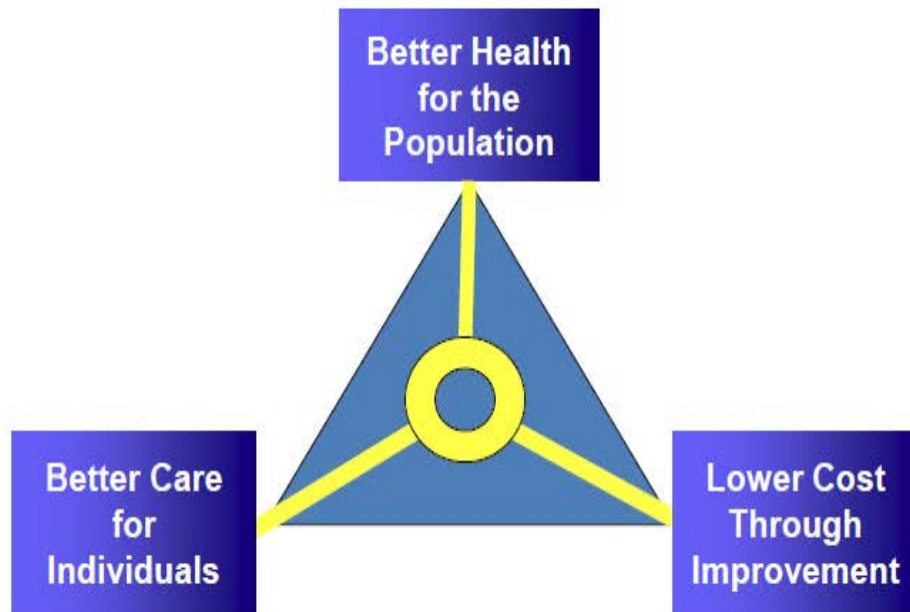
3-PART ACTION PLAN

The Center for Medicare Services Nursing Home Action Plan is based on CMS' Three-Part Aim for improving U.S. healthcare.

The Three-Part Aim comprises three objectives:

1. Improving the individual experience of care;
2. Improving the health of populations; and
3. Reducing the per capita cost of care for populations.

All three components of the Three-Part Aim are interconnected (See Figure Below). The themes outlined in this action plan will guide our efforts to continue progress in improving nursing home safety and quality. CMS' five actionable strategies will be pursued simultaneously, consistent with the Three-Part Aim.



The most effective approach to ensure quality is one that mobilizes and integrates all available tools and resources –aligning them in a comprehensive, actionable strategy. CMS’ strategy consists of five interrelated and coordinated approaches, each of which addresses one or more of the Three-Part Aim objectives:

1. Enhance Consumer Engagement (Objective #1):

Consumers are essential participants in ensuring the quality of care in any health care system. The availability of relevant, timely information can significantly assist consumers to actively manage their own care. Additionally, this information can enable individuals to hold the health care system accountable for the quality of services and support that should be provided. To that end, CMS seeks to provide an increasing array of understandable information that can be readily accessed by the public. For example, the CMS website, www.Medicare.gov, features *Nursing Home Compare* as well as other important educational resources and information for consumers, families, and friends. Enhancements to *Nursing Home Compare* include the *Five-Star Quality Rating System* and publicizing the names of nursing homes in the Special Focus Facility initiative. Involving consumers, families, and others in healthcare policy decisions as well as resident-centered care on an individual basis will enhance the overall individual experience of care.

2. Strengthen Survey Processes, Standards, and Enforcement (Objectives #1, 2, 3):

CMS is engaged in several ongoing initiatives to improve the effectiveness of annual nursing home surveys (standard surveys), as well as the investigations that are prompted by complaints (complaint surveys) from consumers or family members about nursing homes. CMS also has improved the way that data are captured from oversight of state surveys. By strengthening oversight and enforcement standards, CMS believes that state agencies will drive improvement at the population level in nursing homes. This, in turn, is likely to reduce the number of adverse events and preventable healthcare acquired conditions, leading to lower per capita costs.

In addition, CMS is developing a feedback process to improve national consistency and information flow from providers to consumers. A process to communicate consistent, helpful feedback to individual complainants will improve the individual experience of care.

3. Promote Quality Improvement (Objectives #1, 2, 3): CMS continues to promote comprehensive quality improvement programs in a number of key areas, including reductions in the use of physical restraints and the prevalence of preventable pressure ulcers. In an effort to achieve these quality improvement goals, the Agency’s participation in the Advancing Excellence in America’s Nursing Homes program as well as support of the national “culture change” movement continues to grow. The principles behind culture change echo the Omnibus Budget Reconciliation Act of 1987 (OBRA ’87) principles of resident-centered care – enhancing each individual nursing home resident’s quality of care and quality of life. CMS joins the culture change movement in encouraging facilities to examine and transform their organization’s values, structures and practices to transform traditional institutional approaches to those that are person-centered. The adoption of culture change and person-centered care principles can improve the resident’s and the family’s experience of care.

