Health Care Council of Illinois

Regulatory Update: News and Views

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A Star Rating System Should Be Based on Quality, Not Compliance

The following was a response letter sent by the Health Care Council of Illinois to Thomas Hamilton of the Centers for Medicare and Medicaid Services:

The Centers for Medicare and Medicaid Services has announced it will soon launch a five-star rating system for nursing homes, and requested comments and suggestions. We want to express our appreciation for the opportunity to have some genuine input on this initiative, both in the June 25 Open Door Forum and in this letter.

We believe a five-star rating system, properly constructed, could be very helpful to consumers. As with restaurants and hotels, a star-rating system can assist consumers in finding quality nursing homes, motivate nursing facilities to strive to be the best, and encourage identified priority areas of quality that CMS wants to emphasize. It could create a win-win-win situation for everyone.

During the Open Door Forum, Mr. Thomas Hamilton mentioned that the current proposed plan was to base the five stars on a combination of three factors: the facility compliance surveys of the past three years, a selection of Quality Measures, and staffing levels. There are two problems with the selection of these three criteria:

1. CMS is offering no new information to consumers. CMS would be basing the five stars on information already available on Nursing Home Compare. If we truly want to offer some new helpful information for consumers, let's not just rehash already posted information.

2. These identified components do not measure quality; they measure violations. They may help consumers avoid bad nursing homes, but they don't help consumers find a good one. Violations measure compliance; they don't measure quality. Will five stars for a nursing home only mean that it didn't do anything wrong? As was mentioned in the Open Door Forum, this is a lot like giving restaurants five stars because they didn't poison anyone in the last year.

A good facility is not just the absence of violations; it is the presence of quality. Quality is a proactive commitment to improvement and resident-centered service, not just compliance. Both the compliance surveys and the Quality Measures evaluate practices and conditions that indicate lack of quality. For a five-star rating system to be effective in helping consumers find a good nursing home, let's base the stars on positive and progressive measures, not just the absence of negative outcomes. For example, there are more proactive indicators of quality available to CMS from collected MDSs:

Healed Pressure Ulcers (MDS Section M3). The rate of pressure ulcers healed is a greater indication of a facility's aggressive commitment to quality wound management than the actual number of pressure ulcers. As we are all well aware, the facilities that specialize in aggressive wound management and admit fragile high-risk residents will always have a greater number of pressure ulcers than the facilities with no pressure ulcers that primarily admit a healthier residential population. Focusing only on the current pressure ulcer Quality Measure would seem to indicate that the residential facility with restricted admissions does a better job with pressure ulcers than the facility with a specialized wound management program, when in fact the opposite is true. The true measure of quality in this critical benchmark care area is not just the absence of pressure ulcers; it is the history of resolved pressure ulcers.

Pressure Ulcer Prevention Services (MDS Sections M5 and M6). Another benchmark indicator of quality and commitment is the facility that is aggressively protecting residents from pressure ulcers. The practices and treatments in MDS Sections M5 and M6 are effective in preventing pressure ulcers. The facilities that progressively pursue these practices with their residents who do not have pressure ulcers are promoting resident quality of life and quality of care, not just reacting to deteriorating conditions.

Nursing Rehabilitation / Restorative Care Programs and Services (MDS Section P3). The number of restorative programs per resident is an excellent indicator of the facility's commitment to keeping its residents as active and independent as possible, and transitioning short-stay residents back to the community. This basic area of resident functionality improves a resident's quality of care, quality of life, attitude, motivation and involvement. Not only do the rehabilitation and restorative programs improve resident independence and prevent functional deterioration, but also contribute positively to the health and well-being of residents with more serious problems like heart disease, pressure ulcers, Parkinson's disease, arthritis, degenerative joint disease, respiratory diseases, depression and even Alzheimer's disease. An active restorative care program underscores a facility's commitment not to just accept the chronic conditions of aging as inevitable, but to reverse these conditions and improve a resident's involvement in living.

Improvement in ADLs (MDS Section G1 and G9). Regardless of diagnosis, the greatest predictor of morbidity is ADL decline. The facility that is improving residents' ADL functionality is breathing life into its residents. ADL improvement doesn't happen naturally – it takes that extra effort and a facility-wide motivation to improve the residents' capabilities in daily living tasks. Improvement in ADLs is a quality indicator of a facility attitude not to accept the inevitable, but to fight for the health and overall well-being of its residents.

Reduction in Pain (MDS Section J2a or J2b). Pain remains under-assessed in the elderly, regardless of where they live. Quality care facilities go out of their way to encourage residents to report pain so it can be addressed. First assessing, and then reducing, either the frequency or intensity of pain is another mark of quality that goes beyond basic care provision to care improvement.

