

VOL. I



Report to Congress

Study of

- Private Accreditation (Deeming) of Nursing Homes,
- Regulatory Incentives and Non-Regulatory Initiatives, and
- Effectiveness of the Survey and Certification System





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Errata

1. The Skilled Nursing Facility (SNF) Prospective Payment System (PPS) was implemented effective July 1, 1998. References in the report to SNF PPS were written prior to the effective date.
2. On page 541 the fourth column on the right in Exhibit 19.1 should read "Percent of Surveys without Deficiencies" instead of "with".

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Chapter 20:	Evidence on Processes: Problems Corrected? Results of Interviews with Long Term Care Providers	Margaret McKenna and Ruth Perschbacher (Consultants to Abt)

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APPENDICES A - N

Study of Private Accreditation (Deeming) of Nursing Homes, Regulatory Incentives and Non-Regulatory Initiatives, and Effectiveness of the Survey and Certification System

EXECUTIVE SUMMARY

Background - Federal Responsibility

In 1996, about 1.6 million people received care in approximately 16,800 nursing homes across the United States. As the largest single payer for this care, the Federal government is responsible for ensuring: (1) that the health and safety of one of the nation's most vulnerable populations are protected; and (2) that expenditures are prudent. Nursing home care has improved compared to the poor conditions dramatized in scandals during the 1950s and 1960s. In spite of this improvement, some experts and the public continue to feel that the typical nursing home is terrible. Ongoing press reports of questionable practices reinforce a widespread negative perception of the quality of nursing home care and underscore the importance of the Federal government's responsibilities.

The Report's Purpose

The 1996 Appropriations Act required a study and Report to Congress on:

- Private accreditation and deemed status;
- Regulatory and non-regulatory incentives to improve nursing home care; and
- Effectiveness of the current system of survey and certification of nursing homes.

The study's key objective is to assess the effectiveness of the three broad mechanisms identified in the legislation -- private accreditation, incentives, and survey and certification. Limited time and resources have precluded attention to some related topics: current survey and certification resource issues; the introduction of user fees to generate needed revenue; privatization of the survey and certification function; sources of State differences in enforcement; and nursing home staffing issues. This report has focused on the analysis of problems with respect to the Federal nursing home survey and certification system. Although a thorough discussion of possible solutions to redress these problems is beyond the scope of the report, the Department of Health and Human Services is in the process of identifying improvements to the current system.

Methods

In late November 1996, we secured an independent evaluation contractor, Abt Associates, to assist us in conducting this study. Preliminary study plans were developed and shared with very

broad constituencies from whom we sought input. In general, all the groups we met with supported the outlined study approach. The study results follow.

Findings

Private Accreditation (Deeming) of Nursing Homes

Should nursing homes be offered a choice between the traditional State survey process and private accreditation to demonstrate their compliance with Medicare's nursing home requirements for participation?

Discussion

Proponents of private accreditation/deeming argue that:

- The current survey and certification process is punitive and inflexible, with inconsistent implementation and enforcement.
- Most nursing homes strive to provide good quality care, and succeed.
- The Joint Commission on Accrediting Healthcare Organizations (JCAHO), an organization that accredits nursing homes, is more efficient than HCFA because it primarily relies on facility administrators and clinical staff to enforce standards and it relies on industry expertise to set and revise standards.
- If some nursing homes choose accreditation to demonstrate compliance, States can then focus their resources on substandard nursing homes.

In contrast, opponents of private accreditation/deeming agree that the current system does not work as well as it should; however, they argue that:

- The current system should be improved, not scrapped.
- For the most part, nursing homes are not managed by "professionals."
- The average facility has a high level of compliance problems. There is a need for direct government monitoring and enforcement.
- Accreditation does not "work" in other contexts, even hospitals.
- There is an inherent conflict of interest because facilities pay the accrediting organization for the accreditation survey.
- Accrediting bodies are not accountable to the public or to government.

A fundamental question is the appropriateness of allowing a private entity to perform an important public function. In some sense, Congress has already decided the “appropriateness” issue with respect to skilled nursing facilities (SNFs) by granting the Secretary “discretion” to grant deemed status provided that accreditation offers a reasonable assurance that Medicare conditions of participation or, for SNFs, requirements, are met. In another sense, probably due to the concerns expressed by deeming’s opponents, Congress has circumscribed the “appropriateness” issue by exempting SNFs from those accredited provider types for which the Secretary “must” accord deemed status if it is found that private accreditation demonstrates compliance with Medicare conditions of participation or requirements.

The primary issue to be addressed by this report, then, is not the “appropriateness” issue per se - a fundamental policy issue that is unlikely to be resolved in any report - but rather, the empirical issue of whether in fact private accreditation demonstrates compliance with Medicare’s requirements. Accordingly, empirical studies were conducted to determine whether what is currently the most likely organization to be granted deeming authority, JCAHO, has procedures and standards that would provide reasonable assurance of compliance with Medicare’s requirements. The current survey and certification system does not always guarantee such compliance; therefore, implicit in all the empirical studies described is a comparison between the JCAHO and HCFA’s surveys.

Conclusions - Deeming

JCAHO has higher minimum qualifications for surveyors, requiring a master’s degree and five years of long term care management experience. It would not be surprising, then, if JCAHO’s survey were more effective than HCFA’s. However, results of the empirical studies did not support this expectation:

- In terms of content, JCAHO would have to change several standards to provide reasonable assurance that Medicare requirements would be met.
- JCAHO standards are heavily weighted toward structure and process measures, while HCFA standards have a more resident-centered and outcome-oriented focus.
- In contrast to HCFA surveys, observed JCAHO surveys did not collect sufficient information to assure compliance with Medicare requirements. Generally, observations of resident care were not a priority.
- HCFA’s survey system is more stringent in defining steps to be taken to correct deficiencies.
- JCAHO surveyors seem to miss serious deficiencies that HCFA surveyors identify.
- Public access to JCAHO survey findings is severely limited.

Studies found that by authorizing deeming for nursing homes, Medicare may save \$2 million to nearly \$37 million annually, depending on assumptions about costs and on the percent of facilities that choose the accreditation option. However, given that the studies produced overwhelming evidence that the JCAHO surveyors often miss serious deficiencies, in some cases even apparently unjustified deaths, **the potential cost savings to deeming would not appear to justify the risk to the health and safety of the vulnerable nursing home population.**

The problems identified with the JCAHO survey do not necessarily apply to other potential accrediting organizations. Fragmentary evidence from the new Long-term Care Evaluation and Accreditation Program (LEAP), a competitor of JCAHO that began accrediting nursing homes in November 1997, suggests that their survey may be very different from JCAHO's. If future empirical studies produce convincing evidence that LEAP, other accrediting organizations, or a revised JCAHO survey meets all the criteria for comparability with the HCFA survey discussed in this report, then it might be time to revisit the issue of deeming.

Review of Research Linking Payment to Improved Resident Outcomes and Non-Regulatory Quality Improvement Initiatives

Review of Research Linking Payment to Improved Resident Outcomes

The possible use of incentives to improve quality of care and promote quality of life for nursing home residents has been discussed for many years. Incentives could take several forms, including public recognition and/or payments. Although superficially incentive payment is easily understood (incentive payment being a financial award above the standard rate of reimbursement for care, not a restructuring of the payment system in general or an overall increase in nursing home reimbursement rates), there is a troubling lack of agreement about practical implementation issues such as the basis for awarding incentive payments and a method for distribution. Critics also point out philosophical objections, the extreme technical difficulties of linking payment to outcomes, the question of funding, and the challenge of integrating an incentives system with current regulatory standards and payment structures.

Through discussion with researchers and regulators and a literature review, HCFA found past but no presently operating Medicaid incentives systems. Documentation and evaluation of States' efforts are lacking, and the impact that these interventions may have had on residents' quality of care and life cannot be determined. In past State systems, the award of the incentive typically did not depend on resident outcomes measurement. In contrast, an unusually strong outcomes-based research demonstration was implemented in 36 proprietary nursing facilities in the San Diego area from 1980 to 1983. A recent reanalysis of data from this demonstration found "... beneficial effects on access, quality, and cost of care." While this conclusion seems sound for this particular intervention conducted more than 15 years ago, it is important to recognize how the vast changes in nursing homes and their environments over the years could affect this conclusion

for any present-day application. Even advocates for the idea of incentive payment admit that there is no incentives system that could be pulled “off the shelf” and implemented quickly. *Hence, there is a general recognition that additional research demonstrations conducted under current conditions would be necessary before incentive payment could be considered as a viable option.*

Review of Non-Regulatory Quality Improvement Initiatives

The long-term care industry has turned attention to the concept of total quality management, which includes the continuous quality improvement (CQI) model. With the development of outcomes-based quality of care indicators, a number of planned interventions have been undertaken by both private and government entities with the objective of improving nursing home quality, as measured by these indicators. Although some of these interventions are conducted in partnership with Federal or State entities, they essentially lie outside the traditional regulation, hence, our characterization of them as non-regulatory.

The Report discusses a wide variety of long-term care quality improvement initiatives. These kinds of non-regulatory initiatives with their emphasis upon CQI are viewed by the American Health Care Association, JCAHO, and others as important and effective mechanisms for nursing home quality assurance. Some argue that these initiatives can supplant some or a very large part of the normal survey process, as proposed by a South Dakota initiative. It has been argued that the role of the surveyor can be expanded to assist providers in their quality assurance efforts without compromising the traditional role of solely determining compliance with requirements. The State of Washington may provide an example of an expanded information transfer role through the activities performed by their Quality Assurance Nurses. As yet, we have no evaluation to judge the effectiveness of this effort.

Although many of these interventions are appealing with anecdotal reports of positive results, empirical evidence of their effectiveness is lacking. Some projects have no evaluation with none planned or have not gone beyond a good intention. For others, there is an evaluation component, but the data are not in. In the case of still others, there is an evaluation and some evidence is in, but it is weak - either weak because the evidence was mixed or the design was inherently weak.

In contrast to this lack of evidence, we identified two nursing home quality improvement interventions which were accompanied by reasonably strong evaluation designs. One project, an extremely labor intensive intervention to reduce incontinence, produced an impressive reduction in incontinence rates. Unfortunately, these gains were not sustained when the external research staff ceased proving feedback to the participating nursing homes. The other intervention, the Ohio Pressure Ulcer Prevention Initiative, incorporated elements thought essential to proponents of these initiatives and had a strong evaluation design. The evaluation resulted in conclusive evidence that the intervention was not effective. However, it should be noted that in spite of expectations of effectiveness on the part of the proponents of initiatives like the Ohio project, there are compelling reasons to regard these kinds of interventions as weak. It may be too

optimistic to view feedback data on performance alone, or even performance information together with educational “best practices” information, as sufficient to change actual care practices.

We have found little to no evidence to support a belief in the effectiveness of these initiatives *as they are normally implemented in nursing homes*. The absence of evidence supporting these particular interventions does not, however, mean that residents’ status cannot be improved. Moreover, many initiatives are in early stages of development, and it is always possible that future evaluations may yield evidence of their effectiveness. At present, however, removing the protections of a regulatory system that has some degree of effectiveness, as demonstrated in the Report, in lieu of quality improvement initiatives of unproven effectiveness could risk the health and safety of the nation’s vulnerable nursing home population. Even if supportive evidence emerges in the future, the question of how these interventions relate to the system of survey and certification remains.

Evaluation of HCFA’s Nursing Home Survey and Certification System

Background

The Omnibus Budget Reconciliation Act of 1987 (OBRA ‘87) legislation and ensuing regulations and guidelines generated:

- New standards in the area of quality of care, resident rights, resident assessment, and quality of life;
- The Resident Assessment Instrument (RAI), including the Minimum Data Set (MDS), a standardized assessment instrument for all residents in nursing homes;
- A more outcome-oriented survey that emphasizes gathering information directly by observing and interviewing residents;
- Training standards and competency evaluation for nursing assistants; and
- New intermediate enforcement remedies that augmented the rather limited existing options for responding to facility noncompliance with program requirements.

On July 1, 1995 the new enforcement regulation, the final key provision of OBRA ‘87, was implemented. The intent of the new enforcement process was to provide solutions to several longstanding problems in Federal regulation: cyclical nursing home noncompliance with program requirements; the lack of options for addressing noncompliance; and the potentially lengthy intervals between the identification of a nursing home’s compliance problem and its correction. Abandoning the hierarchical requirement systems, the regulation created a system capable of detecting and responding to noncompliance with any requirement. As described in its preamble in the *Federal Register*, the enforcement regulation was “built on the assumption that all

requirements must be met and enforced and that requirements take on greater or lesser significance as a function of the circumstances and resident outcomes in a particular facility at the time the survey.”

Perhaps the most fundamental question with respect to designing the required study about the effectiveness of the current survey is the criterion by which effectiveness is to be assessed; specifically, with what is the current survey to be compared? Two kinds of “effectiveness” comparisons seem both feasible and relevant. First, it is important to know the consequences of the major OBRA ‘87 reforms that were implemented in October 1990, compared to the enforcement system that preceded it. Second, it is important to know the consequences of the final set of OBRA reforms, particularly the enforcement provisions, implemented July 1, 1995, as compared to the enforcement system that preceded it.

With respect to the first comparison, the effectiveness of the initial OBRA reforms, a variety of studies were carefully reviewed for this report. With respect to the second comparison, the effectiveness of the final set of OBRA reforms, two sets of analyses were conducted: one assessed whether residents improved on a number of *outcome* measures due to the implementation of the July 1, 1995 enforcement provisions; the other empirically examined whether a number of survey and enforcement *processes* were in practice working as intended.

Effectiveness of OBRA ‘87 Provisions Implemented in 1990

In the report we have addressed a number of studies that focus on the effectiveness of aspects of the OBRA ‘87 provisions implemented in 1990.

Evaluation of the Resident Assessment Instrument (RAI)

A carefully designed evaluation of the nursing home RAI, a clinical assessment tool consisting of the MDS and a number of problem-focused Resident Assessment Protocols (RAPs), was conducted under contract to HCFA. The results of the RAI evaluation indicated that rates of hospitalization improved quite markedly. On other measures, selected health conditions, and function status measures, evaluators found both improvement and deterioration. However, improvement appeared to outweigh deterioration. Also, improvement occurred in arguably the more crucial areas addressed by the RAI.

Although the improvement appears real and due to the OBRA ‘87 reforms, commenters have found it less clear that the improvement was due to the RAI care planning component of OBRA ‘87, as argued by the investigators.

Study of Changes in the Use of Psychopharmacological Medications

This report presents an exhaustive review of the regulation of psychopharmacologic medication use in U.S. nursing homes from 1954 to 1997. In general, there was a consensus that antipsychotics were overused and antidepressants were under-used before OBRA ‘87. These

medications were specifically targeted in the OBRA '87 guidelines. A synthesis of several studies found improvement in the appropriate use of these medications, with the use of antipsychotics declining by 52.3 percent and antidepressants increasing by 97 percent (which equates to 24.9 percent antidepressant usage rate in 1997). This level of utilization of antidepressants is consistent with research on nursing home prevalence rates for major depressive disorders and depressive symptoms.

The magnitude and timing of the trend data in the use of psychopharmacologic medications combined with the results of separate studies designed to assess OBRA '87 impact indicate that the positive changes observed were due to OBRA '87. This is particularly true with respect to the utilization of antipsychotic and antidepressant medications drug categories that were specifically targeted in the OBRA '87 regulations and guidelines. This does not mean that other factors were unimportant. Indeed, it can be argued that some of these other factors, for example, the evolution of published knowledge and practices of geriatric medicine, contributed to the social and political process that led to the OBRA '87 statutes, regulations, and guidelines in the first place. These other factors, however, were not in and of themselves sufficient to change the general pattern of inappropriate use of psychopharmacologic medications in nursing homes. Only with the implementation of OBRA '87 was an abrupt change seen for the better. Hence, it appears that regulation was at least a necessary condition for the improvements observed. This conclusion is supported by a 1997 survey of randomly selected nursing home administrators in which 77 percent indicated that inappropriate psychopharmacologic medications had been reduced in their facilities in the last two years. Thirty-eight percent of these nursing home administrators said the reason these medications had been reduced was the OBRA '87 regulations.

Effectiveness of OBRA '87 Provisions Implemented in 1995

Stakeholder Perceptions of How the Current System is Working in Practice

Perceptions of the effectiveness of the current system were elicited from nursing home administrators, ombudsmen, consumer advocates, residents, family members, State surveyors, and nursing home personnel. Feedback was obtained in separate surveys of nursing home administrators and ombudsmen, as well as a series of listening sessions with providers, consumer advocates, ombudsmen, residents, family members, facility staff, and State surveyors. A survey of about 720 nursing home administrators using closed-ended yes/no or ranking questions had fairly positive responses related to changes made in response to the new survey and enforcement systems and administrators' satisfaction with the accuracy of the survey process. Results from the administrators' survey suggest that although they are generally satisfied with the accuracy of the certification survey process, they would prefer to have the option of deemed status. A second survey consisting of in-depth interviews with staff and management from 20 facilities, however, produced varied feedback with some negative responses about HCFA's survey and enforcement procedures. Many administrators commented that the "world view" of the survey process is based on a general distrust of providers, emphasizing punishment rather than a collaborative effort toward the joint goal of quality care.

The consumer advocates and ombudsmen expressed concerns with inadequate enforcement, the predictability of the survey, and inadequate staffing. The results of the listening sessions appear later in this report in an already highly concentrated form, as do the ombudsman survey and the provider survey. In a summary document of this nature, it would be impossible to fairly represent the many concerns and comments expressed by the various stakeholders; therefore, the reader is referred to Chapters 16 and 20.

Evidence on Outcomes

While stakeholders' perceptions are important, they are not a substitute for an empirical analysis of how the new system is working. The goal of this analysis was to measure the impact of the new enforcement regulation on nursing home resident outcomes. Because the enforcement regulation as implemented on July 1, 1995, introduced potential penalties for individual deficiencies, facilities may have responded to the new process by improving the overall quality of care. This enhanced quality of care in turn may have improved resident outcomes.

In this analysis, four resident outcomes were analyzed at both the State survey area office level and at the facility level: (1) percent residents physically restrained; (2) percent residents with pressure sores; (3) percent residents incontinent of bladder; and (4) percent residents incontinent of bowel. To control for confounding variables and to investigate whether resident status improvements could be linked to the enforcement regulation, a quasi-experimental study design was implemented that took advantage of the staggered timing of the new regulation.

The results of this analysis offer suggestive evidence that the new enforcement regulation was effective in improving resident status outcomes. At the area office level, the regulation is associated with a 9 to 10 percent reduction in bladder and bowel incontinence rates. There also is some evidence at the facility level that the new enforcement regulation had a very small, negative effect on the rate of physical restraint use. Consistently, facilities located in "low enforcer" area office jurisdictions who never or rarely cite facilities for substandard care were less responsive to the new enforcement regulation compared to facilities not located in "low enforcer" jurisdictions. It is not clear why the area office analysis indicated a positive impact of the July enforcement provisions on bladder and bowel incontinence rates, and the facility analysis indicated no effect in these areas. This could be due to reporting errors in the facility self-reported OSCAR data. These random errors tend to wash out when the variables used in the analysis are aggregated to the area office level. However, the reader should also bear in mind that the absence of a true control group raises the possibility, at least, that what appear to be enforcement effects are in fact due to other causes.

Evidence on Processes

The revised survey and enforcement system was implemented with a number of expectations about how it would work. As a matter of logic, it is possible that the new features of the survey and enforcement systems might work as intended, yet resident outcomes might not improve. We

have found the converse to be true: some of the new features may not in practice be working as intended, yet resident outcomes appear to have improved, as was discussed above.

Although it was not feasible to examine all the new processes generated by the July 1, 1995 changes to the system, we sought evidence with respect to the following selected processes related to: 1. administration; 2. problem identification; and 3. problem correction under the new system.

1. Administration

To what extent have changes in the survey and enforcement system affected administrative processes? One possibility was that administrative processes would clog under the new requirements. The enforcement regulation created new work for the State agencies responsible for conducting nursing home surveys. With respect to the question of whether the system can handle the increased workload, we found no evidence of any change in the frequency with which surveys are being conducted. Additionally, surveyors manage to conduct surveys at about the same rate as in the past.

With respect to the objective that the survey not only be unannounced but unanticipated, the current survey is much less successful. We found the survey interval to be quite variable. However, a facility has near certainty that it will never be surveyed on weekends or during evening hours. These data suggest that nursing homes could, for example, increase daytime staffing levels on Monday and Tuesday for a few months in anticipation of a survey, while not having to worry about weekend or nighttime staffing.

2. Problem Identification

One expectation of the new system was that even one instance of a violation of program requirements should result in a citation for deficient practice. All other factors being equal, this should, on average, have resulted in an increase in deficiencies. Contrary to this expectation, deficiencies declined, indicating that this new process of problem identification is not being implemented as intended. Although changes in facility quality could account for the decline in deficiencies, several pieces of indirect evidence suggest that improvements in facility quality are, at best, only perhaps a partial explanation of the observed decline. Further, it is important to be cautious in making any inferences about changes in surveyor behavior from changes in quality indicators. The indicators may only capture part of what surveyors are responsible for assessing.

Another concern with the new system is its capacity to identify serious problems. "Substandard quality of care" (SQC) was redefined to reflect instances in which the nursing home had more severe problems in providing quality of care or life. SQC is a very consequential designation under the new survey and enforcement systems. Facilities receiving a determination of SQC, in addition to any other remedies, lose their authority to conduct nurse aide training which, consequently, may make the hiring of nurse aides difficult. Because of these major consequences,

it is understandable that this designation might be contested by facilities, and surveyors and the State survey agencies might be hesitant to incur this conflict. Evidence suggests that States' ability or willingness to detect serious problems, as measured by the proportion of facilities that fall into the SQC category, varies considerably. Since the new enforcement provisions became effective, about five States have *no* facilities that are cited for *any* substandard care deficiencies; an additional four to 10 States cite almost none -- 1 to 2 percent of the facilities within their States. If a State has completed enough surveys, it would be expected that at least one (or a few) facilities should properly be designated with SQC. Hence, the extreme situation where no to very little SQC is reported most plausibly reflects surveyor (or State agency) behavior, not true quality differences. Under these circumstances, there is some question as to the capacity of the new system to identify serious problems, although serious problems may be identified as problems and classified on the enforcement grid as less serious.

