

LONG-TERM CARE Survey Alert

Your Guide to Survey Success & Quality Innovations

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QUALITY REPORTING

CMS' Star-Rating System Creates a Maelstrom of Debate

► *Public reporting initiative spotlights challenges to rating true quality.*

Nursing facilities' star ratings are now posted on Nursing Home Compare, but the industry isn't exactly glowing about the Centers for Medicare & Medicaid Services' new public quality reporting system. Long-term care leaders and providers have identified numerous problems with the initiative, as well as suggested ways to give consumers a more accurate reflection of a facility's capabilities.

How the reporting program works: Each nursing home receives from one to five stars (with three being average) based on its performance in three areas: a subset of existing quality measures, its previous three years of survey performance, and nurse staffing data.

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SYSTEMS IMPROVEMENT

Considering a New Program or Care Process? Proceed and Succeed Using These 4 Principles

► *Don't roll out something that paves the way for F tags.*

Out with the old and in with the new may be a good New Year's resolution, but moving ahead with a cutting-edge program can backfire if you aren't careful. Experts suggest covering these key bases to ensure your good deeds produce kudos, not regrets.

1. Walk well before you try to race ahead. A facility should fix its foundation before adding something innovative, advises attorney **Loretta LeBar** in Salt Lake City. LeBar once heard a regulator sum up this edict up by saying he

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Quality Reporting, continued from cover

The survey domain is the most important one in determining the overall rating, according to CMS.

Star Scores Show Glaring Inconsistencies, Say Providers

To some, the rating system seems well intentioned enough, although many providers walked away from their initial ratings puzzled about why they didn't get as many stars as more lackluster or even troubled nursing facilities.

Key example: One facility asked CMS in a Q&A why it got one star when a Special Focus Facility down the road got three. The SFF initiative is for chronic poor performers at risk of getting booted from Medicare

Some providers found their star ratings included deficiencies that they had eliminated or downgraded at IDR or through appeals.

— **Joseph Bianculli, JD**

and/or Medicaid if they don't improve sufficiently. In response, CMS noted that a SFF with a poor survey record could increase its overall number of stars by having higher ratings on nursing home staffing or quality measures. "However, a nursing home that is designated as a SFF will not receive an overall star rating higher than three stars based on their

CMS Identifies 3 Ways for Facilities to Boost Star Scores

► *The agency expects providers will improve over time.*

CMS' suggestions for how facilities can garner more stars in its public rating system targets the three components of the scoring calculation. In a Q&A document on the program, the agency suggests facilities that want to improve should do three things:

Implement changes in care processes resulting in fewer and less serious deficiencies;

Increase the level of RNs, LPNs, and CNAs;

Concentrate on quality improvement actions in the areas reflected in the quality measures. (Review the 10 QMs used in the star-rating calculation on the next page.)

As for facilities worried about what the stars might hold for them moving forward, the agency expects "the distribution to shift towards a higher number of stars over time, as facilities take quality improvement actions to improve their star ratings."

How the stars panned out: In CMS' December posting, about 23 percent of the nursing homes were rated at one-star for overall quality, 21 percent at two-star, 21 percent at three-star, and about 23 percent at four-star. Twelve percent of facilities netted five stars. ■

status as an SFF," CMS writes. (You can download the Q&A at www.cms.hhs.gov/CertificationandCompliance/Downloads/QsandAsFinal.pdf.)

Another example: Higher acuity, more sophisticated Illinois nursing facilities have lower star ratings than more low or intermediate level-of-care facilities that don't admit people with pressure ulcers or serious pain, observes **Terry Sullivan**, executive director of the Illinois Council on Long-Term Care.

"To really understand each nursing facility, you have to know the type of patients they care for," says **Peter Clendenin**, executive VP of the National Association for the Support of Long Term Care, who knows of a number of "fabulous" facilities that have a three-star rating.

Black Box Calculation, Data Inaccuracy Are Top Concerns

Providers want to know how the rating system works, but they don't have the software data specs to duplicate their scoring, says **Rena Shephard, MHA, RN, RAC-MT, CE-NE**, president and CEO of RRS Healthcare Consulting in San Diego. And the calculation is very complex, she adds

For example, "the calculation weights the most recent surveys more so than previous surveys, but it also assigns a weight to scope and severity," Shephard notes. Staffing data are adjusted based on a facility's RUG case-mix, she adds. "And facilities don't calculate RUG scores for all residents."

