DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-05-01

DATE: **October 14, 2004**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: **Guidance on Working with Quality Improvement Organizations**

Letter Summary

- Provide further guidance on CMS' expectation that State survey agencies (SA) work with Quality Improvement Organizations (QIOs) in improving care for nursing home residents.
- Provide information to assist states in collaborating with QIOs.
- Spell out CMS' two Government Performance Results Act (GPRA) goals for nursing homes.

The purpose of this memorandum is to emphasize the importance and expectation of SAs working with QIOs in promoting quality of care in nursing homes. This expectation is consistent with the State Survey and Certification Budget Call letter dated June 8, 2004 that includes collaborating with QIOs as a Tier II priority.

CMS is committed to facilitating an environment for SAs and QIOs to work together at the state level and we have a number of initiatives underway to encourage this collaboration.

- **Leadership Summit** -- At the CMS Leadership Summit in April 2004, QIOs and SAs met and exchanged information about how they can work together to improve care in nursing homes.

- **Collaborative Focus Facilities (CFF)** – This is a pilot project that encourages QIOs and SAs to identify 2-3 nursing homes in each state that could benefit from QIO assistance and to work together to improve quality. The nursing homes can be special focus facilities or other homes that can use this assistance. Enclosed is a list of QIOs who have volunteered to work on this pilot project. (Enclosure A). If the QIO in your state is on the list and you have not already begun working with them, we encourage you to work with them to pilot test this project.

- **Quarterly SSA & QIO Newsletter –** The purpose of this newsletter is to exchange information that furthers the purpose of improving care in nursing homes, and promotes even more collaboration between SAs and QIOs. Two newsletters have already been published (April and July 2004). The next newsletter will be published in October 2004. We invite your contributions to the newsletter of current projects, planned activities or promising practices between your agency and the QIO in your state.

- **State Survey Agency/Quality Improvement Organization Workgroup** – This workgroup is comprised of representatives of SAs and QIOs in four states (Alabama, Maryland, Minnesota, and Rhode Island) that can model an integrated approach to quality improvement in pressure ulcers and reducing unnecessary restraints. If you would like more information on this workgroup or to participate in any way you may contact Carol Benner, who chairs this workgroup, at (410) 402-8018.

In addition to the collaborative activities above, CMS is marshaling the efforts of SAs, QIOs and CMS to achieve breakthrough results in two GPRA goals: **Reducing Unnecessary Restraints** and **Reducing Pressure Ulcers** (Enclosure B). Enclosure C also includes deficiency rates for pressure ulcers that may be helpful for discussion purposes. Some activities to help us achieve these goals include:

- **Better guidance on pressure ulcers** – CMS will shortly issue surveyor guidance and investigative protocols in the State Operations Manual that represents work with a panel of national experts and extensive stakeholder review and comment.

- **Satellite Training –** CMS broadcast a publicly available satellite on pressure ulcers on August 3, 2004. This is available for viewing until August 3, 2005 at www.cms.internetstreaming.com.

- **Culture Change Project –** QIOs will be working with 5% of nursing homes to achieve a culture change in which nursing homes operate without physical restraints.

- **Alternative Resident Management Strategies –** QIOs will work with about 30% of nursing homes to teach alternative resident management strategies that allow substantial reduction in restraint rates in homes that are not yet ready to renounce restraints.

- **CMS Regional Offices will work with states with restraint rates above 10% --** Regional Offices will work with outlier states to determine why the restraint rates are above the national average and then develop strategies to lower those rates.

Collaboration Expectation -- Each SA shall work with its QIO to establish how they will collaborate. At a minimum, work on the two GPRA goals to reduce unnecessary restraints and reduce pressure ulcers is required. This expectation can be met by referring nursing homes to their QIO if the SA identifies a problem or concern in the areas of unnecessary restraints or pressure ulcers. We encourage a more synergistic relationship between QIOs and SAs in the other initiatives stated above.

Effective Date: Immediately.