Although the pattern of deficiency citations is consistent with the hypothesis that several States are not identifying problems as intended by the July 1, 1995 changes, this external analysis does not provide any direct evidence on the appropriateness of problem identification. In contrast, field studies conducted for HCFA by the Center for Health Services Research and Analysis (CHSRA), University of Wisconsin - Madison, provide more direct observational evidence that supports the more quantified analysis of citation patterns. CHSRA conducted two different types of studies, concurrent *surveys* and survey *observations*. For concurrent surveys, the CHSRA research survey teams completed standard Federal certification surveys simultaneously with recertification surveys being conducted by State survey teams. The survey observations were conducted by CHSRA observers who used an observation protocol. The surveys and observations were conducted on facilities broadly representative of nursing homes in the U.S. In general, the independent CHSRA researchers identified more serious problems as reflected in their scope and severity decisions; in no case did a State survey team report a higher scope and severity. These findings, consistent with the deficiency analysis reported above, indicate that the current survey, as implemented, does not sufficiently identify serious problems.

Since July 1995, there have been a number of media reports of abuse and neglect of residents in specific nursing homes in the U.S. It is difficult to know if the number of such reports has increased since July 1995, although this seems likely. It is of course possible that the new survey and enforcement provisions may have improved the outcomes for the average resident, as indicated in the research discussed above, and yet failed to protect a few residents from the kinds of egregious violations alleged in the media. Ultimately, it is difficult to evaluate the media allegations without an intensive, fact-gathering inquiry that is more characteristic of a court proceeding. Notwithstanding these cautions, we have made a limited effort to look behind some of these reports to see if something can be learned about limitations of the current survey system in addressing abuse and neglect.

Our assessment of these media reports and other evidence that has been marshaled to assess their credibility indicates, first, that malnutrition has been and continues to be a serious problem for

many nursing home residents. At present, the survey system does not appear to sufficiently address this problem. Second, the abuse of nursing home residents and the potential threat posed by hiring of nurse aides with violent, criminal histories may be a serious problem. It is likely that the current system under-identifies this problem.

3. Correction of Problems

Finally, there is the question of the effectiveness of the current system in correcting problems once they are identified. This question of problem correction is difficult to study retrospectively. It is also difficult to study without very expensive field work that would make direct observations at nursing homes over a fairly long period of time of what happens after specific problems are identified. We had neither the time nor the resources to conduct such an intensive investigation. We have, however, addressed this question by asking if the central mechanism of the survey process for correcting identified problems, Plans of Correction (POCs), resulted in real behavioral change on the part of providers or just paper compliance. Some assessment of this question was obtained from a modified ethnographic effort to collect and describe data collected from intensive interviews with representatives from a sample of 20 facilities who have had problems - often serious - cited under the new survey and enforcement systems.

We found evidence for both failure and success of the POC as an effective mechanism for problem correction. One example of failure was the frequently reported actions of facilities to provide in-service training to staff to correct identified problems. In the cases examined, there was no evidence bearing on the content and quality of the instruction, very high turnover of staff, and in one instance, a claim by a service union representative that workers were asked to sign an attendance sheet for an in-service they did not actually attend. On the more positive side is the example of a rural facility for which the survey team found substandard deficiencies. As a result of the required POC, the facility implemented a proactive means of resident behavioral monitoring, including meetings every two weeks of an interdisciplinary team to review any instances of individual resident behavior or resident interaction that warranted attention. The facility also implemented another team to review any reported falls and incidents involving residents on a weekly basis. While observing in the facility, the data collector witnessed this team in action during their weekly review. The incident review team is a self-directed effort that was still in place nine months after it was implemented. The other related improvement was that the admissions staff was more consistently completing accurate and comprehensive screening of any prospective residents.

Conclusions

A wide variety of evidence has been arrayed that bears on the three broad strategies for ensuring nursing home quality that Congress asked us to assess:

- With respect to granting deeming authority (the most likely organization to perform this function being JCAHO), evidence indicates that as presently structured, offering the deeming option to facilities would place many residents at serious risk. In contrast, the HCFA survey as typically implemented with its flaws, identifies many serious problems, allows less time for problems to remain uncorrected, and verifies compliance by an actual revisit as compared to JCAHO.
- An assessment of the second strategy, various regulatory incentives and non-regulatory nursing home quality improvement initiatives, provided little to no evidence that these efforts are effective and could supplant the normal survey process. At best, we would have to conclude that the evidence is not in.
- With respect to the third strategy, the existing system of survey and certification, evidence was produced that the OBRA '87 reforms implemented in October 1990 resulted in improved resident outcomes. Also, there is some suggestive but inconclusive evidence that the more recent enforcement provisions resulted in improvements in resident outcomes, although many of the enforcement processes we examined are not working as intended. There is a concern that several States never or very rarely cite a SQC deficiency.

The evidence examined in this study is supportive not only of regulation as the primary bulwark for quality assurance, but of enforcement needing to be more vigorously applied among the States. Although a thorough discussion of possible solutions to redress the problems in the Federal survey and certification process is beyond the scope of this report to Congress, the Department is currently in the process of identifying improvements to the current system.

PART I - BACKGROUND AND REPORT OVERVIEW

1.0 Background and Report Overview

1.1 Federal Responsibility for Financing and Quality Assurance of Nursing Home Care

In 1996, about 1.6 million people received care in approximately 16,800 nursing homes. Approximately 48 percent of nursing home residents have dementia. Eighty-three percent are extremely impaired, needing help with three or more activities of daily living, such as bathing, eating, using a toilet, dressing, mobility, and transferring to a bed or a chair. Another fourteen percent need help with at least one or two activities of daily living.¹ Although a relatively small proportion of the population is in nursing homes at any point in time, the proportion who will enter a nursing home at some point during their lifetime is high. For persons who turned 65 in 1990, an estimated 43 percent will enter a nursing home. Of this group, 55 percent will have a total lifetime use of at least 1 year, and 21 percent will have total lifetime use of 5 years or more.² Currently, the Federal government is the largest single payor of nursing home care, covering 57 percent of all nursing home care expenditures for Medicaid and Medicare in 1994.³ The Federal government has a responsibility to ensure that its expenditures are prudent and that the health and well being of one of the nation's most vulnerable populations are protected.

There is a general recognition that nursing home care has improved compared to the horrendous conditions dramatized in scandals during the 1950s and 1960s.⁴ Much of this improvement has been attributed to the Institute of Medicine's (IOM) 1986 report, *Improving Quality of Care in Nursing Homes*, and the changes introduced by the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) that reflected many of the report's recommendations.⁵ However, a general perception among some experts and the public continues to be that the typical nursing home is a terrible place. A recent survey of seriously ill hospitalized adults reported that of those responding to the key study question, 37 percent were unwilling to live permanently in a nursing

¹ "Nursing Home Update - 1996," Medical Expenditure Panel Survey, July 1997, No. 2, Agency for Health Care Policy and Research

² Kemper, P., and Murtaugh, C. "Lifetime Use of Nursing Home Care," *The New England Journal of Medicine*, Vol. 324, No. 9, p 595-600.

³ "Nursing Home Care in the United States," 1997 Chart Book, p.6, July, 1997, Health Care Financing Administration

⁴ Vladeck, B.C. 1980 *Unloving Care*, New York: Basic Books.

⁵ Vladeck, B., and Feuerberg, M. "Unloving Care Revisited," *Generations*, Vol. XIX, No. 4, p 9-13.

home, alarmingly, 30 percent indicated that they would “rather die.”⁶ Continued press reports of questionable practices reenforce a widespread negative perception of the quality of nursing home care⁷ and underscore the importance of Federal responsibility to ensure nursing home quality.

1.2 Background⁸

Prior to 1965, most nursing home regulation was a State responsibility; however, with the enactment of Medicare and Medicaid in 1965, Federal involvement in payment for nursing home services increased substantially, as did involvement in regulating services provided with Federal funds. Nursing homes that provide services to Medicare and Medicaid beneficiaries enter into provider agreements with the Health Care Financing Administration (HCFA) for Medicare and the individual State Medicaid agencies for Medicaid. To obtain and sustain the agreements (and thereby establish eligibility to receive payment for services rendered to beneficiaries), nursing homes must meet certain requirements set forth in the Social Security Act (the Act) and implementing regulations at 42 Code of Federal Regulations (CFR) 483, Subpart B. Nursing homes have the option of participating in either the Medicare or Medicaid program, both, or neither.⁹ Unless they participate in neither program, they are subject to the Federal regulations that govern the Medicare and Medicaid programs.

To assess compliance with Federal participation requirements, HCFA contracts with State survey agencies (SAs) to survey nursing homes. According to the Act, the statewide average interval between surveys must be no greater than 12 months, with the longest interval permissible between surveys for any given nursing home being 15 months. There are no limitations on how frequently the SA may elect to survey a nursing home, so long as the SA meets the aforementioned minimum requirements.

⁶ Mattimore, Thomas J., et. al, “Surrogate and Physician Understanding of Patients’ Preferences for Living Permanently in a Nursing Home,” *JAGS*, 45:818-824, 1997.

⁷ Thompson, M. Neglect. *Time Magazine*. October 27, 1997. Pages 34-38. Levine, S. Md. Facility is a center of conflict. *The Washington Post*. September 8, 1997, page B3.

⁸ See Chapter 14 for a thorough discussion of the history of nursing home regulation in the United States.

⁹ Requirements for nursing home participation in Medicaid and Medicare are virtually parallel. The provider agreements for program participation are separately executed and administered by HCFA and the relevant State, however. This affects who takes enforcement action against noncompliant nursing homes. In situations where a facility is “dually participating” in both Medicare or Medicaid, there are intricate rules (as specified in 42 CFR 488.452) about what happens when the two entities disagree about compliance or enforcement.

1.2.1 What Led to the Current Process?

During the 1970's, a number of scandals revealed the failure of the Federal nursing home monitoring and enforcement systems. The 1986 IOM report noted widespread quality of care problems and recommended strengthening Federal nursing home regulations. As a response to the far-reaching recommendations in the IOM report, the OBRA '87 legislation and ensuing regulations and guidelines generated: new standards in the area of quality of care, resident rights, resident assessment, and quality of life; the Resident Assessment Instrument (RAI), including the Minimum Data Set (MDS), a standardized assessment instrument for all residents in nursing homes; a more outcome-oriented survey that emphasizes gathering information directly by observing and interviewing residents; and training and competency evaluation standards for nurse aides.

In addition to establishing new Medicare and Medicaid participation requirements for nursing homes and changing the process used to assess compliance with the requirements, OBRA '87 introduced new enforcement provisions, including alternative remedies. The new remedies augmented existing options for addressing noncompliance with program requirements, that, prior to OBRA '87, only included: termination, nonrenewal, or automatic cancellation of the nursing home's provider agreement; denial of program participation for prospective facilities; and denial of payment for new nursing home admissions in lieu of termination of the provider agreement when the nursing home had deficiencies that did not pose an immediate and serious threat to the health and safety of residents. Abandoning the hierarchical requirement system, the new enforcement regulations implemented a system capable of detecting and responding to noncompliance with any requirement.¹⁰ As described in its preamble, the final rule published in the *Federal Register* presented new regulations "built on the assumption that all requirements must be met and enforced and that requirements take on greater or lesser significance as a function of the circumstances and resident outcomes in a particular facility at the time of the survey."¹¹ Deficient nursing home providers would be swiftly and appropriately sanctioned, and correction of problems would be prompt and lasting.

On July 1, 1995, HCFA implemented the new enforcement process, introducing remedies and inaugurating its new philosophical approach toward how to handle noncompliance. The enforcement regulation attempted to solve several long-standing problems: cyclical nursing home compliance (chronically in, then out of, compliance); the lack of options for addressing noncompliance (HCFA's main recourse was to threaten termination of the provider agreement, a threat rarely acted upon since most nursing homes managed to come back into compliance before

¹⁰ Medicare and Medicaid Programs; Survey, Certification and Enforcement of Skilled Nursing Facilities and Nursing Facilities HSQ-156-F Final Rule November 10, 1994 (Federal Register Vol. 59 No. 217)

¹¹ Final Rule, op cit

the termination's effective date); and the potentially lengthy intervals between identification of a nursing home's compliance problem and its correction.

HCFA had several process goals in implementing the new survey and enforcement systems. The first was to promote consistency through extensive training. The second was to link appropriate remedies to deficiencies. Under the statutory and regulatory provisions of the new survey and enforcement system, while all requirements for participation are considered equally enforceable, not all deficiencies have the same impact on residents; therefore it was necessary to develop a calibrated approach to linking the seriousness of the deficiencies to the severity of the remedy. The third goal was to avoid unnecessary procedures.

In changing its processes, HCFA attempted to strengthen enforcement and improve survey procedures with the overarching goal of improved care and quality for nursing home residents.

1.2.2 Current Survey and Enforcement Process

Results of surveys finding noncompliance with the nursing home participation requirements are documented on a Form HCFA-2567 (Statement of Deficiencies). Within 10 days after the survey, the SA sends the nursing home a copy of the HCFA-2567. The HCFA-2567 records observations, interviews, and record and document reviews made by the survey team that substantiate noncompliance with the requirements, refers to the relevant regulation, and cites its text.

If the SA finds noncompliance, it recommends that HCFA and/or the State's Medicaid agency impose appropriate remedies to address poor performance and/or to effectuate prompt nursing home correction of deficiencies.^{12, 13} Available remedies include civil money penalties, State monitoring, a directed plan of correction, installation of a temporary manager, denial of payment for all new Medicare and Medicaid admissions, denial of payment for all Medicare/Medicaid residents, directed inservice training, or HCFA-approved State substitutes or equivalents for any of these remedies. The State and/or HCFA may opt to give the nursing home an opportunity to correct by a specified date, with the remedy held as a threat if correction is not completed. In other instances, remedies may be imposed immediately.¹⁴

¹² The SA may also take whatever actions are warranted and allowed for under its licensing authority.

¹³ As noted earlier, the severity of the remedies has been calibrated to the seriousness of the deficiency. Accordingly, remedies have been categorized and linked to certain deficiency scope and severity levels. The enforcement grid references whether a certain category of remedy is mandatory and/or optional for each of its boxes.

¹⁴ In the immediate remedy scenario, only two remedies do not require prior notification (to fulfill due process requirements): civil money penalties and onsite State monitoring. HCFA's State Operations Manual (SOM) Section 7305 gives detailed guidance about legally required notices and the varying timeframes associated with situations involving immediate jeopardy to resident health and safety versus those that do not pose such a

Remedies are selected based on whether noncompliance is isolated, pattern, or widespread, and whether it: causes no actual harm with the potential for minimal harm,¹⁵ causes no actual harm but has the potential for more than minimal harm that is not immediate jeopardy; causes actual harm that is not immediate jeopardy to resident health and safety; or poses immediate jeopardy to resident health and safety. These ratings place each deficiency on a 3 x 4 grid, with boxes lettered A through L (least serious to most serious), denoting the combined scope/severity score (Exhibit 1.1). A deficiency, for example, affecting a pattern of residents (often a specific subgroup) that poses the potential for more than minimal harm would receive a scope/severity rating of E.

Exhibit 1.1: Scope and Severity Grid

S E V E R I T Y	J	K	L	Immediate jeopardy to resident health and safety
	G	H	I	Actual harm that is not immediate jeopardy
	D	E	F	No actual harm with the potential for more than minimal harm
	A	B	C	Substantial compliance - no actual harm with the potential for no more than minimal harm
	isolated	pattern	widespread	
	S C O P E			

When a facility is cited for multiple deficiencies, remedies are determined based on the deficiency assigned the highest scope/severity rating, also known as the driving deficiency. In addition, deficiencies within the regulatory groupings of Resident Behavior and Facility Practices (42 CFR 483.13), Quality of Care (42 CFR 483.25), and Quality of Life (42 CFR 483.15) that receive a scope/severity rating of F, H, I, J, K, or L result in a determination that the facility is providing substandard quality of care (SQC). The Act mandates that specific, unique consequences result

threat.

¹⁵ A deficiency at this level of severity that is either pattern or widespread does require the submission of a POC; isolated instances at this level of severity do not. However, this level of severity does not incur remedies. If the facility only has deficiencies that fall within this level of severity, it is considered to be in "substantial compliance" with program requirements and eligible for recertification.

from a determination of SQC, such as a ban on the facility's provision of nurse aide training.¹⁶ Remedy options and determinations are examined in greater detail in Chapter 10.

1.3 Report to Congress: Purpose and Scope of Study

1.3.1 Congressional Mandate

Section 516(d)(1) and (2) of the 1996 Appropriations Act required a study and report to Congress on the effectiveness and appropriateness of current mechanisms for surveying and certifying skilled nursing facilities (SNFs). The Act requested a "... specific framework, where appropriate, for implementing a process under which facilities ... may be deemed to meet applicable Medicare conditions and requirements if they are accredited by a national accreditation body," as well as analysis of cost effectiveness and quality implications for deeming. The conference report also indicated interest in innovative regulatory and non-regulatory incentives for quality improvement in nursing homes.

In response, this report has three sections. Part II examines the issues surrounding deeming and its feasibility, and perhaps more importantly, its advisability. Part III discusses interventions such as incentives linked to resident outcomes and quality improvement initiatives. Part IV discusses the question of the effectiveness of the current regulatory survey and enforcement systems that are used to set, monitor, and enforce threshold standards, and ensure and, optimally, promote quality.

1.3.2 Objective

It appears that the key objective of the legislation is to determine whether activity in these three areas can somehow be reconfigured to provide more efficient, effective nursing home quality assurance. Although this is an extremely ambitious and comprehensive objective, limited time and resources have precluded attention to some related topics. Study limits are noted in 1.3.3.

1.3.3 Study Limits

This report to Congress focuses on a number of problems with respect to the Federal nursing home survey and certification system. Although a thorough discussion of possible solutions to redress these problems is beyond the scope of the report, the Department is in the process of identifying improvements to the current system. Further, although this is an extremely

¹⁶ Originally, the law provided that nurse aide training could not be offered in or by a facility that had been subject to an extended or partial extended survey (which would be the case if a finding of SQC was made, hence the association between SQC and suspension of nurse aide training programs for two years). (Other circumstances, as detailed in SOM Section 7809, may also trigger the loss of such a training program.) However, on May 15, 1997, P.L. 105-15, HR 968, provided a possible waiver under which, if certain criteria are met, the facility cannot give its own training but can have a third party come in and provide training in the facility.

comprehensive report, a number of issues remain that would ideally be covered in a report of this nature: 1) resource issues with the current survey and enforcement program, including the impact of directing limited resources primarily to nursing home surveys (as opposed to the survey of other provider types); 2) user fees to generate needed revenue; 3) alternatives to The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation; and 4) the policy implications of relying on survey and certification, accreditation, or other alternatives (e.g., privatization). These issues are beyond the scope and timeframe of the legislation authorizing the study and allocated resources; however, such analysis would be important to a comprehensive assessment of nursing home quality assurance policy options.

Two other issues relating to nursing home quality assurance emerged during this study. First, although we found evidence of State differences in enforcement that impacted on resident outcomes, the sources of these differences are unclear.¹⁷ Second, nursing home staffing issues were frequently mentioned in a survey of States' ombudsmen and "Listening Sessions" where consumers, providers, professionals, States, and other interested persons were invited to voice opinions and experiences with the current survey.¹⁸ Concerns included insufficient staffing (particularly on weekends), high staff turnover, and the specific role of the nurse aide who provides most of the hands on, direct care. These staffing concerns, based largely on anecdotal evidence, are further supported by the recent IOM report.¹⁹ There are also research studies indicating that inadequate nurse staffing is the major factor influencing malnutrition found in nursing homes.²⁰

1.3.4 Evaluation Contractor and Constituency Input

In late November 1996, HCFA contracted with an independent evaluation contractor, Abt Associates, to assist in conducting this study. Preliminary study plans were developed and shared with JCAHO and representatives from The American Health Care Association (AHCA), The American Association of Homes and Services for the Aging, The American College of Health Care Administrators, The National Citizens Coalition for Nursing Home Reform, The National Senior Citizens Law Center, The American Association of Retired Persons, The National Committee to Preserve Social Security and Medicare, The National Association of State Ombudsmen, and a number of State licensing and survey directors.

¹⁷ See Chapter 17, Chapter 18, and Chapter 19.

¹⁸ See Chapter 16.

¹⁹ "Nursing Staff in Hospitals and Nursing Homes - Is it Adequate?" Institute of Medicine, 1996.

²⁰ See Chapter 19.

In general, all groups supported the approach outlined in the study plans, although some expressed concerns about the absence of planned efforts to explore the policy issues inherent in deemed status, the need for further input from consumers and their families, the absence of addressing regulatory incentives for improving care, and the difficulty of making inferences from HCFA's On-line Survey, Certification, and Reporting system (OSCAR) data about changes in the status of nursing home residents. We have incorporated these concerns into the full report's analyses.

1.4 Determinants of Nursing Home Quality

At least six broad factors can affect nursing home quality:

- 1) *Market mechanisms* affecting the demand for nursing home beds. When there is excess demand, there is evidence that nursing homes do not have to compete for residents on the basis of quality.²¹ Although the nursing home occupancy rate may have recently declined somewhat,²² it remains very high (about 87 percent) and is much higher than that of hospitals.²³
- 2) *Professional knowledge*. The diffusion of knowledge from schools of nursing, pharmacy, health administration, geriatric medicine, and professional associations affect accepted practice by nursing home providers and staff.
- 3) *Payment systems* for nursing homes that attempt to address the competing objectives of ensuring access and quality while containing costs. An increasing number of States (25 in 1995²⁴) have opted for various Medicaid case-mix reimbursement systems that seek to adjust nursing home payment to the care needs - the case mix - of the residents. Presumably, higher payment rates for residents with heavier care needs (and consequently greater expense) encourage nursing homes to admit heavy-care residents. Although

²¹ Nyman, J.A. "Excess Demand, Consumer Rationality, and the Quality of Care in Regulated Nursing Homes," *Health Services Research*, 24(1):105-127. 1989.

