CMS
CENTERS for MEDICARE & MEDICAID SERVICES

2008
Action Plan for
(Further Improvement of)
Nursing Home Quality

2008

Executive Summary

About 1.5 million Americans reside in the Nation's 16,000 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 2008, we will undertake several 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." The principles behind culture change echo OBRA principles of knowing and respecting each nursing home resident and providing

individualized care that best enhances each resident's quality of life. The culture change movement encourages facilities to examine and transform their organization's values, structures and practices to transform the traditional institutional approach to care delivery into one that is person directed, and 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. In May 2006, we began partnering with stakeholders to design and then facilitate the *Advancing Excellence in America's Nursing Homes* Campaign. The unprecedented, collaborative campaign seeks to better define quantitative goals in nursing home quality improvement. The purpose of this Campaign is 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.

CMS Nursing Home Quality Milestones: CMS highlighted some key dates in its testimony before the Senate Special Committee on Aging Chairman on November 15, 2007.

Milestones Planned for Additional CMS Action in Nursing Home Quality[1]

Time	Actions
November 2007	**Advancing Excellence Campaign:** CMS, advocacy organizations, foundations, nursing homes, and other sponsorws a national conference to improve nursing home care and expand the campaign for *Advancing Excellence in America's Nursing Homes* (see www.nhqualitycampaign.org)
December 2007	**Special Focus Facilities (SFFs):** CMS posts on CMS' *Nursing Home Compare* website (at www.medicare.gov) the names of SFF nursing homes that have failed to improve significantly.
January 2008	**Budget**: Congress endorses (hopefully) the President's 2008 budget request for survey & certification, improving the Medicare quality assurance program.

[1] This is a sample of some of the milestones. For additional information see CMS' Nursing Home Action Plan published each year at http://www.cms.hhs.gov/CertificationandComplianc/12_NHs.asp#TopOfPage

February 2008	**Quality Indicator Survey (QIS)**: CMS adds one State to the 5 States that fully implements the new, improved Medicare survey process for nursing homes. This major new system has been in development for many years and is now being implemented gradually within existing budget limits.
March 2008	**Value-Based Purchasing:** CMS issues a solicitation to begin the process of inviting States and nursing homes to participate in a demonstration program in which payment is adjusted in a manner to recognize improvements in nursing home quality.
April 2008	**Culture Change:** CMS co-sponsors a national symposium, "Creating Home," to promote culture change and improvement in quality.
May 2008	**Background Checks:** CMS finalizes evaluation of 3-year pilot program demonstrating a comprehensive system of criminal and other background checks before nursing homes hire prospective new employees.
June 2008	**Pressure Ulcers and Restraints Reduction:** CMS publishes information on the national efforts to reduce the incidence of pressure ulcers in nursing homes and reduce the use of restraints.
July 2008	**Better Survey Guidance*:*** CMS publishes new guidance to surveyors on nutrition.
August 2008	**Fire-Safety Protection:** CMS publishes final rule requiring all nursing homes to be fully spinklered by the end of a specified phase-in period.
August 2008	**Quality Improvement Organizations:** New CMS contract sets forth an ambitious 3-year agenda for QIOs to work with nursing homes that have poor quality, including Special Focus Facilities (subject to OMB approval).
September 2008	**Staffing Information:** CMS issues draft methodologies to improve the accuracy of staffing information submitted by nursing homes and posted on the CMS Web site (Nursing Home Compare at www.medicare.gov)
October 2008	**Escrows Accounts for CMPs**: CMS advances for possible inclusion in the President's budget a call for legislation that would permit the collection and escrow deposit of civil monetary penalties (CMPs) if appealed.

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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 10 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 and guidelines to better focus on quality of care, quality of life, 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;
- Built improved infrastructure for the survey and certification system, such as a new ASPEN Complaint Tracking System (ACTS) and the ASPEN Enforcement Manager (AEM) to identify and track needed improvements in the quality of care;
- Provided satellite training on many topics that are available to providers via download; and
- Tested and evaluated prospective improvements to the survey process.

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 (www.cms.hhs.gov/NewFreedomInitiative/)*, 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 2008.

1. **Improving Staffing Data on the CMS Web Site–-**The extent to which a nursing home adequately staffs its facility 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 Nursing Home Compare (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 this system, information sent by nursing homes is reviewed by CMS. 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 and FY 2007 were directed toward further improvements in the accuracy and comprehensiveness of information on NHC. That work will continue into FY 2008.

   As part of a longer term plan to increase the accuracy and comprehensiveness of the staffing data, CMS has been investigating the feasibility of the use of payroll data as a basis for the information on NHC. Payroll data could be used to calculate measures of staff turnover and staff retention in addition to supporting more accurate calculation of the staffing measures currently posted. Specifications for electronic submission of a payroll data extract file for each nursing home have been produced and conversations with payroll vendors and nursing facilities to determine the feasibility and level of burden of electronic submission currently are underway. In FY 2008, CMS will: (a) complete the assessment of the feasibility of use of a payroll database extract; (b) accomplish a management review of the electronic

submission of staffing data, including the costs and burdens of moving to this kind of a system; and (c) after management sign-off, publish a Notice of Proposed Rulemaking to initiate use of this system.

The action steps described below will result in a broader range of more accurate and easier-to-understand information for consumers about staffing levels and staff turnover in nursing facilities.

