

Implementing the Quality First Pledge: Survey of the Alliance for Quality Nursing Home Care

June 2004

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Prepared for:
The Alliance for Quality Nursing Home Care

The Health Strategies Consultancy

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Executive Summary

The Alliance for Quality Nursing Home Care (“the Alliance”) is a coalition of national provider organizations that care for approximately 650,000 elderly and disabled patients each year and that employ more than 400,000 caregivers. In July 2002, as part of a broader initiative to improve the quality of nursing home care in the United States, the Alliance developed the Quality First Pledge and Code of Conduct. Based on seven principles, the Quality First Pledge and Code of Conduct outline specific and measurable steps that Pledge signatories must take to improve quality outcomes in nursing facilities over time. As Quality First Pledge signatories, Alliance member companies must commit to implementing each element of the Pledge and must continuously work toward achieving or improving upon the elements laid out in the Code of Conduct.

In July 2003, the Alliance retained The Health Strategies Consultancy to conduct a baseline assessment of its progress toward meeting the seven elements of the Quality First Pledge. This assessment is intended to assist participating organizations and the Alliance leadership in identifying (1) where companies have successfully met the elements of the Pledge, (2) where companies are not successfully meeting the elements of the Pledge, and (3) which recommendations may help Alliance companies make progress toward fully implementing each element of the Quality First Pledge.

Three key findings emerged from this study.

- » **Continuous quality improvement.** All Alliance companies have implemented the systems, structures, and policies necessary to operate continuous quality and performance improvement programs. The effects of these systems are especially evident when clinical data are used to identify and correct problems.
- » **Workforce excellence.** All Alliance companies are going beyond the Quality First Pledge requirements to overcome significant barriers to recruiting and retaining a well-qualified and competent workforce.
- » **Consumer relationship.** The majority of Alliance companies provide clinical quality information through the Centers for Medicare and Medicaid Services (CMS) Nursing Home Compare website. To date, none of the Alliance companies has provided nonclinical quality information (such as results from patient and family satisfaction surveys) to patients, families, employees, or the public; but individual companies are making efforts to disclose such information.

In summary, the Alliance companies are meeting many elements of the Quality First Pledge, and the Alliance companies should continue to examine and monitor their performance in relation to these elements. However, we identified the companies’ relationships with consumers and the public as the area needing focused attention for improvement. The remainder of the Executive Summary provides a brief overview of the study, the findings from the study, as well as our recommendations. A more in-depth report, conclusions, and recommendations follows.

Description of the Quality First Pledge

The Quality First Pledge contains seven core elements that participating organizations must meet to ensure an ongoing commitment to quality and accountability. Within each of the seven core elements, the Code of Conduct provides several descriptive criteria that clearly outline the parameters that an organization must meet to be considered fully committed to placing quality first. The complete Quality First Pledge and Code of Conduct appear in Appendix A; the core elements of the Pledge are described below.

- » **Commitment to patient well-being through quality care.** Company management must establish patient health and well-being as paramount priorities. Companies must also convey a philosophy of continuous quality improvement by using uniform measures of quality, developing annual quality improvement goals, and identifying clinical best practices.
- » **Public disclosure and accountability.** Participating organizations must disclose information on quality to patients, families, employees, and the public. The company must help consumers access information in a timely manner while protecting confidentiality and complying with all relevant legal requirements.
- » **Patient and family rights.** Signatories must commit to clearly articulating and honoring patient and family rights while working to ensure that employees understand and uphold those rights.
- » **Workforce excellence.** Each participant must maximize the human potential of its workforce through training and education programs that strive to improve the quality of care delivered and that sensitize staff to the special needs of the frail and vulnerable patients seen in nursing homes.
- » **Public input on quality.** A National Commission on Nursing Home Quality with participants from Alliance companies should be created. This Commission will identify opportunities for quality improvement, recommend annual quality improvement goals, and assess the impact of the Quality First Pledge initiative on the quality of care and services. In addition, each of the participating companies will create their own committees to provide guidance on quality improvements.
- » **Ethical practices.** Signatories must develop and implement organization-specific programs that promote ethical and lawful conduct under this element of the Pledge.
- » **Financial stewardship.** Signatories must act as responsible stewards of scarce government resources and champion public financing at levels that will improve quality and enhance staffing.

Methodology

Through a collaborative effort with the Quality First Steering Committee—a group of individuals from Alliance companies that guides the Alliance leadership on issues related to quality of care—we designed a survey to provide a baseline assessment of how well companies were meeting the

elements outlined in the Quality First Pledge.¹ We surveyed 15 signatories to the Alliance for Quality Nursing Home Care's Quality First Pledge and Code of Conduct²: The survey included 11 publicly held, for-profit companies and 4 privately held, for-profit companies (Table ES-1). The capacities of the facilities operated by the companies range from approximately 4,500 to more than 49,000 beds. The information requested by the survey questions directly corresponded to the elements of the Quality First Pledge, and the respondents were asked to report data in the following areas: (1) policy and process descriptions; (2) barriers to implementation; (3) outcomes data, if any were available; and (4) the degree to which the company viewed the criteria as being met, partially met, or not met.

Table ES-1. Participating Companies

Company¹	2002 Bed Count²	Financial Status
Advocat, Inc.	4,526	Public
Beverly Enterprises, Inc.	49,430	Public
Extendicare Health Services, Inc.	14,101	Public
Genesis HealthCare Corporation	23,932	Public
Harborside Healthcare Corp.	6,608	Private
HCR Manor Care Corp.	40,307	Public
Kindred Healthcare	36,592	Public
Mariner Health Care, Inc.	35,139	Public
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NHS Management, LLC	4,987	Private
UHS-Pruitt Corp.	5,529	Private
Sun Healthcare Group, Inc.³	24,267	Public
Tandem Health Care, Inc.	4,951	Public
Trans Health, Inc. ⁴	25,693	Public

¹Companies in boldface are original signatories to the Pledge and signed the Pledge in July 2002.

²The counts were provided by the Alliance, unless otherwise noted.

³The counts are from Centers for Medicare and Medicaid Services (*CMS Health Care Industry Update*, Centers for Medicare and Medicaid Services, Baltimore, May 2003).

⁴The counts combine the total for Trans Healthcare, Inc., and Integrated Health Services, which recently merged.

¹Fourteen Alliance companies have representatives participating in the Quality First Steering Committee. This Committee guides the Alliance on issues related to quality of care, and Committee members assist with the implementation of the Quality First Pledge within their own organizations. Participants are corporate clinical or operational staff with significant experience in the nursing facility profession.

²At present, 14 nursing home organizations participate in this voluntary initiative.

Our findings are limited to the information provided in the self-assessment surveys, supporting materials, and follow-up interviews. The project scope did not include any audits of either interview or survey responses by the evaluators. Despite these limitations, the survey results provide a good first look at both areas of achievement and options for improvement by Alliance companies. A broad self-assessment is a significant step in the right direction for this profession and sets the stage for future additional and more in-depth assessments. The study findings indicate that Alliance members are committed to the Pledge and have been working since July 2002 to implement, improve, and maintain its fundamental elements.

Summary of Findings

The survey responses provided much information about the activities that the companies undertake to implement the Pledge. First, we found that the overall structure necessary to effectively implement continuous quality improvement programs within an organization are in place at the corporate level in all of the companies. Each company provided us with the corporate policies, procedures, and processes that they have put in place to operate quality and performance improvement programs. Although the structures varied, every company

- » Had continuous-feedback cycles at each level of the organization,
- » Used clinical and operational data at all levels of the organization to track and trend changes overtime and to identify problems, and
- » Approached problems by identifying the root cause and taking corrective action through a variety of mechanisms.

The foci of these corporate policies, procedures, and processes were ongoing vigilance and improving the delivery of care.

The companies reported the barriers that they believe prevent the change in culture that would fully support implementation of continuous quality improvement. These included fear of liability, many punitive regulations that fail to reward continuous quality improvement, inadequate reimbursement to appropriately compensate staff, employee turnover at the management and staff levels, inconsistent policy implementation, and balancing performance improvement with other duties and goals of the company. Some Alliance companies are trying to overcome these barriers through a variety of initiatives aimed at improving leadership and the company culture, such as recognition and financial incentives for continuous quality improvement and participation in government quality improvement initiatives. Probably the most important component that creates a change in culture is the commitment of direct-care staff. Some companies reported that they use creative approaches to help these staff understand and implement continuous quality improvement.

The second key finding was that all Alliance companies met the basic criteria—commitment, recruitment, assessment, and training—of the Workforce Excellence section of the Pledge. Yet, the companies that we surveyed and interviewed found that the barriers that they encountered, such as

employee turnover and nursing shortages, were prohibiting maximum workforce effectiveness. They had undertaken significant initiatives to remedy these problems. Some approaches included

- » Using employee recognition and incentive programs,
- » Offering leadership training for directors of nursing and administrators,
- » Providing educational and career incentives,
- » Reducing nurse agency use,
- » Working closely with nursing schools, and
- » Improving training and orientation programs.

The third finding that we identified from the survey results was that although the companies provided evidence that they are all working hard to improve their relationship with consumers, no companies have completed the difficult task of making the full spectrum of data on quality for each facility available to the public in a usable fashion that permits comparisons of facilities. The evidence of the respondents' work in the area of consumer relationships includes the following:

- » **Accountability.** All of the Alliance companies are participating in CMS's Nursing Home Quality Initiative (NHQI). The quality initiative posts facility-level clinical data on the Nursing Home Compare website. These data can be accessed by potential or actual patients, their family members, discharge planners, state surveyors, and the public at large to surmise the performance of an individual facility on several clinical quality measures. The purpose of NHQI and Nursing Home Compare is to increase the nursing home profession's accountability to the public.
- » **Patient education.** Several companies have undertaken efforts to improve their education of patients and families about the nursing home experience and the aging process. They have created formal programs that outline what patients and their families can expect once they enter a nursing facility. The formal education takes on many forms and supplements and enhances the education and emotional support that direct caregivers, supervisors, and administrators in facilities provide every day. This helps both patients and their families improve their experience with the nursing facility and assists the facilities in their interactions with their consumers.
- » **Consumer satisfaction.** In this instance, the consumers are the patients and their families. All of the companies that responded to the survey assess consumer satisfaction through family and resident councils, complaint processes, and satisfaction surveys. In addition, 12 of the companies reported that they set annual quality improvement goals related to the consumer experience. Setting goals and measuring satisfaction allow companies to target problems and work toward an improved consumer experience. These efforts help companies improve not only the clinical quality of care but also the quality of the experience for nursing home patients and their families.

The Pledge criteria related to consumer relationships were the only requirements whose performance across companies is uneven in some areas and poor in others. Therefore, this is the area where we targeted our recommendations for focused improvement efforts.

Recommendations

We recommend that the Alliance and its member companies take the following actions to bolster their ongoing efforts to meet the elements of the Quality First Pledge:

1. Develop a core set of common consumer-friendly survey measures that captures the consumer experience, with the ultimate goal of making the data from this survey publicly available for each facility. This survey would provide a basis for a dialog with individual consumers and the public about the role of nursing homes as long-term-care providers and enhance provider accountability. The National Commission on Nursing Home Quality could use this information to guide its consideration of and recommendations regarding the Quality First Pledge and the changing long-term-care environment.
2. Alliance companies with patient and family education programs should share information regarding these programs with Alliance companies that are interested in developing such programs.
3. Continue to track its progress in meeting the elements and the purpose of the Quality First Pledge. The results of these evaluations should be routinely shared with the public and should form a basis for continuous improvement and focus on areas in which higher performance is required.



Implementing the Quality First Pledge

The Alliance for Quality Nursing Home Care (“the Alliance”) is a coalition of national provider organizations that care for approximately 650,000 elderly and disabled patients each year and that employ more than 400,000 caregivers. In July 2002, as part of a broader initiative to improve the quality of nursing home care in the United States, the Alliance developed the Quality First Pledge and Code of Conduct. Based on seven principles, the Quality First Pledge and Code of Conduct outline specific and measurable steps that Pledge signatories must take to improve quality outcomes in nursing home facilities over time. As Quality First Pledge signatories, Alliance member companies must commit to implementing each element of the Pledge and must continuously work toward achieving or improving upon the elements laid out in the Code of Conduct.

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Background

The Alliance members signed the Quality First Pledge during a time of rapid change for nursing home organizations and the patients for whom they provide care. This section provides the context of the major changes and challenges confronting the nursing home profession. These trends directly and indirectly affect implementation of the Quality First Pledge.

Population

Today nursing home facilities treat individuals who have significant health care needs. Slightly more than half of the patients in nursing home facilities are long-term residents, but nearly as many patients have shorter stays for rehabilitation care after an acute hospitalization.³ According to the National Nursing Home Survey, in 1999 the average length of stay for all discharged patients was 272 days, with 68 percent of discharged patients having lengths of stay of less than 3 months.⁴ The average nursing home patient today is a white, female Medicaid beneficiary over the age of 75 years.⁵ The average patient requires assistance with 3.9 activities of daily living (ADLs), such as bathing, dressing, and toileting.⁶ In addition, Medicaid pays for two-thirds of the total cost of patient care.⁷

Many of the companies we spoke to for this report told us, at least anecdotally, that the number of high acuity patients admitted to their nursing facilities was rising. That is, the nursing facilities were being asked to admit patients more quickly after hospitalizations for surgery or other serious medical conditions than in previous years; consequently nursing facility patients are now sicker on average and have more significant care needs. We were unable to identify systematic research to confirm this reported trend, but we found nothing inconsistent with these reports. More research should be done in this area to assess how the population admitted to nursing facilities has changed in recent years.

Payment

The implementation of the Medicare skilled nursing facility (SNF) prospective payment system (PPS) in 1998 changed how Medicare facilities operate their businesses.⁸ Before 1998, SNFs received

³Centers for Medicare and Medicaid Services (CMS), *CMS Nursing Home Quality Initiative Overview*, January 2004.