²² Strahan, G. "An Overview of Nursing Homes and Their Current Residents: Data From the 1995 National Nursing Home Survey," *Advance Data*, January 23, 1997, National Center for Health Statistics

²³ Branch, L.G., Cowles, M., and Johnson, J., 1994 "Tracking the Supply of Nursing Home Beds" in *Nursing Home Yearbook: 1994*, Health Data Associates, Inc.

²⁴ Harrington, C., Swan, J., Bedney, B., Carillo, H., Studer, L. *1995 State Data Book on Long Term Care Program and Market Characteristics*. Department of Social and Behavioral Sciences, University of California, San Francisco and the Department of Health Services Organization and Policy, College of Health Professionals, Wichita State University, Wichita, Kansas. November 1996. Funded by the U.S. Department of Housing and Urban Development and the U.S. Health Care Financing Administration (p. 4)

Medicare currently reimburses Medicare stays by a system of retrospective cost reimbursement, effective July 1, 1998, a prospective payment system will be in place for SNFs. Apart from these alternative payment systems, a number of States have experimented with incentives payments for nursing homes that attain certain performance goals.²⁵

- 4) *Private accreditation.* JCAHO currently inspects about 1500 nursing homes and accredits those meeting its quality standards. Until recently, JCAHO was the only national nursing home accrediting organization; there appears to be another organization that has begun providing similar accreditation.
- 5) *Regulation,* the system of surveying compliance with the Medicare and Medicaid requirements for participation and various State licensure requirements.
- 6) *Non-regulatory quality improvement interventions* conducted by stakeholders individually and collaboratively.²⁶

With the exception of the first factor listed, this report will address aspects of all the other factors, particularly accreditation and regulation.

1.5 Part II-Private Accreditation/Deeming of Nursing Homes

The government's survey and enforcement processes are used to measure and ensure quality in the nation's nursing homes. However, these processes are not the exclusive mechanisms for quality assurance. Other approaches include States' long term care (LTC) ombudsmen programs, nursing homes' internal systems for promoting quality,²⁷ and voluntary accreditation programs, such as JCAHO's. Two programs that may have some potential to impact and/or assess quality are: 1) intensified Federal government efforts to combat fraud and abuse; and 2) quality improvement programs implemented by Peer Review Organizations (PROs). Up to this point, the

²⁵ See Chapter 12.

²⁶ See Chapter 13 for a review of these interventions.

²⁷ In 1994, HCFA promulgated new regulations requiring the existence of a nursing home quality assessment and assurance committee and governing its composition and frequency for meeting. The regulations also state that the committee should have methods to identify and respond to problems. While the former components are fairly easy to regulate, the latter (i.e., committee effectiveness) may not be due to the need to promote the honest use of such a system by the home. Nursing homes fear that reports of committee activities may be used as a basis for writing deficiencies related to compliance with Medicare/Medicaid participation requirements, thereby incurring sanctions. To alleviate this fear, both the Act, and, perhaps more stringently, the regulations and implementing manuals have restricted surveyor scrutiny of the committee records and actions.

effects of either have been negligible since nursing homes have not been a primary focus of these efforts.

1.5.1 History - Nursing Homes and Deemed Status in Medicare²⁸

With the creation of Medicare in 1965, Congress authorized deeming (the use of privately-conferred accreditation status as proof of compliance with Federal regulations) as an option for certifying hospitals for Medicare program participation.²⁹ Only the JCAH's hospital accreditation program, which then covered 60 percent of U.S. hospitals,³⁰ was immediately approved.³¹ This authority was extended to cover nursing homes and other provider types by amendment of §1865(a), in §§2345 and 2346 of the Deficit Reduction Act of 1984, and §6019 of the Omnibus Budget Reconciliation Act of 1989. Subsequent amendments to the law in 1988 and 1991 gave the Secretary of HHS discretion to grant deeming authority to organizations accrediting a wide variety of eligible facilities, including psychiatric hospitals, home health agencies, hospices, laboratories and clinics, SNFs, and other types of health care providers. Granting deeming authority required HHS to find that accreditation by a national body offers "reasonable assurance" that Medicare conditions of participation (COPs)³² are met. The Omnibus Fiscal Year 1996 Appropriations legislation (P.L. 104-134) mandated expanded use of deemed status in the Medicare program. **With the exception of SNFs**, durable medical equipment suppliers, renal dialysis facilities, and managed care plans, the legislation required that the Secretary must accord deemed status if he or she finds that private accreditation demonstrates compliance with the COPs. The 1996 legislation thus retained the former law with respect to deeming for SNFs - that is, the Secretary *may* grant deemed status but is not mandated to do so.

For more than a decade, Federal policies have promoted gradual deregulation and privatization of the Medicare program. Industry argues that nursing homes should have more choice and flexibility in fulfilling Medicare requirements. In addition to regulatory reform, industry supports the use of deeming. Consumer groups counter that deeming represents an inappropriate

²⁸ A more extensive review of the history of accreditation and deeming, including a history of the JCAHO, the history of deeming in Medicare hospital program, and extension of deeming to the Medicare home health program, may be found in Chapter 3

²⁹ See the Social Security Act §1865(a).

³⁰ McGeary, M.G.H. Medicare conditions of participation and accreditation for hospitals. in *Medicare: A Strategy for Quality Assurance. Volume II. Sources and Methods*. Washington, D.C.: National Academy Press. 1990.

³¹ Currently, the American Osteopathic Association also has deeming authority for hospitals.

³² For SNFs and nursing facilities (NFs), the standards that must be met are referred to as "requirements" rather than "conditions."

surrender of government’s authority to set and enforce standards, and that experience in deeming Medicare-certified hospitals shows that accreditation provides no guarantee of residents’ health and safety. At present, deeming is used for hospitals and home health agencies; however, as Congress expressed interest in investigating this option for nursing homes as well, this report presents study findings about the quality and cost of deeming in comparison with the current survey and enforcement systems.

Two programs currently accredit nursing homes; JCAHO’s, and Survey Solution’s Long-term care Evaluation and Accreditation Program (LEAP). LEAP is a newcomer to the accreditation arena, while JCAHO has acted as an accrediting body for many years.

1.5.2 JCAHO’s Long Term Care Accreditation Process

LTC facilities may choose to be accredited by JCAHO, a private, non-profit entity providing accreditation services to the majority of health care provider types. JCAHO accredits nursing homes based on the results of surveys conducted on a triennial basis to assess compliance with JCAHO standards. Surveyors score the facility’s degree of compliance with each standard on a five-point scale ranging from substantial compliance to non-compliance, as follows:

Score	Definition	Description
1	Substantial Compliance	The organization consistently meets all major provisions of the standard.
2	Significant Compliance	The organization meets most provisions of the standard.
3	Partial Compliance	The organization meets some provisions of the standard.
4	Minimal Compliance	The organization meets few provisions of the standard.
5	Noncompliance	The organization fails to meet the provisions of the standard.

These scores are aggregated, based on a series of algorithms, to scores in 35 substantive areas (called grid elements), grouped into 11 domains such as resident rights, assessment of residents, improving performance, and so forth. The scores in these areas, in turn, aggregate to a single summary score for the facility.

Standards scored higher than 1 (substantial compliance) result in recommendations to the facility, indicating that corrective action should be taken. These recommendations may be one of two types: Type 1 or Supplemental. Type 1 Recommendations require specific follow-up actions (a written progress report or a focused re-survey) for the facility to demonstrate that the non-compliance or partial compliance with standards has been corrected. Type 1 Recommendations generally result from standards scored 3, 4, or 5. Supplemental Recommendations, generally scored 2, identify issues that the facility is expected to address, but require no post-survey follow-

up with JCAHO to ensure correction. Supplemental Recommendations are reviewed prior to a facility's subsequent triennial survey, at which time the surveyor pays closer attention to these standards to determine whether the facility has come into substantial compliance in the areas noted on the previous survey.

The facility's summary score coupled with decision rules related to the types of problems identified result in the assignment of one of five possible accreditation decisions:

- Accreditation with Commendation,
- Accreditation,
- Accreditation with Type 1 Recommendations,
- Conditional Accreditation, and
- Non-Accredited.

In addition to surveying facilities for compliance with general LTC standards, JCAHO offers specialized accreditation of dementia special care units and subacute programs within LTC facilities. More detailed information regarding the JCAHO process, standards, and accreditation decision-making is contained in Chapters 5, 7, and 10.

1.5.3 Options With Respect to the Role of Deeming

With respect to the inclusion of deeming, HCFA has three general options:

1. **Retain its current system**, with or without modification. Under this model, HCFA writes the rules that define nursing home participation requirements and continues to rely on State surveyors to monitor compliance. HCFA enforces rules through sanctions in response to identified deficiencies.
2. **Offer nursing homes a choice** between the traditional survey process and private accreditation. For the private option, HCFA could delegate some or all of its role in: 1) *setting standards* by assuring that the standards set by private accrediting agencies are "comparable" to government standards; 2) *monitoring compliance* through comparable public and private survey programs; and 3) *enforcing compliance* through comparable sanctions.
3. **Mandate a privatized system**, contracting with private entities to conduct all or some survey and certification activities.

The third option would most likely require a legislative change and is unlikely to be implemented at present; in any event, it is beyond the scope of this report. The most obvious vehicle for implementing options two or three is JCAHO's LTC accreditation program since most other accreditation organizations are not active in the nursing home setting. However, LEAP, which

began accrediting nursing homes in late November 1997, may potentially offer JCAHO competition as it enters this field.³³ Aside from issues of how options two and three could be implemented, there are larger questions related to deeming

1.5.4 Stakeholders' Concerns

On the deeming questions, stakeholders tend to fall into one of two groups: the first consists of consumer advocates, some trade unions, and associations of State surveyors, who generally oppose privatizing regulation in general and deeming in particular; the second group is made up of nursing home administrators, nursing home associations, and organizations that accredit health care providers, who generally favor private regulation and deeming. Despite sharp disagreements over government's proper role, proponents and opponents of deeming have agreed on two major points. First, some nursing homes clearly need the punitive threat of review and enforcement to secure improvements. Second, the current survey system has not worked as well as it should to eliminate poor quality nursing home care.

Proponents of deeming argue the ineffectiveness of the current regulatory system, suggesting that it be scrapped or modified to allow providers more choice in proving compliance with regulations. Their position rests on several assumptions and observations:

- The survey and certification processes are bureaucratic and inflexible.
- Even though there are a few poor performers, most nursing homes strive to provide good quality care and succeed. If some nursing homes choose accreditation, deeming will allow States to focus survey and enforcement resources on substandard nursing homes.
- Nursing home administrators are better educated and more experienced managers than they were 10 years ago.
- Many good performers in the industry are positioned to respond to the positive incentives built into the educative, consultative model favored by accrediting organizations. To raise the average level of quality, rewards are needed as well as punishments.
- HCFA's implementation of the new nursing home survey and enforcement system in July 1995 has heightened industry concerns about consistency in enforcement.

³³ As of late January 1998, LEAP had completed 11 accreditation surveys. Obviously, adequate data on the LEAP process and results were not available for inclusion in this study. For more details on the accreditation programs of these organizations, see Chapter 4, "Catalog of Accreditation Entities."

- Based on its experience with hospitals, JCAHO is more efficient than HCFA because it relies on facility administrators and clinical staff to do much of the job of enforcing standards and because it can rely on industry expertise in setting and revising standards.³⁴

Opponents of private regulation agree that the current system does not work as well as it should and that not all nursing homes are poor performers. However, they suspect that serious problems are more widespread than do deeming proponents. They argue that the current survey and enforcement systems should be improved, not scrapped. The main points of their argument are:

- Despite improvements, for the most part, nursing homes are not managed by “professionals.” The shared codes of conduct that govern the clinical professions are not present among nursing home administrators.
- The relatively high frequency of compliance problems among nursing homes (nearly two-thirds of nursing homes are cited with one or more deficiencies annually) shows that the average nursing home is not ready to escape direct government monitoring and enforcement. Reports in the press document questionable and sometimes horrific practices that show the need for vigilance.³⁵
- Accreditation does not “work” in other contexts, even among hospitals for which deemed status has been an option since 1965.³⁶ Few hospitals are decertified or denied accreditation, and there is typically no enforcement. Private accrediting organizations have no authority to enforce Federal regulations. JCAHO surveys are announced well in advance and follow a three-year cycle, characteristics that limit the effectiveness of accreditation in protecting residents.
- Whatever the practical arguments for deeming, accrediting bodies are not accountable to the public or to government.³⁷
- Deeming would “(threaten the) cooperative relationship (between the Federal and state governments) and the sharing of inspection costs...” which would “greatly increase the costs of inspection programs to the states.”³⁸

³⁴ Jost, op. cit. p 881

³⁵ Thompson, M. Neglect. *Time Magazine*. October 27, 1997. Pages 34-38. Levine, S. Md. Facility is a center of conflict. *The Washington Post*. September 8, 1997, page B3.

³⁶ Reap, E. (Association of Health Facility Survey Agencies). Letter to M. Feuerberg. July 3, 1997.

³⁷ Ibid.

³⁸ Ibid.

Although deeming's proponents and opponents generally address the entire process, there are at least two key components of regulation that could be separately privatized: 1) setting standards against which nursing home performance will be measured and 2) enforcing standards, by measuring performance and exacting compliance. The next two sections discuss standard setting and enforcement.

1.5.5 Privatizing Setting Standards

Policy Question

Kinney identifies two functions of accreditation: standard setting, and determining "whether organizations have complied with these standards, thereby warranting accreditation."³⁹ In principle, these functions are separable, allowing the privatization of one while the other could remain under direct Federal control. Government might delegate the setting of standards for nursing homes, in part because private organizations may command readier access to relevant expertise than government. However, critics decry the lack of accountability in the processes accrediting organizations use to set standards, and condemn the current divorce of the survey process from enforcement of regulatory standards in the Medicare hospital program.

The policy question facing the Federal government is whether the standards of private accrediting organizations should be accepted for determining nursing home compliance with Medicare regulations.

Criteria for Assessing the Standard Setting Process

Using criteria that mirror those spelled out in HCFA's rules governing the selection of deeming organizations,⁴⁰ this report compares both the processes and products of accrediting organizations with the current survey and certification systems. These criteria include:

- *Comparability* of the accrediting organization's standards and Federal standards.
- *Validity* of the standards. Do standards for resident outcomes reflect the most rigorous recent research on outcome measurement and linkages of outcomes to organizational structure and the processes of care?

³⁹ Kinney, E. Private accreditation as a substitute for direct government regulation in public health insurance programs: when is it appropriate? *Law and Contemporary Problems*, Vol. 57, No. 4, Autumn 1994, p. 49.

⁴⁰ U.S. Department of Health and Human Services/Health Care Financing Administration. 42 CFR Parts 401, 488, and 489. Medicare Program: Granting and Withdrawal of Deeming Authority to National Accreditation Organizations. Final Rule. *Federal Register* /Vol 62, No. 127, November 23, 1993. Pages 61816-61843.

- *Accountability* in the process of setting and revising standards. Does the public have access?

Evidence

The catalog of accreditation entities presented in Chapter 4 is based on document review and interviews conducted with representatives from a wide array of private accreditation programs. Major differences between private accreditation processes and the Federal survey process across health care settings include: overall philosophy and approach to surveys; frequency of surveys; surveyor requirements and training; and public information disclosure. It is not uncommon for accreditation entities to have roots deep within the industry that they are intended to assess. Such entities are less likely to be viewed by providers/facilities as an arm of enforcement than as an "experienced helping hand." Of the entities examined, only LEAP requires an annual, unannounced survey for all nursing homes seeking accreditation (as does HCFA).

Nursing home standards and requirements. Abt Associates recently examined the comparability of JCAHO's standards and HCFA's requirements. An experienced nurse researcher conducted an intensive analysis of the numbers and types of standards, and the language in the 500 JCAHO standards (effective January 1996) and 185 "F-Tags" that codify the HCFA requirements (current in July 1995). The analysis showed both similarities and substantial differences between the two systems.⁴¹ This exercise demonstrated several instances of close comparability, with other instances in which JCAHO and HCFA addressed similar concerns but with greater or lesser focus.

The reviewer also identified six areas where JCAHO standards diverge from the HCFA regulations, either in the intent of the statement or in the breadth of the focus, so as to cast doubt on a reasonable assurance that the Medicare participation requirements are met: 1) safeguarding and protection of the individual's rights; 2) description of resident's special needs; 3) qualifications of a social worker, activities director, and dietitian; 4) lack of clarity regarding use of medications; 5) subsequent actions that are to follow poor resident outcomes that are stated in the HCFA regulations but not explicitly stated in JCAHO standards; and 6) the provision of physician services. The reviewer concluded that JCAHO would have to make changes in its standards to provide reasonable assurance that Medicare's LTC requirements are met.

With respect to the two other criteria for assessing the standard setting process, validity and accountability, this study found further problems with JCAHO's practices. Consistent with the recommendations of the IOM, both HCFA and JCAHO have recently adopted more resident-centered foci, but JCAHO standards are still heavily weighted toward structure and the presence of policies and procedures, while HCFA has expanded emphases on clinical outcomes and quality

⁴¹ See Chapter 5, "Content Analysis of JCAHO Standards and HCFA Regulations for Long Term Care."

of life. With respect to accountability, the public has no access to JCAHO's processes for setting and modifying standards; HCFA's processes are open to scrutiny through the practice of publishing proposed rules for public comment.

1.5.6 Private Options for Securing Compliance

Policy Question

Can private accrediting organizations assure that nursing homes comply with Medicare LTC requirements?

Criteria

Delegation of survey and enforcement functions to private entities can be evaluated against several criteria:

- *Comparability* of the survey processes, deficiency rules, enforcement, and follow-up procedure between JCAHO and Federal surveys;
- *Capacity* defined by background and numbers of trained surveyors.
- *Validity* of the JCAHO survey process in identifying deficiencies. Does the JCAHO survey process find valid deficiencies: 1) compared to the Federal survey process; and 2) compared to independent assessments of quality of care and quality of life in surveyed nursing homes?
- *Accountability* to the public and government. Do members of the public and government officials have complete access to JCAHO survey findings? Do providers and consumers have access to appeals processes?
- *Effectiveness* in achieving the objectives of Federal regulation.

Evidence

The final report found that essentially any capacity issues (i.e., limits on JCAHO's ability to field sufficient surveyors) would probably be short run in nature. With respect to accountability, there is no disputing critics' contention that accrediting organizations are not fully accountable to the public. Empirical evidence bearing on the other criteria are discussed below.

Comparability. The HCFA and JCAHO survey processes differ on a number of counts:⁴² HCFA surveys facilities on average annually; JCAHO surveys are conducted every three years. Facilities cited for deficiencies by HCFA are required to correct deficiencies by a “date certain,” within at most three months from the survey; the JCAHO process usually allows about six months to demonstrate improved performance with respect to identified problems. Both HCFA and JCAHO report that a majority of facilities have deficiencies that need correction (66 percent and 75 percent from July 1996 through June 1997, respectively) and that most of them correct deficiencies within prescribed time frames.⁴³ In 1996, JCAHO denied accreditation to only one facility (of 722 surveyed).

An intensive observational study of the JCAHO survey process reports that surveyors spend little time assessing quality of life issues or observing clinical treatments. Based on observations of complete accreditation surveys in four facilities, investigators concluded that, although JCAHO surveyors were well-trained and thoroughly professional (“masters-prepared with experience as directors of nursing and/or administrators in long term care”), little time was spent with residents (the numbers of residents surveyed ranged from one to six), and no time was spent observing clinical care delivery. Only one surveyor reviewed charts against direct observation of resident status. Surveyors were free to design their own protocols (with suggestions found in the JCAHO’s *Complete Guide to the Survey Process*). JCAHO software, accessed onsite through surveyor lap-top computers, did not force complete coverage of all standards; surveyors could choose which standards to address. In addition, surveyors did not always enter all issues that were discussed with facility management. Investigators concluded that, despite the high level of professionalism of JCAHO surveyors and their commitment to the consultative function of the JCAHO process, “...the standard JCAHO survey does not collect sufficient information regarding a LTC facility’s compliance with HCFA’s Requirements for LTC Facilities.”⁴⁴

Onsite analysis of LEAP’s standards, procedures, and findings was not conducted since LEAP operation began only recently. It appears that the LEAP surveys resemble JCAHO surveys, with three important differences. First, LEAP surveyors are expected to “interview residents, staff, family members, and legal representatives” and to review a random sample of clinical charts. Second, the automatic scoring software the LEAP surveyors will use onsite has scope and severity dimensions that map readily to HCFA’s system. Third, LEAP “requires an annual unannounced survey for all LTC facilities seeking accreditation.”⁴⁵

⁴² See Chapter 10, “Comparison of HCFA Enforcement and JCAHO Follow-Up.”

⁴³ See Chapter 11.

⁴⁴ See Chapter 7, “Observational Study of the JCAHO LTC Survey Process.”

⁴⁵ Chapter 4

Validity - Comparison of HCFA and JCAHO Surveys. Abt's findings suggest that JCAHO's survey process overlooks serious quality deficiencies that HCFA's surveys uncover.⁴⁶ In a comparison of 179 HCFA and JCAHO surveys completed within a time window of three months at the same facilities, investigators found that "...only 28 percent of the surveys in the sample were found to be relatively comparable, [in the sense that] similar problems were identified by both organizations or because there were no significant problems identified by either group." [Note: The study selected a sample of 200 facilities that fit the 3 month window and other study criteria. Because the focus of this study was to determine whether the JCAHO process provides reasonable assurance than noncompliance with HCFA regulations will be identified, it was decided that the 127 facilities that were surveyed first by JCAHO would automatically be included in the sample so that, to the extent possible given the other sampling criteria, JCAHO survey results would not be confounded by a recent HCFA survey. Hence, nearly two thirds of the original sample were facilities surveyed first by JCAHO. The final sample was reduced somewhat because the HCFA-2567 reports (the Statement of Deficiencies) were not readily available.] Investigators further grouped surveys that failed tests of comparability according to whether these failures compromise the JCAHO's ability to provide reasonable assurance that accredited facilities meet Medicare regulations.