Training: Please share the information contained in this letter with all survey and certification staff, their managers and the State/RO training coordinator.

/s/
Thomas E. Hamilton

Enclosures

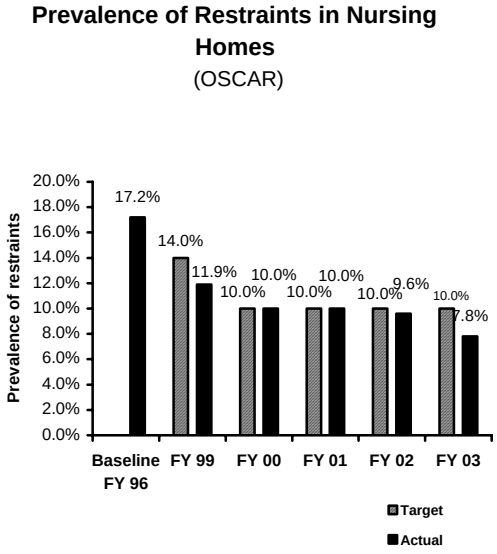
cc: Survey and Certification Regional Office Management (G-5)

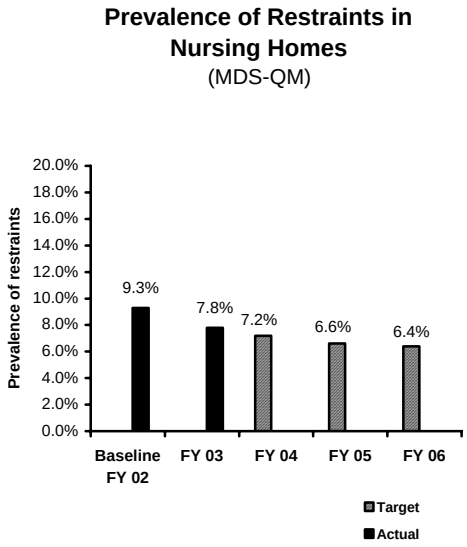
Enclosure A

Quality Improvement Organizations Volunteering for Collaborative Focus Facilities (CFF)
Arizona
Delaware
Florida
Illinois
Iowa
Kansas
Maryland
Michigan
Mississippi
Nebraska
New Jersey
New York
Ohio
Oklahoma
Pennsylvania
Puerto Rico
South Dakota
Tennessee
District of Columbia
West Virginia
Wisconsin

Enclosure B

Decrease the Prevalence of Restraints in Nursing Homes





Discussion: "Physical restraints" are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily and that restricts freedom of movement or normal access to one's body. According to the law, restraints may only be imposed to treat the resident's medical symptoms or to ensure safety and only upon the written order of a physician (except in emergency situations). Restraints should never be used for staff convenience or to punish the resident. CMS is committed to decreasing the prevalence of restraints in nursing homes.

The two charts above present target and actual rates derived from two different data sources. From FY 1996 through FY 2002, the mean facility restraint prevalence was calculated from data reported by the nursing homes at the annual survey. These data were collected in CMS's survey and certification database known as the Online Survey and Certification and Reporting (OSCAR). Beginning in FY 2002, pressure ulcer prevalence measures were also calculated using the Minimum Data Set Quality Measure (MDS-QM) scores used on Nursing Home Compare. Starting in FY 2004, CMS will report the prevalence of restraints in nursing homes using the MDS-QM scores. The purpose of this change is to use a set of measurements that are more consistent with those used in CMS' public reporting initiative.

The prevalence of restraints in nursing homes has decreased steadily since FY 1996. Final performance results for the FY 2003 restraints target shows the prevalence at 7.8 percent using OSCAR. Data for the first quarter of FY 04 show that the prevalence of restraints continues to decrease, although the rate of decrease has slowed.

The reduction in the use of physical restraints has been one of CMS' major quality initiatives. The prevalence of physical restraints is an accepted indicator of quality of care and may be considered a quality of life measure for nursing home residents. The use of physical restraints can cause incontinence, pressure sores, loss of mobility, and other morbidities. Many providers and consumers still mistakenly hold, however, that restraints are necessary to prevent residents from injuring themselves.

