New research points to perks of nursing home-hospice partnerships

High hospice penetration in the nursing home can reduce hospitalization risks for all residents and boost care coordination between settings

As the government continues to encourage coordination across the healthcare continuum, new research indicates that partnerships between nursing homes and hospices are picking up speed—and that these collaborations may yield manifold benefits for their patient populations.

“It’s so important to provide hospice services for individuals in the place where they call home, and those folks in the nursing home, that’s their home,” says Peter Notarstefano, director of home and community-based services at LeadingAge, a Washington, D.C.–based trade organization for nonprofit providers of aging services.

According to the 2014 edition of the hospice facts and figures report released annually by the National Hospice and Palliative Care Organization (NHPCO), the number of hospice patients who died in a nursing home rose from 17.2% to 17.9% between 2012 and 2013—the largest jump in any setting covered by the report.

“As the average life span in the United States has increased, so has the number of individuals who die of chronic progressive diseases that require longer and more sustained care. An increasing number of these individuals reside in nursing homes prior to their death,” NHPCO states in its report. “This rise has been mirrored by growth in the number of hospice patients who reside in nursing homes.”

As a result, there’s a growing coalition of inter-setting teams paving the way for significant improvements in patient outcomes, according to a recent study published in the Journal of Post-Acute and Long-Term Care Medicine (JAMDA). Its findings suggest that a high hospice utilization rate (penetration) in a nursing home can reduce the risk of hospitalization for all of the facility’s residents—regardless of whether they are enrolled in end-of-life services.
Key findings

The study, entitled “The Effect of Hospice on Hospitalizations of Nursing Home Residents,” examined whether residing in a nursing facility with higher hospice penetration reduces the risk of hospitalization for 1) hospice-enrolled residents when compared to their counterparts in facilities with lower hospice penetration and 2) non-hospice residents.

Because a host of previous research had already linked hospice enrollment among nursing home residents with reduced hospitalization rates for these individuals, researchers developed the second prong of their hypothesis to explore additional, more indirect effects the presence of hospice in the setting can have on hospitalization risk, says Nan Tracy Zheng, PhD, research public health analyst at RTI International, a global independent, nonprofit institute based in Research Triangle Park, North Carolina, and lead author of the JAMDA study.

Using a sample of 505,081 non-hospice residents and 241,790 hospice-enrolled residents in 14,030 facilities across the country who died during 2005 to 2007, researchers found that for every 10% increase in hospice penetration, the risk of hospitalization decreases 4.8% for hospice-enrolled residents (a phenomenon the researchers dubbed “the expertise effect”) and 5.1% for non-hospice residents (“the spillover effect”). To determine their hospice penetration variable, the authors of the study calculated the percentage of decedents per nursing home who received hospice care during the last 30 days of life, Zheng explains. Based on this criterion, the researchers found that U.S. nursing homes have an average hospice penetration of 28%.

Although determining whether the difference in magnitude between the spillover and expertise effects is significant fell outside the scope of the study, Zheng says the increased benefit of higher hospice penetration for non-hospice nursing home residents makes sense, as these individuals have a much higher baseline risk of hospitalization compared to their hospice-enrolled counterparts, a fact seemingly confirmed by another finding of the study: In the last 30 days of life, approximately 37.6% of non-hospice residents are hospitalized, compared to only 23.2% of their hospice-enrolled counterparts.
counters. Zheng notes that this latter statistic encompasses all hospitalizations during the last 30 days of life for hospice residents, regardless of whether they occurred before or after enrollment.

In addition to highlighting a major benefit of hospice for enrolled residents, the spillover and expertise effects demonstrate the more far-reaching implications of hospice in the nursing home setting. The reduced risks for hospitalization that occur across the board as hospice penetration increases suggests that simply heightening the exposure of nursing home staff to palliative care practices may influence the confidence and aptitude with which these professionals care for residents during their final days, regardless of their decision about hospice election, Zheng explains.

“There is something about this collaboration that might help nursing home staff improve their competencies and have a better understanding of skills for end-of-life care,” she says, adding that boosted exposure can also strengthen coordination and communication between hospice and nursing home staffs.

**Benefits of reducing hospitalization risks**

The findings of the JAMDA study are particularly important because of the significant and diverse costs associated with the hospitalization of nursing home residents at the end of life.