Action Plan	**Date**
Finish the feasibility test of the use of an electronic payroll data extract file.	Fall 2007
Continue working with the Nursing Home Value-Based Purchasing Demonstration to implement a payroll database system for the demonstration.	Spring 2008
After CMS management review, consider publication of a Notice of Proposed Rulemaking.	Winter 2008-2009
Continue work with the Division of National Systems to refine computer system capacity needs for implementation of the electronic submission of payroll data.	Summer 2008

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. In 2003, the Forum has recommended that CMS include a nurse-staffing quality measure in the set of measures that are publicly reported on Nursing Home Compare. CMS began measurement development efforts in Fall 2003. Phase I of CMS' efforts included review and analysis of the relevant literature, consultation with experts in the field, exploration of options for collecting staffing data, assembly of a research data file as a basis for measurement development, and construction of draft measures. Phase 2 of the project consists of analysis of the use of contract staff, validation of the draft quality measures and consideration of appropriate case-mix and/or risk adjustment. CMS plans to submit the staffing quality measures developed in this project to the National Quality Forum consensus review process.

Action Plan	**Date**
Conduct analysis of contract staff hours.	Fall 2007
Validate draft staffing quality measures against quality outcome data.	Fall 2007
Produce a draft measure of staff immunization for influenza.	Winter 2008
Draft case-mix adjustment plan.	Summer 2008

3. **Develop Immunization Measures in Nursing Homes for Public Reporting—** *Healthy People 2010* set objectives for nursing home resident immunization of 90 percent for both

influenza and pneumococcal vaccines. In support of reaching that goal, a national quality improvement initiative is underway 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. These data will not only help bring residents eligible for immunization to the attention of nursing home staff, but will help nursing facilities, Quality Improvement Organizations, State survey agencies, and State and local health departments monitor immunization rates.

In October 2006, CMS began publishing facility-level influenza and pneumococcal immunization rates on the Nursing Home Compare Web site so consumers also have access to this quality of care information.

Action Plan	**Date**
Conduct first analysis of data from immunization rates measure.	Spring 2008

B. Survey, Standards, and Enforcement Processes

We will undertake several initiatives during 2008 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. **CMS 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 selected seven States (Alaska, Idaho, Illinois, Michigan, Nevada, New Mexico, and Wisconsin) to pilot a program to determine the most efficient, effective, and economical methods for conducting State and national background checks and searches of relevant registries for screening applicants who would have direct access to patients and residents in nursing homes and other long-term care (LTC) providers. Three States (Alaska, Michigan and Wisconsin) received additional funding to deliver a comprehensive training program designed to prevent abuse or neglect by LTC workers. CMS established a technical assistance contract to assist the States with implementing their pilot programs, and an additional contract was established to conduct a neutral evaluation of the results of the background check pilot programs. The pilot State's ability to use grant funding for their background check and abuse prevention training programs ended on September 30, 2007. However, CMS will continue to work closely and monitor the pilot

States during the phase-down period (October 2007 – May 2008), as those States submit their final program summaries, data and cost reports, and answer any questions from CMS or the evaluator. The final evaluation study, including the pilot States' findings to specific questions raised by Congress, is targeted for submission to CMS in spring 2008.

Action Plan	**Date**
Monitor pilot States during phase-down period.	Fall 2007/Spring 2008
Issue final national evaluation study.	Summer 2008

2. **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).

   CMS continues to move toward better fire protection for nursing homes. In 2007, CMS published a Notice (70 FR 64605) proposing that all long-term care facilities that do not have automatic sprinkler systems installed throughout their buildings would be required to install such systems in accordance with the technical provisions of the 1999 edition of NFPA 13, Standard for the Installation of Sprinkler Systems, published by the National Fire Protection Association (NFPA). The proposed rule solicited public comment regarding an appropriate and feasible phase-in period for requiring that all nursing homes be fully sprinklered. The final rule is expected to be published in summer of FY 2008.

   CMS continues to collect and report information on the sprinkler status and survey results for nursing homes. This information is available on the Nursing Home Compare Web site.

   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 continues to re-prioritize both contract and in-house resources to maintain 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 2008. In addition, CMS will implement a new process that will allow Federal Oversight/Support Surveys to be used to oversee LSC surveys.

Action Plan	Date
Implement Federal Oversight Support Survey (FOSS) process for LSC surveys.	Winter 2008
Publish Final Rule-Making that would require all nursing homes (existing and new) to be fully sprinklered.	Summer 2008
Sustain increase in CMS validation surveys for LSC to promote oversight and effective implementation of LSC surveys by States.	Ongoing

3. **Interpretive Guidance to Surveyors—**The CMS continues to revise the Interpretive Guidance to Surveyors for Long Term Care Facilities for selected regulatory requirements. This updated guidance is being developed through an interactive process. 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.

   In addition to the guidance itself, we continue to provide improved methods by which the information is communicated and the training available to both surveyors and providers, including advance copies, training tools, and satellite broadcasts (where needed).

