CMS Measurement System Helps Nursing Facilities Improve Resident Care

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Measuring the quality of clinical care in skilled nursing facilities can be a challenging task; however, the Centers for Medicare & Medicaid Services (CMS) is committed to ensuring that Americans receive top-quality care in nursing facilities around the nation. As a result, CMS has launched the National Nursing Home Quality Care Collaborative and has developed a measurement scale that monitors the improvements being made by participating organizations.

CMS’ new measurement system is referred to as the Quality Measure Composite Score. It is calculated by assessing nursing homes on 13 quality measures related to long-stay residents’ care and quality of life. These 13 measures, which also are currently reported on Nursing Home Compare (www.medicare.gov/nursinghomecompare), identify how each facility is performing in relation to the percentage of residents who:

- Experience one or more major falls with an injury.
- Contract urinary tract infections.
- Self-report moderate to severe pain.
- Develop pressure ulcers.
- Experience loss of bowels or bladder.
- Have a catheter inserted or left in bladder.
- Are physically restrained.
- Need increased help with activities of daily living.
- Lose too much weight.
- Have depressive symptoms.
- Receive antipsychotic medications.
- Receive flu and pneumonia vaccines.

Since higher rates in these areas indicate the occurrence of the condition, a nursing home’s performance against these measurements can be one indicator of the quality of care delivered in the facility. The CMS goal is that all American nursing homes earn a Quality Measure Composite Score of six percent or less, or make improvements in their care to reach this score. In an effort to assist skilled nursing facilities in reaching these CMS standards, the National Nursing Home Quality Care Collaborative strives to (1) install quality and performance improvement practices, (2) eliminate
American Health Care Association Demonstrates Long Term Commitment to Quality by Expanding National Initiative

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The American Health Care Association (AHCA) Board of Governors in 2010 challenged itself to take a bold step and publicly set measurable and shocking goals for quality improvement for skilled nursing facilities and assisted living communities. We debated at length what goals we should set that would have the most significant impact on the lives of those for whom we care. We challenged ourselves to track our performance and hold ourselves accountable, both internally and publicly. In the end, we agreed that “some is not a number and soon is not a date.” In other words, we needed to set measurable goals to be achieved by a specific date. We also agreed that the goals needed to be aggressive – they would be difficult to reach, but if we achieved them, the results would be shocking. We would be making a strong statement that the profession was committed to providing quality care.

As a result of that Quality Initiative, which was officially launched in 2012, AHCA members have achieved reductions in the use of antipsychotics and in hospital readmissions. Specifically, member organizations safely reduced the off-label use of antipsychotic medications by 21.2 percent compared to the national average of 19.4 percent in the fourth quarter of 2014. As a result, 33,100 individuals are no longer receiving these medications. For hospital readmissions, AHCA members successfully prevented 40,424 individuals from returning to the hospital — a 14.2 percent reduction since 2011.

AHCA recently announced the expansion of this nationwide, multi-year initiative to improve quality care in skilled nursing care centers. Building on the progress achieved by the profession over the last three years, the next phase of the initiative includes eight measurable targets with a strategic focus on three priorities: improvements in organizational success; short-stay/post-acute care; and long-term/dementia care. The goals and priorities have been established to improve lives and deliver solutions for the patients, residents and families we serve.

The goals of the Association’s Quality Initiative for the next three years include new areas of focus for quality enhancement. The eight target areas and priorities are:

**Improve Organizational Success by:**
- Increasing staff stability by decreasing turnover among nursing staff by 15 percent or achieve and maintain a turnover rate of 40 percent or less by March 2018;
- At least 25 percent of members measuring and reporting long-stay resident and family satisfaction and/or short-stay satisfaction using the Core-Q survey;
- Reducing the number of unintended health care outcomes by March 2018

**Improve Short-Stay/Post-Acute Care by:**
- Safely reducing the number of hospital readmissions within 30 days during a skilled nursing center stay by an additional 15 percent or achieve and maintain a low rate of 10 percent by March 2018;
- Improving discharge back to the community by 10 percent or achieve and maintain a high rate of at least 70 percent by March 2018;
- At least 25 percent of members adopting and using the mobility and self-care sections of the CARE tool and report functional outcome measures using LTC Trend Tracker;

**Improve Long-Term/Dementia Care by:**
- Safely reducing the off-label use of antipsychotics in long-stay nursing center residents by an additional 10 percent by December 2015 and 15 percent by December 2016;
- Safely reducing hospitalizations among long-stay residents by 15 percent or achieve and maintain a low rate of 10 percent or less by March 2018.

