CMS
CENTERS for MEDICARE & MEDICAID SERVICES

2007
Action Plan for
(Further Improvement of)
Nursing Home Quality

September 2006

Executive Summary

About 1.5 million Americans reside in the Nation's 16,400 nursing homes *on any given day*. And more than 3 million Americans rely on services provided by a nursing home *at some point during the year*. Those individuals, and an even larger number of their family members, friends, and relatives, must be able to count on nursing homes to provide reliable care of consistently high quality.

The Centers for Medicare & Medicaid Services (CMS) establishes quality of care standards and conditions of participation for the Medicare and Medicaid programs. Such requirements are carefully crafted to highlight key areas of quality and convey basic, enforceable expectations that nursing homes must meet. More than 4,000 Federal and State surveyors conduct on-site reviews of every nursing home at least once every 15 months (and about once a year on average). CMS also contracts with quality improvement organizations (QIOs) to assist nursing homes to make vital improvements in an increasingly large number of priority areas. Additionally, CMS supports the Health and Human Services Economic Impact of Health Care Regulations. The goal of this project is to examine the economic impact of major Federal regulations governing the health care industry and identify strategies for simplifying them, while maintaining the highest quality health care and other resident protections.

The most effective approach to ensure quality is one that mobilizes all available tools and aligns them in a comprehensive strategy. This action plan summarizes our comprehensive strategy. It consists of five inter-related and coordinated approaches:

A. ***Consumer Awareness and Assistance:*** Elderly individuals, people who have a disability, their families, friends, and neighbors are all essential participants in ensuring the quality of care in any health care system. The availability of relevant, timely information can significantly help such individuals to be active, informed participants in their care. This information also can increase the ability of such 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. The CMS Web site, www.Medicare.gov, features "Nursing Home Compare" as well as other important information and education resources for consumers, families, and friends.

B. ***Survey, Standards, and Enforcement Processes:*** During 2007, we will undertake more than 14 initiatives, to improve the effectiveness of the annual nursing home surveys, as well as the investigations that are prompted by complaints from consumers or family members about nursing homes.

C. ***Quality Improvement****:* We are promoting a program of quality improvement in a number of key areas. These areas include reduction in the extent to which restraints are used in nursing homes, reduction in the prevalence of preventable pressure sores that threaten the health and well-being of a significant number of nursing home residents, and the Agency's participation in part of a national movement known as "culture change." Culture change principles echo OBRA 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 concept of culture

change encourages facilities to change outdated practices to allow residents more input into their own care and encourages staff to serve as a team that responds to what each person wants and needs.

D. ***Quality Through Partnerships:*** No single approach or actor can fully assure quality. We must combine, coordinate, and mobilize many actors and many techniques through a partnership approach. The QIOs, State survey agencies, and others are committed to such a common endeavor. The differences in their responsibilities remain, but their distinct roles can be coordinated in a number of appropriate ways to achieve better results than can be achieved by any one actor alone. In addition, we plan to strengthen our partnerships with non-governmental organizations who are also committed to quality improvement in nursing homes. We are partnering with stakeholders to facilitate the *Advancing Excellence in America's Nursing Homes* Campaign meeting on September 29, 2006. The unprecedented, two-year collaborative campaign seeks to better define quantitative goals in nursing home quality improvement. The purpose of this summit will be to align the strategies of the many partners who have expressed their commitment to excellent nursing home quality.

E. ***Value-Based Purchasing:*** As the largest purchaser of nursing home services (about $64 billion per year), States and CMS exert leverage to insist on basic levels of quality. "Purchasing power" is an important tool that might be more effectively employed to promote quality in the future. The Nursing Home Value-Based Purchasing Demonstration is intended to augment and reinforce other quality efforts by ensuring that financial investments made by nursing homes to improve quality will be met by payment methods that can discern the difference between excellent, mediocre, and poor quality. The Post Acute Care Instrument Development & Demonstration implements the Deficit Reduction Act of 2005 mandate for a demonstration that supports post-acute care payment reform

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Action Plan for Further Improvement of Nursing Home Quality

Purpose

In this report we set forth our action plan for the continued improvement of quality in nursing homes. Five coordinated sets of actions make up our comprehensive strategy:

1. Consumer Awareness and Assistance
2. Survey, Standards, and Enforcement Processes
3. Quality Improvement
4. Quality Approaches Through Partnerships
5. Value-Based Purchasing

Action Plan

In the past 7 years, the Centers for Medicare & Medicaid Services (CMS) and the States have made progress in holding nursing homes accountable for meeting health and safety standards and improving care. In the process CMS has:

- Revised the survey process to focus on the quality of care and the prevention of abuse and neglect;
- Strengthened enforcement responses to non-compliant nursing homes;
- Provided better information to help consumers make decisions on choosing a nursing home;
- Developed and reported on quality measures, such as the prevalence of pressure ulcers, incontinence, and physical restraints;
- Worked with quality improvement organizations (QIOs) to assist nursing homes in meeting health and safety requirements; and
- Built improved infrastructure for the survey and certification system, such as a new ASPEN Complaints/Incidents Tracking System (ACTS) and the ASPEN Enforcement Manager (AEM) to identify and track needed improvements in the quality of care.

Based on our own analysis, input from Congress, comments from our stakeholders, and work from both the Government Accountability Office (GAO) and the Department of Health and Human Services (DHHS) Office of Inspector General, it is clear that further refinements and new initiatives are essential in order to ensure that nursing home residents can count on adequate support and services in a caring and safe environment.

The themes outlined in this action plan will guide CMS efforts to continue progress in improving the nursing home survey and certification program. We invite public comment on this action plan and welcome the opportunity to discuss with all stakeholders the various methods by which we can work together to ensure optimum services and support, in all settings, for our Nation's elderly and disabled. Please submit comments to Ms. Kathleen Wilson, Ph.D., at kathleenwilson@verizon.net.

A. Consumer Awareness and Assistance

Elderly individuals, people who have a disability, their families, friends, and neighbors are all essential participants in ensuring the quality of care in any health care system. The availability of relevant, timely information can significantly help such individuals to be active, informed participants in their care. Such information can also increase the ability of such 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 Web site, www.Medicare.gov, features "Nursing Home Compare" (NHC) as well as other important information for consumers, families, and friends. Companion CMS Web sites, such as "Home Health Compare" and the President's *New Freedom Initiative*, offer useful information regarding non-institutional alternatives.

We continuously seek to improve the usefulness of information on our Web sites and will make the following improvements on the NHC Web site in 2007.

1. **Improving Staffing Data on the CMS Web Site–-** The extent to which a nursing home adequately staffs its facility program is a critical factor in the quality of care residents receive. For this reason, CMS publishes information about the staffing in each nursing home on NHC. Because the information is self-reported by nursing homes and has certain limitations, CMS cautions users to view the information with care and only in the context of many other factors (more specifically, family visits to nursing homes in their area).

   In order to provide more accurate consumer information about nursing home staffing, CMS implemented in fiscal year (FY) 2005, a stronger "edit and correction system" to the data that are ultimately placed on NHC. Under the new system, information sent by nursing homes is reviewed. Information that is questionable is sent to the State survey agency (SA) for confirmation or correction. CMS also improved the display of information so that it is more understandable to consumers and consistent with the latest research. Activities during FY 2006 were directed toward further improvements in the accuracy and comprehensiveness of information on NHC. That work will continue into FY 2007.

   In 2007, CMS will: (a) complete the analysis of what would be required for a reporting system that is based on payroll data transmitted electronically to CMS, (b) design a payroll database extract system for use in the Nursing Home Value-Based Purchasing Demonstration, (c) initiate a feasibility study of the national use of the payroll database extract, and (d) improve the comprehensiveness of the staffing information on NHC by collecting information on staff turnover and retention.

   Action steps related to collecting information derived from payroll data ((a, b, c) above) are part of a longer term strategy to improve accuracy of the data compared to the current Online Survey, Certification, and Reporting (OSCAR)-based system (that was originally developed for other purposes). This work is included in a contract that was funded in July 2006. Collection of information on staff turnover ((d) above) will provide a broader range of information to consumers. As described below, these steps will provide consumers with

additional and easier-to-understand information about the effect of nurse staffing on the quality of care available in the facility.

Action Plan	**Date**
After a thorough CMS management review, initiate the drafting of either: (a) proposal for statutory change, (b) a Notice of Proposed Rulemaking, or (c) initiate additional actions that can be taken without the need for new statutory or regulatory changes.	Winter 2006/2007
Develop data reporting requirements for submission of payroll data to calculate measures of staffing.	Winter 2006/2007
Design a payroll database system for use in the Nursing Home Value-Based Purchasing Demonstration.	Winter 2006/2007
Produce specifications for an electronic payroll data extract file for submitting data to calculate staffing measures	Spring 2007
Print and distribute the new OSCAR reporting forms.	Summer 2007
Conduct a feasibility test of the national use of an electronic payroll data extract file.	Fall 2007

2. **Develop Nursing Home Staffing Quality Measure, Phase 2—** The National Quality Forum is developing and implementing a national strategy for health care quality measurement and reporting. The Forum has recommended that CMS include a nurse-staffing quality measure in the set of measures that are publicly reported on NHC. Phase I of CMS' efforts, to measure nursing home staffing, investigated key aspects through literature review and consultation with experts in the field, explored options for collecting relevant staffing data, built a research data file, and constructed draft measures. Phase 2 of the project will consist of validation of draft measures constructed from payroll data and consideration of appropriate case-mix and/or risk adjustment.