   In FY 2008, important new guidance will be released for the following areas:

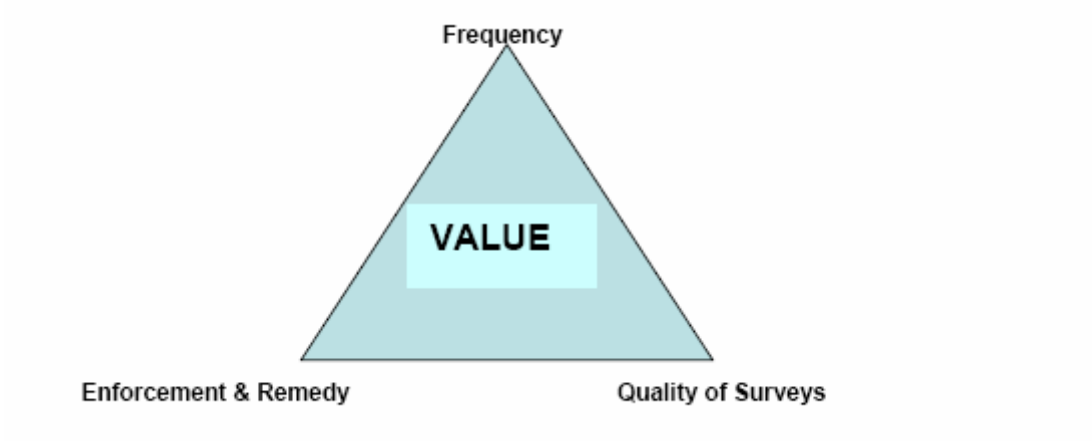
Action Plan	Date
Sanitary Conditions and Nutrition, Safe Food Handling (F325 and F371)	Summer 2008
Pain Management (as part of F309)	Fall 2008

4. **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[2], 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. We made this change to emphasize the fact that the value of the survey program comes from (a) the completion of surveys, (b) the quality of the surveys themselves and proper identification of deficiencies, and (c) appropriate enforcement and remedy of identified problems, preferably through systemic change.

[2] 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.

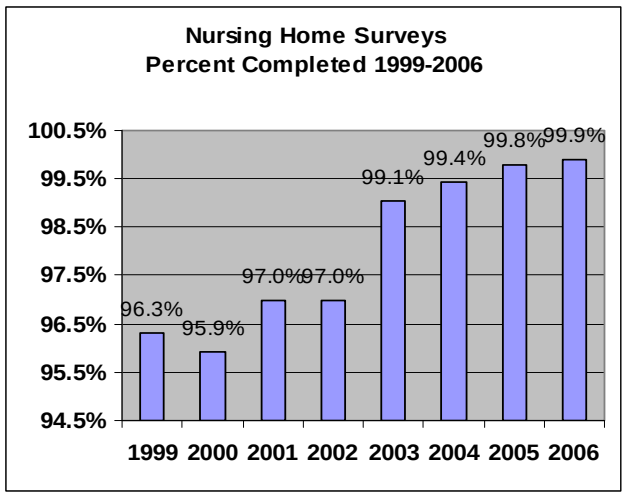
The fundamental elements in the SPSS have remained the same, with improvements made to: (1) align performance measurement with Federal survey and certification priorities, (2) assure that non-nursing home provider/suppliers are being surveyed, and (3) respond to changes made to policies and guidance.



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 of surveys in accordance with Federal standards; documentation of noncompliance; accuracy of documentation; prioritizing complaints and incidents; timeliness of complaints and incident investigations; quality of Emergency Medical Treatment & Labor Act (EMTALA) investigations; and quality of complaint/incident investigations;.
- *Enforcement and Remedy:* Timeliness of processing immediate jeopardy cases; timeliness of mandatory denial of payment for new admissions notification; processing of termination for non-nursing homes; 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 95.9% in FY 2000 to 99.9% in FY 2006.



Action Plan	Date
FY 2008 State Performance Standards effective, with revisions.	Fall 2007
Develop national reports to support the evaluation of the State Performance Standards and to allow for continuous monitoring by the States and Regional Offices.	Ongoing
Monitor State performance and require that States develop and implement corrective action plans to address identified problems.	Ongoing

5. **Federal Comparative Validation Surveys—** Comparative surveys are surveys conducted by CMS, shortly after a State survey, in order to assess the quality of the State survey. In FY 2002, a Government Accountability Office (GAO) study recommended that CMS conduct a greater number of comparative surveys. CMS responding to this recommendation sought to increase the number of comparative surveys through a contract effort. In 2003, CMS awarded a five-year contract to recruit and train surveyors to perform Federal comparative surveys; FY 2008 will be the final year for this contract. Comparative health surveys will remain approximately the same as that for FY 2007. Health surveys will predominantly be conducted in States that historically have had survey problems; and may include facilities with high incidence of pressure ulcers, restraint use and enforcement issues. In addition, CMS will continue improvements to its database to promote improved analysis and follow-up on the findings from the validation surveys.

Action Plan	Date
Continue 200 LSC surveys and approximately 15–50 focused health surveys; and 6–9 Medicare non-LTC surveys.	Ongoing during FY08
Conduct evaluation of contractor performance, including quality, costs, citation rates, timeliness of surveys.	Ongoing until end of contract.
Continue improvements to the validation database to promote improved analysis and follow-up on the findings.	Fall 2008

6. **Improved Surveys Via the "Quality Indicator Survey (QIS)"—** The CMS has been studying methods to improve the consistency 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 Nursing Home Compare Web site and will give nursing home providers useful information on their performance. The desired improvement supports the need for a system that uses data as a decision-making tool. The purpose is to better focus surveyors on potential areas of concern. CMS is evaluating the enhanced surveyor process through the five-State demonstration conducted in FY 2006–2007. The 5 state evaluation is Phase 1 of the demonstration.

   The "QIS" is a two-stage computer assisted 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. Many of the investigations are organized around critical elements with investigative probes for triggered care areas.