One of the main ways in which CMS has promoted the reduced use of physical restraints is through the annual survey process. State and CMS surveyors who conduct annual inspections of nursing homes pay close attention to nursing homes' use of restraints and cite nursing homes for deficient practices when they discover that residents are restrained without clear medical reason. In addition, the Quality Improvement Organizations (QIOs), which are dedicated to working directly with individual providers to improve the quality of care delivered, play an important role in helping nursing homes reduce the use of physical restraints in their facilities. The QIOs are strengthening their commitment to working with nursing homes who are facing challenges in reducing the rate of physical restraint use. We expect to see a continued reduction in the national mean rate of restraint use as a direct result of the QIO efforts.

In establishing quality of care performance goals, CMS focused on measures that have been recognized as clinically significant and/or closely tied to care given to beneficiaries. Individuals in nursing homes are a particularly vulnerable population and, consequently, CMS places considerable importance on nursing home quality measures. A significant portion of both Medicare and Medicaid benefit dollars pay for care in nursing homes. Although not yet updated for FY 2003, 17.1 percent of benefit dollars under Medicaid and 5 percent for Medicare were expended for nursing home care in FY 2002. In FY 2005, CMS is proposing a target restraint rate of 6.6 percent and a target restraint rate of 6.4 percent for FY 2006.

Coordination: CMS' coordination includes State survey agencies, QIOs, and CMS Regional Offices.

Data Source(s): Previously, data on the use of physical restraints were obtained from the Online Survey and Certification and Reporting (OSCAR) database. With this GPRA update, CMS is reporting on the physical restraints using the publicly-reported Quality Measures derived from the Minimum Data Set (MDS-QM). The physical restraints quality measure being used is adapted from one developed by the Center for Health Systems Research and Analysis at the University of Wisconsin, Madison. We report the prevalence of physical restraints—excluding side rails—in the last three months of the fiscal year. If the year is not complete, we report the most recent data available.

Verification and Validation: The MDS is the source of the data used to calculate this measure. The MDS is considered to be part of the medical record. The nursing home must maintain the MDS and submit it electronically to CMS for every resident of the certified part of the nursing home. However, MDS data are self reported by the nursing home.

MDS data quality assurance currently consists of onsite and offsite reviews by surveyors and by CMS contractors to ensure that MDS assessments are reported in a timely and complete manner. In addition, CMS is developing protocols to validate the accuracy of individual MDS items and will continue to provide training to providers on accurate completion of the MDS.

Enclosure B

Decrease the Prevalence of Pressure Ulcers in Nursing Homes

Discussion: "Pressure ulcer" refers to any lesion caused by unrelieved pressure resulting in damage to underlying tissues. The development of pressure ulcers is an undesirable outcome that can be prevented in most nursing home residents except in those whose clinical condition impedes the prevention of pressure ulcer development. CMS is committed to decreasing the prevalence of this condition in nursing homes.

From FY 2000 through FY 2002, the mean pressure ulcer prevalence was calculated using the Minimum Data Set Quality Indicator (MDS-QI) scores. Beginning in FY 2002, pressure ulcer prevalence measures were also calculated using the Minimum Data Set Quality Measure (MDS-QM) scores used on Nursing Home Compare. Beginning in FY 2004, CMS will only report the prevalence of pressure ulcers in nursing homes using MDS-QM scores. The purpose of this change is to use a set of measurements that are more consistent with those used in CMS's public reporting initiative.

Using MDS-QI measures, the prevalence of pressure ulcers in nursing homes decreased slightly from FY 2001 to 2002. Final performance results for the FY 2002 pressure ulcer target shows the prevalence at 9.8 percent using the MDS-QI measures and 8.6 percent using the MDS-QM. Final FY 2003 MDS-QI data show a mean pressure ulcer prevalence of 10.5 percent. Using QM data, the mean pressure ulcer prevalence for the last quarter of FY 2003 was 9.1 percent. For the first quarter of FY 2004, the mean pressure ulcer prevalence was 9.2 percent.

