CMS’ five-star quality rating system for nursing homes has fallen under scrutiny in the past few months, surrounded by allegations that faulty government oversight of facilities’ self-reported ratings data allows providers to “game the system.” But although there seems to be consensus among industry stakeholders that the rating mechanisms are flawed, experts are divided about what the underlying problems are and what reformation should entail.

In August, the *New York Times* featured a front-page exposé that cited a number of perceived gaps with the rating system, which CMS implemented five years ago to help consumers more easily assess the quality of nursing homes. The rating system is also a key feature of *Nursing Home Compare*, a tool that allows consumers to compare information about different nursing homes when evaluating care options. The rating system uses three criteria—quality measures, staffing levels, and health inspection reports compiled during annual surveys (the weightiest component)—to determine a facility’s star rating.

The *Times* article claims that the system’s reliance on self-reported data from providers to calculate the first two rating components has led to a barrage of inflated star ratings that mislead consumers. Consequently, it has launched a firestorm of attention, including several letters from legislators urging CMS to act on the concerns raised.

For *Trudy Lieberman*, a fellow at the Center for Advancing Health, contributing editor to the *Columbia Journalism Review*, and longtime reporter in the nursing home arena, the article’s claims are nothing new.

“I’m not surprised at any of this. This is pretty typical,” she says. She sees the evidence cited in the
article as the continuation of a longtime trend among some nursing home providers to try to bolster public image without improving care.

But some experts think the accusations lobbed at CMS for shoddy management and at providers for unethical practices are blown out of proportion, conflating extreme outliers with typical facilities. “There are always outliers, both positive and negative, and the New York Times article focused on the negative without looking at the majority of cases whereby providers actually improved outcomes with this new transparency five-star imposes,” says Steven Littlehale, MS, GCNS-BC, executive vice president and chief clinical officer at PointRight, Inc., a healthcare analytics consulting firm in Cambridge, Massachusetts, and one of the experts interviewed for the Times piece.

Although he agrees that the system in its current form is not helpful for its intended consumer audience, he qualifies that many of the problems surrounding it stem from misuse and overextension. “The unfortunate thing about five-star is ... the measure itself is used not just by consumers and not just by providers, but it is used throughout the industry in so many different ways,” he explains, naming court proceedings and Department of Housing and Urban Development applications as two of these domains. “It was never intended to be used in those ways, but it is.”

Such rampant use may additionally contribute to the prevalent misconception of the system as a one-stop shop for nursing facilities, which it was also never intended to be, says David Gifford, MD, senior vice president of quality and regulatory affairs at the American Health Care Association (AHCA) in Washington, D.C., and another expert quoted in the Times article.

“No one ever claims that the five-star system should be used exclusively by itself for whatever purpose,” Gifford says. “It’s information that I would use with my family, but I would not rely solely on it.”
On its website, CMS notes that consumers should use Nursing Home Compare “with other information you gather about nursing homes facilities” and that the five-star system “is not a substitute for visiting the nursing home.”

Caveat aside, CMS officials contend that the majority of current users find the system beneficial. “Despite some limitations, the Five Star ratings and website have been hailed by advocacy groups and families as very useful,” agency officials stated in an email. They added that in a user survey conducted in March 2013, 85% of respondents reported finding the information they were seeking, making Nursing Home Compare the highest-rated of CMS’ Compare entities. About 1.4 million visitors access the website each year.

**Mixed takes on self-reported data**

Most prominent among the Times critiques is the five-star system’s heavy leaning on unverified, self-reported data from nursing homes to determine scores for two of the three rating components: staffing and quality measures.

But despite their qualms with the standing system, both Littlehale and Gifford struggle with the article’s implications of foul play by providers.

According to Gifford, the term “self-reporting” mischaracterizes the extensive processes that facilities use to capture data, which is also used internally for care and operational planning purposes.

“When I hear someone say self-reporting, on the face of it, it raises some concern for me,” he says. “Nursing homes are not reporting their actual results that are used on the Nursing Home Compare and the five-star.”

However, even CMS uses this terminology to discuss the strengths and limitations of the system: The agency lists the “self-reported” nature of data in the staffing and quality measures components as a ratings limitation.

