Technical Assistance Report to Bureau of TennCare on the Quality Improvement In Long Term Services and Supports (QuILTSS) Initiative

LIPSCOMB UNIVERSITY | SCHOOL OF TRANSFORMAGING

This report was prepared with support provided through a grant from the Robert Wood Johnson Foundation's State Quality and Value Strategies Program.

Contents

Introduction

This report[1] summarizes the technical assistance provided to date by the Lipscomb University School of TransformAging to TennCare regarding the QuILTSS initiative. **QuILTSS** stands for **Qu**ality **I**mprovement **in L**ong **T**erm **S**ervices and **S**upports**.**

The State of Tennessee's Medicaid program is known as TennCare. TennCare provides physical and behavioral health services, and since 2010, long term services and supports (LTSS) through a managed care delivery system. Tennessee is one of 18 states that have a Medicaid Managed LTSS (MMLTSS) program.[2] QuILTSS is a TennCare value-based purchasing initiative to promote the delivery of high quality LTSS for TennCare members enrolled in the CHOICES program.

TennCare's LTSS Division administers LTSS programs and services that include:

- **CHOICES** – a MMLTSS program including nursing facility (NF) services as well as home and community based services (HCBS) for seniors (age 65 and older) and adults (age 21 and older) with physical disabilities.
- **Money Follows the Person (MFP) program** – a program that assists seniors and individuals with physical or intellectual disabilities served in institutions in transitioning to the community with HCBS and which supports the state's rebalancing efforts.

[1] This report was prepared with support provided through a grant from the Robert Wood Johnson Foundation's State Quality and Value Strategies Program.

[2] Friday Morning Collaborative Webinar, http://www.ancor.org/newsroom/news/fmc-hold-webinar-state-oversight-and-quality-managed-ltss-december-6.

- **Program for All-Inclusive Care for the Elderly (PACE) –** a managed care program providing frail elderly (age 55 and older) Medicare and Medicaid members with comprehensive medical and social services at an adult day health center, at home, and/or inpatient facilities, using an interdisciplinary team and integrated care planning approach. For most participants, the comprehensive service package permits them to continue living at home while receiving services, rather than an institution. PACE is currently available in Tennessee only in Hamilton County. These services are not included in the QuILTSS initiative.
- **Services for individuals with intellectual disabilities** – three Section 1915(c) HCBS waiver programs serving individuals with intellectual disabilities in the community as well as in an ICF/IID (Intermediate Care Facility for Individuals with Intellectual Disabilities) benefit. These services are not included in the QuILTSS initiative.

For Nursing Facility (NF) rates, Tennessee currently utilizes a cost-based reimbursement system, whereby each nursing home has its own unique cost-based reimbursement rate that is inclusive of the covered costs of NF care. NFs submit cost reports to the Office of the Comptroller. The Comptroller establishes a per diem rate based on those cost reports. All of the NF rates are then ranked, and facilities up to the 65th percentile are cost reimbursed. Those in excess of the 65th percentile are capped at the 65th percentile. HCBS rates were carried forward from the Section 1915(c) waiver that existed prior to CHOICES, with only targeted adjustments since implementation.

As part of the QuILTSS initiative, TennCare intends to develop a new payment approach based in part on a quality framework, including a core set of quality domains and quality performance measures that will be collected to measure the quality of services provided by NF providers. The data will be used in the calculation of payments in order to properly align incentives, enhance the customer experience of care, support better health and improved health outcomes for persons receiving LTSS, and improve quality performance over time.

TennCare also intends to develop a modified core set of quality domains and quality performance measures for the provision of core HCBS, including personal care visits and attendant care – those services which include hands-on assistance with activities of daily living. This will include measures that are applicable across service delivery settings (NF and HCBS) as well as additional measures that are specific to the provision of LTSS in home and community-based settings. A modified reimbursement structure is expected to align payment rates with performance on the specified quality measures, driving toward the same objectives across the "Triple Aim" of better health, better care, and increased cost-effectiveness, the same framework originally developed by the Institute for Healthcare Improvement and later adopted as goals by the Centers for Medicare and Medicaid Services (CMS).

TennCare intends to use the following parameters to guide the development of QuILTSS:

- Quality measures will be developed based on input from individuals receiving LTSS and their families, advocacy groups representing seniors and adults with disabilities, NF and HCBS providers, and other LTSS stakeholders.

- Quality measures must include those aspects of service delivery perceived by individuals receiving LTSS and their families to have the greatest impact on quality of care and quality of life.
- Changes in reimbursement based on quality performance must be sufficient to incent improvement – i.e., must represent a significant difference in payment.
- Overall, QuILTSS must be budget neutral (based on the amount of funding that would have been spent under the current reimbursement methodology for the same number of bed days in a NF or the same amount of HCBS), unless additional funding is identified.
- QuILTSS is expected to be phased in over time to establish data collection processes and benchmarks, and to ensure the stability of the LTSS system.

As part of the Robert Wood Johnson Foundation's State Quality and Value Strategies (SQVS) program, Tennessee was awarded a grant for technical assistance to TennCare in the QuILTSS Initiative.

The funding award to Lipscomb University via a contract with Princeton University provides technical assistance which includes facilitation of opportunities for broad stakeholder review and input regarding proposed quality improvements, the engagement of key stakeholders in the program design process, assistance in gathering input/information, review of the literature, interviews regarding best practices, program design and effectiveness of pay for performance (P4P) programs, and recommendations to TennCare regarding the quality framework and implementation process. The technical assistance contract period is August 1, 2013 through March 31, 2014.



Background

The quality of care provided in nursing facilities (NFs)[1] is a concern of long standing, dating at least as far back as an investigation by the Public Health Service in the early 1960s, which led to the publication of a guide for minimum standards in nursing homes (Castle & Ferguson, 2010). A subsequent inquiry in 1984 led to the passage of the 1987 Nursing Home Reform Act, which mandated the creation of the Minimum Data Set (MDS[2]) and other structures and processes designed specifically to measure and encourage quality care in NFs (Mor, 2005).

Initial efforts to improve the quality of care consisted primarily of punitive measures triggered by the failure of a facility to meet federal and state standards. However, over the past two decades, a new approach has emerged, one that utilizes quality indicators and payment systems to incentivize improved performance. These new Pay for Performance (P4P)[3] systems employ a variety of rate structures which include differential rates, add-ons, or payments based at least in part on how the provider performs on measures of care quality or other identified areas of performance (Arling, Job, & Cooke, 2009).

Federal Quality Initiatives in Long Term Services and Supports (LTSS)

As Arling and colleagues (2013) have observed, Federal efforts have produced a considerable infrastructure to support and promote quality in NFs. A number of efforts aimed at quality improvements in long term services and supports (LTSS) in both the NF and home and community based (HCBS) settings are underway nationally, including in Tennessee. These include the Centers for Medicare and Medicaid Services (CMS) 5-Star Quality Rating System, the Advancing Excellence in America's Nursing Home Campaign, the Partnership to Improve

[1] As it is used in this document, "Nursing Facility" or "NF" encompasses both Skilled Nursing Facilities or SNFs, certified for participation in the Medicare program, and "Nursing Facilities" or "NFs", certified for participation in the Medicaid program to offer skilled nursing and related care, rehabilitative services, and only in the case of Medicaid NFs, long-term health-related care and assistance (beyond room and board) that is needed on an ongoing basis because of a physical or mental condition, and can only be provided in an institution.

[2] The Long-Term Care Minimum Data Set (MDS) is a standardized, primary screening and assessment tool of health status that forms the foundation of the comprehensive assessment for all residents in a Medicare and/or Medicaid-certified long-term care facility. The MDS contains items that measure physical, psychological, and psychosocial functioning. The items in the MDS give a multidimensional view of the patient's functional capacities and helps staff to identify health problems (CMS.gov). MDS data form the basis of many of the measures on the CMS Nursing Home Compare website (www.medicare.gov/nursinghomecompare).

[3] State P4P initiatives to incentivize improved quality of care are discussed in the Literature Review section of this report.

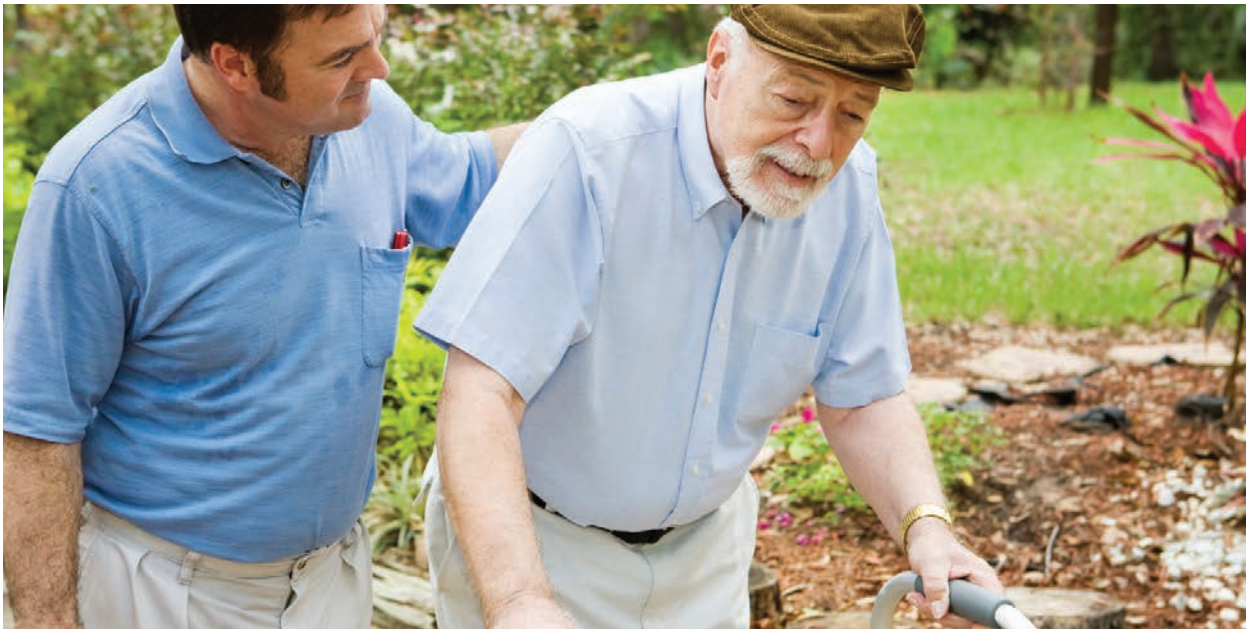
Dementia Care in Nursing Facilities, and Quality Assurance Performance Improvement (QAPI). Key initiatives focused specifically on improving home health services, as well as the quality of HCBS provided pursuant to section 1915 (c) waivers[4] include the Outcome-Based Quality Improvement (OBQI) program and HHQI, the Home Health Quality Initiative (Murtaugh, Peng, Aykan & Maduro, 2007).

The **5-Star Quality Rating System** was developed by CMS to help consumers, families, and caregivers have a basis from which to compare NF quality. NFs receive both an overall rating of one to five stars, as well as a separate one to five star rating for each of the three component areas: health inspections, staffing, and quality measures. Rankings are posted on a CMS Nursing Home Compare website (www.medicare.gov/nursinghomecompare). A five star rating reflects quality which is "much above average," while a one star rating is indicative of quality that is "much below average." A three-year analysis of performance since implementation of the 5-Star system (2008-2011) shows a general improvement in health inspection scores, except in one-star facilities; higher overall performance on self-reported quality measures; modest improvement with respect to self-reported staffing—in particular reported levels of RN staffing; and improvements in overall quality rankings. The proportion of 5-star facilities has increased slightly (from 7.2% to 10.3%); 4-star homes have increased more (from 31% to 41%), and 1-star facilities have declined (from 23% to 12%) (www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/FSQRS-Report.pdf). The overall average rating for Tennessee NFs is 2.9 stars, which ranks 48th nationally (www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS.html).

Advancing Excellence in America's Nursing Homes is a voluntary nationwide program, in which approximately 50% of Tennessee NFs participate. Each participating NF chooses three goals related to quality on which to focus each year. Training and technical assistance is provided, and improvement is tracked across nine measures. These measures are grouped as Process Goals and Clinical Goals. Process Goals include staff stability, consistent assignment, person-centered care planning and decision-making, and safe reduction in hospitalizations. Clinical Goals consist of appropriate use of medications, increased resident mobility, and decreased rates of infections, pressure ulcers, and pain symptoms (www.nhqualitycampaign.org).

The **Partnership to Improve Dementia Care in Nursing Facilities** (Partnership) is a national initiative to improve person-centered care and behavioral health and reduce the use of antipsychotic drugs in NFs. More than half of all NF residents have some form of dementia. For residents with dementia, challenging behaviors are often an indication of unmet needs, because they have no other effective means of communication. Unfortunately, antipsychotic medications are often prescribed in an attempt to control the behavior, rather than identifying and addressing the underlying need. Such drugs increase the risk of stroke, heart attack, falls with fractures, hospitalizations, and other complications that result in higher cost and poorer quality of care and quality of life for these residents.

[4] Section 1915 (c) has been the primary federal authority for HCBS. The 1915(c) waivers are one of many options available to states to allow the provision of long term care services in home and community based settings under the Medicaid Program. States can offer a variety of services under an HCBS Waiver program (www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Home-and-Community-Based-1915-c-Waivers.html).



The Partnership tracks the percent of long-term NF residents who are receiving an antipsychotic medication, excluding those who are diagnosed with schizophrenia, Tourette's Syndrome, or Huntington's disease. In the fourth quarter of 2011, 23.9% of long-stay NF residents were receiving antipsychotic medication nationally; the most recent figures for the third quarter of 2013 reveal a 13.1% improvement to 20.8%. During this same period, Tennessee also improved on this measure; in the third quarter of 2013, 23.98% of Tennessee NF residents received antipsychotic medication, compared with 29.27% in the first quarter of 2011. Tennessee is ranked 47th in the nation on this measure (http://www.amda.com/advocacy/AP_package_070513.pdf).

Quality Assurance Performance Improvement (QAPI) combines two complementary approaches to quality management. The first is quality assurance—a process of ensuring that minimum quality standards are met. It is typically a reactive and retrospective review to determine why a facility failed to achieve minimum quality standards, with efforts to correct identified deficiencies. Once the standards are achieved, the process typically ends. Performance improvement is proactive and seeks to review processes on an ongoing basis in order to prevent or decrease the likelihood of problems and to achieve higher quality performance even after minimum standards are met. QAPI engages individuals at all levels of the organization to:

- identify opportunities for improvement; address gaps in systems or processes;
- develop and implement an improvement or corrective plan; and
- continuously monitor effectiveness of interventions.

The **Outcome-Based Quality Improvement (OBQI)** program furnishes reports on patient outcomes[5] collected through the Outcome and Assessment Information Set (OASIS) to home health providers in every state. These reports can be used for improving the quality of services, as providers identify potential problems and corresponding strategies for

[5]Not long after NFs became obligated to submit MDS data, Medicare-certified home health agencies were also required to begin collecting and providing standardized data sets regarding the status of patients receiving home health services. The Outcome and Assessment Information Set (OASIS) data seeks to measure outcomes of care for home health patients, and since 2010, includes process measures regarding the delivery of care.

solutions. OBQI measures include clinical outcomes in areas of functioning (such as physical, emotional/behavioral, and cognitive functioning) as well as measures of health care utilization (Murtaugh et al., 2007).

