

Briefing Report

Quality Group for Long Term Care Task Force

October 25, 2005

In November 2001 a state-employee workgroup was established at the request of Secretary Howard Hendrick with the support of other Agency Directors such as Dr. Leslie Beitsch (Oklahoma State Department of Health), Mike Fogarty (Oklahoma Health Care Authority), and Dr. Terry Cline (Oklahoma Department of Mental Health and Substance Abuse). The purpose of the workgroup was to develop quality initiatives that might be useful in the long-term care industry. More specially, the group was established to develop positive rewards for those nursing facilities serving the Medicaid Program and delivering quality services.

The group, made up of employees from each agency (OKDHS, OHCA, ODH, and ODMHSAS). This group has met monthly or every other month for several hours per meeting. The group started meeting in March 2002 and is still meeting thru the present. The group's first task was to decide what issue or issues could create opportunities for quality care in nursing facilities. Based on input from several agencies, a review of statistics and employees knowledge base it was decided that the training of nurse aides and care of nurse aides provided a huge opportunity to change the quality of care delivered in nursing facilities. It was noted that within the industry much disparity existed in the training of nurse aides and that there was much turnover in this area. Based upon this opportunity the group made the following recommendation.

I. Uniform Training Program for Nurse Aides

OPPORTUNITY

Currently nursing homes are receiving 23 cents a day per patient for the training of approximately 9,000 nurse aides per year. The existing training is very fragmented with a turnover rate of 50% for nurse aides according to statistics at the Health Department. Some facilities provided five hours of training and placed the nurse aide out on the floor for the seventy remaining hours of training required for certification. The law changed in November 2004 where the nurse aides have to be certified before they are allowed to provide care to residents. We reviewed how training opportunities could be expanded; training and testing improved and made more uniform and how we might lessen the burden now placed squarely on the industry.

RECOMMENDATION

It was our desire to issue a Request for Proposal (RFP) statewide for one entity to deliver nurse aide training services and nurse aide testing to all nurse aides. Training and testing costs would be assumed by the state with a single curriculum taught by the vendor. Training and Testing would take place throughout the state in multiple locations. Training hours have been increased from a current state requirement of 75 hours to 80

hours. The Oklahoma Health Care Authority appropriated dollars for the funding of this project. OKC/OSU received the contract for the pilot training and started the program in May 2005. The pilot runs through February 2006 and to date approximately 178 certified nurse aides have been trained. **As a result of this project current rates of nursing facilities did not get reduced.** We believe the advantages to this project have been the following: uniform training for all nurse aides, lower burden on facilities to train and test aides, higher retention rate of employees, increased quality of care delivered in homes, more career opportunities as nurse aides.

It is important to stress that because the training is delivered by the state free for those agreeing to work in a facility for one year or more we expect that more persons will decide this is a career opportunity and to date they are. It is also important to note that when we surveyed other states as to their training requirements we found that the Oklahoma requirement of the federal minimum (75) hours of training was lower than most states. .

II. Quality Reimbursement

THE OPPORTUNITY

Historically, Oklahoma has approached nursing facility reimbursement with a flat rate and then penalized facilities who are non-compliant with state and federal regulatory requirements. While we recognize the necessity of this system, we would like to create new opportunities for some facilities. We have an opportunity to change the landscape from a rate and penalties to a rate, penalties and positive enforcement for those facilities that consistently deliver quality care.

RECOMMENDATION

It is our desire to establish criteria for additional nursing facility reimbursement tied to quality. There would be one level of reimbursement for a regular licensed facility (currently with and without those facilities that participate in the wage enhancement program) and a separate of reimbursement for a specially designated facilities Care + program. While the group discussed several ways to compensate the quality facility, in the end we recommend that this compensation be made in a lump sum. The lump sum of fifty thousand per facility was mentioned with about ten percent of facilities at first meeting the CARE + criteria. The group preferred a lump sum approach to any add-ons to reimbursement. For the state to receive additional appropriations for such reimbursement, the group realized that the performance of the quality facility would need to be above the base regulatory requirements of all other facilities. To designate these items we searched for those issues and items that we believed might create the greatest difference in quality of care. Thus, we recommend that a quality facility would have to meet the following requirements for a period of one year:

A. Quality of Care Tags on the 2567 Survey for a Quality Facility

- No substandard Quality of Care deficiencies on a facility's survey results.
- No nursing or life safety code waivers will be allowed.
- No deficiencies with a scope and severity of F or higher will be approved.
- No Quality of Care tags with a scope of E or higher will be allowed.
- There will be no deficiencies for an Activity Tag.

B. Training Requirements for a Quality Facility

- A facility would have 25% of their nurse aides enrolled in or having completed an approved educationally based career ladder program.
- For two months after certification, a new Certified Nurse Aide (CNA) would work in a mentor/preceptor situation with an experienced CNA.
- Increase "in-service" training for CNA's to an additional one-hour every three months, or two hours every six months with specific topics i.e.; time management, problematic behavior intervention, respectful communication, socialization, family support and communication, verbal abuse and neglect. The Registered Nurse, Ombudsmen, or Social Service Director could conduct this training.

