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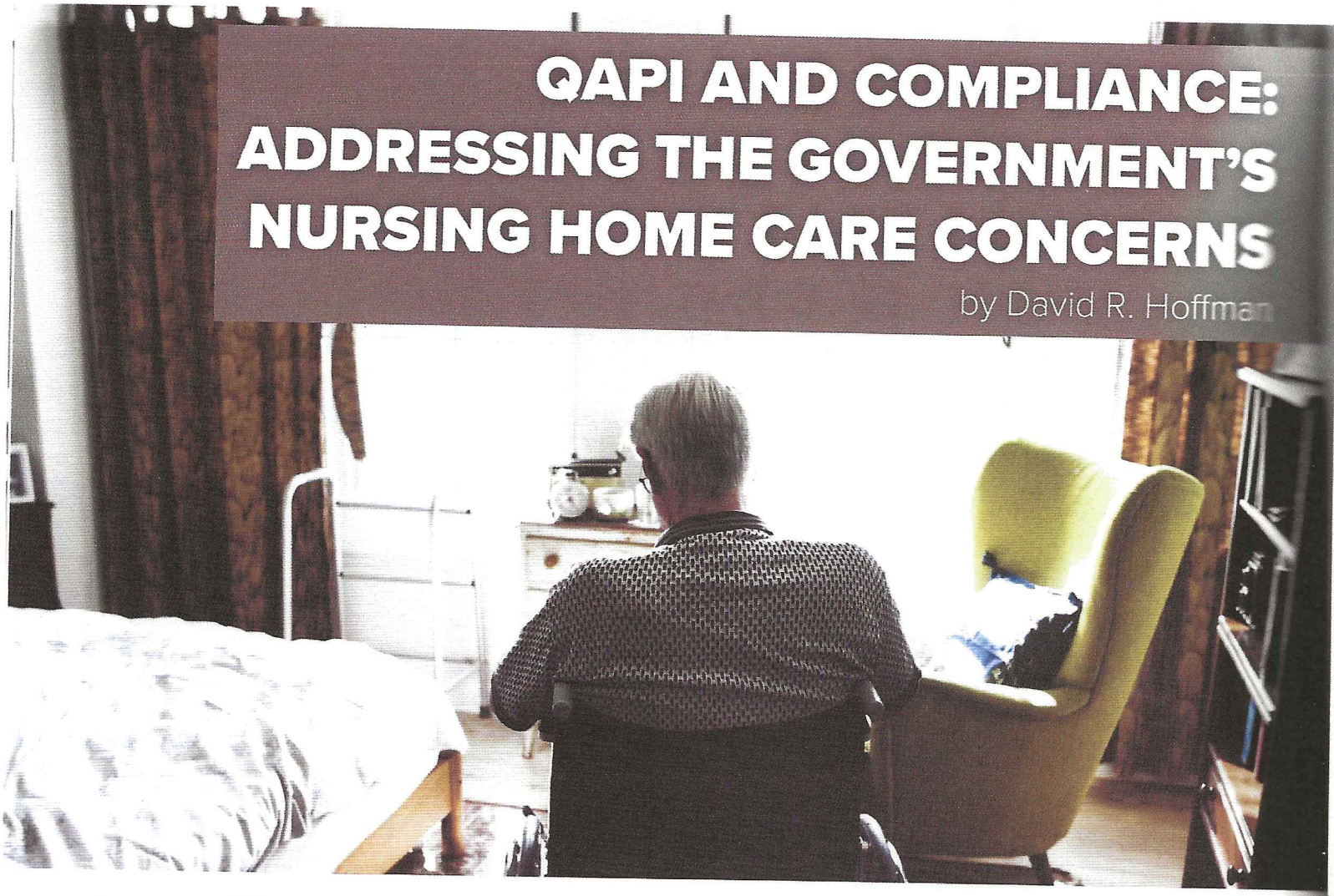
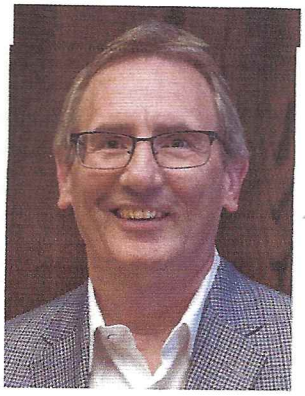
QAPI AND COMPLIANCE: ADDRESSING THE GOVERNMENT'S NURSING HOME CARE CONCERNS

by David R. Hoffman





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On September 6, 2018, Ruth Ann Dorrill, the Regional Inspector General of the Department of Health and Human Services, Office of Inspector General (OIG), testified before the U.S. House of Representatives regarding federal efforts to ensure quality of care and resident safety in nursing homes. Her testimony focused on: (1) harm to residents, (2) nursing home emergency preparedness, and (3) state agency enforcement.[1]