The Home Health Quality Initiative (**HHQI)** utilizes a subset of the OBQI data and makes it publicly available in order to provide potential consumers of the service with a basis for decision making regarding home health services. It also serves as an incentive for home health providers to improve the quality of care. This is a similar approach to the one used in the Five-Star Quality Rating System for NFs. Data are reported on a CMS Home Health Compare website (www.medicare.gov/homehealthcompare) across two domains: process measures and outcome of care measures. Process measures include timely initiation of care, immunizations, heart failure, diabetic foot care, pain assessment and intervention, depression assessment, drug education on medications, and pressure ulcer risk and prevention. Outcome of care measures are comprised of improvements in ambulation, bed transfer (getting in and out of bed), pain interfering with activity, bathing, management of oral medications, dyspnea, status of surgical wounds, acute care hospitalizations, and use of emergent care (http://www.medicare.gov/HomeHealthCompare/Data/Quality-Measures-List.htm).

There is also a voluntary national campaign to improve the quality of home health services, similar to Advancing Excellence in America's Nursing Homes. Initiated in 2007, the **Home Health Quality Improvement Campaign** (www.homehealthquality.org) includes 10,771 participants from 5,661 agencies, and offers participating home health providers resources, training, and technical assistance in improving care delivery and patient outcomes.

CMS is also focused on measuring and improving quality across HCBS provided pursuant to Section 1915 (c) of the Social Security Act. Following a report by the General Accounting Office in 2004, CMS initiated a new evidentiary approach to its quality oversight of section 1915 (c) waiver programs, focused on ensuring states' compliance with waiver assurances set forth in federal regulation. Revisions to the new quality requirements were released in 2007, along with an online version of the 1915 (c) waiver application. Three critical steps of the quality review cycle are embedded throughout the application: 1) discovery – activities to measure and identify instances of non-compliance; 2) remediation – 100% remediation of all instances of non-compliance; and 3) system improvement - efforts to examine and address underlying quality concerns and promote quality improvement across the HCBS deliver system on an ongoing basis.

Measurement is a challenge in HCBS due to the spectrum of services, the large number of providers, the home setting, and the lack of standard measures. To address this, CMS is funding the demonstration grant TEFT (Testing Experience and Functional Assessment Tools in Community Based Long Term Services and Supports). This project is designed to test quality measurement tools and demonstrate e-health in Medicaid LTSS (www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Long-Term-Services-and-Support.html). While Tennessee did not apply for a demonstration grant, it was selected as a pilot site for testing the new HCBS Consumer Assessment of Healthcare Providers tool.

Federal Pay for Performance (P4P) Initiatives

In addition to the preceding initiatives to develop infrastructure to support quality in LTSS, CMS has also tested the effect of financial incentives in improving care in both the NF setting and in home health.

One such initiative, the three-year **Nursing Home Value-Based Purchasing (NHVBP) Demonstration,** was initiated to explore how P4P affects both NF performance and cost within Medicare. 182 NFs in the states of Arizona (41), New York (79) and Wisconsin (62) voluntarily participated in the project, which began July 1, 2009, and concluded in July of 2012. All facilities submitted data on four domains: nurse staffing, resident outcomes, appropriate hospitalizations, and state survey inspection deficiencies. Data on nurse staffing included agency staff data along with payroll and resident census information. MDS data was used for resident outcomes, inpatient hospital claims were tracked to monitor hospitalizations, and state health inspection reports were used to evaluate survey deficiencies. CMS risk-adjusted certain measures to control for differences in resident populations or individual NF characteristics. NFs were eligible for financial incentives based on either attainment or improvement of quality indicators. The program was designed to be budget neutral and relied on funding resulting from state-specific Medicare savings related to lower hospitalization rates in the test group compared to a control group ("Plan to implement," n.d.).

Although the full evaluation has not yet been completed, preliminary findings have been published and are reported to be mixed. According to a report to Congress, several NFs have experienced improvements in quality measures related to pressure ulcers, restraints, and hospital admission rates for heart failure. However, while savings in Wisconsin nursing homes were sufficient for significant incentives, there were fewer savings in Arizona, and none in New York (Graham, 2012).

Lessons learned from the NHVBP Demonstration are reported to include: new processes which were developed to address the lag time between data collection and performance updates; the calculation of measures related to hospitalizations and episodes of care; high sustained levels of participation (which may be attributable to the flexibility extended to NFs in implementing initiatives and support from CMS for sharing lessons learned); and the learning curve experienced by some NFs in reporting payroll data ("Plan to implement," n.d.).

CMS also funded a Medicare **Home Health Pay-for-Performance Demonstration** from January 2008 through December 2009. Similar to the NHVBP Demonstration, home health agencies (HHAs) qualified for incentives based on either attainment or improvement of quality indicators. As reported by CMS, 567 HHAs participated in the demonstration, with 280 in the treatment group and 287 in a control group (p. 20). Participating HHAs represented more than 30 percent of all Medicare certified HHAs in their respective states and were located in Illinois (66), Connecticut and Massachusetts (48), Alabama, Georgia, and Tennessee (99), and California (67). OASIS measures were used and included: incidence of acute care hospitalization; incidence of any emergent care; improvement in bathing; improvement in ambulation/locomotion; improvement in transferring; improvement in management of oral medications; and improvement in status of surgical wounds ("Plan to implement," n.d.).

Incentives were calculated from differences between the experimental versus control groups beneficiaries' Medicare costs, including home health care, inpatient hospital care, nursing home and rehabilitation facility care, outpatient care, physical care, durable medical equipment, and hospice care. Successful HHAs were described as patient and community centered, quality focused, used technology to enhance care, and implemented specific, targeted strategies to succeed in improving poor performance areas ("Plan to implement," n.d.).

LTSS in Tennessee

As with the rest of the country, the quality of LTSS in Tennessee, particularly in NFs, has been a longstanding source of concern. As noted above, in spite of improvements in recent years, Tennessee ranks 47th in the percentage of NF residents who are treated with antipsychotic medication, and 48th nationally in the average NF star ratings under the 5-Star Quality Rating System. A 2009 report commissioned by the American Association of Retired Persons ("Quality of care," 2009) reviewed litigation in Tennessee NFs, in which it found "distinguishing quality and structural characteristics—below average staffing levels, large average facility size, and a high percentage of for-profit and chain-owned facilities—associated with increased risk of quality problems and litigation." These problems are further compounded by the finding that "Tennessee surveyors have performed far below the national average in accurately detecting serious violations of quality standards" (p. ii). The report makes several recommendations for improving this situation, among which is to "provide incentives for good quality care, paired with oversight and citations of deficiencies" (p. 32).

In order to address long-term care quality concerns, the Tennessee legislature mandated, as part of the comprehensive reform of the long-term care delivery system, the development of a quality approach that promotes continuous quality improvement and focuses on the experience of the consumer. **Tennessee's Long-Term Care Community Choices Act of 2008** embraced quality as a key objective of the LTSS delivery system and included a specific section dedicated to assuring and improving quality, with a key focus on quality as it is perceived by those receiving services.

TCA 71-5-1402(i) provides that:

> *"The long-term care system shall include a comprehensive quality approach across the entire continuum of long-term care services and settings that promotes continuous quality improvement and that focuses on customer perceptions of quality, with mechanisms to ensure ongoing feedback from persons receiving care and their families in order to immediately identify and resolve issues, and to improve the overall quality of services and the system."*

TCA 71-5-1415 continues:

> *"The commissioner shall develop and implement quality assurance and quality improvement strategies to ensure the quality of long-term care services provided pursuant to this act and shall specify in contractor risk agreements with contractors responsible for coordination of Medicaid primary, acute and long-term care services requirements related to the quality of long- term care services provided. Such strategies may include the use of electronic visit verification for data collection and reporting, HEDIS measures pertaining to long-term care services, and shall include mechanisms to ensure direct feedback from members and family or other caregivers regarding the quality of services received. "*

The quality strategy for CHOICES is part of an integrated quality management strategy for the entire TennCare program, and includes:

- ◆ Uniform measures of system performance;
- ◆ Detailed reporting requirements;
- ◆ Ongoing audit and monitoring processes;
- ◆ Measures to immediately detect and resolve problems, including gaps in care (e.g., Electronic Visit Verification);
- ◆ Independent review by an External Quality Review Organization, the National Committee on Quality Assurance (NCQA, an accrediting body for Managed Care Organizations), and the Tennessee Department of Commerce and Insurance;
- ◆ A key focus on member perceptions of quality, including a modified Quality of Life survey for LTSS members; and
- ◆ Advocacy for members across the managed long term services and supports (MLTSS) system.

With **QuILTSS**[6], TennCare intends to build on the lessons learned and infrastructure of quality efforts already underway, both for NF and HCBS, while also incorporating those measures of quality that are most important to people receiving LTSS and their families. Moreover, as the largest payer of LTSS in Tennessee, TennCare intends to utilize its purchasing procedures and payment system to incentivize quality care, improve how Tennesseans experience LTSS, and improve both the performance of LTSS providers and the healthcare outcomes and quality of life of consumers over time.

[6]QuILTSS is described in the Introduction section of this report.

Literature Review

The purpose of this section is to review relevant literature on the empirical study of the impact of Pay for Performance (P4P) in nursing facilities (NFs) and home and community based services (HCBS), along with closely related articles from the public policy arena, to identify and discuss salient issues and best practices which may inform the design of Tennessee's program through QuILTSS.

As discussed in the Background section of this report, the quality of care provided in the nursing home setting is a concern of long standing, dating at least as far back as an investigation by the Public Health Service in the early 1960s (Castle & Ferguson, 2010). More than fifty years of review and increasing oversight and regulation have failed to effectively remedy the situation (Arling et al., 2013). While these efforts have produced a considerable infrastructure to support and promote quality, the payment system itself for long term services and supports (LTSS) in general, and particularly for NF care, has typically been based on cost and lacks incentives for the provision of quality care. Therefore, state Medicaid payment systems, as the single largest payer of LTSS care, may be in a position to utilize their regulatory and purchasing power to leverage improvements in this sector ("Plan to implement," n.d.; Arling et al., 2013).

State Pay for Performance (P4P) Programs

As regulatory and punitive measures failed to improve nursing home care quality, state Medicaid agencies have sought to stimulate change through market forces with P4P incentive programs (Briesacher, Field, Baril & Gurwitz, 2009; Werner, Kontetzka, & Polsky, 2013). Rather than basing reimbursement on fee schedules or historical costs, in P4P programs, payments to nursing homes depend at least in part on level of performance on defined measures of quality (Briesacher et al., 2009; Werner et al., 2013), thus creating motivation for NFs to shift focus from the amount and types of services provided to the level of quality of care. While this strategy has gained popularity, efforts to evaluate its effectiveness have been limited, and results from extant studies are mixed (Werner et al., 2013; Arling, Job, & Cooke, 2009; Briesacher et al., 2009).

Defining and Measuring Quality

A foundational issue for P4P has been determining how to define and measure quality. The Donabedian approach, often used in long-term care, divides quality measures into structure, process, and outcome measures (Castle & Ferguson, 2010, p. 427). Many studies on long-term care quality measures divide measures into these three categories. Structural measures pertain to organizational characteristics, such as ownership or for-profit or non-profit status; process measures are concerned with things done to and for the resident in the provision of care, such as immunizations or risk assessment tools; and outcome measures are the end state of care, such as pressure sores or improved functioning in activities of daily living (ADL). The theory behind this paradigm is that good structure facilitates good processes, and good processes produce good outcomes (Castle & Ferguson, 2010; Mor, 2005). However, Castle & Ferguson point out that this theory was not developed specifically for nursing homes, has not always been validated in the literature, and is sometimes modified, for instance, by being used in combination with contingency theory.

Vincent Mor (2005) explores the issues of the "conceptual and empirical validity underlying the quality measures now in use in long-term care" (p. 335). He points out that the issue of how to actually measure quality is a subject of a great deal of debate and emphasizes the difference between the process of caregiving and the outcome of that care, though both are used as measures. Given the lack of standardization in medical care and the heterogeneity of patient populations, comparisons can be difficult to make and require the use of risk adjustments. Many facilities specialize in a particular area (such as pressure ulcers) and thus bias is introduced into the system. He concludes that though the long-term care field now utilizes consistent clinical measures, "substantial gaps remain in our knowledge about the quality of existing measures, how they are reported, how to get the designated audiences to use the information, and whether and how providers can institute quality improvement programs" (p. 350). These issues may play a part in the inconsistencies of research findings on the effectiveness of P4P and other incentives discussed later in this review to improve the quality of care, since those efforts rely heavily on quality measures to assess performance.

Additional Strategies to P4P

P4P is not the only strategy in use to motivate improvements in the quality of care in LTSS. Examples such as market competition, publishing quality "report cards", and facilitating increased pressure from consumers and consumer groups are also found in the literature. Starkey, Weech-Maldonado, & Mor (2005) examined the relationships between the level and type of competition in the market and nursing home quality. The researchers used the Minimum Data Set (MDS), Online Survey Certification of Automated Records (OSCAR), and HealthCare Financing Administration's Multi-State Case-Mix and Quality Demonstration from 1996 (states of New York, Maine, Vermont, Kansas, and South Dakota). Evidence was found that competition is associated with higher levels of quality in nursing homes. The study found support for an association between active certificate of need laws (which reduce competition by discouraging new entrants into the service area) with lower quality NF care, and higher quality of NF care where there are a large number of home health agencies (alternatives to nursing homes), a larger supply of hospital-based sub-acute care beds, and higher levels of excess demand, all conditions which create competition for NFs. However, the researchers failed to find support for the hypothesis that nursing homes in markets where the ratio of hospitals to nursing homes is low would demonstrate higher quality of care, and found mixed results for the hypothesis that nursing homes with higher Medicare managed care rates would be associated with higher quality.

Another study examined the relationship between published quality report cards and trends in quality measures (Mukamel, Weimer, Spector, Ladd, & Zinn, 2008). The idea behind report cards is that increased access by consumers to information creates greater awareness of and demand for quality care, thus creating a motivation for providers to invest in quality improvement. The researchers specifically examined the effect of the Federal Nursing Home Compare (NHC) report card published by the Centers for Medicare and Medicaid (CMS) since 2002 relative to actions taken in response to the report card and subsequent performance on quality measures, using MDS data for comparisons. Their analysis reveals that the NHC quality report card did lead to improved quality, but only in some areas. Importantly, a stronger link was found between the number of specific quality improvement actions taken by nursing homes in response to the report card and performance on quality measures, with the best results related to relatively fewer, focused corrections. They suggest that pairing report cards with educational programs regarding effective quality improvement methods for nursing homes may be the most effective use of report cards.

Consumer Involvement and Satisfaction

Along with access to information, an active and involved consumer constituency is thought to create an environment in the market that leads to motivation for improvements in nursing home care. Miller and Rudder (2012) examined efforts to promote consumer engagement in the development of Medicaid nursing home reimbursement policy in New York and Minnesota. The authors believe that "the effectiveness of elder advocacy has languished in recent years" (p. 628), having fallen victim to an increased focus on individual responsibility and an image of aging adults as a "flourishing population cohort" (p. 628). Through structured interviews, the study found that active consumer representatives were able to help to develop

acuity-adjusted payments and support rate equalization and wage encumbrance, which are all factors important to access to and quality of care. The ombudsmen program was found to focus on individual versus system concerns, lacked policy expertise, and was hindered by the need to preserve relationships with government funders. Strategies for increased and successful consumer engagement are discussed, including targeting key legislators, testifying at legislative proceedings, interacting with state administrators, serving as a convener for state agencies, interacting with taskforces and workgroups, and utilizing grassroots approaches such as stimulating media coverage, letter writing, and e-mails.