C. Comprehensive Activity Program for a CARE + Facility

CARE + STANDARDS FOR NURSING FACILITY ACTIVITY PROGRAMS

- The facility completes a comprehensive Resident Activity Assessment for each resident, in addition to the MDS. A facility may use its own Activity Assessment tool, which must include at least the information included in the attached sample tool. Each resident's activity preferences are documented in the resident's care plan and addressed at each care plan update.
- At least three activities are offered daily to meet the needs of residents of varying abilities, taking into consideration residents' cognitive and physical functioning. The facility arranges at least one "family" activity each month. The facility offers at least two "field trip" activities outside of the facility each month, compatible with the interests of mobile residents. When family activities and field trips occur, they may be included as one of the three daily activities.
- All residents have the opportunity to participate in activities, including bedfast or room bound residents. The Activity Director maintains documentation of resident participation in activities. Residents who do not participate in activities are reassessed at least quarterly to determine reasons for non-participation. Reviews are documented along with

alternate strategies to meet the resident's activity needs. This should be evidenced in the care plan.

- Observation and residents' feedback indicates residents are satisfied with the variety and frequency of activities offered.
- The facility completes a comprehensive Resident Activity Assessment for each resident, in addition to the MDS. The activity director will complete the assessment or an employee with the requisite knowledge of the residents.

Our desire regarding the funding of the increased reimbursement is to seek additional appropriations. We envision one sum of money to be divided among those facilities that qualify for the quality designation. We also envision advertising that facilities with quality designations have such a designation. We believe that given the statistics that bed days are diminishing in the industry generally, advertisement of the quality indicator would help increase the bed occupancy of the homes with the quality designation. We would also allow facilities to advertise the fact that they have a quality designation.

In summary, someday you may have to make the hard decision of placing your loved one in a quality nursing facility. We want you to know upfront where the quality facilities are. Our goal is that nursing homes in Oklahoma will strive to meet the highest standards and focus extra attention on the quality of life and care experienced by their residents, in order to attain the "Cares +" label from the State of Oklahoma.

Briefing Report

Quality Group for Long Term Care Task Force

January, 2004

In November 2002 a state-employee workgroup was established at the request of Secretary Howard Hendrick with the support of other Agency Directors such as Dr. Leslie Beitsch (Oklahoma State Department of Health), Mike Fogarty (Oklahoma Health Care Authority), and Dr. Terry Cline (Oklahoma Department of Mental Health and Substance Abuse). The purpose of the workgroup was to develop quality initiatives that might be useful in the long-term care industry. More specially, the group was established to develop positive rewards for those nursing facilities serving the Medicaid Program and delivering quality services.

The group, made up of employees from each agency (DHS, OHCA, ODH, and ODMH) met monthly or every other month for several hours per meeting and met between November 2002, to October, 2003. The group's first task was to decide what issue or issues could create opportunities for quality care in nursing facilities. Based on input from several agencies, a review of statistics and employees knowledge base it was decided that the training of nurse aides and care of nurse aides provided a huge opportunity to change the quality of care delivered in nursing facilities. It was noted that within the industry much disparity existed in the training of nurse aides and that there was much turnover in this area. Based upon this opportunity the group makes the following recommendation.

I. Uniform Training Program for Nurse Aides

OPPORTUNITY

Currently nursing homes are receiving 22 cents a day per patient for the training of approximately 9,000 nurse aides per year. The existing training is very fragmented with a turnover rate of 50% for nurse aides according to statistics at the Health Department. Some facilities provide five hours of training and place the nurse aide out on the floor for the seventy remaining hours of training required for certification. The law is changing in November 2004 where the nurse aide will have to be certified before they are allowed to provide care to residents. We reviewed how training opportunities could be expanded, training and testing improved and made more uniform and how we might lessen the burden now placed squarely on the industry.

RECOMMENDATION

It is our desire to issue a Request for Proposal (RFP) statewide for one entity to deliver nurse aide training services and nurse aide testing to all nurse aides. Training and testing costs would be assumed by the state with a single curriculum taught by the vendor. Training and Testing would take place throughout the state in multiple locations. Training hours would be increased from a current state requirement of 75 hours to 80

hours. Nurse aides could deliver care after 70 hours of classroom training. The Oklahoma Health Care Authority would need to be appropriated dollars for the funding of this project. **As a result of this project current rates of nursing facilities would not be reduced.** We believe the advantages to this project would be the following: uniform training for all nurse aides, lower burden on facilities to train and test aides, higher retention rate of employees, increased quality of care delivered in homes, more career opportunities as nurse aides.

It is important to stress that because the training is delivered by the state free for those agreeing to work in a facility for one year or more we expect that more persons will decide this is a career opportunity. It is also important to note that when we surveyed other states as to their training requirements we found that the Oklahoma requirement of the federal minimum (75) hours of training was lower than most states. Whether or not this initiative is begun, we think the hours of training now delivered is insufficient.