1. Of least concern regarding "reasonable assurance," *in about 19 percent of the sampled cases, HCFA found isolated deficiencies (i.e., limited to a small number of residents) that JCAHO did not find.*
2. Of greater concern, *for 46 percent of the sample, HCFA found relatively severe problems affecting patterns (and potentially all) residents, with "potential for adverse impact on numerous residents" but no determination of SQC. JCAHO did not report these deficiencies.*
3. Most troubling was the finding that *in 7 percent of cases, HCFA found facilities "providing substandard quality of care and [causing] actual harm to residents."* JCAHO reported no such problems in these facilities, despite documented histories of past problems, and in two instances awarded facilities in this category Accreditation with Commendation.

Investigators concluded that "JCAHO accreditation may be comparable to HCFA certification in facilities where there are no serious problems." However, "...[it] is questionable whether the JCAHO process, as currently applied in most cases, is capable of uncovering serious quality of care and quality of life deficiencies that have the potential to severely compromise resident health, safety and/or psychosocial well-being." Given that JCAHO has higher minimum qualifications for surveyors, requiring a master's degree and five years of LTC management experience, it would

⁴⁶ See Chapter 8, "Comparative Analysis of HCFA and JCAHO Survey Results."

not be surprising if the JCAHO survey was superior to HCFA's.⁴⁷ Clearly, the results of the empirical studies did not support this expectation.

Validity - Comparison of JCAHO and "Gold Standard" Surveys. The study by Abt Associates, described above, compares the results of JCAHO and HCFA surveys and finds a troubling portion of surveys where HCFA identified a serious problem that was not identified by the JCAHO survey. Another approach to validity is to compare the JCAHO survey with a concurrent "gold standard" survey conducted by independent experts. Consistent with the IOM's recommendations on nursing home quality, University of Colorado researchers (CU) have developed a survey utilizing resident-centered and outcome process indicators with consideration for case mix. For this report, CU researchers conducted 14 surveys concurrently with JCAHO surveys between September 8, 1997, and November 14, 1997. The sites were randomly selected by CU with some effort to maximize variation in the JCAHO surveyors, geographic regions, and some representation of nursing homes with hospital-based, subacute, and dementia units. Primary data from the Minimum Data Set assessment, nursing home record, observations, and interviews of staff and residents were collected on 1088 residents over the course of this project. These data were configured into a number of quality of care indicators covering 17 domains which could then be "mapped" to a comparable JCAHO standard. The analysis consisted essentially of "tests of agreement" for each domain and across domains (i.e., an overall facility level score) between the JCAHO and CU surveys.

CU researchers found moderate agreement between the JCAHO and CU surveys for quality in the domain of personal environment and fair agreement in the domains of restraints, pain, and rehabilitation. However, in 10 quality domains, CU found that the JCAHO survey was not sensitive to important quality of care issues detected by the CU survey. These included: nutrition; function; falls; continence; psychotropic medications; personal care; deaths; pressure sores; contractures; and behavioral problems. The quality of care problems identified in the CU survey were resident-level outcome and process problems that were detected both because of their prevalence in the facility and the severity of the problems noted in individual cases. When quality of care indicators were aggregated to the facility level, the CU survey identified four

⁴⁷ A comparison of HCFA and JCAHO surveyor training, presented in Chapter 6, is based on information and materials collected from staff at both organizations, group interviews with state surveyors and a questionnaire administered to a sample of State surveyors attending HCFA's LTC BASIC surveyor training course. The comparison shows that both organizations provide an initial training session for new surveyors. JCAHO has higher minimum qualifications for surveyors, requiring a master's degree and five years of LTC management experience. JCAHO surveyors have formal performance reviews and attend updated surveyor training sessions annually. No continuing education is required of HCFA surveyors and many States do not support it -- offering little to no financial assistance or paid leave to facilitate surveyor attendance at continuing professional education programs. HCFA surveyors must pass a Surveyor Minimum Qualifications Test, but no additional assessments are mandated by the Federal government. Because surveyors are State employees, minimum requirements and performance review criteria and methods vary on a State-by-State basis.

facilities with significant quality problems, while JCAHO surveyors accredited all 14 facilities (scores of 80 percent or above). Furthermore, two of these four facilities, including the worst one according to the CU survey, ranked in the top four JCAHO surveys.

In addition to the comparative analysis, Chapter 9 presents summaries of some disturbing findings of specific cases that were reviewed because the CU researchers believed that the selected cases demonstrate the validity of the quality problems. The CU analysis required clinicians to decide whether poor outcomes were justified by the resident's underlying health conditions or the facility's attempts to avoid adverse outcomes. These examples of disturbing findings include three deaths found in closed records. In all cases there was lack of attentiveness to patient signs and symptoms by skilled nurses, despite resident complaints or ample evidence of a health problem. While in many cases a nursing home death is justified because aggressive intervention is neither warranted nor wanted, some are not. Other examples relate to situations where rehabilitation is inadequate, resident function declines substantially, skin is not protected, no attempt is made to prevent incontinent episodes, restraints are used excessively or incorrectly, psychotropic medications are used without a supporting diagnosis or without review, residents are malnourished and receive no supplements, new pressure sores occur because immobilized residents have no protection, pain is not treated, and residents do not receive morning care or are dressed in nightshirts.

It can be argued that the comparison between JCAHO survey findings and CU's "gold standard" survey is unreasonable. It may not be realistic to expect any operational survey - JCAHO's or HCFA's, for that matter - to compare favorably with a survey conducted by independent experts as part of a research study. Ideally, a HCFA survey would have been conducted at the same time as the CU and JCAHO surveys so that we could make a three-way comparison of findings. However, time, resource, and logistical constraints precluded this study design. While this three-way comparison did not occur for all 14 facilities, there was one facility where the HCFA survey occurred at the same time and three others where the HCFA survey occurred within the prior 6 weeks of the CU and JCAHO surveys. Despite the fact that HCFA findings may have been addressed to some extent in facilities where the HCFA survey was completed several weeks prior to the CU and JCAHO surveys, there were a number of similarities between the CU's and HCFA's survey findings. In one facility, problems related to nutritional supplementation and rehabilitation were identified in both surveys. In a second facility both CU and HCFA found problems with residents' personal care, including grooming and cleanliness, and both surveys found problems with pressure sores. Nutrition, pressure sores, and the personal environment were found as problems in a third facility by both HCFA and CU surveys. In the final facility, the personal environment was identified as a problem in both surveys. Similarities between the HCFA and JCAHO survey across all four facilities consisted only of the finding related to the personal environment. The citations in the HCFA survey were based upon observations of residents, use of charts, and staff interviews. HCFA citations referenced individual resident outcomes and process of care. This suggests a stronger relationship between the CU survey and HCFA findings

because domains such as pressure sores, nutrition, and personal care are emphasized in these surveys in contrast to the JCAHO survey.

At the same time, the HCFA survey did not identify problems that were found in the CU survey in three domains. First, in all four facilities the CU surveyors identified problems with the use of psychotropic medications, such as lack of an appropriate diagnosis and no reevaluation, including attempted dose reductions, particularly for benzodiazepines. Second, problems with unrecognized pain that were prevalent in two facilities were not identified in the HCFA survey. Third, two issues related to skilled nursing care leading to deaths that were found in the CU survey were not detected by HCFA. Although this comparison is based on only four facilities, the CU researcher notes that these findings “suggest that HCFA should consider their process for reviewing quality in these three areas and whether further guidelines are required.”

The CU study found that survey findings identified by JCAHO were more likely to be facility-level processes and procedures, or resident-level assessment process without a link to outcomes. As noted above, the HCFA citations referenced individual resident outcomes and process of care. CU’s conclusion appears reasonable: “Thus, providing deemed status to the Joint Commission would take a step away from the current focus on outcomes and processes of care at the resident level and a step backward in time relating to survey activities. For these reasons, the JCAHO survey does not appear to be an appropriate substitute for the HCFA survey.”

Effectiveness. The discussion above, particularly the validity analyses, raises serious doubts about the capability of the JCAHO survey to secure compliance. However, the adequacy of problem identification is only part of the story. Ultimately, we need to know the end result - i.e., the effectiveness of HCFA and JCAHO in protecting health and safety of nursing home residents. Essentially, we need to know the impact on resident outcomes. Unfortunately, we have no way to access this issue for JCAHO. For the HCFA survey, this issue is addressed in a recent empirical analysis of resident status outcomes (i.e., physical restraints, pressure sores, and incontinence) that may be linked to the new HCFA survey and enforcement provisions implemented on July 1, 1995. The results of this analysis offer suggestive evidence that the new HCFA survey and enforcement provisions were effective in improving resident status outcomes.

Although there are no data that permit a comparison of JCAHO and HCFA with respect to resident outcome measures, we have conducted an analysis of what might be viewed as an intermediate aspect of effectiveness - processes of enforcement that may occur between problem identification by the survey (either JCAHO’s or HCFA’s) and resident outcome.⁴⁸ Resources for this study included: HCFA’s SOM and JCAHO’s *Comprehensive Accreditation Manual for Long Term Care*; telephone conversations with key informants at HCFA, JCAHO, and State agencies; and data supplied by HCFA and JCAHO. The approaches of the two systems are fundamentally

⁴⁸ A comparison of HCFA and JCAHO enforcement and follow-up is presented in Chapter 10.

different. In the HCFA process, substantial compliance with all LTC requirements is mandatory. HCFA's strategy is to impose sanctions that compel providers to comply with Federal requirements or risk losing Federal payments. Nursing homes may have up to 90 days to correct deficiencies before imposition of a statutorily-required denial of payment for new admissions; however, depending on the home's record of performance and/or the seriousness of the problems identified, enforcement action may be taken much sooner. Generally, onsite revisits are conducted to assess correction and compliance.

By contrast, JCAHO's accreditation requirement is that a facility demonstrate "overall compliance with the standards, not necessarily compliance with each standard." The JCAHO strategy is to motivate providers to make improvements. Facilities may have up to a year or more to demonstrate improvement. JCAHO relies primarily on written progress reports from the homes to demonstrate that deficiencies are corrected.

1.5.7 Benefits and Costs of Deeming

Privatizing part or all of nursing home regulation has implications both for providers and residents. Although a rigorous comparison of benefit cost ratios for alternative regulatory models cannot be made (largely because valid comparative data on benefits are not yet available), it is informative for considering policy options to compare net costs of the accreditation and traditional survey models.

1.5.7.1 Net Costs

For a range of assumptions about unit survey costs, the percentage of nursing homes that achieve deemed status, and their success in passing along the costs of accreditation surveys⁴⁹ to Medicare, Medicare should save from \$2 million to nearly \$37 million annually if HCFA allows deemed status for accredited nursing homes.⁵⁰ Under the most likely assumptions (unit costs at the current average, 14 percent of facilities choose the deeming option, and 54 percent of survey costs passed on to Medicare), Medicare should save \$9.3 million, representing about 9.6 percent of the total certification budget for Federal fiscal year 1998.

Based on 1996 data provided by HCFA and JCAHO, a standard HCFA nursing home survey is estimated to cost \$2,758 more than the average fee charged for a JCAHO LTC general survey

⁴⁹ Accrediting organizations charge the nursing home for the surveying and accreditation service.

⁵⁰ Except where indicated, the information in this section comes from Chapter 8, "Comparative Analysis of HCFA and JCAHO Survey Costs."

(\$8,972, compared to \$6,214).⁵¹ However, if the estimate includes an entire HCFA survey “package,” including a standard/extended survey, complaint survey, and follow-up/revisit, the discrepancy increases to nearly \$6,800 (\$13,008, compared to \$6,214). This does not mean that, with the implementation of deemed status for nursing homes, HCFA would save the full cost difference on each survey or survey package. The net costs or savings of deeming depend on several factors: Medicare’s share of the costs of deeming and how nursing homes shift costs among payers; provider enthusiasm for deeming; and changes to the JCAHO process and possible efficiency gains for either JCAHO or HCFA.

With respect to efficiency, there is tremendous State variation in nursing home survey costs, from a low of \$2,414 per survey for New Hampshire to a high of \$29,831 for Michigan (in fiscal year 1996). This great variation among States naturally leads to the question of what accounts for these variations. Following general economic theory of cost, one would expect unit costs to be influenced by: volume and type of surveys provided; unit costs of inputs (e.g., wages and other input prices); and other variables that may affect the level of fixed costs or the way LTC survey services are organized. A key component of fixed costs and survey organization would be the number of FTE LTC surveyors on staff in each State. Unfortunately, the small data (i.e., 50 States) set permitted only a very limited analysis. Nevertheless, this analysis indicated that unit cost per standard survey is correlated only slightly with the average number of hours per survey and not correlated with any of the remaining variables examined: number of substandard deficiencies; number of SNFs and nursing facilities (NFs); number of SNF and NF beds; number of surveys (all types); and number of FTE LTC surveyors. The sources of this variation unexplained by normal cost factors are unknown.

It should be noted that this cost analysis did not take into account differences in the technical content or procedures of the LTC surveys conducted by HCFA and JCAHO. As discussed earlier, the results of the two surveys are vastly different and this study’s findings raise serious doubts as to whether the JCAHO survey sufficiently protects the health and safety of nursing home residents. While the costs of the HCFA survey are higher, the “benefits” appear to be much greater as well. If the results of a JCAHO and HCFA survey were roughly comparable, there might be some reason to take into consideration higher costs for no or marginal improvements in benefits. However, if there are vast differences in the capacity of the two surveys to protect health and safety, as has been found in this study, the cost differences are irrelevant.⁵²

⁵¹ LEAP’s projected fees appear to be lower than JCAHO fees, though the average fee will depend on the size of the facilities that LEAP surveys. In addition to a \$150 application fee, a facility with from 51 to 100 beds would pay an accreditation fee of \$2,500, plus surveyors’ travel expenses (Chapter 4). The base fee (for the average JCAHO-accredited facility of 139 beds) is currently \$4,035 (Chapter 11).

⁵² Another way to put this issue is to ask if any of us would be willing to fly on an airline that had substantially increased risk of crashing even though the fare for other (safer) airlines was 43 percent higher. It is doubtful that many would choose the less expensive airline even if the risk was only slightly higher.

1.6 Part III - Regulatory Incentives and Non-Regulatory Initiatives for Improving Nursing Home Care

1.6.1 Review of Research Linking Payment to Improved Resident Outcomes

The possible use of incentives to improve quality of care and promote quality of life for nursing home residents has been discussed for many years. Incentives could take several forms, including public recognition and/or payments as noted at 42 CFR 488.303(b) (which provides that a State may give these types of incentives to nursing homes that provide the highest quality care to residents, and that the cost for this may be submitted under the State plan. No parallel authority currently exists for Medicare). Through discussion with researchers and regulators and a literature review, HCFA found past, but no presently operating, Medicaid incentives systems. HCFA's historical review of these systems is not exhaustive; nor can it claim to be representative of the opinions of everyone involved with implementing and running these systems, due to the difficulty of locating people who worked with the now extinct programs. Excepting one relevant article (an evaluation of Illinois' system), documentation and evaluation of States' efforts is lacking, and the impact that these interventions may have had on residents' quality of care and life cannot be determined.

Research about the effectiveness of non-monetary incentives has been scant; researchers and regulators have tended to focus on financial incentives. Although superficially incentive payment is easily understood (incentive payment being a financial award above the standard rate of reimbursement for care, not a restructuring of the payment system in general or an overall increase in nursing home reimbursement rates), there is a troubling lack of agreement about practical implementation issues such as the basis for awarding incentive payments and a method for distribution. Critics also point out philosophical objections, the extreme technical difficulties of linking payment to outcomes, the question of funding, and the challenge of integrating an incentives system with current regulatory standards and payment structures.

In past State systems, the award of the incentive typically did not depend on resident outcomes measurement. These systems used a variety of measures of achievement, such as independently formulated structural and procedural requirements, judgements about the degree of compliance with Federal regulations, and subjective evaluation. The research efforts of Robert Kane and a research/demonstration project by William Weissert differed from past State systems by basing incentive payment on measured resident outcomes.

During the past 15 years, Robert Kane probably has been one of the most recognized experts supporting some form of incentive based payment for nursing home care. His initial empirical work developed and tested a variety of data instruments and summary scales designed to reflect domains of functioning within the nursing home. The central analysis problem was to determine if the various outcomes were predictable. If not predictable, then it would hardly be feasible to link incentive payment to outcomes that seem random or unrelated to facility care. In general, this

empirical work argued for the technical feasibility of developing a comprehensive set of outcome measures that could be linked to incentive payments, adjusted for risk factors, and, perhaps, for value preferences.

William Weissert has gone beyond research on measured resident outcomes by designing an outcomes-based incentive payment for Medicaid that was implemented in 36 proprietary nursing facilities in the San Diego area from 1980 to 1983. This was an unusually strong research demonstration design that included randomization, incentive payments sufficient to cover cost and risks, independent assessment of subject eligibility and achievement of goals, and sufficient duration to approximate “real life” rather than “demonstration” conditions. Initially, an independent evaluation found “...no evidence that goal-related reimbursement incentives improve patient outcomes.” However, a more recent assessment of the same data employing what appears to be a more appropriate statistical model found “... beneficial effects on access, quality, and cost of care.” While this conclusion seems sound for this particular intervention that was conducted over 15 years ago, it is important to recognize the vast changes in nursing homes and their environment, which could alter this conclusion. Even advocates for the idea of incentive payment admit that there is no incentive system that could be pulled off the shelf and implemented quickly. Hence, there is a general recognition that additional research/demonstrations conducted under current conditions would be necessary before incentive payment could be considered as a viable option.

1.6.2 Review of Non-Regulatory Initiatives for Quality Improvement

LTC industry has turned its attention to the concept of total quality management (TQM), a management style adapted from the manufacturing industry that includes continuous quality improvement (CQI). With the development of outcomes-based quality of care indicators, a number of planned initiatives and interventions have been undertaken by both private and governmental entities with the objective of improving nursing home quality, as measured by these indicators. Although some of these interventions are conducted in partnership with Federal or State entities, they essentially lie outside the traditional regulation; hence, our characterization of them as non-regulatory.

The key players in instituting non-regulatory initiatives for quality improvement have been the State survey agencies, HCFA central and regional offices, State nursing home associations, JCAHO, and the one of the national associations of LTC facilities, the American Health Care Association (AHCA). The quality improvement efforts initiated by HCFA’s central and regional offices have been separate and largely independent; the same is true of efforts developed and implemented through provider organizations and State nursing home associations. The purposes of this study on non-regulatory initiatives are to: 1) describe the range of initiatives and their current status; 2) assess the available evidence of their effectiveness; 3) examine the issues involved in integrating quality improvement initiatives into the system of survey and certification.

The relevant interventions appear to fit within three categories: 1) *clinical topics*: efforts undertaken at a State, regional, or national level that related to improving outcomes for specific clinical conditions, such as pressure ulcers and incontinence, or the use of physical restraints and psychotropic drugs; 2) *general interventions affecting facility behavior (rather than modifying or building upon survey and enforcement processes)*: changes in individualized resident care that are major shifts from the medical model and task-focused resident care; and 3) *data interventions and changes affecting SA behavior*: applications or tests of quality indicators or alternative survey strategies and means to collect and disseminate information.

1.6.2.1 Evidence

Chapter 13 discusses a wide variety of LTC quality improvement initiatives. These kinds of non-regulatory initiatives with their emphasis upon CQI are viewed by AHCA, JCAHO, and others as important and effective mechanisms for nursing home quality assurance. For some, it is argued that they can supplant some or a very large part of the normal survey process, as proposed by the South Dakota Initiative. Although many of these initiatives are appealing with anecdotal reports of positive results, empirical evidence of their effectiveness is lacking. Some projects have no evaluation with none planned or have not gone beyond a good intention. For others, there is an evaluation component, but the data are not in. In the case of still others, there is an evaluation and some evidence is in, but it is weak - either weak because the evidence was mixed or the design was inherently weak.

In contrast to this lack of evidence, we identified two nursing home quality improvement interventions which were accompanied by reasonably strong evaluation designs. One project, an extremely labor intensive intervention to reduce incontinence, produced an impressive reduction in incontinence rates.⁵³ Unfortunately, these gains were not sustained when the external research staff ceased proving feedback to the participating nursing homes. The other intervention, the Ohio Pressure Ulcer Prevention Initiative, incorporated elements thought essential to proponents of these initiatives and had a strong evaluation design. The evaluation resulted in conclusive evidence that the intervention was not effective. However, it should be noted that in spite of expectations of effectiveness on the part of the proponents of initiatives like the Ohio project, there are compelling reasons to regard these kinds of interventions as weak. It may be naive to view feedback data on performance alone, or even performance information together with educational "best practices" information, as sufficient to change actual care practices.

Hence, we have found little to no evidence to sustain a belief in the effectiveness of these initiatives *as they are normally implemented in nursing homes*. The absence of evidence supporting these particular interventions, however, does not mean that residents' status cannot be

⁵³ See Schnelle, J. F., McNeese, P., Crooks, V., and Ouslander, J.G. "The Use of a Computer Based-Model to Implement a Incontinence Management Program." *The Gerontologist*, 35(5)656-665. 1995.

improved. Moreover, many of these initiatives are in early stages of development, and it is always possible that future evaluations will yield evidence of their effectiveness. For now, however, it would be a risk to the health and safety of the nation's vulnerable nursing home population to remove the protections of a regulatory system that has some degree of effectiveness, as demonstrated in Chapters 17 to 20, in lieu of quality improvement initiatives of unproven effectiveness.