Gifford says that data on the total number of staff (e.g., RNs, LPNs, CNAs, and licensed vocational nurses) is collected from timesheets submitted two weeks prior to a survey, which CMS then uses to calculate the facility’s risk-adjusted hours per patient day. However, the agency plans to overhaul this process soon, as it has developed a pilot system for collecting auditable staffing data directly from payroll systems.

**Robyn Grant, MSW**, director of public policy and advocacy for the National Consumer Voice for Quality Long-Term Care in Washington, D.C., sees this impending update as CMS’ implicit acknowledgement that there are problems with the current methods of data collection.

In addition to this upcoming transition, CMS recently issued a press release promising several other improvements to the system in 2015, including updated scoring methodology, as well as extra quality measures and a focus on capturing timely and complete inspection data by introducing a user-friendly website for surveyors. Based on its piloting of special surveys for accuracy on the MDS—the assessment that contributes to the quality measures component of a facility’s star rating—earlier this year, the agency also intends to implement focused survey inspections for a sampling of nursing homes across the country.

In the meantime, though, Littlehale says the MDS is such a complex assessment that trying to intentionally falsify sections for a ratings boost would be a sizable undertaking even without the additional oversight CMS has planned.

“No one ever claims that the five-star system should be used exclusively ... It’s information that I would use with my family, but I would not rely solely on it.”

—David Gifford, MD

There are so many bells and whistles in place in the MDS to ensure accuracy that to think that someone is actually purposefully able to figure out how to manipulate that is a bit of a stretch,” says Littlehale, citing the f-tags related to resident assessment accuracy that compel surveyors to compare residents’ apparent conditions with corresponding chart and MDS data during their visits. Plus, if facilities attempted to alter MDS coding to improve the quality measures that drive the five-star quality domain, they might end up jeopardizing their case mixes and reducing their reimbursements, he adds.

Although Littlehale doesn’t believe fraud is widespread in the industry, he thinks coding accuracy is a pervasive problem that can affect providers’ ratings.
and reimbursements. He says a whopping 70% of MDS assessments brought to PointRight have data inaccuracies and coding errors in their MDS assessments, many times after their electronic health records have scrubbed the reports.

“I think assessment errors are made quite a bit, but I also think that the errors are just that and not systematic attempts to game the system,” he says.

But Grant says the system’s lack of oversight is still problematic. She says that disparities reported in the Times article between facilities’ scores on health inspection reports, the sole rating component that doesn’t rely on some type of self-reported data, and the other two measures—which are often much more favorable—are another indication that something is amiss.

The current system grapples with such inconsistencies by weighting the health inspection reports, which comprise the results from annual surveys, most heavily.

According to CMS officials, the five-star system is “primarily driven by the health survey rating.” This rating, which officials say is calculated from the results of 180,000 on-site inspections of nursing homes carried out over the most recent three years by trained, objective surveyors from state health departments and CMS, serves as the foundation of a facility’s score. From there, one star can be added or subtracted based on the staffing component. Ditto for the quality measures score.

But Littlehale thinks the touting of health inspection data as objective is problematic.

“The No. 1 predictor of a survey outcome is your zip code,” he says, referring to variations in reporting practices between states and even within states as a barrier to the meaningful comparison of facilities across the country.

Although CMS acknowledges differences in how individual states conduct inspection processes, and consequently advises consumers to tread with caution when using the system to compare facilities from different states, Littlehale says even intra-state comparisons in densely populated regions with multiple survey teams, such as California and Florida, can be misleading.

“I can’t even compare California to California because there are so many different survey teams [that] interpret federal guidelines differently,” he explains, adding that this lack of uniform evaluation practices can affect the number and type of deficiencies for which a facility is cited.

However, according to Lieberman, inspectors have historically been lenient toward facilities in the way of penalties.

When she was a reporter for Consumer Reports, Lieberman conducted two large-scale investigations of nursing homes. For the latter of the two, which was carried out in 2006, she analyzed each of the three measures that correspond to today’s criteria for the CMS rating system, homing in on state inspection reports, staffing levels, and quality indicators for 16,000 U.S. nursing homes. During her evaluation of state documentation and facility premises for the investigation, Lieberman saw a lot of “slap-on-the-wrist fines” and low-level deficiencies cited to nursing homes for significant infractions, which she attributes to state inspectors caving to pressure from the industry to divert attention from problems.