⁴National Center for Health Statistics, *1999 National Nursing Home Survey*, 1999.

⁵American Health Care Association (AHCA), *AHCA Facts and Trends*, 2001.

⁶AHCA, *December 2003 update of CMS OSCAR Data Current Surveys*, 2003.

⁷Ibid.

⁸SNFs are Medicare-certified nursing facility providers. To receive payment for nursing facility services under Medicare, a higher level of skilled nursing care is required by Medicare relative to the level required by Medicaid and other payers of nursing home care. However, the majority of facilities in the United States are Medicare and Medicaid certified. References to nursing facilities throughout this study refer to Medicare- and Medicaid-certified facilities, unless otherwise noted.

“Securing adequate payment and reducing liability costs are likely to be ongoing concerns for SNFs as the number of aging baby boomers increase demand for long-term-care services.”

payments for the Medicare services that they provided on a cost basis. Under the SNF PPS, skilled nursing facilities are paid on the basis of a Medicare patient’s clinical condition, functional status, and expected use of services or types of services. On the basis of these criteria, patients are classified into resource utilization groups (RUGs). The payments assigned to each RUG are expected, with a few exceptions, to cover the cost of all routine patient needs and nursing costs.⁹

The SNF PPS introduced a new dynamic into the nursing home profession that requires facilities to deliver care in the most efficient manner, placing downward pressure on costs. This pressure caused problems during the early years of the PPS and contributed to financial problems that caused five of the top eight SNF chains to file for bankruptcy.¹⁰ Since then, SNFs

have recovered in part because of temporary provisions from the U.S. Congress to ease the transition to the PPS and in part because SNFs have become more efficient in their operations and care delivery.

Nursing facilities today must contend with increasingly inadequate reimbursements from the Medicaid program. Although Medicare provided reimbursement for 12 percent of 2001 free-standing SNF expenditures, Medicaid provided reimbursement for 48 percent of free-standing SNF expenditures in that year.¹¹ The fiscal pressures that states have recently encountered have forced many state Medicaid programs to freeze or reduce payments to SNFs, causing shortfalls in Medicaid reimbursements. A recent report from BDO Seidman, LLP, for the American Health Care Association (AHCA) determined that the average shortfall in Medicaid reimbursement was more than \$11 per Medicaid patient day in 2001.¹²

In addition to Medicaid payment concerns, liability insurance costs are increasing rapidly.¹³ According to AON Risk Consultants, the average liability costs per occupied bed increased 23 percent from 2001 to 2002.¹⁴ These two pressures have led many SNFs to be concerned about their future operating costs and reimbursement. Securing adequate payment and reducing liability costs are likely to be ongoing concerns for SNFs as the number of aging baby boomers increase demand for long-term-care services.

Nurse Shortages

Beginning in 2000, public health officials, hospital administrators, home health agencies, and nursing facility administrators began to report that they were having difficulties hiring nurses and contending with high turnover rates. Nurses themselves cited increasing job dissatisfaction as well as burnout as the cause.¹⁵ This shortage is likely to continue for both registered nurses (RNs) and licensed practical nurses (LPNs) because of a variety of factors. Young men and women are not choosing nursing as a

⁹General Accounting Office (GAO), *Skilled Nursing Facilities*, December 2002.

¹⁰CMS, *Health Care Industry Market Update: Nursing Facilities*, May 2003.

¹¹Ibid.

¹²BDO Seidman, LLP, *A Report on Shortfalls in Medicaid Funding for Nursing Home Care*, December 2003.

¹³CMS, *Health Care Industry Market Update: Nursing Facilities*, May 2003.

¹⁴Bourdon and Dubin, *Long Term Care General Liability and Professional Liability Actuarial Analysis*, March 2003.

¹⁵American Association of Colleges of Nursing, *Nursing Shortage Fact Sheet*, April 2003.

profession, and the number of nurses approaching retirement is rising, with few younger replacements. One study indicates that unless more people enter the nursing profession, by 2020 there will be a 20 percent difference between the number of RNs and the demand for RNs.¹⁶ In addition, schools of nursing find it difficult to retain enough faculty to expand enrollment.¹⁷

The nursing shortage has had a significant impact on long-term care, particularly nursing facility care. Licensed nurses provide the majority of direct care and supervise nurse's aides, and facilities cannot continue to offer effective, clinically sound care without adequate numbers of well-trained, licensed staff. Many nurses also often perceive the provision of long-term care to be less sophisticated than the provision of care in a hospital setting.

Quality

Over the last decade, expectations for quality patient care have increased across the nursing home profession. Nursing facilities, the U.S. Congress, federal and state policy makers, families, and patients have focused on improving the quality of care provided to patients in long-term-care facilities. The U.S. Congress has paid close attention to this issue and asked the General Accounting Office (GAO) and the Office Inspector General (OIG) of the U.S. Department of Health and Human Services to conduct several studies regarding the nursing home survey and certification process, as well as the quality of care, as measured through the survey process. Such studies have been conducted since the late 1990s.

Congress's desire to increase the quality of nursing facility care has been reinforced by Centers for Medicare and Medicaid Services' (CMS's) efforts to monitor care in nursing home facilities. CMS monitors nursing home quality through a variety of sources, including inspections by state surveyors and tracking of staffing ratios and performance on quality indicators. State surveys are conducted at least every 15 months, when patients or their families complain to state agencies, or as a follow-up to previous surveys. During the surveys conducted every 15 months, the surveyors inspect the entire facility and identify the deficiencies in each facility that must be corrected. Facilities are also required to report staffing ratios to the states and CMS. These are used to detect problems with staff sufficiency. Quality indicators are developed by using a patient assessment instrument called the Minimum Data Set (MDS).

MDS is used not only to evaluate patient conditions upon admission and throughout their stay but also for payment purposes and to monitor quality and adverse events in nursing facilities. MDS provides information about each patient's conditions and diagnoses; this information is used to develop quality indicators for each facility. The quality indicators show the prevalence of patients with certain conditions, such as pressure ulcers, or the number of falls within a certain time period. Since 1994, nursing facilities and state surveyors have used these indicators to monitor quality performance in nursing facilities. The quality indicators themselves do not indicate high-quality care, but they do serve as an early warning system or a benchmark for future improvement. Poor performance on an indicator may show that there is a particular problem in that facility, or the poor performance may be indicative of something else, such as a change in how conditions are diagnosed and noted on the MDS.

¹⁶ Buerhaus et al, *Implications of an Aging Registered Nurse Workforce*, June 14, 2000.

¹⁷ American Association of Colleges of Nursing, *Nursing Shortage Fact Sheet*, April 2003.

In the fall of 2002, CMS took an unprecedented step toward making nursing facilities more accountable for quality of care by implementing the Nursing Home Quality Initiative (NHQI) in November 2002. NHQI has three goals: (1) to provide consumers with additional information about nursing home quality through Nursing Home Compare, (2) to generate competition among nursing facilities through public disclosure of performance, and (3) to help nursing home providers improve quality of care by providing resources and assistance from state quality improvement organizations (QIOs). The second and third elements have encouraged nursing facilities to work with their state QIOs to identify areas for quality improvement in their facilities and design plans to improve outcomes.

“[The NHQI has] encouraged nursing facilities to work with their state QIOs to identify areas for quality improvement ... and design plans to improve outcomes.”

Nursing Home Compare uses each facility’s MDS reports to present a series of quality indicators for that facility. The 14 quality indicators—or measures, as they are called by CMS—indicate the percentage of patients within a facility with pressure sores, loss of ADL function, pain, physical restraints, delirium, and as well as other conditions; and these percentages are posted on the CMS Nursing Home Compare website for public review. It is designed to improve nursing facility accountability by allowing potential nursing home patients or their families to compare the performance of facilities in their area based on the quality measures.

At the time of Nursing Home Compare’s release, however, GAO and other policy makers noted methodological and other concerns with the initiative’s quality measures.¹⁸ According to GAO, Abt Associates, Inc., which was hired to validate the measures, had not yet completed its analysis; and there were unresolved questions about adjusting the quality measures to reflect the variable case-mix of patients (i.e. risk adjustment), the validity of the MDS data, and concerns about assisting consumers with the information. The National Quality Forum (NQF), which was tasked with reviewing the Abt report and recommending core quality measures, had also not completed its work.¹⁹ In response to those concerns, CMS released an enhanced set of quality measures on Nursing Home Compare website in January 2004. These updated measures reflect the analysis and recommendations of NQF committee members. It is likely that CMS, with input from NQF and the nursing home profession, will continue to evaluate the success of Nursing Home Compare and make improvements to the quality measures overtime.

Conclusion

Changes in reimbursement, the workforce, and the nursing facility population have made it difficult for nursing home organizations and nursing facilities themselves to focus on their future. In addition, the increasing expectation for quality care has made it impossible for the nursing home profession to ignore operational problems that might impede the provision of effective and appropriate care for each patient. Nursing facilities must remain solvent while achieving positive outcomes on state surveys and quality measures.

¹⁸GAO, *Nursing Homes*, October 2002.

¹⁹NQF is a private, not-for-profit membership organization created to develop and implement a national strategy for health care quality measurement and reporting. It uses consensus-based endorsement of national standards for measurement or public reporting of health care performance data.

Despite the instability and competing pressures in the present environment, the Alliance for Quality Nursing Home Care has chosen to focus its efforts on quality care and performance improvement. The Quality First Pledge is designed to steer participating companies toward ongoing monitoring, improvement, and self-assessment, which will lead to better care and improved outcomes.

This focus on quality improvement is distinct from the historic emphasis on improving quality through regulation and government oversight. The OIG of the U.S. Department of Health and Human Services has noted that there is often a heavy regulatory emphasis in nursing facilities, and its nursing facility compliance program guidelines indicate that a balance must be struck between regulatory activity and oversight and the implementation of organizational quality improvement processes.^{20,21} The elements of the Pledge are geared toward enhancing quality by identifying best practices and implementing them throughout an organization and are not focused on regulatory performance standards.

By signing the Pledge, the Alliance companies have taken the first step toward working within their profession to cooperatively and creatively balance regulatory compliance with continuous quality improvement. The study findings indicate that Alliance members are committed to the Pledge and have been working since July 2002 to implement, improve, and maintain its fundamental elements. The Alliance companies have continuous quality improvement structures in place, demonstrate commitment to continuous quality improvement, and are committed to a well-trained workforce and financial stewardship.

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Methodology

The methodology used for this assessment of the Quality First Pledge was based on a scope of work defined by the Quality First Steering Committee. The details are described below.

Companies Surveyed

We surveyed 15 signatories to the Alliance’s Quality First Pledge and Code of Conduct.²² The survey included 11 publicly held, for-profit companies and 4 privately held, for-profit companies (Table 1) that have capacities that range from approximately 4,500 to more than 49,000 beds.

²⁰U.S. Department of Health and Human Services, *The External Review of Hospital Quality*, July 1999.

²¹OIG Compliance Program Guidance for Nursing Facilities, March 16, 2000.

²²At present, 14 nursing home companies are participating in this voluntary initiative.

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Company ¹	2002 Bed Count ²	Financial Status
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⁴The counts combine the total for Trans Healthcare, Inc., and Integrated Health Services, which recently merged.

Survey Design

Through a collaborative effort with the Quality First Steering Committee—a group of individuals from the Alliance companies that advise Alliance leadership on issues related to quality of care—we designed a survey to assess whether companies were meeting the elements outlined in the Quality First Pledge.²³ The survey was designed as an initial baseline assessment of ongoing efforts to meet the criteria described in the Quality First Pledge. The information requested by the survey questions directly corresponds to the elements of the Quality First Pledge, and the respondents

²³Fourteen Alliance companies have representatives participating in the Quality First Steering Committee. This Committee guides the Alliance on issues related to quality of care, and Committee members assist with the implementation of the Quality First Pledge within their own organizations. Participants are corporate clinical or operational staff with significant experience in the nursing facility profession.

were asked to report data in the following areas: (1) policy and process descriptions; (2) barriers to implementation; (3) outcomes data, if any were available; and (4) the degree to which the company viewed the criteria as being met, partially met, or not met. Companies were also encouraged to submit any supporting materials necessary to fully describe survey responses. We sent company representatives surveys in August 2003 and received responses and supporting materials back from the companies in September 2003.

Assessment

After receiving the surveys back from the companies, our team reviewed all responses to all sections of the Pledge to ascertain the degree to which each company was meeting each element of the Pledge. Many companies sent back with the surveys supporting materials describing the company. These materials included quality improvement policies and procedures, data support system descriptions, human resource policies and procedures, company descriptions, employee handbooks, orientation and training materials, and videotapes about the company, among other materials. To further understand company policies and to clarify any questions that arose from the survey responses, we referenced these materials as necessary. We also reviewed company websites or annual reports, if they were available.

To clarify any responses in the surveys or supporting materials, we conducted follow-up interviews with representatives from each of the 15 participating companies. Each interview lasted approximately 1 hour, and the respondents were given opportunities to further explain their responses, barriers to implementation of the Pledge, and any additional concerns regarding the current challenges affecting the quality of care in nursing facilities. Finally, we completed a general review of nursing and staffing studies, descriptions of state-initiated quality improvement efforts, existing quality improvement efforts, and nursing home regulations and guidance to help us understand the context in which Alliance companies are operating.

Limitations

Our findings are limited to the information provided by respondents in the self-assessment surveys, supporting materials, and follow-up interviews. The project scope outlined by the Quality First Steering Committee did not include any audits of either interview or survey responses. Because this process involved a self-assessment, the response explanations were also not always consistent across all companies. For example, although some companies identified barriers, others did not. Follow-up interviews focused on items to which the companies provided no response as well as clarification of the responses, and the nature of the questions discussed during the interviews varied. Also, a certain amount of responder bias was present because of the various professional positions of the individuals interviewed. Although some held positions more clinical in nature, others held positions related more to compliance or government relations. This may have affected an individual's familiarity with various topics and, consequently, the types of responses provided.