Quality improvement is a journey, and the next three years of the Quality Initiative will position nursing care providers to achieve even greater successes in improving outcomes for their patients and residents. This is an exciting initiative that I am proud to be a part of. I am even more proud to be part of a profession which is willing to publicly set goals for improvement and hold ourselves accountable to reaching those goals and dramatically improving the lives of those entrusted to our care.
Person Centered Care and Care Plans

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Person-centered care is taking hold in Ohio nursing facilities. Person-centered care is an approach to learn and honor a resident’s preferences, strengths, and needs. While this monumental movement has been slowly spreading across the country, the question remains: how does it actually work day-to-day? The answer lies, in part, within a resident’s plan of care.

A plan of care, or “care plan,” is meant to be a blueprint for meeting each resident’s needs as identified in a comprehensive assessment. A well-thought-out and collaborative care plan should address physical, emotional, spiritual, and social needs – all aspects of life. It is important to create a care plan with the resident, not just about the resident.

Typically, care plans are developed and revised during care conferences that must occur at least quarterly. Residents and, if desired, family or a representative should participate in the meeting to ensure that care and services are personalized and include preferences. Residents should feel free to discuss their preferences and any successes and problems they have experienced. Key members in the care team should be present and often include the Director of Nursing, Social Worker, Therapist, Activities, State-Tested Nurse Aides, and nurses. If there is a specific aide and/or nurse who knows the resident well, they should participate as well.

Residents and their representatives can take steps to ensure that care plans reflect what is most important. Below are tips for effective preparation and participation:

- Make a list of questions
- Go to the meeting with a goal
- Identify timelines (e.g., I want to return home after rehabilitation within two months)
- Preferences such as personal hygiene, food, beverages, sleep habits, leisure activities
- Priorities (If your favorite foods aren’t available as often as you would like them, what are some alternatives?)

Residents and representatives should feel comfortable to ask questions anytime, not just during meetings. For example:

- What options are available for the things that are important?
- Ask about medical terms that are unfamiliar.
- If I have a problem with my shower routine, who can change it?
- Ask for a copy of the care plan. It should be written in language that is clear.

To illustrate what a care plan might look like, consider the example of Mrs. Smith who prefers to take her showers every evening after dinner. Her care plan might look like this:

- Mrs. Smith requests a shower every day after dinner.
- Goal: Independent showers
- Assigned aide or nurse will offer a shower after the evening meal or by 6:30 p.m.
- Mrs. Smith will gather her preferred soap and shampoo and dress in a robe. She is able to wash her upper body but needs help with lower legs.
- Therapy will suggest exercises to help Mrs. Smith’s flexibility so that she can shower independently.
- Goal date: 1/1/16

This is an example of a plan that will help Mrs. Smith achieve her highest level of well-being. It is written in common language that can be easily understood by everyone involved. Although Ms. Smith receiving her showers every evening may not sound like a major request, it is an identified preference for the resident and now that it is included in her care plan, all staff is required to follow her plan of care.

Residents have the right to be included in care planning, to have their preferences honored, and most importantly, to have their plan of care implemented. When everyone works together on person-centered care, residents, families, and staff all benefit.
Celina Manor Earns AHCA/NCAL Silver Quality Award

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Celina Manor, a 110-bed, dually certified skilled nursing facility located in rural Mercer County in Northwest Ohio and providing services for over 35 years, recently received the 2015 American Health Care Association and National Center for Assisted Living (AHCA/NCAL) Silver – Achievement in Quality Award for excellence in providing long-term care.

Our care community provides the disabled and seniors in our community a range of services in a homelike, patient-centered care environment that promotes quality of life. These services include: short-term skilled nursing; short-term rehabilitation care providing physical, occupational, and speech therapies; long-term care; Alzheimer’s care; restorative nursing program; respite care; hospice care; and outpatient rehabilitation.

Within this we offer a number of skilled nursing services, including but not limited to wound management, IV therapy, and tracheotomy care. These post-acute medical services are tailored to meet the individual health care needs of the patient. Additionally, our facility partners with Heritage Home Health to provide continuity of care when a resident is ready and able to return home.