Even if evidence in support of some quality improvement initiatives emerges in the future, there still remains the question of how these interventions relate to the system of survey and certification. For example, is it permissible, or even appropriate, for surveyors to offer technical assistance on quality improvement to providers? Current HCFA policy clearly states that the fundamental role of surveyors is to determine compliance with LTC requirements. HCFA policy further delineates that it is not the position of the surveyors to identify the root cause of a deficiency or the acceptable remedy for a deficiency.

This raises the question of whether the traditional role of the surveyor can be expanded to assist providers in their quality assurance efforts without compromising the traditional role of solely determining compliance with the requirements. The State of Washington may provide an example of this expanded information transfer role by the activities performed by their Quality Assurance Nurses (QANs). The role of the QAN is to explain to the facility staff what a regulation requires and how it is reviewed on survey visits. But, the QAN does not consult with the facility on actions to take to address an issue. This "information transfer" function QANs perform also consists of validating best practices, identifying exemplary practices, and identifying problem areas while they are small and manageable.

Although we have found no support for supplanting any part of the survey with the quality improvement initiatives examined in this chapter, the QANs appear to enhance and not replace the survey. Further, the QAN program is not a stand-alone effort, but has been implemented statewide, although there does not appear to be an evaluation of its success. As we indicated elsewhere, "A QAN... increases the frequency with which a representative of the State survey agency has the opportunity to view and assess the conditions in a nursing facility... Ultimately, all other things being equal, more frequent assessment should lead to improvement in the quality of services." Of course, this intervention may not lead to actual improvement; hence, the need for a truly independent and strong evaluation.

1.7 Part IV - Evaluation of HCFA's Nursing Home Survey and Certification System

1.7.1 Regulation: Judging Effectiveness

Perhaps the most fundamental question with respect to designing the required study about the effectiveness of the current survey is the criterion by which effectiveness is to be assessed. Specifically, with what is the current survey to be compared? As an abstraction the current

enforcement system might be compared to a system of no enforcement, perhaps with deeming or various regulatory and non-regulatory incentives as the only alternatives for ensuring quality standards. Whatever the merits of this approach, it is empirically impossible to study the consequences of no enforcement when this situation does not and is not likely to occur. Two kinds of “effectiveness” comparisons seem both feasible and relevant. First, it is important to know the consequences of the major OBRA ‘87 reforms implemented in October 1990, compared to the enforcement system that preceded it. Second, it is important to know the consequences of the final set of OBRA reforms, particularly the enforcement provisions, implemented July 1, 1995, as compared to the enforcement system that preceded it.

With respect to the first comparison, the effectiveness of the initial OBRA reforms, a variety of studies were carefully reviewed for this report. With respect to the second comparison, the effectiveness of the final set of OBRA reforms, we have conducted three sets of analyses. First, we queried a wide variety of stakeholders on how the current system is working in practice. Through a variety of methods, we elicited the perceptions of nursing home administrators, ombudsmen, consumer advocates, residents, family members, State surveyors, and nursing home personnel. Second, we investigated if resident status on a variety of *outcome* measures has improved or deteriorated since July 1995. Third, we conducted empirical analyses to determine if a number of survey and enforcement *processes* are working as intended.

1.7.2 Effectiveness of OBRA ‘87

We have interpreted the Congressional mandate for a study “... on the effectiveness... of current mechanisms for surveying and certifying skilled nursing facilities,” both broadly and more narrowly. This chapter in the Report presents the results of the broad approach by assessing whether the sweeping legislation and ensuing regulations and guidelines that structure the current regulatory system have been effective. Other chapters focus more narrowly on the impact of the most recently implemented revisions to OBRA ‘87, particularly the survey and enforcement provisions effective July 1, 1995.

In this chapter, we assess the results of a carefully designed evaluation of the nursing home Resident Assessment Instrument (RAI), a clinical assessment tool consisting of the Minimum Data Set (MDS) and a number of problem-focused Resident Assessment Protocols (RAPs). The results of this study, published in several articles appearing in the *Journal of the American Geriatric Society* indicate that several outcomes for nursing home residents improved after implementation of the RAI. We further examine the impact of OBRA ‘87 by an extensive case study of the effectiveness of regulation in a very specific problem area targeted by OBRA ‘87, inappropriate psychopharmacologic medication; specifically, this analysis reviews the history and impact of regulation of inappropriate psychopharmacologic medication use in U.S. nursing homes from 1954 to 1997.

1.7.2.1 RAI Evaluation

This evaluation addressed two basic questions: first, did the quality of care received by nursing home residents improve under OBRA '87; second, can any improvement can be attributed specifically to the RAI, only one component of the OBRA '87 reforms? As we shall see, there is more evidence (and acceptance) of OBRA '87 contributing to real improvement of nursing home resident care than there is for attributing that improvement solely or even primarily to the RAI.

As is common when Federal legislation requires reforms to be implemented nationwide, a randomized clinical trial is not possible. However, the evaluators employed a quasi-experimental study design, with data collected before (1990) and after (1993) implementation of OBRA '87. Two independent cohorts from each of the two periods - each cohort of over 2,00 residents providing data on changes in health status during a 6 month interval - were collected from a random sample of 254 nursing homes located in metropolitan statistical areas in 10 States. If OBRA '87 was effective in improving the health status of nursing home residents, we would expect less decline and more improvement over the 6 month interval in the post as compared to the pre-OBRA period. In comparing the changes in health status from the two periods, the evaluators controlled for a number of other non-OBRA factors (e.g. changes in case mix, age, gender, the presence of advance directives), which could affect the health status measures under consideration. The most important changes examined were of measures of hospitalization, selected health conditions, and selected functional outcomes.

With respect to hospitalization, "... the 6-month hospitalization rate dropped from 21 percent for the pre-RAI cohort to 15 percent for the post-RAI cohort... One of the more striking changes documented by this study is the significant reduction in hospitalization among the more cognitively impaired residents, without a concomitant increase in mortality." With respect to selected health conditions, eight were examined in the analysis: dehydration; falls; nutritional status; vision; stasis ulcers; pressure ulcers; daily pain; and broken teeth. Two of these measures, dehydration and stasis ulcer, showed statistically significant reductions (i.e., improvement) from the pre baseline to post baseline. A third measure, daily pain, showed statistically significant increases.

The evaluation also conducted an analysis of nine functional areas. The results were mixed: ADL function, cognitive performance, and social engagement showed improvement; communication, mood, and behavior outcomes were significantly worse; the other functional areas showed no change in the two cohorts. In addition to the indicators, differences in prevalence of problems in the two cohorts in process quality showed statistically significant improvement in prevalence rates in six areas, including "any advanced directives," indwelling urinary catheter, "not involved in activities," "restraints used," and "residents with inadequate hearing and no hearing aid or hearing aid not used."

In summary, it appears that rates of hospitalization improved quite markedly. On other measures, selected health conditions and function status measures, we see both improvement and deterioration. However, improvement appears to outweigh deterioration. Also, improvement occurs in arguably the more crucial areas, areas addressed by the RAI.

The fundamental conclusion of this section on the RAI evaluation and the case study below on inappropriate psychopharmacologic medication is that the regulatory environment created by OBRA '87 has been effective in improving the health status of nursing home residents. However, as has been discussed above, OBRA '87 and the regulations and guidelines promulgated under OBRA do not constitute a single unidimensional intervention, but really should be viewed as a bundle of related interventions. Although less central to the fundamental conclusion that OBRA '87 resulted in improvement in resident health status, there is a question of whether one component of that bundle - the RAI - is the most important factor or even a factor in the positive improvement observed. With some important qualifications, the RAI evaluators attribute the positive improvements to the RAI. Commenters found this portion of their argument less convincing primarily because there was no direct evidence that the RAI generated care plans were actually implemented.⁵⁴ Further, the evaluators developed a measure of RAI implementation with the expectation that improvement would be greatest among "those post-RAI residents in facilities with practices that seemed to imply strong implementation of the intervention"; the evidence contradicted this expectation.

1.7.2.2 Impact of OBRA '87 on Inappropriate Use of Psychopharmacologic Medications

The results above on the impact of OBRA '87 on the health status of nursing home residents as well as an extensive study presenting new findings on the effect of OBRA '87 on the inappropriate use of psychopharmacologic medications can be found in Chapter 15. Complaints about "over-drugging" and the use of psychopharmacologic medications as "chemical straight-jackets" in U.S. nursing homes were significant factors in public and Congressional debate that lead to the passage of OBRA '87. Despite professional reports about the harmful effects of some of these medications and government efforts to stimulate peer review regarding the proper use of these medications, published studies and testimony before Congress demonstrated a continuing systemic misuse of psychopharmacologic medications before the implementation of OBRA '87. Of particular concern was the over-use of antipsychotic and hypnotic medications and the under-use of antidepressant medications. These medications were specifically targeted in the guidelines issued under OBRA '87.

Synthesizing the results of several studies, this analysis found that antipsychotic medication use has decreased from 33.7 percent prior to the implementation of OBRA '87 to 16.1 percent in

⁵⁴ Uman, G. "Where's Gertrude?," *JAGS*, 45:1025-1026, 1997.

1997. This represents a **59.8 percent decrease** in the use of these medications. On the other hand, antidepressant medication has increased from 12.6 percent prior to the implementation of OBRA '87 to 24.9 percent in 1997.⁵⁵ This represents a **97.0 percent increase** in the use of these medications. This outcome is important because professional research indicated that depression was under diagnosed and under treated in American nursing homes and associated with significant morbidity.

1.7.2.3 *The Importance of Regulation: Did OBRA '87 Make the Difference?*

The magnitude and timing of the trend data in the use of psychopharmacologic medications combined with the results of separate studies designed to assess OBRA '87 impact indicate that the positive changes observed were due to OBRA '87. This is particularly true for some domains, for example, with respect to the utilization of antipsychotic and antidepressant medications drug categories that were specifically targeted in the OBRA '87 regulations and guidelines. This does not mean that other factors were unimportant. Indeed, it can be argued that some of these other factors, for example, the evolution of published knowledge and practices of geriatric medicine, contributed to the social and political process that led to the OBRA '87 statutes, regulations, and guidelines in the first place. These other factors, however, were not in and of themselves sufficient to change the general pattern of inappropriate use of psychopharmacologic medications in nursing homes. Only with the implementation of the OBRA '87 was an abrupt change for the better seen. Hence, it appears that regulation was at least a necessary condition for the improvements observed. This conclusion is supported by a 1997 survey of randomly selected nursing home administrators in which 77 percent indicated that inappropriate psychopharmacologic medications had been reduced in their facilities in the last two years. Thirty-eight percent of these nursing home administrators said the reason these medications had been reduced was the OBRA '87 regulations.⁵⁶

⁵⁵ The appropriateness of this level of utilization (24.5 percent) of antidepressant medication in nursing homes might be questioned; however, this level of utilization is consistent with research on prevalence rates for depression in nursing homes. In a 1991 study, psychiatrists examined 454 consecutive admissions to nursing homes and followed them for one year. Of the 454 admissions, 12.6 percent had a major depressive disorder, and 18.1 percent had depressive symptoms. (Rovner, B.W., German, P.S., Brant, L.J., Clark, R., Burton, L.I., and Folstein, M.F. "Depression and Mortality in Nursing Homes." *JAMA*, Feb 27, 1991; Vol. 265. No. 8. All of these residents (12.6 percent plus 18.1 percent = 30.7 percent) would be appropriately treated with antidepressant medications.

⁵⁶ See Chapter 16.

1.7.3 Effectiveness of Current System of Survey and Certification

1.7.3.1 *Stakeholder Perceptions of How the Current System is Working in Practice*

Perceptions of the effectiveness of the current system were elicited from nursing home administrators, ombudsmen, consumer advocates, residents, family members, State surveyors, and nursing home personnel. The methods and purposes for gathering this feedback information from these parties differed. During the summer of 1996, "listening sessions" were conducted to listen and learn from consumers, professionals, States, and other interested persons about their experiences with, and the impact of, the nursing home survey, certification, and enforcement processes. One-day sessions were held in Seattle, Chicago, and Atlanta. A structured, closed-ended nursing home administrators' survey was conducted in August 1997. Less structured open-ended telephone interviews of State ombudsmen across the country were conducted in April 1997.

Although nursing home administrators generally reported satisfaction with the accuracy of the survey process, they indicated they would prefer to have the option of deemed status. The survey also revealed that the current enforcement and remedy system is an important factor in improving resident care. Fairly large proportions of respondents reacted to the survey process by reducing the use of restraints, reducing inappropriate use of psychotropic drugs, increasing staff training, and strengthening internal quality assessment. Generally, nursing home administrators felt that plans of correction were effective in improving resident care. In a sense, the administrators' survey results were surprising; their feedback about the survey and enforcement processes overall was fairly positive, which is a sharp contrast to the negative opinions and anecdotes HCFA typically receives about these processes from industry representatives and lobbyists.

Several subjects and concerns repeatedly surfaced in the ombudsmen interviews, the most common being staffing. Specifically, interviewees mentioned: inadequate staffing levels; the lack of staff training on topics such as dementia and Alzheimer's; staff turnover; and the level of staff (including nursing home administrator) professionalism. Additional problems mentioned were theft and loss of resident property and inappropriate resident discharge or transfer.

Another common observation was the predictability of surveys. Ombudsmen frequently recounted how conditions in the facilities change right before a survey so that the survey team is presented with a false environment for observation. Some ombudsmen felt the predictability of surveys is due to the use of the same survey schedule year after year. Several ombudsmen reported that States are beginning to stagger surveys to combat this problem. In other States, the homes seem to be tipped off about the forthcoming survey.

Weak enforcement represented an additional concern. Ombudsmen expressed disappointment in HCFA's and States' reluctance to use sanctions, noting that sanctions often are proposed but not imposed. Civil money penalties are effective in bringing about correction, but in many instances

the penalties are lessened, are not stiff enough, or are dropped altogether. Many ombudsmen called for stronger enforcement. While discussing enforcement, several noted that HCFA's enforcement grid is difficult to use and understand. They also reported that deficiencies are often cited with inadequate scope and severity. While quality of care deficiencies may be adapted to the grid, the grid does not appropriately capture quality of life issues.

Responses to questions about how quality of care and life had been affected by the 1995 survey and enforcement changes varied. Some ombudsmen reporting seeing no change in any of the areas; a few even noted decline. Many described poor conditions in care areas such as toileting and care for incontinence and the prevention and care of pressure sores. Most respondents remarked upon the improvement in restraints use, which is not surprising given the degree of national emphasis on restraints reduction. The survey also questioned respondents for their observations about changes in quality of life. These answers varied from poor to improving.

Ombudsmen reported differing degrees of participation in the survey. They often provide the SA with information such as their observations, suggestions for the resident sample, and complaints received prior to the survey. The level of cooperation and collaboration between ombudsmen and the State survey agencies in some States is very high, with positive results and improvements noted. In other States, however, such a relationship is lacking, and ombudsmen are frustrated that their input is disregarded or even discouraged. The ombudsmen expressed an interest in increased participation and partnership, particularly noting a desire to be involved in the informal dispute resolution process.

Listening session comments reflected both the aforementioned opinions of providers and ombudsmen and added the voices of the residents and family members, surveyors, and facility staff members. As the listening sessions summary that appears in Chapter 16 is already a bare bones synopsis of the concerns and opinions expressed, it is impossible to do justice to all viewpoints without referring readers to the full text.

1.7.3.2 Current System of Survey and Certification: Evidence on Outcomes

Perceptions of how the current system is working, while important, are not a substitute for an empirical analysis of how it is working. This analysis was conducted with the goal of measuring the impact of the new enforcement regulation on nursing home resident outcomes. Because the enforcement regulation introduced potential penalties for individual deficiencies, nursing homes may have responded to the new process by improving the overall quality of care. This enhanced quality of care in turn may have improved resident outcomes.

Restraints, pressure sores, bladder incontinence and bowel incontinence are among the problems most frequently identified in LTC populations.⁵⁷ The presence of chronic illnesses, self-care deficits, mobility deficits, altered level of consciousness and/or altered nutrition increase a nursing home resident's risk of experiencing these conditions. This risk is diminished if residents receive quality care. Although not all pressure sores can be prevented, with consistent care and attention most can be prevented or made less severe. Incontinence is a symptom of one or more underlying problems and not part of the normal aging process. If left untreated, incontinence, both bladder and bowel, can lead to other serious physical complications including urinary tract infections, skin breakdown, and sepsis.

In this analysis, these four resident outcomes were analyzed at the State survey area office level and at the nursing home level: (1) percent residents physically restrained; (2) percent residents with pressure sores; (3) percent residents incontinent of bladder; and (4) percent residents incontinent of bowel. It should be noted that a negative change in an outcome measure, e.g., prevalence of pressure ulcers, from pre to post implementation of the enforcement regulation does not necessarily mean that the quality of care delivered by the nursing home deteriorated. If the facility had a greater proportion of residents who were admitted with a pressure ulcer, the outcome measure would deteriorate, all other factors being equal.

To control for confounding variables and to investigate whether resident status improvements can be linked to the enforcement regulation, a quasi-experimental study design was implemented that took advantage of the staggered timing of the new regulation. The new enforcement regulation was introduced to individual facilities between July 1995 and July 1996. Facilities both within and across States were surveyed at different points in time. Using this feature of the survey process, an artificial control group was created. The control group consists of facilities that were subject to the new enforcement regulation for the first time between January and June 1996. The treatment group consists of those facilities that were introduced to the new enforcement regulation for the first time between July and December 1995. A comparison was made between the control group and the treatment group's resident outcomes during 1996.

The analysis was conducted both at the State survey area office level and at the facility level. At the facility level, the dependent variable in the model is the outcome for the facility measured in 1996. For the treatment group, this 1996 outcome is measured about one year after the new enforcement regulation was implemented. For the control group, the 1996 outcome is measured at the time the new enforcement regulation is introduced for the first time. The model controls for facility and State level covariates that are expected to affect the outcomes of interest including case-mix variables, lagged values of the outcomes, State and regional fixed effects, and the time in months since the new regulation was enforced. The same model is used to analyze the data aggregated to the area office level. The dependent variable in this model is the average value of

⁵⁷ Haight, B.K. Research in Long-term Care. NLN Publications 20-2992, 7, 1989.

the outcome for the area office jurisdiction (e.g. average percentage of nursing home residents physically restrained in a particular area office jurisdiction in New York).

The measurement of the “treatment” variable, enforcement, is critical to this analysis. Enforcement is inherently difficult to measure. This analysis separates two different aspects of enforcement. The *prevalence* of enforcement is captured in the artificial control group design discussed above - i.e., either a facility is in the treatment group and subject to the new enforcement regulation, or not. (Similarly, area offices differed by the percentage of facilities that were in the treatment group.) The other aspect captures the *degree* of enforcement by treating it as a *variable*. Facilities in States and area offices where no or very few substandard care citations are given are presumed to be “low enforcer” areas. Although it is possible that the nursing home care in these areas may be better than the “non-low enforcer” areas, it is implausible that there would be no or so few substandard care citations. Hence, the more plausible hypothesis is that for these area offices, the new provisions are not being fully implemented.⁵⁸ If the new enforcement provisions have a positive effect on resident outcomes, we would expect residents in the low enforcer areas to have poorer outcomes as compared to residents in the non-low enforcer areas.

The results of this analysis offer suggestive evidence that the new enforcement regulation was effective in improving resident status outcomes. At the area office level, the regulation is associated with a 9 to 10 percent reduction in bladder and bowel incontinence rates. There also is some evidence at the facility level that the new enforcement regulation had a very small, negative effect on the rate of physical restraint use. Consistently, facilities located in “low enforcer” area office jurisdictions were less responsive to the new enforcement regulation compared to facilities not located in “low enforcer” jurisdictions. It is not clear why the area office analysis indicated a positive impact of the July enforcement provisions on (lowering) incontinence rates, and the facility analysis indicated no effect. This could be due to facility reporting errors in the self-reported OSCAR data. These random errors tend to wash out when the variables used in this analysis are aggregated to the area office level.⁵⁹

1.7.3.3 Current System of Survey and Certification: Evidence on Administrative Processes

As noted above, the revised systems of survey and enforcement were implemented on July 1, 1995, with a number of expectations about how they would work. As a matter of logic, it is possible that the new features of the survey and enforcement systems might work as intended, yet resident outcomes might not improve. We have found the converse to be true: many of the new

⁵⁸ See discussion of substandard quality of care as a measure of low enforcement in section 1.8.3.4.

⁵⁹ The reader should also bear in mind that the absence of a true control group raises the possibility, at least, that what appear to be enforcement effects are in fact due to other causes.

features may not in practice be working as intended, yet resident outcomes improved, as was discussed above. Although it was not feasible to examine all the new processes generated by the July 1, 1995, changes to the systems, we have sought evidence with respect to selected processes related to administration, problem identification, and problem correction under the new system.

To what extent have changes in the survey and enforcement systems affected administrative processes? One possibility is that the administrative processes would clog under the new requirements. The implementation of the enforcement regulation on July 1, 1995, created new work for the State survey agencies: it established a more intricate administrative process for processing the results of nursing home surveys than had previously existed.⁶⁰ At the same time, surveyors were faced with having to learn a new, and perhaps more complex, method for conducting onsite inspections of nursing homes. The new enforcement regulation also emphasized citing each identified problem as a deficiency. A reasonable expectation is that this change in the way in which surveyors assessed deficiencies would result in a probable increase in the number of deficiencies, further adding to the administrative burden. Finally, the administrative process increased the number of opportunities open to nursing homes to challenge the findings of nursing home surveys. Each challenge to survey findings consumes State survey agency time and resources in responding to the challenge.

To examine these administrative processes under the new survey and enforcement system, OSCAR data for all standard nursing home surveys conducted between January 1, 1994 and December 31, 1997 were collected. Data on the arrival dates for each surveyor participating in nursing home surveys were examined. Survey intervals were calculated as the amount of time elapsed between the starting dates for successive surveys of the same nursing home. Mean intervals were then calculated for each year. The number of surveys that each surveyor conducted was calculated from individual surveyor records contained in OSCAR. Data on the earliest start date for each survey was used as the starting date for each survey in counting the number of surveys that started on each day of the week. Onsite time, recorded for each survey team member, categorized by time of day, was used to calculate the portion of onsite survey time spent during day, evening, and night hours.