CMS is continuing to investigate the source of the increase in the reported prevalence of pressure ulcer prevalence. However, probable causes of this increase are 1) an artifactual effect due to facilities' change in coding behavior resulting in reporting of pressure ulcers that would not previously have been reported; 2) an increase in case-mix (severity of illness) of the nursing home population resulting in part from an increasing proportion of subacute patients; and 3) decreasing quality of care. Small changes may also reflect random variation in the detection and recording of pressure ulcers.

Reduction of facility-acquired pressure sores remains a high priority of the agency. CMS has tasked the Quality Improvement Organizations (QIOs) with assisting nursing homes in creating quality improvement protocols directed toward preventing and treating pressure ulcers. In addition, CMS will work closely with the QIOs to address a wide variety of measurement issues related to the detection, recording, and reporting of pressure ulcers. Some of these measurement issues include standardized assessment protocols and the stratifying the reporting of pressure ulcer prevalence measures to separate chronic care from subacute care settings. In addition, the QIOs will work with providers and patients in both long term care and hospital settings to try to improve communication and standardization of pressure ulcer prevention and treatment protocols in both of these settings. CMS and the QIOs will also work closely with nursing homes who have been successful in treating and preventing pressure ulcers to see if these homes' treatment practices can be carried over to other, less successful, providers.

Additionally, CMS has convened a panel of national clinical experts in pressure sore treatment and prevention who have helped CMS revise the interpretive guidelines and investigative protocols used by surveyors and to improve surveyor training. Changes to the protocols include: adding information about the location of current clinical practice guidelines; enhancing the definitions related to pressure ulcer identification; providing an overview of current processes and practices for the prevention and treatment of pressure ulcers; and revising the investigative protocol for determining if pressure ulcer development was avoidable by the facility. In addition, it is planned that educational opportunities regarding the final products will be provided to both surveyors and providers, utilizing nationally recognized clinical experts in pressure ulcer care. CMS anticipates that the guidance will be finalized in the Summer of 2004. CMS plans to offer training via satellite broadcast on that guidance during the summer of 2004.

Coordination: CMS' coordination includes State survey agencies, QIOs, and CMS Regional Offices. CMS is working with provider organizations, States, and consumer advocates on an ongoing basis in developing survey instruments and guidelines. In addition, we have invited nationally recognized pressure ulcer experts from the National Pressure Ulcer Advisory Panel to help us develop consistent nursing home survey protocols.

Data Source(s): Prior to FY 2004, CMS reported the prevalence of pressure ulcers with MDS-QI scores. Beginning in FY 2004 CMS will solely use the quality measures derived from the Minimum Data Set (MDS) to measure the prevalence of pressure ulcers in long term care facilities. Nursing homes submit this information to the State MDS database, which is linked to the national MDS database. The measure being used for the pressure ulcer goal is adapted from one developed by the Center for Health Systems Research and Analysis at the University of Wisconsin, Madison. For this goal we report the prevalence of pressure ulcers measured in the last three months of the fiscal year. If the year is not complete, we report the most recent data available. The numerator consists of all residents with a pressure ulcer, stages 1-4, on the most recent assessment and the denominator is all residents. Pressure ulcers counted on admission assessments are excluded.

Verification and Validation: The MDS is the source of the data used to calculate this measure. The MDS is considered to be part of the medical record. The nursing home must maintain the MDS and submit it electronically to CMS for every resident of the certified part of the nursing home. However, MDS data are self reported by the nursing home.

MDS data quality assurance currently consists of onsite and offsite reviews by surveyors and by CMS contractors to ensure that MDS assessments are reported in a timely and complete manner. In addition, CMS is developing protocols to validate the accuracy of individual MDS items and will continue to provide training to providers on accurate completion of the MDS.