The Times article highlights a contemporary instance of this practice, claiming that until recently, California often neglected to cite nursing homes for federal-level violations, the only type that affects a star rating.

The current state of transparency

Lieberman’s analysis broaches another thread explored by the Times article: transparency. The article touches on the evolution of providers’ attitudes toward the five-star system, which arc from protest and resistance at the system’s implementation in 2009 to widespread acceptance today.

To Lieberman—who has written that the louder an industry’s outcry about publicizing inside information, the more illustrative that information is—providers’ current contentedness with the rating system is a red flag that it’s not as accurate as it used to be.

In contrast, Littlehale and Gifford see the industry’s current silence on the subject as a testament to providers growing accustomed to negotiating public exposure by shaping up care delivery.
“Transparency at this point is not a big issue,” says Littlehale. “It’s expected. People came to it perhaps reluctantly, but they’re fine with it.”

Gifford, who admits he was wary of public reporting when the five-star system was first introduced, thinks the ratings have been the direct impetus for change among providers, shedding light on problematic practices that would otherwise still fly under the radar.

“One thing that you will see when you start public reporting is, people pay attention to what they used to record ... so over a couple-year period, you suddenly see the data improve in accuracy where it wasn’t there before,” Gifford explains.

Since the system’s inception, CMS officials say they’ve seen long-term reductions in the use of physical restraints and the prevalence of pressure ulcers throughout the industry, as well as recent reports of reduced usage of antipsychotic medications.

“Staffing up” or staffing on the up-and-up?

The Times article cited staffing as another ratings hotspot, claiming that self-reporting in this domain allows facilities to “staff up” prior to their annual survey—a practice that falls into the “yo-yo compliance” camp, says Lieberman, who’s observed facilities tighten and slacken practices depending on the proximity of a survey.

Littlehale also admits he’s seen this practice before; however, he argues that it’s a difficult strategy to execute on a large-scale or consistent basis because “survey windows,” the segments of time during which the chances that a provider will be surveyed are especially high, can be months long.

“Purposefully bulking up staffing for several months at a time is not really realistic,” he says. Instead, PointRight often finds that facilities don’t fully capture the staff that they should on their CMS-671 form, a mistake that could result in underreporting employee numbers.

Gifford names the regulators who visit facilities throughout the year to investigate resident complaints as another safeguard against such practices.

“If there’s a really bad egregious complaint investigation, you would actually expect to see more citations related to low staffing ... and we haven’t seen a change in that,” he says, though he still questions whether staffing levels are high enough yet.

Playing catch-up

Despite their grievances with the Times article, Gifford and Littlehale agree that the system could use a makeover. They say one of the overarching problems with the system’s current form is that it hasn’t evolved to meet the demands of the ever-expanding long-term care landscape.

Historically, the industry has been dominated by long-stay and permanent residents. But in recent years, it has grown to accommodate those who have been discharged from hospitals for temporary stints in an intensive rehabilitation environment—a group that now comprises the majority of the nursing home population. Last year, 60% of the more than 3 million Americans who were admitted to skilled nursing facilities eventually returned to the community.

But as it stands, the five-star system is not helpful for this significant subset.

“There’s very little information on there that would help guide the selecting of a nursing facility for short-term rehabilitation. I think that’s a big shortcoming,” says Gifford, though he notes that CMS is working on a plan to better accommodate the needs of this growing population in future iterations of the rating system. CMS’ recent press release didn’t seem to reference any changes intended for this realm in 2015.

Littlehale—who consulted the five-star system when searching for a facility for his mother, who needed short-stay, intensive therapy while recovering from orthopedic surgery, and again for his mother-in-law, who required permanent residence with a focus on skilled nursing—thinks that the system as a standalone tool is ineffective for both populations.

“It’s a pretty blunt instrument,” he says, explaining how the system’s suggestions for his mother-in-law centered on acute rehab-focused facilities with minimal long-stay populations. For his mother, Littlehale had to apply his own parameters to sift through the recommendations the system provided, which lacked key information, such the number of days per week a patient could receive therapy services.

To remedy the current dearth of customization, Littlehale says the system should be updated to include a simple set of initial questions that serve to assess consumers’ primary needs (e.g., for a short or
long stay; a therapy or nursing emphasis) right away.