Action Plan	**Date**
Development of Training Model–two-state demonstration (FL,CT).	Fall 2007
Complete second part of QIS Evaluation Phase I five-state demonstration (Summative Evaluation).	Winter 2007-2008
Final report of evaluation, Phase I & Action Plan for Phase II.	Spring 2008
Conduct "Train the Trainer Program" in participating States	Fall 2007-Spring 2008
Expand Statewide implementation of QIS to 1-3 new States for a total of up to 8 States	Winter 2008-Fall 2008

7. **Establishment of Escrow Accounts for Civil Monetary Penalties**—Presently, imposed Civil Monetary Penalties (CMPs) are not due and payable until after a final administrative decision is made about the noncompliance upon which the penalty was imposed. Often, facilities do not actually pay the CMP until years after its imposition due to a statutory requirement that provides that payment of the CMP is suspended until after the appeal has been adjudicated. Delays in collecting these CMPs diminishes their deterrent effect. Based on action from Congress, CMS will develop and publish a Notice of Proposed Rulemaking to implement any new legislation.

Action Plan	**Date**
Develop and submit a legislative proposal to establish an escrow account whereby CMPs would be collected and put into an escrow account pending the outcome of the appealsprocess. [Note: The Federal executive branch does not introduce legislation. The only value of CMS' proposal is to signal to Congress the desirability of congressional action.]	Completed
Develop and publish a Notice of Proposed Rulemaking to implement any legislation that Congress passes.	Dependent upon new legislation.

8. **Monitor Civil Monetary Penalty Amounts**—CMS will monitor the amounts of CMPs recommended by States to insure consistency with statutory and regulatory factors such as scope and severity, repeated deficiencies, and numbers of deficiencies**.**

Action Plan	Date
Monitor appropriateness of tool amounts and RO's findings about consistency with State-proposed penalty amounts.	Ongoing

9. **Special Focus Facilities** – In the years 2000 to 2006, the CMS certified an average of 16,352 nursing homes each year. While many nursing homes meet minimum nursing home requirements either upon survey or within a short period afterwards, there are some nursing homes that pass one survey only to fail the next (for many of the problems as before). Our experience shows that such facilities rarely address the underlying systemic problems that have given rise to repeated cycles of serious deficiencies.

   In recognition of this phenomeon, the CMS created the Special Focus Facility (SFF) program in 1998 as one of the initiatives of the Nursing Home Oversight and Improvement Program. The purpose of the SFF program was to decrease the number of persistently poorly performing nursing homes by focusing more attention on nursing homes with a record of poor survey performance. In January 1999, CMS directed State survey agencies (SAs) to conduct two standard surveys per year for each SFF instead of the one required by law. CMS also requested that States submit a monthly status report listing any surveys, revisits, or complaint investigations of SFF they had conducted in that month.

   CMS and the States identified areas where the SFF program could be improved. In December 2004, CMS augmented the SFF program by:
   - ***More Nursing Homes:*** Increasing the total number of facilities by about 30%, with larger States doing more than smaller States (instead of 2 nursing homes in every state).
   - ***Better Selection***: Improving the data and methods by which substandard nursing homes are identified. Facilitating the ability of States to move on to other nursing homes on the candidate list if the original facilities show significant improvement.
   - ***Stronger Enforcement***: Implementing more robust enforcement for nursing homes that fail to make progress.
   - ***Reduced reporting burden***: Removing the monthly reporting requirement for States. Current requirements for surveying each SFF twice a year remain unchanged.
   - ***Building in Timeframes for Action***: Requiring that nursing homes have three standard surveys to make improvements and graduate from the program, make significant improvement or face termination.

   In FY 2008, CMS is further improving the SFF initiative. The first improvement is to require that States notify nursing homes that have been designated as a SFF. We are also requiring that States notify other accountable parties such as owners, governing parties, etc. We are further requiring that States notify additional parties such as the State Ombudsman, the State Medicaid Agency, and a State's Quality Improvement Organization.

In addition, we are posting on the CMS Web site the names of all SFF nursing home homes. The names are organized so consumers and families can distinguish between nursing homes that have significantly improved or not, have graduated, and those that have terminated participation in the Medicare, as well as SFF nursing homes that have recently been added to the SFF initiative. Finally, CMS will also "flag" nursing homes on its Nursing Home Compare Web site for those nursing homes that are part of the SFF initiative.

Action Plan	***Date***
Issue final policy with guidance on notification requirements.	Fall 2007
Post all SFF names on CMS website. (see http://www.cms.hhs.gov/CertificationandComplianc/12_NHs.asp)	Spring 2008
Add SFF designation to specific nursing homes on Nursing Home Compare.	Spring 2008

10. **Update Nursing Home Nurse Aide Training Curriculum**—CMS has contracted Abt Associates to more extensively document the problems with nurse aide training. This information is being used to assist CMS to develop specific policy and program options to improve nurse aide training. Although CMS originally anticipated completing their report in 2005, it became clear there was a need to conduct additional analyses of mechanisms that will ensure effective Federal and State oversight of whatever options might be selected for improvement. That component has been added to the report with an expected completion date of March 2008.

Action Plan	***Date***
Complete draft of Phase I report.	Fall 2007
Circulate selected chapters for experts for review.	Fall 2007
Revise draft Phase I report.	Winter 2007/2008
Complete draft of Phase II report.	Winter 2007/2008
Circulate selected chapters for experts for review.	Winter 2007/2008
Revise draft Phase I report.	Winter 2007/2008
Issue final report of Policy Options	Summer 2008

11. **Training—** In FY 2008, 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 have piloted 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). Pilots in Florida and California should be completed and evaluation documented by early FY 2008. We want to complete these actions before widely offering the MAT products to other areas.