“Overall themes surfaced that demonstrate both significant achievements and potential areas of improvement for Alliance companies.”

Despite these limitations, overall themes surfaced that demonstrate both significant achievements and potential areas of improvement for Alliance companies. This baseline assessment was designed to present a snapshot of the progress of the Alliance companies toward meeting the various elements of the Quality First Pledge. To the extent that companies presented information regarding their Quality First Pledge-related activities, we identified common accomplishments across companies. More importantly, the self-assessment helped uncover where companies had encountered significant barriers or simply had not approached certain aspects of the Pledge. At times, this absence of information was the most helpful data that we received. Combined with the affirmative responses, this information has allowed us to identify

where progress has been made and where it has not. This information has also allowed us to identify a variety of options that the members of the Alliance can use to bolster their commitment to quality nursing home care in the future.



Universal Themes

During our research we identified several universal themes that emerged from the survey and interviews with each of the participating companies. This report outlines in great detail the findings from the surveys for each of the seven core elements of the Quality First Pledge in the Results section, but first we present an overview of the major findings that emerged from our assessment.

- » **The overall structures necessary to effectively implement continuous quality improvement programs within an organization are in place.** Each company showed us the corporate policies, procedures, and processes that they have put in place to operate quality and performance improvement programs. Although the structures varied among the companies, each company had continuous-feedback cycles at each level of the organization. All levels of the companies' organizations used clinical and operational data to track changes over time, to detect trends, and to identify problems. The companies then approached the problems that they detected in various ways to identify the root causes and to take corrective actions. The focus of these corporate policies, procedures, and processes was on ongoing vigilance and improving the delivery of care.
- » **Fear of liability and a high degree of regulation, inadequate reimbursement, employee turnover at the management and staff levels, inconsistent implementation, and the balancing of performance improvement with other company duties and goals are barriers that impeded full implementation of continuous quality improvement and performance improvement structures.** Some Alliance companies are trying to overcome these barriers through a variety of initiatives aimed at improving leadership and company culture, such as recognition and financial incentives for continuous quality improvement and participation in government quality improvement initiatives.
- » **The most important activity for creating change in the SNF culture is cultivating the commitment of direct-care staff. Some companies reported creative approaches to helping these staff understand and implement continuous quality improvement principles.** All of the companies met the basic criteria—commitment, recruitment, assessment, and training—of the Workforce

Excellence section of the Pledge. Yet, the companies that we surveyed and interviewed found that the barriers that they encountered, such as employee turnover and nurse shortages, were prohibiting maximum workforce effectiveness. They had undertaken significant initiatives to remedy these problems. Some approaches included

- » Using employee recognition and incentive programs,
 - » Offering leadership training for directors of nursing and administrators,
 - » Providing educational and career incentives,
 - » Reducing nurse agency use,
 - » Working closely with nursing schools, and
 - » Improving training and orientation programs.
- » **No companies have completed the difficult task of making the full spectrum of clinical and nonclinical quality data available to the public in a usable fashion for consumers.** This was the strongest finding that arose from the surveys and interviews. Despite significant efforts to improve their relationship with consumers through improved accountability, education, and satisfaction, some efforts that could ultimately enhance their accountability to the public and fuel improvements in the consumer's nursing facility experience have yet to be completed by the survey respondents.

At this time, the majority of Alliance companies provide clinical quality information solely through the CMS Nursing Home Compare website. None of the Alliance companies, nor the nursing profession as a whole, has disclosed nonclinical information to the public regarding patient satisfaction, family satisfaction, or the quality of the consumer experience. However, our research uncovered a solid basis for the collection and distribution of information in this area. All of the facilities are assessing consumer and family satisfaction, and many are using the same outside vendors to do it. In addition, several of the participating companies have evaluated the feasibility of disclosing satisfaction surveys to the public, but they have encountered significant barriers that prohibit them from releasing useful and valid data to the public.

In addition to public disclosure, improving the consumer relationship requires improving accountability, properly educating consumers about the nursing home experience, and improving consumer satisfaction. Our research uncovered several efforts undertaken by the companies in other related areas to improve their relationship with consumers:

- » **Accountability.** All of the Alliance companies are participating in CMS's NHQI. The quality initiative posts facility-level clinical data on the Nursing Home Compare website. These data can be accessed by potential or actual patients, their family members, discharge planners, state surveyors, and the public at large to surmise the performance of an individual facility performance on several clinical quality measures. The purpose of NHQI and Nursing Home Compare is to increase the nursing home profession's accountability to the public. The Results section contains a more complete discussion of this initiative and issues surrounding its use.

- » **Patient education.** Several companies have undertaken efforts to improve their education of patients and families about the nursing home experience and the aging process. They have created formal programs that outline what patients and their families can expect once they enter a nursing facility. The formal education takes on many forms and supplements and enhances the education and emotional support that is direct caregivers, supervisors, and administrators in facilities provide every day. This helps both patients and their families improve their experience with the nursing facility and assists the facilities in their interactions with consumers.
- » **Consumer satisfaction.** In this instance, the consumers are the patients and their families. All of the companies that responded to the survey assess consumer satisfaction through family and resident councils, complaint processes, and satisfaction surveys. In addition, 12 of the companies reported that they set annual quality improvement goals related to the consumer experience. Setting goals and measuring satisfaction allow companies to target problems and work toward an improved consumer experience. These efforts help companies to improve not only the clinical quality of care but also the quality of the experience for nursing home patients and their families.

This platform is the foundation for our recommendations in this report—improving the consumer relationship will be critical to future efforts to meet all the criteria in the Quality First Pledge and essential to improving the Alliance companies' commitment to quality nursing home care. The Alliance companies have in place the basic elements to improve their relationship with consumers; and with continued work among the Alliance members, common consumer measures could be identified, developed, and tested by the companies in the future.



Results

Commitment to Patient Well-Being Through Quality Care

The first section of the Quality First Pledge is the lengthiest and most detailed component of the Pledge. It is also the section most centered on ensuring that the care directly delivered to nursing home patients is of the highest quality and that there is an ongoing commitment to improving the quality of care over time. The first section of the Pledge identifies four elements necessary for this ongoing commitment:

- » **Leadership commitment to quality.** Management must exhibit leadership by playing an active role in the establishment and implementation of a code of conduct that articulates the organization's expectations of all employees, states the principles that guide the organization's operations and that reflects its values, and develops and implements clear policies and guidelines that support a commitment to high-quality performance.
- » **Continuous quality improvement.** The organization must routinely evaluate clinical performance and assess patient, family member, and employee concerns about performance. It must also develop processes to identify and assess legislation, regulations, and changes in standards of practice to determine the adequacy of the resources available for the implementation of new guidelines or regulations.

- » **Quality improvement goals.** The organization must seek input to establish annual quality targets and quality improvement goals. To establish these annual targets and goals, it must use data from government-developed clinical quality measures and inspection reports; customer satisfaction surveys; patient, family, and employee communications; and internal quality monitoring.
- » **Uniform measures of quality.** The organization must work with others to create and refine quality measures that are reliable, uniform, adjusted for risk, easy for consumers to access and understand, and relevant to the quality of care in nursing facilities.

Description of Activity

This section is the lengthiest part of the Quality First Pledge. It is also the part of the Pledge with the most variation in whether the criteria were met or not met. However, in general, when one company was not meeting a specific criterion, no companies were meeting the criterion. On the positive side, all of the companies reported having the corporate policies, procedures, and processes in place to implement continuous quality improvement programs at all levels of their organizations. As part of this process, each company reported setting annual quality improvement goals, including clinical as well as consumer-related goals.

The survey respondents have had less success with two other components of the Commitment to Patient Well-Being section of the Pledge. First, our research found that beyond CMS Nursing Home Compare, there have been few efforts to establish uniform measures of quality across the Alliance companies. However, the Nursing Home Compare quality measures and internal data collected by facilities through MDS and other mechanisms show significant overlap in the types of data collected and the measures used by each company.

In a second area—leadership commitment to quality—we found evidence of inconsistent implementation among the survey respondents. Some companies have chosen to go above and beyond the basic elements of the Pledge and regulations to break down barriers to effective leadership and improve the company's commitment to quality; others have made more limited progress in this area.

Leadership Commitment to Quality

The leadership component of this part of the Pledge has three subelements that ask the following: (1) Are management and the organization committed to improvement? (2) Does the organization have policies regarding quality? and (3) Are there quality goals, and if so, how are they established?

- » **Management and organization commitment to improvement.** All of the survey respondents reported that organization management was committed to quality. We read many of the companies' corporate policies and procedures to assess how each company's policies reflected quality and a commitment to improvement. In that analysis we evaluated human resource policies, specific continuous quality improvement policies, complaint process policies, compliance programs, and management policies. All of the companies have highlighted quality improvement and quality of care as paramount outcomes in their corporate policies and procedures. The respondents reported that this commitment was visible to patients, families, employees, and the government at each facility and all levels of the organization.

All the respondents reported that they work within their organizations and with other organizations to share best practices as well. Corporate clinical personnel regularly attend a clinician meeting where best practices and current issues related to care delivery are discussed among senior clinicians from both for-profit and not-for-profit nursing home organizations. In addition, the majority of respondents reported working with state QIOs, and several are also participating in the QIO pain collaborative as part of CMS's NHQI.²⁴

“The majority of respondents reported working with state QIOs.”

- » **Organization policies regarding quality.** All of the Alliance companies provided us with information and documentation regarding company policies and procedures. Each organization charges its employees with the responsibility to comply with current laws and regulations and the organization's quality standards. Eight of the companies reported that they link performance incentives to quality improvement as well as other variables, such as performance according to state surveys or satisfaction surveys. Each company has policies in place to routinely review and evaluate organization policies and practices related quality of care and quality improvement.
- » **Quality goals.** The greatest variation found among the companies was in the subelement of quality goals. This subelement requires companies to set annual quality improvement goals based on organization-wide performance as well as input from employees, patients, and family members. The goals should address clinical as well as patient and family satisfaction levels and should be shared with employees, patients, families, shareholders, and the public. These goals should be monitored, and the outcomes should be shared with the public.

All of the companies in the survey set annual goals related to clinical performance, but only 12 reported that they set annual goals related to patient or family satisfaction. These goals were developed with input from a variety of sources, including clinical data and satisfaction surveys.

- » **Clinical goals.** Each company develops clinical goals on the basis of its own internal quality monitoring and CMS Nursing Home Compare quality measures. Every company has a data collection mechanism—either manual or electronic—with which it tracks the clinical progress of patients and monitors adverse events. We found that all companies collected data for each patient on pressure ulcers, falls, and the use of restraints. The trends for these clinical data are then evaluated for facilities, regions, and the company to establish current performance and benchmarks, goals, or thresholds for quality improvement that have been developed.
- » **Consumer-related goals.** All companies reported that they had surveyed family satisfaction, and 11 reported that they had used patient satisfaction surveys. In many cases, these surveys are used by corporate management used the findings from these surveys to capture consumer input when they set annual goals. Companies that use outside vendors to develop and conduct surveys were more likely to use satisfaction survey results for goal development at the corporate level. Table 2 shows the relationship.

²⁴The CMS QIO pain collaborative was established in 2003 as part of NHQI. The goal of the project is to develop and test a multifaceted educational and behavioral intervention to improve pain-alleviating practices in nursing homes.

Table 2. Relationship Between Use of Outside Vendor or Resource and Use of Customer Satisfaction Data at the Corporate Level

Company	Use of Outside Vendor or Resource	Customer Satisfaction Data Used at Corporate Level to Set Consumer-Related Annual Goals
1	No	No
2	Yes	Yes
3	Yes	Yes
4	No	No
5	Yes	Yes
6	No	Yes
7	Yes	Yes
8	Yes	No
9	Yes	Yes
10	No	Yes
11	Yes	Yes
12	Yes	Yes
13	Yes	Yes
14	Yes	Yes
15	Yes	Yes
Total Yes	11	12

Although all companies reported that they have developed annual clinical goals or quality goals, or both, how these goals were shared and with whom they were shared varied widely. All companies share their annual goals with their employees, only 10 companies reported that they explicitly share their goals with patients and families, and 6 reported that they share their goals with shareholders or the public.²⁵

²⁵Note that some companies are privately held and do not publish annual shareholder reports or other correspondence for shareholders that would contain information about annual goals.

Continuous Quality Improvement

The continuous quality improvement element of the Quality First Pledge describes the structures and activities necessary as first steps to implementation of continuous quality improvement. Companies are largely meeting this element of the Quality First Pledge, of which there are four subrequirements: (1) an organization-wide quality improvement process, (2) individuals with responsibility for quality improvement, (3) consistent monitoring of quality by the organization, and (4) organization evaluation of its quality policies and processes. An effective continuous quality improvement structure allows organizations to respond to changing legislation, regulations, or standards of practice in a timely manner.

