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PROVIDERS COLLABORATE ON QUALITY INITIATIVES

TWO NEW REPORTS SHOW HEARTENING PROGRESS
IN QUALITY ACHIEVEMENTS.

WHAT IS QUALITY?

The answer changes depending on who one asks.

Quality to Eileen Kramer, for example, spokesperson for Peabody Home in Franklin, N.H., which recently won a Quality of Life Award from the local Department of Health and Human Services, says that quality is all about culture change. It is about “transforming a nursing facility into a home, a patient into a person, and a schedule into a choice,” Kramer says.

“Our most important measure of quality is whether we are satisfying the needs and desires of our residents and their families,” says Scott Pilgrim, who owns or manages four long term care facilities in Oklahoma. “Our success depends upon their satisfaction.”

In long term care, the profession and government alike are pressing for more and faster quality improvement with an array of initiatives and tools. At the same time, the recession and cuts to Medicaid in many states, among other factors, have made just remaining operational difficult, much less finding the physical,

personnel, and financial resources to expend on quality improvement efforts.

Still, perhaps because of the initiatives, virtually all nursing facilities are actively working to improve their quality, according to a new report, the “2009 Annual Quality Report,” published this September by the American Health Care Association (AHCA) and the Alliance for Quality Nursing Home Care, both of Washington, D.C. With the well-being of the resident at heart, as always, long term care facilities are finding a way to make it happen.

TABLE 1

QUALITY INDICATOR TRENDS, 1999-2007

QUALITY INDICATOR	PERCENT IMPROVEMENT
Accidents	
New fractures	16.7%
Falls	7.9%
Behavior/Emotional/Cognitive Patterns	
Residents more anxious or depressed	11.5%
Behavioral symptoms affecting others	23.5%
Depressive symptoms without anti-depressant therapy	40.5%
Incontinence Care	
Patients with catheters kept in their bladders	18.6%
Prevalence of incontinence without a toileting plan	8.6%
Fecal impaction	90.9%
Nutrition/Eating	
Residents losing too much weight	19.5%
Prevalence of tube feeding	17.3%
Prevalence of dehydration	81.3%
Pain Management	
Residents with moderate to severe pain	36.5%
Physical Functioning	
Residents who need more help with daily activities	3.1%
Residents who spend most of their time in bed or a chair	40.0%
Incidence of decline in range of motion	29.6%
Quality of Life	
Residents who were physically restrained	50.5%
Prevalence of little or no activity	75.7%
Skin Care	
Pressure ulcers	12.0%

Source: "2009 Annual Quality Report," AHCA, Alliance for Quality Nursing Home Care, September 2009

The report is the sector's first to comprehensively examine quality trends in nursing facilities across the United States, and it found that quality is improving, particularly for facilities that are taking advantage of the Advancing Excellence quality initiative (see Table 2, above).

A related study, "Changes in the Quality of Nursing Homes in the U.S.: A Review and Data Update," published in August and written by Vincent Mor et al. found that "quality" isn't a simple thing to measure. Mor is a professor and chair of the Department of Community Health at the Brown University School of Medicine.

Quality Has Improved

Quality is multi-dimensional in long term care residences, said Mor, going

along with a host of other components.

Quality is also a moving target; a facility never "gets there" and "just maintains." Quality, as nearly all nursing facilities have demonstrated, involves a continuing process of improved data collection, analysis, process implementation or alteration, monitoring, and feedback.

Both studies found that as nursing and rehabilitation facilities are in the midst of numerous changes, from technological to cultural to case-mix makeup, quality does appear to be improving.