(b) Web Based Training (WBT). The "Abuse and Neglect Complaint Investigations" WBT was launched in early 2007 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 six in Life Safety Code (LSC) currently are offered. To make training more easily accessible, we created and are piloting (September 2007) what we call the Virtual Classroom version of the LSC Basic. This will allow surveyors to access training at any time of day via the internet 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 WBT available through other mediums.
(d) Specialized training on the National Fire Protection Association Standard for Gas and Vacuum Systems (NFPA 99). Two classes are offered annually on this topic.

In addition to classroom training for basic classes, satellite broadcasts and Web casts have been increased and archived by CMS for later viewing. These are on relevant clinical and program topics to increase consistency and understanding of Federal requirements among surveyors and providers. The Web casts, satellites, and related videos are available for one year after they are first presented. Subject Matter Experts extend the life of these training tools at the end of each year to assure that the materials are still current. In addition, DVDs, and CDs have been distributed to Regional Offices and major stakeholder groups. Finally, to assure a sustainable, trained workforce, a specialized contractor will review outcomes of relevant studies mentioned above to create a more robust integration of training topics that include elements of ACTS, complaint investigation, basic surveyor, and other advanced or specialized skills. The outcome of the contractor's work will produce a "life cycle" curriculum for both new and established surveyors. This life cycle curriculum is being developed incrementally in priority order, pilot tested, and launched. Then this training is linked into a sequence of training. For example, a student now takes the Basic LSC Class, followed by the FSES/Health Care and NFPA 99 trainings. Then these surveyors are considered fully qualified to survey in all areas of the LSC that apply to regulated entities.

Action Plan	**Date**
Add a southern venue, in addition the western venue developed last year.	Fall 2009
Launch courses on "Abuse and Neglect Complaint Investigations," as well as other topics in a WBT format.	Completed and being added as new WBT as needed
Conduct eight basic surveyor training courses in both health surveys and LSC, adding an additional LSC classes to address oversight surveys. Develop Life Cycle Curriculum	Completed and being maintained Fall 2009 – Summer 2010

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 specifically related to improving care in nursing homes: reduce pressure ulcers and reduce unnecessary restraints. CMS has worked diligently to address these problems. However, 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 2007, 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 12.8%, a relative improvement of about 7%. There are even more encouraging results from those nursing homes recently working closely with their QIOs. Their high risk pressure ulcer measure decreased from 13.4% in the second quarter of 2004 to 11.9% in the first quarter of 2007—a relative improvement of 11%.

            In 2008, CMS will redesign the QIO program while continuing to improve quality of care and services in nursing homes.

        ii. QIO Initiatives with Nursing Homes: In 2007 and 2008, every QIO was 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, 5.9% in 2006, and 5.6% in the first quarter of 2007.

      In 2008, CMS will redesign the QIO program while continuing to improve quality of care and services in 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.

   RAND will complete its MDS 3.0 validation study in spring 2008 and there will be a second town hall meeting to discuss any changes with the providers, States, clinicians, etc. As noted in this report, CMS is also initiating a Post Acute Care Payment (PAC) Reform Demonstration utilizing the Continuity Assessment and Record Evaluation (CARE) tool to be used at hospital discharge and across PAC settings including nursing homes in early 2008 and a Staff Time Resource Intensity Verification (STRIVE) to enhance the accuracy and efficiency of nursing home reimbursement systems including recalibrating the resource utilization group III (RUGs III) grouper. CMS staff and its contractors are working closely to coordinate activities on these projects with other CMS initiatives.

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

3. **Data Assessment and Verification Contract (DAVE) 2: MDS 2.0—** CMS awarded a contract in September 2005 to Abt Associates to implement DAVE 2. DAVE 2 is the second phase of an effort begun in December 2004 to assess and verify the accuracy of data nursing homes' collect through the Minimum Data Set (MDS), and to provide tools for improving MDS coding accuracy.

   The MDS is a core set of screening, clinical and functional status items that forms the foundation of the federally mandated, comprehensive assessment administered to all patients and residents of nursing homes (NH) certified to participate in the Medicare and/or Medicaid program.

   Accuracy with coding MDS items, and verification of supporting clinical information, are essential since many of these items trigger care planning activities, drive publicly reported quality measures and quality indicators used in the NH survey/certification process and generate payment groupers for Medicare's prospective payment system, and for some States' Medicaid payment systems.

   DAVE 2 activities are slated to end on September 30, 2007. Activities drawing to a close include: focused on-site NH reviews of MDS data accuracy and reliability, development of targeting protocols and development of training and educational materials to help NHs improve coding accuracy. Coding Tip sheets developed this past year have been posted on the Web. Additional Tip sheets are in progress and will be posted before the end of 2007. Other DAVE 2 tasks for 2007 include: development and testing of targeting protocols to identify facilities at high risk for MDS coding errors, development and testing a NH self-audit process, and exploration of options for Federal/State partnerships to monitor and improve MDS accuracy.

   Starting October 1, 2007, Abt Associates will be retained under a contract designated, "MDS Technical Support" to manage CMS' electronic mailbox for MDS Questions and Answers, manage updates and revisions to the RAI Users Manual for the MDS Version 2.0, implement small-scale validation testing of targeting protocols, continue work on the two Special Studies involving the development and testing of Federal-State MDS accuracy partnership, and for development and testing of a provider self-audit tool and 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.	DAVE 2 effort to end on September 30, 2007
Manage CMS' electronic mailbox for MDS Questions and Answers. Manage updates and revisions to the RAI Users Manual for the MDS Version 2.0. Implement small-scale validation testing of targeting protocols. Continue work on the two Special Studies involving the development and testing of Federal-State MDS accuracy partnership, and development and testing of a provider self-audit tool and process.	"MDS Technical Support" to start October 1, 2007

4. **STRIVE National Nursing Home Time Study**—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 resident 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.

