



CMA Weekly Alert – September 21, 2006

THE “NEW” NURSING HOME QUALITY CAMPAIGN: DÉJÀ VU ALL OVER AGAIN

On September 29, 2006, the nursing home industry and the Centers for Medicare & Medicaid Services (CMS) will unveil a “new” quality campaign, *Advancing Excellence for America’s Nursing Home Residents*. Unfortunately, the campaign is not new; it repeats the industry’s same, but unfulfilled, promise to improve care for residents. Most troubling, the campaign presents itself as a different way for the public to evaluate the care provided by nursing facilities. As an alternative to the public regulatory system’s unannounced surveys, citation of deficiencies, and enforcement actions, which are publicly disclosed, the campaign sets out a voluntary and secret system of goals and targets and promises less than federal law currently requires.

The two-year “voluntary” campaign has eight goals, with participating facilities selecting at least three:

1. Reduction in high risk pressure ulcers
2. Reduction in the use of daily physical restraints
3. Improvement in pain management in long-stay residents
4. Improvement in pain management in short-stay (post-acute) residents
5. Setting individualized quality improvement targets
6. Regularly assessing resident and/or family satisfaction and incorporating this information in their quality improvement activities
7. Regularly measuring staff turnover and working to reduce turnover rates
8. Adoption of consistent assignment whereby residents are regularly cared for by the same caregiver¹

Although the goals may seem laudable, the campaign is actually a step backwards in efforts to improve quality of care and quality of life for nursing home residents.

The campaign’s four clinical goals (listed as goals 1-4, above) and one quasi-clinical goal (goal 5, above) set a standard of care that is lower than the standard of care mandated by the federal Nursing Home Reform Law, and thus undermine compliance with federal law.²

While the Nursing Home Reform Law (1987) sets high standards of care for nursing homes that receive Medicare reimbursement or Medicaid reimbursement, or both, and requires facilities to provide care and services to attain or maintain each resident’s “highest practicable physical, mental, and psycho-social well-being,”³ the campaign implicitly accepts non-compliance by condoning lower performance goals. For example, federal regulations addressing pressure ulcers state

¹ Letter of invitation to Summit meeting (Aug. 14, 2006).

² 42 U.S.C. §§1395i-3(a)-(h), 1396r(a)-(h), Medicare and Medicaid, respectively.

³ 42 U.S.C. §§1395i-3(b)(2), 1396r(b)(2), Medicare and Medicaid, respectively.

- (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and
- (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.⁴

In sharp contrast to the protection for *each* resident that has been mandated by federal law since 1990, the Campaign sets four different, and considerably lower, "objectives" for the goal of preventing and minimizing pressure ulcers for residents as a group:

- a) The national average for high risk pressure ulcers is below 10%.
- b) 30% of nursing homes will regularly report rates of high risk pressure ulcers below 6%.
- c) No nursing home will a report [sic] rate of high risk pressure ulcers that exceeds 24%.
- d) Compared to June 2006, approximately 50,000 fewer residents will have pressure ulcers.⁵

These objectives not only contradict the standard of the Reform Law; they also condone higher percentages of noncompliance with federal law than currently reported by nursing facilities. On CMS's website *Nursing Home Compare*, the national average of high risk residents with pressure sores is reported as 13%, the national average of low risk residents, 2%.

The fifth quasi-clinical measure, "Setting individualized quality improvement targets," (goal 5, above) addresses the same four clinical factors (goals 1-4, above), but is both less prescriptive and totally secret. This measure involves using the Nursing Home STAR Site (Setting Targets – Achieving Results).⁶ STAR allows facilities to define their own goals for improving performance in four clinical areas: physical restraints, high risk pressure ulcers, depression, and chronic care pain. Facilities select individual targets solely for their "internal use;" they are not evaluated on whether they actually achieve their targets. Moreover, whether facilities achieve their goals is not disclosed to survey agencies or to the public. In fact, the STAR website promises complete confidentiality to facilities.⁷

No facility-specific data, other than the quality measures reported on *Nursing Home Compare*, will be publicly disclosed; only aggregate data results will be posted on the campaign website.⁸

The measures of quality that the campaign will use, particularly the pain measures, are not valid indicators of high quality care.

Resident assessment data reported by nursing facilities, but not audited by any government agency, are now posted by CMS on the website *Nursing Home Compare* as "quality measures." Considerable evidence questions the validity of these measures, especially the pain measure, as true indicators of quality:

1. CMS's recently-announced quality-based purchasing demonstration (formerly called pay-for-performance) will not use either of the publicly-reported pain measures "because of concerns about differences across nursing homes in how they assess pain."⁹

⁴ 42 C.F.R. §483.25(c)(1), (2).

⁵ <http://nhqualitycampaign.org/files/NHQualityCampaignGoals.pdf> (site accessed Sep. 13, 2006).

⁶ <http://128.121.248.227/>.

⁷ http://128.121.248.227/star_index.aspx?controls=help#top.

⁸ http://nhqualitycampaign.org/star_index.aspx?controls=goals (site accessed Sep. 14, 2006).