A measure of growing interest in quality performance is consumer satisfaction. The SCAN Foundation supported research that resulted in two publications on satisfaction levels in older adult recipients of LTSS (Miller, Cohen & Shi, 2013; Cohen, Miller, & Shi, 2013). This research was conducted using data from private long-term care insurance policy-holders, which allowed the study to avoid the confounding variable of the cost or affordability of the care. Data were collected between 2004 and 2008. The study found that satisfaction is highest among those receiving services in home, followed by satisfaction levels with residents of assisted living facilities, and lowest for nursing home residents. Satisfaction was found to be highest at the inception of service and to decline over time across all three settings. Miller et al. (2013) found that the following were most important to residents: having someone available to assist when needed (53%); feeling safe (28%); having control over schedule and daily routine (8%); personal privacy (7%); and being around peers (4%) (p. 5). The authors suggest that declining satisfaction may be prevented by periodically re-assessing the patient's needs to ensure the care is commensurate with current requirements, and to ensure that caregivers' relationships skills are commensurate with technical caregiving skills (Miller et al., 2013). Cohen et al. (2013) additionally found that those who are not very satisfied with their care tend to be found in a different care setting within eight to twelve months, a finding that might not be replicated among Medicaid recipients. The study also found that upon transfer to home care from a facility, satisfaction rates rose from 31% to 63% (p. 9). They found that provider characteristics (able to understand the caregiver, provides quality care, good at what they do, trustworthy, reliable, gets along with consumer, spends enough time with consumer) are highly related to levels of satisfaction (p. 11). Interestingly, the presence of a care manager was found to be unrelated to later satisfaction with care. Building trust and communication with the consumer was found to be of paramount importance (p. 21).

State P4P Strategies and Effectiveness

While measurement science continues to evolve, and the reliability and validity of quality measures is debated, states have increasingly turned to various forms of P4P to incentivize improvements in care in LTSS. The efforts of eight states with P4P programs are discussed elsewhere in this report. Briesacher et al. (2009) evaluated thirteen P4P programs, seven of which were still active at the time of the study. The objective of the review was to describe and compare these programs and examine any evaluations of their impact. Included for study were functional payment systems located in nursing homes, focused on quality (versus efficiency), based on financial (versus recognition) incentives, and located in the United States. According to this review, the only study to date to provide conclusive results occurred in San Diego, California in the early 1980s. 32 nursing homes were randomly assigned to an experimental or a control group, and incentive payments were given for

admitting patients with the highest need for functional assistance, improved patient functioning within 90 days of admission, rapid discharge of patients, and patients remaining out of the facility for at least 90 days. More than 11,000 nursing home residents were tracked for 2 ½ years. The incentive payments were clearly shown to produce greater admissions of individuals with severe disabilities, and less likelihood of death or hospitalization occurred in the experimental group. However, costs to Medicaid rose by about 5 percent (Briesacher et al., 2009). Overall, this study found "little empirical evidence that pay-for-performance programs increase the quality of care of residents or the efficiency of the care in nursing homes" (p. 10).

A more recent review of P4P programs was conducted in 2013 by Werner and colleagues (Werner et al., 2013). These researchers sought to test the effect of P4P for nursing homes by state Medicaid agencies. 2001-2009 MDS and OSCAR data were used to compare eight states with P4P programs with 42 states and the District of Colombia without P4P. States with P4P included Colorado, Georgia, Iowa, Kansas, Minnesota, Ohio, Oklahoma, and Utah. The review encompassed 17,579 nursing homes, of which 3,513 were in a state with P4P. P4P was found to be associated with decreased physical restraints, pain, and pressure sores. Unexplained weight loss and incidence of residents with a catheter reflected a small increase (0.2 percentage points). The results were the same two years after P4P implementation. Staffing measures (total staff and skilled staff hours per day) were unchanged. Georgia's program saw a consistent effect of P4P, with results in other states inconsistent. These authors find "little evidence" to support the use of P4P (p. 1406). In discussing possible reasons for these findings, the researchers consider whether the choice of targeting high-Medicaid facilities (which they speculate may be less able to improve due to financial performance); the small incentive size; the payment of bonuses to facilities rather than individual staff or managers; and limitations of the research design were factors. The authors conclude with stressing the need for careful design of P4P programs and considering combining P4P with other incentives (such as more frequent feedback and payments), and larger financial incentives in future P4P programs.

One challenge to effective P4P program implementation is the potential for unintended consequences of the system. Arling et al. (2009) points out that a few of these consequences include neglecting quality measures that are not incentivized through the system and falsifying data and documents in order to receive financial incentives. These authors recommend involving key stakeholders in P4P system design and implementation, using a process to "strike a balance between diverse interests with everyone having a positive stake in the P4P system" (p. 591). They also endorse the use of credible, evidence-based measures, a system that encompasses a range of quality issues, and ensuring wide access to performance information for consumers and providers. The researchers suggest that states should assist providers to access the necessary tools and methods for improvement, provide sufficient financial incentives to offset the necessary financial investment, and design a system that stimulates improvement among providers at all levels of quality of care, from low to high performance. Further recommendations include that the P4P system be placed in the context of an overall comprehensive approach to quality improvement, be very transparent, be rigorously evaluated on an ongoing basis, and be continuously monitored so that negative or unintended consequences can be minimized.

Increasing Motivation for Improved Quality

While early large scale reviews of P4P programs have reported mixed results, three studies show more promising results when reviewing quality improvement efforts on a smaller scale. Rantz, Flesner, & Zwygart-Stauffacher (2010) used complexity science in a case study design to see if and how quality improvements could actually take place in a nursing home. This study showed that employing a process improvement team (PIT) with representation from all staffing levels, meeting regularly to brainstorm solutions to a quality improvement issue, training and mentoring the staff, and rewarding improvements in quality measures led to a dramatic improvement in a clinical outcome related to bladder and bowel incontinence (Rantz et al., 2010). This study demonstrates some effective strategies for quality improvement and may be applicable in future quality improvement programs.

Similarly, Baier, Butterfield, Harris, & Gravenstein (2008) set out to evaluate relative improvement among nursing homes that set targets using the Nursing Home Setting Targets – Achieving Results (STAR) site for two quality measures. Quality measures included physical restraints and pressure ulcers. Nursing homes that set a target had a statistically significant relative improvement on the targeted measure compared to nursing homes that did not set targets. The authors point out that although the absolute improvement (less than 1% for each measure) is relatively small, if achieved in all nursing homes nationwide, these improvements would benefit 45,000 residents who would experience fewer pressure ulcers and restraints over the course of one year.

Evaluation of Minnesota's Performance-Based Incentive Payment Program

A newly published article by Arling and colleagues (Arling et al., 2013) reviews Minnesota's provider initiated Performance-Based Incentive Payment Program (PIPP)[1]. The PIPP is an alternative P4P approach that provides funding as providers select, design, and implement a quality improvement project. Minnesota allocates substantial funding to this prong of its P4P program, about $18 million a year. Projects are funded through a competitive proposal process, in which facilities must provide evidence demonstrating the importance of the problem, the quality of the design, the potential for success of the initiative, and sustainability after funding ends. Projects range from one to three years. Quality of care was measured using MDS data and compared 373 Minnesota nursing homes with PIPP projects (PIPP facilities) to 199 facilities without projects (that either did not apply or were not funded). Baseline data was computed from 2007 data and evaluated through four rounds of funding ending in 2010. A composite quality score was calculated for all facilities using quality measurements from the dataset. The two groups did not differ in their quality score, staff retention, or survey deficiencies before PIPP, though PIPP facilities were more likely to be larger, non-profit, affiliated with a chain, and had a higher case-mix acuity. PIPP facilities not only demonstrated a significantly higher quality score than the comparison group, they also had no decline in individual quality indicators, saw improvements in areas unrelated to the PIPP (had a generalized beneficial effect on quality), and sustained improved scores during 2010-13.

[1] Minnesota is one of the states interviewed for this technical assistance project, and PIPP is described in more detail in that section.

These three studies suggest that, as Arling and colleagues (2013) point out, "local solutions can foster innovation and increase motivation because providers initiate and control the quality improvement process" (p. 1632). As part of the Arling et al. (2013) study, interviews were conducted with PIPP facilities, with the following result:

> Project leaders and nursing home staff reported that PIPP project participation resulted in more attention to evidence-based practices; collection and analysis of data; focus on system-level change; improved teamwork and communication; and better relationships among nursing home management, staff, residents and family members (p. 1636).

Similarly, Rantz et al. (2010) report that "improved working relationships between the members" of the performance improvement team were noted by the onsite study staff (p. 5). Baier et al. (2008) note that "STAR appears to foster self-management, where staff follow their nursing home's performance longitudinally and derive reinforcement from watching their quality measure performance improve relative to their peer's performance" (p. 597).

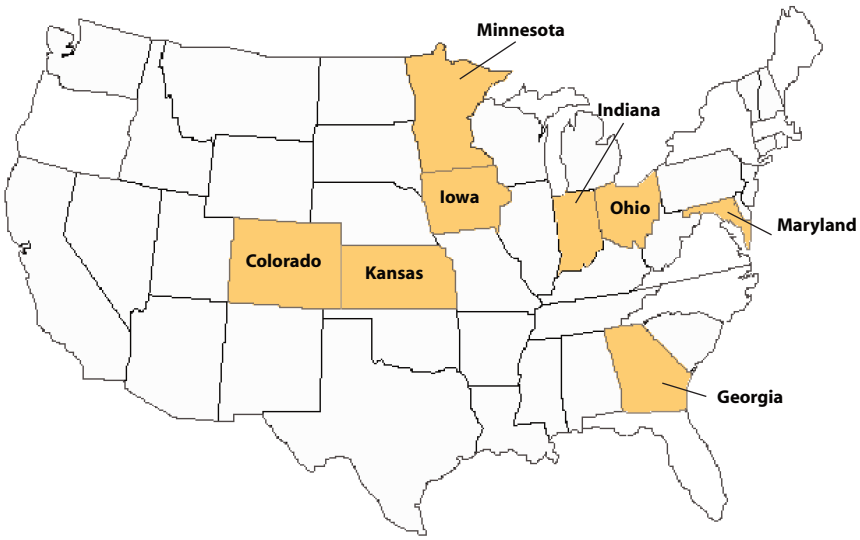
The Future

The future of long-term care quality improvement and P4P system implementation is both complicated and full of opportunities. There is a growing emphasis, particularly from patients and family members, on culture change and resident-centered care (Miller et al., 2013). As this practice becomes more important and widespread, there will be a need to improve upon current measures of consumer and family satisfaction. Currently, response rates to quality of life and satisfaction surveys are low. An exception to this is Minnesota, which employs an in-person survey with an 87% response rate (Arling et al., 2009). Other concerns for the future include involving all stakeholders in the entire P4P design, implementation, and monitoring process, equipping providers and managerial staff to make necessary changes to improve quality, and designing a system that is accessible, honest, and open to change (Arling et al., 2009).



Key Informant Interviews from Other States

States Interviewed



Overview

Technical assistance to the QuILTSS initiative provided by Lipscomb University included interviewing key informants to discover best practices and lessons learned from quality improvement and Pay for Performance (P4P) programs in other states.

Eight of fifteen states identified in a 2011 review of nursing home value-based purchasing review by National Research Corporation were interviewed. Generally, states with longer experience in value-based purchasing were included for interviews. Key informants were identified as staff in the state Medicaid agency (or its equivalent) who were working with value-based purchasing or P4P in their state. These informants were contacted and informed of the QuILTSS initiative, the RWJ award, Princeton University's contract, and Lipscomb's role in providing technical assistance. Each informant was provided with a list of questions and was asked to identify materials for review in advance of the interview.

Each state was asked to provide both high level policy information and details on quality and value purchasing initiatives, measurement tools, data collection methods, size and structure of incentives, funding mechanisms, stakeholder involvement, lessons learned, and whether any formal evaluation was in place. It should be noted that while the interviews were structured in terms of starting with the same set of questions, informants were free to respond to or expand on individual items and to include other information relevant to the topic.

States varied considerably in the amount of information and access to staff provided prior to and during the interviews; several states provided access for up to three participants on a conference call, while others included one responder. A number of interviewees were clearly passionate about their state's effort to improve the quality of Long Term Services and Supports (LTSS). In other states, informants were either less familiar or less engaged with the initiative. In one state, the initiative had been inactive for several years, and the informants had limited information on details of how it operated and its results. This response variation may reflect the wide variety of staff roles represented in the respondent pool – from high-level policymakers to program administrators with direct operational responsibilities. This report is a compilation of interview responses and ancillary materials and is not intended to represent an exhaustive report on each state's value-based purchasing efforts.

We wish to thank all of the participants for their time, service to their respective states, generosity, knowledge, and willingness to share their learning with Tennessee. All informants expressed interest in and a desire for follow-up and access to the final report on the technical assistance project for Tennessee.

As the interviews progressed, a number of themes repeated themselves beyond the content of the questions. These themes relate to vision for the initiative, stakeholder input, time to maturity of the effort, dynamic nature of the process, and measurement issues. Each of these themes will be explored briefly before proceeding to summaries of the interviews for each state. These themes are consistent with other reviews of value-based purchasing and represent best practices and lessons learned from other states.

Vision

Several states stressed that it is essential for the initiative to have a broad but clear vision of what the initiative seeks to achieve. In at least two states, this vision came from the Governor's office, as in one case, their Governor "announced we are going to have a report card. It wasn't optional." As an informant in another state put it, "…it's about values, you have to know what you care about." Another summarized their vision search as, "Can we figure out what we want [nursing home care] to look like, define what expectations do we want our providers to fulfill, then create benchmarks and outcomes as a map, and pay for those outcomes? It has to include a business model that will work for providers."

Stakeholder Input

Whether the vision came from the Executive Branch, or as in other states, from advocacy groups or coalitions, each state interviewed stressed the importance of strategic, broad-based, inclusive, meaningful, and ongoing stakeholder input. Even in states where the chief executive clearly initiated change, the advantages of a widely shared vision and plan were repeatedly underscored. One interviewee praised the skill of the administration in her state in engaging and working with stakeholders, and the necessity of developing action steps that lead to a program which is "politically achievable." In some states, this process included encoding the P4P or value-based reimbursement approach into statute, with committees composed of various stakeholders working alongside legislators to craft and refine the legislation, and report on its implementation and progress.

Broad-based sources for input typically include associations representing both for-profit and not-for-profit nursing facilities, ombudsmen, state agencies conducting Skilled Nursing Facility (SNF) and Nursing Facility (NF) surveys, advocates, and consumers. One respondent wished there had been even more consumer involvement, citing the impact of a particular consumer, who was wheelchair bound, on the discussion of pressure ulcers. The impact of her direct experience in dreading and avoiding this potentially life-threatening condition for her lent a level of reality and authenticity to the debate about clinical measures.

Among the states interviewed, a common presence in stakeholder meetings and discussions is that of a respected university partner. As one state put it, the neutral expertise of the academic institution "is a comfort to consumers" and "having 'experts' helped lower resistance." In these states, universities and other types of public and private sector contractors also conduct family and consumer satisfaction surveys, prepare and deliver provider training and technical assistance for culture change, review and score provider quality incentive applications, and report on the overall initiative to the public and legislature.