- » **Quality improvement process.** Each company reported that it has developed and implemented an organization-wide quality improvement process and has established a system for verifying quality improvement processes and their ongoing implementation. As mentioned above, all companies reported that they annually develop quality improvement goals as part of this process; however, each company approaches the process differently. As suggested later in this section, company quality monitoring programs are the foundation for many of these processes, and they can vary significantly from organization to organization (see Box 1). Despite this high degree of variability, each company has quality improvement processes that involve problem identification and analysis at each level of the organization. Each organizational level is also required to respond to problems; and every company overlays this with a series of checks, consultations, and audits on a frequent and regular basis.
- » **Quality improvement responsibility.** Each company indicated that one or more individuals has explicit responsibility for assessing quality trends within the company and for monitoring performance. In many cases, these individuals were those who had completed the survey and who had participated in follow-up interviews with us.
- » **Quality monitoring.** Each company had outlined in its policies and procedures a significant structure for quality monitoring and ongoing quality improvement. To verify this information and understand how it works on a daily basis, during the follow-up interviews we asked the interviewees to describe the monitoring process as well. Each company participating in the survey reported that the structure that it uses to monitor quality contains the following six elements:
 1. Clinical outcomes data and other information to routinely monitor clinical quality performance (i.e., the percentage of falls or pressure ulcers per facility, facility-level staff turnover, patient satisfaction, nurse agency use, etc.);
 2. Annual quality performance assessments;
 3. The ability to conduct focused quality assessments and technical assistance when a facility is not meeting performance standards;
 4. Mechanisms at each level of the facility to develop quality improvement action plans in response to identified problems or issues;
 5. Documented protocols for investigating accidents and incidents to uncover root causes and recommending corrective actions; and

6. Clear communication to employees of the outcomes of quality assessments and quality improvement plans.

Although these six elements were common to all of the companies, the operations at individual companies varied widely. Each company had a quality assurance or quality improvement committee that operated at the facility level. These committees meet an average of monthly—but meet at least quarterly, as required by law—to review clinical and operational data about their patients.²⁶ The manners in which these committees approached problems once they were identified varied to a great degree, and the manners in which the companies set annual quality improvement goals were highly variable. Some companies require every level of the organization, from the facility level to the corporate level, to set annual goals and develop quality improvement plans to meet those goals. The goals can be specifically tailored to meet guidance or directives from corporate leadership, or they can be developed entirely independently of other levels of the organization. Box 1 shows examples of how two different companies meet the requirements of the six elements of quality monitoring in two different ways.

Box 1: Examples of Continuous Quality Improvement Structures

Company A

Company A uses a software-based data system from an outside vendor to collect and quantify data. This data are used at the facility, regional, and corporate levels to track quality. At the facility level, the quality improvement committee meets monthly to discuss trends, identify problems, and develop action plans.

Clinical consultants from the region visit the company's facilities monthly or more often to assist facilities with clinical problem identification and corrective planning. Regional operations consultants provide similar guidance for the housekeeping, billing, and dietary divisions of the company. In addition, each facility is audited by different corporate departments on a regular basis. More focused visits occur when “trigger” events are identified through the incident and accident reporting system or the quality data software.

Quality improvement plans are initiated at the facility level in response to problems. Overall planning and annual quality improvement goals are established at the corporate level and are passed down to facilities. Goals are reevaluated annually at the corporate level and are reintroduced if the previous year's goals have not been met.

(Box 1, continued on next page)

²⁶ Social Security Act §1919(b)(1)(B).

(Box 1, continued from previous page)

Company B

Similar to Company A, Company B uses a software-based data system from an outside vendor to collect and quantify data. These data are used at the facility, regional, and corporate levels to track quality. At the facility level, the quality improvement committee meets monthly to discuss trends, identify problems, and develop action plans. The quality improvement committee is also responsible for developing its own annual facility quality improvement plan with a schedule of focused reviews throughout the year. This annual quality improvement plan must incorporate corporate annual goals.

At Company B, facility administrators are encouraged, but not required, to have a presurvey readiness assessment done. This assessment focuses on survey performance, as well as other important areas, and is done by peers from other facilities in the region. Focused visits to correct problems are done on an ad hoc basis in response to reported incidents or accidents or other concerns.

A corporate quality group guides overall quality improvement evaluation and annual goal planning with significant input from regional representatives. The corporate quality group works with regional staff to ensure that the goals are met. If they are not met within specific facilities or regions, additional attention is directed to that facility or region.

- » **Quality policy and process evaluation.** All 15 companies participating in the survey reported that they conduct some type of evaluation of their quality improvement policies and processes at least annually; and the majority of respondents reported that they obtain continual updates of policies and processes related to quality improvement through standards of care committees, board compliance committees, or other entities created especially to update policies and procedures. In addition, each company has established processes to investigate, report, and respond to the areas of concern, incidents, or accidents identified.

Quality Improvement Goals

Under the quality improvement goals element of the Pledge, signatories have made the commitment to establish annual quality targets and quality improvement goals. To establish these annual targets and goals, the companies must use data from government-developed clinical quality measures and

inspection reports; customer satisfaction surveys; communications with patients, families, and employees; and internal quality monitoring.

All of the companies use data from their own internal quality monitoring systems, CMS's Nursing Home Compare quality measures, and state survey reports to develop annual clinical goals. Each company has an internal data collection mechanism—either manual or electronic—with which it tracks the clinical progress of patients and monitors adverse events. The trends detected from these clinical data are then evaluated for facilities, regions, and the company to establish current performance and the benchmarks, goals, or thresholds for quality improvement that have been developed. Companies also reported that they use CMS's Nursing Home Compare quality measures and state surveys to set goals. Individual facilities can use this information, although less timely, to compare the number of survey deficiencies with statewide and national averages and to compare facility quality measure performance with state and national averages.

All of the companies reported that they use some form of communication—whether through satisfaction surveys or resident councils—from patients, families, and employees to monitor trends. However, as discussed above, only 12 of the 15 companies participating in the survey reported that they use this information to develop their annual quality improvement goals. Only seven companies reported that they use employee satisfaction surveys to gather employee input.

Uniform Measures of Quality

Under the uniform measures of quality element of the Pledge, companies agree to work with others to create and refine quality measures that are reliable, uniform, risk adjusted, easy for consumers to access and understand, and relevant to the quality of care in nursing facilities. All companies reported that they work closely with CMS and others to improve the CMS's Nursing Home Compare quality measures, which attempt to assess the clinical quality of care in facilities, but there has been little recent activity beyond this initiative.²⁷

“Each company has an internal data collection mechanism...with which it tracks the clinical progress of patients and monitors adverse events.”

²⁷ See Public Disclosure and Accountability section of this report for a more extensive discussion of CMS's Nursing Home Compare and recent quality initiatives.

“CMS’s NHQI and Nursing Home Compare represent significant efforts by federal policy makers at CMS and the nursing home profession to begin to provide quality information to the public.”

CMS’s NHQI and Nursing Home Compare represent significant efforts by federal policy makers at CMS and the nursing home profession to begin to provide quality information to the public. Although survey respondents had concerns with the quality measures, they agreed that these clinical measures are a significant step to establishing measures that are uniform, reliable, risk adjusted, and relevant to the quality of care in nursing homes.

In light of these concerns, we anticipated that Alliance companies would be working with others in the nursing home profession to develop more accessible and easy-to-understand measures for their consumers, including, in particular, information regarding the customer experience, which NQF acknowledges is essential for consumers to make comparisons.²⁸ We found no evidence of

any efforts to develop uniform measures of quality across the nursing home profession or Alliance companies. However, individual companies reported that they undertake significant efforts to engage and work with universities and outside vendors to develop and administer customer and employee satisfaction surveys. Some companies reported that they undertake evaluations to ascertain the feasibility of releasing satisfaction survey data to the public; however, they have encountered significant barriers. Respondents found that any satisfaction measure that they released would be difficult for consumers to understand in the context of other company’s or facility’s satisfaction scores, which may be determined on the basis on entirely different scales and under different collection methodologies.

Barriers

This section discusses both the internal and external barriers that the Alliance companies experience in meeting their commitment to patient well-being through quality care. The barriers discussed in this section represent those most frequently cited in the survey responses and interviews and do not necessarily reflect the barriers identified by each individual company that responded to the survey.

Internal Barriers

- » **Focus on lawsuits and liability.** All of the companies reported heightened concern with the current legal environment. This fear drives what many companies measure and what they choose to monitor. It also drives how events are documented and how problems are resolved. This response to the external environment does not necessarily prohibit continuous quality improvement processes or quality monitoring. However, the respondents reported that the fear can limit innovative problem solving and thinking because missteps might open the window to liability.

²⁸ National Quality Forum Press Release, October 3 2003.

- » **Facility management turnover.** Respondents reported that the instability that occurs when facility administrators or directors of nursing leave can prohibit the continuation or implementation of quality improvement processes. This turnover may also temporarily diminish the leadership capabilities within facilities, as it takes time for new managers to establish rapport with facility staff.
- » **Staff turnover.** With the high degree of turnover of nurse's aides and nurses in the nursing home profession, there is a constant need for training and education of new staff and little time to move beyond the basics required to care for patients. In addition, turnover may stimulate heavy reliability on nurse staffing agencies, which are costly and which may diminish the overall quality and continuity of care.
- » **Inconsistent continuous quality improvement implementation.** Not every facility management team or employee is equally vested in and committed to the culture necessary for continuous quality improvement to occur. In addition, individuals at the facility level may implement in-house policies that depart significantly from company policies. Both of these problems can inhibit the implementation and maintenance of an environment in which problems are identified and actions plans are developed to solve problems in an efficient and appropriate manner.
- » **Balancing crises with continuous quality improvement.** The survey respondents reported that immediate concerns can override the commitment and time available for problem identification, problem reporting, action plan development, and continued resolution of problems.
- » **Balancing financial performance and regulatory performance with continuous quality improvement.** Respondents reported that facilities must maintain a high census, ensure that the facility routinely passes state surveys, and ensure that the facility has high marks for performance on CMS quality measures. Balancing these concerns with ongoing efforts to monitor quality in all areas of the facility and to make improvements that do not have a direct effect on survey or financial performance can be difficult. These concerns can also override investments in the technology and resources necessary to fully implement a continuous quality improvement structure with adequate quality monitoring.

External Barriers

- » **Nature of regulatory environment.** Respondents reported that the current federal and state nursing home regulations can be burdensome and not conducive to the problem solving required to implement continuous quality improvement processes and effectively monitor quality of care. Surveys and the survey process are established in regulation, and state surveyors have little flexibility when deficiencies are observed. Sanctions are levied, and surveyors are prohibited from working consultatively with facilities during a survey to correct problems and educate staff. This limits a nursing facility's ability to focus resources beyond those required for annual performance surveys.

- » **Liability.** Each company has an internal focus on protecting the company’s facilities and the company from lawsuits and liability. Respondents reported that this limits innovative problem-solving activities within the company because of the fear of risk or failure. This internal barrier—a fear of liability—has arisen as a result of the highly litigious environment in which nursing homes operate. The number and scope of nursing home-related lawsuits have risen dramatically over the last decade, and liability premiums are driving nursing home companies out of business in certain states.²⁹ This barrier has forced nursing home companies to designate to risk management significant resources that could be used for quality improvement.
- » **Reimbursement is inadequate to attract and retain high-quality staff.** The current reimbursement environment creates a wage divide between the long-term-care industry and the acute-care industry for professional staff. Lower reimbursement levels has led to lower salaries in nursing facilities relative to those in other acute-care organizations. In addition, the hiring process can, in some states, be more onerous than that in other health care settings. This limits hiring ability.³⁰

Approaches to Addressing Barriers

The Alliance companies provided us with significant information about how they are working to overcome the barriers that they encounter and to improve upon their existing performance in this area of the Quality First Pledge. Below is a snapshot of the most common activities undertaken by companies.

- » **Recognition and financial incentives for continuous quality improvement.** To counterbalance the punitive nature of the survey process and to promote quality improvement, many of the companies have implemented programs that recognize achievements in the area of continuous quality improvement. These programs focus on facility-level employees and reward them for such activities as participation on facility performance improvement committees, identification and resolution of problems, and high-quality customer service.

Companies reported that they use financial incentives for managerial staff to promote their continuous quality improvement objectives as well. In half of the companies, financial incentives are offered to employees throughout the corporate structure,

including facility administrators and directors of nursing, to promote these objectives. These companies attach a percentage of compensation to clinical and consumer-related outcomes. The focus, they reported, is not just on survey outcomes but also on quality improvement. This has been reported to greatly improve staff commitment to formalized quality monitoring and continuous quality improvement activities within these organizations.

“Companies reported that they use financial incentives for managerial staff to promote their continuous quality improvement objectives....”

²⁹ Bourdon and Dubin, *Long Term Care General Liability and Professional Liability Actuarial Analysis*, March 2003.

³⁰ See Workforce Excellence section of this report for a more complete discussion of this barrier.

- » **Participation in the CMS QIO pain collaborative.** One component of CMS's NHQI is a QIO demonstration project on pain and pain management. The goal of the project is to develop and test a multifaceted educational and behavioral intervention to improve pain treatment practices in nursing homes. Several of the companies reported that they work with CMS on this initiative. They reported that despite the significant investment in time and resources, the pain collaborative demonstration project has been helpful in allowing the companies to share their best practices with those of other nursing facility companies and to learn from others' work. It has helped many of the companies to better identify and deal with pain in patients at participating facilities, ultimately improving the overall quality of care monitoring and improvement processes.

The majority of the survey respondents reported that they work with individual state QIOs as well. Alliance companies reported some initial problems with working with the QIOs, but some companies have found the relationship to be a positive learning experience for both the facilities and the QIO. These activities will likely continue in the future and have provided facilities with an avenue to focus on quality improvement. Many of the respondents participating in these initiatives believed that QIOs may help educate state surveyors about quality improvement and help them see a new dimension of nursing facility operations and care during the survey and certification process.

- » **Assisting direct-care staff.** An often-cited concern from survey respondents was the sheer volume of policies and procedures that have been produced to balance the current regulatory environment with company objectives for clinical, consumer, operational, and financial performance. It can be difficult for direct-care workers, such as nurse's aides and LPNs, to sort through and retain all of the information necessary to perform their jobs effectively. In response, several companies have created easy-to-read or at-a-glance pocket guides or reference cards that walk staff through procedures or policies in popular topic areas, for example, how to report an incident or identify pressure ulcers and answers to questions about Medicare coverage. These guides have become extremely popular with staff and have helped improve the direct delivery of care to patients.