He also believes that the system, and Nursing Home Compare, is lacking consumer satisfaction information. Versions of a standardized data set called the Consumer Assessment of Healthcare Providers and Systems are available in acute care and home health, but not the nursing home industry.

Littlehale explains that transforming considerations from a satisfaction scale into criteria for the five-star system would better represent the areas of care most important to prospective residents, which often defy the quantitative measures that currently determine ratings.

“I’m always struck when I have conversations with the consumers of nursing home services [because] they won’t make value statements that can be mapped to quality measures ... [or] to survey deficiencies,” he says.

Instead, rehab patients name key considerations like frequency of therapy to expedite recovery, privacy, Internet access, and “spa-like” benefits; meanwhile, quality of food, prevalence of measures to minimize pain, and the ability to visit with loved ones or house a pet may top the list of interests for long-stay residents.

“Five-star was intended to be for consumers,” says Littlehale. “Let it be what’s important to them.”

He emphasizes that instigating all of the necessary reforms to five-star is not just up to CMS, but the industry at large.

“One of the problems is ... we wait for CMS to tell us [to change],” he explains. “It was CMS that said that we need to be transparent; it was CMS that said we had to have standardized assessments and quality measures, [but] we as an industry have to get together and make it better.”

He suggests that providers team with trade organizations, consumer advocacy groups, and vendors to propose solutions that help accomplish the goals of all stakeholders for the system.

AHCA has already made moves in this area, according to Gifford, who says the trade group has

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Ramp up your facility’s ratings the honest way

Despite discord surrounding the current five-star rating system for nursing homes, experts agree that there are concrete steps providers can take to boost ratings—and the quality they are intended to represent—honestly.

To start, Steven Littlehale, MS, GCNS-BC, executive vice president and chief clinical officer at PointRight, Inc., a healthcare and insurance consulting firm in Cambridge, Massachusetts, recommends considering each of the system’s rating criteria separately:

- **Health inspection results.** To prepare for surveys, Littlehale recommends providers abandon dedicated survey readiness preparation programs, which he deems “reactive and very old school,” in favor of a durable operational framework that positions quality care delivery as a daily concern.

  He adds that simply being deficiency-free, which means a facility is meeting the government’s minimum standards for compliance, doesn’t necessarily grant a nursing home bragging rights. Instead, he says providers should be setting their own standards that exceed these basic requirements.

  When considering performance on surveys, Littlehale recommends that facilities limit the scope of their self-comparisons to those in their locality, as he finds the validity of performance comparisons falters when considering facilities in different jurisdictions. In this way, providers can evaluate whether the deficiencies they receive are common throughout the district, or unique and in need of immediate addressing.

  If a provider receives repeat citations, Littlehale says this is a clear indication that there are underlying, systemic problems that require attention; by tracking these, providers can fashion “a road map for improvement.”
Ramp up your facility’s ratings the honest way (cont.)

On the other hand, if a facility is fielding complaints from off-premises consumers, even after earning a clean bill of health from a surveyor, this could be an indication that the facility needs to ramp up its customer service and build stronger relationships with residents’ families, he explains.

• **Staffing.** For Robyn Grant, MSW, director of public policy and advocacy for the National Consumer Voice for Quality Long-Term Care, in Washington, D.C., good staffing is at the root of all performance improvement.

  “We know that there’s a strong connection between better staffing and better care, and I think that better ratings just flow … from that,” she says, adding that facilities should ensure their key players, such as nurses and CNAs, are well-trained, well-supervised, and consistently assigned to care for the same residents.

  Littlehale says that the industry’s shift away from hiring temporary workers through third-party agencies is a step in the right direction, serving as a vehicle for cutting costs and improving care by retaining staff who are better equipped to deliver consistent services that align with the facility’s vision. However, he points to the high rates of turnover that continue to pervade the industry as evidence that providers still have a way to go in terms of motivating and retaining staff. He urges leadership to foster a positive work environment and provide generous compensation to get—and keep—valuable employees on board.

• **Quality measures.** Littlehale points to analytics as an indispensable tool in the quality arena, as it can identify specific quality lapses and serve as a launching pad for improvement. For example, using the QAPI model, providers can analyze which outcome areas are negatively affecting the quality component of their rating and quantify how much improvement it will take to elevate them to the next star level. He adds that analytics can also provide valuable insight in the health inspection and staffing domains.