Action Plan	**Date**
Develop data reporting requirements for submission of payroll data to calculate measures of staffing.	Winter 2006/2007
Conduct a feasibility test of the national use of an electronic payroll data extract file.	Fall 2007
Produce draft outcome quality measures based on staffing data.	Fall 2007
Produce a draft measure of staff immunization for influenza.	Fall 2007
Analysis of contract staff hours.	Fall 2007

3. **Develop Immunization Measures in Nursing Homes for Public Reporting—** The CMS has partnered with the Centers for Disease Control and Prevention to develop a Nursing Home Immunization Breakthrough Initiative to dramatically increase immunization rates, and decrease illness and death of Medicare and Medicaid beneficiaries living in nursing homes. The goal is to meet *Healthy People 2010* objectives of 90 percent for both influenza and pneumococcal immunization rates of nursing home residents. This will be accomplished through a national quality improvement initiative that will ensure all nursing facility residents are offered and, where appropriate, receive influenza and pneumococcal vaccinations.

   In October 2005, nursing homes began collecting data on the influenza and pneumococcal immunization status of their residents through new items in the Minimum Data Set (MDS), Section W. Routine surveillance of nursing home resident immunization status will not only help bring residents eligible for immunization to the attention of nursing home staff, but will help nursing home facilities, QIOs, SAs, and State and local health departments monitor immunization rates.

   Once national data are compiled, CMS will publish facility-level influenza and pneumococcal immunization rates on the NHC Web site so consumers have more information available to help them compare the quality of care in nursing homes.

Action Plan	**Date**
Add new items to MDS to collect data on influenza and pneumococcal immunization status.	October 2005
Public Reporting of Immunization Rates on Nursing Home Compare.	October 2006
First analysis of data from immunization rates measure September 2007.	Fall 2007

B. Survey, Standards, and Enforcement Processes

We will undertake more than 14 initiatives during 2007 to improve the effectiveness of the annual nursing home surveys, as well as the investigations that are prompted by complaints from consumers or family members about nursing homes.

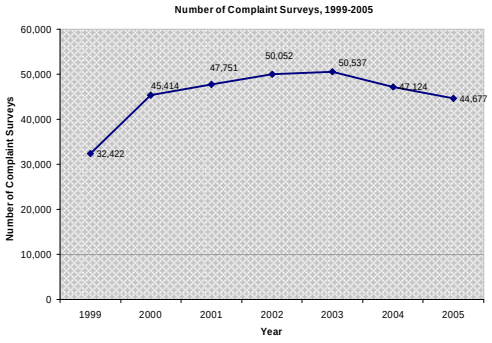
1. **Complaint Investigations—** Prompt and appropriate response to consumer and public complaints regarding services received in a nursing home is a vital protection offered by the Nation's survey and certification system. Since problems may occur between routine surveys, complaint investigations allow States to assess whether nursing homes are promoting and protecting the health, safety, and welfare of residents.

   The CMS and States have worked to improve the management of complaints and have increased the consumer's awareness of the complaint investigation system, as evidenced by the following actions:

- In January 2004, CMS required that the States use the ACTS, a national, electronic tracking system that monitors the processing and investigation of complaints. No such national system previously existed, and the reliability of individual State systems varied. ACTS processes individual complaints from intake to resolution and can be reviewed locally or nationally by tracking and reporting complaints and incidents across provider and supplier types. It provides the infrastructure for analysis to assure that reports from beneficiaries, their friends, and their families about poor quality in nursing homes are managed in an appropriate and timely manner.
- The CMS conducts annual performance reviews of the SAs to assess whether complaints are investigated in a timely manner.

The following graph portrays the 45 percent increase in the number of complaint surveys conducted by CMS and States as a result of the high priority we place on responding to concerns of residents and family members.

Number of Complaint Surveys, 1999–2005



As the graph indicates, the number of complaints investigations by States or CMS increased from 32,422 in 1999 to 44,677 in 2005. We believe that the number of complaints has been relatively consistent. In addition, the ACTS is enabling us to track the total number of complaints made (which require investigation). While budget limitations may lead to a decline in the number that we are able to investigate, we expect to continue a high level of responsiveness to consumer complaints. We also expect that the new complaint tracking system will enable us to identify important trends more quickly.

Action Plan	**Date**
Produce tracking reports using ACTS data and distribute to CMS regional office (RO) senior management and staff for their use to monitor, assist, and follow-up with SAs.	Ongoing
Assess and provide additional ACTS training to the extent needed and resources permit.	Winter 2007
Implement guidance to improve the completeness of survey and complaint data.	Winter 2007

2. **Background Check Pilot: Preventing Abuse and Neglect—** Nursing home residents have a right, by law, 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 workers (as well as supervisors) are essential to ensuring a viable workforce.

   In 2005, in accordance with section 307 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), CMS: (a) implemented a pilot program with seven States to implement expanded and more effective systems of conducting state and national background checks and searches of relevant registries for individuals seeking employment in nursing homes and other long term care (LTC) providers, (b) funded three such States to implement a comprehensive training program (and possibly other techniques) designed to reduce the potential for abuse or neglect by LTC workers, (c) engaged a national organization to provide technical assistance to States implementing expanded background check programs**,** and (d) enlisted a national contractor to evaluate the pilot programs. The pilot period runs from January 1, 2005 through September 30, 2007. We hope to learn about the effectiveness of State-administered background check programs for health care workers and to identify the most efficient, effective, and economical procedures. In 2007, CMS will continue to monitor the pilot program in all seven participating States, oversee the independent and neutral evaluation, and conduct the 3rd Annual National Conference for Pilot States.

Action Plan	**Date**
Continue full program implementation in all pilot States.	Spring 2007
Issue draft national evaluation report.	Winter 2006/2007
3rd Annual National Conference for Pilot States.	Summer 2007

3. **Improving Fire Safety in Nursing Homes—** The CMS' initiatives to reduce nursing home fires focuses 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), and
   - Better Enforcement (such as improved methods of citing deficiencies).
   -

   In the area of better protection: In 2005 CMS published an administrative rule requiring the installation of smoke detectors in resident rooms and public areas in nursing homes that do not have a facility-wide sprinkler system installed or a hard-wired smoke detection system in those areas.

   Current CMS regulations require sprinklers in all new construction or when a nursing home undergoes a major renovation. Older homes may continue to be unsprinklered only if comprised of fire-resistant materials. A CMS survey, in June 2006, revealed that

approximately 80 percent of nursing homes are fully sprinklered, and another 16 percent are partially sprinklered. In FY 2007, CMS intends to promote optimum fire-safety in nursing homes through a proposed rule that all nursing homes (existing and new) be fully sprinklered in the future. Included in the Regulations Agenda published in the *Federal Register* on October 31, 2005, the outline of the proposed rule would require sprinklers in all nursing homes "and solicit public comment regarding an appropriate and feasible phase-in period for this regulation" (see 70 FR 64605, entry numbered 1132—Fire Safety Requirements for Long-term Care Facilities: Sprinkler Systems (CMS-3191-P)).

In the area of better information: The CMS will begin posting information on the CMS NHC Web site regarding whether the nursing home is fully sprinklered, partially sprinklered, or not sprinklered.

In the realm of better monitoring and enforcement: The CMS has instructed SAs to consider nursing home fires with injuries to be investigated using CMS complaint policies and procedures for the level of "immediate and serious jeopardy." CMS also has re-prioritized both contract and in-house resources to accomplish a 17-fold increase (compared with 2004) in the number of validation surveys CMS conducts to monitor the adequacy of State Life Safety Code (LSC) surveys. This level was sustained in 2006 and will continue into 2007.

Action Plan	**Season**
Publish a Notice of Proposed Rule-Making that would require all nursing homes (existing and new) to be fully sprinklered, and invite public comment.	Fall 2006
Publish report on CMS Initiatives to Reduce Nursing Home Fires.	Fall 2006
Sustain 17-fold increase in CMS validation surveys for LSC.	Ongoing
Pilot new Federal Oversight Support Survey (FOSS) process for LSC surveys.	Winter 2006/2007
Post information on the CMS Web site regarding whether each nursing home is fully sprinklered, partially sprinklered, or not sprinklered.	October 2006

4. **Interpretive Guidance for Surveyors—** The CMS is revising nursing home surveyor guidance for selected regulatory requirements that relate to quality of care (such as pressure ulcers and incontinence). This updated guidance is being developed through an interactive process, including nationally recognized experts and stakeholders. The guidance will support a nationally consistent application of the survey process in evaluating facilities for compliance with nursing home requirements. The products include interpretive guidance based on current standards of practice, investigative protocols, and guidance to determine the

severity of deficiencies identified in a survey. Guidance that was issued in FY 2006 includes: Activities, Psychosocial Outcomes, and Quality Assurance.