Conclusion

The first section of the Pledge covers a wide array of criteria that touches on every aspect of care and care delivery in nursing facilities. The results show that Alliance companies have recognized the importance of leadership, structure, and goals in providing quality care to patients. The survey results show that

- » Alliance companies' leadership is committed to quality and quality improvement;
- » Continuous quality improvement policies, procedures, and structures are in place; and
- » Each Alliance company has set clinical quality goals.

These results have gone a long way toward meeting the basic elements of Commitment to Patient Well-Being section of the Pledge; however, Alliance companies reported that they are not meeting some critical criteria. First, not all companies appear to use employee and consumer inputs to develop annual quality improvement goals, particularly goals related to consumer experiences. Performance related to this particular element varied widely from company to company and each organization should do its own internal assessment to determine how it is performing in this area.

Second, Alliance companies have not yet begun to work with others to create and refine quality measures that are accessible and easy for consumers to understand. There has been active participation in CMS's Nursing Home Compare, but Alliance companies have been unable to appropriately quantify the consumer experience and provide those results to potential consumers. The next section discusses the second finding in more detail.

Public Disclosure and Accountability

This part of the Quality First Pledge recognizes the important role that disclosure of quality information plays in accountability to the public. The Pledge articulates this principle through the following statements:

“The organization currently discloses significant amounts of quality information and will continue to disclose that information, while protecting the confidentiality and complying with other legal requirements. As part of its disclosure process, the organization has developed policies and systems for routinely disclosing quality performance information and will assist our employees, our patients, their family members, and the general public in accessing this quality information in a timely manner.”

Description of Activity

The Alliance companies are largely meeting the public disclosure and accountability part of the Pledge as participants in CMS's NHQI and its mandatory component, Nursing Home Compare.³¹ This component requires each Medicare-certified nursing facility in the United States to disclose significant clinical quality information through CMS's Nursing Home Compare website (www.medicare.gov/NHCompare/home.asp). In addition, each facility's staffing ratios and survey performance are posted on Nursing Home Compare as well as in its facilities.

Nursing Home Compare, which was implemented in November 2002, uses each facility's MDS reports to establish quality measures unique to each nursing home. The 14 quality measures indicate the percentage of patients within a facility with pressure sores, loss of ADL function, pain, physical restraints, delirium, and as well as other conditions; and these percentages are posted on

³¹ CMS's NHQI was implemented in November 2002 with three goals: (1) provide consumers with additional information about nursing home quality through Nursing Home Compare, (2) generate competition among nursing facilities through public disclosure of performance, and (3) help nursing home providers improve quality of care by providing resources and assistance from state QIOs.

the CMS Nursing Home Compare website for public review. It was designed to improve nursing facility accountability by allowing potential nursing home patients or their families to compare the performances of facilities in their areas on the basis of the quality measures. Despite methodological concerns with the quality indicators, CMS has elected to operate Nursing Home Compare and work with organizations such as NQF to improve the quality measures over time.³²

Alliance companies reported that they are active participants in the development, piloting, and implementation of Nursing Home Compare. Some respondents also reported that they continue to work with CMS to improve the quality indicators as well as the MDS in an effort to establish better indicators with more significance for potential patients and their families.

Despite the significance of Nursing Home Compare, Alliance companies are not yet meeting the following elements of this portion of the Pledge, as described below.

- » **Disclosure.** Only two Alliance companies have elected to disclose company-wide clinical quality information to patients and their families through their websites or newsletters. None of the companies discloses information regarding consumer satisfaction.
- » **Routine.** None of the Alliance companies has developed specific policies for routinely disclosing quality information.
- » **Assistance.** None of the Alliance companies assists the public with accessing their quality information.

Barriers

The Alliance company survey respondents and follow-up interviews identified a number of barriers and problems associated with public disclosure. The barriers identified were generally of two types: those specific to CMS's Nursing Home Compare quality indicators and those regarding the legal environment.

- » **Methodological problems and consumer relevance.** The survey respondents reported methodological concerns with the CMS quality measures in Nursing Home Compare. Their concerns centered on risk adjustment and the reliability of the MDS as a tool for the collection of data regarding quality. In addition, many respondents believed that insufficient consumer education and information was paired with the quality measures. The respondents were interested in discussing how Nursing Home Compare could be enhanced to allow consumers to more easily compare the performances of different facilities and to improve its accessibility to consumers.

³²See the Background section for more detail. Upon Nursing Home Compare's release, GAO reported concerns with CMS's selection of measures and encouraged CMS to hold up the release until NQF, which along with Abt Associates, was contracted with CMS to review the quality measures for public disclosure, released its final report (GAO, Nursing Homes, October 2002). NQF's report was published in October 2003. In response to that report, CMS released an enhanced set of quality measures on Nursing Home Compare in January 2004.

“[Nursing Home Compare] was designed to improve nursing facility accountability by allowing potential nursing home patients or their families to compare the performances of facilities in their areas on the basis of the quality measures.”

- » **Liability and the culture of fear.** The second series of barriers that the respondents identified focuses on what they perceive as a regulatory environment in which fears and concerns about regulatory success (i.e., successful survey performance and regulatory compliance) and punitive legal action override much of the day-to-day decision making. The fear-based culture stems from the constant concern—from the chief executive officer of the nursing home company down to the nurse’s aide at the patient’s bedside—about successful survey outcomes as well as concerns about legal liability. This fear makes companies slow to publish their own quality information that may be perceived as an indicator of poor or substandard care by surveyors or attorneys.

Conclusion

Alliance companies reported a continued commitment to the CMS NHQI through ongoing participation, including active support of the revision and development of better Nursing Home Compare quality measures and with additional information and education for consumers. They recognize the important role of disclosing clinical quality information in their own accountability. However, barriers must be resolved before progress can be made, including a change in the legal environment that can sometimes discourage public disclosure of information that may be damaging.

“There has been little effort to standardize information regarding the consumer experience and consumer satisfaction with nursing facility care across Alliance companies.”

The most important lesson from our investigation of this portion of the Pledge is that, despite today’s substantial disclosure of quality information through CMS’s Nursing Home Compare and the nursing home profession’s and NQF’s interest in improving the measures on Nursing Home Compare, more disclosure may be necessary. As we indicated earlier in this section of the report, a few individual companies have considered the disclosure of consumer experience information to the public,

but these efforts have been stymied by barriers that limit the comparability of consumer experience measures from company to company. There has been little effort to standardize information regarding the consumer experience and consumer satisfaction with nursing facility care across Alliance companies. The assessment of the levels of adherence to this section of the Pledge shows that Alliance companies must do more to standardize and publicly share this information. Alliance companies have accomplished much vis-à-vis CMS’s NHQI, but survey respondents acknowledge that more must be done to disclose quality measures related to quality of life and consumer satisfaction.

Patient and Family Rights

The third section of the Quality First Pledge addresses the articulation of patient and family rights. As required by federal and state laws and regulations, all patients have a set of rights; and facilities must ensure that these rights are upheld for each patient.³³ The Pledge, mirroring federal statute, requires

³³ Social Security Act §1919(c).

that these rights be clearly articulated to patients upon admission and made available within the facility and upon request. The Pledge also requires that facilities that include additional protections make these protections available in writing for patients, their families, and employees.

Listed below are the patient's rights that Pledge signatories must articulate upon admission and anytime throughout a patient's stay in their facilities:

- » Access to care in a safe and supportive setting
- » Freedom from abuse and neglect
- » Patient choice and involvement in care-related decisions
- » Access to personal medical information
- » Privacy and confidentiality protections
- » Freedom from physical and chemical restraints
- » Freedom to create patient-family councils
- » Protection of patient funds and of patient financial affairs and information
- » A grievance process
- » Self-determination and advanced directives
- » Access to social and spiritual activities
- » Dignity during caregiving

Description of Activity

All survey respondents reported that they meet this element of the Quality First Pledge. Each company distributes a written copy of patient rights upon admission, and several provide patient handbooks to the patients and their families upon admission. These handbooks contain information about the patient's rights; facility operations; frequently asked questions; as well as information about how to register complaints or concerns with staff, administrators, and outside organizations. In the surveys or during the interviews, each company expressed a commitment to ensuring patient and family rights and had developed corporate policies and procedures to ensure that all facilities exercise the same commitment to these rights and that company leaders closely monitor adherence to these policies.

In part, because the patient's rights and standards for accessing those rights outlined in the Quality First Pledge are similar to existing laws and regulations, the respondents reported few barriers with implementing this element of the Pledge. However, some Alliance company survey respondents

reported that they work to go above and beyond the mandates in federal and state laws to create more proactive materials or programs that educate patients and their families about their rights, the aging process, and the nursing home environment either upon admission or throughout their stays at facilities. Some of these efforts are described below.

- » **Written materials.** Two facilities provided us with the brochures and journals that are distributed to patients and their families upon admission. These publications describe the aging process and the end-of-life experience. One company provides a journal to family members that explains the jargon that one might hear from staff, the emotions that a family and their loved one may experience, care planning, and how to make the most out of one's visit.
- » **Video instruction.** One Alliance company reported that upon admission it shows patients and their families a video about realistic expectations. The video describes the realities of aging and what to expect in the nursing home environment, including information regarding the freedom of movement, the patient-physician relationship, nutrition and hydration, and financial aspects of care.
- » **Customer liaisons.** Three Alliance companies have a formal customer liaison program that operates in each facility. The programs vary; but essential elements include a designated person who works closely with patients one on one, particularly during the first weeks of their stay, to hear their questions or concerns. The liaisons are charged with resolving or responding to patient or, in some cases, family complaints. The critical element is establishing a designated employee who is responsible for responding to each patient's complaints or concerns.

Conclusion

All of the companies participating in the survey have systems in place to ensure patient and family rights. Some companies have elected to implement more proactive approaches to notifying and explaining these rights to patients and their families. As investigators, we recognized, and the respondents acknowledged, that the proactive approaches have been created for two reasons: (1) to improve the consumer and family experience and (2) to manage the liability risks associated with adverse patient events that may occur in facilities. The published materials, video, and customer liaisons have important roles in teaching families and patients what to expect during their stays in a nursing facility. They also teach families about what to do when a problem arises, encouraging families to work closely with staff within the facility to resolve problems. These two efforts help nursing facilities resolve concerns long before outside government agencies, such as survey and certification activities or an ombudsperson, gets involved. In many cases, this can limit the risk of future liability through lawsuits.³⁴

“Some companies have elected to implement more proactive approaches to notifying and explaining... rights to patients and their families.”

³⁴Vickery, K. *Building a Foundation of Trust*, July 2003.

The results of the survey and our interviews indicate that the goals of managing liability and improving the consumer experience, when balanced effectively, can be complementary and can assist both nursing facilities and patients and their families. Improved expectations and better problem-solving responses from staff can only enhance the efficiency with which a patient's problem is solved and the patient's rights and well-being are restored. It can also help nursing facilities operate in an environment with a reduced risk of liability.

Workforce Excellence

The workforce excellence section of the Pledge outlines the requirements that relate specifically to nursing home employees. To maintain a high quality of patient care and quality goals, nursing homes must ensure the integrity of the individuals who will be serving the needs of patients. The Pledge outlines the criteria that comprise this element. These are described below.

- » **Employee recruitment and assessment.** The employee recruitment and assessment subsection outlines the requirements of nursing facilities for the active recruitment, screening, and evaluation of job candidates by a selection process that allows for the scrutiny of individuals who might care for nursing home patients. The assessment process includes background checks, abuse registry checks, verification of certification and licenses, criminal disclosures, and appropriate drug tests.
- » **Employee training.** In addition to the recruitment process, companies must ensure that employees are well trained. When employees are trained, it must be ensured that they are aware of company policies, including any quality improvement policies; new employees must be provided with task-specific orientation programs; and employees must be informed about occupational safety. Company policies may be communicated through a variety of means, including employee handbooks, general and departmental orientation programs and materials, continuing education, and publicly visible posters. The organization also provides employees with clearly outlined job expectations, roles, and responsibilities.
- » **Commitment to employees.** Finally, Alliance companies pledge to demonstrate a commitment to provide employees with the most satisfactory work environment possible. Companies can promote employee satisfaction through a variety of methods. Alliance companies should have systems in place to recognize the achievements of employees, maintain safety in the workplace, prevent instances of discrimination or harassment, and support public policy initiatives to ensure adequate levels of compensation.

Description of Activity

Each company in the survey reported that it had has formal systems in place to address the workforce excellence elements of the Pledge. For example, all companies have formal procedures for employee recruitment and assessment, including

- » The use of screening and interview procedures to assess and evaluate candidates' backgrounds during employment eligibility determinations (e.g., referencing nurse aid registries, using standardized interview forms, and conducting behavioral and situational interviews);

- » The use of formal reference check procedures outlined in human resource policies and procedures manuals;
- » Conduct of criminal background checks³⁵ and examination of OIG exclusion list references³⁶;
- » Institution of the requirement that all employees abide by the terms of drug policies that prohibit the presence of illegal drugs, alcohol, or controlled substances in the workplace;
- » Verification of licensure, certifications, etc.; and
- » The use of introductory, probationary periods upon hire to closely monitor and mentor new employees to ensure that they are prepared to operate independently (supervisors must provide written authorization at the end of the probationary period to confirm that the employee is adequately prepared for patient contact).

Regarding employee training, all companies reported that they have the following systems or variations of the following systems in place to address this element of the Pledge:

- » Mandatory orientation programs attended by all new employees upon hire that address employee roles and responsibilities and company philosophies, including quality improvement approaches, patient care responsibilities, task-specific skills, and background information on regulatory requirements;
- » Formal methods of disseminating information, e.g., videos, classes, reference materials, and employee handbooks;
- » Written evaluations to assess and test proficiency with orientation content;
- » Methods of obtaining employees' written acknowledgement of receiving orientation materials;
- » Clearly outlined methods of explaining workplace safety issues, fraud and abuse laws, and the organization's compliance program; and
- » Refresher courses designed to ensure that employees continue to abide by company policies.