Time to Maturity of Initiative

All states interviewed had invested considerable preparation before launching their initiative. Some states also noted that the system continues to evolve after implementation. Several states built upon longstanding data collection or initial quality improvement efforts that dated back decades. Other states were in their second or third iteration of their quality improvement program. Stakeholder engagement involved taking up to a year or more to bring together everyone who needed to be engaged and working together to come to common definitions of the basic and key elements of the plan: defining quality, choosing measures, and building and funding the system of rewards.

As one high-level policy maker reflected, "It's hard to rush this stuff." His advice: put forth a proposal or concept, gather lots of input and give lots of room for discussion and disagreement, and develop a good strong work plan. But, at some point, he noted, "you have to do it."

Dynamic Nature of Defining, Measuring, and Rewarding Quality

One of the questions in the interview concerned whether measures had changed over time. Every state reported some modifications and adjustments to the original effort, but beyond that, most described a dynamic process of establishing benchmarks, testing how the benchmarks themselves performed in improving quality and achieving desired changes, and then improving the quality of the quality improvement system itself in an ongoing, iterative process. One state meets every other year to review the status of the program and recommend changes to the legislature for the program's following two years (since the program is codified in statute). It is felt that this ongoing review contributes significantly to the success and acceptance of program by stakeholders. As two interviewees observed, "it [quality improvement] is definitely an evolving process" and it "takes constant attention" to keep it moving forward.

Measurement Issues

A key issue for all states to resolve and refine in these efforts is the definition and measurement of quality. States report that a clear vision for the goals of the quality initiative and substantial and substantive stakeholder input provides support for a successful quality measurement framework.

A prime consideration in choosing measures is the utilization of data which is already available and which does not impose an additional burden on providers. At least two states had statutory directives to minimize the impact of data collection on NFs in their quality initiatives. States achieved this goal through thoughtful and strategic use of the Minimum Data Set (MDS), (including the section called Quality Measures (QM)), existing provider reports on costs and staffing, survey results, and in some cases especially with early initiatives, indicators of efficiency and fiscal management. As some states moved into measures of culture change, satisfaction surveys and other measures were developed, but with careful planning to avoid placing an additional burden on providers. At least two states utilized an outside contractor to conduct independent consumer and client satisfaction surveys. While this raised concerns with providers, it also minimized additional work. Other new measures, when needed, have been structured so that data collection is "super easy" for providers.

Measurement issues also seemed to be at least partly behind the exclusive focus on NFs for value-based purchasing in the states interviewed. One state had plans to begin formulating measures for Home and Community Based Services (HCBS), but had not yet begun. As one informant from that state pointed out, the pool of entities covered expands from the hundreds for NFs to the thousands for HCBS providers, and in addition "Nursing Facilities have a huge head start [in data collection] with the Minimum Data Set." Differences in how HCBS providers are regulated is also a complication, as is the lack of readily available reviews of the services themselves.

One other issue common across states on measurement is the need to coordinate the quality improvement process with the independent facility survey process. Many states included the survey agency in their stakeholder groups, and others meet frequently to ensure that the directives from the survey agency do not inadvertently conflict with those of the quality improvement program. This was particularly true in states where culture change is a primary focus. One state highlighted their challenge to work with surveyors to understand how a person (consumer) centered culture is consistent with current regulations, though these are primarily based on a medical model. This kind of support is key to a successful effort by providers to change the culture of their facilities.

The following is a brief summary of each state's initiatives and highlights of their lessons learned.

Colorado

Colorado's P4P program dates from 2009. A 100-point scale is used which covers two domains: Quality of Life and Quality of Care. Thirty measures are used to score these two domains, which are worth up to 50 points each. According to how many points are scored, providers receive an incentive in addition to the base rate. Incentives range from $1-$4 per resident per day depending on total number of points earned. The program is voluntary, and over half of the 219 nursing facilities in the state participate.

To participate in the program and qualify for the additional funding, each NF completes an application. In this application, the NF chooses the measures upon which it bases its request. NFs must score a minimum of 21 points to receive P4P funding. Colorado contracts with Public Consulting Group (PCG) to review, evaluate, and validate the nursing homes' applications to the P4P program. PCG is also responsible for developing and implementing the evaluation tool used in the program's scoring system, and for providing an annual written report on the program.

The Quality of Life Domain is primarily targeted to culture, and measures include:

- Resident-Centered Care and Activities
  - Enhanced dining
  - Flexible and enhanced bathing
  - Daily schedules
  - End of Life Program
- Home Environment
  - Resident rooms
  - Public and outdoor space
  - Overhead paging
  - Communities
- Relationships with staff, family, resident, and community
  - 50% consistent assignments
  - 80% consistent assignments
  - Internal community
  - External community
  - Daily living environment
  - Volunteer program
- Staff Empowerment
  - Care planning
  - Career ladders/career paths
  - Person-directed care
  - New staff program

The Quality of Care Domain is distributed across measures of:

- Direct caregiver continuing education
  - 12 hours continuing education
  - 14 hours continuing education
  - 16 hours continuing education
- Participation in Advancing Excellence in America's Nursing Homes or equivalent
- MDS measures
  - Falls with major injury
  - Moderate/severe pain
  - High risk resident with pressure ulcers
  - UTI
  - Reducing rehospitalizations
  - Antipsychotic medication
- Facility management
  - 5 or 10% Medicaid above state average
- Staff stability
  - Staff retention rate
  - Staff retention improvement
  - Director of Nursing retention
  - Nursing Home Administrator retention
  - Employee satisfaction survey response rate

Colorado reports that culture change in that state is stimulated by a large culture change movement, spearheaded by the Colorado Culture Change Coalition. In addition, Colorado also believes a focus on aggregate data at a state level – rather than facility by facility – might promote more system change. Colorado also observes that its program may provide an advantage to facilities that are doing well, with less effect on those which are already behind.

Georgia

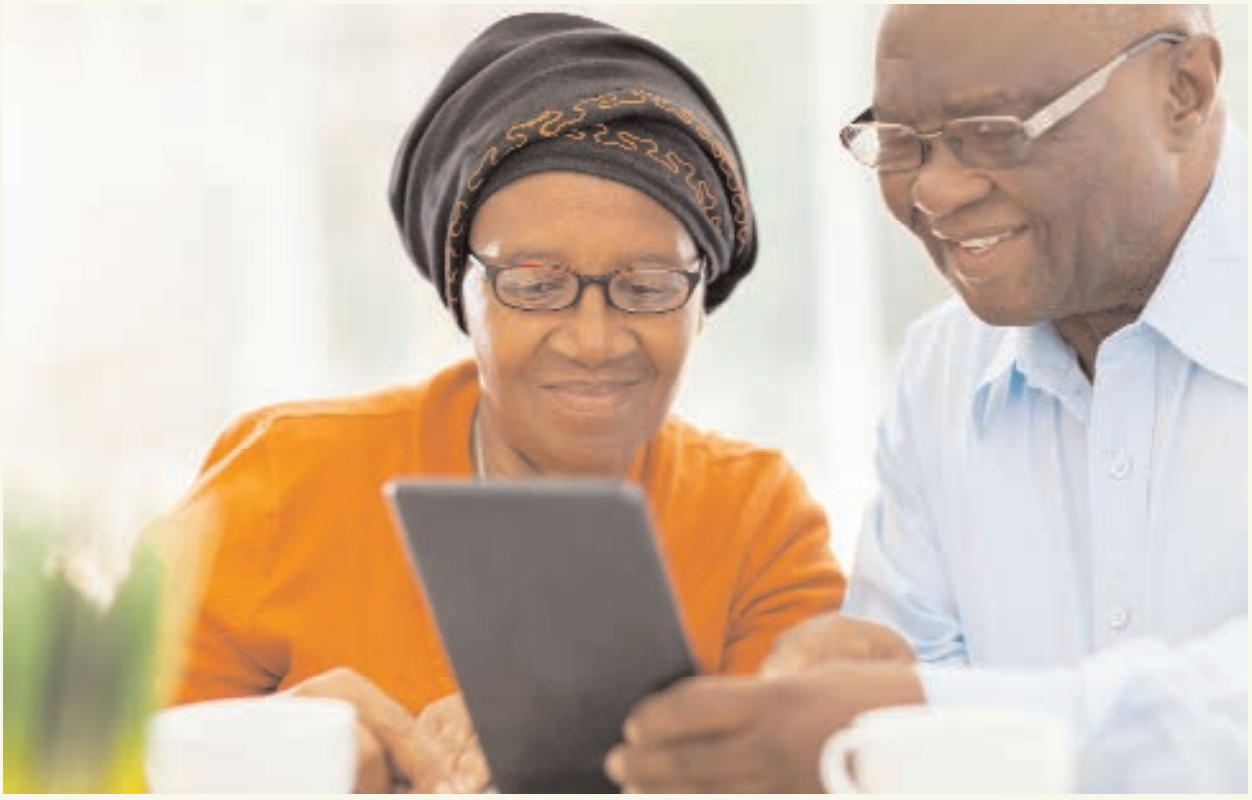
Georgia's Quality Improvement Initiative Program was first initiated in 2003, and fully in place by 2005. It began with a 1% incentive, with a second 1% incentive added beginning in fiscal year 2009. The program is voluntary and requires enrollment by the NF. NFs which are designated as a Special Focus Facility by the Centers for Medicare & Medicaid Services (CMS) are not eligible for the incentive payment until certain conditions have been met.

Georgia's NF per diem has the following components:
Case mix index – computed on average Resource Utilization Group (RUG) scores
Allowed per diem – usually calculated from the facility's cost report
Add-ons – which include a staffing incentive, cognitive impairment compensation, and the quality improvement program incentive. This includes both clinical measures and non-clinical measures.

The staffing incentive computes nursing hours per patient day and rewards 2.5 nursing hours per day or greater with a 1% increase in the Routine Services rate component. Participation in the Quality Improvement Program is required.

The Cognitive Impairment Compensation is based on the Brief Interview for Mental Status scores of residents, with qualifying scores receiving a 1-4.5% increase to the routine services rate component (participation in the Quality Improvement Program required).

The Quality Improvement Program Incentive awards one point for each quality measure in excess of the Georgia state average. Three points earned (minimum of one point from the clinical domain, and one point from the non-clinical domain with the remaining point from either area) qualifies the facility for a 1% increase to the Routine Services rate component. A second 1% is available to facilities which earn a minimum of three points in the clinical domain and one point in the non-clinical domain, with the remaining two points from either area.



Georgia continued

Georgia's clinical measures are as follows (each measure is worth 1 point):

- Percent of high-risk long-stay residents who have pressure sores
- Percent of long-stay residents who were physically restrained
- Percent of long-stay residents who have moderate to severe pain
- Percent of short-stay residents who had moderate to severe pain
- Percent of residents who received influenza vaccine
- Percent of low-risk long-stay residents who have pressure sores

NFs that do not generate sufficient data to report through CMS use the following measures from the Quality Value Profile generated by the contractor My InnerView:

- Chronic care pain – residents without unplanned weight loss/gain
- PAC pain – residents without acquired pressure ulcers
- High-risk pressure ulcer – residents without acquired pressure ulcers
- Physical restraints – residents without acquired restraints
- Vaccination – flu – residents without falls
- Low-risk pressure ulcer – residents without acquired catheters

Non-clinical measures are as follows (each measure is worth 1 point):

- Participation in Employee Satisfaction Survey
- Most current Family Satisfaction Survey score for "Would you recommend this facility?" is 85% or greater responses either "excellent" or "good" combined
- Quarterly average for nursing staff stability (retention) meets or exceeds state average
- Quarterly average for CNAs/NA stability (retention) meets or exceeds state average

Georgia's program is credited with having established expectations and a good foundation for quality improvement efforts. Its program is longstanding and has been widely recognized. Ensuring the incentives are based on objective data is considered a challenge in this state.

Indiana

Nursing Facilities (NFs) can receive up to $14.30 per day as a quality add-on to the their per diem rate (the average is 4.9%). While NFs submit annual cost reports, the NF rate changes quarterly to incorporate updated Minimum Data Set (MDS) information. Initially, the quality add-on was calculated exclusively from Nursing Home Report Card Scores received from the Indiana State Department of Health (ISDH). Indiana is now transitioning to a Nursing Facility Total Quality Score. The following components comprise the total NF quality score:

1. Nursing Home Report Card Score
2. Normalized weighted average nursing hours per resident day
3. RN/LPN retention rate (Registered Nurse/Licensed Practical Nurse)
4. CNA retention rate (Certified Nurse's Aid)
5. RN/LPN turnover rate
6. CNA turnover rate
7. Administrator turnover
8. Director of Nursing turnover

In 2013, Indiana implemented a resident, family/friend, and employee satisfaction survey. The survey was administered to all NFs enrolled in the Medicaid program and surveyed all residents who passed a cognitive screening tool regardless of payer source (Medicare, Medicaid, or private pay).

Press Ganey was selected as the satisfaction survey contractor (www.pressganey.com). Results from the three surveys had been disseminated to the NF industry at the time of this interview. While many states may be unsure if their efforts produce substantive changes in NF quality indicators, Indiana has seen a dramatic improvement in NF Report Card Scores. The ISDH's report reflects that scores have improved on surveys. In addition, extensive collaboration between ISDH and the Office of Medicaid Policy and Planning (OMPP) and the Division of Aging (DA) has resulted in NF surveys that are more focused on quality.

Indiana also emphasizes the importance of avoiding a government-down approach, stressing the need for stakeholder engagement and the necessity of involving university partners and other stakeholders to ensure the formation of a group of constituents that is as diverse as possible. Indiana believes in this approach, along with maintaining the longstanding and professional relationships the DA and the OMPP have with the NF industry and NF associations.

Iowa

While Iowa's staff was most responsive and cooperative, the interview revealed that Iowa's initiative was defunded several years ago. Iowa is currently focused on the creation of an Accountable Care Organization through a System Improvement Grant the state is seeking from CMS. Through this new effort they seek to establish care coordination at a systemic level, which takes the whole person into account. In addition, Iowa is working on its expansion of Medicaid. Even though the quality program is in statute, there are no plans to revive it at this time. Since Iowa's program was the initial basis for Ohio's effort, a summary of its P4P program as codified in statute is included.

The benchmarks in Iowa's program include characteristics in four domains: quality of life, quality of care, access, and efficiency, as follows:

Quality of life:

Subcategory: Person-directed care

- Enhanced dining
- Resident activities
- Resident choice
- Consistent staffing
- National accreditation

Subcategory: resident satisfaction

- Resident/family satisfaction survey
- Long-term care ombudsman (complaint rate)

Quality of care:

Subcategory: survey

- Deficiency-free survey
- Regulatory compliance with survey (no on-site visit required for recertification or complaint)

Subcategory: staffing

- Nursing hours provided
- Employee turnover
- Staff education, training, and development
- Staff satisfaction survey

Subcategory: nationally reported quality measures

- High-risk pressure ulcer
- Physical restraints
- Chronic care pain
- High achievement of nationally reported quality measures

Access:

- Special licensure classification (licensed for care of residents with chronic confusion)
- High Medicaid utilization (at or above state median plus 10%)

Efficiency:

- High occupancy rate
- Low administrative costs

Kansas

Kansas described their culture change efforts as multi-pronged and multi-faceted – and not all under one umbrella. This presents both advantages and challenges. The Kansas initiative is named PEAK – Promoting Excellent Alternatives in Kansas Nursing Homes.