   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. CMS worked 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. STRIVE completed its on-site studies of 15 States in August 2007: District of Columbia, Florida, Illinois, Iowa, Kentucky, Louisiana, Michigan, Montana, Nevada, New York, Ohio, South Dakota, Texas, Virginia, and Washington. About 200 nursing homes from a randomly selected sample volunteered to participate.

   STRIVE has now turned to analysis of the data collected, which reflects the most recent care practices and resource needs of nursing homes. This data will be used to update Medicare's RUG-III case mix structure and payment rates. Since almost half the states in the country 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, including a new depression item, and new pain and pressure ulcer items for use in quality measurement. CMM and OCSQ have been in contact almost weekly coordinating efforts regarding the MDS 3.0 project and STRIVE. STRIVE will continue to share information on the items studied, including inter-rater reliability analysis of the pain and pressure ulcer items. CMM also is partnering with the Center for Medicaid and State Operations (CMSO) to test new MDS discharge potential items in support of the Money Follows the Person Demonstration. These items may be useful to identify residents suitable for community placement. Items tested for CMSO, for example, directly ask residents whether they: want to learn about options for living in the community, have available places to live, and prefer to live in the community. STRIVE continues to provide CMSO with feedback regarding the items. STRIVE also asked participating facilities to voluntarily complete a survey, "Artifacts of Culture Change," developed by CMSO and a contractor. This survey captures information about changes to traditional nursing home staffing and work environment--information which may help future analytic efforts.

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**
Publish Notice of Proposed Rulemaking for SNF PPS.	Spring 2008
Issue Final Rule for SNF PPS.	Summer 2008

5. **Study of State Feeding 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 long-term care facilities the option to use paid feeding 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 feeding assistants. The final rule permits a long-term care facility to use paid feeding assistants to supplement the services of certified nurse aides under certain conditions. States must approve training programs for feeding assistants, using Federal requirements as minimum standards. Feeding 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 feeding 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) wished to be attentive to the concerns about potential problems expressed when it was promulgated. In 2004, through a joint effort, CMS and AHRQ awarded a two-phase contract to Abt Associates to study feeding assistant

programs. In order to gain a sound understanding of the implementation of paid feeding assistant programs among the States, the first phase requires using a descriptive study design to gather information about a wide array of characteristics of feeding assistant programs. Phase I started in October 2004 and was completed in September 2006.

Phase II of the contract started in September 2006. The purpose of this study is to design, implement, and evaluate an optimal feeding assistant program, one that is not only consistent with Federal requirements for paid feeding assistant training, but that provides more hands-on guidance for both supervisory and feeding assistant staff about how to enhance the quality of both the dining experience and the nutritional intake of the nursing home resident. The final deliverable from this contract will include a training manual that providers can use to help implement paid feeding assistant programs. This will be completed by the end of September 2008.

Action Plan	**Date**
Completion of Phase II of project.	Fall 2008
Completion of project report and training manual.	Fall 2008

6. **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[3].

   The QIOs operate under three-year contracts. Under the QIO's 8th contract (which began in August 2005, and extends to August 2008) QIOs will continue to (a) provide assistance on care process changes, (b) working with nursing homes to set quality improvement targets, (c) helping nursing homes to track whether they are effectively implementing changes in processes of care, and (d) providing assistance to help nursing homes make organizational changes that focus on the needs of residents and decreasing staff turnover. These organizational changes have been shown to have a positive effect on clinical measures.

[3] 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.

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 help 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. QIOs then help 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.

Action Plan	**Date**
9th Scope of Work Re-design.	August 2008

7. **Expansion of Collaborative Focus Facility (CFF) Project—** Between August 2004 and August 2005, a subset of Quality Improvement Organizations (QIOs) worked closely with their State agencies (SA) 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].
   - 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**
Teaching nursing homes how to track their own clinical care processes.	Ongoing
End of contract and final evaluation.	Spring 2008

8. **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 participated 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 Quality Improvement Organizations (QIO) 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), and a series of satellite broadcasts in FY2007 on various aspects of culture change.

   In FY 2008 CMS is sponsoring a public symposium in Washington, DC titled *Creating Home in the Nursing Home: A National Symposium on Culture Change and the Environment Requirements*. The symposium will gather experts and stakeholders to discuss

issues of changes to the environment that may be impacted by Federal and State regulations and the Life Safety Code. A public one-day symposium will be followed by an invitational workshop to permit further discussion of issues and do action planning with experts, stakeholder groups, CMS, AHFSA, and the National Fire Protection Association.

CMS also will participate on and advisory committees for a culture change project with the Rhode Island survey agency titled: Promoting Individualized Care: The Regulatory Imperative. The project is testing enhancements to the survey and enforcement processes to promote individualized care in accord with federal quality of life requirements.

In addition, the agency will participate in a Veterans Administration (VA) culture change steering committee. The VA is in the beginning stages of applying the principles of culture change to all their nursing home care units. CMS also will participate in an advisory capacity with stakeholder organizations that are working toward the automation of the CMS Artifacts of Culture Change tool into a publicly available online data base in which a home can compare its level of culture change accomplishments to peer homes in its State and nationally.