Relying primarily on publicly available government data and findings from some of the country's leading researchers in long term care, the "2009 Annual Quality Report" surveyed organizations representing 5,713 nursing

TABLE 2

QUALITY IMPROVEMENT TRENDS BY ALL NURSING FACILITIES AND ADVANCING EXCELLENCE PARTICIPANTS

	2005	2008	% Change
High Risk Pressure Ulcers			
All nursing facilities	12.9%	11.5%	-10.8%
Advancing Excellence participants	12.7%	11.2%	-11.8%
Physical Restraints			
All nursing facilities	6.6%	3.9%	-40.9%
Advancing Excellence participants	8.0%	4.1%	-48.8%
Chronic Care Pain			
All nursing facilities	5.7%	3.9%	-31.6%
Advancing Excellence participants	5.8%	3.9%	-32.8%
Post-Acute Care Pain			
All nursing facilities	22.9%	20.6%	-10.0%
Advancing Excellence participants	23.0%	20.6%	-10.4%

Source: Data from the Medicare Quality Improvement Organization for Colorado and the Advancing Excellence Web site, cited in "2009 Annual Quality Report," AHCA, Alliance for Quality Nursing Home Care, September 2009

far beyond quality of care to being a literal home that has very satisfied residents and families, committed staff, financial stability, and operational efficiency,

and rehabilitation facilities, along with 631 independent facilities.

This survey, conducted between April and May of this year by Avalere Health, Washington, D.C., was designed to determine the extent to which Quality First is being used by facilities to improve quality and identify areas needing improvement. The survey showed that the majority of facilities do frame their quality improvement efforts using many of the elements of the Quality First pledge.

The report shows that virtually all—99 percent—of facilities have a continuous quality improvement program, and all—100 percent—have taken at least one step toward improvement in the Centers for Medicare & Medicaid Services' (CMS) 10 quality measures used in the Five-Star Quality Rating Program.

In addition, quality has particularly improved in a number of clinical areas, the quality report says, citing data from the Office of Inspector General.

Gains Are Huge

Between 1999 and 2007, the prevalence of dehydration dropped a whopping

81.3 percent, to 0.3 percent. The percentage of restrained residents plummeted by 50.5 percent, to 5.2 percent.

The improvement in quality measures between 1999 and 2007 goes on and on (see Table 1, page 22). The number of residents who spend most of their time in bed or in a chair dropped 40 percent, while the prevalence of little or no activity dropped 75.7 percent, and the percentage of residents losing weight dropped 19.5 percent, to 9.9 percent. The percentage of residents experiencing pain fell 36.5 percent, to 8.7 percent.

According to the Mor report, national survey data show that the percentage of nursing and rehabilitation facilities cited for substandard care decreased by 11 percent between 2000 and 2009. This was at the same time that the number of deficiencies overall increased by a bit more than one deficiency per nursing and rehabilitation facility.

“Most of the CMS-reported outcome measures, particularly for the long-stay population, have improved over time from ADL [activities of daily living] decline to facility-acquired pressure ulcers,” said Mor.

He did note, however, that incontinence has worsened and that psychotropic drug use has increased, but the authors attributed this to greater use of antidepressants rather than to the use of antipsychotics, which seems to have leveled off.

And the quality report’s authors found evidence that, despite not being measured by CMS, satisfaction survey results are important measures of quality.

Satisfaction Surveys Key Measures

“We now have empirical evidence that ongoing national collaborative partnerships such as the Quality First initiative, CMS’ Nursing Home Quality Initiative, and the Advancing Excellence in America’s Nursing Homes campaign may be helping to improve levels of

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TRANSACTIONS SPEAK LOUDER THAN WORDS



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NATIONAL INITIATIVES IMPORTANT IN TREND TOWARD HIGHER QUALITY NATIONWIDE

Quality initiatives, such as Quality First, appear to have been at least part of the reason for the quality improvement seen across the board in nursing and rehabilitation facilities. Help can come from any number of directions, but they can be classified into two groups: profession-driven and government-driven quality initiatives.

PROFESSION-DRIVEN QUALITY INITIATIVES

The American Health Care Association (AHCA) is about as hooked on national quality initiatives as it's possible to be and has been involved in advocating for improved long term care quality outcomes since the late 1980s but the real visible effort started in 2002 when the entire network of long term care provider associations introduced the Quality First initiative, which established a set of principles, benchmarks, and an abiding sense of 'doing the right thing.'