In addition to the guidance itself, we are also improving the methods by which the information is communicated and the training available to surveyors:

- ***Advance Copies***: Well in advance of its implementation, a copy of new guidance is released, and is available on the CMS Web site;
- ***Training Tools***: CMS has developed a national surveyor training tool for use in training regional and State surveyors. That tool, which was vetted through CMS RO survey staff before national distribution in order to ensure its understandability and usefulness, was distributed before the implementation date of the new guidance, and was made available on the CMS Web site for use by providers and other stakeholders;
- ***Satellite Broadcasts***: Guidance that contains considerable clinical information is being supported by a satellite broadcast, which is available via webcast; and
- ***Coordination***: Future releases will occur in a manner coordinated with State agencies and key stakeholders in order to maximize the use of the resources.

In 2006, 2007, and 2008, important new guidance will be released for the following areas:

Action Plan	**Date**
Medical Director (F-Tag 501)	Completed
New Tag: Influenza and Pneumonia (F-Tag 334)	Fall 2006
Unnecessary Drugs (F-Tags 329, 330, 331) Pharmacy Services (F-Tags 425, 432)	Winter 2006/07
Eating Assistant (F-Tag 373)	Spring 2007
Accidents (F-Tags 323, 324)	Spring 2007
Sanitary and Nutrition (F-Tags 325 and 371)	Summer 2007
Pain Management	Fall 2007
End-of-Life (F-Tag 309)	2008
Abuse (F-Tags 223-226)	2008
Infection Control	2008

5. **Immunizations—** A final rule published by CMS on October 7, 2005, requires Medicare- and Medicaid-participating nursing homes to provide residents with the opportunity to be immunized against influenza and pneumonia. This new rule is under the Federal Quality of Care requirements at 42 CFR section 483.25(n). The LTC facility is required to ensure that before offering the immunization, each resident, or resident's legal representative, receives education regarding the benefits and potential side effects of immunization.

Under the new regulation each facility must ensure that:

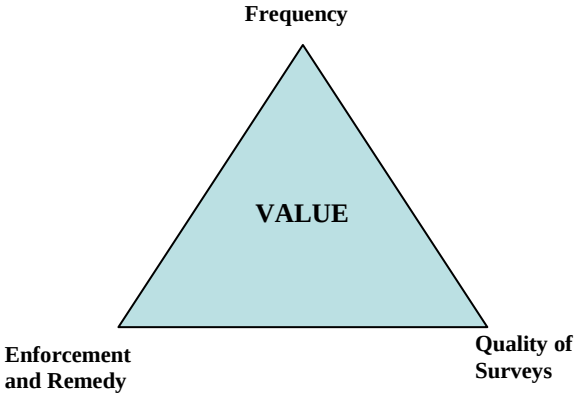
- Residents or their legal representatives receive education regarding the benefits and potential side effects of the immunizations before they are offered the immunizations.
- As appropriate, residents will be offered the opportunity to receive the immunizations, annually (October 1–March 30) for influenza, and once for pneumonia.
- Residents or their legal representative have the right to refuse the immunizations.
- Documentation of the provision of education, and if the resident received the immunization or refused, is included in the resident's medical record.

These requirements will be covered under a new survey tag, Tag F334. Surveyor guidance pertaining to this Tag will be released in the Fall of 2006, based on the experience gained in the 2005–2006 implementation season under the final rule and interim surveyor guidance. Additionally, this time will allow for the incorporation of the new immunization quality measure that CMS also plans to release in Fall 2006.

Action Plan	**Date**
Issue final surveyor guidance and accompanying training materials.	Fall 2006
Final surveyor guidance effective.	Fall 2006

6. **Refinement of State Performance Standards—** In FY 2001, CMS implemented uniform State performance standards for the States. In FY 2002, CMS added hospitals, end-stage renal disease (ESRD) facilities, intermediate care facilities for people with mental retardation, and home health agencies to the State performance standards. By 2005 the system had expanded to cover seven areas[1], each with its own subparts, and was at some risk of losing its understandability.

   For FY 2006, we reorganized the State Performance Standards System (SPSS) to a three-dimensional model (at right). We made this change to emphasize the fact that the value of the survey program comes from (a) completing surveys, (b) the quality of the surveys themselves and proper identification of deficiencies, and (c) appropriate enforcement and remedy of identified



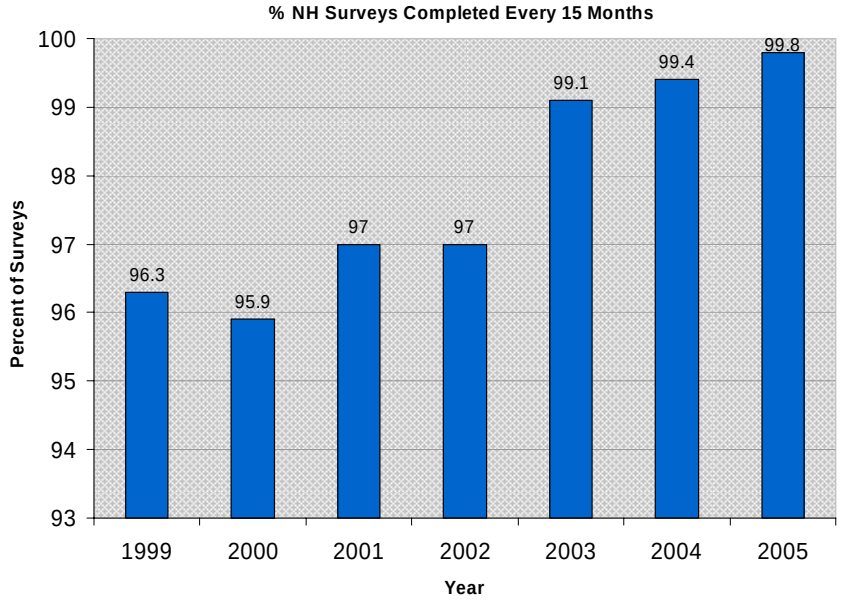
[1] Frequency of surveys; Accuracy of survey documentation; Results of surveys performed by Federal surveyors concurrent with State surveyors; Timeliness of processing surveys and sanctions; Budget expenditures; Prioritizing and investigating complaints; and Timely entry of data into tracking system.

problems, preferably through systemic change. The fundamental elements in the SPSS remained the same, with two exceptions: (1) elimination of the standard on budget (since States must prepare an approved budget in order to be funded), and (2) the addition of more provider types (e.g., ESRD) for which we will measure survey frequency.

Frequency + Quality of Surveys + Enforcement and Remedy = Value

- *Frequency:* Off-hour surveys for nursing homes, frequency of surveys, frequency of data entry of standard surveys;
- *Quality of Surveys:* Documentation of deficiencies; conduct surveys in accordance with Federal standards; documentation of noncompliance; accuracy of documentation; prioritizing complaints and incidents; timeliness of complaints and incident investigations; timeliness of Emergency Medical Treatment & Labor Act (EMTALA) investigations; and quality of compliant/incident investigations;.
- *Enforcement and Remedy:* Timeliness of processing immediate jeopardy cases; timeliness of mandatory denial of payment for new admissions notification; adherence to the conditions of participation; and conditions for coverage, and special focus facilities.

The SPSS has contributed to improved performance in key areas. The following graph,



for example, shows the percentage of nursing homes for which a survey was conducted every 15 months. Performance increased from 91 percent in FY 2000 to more than 98 percent in FY 2004.

We expect continued improvement in 2007. We will engage with States and other stakeholders to review the standards system to make additional refinements according to the following schedule.

Action Plan	Date
FY 2007 State Performance Standards effective, with revisions	Fall 2006
Promote consistency of evaluation of the State Performance Standards, through training to the ROs	Fall 2007
Develop national reports to support the evaluation of the State Performance Standards and to allow for continuous monitoring by the States and ROs.	Spring 2007
Monitor State performance and require that States develop and implement corrective action plans to address identified problems.	Ongoing

7. **Federal Comparative Validation Surveys—** In FY 2002, a GAO study recommended that CMS conduct a greater number of comparative surveys. Comparative surveys refer to surveys conducted by CMS, shortly after a State survey, in order to assess the quality of the State survey. In order to accomplish this goal, CMS contracted with Ascellon in September 2003. The purpose of the contract is to recruit and train surveyors and to conduct Federal comparative surveys (Health and LSC). For 2007, comparative surveys will continue for both Health and LSC. Health surveys have been phased down and will target States that historically have had survey problems; and may include facilities with high incidence of pressure ulcers, restraint use and enforcement issues. In addition, a small number of Medicare non-long-term care facilities also will be surveyed.