Participation in Advancing Excellence and other programs that set targets for performance improvement are likely to lead to improved health of the nursing home population. In many cases, improved quality may lead to reduced costs, in areas such as potentially preventable hospitalizations

of nursing home residents, prevention of pressure ulcers, and the prevention of rehabilitation costs associated with hip fractures due to falls.

4. Create Strategic Approaches through Partnerships (Objectives #2, 3):

No single approach or individual can fully assure better health care. Rather, CMS must combine, coordinate, and mobilize many people and techniques through a partnership approach. Marking the largest national public and private effort on quality, patient safety, and affordability of health care, the Department of Health and Human Services (HHS) launched “Partnership for Patients” (PfP). PfP is deploying, from CMS, a total of \$1B in funding to achieve two bold aims by December 2013: a 40% reduction in preventable Hospital Acquired Conditions, and a 20% reduction in 30 day readmissions. Up to \$500M of that funding is through the CMS Innovation Center (to improve patient safety). \$500M is to reduce 30d readmissions through the ACA Section 3026 Community-Based Care Transitions Program.

Quality Improvement Organizations (QIOs), State Survey Agencies (SAs), and other partners are committed to a common endeavor. Although these entities have different responsibilities, their distinct roles can be coordinated in a number of ways to achieve better results than can be achieved by any one agency alone. QIOs, through the 9th Scope of Work (SOW), were tasked with improving nursing home care by working with nursing homes with the highest rates of pressure ulcers or physical restraints. Additionally, QIOs were tasked with

working with homes that had been identified by Survey and Certification as either Special Focus Facilities (SFF), or candidates on the SFF List that had high rates of pressure ulcers and physical restraints. QIOs could work with up to three of these homes over the course of the three-year contract period. Similarly, in the 10th SOW, QIOs will continue to build upon previous successes in the reduction of pressure ulcers and work towards the reduction or elimination of physical restraints in those nursing homes with the highest rates.

Beginning in August 2012, CMS will launch a National Nursing Home Collaborative that focuses on preventable healthcare acquired conditions (HACs). As part of that initiative, QIOs and their nursing home partners will work to solidify the building blocks of change that are essential in enabling nursing homes to make significant gains in the quality of life and clinical outcomes experienced by their residents. These building blocks may include but are not limited to nursing home staffing, operations, finance, and leadership. To fully leverage the QIOs in this endeavor, the Division Nursing Homes will continue to strengthen our partnership by aligning resources, encouraging collaborative participation and ensuring that each SA is a collaborative partner.

In 2006, CMS partnered with stakeholders to design and facilitate the *Advancing Excellence in America's Nursing Homes* Campaign (www.nhqualitycampaign.org). This unprecedented, collaborative campaign seeks to better define quantitative goals in nursing home quality improvement and aligns the strategies of numerous national and local partners who have expressed their commitment to excellence in nursing home quality. To date, 7,600 nursing homes have joined the Campaign with promising results.

By partnerships with SAs, QIOs, and Advancing Excellence Local Area Networks for Excellence (LANEs), quality improvement may be addressed at the state and national level, leading to improvement in the health of nursing home populations. This, in turn may reduce health care costs (which is both a goal of the Aim and Partnership for Patients). This in turn, may achieve better care, better health and higher quality while reducing costs, which is a fundamental goal of the PfP.

5. *Advancing Quality through Innovation and Demonstration (Objective #3):* 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.

ACTION PLAN FOR FURTHER IMPROVEMENT OF NURSING HOME QUALITY

1. Enhance Consumer Awareness and Assistance

Older adults, people with disabilities, their families, friends, and neighbors are all essential stakeholders to consider when ensuring the quality of care in any health care system. The availability of relevant and timely information can significantly enable individuals to be active and informed participants in their care. Such information also can enable those individuals to hold the health care system accountable for the quality of services and support that should be provided. To that end, CMS seeks to provide an increasing array of understandable information about nursing homes that can be accessed readily by the public. The CMS website, www.Medicare.gov, features the Nursing Home Compare website as well as other important information for consumers, families, and friends. Companion CMS websites, such as Hospital Compare, Home Health Compare, and the President's New Freedom Initiative (www.cms.hhs.gov/NewFreedomInitiative/), are additional resources for providing healthcare options information within and outside of facilities.

A. Five-Star Quality Rating System

Background

The CMS created the Nursing Home Compare website in 1998. Since the creation of the website, CMS has routinely improved the information available to beneficiaries and their families about quality of care in nursing homes. In 2002, CMS added 10 quality measures (QMs), gradually increasing the number to the current 19 reported measures. In 2005, CMS expanded the Nursing Home Compare website to include Life Safety Code inspection results. In 2007, CMS began publishing the names of nursing homes that are a part of a more intense monitoring program for selected nursing homes with a history of performance issues. Further explanation of this monitoring program (called the Special Focus Facility program) can be found on page 11 of this document.

