PROMISING PRACTICES IN STATE SURVEY AGENCIES

Achieving Better Outcomes Using Survey & Certification Enforcement Strategies

North Carolina

Summary

In 2006, the Division of Health Service Regulation (DHSR) at the North Carolina Department of Health and Human Services implemented a directed plan of correction program for nursing home providers in collaboration with The Carolinas Center for Medical Excellence (CCME), the Quality Improvement Organization for North and South Carolina. Under this program, the DHSR directs facilities with repeat and/or severe care problems to work with a CCME Quality Improvement Consultant to improve care in specified areas.

Introduction

This report describes the structure and functioning of North Carolina's directed plan of correction program, its impact, and lessons learned that might benefit other agencies considering similar enforcement approaches. The information presented is based on interviews with agency management staff as well as staff at The Carolinas Center for Medical Excellence.

Background

The directed plan of correction program in North Carolina evolved out of the state's recognition that certain facilities, particularly those with repeat and/or severe compliance issues, could greatly benefit from targeted consultative assistance in certain care areas. As a mechanism for providing such intensive consultation, DHSR contracted with CCME, the state's Quality Improvement Organization, to provide consultative services for five selected clinical areas: restraint use, pressure ulcers, medication management, urinary incontinence, and fall prevention. These five care areas were selected based on a number of factors, including state priorities, CMS goals for reducing pressure ulcers and use of restraints under the Government Performance and Results Act (GPRA) of 1993, and CCME's areas of expertise. Although a directed plan of correction had always been an available remedy for enforcement, this approach had not been utilized previously in North Carolina, mostly due to the perception that directed plans were primarily used for structural (e.g., life safety code) issues rather than those involving resident care. However, with the directed plan of correction remedy defined in the State Operations Manual (SOM) as a plan that the state develops "to require a facility to take action within specified time frames", DHSR chose to utilize this mechanism as a way of directing facilities to work with a CCME Quality Improvement Consultant in addressing their resident-focused quality of care problems.

Intervention

Under the directed plan of correction program, survey teams identify facilities that might benefit from CCME consultation upon completion of a survey by notifying DHSR management. DHSR management staff then promptly send a referral to the CCME Quality Improvement Consultant, who arranges for a one-day onsite visit with the facility.

Prior to the visit, the CCME consultant sends the facility a packet of information, including a letter of introduction that describes the purpose of the visit, an agenda, and recommendations for the types of facility staff who should be present at the visit. In preparation for the visit, the CCME consultant reviews the survey report to familiarize herself with the systems/care problems that led to the deficiency.

Once onsite, the CCME consultant meets with facility staff to conduct a root cause analysis of the problem. A discussion of the facility's previously proposed solutions and potential new solutions for consideration takes place, followed by a discussion of plans for implementation and evaluation. The CCME consultant provides the facility with a toolkit for the targeted care area, which contains general quality improvement information, as well as topic-specific information on best practices, recent literature reviews, clinical guidelines, and quality improvement tools. During the visit, the consultant also makes note of additional resources that may be helpful for facility staff in addressing specific problems, and sends those materials to the facility electronically upon completion of the visit.

Following the onsite consultation, the CCME consultant prepares a written report for the facility that includes the agreed upon action plan, which consists of all recommendations that were generated during the visit and proposed methods for implementation. Once complete, a copy of the report is sent to the facility.

Approximately three weeks following the visit, the CCME consultant conducts a one-hour conference call with the facility to assess the extent to which the recommendations documented in the report were implemented, any barriers encountered and solutions for addressing them, and progress achieved. A second one-hour call following this format is conducted approximately three weeks following the first call, or six weeks following the initial visit. These two progress monitoring calls also are used for contract evaluation purposes in assessing the effectiveness of the CCME's consultation intervention. In addition to the two scheduled calls, facilities are also invited to contact the CCME consultant as needed by phone or e-mail for additional advice.