Action Plan	Date
Continue 200 LSC surveys and 45-50 focused health surveys; and 6–9 Medicare non-LTC surveys	Fall 2007
Evaluation of contractor performance to include quality, costs, citation rates, timeliness of surveys.	Ongoing

8. **Improved Surveys Via the "Quality Indicator Survey (QIS)"—** The CMS has been studying methods to improve the consistency, value, and effectiveness of the survey process pursuant to internal CMS recommendations and GAO studies. This is critically important to improve CMS' ability to gather and compare surveyor data among States. Such improved consistency also will provide better data for consumers through the NHC Web site. The desired improvement requires a system that uses data as a decision-making tool to better focus surveyors on probable areas of concern, and requires full testing before full implementation. To assure that this improved process works as intended, CMS evaluated the enhanced surveyor process through a five-State (California, Connecticut, Kansas, Louisiana, Ohio) demonstration in FY 2005–2006.

   The "QIS" is a two-stage process. Stage 1 consists of both (a) off-site data [such as MDS] and (b) data collected on-site from two samples. The information is used to derive a set of Quality of Care Indicators that can be compared to national norms.

Stage 2 is a systematic investigation of areas flagged in Stage 1 and organized around critical elements with investigative probes for any care area that is triggered. An independent evaluation of the five-State demonstration and report of the evaluation occurred in 2006. CMS will determine whether to proceed with further implementation of the QIS following a review of the evaluation. Assuming a favorable evaluation CMS will undertake Phase II, a limited multi-state implementation of the QIS, the last quarter of the federal fiscal year.

Action Plan	**Date**
Complete first part of QIS Evaluation Phase I (Formative Evaluation)	Spring 2006
Complete second part of QIS Evaluation Phase I (Summative Evaluation)	Winter 2006/2007
Final report of evaluation.	Winter 2006/2007
Initiate Phase II (limited implementation of QIS)	Late Summer 2007

9. **Improving Enforcement Actions via the new "AEM"—** On October 1, 2004, CMS and States implemented a new electronic data management system that is improving data collection and reporting for survey and enforcement activities for nursing homes in every State. For the first time, all types of enforcement actions are available to each SA and CMS in an integrated electronic medium that enables better tracking, follow-up, analysis, and management of enforcement actions taken or in process pursuant to findings of deficiency in nursing homes. Such enforcement actions include civil monetary penalties, denial of payment for new admissions, proposed or effected terminations of provider agreement, directed plan of correction, on-site monitoring, and similar enforcement tools designed to ensure corrections are implemented.

   Because AEM is a real-time reporting system, up-to-the-minute information about any facility is available instantaneously to systems users, either onscreen or through the comprehensive reporting capability. This enhanced access to enforcement information enables CMS and States to more effectively track and evaluate facility performance and compliance status, as well as respond quickly as issues emerge. AEM's national collection and reporting of specified and detailed data will permit meaningful comparisons and evaluations of like measures and will serve as a primary tool on which to base policy decisions as well as new initiatives, and strategies for improving care to our Nation's nursing home population.

Action Plan	Date
Monitoring and follow-up.	Ongoing
Issue the first national report.	Fall 2007

10. **Reporting Surveyor Concerns—** This is an RO system designed and established to identify and follow up on information that suggests systemic practices of overlooking or downgrading the scope and severity of survey findings, among other various important issues provided to ROs by State surveyors. This initiative is designed to ensure the integrity of the survey process that is designed to identify quality of care issues in nursing homes.

11. **Issue Guidance on Use of Photographic Evidence—** Currently, surveyors gather information primarily through interview, record review, and personal observation. Photographic evidence is not a routine method of gathering information. The use of photographic evidence could assist the surveyor in gathering information and strengthen determinations of noncompliance with certain Federal requirements.

    CMS will develop guidance for surveyors on the proper use of photographic evidence. For example, when surveyors are using photographs to document care they should use forensic techniques such as using a ruler next to the site being photographed. The policy will ensure resident privacy.

Action Plan	Date
Issue a Survey and Certification Letter on use of photographic evidence.	Fall 2006

12. **Civil Money Penalty Quality Improvement Project—** Civil Money Penalties (CMPs) are an important incentive for compliance and are imposed on facilities that are shown to have continuing problems with care. CMS identified the CMP tracking and collection process as an area that could benefit from comprehensive process analysis and a true quality improvement effort. This project will improve the quality of the CMP tracking and collection process to make CMPs a more effective enforcement tool. Staff from diverse components of CMS combined forces to formulate improved methods of tracking and collecting CMPs. The team, chartered in April 2004, mapped out the current process, identified where the process was not working, and made recommendations to CMS management for improvement.

Action Plan	Date
Issued SCOPE letter SCG-06-08 on the new CMP Collection Procedures.	Fall 2006
Update CMP Tracking System to Oracle platform.	Winter 2007

13. **Training—** In 2007, CMS will expand training opportunities for surveyors to better equip them. Expanded training will include:
    (a) Adding a southern venue, in addition to the western venue developed last year. This targets a select number of courses to ensure improved training access for States in time zones most distant from Baltimore, Maryland. We also will pilot new approaches to partnering with State Agencies that allow us to better use the more sophisticated State Training groups to expand our training resources. We refer to these as Magnet Area Training (MAT) and will conduct pilot tests in Florida and California before widely offering the MAT products to other areas.
    (b) Web Based Training (WBT) We are launching courses on "Abuse and Neglect Complaint Investigations," as well as other topics in a WBT format. These WBT formats also may be offered to providers to establish an idea of what they should expect from surveyors.
    (c) Eight basic surveyor training courses in both Health Surveys and LSC, adding an additional LSC Basic to address oversight surveys, To make training more easily accessible, we are experimenting with a Virtual Classroom version of the LSC Basic. This will allow surveyors to access training at any time of day and to still have opportunities for interaction with students and instructors. This is a live-instructor-facilitated training and goes beyond the depth and complexity of the WBT available through other mediums.
    (d) Specialized training on the National Fire Protection Association Standard for Gas and Vacuum Systems (NFPA 99).

    In addition to classroom training for basic classes, satellite broadcasts and Web casts will be increased and presented by CMS on relevant clinical and program topics to increase consistency and understanding of Federal requirements among surveyors and providers. The Web casts, satellites, and related videos will be available for one year after they are first presented. In addition, master tapes, DVDs, or CDs will be distributed to 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.

Action Plan	Date
Adding a southern venue, in addition the western venue developed last year.	Fall 2006

Launching courses on "Abuse and Neglect Complaint Investigations," as well as other topics in a WBT format.	Fall 2006
Eight basic surveyor training courses in both health surveys and LSC, adding an additional LSC Basic to address oversight surveys.	Fall 2006–Fall 2007
Life Cycle Curriculum Development	Fall 2008–Summer 2009

14. **Improving Timeliness and Effectiveness of Enforcement Actions—** The CMS seeks ways to improve the timeliness of enforcement actions when a nursing home fails to meet health and safety requirements. Two key actions are (a) denial of payment for new admissions (DPNA) after 3 months of failure to achieve substantial compliance with the Conditions of Participation, and (b) termination from Medicare and Medicaid after failing to achieve substantial compliance after 6 months. For the former (DPNA) CMS will study the feasibility, through a pilot, of issuing the formal notice of a DPNA for new admissions sanction at the time it issues the statement of deficiencies. This will streamline the process of sending out sanction notices and will give nursing homes more than 15 days notice before sanctions are put in place. With regard to termination, CMS will test a triage review system at the 5-month stage. The review will seek to determine if other resources or actions ought to be brought to bear in order to promote remedy, or if the prospects are dire and assertive efforts ought to be undertaken to prepare for termination. Insofar as relocation of residency poses particular hardship for nursing home residents, remedy is always the preferred outcome.

	Action Plan	**Date**
Triage System	Draft triage review protocol to identify facilities that may need a shorter timeframe to be in compliance.	Spring 2007
	Finalize triage review protocol to identify facilities that may need a shorter timeframe to be in compliance.	Fall 2007
	Monitor protocol.	Ongoing
DPNA Notice	Engage States to participate in the pilot of issuing the formal notice of DPNA at the time of issuing the Statement of Deficiencies.	Winter 2006/2007
	Begin pilot.	Summer 2007
	Evaluate pilot.	Fall 2007

C. Quality Improvement

We are promoting a program of quality improvement in a number of key areas. These areas include reduction in the prevalence of preventable pressure sores that threaten the health and well-being of a significant number of nursing home residents and reduction in the extent to which restraints are used in nursing homes.

1. **Government Performance and Results Act (GPRA) Goals—** The CMS has two goals in improving care in nursing homes: reduce pressure ulcers and reduce unnecessary restraints. CMS has worked diligently to address these problems. However, huge disparities remain in rates among regions, states, and across nursing homes. The effort now needs additional impetus, especially in those States where physical restraint and pressure ulcer rates exceed the national average, in order to reduce the national average. To assist us in our efforts, CMS has 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 CMS measure the success of their efforts to improve these two care issues.

    a. **Reduce Pressure Ulcers—**Over the last several years, CMS, SAs, and QIOs have worked with LTC facilities to improve performance with respect to pressure ulcer prevention.

        i. **Regional Follow-up and Data Analysis—** Although other quality measures (such as restraint use and pain management) have improved, reducing the prevalence of pressure ulcers nationally has proven to be more difficult. While pressure ulcer rates had been steadily increasing for years, CMS now has the first data to indicate that there may be a decline in the rate of some pressure ulcers. Between the third quarter of 2003 and the first quarter of 2006, the prevalence of pressure ulcers declined from 8.9 percent to 8.7 percent. Using a new quality measure for high risk pressure ulcers, over the same time period, the rate dropped from 13.8% to 13.1%, a relative improvement of about 5%. 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 12.3% in the first quarter of 2006—a relative improvement of 8%.