⁹ Abt Associates, Inc., *Quality Monitoring for Medicare Global Payment Demonstrations: Nursing Home Quality-Based Purchasing Demonstration, Final Design Report*, page 43 (June 2006),

2. Independent researchers recognize that the prevalence of resident pain is generally understood to be 45-80%; many times greater than the percentages now publicly reported by facilities. Independent studies found that more than half the residents who reported pain to the researchers had “nurse-assessed pain scores of zero during the preceding month.”¹⁰
3. A CMS-sponsored project, Data Assessment and Verification (DAVE), designed to help facilities conduct more accurate resident assessments, found that facilities had the highest discrepancy rates in their assessments of medications and pain.¹¹
4. Facilities that are objectively found to provide poor care nevertheless can, and do, report good quality measures. *Consumer Reports* recently identified 12 facilities nationwide that had serious quality problems in each of Consumer Union’s annual nursing home reports since 2000. Facilities included in the “Deficient Dozen” report their quality measures as being as good as, and often better than, the statewide averages, particularly in the area of pain reduction. For example, Valley Manor Convalescent Hospital in North Hollywood, California reported data for 11 of the 15 measures.¹² For each of these 11 measures, including the four measures in the new quality campaign, the facility reported performance that was better than the statewide average.¹³

The campaign’s approach is virtually the same voluntary campaign that the industry has repeatedly promoted in the past.

Advancing Excellence in America’s Nursing Homes is not new in either its sponsorship or its content. Both the clinical and the non-clinical measures have been the subject of prior quality campaigns promoted by the nursing home industry.

In July 2002, the three national nursing home trade associations – the American Association of Homes and Services for the Aging, the American Health Care Association, and the Alliance for Quality Nursing Home Care – jointly announced a four-year campaign, *Quality First: A Covenant for Healthy, Affordable and Ethical Long Term Care*, which promised demonstrable improvement in many of the same clinical areas as the new campaign and in two identical non-clinical measures, improved customer satisfaction and reduced staff turnover.¹⁴ (The single new component in the 2006 campaign

<http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=data&filterValue=Upcoming%20Demonstrations&filterByDID=2&sortByDID=3&sortOrder=ascending&itemID=CMS042090>

¹⁰ Anna Rahman, “Debate Looms on CMS Use of Pain Measure in Nursing Homes,” *Aging Today*, Vol. XXVI, No. 2 (Mar.-Apr. 2005),

<http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=data&filterValue=Upcoming%20Demonstrations&filterByDID=2&sortByDID=3&sortOrder=ascending&itemID=CMS042090>. Quality Improvement Organizations report that moderate daily pain or severe pain any time in the past seven days declined from 10.5% to 6.8% and pain in short-stay residents declined from 24.9% to 22.5% following their work with nursing facilities. William Rollow, et al, “Assessment of the Medicare Quality Improvement Organization Program,” *Annals of Internal Medicine*, Vol. 145, No. 5, 342 (Sep. 2006), <http://www.annals.org/cgi/reprint/0000605-200609050-00134v1.pdf>.

¹¹ GAO, *Nursing Homes: Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety*, GAO-06-117, page 34, note 50 (Dec. 2005), <http://www.gao.gov/new.items/d06117.pdf>.

¹² *Nursing Home Compare* for this facility was accessed on August 8, 2006.

¹³ On pressure ulcers, it reported 0% of low-risk residents who had pressure sores, compared to the statewide and national average of 2%; it reported no information on high-risk residents or short-stay residents who have pressure sores. On restraints, it reported 13% restraint use, compared to the statewide average of 14% and the national average of 6%. It reported no information on short-stay residents with moderate to severe pain; it reported 2% of residents have moderate to severe pain, compared to the statewide and national averages of 5% (site accessed Aug. 8, 2006).

¹⁴ As part of the Covenant, the trade associations announced EXPECTED OUTCOMES by 2006:

1. There will be continued improvement in compliance with federal regulations.
2. There will be demonstrable progress in promoting financial integrity and preventing occurrences of fraud.

is the last measure, consistent assignment of staff.) *Quality First* was a companion to CMS's *Nursing Home Quality Initiative* announced earlier in 2002, which involved reporting 15 clinical measures as quality measures (including the four measures in the new campaign), and providing technical assistance to nursing facilities, through Quality Improvement Organizations, to improve performance in these same areas.¹⁵

The industry-sponsored *Quality First* Initiative was itself not new. Paul Willging, former president of the American Health Care Association, described *Quality First* as similar to the *Quest for Quality* program that AHCA initiated in the early 1980s during his tenure. Writing in *Nursing Homes and Long Term Care Management* in January 2005, Dr. Willging described the industry's *Quality First* campaign:

*Nothing is really new about "Quality First" except some repackaged programs. I recall, during my tenure as president of the American Health Care Association (AHCA), launching a similar project, also within the context of quality management. Materials were produced; sound bites were developed; and the media were engaged. And I doubt whether we changed any more minds about the industry's intentions than will the current initiative.*¹⁶

Conclusion

Nursing facilities must provide high quality of care and high quality of life to each of their residents. This is the standard of care set out in federal law and it is the standard by which facilities are paid by the Medicare and Medicaid programs.

Improving the quality of nursing home care for residents is necessary and long overdue. That goal is not achieved, however, by watering down the standards of care, by allowing facilities to set their own undisclosed goals and targets for improvement, or by reducing the federal law's focus on individual residents. The goal will be met when nursing facilities improve their staffing and fully comply with the Nursing Home Reform Law.

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3. There will be demonstrable progress in the quality of clinical outcomes and prevention of confirmed abuse and neglect.
 4. There will be measurable improvements in all Centers for Medicare and Medicaid Services Continuous Quality Improvement measures.
 5. High satisfaction on consumer satisfaction surveys will indicate improved consumer satisfaction with services.
 6. There will be demonstrable improvement in employee retention and turnover rates.

<http://qualityfirstnursinghomes.com/> (site accessed Aug. 11, 2006).

¹⁵ http://www.cms.hhs.gov/NursingHomeQualityInits/01_Overview.asp (site accessed Aug. 11, 2006).

¹⁶ Paul Willging, "It's time to take the politics out of nursing home quality," *Nursing Homes and Long Term Care Management* (Jan. 2005), http://www.nursinghomesmagazine.com/Past_Issues.htm?ID=3785.