In 2008, CMS unveiled the *Five-Star Quality Rating System*. This rating system was developed to help individuals, family members, and the public compare the quality of nursing homes more easily. The website can be found at: www.Medicare.gov/NHCompare/Home.asp. CMS continuously seeks to improve the usefulness of information on our websites. In 2009, CMS began issuing structured surveys to obtain and analyze systematic information about how users search and employ the new information, the perceived strengths and limits of the website, and the overall usefulness of the website.

In 2012, improvements to Nursing Home Compare included 7 additional quality measures derived from MDS 3.0 data. CMS also is continuing to evaluate additional quality measures for nursing homes, particularly measures of hospitalization, discharge to community, and functional status improvement in both short- and long-stay nursing home residents. Nursing Home Compare was redesigned to make the website easier to use and understand.

B. Improving Staffing and Ownership Data on the CMS website

Background

Adequate quantity and quality of staffing in a nursing home are key determinants of the level of care residents receive. Consequently, CMS publishes staffing information for each nursing home on Nursing Home Compare. This information is self-reported by nursing homes; therefore, CMS urges consumers to complement the use of these data with other practices, such as visits to nursing homes of interest.

Staffing is one of three domains that make up the *Five-Star Quality Rating System* for nursing homes and was first posted on *Nursing Home Compare* in 1999. Staffing data are case-mix adjusted using the Resource Utilization Group (RUG III) categories. Case-mix adjustments allow for a fair comparison of staffing across facilities with different levels of resident acuity.

As part of a longer term plan to increase the accuracy and comprehensiveness of staffing data, CMS has been evaluating the use of payroll data as a basis for the information on *Nursing Home Compare*. Payroll data can be used to calculate measures of staff turnover and staff retention in addition to supporting more accurate calculation of the staffing measures currently posted. A two- phase field

study of the feasibility of collecting payroll data was completed. The first phase involved interviewing nursing homes, nursing home corporations, and payroll vendors. The second phase included providing data specifications to a sample of facilities to determine their capacity to generate and submit data.

Between 2008 and 2010, CMS achieved the following:

- Implemented a case-mix adjustment system for the staffing domain of the *Five-Star Quality Rating System* for nursing homes
- Collaborated with the Nursing Home Value-Based Purchasing Demonstration to implement a payroll database system for the staffing data for demonstration
- Collected public comment on mandatory electronic data collection through an addition to the 2010 skilled nursing facility (SNF) Prospective Payment System Rule.

Affordable Care Act Changes

The Patient Protection and Affordable Care Act (P.L. 111-148, March 23, 2010) (Affordable Care Act) requires CMS to make a number of changes to the Nursing Home Compare website. These changes include: posting of nursing home staffing data taken from payroll reporting, posting of nursing home complaint and enforcement data, and creation of a standardized complaint form to make it easier for consumers to report complaints.

The Affordable Care Act also requires nursing homes to report a considerably expanded amount of information about the management and ownership of their facilities. CMS plans to collect these data in the Provider Enrollment and Chain Ownership System (PECOS) database. Although it is not a requirement of the Affordable Care Act, CMS is developing scenarios under which some of this ownership information would be displayed on Nursing Home Compare.

2. Strengthen Survey Process, Standards and Enforcement

The CMS Survey and Certification Group (SCG) acts to assure basic levels of quality and safety for Medicare and Medicaid beneficiaries. Within SCG, the Division of Nursing Homes (DNH) focuses on optimizing the health, safety, and quality of life for people living in nursing homes, through close coordination with other Divisions. Approximately 5,000 Federal and State surveyors conduct on-site surveys of certified nursing home every 12 months on average to assure basic levels of quality and safety for beneficiaries.

The CMS has undertaken several initiatives during 2012 to improve the effectiveness of the annual nursing home surveys, as well as the investigations prompted by complaints from consumers or family members about nursing homes.

A. National Background Check Program

Background

Nursing home residents have a statutory right to be free from abuse, neglect, or misappropriation of their own funds. A competent and caring workforce is instrumental in fulfilling these legal rights. Effective recruitment, screening, supervision, and training of direct and indirect care providers and supervisors are essential to ensuring a knowledgeable, capable, and sustainable workforce.

In accordance with section 307 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, in January 2005, CMS issued grants to seven selected States (Alaska, Idaho, Illinois, Michigan, Nevada, New Mexico, and Wisconsin) to pilot a program to determine the most efficient, effective, and economical method for conducting state and national background checks. Developed background check processes were required to include searches of relevant registries for screening applicants who would have direct access to nursing home patients and residents and other long-term care (LTC) providers.

After reviewing CMS' background check pilot results, Congress took the next step in funding State background check systems by including a provision in the March, 2010 Affordable Care Act for the development of a Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-Term Care Facilities and Providers. The program's purpose is to identify efficient, effective, and economical procedures for conducting background checks. The program will be administered by the Centers for Medicare & Medicaid Services (CMS), in consultation with the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI). CMS was given responsibility to provide 3-to-1 matching grants to all applying states and U.S. Territories up to \$3 million each for this multi-year program effort. In order to receive an award, each state must agree to cover all LTC provider types, cover all job applicants to these providers that will have direct access to residents/clients, consult registry information in all states in which the applicant resided, and must provide rolled fingerprints to the Federal Bureau of Investigations (FBI). The Federal matching funds must be encumbered by September 2012 and spent within 36 months of the State receiving award funds. CMS is working with the FBI on implementation of this program. The CMS also has awarded a major technical assistance contract for this project to the CNA Corporation. Approximately half of the states already have applied for this program and more are expected during the final solicitations. CMS has awarded more than \$38 million to 17 States to design comprehensive national background check programs for direct patient access employees.