Once established, Quality First spawned the next voluntary quality initiative with the 2006 roll out of Advancing Excellence in America's Nursing Homes (AE).

"Overall, the results of the first AE campaign show faster quality improvement in clinical goals for nursing homes participating over facilities not participating," says Chris Condeelis, AHCA senior director of quality and professional development. "Nationally, AE provides the profession with greater agility in adapting to significant trends such as the Pioneer Network's culture change movement, small houses, green houses, and operational advances such as consistent assignment of staff to certain residents."

Quality First

In 2002, AHCA and other long term care associations launched the Quality First initiative to demonstrate the profession's commitment to quality improvement. Today, the



initiative continues as the overarching theme for quality efforts within the long term care community. In 2010, AHCA is promoting use of a Quality First Agenda as its primary theme for quality efforts within the AHCA member community. This program aims to

provide nursing facilities with Quality Tools that offer measurable outcomes and a clear definition of success for staff as well as for the public:

- Advancing Excellence in America's Nursing Homes promotes use of three of eight possible goals to incorporate into a facility's quality improvement efforts.
- Resident/Family Satisfaction Surveys by My InnerView create actionable quality reports for nursing facilities.

- Staff Satisfaction Surveys by My InnerView create actionable staff satisfaction reports.

- LTC Trend Tracker is offered free to AHCA members. It analyzes performance derived from OSCAR data, CMS' Quality Measures and Cost Report and Medicare Utilization Report to allow a facility to enhance internal measurement of performance, to compare its performance to other facilities and to gather market intelligence.

- The AHCA/NCAL National Quality Awards Program (see page 26).

Advancing Excellence

Advancing Excellence in America's Nursing Homes (AE) is the first and largest coalition of its kind to measure quality improvement by setting clinical and organizational goals. It is supported by providers, caregivers, consumers, and both federal and state governments—a total of 28 organizations.

AE provides a wide array of free, up-to-date, and practical evidence-based resources and tools to help nursing and rehabilitation facilities improve their quality on a number of fronts.

To participate in the campaign, providers must choose at least three goals from the eight featured by AE—one clinical goal, one organizational goal, and one goal in either category. Best practices and other tools are collected and disseminated at no charge on each campaign goal. These efforts result in AE facilities performing better on quality measures than other facilities (see Table 2, page 22).

Advancing Excellence has entered Phase 2, which includes these revised goals:

- Reducing staff turnover;
- Ensuring the consistent assignment of specific staff members to specific residents;
- Reducing use of physical restraints;
- Preventing pressure ulcers and treating them appropriately when they do develop;
- Minimizing episodes of moderate or severe pain;
- Discussing and recording advance care plans with residents before completing or updating the care plan;
- Assessing resident and family satisfaction and incorporating the data into quality improvement activities; and
- Assessing staff satisfaction at least annually and upon separation, and incorporating the data into quality improvement efforts.

The clinical goals require target setting, which has proven to be invaluable in more quickly improving quality.

Providers who already participate in AE will need to update their profiles online and set targets for their goals. ➤

Because AE has new goals, providers will also need to review them and decide whether to change their current goals.

AHCA/NCAL National Quality Awards

The AHCA/NCAL National Quality Awards are designed to recognize facilities that have made demonstrable quality improvements. The step approach—a facility must achieve each award in order, and the difficulty increases dramatically—is designed to provide a pathway for providers toward excellence. Each application is reviewed by trained examiners who then give the facility feedback on what might be improved. The program is based on the Malcolm Baldrige National Quality Award Program criteria.

GOVERNMENT-DRIVEN QUALITY INITIATIVES

The profession isn't alone in trying to set measurable quality improvement programs in place. The government, through CMS, is taking steps as well.