Upon completion of this process, a member of the CCME staff (someone other than the CCME consultant) conducts a post-consultative services interview with the facility administrator or director of nursing to assess the facility's overall satisfaction with the consultation and to obtain feedback regarding the extent to which the facility staff's confidence in their ability to correct the identified care problems improved as a result of the consultation. During this interview, the facility contact also is asked to comment on aspects of the consultation that were most and least helpful and to provide suggestions for improving the consultation.

Funding for the North Carolina directed plan of correction program is provided through Civil Monetary Penalty (CMP) funds. Therefore, the CCME consultative services are provided at no direct cost to the facilities involved.

Implementation

The directed plan of correction program in North Carolina was generated through a longstanding collaborative relationship between DHSR and CCME focusing on quality improvement related to medication safety. DHSR initiated a contract with CCME to develop a new protocol for providing nursing homes individualized consultation in the five targeted clinical areas. The initial one-year contract covered a .75 full-time equivalent (FTE) CCME staff member to develop a toolkit for each of the five areas and to conduct both the onsite consultative visits and the conference calls at three and six weeks.

The current CCME Quality Improvement Consultant is a physical therapist with a background in research and public health who has worked in nursing home quality improvement for more than three years. Due to the initial resistance often encountered in facilities during the onsite visits, an important quality of the consultant is that he or she be adept at building rapport with facility staff, fostering a positive atmosphere, and facilitating discussion amongst staff in generating solutions.

Impact

Although this program has been in place for only one year (and limited to nine facilities), feedback received from providers thus far through the post-consultative services interview has been very positive. One suggestion received was that the visits be longer than one day to allow the CCME consultant more time in the facility to observe some of the changes that had been

implemented in the facility prior to the visit in response to the survey recommendations. Based on this feedback, and to allow for a more in-depth discussion of the issues, the program has been revised to allow for an expanded initial visit when needed.

Based on the progress monitoring calls conducted at six weeks following the onsite visit, most of the nine facilities were able to implement 80 to 90 percent of the recommendations generated through the consultation. Although progress beyond the six-week point is not formally monitored, one facility that became restraint-free following the onsite visit was found to have remained restraint-free for six months after the initial consultation.

The most definitive measure of this program's success will be the performance of the nine facilities during their next survey. With the program in place for only one year, most of the nine facilities visited to date have not yet had another survey visit. However, one facility that was surveyed the following year did not have deficiencies in the area addressed through the consultation. Overall, the North Carolina DHSR has been pleased with the progress of the program thus far, and has entered into another two-year contract with CCME to continue the program with additional consultative staff.

Lessons Learned

A key factor in the success of this program is the ability to move the process forward quickly so that the onsite consultation can take place before the facility's plan of correction is due. To achieve this, a strong communication system is required between both the survey teams and DHSR management staff to identify facilities in need of consultation, and between DHSR management staff and the CCME consultant to enable the consultant to schedule the onsite visit as expeditiously as possible.

It is essential to be able to adapt the intervention and resources provided during the consultation based on each facility's unique needs and problems. Also important is a process for soliciting facility feedback in terms of the most and least effective aspects and modifying the consultation based on that feedback.

Contact Information

For further information regarding the directed plan of correction program at the Division of Health Service Regulation, North Carolina Department of Health and Human Services, please contact Cindy DePorter, Program Manager, by e-mail at Cindy.Deporter@ncmail.net or by phone at 919/733-7461, or Beverly Speroff, Section Chief, by e-mail at Beverly.Speroff@ncmail.net or by phone at 919/855-4555. For further information regarding the CCME consultation and quality improvement toolkits, please contact Franzi Rokoske, Quality Improvement Consultant at The Carolinas Center for Medical Excellence, at FRokoske@thecarolinascenter.org.

This document is part of an issue brief on effective enforcement practices in State Survey Agencies. The issue brief is one of a series by the Division of Health Care Policy and Research, University of Colorado Health Sciences Center, for the U.S. Centers for Medicare & Medicaid Services (CMS) highlighting promising practices in State Survey Agencies. The entire series is available online at CMS' Web site, http://www.cms.hhs.gov/SurvCertPromPractProj. The issue briefs are intended to share information about practices used in State Survey Agencies and are not an endorsement of any practice.