II. Quality Reimbursement

THE OPPORTUNITY

Historically, Oklahoma has approached nursing facility reimbursement with a flat rate and then penalized facilities who are non-compliant with state and federal regulatory requirements. While we recognize the necessity of this system, we would like to create new opportunities for some facilities. We have an opportunity to change the landscape from a rate and penalties to a rate, penalties and positive enforcement for those facilities that consistently deliver quality care.

RECOMMENDATION

It is our desire to establish criteria for additional nursing facility reimbursement tied to quality. There would be one level of reimbursement for a regular licensed facility (currently with and without those facilities that participate in the wage enhancement program) and a separate of reimbursement for a specially designated facilities (such as a star facility or quality label.) While the group discussed several ways to compensate the quality facility, in the end we recommend that this compensation be made in a lump sum, perhaps given half at the front end of the award and half at the end of the period that we designate. For example, if the award is given each year then half of the lump sum be given at the beginning of the year and the other at the end of the year. The group preferred a lump sum approach to any add-ons to reimbursement. For the state to receive additional appropriations for such reimbursement, the group realized that the performance of the quality facility would need to be above the base regulatory requirements of all other facilities. To designate these items we searched for those issues and items that we believed might create the greatest difference in quality of care. Thus, we recommend that a quality facility would have to meet the following requirements for a period of one year:

A. Quality of Care Tags on the 2567 Survey for a Quality Facility

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B. Training Requirements for a Quality Facility

- A facility would have 25% of their nurse aides enrolled in or having completed an approved educationally based career ladder program.
- For two months after certification, a new Certified Nurse Aide (CNA) would work in a mentor/preceptor situation with an experienced CNA.
- Increase "in-service" training for CNA's to an additional one-hour every three months, or two hours every six months with specific topics i.e.; time management, problematic behavior intervention, respectful communication, socialization, family support and communication, verbal abuse and neglect. The Registered Nurse, Ombudsmen, or Social Service Director could conduct this training.

C. Comprehensive Activity Program for a Star Facility
STAR STANDARDS FOR NURSING FACILITY ACTIVITY PROGRAMS

- The facility completes a comprehensive Resident Activity Assessment for each resident, in addition to the MDS. A facility may use its own Activity Assessment tool, which must include at least the information included in the attached sample tool. Each resident's activity preferences are documented in the resident's care plan and addressed at each care plan update.
- At least three activities are offered daily to meet the needs of residents of varying abilities, taking into consideration residents' cognitive and physical functioning. The facility arranges at least one "family" activity each month. The facility offers at least two "field trip" activities outside of the facility each month, compatible with the interests of mobile residents. When family activities and field trips occur, they may be included as one of the three daily activities.
- All residents have the opportunity to participate in activities, including bedfast or room bound residents. The Activity Director maintains documentation of resident participation in activities. Residents who do not participate in activities are reassessed at least quarterly to determine reasons for non-participation. Reviews are documented along with alternate strategies to meet the resident's activity needs. This should be evidenced in the care plan.

- Observation and residents' feedback indicates residents are satisfied with the variety and frequency of activities offered. (See attached monitoring report, to be completed by the quality initiative reviewer.)
- The facility completes a comprehensive Resident Activity Assessment for each resident, in addition to the MDS. The activity director will complete the assessment or an employee with the requisite knowledge of the residents. (Attachments 1 and 2)
- At least three activities are offered daily to meet the needs of residents of varying abilities, taking into consideration residents' cognitive and physical functioning. The facility arranges at least one "family" activity each month. The facility offers at least two "field trip" activities outside of the facility compatible with the interests of mobile residents.
- All residents have the opportunity to participate in activities, including bedfast or room bound residents. Access to and participation in activities is documented daily in residents' charts. Residents who do not participate in activities are reassessed at least quarterly to determine reasons for non-participation.
- Observation and residents' feedback indicates residents are satisfied with the variety and frequency of activities offered.

Items A, B, and C are the items we are recommending at this time for those required to receive the increased reimbursement. The group did focus on quality initiatives, we believed facilities already had an infrastructure in place to complete. The group attempted to compile quality indicators without more regulation and requirements. We envision this program working in such a way that facilities that desire the quality designation and reimbursement to submit an application to OHCA within certain time frames each year and that application would be graded by a workgroup made of employees from several agencies. In addition to the requirements in A, B, and C additional quality indicators were discussed which we seek comment upon. Those are:

D. Other Quality Requirements

- Have a registered nurse on staff more than eight hours a day.
- Criminal arrest checks for Certified Medication Aide CMA's every two years.
- Nurse aide inquiries every 12 months on employment anniversary.
- Have a turnover rate of less than 65%.
- Injury rate for nurse aides less than 25% annually.
- Resident skin tear rate less than 10% quarterly.
- A Peer Review and a Nurse Aide Council would be incorporated into management practices.

Our desire regarding the funding of the increased reimbursement is to seek additional appropriations or use penalty monies now collected by the state. While there are advantages to both systems, we envision one sum of money to be divided among those facilities that qualify for the quality designation. We also envision advertising that facilities with quality designations have such a designation. We believe that given the statistics that bed days are diminishing in the industry generally, advertisement of the quality indicator would help increase the bed occupancy of the homes with the quality designation. We would also allow facilities to advertise for themselves that they have a quality designation.