National Quality Forum (NQF)

A private, not-for-profit organization, NQF takes a broad look at quality issues in the health care system as a whole.

Among its goals are ensuring that care is well-coordinated across care settings and guaranteeing appropriate care for people with life-limiting illnesses, such as better management of pain, patients' weight, delirium, depression, palliative care, and making sure people have advance directives.

"Each of these priority areas has a work group, and each of these work groups will be looking to develop ways to collect information and measure results," says Sandra Fitzler, AHCA

senior director of clinical services. NQF also administers the National Commission for Quality Long-Term Care. Its "Roadmap for Reform" focuses on six issues for 2010:

- Furthering culture change;
- Empowering individuals and families;
- Improving work conditions, pay, benefits, and career paths for staff;
- Using technology more effectively, such as health information technology;
- Changing the regulatory environment to reflect accurate and timely information and to encourage continually improved quality; and
- Ensuring seniors have access to long term care funding.

Nursing Home Quality Initiative (NHQI)

Like Quality First, CMS launched NHQI in 2002. One of the Web pages on the CMS site that discusses NHQI notes that "many nursing homes have already made significant improvements in the care being provided to residents by taking advantage of these materials and the support of Quality Improvement Organizations [QIO] staff." NHQI consists of CMS ongoing regulatory and enforcement systems, Nursing Home Compare, and partnerships with stakeholders.

QIOs

CMS contracts with a QIO—usually a private, not-for-profit organization staffed by health care professionals—in each state, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. The QIOs' purpose is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries.

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consumer and workforce satisfaction nationwide," wrote the quality report's authors.

In fact, satisfaction has improved in nursing and rehabilitation facilities across the country, according to the "2008 National Survey of Consumer and Workforce Satisfaction in Nursing Homes" released by My InnerView in May of this year.

My InnerView provides and tabulates results of a national consumer and workforce satisfaction survey tool used by more than 5,000 nursing and rehabilitation facilities that assess performance and use the data to improve organizational excellence. My InnerView, based in Wasau, Wis., also

establishes performance benchmarks. The database developed from the survey results is by far the largest ever assembled in the long term care sector, drawing on the responses from 425,000 residents, families, and workers.

Eighty-five percent of consumers (patients and families) rated their overall satisfaction as either excellent or good, an increase of 3 percent from 2007 to 2008. Those rating their satisfaction as excellent increased from 31 percent in 2007 to 35 percent in 2008. Eighty-one percent of consumers would recommend their facility to others. The most important factors for whether a resident or family member would recommend a facility all had to do with staff: whether they show

concern, their competence, the quality of their service, and their attention to residents' choices and preferences.

"Staffing levels are often thought of as the *sine qua non* of nursing home quality since without adequate staff it is not possible to care for the frail population," wrote Mor, citing several studies.

Mor found that "when all facilities are averaged, we see growth in the number of aides per resident day, the number of licensed practical nurses per day, and stability in the number of RNs [registered nurses] per resident day."

Consumers (residents, patients, and family members) and workers did identify areas needing more improvement: greater choice, bet-

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FIVE-STAR: A CONTROVERSIAL RATING SYSTEM

A highly controversial program that celebrates its first anniversary this month, the CMS Five-Star Quality Rating program rates nursing facilities on a scale of one star (for much below average) to five stars (for much above average).

Almost 100 percent of respondents to the portion of the “2009 Annual Quality Report” that was written and researched by Avalere Health reported that long term care facilities had at least begun to improve their performance on the 10 quality measures tracked by Five-Star.

These 10 measures include reducing new pressure ulcers, decreasing pain, maintaining mobility (whether by walking or in a wheelchair), decreasing urinary tract infections

THE STAR RATING FORMULA DOESN'T INCLUDE ANY SATISFACTION SURVEY DATA, 'A VERY IMPORTANT INDICATOR OF QUALITY.'

and indwelling catheters, and reducing the use of physical restraints and the incidence of delirium.