            In 2007, CMS will (a) translate the national goal into their regional equivalents, (b) increase the level of regional follow-up with States, and (c) support the follow-up with improved data analysis of the rates of pressure ulcers in States and in particular nursing homes.

        ii. **QIO Initiatives with Nursing Homes**: In 2007, every QIO will be charged with working with nursing homes to improve the prevention and treatment of pressure ulcers. In this initiative, each QIO helps participating nursing homes set goals and develop methodologies by which those goals may be realistically reached. AHRQ is funding a real time intervention research project for preventing pressure ulcers. This project is working with QIOs in several states and helps fulfill the 8th Scope of Work goal of pressure ulcer prevention.

    b. **Reduce unnecessary restraints—** Over the last several years, CMS, SAs, and QIOs have worked with LTC facilities to improve performance in key quality of life and quality of care issues, such as restraint use, pain management, and pressure ulcer prevention.

i. **Regional Follow-up and Data Analysis—** The CMS, SAs, and QIOs are all working with nursing homes to reduce unnecessary restraints in nursing homes. There has been a consistent decrease in the prevalence of physical restraints since the beginning of the measure in the second quarter of 2002; the prevalence of physical restraint use in nursing homes was 9.3 percent in 2002, 7.8 percent in 2003, 7.2 percent in 2004, 6.6 percent in 2005, and **6.4**% in the first quarter of 2006

In 2007, CMS will (a) translate the national goal into their regional equivalents, (b) increase the level of regional follow-up with States, and (c) support the follow-up with improved data analysis of the rates of physical restraint use in States and in particular nursing homes.

ii. **QIO Initiatives with Nursing Homes**: In 2007, every QIO will be charged with working with nursing homes to reduce unnecessary restraints. In this initiative each QIO helps participating nursing homes set goals and develop methodologies by which those goals may be realistically reached. In this contract cycle, there are two QIO intensive groups.

2. **Development and Validation of MDS 3.0—** The current MDS version 2.0, which is part of the Resident Assessment Instrument (RAI) and was developed in 1990 as part of the Nursing Home Reform Law of 1987 (OBRA 87), needs to be updated to more accurately reflect current standards of practice, in particular sections, and some areas may need to be simplified. Many providers feel that it is cumbersome, not useful to them as a management tool (as it is not in real-time), and does not allow for immediate analysis of a resident. This may reflect a shift in the type of residents for whom many nursing homes are now providing care. Since MDS 2.0 drives payment, publicly reported quality measures, quality indicators, the survey process, and 22 State Medicaid case-mix payment systems, modifications are required to support CMS and State activities. CMS has a memorandum of understanding with the Department of Veterans Affairs to assist with the development and testing of validation protocols for MDS 3.0. CMS also has contracted with RAND to develop and validate the MDS 3.0 and ensure that new and existing MDS items are reliable.

Action Plan	**Date**
Completion of the Department of Veterans Affairs MDS 3.0 Validation Protocol Research of New MDS items.	Completed
National MDS Validation.	Summer 2006
Complete MDS National Validation.	Fall 2006
Complete MDS National Validation Analysis.	Summer 2007
Town Hall Meeting with nursing home stakeholders.	Fall 2007
Final Validation Report.	Spring 2008

3. **MDS 3.0 Consolidated Health Informatics Review—** The Presidential Consolidated Health Informatics (CHI) Initiative establishes a portfolio of existing clinical vocabularies and messaging standards enabling federal agencies to build interoperable federal health data systems. In partnership with the Office of the Assistant Secretary for Policy and Evaluation (ASPE), we have a contracted with a medical terminology and vocabulary contractor to examine domains in MDS 3.0 that can adopt an existing health information interoperability standard. The new standards agreed to by federal agencies and being examined for MDS 3.0 include the College of American Pathologists Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT) for laboratory result contents, non-laboratory interventions and procedures, anatomy, diagnosis and problems, and nursing, Logical Observation Identifier Names and Codes (LOINC) for laboratory result names and laboratory test order names; and Health Level Seven (HL7) vocabulary standards for demographic information, units of measure, immunizations, and clinical encounters, and HL7's Clinical Document Architecture standard for text based reports.. Using CHI-standardized terminology ultimately will facilitate CMS in evaluating quality of care across care settings and move toward a standardized electronic health record system. CMS has provided preliminary CHI terminology recommendations to the MDS 3.0 validation contractor and is working with other Federal partners and CHI standards agencies to identify future steps and explore additional nursing home CHI studies.

CMS is working to improve its use of health information technology and take steps toward the development of electronic health records in several ways. First, we are considering improvements to MDS information technology with a 1-State pilot using a web-based MDS submission process. Second, we are working with the VA to enhance the Resident Assessment Validation and Entry System (RAVEN) freeware data entry tool. Third, we are working with federal partners to pilot test an electronic evidenced-based depression resident assessment protocol (RAP), to move in the future toward electronic RAPs. Fourth, CMS is collaborating with the Agency for Healthcare Research and Quality (AHRQ) on piloting foundation standards for electronic prescribing in a long-term care setting in nursing homes in Minnesota. Currently, long-term care facilities are exempt under MMA from using these standards if they choose to prescribe electronically. However, results from this pilot may eventually clear the way to implementation of e-prescribing in long-term care as appropriate, with a commensurate, anticipated decline in medication errors and enhancement to patient care. Finally, we are exploring the challenge of crosswalking MDS domains to standard healthcare terminologies such as SNOMED CT that ultimately is aimed at building an interoperable data system that can reuse information without the high cost of translation or data re-entry.

Action Plan	**Date**
Lexical and semantic matching of MDS against CHI-endorsed standards, SNOMED-CT, and other sources.	Winter 2005/2006
Enhancing and refining MDS 3.0 clinical content.	Spring 2006
Interim Report with recommendations for phased analysis of MDS 3.0	Winter 2006

clinical content items.	
Review results from LTC electronic prescribing pilots and subsequent recommendations to NCVHS Standards and Security Subcommittee.	Winter 2006/Spring 2007

4. **Data Assessment and Verification Contract (DAVE) 2: MDS 2.0—** The current Minimum Data Set (MDS) version 2.0 is part of the Resident Assessment Instrument (RAI) developed in 1990 under OBRA 87. Accuracy with coding MDS items, and verification of supporting clinical information, are essential since many of these items drive publicly reported quality measures, quality indicators, the survey process, the case-mix adjustment under Medicare's skilled nursing facility prospective payment system, and some State Medicaid payment systems.

   The DAVE 2 project is the second phase of a CMS initiative, begun in December 2004 to evaluate and support improvements in the accuracy of MDS items generated by nursing homes. Oversight of this task order was assumed by the Office of Clinical Standards and Quality (OCSQ) at the conclusion of the original DAVE effort and was awarded to Abt Associates for fiscal year 2006.

   DAVE 2 continues to evaluate the accuracy and reliability of national CMS data through focused on-site reviews of the MDS 2.0 and pertinent clinical information, develop targeting protocols and conduct analysis, and help improve accuracy by developing process improvements, assessment tool improvements, and training and educational materials for key stakeholders. Since April 2006 the DAVE 2 team has reviewed MDSs and medical records in a national sample NHs across states to measure and analyze MDS discrepancies and identify root causes of errors providing feedback on coding errors and educational guidance at the close of each on-site visit. A new coding TIP sheet will be posted on the web this fall and additional TIP sheets will be developed and provided on-line to NHs over the next year. DAVE2 team will initiate a new task for fiscal year 2007 to partner with regional, state and nursing home entities to develop tools and processes for local monitoring and improvement of MDS accuracy. Additional tasks will include developing and testing protocols that identify facilities at high risk for MDS coding errors, developing and testing the feasibility of a federal/state partnership to monitor and improve MDS accuracy, as well as developing and testing a provider self-audit process.

Action Plan	**Date**
Continue on-site MDS reviews at nursing homes. Analyze data, produce discrepancy reports, recommendations, and educational products to improve MDS accuracy.	Ongoing
Partner DAVE 2 team with regional, state and nursing home entities to develop tools and processes for local monitoring and improvement of MDS accuracy	Winter-Summer 2007

5. **National Nursing Home Time Study**— The CMS reimburses Medicare Part A skilled nursing services on a prospective payment system (PPS), which uses the Resource Utilization Group, version 3 (RUG-III), classification system to determine payments based on patient data. This skilled nursing facility PPS was introduced in 1998, and was constructed on the basis of staff time measurement studies conducted in 1990, 1995, and 1997.

   The CMS awarded a contract in September 2005 for a national study called STRIVE (Staff Time and Resource Intensity Verification) to examine how nursing homes allocate their staff time and resources. This study will reflect the most recent care practices and resource needs of nursing homes, and will be used to update Medicare's RUG-III case mix structure and payment rates. CMS also is working actively with state Medicaid agencies and nursing home associations to make this study a comprehensive examination of both post-acute and long-term care populations. Since almost half the states use a version of the RUG-III system to determine payment rates for their Medicaid nursing homes, the national data will be made available to state Medicaid agencies to evaluate their payment structures.