Hospital stays during this difficult time can severely jeopardize a resident’s well-being on multiple fronts, Zheng explains. They can incite adverse clinical outcomes, including infection, irreversible functional decline, and new or worsened pressure ulcers, while the implications of relocating can place extra physical and emotional stress on already vulnerable individuals. In addition, the move can disrupt execution of the care plan, defy a resident’s wishes or beliefs, and place more financial strain on the individual and his or her family.

But increased hospice penetration in nursing homes can diminish these harmful side effects by shrinking hospitalization risks. “Overall, the evidence shows that there are opportunities for improved quality of care and quality of life for end-of-life residents by reducing hospitalizations at the end of life,” Zheng explains.

In addition to presenting new possibilities for improving residents’ well-being during their final days, reducing hospitalization risks by partnering with hospice providers can be cost-neutral for nursing homes, or even generate savings in some cases, such as when the decreased risk stems from earlier identification and management of an individual’s symptoms, Zheng explains. However, she notes that nursing homes may incur some additional costs in cases where the decreased risk results from the provider learning to manage conditions that would have previously compelled it to hospitalize a resident.

But in either scenario, Zheng stresses that nursing homes’ conscious effort to lower hospitalization rates among residents by teaming with hospice providers may result in significant societal savings by alleviating the heavy financial, health, and emotional expenditures associated with hospital stays.

In addition, although the JAMDA study only explored the impact of hospice penetration on hospitalization risk among nursing home residents, Zheng points to a large body of research that highlights hospice penetration’s association with more effective pain management, better care processes (e.g., lower rates of physical restraint usage and potentially inappropriate feeding tubes), and higher family satisfaction rates in the nursing home community. Zheng says this last component might be due to the heightened emotional attention and support hospices often offer to beneficiaries and their families.

But nursing home cultures aren’t the only things that benefit from high hospice penetration, according to Notarstefano, who calls inter-setting collaborations “a win-win for both providers.” He explains that while nursing home staffs learn more specific strategies and philosophies for providing effective end-of-life care, hospice personnel likewise gain important insight about how to provide holistic care for individuals with multiple conditions and comorbidities. He adds that the two entities are particularly well-suited for teaming up because both have been evolving over the years to care for advanced illnesses that would have previously landed a patient in a hospital.

**Forging successful partnerships**

Frank Russo, vice president of risk management and privacy officer of Silverado Care, a postacute care agency based in Irvine, California, says that partnerships between nursing homes and hospices can flourish
when the two providers share similar attitudes toward care and place trust in one another—both of which facilitate the inter-setting team’s delivery of seamless care to the patient.

“We want the patient not to be disrupted whatsoever and get the care that’s necessary to them,” Russo says, explaining that this coordination of care delivery across settings is an especially high priority for Silwerado because of the three distinct services it provides: homecare, hospice care, and memory care. This final offering takes the form of assisted living communities whose methods and types of care are often comparable to nursing home settings, he adds.

Despite the centrality of shared values and trust to effective partnerships, Russo also points to the importance of ensuring that pivotal operational resources for hospices and nursing homes (e.g., staffing and training) don’t bleed into one another, especially for organizations that offer both services.

“[Hospice] is very unique in both its challenges and requirements compared to an assisted living or a nursing home setting,” Russo explains, warning providers against foraying into hospice without the specific expertise, policies, and education it requires. “For providers offering both services like us, ensure that service lines operate in a collaborative environment ... [but don’t] attempt to manage co-joined resources.”

To strike this delicate balance between independence and teamwork, Silverado coordinates regular care meetings between its hospice and memory care entities to discuss the needs of residents who are enrolled in both services and to share any pertinent documents and information, Russo explains. Silverado also attempts to coordinate care with the outside hospice providers with which its residents elect care, though the organization experiences less consistent success on this front, Russo adds. He explains that without the shared requirements, protocols, and reporting thresholds inherent in being run by a single company, collaboration between two disparate settings takes more willpower.

“Challenges ... usually stem from communication, coordination, ensuring the plan of care is communicated by both sides, and medication delivery is appropriate,” he says.

Notarstefano agrees that these are make-or-break areas, and advises providers pursuing partnerships to focus on improving them. In particular, he emphasizes the importance of creating an effective, customized care plan by consulting all affected parties: the nursing home and the hospice, as well as the resident and his or her family. This means that residents should understand and approve of their care plans and that all healthcare providers should honor their contents. In addition, Notarstefano says the respect for a patient’s specific needs and desires should permeate all departments and practices within an organization—including marketing. For example, he explains that hospices should exercise ethical marketing strategies by providing nursing homes and prospective patients with transparent and easily accessible tools, resources, and information to understand eligibility criteria.