PEAK has been in existence in Kansas for about 15 years. The program evolved from a voluntary and competitive recognition program into a P4P/incentive program in 2012. Kansas is in the process of making programmatic changes that are scheduled to be implemented July 1, 2014.

Initially there was resistance to PEAK, as NFs feared it would prove to be too costly. The department reported spending a great deal of time in dialogue with the facilities, and subsequently de-emphasized the necessity of physical plant changes and large capital investments. Staff also located and disseminated research and information from Advancing Excellence in America's Nursing Homes, which demonstrated how improved quality could lower NF costs and address the rising expectations of Millennials and Generation Xers, who are making decisions about care for their parents. Kansas has lots of small caregivers that still find PEAK to be a challenge, but the program is gaining acceptance.

Another support for PEAK is that Kansas has transitioned to managed care, and the managed care organizations (MCOs) are responsible and accountable through their performance measures to increase the number of NFs participating in PEAK. The MCOs are expected to work with the leadership of the NFs to encourage change and to provide additional incentives through their rates. The Kansas State University Center on Aging has also been a very important resource for PEAK 2.0.

Under the PEAK program, facilities must submit a detailed application indicating which level of the program they are applying for, and include documentation of their achievement. There are 5 levels of performance:

1. Pursuit of Culture Change
2. Culture Change Achievement
3. Person-Centered Care Home
4. Sustained Person-Centered Care Home
5. Person Centered Care Mentor Home

Site visits are conducted by state staff, along with the ombudsman's office, Kansas State University, and the University of Kansas Medical Center, in 3 person teams.

Incentives range from $0.50 per day to $4.00 per day and are added on to the base rate. There is also an incentive factor for efficiency, from 0-$7.50 per day. In spite of the relatively small incentive amount, Kansas advised that even $0.50 per day is "huge" for some facilities. Facilities must reapply and re-qualify to advance along the continuum of levels and to maintain their add-on. This leads to a challenge, as once earned, the add-on becomes expected, and there is disappointment when it is lost if performance is not maintained.

Kansas was surprised at the level of response to the initial round of applications for P4P. The goal during year one was to engage one-third of NFs. The response, however, was much higher than the target, as 172 facilities applied. At the time of the interview, 142 NFs are participating and 37 more will soon be added.

A challenge PEAK faces is the coordination of Person Centered Care (PCC) within the medical model, which dominates nursing home regulations. The Kansas Department of Aging and Disability Services (KDADS) works closely with surveyors to ensure that PCC is consistent with regulations, in order to avoid inadvertently penalizing a facility in their survey for taking initiatives KDADS encourages as part of PCC.

Maryland

Maryland's P4P program is two-pronged, and rewards both absolute quality and quality improvement. Eligible NFs are those with more than 45 beds that score within acceptable quality parameters on surveys.
The following reflects the scoring items and weights:

- Maryland Health Care Commission Family Satisfaction Survey (40%)
- Staffing levels and Staff stability in Nursing Facilities (40%)
- MDS Quality Indicators (16%)
- Employment of Infection Control Professional (2%)
- Staff Immunizations (2%)

The highest scoring facilities representing the top 35% of eligible days of care receive a quality incentive payment. Selecting the top 35% for incentive payment targets the highest performers. Payments range from $2.57- $5.14 per Medicaid patient day. In addition, facilities that do not receive a P4P incentive but whose scores have improved from the previous year are eligible for $0.46 - $0.92 per Medicaid patient day.

Data are also scored for facilities that are not eligible for P4P in order to provide performance feedback.

Although elements of the Maryland initiative have been in place for many years and predate the current P4P program, the current initiative began in 2007. The legislature created a "Quality Assessment" (QA) as a mechanism to restore funding to NFs which had previously been reduced, with part of the new revenue generated earmarked for rewarding quality. The funding pool for P4P still derives from the QA and is capped at one-half of one percent of the budget for nursing home care.

Maryland reported that measurable results have been challenging to demonstrate due to the P4P scoring system. However, with two years of payment data and about four years of overall data, Maryland believes there is sufficient material for an analysis of the effects of P4P. Data analysis in Maryland is performed by the Hilltop Institute (http://www.hilltopinstitute.org).

Maryland continued

Maryland reports satisfaction with the design of their P4P program. For example, their model includes a good balance and mix of indicators and includes satisfaction levels, staffing, MDS, and survey results, along with a unique incentive for employing an Infection Control professional. Maryland believes these are the indicators which are most relevant to ensuring quality, and anecdotal results support this belief. Maryland also cited the importance of selecting objective and reliable measures to support the credibility of the program. Culture change measures were considered for the scoring system but ultimately were not included due to the lack of reliable measures in that area.

An anecdotal example of the program's success concerns data quality. Over time, providers have come to understand that failing to submit accurate data to the Department has financial consequences, as this data is used to calculate scores and resulting payments. This realization has produced improved quality of data, as providers take more care, for instance, with staff assigned to complete the wage survey.

Another strength of Maryland's program design is that it is built on existing data collection systems. Wage data, for example, had been collected for many years because it was used to calculate differential rates for the nursing service portion of the rate. This meant that staffing levels could be measured against acuity of services. Under the new P4P system, length of service became a factor, which represented a new data set. Building on the existing data collection system allowed for a simple solution of adding a field for date of employment so length of services could be incorporated into the data collection system.

Similar to Colorado, Maryland believes that the newly created Maryland Culture Change Coalition will bring stakeholders together to promote culture change in NFs and to urge the inclusion of culture change measures in the P4P program. Maryland is considering the CMS Artifacts of Change tool (http://www.pioneernetwork.net/Providers/Artifacts/) as a potential part of the measurement system.

Maryland expressed satisfaction with their consensus building process and did not recommend changes to their approach to encouraging stakeholder buy-in. A workgroup was formed, which met for a year or more, with a cross section of NF providers/representatives, plus Voices for Quality Care (an advocacy organization), Office of HealthCare Quality (the survey organization), the HealthCare Commission, (a unique resource in Maryland, described below), budget staff and others. After achieving a working consensus on the standards, the group continued to meet with the contractor as the statistical analysis for scoring was being designed and modeled. A part of this involved numerous presentations to the broader stakeholder group on how the scoring system would work and a great deal of discussion as it was being developed.

The Maryland HealthCare Commission is a merged entity, under the Maryland Department of Health and Mental Hygiene (DHMH) for administrative purposes, but is independent from both DHMH and the Maryland Department of Human Resources. The Commission is appointed by the Governor, and is both a regulatory and an advisory Commission. It formed from the merger of the healthcare planning entity (which for example, issued Certificate of Need for NFs) and another group formed to deal with Maryland's healthcare reform efforts of 20 years ago, and is a real resource in Maryland on health issues, as it is a credible, and longstanding entity in the state.

Minnesota

Minnesota stands out from other states in their approach to LTSS, which is administered by the Minnesota Department of Human Services. Ranked first in the nation by AARP's State Scorecard on Long-Term Services and Supports, its performance outdistanced all other states, with 15 of 25 indicators in the top quartile and 11 among the top five. The AARP Case Study on Minnesota points out several features unique to this state, such as:

- A mature LTSS system with the majority of the spending balanced toward home and community based services (HCBS)
- A statewide managed care system which incentivizes the use of HCBS, and ensures those seeking admission to a nursing home receive an assessment and information about all available options
- Collaboration between state officials and consumers and other stakeholders
- Public disclosure of quality measures through the Nursing Home Report Card and performance-based incentive payment program
- Emphasis on advance planning for the demographic shifts of the aging population, which began as early as 1988
- A "rate equalization" policy (unique in the country) which prevents nursing homes from charging private-pay residents more than Medicaid rates for those sharing a room
- Public policy support, through public education and tax incentives, of long-term care insurance and planning for its residents regarding their long-term care needs
- Widespread and population level provision of extensive information on LTSS to Minnesotans, accomplished through its long-term care consultation service, the Minnesota Help Network, and consistent screening of all older adults enrolled in a managed LTSS plan

There are at least two programs in Minnesota to incentivize improvements to the quality of care in nursing homes. One is directly tied to payment, while the other is indirectly tied. These two approaches were described as related, and they are a part of an overall strategy.

The first step was to establish an overall measurement system and share the results with NFs, so they could benchmark against themselves and each other. With this effort, the state was attempting to instantiate a process improvement culture in care centers, in a positive way.

The first program is the Minnesota Nursing Home Report Card (MNHRC). Participation in this program is mandatory and the program began in 2004 with Governor Pawlenty's announcement of the new initiative. The website for the Report Card was launched in 2006. It provides a searchable database of information on quality measures in every nursing home across the state. Users can choose which measures are of greatest interest and have their results sorted by those domains and geographic location of facility. Or, they can search by location and receive information on quality measures for the facilities in their target location. The information is very current; based on reports from 2012 and (at the time of the interview) as recent as July 8, 2013. Minnesota reports the site boasts fairly robust traffic (about 2500 visits a month) but is aware that much of that traffic may reflect Department staff and provider use.

The measures were designed to minimize additional data collection burdens on providers. All measures are already collected for other purposes, with the exception of the Resident Quality of Life Ratings. These ratings are developed from on-site interviews with residents, which are conducted by a third party contractor (Vital Research in Los Angeles – www.vitalresearch.com). Minnesota's reliance on measures that are currently available also contributes to a very low cost of administration for the program.

Minnesota continued

The quality measures tracked by the MNHRC are as follows:

- Resident Quality of Life Ratings
- Minnesota (Risk-Adjusted MDS) Quality Indicators
- Hours of Direct Care
- Staff Retention
- Temporary Staff Use
- Proportion of Single Rooms
- State Inspection Results

Each nursing home can receive from one to five stars on each measure.

As opportunities arise, the department seeks legislative appropriations for increased rates in NFs. Most recently, the rate increase was 5%, with 3.75% allocated for across the board increases to all facilities and the remaining 1.25% accessible as a quality add-on. Facilities receive the quality add-on when funds are available according to their performance on the MNHRC, based on three of the seven report card measures, Resident Quality of Life Ratings, Minnesota (Risk-Adjusted MDS) Quality Indicators, and State Inspection Results. This increase then becomes an ongoing addition to the facility's base rate.

The second P4P mechanism is the Performance-Based Incentive Payment Program, or PIPP. This initiative launched in 2005. In contrast to the MNHRC, which covers all facilities, participation in PIPP is voluntary and competitive. PIPP is funded by an annual appropriation of the legislature, with approximately $18-20 million in total spending per year. Individual facilities submit a competitive and detailed application for PIPP, in which they must describe the area targeted for improvement. An improvement target is set which the NF is accountable to attain during the funding period. This approach allows even lower performing NFs to benefit from participation, as improvements can be narrowly targeted and still qualify.

Facilities must agree to share their learning and frequently make presentations at state and national workshops and conferences related to their initiative. Facilities may collaborate in their applications, but rate increases are awarded individually. Facilities receive a rate increase of up to five percent for the duration of the project, which can be for one, two, or three years. Through this program, the Department seeks to leverage change with both participating and nonparticipating providers.

The Department described one initiative funded by PIPP, which was a fairly large collaborative of facilities working to reduce falls. The approach included the use of root cause analysis to determine the causes of falls, and the results led to changes in several different areas of NF operations. For example, it was discovered that nursing staff entering rooms at night disrupted sleep – which was not a surprise. This lack of sleep led to residents who were drowsy throughout the day and prone to falling asleep and falling from their chairs. More surprising was the discovery that even entering the resident's room with a flashlight still disturbed sleep – unless the flashlight had a yellow or red light, which did not have the same disruptive effect on the brain or sleep.

Although PIPP allows for narrowly targeted performance improvement targets, the program still poses significant barriers to entry for a number of providers. One fourth of Minnesota's nursing homes have never participated in a PIPP during the eight years of the program. This is due to the fact that the competitive application process requires a great deal of resources for the necessary root cause analysis and study required to accurately identify the area in need of improvement. Accuracy in problem identification and target setting is important; if a facility is awarded a PIPP project and fails to achieve the targeted improvement, it incurs financial penalties.

Minnesota continued

For this reason, the Department is developing a new program that will make it easier for lower performing facilities to qualify for quality incentives. Under this program, which is targeted for launch on October 1, 2015, each NF will elect one area for improvement in one of the Quality of Life domains or Minnesota Quality Indicator measures. The goal will be to increase performance over baseline by one standard deviation from the baseline or to the level of the 25th percentile, whichever is greater. Based on achievement of the targeted improvements, facilities will receive payments commensurate with their progress on the targeted measure.

This new policy highlights a key choice in P4P program design: whether to incentivize NFs with the highest quality performance, sometimes called absolute quality, or whether to target and reward NFs with the greatest improvements in quality (as scored by the program). While compatible, the two approaches do differ, and each offers advantages.

In Minnesota, the Report Card incentivizes high quality performance, and the highest performers are rewarded when quality add-on funding is available. The PIPP incentivizes quality improvement, but the competitive and resource intense nature of the application process may exclude lower performing facilities. The new program is intended to make rewards for improvements in quality more accessible for all facilities.

While the P4P system in Minnesota is well developed for NFs, the state is just beginning its efforts to reward quality in HCBS. A program patterned on the MNHRC and PIPP is under development in collaboration with stakeholders. Last year the department proposed legislation to replicate the MNHRC and PIPP with HCBS.

The Department pointed out several considerations with HCBS which pose challenges to the implementation of quality reporting for these services. First, HCBS encompass both older adults and adults with disabilities, which brings a new set of factors and dynamics to the services and measuring their success. Next, the scale of the effort is multiplied by the number of HCBS providers. In any state, there are typically hundreds of NFs versus thousands of providers of HCBS. And finally, NFs have a long head start on measuring quality due to years of collection of data through the MDS. Clinical indicators are therefore not as readily available for HCBS and do not necessarily encompass indicators related to quality of life that are highly valued. In addition, regulation of HCBS providers in Minnesota is not as process oriented or as timely as it is for NFs. The Department of Human Services is working with the Department of Health as well as with legislated advisory committees and task forces that are assigned the role of assisting the department with improving quality to develop more resources and strategies to address underperforming HCBS providers and to replicate quality measures with appropriate adjustments for HCBS services.

In identifying what is working well, Minnesota described the PIPP and the MNHRC as successful. Also cited was broad collaboration across a diverse array of stakeholders, which allows for the development of functional consensus among those with divergent viewpoints, who are united in their commitment to improve quality. Minnesota pointed out that in these forums, it is important to identify both areas of agreement and disagreement – and to allow for discussion of both. Minnesota believes quality is a topic that has brought people together in their state. These informants stressed that supporting improvements in quality is an ongoing and continuous process of negotiations, that there are always differing opinions about new money and new measures, and that the program requires constant attention to continue to move forward.

There was considerable initial resistance to the notion of the state measuring and publicizing quality in nursing facilities. Some NF providers resisted what was seen as state intervention, believing instead that consumers should consult the provider directly if there were questions or concerns about quality. At one

Minnesota continued

point, consumer advocates formed a coalition with labor in order to advocate for increased funding to go directly to improve staffing in facilities. However, through a collaborative and inclusive process that encompassed academia, providers, advocates, and others, a great deal of progress has been made. There has been such a dramatic shift in this perspective that some providers now express surprise when hearing what the initial resistance was like. This shift may be due to the role that the Department defined for itself as a support and a resource for NFs as they sought to improve quality. Though at first it was difficult to establish a level of trust and confidence, the state targeted its interaction with NFs in a way that communicated the message "identify how you want to improve – and we will help you do that."