  Despite the importance of unpacking quality scores and identifying areas for improvement, David Gifford, MD, senior vice president of quality and regulatory affairs at the American Health Care Association in Washington, D.C., advises providers to avoid going overboard with self-analysis.

  “Lot of people spend an inordinate amount of time trying to understand why [the] measure they calculated … [is] slightly different from what’s on five-star,” he says. “I think that’s wasted time and energy.”

  CMS officials suggests that providers take advantage of the opportunities for technical assistance through the agency’s existing quality programs and initiatives, such as the Advancing Excellence Campaign, a project launched by the Quality Improvement Organization program, and the National Partnership for Improving Dementia Care.

  Trudy Lieberman, a fellow at the Center for Advancing Health, contributing editor to the *Columbia Journalism Review*, and longtime reporter in the nursing home arena, recognizes constraining budgets and resource deficits as common barriers to providing quality care. But she says that not all improvements have to be large in scale or scope to have a significant impact on residents.

  “You want to interact with the residents and make them feel it’s their home because it is,” she says, recalling visits to facilities where staff would help residents paint their nails, engage them in meaningful conversation, or organize an outdoor activity. “I think the best facilities do that, [and] it doesn’t cost that much to have an hour a day playing ball.”

  She adds that ensuring residents have sufficient access to food when they want it, such as for a midnight snack, is another easy way to improve consumer satisfaction and win over surveyors.
advocated that CMS add rehospitalization measures to the rating system. This recommendation was duly noted by the agency: Among the additional quality measures CMS specifies in the press release are claims-based data on rehospitalization and community discharge rates.

**Star systems on the horizon**

In June, CMS announced plans to roll out new Compare websites modeled after Nursing Home Compare’s star system in the home health, hospital, and dialysis facility realms. The agency slated late this year and early next year as tentative launch dates. However, in light of the scrutiny the SNF five-star system is facing, experts are divided about whether CMS will—and should—stay the implementation course.

Gifford says he sincerely hopes the effects of recent criticism won’t delay the sites’ launch because of the “profound effect on practice” he’s seen the existing system have in the long-term care realm.

But Grant hopes the system’s new position under the microscope will give CMS pause, inciting the agency to regard the new sites as an opportunity to incorporate more stringent auditing measures and relevant data upfront this time around.

> “Having a rating system like this is very important ... but major improvements are needed, and I think once those are made that we could have a system that consumers can have confidence in.”
> —Robyn Grant, MSW

“I hope that they will actually learn from this and ... that this will bring attention to how important it really is to have integrity of the information,” she says. “I think that having a rating system like this is very important ... but major improvements are needed, and I think once those are made that we could have a system that consumers can have confidence in and that they can trust.”

**MDS 3.0 RAI Manual v1.12 now effective**

The latest manual version carries few weighty updates

On October 1, new updates to the RAI manual took effect. But according to Diane L. Brown, BA, CPRA, director of postacute education at HCPro, a division of BLR, in Danvers, Massachusetts, *MDS 3.0 RAI Manual v1.12* is light on significant changes.

Still, Brown says there are several areas in the latest manual version that constitute major alterations. These include:

- **The implementation of the Change of Therapy (COT) OMRA policy update** (Sections 2.9 and 2.10), which was officially provisioned by CMS’ release of the final rule for fiscal year 2015 and closes a loophole that left a small population of residents who were eligible for a therapy RUG classification stuck in a nursing category. The finalized policy change will now allow providers to use the COT process for patients who were originally classified into a RUG-IV therapy group, but who were shifted into a nursing category during a COT observation window after inadvertent scheduling changes in therapy caused disqualification from a rehab RUG category, and who have since resumed their regular therapy schedules, thus re-qualifying them for a RUG-IV therapy classification.

However, this new policy update will not apply to situations where an End of Therapy (EOT) assessment is performed because therapy ended during a COT window.

Furthermore, as the new policy currently stands in the MDS 3.0, the option to use the COT process will be restricted to cases in which a COT assessment initially disqualified a resident from therapy and cannot be applied when a scheduled assessment kindled the shift in categories. However, due to the many protests from callers...
during a recent Open Door Forum, CMS will be reevaluating this component of the policy update. (For more information on the new COT OMRA update, see PPS Alert’s October issue.)