Anna Bojarczuk-Foy of ElderWood Health Care at Wedgewood sees problems with the Five-Star system, although she believes it works for some facilities. “I think it works very well for the extremely, exceptionally good and poor facilities, but I think it's very flawed in the in-betweens, because there are so many things that go into [quality] that cannot be standardized. If you're exceptionally good, you're going to be a five regardless.”

But certain facilities, especially those that provide specialized services, may receive only three or four stars when in terms of quality the facility may actually be in the top 10 percent of that kind of facility, she says.

Association Voices Concerns

AHCA has been very vocal about its concerns with the flaws in the Five-Star program, providing comments and participating in meetings with CMS. “We have never opposed the concept of having some sort of rating system or system to compare facilities,” says Lyn Bentley, director of regulatory services, survey, and certification at AHCA, “provided it's based on accurate information and truly identifies the things that are going to be most useful to the consumer. We don't believe that the way the Five-Star system is designed meets those criteria.”

As most providers know, the Five-Star rating system is based on three domains: survey, staffing, and quality measures. The past three years' surveys are examined, with more recent years' surveys receiving greater weight in the

calculation. Points are assigned to deficiencies, with the more severe deficiencies receiving more points. CMS also looks at complaint surveys over the past year, and those that received deficiencies are given points. Then they compare each facility to its peers within the state and assign a star rating.

Within each state, only 10 percent of facilities are allowed to receive a five-star ranking—so, say, out of 100 facilities, 50 were operating with optimal quality, 40 would be denied the five-star rating no matter what they did. Of those 100 facilities, 20 would be assigned one star, even if they provided quality care. The remaining 70 facilities would be split between two-, three-, and four-star ratings.

“We have taken great issue with this,” says Bentley, “because it means if I have a survey this month and I get a five-star rating, that rating could change next month” because another facility received a better survey. “You could never have everyone get a five-star rating, even if they all got perfect surveys.”

In the staffing domain, CMS examines the staffing for two weeks prior to a survey as it compares to the patient population and acuity levels. In the quality measure domain, CMS focuses on 10 of the reported 19 quality measures—some short-stay and some long-stay. Each domain receives a star rating, as well as the overall star rating.

Stakeholders Call For Restructuring

The formula used to arrive at the Five-Star ratings is very complex, says Bentley, who has been working intimately with the issue for the past year, and she thinks that few consumers read the information about the formula provided on the Web site, but instead just look to see how many stars a facility has.

“Key things it doesn't tell consumers: the facility's specialties—for example, there's no way to tell that the facility has a ventilator unit or that they specialize in rehabilitation for closed head injuries,” notes Bentley. The star rating formula also doesn't include any satisfaction survey data, “and we believe that's a very important indicator of quality,” says Bentley.

CMS says the satisfaction surveys will not provide useful, comparable data unless it's a nationally standardized survey conducted by a third party. “At this point they are considering putting a link [on the site] that says, ‘This facility conducts satisfaction surveys,’” says Bentley. “That is in the talking stages at this point.”

Bentley believes some kind of compromise regarding satisfaction surveys will be achieved, because not only providers, but consumers, are saying that would be important information to know.

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 ter communication from management, and more relief from significant job stress. A recent My InnerView paper, “Leadership Competencies and Employee Satisfaction in Nursing Homes,” found that leadership competencies were strongly correlated with worker satisfaction. The paper recommended that providers develop leadership competencies to further quality improvement efforts.

Staff Satisfaction Important

“Clearly, an effective strategy for quality improvement has to include a focus on the workforce that provides care for residents and their family members,” wrote the quality report’s authors.

Many providers are using the satisfaction surveys to identify areas needing improvement and to make changes to resolve those issues, the quality report says. For example, 51 percent of providers surveyed “have made changes to dining selections and/or implemented an open dining program [that] allows residents to eat according to their own schedules and needs,” the report’s authors wrote.