The advice of both Russo and Notarstefano is backed by long-standing research. Zheng points to a report NHPCO published in 2007 that studied six nursing home–hospice collaborators to determine practices that can foster successful inter-setting partnerships. In addition to highlighting the importance of developing systematic processes to promote consistent communication between settings and sharing similar philosophies of care, the report listed some specific “collaborative solutions,” including:

- Open acknowledgement by nursing homes that death occurs in the setting and the consequent establishment of practices that provide special support to dying residents and their families
- Implementation of mechanisms to facilitate regular assessment of the partnership
- Use of joint education to address relationship building and conflict resolution, as well as the care aspects, regulations, and environmental factors that are unique to each provider
- Facilitation of regular dialogues between the CEOs of both providers
- Prompt response by the hospice to requests made by the nursing home and purposeful structuring of hospice visits
- Expedient Medicare per diem payment by nursing homes (even when state Medicaid payment is slow) and 100% per diem payment by hospices
- The offering of support by hospices to nursing homes during key operational processes, such
as surveys, Medicaid applications, and hospice resident follow-ups

The legislative element

Although these strategies can help providers overcome day-to-day partnership challenges posed by negotiating the unique cultures, values, and motivations of disparate settings, Notarstefano says the significant flaws in the payment structures that underlie today’s healthcare systems are much more encompassing barriers to effective collaboration. He believes that current reimbursement models—which were implemented when providers worked in unchallenged silos—incen-
tivize increasing profit margins more than improving patient outcomes.

“It’s not the hospice-nursing home partnership that’s the problem. ... It’s the payment system that I think is broken,” he says.

But Notarstefano also acknowledges that the pitfalls of today’s payment structures have not gone unnoticed by the government, which has been working to get long-standing regulations up to speed with evolving attitudes toward care and coordination throughout healthcare. He points to recent legislative pushes for standardized quality measures across settings, as well as the continued development of accountable care organizations and bundled payment models. He hopes that Congress continues to introduce similarly productive legislation by translating important research findings about best practices—like those presented by the JAMDA study—into policy that furthers today’s focus on reforming payment structures, advancing health-care standards, and improving patient outcomes across settings.

“Congress has passed legislation that has really broken down some silos, ... [so] we’ll be able to compare ... what’s working and what’s not working and what’s really improving the quality of life for individuals,” he explains. “We’re comparing apples with apples, and in the past we weren’t able to do that.”

Medicare Advantage Q&A

Medicare Advantage plans, also known as managed care, Part C, and MA plans, are offered by Medicare Advantage Organizations (MAO), which are private companies that contract with Medicare to provide beneficiaries with Part A and Part B services. These health plans—which include health maintenance organizations, preferred provider organizations, private fee-for-service plans, special needs plans, and Medicare medical savings account plans—are girded by a complex web of regulations, and as they continue to gain a stronger foothold in long-term care, they’ve become increasing pain points for some in the SNF community, who have criticized MAOs for communication lapses and onerous billing practices.

To help providers navigate the evolving Medicare Advantage landscape, HCPro asked long-term care readers to share their most pressing questions, concerns, and challenges in this arena. We compiled a list of your responses and recruited our resident director of postacute education, Diane L. Brown, BA, CPRA, to shed some light.

If you have additional questions or feedback regarding Medicare Advantage or any other long-term care topic, please email Associate Editor Delaney Rebernik at drebernik@hcpro.com.

Q We have chronic problems with delayed discharges from Care Improvement Plus [an MA special needs plan] because of their pre-certification system.

They require initial PT [physical therapy] and OT [occupational therapy] assessments before they will initiate a precertification for acute rehab or NH [nursing home], and then they have a 48-hour turnaround time for making a decision.

We had a patient that was admitted on Monday with acute CVA [cerebral vascular accident], needing all three disciplines. We requested acute rehab, they denied acute rehab, and then I had to initiate another precertification for NH, waiting another 48 hours.

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Also, we had the weekend issue. The patient was discharged on Monday after a seven-day hospital stay. If she had been on regular Medicare, she would have discharged easily on day 3 or 4. This is substandard care for the patient and unfair delayed LOS [length of stay] for the hospital.