- **Clarification on determining what constitutes a treatment day to adhere to EOT OMRA submission timelines** (p. 2-48). The new addition specifies that “for purposes of determining when an EOT OMRA must be completed, a treatment day is defined exactly the same way as in Chapter 3, Section O, 15 minutes of therapy a day. If a resident receives less than 15 minutes of therapy in a day, it is not coded on the MDS and it cannot be considered a day of therapy.” Section 6.4 (p. 6-12) also provides a new example for when to complete an EOT-R.

- **Updates to A0410 terminology,** which Brown says add some “much needed clarity.” The Chapter 3, Section A item (Ch. 3, p. A-8), formerly known as “Submission Requirement,” is now entitled “Unit Certification or Licensure Designation” and decked out with new coding instructions, which convey much of the original information, but in a clearer, more thorough manner, says Brown.

  For example, under Code 3, CMS specifies that a facility is required to submit a resident’s MDS records to the QIES ASAP system—regardless of payer source—and directs providers to Section 5.1 of the manual for a rundown of appropriate record types for submission.

  Additionally, CMS includes new language in Section 5.1 that specifies when a correction can be submitted for an accepted record: “within 3 years of the target date of the record for facilities that are still open. If a facility is terminated, then corrections must be submitted within 2 years of the facility termination date” (p. 5-10).

  This update serves as a good reminder of CMS’ considerations in this arena, says Brown. “CMS expects data to be corrected to accurately reflect a resident’s identification, location, overall clinical status, or payment status,” she explains.

  In other Chapter 3, Section A news, CMS also added item A1900 (Ch. 3, p. A-29), entitled “Admission Date” to specify the date a given episode of care begins for a resident in the facility, which Brown deems a useful addition for tracking a resident’s care episode and/or readmission.

  - **The elimination of a scheduled PPS assessment for readmission or return** (p. 6-8), a previous requirement that Brown considered unnecessary thanks to newer documentation methods.

  In addition to the important considerations above, Brown says that the newest manual version also includes a handful of notable minor changes, such as:

  - **Tweaks to entry tracking record wording** (p. 2-33).
  - **The removal of redundant definitions for “unscheduled assessment.”** The term is no longer delineated in Section 2.8; it’s now only defined in Section 2.9.
  - **The addition of full-fledged definitions for activities of daily living** (Ch. 3, p. G-3).
  - **An edit to the Chapter 3, Section O title,** which now reads “Special Treatments, Procedures, and Programs in multiple chapters” (emphasis added).
  - **Added language to clarify coding practices for item O0100F, Ventilator or respirator** (Ch. 3, p. 0-3): “Residents receiving closed-ventilation via an endotracheal tube (e.g., nasally or orally intubated) as well as those residents with a tracheostomy.”
  - **Updated requirements for MDS assessments, discharge assessments** (Section 2.5), and **hospice elections** (Section 2.6).

  There are also a smattering of gratuitous changes, says Brown, including alterations to capitalization for some terms, the addition of extra acronyms and page endings, the supplanting of the term “progress notes” for “clinical records” in multiple locations, and updated URLs.

Editor’s note: This article is part 1 in a two-part series that covers how long-term care providers are using food to fuel culture change. Part 2, which will appear in next month’s issue, will help providers navigate potential challenges when launching their own dining practice makeovers.

Grilled steak, newly-harvested potatoes, and fresh berry pie. It’s a creation inspired by the slow food philosophy of accomplished restaurateur Mataio Gillis, but the diners are not clientele of Ciao Thyme, his upscale cafe and catering establishment in Bellingham, Washington. Instead, they are residents of Mt. Baker Care Center, a skilled nursing facility in the same town, and the hearty fare they’re noshing comprises just one entrée from a rotating, seasonal menu spun from their input and a collection of ingredients that are locally-sourced, fresh, and natural.

The new menu is a far cry from the high-protein ice cream, shakes, and assortment of other supplements and packaged snacks that studded residents’ diets just two years ago, says Andrea Leebron-Clay, RN, owner of the nursing home. “We were using a lot of food supplements because the food was so bad,” she says. “Huge cost, and really, now we know that food isn’t much better than a candy bar anyway. We don’t have to do that anymore. People are eating the food and enjoying it.”