Key lessons learned in Minnesota include the importance of having a good work plan, being inclusive, and allowing enough time for the process to develop. One informant observed that "It's hard to rush this stuff. You have to put it out there and give people time to react and work through it. It's hard to bring everybody along." It is necessary to involve experts, consultants, and stakeholders, and to take time for everyone to define together essential program elements, such as how quality will be measured and how adjustments will be made for different levels of care and risk. While Minnesota believes it is possible to launch a program in less than the six or seven years it took for them to develop their first report card, it also cautions against unrealistic expectations that can lead to rushing the process.

On the other hand, Minnesota also pointed out that after discussion and planning, it is also important to act: "At a certain point in time you have to do it. Realize the world doesn't end. The Report Card did not put anyone out of business. But it did foster healthy competition and accountability, as Boards of Directors and County Commissioners wanted to know why their facility's scoring wasn't as high as others."

One final challenge Minnesota highlighted is the challenge of marketing the MNHRC and its website to potential users. While a general marketing approach would require considerable resources and may yield limited results (since the general public is not interested in nursing home quality), a targeted approach could put the information in the hands of consumers when it is most needed: at the time of making decisions about care for a loved one.

Ohio

The roots of Ohio's P4P program trace to the passage of the 2006-07 budget by the Ohio General Assembly, which provided for Ohio's initial transition to price-based reimbursement and included provisions for a P4P program. The transition to price-based reimbursement was not without controversy.

Ohio's early P4P efforts were loosely based on Iowa's program, which focused more on efficiency and fiscal indicators than on measures of quality of care provision, though some staff indices were included, such as retention and turnover. However, Ohio was not entirely satisfied with that incentive system, and in addition was observing wide price variations among facilities, even within a geographic peer group. Ohio therefore was interested in addressing both the variation in rates and incentives for quality. The Ohio Medicaid program has strong leverage to influence both quality and price due to the fact that Medicaid comprises 65-70% of the nursing home market, with 925 of 960 total nursing homes in the state participating in the Medicaid program.

In 2011, a new gubernatorial administration took office with what was described as a "real vision" for reviewing what the state was paying for LTSS and ensuring consumers were getting value for those expenditures, along with access to quality LTSS across the continuum. The state also wanted to impact the manner in which care was provided and shift from primarily financially based performance incentives to a more resident-centered quality of care approach. The Governor's Office issued guiding principles for the development of the new P4P system.

The P4P program is called the Ohio Long Term Care Quality Initiative. Along with the Governor's guidelines, Ohio incorporates and presents its quality improvement initiatives based on Everett Rogers' Diffusion of Innovations, the seminal book on how and why new information is spread through cultures. Assistance for understanding and implementing each measure is broken down into Rogers' five attributes of innovation:

- **Relative Advantage** - The degree to which an innovation is perceived as better than the idea or practice it supersedes.
- **Simplicity** - The degree to which an innovation is perceived as simple to understand, apply, and use.
- **Compatibility** - The degree to which an innovation is perceived as being consistent with the existing values, experiences, beliefs, needs, and practices of potential adopters.
- **Trialability** - The degree to which an innovation can undergo a trial and be tested on a small scale.

Ohio continued

- **Observability** - The degree to which the use of an innovation and the results and impacts it produces are apparent and/or visible to those who should consider it. (http://aging.ohio.gov/ltcquality)

Ohio's quality framework tracks quality with 20 measures across 5 domains, as follows:

Performance

- Satisfaction Survey Overall Scores
- Participation in the Advancing Excellence in America's Nursing Homes campaign
- Resident Review Compliance
- Standard and Complaint Survey Performance

Choice

- Choice in Dining
- Choice in Bathing
- Choice in Rising and Retiring
- Advance Care Planning

Clinical

- Pain
- Pressure Ulcers
- Restraints
- Urinary Tract Infections
- Hospital Admission Tracking
- Immunizations

Environment

- Private Rooms
- Eliminate Overhead Paging

Staffing Measures

- Consistent Assignment
- Staff Retention
- Staff Turnover
- Aide Participation in Care Conferences

NFs must score a total of five points (including one for a clinical measure) to receive the maximum quality add-on payment of $16.44 (for fiscal year 2014). The percentage of the overall payment that this represents is estimated at 7-10%. If the amount allocated for quality incentive payments is not fully expended due to fewer facilities qualifying for the full amount, the remainder is distributed among facilities scoring more than five points.

The measures selected were focused on those the NF industry could support. Relatively achievable benchmarks were set using the Quality Measures (QMs). Benchmarks were gauged to be attainable by about half of NFs. Measures included indicators scored by attestation – such as having a written policy in place. Data had to be already available (MDS data, certification, and survey data) or easily collected. After the first set of indicators was implemented, the stakeholder group was reconvened to review the results. The current statute is the second iteration of measures. Some measures became more rigorous with tighter reporting or measurement requirements, some were transitioned to licensure standards, some were new, and some had benchmarks adjusted. Ohio credits this iterative, ongoing, participatory, rolling process of reviewing and refining benchmarks with producing buy-in among providers.

Ohio funded its program by repurposing its franchise permit fee – the rate component was eliminated, and funds were added to the existing resources for quality. The incentive payment then went from $3 to $16 per day. The increase is not an automatic add-on, but instead is attached to quality points – which was a very controversial proposal. Ohio reported that P4P funding was much more easily accepted when it represented new funding, as opposed to repurposed funding.

Regarding results, Ohio observes that pricing is much more homogenous now, with less variation and the biggest payer (Medicaid) driving the cost. Due to the iterative nature of the measures in any given year (the goal is to keep the number of measures at 20, but those may vary in substance and in measurement from two-year cycle to cycle), it is difficult to track changes in how NFs are scoring.

Stakeholder Input

Introduction

In order to provide opportunities for input regarding the QuILTSS initiative, TennCare and Lipscomb University jointly hosted, and Lipscomb University facilitated, various stakeholder processes. Self-report data was gathered from consumers and providers via an online survey and a series of statewide QuILTSS Community Forums. The goal was to identify which indicators are most important to the various constituencies in long term services and supports (LTSS), with particular emphasis on the perspective of care recipients. Additionally, discussions with providers and provider organizations were held to elicit input on topics ranging from quality indicators to implementation and funding.

Community Forums

Eighteen Community Forums were held across Tennessee during the time period of October 24, 2013 through November 4, 2013. Two sessions were held in each of the nine districts of the Area Agencies on Aging (AAAD). A geographical representation of the AAADs is available at the following link: www.tn.gov/comaging/localarea.html. In each location, one session was held for consumers, family members, and other stakeholders representing consumer interests (e.g., advocates, Long Term Care (LTC) Ombudsmen, etc.), and one for providers – both nursing facility (NF) and home and community based services (HCBS) – in each region. Consumers

were encouraged to attend the consumer group sessions (Consumer Forums), and providers were directed to attend the provider sessions (Provider Forums).

Press releases were sent twice to 298 media outlets encompassing the nine regions: once to announce the forums and provide information about their purpose; and again closer to the date of each local forum to further encourage participation. In addition to these press releases, the AAADs distributed letters and flyers promoting the forums to constituents, with a special focus on engaging consumer attendance. TennCare sent invitations directly to NF providers. In addition, TennCare enlisted MCOs in disseminating the provider invitation to all contracted NF and HCBS providers. All provider invitations included a copy of the consumer invitation and a request that providers distribute to persons served by their agency. MCOs were also asked to assist (e.g., through Care Coordination contacts, etc.) in disseminating the invitation to members. The invitations were sent to all members of the TennCare LTSS Stakeholder group (including representatives from AARP and the disability advocacy community, as well as provider associations for NF and HCBS providers), with request to disseminate to their membership and other interested community members. The invitations were also sent to members and staff of the Tennessee Commission on Aging and Disability as well as all paid and volunteer LTC Ombudsmen and volunteer monitors, and members of the State's Advancing Excellence Coalition. Finally, TennCare developed and distributed to members of the Tennessee General Assembly a letter describing the QuILTTS initiative and inviting their participation. The availability of the online survey was highlighted in the press releases and invitations.[1]

The three Managed Care Organizations (MCOs) contracted with TennCare sponsored and had staff present at all eighteen sessions. Input was also gathered separately from this group. 290 consumers (including family members and other stakeholders representing consumer interests) and 831 provider representatives attended the forums statewide (388 NF providers and 443 HCBS providers), along with 82 MCO staff, for a total of 1,203 participants. It is worthwhile to note that most of the consumers who attended the forums were not NF residents, but rather recipients of HCBS.

Consumer Forums and Provider Forums began with a twenty-minute PowerPoint presentation describing the purpose and vision behind the QuILTSS initiative[2] This presentation allowed attendees to better understand the context of the concepts to be discussed later in the forum, providing a starting point in their thinking. At the conclusion of the presentation, participants moved to discussion circles, described below.

Discussion Circles

A discussion circle methodology was used to generate a menu of priority recommendations from Consumer Forum and Provider Forum participants. The composition of these circles was structured to create conversations between participants with similar roles and responsibilities. A forced randomization was used to minimize the likelihood that those who work together or were acquainted were in the same group.

The discussion circles contained 8-14 participants. Each team had a flip chart pad and about two hundred index cards. The large group facilitator instructed each group to identify

[1].Copies of the invitations and online survey are available in the Appendix Section.

[2]Copies of the Community Forum and Provider Forum presentations are available in the Appendix Section.

the person whose birthdate was closest to the date of the community forum as the scribe for the group. Consumer Forums were conducted with a slightly different process from the Provider Forums. Each process is described below.

Consumer Forums

In round one of the discussion group, the large group facilitator instructed the small groups to reflect on the presentation just heard, and asked each attendee to write down the five most important clinical indicators of quality, one idea on each of five index cards. Then in round-robin fashion, each participant's ideas were listed on the flip chart pad one idea per round and numbered by the scribe. After recording each participant's ideas, the scribe collected the cards. Next, the large group facilitator instructed each group to list the non-clinical indicators of quality, using the same five ideas per person process. Participants' ideas were then transcribed to the flip chart.

In round two, each participant was given six new notecards and asked to review the total list of clinical and non-clinical quality indicators. The facilitator then instructed participants to identify their top three quality indicators from the list of clinical indicators, and their top three from the list of non-clinical indicators. Participants were then instructed to rank their top three choices in the clinical category as follows: the card with the most important indicator was marked with a "three", the least important was designated with a "one", and the remaining choice was indicated as a "two." This process was repeated to rank the non-clinical indicators.

The scribe then recorded each participant's scores for the corresponding items on the flip chart, and the points for each indicator were totaled. To complete the process, each group reported out the top three clinical and top three non-clinical indicators among their members to all the Forum participants. The facilitator noted common themes from the groups along with highlighting differences found among responses in Forums from other parts of the state. This immediate feedback to the participants provided context for their responses relative to their counterparts in other parts of the state, and framed individual concerns within a wider perspective.

Provider Forums

During registration, providers were asked to select a group they represented: NF or HCBS (non-medical direct care providers, home health agencies, social service agencies, etc.), or MCO. Using the same forced randomization process described in the Consumer Forums, participants were assigned to a discussion group within those three categories.

Provider Forums also began with a PowerPoint presentation, which was similar in theme and content to the presentation from the Consumer Forums, but included additional slides with detailed information pertinent to service providers. Provider participants were asked to join their discussion circles following the presentation. Provider discussion circles were conducted using the same process for obtaining input as described in the consumer discussion circles above. In addition, providers were asked to list out barriers to implementation of pay-for-performance as the last segment of their session.[3]

[3] Please see the Appendix Section for a summary of the input provided in this segment of the Provider Forums.

After each forum, all the flip charts were collected, identified by date, type of forum (consumer or provider) and subgroup (NF, HCBS, MCO) for data collection purposes. All of the response data was then transcribed, and together with data from the online survey, became the basis of the data analysis, described below.

Online Survey

An online survey was developed in order to provide a means for input for those who could not attend the Community Forums. The survey was composed of nearly 60 topics related to a potential measurement and payment system for quality that respondents were asked to rate from *Not Important* to *Extremely Important* on a 4-point Likert scale, along with providing basic demographic information about their relationship to LTSS (categories such as consumer, family member, provider) and if a provider, whether their work was related to NF care or HCBS. Through AARP of Tennessee, volunteers were made available to assist consumers who were unable to access or complete the survey via the internet. Lipscomb's School of TransformAging provided a toll-free number for survey participants to call if they wished to take the survey by telephone. The survey was open and continuously accessible via Survey Monkey from October 9, 2013 through November 8, 2013.

Key Informant Interviews

At the conclusion of each forum, participants were encouraged to contact the facilitator with any additional questions, thoughts, or concerns, and were given contact information for that purpose. Several representatives from organizations in attendance requested follow up meetings, including the Tennessee Health Care Association, LeadingAge Tennessee, and National Healthcare Corporation. The first two entities are the trade associations in Tennessee that represent most of the nursing and assisted living facilities.

In addition, a meeting was held with Golden Living, a participant in Medicare Pay for Performance, to gain their insights and recommendations. Input and recommendations on quality in HCBS were also obtained from the Tennessee Association for Home Care.[4]

These meetings revealed the following provider perspectives on QuILTSS:

- Stakeholder input about QuILTSS is needed from development until implementation and beyond;
- Coordination among the MCOs, the Bureau of TennCare, and state survey and licensing agencies as QuILTSS is implemented is essential;
- Interest and support exists for exploring additional funding mechanisms, including alternative revenue sources, such as an increased bed tax rate with new funds earmarked for quality improvement;
- Developing a quality "dashboard" may have potential;
- The Bureau of TennCare's support for both improvement in underperforming agencies and recognition of high performing providers is important;
- A straightforward and non-burdensome measurement system is key; and
- Financial support for culture change is needed.

[4] Materials from collateral interviews and from the Tennessee Association for Home Care are included in the Appendix Section.
[5] The full report of the data analysis is included in the Appendix Section.

Data Analysis[5] of Stakeholder Input from Forums and Surveys

The community forums yielded data from 290 consumers (including family members and other stakeholders representing consumer interests), who provided a total of 463 responses; 388 NF providers and 443 HCBS providers, who contributed 1,155 provider responses; and 82 staff from MCOs, who added 137 idea responses indicating potential indicators[6] of quality in LTSS and how important participants rated each of the 52 indicators. Combining these, a total of 1,755 idea responses from 1,203 respondents were collected at the forums and subsequently analyzed. Responses at the forums were captured as described in the Stakeholder Input section, under the broad topics of Clinical indicators and Non-clinical indicators. After the data were tabulated, responses receiving votes were further sorted into seven overarching categories, six of which were comprised of indicators, as reflected in Table 1 below.