Can the System Handle the Increased Workload?

Only indirect evidence is available to answer this question. The OSCAR data indicate that, although the number of nursing homes increased from 15,961 in 1994 to 17,121 in 1997, the number of surveys conducted increased at a slightly higher rate in that period of time. At the same time, the mean time interval between surveys decreased during this period. These two pieces of evidence suggest that, at a minimum, standard nursing inspections were being conducted at a regular rate during this period of time. At any rate, these data do not suggest that after July

⁶⁰ See Chapter 14 for a more complete description of the changes brought about by the enforcement regulation.

1, 1995, there was a marked change in the frequency with which surveys were being conducted. Finally, the number of surveys that each surveyor conducted in a year remained roughly constant from 1994, at a little over 17 surveys per surveyor per year. This has occurred despite a slight decrease in the number of surveyors performing nursing home surveys: from about 4000 in 1994 to about 3700 in 1997. This evidence also suggests that surveyors still managed to conduct nursing home surveys at about the same rate throughout this period.

Is the Timing of the Survey Predictable?

By statute, every nursing home participating in Medicare or Medicaid must be surveyed within at least 15 months of its previous survey, with a statewide average for survey interval not exceeding 12 months. In some circles, this requirement has been misinterpreted as meaning that the survey team can go into any given home no more frequently than every nine months. Section 7205 of HCFA's SOM, however, notes that, "Facilities with poor records of compliance may be surveyed as frequently as necessary to ensure that residents are receiving quality care in a safe environment." The Act also requires that surveys be unannounced; nursing homes must not know when surveyors will arrive. The Act imposes strict requirements about maintaining the secrecy of the survey date and establishes penalties for anyone who informs the nursing home about the timing of the survey.

Despite these protections, anecdotal evidence and conventional wisdom suggest that nursing homes still know when they are likely to be surveyed. Comments collected in the Ombudsmen's Survey⁶¹ speculated that providers may receive advance information about survey timing, but assessing the accuracy of that observation is beyond the scope of this study. Conventional wisdom holds that surveyors throughout the country conduct surveys at precise twelve month intervals, ensuring predictability. Despite the strength of these held beliefs, evidence recorded in OSCAR suggests that survey intervals are much less predictable than commonly thought. Although the national mean interval between surveys is about one year (although the mean interval is decreasing slightly with time), the standard deviation of the mean interval is high, about two months. Another way of stating this is to say that the middle 50 percent of facilities are surveyed between 336 and 400 days after their previous survey.

Although survey intervals do not appear to be as predictable as widely held, surveyors do appear to spend virtually all of the survey time during regular business hours, Monday to Friday, 8 a.m. to 6 p.m. For surveys conducted from 1994 through 1995, less than 0.5 percent of onsite survey time, according to data captured in OSCAR, was spent in evening or night investigations. A slightly higher proportion of time was spent at night, rather than in the evening, but both numbers are minuscule. Furthermore, the proportion of time spent in the facility at night or in the evening has remained virtually constant for the last four years.

⁶¹ See Chapter 16.

In addition to spending little time in nursing homes outside of daylight hours, surveyors predictably start their surveys on Monday or Tuesday, for the most part. About 45 percent of surveys conducted between 1994 and 1997 began on a Monday, while 35 percent began on Tuesday. Only 0.6 percent of surveys began on Saturday or Sunday during that time period. These proportions have remained relatively constant during this time period.

With respect to the question of whether the system can handle the increased workload, we found no evidence of any change in the frequency with which surveys were being conducted, additionally, surveyors managed to conduct surveys at about the same rate as in the past. We were unable to assess within the scope of this study, however, the extent to which States accomplished surveys of nursing homes by restricting the scope of revisit surveys or complaint surveys or by curtailing surveys of other provider types. We observed that the ratio of revisit to standard surveys, however, has remained constant since July 1995. With respect to the objective that the survey not only be unannounced but unanticipated, the current survey is much less successful. Although the survey interval is quite variable, a facility has near certainty that it will never be surveyed on the weekends or during evening hours. These data suggest that nursing homes could, for example, increase daytime staffing levels on Monday and Tuesday for a few months in anticipation of a survey, while not having to worry about weekend or nighttime staffing.

1.7.3.4 Current System of Survey and Certification: Evidence on Problem Identification

The scope and severity grid implemented with the July 1, 1995 survey changes was intended not only to improve the identification of *existing* quality problems, but also to improve surveyor assessment of the seriousness of these problems. We have employed three very different methods to assess how well the current system fulfills this objective. First, from the OSCAR administrative database we analyzed the pattern of survey findings for all standard survey conducted since January 1, 1994. This largely descriptive analysis provides quantified data on all certified nursing homes over several years. Second, we presented the results of a more qualitative study of the survey process conducted for HCFA by the Center for Health Systems Research and Analysis, University of Wisconsin - Madison. Third, we have made a limited effort to look behind a number of media reports, occurring after July 1995, of abuse and neglect of residents in specific nursing homes in the U.S. Although examining the specific allegations are beyond the scope of this study, we have arrayed some evidence that bears on the question of whether the current survey system adequately identifies problems of abuse and neglect.

Problem Identification: Every Problem a Deficiency?

The revised system of survey and enforcement implemented on July 1, 1995, held a number of expectations. One such expectation was that even one instance of a violation of the LTC

requirements for participation in Medicare and Medicaid should result in a citation for deficient practice. This is a departure from previous practice, which dictated that, for some types of deficiencies governing the provision of nursing care, for example, surveyors should consider the extent of deficient practice before deciding whether to issue a citation. Under the new enforcement regulation, the scope and severity of the violation is considered in deciding how severe a penalty to assess, not in whether to cite a deficiency. This change in the survey process gives rise to the hypothesis that the number of deficiencies assessed against nursing homes should, on average, have increased after July 1, 1995.

Instead, the mean number of citations given in nursing home surveys has declined steadily for the last few years: from 8.3 deficiencies per survey (for surveys in which deficiencies were found) in 1994, to 6.2 deficiencies per survey in 1997. It is important to note that this decrease occurs in survey data adjusted for the changes in deficiency coding that occurred on July 1, 1995.⁶² The decrease in the number of deficiencies cited appears to be linear. There is also no evidence that rate changed meaningfully after July 1, 1995. This trend holds across most, but not all, States. This finding suggests that surveyors are citing fewer deficiencies in surveys. A similar trend was noted for the proportion of homes found to have zero deficiencies. The fraction of nursing homes with zero deficiencies increased from 13 percent in the first quarter of 1994 to 22 percent -- a 69 percent increase -- at the end of 1997.

Changes in State survey agency practice or improvements in facility quality are the most probable explanations for this declining trend in deficiency citation. However, several pieces of indirect evidence suggest that improvements in facility quality are, at best, only a partial explanation of the decline in mean survey deficiencies. The four quality measures derived from OSCAR data that were utilized in the outcome analysis described above indicate both improvement and stability. The percentage of nursing home residents incontinent of bladder or bowel has remained stable from 1994 through 1996. The percentage of residents with physical restraints or with pressure ulcers has declined 11.1 percent and 12.6 percent, respectively.

It is possible that increasing resident acuity could mask improvements in nursing home quality. This could be particularly true for resident status measures such as prevalence of pressure ulcers that do not adjust for risk factors. However, the OSCAR data present a mixed picture of changes in resident acuity - some measures indicate increasing acuity; other measures indicate decline. Quality indicators derived from the Minimum Data Set (MDS) individual resident data permit more adequate risk adjustment than the quality measures derived from the aggregate OSCAR data. With respect to pressure ulcers, unpublished data from four States indicate substantial improvement for high-risk residents and no improvement for low-risk residents. There appears to be no improvement for incontinence, both for high and low risk residents. As with the OSCAR

⁶² See Chapter 19.

measure, prevalence of daily physical restraints derived from MDS data indicates a substantial decline.

It appears that the analysis of OSCAR and MDS quality measures indicates real improvement in nursing home quality, at least with respect to some measures. Further, the new enforcement regulation, *all other factors being equal*, should have resulted in a substantial increase in deficiencies due to the definitional change as to what constitutes a deficiency. Even if the relationship between quality and deficiencies is very roughly linear (i.e., as quality increases, deficiencies remain the same or decline), it is unclear, perhaps doubtful, that the degree of quality improvement observed here would result in a decrease in deficiencies sufficient to not only outweigh the increase caused by the new enforcement regulation, but also to result in no apparent change in the downward trajectory of deficiency citations. There is no evidence that the new enforcement regulation has affected this pre-existing downward citation pattern. In that sense, the new enforcement regulation does not appear to be working as intended.

Finally, even if marked improvements had occurred in the quality of nursing care in these nursing homes from 1994 to 1997, it is uncertain how much this change in quality would affect the numbers of deficiencies found. It is unlikely that the relationship between deficiency citation rates and these measures of nursing home quality is an invariant one. Surveyors look at many aspects of nursing home care not reflected in these measures.

OSCAR Data: Are Serious Problems Identified by the Survey Process?

Enforcement is inherently difficult to measure. Although there is considerable variation among States in the degree of enforcement, as measured by rates of deficiency or substandard quality of care determination, it is difficult to separate what proportion of the variation is due to true differences in nursing home quality and what proportion is attributable to differences in surveyor behavior. Surveyor behavior may manifest itself in the differential ability to identify citeable problems and the differential propensity to cite deficiencies once problems are identified. These measurement issues notwithstanding, we think a crude ordinal measure is both possible and useful. It assumes that if a State has completed enough surveys, then at least one facility should properly be designated substandard with respect to some requirement. Hence, in the extreme situation when no to very little substandard care is reported, this most plausibly reflects surveyor (or state agency) behavior, not true quality differences. Consistent with this rationale, we have developed a measure of enforcement which differentiates the low enforcer States or area offices, those with no or an extremely low rate of reported substandard care, from the other, residual, non-low-enforcers States or area offices. It should be noted that this measure of low-enforcement in the analysis of resident outcomes reported above was found to be a significant predictor of some resident outcomes.

A primary expectation for the new survey and enforcement processes put in place on July 1, 1995 was the more sensitive identification of serious problems in the provision of care or in the

protection of the residents' rights. Increased emphasis on surveyors conducting interviews with residents and their families, making frequent tours of the facility, and citing individual instances of violations of the requirements for participation, were designed to improve the chances of detecting serious problems in the nursing home being inspected. "Substandard quality of care" (SQC) was redefined to reflect instances in which the nursing home was particularly lax in performing its duties. SQC is a new and very consequential designation under the new survey and enforcement system. Facilities receiving a determination of SQC, in addition to any other sanctions, lose their authority to offer nurse aide training which, consequently, may make the hiring of nurse aides difficult. Because of these major consequences, it is understandable that this designation might be contested by facilities, and surveyors and the State survey agencies might be hesitant to incur this conflict.

Evidence suggests that States' ability or willingness to detect serious problems, as measured by the proportion of facilities that fall into the SQC category, varies considerably. In 1995, when the enforcement regulation was first implemented, the proportion of facilities found to be in substandard quality of care ranged in each State from 0 to 34 percent. The median State percentage equaled 8 percent.⁶³ By 1997, there had been a significant change in the pattern of substandard quality of care determination by State. In that year, the proportion of facilities found to be in substandard quality of care ranged in each State from 0 to 14 percent. The median State percentage declined to 4 percent.⁶⁴ The number of states that report no substandard care has been stable at about five for each of the three years since the implementation of enforcement. However, the number of states that report an extremely low rates of substandard quality of care determination -- an implausible reflection of the true rate -- of 1 to 2 percent has been 4, 8, and 10 for 1995, 1996, and 1997, respectively.

Another measure of a State's ability or willingness to cite serious problems of care is the proportion of facilities receiving deficiency citations at spot "D" or above. In 1995, the proportion of facilities in each State that received deficiency citations at "D" or above ranged from 3 percent to 100 percent. The median State proportion was 64 percent. By 1997, the range had narrowed to 22 percent to 100 percent, although the median State percentage had decreased only slightly from 1995 levels, to 62 percent.

In sum, the pattern of citations suggests that States probably vary widely in their ability or willingness to detect serious problems in nursing homes, even given likely variations in the quality of nursing homes from State to State.

⁶³ In 1995, approximately 13 percent of all facilities in the country were found, based on the results of certification surveys, to be providing substandard quality of care.

⁶⁴ The percentage of facilities in the country found to be providing substandard quality of care equaled 5.9 percent in 1996 and 4.6 percent in 1997.

CHSRA Survey Studies: Are Serious Problems Identified by the Survey Process?

The above analysis of citation patterns has the advantage of providing extensive quantified data on the outcomes (i.e., deficiencies cited) of surveys for all certified nursing homes for several years. Although the pattern described is consistent with the hypothesis that several States and area offices are not identifying problems as intended by the July 1, 1995 changes, this external analysis does not provide any direct evidence on the appropriateness of problem identification nor the internal dynamics of surveyor decision making. In contrast, the CHSRA field studies provide more direct observational evidence that supports not only the findings from the OSCAR analysis of citation patterns, but also serves as a window on the black box of surveyor behavior. Of course, the inherent labor intensity and expense of field work achieves more detailed direct evidence at the expense of far fewer cases examined.

There was a two-fold purpose for the CHSRA studies; first, to monitor implementation of the revised long-term care survey process that was effective July 1, 1995; second, to identify possible reasons for variations in survey findings among the States. The project utilized two different types of studies, concurrent surveys and survey observations:

- For **concurrent surveys**, the CHSRA research survey teams completed standard Federal certification surveys simultaneous with recertification surveys being conducted by State survey teams;
- **The survey observations** were conducted by CHSRA observers who used an observation protocol structured by a series of questions about each specific task in the revised LTC survey process.

Facilities were selected to be broadly representative of U.S. nursing homes. The essential feature of the concurrent surveys was the comparison of what actual surveyors identified as a problem with what an independent, “gold standard” survey team (i.e., the independent experts on the CHSRA research survey team) found *for the same facility at the same point in time*. Although the CHSRA survey *observations*, as opposed to the concurrent *surveys*, did not conduct a survey, the CHSRA observers were asked to give their opinions about the deficiencies cited by the State survey teams, and to identify any other deficiencies they believed could potentially have been cited. Twenty-nine CHSRA survey studies were completed, including 6 concurrent survey and 23 survey observations. In general, the CHSRA survey teams and observers identified more serious problems, as reflected in the scope and severity decision. In no case did the State survey team identify serious deficiencies (actual harm or substandard care) that was not identified by the CHSRA team. **These findings, consistent with the OSCAR deficiency analysis reported above, indicate that the current survey, as implemented, does not sufficiently identify serious problems**

Media Reports of Abuse and Neglect of Nursing Home Residents: Are Serious Problems Identified by the Survey Process?

Since July 1995, there have been a number of media reports of abuse and neglect of residents in specific nursing homes in the U.S. It is difficult to know if the number of such reports has increased since July 1995, although this seems likely. It is of course possible that the new survey and enforcement provisions may have improved the outcomes for the average resident, as indicated in the research discussed above, and yet failed to protect a few residents from the kinds of egregious violations alleged in the media. Ultimately, it is difficult to evaluate the media allegations without an intensive, fact-gathering inquiry that is more characteristic of a court proceeding. Notwithstanding these cautions, we have made a limited effort to look behind some of these reports to see if something can be learned about limitations of the current survey system in addressing abuse and neglect.

Three such reports were examined. First, hiring practices was examined in a six-part series of articles resulting from a year-long investigation of local nursing homes located in the area on the Iowa-Illinois border.⁶⁵ We examined the articles and queried the reporter and the Iowa State Department of Inspections and Appeals. In general, we found support for the view that many of these nursing homes have hiring practices that result in individuals with a history of violent criminal behavior routinely being employed as direct care givers. It is not unlikely that these hiring practices result in some violence and abuse towards residents.

The second media report consisted of a five-day special report which focused on the uncertainty that Michigan nursing home residents face relative to the quality of care they will receive once they require nursing home care.⁶⁶ Specifically, the articles revealed that during the winter of 1995, five Michigan nursing home residents wandered undetected from their homes in the freezing cold and died. After a full investigation by the State, four of the above five facilities were found responsible for neglect which enabled residents to wander unnoticed from their homes. The neglect ranged from facility failure to provide adequate supervision in order to prevent accidents to disconnected door alarms. As a result of the State's findings, three of the four homes were subject to civil money penalties and all four were required to develop a corrective action plan to address how the facility was going to ensure that there would be no future elopements. None of the homes where these tragedies occurred had any prior history of wandering residents and, therefore, no predictability factor existed to trigger increased surveillance by facility staff or by the State in order to prevent the occurrence. Nevertheless, we might expect that normal surveillance

⁶⁵ Kauffman, C. (1996). Abuse & Neglect: An Investigative Report on Quad-City Nursing Homes. *Quad-City Times*. Series. December 1, 1996 through December 8, 1996.

⁶⁶ Young, A. (1996). Who Cares? Inside Michigan's Nursing Homes. *Detroit Free Press*, October 7, 1996, 6A-9A, October 8, 1996, 5A-7A, October 9, 1996, 8A-9A, October 10, 1996, 7A-9A, October 11, 1996, 1A, 1A-1S-8S.

by facility staff would prevent such an occurrence. Although the effectiveness of the State sanction will ultimately depend on whether there is a reoccurrence, the State clearly responded once the problem was identified.

The third and most recent media report to come to our attention was a *Time* magazine article that drew national attention to resident abuse, malnutrition and dehydration, and inappropriate use of restraints, specifically in California.⁶⁷ Based on a study of death certificates in California between 1986 and 1993, attorney Von Packard alleged that 7 percent of all Californians who died in nursing homes died, at least in part, from lack of food and water, infections, or other generally preventable ailments. Assessing some of these allegations requires an examination of medical records. Such an examination is clearly beyond the scope of this investigation, although the Government Accounting Office (GAO) is conducting an inquiry. Although the defensibility of basing such extreme allegations solely on the examination death certificates, independent of any other evidence, is highly questionable, we do not deny that areas such as malnutrition and dehydration continue to be serious problems in the nursing home setting.

In recent testimony before the U.S. Senate Special Committee on Aging, evidence from various studies was cited that “between one-quarter and one-third of all nursing home residents have a low Body Mass Index, while between 10 and 14 percent experience significant weight loss.”⁶⁸ Similar findings were found for these nutritional markers in the CU study.⁶⁹ *While investigators were cautious in interpreting these nutritional markers as necessarily avoidable or treatable, especially for residents suffering from long-standing and profound chronic illnesses, clearly too much of this malnutrition is “. . . caused or exacerbated by poor care practices”* such as facility failure to provide nutritional supplementation in underweight residents or adequate assistance with eating.

Unfortunately, these outcome studies provide no direct evidence on the extent and nature of these poor care practices. Some direct evidence can be found in a series of recent research articles presenting the findings from a four-year anthropological study that investigated the social, cultural, and clinical factors that influence eating in nursing homes.⁷⁰ The study employed

⁶⁷ Thompson, M. (1997). Fatal Neglect. *Time Magazine*, October 27, 1997, Vol. 150 No. 17.

⁶⁸ Statement by Catherine Hawes, Ph.D., Director of Program on Aging and Long Term Care, Research Triangle Institute, for U.S. Senate Special Committee on Aging, October 22, 1997. See Appendix M.

⁶⁹ See Appendix M: “Recent Data Relating to Nutritional Status,” private communication from Andrew Kramer, M.D., to Marvin Feuerberg, Ph.D., November 6, 1997.

⁷⁰ See Kayser-Jones, J., “Inadequate Staffing at Mealtime - Implication for Nursing and Health Policy,” *Journal of Gerontological Nursing*, 1977, 23(8): 14-21. Also see Kayser-Jones, J., Schell, E., Porter, C., Paul, S., “Reliability of Percentage Figures Used to Record the Dietary Intake of Nursing Home Residents,” *Nursing Home Medicine*, 1977, 5(3): 69-76.

participant observation and in-depth interviews with physicians, nursing staff, nursing home residents, and families. Also, to study eating problems more directly, very careful observations were made weekly and detailed field notes were recorded at all three meals, seven day a week for 100 residents who were not eating well. The study found many factors, such as poor oral health, undiagnosed swallowing disorders, lack of ethnic foods, and lack of sensitivity to individual needs, as contributing to eating problems. However, "... inadequate staffing emerged as the major factor that influenced nutritional care."

Although evidence was presented in the Senate testimony that these nutritional problems had not improved under the new survey, deficiencies for Menus and Nutritional Adequacy (F363) have declined from 15 percent of facilities being given deficiency citations in 1991 to just over 5 percent in the last 6 months of 1995⁷¹ to under 5 percent for 1996.⁷² While it is true that deficiency citations have declined in other areas as well, the decline of deficiencies in this specific area of nutrition does not appear justified by any decline in what many regard as a serious problem. Although HCFA has initiated several activities to address this problem, including an increased emphasis on nutrition in surveyor training, it is too early to judge their effectiveness.

What then can we conclude from media reports and other evidence that has been marshaled to assess their credibility? First, that malnutrition has been and continues to be a serious problem for many nursing home residents. At present, the survey system does not appear to sufficiently address this problem; it is too early to judge the effectiveness of newly initiated activities to improve this situation. Second, that the resident elopements that resulted in death may have been a one-time occurrence; however, if repeated, they warrant a serious investigation. Third, that the abuse of nursing home residents and the potential threat posed by hiring of nurse aides with violent, criminal histories may be a serious problem. We have only examined the results of an investigative reporter in one area of one State, Iowa. The prevalence of what amounts to criminal behavior is inherently difficult to study because it is hidden. However, the detailed reports from Iowa are consistent with widespread reports of patient abuse across the country by ombudsmen in their annual report, in contrast to the relatively few deficiencies that are written in this area. This suggests that the current system under-identifies this problem. Further, two independent studies by Abt Associates, one on State LTC complaint investigation processes and another a survey of ombudsmen, reported that surveyors are not well trained in the complex investigative techniques necessary for effective complaint investigations and have difficulty analyzing the underlying causes of problems.