Through their company, Clay Senior Management, Leebron-Clay and her husband own, in whole or part, about 20 nursing homes and 10 assisted living facilities based primarily in the Northwest and Hawaii. Two years ago, Leebron-Clay came out of a 20-year retirement from the healthcare industry to resume management duties for two of the company’s key nursing homes, testing some unconventional tactics in the hopes of boosting care and morale.

Leebron-Clay enlivened these facilities by convening drumming circles, holding yoga sessions, hitting a local car show, and organizing beer and wine tastings. As the targeted nursing communities reap social, clinical, and financial gains, the moves are slowly catching on with staffs, many of whom have long been accustomed to regimented care and strict compliance with traditional regulations, she says.

A 40-year veteran of the healthcare industry, Leebron-Clay says her inspiration for reshaping long-standing conventions is her acute understanding of baby boomers, the expansive generation whose members have started to consume long-term care services at unprecedented rates. “These are not the people that are going to want to listen to big band swing,” she notes. “These are my people.”

After her hiatus from the industry, Leebron-Clay professes that she initially thought her tactics would be the first of their kind, recalling the rigid, standardized practices she had to follow as a nurse, which included rousing residents from bed at 5 a.m. and lining them up in the halls to distribute breakfast. But she says an Internet search quickly revealed that her planned overhauls represent a push for culture change that’s been increasingly permeating the long-term care industry for the past two decades, and food—a historic purveyor of health, happiness, memory, and culture—is often at the forefront of the movement.

Refreshing stale practices

In March 2013, CMS issued a memo addressed to state survey agency directors announcing its support of New Dining Practice Standards, a set of expert recommendations compiled in 2011 by an interdisciplinary task force composed of 12 national clinical organizations that set standards of practice. The impetus for the task force was a 2010 symposium sponsored by CMS and Pioneer Network, a national nonprofit based in Rochester, New York,
that advocates for person-directed care and supports for elders. The organization promotes a movement away from institutional provider-driven care to more human consumer-driven models that embrace flexibility and self-determination.

The memo pointed state surveyors to a final copy of the standards, as well as a 24-minute CMS training video. The agency also requested that surveyors share the standards with providers.

Since then, the Pioneer Network conferences that Leebron-Clay and her staff frequent have been dedicated to training both providers and surveyors on the fine points of the standards—a practice that provides extra incentive for workers to get on board with more progressive views toward dining, Leebron-Clay says.

“I can go back to my staff and say, ‘Hey, even the surveyors are learning this. You certainly don’t want to not learn it,’ ” she explains.

Recently, the Pioneer Network transformed the dining standards from a static document into a dynamic toolkit, which it debuted at its national educational conference in early August.

“Really the reaction [to the dining standards] was, ‘Do you have any tools? Do you know any homes that have implemented them?’ And so it became pretty clear right away that we needed to give tools,” says Carmen Bowman, MHS, BSW, owner of Edu-Catering: Catering Education for Compliance and Culture Change, a consulting, training, and public speaking business in Brighton, Colorado.

As a subcontractor for CMS, Bowman helped coordinate the original dining symposium, a task which included recording the thousands of reform ideas that stakeholders contributed. She also facilitated the taskforce that funneled those ideas into the standards and a subsequent one that developed the Dining Standards Toolkit.

The toolkit provides sample policies and procedures, tip sheets and forms, and brochures to distribute to residents and families. Among its most valuable offerings is the Informed Choice Form, says Bowman, which helps providers balance resident choice with risk mitigation when making diet decisions—two essential regulations that often receive unequal weight in practice.

“We really have two things that we have to do, and they’re both required by law. We’re supposed to on one side prevent accidents, but on the other side, we’re supposed to honor choice,” Bowman explains. “Unfortunately, the safety side has gotten all the attention.”

In addition to the for-purchase resource, Pioneer Network offers a free compilation of literature, forms, and videos from around the Web to help providers kick-start dining transformations.

According to Lynda Crandall, executive director of Pioneer Network, the organization decided to dedicate so much attention to dining practices because food is a universal concern in nursing homes and one of the most prominent topics of discussion during resident council meetings.