We have just encountered another problem regarding SB patients under Medicare Advantage plans. Although we are not required to do a PPS assessment through CMS for SB Advantage plan patients, they [Care Improvement Plus] require us to do the assessments, and we bill for services based on the RUG rate generated by the assessment.

As of October 1, 2014, the jRaven assessment tool will not allow you to complete the assessment unless you have a valid Medicare number. Now we have no way to generate a RUG rate. How do we resolve this billing issue?

You should follow through with the serious issue you have identified with your Medicare Advantage insurer, perhaps in conjunction with the hospital. At a minimum, I would notify CMS (one avenue would be through the SNF Open Door Forum) and perhaps your state’s insurance commissioner. Do you have a contract with the insurer? If so, perhaps this could be addressed through the contract. In general, if the patient needs services, then you must provide them (after admission) regardless of payer source.

Your second issue is software related, and I encourage you to see if jRaven offers a workaround solution for you to accomplish what the insurer requires.

We have a resident being admitted with a new G-tube, NPO [nil per os, nothing by mouth] status and receiving all nutrition via tube feeding. The resident is under Medicare Advantage (Humana).

Under the Medicare Benefit Policy Manual, this would be considered a direct skilled nursing service, so we could potentially skill this resident for 100 days since it is the beneficiary’s need for skilled care.

It has been my understanding that Medicare Advantage plans follow the same guidelines as Medicare Part A, per the Medicare Benefit Policy Manual. However, when our business office contacted Humana regarding this particular resident, they said they would not be able to cover for 100 days on the need for skilled services for the tube feeding. Is this correct?

I’m enclosing the Medicare Basic Rule for covered services:

100-16 MMCM, CH4 Benefits and Beneficiary Protections, §10.2 Basic Rule An MA organization (MAO) offering an MA plan must provide enrollees in that plan with all Part A and Part B, Original Medicare services, if the enrollee is entitled to benefits under both parts, and Part B services if the enrollee is a grandfathered “Part B only” enrollee. The MAO fulfills its obligation of providing Original Medicare benefits by furnishing the benefits directly, through arrangements, or by paying on behalf of enrollees for the benefits.

It is also true that a beneficiary with a G-tube that receives at least 26% of calories and 501 ml of fluid through that tube is considered skilled under Medicare Part A. This being said, it is not an automatic 100 days because of the variables related to medical necessity. It is up to 100 days if the beneficiary continues to meet the coverage guidelines. The patient could potentially be weaned off the tube, the patient may be discharged back to the community before the 100 days is concluded, or the patient may not need the tube. Also, in order to determine what the next step to take would be, you need the time frame that would be covered (at least initially) by the Medicare Advantage insurer.

It’s important to know exactly how this was presented to the insurer in order to fully answer your question. Did you receive an initial authorization? Can you receive additional authorizations depending on the condition of the patient? Or did they outright deny the skilled care? There is an appeals process that can be initiated, but the denial of the authorization must be in writing along with the rationale and the appeals process.

How do I know if my resident is traditional Part A or has a Medicare Advantage plan?

My confusion comes into play when the business office admits a Medicare Part A patient into our skilled nursing facility, but then I see copies of insurance cards that say Blue Cross Anthem, Blue Shield, Secure Horizons, AARP, etc.
I am sending the RUGs straight to Medicare for billing and not through to the insurance company. Is this the correct process?

A

Part 1: It’s important to discuss insurance options with the family, then validate the information in the Common Working File to know which type of insurance the patient has. You can also check with the hospital’s billing department to see if they have any additional information.

Part 2: If the patient has Medicare Part A, then the RUG scores are submitted via the UB-04 to the Medicare Advantage Contractor (MAC) and the scheduled Medicare-only MDS is submitted to the ASAP system. If the patient has a Medicare Advantage Plan (Part C), then an informational only (no-pay) bill is submitted to the MAC so the Common Working File can deduct the Medicare days from the total. But it is the insurance company that will pay you, and you need to abide by their contractual rules for billing. The new rule regarding submission of a RUG score to the MAC—which went into effect in July 2014—is used with an OBRA assessment, which calculates the RUG score for the insurance company. The insurance company in turn submits to CMS.

Q If a beneficiary changes from one Medicare Advantage plan to another, do they automatically get 100 new days of skilled nursing? MAOs do not report days paid to the Common Working File, and unless the SNF informs the new plan of days paid under another plan or that the beneficiary has had previous stays, we may not know they have used days.