Finally, all companies demonstrate a commitment to employees through policies and procedures that include variations of the following:

- » Formal employee recognition programs that include monthly, quarterly, or annual recognition awards to reward outstanding performance;
- » Plans and processes to educate employees about occupational health and safety hazards through orientation programs or employee reference materials;

³⁵ According to the OIG report *Quality of Care in Nursing Homes: An Overview* (March 1999), no federal requirement for criminal background checks of nursing home staff exists, but 33 states mandate that such checks occur.

³⁶ OIG urges health care providers and entities to check the OIG List of Excluded Individuals/Entities on the OIG website (www.hhs.gov/oig) before hiring or contracting with individuals or entities. No federal health care program payments may be made for any items or services (1) furnished by an excluded individual or entity or (2) directed or prescribed by an excluded physician (**OIG Special Advisory Bulletin**, *The Effect of Exclusion from Participation in Federal Health Care Programs*, September 1999).

- » Written materials that articulate company expectations regarding harassment, discrimination, and exploitation policies; and
- » Systems to monitor current wages and salaries to ensure appropriate levels of employee compensation.

“The companies identified several issues that adversely affect their ability to meet the workforce elements of the Pledge.”

Although all companies have a framework in place to address these elements of the Pledge, the companies identified several issues that adversely affect their ability to meet workforce elements.

Internal Barriers

- » **Difficulty retaining staff.** Companies reported that they have difficulty retaining staff to ensure a high quality of care and continuity of care. During follow-up interviews, company representatives explained several potential reasons why this difficulty exists. First and foremost, the challenging nature of the work in the nursing home setting may result in general job dissatisfaction among employees. Working with nursing home patients who have chronic disabilities and who require ongoing assistance with ADL is both physically draining and emotionally stressful for direct-care staff. Combined with the long hours and irregular shifts characteristic of the nursing profession, the challenging nature of working with nursing home patients may cause nursing home staff to feel especially underappreciated. Additionally, given the day-to-day demands that employees consistently face, the respondents believed that salaries do not adequately compensate employees. Finally, a lack of strong clinical and administrative leadership (discussed below) may result in frustrations in the workplace that lead to turnover.
- » **Quality control of candidate pool.** Several company representatives expressed concerns over the effectiveness of current procedures in determining the employment eligibility of candidates.
 - » **Limitations of background checks.** Even though the nurse’s aide registries maintained by each state are supposed to ensure that nurse’s aides have successfully completed nurse’s aide training and competency evaluation programs, this information may not necessarily be indicative of how well that individual can function in the nursing home setting. The information may also be dated, making it less useful as a screening tool. Finally, these registry checks are intrastate, and there is no existing mechanism to verify a person’s record outside of one’s state.
 - » **Nurse employment agency use.** Unfortunately, the labor demand created by turnover results in the need for additional help with the hiring process, and this creates a cycle of turnover and nurse employment agency use. Although the use of agencies may alleviate the administrative burden of the hiring process, several companies stated that the employees found through employment agencies may lack the same level of company loyalty as permanent employees.

- » **Workforce demands constrain the available training time.** Although CMS requires nurse's aides to complete a total of at least 16 hours of training before any direct contact with patients, several Alliance companies expressed concern that the training is not sufficient and that workforce demands create a barrier to more training. Although state requirements are technically being met, respondents suggested that continuing education and in-service training are often of lower priority than simply keeping up with the day-to-day demands of staffing the facility. The high demand on nurses and support staff may detract from their ability to make time for comprehensive training.
- » **Overwhelming orientation process makes information retention difficult.** All Alliance companies have formal, mandatory orientation programs for all new employees. The programs typically range from 2 days to 5 days in length. Upon hire, new employees are required to attend these training sessions. Many respondents identified the orientation process as being somewhat overwhelming for new employees, which may result in a limited amount of information retention. Orientations typically train employees on rules and regulations, safety issues, compliance, ethics, and company policies and procedures. Absorbing all this information in such a short period of time may be difficult for employees, and although employees must be tested on the orientation materials, performance on these assessments may not be indicative of actual information retention.

External Barriers

- » **Nursing shortage.** The clinically demanding nature and independence required to provide nursing home care make it difficult to find well-qualified staff who are able to effectively handle the demands and responsibilities associated with frequent patient contact. Respondents stated that nursing schools are simply not graduating enough students to keep up with the demand for long-term-care nurses.
 - » **Licensed practical nurses.** Respondents identified a limited LPN labor pool as a major external barrier in maintaining workforce excellence. Most companies agreed that the LPNs may have an unfavorable impression of nursing homes. Consequently, LPNs tend to view nursing opportunities in long-term-care facilities as less favorable or less prestigious career options than nursing positions in hospitals. The low levels of monetary compensation that nursing home nurses receive compared with those that they receive in acute-care settings results in many well-qualified nurses choosing the latter as the work environment of choice.
 - » **Certified nursing assistants.** The burdensome hiring process that involves background checks, reference checks, and certification verification may dissuade individuals from pursuing this type of career path when they could pursue other careers with less stringent hiring requirements and oversight. Job seekers are also likely to seek other career opportunities where monetary compensation is more attractive and the degree of government oversight is less overshadowing.
- » **Difficulty hiring nurses with leadership training.** Many company representatives interviewed stated that one major issue in quality improvement efforts is the limited number of both clinical staff and administrators with formal managerial or leadership training. Although nursing schools provide students with clinical training, few, if any, devote significant portions of their curricula to leadership, organizational, or management training. Consequently, directors of nursing may lack

a formal understanding of how to manage a clinical team of nurses. Even individuals who have work experience may lack leadership training because, other than on-the-job training, few formal programs exist to develop these skills among directors of nursing (DONs) or administrators.

Approaches to Addressing Workforce Excellence Barriers

Although companies attempting to improve and maintain workforce excellence must address many barriers, all Alliance companies recognize one or more of the barriers mentioned above. The following are examples of innovative and proactive steps that individual Alliance companies have taken to address barriers.

- » **Improving employee satisfaction.** The majority of companies have taken steps to improve employee satisfaction in the workplace. One method of improving satisfaction involves making special efforts to recognize employees. One company reported the development of a special quarterly publication specifically created to recognize outstanding performance in the areas of customer service, leadership, etc. Another example of a means of improving employee job satisfaction is the use of formal employee focus groups. These groups meet on a regular basis and allow employees to provide input about their workplace experiences, along with suggestions for improvements regarding all aspects of facility operations.
- » **Leadership training.** Three companies have developed programs specifically designed to cultivate strong leaders to manage and supervise the nursing staff. For example, one company offers a nursing leadership training development program that provides staff with an opportunity to develop organizational and managerial skills. Another company offers a similar program for administrators.
- » **Enhanced educational offerings.** In an attempt to improve employee satisfaction, reduce turnover, and improve the quality of the workforce, five companies reported that they have developed innovative methods of offering educational opportunities to employees. For example, one company reported that it offers educational assistance programs that provide employees with the opportunity to receive tuition reimbursement and flexible hours when they work toward advanced degrees or credentials in the health care field. Another company provides online, accredited class offerings to supplement the orientation and continuing education offerings that it provides to its employees.
- » **Quality control of candidate pool.** Two companies reported that they have explored alternatives to the use of employment agencies in the hiring process. One company has chosen to outsource its hiring process to a separate clinical employment agency owned by that company to relieve the facilities of the administrative burden of performing the hiring process while ensuring that candidates are drawn from a qualified registry of applicants that adhere to a set of standards outlined by the company. Another company has chosen to handle all hiring processes in-house to eliminate problems that result from hiring candidates drawn from outside employment agencies. That company has attempted to keep the level of employment agency use at or near zero.

“Three companies have developed programs specifically designed to cultivate strong leaders to manage and supervise the nursing staff.”

- » **Improved outreach efforts.** To improve the visibility of employment opportunities in nursing facilities and to promote interest in nursing facility employment, efforts have been made to actively promote the inclusion of nursing student clinical rotations in nursing homes. Two companies specifically mentioned the creation of on-site training programs to improve visibility and to allow nursing students to gain firsthand experience in the nursing facility setting.
- » **Techniques of managing training information.** Most companies recognize the need to manage the training process so that employees can more effectively retain the information provided during orientation programs. In understanding the difficulties that employees face in absorbing all the material presented during orientation, companies have sought alternative methods of disseminating this information. For example, four companies reported that they have created quick-reference, pocket handbooks that they distribute to all employees. These handbooks provide convenient summaries of the content disseminated during orientation and training.

“All companies must address issues related to limited leadership training, turnover, employee dissatisfaction, and the nursing shortage.”

Conclusion

Each company participating in the survey has policies and procedures in place to address all components of the workforce excellence portion of the Pledge. Not all companies included in the survey identified barriers; however, the common barriers that were acknowledged by many companies detract from the entire profession’s ability to maintain a high degree of workforce excellence. During the follow-up interviews respondents agreed that all companies must address issues related to limited leadership training, turnover, employee dissatisfaction, and the nursing shortage.

The results of this survey and our interviews indicate that the degree to which companies address each subcomponent of the workforce excellence elements ranges from meeting the basic requirements of the Pledge to proactively exploring innovative methods of overcoming workforce barriers. Companies should continue to work internally and with external organizations to identify strategies that they can use to support innovative company efforts to address workforce barriers and opportunities for collaboration with governments. For example, the Alliance is participating with AHCA in a workforce initiative aimed at increasing funding for direct care.³⁷

“Companies are proactively exploring innovative methods of overcoming workforce barriers.”

³⁷ AHCA Press Release, November 5, 2003.

Public Input on Quality

The fifth element of the Quality First Pledge commits the nursing home organizations participating in the Quality First Pledge initiative to creating a National Commission on Nursing Home Quality. The Commission will consist of 15 individuals, including consumers, family members, health care professionals, academics, business executives, employee representatives, and other individuals from different regions of the country. The Commission is charged with the following:

- » Reviewing quality-related information and data to identify profession-wide clinical successes and opportunities for improvement,
- » Providing advice on national quality improvement targets,
- » Providing advice annually on national quality improvement goals,
- » Assessing the impact of the voluntary quality initiative on quality of care,
- » Reporting in an annual public letter on the impact that the initiative is having on quality,
- » Recommending changes and improvements in the voluntary initiative, and
- » Participating in structured visits to facilities to ensure that the Commission members have an accurate understanding of the current long-term-care, post-acute-care environment.

In addition, all nursing home companies that are members of the Alliance must create their own internal committees to provide advice on quality improvements.

Description of Activity

The Alliance, along with AHCA and the American Association of Homes and Services for the Aging, has contracted with the National Quality Forum—a nonprofit, private organization created to establish standards for health performance data—to construct and operate the National Commission on Nursing Home Quality. The nursing home organizations participating in the Pledge have submitted nominations for the panel, and NQF is reviewing the nominations to make its final selections for the panel.

The companies responding to the survey did not know the status of the Commission and requested more information. Several companies requested guidance on establishing their own quality improvement advisory committees and an explanation about how such committees would complement existing quality improvement activities and their own quality improvement committee activities.

Conclusion

This element of the Pledge is still under development, but it could serve an important role in advancing quality and quality improvement leadership within Alliance member companies.

Ethical Practices

The sixth section of the Pledge describes the development of responsible laws, regulations, and other policies and procedures to address the quality-of-care practices in skilled nursing facilities. Companies must demonstrate a formal commitment to preventing fraud, abuse, and exploitation from occurring by implementing programs that address or perform the following:

- » Standards of conduct,
- » Identification of a compliance officer,
- » Employee education and training,
- » Complaint processes,
- » Audits and other monitoring methods, and
- » Processes related to disciplinary action.

The elements of this section mirror OIG guidance on nursing facility compliance programs.³⁸ Published in 2000, this guidance contains suggestions for internal controls and procedures that promote adherence to applicable statutes and regulations of federal health care programs and private insurance program requirements. OIG states that compliance programs strengthen government efforts to prevent and reduce fraud and abuse while furthering the mission of all nursing facilities to provide quality care to patients. In response to this guidance, many nursing facilities, including all Alliance companies, have implemented corporate compliance programs.

Description of Activity

All 15 of the companies participating in the survey have developed official, written policies and procedures that address this section of the Pledge.

- » **Standards of conduct.** All companies reported that they have developed a clear corporate statement of principles that serves as a brief overview of how the operations within each nursing facility should be carried out. The companies' codes of conduct clearly articulated the expectations of employees and outline the basic legal concepts under which the organization should operate (e.g., zero tolerance for fraud, discrimination, and sexual harassment). The codes of conduct articulate each company's overall philosophy and briefly outline the zero-tolerance policies and the consequences for those employees who violate the code or those situations that result in violation of the code. All companies also require employees to provide written acknowledgment of receipt of the policies upon hire.

³⁸ OIG Compliance Program Guidance for Nursing Facilities, March 16, 2000.