Another problem: So much of the rating depends on survey results,

which continue to be arbitrary, varying from state to state and from survey team to survey team, says **David Hunter**, CEO of Mary Wade Home in New Haven, Conn.

Some providers found their star ratings included deficiencies that they had eliminated or downgraded at IDR or through appeals, reports **Joseph Bianculli**, an attorney in private practice in Arlington, Va. Illinois Council's Sullivan also talked to a provider to whom that had happened. (CMS did give providers a hotline number in their preview materials to call about inaccuracies, and promised to talk to state survey agencies to correct any inaccuracies.)

Trade Groups on the Stump for Changes

Long-term care organizations don't plan to take CMS' public reporting system lying down.

The American Health Care Association will be meeting with CMS about the system "from a database standpoint" to make sure the agency understands it and ways to improve it. "In effect, we are going to see if we can work something out [with CMS]," AHCA president and CEO **Bruce Yarwood** told **Eli** in an interview. "If not, we will look at the legal side — is there some facility jeopardized because it got one star based on erroneous information, and now the facility is a pariah in the community?" Yarwood says he doesn't know if that will happen to facilities as a result of the rating system, although a lot of people are worried about that type of scenario. AHCA also plans to talk to federal lawmakers about the system, Yarwood adds.

The American Association of Homes & Services for the Aging has asked for the following changes:

- Immediate development of a data collection tool around staffing;
- Coordination of the rating system with the Advancing Excellence in America's Nursing Homes campaign;
- Overhaul of the survey and certification system with funding provided for a new system;
- Medicaid and Medicare reimbursement that flow through directly for caregiving.

In addition, CMS and providers need to provide guidance to consumers on other factors for evaluating a nursing home, said AAHSA president and CEO **Larry Minnix** in a press statement.

Examples include a "five-senses test when visiting a nursing home, relying on community reputation, observation of staff-resident

interactions — and availability of senior management to address resident and family concerns."

Looking on the Bright Side

The star rating system may provide additional impetus for the industry, CMS, and lawmakers to come up with better ways to measure and convey quality.

Bianculli believes long term care regulation should move away from a system that punishes facilities for every deficiency. "We need to get advocates on board to agree that the current system does not ... identify really bad facilities or help or protect consumers. [And] we need Congress to understand the link between goals and regulations." ■

5-Star Program Uses 10 Publicly Reported Quality Measures

► *Pay special attention to 2 of these measures.*

Long-stay residents:

- Percent of residents whose need for help with daily activities has increased.
- Percent of residents whose ability to move in and around their room got worse.
- Percent of high-risk residents who have pressure sores.
- Percent of residents who had a catheter inserted and left in their bladder.
- Percent of residents who were physically restrained.

- Percent of residents with urinary tract infections.
- Percent of residents with moderate to severe pain.

Short-stay residents:

- Percent of residents with pressure sores.
- Percent of residents with moderate to severe pain.
- Percent of residents with delirium.

Note: The two ADL measures constitute 40 percent of the overall weight on the long-stay measures, states CMS. ■

Quality Improvement continued from cover

didn't care "what the heck a facility is doing if it can't do what the regulations and State Operations Manual required." Thus, if a facility has a lot of negatives historically and wants to "run with a new program" and tout it to surveyors, LeBar tells them to focus on the basics first.

2. Identify the goal and think through how to best achieve it.

One facility in an urban area wanted to implement a 24/7 open visitation policy in order to improve its census, LeBar recalls. Its reasoning? Competitors in a nearby, more rural area were successfully using such programs as a marketing advantage. But the urban facility resided in a higher crime area; thus, allowing access to the building all night might leave the door open, literally, to intruders. Also, staff might not have felt safe with the policy in place. Thus, the consequences of the approach could have had a negative effect on the facility's census and staffing levels, LeBar notes.

3. Assemble all the pieces of the program before the rollout. Otherwise, you may find the program doesn't have the wheels or other machinery to get going and stay in motion.

Example: Suppose the facility wants to implement a restraint-reduction program. If the facility lacks the budget to pay for alternative methods to prevent falls and address other reasons for using restraints, it's "already at a failure level," cautions **Reta Underwood**, a long-term care consultant in Buckner, Ky.