⁷¹ Harrington, C., et. al., *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1991 Through 1995*, Table 52, Department of Social and Behavioral Sciences, University of California, San Francisco, January 1997.

⁷² Cowles, C.M. *Nursing Home Statistical Yearbook, 1996*, Table IV-3, Cowles Research Group.

1.7.3.5 *Current System of Survey and Certification: Problems Corrected?*

This question of problem correction is difficult to study retrospectively. It is also difficult to study without very expensive field work that would make direct observations at nursing homes over a fairly long period of time of what happens after specific problems are identified. We had neither the time nor the resources to conduct such an intensive investigation. We have, however, addressed this question by asking if the central mechanism of the survey process for correcting identified problems, Plans of Correction (POCs), resulted in real behavioral change on the part of providers or just paper compliance.

Some assessment of this latter question was obtained from a modified ethnographic effort to collect and describe data collected from intensive interviews with representatives from a sample of 20 facilities who have had problems - often serious - cited under the new survey and enforcement system. Almost all the respondents had some experience with POCs. Administrators, directors of nursing, other facility staff (including nursing assistants), and residents and family members were interviewed. About half of these interviews were conducted face-to-face, onsite at the facility. The study revealed several examples of changes initiated as a result of POCs. Changes fell into two major categories: 1) personnel or behavior changes that relate to resident care; and 2) facility-specific environmental, or physical plan changes. Many of these positive changes were real and apparently lasting. In other cases, there was evidence that the corrective actions taken in response to a POC were not supported by changes in facility practices or procedures but were only statements made as part of the process to come into compliance, particularly if the nursing home administrator did not concur with a survey team finding.

Example of POC Leading to Paper Compliance - a Temporary Fix

Another type of action on the POC that may be only paper compliance is inservice instruction for different categories of staff. One of the most frequently reported actions by a facility is to provide inservice training to the staff. In the majority of the situations that were explored for purposes of this report, the data collector requested and reviewed log books of staff inservice that occurred as part of the POC.

While the data collector found that in each facility the log books for inservice were produced, which would be evidence that staff training did indeed take place, there was no means to assess the content and quality of the instruction that was provided. The isolated inquiries to staff members to verify whether they recalled an inservice being provided met with very mixed responses. Generally, if the staff member who was questioned was present in the facility at the time of the survey or shortly thereafter, he or she recalled inservice training. Actually, the staff referred to series of inservice trainings, and, as one aide recalled, that following the survey that was the topic of inquiry, "It was inservices all the time. It was every other day, it seemed like."

However, there is a high turnover in nursing facility staff. Often the staff present in the facilities when the data collection was completed had not worked in that facility at the time of the last survey, and therefore, probably would not have participated in inservice training resulting from the POC for that survey. This was most evident in the facilities that were selected from the sub-groups of facilities whose surveys were conducted in late 1996.

One key informant who is a service union representative indicated that workers in one facility were asked to sign an attendance sheet for an inservice they did not actually attend. This same informant also indicated that the length of inservices is generally too short; the content is not provided in sufficient detail and with time to practice the acquisition of knowledge or skills that would be needed by workers. This representative indicated that content is not specific to the work units that would benefit from on-the-job instruction, e.g. procedures for housekeeping personnel, practices to be used by dietary personnel. There were variations in the extent to which the facilities provided adequate information in an appropriate medium for the workers. One informant indicated that facility management team members may produce written forms for recording resident information that staff should use but the forms are not explained and the workers are not familiar with the expected paperwork. Per the informant, smaller, independently owned facilities were more thorough in inservice instruction.

Example of Behavioral Change as a Result of the Survey Process and POC

In contrast to the illustration that the survey process does not induce behavioral change is another example of how the POC and remedies did induce a positive change in staff behavior. In one rural facility that had undergone swift turnover in administrators and directors of nursing, the survey team found standard quality of care deficiencies and other deficiencies that were focused on resident care. The findings were indicative that resident assessment systems and care plans were not being implemented in a timely and accurate manner. As a result of the required POC, the facility implemented a proactive means of resident behavioral monitoring, including meetings every two weeks of an interdisciplinary team to review any instances of individual resident behavior or resident interaction that warrants attention. The facility also implemented another team to review any reported falls and incidents involving residents on a weekly basis. While observing in the facility, the data collector witnessed this team in action during their weekly review. The incident review team is a self-directed effort that was still in place nine months after it was implemented. The other related improvement was that the admissions staff was more consistently completing accurate and comprehensive screening of any prospective residents.

In this facility, the administrator indicated that the remedies that were imposed forced the facility to hasten its pace to correct the systems that had been neglected or overlooked. Had the POC not been required, the facility would have taken much longer to have achieved the changes that occurred. The components were put into place to facilitate and maintain the positive changes that occurred in this facility included:

- As the POC was submitted, a new administrator and a director of nursing who were focused on resident care assumed their positions and initiated new systems.
- Inservice instruction was provided to all staff members on all three shifts, e.g., staff were taught about resident behavior. Records of inservice content were checked and a nursing assistant confirmed the series of inservices that were held.
- Resident behavior flow sheets to describe activity, medications, changes in behavior were implemented and were observed to be in use.
- The Behavioral Monitoring team review was started, and it remains active. The residents who were selected for careful monitoring have improved and job satisfaction has increased for the nursing assistants and the licensed staff who have been involved in the care of these residents. Those two factors have reinforced the success of the team so they continue to meet and conduct assessments and planning for resident care and behavioral monitoring.

The above changes aimed at improving the staff members' abilities to work with residents were supported by some changes in the residents' environment. The lighting was improved in resident care areas. The bed height was lowered and room wanderer guards were added to deter residents from disturbing other residents. Thus, the POC induced some behavioral change in the residents as well as in the staff, who became much more aware of monitoring and assessing changes in residents' actions.

1.8 Conclusions

A wide variety of evidence has been arrayed that bears on the three broad strategies for ensuring nursing home quality that Congress asked us to assess:

- With respect to granting deeming authority (the most likely organization to perform this function being JCAHO), evidence indicates that as presently structured, offering the deeming option to facilities would place many residents at serious risk. In contrast, the HCFA survey as typically implemented with all its flaws, identifies many serious problems, allows less time for problems to remain uncorrected, and verifies compliance by an actual revisit as compared to JCAHO.
- An assessment of the second strategy, various regulatory incentives and non-regulatory nursing home quality improvement initiatives, provided little to no evidence that these efforts are effective and could supplant the normal survey process. At best, we would have to conclude that the evidence is not in.
- With respect to the third strategy, the existing system of survey and certification, evidence was produced that the OBRA '87 reforms implemented in October 1990 resulted in improved

resident outcomes. Also, there is some suggestive but inconclusive evidence that the more recent enforcement provisions resulted in improvements in resident outcomes, although many of the enforcement processes we examined are not working as intended. There is a concern that several States never or very rarely cite a substandard care deficiency.

The evidence examined in this study is supportive not only of regulation as the primary bulwark for quality assurance, but that enforcement needs to be more vigorously applied among the States. Although a thorough discussion of possible solutions to redress the problems in the Federal survey and certification process is beyond the scope of this report to Congress, the Department is currently in the process of identifying improvements to the current system.

2.0 PRIVATE REGULATION OF NURSING HOME QUALITY

2.1 Background

2.1.1 Motivation for This Study

For more than a decade, Federal policies have promoted gradual deregulation and privatization of the Medicare program. The expansion of Medicare managed care reduces government's direct role in paying and monitoring providers while offering beneficiaries more choices. These trends have accelerated in the 1990s, and the Balanced Budget Act of 1997 further expands both managed care and fee for service options.

Throughout this period, debates over government's role as health care regulator have persisted. None generates more heat than the ongoing debate over how best to protect the health and safety of nursing home residents. Historically, the Health Care Financing Administration (HCFA) has relied on regular surveys of nursing homes to monitor and enforce compliance with long-term care (LTC) program requirements. State survey agencies conduct these surveys.

Nursing home industry argues that nursing homes should have more choice and flexibility in fulfilling Medicare participation requirements. In addition to reforming the regulations governing the survey and certification process, industry asserts that government should allow providers to use privately-conferred accreditation status as proof of compliance with Federal regulations, that accredited providers be "deemed" to be in compliance. Consumer groups counter that deeming represents an inappropriate surrender of government's authority to set and enforce standards, and that experience in deeming Medicare-certified hospitals shows that accreditation provides no guarantee of residents' health and safety.

In the early 1980s, a Reagan Administration proposal to deregulate external quality assurance for nursing homes, in part by conferring deemed status on homes accredited by the Joint Commission on Accreditation of Hospitals (JCAH),⁷³ met stiff resistance from well-organized public interest groups. Despite a subsequent move to strengthen regulations in the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), Congress recently reopened the issue of reforming the nursing home survey and certification process and providing a deemed-status option, calling for a study to inform the process. To this end, HCFA contracted with Abt Associates, Inc., to evaluate the potential for private accreditation and deemed status for nursing homes. This chapter combines these evaluations with other literature and opinions from interested parties to review the policy options open to HCFA.

⁷³ In 1987, the Joint Commission on Accreditation of Hospitals (JCAH) changed its name to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), in recognition of the wider scope of its mission. This chapter refers to the organization as the JCAH before 1987 and the JCAHO after 1987.

2.1.2 Medicare's Nursing Home Quality Assurance Program

Medicare's quality assurance (QA) program for nursing homes rests on a survey and certification process that determines compliance with standards defining LTC requirements for participation in Medicare. However, HCFA's survey process fits into a larger system for assuring nursing home quality that includes components other than accreditation.

Since the early 1970s, State LTC ombudsmen have had authority to address nursing home residents' concerns about quality of care. OBRA '87 and the 1987 reauthorization of the Older Americans Act strengthened this authority, giving residents of nursing and board and care facilities "direct and immediate access" to ombudsmen and mandating more interaction between ombudsmen and State survey agencies. In its assessment of quality in nursing homes, the Institute of Medicine (IOM) notes that "...the ombudsman program, which was created, in part, to address some of the limitations and shortcomings of the regulatory system" has coexisted uneasily with the survey and certification program. Ombudsmen may pass on information about a facility to State surveyors and may participate in exit conferences. However, IOM reported that staffing shortages in some States restricted ombudsman participation in the survey process. In the final analysis, ombudsmen may advocate for residents and make representations to other organizations about quality and compliance problems in facilities, but they need not base their actions on the Medicare participation requirements, and they have no authority to enforce compliance with State or Federal regulations.⁷⁴

Surveyors generally operate with little input from nursing homes' own QA systems. In 1994, HCFA wrote new rules requiring surveyors to determine whether nursing homes have operating QA committees with methods to identify and respond to deficiencies. In accordance with the Social Security Act (the Act) and implementing regulations, HCFA's guidance to surveyors has afforded these committees a certain amount of privacy to encourage nursing homes strengthen their internal QA programs.⁷⁵ Accordingly, specific QA information is not typically used in the survey, unless to cite a deficiency in the requirement for the QA program's existence, meetings, composition, or function.

⁷⁴ The IOM identified two other State programs that investigate and advocate for residents' rights: adult protective services, which in some States have limited authority for elders living in facilities, deals with complaints of abuse, neglect and exploitation; and protection and advocacy systems that assist persons with disabilities. Although these programs sometimes coordinate with State LTC ombudsmen, they have no mandate to share information or tasks with the State survey agency. IOM, *Real People, Real Problems. An Evaluation of the Long-Term Care Ombudsman Programs of the Older Americans Act*. Washington, D.C. 1995.

⁷⁵ See the introduction in Chapter 13 for the appropriate citations and a more detailed discussion of HCFA's relationship to facilities' QA systems.

The QA program requirement reflects a new emphasis on quality improvement, originating in Executive Order 12862 (September 11, 1993) "Setting Customer Service Standards," and guided by HCFA's Strategic Plan (February, 1994). Proponents of deeming assert that accrediting bodies such as JCAHO are better positioned than government to implement a continuous quality improvement (CQI) program in nursing homes, pointing to the educational and consultative functions that have long been a part of JCAHO's program. Thus, as HCFA redesigns its rulemaking and enforcement procedures to be more responsive to constituent needs, provider groups assert the superiority of JCAHO and other accrediting bodies for attaining the government's quality improvement goals.

Two programs that so far have had little effect on nursing homes but have some potential to do so in the future are: 1) intensified Federal government efforts to combat fraud and abuse; and 2) quality improvement programs implemented by Peer Review Organizations (PROs).

Federal efforts to control fraud and abuse have begun to intersect with the broader beneficiary protection functions embodied in survey and certification, particularly in the home health industry. Since passage of the Health Insurance Portability and Accountability Act (HIPAA) in 1996, and as a consequence of an extension of Operation Restore Trust, a demonstration of the feasibility of intensified anti-fraud measures coordinated across the Departments of Health and Human Services (DHHS) and Justice, both the DHHS Office of the Inspector General and HCFA have designed and implemented survey procedures to detect fraud, targeted in the "Wedge Project" toward the home health industry. Despite some suggestion that "...[skilled nursing facilities] will undergo (Wedge Project) audits in some states," the effort currently remains focused on home health.⁷⁶

PROs have historically concentrated their efforts on reviewing utilization managed by physicians, in hospital and outpatient settings. Under the Tax Equity and Fiscal Responsibility Act of 1982 and §1154 of the Act, PROs have a mandate to "review those services furnished by physicians, other health care practitioners, and institutional and non-institutional providers of health care services... as specified in their contract with the Secretary." However, the most recent PRO scope of work concentrates heavily on PRO participation in HCFA's quality improvement initiative, but makes no mention of nursing homes.⁷⁷

⁷⁶ *Home Health Compliance Alert*. 1:6. June 1997. p 69.

⁷⁷ U.S. Department of Health and Human Services/Health Care Financing Administration. Medicare program; description of the Health Care Financing Administration's evaluation methodology for the Peer Review Organization 5th scope of work contracts. *Federal Register*. Vol. 62:No. 127. July 2, 1997. p 35824-35826.

2.1.3 Brief History of Deemed Status in Medicare⁷⁸

With the creation of Medicare in 1965, in §1865(a) of the Act, Congress authorized deeming as an option for certifying hospitals for participation in the Medicare program. Only the JCAH's hospital accreditation program, which covered 60 percent of U.S. hospitals in 1965,⁷⁹ was immediately approved as a substitute for survey and certification.

This authority was extended to nursing homes and other providers by amendment of §1865(a) in §§2345 and 2346 of the Deficit Reduction Act of 1984 and §6019 of the Omnibus Budget Reconciliation Act of 1989. Amendments to the law in 1988 and 1991 gave the Secretary of HHS discretion to grant deeming authority to organizations accrediting a wide variety of eligible facilities, including psychiatric hospitals, home health agencies (HHAs), hospices, laboratories and clinics, skilled nursing facilities (SNFs), and other types of health care providers. Granting deeming authority required HHS to find that accreditation by a national body offers "reasonable assurance" that Medicare conditions of participation (COPs)⁸⁰ are met. The Omnibus Fiscal Year 1996 Appropriations legislation (P.L. 104-134) mandated expanded use of deemed status in the Medicare program. **With the exception of SNFs**, durable medical equipment suppliers, renal dialysis facilities, and managed care plans, the legislation required that the Secretary must accord deemed status if he or she finds that private accreditation demonstrates compliance with the COPs. The 1996 legislation thus retained the former law with respect to deeming for SNFs - that is, the Secretary *may* grant deemed status but is not mandated to do so.

Deeming has never been without controversy, even in the hospital industry. In the early 1970s, the National Welfare Rights Organization and other consumer groups met with the JCAH to present demands "for opening up the accreditation process and for altered standards to require of hospitals more consumer participation."⁸¹ At the same time, consumer groups sued the Department of Health, Education and Welfare, claiming that the delegation of any part of the certification process to a private body was unconstitutional.⁸² Partly in response to consumer

⁷⁸ A more extensive review of the history of accreditation and deeming, including a history of the JCAHO, the history of deeming in Medicare hospital program, and extension of deeming to the Medicare home health program, may be found in Chapter 3.

⁷⁹ McGeary, M.G.H. "Medicare conditions of participation and accreditation for hospitals" in *Medicare: A Strategy for Quality Assurance. Volume II. Sources and Methods*. Washington, D.C.: National Academy Press. 1990.

⁸⁰ For SNFs and nursing facilities (NFs), the standards that must be met are referred to as "requirements for participation" rather than "conditions of participation."

⁸¹ Jost, T. "The Joint Commission on Accreditation of Hospitals: Private regulation of health care and the public interest." *Boston College Law Review*. Vol. 24: No. 4. July 1983. p 855.

⁸² Jost, op. cit., Mc Geary, op. cit.

criticism, the JCAH revised its procedures to place more emphasis on outcomes in quality review. By the late 1970s, government viewed JCAH's performance in hospitals more favorably, in contrast to traditional surveys which the General Accounting Office (GAO) found to be less reliable and less effective than the JCAH's process.⁸³ Critics of deeming have continued to focus on JCAHO performance in hospitals, in part because the scope and history of the program provides evidence of problems that might occur in other deeming programs.⁸⁴

After over 20 years of experience with hospitals, HCFA agreed in 1987 to confer deeming authority for HHAs to the National League of Nursing's Community Health Accreditation Program (CHAP). One year later, JCAHO was also approved for deeming in home health. Implementation was delayed until 1992 to allow HCFA to complete an extensive revision of home health COPs. Final rules for home health deeming included extensive "look behind" provisions authorizing Federal or State agencies to conduct additional inspections to validate JCAHO findings.

Though JCAH began to accredit nursing homes in 1965, by 1992, only 1200 of over 15,000 nursing homes in the U.S. were JCAHO accredited. It was not until 1982, 17 years after JCAH was extended deeming authority for hospitals, that the Administration seriously proposed to extend accreditation as an option for Medicare certification of nursing homes.

The Reagan Administration's proposal was not successful, failing before a hostile Congress and substantial criticism from consumers' groups and others.⁸⁵ In addition to constitutional and legal concerns, critics presented anecdotal evidence of serious quality problems in nursing homes. Congress responded by placing a moratorium on the Administration's proposal and by commissioning the IOM to study and report on the quality of care in U.S. nursing homes. The IOM issued a report in 1986 documenting widespread quality problems.⁸⁶

⁸³ General Accounting Office. *The Medicare Hospital Certification System Needs Reform*. HRD-79-37. Washington, D.C.: GAO. 1979.

⁸⁴ Dame, L., and Wolfe, S. *The Failure of "Private" Hospital Regulation. An Analysis of the Joint Commission on Accreditation of Healthcare Organizations' Inadequate Oversight of Hospitals*. Public Citizen Health Research Group. July 1996.

⁸⁵ Hearings conducted by the Senate Special Committee on Aging brought together Committee opponents of deeming, including the Chairman, Senator Heinz, and consumer critics, including the National Senior Citizens Law Center, the Association of State and Territorial Health Officials, the Association of Health Facility Licensure and Certification Directors, and the National Citizens' Coalition for Nursing Home Reform. (Special Committee on Aging, U.S. Senate, "Nursing Home Survey and Certification. Assuring Quality Care " Hearing July 15, 1982).

⁸⁶ Institute of Medicine. Committee on Nursing Home Regulation. *Improving the Quality of Care in Nursing Homes*. Washington, DC: National Academy Press. 1986.

Responding to the IOM report and consumer concerns, Congress passed the OBRA '87 legislation. In many respects, OBRA '87 represented a break in a general trend toward less Federal regulation of Medicare providers. At the same time, OBRA '87 echoed growing demand among public and private payers that the quality of care be assessed against resident-centered criteria, particularly clinical and functional outcomes. As a result, State surveyors were required to include nursing home residents in the survey process, to protect not only health and safety but also to protect residents' rights, and to promote enhanced levels of physical function.

Despite the stringent provisions of OBRA '87, industry groups continued to press for deemed status. Two events encouraged the proponents of deeming. The first was HCFA's decision to allow deeming in home health. Second, in 1993, HCFA issued rules to guide the selection and management of organizations for deeming of all Medicare providers.⁸⁷

In July 1995, after extensive preparation, HCFA introduced new survey and enforcement provisions designed to implement the remaining portions of the OBRA '87 legislation. Industry representatives reported widespread concerns from constituents about an increase in burden of the process, inconsistent decision making on deficiencies, and other issues. Recently, Congress mandated an assessment of the new survey and enforcement processes, with attention to the implications of permitting deemed status for accredited providers.

2.2 Survey and Certification Policy Options for Medicare

Promoting better quality in nursing homes is obviously a goal that government might hope to achieve by both regulatory and non-regulatory means.⁸⁸ Government has three broad options for reforming the regulatory nursing home survey and enforcement systems:

1. **Retain the current system**, with or without modification. Under this model, HCFA: writes rules that define nursing home participation requirements; continues to rely on State surveyors to monitor nursing home compliance; and enforces rules through sanctions in response to identified deficiencies.
2. **Offer nursing homes choices for demonstrating compliance**, between the traditional State survey process and private accreditation. For the private option, HCFA delegates some or all of its role in: *setting standards* by assuring that the standards set by private accrediting agencies are "comparable" to government standards; *monitoring compliance*, through comparable public and private survey programs; and *enforcing compliance* through comparable sanctions.

⁸⁷ 42 CFR Parts 401, 488, 489, in 58 Federal Register 61816 (November 23, 1993).

⁸⁸ For a discussion of regulatory incentives and non-regulatory initiatives for improving nursing home care, see Chapters 12 and 13 of this report.

3. **Mandate a privatized system**, contracting with private entities to conduct all or some survey and certification activities.

The last option seems extreme and unlikely to be implemented at present; in any event, it is beyond the scope of this report. The first option will be addressed in greater detail elsewhere in this study. This chapter focuses on the “choice” proposal (option number two).