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

Action Plan	**Date**
Convene a Symposium/Work Shop on Culture Change and the Environment.	Spring 2008
Participate on advisory committees for culture change project on Promoting Individualized Care.	Ongoing through FY '08
Participate on Veterans Administration culture change steering committee.	Ongoing throughout FY '08

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 AARP, 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.

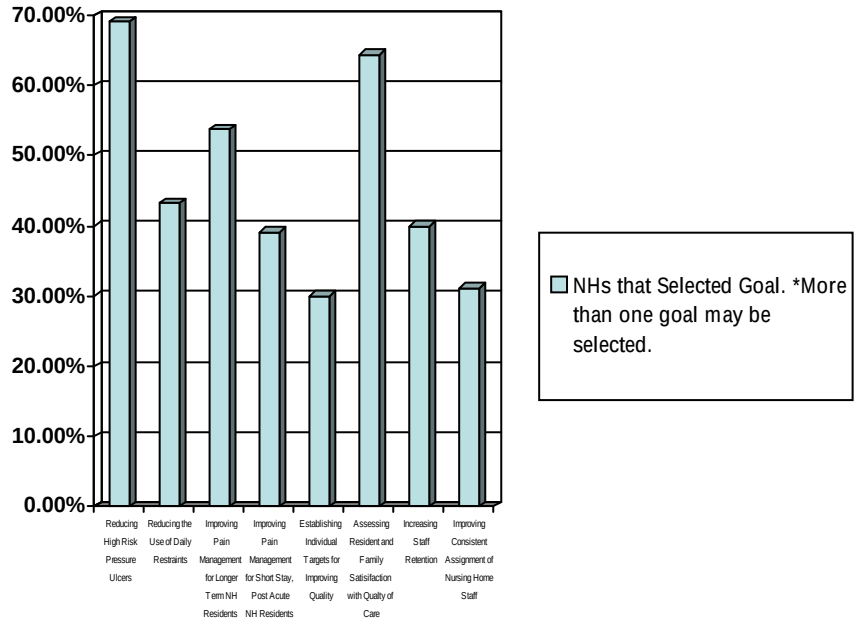
2. **Leadership Summit—** The CMS will sponsor the fifth annual joint meeting with SAs in April 2008 in the Baltimore area, to build better communication and strengthen understanding of program initiatives. Although the agenda covers all providers and suppliers in the survey and certification program, 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 AARP for purposes of exchanging information.

4. **Advancing Excellence in America's Nursing Homes Campaign—** CMS is collaborating with more than 20 national organizations to facilitate a national nursing home quality campaign entitled *Advancing Excellence in America's Nursing Homes*. The unprecedented, 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 is helping 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.

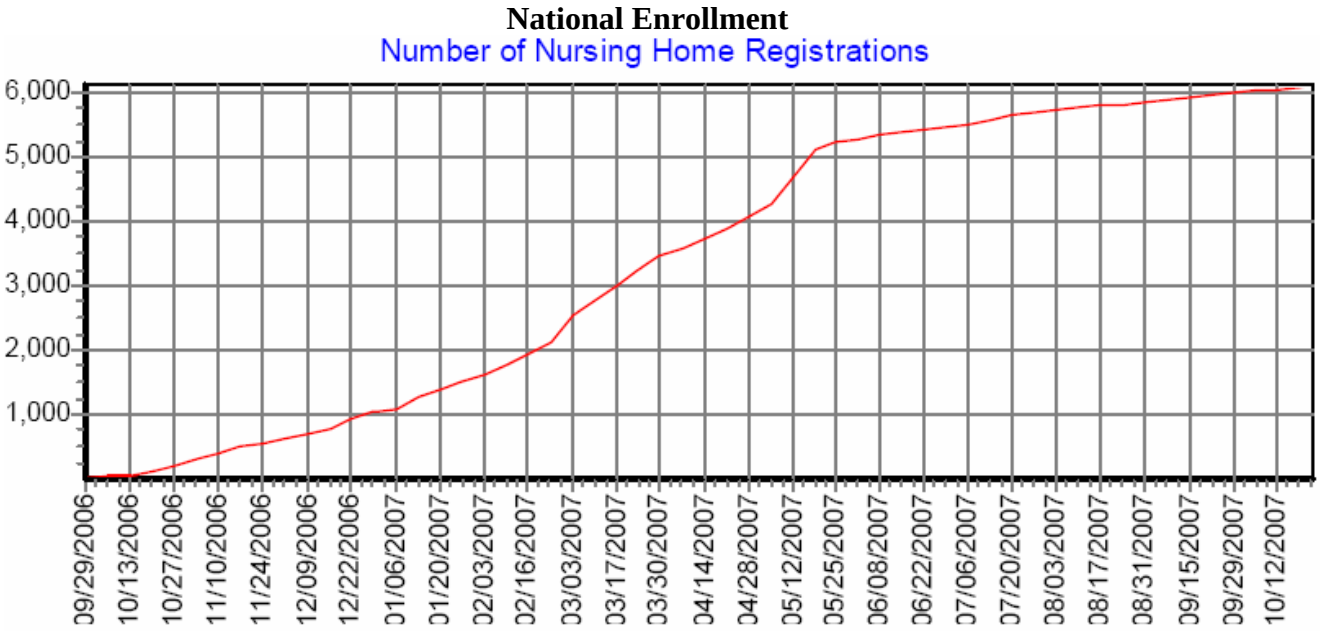
   The national campaign is focused on the following measurable goals:
   - Reduction in high risk pressure ulcers
   - Reduction in the use of daily physical restraints
   - Improvement in pain management in long stay residents
   - Improvement in pain management in short stay (post acute) residents
   - 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.