This testimony highlighted the February 2014 OIG report titled "Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries," in which the "OIG found that one-third of residents in SNFs experienced harm from the care provided in nursing homes and more than half of the harm (adverse events) were preventable had the facilities provided better care."[2]

Ms. Dorrill noted that:

> What is needed is a shift in thinking about the care provided in nursing homes. Our work identifying adverse events in nursing homes and other settings showed that nursing home residents often had care needs similar to patients in hospitals, with residents sometimes seriously ill and impaired. The hospital community has focused keenly on patient safety and, while still experiencing high harm rates in some categories, has made substantial changes in the provision of patient care and safety systems. Sustained improvements in nursing homes will require a cultural shift that recognizes clinical harm and elevates reduction of harm as a priority for *nursing home care.*

It should be noted that nursing home providers, for the most part, subscribe to the belief that reduction of harm *is* a priority. However, there are significant reimbursement factors that distinguish hospitals from nursing homes and affect their ability to prevent and address adverse events successfully. Of course, money is no excuse for systemic failure to deliver compassionate and compliant care to vulnerable residents. The OIG recommended that Quality Assurance and Performance Improvement (QAPI) programs be the focal point for guidance by the Centers for Medicare & Medicaid Services (CMS) in order to address this issue.

CMS, to its credit, has disseminated a significant amount of valuable information regarding the QAPI process, not only in nursing homes but in the home health and hospice arenas as well. The challenge remains for many healthcare providers as to how to integrate the QAPI program into practice. Nursing home QAPI is:

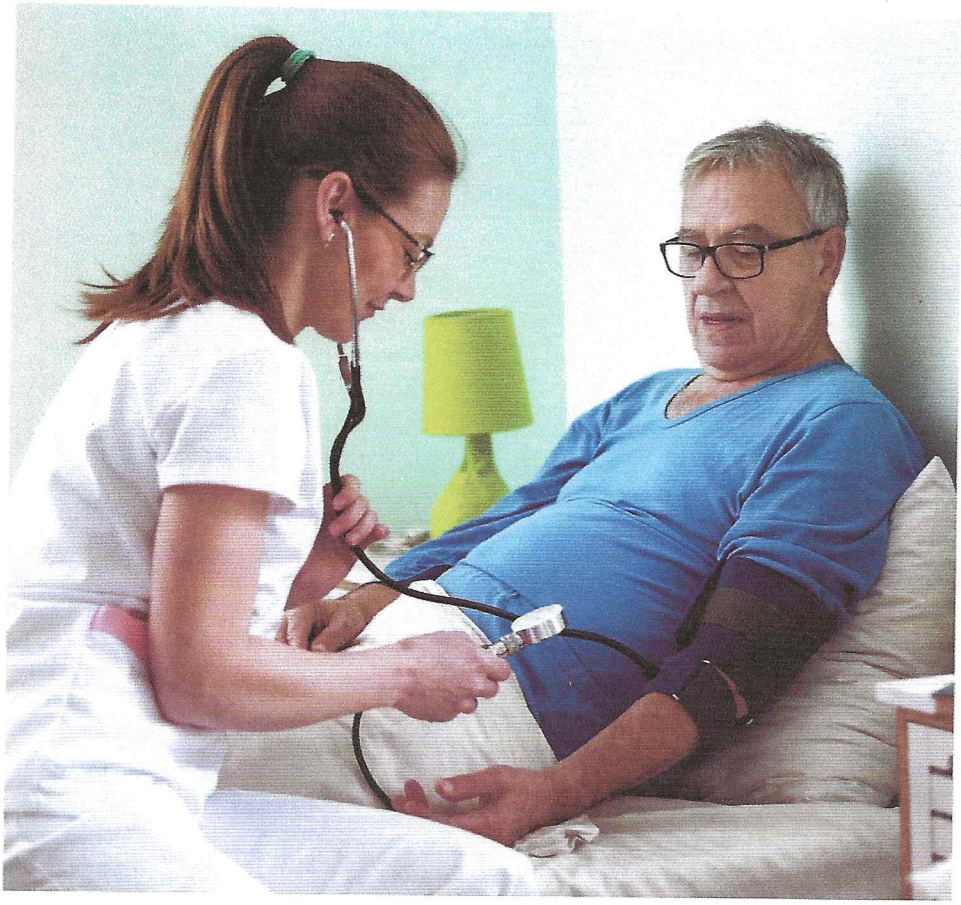
> ...the coordinated application of two mutually-reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI takes a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving residents, families, and all nursing home caregivers in practical and creative problem solving.
>
> QA is the specification of standards for quality of care, service and outcomes, and systems throughout the facility for assuring that care is maintained at acceptable levels in relation to those standards. QA is on-going, both anticipatory and retrospective in its efforts to identify how the organization is performing, including where and why facility performance is at risk or has failed to meet standards.
>
> PI (also called Quality Improvement or QI) is the continuous study and improvement of processes with the intent to improve services or outcomes and prevent or decrease the likelihood of problems, by identifying opportunities for improvement and testing new approaches to fix underlying causes of persistent/systemic problems or barriers to improvement. PI in nursing homes aims to improve facility processes involved in care delivery and enhanced resident quality of life. PI can make good quality even better.
>
> As a result, QAPI amounts to much more than a provision in Federal statute or regulation; it represents an ongoing, organized method of doing business to achieve optimum results, involving all levels of an organization.[3]

