Long-Term Care Survey Alert

Quality Initiative: PILOT QUALITY INITIATIVE A STEADY RIDE FOR MOST FACILITIES

If the **Centers for Medicare & Medicaid Services**' pilot Nursing Home Quality Initiative is any indication, most providers won't be holding onto their hats during the national rollout.

But providers might do well to take lessons from facilities that went through CMS' six-month test run of the national initiative, which is now scheduled for launch in mid-November.

"CMS' pilot initiative and publication of facilities' percentage scores on several quality measures surfaced with the initial press coverage and then went back below the surface," reports **Peter Van Runkle**, president and CEO of the **Ohio Health Care Association.** CMS tested its new publicly reported quality monitoring system in Ohio, as well as Colorado, Florida, Maryland, Rhode Island and Washington.

As will happen in the national initiative, CMS posted pilot facilities' prevalence of residents with pressure sores, pain, infection and other negative outcomes on its Nursing Home Compare Web site, and ran full-page newspaper advertisements listing some of the larger facilities' scores.

(For a rundown of the quality measures selected for the national initiative, see article 3)

A 'Relative Non-Event'

Yet for **Eben Ezer Lutheran Care Center** in Brush, CO, the pilot initiative turned out mostly to be just another report for its quality assurance team to analyze to see if the facility's care was on target.

"We looked at the scores in terms of why some were higher or lower than average and explained that to our board of directors," says Reverend **Raymond Larson**, the facility's administrator and CEO. "But we had no inquiries from people in the community about our scores," he tells **Eli**. Larson attributes the lack of community response, in part, to the fact that the facility is in rural Colorado where not a lot of people cruise the Web. "Also, most of the residents come from our region and we have a good reputation," he adds.

The **American Health Care Association** confirms that its members in pilot states generally found the initiative to be a relative "nonevent" if they educated staff, residents and families about what the scores did and did not mean, says **Sandra Fitzler**, director of clinical services for the trade group. She also suggests facilities extend their educational efforts to include referral sources, such as physicians, discharge planners and clergy.

Continued Risk Adjustment Concerns

CMS' public "quality outing" did unfairly depict some good performing facilities in the pilot. For example, **Hennis Care Centre of Dover** in Ohio got singled out by the media for its performance on some of the quality measures. The facility had high rates of residents with infection, pain and delirium compared to the average for pilot facilities.

"Yet the facility is one of the best run [high-acuity] facilities in Ohio whose patients & require IV medications to treat infections and pain management for post-orthopedic surgeries," notes **Leah Klush**, a nurse consultant and executive director of **Alliance Training Center** in Alliance, OH. "That's why it looked bad on the QMs."

"Hennis Care Centre is one glaring instance where a newspaper did not contact a facility to get an explanation of its scores before writing about them," says OHCA's Van Runkle. (Hennis administrators did not return **Eli**'s calls.) And

facilities that differ from the norm in some way may still be vulnerable to unfair negative exposure in the national initiative.

"There are still outstanding issues about risk adjustment that CMS is working on but they haven't been completely resolved," says **Ruta Kadonoff**, a health policy analyst with the **American Association of Homes and Services for the Aging** (see article 5).

That's why facilities should be prepared to explain shortfalls in the risk adjustment that may skewing their performance scores.

Klusch notes, for example, that the post acute measures rely predominantly on the 14-day minimum data set, which has a seven-day look-back, and may be performed before day 14. "So the MDS captures higher acuity patients early in the stay when they will have more infections and pain," Klusch points out.

Lower Your Numbers, Check MDS

Even so, if facilities can lower the number of residents with a condition measured by the quality measure - either by providing better care or by coding the MDS more accurately - they'll look better on the quality measures, regardless of the risk adjustment, suggests geriatrician **David Gifford**. Gifford is clinical coordinator for **Rhode Island Quality Partners**, the state-run quality improvement organization that consulted with nursing facilities in that state during the pilot and is supporting QIOs in the national rollout.

For example, MDS software that automatically carries forward ICD-9 diagnosis codes from one assessment to the next can cause a facility to score high on the infection quality measure - even though the residents' pneumonia, wound infection or urinary tract infection, etc., long ago resolved.