The team at Celina Manor focused its quality improvement efforts through our QAPI program and the use of PDSA improvement plans. As a result of these programs, we have achieved quality improvement through a number of indicators, but especially with re-hospitalizations and pressure ulcers.

Re-hospitalization of our Medicare Patients became a focus for us dating back to 2012. We began to monitor our rates and evaluate why our patients were being re-hospitalized. Focusing efforts on developing a CHF Pathway Program through our QAPI efforts and partnering with experts in the hospital setting, we developed a comprehensive program to prevent re-hospitalization. In addition, we provided education and outreach to our employee stakeholders and our community. Since, our hospitalization rate has trended well below the state and national averages.

With the Quality Assurance Process our team has been able to control pressure ulcers in high risk residents. Utilizing our QAPI Process and Plan, we employed a Wound Care Nurse who made rounds each week and as needed. Since then, our team has been able to continue to trend below state and national averages for pressure ulcers.

Celina Manor has recently received numerous awards, including a deficiency-free health and Life Safety survey in 2014 and the 2014 Business of the Year Award for our strong business development efforts in Mercer County. The 2015 AHCA/NCAL Silver – Achievement in Quality Award adds to a banner year for our care community, and further displays a commitment to improvement.

Our facility is proud and honored to have received the 2015 AHCA/NCAL Silver – Achievement in Quality Award. We believe this prestigious award to be an excellent indicator of the high quality care we are providing – and a reflection of the dedication and commitment that our care team has displayed throughout our history in Celina.
Supportive Living Facilities and Medicaid Waivers: Addressing the Wave of Low- and Moderate-Income Seniors

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In 2011, the Baby Boomer wave began to crash upon the shores of retirement. By 2030, 72.8 million Americans will be over the age of 65, an increase from 43.1 million in 2012. While developments in health care have added quality as well as quantity to the average lifespan, aging often still brings the need for assistance with Activities of Daily Living (ADLs). Many individuals retain the majority of their physical and mental abilities and yet still require some assistance with one to three ADLs. A segment of these individuals without the physical capacity to care entirely for themselves are low- to moderate-income seniors unable to afford traditional assisted living (AL) services. These individuals present an opportunity for operators and states to think creatively about how best to care for their financial, physical and mental needs.

In past years, a low- to moderate-income individual requiring any level of assistance would likely have had only one option through Medicaid: a skilled nursing facility (SNF). While these facilities meet residents’ physical needs, such settings may not be appropriate for all seniors, particularly those needing assistance with a minimal number of ADLs. For such individuals, it is important for them to maintain a sense of freedom and independence in a supportive setting, and the full spectrum of care offered in a SNF may curtail that independent spirit. In addition, a state’s Medicaid payment for an AL facility may be 60% of the cost of a SNF, generating potential Medicaid cost savings for the state.

Medicaid is designed to offer health care for vulnerable Americans, and the dramatically increasing number of seniors will continue to place pressure on these budgets. Gardant Management Solutions, the largest provider of affordable AL services in the country, reports that 70% of seniors with income less than 60% of the Area Median Income (AMI) ($26,000 to $32,000) have less than $10,000 in assets. By 2024, 6.5 million 50-and-over households will have income under $15,000, a 37% increase in a single decade. As these seniors look to Medicaid for assistance in finding safe and affordable housing, states have the opportunity to be proactive about preparing solutions for the level of care desired.

Supportive Living Facilities

Illinois is an example of a state attempting to proactively address the financial crunch while simultaneously ensuring that low- to moderate-income seniors can have access to affordable housing that meets their physical needs. Starting in the mid-1990s, Illinois launched Supportive Living Facilities (SLFs) with the “aim of preserving privacy and autonomy while emphasizing health and wellness for persons who would otherwise need nursing care.”

There are numerous funding options for those looking to construct SLFs. Agency and private sector debt capital can be used, as well as both private equity and low-income housing tax credit (LIHTC) equity. The program works well with U.S. Department of Housing and Urban Development (HUD)/Federal Housing Administration (FHA) Sec. 232 financing because it focuses on low-income individuals, which matches HUD’s mission to assist vulnerable populations.