TABLE 1

Categories and Indicators of Quality from Community Forums

Building/Grounds (BG) ◆ Clean ◆ Safe ◆ Home ◆ Privacy ◆ Affordable ◆ Finance	**Clinical (C)** ◆ Medicines ◆ Falls ◆ Wound/sore ◆ Emergency room (utilization) ◆ Infection ◆ Transition ◆ Improve outcomes ◆ Antipsychotic medication (use) ◆ Pain ◆ Restraint	**Health/Wellness (HW)** ◆ Needed care ◆ Nutrition ◆ Preventative ◆ Chronic ◆ Active ◆ Mental health ◆ Activities of Daily Living ◆ Weight
Meaningful Day (MD) ◆ Life ◆ Transportation ◆ Activities ◆ Religious (access to) ◆ Social Independence	**Person-Centered Care (PCC)** ◆ Choice ◆ Hygiene ◆ Individual ◆ Communication ◆ Consumer satisfaction ◆ Family	**Workforce (W)** ◆ Dignity/caring ◆ Trained ◆ Consistent/stable ◆ Employee retention/ satisfaction ◆ Reliable ◆ Coordination ◆ Responsive ◆ Compatibility ◆ Flexibility ◆ Ethical/professional ◆ Abuse ◆ Supervision
Discharge to Home (No indicators)		

[6] It is helpful to provide some further distinction between "indicators" and "measures" of quality as used in this section. Quality "measures," especially as used by the Centers for Medicare and Medicaid, refer to rates or scores on specified events or processes linked to quality outcomes (such as pressure ulcers or immunizations). Quality "indicators," on the other hand, is a term that is often used somewhat more broadly to cover various ways of identifying and tracking conditions or practices related to quality. While there clearly is overlap between the terms, participants in Community Forums were asked to identify and rank potential indicators of quality, and survey participants were similarly asked to rank among identified indicators, which were used with only broad definitions in the forums and the online survey. These responses form the basis for the data analysis, and hence will be referred to as "indicators."

In addition, 91 respondents to the online survey provided additional data in the form of responses to a list of questions covering nearly 60 topics which were rated using a 4-point Likert scale according to the relative importance of potential indicators related to quality of care. These respondents consisted of consumers (59), providers (30) and MCO staff (2).

A statistician, Jenny Mason, M.Ed., of Lipscomb University, was retained to evaluate and analyze the data collected from participants in the Community Forums and the online survey. Ms. Mason did not attend the Community Forums nor did she participate in the development of the survey. Her role was to objectively analyze responses from stakeholders gathered through these processes for trends, commonalities, and differences using accepted statistical methods.

Data were analyzed in several different ways. Community Forum and online survey data were analyzed individually and collectively. Data were first screened and not found to require cleaning. Distributions were found to be acceptable for analysis. Data were tested for level of differences between respondents and responses and across different categories of care, focusing on which respondents are most likely to agree on measures and which categories are viewed as interconnected. Statistical analysis revealed that the responses of consumers and advocates in the online survey were so similar that they were better understood as a single group of responders. In addition, consumers and advocates were grouped together in the Community Forums; therefore they are treated as a single group in the tables presented below.

This section summarizes the combined data analysis. Once data from the forums and online survey were pooled into a single data set, analyses were computed to determine the overall level of differences between respondents and categories of responding. Specific analyses included comparisons of consumers to providers and MCO staff, and whether those providers worked in a NF or HCBS, clinical versus non-clinical response topics, and categorical differences. Finally, all six categories were ranked by these comparisons based on their specific topics to display levels of interest for respondents and further delineated by whether they were clinical or non-clinical.

For consumers, it was found that the largest difference in response was between the categories of Building & Grounds versus Clinical, while the smallest difference in response was between the categories of Person-Centered Care and Workforce. NF providers differed the most on categories of Building & Grounds versus Meaningful Day and least between the categories of Person-Centered Care and Workforce. HCBS providers differed most on categories of Meaningful Day and Building & Grounds, and differed least on categories of Health & Wellness versus Person-Centered Care.

When separating the pooled data based on whether a respondent was a consumer (including consumer advocates), a provider or an MCO staff, some overarching topics of quality care were found to be more important than others. The overall highest ranked topics for consumers were having a Well-trained Workforce and higher Quantities of Workforce. The lowest ranked topic for quality care according to consumers were Meaningful Day's topic of Social and Clinical's topic of Making a Transition. MCO staff gave the highest rankings for Flexibility and Quantity in the Workforce, and gave the lowest scores to Training within the Workforce category and Safety in Building & Grounds.

Providers were further subdivided based on their self-reported place of work: NF or HCBS. NF providers indicated that Dignity/Caring in the Workforce and Choices in Person-Centered Care were most important, while ranking lowest topics Compatibility in Workforce and Flexibility in Person-Centered Care. HCBS providers ranked Dignity/Caring in Workforce and Well-trained in Workforce most important, while Supervision in Workforce and Needed Care in Building & Grounds were ranked lowest.

The following tables reflect the percentage of highest-scoring responses from pooled data (the combined responses from community forums and the online survey) from consumers (Table 2), NF providers (Table 3) and HCBS providers (Table 4).

TABLE 2

Highest Ranked Response Topics in Pooled Consumer Data

	RANKING			
CATEGORY	1	2	3	4
BG	Clean (44%)	Safe (25%)	Home (16%)	Privacy (15%
C	Medicine (57%)	Wounds/Sores (28%)	Infection (8%)	ADL (4%)
HW	Nutrition (20%)	Hygiene (18%)	Falls (14%)	Prevent (11%)
MD	Life (46%)	Activities (26%)	Religious (14%)	Social (14%)
PCC	Choice (44%)	Needed Care (25%)	Individual (11%)	Communication (7%)
W	Dignity/Caring (24%)	Trained (18%)	Quantity (13%)	Consistent/Stable (12%)

Note: Category listing are BG=Building & Grounds, C=Clinical, HW=Health & Wellness, MD=Meaningful Day, PCC=Person-Centered Care, W=Workforce.

TABLE 3

Highest Ranked Response Topics in Pooled NF Provider Data

	RANKING			
CATEGORY	1	2	3	4
BG	Home (34%)	Clean (26%)	Safe (20%)	Privacy (7%)
C	Pain (26%)	Wounds/Sores (23%)	Infection (17%)	Medication (17%)
HW	Falls (31%)	Nutrition (23%)	Weight (15%)	ER (11%)
MD	Activities (69%)	Religious (11%)	Social (10%)	Life (10%)
PCC	Choice (33%)	Individual (17%)	Satisfaction (14%)	Needed Care (9%)
W	Dignity/Caring (39%)	Trained (18%)	Quantity (17%)	Responsive (9%)

Note: Category listing are BG=Building & Grounds, C=Clinical, HW=Health & Wellness, MD=Meaningful Day, PCC=Person-Centered Care, W=Workforce. ER = Emergency Room.

TABLE 4

Highest Ranked Response Topics in Pooled HCBS Provider Data

	RANKING			
CATEGORY	1	2	3	4
BG	Home (38%)	Safe (27%)	Privacy (14%)	Clean (11%)
C	Medicine (42%)	Wounds/Sores (16%)	Infection (13%)	Pain (11%)
HW	Nutrition (19%)	Falls (18%)	ER (17%)	Transportation (9%)
MD	Activities (56%)	Life (26%)	Social (18%)	
PCC	Choice (28%)	Satisfaction (15%)	Needed Care (14%)	Individual (13%)
W	Dignity/Caring (24%)	Trained (20%)	Consistent/Stable (19%)	Coordination (8%)

Note: Category listing are BG=Building & Grounds, C=Clinical, HW=Health & Wellness, MD=Meaningful Day, PCC=Person-Centered Care, W=Workforce. Meaningful Day only received scores for three topics.

Summary and Conclusions

A broad cross-section of stakeholder input was gathered for this technical assistance project. Input was gathered face -to- face in QuILTSS Community Forums held throughout the state in both urban and rural areas, as well as through online surveys and informant interviews. Extensive efforts were made to widely promote the availability of the forums and survey for providing input. All of those responding to the invitations to attend a Community Forum were afforded the opportunity to attend and participate. This section summarizes and compares top choices in recommendations for possible quality indicators among the three primary stakeholder groups: consumers, NF providers, and HCBS providers.

Participants were asked to rank topics in order of importance based on clinical and non-clinical categories. Thus, further analysis was conducted along these distinctions. There were too few MCO responders when taken collectively to constitute sufficient statistical power to delineate them as an individual group. MCO staff responses were therefore removed from this particular data analysis process. Clinical and non-clinical topic rankings are discussed here as separated by consumers, NF providers, and HCBS providers.

Under clinical topics, consumers ranked Medicine and Nutrition as highest, under the categories of Clinical and Health & Wellness, respectively. NF providers scored Nutrition and Pain (in the category of Clinical) as most important, while HCBS providers ranked Medicine (in the Clinical category) and Nutrition in Health and Wellness first and second. In the non-clinical topic areas, consumers raked Dignity/Caring in the category Workforce and Choice under Person-Centered Care highest in importance. NF and HCBS providers agreed on Dignity/Caring as their highest scoring topic, but NF providers ranked Choice under Person-Centered care second, while HCBS providers chose Training under Workforce for their second spot.

The next two tables present the highest ranked responses for each of the three stakeholder groups for clinical measures (Table 5) and non-clinical measures (Table 6).

TABLE 5

Respondent Rankings on Clinical Topics with Accompanying Category Listings

RANKING	CONSUMER	NF PROVIDER	HCBS PROVIDER
1	Medicine (C)	Nutrition (HW)	Medicine (C)
2	Nutrition (HW)	Pain (C)	Nutrition (HW)
3	Hygiene (HW)	Falls (HW)	Falls (HW)
4	Falls (HW)	Wounds/Sores (C)	ER (HW)

Note. Category listings are C=Clinical, HW=Health & Wellness.

TABLE 6

Respondent Rankings on Non-Clinical Topics with Accompanying Category Listings

RANKING	CONSUMER	NF PROVIDER	HCBS PROVIDER
1	Dignity/Caring (W)	Dignity/Caring (W)	Dignity/Caring (W)
2	Choice (PCC)	Choice (PCC)	Trained (W)
3	Trained (W)	Home (BG)	Consistent/Stable (W)
4	Quantity (W)	Activities (MD)	Choice (PCC)

Note. Category listings are BG=Building & Grounds, MD=Meaningful Day, PCC=Person-Centered Care, W=Workforce.

Overall results for the data analysis determined that statistically significant differences in responses occurred between consumers, providers, and staff from MCOs. The results show little agreement in the response choices and preferences about potential indicators of quality of care in Tennessee's Medicaid program among these stakeholders. However, similar responding was found between consumers and advocates, making them better understood as a single group of responders in this analysis. It was found in the pooled data that consumers believe having a more well-trained workforce to be most important in care, while providers felt making sure the workforce demonstrates dignity and caring to consumers, while providing choices to consumers in person-centered care was most important.

Thus, the commonalities are in the persons who care for those in TennCare's services. Again, there are significant differences, making these findings both statistically and clinically meaningful, which means that consumer, provider, and MCO responses should be taken into account separately. Categorical rankings were also provided for different service settings as it is believed that different settings have different needs in quality of care. Providers working in NFs had similar responses to overall provider data, ranking Dignity/Caring and Consumer Choices at the top, while providers working in HCBS agreed on Dignity/Caring, but also ranked Training in the Workforce as high. To respondents in the forums and online survey, it seems that those serving the consumers have the greatest impact on quality of care.

Process Recommendations

Based on the literature review, stakeholder input, and lessons learned from interviews with other states with Pay for Performance programs, the following recommendations have been developed for the process to be used for the planning and implementation of QuILTSS:

The state should continue to establish and clearly articulate the vision for QuILTSS, its aim, purpose and scope, and definition of success.

A clear vision for QuILTSS will provide consumers, providers and the public with a set of expectations for the quality of LTSS in Tennessee, as well as define appropriate roles and responsibilities among LTSS partners and stakeholders.

Engage a diverse and inclusive array of stakeholders and experts in the development of the implementation plan.

This best practice, which was used successfully by TennCare in developing its approach to managed care in LTSS (MLTSS), was emphasized virtually universally among the states interviewed. The large attendance, particularly by providers, at the eighteen community forums is evidence of a high degree of interest in QuILTSS and in providing input to its development. Analysis of stakeholder input reveals differing perspectives on quality measures and the relative importance of various quality domains. This poses a potentially important barrier, one that can be effectively addressed through an ongoing collaborative process for input.

In collaboration with stakeholders, develop guiding principles for the selection and implementation of quality measures.

In situations where perspectives differ, it is often more effective to first identify overarching values that enjoy broad support among diverse constituencies at the beginning of the process. For example, according to the stakeholder analysis, there is widespread recognition of the importance of measuring and improving quality. This understanding could form the basis for a guiding principle. The recommended ongoing dialogue with stakeholders provides a forum for the identification, review, and vetting of values and priorities, which over time has the potential for increased levels of clarity and shared understanding among the various constituencies.

Emphasize simplicity in the program design.

A relatively simple and straightforward quality framework has several advantages. It is easier and less expensive to administer both for the state and for providers. This feature is important for gaining provider acceptance as well as conserving state resources. A leaner framework is more easily understood by consumers and the general public, which is key to its eventual usefulness as a decision-making tool for patients and families. As the program is implemented and tracked for unintended results, fewer variables also mean greater likelihood of success in pinpointing cause. Measures should be objective, reliable, valid, and whenever possible, derived from existing and auditable data.

Consider a provider-driven component for inclusion in the program.

This recommendation is supported both by the literature review and best practices from several states. Examples include (but are certainly not limited to) the PEAK program in Kansas, in which nursing homes choose their level of participation (including whether they may be eligible for quality payments) and how to pursue person-centered care, and the Performance-Based Incentive Payment Program (PIPP) in Minnesota. PIPP is voluntary and competitive (although other components of Minnesota's quality program and associated payments are applicable across all facilities). Facilities select a targeted area for improvement, complete an application process and must agree to share their learning. Change efforts that are identified by the provider are more likely to gain acceptance and endure than those that are driven by penalties or prescribed interventions.

Consider the use of composite measure scoring.

Composite measures combine scores across various quality domains, and reduce the risk of penalizing providers whose overall performance is strong. Composite scoring is also simpler to calculate and report.

Utilize rewards and quality capacity-building to promote change.

The program should reward high performing service providers, while providing assistance and incentives for improved quality in both high performers and underperformers. Examples of such assistance could include offering training materials and programs that build an organization's capacity to deliver quality care, similar to efforts in Kansas and Minnesota. Utilizing a capacity-building approach is both more likely to produce higher levels of improved quality of care and foster broad-based support for the initiative.

Include measures of both absolute quality performance and quality improvement in the quality framework.

These two axes of quality measurement – absolute performance and improvement – are both necessary for the advancement of quality of care to consumers. Factoring incentives for both types of performance provides a more comprehensive framework and concurrently recognizes and rewards high performers while still supporting much-needed improvements in lower performers.

Implement QuILTSS in stages, with separate timetables for NF and HCBS implementation, as follows *(note: stages may overlap and may be implemented concurrently):*

i) Dialogue, education, and increasing shared understanding
ii) Development of measurement system
iii) Collection of baseline data, and impact analysis of proposed measures based on baseline data
iv) Benchmark setting/tracking without impact on payment
v) Full implementation of P4P
vi) Monitor for unintended results and adjust as needed
vii) Ongoing review and refinement of measures

A phased approach for QuILTSS allows for opportunities for dialogue with stakeholders as each phase is implemented. Although forecasting the timeframes for each phase is beyond the scope of these recommendations, different timelines can be expected between NF and HCBS implementation.

If possible, identify new revenue source(s) to contribute to the new payment system.

The need for LTSS is increasing at a time when resources are tightening both at the state and Federal levels. Budget neutrality is nearly a given for new initiatives in this environment. There is significant industry concern about changes to base payments, and funding issues have posed challenges in other states. While quality should be an expectation of all LTSS, Tennessee should be deliberate in its choice of funding model.