Selection of Campaign Goals by Nursing Homes
March 1, 2008



The Campaign was launched at a National Nursing Home Quality Summit meeting in Washington, DC on September 29, 2006. As of May 2007, more than 5,000 facilities had joined the Campaign, committing to work on at least three of the campaign's eight measurable goals to improve their quality of care. In addition, more than 1,100 consumers have joined the Campaign. Participating consumers are promoting the Campaign by:

- Encouraging nursing homes to sign onto the campaign; and
- Asking nursing home administrators if they are participating and which goals they have chosen.



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 Web site at: www.nhqualitycampaign.org.

5. **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) Web site, 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**
Conduct MedQIC redesign.	Summer 2008

6. **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 been working and collaborating with the State agencies (SA), and other emergency partners to develop an integrated and coordinated process to ensure continuity of essential survey and certification (S&C) 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 working closely with other HHS operating divisions and the Department of Homeland Security, to develop updated plans to ensure local, State, interstate, regional, and tribal entities are able to effectively respond to populations that are at risk. CMS plans to improve the survey and certification emergency planning process through the following activities:

   a. Establish emergency preparedness requirements for SAs regarding communication, system capabilities for tracking provider status, maintaining data reports during disruptive events, and essential business functions.
   b. Continue working with the Survey and Certification Emergency Preparedness Stakeholder Communication Forum, to ensure effective and updated guidance, recommendations, and tools are maintained to assist SA and health care provider emergency planning efforts, as well as provide clear direction regarding the roles, responsibilities and actions of the S&C Central/Regional Offices and SAs.
   c. Update the *State Operations Manual* to provide thorough and effective guidance regarding current health care provider emergency preparedness requirements.
   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 patients and residents in nursing home and other health care settings (including home and community-based settings).
   e. Maintain a user-friendly S&C Emergency Preparedness Web site that will help to disseminate information, resources, checklists and other tools to SAs and providers.

Action Plan	Date
Maintain the S&C Emergency Preparedness Web site, including SA and provider promising practices, resources, and other tools.	Ongoing
Maintain regular communication with Emergency Preparedness Stakeholder group, to collaborate and dialogue on improvements to health care emergency planning and response. (See http://www.cms.hhs.gov/Emergency for CMS Website).	Ongoing
Issue updated and improved emergency preparedness interpretative guidance.	Fall 2008
Developing Notice of Proposed Rulemaking that would go across all provider types.	Summer 2008

7. **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.

8. **Long-Term Care Rebalancing —** CMS has awarded a total of $1.4 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* (MFP) "rebalancing" initiative was included in the Deficit Reduction Act of 2005 (DRA). Demonstration grants were awarded to 31 States in January and May of 2007 and the demonstrations will continue through September 30, 2011.

   Specifically, the demonstration will support State efforts to:
   - Rebalance their long-term care support system so that individuals have a choice of where they live and receive services.
   - Transition individuals from institutions who want to live in the community.
   - Promote a strategic approach to develop and implement a quality management strategy that ensures the provision 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. These funds will be available throughout the duration of the demonstration and CMS awarded a contract in August for the provision of technical assistance.

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 currently is exploring whether refinements to the MDS may assist States in achieving their rebalancing goals.

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 (NHVBP). 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 can exert leverage to insist on high levels of quality. The NHVBD 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 will 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 will 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 some hospitalizations, producing savings to Medicare. These savings will be shared with nursing homes that either improve quality or maintain high quality of care.

   We will conduct the demonstration in four or five States. We expect to select the host States in the winter of 2008. Then we will solicit for volunteer nursing homes within the host States. We anticipate that the participating nursing homes will be selected by the summer of 2008. After we obtain waiver approval from the Office of Management and Budget, we expect to begin the three-year demonstration in the fall of 2008.

Action Plan	Date
Select States to host the demonstration.	Spring 2008
Solicit and select participating nursing homes.	Summer 2008
Begin demonstration.	Winter 2009

2. **Post-Acute Care Instrument Development & Demonstration—**Under Section 5008 of the Deficit Reduction Act (DRA) of 2005, CMS is required to implement a demonstration to support post-acute care payment reform and to develop a single comprehensive patient assessment instrument, predictive of outcomes and resource use, for use in this demonstration. A report is due to Congress in 2011.

   CMS has contracted to develop this instrument now referred to as CARE (Continuity Assessment Record & Evaluation). During the demonstration, CARE will be administered to Medicare fee-for-service beneficiaries at hospital discharge and upon admission and discharge from Post-Acute Care (PAC) settings, which will include skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals.

   CARE will be an internet-based tool consisting of a common set of assessment items organized under domains of medical, functional, cognitive, social/environmental, and continuity of care. Results from pilot tests of CARE in nine Chicago provider sites, from April through July 2007, have been very positive. The Office of Information Services currently is developing the applications and IT support system for the internet version of CARE for the demonstration starting in January 2008.

   CMS expects CARE to be implemented beyond the demonstration, potentially starting with the 9th scope of work slated to begin in 2008.

Action Plan	Date
Develop, pilot test CARE.	Summer 2007
Publish Federal Register Notice and solicit public comments.	Fall 2007
Obtain OMB clearance.	Winter 2008
Conduct User Acceptance Testing. Conduct CARE and internet training. Provide help desk support.	Winter 2008
Potential implementation of CARE beyond PAC-demonstration.	Spring 2008 and onward