A There are only 100 days in a spell of illness, regardless of how many plans the patient was on during that time frame. It is the SNF’s responsibility to submit special no-pay bills for Medicare Advantage plans to the MAC so that the days are all accounted for. Excerpts of the Medicare manual are below.

• IOM 100-04 Medicare Claims Processing Manual, Chapter 6, §90—Medicare Advantage (MA) Beneficiaries (Rev. 1252, issued 05-25-07, effective 10-01-06, implementation 08-27-07): For billing to MA plans, SNFs follow the requirements of the agreement they have with the plans. In cases where the patient may have enrolled or disenrolled from the plans during the billing period, the SNF will split the bill and send the plan’s portion to it and the remaining portion to the FI [fiscal intermediary].

• IOM 100-04 Medicare Claims Processing Manual, Chapter 6, §90.2—Medicare Billing Requirements for Beneficiaries Enrolled in MA Plans (Rev. 1394, issued 12-14-07, effective 10-01-06, implementation 03-17-08): Count the number of days paid by the plan as Part A days used (this IS the beneficiary’s 100 days of Medicare SNF benefits).

Submit a claim to the “fee for service” intermediary to subtract benefit days from the Common Working File records. (Note: The plans do not send claims to the Common Working File for SNF stays.)

Failure to send a claim to the FI will inaccurately show days available. If a beneficiary no longer requires skilled care under the MA plan, the SNF may discharge the patient using patient status code 04. No-payment bills are not required for beneficiaries that are receiving non-skilled care and are enrolled in an MA plan.

If the beneficiary again requires skilled care after a period of non-skilled care, the provider should begin a new admission claim for Medicare to continue the spell of illness.

• Billing requirements: Submit covered claims and include a HIPPS code (use default code AAA00 if no assessment was done), room and board charges, and condition code 04.

Q How do I appeal a denied managed care claim?

A As a reminder, there is both a grievance and an appeals process for Medicare Advantage claims, and in certain circumstances both can be used. You must request an expedited process for the shorter time response. It is always recommended that providers have a contract with the Medicare Advantage insurer in order to have a clear understanding of billing terms and protection from denials. To see a graphic depicting the process, visit http://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Managed-Care-Appeals-Flow-Chart-.pdf.
Dementia capable care insights

Five reasons to identify the disease stage of individuals with dementia

Editor’s note: “Dementia capable care insights” is a new, semi-regular column written by Kim Warchol, OTR/L, DCCT, president and founder of Dementia Care Specialists, a specialized offering of CPI, a Milwaukee-based training and consulting firm. It will explore the latest research, best practices, and regulations to help long-term care providers navigate the evolving dementia care landscape. To submit a dementia care question or topic for discussion, email Associate Editor Delaney Rebernik at drebernik@hcpro.com.

A person diagnosed with Alzheimer’s disease or a related dementia will often go through rather predictable stages of the disease. For example, a person is often first diagnosed in the early stages of dementia and will gradually decline over many years, eventually progressing through middle, late, and end-stage dementia. Each stage is typically characterized by a progressive loss of ability to complete activities of daily living (ADL) and instrumental activities of daily living (IADL). Specific declines associated with each stage are outlined below:

• **In the early stage,** the person will experience cognitive changes such as difficulty solving problems, poor judgment, and trouble learning something new. These changes interfere with the independent and safe performance of IADLs, such as the ability to handle finances, drive, cook, and manage medications. Later in this stage, a person may begin to experience changes in ADL functioning, with noticeable alterations in the quality of activity performance. For example, the person may change clothes less often, make inappropriate clothing selections for an event or weather condition, and may not bathe as often as usual.

• **In the middle stage,** ADL functioning is very noticeably impaired because the person can no longer sequence him- or herself through each step of an activity. This individual will require one-on-one support to participate in ADLs such as getting dressed or eating a meal.

• **By the late stage,** most ADLs are completed by care partners because abilities have been severely compromised. The person may not be able to use objects or tools he or she once could or have very poor attention span and communication abilities. The exception, however, is self-feeding. Individuals at this stage maintain their ability to hold a cup or finger food and feed themselves at least part of a meal.

• **By the end stage,** the individual requires total assistance for all aspects of daily living but can still feel and express love and other emotions.