B. Improving Fire Safety in Nursing Homes

Background

The CMS initiatives to reduce nursing home fires focus on four action themes:

- Better Protection (such as improved standards)
- Better Information and Reporting (such as improved information on the Web)
- Better Monitoring (such as more CMS validation surveys)
- Better Enforcement (such as improved methods of citing deficiencies).

The CMS continues to move toward better fire protection for nursing homes. On August 13, 2008, CMS published a final rule requiring that all long-term care facilities must have automatic sprinkler

systems installed in accordance with the technical provisions of the 1999 edition of the NFPA 13, Standard for the Installation of Sprinkler Systems, published by the National Fire Protection Association (NFPA). The requirement includes a five-year phase-in period for installation. CMS will continue to collect and report information on the sprinkler status and survey results for nursing homes and post this information on the *Nursing Home Compare* website.

In the interest of improving monitoring and enforcement, CMS has instructed SAs to consider nursing home fires with injuries to be investigated using our complaint policies and procedures for the level of “immediate and serious jeopardy.” Additionally, CMS continues to reprioritize both contract and in-house resources to maintain a 17-fold increase (compared to 2004) in the number of validation surveys CMS conducts to monitor the adequacy of State Life Safety Code (LSC) surveys. This level has been sustained and is expected to continue in FY2012.

C. Interpretive Guidance to Surveyors

Background

The CMS continues to revise the State Operations Manual (SOM) including the *Interpretive Guidance to Surveyors for Long Term Care Facilities* for selected regulatory requirements through an interactive process using expert panels and stakeholder comment periods. The guidance will support a nationally consistent application of the survey process in evaluating facilities for compliance with nursing home requirements. The final product will include interpretive guidance based on current standards of practice, investigative protocols, and guidance to determine the severity and scope of deficiencies identified in a survey.

In addition to the guidance, CMS continues to provide improved methods of communicating this information. Training is made available to both surveyors and providers, via advance copies, training tools, and satellite broadcasts as needed. Beginning in 2012, bi-monthly conference calls with Central and Regional Offices provide enhanced information to policy makers in Central Office regarding implementation of interpretive guidance in states and regions and how this process can be continuously improved.

D. State Performance Standards

Background

In FY 2001, CMS implemented a uniform State Performance Standards System (SPSS). In FY 2002, CMS added hospitals, end-stage renal disease (ESRD) facilities, intermediate care facilities for people with intellectual disabilities (ICF-ID) – formerly referred to as intermediate care facilities for people with mental retardation (ICF-MR) – and home health agencies (HHAs) to the SPSS.

In FY 2006, CMS reorganized the SPSS into a tri-component model (Figure 2). This change by CMS was made to emphasize that the value of the survey program comes from (a) the frequency of surveys, (b) the quality of the surveys themselves, including proper identification of deficiencies, and (c) appropriate enforcement and remedy of identified problems, preferably through systemic change. The

fundamental elements in the SPSS have remained the same, with improvements made to: (1) align performance measurement with Federal survey and certification priorities, (2) assure that non-nursing home provider/suppliers are being surveyed, (3) respond to changes made to policies and guidance, and (4) detect whether problems exist in the identification of deficiencies during surveys.

SPSS Tri-Component Model

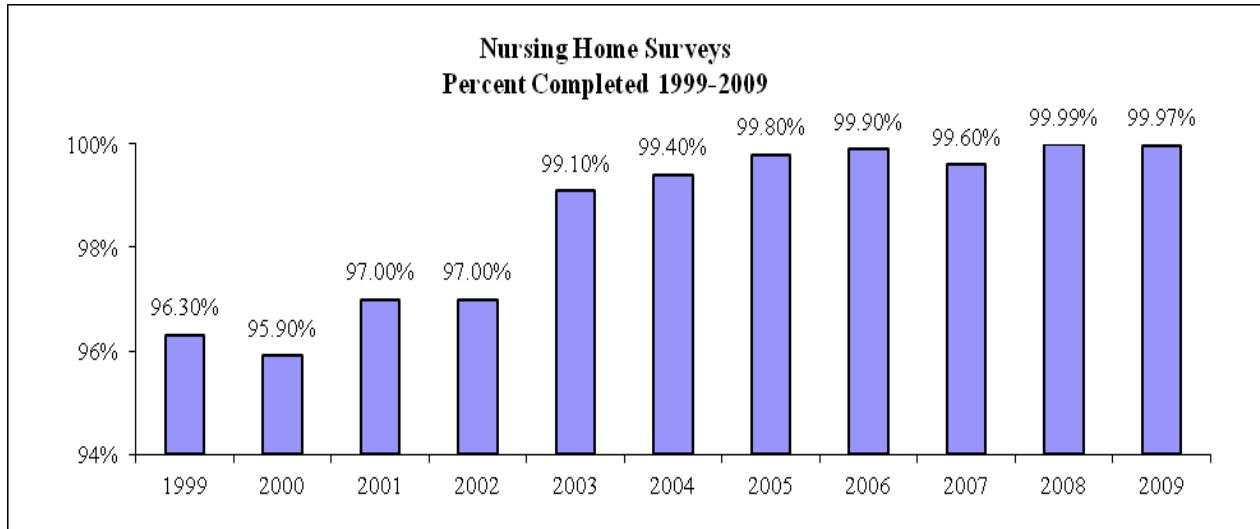
Frequency + Quality of Surveys + Enforcement and Remedy = Value