In addition to nailing down the necessary budget, consider the following activities before implementing a new program, Underwood suggests:

- **Establishing the standard of care for the program and how it relates to the regulations and reimbursement;**
- **Determining who's responsible and accountable** for the program;
- **Developing new policies and procedures;**
- **Administering staff competency evaluations before and after** implementing the new program or best practice;
- **Developing assessment tools and educational** modules;
- **Obtaining any necessary equipment;**
- **Designing the QA aspect** to evaluate, monitor, and document the new program.

Beware: "You can shoot yourself in the foot if a new process doesn't meet the accepted clinical standards of care," cautions consultant **Patricia Boyer, RN, MSM, NHA**, who sometimes sees facilities roll out programs with no evidence behind them. Deciding what to do is tough because new studies come out all the time, Boyer adds. "But you have to use what's generally recognized in the industry," says Boyer, principal of Boyer & Associates Inc. in Brookfield, Wis.

Example: One facility's pain management program had no scale for non-verbal residents, says Boyer. Yet the evidence-based practice is to use a nonverbal scale for pain assessment in non-verbal and dementia populations, she notes.

Know and show: Boyer has also seen facilities get in trouble with surveyors when staff can't really identify the evidence supporting a program or intervention. The solution? Include the source of that information right on the policy and procedure, she suggests.

4. Watch the pace, maintain the gain. "Sometimes facilities try to tackle too much at one time, particularly if they have several systems they want to address," says **Rena Shephard, MHA, RN, RAC-MT, CE-NE**. "And even when the new programs or processes are implemented well, staff can get overwhelmed."

Or the facility may successfully implement a system that's going well, but then leadership drops the ball when it moves on to the next initiative, observes Shephard, president and CEO of RRS Healthcare Consulting in San Diego and founding chair and executive editor for the American Association of Nurse Assessment Coordinators.

Cover the bases: "If leadership doesn't continue to monitor and support staff in maintaining a new program, many people will backslide — and there won't be a permanent improvement," Shephard warns. The oversight has to involve not just the DON but also frontline supervisors, she adds. ■

RISK MANAGEMENT

Know the Dos and Don'ts for Dealing With Government Investigators

► *The outcome of a non-survey investigation can hinge on how well you manage it.*

These days a survey issue or complaint can quickly morph into a fraud and abuse or even a criminal investigation. Your facility won't be left in the lurch, however, if managers and staff know the rules of engagement and what to do at each step of the process.

Rule No. 1: Cooperate but with due caution. When confronted with a non-survey investigation, the facility has to decide if it wants to require the investigating agency to serve formal demands for information, including subpoenas, or respond to informal requests for documents, etc., says **Jennifer Gimler Brady** with Potter Anderson & Corroon LLP in Wilmington, Del. Facilities generally find it's beneficial to cooperate with requests for information and to make staff available for interviews, she notes — at least until the facility discovers that the investigation may be taking on a different scope or intensity than initially anticipated. At that point, the facility may decide that all communications should go through its legal counsel, Brady counsels. If there's a possibility of a criminal investigation, it's a good idea for the facility to consult with criminal defense counsel, she suggests.

Rule No. 2: Weigh carefully whether to provide staff legal counsel. Facilities often do provide

counsel but don't have to unless a union contract provision requires it, notes **Joseph Bianculli**, an attorney in private practice in Arlington, Va. If the facility does offer legal representation, it should make clear that the arrangement works until the facility

Staff should know there's nothing wrong with telling investigators who contact them at home, "I'd be happy to talk to you at my workplace."

— **Paula Sanders, JD**

becomes aware of evidence that the employee acted improperly — that is “contrary to facility policies or outside the scope of employment,” Bianculli says.

At that point, the nursing facility's and staff person's interests may be in conflict, he points out. Staff may, of course, obtain their own legal representation.

Rule No. 3: Educate staff about their rights. Bianculli advises routinely giving staff general guidance about their rights and obligations in case of an investigation. Then reinforce the information in a specific case, he advises. Address the following two key issues:

- **The obligation to cooperate.** You ordinarily expect staff members to cooperate with official investigations, although they have the right to refuse to do so and not incriminate themselves, Bianculli says. Even so, “it's perfectly legal” for an employee handbook or union contract, etc., to require discipline or even dismissal if someone refuses to cooperate.

- **Rules for communicating.** Staff should never speak with anyone, even a surveyor, over the phone due to HIPAA issues, emphasizes Bianculli. “You'd be amazed at how often employees do this ...” If confronted by someone flashing a badge, staff should ask for a business card, he says.