Others changed laundry providers, created more spiritual opportunities for residents, changed the types and variety of resident activities, changed staffing levels or assignments, and restructured case management and discharge planning. A full 77 percent increased training on issues raised by the satisfaction surveys.

Ninety-six percent reported improved quality as a result of being able to use satisfaction survey data to identify quality problems and monitor improvements.

Sixty-six percent of workers said their facility was an excellent or good place to work, and 73 percent said it was an

TABLE 3	
MAJORITY OF FACILITIES USE CQI PROCESSES	
■	81% have a written statement of commitment to continuous quality improvement (CQI)
■	95% have established processes to address customer grievances and complaints
■	96% use data to identify quality problems and monitor improvement
■	95% use interdisciplinary employee teams to analyze and improve processes
■	78% conduct employee satisfaction surveys at least every two years
■	85% have a clearly defined list of their facility’s key processes and performance measures for which all staff receive training
■	99% conduct regular resident and family satisfaction surveys
■	82% empower employees to take action on quality problems
WAYS FACILITIES ARE USING CQI RESULTS	
■	83% found that empowering employees to take action on quality problems produced positive results
■	90% discovered that systematically evaluating resident and employee satisfaction data improved quality
■	92% said that using interdisciplinary employee teams to analyze and improve processes was a successful quality improvement tool
<i>Source: “2009 Annual Quality Report,” AHCA, Alliance for Quality Nursing Home Care, September 2009</i>	

excellent or good place to receive care. Management practices were the most important factors to workers.

Mor’s findings indicated that the proportion of facilities with high levels of nurse staffing has increased. However, Mor also saw an increase in the proportion of facilities whose nurse staffing has fallen below minimum levels.

Mor noted that most measures of staffing ignore therapists, the fastest-growing segment of facility staffing, especially at facilities with many Medicare patients.

The Reimbursement Link

Among the quality report’s key findings was a strong correlation between adequate reimbursement rates and quality improvements, along with access to care. The report’s authors urged policy makers to keep reimbursement rates for public programs stable.

“Because facilities devote a full 70 percent of operating expenses to wages, benefits, and other labor costs,” Alan

Rosenbloom, president of the Alliance, said in a statement. “Medicare funding stability from Washington is essential to the ongoing successful operation of our quality improvement programs.”

Mor observed that higher Medicaid reimbursement rates “appear to be associated with great improvements in quality and lower rates of hospitalizations.”

In fact, facilities that rank lowest in quality tend to have more Medicaid patients and are much more likely to fail and have chronic quality problems, according to a number of studies. Other studies have shown a correlation between higher state Medicaid reimbursement rates and nursing facility quality. Higher payment rates have been found to be associated with fewer pressure ulcers, more staffing,

fewer hospitalizations, fewer physical restraints and feeding tubes, and fewer government-cited deficiencies, Mor said.

Further, the report found mounting evidence that rehabilitative and medically complex care is more cost-effective in nursing and rehabilitation facilities than in other sites, such as inpatient rehabilitation facilities.

Providers Contemplate Techniques

Virtually all nursing facilities are involved in some kind of quality improvement, according to the quality report, especially continuous quality improvement (CQI), which is a management philosophy of injecting quality processes into all operations to improve resident and family satisfaction and patient outcomes. The CQI effort may include monitoring patient conditions, holding training sessions on quality improvement techniques, and making care more effective.

Mark Cairns, administrator of Ma-

donna Living Community in Rochester, Minn. (owned by Benedictine Health System [BHS]), and Assistant Administrator Beth Redalen say their quality improvement efforts have really paid off for the residents, as well as in an AHCA/National Center for Assisted Living (NCAL) Step III Quality Award. Tracking that improvement is a satisfying experience.

“We’ve made great strides in falls and pain,” says Redalen, “and have tracked those [among other indicators] for the last three years. We’ve substantially met the goals because of new processes that we’ve put in place.”

“I feel that whether it was the quality award or any of the initiatives,” says Cairns, “what it does is help you focus in on an area so you can measure it. Then you start tracking it and try to benchmark it against other facilities.