- *Timeliness and Frequency of surveys:* Off-hour surveys for nursing homes, frequency of surveys, frequency of data entry of standard surveys
- *Quality of Surveys:* Documentation of deficiencies; conduct of surveys in accordance with Federal standards; documentation of noncompliance, accuracy of documentation, prioritizing complaints and incidents, timeliness of complaints and incident investigations; quality of Emergency Medical Treatment & Labor Act (EMTALA) investigations; and quality of complaint/incident investigations.
- *Enforcement and Remedy:* Timeliness of processing immediate jeopardy cases, timeliness of mandatory denial of payment for new admissions notification, processing of termination or non-nursing homes, and Special Focus Facilities

The SPSS has provided feedback to states and regions that may have contributed to improvement in key areas. The following graph, for example, shows the percentage of nursing homes for which a survey was conducted every 15 months.

The percentage of surveys completed decreased by approximately 1% in 2010 and 2011. States report that decreases are due in part to state-level restrictions on salaries and employee hiring as well as difficulties in recruiting qualified surveyors. Starting in the Spring of 2012, CMS is generating a quarterly report on performance to help Regional Offices identify states that are in the early stages of falling behind on the completion of surveys, so that early interventions can be initiated.

Figure 3. Nursing Homes Survey Percent Completed



E. Federal Comparative Validation Surveys

Background

Comparative surveys are surveys conducted by CMS, shortly after a State survey, in order to assess the quality of the State survey. In FY 2002, a Government Accountability Office study recommended that CMS conducts more comparative surveys. CMS responded by seeking to increase the number of comparative surveys through a contract effort. In 2003, CMS awarded a five-year contract to recruit and train surveyors to perform Federal comparative surveys; FY 2008 was the final year for this contract. In FY 2009, CMS awarded a second five-year contract to continue to perform comparative LSC surveys to support the Regional Offices (RO) efforts at oversight of State LSC surveys. CMS will continue comparative LSC surveys to assure that fire safety issues are adequately addressed.

Based on previous work, a new contract was awarded in 2011 to design an integrated approach using contracted surveyors in one region to enhance the number of comparative surveys performed by federal survey teams. In addition, this work is designed to allow officer leaders more time to pursue quality improvement work and oversight of state agencies.

F. Improved surveys via the Quality Indicator Survey (QIS)

Background

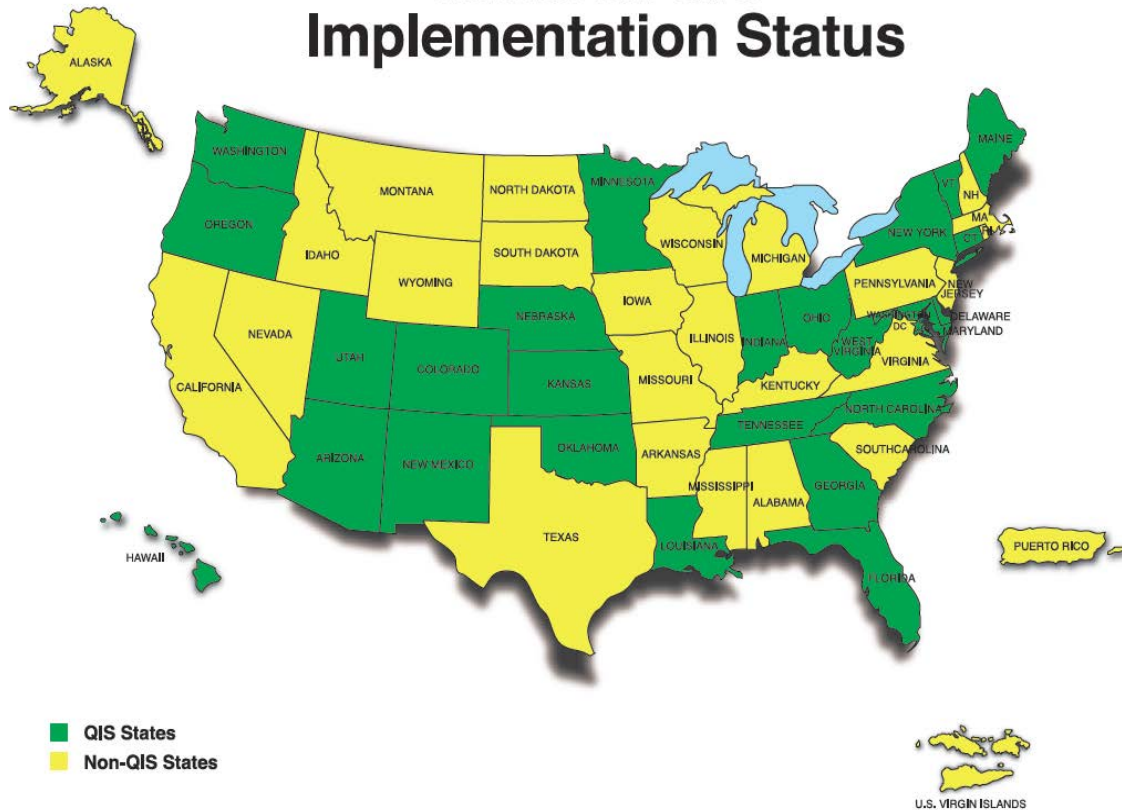
The QIS uses customized software (ASE-Q) on tablet personal computers to guide surveyors through a structured investigation. The QIS is a two-stage process to systematically review specific nursing home requirements and objectively investigate regulatory areas that are triggered. Although the survey process has been revised under the QIS, the Federal regulations and interpretive guidance remain unchanged. The CMS continues implementation of the QIS process to survey nursing homes to determine compliance with the Federal requirements. The QIS was developed to:

- Improve consistency and accuracy of quality of care and quality of life problem identification
- Enable timely and effective feedback on survey processes for surveyors and managers
- Systematically review requirements and objectively investigate all triggered regulatory areas within current survey resources
- Provide tools for continuous improvement; enhance documentation by organizing survey findings through automation
- Focus survey resources on facilities (and areas within facilities) with the largest number of quality concerns.

QIS history, status and schedule

In the fall of 2009, CMS released a detailed implementation plan and priority schedule for the national rollout of the QIS. The CMS remains committed to the schedule and priority order originally outlined in 2009; as of publication of this Nursing Home Action Plan, 26SAs are in some phase of QIS implementation ranging from fully implemented to just beginning the overall training process. With the release of Admin-Info 12-02 CMS suspended the implementation of the QIS on November 10, 2011. This action does not affect those states that had already begun the implementation process; see Figure 1 below for current implementation status.

National QIS Implementation Status



G. Collecting Civil Money Penalties Prior to Appeal

Background

Use of civil money penalties (CMPs) as an enforcement tool to encourage nursing homes to attain and maintain compliance has been in place since the implementation of nursing home reform in the mid-1990s. In its present form, imposed CMPs are not due and payable until a final administrative decision is made regarding the noncompliance upon which the penalty was imposed. Final CMP disposition can lead to facilities not paying the CMP until years after its imposition because the penalty may not have been collected until after the appeal. With the passage of the Affordable Care Act in March 2010, Congress gave us discretionary authority to collect CMPs and put such funds in an escrow account prior to the appeal process. If CMPs are put in escrow, CMS is required to make an independent informal dispute resolution process available. CMS published a Final Rule titled, “Civil Money Penalties for Nursing Homes” on March 18, 2011.

H. Monitor Civil Monetary Penalty Amounts

Background

The CMS will continue to monitor the number and amount of CMPs imposed by states to ensure

consistency with statutory and regulatory factors such as scope and severity, repeated deficiencies, and numbers of deficiencies. A workgroup composed of regional and central office leadership is developing process and guidance on CMP consistency.

I. Special Focus Facilities (SFF)

Background

Between 2005 and 2010, CMS certified an average of 16,050 nursing homes each year. While many nursing homes meet minimum nursing home requirements either upon survey or within a short period afterwards, some nursing homes pass one survey, only to fail the next survey for issues identified previously and perhaps intensified. CMS' experience shows that such facilities rarely address the underlying systemic problems that have given rise to repeated cycles of serious deficiencies.

In recognition of this phenomenon, CMS created the SFF program in 1998 as one of the initiatives of the Nursing Home Oversight and Improvement Program. The purpose of the SFF program was to decrease the number of persistently poor performing nursing homes by directing more attention to nursing homes with a record of poor survey performance. In January 1999, we instructed SAs to conduct two standard surveys per year for each SFF instead of the one required by law. CMS also requested that States submit a monthly status report listing surveys, revisits, or complaint investigations of SFFs they conducted in that month.

With collaboration with the States, CMS identified areas where the SFF program could be improved. In December, 2004, CMS augmented the SFF program by:

- ***Increasing the Number of Nursing Homes in the SFF program:*** we increased the total number of facilities by about 30%, with larger states having more SFFs than smaller states (instead of 2 nursing homes in every state)
- ***Better Selection:*** Improving the data and methods by which substandard nursing homes are identified, thereby enabling states to move on to other nursing homes on the candidate list if the original nursing homes show significant improvement
- ***Stronger Enforcement:*** Implementing more robust enforcement for nursing homes that fail to make progress
- ***Reduced Reporting Burden:*** Removing the monthly reporting requirement for states; current requirements for surveying each SFF twice a year remain unchanged
- ***Building in Timeframes for Action:*** Requiring that nursing homes have three standard surveys to make improvements and graduate from the program, make significant improvement or face termination.