   As the lead component for this study, the Center for Medicare Management (CMM) has benefited from the collaborative approach encouraged through the Long Term Care Task Force, and has incorporated aspects of other CMS initiatives into the study design. For example, CMM is working with the Office of Clinical Standards and Quality (OCSQ) to test both potential MDS 3.0 items and new quality measures for pain and pressure ulcers. CMM also is partnering with CMSO to support the Money Follows the Person Demonstration Program, which is part of the New Freedom Initiative, to collect data related to the potential community placement.

   CMS believes the study results will reflect current practices and update the existing nursing home payment system while using that system to promote high quality care.

Action Plan	**Date**
Conduct national time study.	Spring 2006– Spring/Summer 2007
Issue report.	Winter 2007/2008
Rulemaking.	2008

6. **Study of State Eating Assistant Programs—** In September 2003, CMS published a final rule, "Requirements for Paid Feeding Assistants in Long Term Care Facilities" (68 CFR, 55527), that allows LTC facilities the option to use paid eating assistants, if consistent with State law. This rule was published in response to the recognition of the

adverse affects that a shortage of nurse aide staff can have on assisting nursing homes residents with eating, the difficulties providers face with recruiting and retaining nurse aide staff, and, subsequently, the absence of a provision in the regulations that would allow for the use of single-task workers, such as paid eating assistants. The final rule permits an LTC facility to use paid eating assistants to supplement the services of certified nurse aides under certain conditions. States must approve training programs for eating assistants, using Federal requirements as minimum standards. Eating assistants must successfully complete a State-approved training program and work under the supervision of a registered nurse or licensed practical nurse. The intent is to provide more residents with help in eating and drinking and reduce the incidence of unplanned weight loss and dehydration.

While a few States had extensive experience with such eating assistants without any indications of adverse consequences, it is important that CMS track and analyze the results when more States are involved. Both CMS and the Agency for Healthcare Research and Quality (AHRQ) also wished to be attentive to the concerns about potential problems that had been expressed about the rule by some parties when it was promulgated. In 2004, through a joint effort, CMS and AHRQ awarded a two-phase contract to Abt Associates to study eating assistant programs. In order to gain a sound understanding of the implementation of paid eating assistant programs among the States, the first phase of the contract requires using a descriptive study design to gather information about a wide array of characteristics of eating assistant programs. Depending upon the findings of the initial phase, a second phase of the contract might be undertaken to examine the impact of paid eating assistant programs on the quality of care in nursing homes. Phase I started in October 2004 and is expected to be completed in May 2006.

Action Plan	**Date**
Completion of Phase I of project	Spring 2006
Completion of report on project.	Fall 2006

7. **Working with Quality Improvement Organizations—** QIOs are Medicare contractors located in every State and territory that provide free assistance on a voluntary basis to nursing homes to address issues related to quality of care.

   Between August 2002 and July 2005, QIOs worked with nursing homes, focusing primarily on the areas of pain, physical restraints, and pressure ulcers, through the provision of assistance to help them make changes to care processes. Facilities working intensively with a QIO showed significant improvement. Those homes that worked closely with a QIO were very successful in reducing their rates of pain and use of physical restraints. Homes working with a QIO did not see a significant decrease in their rate of pressure ulcers, however the rate of pressure ulcers in these homes did not

increase as it did in the rest of the Nation's nursing homes, from 2002 to 2005[2].

The QIOs operate under 3-year contracts called Scopes of Work. Under the 8th Scope of Work, which began in August 2005, and extends to August 2008, QIOs will continue to provide assistance on care process changes but also are promoting the setting of quality improvement targets by nursing homes, helping them track whether they are effectively implementing changes in processes of care, and are providing assistance to help facilities make organizational changes that focus on the needs of the residents and decreasing staff turnover. These organizational changes have been shown to have a positive effect on clinical measures.

The QIOs are providing intensive assistance to approximately 2,400 nursing homes, with the following aims:

- Reduce pressure ulcers
- Reduce the use of physical restraints
- Reduce the prevalence of pain
- Improve detection and management of depression
- Increase a focus on person-centered care, and improve nursing staff retention

To accomplish this, QIOs are helping participating nursing homes make changes to clinical care processes, and move away from an institutionalized care model and toward a more person-directed care model that is individualized to meet the needs of each resident. As part of this work, QIOs are helping these nursing homes to monitor their levels of staff turnover and to help them implement an annual survey of resident satisfaction as well as an annual survey of staff satisfaction. The QIOs are then helping the nursing homes use the feedback from these surveys to redesign processes to better meet the needs of residents and staff, resulting in a more efficient and effective environment.

8. **Expansion of Collaborative Focus Facility (CFF) Project—** Between August 2004 and August 2005, a subset of QIOs worked closely with their SAs to identify homes that might benefit from some intensive assistance from the QIOs in redesigning their approach to clinical care. Some of these homes included Special Focus Facilities, while other homes were recommended because of a history of repeat survey deficiencies. After 12 months of intensive assistance, 42 nursing homes across 18 States illustrated the success of this demonstration in improving clinical quality and reducing the number of serious survey deficiencies. As of November 2005, nursing homes that participated in this project showed dramatic improvement as a result of the effective collaboration between SAs and QIOs.

    - High-risk pressure ulcers decreased by 18 percent [compared with no improvement nationwide during this same time period].
    - Low-risk pressure ulcers decreased by 49 percent among the CFF nursing homes [compared with no improvement nationwide.]

[2] Rollow W, Lied T, McGann P, et al. "Assessment of the Medicare Quality Improvement Organization Program". Annals of Internal Medicine, 2006:145(5):342-353. 5 September 2006.

- Nursing homes referred by SAs that participated in this pilot reduced their use of daily physical restraints by 37 percent compared to an 8 percent nationwide reduction in the use of daily physical restraints.
- Total number of deficiencies decreased by 11 percent among participating homes while deficiencies cited as level G (potential for serious harm) or worse, decreased by 26 percent.

The involved nursing homes had been cited repeatedly for serious deficiencies and had not improved in the past. The CFF project indicates that collaboration of both SAs and QIOs to work with low performing homes can improve the quality of care provided in these homes.

As a result of these successes, this project has been expanded into a mandated portion of the QIO 8th Scope of Work. Under the new contract, QIOs working in partnership with their SAs have identified homes that have shown persistent survey deficiencies and might benefit from QIO assistance. QIOs are now assisting them to decrease their rates of pressure ulcers and use of physical restraints while redesigning their organizational structure to better meet the needs of residents and staff.

Action Plan	**Date**
QIO working closely with State partners to identify homes for intensive intervention.	Completed Fall 2005
Recruitment of nursing homes that will work intensively with QIO.	Completed Winter 2005/2006
Helping nursing homes to set their own improvement target goals.	Completed Winter 2005/2006
Teaching nursing homes how to track their own clinical care processes.	Ongoing
End of contract and final evaluation.	Winter 2007/2008

9. **Culture Change—** The CMS began its efforts to improve the quality of care and quality of life in nursing homes with the passage of the Health Care Financing Administration's (HCFA, now CMS) regulations that implemented the OBRA 87 law's mandates for quality of life, quality of care, and resident rights. To further the Agency's work to implement these important aspects of the law and regulations, the Agency has become a part of a national movement known as "culture change." (Other terms include "resident-directed care," "person-centered care," and "individualized care.") Culture change principles echo OBRA 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 regulations are not, as is commonly perceived, a barrier to culture change, but in fact support it as an optimum implementation of the law that mandates resident dignity, autonomy, and quality of life. The concept of culture change encourages facilities to change outdated practices to allow residents more input into their own care and encourages staff to serve as a team that responds to what each person wants and needs.

The CMS has been participating in several initiatives and projects to assist facilities in incorporating the concept of culture change. This includes surveyor training in a 2002 satellite broadcast that introduced culture change principles to the surveyors; a joint project with QIOs to teach nursing homes in every State about these principles; providing regulatory answers to facilities that want to institute the concept of culture change; collaboration with QIOs in their national culture change Scope of Work; the 2006 release of a report of culture change outcomes and a new questionnaire tool to assist nursing homes to evaluate their degree of culture change (Artifacts of Culture Change, located at http://siq.air.org), as well as consultation and collaboration with the Pioneer Network and other culture change innovators in various projects and training efforts.