Once you get those answers, you develop a process so that you can maintain that quality level.”

To improve quality, Redalen says, first measure performance. This allows identifying opportunities for improvement. Once these are identified, come up with—and implement—an action plan for addressing the issue, she says. Continue to measure performance in order to track the progress being made, and generate reports on the progress of various quality improvement efforts. These can be used for comparative data, public reporting, pay for performance, and accreditation, Redalen says.

Going After The Primary Cause

One way to determine and eradicate the root cause of a problem is called root cause analysis (RCA). The premise is that by eliminating the root cause of a problem, rather than “treating the symptoms,” the likelihood that

the problem will recur is minimized, experts say. RCA needs to be conducted systematically, using documented evidence for all conclusions. When investigating the root cause, remember that usually more than one potential root cause exists. To determine the correct causes, document all known causal relationships between the causes and the problem.

Once that’s done, providers should figure out a solution that could prevent recurrence, provided the solution meets the facility’s goals and objectives and it doesn’t cause other problems. The next steps are to implement the solution and measure its effectiveness, adjusting as necessary.

While RCA begins by reacting to an event and trying to discover the root cause, with practice and several periods of analysis it can become a proactive tool, actually predicting when

a problem is likely to take place. That can help change the culture of the facility from one of putting out fires to one of resolving problems while they’re still small. And that reduces risk.

A useful way to break change, which can seem like an insurmountable task, into manageable chunks is called Plan-Do-Study-Act (PDSA). The main idea behind PDSA is to test the proposed change in a small area and analyze the results before implementing the change across the organization.

The “classic quality paradigm (structure, process, outcomes) can have another key component, which is a feedback loop,” said the quality report’s authors. Structure refers to staffing, processes to deficiencies and selected aggregated minimum data set measures, and outcomes to measures like ADL decline or pain, according to Mor.

“In order to improve quality, providers should periodically engage in critical self-evaluation to assess the extent to which the quality improvement structures, processes, and outcomes they have committed to are actually being implemented.”

Identifying Early Indicators

BHS, which had two of the three AHCA/NCAL Step III Quality Award winners this year, is focusing on developing leading indicators, rather than always relying on lagging indicators. A lagging indicator might be a low satisfaction score on a survey. Leading indicators could predict the areas of dissatisfaction before they take place, so that they can be prevented.

With lagging indicators, “the data is slow to get back,” says Redalen. “It could take up to six months to get the results, and by that time you could have

TABLE 4
OUTCOME TRENDS

	2005	2009	% Change
Percent of Residents with:			
Facility-acquired pressure ulcers	3.5%	3.1%	-11.4%
Facility-acquired restraints	5.7%	3.5%	-38.6%
Facility-acquired catheters	1.9%	1.7%	-10.5%
Pneumonia immunization	32.2%	61.8%	+47.9%
Influenza immunization	60.5%	70.7%	+14.4%
Pain management	24.6%	27.6%	+10.9%
Bladder training	5.7%	6.4%	+10.9%
Antipsychotic medications	26.1%	24.6%	-5.7%
Anti-anxiety medications	17.3%	20.1%	+13.9%
Antidepressant medications	45.0%	48.2%	+6.6%

CMS QUALITY MEASURE TRENDS

Quality Measure	2004	2008	% Change
ADL decline	15.7%	15.2%	-3.2%
Pain in long-stay residents	6.3%	4.0%	-36.5%
Pressure ulcers in long-stay residents	13.7%	12.0%	-12.4%
Incontinence in low-risk residents	46.9%	49.8%	+5.8%
Adjusted prevalence of indwelling catheter use	5.9%	5.5%	-6.8%
Worsening mobility	12.5%	11.9%	-4.8%
Urinary tract infection	8.5%	9.1%	+6.6%
Delirium in short-stay patients	3.2%	1.8%	-43.8%
Pain in short-stay residents	22.7%	20.0%	-11.9%

Source: “Changes in the Quality of Nursing Homes in the U.S.: A Review and Data Update,” Mor et al., August 2009

a big problem.” With leading indicators, results come back very quickly. “Leading indicators are short-term indicators where you can measure data” and see it promptly, she says.