“You could literally go across the country and ask for the agenda for this week’s or this month’s meeting and often food is on the agenda, so it’s a topic of high concern to many people,” Crandall says.

According to the goal statement of the dining standards, the purpose of the document is to use food as a vehicle for promoting “individualized care and self-directed living” over “traditional diagnosis-focused treatment.”

To accomplish these aims, the document provides evidence-based approaches for individualizing overall nutrition. In addition, it includes specific sections dedicated to reshaping diets for conditions that would typically call for restricted meals, such as diabetes and hypertension, and others that question the validity of traditional dining alternatives, such as tube feeding and altered consistency meals.

The standards advocate residents’ choice and quality of life, which have historically fallen by the wayside as providers concentrate on clinical outcomes and operational efficiency, says Crandall.
However, dining is inextricably linked to both; according to research quoted in the standards, 50%–70% of residents leave 25% or more of their food uneaten at most meals, which not only has an effect on residents’ health, but can drain facilities’ resources. Other studies found that 25% of residents experienced weight loss during their stay in nursing facilities. Furthermore, malnutrition stemming from protein undernutrition, which can affect from 23% to 85% of a facility’s residents, is a pervasive problem linked to poor outcomes and increased mortality. Research indicates that most residents who exhibited evidence of malnutrition were on restricted diets—a statistic that calls into question the legitimacy of a practice that has traditionally girded long-term care.

“Our people learned about being passionate and really taking pride in what you’re serving. It’s really made a huge difference.”
—Andrea Leebron-Clay, RN

“We think we’re preventing choking [and] weight loss ... but in fact, all these restricted diets are ending up with people not eating the food,” says Bowman, who names dehydration and skin problems such as pressure ulcers as other byproducts of limited diets.

Instead, for residents who require modifications to ensure safe eating, she suggests making minor tweaks to practices—and major revisions to language—to make food more appealing. For example, if a resident who is at risk for choking refuses to eat a pureed meal, staff should ask if he or she would prefer finely chopped food, which is more palatable and cost- and time-efficient than alternatives like ground items.

In addition, Bowman says that asking residents about their preferences can facilitate an important shift in mind-set among staff, enabling them to recognize that they are helping residents eat what they want, rather than allowing them to do so.

“You don’t allow someone to eat what they want to eat,” says Bowman, who adds that such language is pejorative. “They’re adults, so we need to change our system to support people.”

Early investment pays off

However, long-held attitudes towards what constitutes proper care are not the only obstacle to change, Crandall says. In addition, she finds that providers often worry about how surveyors will interpret prospective updates to dining practices and cite low reimbursement rates as a prevalent barrier to embracing change.

Leebron-Clay has experienced this latter challenge first-hand.

“I think that was the biggest shock to our chefs that we brought in to help us out,” she says of the meager funds the facility uses to cover food costs.

When Leebron-Clay first recruited Mataio Gillis and his partner, Lisa Samuels—a registered dietitian who interned in long-term care as part of her credentialing, and who now teaches cooking and healthy eating classes throughout the Whatcom County community—Mt. Baker Care Center was three times over its budget, and the kitchen staff was as uninspired as the food was lackluster.

“When Mataio first came in to look at the food he said, ‘You know, you have to try to mess things up this bad,’ ” Leebron-Clay recalls.

To rejuvenate the kitchen, Leebron-Clay and Gillis swapped staffs for a few days. The chefs from Ciao Thyme took over the facility’s kitchen, cooking for the residents as a volunteer initiative, and the Mt. Baker staff cycled through Gillis’ cafe to learn about the possibilities that food can carry.

“Our people learned about being passionate and really taking pride in what you’re serving,” Leebron-Clay says. “It’s really made a huge difference.”

Plus, after an initial dip in funds, the facility has been experiencing significant savings on a number of fronts. The food tastes good, so residents are eating, which minimizes waste and the necessity to purchase expensive supplements, Leebron-Clay says. In turn, residents are healthier and happier, with fewer hospitalizations and more loyalty to the facility; Leebron-Clay estimates that she’s seen a 20% increase in the facility’s private census since implementing the new program.

“There is an investment in the front end where you’re going to be spending more money than you thought you wanted to, but that eventually works out,” she says.