Recommendations Regarding Quality Domains

Quality domains relate to the various aspects of service delivery which impact how care is delivered and the outcomes that result. Accordingly, quality domains will likely vary somewhat between nursing facilities (NFs) and home and community based services (HCBS).

Likewise, the availability of existing data sources differs across service settings. NFs have long collected data for the Minimum Data Set (MDS), while certified Home Health Agencies use the Outcome and Assessment Information Set (OASIS) tool to report outcomes for individuals receiving home health services. However, quality measures for persons receiving other types of HCBS similar to those provided under CHOICES, when they exist, have little standardization. Furthermore, measures that span the NF and HCBS settings are lacking, making comparisons difficult.

It is recommended that QuILTSS include the following domains in its measurement system.

Non-clinical Domains

Quality of Life: These measures concern how meaning and purpose in living is supported in LTSS, regardless of setting, condition, or functional needs. Measures may include assessments of how the NF and HCBS provider actively assist residents/clients in living in meaningful ways by offering personalized activities and supports designed to specifically respond to individual preferences. Examples of these activities can include access to the outdoors and gardening, religious services of the resident/client's choosing, employment and volunteer opportunities, and music, art, and pet therapy. In NFs, performance scores might reflect how the facility fosters a resident's purposefulness and the development of a sense of community by supporting meaningful social interactions amongst residents and staff, and how the NF continues to support residents' engagement with family and friends outside the facility.

Culture Change: Primarily focused on NFs, these measures reflect how LTSS employ a person-centered culture, which allows residents/clients to choose how they wish to receive their care, in contrast with the traditional and inflexible "institutional" approach. This is clearly centered on choice – choice in bathing, sleep patterns, roommates, food, etc. Culture change also includes increased communication with residents and their families when creating individualized care plans and actively involving family in the lives of consumers. The goal is to treat each resident with respect and as an individual, and allow for as much independence as is safely possible.

Satisfaction (resident/family/employee): As states move beyond the MDS as a primary source of quality data, satisfaction among residents/clients and their families are often among the non-clinical measures chosen. Employee satisfaction is thought to be related to both turnover and quality of care. Important considerations with satisfaction measures are administration, cognitive functioning of consumers, and response rates. Another strategy involves assuring that families and consumers are able to give honest feedback on the performance of caregiving employees without fear of retribution.

Staffing/Staff Competency (training, turnover, consistent assignment, amount of nursing/CNA/PSSA staff hours per day): Workforce issues are a reality in nursing home and HCBS care, however, quality care depends upon staff who demonstrate a commitment to maintaining the dignity of the individuals receiving services and ensure that services are free of abuse and neglect. Care should be coordinated to avoid both duplication of services and service delivery failures (when staff fails to show for a shift). Families and consumers prefer the opportunity to choose their caregiver for compatibility purposes and then desire consistent and stable assignment of workers. Staff must know patients' rights and ensure those are not violated. Sufficient staff is essential to ensure quality of care. Training is key to staff performance, and recordkeeping should allow consumers to compare the quality and quantity of caregiver training. Further, individualized training on the needs and preferences of consumers is important.

Quality Systems

QuILTSS offers an opportunity to incentivize robust internal quality assurance and improvement in NFs and HCBS. Recognition and reward could be given for voluntary participation in national quality improvement campaigns, demonstrated improvement in targeted areas, achievement of accreditation (particularly where that accreditation standard requires the use of data and quality systems to evaluate performance and proactively prevent undesirable outcomes), and the inclusion of provider-driven, data based improvement initiatives similar to those in other states, discussed elsewhere in this report.

Survey Results

While some states directly reward performance on NF survey results (both complaint and standard), others use survey results as an eligibility threshold, so that facilities with serious deficiencies are precluded from quality payments or incentives. However, at least one state still computes quality scores for those facilities for informational and improvement purposes. HCBS licensure requirements are largely focused on documentation, and monitoring is less frequent and structured; these requirements should be reviewed to ensure there is appropriate regulatory oversight while also exploring alternative quality monitoring and improvement approaches. The potential for undetected and unreported abuse and neglect are heightened in the home setting, where the consumer is frequently more isolated, and measures should be implemented to provide increased safeguards.

Clinical Domains

Clinical Indicators and Outcomes – Clinical indicators have traditionally been recognized as objective data for evaluating outcomes. In addition, these measures can be drawn from a longstanding practice of data collection. For NFs, the Minimum Data Set (MDS) has been collected since 1996, and providers are accustomed to this reporting. Home health providers participate in OASIS; however, this does not capture data related to most of the TennCare members receiving HCBS under CHOICES. Initially, it is likely that HCBS providers will be more challenged by clinical indicators, while NFs will find measures related to Culture Change and Quality of Life more difficult to incorporate. Examples of clinical indicators used in other states include, but are not limited to incidence of: pressure ulcers, urinary tract infections, falls, pain, restraints, use of antipsychotic medication, immunizations, and hospitalizations.

References

AARP, (2009). *Quality of care and litigation in tennessee nursing homes*. Retrieved from The Lewin Group website: http://assets.aarp.org/www.aarp.org_/cs/misc/qualitynursinghomereporttn2009.pdf. ("Quality of care," 2009)

Arling, G., Cooke, V., Lewis, T., Perkins, A., Grabowski, D., & Abrahamson, K. (2013). Minnesota's provider-initiated approach yields care quality gains at participating nursing homes. *Health Affairs*, *32*(9), 1631-1638. doi: 10.1377/hlthaff.2013.0294. (Arling et al., 2013)

Arling, G., Job, C., & Cooke, V. (2009). Medicaid nursing home pay for performance: Where do we stand?. *The Gerontologist*, *49*(5), 587-595. doi:10.1093/geront/gnp044. (Arling, Job & Cooke, 2009)

Baier, R., Butterfield, K., Harris, Y., & Gravenstein, S. (2008). Aiming for star performance: The relationship between setting targets and improved nursing home quality of care. *Journal of the American Medical Directors Association*, *9*(8), 594-598. doi: 10.1016/j.jamda.2008.06.008. (Baier, Butterfield, Harris & Gravenstein, 2008)

Briesacher, B., Field, T., Baril, J., & Gurwitz, J. (2009). Pay-for-performance in nursing homes. *Health Care Financing Review*, *30*(3), 1-13. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2758526/pdf/nihms132435.pdf. (Briesacher, Field, Baril & Gurwitz, 2009)

Castle, N., & Ferguson, J. (2010). What is nursing home quality and how is it measured?. *The Gerontologist*, *50*(4), 426-442. doi: 10.1093/geront/gnq052. (Castle & Ferguson, 2010)

Cohen, M., Miller, J., & Shi, X. The SCAN Foundation, (2013). *Satisfaction with long-term services and supports across the continuum of care*. Retrieved from LifePlans website: http://www.thescanfoundation.org/sites/thescanfoundation.org/files/lifeplans_satisfaction_of_ltss_across_the_continuum_of_care-9-18-13_0.pdf. (Cohen, Miller & Shi, 2013)

Graham, J. (2012, August 14). Medicare studying plans to pay nursing homes based on quality. *Kaiser Health News*. Retrieved from http://www.kaiserhealthnews.org/stories/2012/august/15/medicare-nursing-homes-quality.aspx?referrer=search. (Graham, 2012)

Miller, J., Cohen, M., & Shi, X. The SCAN Foundation, (2013). *Understanding satisfaction among older adults using long-term services and supports*. Retrieved from LifePlans, Inc. website: http://www.thescanfoundation.org/sites/thescanfoundation.org/files/lifeplans_understanding_satisfaction_among_older_adults_using_ltss-9-18-13.pdf. (Miller, Cohen & Shi, 2013)

Miller, E., & Rudder, C. (2012). Engaging consumers in Medicaid nursing home reimbursement policy: Lessons from New York and Minnesota. *The Gerontologist*, *53*(4), 627-640. doi: 10.1093/geront/gns141. (Miller & Rudder, 2012)

Mor, V. (2005). Improving the quality of long-term care with better information. *The Milbank Quarterly*, *83*(3), 333-364. doi: 10.1111/j.1468-0009.2005.00405.x. (Mor, 2005)

Mukamel, D., Weimer, D., Spector, W., Ladd, H., & Zinn, J. (2008). Publication of quality report cards and trends in reported quality measures in nursing homes. *Health Services Research*, *43*(4), 1244-1262. doi: 10.1111/j.1475-6773.2007.00829.x. (Mukamel, Weimer, Spector, Ladd & Zinn, 2008)

Murtaugh, C., Peng, T., Aykan, H., & Maduro, G. (2007). Risk adjustment and public reporting on home health care. *Health Care Financing Review*, *28*(3), 77-94. Retrieved from http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/07springpg77.pdf. (Murtaugh, Peng, Aykan & Maduro, 2007)

Rantz, M., Flesner, M., & Zwygart-Stauffacher, M. (2010). Improving care in nursing homes using quality measures/indicators and complexity science. *Journal of Nursing Care Quality*, *25*(1), 5-12. doi: 10.1097/NCQ.0b013e3181c12b0f. (Rantz, Flesner & Zwygart-Stauffacher, 2010)

Starkey, K., Weech-Maldonado, R., & Mor, V. (2005). Market competition and quality of care in the nursing home industry. *Journal of Health Care Finance*, *32*(1), 67-81. (Starkey, Weech-Maldonado & Mor, 2005)

Tenn. Code Ann. § 71-5-1402 (i), (2013).

Tenn. Code Ann. § 71-5-1415, (2013).

U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS). (n.d.). *Report to Congress: Plan to implement a medicare skilled nursing facility value-based purchasing program*. Retrieved from website: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/SNF-VBP-RTC.pdf. ("Plan to implement," n.d.)

Werner, R., Konetzka, R., & Polsky, D. (2013). The effect of pay-for-performance in nursing homes: Evidence from state Medicaid programs. *Health Services Research*, *48*(4), 1393-1414. doi: 10.1111/1475-6773.12035. (Werner, Konetzka & Polsky, 2013)

Acknowledgements

This product was prepared with support provided through a grant from the Robert Wood Johnson Foundation's State Quality and Value Strategies Program.

A project of this scope relies on the efforts of many in order to come to fruition. Lipscomb would like to thank all those who contributed their time, knowledge, and viewpoints to this project.

We thank the Robert Wood Johnson Foundation and Princeton University for the financial resources that made this work possible. Staff from the Bureau of Tenncare's (TennCare's) Long Term Services and Supports (LTSS) Division worked diligently with us throughout this process. This includes Patti Killingsworth, Assistant Commissioner and Chief of LTSS; Jay Taylor, Deputy LTSS Audit and Compliance; John Goetz, TennCare Legislative Liaison; Molly Greenwade, Assistant Deputy LTSS Audit and Compliance; Michelle Morse Jernigan, Deputy LTSS Quality and Administration; Rachel Turner, Assistant Deputy LTSS Quality and Administration; and Amanda Johnson, LTSS Director Elderly/Disabled Services. We appreciate the assistance of the Area Agencies on Aging and Disability (AAADs), and the Managed Care Organizations (Amerigroup, BlueCare and UnitedHealthCare) across Tennessee for their sponsorship of refreshments for the Community Forums. We are also grateful to Rebecca Kelly of AARP for arranging volunteers and other assistance.

We thank the more than 1,400 Community Forum attendees and Survey Monkey respondents for their thoughtful participation and input. We are grateful for the generosity of time and expertise provided by the key informants interviewed from state Medicaid agencies, who shared invaluable insights into programs in their respective states along with supporting documentation, as well as for the dedicated staff from provider organizations, for articulating their perspectives both through interviews and opinion papers.

Personnel from Lipscomb University's School for TransformAging® conducted the research and have prepared this report. This team included Dr. Charla Long, Dean of the College of Professional Studies; Beverly Patnaik, Academic Director, School of TransformAging®; Kathryn O'Day, Executive in Residence; and Nancy Childers, Graduate Assistant. Kim Chaudoin, Assistant Vice President for University Communication and Marketing for Lipscomb, developed the report format and final document.

The School of TransformAging® at Lipscomb is designed to address the issues facing seniors and the individuals who serve them by finding lasting and meaningful solutions to America's aging crisis. This crisis requires everyone to think differently about aging services and demands innovative leadership from all sectors, including education.

The School of TransformAging® offers innovative multidisciplinary undergraduate degrees, including certificate programs and a master's program in aging services leadership. The School strives to develop a new workforce to passionately pursue careers with the aging and demonstrate a holistic skill set. It also serves as a neutral convener of conversations of significance regarding aging issues; provides useful and timely information and training for both professional and family caregivers; and serves as the catalyst for applied research and design for professionals in the field.

Appendix

In the course of developing this Technical Assistance Report, many of those interviewed generously shared supporting documentation from Pay for Performance programs in other states that may be helpful to the reader. In addition, the report references materials such as the invitations to consumers and providers for the Community Forums, the online survey, and reference materials furnished by service providers, which may also be of interest to readers.

These documents form a wealth of information on LTSS and Pay for Performance. However, their total volume is too great to produce in printed form with this report. Instead, readers who wish to access these materials can visit www.lipscomb.edu/transformaging/TAReport to download any or all of the appendices to this report.

The following Appendices can be found at the web address provided above:

State Interviews:

- Colorado
  - CO – PCG 2012 NF P4P Performance review
  - CO – PCG 2013 NF P4P Performance review
  - Colorado legislation
- Georgia
  - GA – GHCA Quality Report
  - GA – Nursing Facility 04-10-13 144752
  - GA – Applicable pages are XI 21
  - GA – NF Rate Calculations in Shorthand-DT-2
- Indiana
  - IN statute 405 IAC 1-14
- Iowa
  - IOWA – Chapter.441.81
- Kansas
  - KS – 75-7435 Quality care assessments
  - KS – Action plan form – revised
  - KS – Core Practices 10-24 vers revised
  - KS – KCCI Leader Version
  - KS – KCCI Staff Version
  - KS – Notice of Final Rates for FY14
  - KS – PEAK 2.0 Webinar
  - KS – Resource kit
  - KS – Person-Centered Care Home Evaluation Form…Environment
  - KS – Person-Centered Care Home Evaluation Form…Meaningful Life
  - KS – Person-Centered Care Home Evaluation Form…Choice
  - KS – Person-Centered Care Home Evaluation Form…Empowerment
- Maryland
  - MD – 4.19 D pp 7C and 7D
  - MD – 2012 MHCC NF Family Survey
  - MD – 2012 NF P4P Scores PT 11-13
- Minnesota
  - AARP Minnesota LTSS Case Study
  - MN – NH Report Card Fact Sheet
  - MN Report Card Technical User Guide
  - MN Status of LTSS

Stakeholder Input:

- Barriers to implementation summary
- CAHPS Survey
- Collateral – Elijay Report 2012 Payment System
- Collateral – FY 2013-14 Medicaid Wage Index
- Collateral – FY 2014-15 Medicaid Wage Index
- Collateral – Medicare rates THCA comments
- Collateral – Medicare rates
- Collateral – SE states Ave FY 2013-14 Medicaid rates
- Community Forum Consumer Invitation with schedule
- Community Forum Provider Invitation
- Community Forum CONSUMER PRESENTATION
- Community Forum PROVIDER PRESENTATION
- Data Analysis for TennCare's QuILTSS Initiative
- Survey Monkey QuILTSS
- TAHC Work Group Feb 2014-2

Miscellaneous

- Abt Nursing Home Compare Five-Star Quality Report