In FY 2008, CMS made further improvements to the SFF initiative by requiring that states notify nursing homes designated as a SFF and requiring that states notify other accountable parties such as owners, governing parties, and other additional parties such as the State Ombudsman, the State Medicaid Agency, and a state's Quality Improvement Organization.

The second improvement was posting the names of all SFF nursing homes on the Nursing Home Compare website. SFF's names are organized so consumers and families can distinguish between nursing homes that have significantly improved and those that have not, have graduated, or have

terminated participation in the Medicare Program, as well as SFF nursing homes that have recently been added to the SFF initiative.

The third improvement was the inclusion of a SFF icon for those nursing homes on Nursing Home Compare website, which are part of the SFF initiative.

In FY 2011, CMS made further improvements to the SFF initiative by initiating quarterly calls to the Regional Offices (RO) to discuss the status of any nursing home that continues on the SFF program for a time exceeding 24 months. CMS discusses the history of the nursing home as to how the past survey results led to their designation as a SFF. The CMS and ROs also discuss enforcement remedies, quality assurance programs such as the Advancing Excellence program, QIOs, conferences with ownership and management of the facility, monitoring tools from the State Survey Agency and RO and recommendation for Termination or a System Improvement Agreement.

J. Surveyor and Regional Office Training

Background

QIS/LTC and Magnet Area Training (MAT). The CMS piloted new approaches to partnering with state agencies that allow us to better use more sophisticated state training groups to expand our training resources. Initial pilots in Florida (for home health agencies) and California and Texas (long-term care facilities) were successfully completed and evaluation measurements showed that MAT instruction produced results comparable to our other training resources.

Web-Based Training (WBT). The CMS has continued to add resources to the online curriculum. Most notable in FY 2010 were the widespread acceptance of the online Basic Life Safety Code and Office of Civil Rights courses. More satellites will be made available in FY 2011. Satellites and traditional WBT tools are typically for shorter training messages, while longer items are placed on the Blackboard learning management system. Select courses, such as the Minimum Data Set (MDS) training, is placed in the traditional WBT setting to allow for provider access to the training. Tens of thousands of “hits” have been received for these trainings.

Eight basic surveyor training courses in Health Surveys and three in Life Safety Code (LSC) currently are offered. To make training more readily available, CMS created and piloted what CMS calls the Virtual Classroom (Blackboard) version of the LSC Basic. This allows surveyors to access training at any time of day via the internet and to still have opportunities for interaction between students and instructors. This is a live-instructor-facilitated training and goes beyond the depth and complexity of WBT available through other mediums. Evaluation of this process showed that the Virtual Classroom produced results measurably better than that of the traditional classroom version. This has been replicated multiple times since the pilot. The CMS is now adding additional components of the LSC series of training to the online environment and anticipates having these online by the end of FY 2012.

Specialized training on the National Fire Protection Association Standard for Gas and Vacuum Systems (NFPA 99). Classes are offered annually on this topic depending upon the SAs projections of needs for surveyors in this class.

Complaint Investigation and Supervisory Review Training. Begun as a response to areas identified in the Affordable Care Act, this two-part project encompasses the creation of advanced training for

surveyors and their managers in the skills needed to more effectively complete a (1) a complaint investigation, and (2) review of documentation from the survey to determine whether it is complete and supports assertions in survey documentation. A needs assessment began in November 2010 and will lead to the design and development of the trainings.

In addition to classroom training for basic courses, satellite broadcasts and webcasts have been increased and archived by CMS for later viewing. These are on relevant clinical and program topics to increase consistency and understanding of Federal requirements among surveyors and providers. In FY 2008 we had more than 94 titles for surveyors' use. The webcasts, satellites, and related videos are generally available for one year after they are first presented, but it is possible to keep topics of interest for longer periods. Subject matter experts (SMEs) extend the life of these training tools at the end of each year to assure that the materials are still current. DVDs and CDs have been distributed to CMS, ROs and major stakeholder groups.

Finally, to assure a sustainable, trained workforce, a specialized contractor will review outcomes of relevant studies mentioned above to create a more robust integration of training topics that include elements of ACTS, complaint investigation, basic surveyor, and other advanced or specialized skills. The outcome of the contractor's work will produce a "life cycle" curriculum for both new and established surveyors. This life cycle curriculum is being developed incrementally in priority order, pilot-tested, and launched. Then this training is linked into a sequence of training. For example, a new surveyor now takes the Basic LSC Class, followed by the FSES/Health Care and NFPA 99 trainings. Then these surveyors are considered fully qualified to survey in all areas of the LSC that apply to regulated entities.