This care delivery and analytical framework makes sense, yet the promise of QAPI is not being fulfilled by many in the nursing home industry. There are several reasons for this, but one I have observed is a fundamental lack of understanding regarding how to accomplish these analytical and performance-based tasks coupled with a lack of staffing to implement them. If staff (especially medical directors) are not educated, understanding, and invested in implementing an effective QAPI program, it simply will not succeed.

Sustained improvements in nursing homes will require a cultural shift that recognizes clinical harm and elevates reduction of harm as a priority for nursing home care.

Reporting patient neglect

Next, Ms. Dorrill testified about nursing homes' failure to report "allegations or potential cases of abuse and neglect of nursing home residents." I believe that this failure to report to law enforcement is based, in part, on the definition of "neglect" and, secondarily, how the various state survey agencies cite neglect as a deficiency. "Neglect," as defined at 42 CFR §483.5, means "the failure of the facility, its employees or service providers to provide goods and services to a



resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress."[4]

Virtually everything that is performed by nursing staff at a nursing home is necessary to avoid an adverse physical, mental, or emotional outcome. In effect, every failure to turn or re-position a resident, every missed medication, every failure to assess and follow the plan of care appropriately fits the definition of neglect. Do all state survey agencies cite this as neglect? No. Are all of these items reportable to law enforcement? Should they be? And if they are, what will law enforcement's response be? Simply stated, every failure does not implicate a report to law enforcement nor should it. Rather, patterns of neglectful conduct, or even a single failure that constitutes gross negligence with resulting resident harm, should be reported to law enforcement.

Emergency preparedness

Next, Ms. Dorrill focused on the importance of emergency preparedness by nursing homes, citing the multiple hurricanes that have occurred over the years and the disastrous consequences associated with a failure to plan.

Interestingly, CMS strengthened its emergency preparedness requirements in 2016, only to issue proposed regulations in September 2018 that would, amongst other things:

> Emergency program: Give facilities the flexibility to review their emergency program every two years, or more often at their own discretion, in order to best address their individual needs. A comprehensive review of the program can involve an extensive process that may not yield significant change over the course of one year. Facilities may review the plan more frequently should significant changes become necessary as determined by the individual needs of the facility. The combination of all Emergency Preparedness requirements (policies and procedures, testing, communication plan) will continue to hold facilities accountable for their outcomes while allowing them more time to focus on their unique needs and specific circumstances.[5]

In addition, CMS is proposing to eliminate the requirement that the emergency plan include *documentation* of efforts to contact local, tribal, regional, state, and federal emergency preparedness officials and a facility's participation in collaborative and cooperative planning efforts, because this requirement is contained in other regulatory requirements. From a compliance perspective, it is imperative that emergency preparedness plans be reviewed at least annually in order to ensure resident safety. Circumstances may change as environmental risk factors change. Communication and coordination are critically important and an *annual* emergency preparedness review has merit.