Medicaid Waivers

Another existing program that can serve as a pressure release valve on state budgets is Medicaid waivers. These waivers offer income, age, and need-qualified senior candidates alternatives to SNFs by steering them towards solutions that are most appropriate to their needs while also offering the state significant savings. Indiana is using Medicaid Aged and Disabled waivers to support individuals who might otherwise require care in a nursing facility. These waiver services offer flexibility to the recipients, allowing the individual to remain in their own home or to be in a community setting such as apartments or AL.

Indiana and Illinois provide two examples of states addressing the growing demographic of low- and moderate-income seniors who need assistance with ADLs but are not in need of the full scope of care provided by a SNF. An economic and political opportunity exists on both the state and federal levels for creative solutions that will both best serve seniors in need of affordable options while simultaneously relieving some of the pressure on Medicaid budgets.

As the demographic wave continues to swell and an increasing number of seniors look to the states for assistance, more innovative thinking will be required to ensure that the financial, physical and mental needs of seniors are met amidst the economic constraints of state and federal budgets.
healthcare-acquired conditions, and (3) dramatically improve resident satisfaction by focusing on the systems that impact quality. Health Services Advisory Group (HSAG) is the Medicare Quality Improvement Organization (QIO) that is responsible for organizing the Collaborative in Ohio.

By educating Ohio nursing homes about the forthcoming CMS regulations that require Quality Assurance & Performance Improvement practices as well as upcoming changes in the Medicare payment system to reimbursing for quality of care versus quantity of care, HSAG is helping Ohio nursing homes to actively improve their care delivery and decrease their Quality Measure Composite Score. Currently, more than 440 Ohio nursing facilities are enrolled in the Nursing Home Quality Care Collaborative, and 58 of the participating facilities have already met or surpassed the CMS Composite Score target.

Overall, the state Composite Score average is also improving. March 2015 data reveal an average Composite Score of 9.2 percent across the state, with May data showing the average dropping to 8.9 percent. To learn more about the Collaborative and the efforts being made to improve the quality of care delivered in Ohio nursing homes, visit www.hsag.com/ohnursinghome. When it comes to using data and measuring the quality of care, CMS, HSAG, and Ohio facilities are working together in unprecedented ways.

Faces of Long-Term Care

Many Ohioans have had their lives touched by long-term care as a resident, care provider, family member or loved one. Even if they have not had direct experience, chances are they know someone who has.

*Faces of Long-Term Care* is an initiative to give a voice and public presence to residents and caregivers through a variety of forums. The Ohio Health Care Association is working with the American Health Care Association (AHCA) to establish a presence on Facebook, websites and other social media featuring the images and words of residents, family members, caregivers and others.

The first step in this initiative features a series of weekly “Faces of Long-Term Care” posts to the OHCA Facebook page, which have resulted in numerous “likes” and re-posts. In addition, AHCA/NCAL has established a “Faces of Assisted Living” website that will serve as the base for future efforts.

Providers, family members and residents who would like to take part in this program can post images, stories and quotes directly to the Association’s Facebook page. Providers posting images or quotes from residents should have signed releases in the residents’ files.

Watch for future activity as this initiative kicks off. *Faces of Long-Term Care* is designed to grow into a rewarding community where participants can share and enjoy the experiences and successes of others.

**Care Conversations: Changing the Conversation**

Seventy percent of us will need long-term care after age 65, yet few of us openly discuss care needs and wishes.

**Care Conversations** ([http://careconversations.org/home.aspx](http://careconversations.org/home.aspx)) is bringing people together to change this conversation trend. The website provides information and resources to get people talking with loved ones, health care providers and industry experts. Working together, we can plan and prepare for our future and ensure care needs are met every step of the way.

Conversations focuses on people and the honest discussions needed to plan and prepare for the future. Finding care may seem difficult or even overwhelming at first. Whether you’re seeking care for yourself or for a loved one such as a spouse, parent or sibling, Care Conversations can help you every step of the way. Worry less about tomorrow. Start a conversation today.

**Getting Started with Care Conversations**

Because everyone’s situation is different, no two Care Conversations will be the same. The website helps you start a conversation, explore options, and find solutions that are right for you. The website allows users to:

- Hear others share their personal experiences.
- Watch featured conversations throughout the site and in the video library.
- Learn how to start a Care Conversation.