K. Surveyor Testing

Background

OBRA '87 requires that all surveyors of Medicare/Medicaid certified nursing homes meet minimum qualifications and complete training and testing programs. In response to the OBRA '87 mandate, CMS developed the Surveyor Minimum Qualifications Test (SMQT). Surveyors must successfully complete the SMQT to survey nursing homes independently. The SMQT is periodically updated to remain consistent with new survey guidance. In advance of the release of changes in long-term care guidance, the CMS contractor does a search of the item bank for all test questions related to the subject of the new guidance. The steps involved in the process consist of the following:

- Subject Matter Experts (SMEs) write new questions
- SMQT contractor completes the first review of new questions
- Questions are reviewed by CMS SMEs
- Questions that are inconsistent with new guidance are deleted or edited to be consistent with current guidance
- When questions require major changes, they are added to the review of new questions at a pilot-test meeting of SMEs selected from ROs and states
- Questions that survive both reviews are then field tested before they are included in the item bank
- New questions are currently being written by SMEs who are considered experts by the Regional Offices and State Survey Agencies

- These new questions will go through the same review process before they are added to the item bank.

Field testing of the SMQT questions was completed in June 2010.

L. Notice of Facility Closure of Nursing Homes

Background

Section 1128I(h) of the Social Security Act, as added by section 6113 of the Affordable Care Act specifies that nursing home administrators (NHA) meet stated requirements when a nursing home is closing. Specifically, the NHA must notify the State, CMS, long-term care ombudsman, residents of the facility, and legal representatives (or other responsible parties) 60 days prior to closure. The NHA must also ensure that the facility does not admit new residents and the facility must provide a plan for the transfer and adequate relocation of residents. Lastly, the Act requires that CMS impose CMPs against the NHA (up to \$100,000) for failure to meet closure notice requirements as published as an interim final rule in the *Federal Register* in February 2011. In April 2011 an S&C Memo was issued to the State Survey Agency Directors highlighting the regulations of Section 6113 of the Affordable Care Act “Notification of Facility Closure” with a copy of the interim file rule.

M. Complaint Consistency Workgroup

Background

In the Fall of 2010, the Training Division of CMS Central Office established the Complaint Investigation and Supervisory Review (CI/SR) and Long Term Care (LTC) Analysis Tasks under a CMS Contract. The objectives of this project were:

- To gather information concerning the investigation of complaints and supervisory review in SAs and ROs,
- To identify the challenges facing those agencies in performing these tasks,
- To investigate causes of under-citation of deficiencies and obtain information from stakeholder groups about their perception of current problems with the complaint investigation process.

In March 2011, the Complaint Consistency Workgroup was established in response to the Government Accountability Office (GAO) Draft Report: “Nursing Homes: More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations (GAO-11- 280).” The report focuses on the timeliness and adequacy of complaint investigations and CMS’s oversight at the Central and Regional Office levels.

The Complaint Consistency Workgroup was formed to improve consistency in:

- SA’s complaint intake and triage procedures (including prioritization and processing);
- Use of the ACTS (ASPEN Complaint Tracking System) database;
- Survey investigations, substantiation/ decision making, reporting of results (disclosure of information to complainants);

- Regional Office oversight of the procedures and investigations conducted at the SA level; and,
Surveyor investigative skills (which include creation of training components).

The Complaint Consistency Workgroup includes 5 subgroups that focus on the following areas:

- Intake and triage;
- Revision of the *State Operations Manual* (SOM), including SOM Chapter 5 and Appendix Q;
- Investigative skills for surveyors;
- SA/RO burden (effectively addressing resource limitations while improving the complaint process); and,
- Aspen Complaint Tracking System (gathering, analyzing, and monitoring complaint data in ACTS).

State Agency and Regional Office (RO) members were invited to participate by CMS Central Office Workgroup leadership. Each member brings unique talents to the Workgroup based on experience and/or expertise of complaint investigation processes, and associated State and Federal survey processes and regulations. A Complaint Consistency Steering Committee was formed to ensure continued efforts and to enhance discussions across all subgroups and is composed of the subgroup chairs and co-chairs, RO personnel and contractors.

An initial Steering Committee project will include a brief survey that is conducted with each State Agency to determine their current complaint processes and training methods. The results of the survey will be utilized to determine inconsistencies across the State Agencies and obtain necessary information to move forward with each subgroup's proposed deliverables and timelines.

Extensive collaboration between the subgroups is necessary to ensure new materials, tools, guidance and/or strategies are developed with consistency and that the action plan for 2012 is comprehensive.

3. Promote Quality Improvement

The CMS promotes a system-based, comprehensive program of quality improvement as well as improvement in a number of specific areas. These areas include reduction in the incidence of preventable pressure sores and reduction in the extent to which physical restraints are used in nursing homes.

A. Government Performance and Results Act (GPRA) Goals

Background

The CMS has two goals specifically related to improving care in nursing homes: reduce pressure ulcers and reduce injurious falls. Although CMS is working diligently to address these problems, disparities in the rates of these adverse events remain among regions, states, and across nursing homes.

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 Project™ 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 CCTP 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.

Reports to Congress: Plans for a Value-Based Purchasing Program for SNFs and HHAs

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; and
- 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).”