Identifying the stage of dementia in which the person with Alzheimer’s/dementia is currently functioning is an essential assessment step. The stage of dementia is extraordinarily informative; it’s like having a care road map. If we understand the characteristics of the stage one of our residents is in, as well as the deficits and remaining abilities associated with it, we can then understand how to enable this individual to successfully coexist with his or her disease throughout the care journey.

I often say the value of understanding a dementia stage is comparable to that of understanding the developmental age of a child. The age informs us how we must adapt for the child to be safe and successful. It helps us to set our expectations and predict functional independence, ability, and behavior responses. A dementia stage, when used appropriately, can have similar value.

There are many ways in which a dementia stage can inform and guide our care, including influencing daily clinical approaches, inspiring the design of the care environment, and informing the quantity of staff necessary in the nursing home. I will highlight five of the many important ways identifying a dementia stage can help guide care for affected individuals:

1. **By revealing functional performance potential and setting our expectations.** Cognitive capacity is the primary predictor of functional capability. Cognition underlies and drives functional...
performance. We can correlate stages of dementia to functional ability level as detailed in the sidebar to this article.

2. By helping us understand how we can adapt to facilitate resident success. At each dementia stage, a resident retains certain abilities. We must capitalize on these abilities and compensate for the cognitive functions lost. Parents adapt the world for children of all ages to ensure they feel and become successful. Those providing care for individuals with dementia must take the same approach. Once we understand the characteristics of a stage and its functional performance expectations, we can adapt activities to provide just enough of a challenge to help residents exercise their abilities.

3. By helping us recognize patterns to manage challenging behavior. At each stage of dementia, there are some typical mood and behavior changes. If we are aware of these common shifts, we can become more prepared to care for residents effectively, in part by facilitating more positive feelings and responses. For example, a person in the early stages may believe one of his or her personal items (e.g., a purse or bag) is being stolen when he or she might have simply misplaced the item—a common symptom of early-stage dementia. Armed with this information, we can help a person to feel less suspicious and more in control by, for example, having multiple quantities of the item in question so that if it is misplaced, we can come to the rescue with another.

4. By allowing us to establish a proactive plan to minimize the chances of risks becoming realities. There are common health and safety risks at every stage of dementia. For example, medical problems arising from falls, infections, or over-/undermedication are often seen in the early stages. People in these stages may still be trying to manage their everyday activities alone but prove unable to do so without some assistance. If we provide the correct amount of oversight and support for IADLs (e.g., taking medications) during early stages, these individuals will be at less risk to over- or undermedicate. In addition, if we check in on these residents every day, we can better observe hazards or behaviors that are putting them at risk for falls. We can then attempt to eliminate these hazards to keep these individuals safer.

5. By helping care partners maintain more control. The unknown is a scary prospect for many. Because the stages of dementia are rather predictable, they can bring comfort to a resident’s loved ones and other care partners by empowering them with the knowledge of what to expect in the moments, days, and years ahead.

Source: This column is a product of “The Warchol Report,” published by CPI.

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<th>Dementia stage</th>
<th>Highest level of independence possible</th>
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<td>High early stage</td>
<td>- May need some minimal assist with IADLs (may not be able to drive)</td>
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<tr>
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<td>- Is independent with simple, familiar ADLs</td>
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<td>Low early stage</td>
<td>- Needs one-on-one assist with IADLs (no longer capable of driving safely)</td>
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<td>- Begins to need some minimal assist for ADLs (e.g., reminders to change clothes)</td>
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<td>Middle stage</td>
<td>- Needs extensive assist with IADLs (i.e., activities need to be almost exclusively done for the person)</td>
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<td>- Needs one-on-one assist for all ADLs, but can participate in aspects of ADLs with the appropriate adaptations and approach</td>
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<td>Late stage</td>
<td>- Requires total assist for IADLs</td>
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<td>- Requires almost total assist for ADLs; however, can still participate in self-feeding with appropriate adaptations and approach</td>
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<tr>
<td>End stage</td>
<td>- Requires total assist in both IADLs and ADLs</td>
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Laying the preliminary framework for an effective QAPI program

Editor’s note: This article was adapted from HCPro’s Quality Assurance and Performance Improvement: A Nursing Home’s Guide to Implementation and Management, written by Frosini Rubertino, RN, BSN, C-NE, CDONA/LTC. The complete manual provides readers with an in-depth look at the QAPI approach, how it came to realization, and how it can be harnessed by long-term care providers to identify opportunities for quality improvement and implement strategies to achieve it. For more information or to order, call customer service at 800-650-6787 or visit www.hcmarketplace.com.