A priority area for which BHS is implementing leading indicators is in the area of pain, says Redalen.

Two years ago, BHS identified certain indicators—outcome-based measures—for the whole organization to monitor, says Jeri Reinhardt, director of quality for BHS. The organization uses the results of the monitoring to inform its strategic planning.

The philosophy centers around five pillars of quality. These are:

- Care—to develop and deploy evidence-based care and systems to produce superior outcomes and ensure patient/resident safety;

- Service—to consistently exceed customer expectations;

- People—to be the work community of choice and a leader in values-based recruitment, retention, leadership development, and employee satisfaction;

- Finance—to optimize financial results while developing and deploying sustainable models; and

- Growth—to grow the ministry to both existing and new markets.

For each pillar, lagging indicators have been traced for more than three years, says Reinhardt. For Care, they’re acquired pressure ulcers, prevalence of falls, percent of pain, and percent of pain for short-stay patients. For Service, the quality indicators are resident satisfaction and family satisfaction. For People, they’re the mission values survey, nursing employee retention for the skilled nursing portion of the facility, and employee retention for the assisted living portion. For Finance, the quality

indicators are cash flow, fiscal year-to-date, and community benefit. And, finally, for Growth, they’re market growth, philanthropy, and grants.

But saying “Let’s fix our overall satisfaction rate” is a daunting task. Instead, BHS looked at the lagging indicators and then identified leading indicators, such as “Do we acknowledge concerns within 24 hours of receipt?” If they’re not acknowledging concerns that quickly, staff can fix the process. That will help prevent any future issues from becoming full-blown problems, and, in turn, improve the satisfaction survey results.”

Continuous Quest For Quality

Reinhardt doesn’t think this is really anything new in long term care. “All long term care organizations have lots of things they measure,” she notes. “But do you actually look at what you



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FACILITIES ACT PROMPTLY ON COMPLAINTS

Nearly all facilities educate consumers and staff on how they may report problems without fear of retribution, have written policies and procedures and a code of conduct, and conduct additional training, according to the “2009 Annual Quality Report.” More than 90 percent reported that they strive to react promptly to problems and resolve them, and 87 percent conduct internal monitoring and auditing.

measure, and do you find the meaning in it?” While having the measures isn’t rare, organizing them around a pillar with leading and lagging indicators is more so, she says. “What we’re trying to do is organize them around our pil-

lars and identify the leading indicators that are most important to our future success.”

Continuing to reach for ever-higher realms of quality is the vision of Anna Bojarczuk-Foy, administrator of ElderWood Health Care at Wedgewood in Amherst, N.Y., winner of an AHCA/NCAL Step III Quality Award. Receiving the award doesn’t mean Foy is going to rest on her laurels. In fact, as the Quality Awards examiners were conducting a site visit, she was already in the midst of further quality efforts.

“Step III was an exceptional award for me and my staff—it’s our award—but if we stop now, we really don’t deserve it. You have to always continually challenge yourself to be better every day. If we settle in and say, ‘We got this [award], we’re great,’ we’re not going to be so great. When you take care of people it’s always changing,

and technology changes, so we have to challenge ourselves to do more, to do things differently. I’ve been in [health care] for over 30 years, and I will never stop challenging the staff to see what we can do better or differently for next year. I’m thrilled that we got the Step III award, and it’s not by accident, because we worked hard for it. But we can’t stop now. We’re already on to other things.” ■

Kathleen Lourde is a freelance writer based in Dacoma, Okla.

For More Information

■ For links to “Online Quality Resources” and “Successful Quality Award Applications,” go to ProviderMagazine.com under “Current Extra News Online.”

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