The OIG then commented on state agency oversight of skilled nursing facilities (SNFs) and made five specific recommendations:

(1) strengthen the regulations on care and discharge planning, (2) provide guidance to SNFs to improve planning, (3) increase surveyor efforts to identify problems, (4) link payments to meeting quality-of-care requirements, and (5) follow up on SNFs that failed to meet requirements.

According to Ms. Dorrill's testimony, OIG "determined that CMS had fully implemented these recommendations."

Finally, she also noted that "Allegations involving patient harm remain a top OIG enforcement activity. OIG will continue to investigate potential criminal conduct and pursue administrative actions to hold accountable those who victimize residents of nursing homes."

In February 2019, consistent with its stated goal of protecting nursing home residents, the OIG issued a report titled "CMS Guidance to State Survey Agencies on Verifying Correction of Deficiencies Needs To Be Improved To Help Ensure the Health and Safety of Nursing Home Residents."[6] The OIG noted that "[i]f State agencies certify that nursing homes are in substantial compliance without properly verifying the correction of deficiencies and maintaining sufficient documentation to support the verification of deficiency correction, the health and safety of nursing home residents may be placed at risk." It is extremely important that promises made by a facility to correct cited deficiencies, through an accepted plan of correction, are kept.

Compliance tips

So, what should a compliance and ethics officer do after reading this testimony? No need to panic, but there is a need to strengthen the link between quality and compliance. The connection between compliance and quality care delivery has been debated for years. What should the compliance department's role be in evaluating, auditing, monitoring quality care?

From my perspective, at a minimum, quality dashboards, which detail the data that measures resident outcomes in such areas as falls, medication errors, and psychotropic medication usage, should be presented in compliance committee meetings for the purpose of evaluating the response of the facility to identified care concerns and possible vulnerabilities.

The next step is identifying the role of the compliance department in performing follow-up auditing or monitoring of care delivery interventions that have been implemented to achieve and sustain regulatory compliance. To me, a robust partnership between those performing the QAPI function and those on the compliance side makes good compliance sense.

Finally, the compliance officer should ensure compliance with the regulations that govern QAPI.[7] An effective QAPI program is key to ensuring quality care delivery. A compliance review of QAPI committee meeting minutes, analyses, and action plans from a regulatory and systems perspective is a good proactive step to address and prevent resident harm. CT

Endnotes

1. Testimony of Ruth Ann Dorrill before the United States House of Representatives Committee on Energy and Commerce: Hearing on "Examining Federal Efforts to Ensure Quality of Care and Resident Safety in Nursing Homes" September 6, 2018, p 4. https://bit.ly/2EaT65i
2. DHHS Office of Inspector General, "Adverse Events in Skilled Nursing Facilities: National Incidence among Medicare Beneficiaries. (OEI-06-11-00370) February 2014. https://bit.ly/1i2DUWZ
3. CMS.gov, QAPI Description and Background. https://go.cms.gov/1XzQL6D
4. 42 CFR §483.5 Definitions. https://bit.ly/2H8oHYf
5. CMS: Medicare and Medicaid Programs; Proposed Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction: Emergency Preparedness. September 17, 2018. https://go.cms.gov/2xkTYRZ
6. DHHS OIG, "CMS Guidance to State Survey Agencies on Verifying Correction of Deficiencies Needs To Be Improved To Help Ensure the Health and Safety of Nursing Home Residents" (OEI-A-09-18-02000) February 2019. https://bit.ly/2tlmm4d
7. CMS: Nursing Home Quality Initiatives, Questions and Answers, August 29, 2017. https://go.cms.gov/2tBHLGe

Takeaways

- The government has issued multiple reports regarding serious systemic failures of care in nursing homes.
- Recent testimony evidences the OIG's continued concern regarding the nursing home industry's provision of quality care.
- A meaningful Quality Assurance and Performance Improvement (QAPI) program is key to addressing government care concerns.
- Compliance officers should play an active role in monitoring nursing home QAPI programs.
- Compliance officers should monitor the nursing home's internal and external reporting system related to resident abuse and neglect.