In March 2010, Congress passed the Affordable Care Act (ACA). Section 6102(c) of the legislation set forth additional accountability requirements for skilled nursing facilities and nursing homes. Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) establishes accountability for sustaining quality of care and quality of life for nursing home elders through Quality Assurance and Performance Improvement (QAPI).

This new provision will significantly expand the scope of quality activities in nursing homes, focusing on prevention by continuously improving processes to meet standards, instead of solely measuring compliance with these expectations. To adhere to these more stringent quality requirements, a successful QAPI program must be ongoing, comprehensive, and able to accommodate the full range of services and departments that exist at a nursing home. It should promote safety and quality in all clinical interventions, as well as autonomy and choice in residents’ daily lives.

Based on its findings after testing a QAPI prototype among select nursing homes in 2011, CMS developed a framework for implementing QAPI that contains five key elements, all based on effective quality management. This framework is the basis for the unification of two approaches to quality: quality assurance (QA) and performance improvement (PI). While one element from the framework does not sequentially build on the other, there is a substantial link between each. Consequently, this article will home in on the first element: design and scope.

Coordinating QAPI with your current Quality Assessment and Assurance (QAA) policies

Determining the design and scope of your prospective QAPI program is the first of five elements that are integral to developing an effective initiative and will help lay the preliminary framework for the entire endeavor.

To begin the process, designate the individuals who will make up the QAPI committee. This group should minimally include the key individuals from prior or existing QAA teams:

- The director of nursing services
- A physician selected by the facility
- At least three other facility staff members, such as the administrator, medical director, direct care staff, or staff with responsibility for the physical plant

Per QAA provisions, the committee should:

- Meet at least quarterly to identify issues with respect to which quality activities are necessary.
- Develop and implement appropriate plans of action to correct quality deficiencies. Once deficiencies are identified, the facility should implement a plan of action to correct and monitor the effect of the changes and revise the action plan as necessary.

Committee members should consider how the information discussed during meetings is communicated to those who, although outside the group, hold essential responsibilities related to care or departmental oversight. In addition, if the medical director is not on the committee, he or she should stay in close contact with members to enhance the function of the group.

The new QAPI expectations will broaden the scope of responsibility established by the more basic QAA provisions. Whereas the QAA committee has been traditionally focused on correcting facility shortcomings, QAPI will encompass performance improvement, with an intensive, ongoing focus on how to sustain changes and identify other opportunities for improving care.
This means that under QAPI principles, when a facilitator asks for the number of acquired pressure ulcers or how many falls occurred during the previous month, the next question will be, “Has a root cause analysis been performed, and what is our improvement plan?” These plans will be based on concrete benchmarks determined by the performance improvement project team.

Whereas surveyors may not review the records of committee meetings—unless the facility chooses to provide them—they will study other documents and information used by the committee to determine whether its members are performing the functions required by QAPI regulations. For example, repeat deficiencies or subpar practices that have not been identified by the committee can serve as red flags to surveyors that a committee is not functioning effectively.

When considering these shortcomings, surveyors will focus not only on the adverse event but also on the facility’s internal processes for improving outcomes and preventing future occurrences.

Laying the preliminary framework

Your QAPI program cannot not be successful until the entire QAPI team and leadership entities come together to complete an initial facility self-assessment. This can be accomplished during a roundtable discussion that covers all bases necessary to determine the state of the facility’s current performance improvement efforts. When completing a self-assessment, staff must objectively evaluate where the facility is in the performance improvement process—not where it wants to be. This assessment process should be repeated annually or semiannually.

Once relevant staff have assessed the strength of current performance improvement efforts, the facility should begin creating the preliminary structures necessary to support QAPI, including a detailed plan that specifies broad design elements, such as the prospective program’s:

- Mission, vision, and purpose statement
- Guiding principles
- Scope of services and goals

Writing the mission, vision, and purpose statement

Developing a purpose statement to describe how QAPI will support your facility’s vision and mission is the first component in creating a sound foundation for your fledgling program.

If the facility’s current vision and mission statements no longer apply, you may choose to develop new ones. Take a look at the following example of vision, mission, and QAPI purpose statements for a fictional facility, Oak Trail Nursing and Rehabilitation Center:

**Our Vision** – To create an environment where respect and recognition of our elders are at the forefront of person-centered, exceptional care.