Help staff counter these fears: Staff should know there's nothing wrong with telling investigators who contact them at home, “I'd be happy to talk to you at my workplace,” says attorney **Paula Sanders**, with Post & Schell in Harrisburg, Pa. The better approach is for the staff person to set up an interview at the facility, advises Bianculli.

People sometimes believe that telling investigators they'd like their attorney present in an interview sends the wrong message, Sanders observes. Yet given the potential consequences of being involved in an investigation, the government is starting to realize that people in such a situation have a right to have

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counsel present during an interview — “and that investigators should not hold it against the person [who exercises that right].”

Rule No. 4: Avoid crossing the line. The facility can educate staff about their rights and what to expect in an interview, says Brady.

But don't ever tell staff members how to answer questions, such as, “If they ask you about whether Mrs. Jones ever eloped before, say no.” That constitutes obstructing an investigation and possibly suborning perjury, Brady warns. ■

Be Prepared for This Investigator Ploy

► *Help staff even the playing field during interviews with investigators.*

Picture this: A nurse agrees to talk to investigators who want information about a resident fall that occurred months ago. And the investigators — who, by the way, have practically memorized the resident's medical record — press the nurse to recall specific details of the incident.

Best approach: When investigators ask a staff member about an error or incident, the staff person should know they have the right to ask to see the chart. “Staff members need to resist the temptation to give uninformed responses,” emphasizes attorney **Jennifer Gimler Brady**,

with Potter Anderson & Corroon LLP in Wilmington, Del. “The passage of time clouds recollections. And off-the-cuff answers can lead to serious consequences for staff members, as well as the facility.”

Also advise staff not to speculate about things they don't know for a fact, advises attorney **Joseph Bianculli**, in private practice in Arlington, Va. For example, “if an investigator shows you a note or document created by someone else, do not speculate what that person meant,” he says. ■

SURVEY TRENDS

New Hospice Survey Guidance Turns Eye to Nursing Homes

► *Find out what this focus means for your facility.*

If you don't feel like your facility is definitely on the same page with its hospice providers, it might be time to see what surveyors will be expecting in that regard.

The January 2009 interim final interpretive guidance for hospices emphasizes coordination of care between the two providers. And the word is that both hospice and nursing surveyors will be looking closely to see if that is indeed happening.

“We're hearing from surveyors on both ... sides” that they are focusing on ensuring communication and coordination between the two providers related to the plan of care, documentation — and communication about changes in the hospice patient's condition, reports

Judi Lund Person, with the National Hospice & Palliative Care Organization (NHPCO).

And if hospice surveyors find a problem with the nursing home's coordination of care or communication, don't count on them keeping it to themselves. “There's good communication between the agencies, in my experience,” says **Beth Carpenter**, president of **Beth Carpenter and Associates** in Lake Barrington, Ill.

Coordinate the Care Plan

The new hospice conditions of participation that went into effect on Dec. 2 talk about hospices having one

care plan, notes **Cherry Meier, RN, MSN**, with VITAS Innovative Hospice Care in Flat Rock, N.C. Yet, as many in the industry had hoped, the January 2009 hospice interpretive guidance clarifies that the hospice and nursing home may divide the coordinated care plan into two parts. “CMS folks expect the hospice plan of care to relate to the terminal illness — and the nursing home plan of care to relate to every other part of care provided to the resident,” says NHPCO's Person.

“The coordinated plan of care must identify which provider (hospice or facility) is responsible for performing a specific service,” states the guidance. And “based on the

shared communication between providers,” each provider’s part of the care plan should identify:

- **A common problem list**
- **Patient goals**
- **Palliative interventions**
- **Palliative outcomes**
- **Responsible discipline and provider.**

Watch out: Nursing home and hospice care plans that appear to be in conflict make it fairly easy for surveyors to write deficiencies, cautioned **Harold Bob, CMD, MD**, a nursing home and hospice medical director in a presentation on palliative care and survey regulations at the 2008 American Medical Directors Association annual meeting. “When the care plans don’t coincide, it probably leads to poor care,” he said.

Risk management: Lay the two plans side by side to see if they jibe, experts suggest.

Focus on Pain Management

Make sure you’re in synch with the hospice in managing hospice patients’ pain. Maryland survey agency head nurse **William Vaughn, RN**, has seen nursing home patients on hospice — usually nonverbal patients — who get their PRN dose of pain medication only when the hospice nurse comes in. And when that happens, surveyors may take a look at what’s going on, cautioned Vaughn, who co-presented with Bob in the AMDA session.