- » **Identification of a compliance officer.** All companies reported that they have an appointed compliance officer whose duties include overseeing and monitoring the implementation of the compliance program, reporting on the degree to which facilities are meeting compliance requirements, and independently investigating and acting on matters related to compliance.³⁹ Compliance officers' roles ranged from a sole responsibility to monitor compliance to the responsibility to monitor compliance as well as to perform additional roles, such as vice president for government relations or reimbursement. The procedures regarding the hiring of a compliance officer vary from company to company.
- » **Employee education and training.** All companies require employees to participate in orientation, in-service training, continuing education classes, and skills refresher courses that address compliance program elements (e.g., fraud, abuse, and discrimination). Companies reported that they offer these classes through a variety of means, including online courses and daytime and evening classes. Course offerings are communicated to employees upon hire through course catalogs, in-service requirement listings, or online catalogs. Attendance records are kept to ensure that employees are attending all necessary training functions.
- » **Complaint processes.** As evidenced in company materials and employee training reference materials (e.g., employee handbooks), all companies have outlined formal complaint policies and procedures to address violations of facility standards, conduct, policies, and procedures.
 - » **Employees.** All companies have corporate integrity hotlines available to employees. Some companies' hotlines are available 24 hours a day, 7 days a week. Other companies have hotlines that are staffed primarily during business hours but that have systems in place to allow employees to leave after-hours messages that are checked regularly by compliance staff. These hotlines are established to allow employees to report complaints or concerns about company or employee actions anonymously, which reduces the fear of retaliation from those individuals reported. Several companies also clearly outline in their employee handbooks alternative procedures for complaint reporting, including procedures for reporting to supervisors directly, contacting the regional compliance liaison, or reporting to the compliance officer directly. Additionally, some companies also use less formal employee relations surveys to gather information about employees' experiences in the workplace.
 - » **Families and patients.** Companies also reported that they have formal systems for patient complaint processes and grievance procedures. Companies clearly communicate complaint procedures to families primarily through family-patient admissions packets. Companies also have social workers who work with patients and families to explain complaint procedures, facilitate communication, and settle grievances. Companies use telephone hotlines through which families and patients can express their concerns over patient care, rights, services, etc. One company reported that it uses its resident and family councils to solicit feedback about employee behavior. The accessibility of these complaint procedures to employees varies (e.g., not all companies include detailed information about patient complaint processes in employee handbooks), which may potentially affect employees' familiarity with these procedures.

³⁹This reflects OIG guidance regarding compliance programs in nursing facilities (OIG Compliance Program Guidance for Nursing Facilities, March 16, 2000.)

- » **Audits and other monitoring methods.** OIG, in its *Publication of the OIG Compliance Program Guidance for Nursing Facilities*, recommended that nursing homes incorporate monitoring and ongoing evaluation processes.⁴⁰ The performance of regular audits by internal or external auditors focuses on day-to-day operations, claims, billing, and cost reports. Although compliance with the OIG recommendations is voluntary, all companies have formal audit procedures that are outlined in their company policies and procedures manuals, corporate compliance programs, or corporate integrity agreements (CIAs). Four of the five companies that have emerged from bankruptcies filed in 1999 and 2000⁴¹ have CIAs. CIAs require organizations to face 3 to 5 years of monitoring and establish reporting requirements.
- » **Processes related to disciplinary action.** The company materials that we received revealed that most disciplinary and corrective action procedures are summarized in employee handbooks or human resources policies and procedures manuals. Most companies use progressive disciplinary procedures that generally follow these steps: (1) verbal counseling, (2) a first written warning, (3) a second written warning, (4) suspension, and (5) termination. These steps are summarized in employee handbooks or are described in detail in human resource policies and procedures.

Barriers

The main barriers related to ensuring ethical practices that we identified relate more to the implementation and less to the structure of compliance programs. Although policies and procedures are in place to address the components of the ethical practices portion of the Pledge, carrying out and maintaining ethical practices in the workplace may be adversely affected by issues related to the workforce's ability to understand and fully integrate these policies into day-to-day operations.

- » **Training time constraints.** Companies expressed concern over the time constraints that employees face for training in ethical practice policies and procedures. This is because employee time is already constrained because of their regular duties, and they may not have adequate time to devote toward fully assimilating company philosophies into their day-to-day operations. Employee turnover further exacerbates this problem by generating an increased need for employee training. Additionally, staff turnover may result in the hiring of employees who are accustomed to the former employer's policies and procedures. Retraining of such employees is challenging, and more time than usual is often needed for an employee to adopt new workplace standards.
- » **Leadership turnover.** Of special concern is turnover at the leadership level. Leaders such as administrators or directors of nursing are expected to possess a strong understanding of company ethics and expectations. These individuals often serve as role models for others in the workplace.

⁴⁰ OIG Compliance Program Guidance for Nursing Facilities, March 16, 2000.

⁴¹ CMS, *Health Care Industry Market Update: Nursing Facilities*, May 20, 2003.

When leaders turn over in nursing facilities, there is often an adverse, trickle-down effect on the rest of the facility workforce. For example, new directors of nursing may not be as familiar with company compliance policies, rules, and regulations. Therefore, these individuals may struggle to accurately and effectively communicate these requirements and compliance goals to staff.

“When leaders turn over in nursing facilities, there is often an adverse, trickle-down effect on the rest of the facility workforce.”

Conclusion

Although all companies reported that they have policies and procedures in place to meet the ethical practice requirements outlined in the Pledge, workforce barriers may also adversely affect a company’s ability to ensure that company policies and procedures are being enforced as effectively as possible. Efforts to minimize turnover may address ethical practice barriers. The role of corporate leadership in promoting ethical practices is also worth noting. The direct roles that corporate leaders play in promoting and ensuring day-to-day ethical operations within a company were not directly measured or assessed in the Pledge. The role is therefore somewhat unclear and could be further explored. Defining what constitutes an actual corporate commitment to ethical practices may be difficult, but further investigations of how one measures this may be useful for future assessments of ethical practices.

Financial Stewardship

The final section of the Pledge states that Alliance companies recognize the importance of acting as responsible stewards of both the company’s and the patients’ financial resources. Companies should demonstrate a commitment to the following components of financial stewardship:

- » Accurate and timely billing and claims documentation;
- » Maintenance of complete, accurate, and timely documentation of care services, including subcontracted services, as well as MDS information;
- » Maintenance of the records necessary to demonstrate the integrity of the nursing facility’s financial management system;
- » Compliance with antikickback laws; and
- » Efforts to secure adequate public financing to support quality long-term care.

Description of Activity

All companies reported that they comply with the financial stewardship elements of the Pledge, although the frequencies of audits varied somewhat among the companies surveyed. Our methodology did not

include any sort of actual audit of the companies' financial information, so the findings presented here are based only on the information reported and the materials that the companies shared with us.

- » **Billings and claims documentation.** Facilities are routinely audited both by external auditors and through in-house consultants to verify that the MDS accurately reflects all the services provided for appropriate reimbursement.
- » **Service documentation.** Along with formal audit procedures, companies described that they have their own routine, internal control procedures that ensure billing and reimbursement integrity.
- » **Financial records.** Companies reported that they have financial and medical documentation retention policies and guidelines in place to ensure accurate record keeping.
- » **Antikickback law compliance.** Through corporate compliance programs, corporate integrity agreements, and codes of conduct, companies have formal systems in place to guard against and deter financial fraud. Policies and procedures are normally communicated through compliance training.
- » **Public financing.** Alliance companies are working with other entities to secure adequate Medicare and Medicaid funding to support quality long-term care. All of the Alliance companies surveyed participate in or are members of the American Association of Homes and Services for the Aging, the AHCA, and the Alliance for Quality Nursing Home Care Covenant for Healthy, Affordable and Ethical Long Term Care.

Barriers to Financial Stewardship

Although companies have the financial systems in place to meet the financial stewardship section of the Pledge, those participating in this survey reported that they are making ongoing efforts to fully adapt to the expanded responsibilities of management and the new internal reporting challenges that have resulted from enactment of the Sarbanes-Oxley Act of 2002 by the U.S. Congress. The Sarbanes-Oxley Act, which was implemented on July 30, 2002, in response to prominent cases of corporate scandal, contains 11 titles that cover a variety of areas, ranging from more stringent audit committee responsibilities to more severe penalties for securities fraud.⁴² The new standards for corporate accountability and penalties for corporate wrongdoing have caused Alliance companies to reexamine their structures and internal controls to improve the corporate reporting processes.

Conclusion

In general, companies have reported that they are compliant with the elements of the financial stewardship elements of the Pledge. Companies possess external and internal controls to promote sound fiscal practices. Most companies reported that they are currently focused on the reforms associated with the Sarbanes-Oxley Act, but it remains unclear what direct impact this legislation will play in companies' continuing quality improvement efforts.

⁴²PriceWaterhouse Coopers, *The Sarbanes-Oxley Act of 2002*, 2002.



Report Summary and Conclusions

This self-assessment demonstrates an overall commitment to performance and quality improvement among the participating companies. All of the participating companies have recognized quality of care and continuous evaluation and improvement as top priorities within their organizations. The companies reported that they put these priorities into action through a variety of mechanisms, and many reported that they use the elements of the Quality First Pledge as guidelines for the planning and implementation of their quality and performance improvement goals. Health Strategies Consultancy was able to use the respondents' assessments to identify several successes in meeting the elements of the Quality First Pledge, as well as areas in which companies need to invest more time and thinking to meet their commitment. These are summarized and described below.

There Is Structure and Commitment

Continuous quality improvement policies, procedures, and structures are in place at each company; and corporate management at each of the companies has recognized the importance of leadership, structure, and goals in providing quality care to patients. Companies have encountered several barriers while implementing the policies, procedures, and structures for continuous quality improvement; but many have chosen to bolster the education and training of their workforces and to use managerial incentives to boost performance in these areas.

Uniform Consumer Measures Are Lacking and More Disclosure Is Needed

Alliance companies have not yet begun to work with others to create and refine quality nonclinical measures that are accessible and easy for consumers to understand. Although there has been significant activity around CMS Nursing Home Compare, Alliance companies have made few efforts to quantify the consumer experience in a meaningful, standardized way for use by potential consumers. Some respondents reported that they have considered providing disclosures regarding consumer satisfaction and the consumer experience by their own companies, but no Alliance companies disclose this information at present. Along with other leaders in the nursing home profession, there is an opportunity for collaboration with CMS and other governmental organizations to improve efforts in this area.

Some Companies Are Trying to Educate Families and Patients About the Nursing Home Experience and The Aging Process

Several companies have attempted to educate families and patients about the aging experience as people are admitted to their facilities through video instruction and the provision of written materials. Still other companies designate customer liaisons for each patient to assist them with complaints,

education, and concerns. These activities assist patients and their families and can be a valuable risk management tool for nursing facilities. However, the majority of Alliance companies have not yet adopted these initiatives.

Companies Are Committed to Improving Their Workforces

Each company has a formal and extensive employee recruiting, hiring, assessment, and training process. Feeling the negative impacts of high rates of employee turnover at the staff and managerial levels and the effects of the nursing shortage, companies have undertaken many activities to improve the quality of their workforces and the commitment that each employee has to providing high-quality care.

Compliance Programs Are in Place

Each of the companies has in place a formal compliance program that addresses standards of conduct, complaint processes, employee education and training, audits and monitoring, and processes for disciplinary action. These programs have allowed the companies to identify problems as they arise and to develop plans for improvement. Many of the barriers to the implementation of these programs that companies experience are associated with workforce turnover and training. As the companies strive to improve the quality and capacity of their workforces, they reported that they dedicate more resources and time to training, including programs regarding laws, regulations, and standards of conduct.

Companies Are Committed to Responsible Financing

The companies possess external and internal controls to promote sound fiscal practices. The companies are also taking another look at their corporate structures and regulations within the context of the Sarbanes-Oxley Act.



Recommendations

Our findings show that although the Alliance companies have made significant progress toward meeting several of the elements of the Quality First Pledge, there are some efforts that have yet to be undertaken that could ultimately enhance their accountability to the public and fuel improvements in consumers' nursing facility experience.

There is a general consensus among the nursing home profession, academia, and the public policy community that the public disclosure of health care quality information is a critical key to accountability. CMS, as a primary payer for long-term-care services, has inherently recognized the importance of the public disclosure of nursing home quality information through establishment of NHQI. The Institute

of Medicine has recognized the importance of disclosure, with appropriate protections, as critical being as well.⁴³ Organizations such as NQF have also recognized public disclosure as a critical element in advancing quality and accountability.⁴⁴

These organizations see disclosure as an avenue for potential consumers to access and understand the critical differences between facilities and the care that they may provide. Many also see it as a mechanism to promote competition among nursing home providers, with proponents seeing facilities competing with other local providers to obtain the most favorable profiles in their communities. The Alliance company representatives whom we interviewed largely held the same view.

There is an opportunity for the Alliance companies, through the Quality First Pledge, to improve the disclosure process for direct consumers—potential or actual patients and their families—of nursing facility care. The respondents reported that consumers need more information to make informed decisions about where to receive long-term care. The companies surveyed however, have not taken the initiative with other providers to offer a complementary or alternative to Nursing Home Compare that provides more consumer-friendly information about the nursing home experience. The consumer experience, in addition to clinical quality measures, is a critical part of evaluating which nursing facility meets a individual’s or a family member’s needs.

“There is an opportunity for the Alliance companies, through the Quality First Pledge, to improve the disclosure process for direct consumers of nursing facility care.”

“A consumer-friendly survey that captures the consumer experience would provide a basis for a dialog with individual consumers and the public about the role of nursing homes as long-term-care providers.”

The Alliance should work with its member companies to develop a uniform, standardized consumer satisfaction survey that assesses not only satisfaction with the nursing facility experience but also the quality of the experience for consumers. A consumer-friendly survey that captures the consumer experience would provide a basis for a dialog with individual consumers and the public about the role of nursing homes as long-term-care providers. It would also provide another mechanism, in combination with CMS Nursing Home Compare, for provider accountability.

This task is a significant undertaking, and the Alliance companies should consider the following issues if it elects to focus on a consumer-friendly survey:

- » “Quality of experience” must be defined at the outset. The Alliance companies must decide how it is different or overlaps with “quality of life” of nursing home patients.⁴⁵

⁴³Institute of Medicine. *Crossing the Quality Chasm*, 2001.

⁴⁴National Quality Forum Press Release, October 3, 2003.

⁴⁵Quality of life for nursing home patients is a concept defined in federal statute (**Social Security Act §1919(b)(1)(A)**).

- » The Alliance should identify where it is already collecting the same or similar information about consumer and family satisfaction.
- » The Alliance should establish a formal mechanism to share any consumer-friendly survey measures with the public in an accessible and routine manner.
- » The survey should be a usable tool not only for consumers but for individual companies' quality improvement programs.