To further CMS' work in fostering individualized and resident-directed care, CMS plans the following action items:

Action Plan	**Date**
Mandatory satellite broadcast for surveyors on innovative culture changes in medical and nursing care : "Clinical Case Studies in Culture Change". The show will highlight how innovative facilities are learning to provide care according to resident wishes instead of according to old, institutionalized practices, and how this conforms to the regulations. Show will be part of a four volume series of culture change broadcasts (remaining 3 developed by the Quality Improvement Organizations).	Fall 2006–Summer 2007
Deploy workforce stabilization materials to 15% of nursing homes nationwide.	Winter 2006/2007
Provide series of four culture change Pic-tel presentations, so that CMS Regional Office survey personnel can discuss components of culture changes with leading culture change experts.	June 2006. Three additional pic-tels will be scheduled periodically in FY'07
CMS Public Symposium: Culture Change and the Physical Environment and Life Safety Code in Nursing Homes. Gathers experts and stakeholders to discuss issues of culture changes to the environment that impact these regulations. Public one-day symposium will be followed by an invitational workshop to permit further discussion of issues with experts, stakeholder groups, and CMS.	Fall 2007

D. Quality Approaches Through Partnerships

Effective assurance of quality in nursing homes can only be achieved through the combined, motivated, and, preferably, coordinated action of many actors in the health care system, including:

- Consumers, their families, and their friends;
- Providers;

- Purchasers, including CMS, States, and private and public health care 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 organizations;
- Legal rights organizations, including advocacy organizations such as the American Association for Retired Persons and State Ombudsmen and law enforcement.

Each individual in the system has a different role and set of responsibilities. However, the goal of quality care is advanced when more and more principals in the system can act in concert toward common objectives. When such concerted action is achieved, the total can indeed become greater than "the sum of its parts." CMS seeks to expand the level of collaboration among the principals who have responsibility for ensuring quality.

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

2. **Leadership Summit—** The CMS will sponsor the fourth annual joint meeting with SAs in April 2007 in the Baltimore/Washington, D.C. 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.

3. **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 American Association of Homes and Services for the Aging, as well as interim meetings with the regulatory subcommittee and the legislative training session held in Washington, D.C., each year. We also hold stakeholder meetings periodically on various topics of interest. CMS also meets with consumer advocates such as the National Citizens Coalition for Nursing Home Reform and the American Association for Retired Persons for purposes of exchanging information.

4. **Advancing Excellence in America's Nursing Homes Campaign—** CMS is collaborating with 11 national associations to facilitate a national nursing home quality campaign entitled *Advancing Excellence in America's Nursing Homes*. The unprecedented, two-year collaborative campaign seeks to dramatically advance the quality of care and quality of life for those living or recuperating in America's 16,000 nursing homes. The *Advancing Excellence in America's Nursing Homes* Campaign will help nursing homes and others coordinate their energy and resources to build upon various current initiatives such as Quality First, CMS' Nursing Home Quality Initiative, the Campaign for Quality Care, and the culture change movement.

   The national campaign will focus on the following measurable goals:
   - Reduction in high risk pressure ulcers
   - Reduction in the use of daily physical restraints

- Improvement in pain management in long stay residents
- Improvement in pain management in short stay (post acute) residents
- Setting individualized quality improvement targets
- Regularly assessing resident and/or family satisfaction and incorporating this information in their quality improvement activities
- Regularly measuring staff turnover and working to reduce turnover rates
- Adoption of consistent assignment whereby residents are regularly cared for by the same caregiver.

The Campaign will be launched at a National Nursing Home Quality Summit meeting in Washington, DC on September 29, 2006. The campaign will continue for two years with participation of providers, consumers, and supporting organizations. Progress toward the goals will be posted on the campaign's website at: www.nhqualitycampaign.org.

5. **Promising Practices: Sharing Innovations & Removing Barriers to State Agency Efficiency and Effectiveness—** The CMS has established the Promising Practices Project to sponsor the development of a series of issue briefs on useful practices or techniques utilized by SAs to address barriers; enhance the efficiency and effectiveness of the survey process; and provide a forum to share a variety of promising practices being utilized by SAs.

   A workgroup has been established with representatives from SAs and CMS Central and Regional Offices, to help guide these efforts. CMS has collaborated with the SAs to identify creative and innovative techniques that have helped to improve efficiency or effectiveness in the survey process. The initial focus of the issue briefs was on effective recruitment and retention of surveyor staff, as SAs identified this issue as their number one challenge in meeting their state performance requirements. The project has been expanded to include other regulatory practices.

   Follow-up interviews by the University of Colorado project team are conducted with SAs' staff to acquire detailed information on featured practices, and review relevant supporting documentation. Each study results in an issue brief that includes the methodology resulting in improvement, a State profile, and contact or resource information. Each approved issue brief is posted to an enhanced, user-friendly CMS Promising Practices Web site, thus, heightening awareness, sharing information, and increasing accessibility across the Nation on these important efficiency topics. Posted issue briefs include topics such as teleworking, team-based scheduling, using technology for interactive meetings and trainings, and training on the legal aspect of the survey process. Future promising practices issue briefs will be developed on topics such as effective emergency preparedness, innovative enforcement strategies, and effective complaint strategies.

   A report will be prepared at the end of the project (September 2007) that will evaluate the utility and effectiveness of disseminating the Issue Briefs via the Web site.

Action Plan	**Date**
Update and enhance Promising Practices Project Web site.	Fall 2006–Spring 2007

Develop regulatory issues briefs, in collaboration with Promising Practices Project Workgroup.	Fall 2006–Spring 2007
Post approved Issue Briefs on a regular basis.	Fall 2006–Fall 2007
Present final report.	Fall 2007

6. **Medicare Quality Improvement Community (MedQIC)—** Created and sponsored by CMS, MedQIC (www.medqic.org) is a free online resource that supports quality improvement work by nursing home providers, and their respective state QIO, working on the priority topics of Medicare's QIO Program. MedQIC enables QIOs and providers to acquire and disseminate information that supports the four key strategies for the National QIO Program Priorities: (1) measure and report performance, (2) adopt health information technology, (3) redesign care process, and (4) transform organizational culture. These strategies are catalysts of organizational change for improving clinical care processes and support movement away from an institutionalized care model toward more person-directed care.

   MedQIC resources supporting these strategies include QIO/QIOSC-developed assessment and data collection tools like the Nursing Home Improvement Feedback Tool (NHIFT), and the Setting Targets - Achieving Results (STAR) website, to evidence-based clinical practice recommendations by leading academic organizations, research and guidance by professional quality improvement organizations, and consumer advocacy groups at the forefront of healthcare transformation.

   Other resources found on MedQIC support broad administrative goals regarding leadership, reducing workforce turnover, and improving staff satisfaction. QIOSC staff adds new content daily to MedQIC to support the quality measures defined by CMS in the 8th Scope of Work. Specifically, QIOs and providers will find a significant amount of content focused on: (1) reduction of pressure ulcers, (2) reduction of physical restraints use, (3) reduction of the prevalence of pain, (4) improvement of detection and management of depression, (5) increase in immunizations rate, and (6) offering of person-centered care.

   Recent improvements to the site include practice setting tabs across the top with topics easily displayed when the setting tab is clicked, enhanced search results, a features box with the most prominent topics and tools, and improved literature categories with article publication dates. Future enhancements are listed below:

Action Plan	**Date**
The next version of MedQIC will include improved navigation with fewer clicks, a strength of evidence classification system, and new sections for Communications and Physician Practice Pharmacy.	Spring 2007

7. **Emergency Preparedness in Nursing Homes**— Hurricanes Katrina and Rita highlighted the need for a more effective and comprehensive Emergency Preparedness Plan that will

prepare nursing homes for incidents that range in severity from local isolated disasters to a total system collapse, as witnessed in New Orleans. The CMS has established a series of workgroups that have been reviewing and analyzing the Federal and State emergency response systems. The overall goal is to collaborate with SAs and other emergency agency partners to develop an integrated and coordinated process to ensure continuity of essential business functions, data capability and protection, and an effective emergency response in the face of any potential disruptive event (e.g., hurricane, tornado, earthquake, fire, chemical spill, nuclear or biological attack, pandemic, etc.). CMS is also participating in workgroups sponsored by the Department of Homeland Security and HHS, to develop updated requirements for local, state, interstate, regional and tribal entities to ensure measures are implemented for special need populations. CMS plans to improve the survey and certification emergency planning process through the following activities:

a. Establish a SA emergency preparedness/readiness baseline, by gathering basic information regarding communication, system capabilities for tracking provider status, maintaining data reports during a disruptive event, and essential business functions.
b. Establish several CMS internal workgroups to review, analyze and update current emergency preparedness plans, to ensure CMS Central and Regional Offices have the necessary information to conduct critical business functions, provide consistent guidance for the roles, responsibilities and actions of the SAs and their emergency response partners, and provide consistent, robust and effective policies, guidelines and requirements to nursing homes and other health care providers, to ensure the protection of the health and safety of the beneficiaries. The CMS has established the following S&C Emergency Preparedness Workgroups:
    - S&C Continuity of Operations
    - Interagency Role and Integration
    - Provider Standards, Policies & Guidance
    - Monitoring and Enforcement
    - Information Infrastructure
    - Communication & Outreach
    - Education & Technical Assistance
c. Establish an emergency preparedness stakeholder workgroup to develop guidance, recommendations and tools to assist SA and health care provider emergency planning efforts, as well as clarify the roles, responsibilities and actions of the CMS Central/Regional Offices and SAs.
d. Analyze current health care provider emergency planning regulations, standards and policies, and develop consistent and robust provider requirements and policies that ensure the health and safety of residents in nursing homes and other health care settings.
e. Create a user-friendly CMS Web site that will provide information, resources and tools to SAs and providers.