Also develop a standardized system, if you haven’t already, to notify the hospice when a patient requires an increasing number of PRN doses of pain medication. “Hospice uses PRNs to supplement scheduled medications,” says Meier. And if the patient needs too many PRNs for break-through pain, hospice will

change the regularly scheduled pain medication to improve relief.

Beware: If hospice surveyors have concerns about coordination and implementation of the hospice patient’s plan of care for pain control and symptom management, the guidance directs them to interview the facility’s nurse aides who provide direct care to the patient to determine:

- If they are aware of any complaints of pain from the patient or signs and symptoms that could indicate the presence of pain or discomfort;
- To whom they report the patient’s complaints, signs, or symptoms;
- If they are aware of and implement interventions for pain/discomfort management for the patient consistent with the patient’s plan of care (for example, allowing a period of time for a pain medication to take effect before bathing and/or dressing).

Risk management tip: If your facility admits a lot of hospice patients — and has higher-than-average pain QM scores — dig deeper to see what’s going on. The expectation is that in most cases, hospice patients’

pain will be under control, says **Rena Shephard, MHA, RN, RAC-MT, CE-NE**, a consultant in San Diego and founding chair and executive editor for the American Association of Nurse Assessment Coordinators. When confronted with an elevated QI/QM, including pain, look to see who’s in the numerator, Shephard advises. Then review their charts to see if the items are coded correctly in most cases or each case, she adds. “And if the score still isn’t good,” the next step is to look at resident assessment and process improvement systems, Shephard counsels.

Resource: You can download an advance copy of the hospice interpretive guidance at www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter09-19.pdf. CMS says the guidance will ultimately be published in Section M of the State Operations Manual and may differ slightly from the advance copy. ■

MDS CORNER: WHAT DO YOU THINK?

How Long Should You Code Pneumonia in Section I2 of the MDS?

Question: If a resident comes to the facility with a hospital diagnosis of pneumonia, how long should we code this diagnosis on the MDS?

Answer: If a resident’s pneumonia treated in the hospital has resolved on the chest X-ray, but the person is still getting antibiotics — and the nursing staff are monitoring his lung sounds and vital signs — code the pneumonia diagnosis in Section I2, advises **Rena Shephard, MHA, RN, RAC-CT,**

CE-NE, president and CEO of RRS Healthcare Consulting in San Diego, and founding chair of the American Association of Nurse Assessment Coordinators. However, I2 is really looking for an “active, acute condition,” she adds. Thus, “once the resident’s treatment is finished and the nursing staff isn’t even monitoring [the person’s] respiratory status any more than they monitor anyone else, you wouldn’t code pneumonia anymore.” ■

CLINICAL NEWS TO USE

Technology can help address specific fall risks for “frequent fallers” or residents at highest risk for fall-related injuries. For example, Guido, a smart robotic walker, helps prevent people with low vision and mobility problems from banging into or stumbling over obstacles. The system scans the environment and gives the user warning messages to help her steer clear of obstacles. If the user fails to heed the warning, Guido refuses to head in the direction of the obstacle. For more information, go to www.haptica.com/id2.htm.

LaserCane can help residents with Parkinson’s disease who tend to shuffle or freeze. As the person presses the tip of the cane down, it beams a red laser line in front of the feet to remind the person to lift his foot higher and move forward with less shuffling. For more information, go to www.ustep.com/cane.htm.

FallSaver is a wireless fall alarm (a patch placed on the person’s leg). The alarm goes off when the person’s

leg is at a certain angle indicating that he’s trying to get up, says **Jonathan Weatherly**, CEO of Your Choice Living, which sells the product.

“Unlike other fall alarms, this one goes off if the person sits down on his own,” he tells **Eli**.

Related software identifies an individual’s pattern of trying to stand up unassisted so that staff can preempt the person’s needs. The software can also identify patterns of residents trying to get up unassisted in certain areas of the facility or during certain times of the day, which may reflect staffing or care issues, Weatherly says. For more information, go to www.ycliving.com/fallsaver_prod.php.

Editor’s note: *For a fall-risk assessment checklist that includes medications known to increase fall risk, go to www.va.gov/NCPS/CogAids/FallPrevention/index.html#.* ■

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