**Our Mission** – To create a culture of continuous performance improvement, and in turn, to build meaningful relationships with those we serve.

**Our Purpose** – The purpose of implementing QAPI practices in our care center is to realize our vision of fostering an environment of respect through the participation and support of all staff members.

Writing the guiding principles

Once the vision, mission, and purpose statement are developed, the facility is ready to establish the guiding principles for its program. These principles will describe the provider’s beliefs and philosophies in regard to quality assurance and performance improvement. As an example, the Oak Trail Nursing and Rehabilitation Center’s guiding principles are outlined below.

**Guiding Principle 1** – Our facility uses QAPI to guide our decision-making processes on care delivery.

**Guiding Principle 2** – We make our decisions based on data and input from staff, residents, family, and other healthcare practitioners.

**Guiding Principle 3** – We have created a culture of ongoing performance improvement that encourages staff, in a nonpunitive manner, to identify system breakdowns and errors.

Defining the scope

Your scope will outline the types of services provided by your facility. These services impact care, quality of life, resident choice, and care transitions. Our fictional Oak Trail Nursing and Rehabilitation Center offers several services, and each one will use QAPI on an ongoing basis to assess, monitor, and improve performance:

**General** – Oak Trail Nursing and Rehabilitation Center offers care and services for dementia care,
postacute care, palliative care, and ventilator care.

Specific (Dementia care) – We provide comprehensive person-centered dementia care to residents with individualized services that focuses on life activity preferences, resident choice, and physical care needs.

Specific (Postacute care) – We provide care to residents who need postacute nursing and therapy services aligned with their goals for improvement and discharge.

Specific (Palliative care) – We provide quality end-of-life care that meets the spiritual and physical care needs of our residents by emphasizing compassion during all interactions with residents and their loved ones.

Specific (Ventilator care) – We provide ventilator care for our residents while meeting their physical, mental, and psychosocial care needs.

Once the vision, mission, purpose, guiding principles, and scope are developed, you’ve finished laying your foundation. These preliminary elements will set the stage for the rest of your QAPI plan and assist you with articulating the goals and objectives your facility hopes to accomplish with the new program. Many facilities choose to post the documents that spell out these components in a common area that all staff and visitors can access.

As you integrate the remaining four elements into your QAPI plan, it will evolve and expand, ultimately helping you foster a culture of performance improvement by allowing you to achieve the vision, mission, purpose, and guiding principles you articulated during this first stage of program development.

Writing your goals

Use your structural framework along with input from caregivers in all roles to develop your facility’s overarching goals for the QAPI program. Ensure each goal is clear and measurable by using the Specific-Measurable-Attainable-Relevant-Time bound (SMART) formula. Take a look at Oak Trail Nursing and Rehabilitation Center’s goals for inspiration.

Specific: Define what you want to accomplish.
• Oak Trail Nursing and Rehabilitation Center will develop a person-centered model of care to meet the psychosocial and spiritual needs of our elders
• All staff will be involved in the process to develop a person-centered culture in our care center
• The transition to a person-centered model of care will take place in all departments at the care center

Measurable: Determine how you will measure your progress.
We will measure our success using the following criteria:
• Maintenance of at least an 80% customer satisfaction rate based on surveys from elders and their family members
• Preservation of an antipsychotic usage rate that’s lower than the national benchmark
• Improvement on survey outcomes
• Ability to decrease preventable hospital readmissions by 75%

Attainable: Set a realistic goal.
We will use evidence-based research and clinical guidelines for dementia care, postacute care, palliative care, and ventilator care. This approach will reinforce our commitment to our mission, vision, and purpose. The outcome will improve clinical care, quality of care, and resident choice.

Relevant: Describe how the goal is relevant to the care you deliver.
Through commitment to our guiding principles, we will move toward our goal of delivering a quality, person-centered model of care.

Time-bound: Designate a timeline for achieving the goal.
Our efforts toward our goal will be a continuous process supported by our guiding principles.

Oak Trail Nursing and Rehabilitation Center’s well-laid plan could not have come to fruition without the provider’s upfront development of a mission, vision, purpose, and guiding principles for its QAPI program.

The next step in your QAPI journey is to weave the four remaining elements (governance and leadership; feedback, data systems, and monitoring; performance improvement projects; and systemic analysis and systemic action) into your program plan.