Action Plan	**Date**
Conduct SA emergency preparedness survey and establish baseline.	Fall 2006–Spring 2007
Establish CMS internal emergency preparedness workgroups to analyze	Spring 2006–Spring

current practices, procedures and regulations, and recommend improvements for robust and effective SA and provider practices.	2007
Create an CMS Emergency Preparedness Web site.	Fall 2006–Spring 2007
Establish stakeholder workgroup and develop recommendations for issues such as refining interagency emergency preparedness roles and health care provider emergency planning requirements.	Fall 2006–Spring 2007
Post SA and provider emergency planning best practices on Web site.	Fall 2006–Spring 2007
Standardize emergency preparedness requirements across provider types.	Fall 2007–Fall 2008

8. **Long-Term Care Task Force—** In 2005, CMS formed an internal LTC Task Force. The principal goal of the group is to have a full alignment of all different aspects of LTC, from payment, to technical assistance, to oversight. The task force has representation from the Center for Medicaid and State Operations, the Office of Clinical Standards and Quality, the Center for Medicare Management, the Center for Beneficiary Choices, the Office of Research, Development, and Information**,** and from CMS ROs.

   Although the task force is engaged around the general issues of alignment and developing improved coordination, the members also develop and promote solutions in key areas with need for advancement. Initially, these areas have included prevention and ensuring treatment of pressure sores, staffing issues and their correlation with quality outcomes, reduction in the use of restraints, development of the Nursing Home Action Plan, and creation of the value-based purchasing demonstration.

9. **Medicare Prescription Drug Benefit—** The new Medicare Part D prescription drug benefit, enacted as part of the MMA became, effective January 1, 2006. The benefit replaces Medicaid coverage for prescription drugs for people who are dually eligible for Medicare and Medicaid.

   People with Medicare may voluntarily enroll in a PDP, which offers standalone coverage for prescription drugs, or a Medicare Advantage prescription drug plan, which combines medical and prescription drug benefits. Individuals may enroll at the time they become eligible for Medicare (called their Initial Enrollment Period) and may also join, switch or disenroll from their plan once each year during the Annual Enrollment Period that runs from November 15 through December 31 of each year. Choice made during this time are effective on the following January 1.

   Some of the challenges facing nursing homes regarding the Medicare Prescription Drug Benefit include ensuring resident rights on choice of plans, and ensuring that each resident receive the right drug at the right time.

   In November 2005, CMS presented satellite training for SAs that provided general information on the (then new) Medicare Part D benefit and its implications for surveyors in the LTC survey process. The satellite will remain available via web-cast for 1 year. In early 2006, CMS convened a national conference call to update State and regional surveyors

on the status of the Part D benefit, provide resources that may be helpful, and answer policy questions related to the LTC survey process.

Action Plan	**Date**
Satellite training for SAs.	Fall 2005
Automatic enrollment of dual eligibles into PDPs.	Ongoing monthly
Medicare prescription drug benefits become available to individuals who are enrolled in Part D plans by December 31, 2006.	January 1, 2007
Annual coordinated election period for 2007 benefits.	November 15–December 31, 2006

10. **Long-Term Care Rebalancing —** CMS will be awarding a total of $1.75 billion, 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 for seniors and persons with disabilities from all age groups, including home and community-based services. This *Money Follows the Person* "rebalancing" initiative was included in the Deficit Reduction Act of 2005 (DRA). Demonstration grants will be awarded on or about from January 1, 2007 and continue through September 30, 2011.

    Specifically, the demonstration will support State efforts to:
    a) Rebalance their long-term support system so that individuals have a choice of where they live and receive services.
    b) Transition individuals from institutions who want to live in the community.
    c) Promote a strategic approach to develop and implement a quality management strategy that ensures the provision of, and improvement of such services in both home and community-based settings and institutions. The strategy must ensure the health and safety of demonstration participants before, during and after transition to the community, as well as ensure health and safety and those remaining in the institution.

    Included in the MFP Demonstration project, was the 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 HCBS waivers. A total of $2,400,000 has been appropriated for this component of MFP. These funds will be available throughout the duration of the demonstration and CMS expects to issue a request for proposals this fall.

    The MFP demonstration also includes a requirement that States demonstrate, in their applications, a thorough plan of engagement of institutional providers to maximize the effectiveness of the demonstration. Successfully rebalancing a State's long term care system to favor home and community-based services cannot be achieved without the engagement of the institutional providers in the State.

    Lastly, as part of the work discussed in item C.2., Development and Validation of MDS 3.0, CMS is currently exploring whether refinements to the MDS may assist states in achieving their rebalancing goals.

Action Plan	Date
Release of the MFP Solicitation.	July 26, 2006
Expected Award of the Demonstration Grants.	January 1, 2007
Issuance and Award of a MFP Quality Contract.	Fall 2006
Issuance and Award of a MFP Evaluation Contract.	Fall 2006

11. **Special Needs Plans** — The Special Needs Plans (SNP) program was established as part of the Medicare Prescription Drug and Improvement Act (MMA) which was enacted on December 8, 2004. The Medicare Advantage (MA) regulations reform and expand the availability of private health plan options to Medicare beneficiaries.

    Under the MMA, Congress created a new type of MA coordinated care plan to focus on individuals with special needs. Special needs individuals were identified as (1) institutionalized beneficiaries; (2) dually eligible; and/or (3) beneficiaries with severe or disabling chronic conditions.

    Effective January 1, 2006, CMS has 37 plan level special needs plans serving approximately 38,000 institutionalized beneficiaries. CMS has defined institutional as residing in and SNF, NF or in the community with an institutional level of care.

Action Plan	Date
Begin development, in collaboration with OCSQ, of the Quality Measures for SNPs for the 2009 reporting year.	Fall 2006
Include Subsetting in the 2008 SNP application.	Fall 2006

E. Value-Based Purchasing

The CMS has various initiatives to encourage improved quality of care for Medicare beneficiaries. Among these is the Nursing Home Value-Based Purchasing Demonstration. Under this initiative, payment would be more sensitive to differences in quality. Payment would be structured to provide better assurance that investments in improving quality will be recognized financially.

1. **Design Nursing Home Value-Based Purchasing Demonstration—** As the largest purchaser of nursing home services (about $64 billion per year), States and CMS exert leverage to insist on basic levels of quality. "Purchasing power" is an important tool that might be more effectively employed to promote quality in the future. The Nursing Home Value-Based Purchasing (VBP) Demonstration is intended to augment and reinforce other quality efforts by ensuring that financial investments made by nursing homes to improve quality will be met by payment methods that can discern the difference between excellent, good, mediocre, and poor quality.

Under this initiative, CMS would assess the performance of nursing homes based on selected measures of quality of care. The categories (or domains) for the potential measures include staffing, appropriate hospitalizations, resident outcomes, and survey deficiencies. The demonstration would include 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). We expect that improvements in quality may result in avoidance of certain kinds of hospitalizations, producing savings to Medicare. These savings would be shared with nursing homes that either improve quality or maintain exceptionally high quality of care. Thus, supplemental payments to be made to the best performing nursing homes would be sensitive to differences in quality.

We would conduct the demonstration in several States with a few hundred nursing homes. We also plan to collaborate with State Medicaid agencies to partner in this initiative. We would therefore first issue a solicitation to States during 2006. After selecting 4-5 participating states and providing those states with considerable time to organize any Medicaid activities that would be coordinated with CMS' Medicare demonstration, we would solicit for volunteer nursing homes within the participating states in mid 2007. This schedule will permit an optimum level of review and dialogue both within HHS and with stakeholders.

Action Plan	**Date**
Seek interested State Medicaid agencies for collaboration.	Summer/Fall 2006
Select States	Winter 2006/2007
Solicit & select participating nursing homes	Summer/Fall 2007
Demonstration begins.	Winter 2007/2008

2. **Post Acute Care Instrument Development & Demonstration—**Section 5008 of the Deficit Reduction Act (DRA) of 2005, signed into law on February 8, 2006, mandates a demonstration that supports post-acute care payment reform. CMS is charged with developing a single comprehensive patient assessment instrument for use at the time of hospital discharge and across Post-Acute Care (PAC) settings, as well as its implementation in a payment reform demonstration. Through the DRA, Congress also described the following requirements and expectations for the proposed assessment instrument, the instrument shall: (1) detail the needs of the patient, (2) describe the clinical characteristics of the patient's diagnosis that determine the appropriate post-acute care setting for treatment, (3) be used across all post-acute care sites in order to measure functional status and other factors, and (4) be used during the treatment, at discharge from each provider, and at the end of the episode of care. The instrument will be used for a 3-year demonstration project, which will include hospitals, nursing homes as well as other PAC settings.

Action Plan	**Date**
Develop PAC Patient Assessment Instrument (PAC-PAI) Scope of Contract .	Fall 2006–Summer 2007
Test, refine, provide training for implementation of the proposed PAC-Patient Assessment Instrument during the DRA required Demonstration to begin January 1, 2008.	Fall 2007–Winter 2007/2008