Specialty Services (MDS Sections P1a and P1b). Five-star hotels provide the extra level of amenities and services that you would not normally find. Facilities that go beyond basic nursing services and provide the specialty skilled treatments and programs for complex conditions (P1a) or therapies (P1b) indicate a higher level of quality and medical sophistication – not because they have to offer these services, but because they want to be the best and offer the best for their customers.

Emotional and Psychological Well-being (MDS Section P2). Human beings are a complex fusion of mind, body and spirit. As we age, deteriorating in one area is inextricably intertwined with the other areas. Nursing facilities do not just care for the body; they care for the resident's spirit, in holistic efforts to assist a resident in reaching his or her highest practicable physical, psychological and mental functioning. Facilities committed to improving a resident's emotional

and mental functioning make the extra effort to provide quality interventions for the mental and emotional health of as many residents as possible.

There are other notable non-MDS measures of positive quality that are not currently collected by CMS, but perhaps they should be considered:

Staffing Stability. Any nursing director will tell you that it is far more important to have a stable, well-trained and caring staff who know the residents than more "bodies" who don't necessarily know what they are doing. A study was conducted in Illinois in the 1990s which compared the number of nursing violations with the number of nursing staff and the number of dietary violations with the number of dietary staff – and found no correlation to the number of violations and just the number of staff. More staff in those departments did not result in fewer violations. Interestingly, there was a direct correlation in the number of violations to the number of MDS coordinators and quality assurance nurses. The more MDS coordinators and quality assurance nurses a facility had, training its staff, reviewing documentation, analyzing delivery systems and improving practices, the fewer mistakes and fewer violations those facilities had. More staff does not equal quality; trained, consistent, knowledgeable and caring staff does equal quality. As the CMS *Artifacts of Culture Change* already recognizes, low turnover is a greater indicator of quality than more staff.

Customer Satisfaction Surveys. In any field, pleasing the customer is quality job #1. Facilities that actively solicit customer feedback and want to know how to do a better job already have the essential priorities for a quality environment. Most standardized customer satisfaction surveys have two purposes that are consistent with each other: soliciting areas of improvement with specific questions and then gauging overall satisfaction and willingness to recommend the facility. Facilities that do a good job in seeking out and addressing customer concerns often receive excellent overall satisfaction ratings from those same customers. Just about all of the standardized customer satisfaction surveys ask about overall satisfaction and willingness to recommend the facility, and those bottom line questions are generally the only ones reported on any of the state Web sites that report customer satisfaction rates. It would not be difficult for CMS to work with the states that do this and the major satisfaction survey companies to agree on one or two standardized customer satisfaction ratings that could be reported on the CMS Web site.

Pioneer Practices. The future of quality care is in resident-centered pioneer practices. While a great deal of innovation is already taking place, more needs to be encouraged – and what better way to focus and motivate that process than in a five-star quality recognition system? CMS already has a blueprint for evaluating pioneer practices with its *Artifacts for Culture Change*, covering quality improvement areas such as encouraging independence, personalized environments, family and community involvement, an integrated approach to care practices, and staff empowerment, as well as staff and management stability.

Freedom from pressure ulcers and pain, greater resident independence, a positive and meaningful involvement in life, specialty services, satisfied customers, a stable team of knowledgeable and empowered caregivers, and a resident-centered environment – aren't these the kind of quality practices we see in good nursing homes? Aren't these the kind of quality interventions we want to see in all nursing homes? Isn't this the kind of quality care we all want to reward, to encourage, and to recognize?

We raise good kids by giving them the motivation to learn, to grow, to problem solve, to work with others, and to explore better ways of doing things. We raise good kids by supporting them, helping them learn from their mistakes, and praising them when they do a good job. We want to raise five-star kids.

We don’t raise good kids by constantly criticizing them, penalizing them, publicizing their faults on the Internet and in the school newspaper, and telling them that the only good thing about them was that they didn’t do anything wrong today.

If we are going to use a five-star rating system to assist consumers in finding a good nursing home, let’s use it to recognize and encourage positive elements of quality, not just highlight lack of quality.

The five-star rating system is a golden opportunity to begin that journey. Let’s not make it a wasted opportunity by focusing on the tired benchmarks of the past.

Let’s stop talking about the future of nursing home care and help make it happen.

Sincerely,

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Mr. Sullivan is Executive Director of the Illinois Council on Long Term Care and Regulatory Coordinator for the Health Care Council of Illinois. The Health Care Council of Illinois is the combined government affairs program of the Illinois Health Care Association and the Illinois Council on Long Term Care, representing more than 50,000 professionals and caregivers serving 65,000 residents in more than 600 Illinois nursing homes.