In addition to a consumer-friendly survey, the Alliance has an opportunity to improve patient and family education about the aging process and what to expect when one enters a nursing facility. A few companies reported that they are making efforts in this area, but relative to other initiatives regarding leadership and workforce issues, they were newer and are still evolving. As investigators we recognized and the respondents acknowledged that these proactive educational approaches had been created to improve the experiences of consumers and their families and to manage the liability risks associated with adverse patient events that may occur in facilities. The results of the survey and our interviews indicate that the goals of managing liability and improving the consumer experience,

“The Alliance should continue to track its progress in meeting the elements and the purpose of the Quality First Pledge.”

when balanced effectively, can be complementary and can assist both nursing facilities and patients and their families. Because these provider initiatives are not yet widespread, there is an opportunity for Alliance companies to share their experiences with the development of these programs with other Alliance members.

Finally, we believe that the Alliance should continue to track its progress in meeting the elements and the purpose of the Quality First Pledge. The results of

these evaluations should be routinely shared with the public and should form a basis for continuous improvement and focus on areas in which higher and better levels of performance are required. The Alliance should also continue to foster the identification and sharing of processes and initiatives that have improved their continuous quality improvement and performance improvement programs and should provide a vehicle for the provision of technical assistance to companies that request it.



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Appendix A



QUALITY FIRST

A PLEDGE TO IMPROVE QUALITY THROUGH ACCOUNTABILITY, COMPASSION, AND LEADERSHIP

As providers of long-term care and short-term skilled nursing care, we recognize our unique obligations to the individuals we serve. Through dedicated care staff, many of whom live on the margins of poverty, we care for a vulnerable population that, in many cases, is frail and poor and paid for, at least in part, by government-funded programs. Because of the nature of the care we provide and the people we serve as well as the government resources available, we have different obligations than do other health care providers. Providing care to vulnerable individuals requires more than clinical expertise; it requires us to attend to the emotional, spiritual, social, psychological, and physical needs of our patients. To succeed in that mission, and to engender the trust of the American people, we hereby embrace a single set of voluntary principles beyond those required by law to guide our companies now and into the future. By articulating the principles contained in this covenant, we pledge our commitment to the people we serve, and we agree to lead our companies in ways that benefit the frail and vulnerable, our employees, and society as a whole.

We, the undersigned, acknowledge our quality commitment, adopt this Code of Conduct, and commit to its timely implementation in our organizations.



Our Quality Commitment

1. We are committed to making patient health and well-being paramount priorities in our organization's management. We also are committed to a philosophy of management that stimulates continuous quality improvement through the establishment of uniform quality measures, the creation of annual quality improvement goals, and the identification and use of clinical "best practices" in an effort to achieve appropriate patient outcomes.
 2. We are committed to continuing to disclose information on quality to patients, employees, and the public, and we will assist them in accessing this information in a timely manner, while protecting confidentiality and complying with other legal requirements.
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3. We are committed to clearly articulating and honoring patient and family rights, and working to ensure that our employees understand and uphold those rights.
4. We are committed to enhancing the human potential of our employees through education and training programs that strive to improve the quality of care delivered, and we are committed to sensitizing our staff to the special needs of frail and vulnerable patients.
5. We are committed to seeking the input of consumers as we work to improve quality, and we will work with others—in the private and public sectors—to identify, understand, and, ultimately, to resolve concerns associated with care practices or patient outcomes.
6. We are committed to developing and implementing organization-specific programs that promote ethical and lawful conduct, and we will lead in the development of responsible laws, regulations, and other standards supporting the quality of care in the facilities we manage.
7. As providers of care to a unique patient population that is funded in large part by government programs, we are committed to acting as responsible stewards of scarce financial resources. We also recognize our responsibility to serve as champions for public financing levels that will support improved quality and enhanced staffing.



Charter Signatories:

Advocat, Inc.

Integrated Health Services, Inc.

Beverly Enterprises, Inc.

Kindred Healthcare

Centennial HealthCare Corp.

Mariner Health Care, Inc.

Extendicare Health Services, Inc.

Medical Facilities of America

Genesis Health Ventures, Inc.

National Healthcare Corp.

Harborside Healthcare

Sun Healthcare Group, Inc.

HCR Manor Care Corp.

Tandem Health Care, Inc.



CODE OF CONDUCT AND ETHICAL MANAGEMENT PRACTICES

1. Commitment to Patient Well-Being Through Quality Care

a. **Leadership Commitment to Quality**—Management exhibits leadership by playing an active role in the establishment and implementation of a code of conduct that articulates the organization's expectations of all employees, a statement of principles that guides the organization's operations and reflects its values, and the development and implementation of clear policies and guidelines that support a commitment to high quality performance. Management's involvement demonstrates that the organization places a high priority on quality care, quality improvement, and organizational integrity.

i. Management and Organization Commitment to Improvement

1. Policies reflect management's commitment to quality.
2. The ethic of continuous quality improvement is evident throughout the organization and is embedded in its policies and communications.
3. Management believes and demonstrates that quality performance supports strong financial performance.
4. Management's commitment to standards for quality is visible to employees, patients, family members, and government.
5. Management demonstrates its commitment to quality care and to ongoing improvement through the identification and sharing of best practices throughout the organization and the long term care provider community.

ii. Organization Policies Regarding Quality

1. Organization policies related to quality and quality improvement state implicitly or explicitly that each employee is charged with responsibility to comply with current laws, regulations, and with the organization's quality standards.
2. The organization has developed a process to ensure routine review and evaluation of organization policies and practices related to quality care and quality improvement.

iii. Quality Goals

1. Management sets annual quality improvement goals based on data reflecting organization-wide performance as well as input from employees, patients, and family members.
2. Quality goals address both clinical quality as well as patient and/or family satisfaction levels.

3. Goals are shared with employees, patients, families, shareholders, and the public.
 4. The organization has created a monitoring system for evaluating quality performance against quality goals.
 5. The organization reports the results of its efforts to the public.
- b. **Continuous Quality Improvement**—The organization routinely evaluates clinical performance and assesses patient, family member, and employee concerns about performance. The organization also has developed processes to identify and assess legislation, regulation, and changes in standards of practice to determine the adequacy of resources available for implementation.
- i. **Quality Improvement Process**
 1. The organization has developed and implemented an organization-wide quality improvement process.
 2. The organization has a system for verifying quality improvement process implementation.
 3. The quality improvement process includes the development of annual quality improvement goals.
 - ii. **Quality Improvement Responsibility**
 1. The organization has individuals with clear responsibility for assessing quality trends using pre-identified quality indicators.
 2. These individuals routinely monitor performance and make recommendations for quality improvement targets, process changes, and policy reform.
 - iii. **Quality Monitoring**
 1. The organization uses clinical outcomes data and other available information to assist in the routine monitoring of clinical quality performance.
 2. The organization conducts quality performance assessments at least annually.
 3. The organization conducts more frequent focused quality assessments when data indicate issues related to achieving anticipated clinical and other quality of care outcomes.
 4. The organization, at the appropriate level, develops quality improvement plans to address issues related to achieving anticipated clinical and other quality outcomes.

5. The organization has a documented protocol for investigating accidents and other incidents to discover root causes and for recommending corrective and/or preventive action.
6. The organization communicates with employees about the outcome of quality assessments and plans for quality improvement.

iv. **Quality Policy and Process Evaluation**

1. The organization routinely evaluates policies and processes vis-à-vis their impact on quality improvement.
2. The organization evaluates annually the impact of its quality improvement processes on quality.
3. The organization has a process for investigating, responding to, and reporting of identified areas of concern.

- c. **Quality Improvement Goals**—The establishment of quality goals is critical to stimulating sustainable quality improvement. Therefore, the organization will seek input as it establishes annual quality targets and quality improvement goals. As part of the establishment of annual targets and goals, the organization will evaluate data from the following sources, among others:

- i. Government-developed clinical quality measures,
- ii. Government inspection reports,
- iii. Customer satisfaction surveys,
- iv. Patient, family, and employee communications,
- v. Internal quality monitoring information.

- d. **Uniform Measures of Quality**—In addition to complying with applicable federal and state government standards as well as organization-established standards, the organization will work with others to create and refine quality measures that are:

- i. Reliable,
- ii. Uniform,
- iii. Risk adjusted,
- iv. Easy for consumers to access and understand,
- v. Meaningful with regard to the quality of care being delivered in our facilities.

2. **Public Disclosure and Accountability**—The organization recognizes the important role public disclosure of quality information plays in accountability. The organization currently discloses significant amounts of quality information and will continue to disclose that information, while protecting confidentiality and complying with other legal requirements. As part of its disclosure process, the organization has developed policies and systems for routinely disclosing quality performance information and will assist our employees, our patients, their family members, and the general public in accessing this quality information in a timely manner.
3. **Patient and Family Rights**—Patients and families have a set of rights, which the organization articulates clearly upon admission and makes available within the facility and upon request. These rights are articulated in current federal and state law and regulation and may include additional protections deemed appropriate by the organization and which are available in writing to consumers, their families, and employees. Basic patient rights cover the following areas:
 - a. Access to care in a safe and supportive setting
 - b. Freedom from abuse and neglect
 - c. Patient choice and involvement in care-related decisions
 - d. Access to personal medical information
 - e. Privacy and confidentiality protections
 - f. Freedom from physical and chemical restraints
 - g. Freedom to create patient/family councils
 - h. Protection of resident funds and financial affairs/information
 - i. A grievance process
 - j. Self-determination and advance directives
 - k. Access to social, spiritual activities
 - l. Dignity in caregiving
4. **Workforce Excellence**—The organization develops and implements systems to meet government and organization-defined quality requirements to achieve patient care and quality goals, to ensure the integrity of the organization’s workforce, and to safeguard the welfare of patients. These management systems include the recruitment and ongoing training of employees, while respecting federal and state laws.

a. Employee Recruitment, Assessment

- i. The organization actively recruits candidates that have a demonstrated commitment to caring for elderly and frail patients.
- ii. The organization evaluates candidates using screening tools, including the administration of background checks and the verification of certifications and licenses, consistent with state and federal laws, before hiring employees who have access to patients or their possessions or who have discretionary authority to make decisions that may involve compliance with the law or regulation.
- iii. The organization requires prospective employees and current employees to disclose any criminal conviction or exclusion from participation in federal health care programs, as permitted by state and federal laws.
- iv. The organization has a policy regarding employee drug testing.

b. Employee Training

- i. The organization ensures that each employee receives and certifies that he/she has read organization policies and procedures related to quality of care and organization obligations related to federal and state laws and regulations.
- ii. The organization has a process for clearly identifying employee roles and responsibilities in the execution of quality-related and care-related tasks.
- iii. Employee training programs include an orientation program that clearly articulates the organization's philosophy about and commitment to patient care and quality performance as well as ongoing improvement.
- iv. Employee training programs cover task-specific skills and competencies, as well as awareness of regulatory requirements appropriate to care-related tasks.
- v. Employee training programs address patient rights and dignity protections.
- vi. Training programs address activities designed to minimize occupational health and safety risks faced by employees.
- vii. Training programs for management and health care professionals address the organization's compliance program, fraud and abuse laws, and federal health care program requirements.

c. Commitment to Employees

- i. The organization recognizes that its ability to deliver high quality services is largely dependent upon having trained direct care staff.
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- ii. The organization has developed plans and processes to educate employees about occupational health and safety hazards associated with health care settings and protection against harm from those hazards.
 - iii. The organization has systems in place to recognize and reward employees for exceptional performance.
 - iv. The organization has established, documented, and clearly articulated policies to prevent instances of discrimination, harassment, or other types of exploitation of employees.
 - v. The organization supports public policy initiatives that will allow providers to offer levels of compensation that are commensurate with levels offered by hospitals and other health care providers.
5. **Public Input on Quality**—The organization recognizes that the creation of mechanisms for public input and advice is essential to quality improvement. Therefore, nursing home organizations participating in this initiative will create a National Commission on Nursing Home Quality, consisting of approximately 15 individuals, including consumers, family members, health professionals, academics, business executives, employee representatives, and others from different regions of the country. The panel will be charged with:
- a. Reviewing quality-related information and data to identify profession-wide clinical successes and opportunities for improvement.
 - b. Advising on national quality improvement targets.
 - c. Advising annually on national quality improvement goals.
 - d. Assessing the impact of the voluntary quality initiative on quality of care.
 - e. Reporting via annual public letter on the impact the initiative is having on quality.
 - f. Recommending changes and improvements in the voluntary initiative.
 - g. Participating in structured visits to facilities to ensure an accurate understanding of the current long-term care/post-acute environment.

In addition, organizations will create their own committees to provide advice on quality improvements.

6. **Ethical Practices**—The organization and its management will play a leadership role in the development of responsible laws, regulations, and other standards addressing the quality of care provided in the skilled nursing facilities we own or manage. The organization makes a formal commitment to developing and implementing a program which is designed to prevent fraud

and abuse from occurring, which is evaluated routinely for effectiveness, and which includes the following:

- a. Standards of conduct
 - b. Identification of a compliance officer
 - c. Employee education and training
 - d. A process for handling complaints
 - e. Audits and other monitoring methods
 - f. Processes and policies related to disciplinary action
7. **Financial Stewardship**—The organization recognizes the important and unique role it plays in health care by caring for a vulnerable population whose care is funded at least in part by government programs. As providers of care to this unique population, the organization must act as a responsible steward of scarce financial resources.
- a. The organization is committed to accurate and timely billing and claims documentation.
 - b. The organization is committed to maintaining the complete, accurate, and timely documentation of care services, including subcontracted services, as well as minimum data set (MDS) information.
 - c. The organization maintains records, including billing and claims documentation, audit data that support and explain cost reports, and other records necessary to demonstrate the integrity of the nursing facility's financial management system.
 - d. The organization maintains compliance with anti-kickback laws.
 - e. The organization supports efforts to secure adequate public financing to support quality long-term care.