At present, HCFA’s only practical alternative for national implementation of options two or three is the LTC program of the JCAHO. Most other organizations that accredit are active in other settings (e.g., the National Committee for Quality Assurance for managed care organizations, the Rehabilitation Accreditation Commission, which accredits rehabilitation programs within organizations, CHAP and the Accreditation Commission for Home Care, which accredit HHAs, and the National PACE Association, which accredits PACE programs). However, the Long-term Care Evaluation and Accreditation Program (LEAP) developed by Survey Solutions, Inc., began operation in November 1997 and may offer JCAHO future competition in accrediting nursing homes.⁸⁹ Throughout this chapter, whenever appropriate, JCAHO and LEAP program characteristics will be compared.

The rest of this chapter describes in greater detail the arguments on deeming, findings that support or refute these arguments, and policy options for HCFA. Section 2.3 reviews points of agreement and disagreement among major stakeholders. Sections 2.4 and 2.5 evaluate the arguments for delegation of authority to set standards and secure compliance against several effectiveness criteria. Section 2.6 presents estimates of the net costs of deeming by comparing accreditation with the current survey and certification program. Section 2.7 summarizes policy options and assesses how trends in the health care system may affect both internal and external quality assurance in Medicare-certified nursing homes.

2.3 Stakeholders’ Concerns

2.3.1 Key Stakeholders

On questions of delegating HCFA’s authority to regulate Medicare-certified nursing homes, the major stakeholders divide into two groups:

- Consumer advocates, some trade unions, and associations of State surveyors generally oppose private regulation in general and deeming in particular. Consumer advocacy groups taking positions on deeming include the National Senior Citizens Law Center, the National Citizens Coalition for Nursing Home Reform, the National Association of State LTC Ombudsmen,

⁸⁹ For more details on the accreditation programs of these organizations, see Chapter 4 of this report, “Catalog of Accreditation Entities.”

The National Committee to Preserve Social Security and Medicare, the American Association of Retired Persons, and the Grey Panthers. The Service Employees International Union AFL-CIO has also opposed JCAHO deeming.⁹⁰ The Association of Health Facility Licensure and Certification Directors, representing State surveyors, also opposes deemed status for LTC.

- Nursing home administrators, nursing home associations, and organizations that accredit health care providers generally favor private regulation. In addition to JCAHO, several provider associations have testified in favor of deeming for nursing homes, including the American College of Health Care Administrators, the American Association of Homes and Services for the Aging, and the American Health Care Association.

2.3.2 Areas of Agreement

Despite sharp disagreements over government's proper role, proponents and opponents of deeming have agreed on two major points.

First, there are clearly some nursing homes that need the punitive threat of review and enforcement to secure improvements. During 1982 Senate hearings, Jack A. MacDonald of the National Council of Health Centers testified that proposed revisions to the survey process, including deeming, would allow the States to "...focus on the real problems with the care provided by substandard facilities."⁹¹

Second, the current survey system has not worked as well as it should have to eliminate poor quality nursing home care. Proponents of deeming argue that, despite years of Federal regulation, performance of the "worst" nursing homes has not improved. Dennis Bozzi, quoted in Rajecki, reports that "...the Illinois Association of Homes for the Aging) tracked one facility that was in the paper in 1972 for poor quality (and) twenty years later . . . it still has a bad record of a lot of problems and it's still open."⁹² Opponents agree that the current system has not fully succeeded, but suggest improving and strengthening existing systems rather than introducing deeming.

⁹⁰ The SEIU reports on its problems with JCAHO's accreditation process, based on experience in one facility, Columbia Sunrise Hospital in Las Vegas, in SEIU Research Memorandum. *The Joint Commission on Accreditation of Healthcare Organizations: a review of recent problems*. January 1997.

⁹¹ Special Committee on Aging, op. cit., p 89.

⁹² Rajecki, R. "Going their own way: deemed status edges ahead." *Contemporary Long Term Care*. January 1993. p 42.

2.3.3 Proponents of Private Regulation

Proponents of private regulation argue that the current system does not work, and so it should be scrapped or modified to allow providers more choice in proving compliance with regulations. Their position rests on several assumptions and observations:

- The survey and certification process is bureaucratic and inflexible.
- Even though there are a few poor performers, most nursing homes strive to provide good quality care, and succeed. If some nursing homes choose an accreditation option for compliance, deeming will allow States to focus survey and enforcement resources on substandard nursing homes.
- Nursing home administrators are better educated and more experienced managers than they were ten years ago. In 1982, Laurence Lane of the American Association of Homes for the Aging praised the “. true professionalization that has occurred in the field,” noting 34 percent masters degrees for administrators with college training.⁹³
- Many good performers in the industry are positioned to respond to the positive incentives built into the educative, consultative model favored by accrediting organizations. To raise the average level of quality, rewards are needed as well as punishments. The standard punitive approach is out of date and counterproductive for most nursing homes. The current system is a blunt instrument, because excellent nursing homes are treated in the same way as poor nursing homes.
- HCFA’s implementation of the new survey and enforcement systems for nursing homes has heightened industry concerns about consistency in enforcement.
- Based on its experience with hospitals, JCAHO is more efficient than HCFA because it relies on facility administrators and clinical staff to do much of the job of enforcing standards and because it can rely on industry expertise in setting and revising standards.⁹⁴

2.3.4 Opponents of Private Regulation

Opponents of private regulation agree that the current system does not work as well as it should. They also agree that not all nursing homes are poor performers. However, they suspect that serious problems are more widespread than do proponents of deeming, and they argue that the system should be improved, not scrapped. The main points of their argument are:

⁹³ Special Committee on Aging, *op cit.*, p 91.

⁹⁴ Jost, *op. cit.*, p 881

- Despite improvements, for the most part, nursing homes are not managed by “professionals.” The shared codes of conduct that govern the clinical professions are not present among nursing home administrators. Owners of nursing homes and nursing home chains pursue business interests that are often at odds with the goals of good quality care.⁹⁵ Therefore, there is no reason to expect that the average nursing home will take steps to incorporate continuous quality improvement methods. Evidence collected by the Food and Allied Services Trade Department of the AFL-CIO on an intensified QA initiative, implemented by Beverly Enterprises in its Missouri nursing homes under agreement with the State, suggested that the intensified QA program identified violations of care standards, but did not prevent recurrence of care problems.⁹⁶
- The relatively high frequency of compliance problems among nursing homes (nearly two-thirds of nursing homes are cited by State surveyors with one or more deficiencies annually) shows that the average nursing home is not ready to be released from direct government monitoring and enforcement. Reports in the press document questionable and sometimes horrific practices that show the need for vigilance.⁹⁷
- Accreditation does not “work” in other contexts, even among hospitals for which deemed status has been an option since 1965.⁹⁸ Few hospitals are decertified or denied accreditation, and there is typically no enforcement. Private accrediting organizations have no authority to enforce Federal regulations. JCAHO surveys are announced well in advance and follow a three-year cycle, characteristics that limit the effectiveness of accreditation in protecting residents.
- Whatever the practical arguments for deeming, accrediting bodies are not accountable to the public or to government. In fact, because organizations like JCAHO are paid by the providers they accredit, there is at least the appearance of conflict of interest, “if the objective of the inspection is to ensure that the public health and safety is protected.” JCAHO survey findings are not available to the public, which “removes the financial incentive of good inspection reports for nursing home operators” and “provides no incentive to nursing home operators of avoiding the financial losses associated with bad publicity.”⁹⁹

⁹⁵ Tomsho, R. “Old problem. A train of complaints slows but can’t stop nursing-home mogul.” *The Wall Street Journal*. Wednesday, September 3, 1997. p A1, A6.

⁹⁶ National Senior Citizens Law Center. *The Nursing Home Law Letter*. 1995 1. May 16, 1995. p 4.

⁹⁷ Thompson, M. “Neglect.” *Time Magazine*. October 27, 1997. Pages 34-38. Levine, S. Md. Facility is a center of conflict. *The Washington Post*. September 8, 1997, p B3.

⁹⁸ Reap, E. (Association of Health Facility Survey Agencies). Letter to M. Feuerberg. July 3, 1997.

⁹⁹ Idem

- Deeming would “[threaten the] cooperative relationship [between the Federal and State governments] and the sharing of inspection costs,” which would “greatly increase the costs of inspection programs to the States.”¹⁰⁰

Although proponents and opponents of private regulation generally address the entire process, there are at least two key components of regulation that could be separately privatized: 1) setting standards against which nursing home performance will be measured; and 2) enforcing standards, by measuring performance and exacting compliance. The next two sections discuss standards setting and enforcement.

2.4 Private Options for Setting Standards

2.4.1 Policy Question

Kinney identifies two functions of accreditation; standard setting and determining “whether organizations have complied with these standards, thereby warranting accreditation.”¹⁰¹

In principle, government might treat these functions as separable, privatizing one but retaining direct Federal control of the other. Government might delegate the setting of standards for nursing homes, in part because private organizations may command readier access to relevant expertise than government. However, critics decry the lack of accountability in the processes accrediting organizations use to set standards and condemn the current divorce of the survey process from enforcement of regulatory standards in the Medicare hospital program.

The policy question facing the Federal government in this regard is whether the standards of private accrediting organizations should be accepted for determining nursing home compliance with Medicare regulations.

2.4.2 Criteria For Assessing The Standard Setting Process

To explore this question, it is appropriate to compare both the processes and products of accrediting organizations with the current survey and enforcement systems, according to certain

¹⁰⁰ Idem

¹⁰¹ Kinney, E. “Private accreditation as a substitute for direct government regulation in public health insurance programs: when is it appropriate?” *Law and Contemporary Problems*. Vol. 57 No. 4. Autumn 1994. p 49.

criteria. These mirror criteria spelled out in HCFA's rules governing the selection of deeming organizations.¹⁰² They include:

- *Comparability* of the accrediting organization's standards and Federal standards. In practice, there are at least two ways to make this assessment: 1) through a standard-by-standard comparison, to determine differences and similarities in scope and intent; or 2) through a side-by-side observation of how surveyors use the two sets of standards, comparing the number and types of deficiencies cited within broad domains (for example, resident rights, quality of care).
- *Validity* of the standards. Do standards for resident outcomes reflect the most rigorous recent research on outcome measurement and linkages of outcomes to organizational structure and the processes of care?
- *Accountability* in the process of setting and revising standards. Does the public have access? Does government have sufficient access to allow it to oversee the private standard-setting process and exert needed leverage to assure comparability with Medicare participation requirements?

2.4.3 Evidence

2.4.3.1 *Applicable Law and Regulations*

The concept of privatized standard setting in the Medicare program is well-established in legislation and defined for implementation through regulations. Section 1865 of the Act, as amended in the Deficit Reduction Act of 1984 and the Omnibus Budget Reconciliation Act of 1989 authorizes the Secretary of HHS to grant deeming authority for providers other than hospitals to accrediting organizations if those organizations can "provide *reasonable assurance* that the applicable participation requirements are met."

HCFA's regulations address comparability of Federal and private standards without providing exact decision rules for officials charged with making these comparisons. In 1993, in amendments to 42 CFR Parts 410, 488, and 489, HCFA wrote rules to govern the process of "(Granting) and Withdrawal of Deeming Authority to National Accreditation Organizations." Section 488.6 requires that an accreditation organization's requirements "... must be at least as stringent as the Medicare conditions, when taken as a whole." Section 488.9 contains standards for evaluating applications from accrediting organizations, and HCFA comments in discussing the final rule that "... HCFA plans to evaluate an accreditation organization's accreditation requirements to determine

¹⁰² U.S. Department of Health and Human Services/Health Care Financing Administration. 42 CFR Parts 401, 488, and 489. Medicare Program: Granting and Withdrawal of Deeming Authority to National Accreditation Organizations. Final Rule. *Federal Register* /Vol 62:No. 127. November 23, 1993. p 61816-61843.

whether they are equivalent to ours.” HCFA adds a list of information requirements for applicants which include a “...detailed comparison of individual accreditation requirements with the equivalent Medicare conditions, i.e. crosswalk.” In response to comments, HCFA noted that “...[it] is acceptable for an accreditation organization to organize its requirements differently than HCFA does, and to have requirements that are not identical but are at least equivalent to Federal requirements” as long as the applicants provided “reasonable assurance that all applicable Medicare conditions would be met.” HCFA can revisit the comparability question, if an accrediting organization with deeming authority proposes to adopt new requirements, or if an organization’s deeming authority has been in effect for the maximum term.

On questions of accountability and government’s ability to secure changes in an accrediting organizations standards, the rules are silent. Federal rules make no provision to require public or government access to the processes by which accrediting organizations set and change standards. In addition, HCFA has no authority to cause an organization to change its standards to fit HCFA’s requirements other than by rejecting its application for deeming authority or by removing authorization.

To date, legal challenges to the notion of privatizing standard setting largely ended with *Cospito v. Heckler*, in which “the U.S. Court of Appeals for the Third Circuit upheld Medicare’s use of private accreditation to set standards for health care institutions against a challenge that such standard-setting was an improper delegation.”¹⁰³

2.4.3.2 Comparability

Hospital and home health facility standards and requirements. A requirement that, as part of the process of approving an accrediting organization for deemed status authority, accrediting and regulatory standards be compared at a “micro” level is a relatively recent phenomenon. Because deeming authority for hospitals was part of Medicare from the beginning, no baseline crosswalk of JCAH and HCFA standards was developed. Similarly, when HCFA conferred deeming authority for HHAs on CHAP and JCAHO, no crosswalks were required. Jost notes that “HCFA seemed willing to overlook some major differences between Medicare’s written standards and a private accreditor’s requirements... [stressing that] the precise requirements and procedures adopted were less important than the general reliability of the private organization to detect deficient services.” In addition, HCFA later “indicated that CHAP had tailored most if not all of its accreditation requirements and procedures to be ‘equal or superior to’ HCFA’s requirements and procedures.”¹⁰⁴ The crosswalk became a requirement for applicant organizations in 1993. No systematic analysis has been done to compare accrediting standards to HCFA standards for home

¹⁰³ Kinney, op. cit. p 57.

¹⁰⁴ Jost, T. “Medicare and the Joint Commission on Accreditation of Healthcare Organizations: A healthy relationship?” *Law and Contemporary Problems*. Vol. 57. 1994.

health and hospitals. It should be noted that it was the job of the applicant organization to produce the crosswalk. HCFA's use of it, in awarding deeming authority, was not specified in the rules.

Nursing home standards and requirements. HCFA first reviewed the comparability of Federal and JCAH standards in the early 1980s, asserting that JCAH and the traditional survey were comparable. More recently, an experienced nurse researcher conducted an intensive analysis of the numbers and types of standards, and the language in the 500 JCAHO standards (effective January 1996) and 522 "F-Tags" that codify the HCFA requirements (current in July 1995). Analysis showed both similarities and substantial differences between the two systems.¹⁰⁵ This exercise demonstrated several instances of close comparability, as well as other instances in which JCAHO and HCFA addressed similar concerns but with greater or lesser focus.

The reviewer also identified six areas in which JCAHO standards diverge from the HCFA regulations, either in the intent of the statement or in the breadth of the focus, so as to cast doubt on a reasonable assurance that the Medicare participation requirements are met: 1) safeguarding and protection of the individual's rights; 2) description of resident's special needs; 3) qualifications of a social worker, activities director, and dietician; 4) lack of clarity regarding use of medications; 5) subsequent actions that are to follow poor resident outcomes that are stated in the HCFA regulations but not explicitly stated in JCAHO standards; and 6) the provision of physician services. The reviewer concluded that JCAHO would have to make changes in its standards to provide reasonable assurance that Medicare's participation requirements are met.

2.4.3.3 Validity

Although there is substantial agreement among researchers on what constitutes valid measures of health status, function, and well-being, there is considerably less agreement on how these measures relate to the quality of services provided by nursing homes. Castle and his colleagues note that many models of quality measurement for nursing homes exist, but that "...relationships between structure, process and outcome measures of quality in the nursing home setting have not been established."¹⁰⁶ Despite these conceptual gaps, government and, belatedly, private agencies have begun to implement standards that reflect a model of resident-centered quality assurance (or quality improvement). This model requires the collection and interpretation of clinical outcome and quality of life measures.

¹⁰⁵ See Chapter 4 of this report, "Content Analysis of JCAHO Standards and HCFA Regulations for Long Term Care."

¹⁰⁶ Castle, N.J., et al. "Quality improvement in nursing homes." *Health Care Management: State of the Art Reviews*. November 1996.

Through legislation and regulation, the Federal government has shifted the focus of its QA requirements for nursing homes from structure and process toward outcome measures of quality. Following the IOM report on nursing home quality in 1986, HCFA began to link its standards to the most recent advances in outcomes measurement. OBRA '87 mandated the development of a resident assessment instrument (RAI) to support care planning and promote quality improvement in nursing homes. The RAI "...[identifies] a resident's preferences, strengths, and needs in key areas of functioning, as a guide to the development of the resident's care plan."¹⁰⁷ Consistent with these new record-keeping requirements, HCFA's survey process was redesigned to reflect LTC requirements based on quality of care and quality of life measures recommended by the IOM.¹⁰⁸ HCFA's nursing home survey requires surveyors to sample residents for interviews and observation of care.

JCAHO's standard survey remains shaped by structural criteria, based on the assumption that if a facility has the correct policy in place then correct care processes will follow. However, in response to pressure from providers that "are finding it necessary to have objective quantitative information about their own performance which they can use externally to demonstrate accountability,"¹⁰⁹ JCAHO will implement the ORYX system for hospitals and nursing homes. ORYX, according to JCAHO, "will integrate outcomes and other performance measurement data into the accreditation process." Nursing homes will choose one from among 60 performance measurement systems that have contracted with the JCAHO. Nursing homes must then choose a minimum of two clinical indicators from this system, and begin quarterly reporting of these indicators to JCAHO by the first quarter of 1999.

Critics of HCFA's survey process have argued that time consumed by legislation and rulemaking makes Federal standards less responsive to changes in knowledge and industry conditions than JCAHO standards. However JCAHO cannot revise standards without reference to industry opinion. In addition, history shows that the Federal government's response to improved resident outcome measures was swifter than the JCAHO's. Kinney observes that "... the JCAHO... has really not been the leader in developing quality standards for any health care institution," adding that only in response to pressure from institutions and the research community did JCAHO revise standards to reflect advances in outcomes measurement and quality improvement methods.¹¹⁰ Therefore it would be difficult to argue that either JCAHO or HCFA standards are more likely to

¹⁰⁷ Idem, p 4.

¹⁰⁸ IOM, op. cit.

¹⁰⁹ JCAHO, *ORYX: The Next Evolution in Accreditation. Fast Facts*. Letter from Dennis S. O'Leary. February 21, 1997.

¹¹⁰ Kinney, op. cit., p 72.

remain abreast of advances in measurement and understanding of factors that affect the quality of care in nursing homes.

2.4.3.4 Accountability

Democratic governments are accountable to the public. Private organizations are accountable to their owners, members, or contributors. This distinction drives critics to argue that an accrediting organization cannot be publicly accountable unless it is forced to be accountable. This may be achieved through guarantees of *direct public access* to the process of standard-setting or to *indirect access* of the appropriate government agency.

There are no legal guarantees of public access to the process by which accrediting organizations set standards. Kinney contrasts the “notice-and-comment” procedures of Federal rulemaking with “... (private) accreditors which do not have comparable formal processes by which to contact consumers in a systematic fashion and to assure that all consumers have an opportunity to influence the content of the standards.”¹¹¹

2.4.3.5 Summary of the Evidence

Private standard setting for regulatory purposes has consistently received support in Congress and the courts. JCAHO’s practices in this regard provide the standard against which this section has evaluated the standard setting function:

- In a thorough comparison of the content of JCAHO and HCFA standards, there was evidence that JCAHO would have to change several standards to provide reasonable assurance that Medicare participation requirements would be met.
- Both HCFA and JCAHO have recently adopted more resident-centered foci, but JCAHO standards are still heavily weighted toward structure and the presence of policies and procedures, while HCFA has expanded emphases on clinical outcomes and quality of life.
- The public has no access to JCAHO’s processes for setting and modifying standards; HCFA’s processes are open to scrutiny through the practice of publishing proposed rules for public comment.

¹¹¹ Idem, p 73.

2.5 Private Options for Securing Compliance

2.5.1 Policy Question

Private and public options for enforcing nursing home regulations differ in philosophy and process. JCAHO trains surveyors to both ensure that accreditation standards are met and to consult on how to re-engineer nursing home processes to secure improvements. This is generally true of accrediting organizations, which “are not viewed as an arm of enforcement, but rather as an experienced helping hand.”¹¹² HCFA’s surveyors focus on enforcement. The efficiency of the survey process for enforcing compliance also depends partly on the standards surveyors use for finding and classifying deficiencies. As Chapter 5 shows, HCFA and the JCAHO differ considerably both in the content and format of standards.

The policy question facing the Federal government is whether private accrediting organizations assure that nursing homes comply with Medicare participation requirements.

2.5.2 Criteria

Delegation of survey and enforcement functions to private entities can be evaluated against several criteria:

- *Comparability* of the survey processes, deficiency rules, enforcement and follow up procedure between JCAHO and Federal surveys;
- *Capacity* defined by background and numbers of trained surveyors. Are JCAHO surveyors trained to collect the appropriate data and make judgments required to enforce compliance with Medicare regulations? Are there sufficient numbers of trained JCAHO surveyors available to handle the number of surveys that would be required if deeming for nursing homes was allowed?
- *Validity* of the JCAHO survey process in identifying deficiencies. Does the JCAHO survey process find valid deficiencies: 1) compared to the Federal survey process; and 2) compared to independent assessments of quality of care and quality of life in surveyed nursing homes?
- *Accountability* to the public and government. Do members of the public and government officials have complete access to JCAHO survey findings? Do providers and consumers have access to appeals processes?

¹¹² Chapter 4, “Catalog of Accreditation Entities.”

- *Effectiveness* in achieving the objectives of Federal regulation. Does JCAHO’s survey/accreditation process do a better job of protecting health and safety than the Federal government’s survey and certification process?

2.5.3 Evidence

2.5.3.1 *Applicable Law and Regulations*

42 CFR Part 488, as amended, spells out how accrediting organizations applying for deeming authority will be chosen and monitored. Section 488.8 lists as criteria for HCFA’s “review and evaluation” of applicants’ aspects of the survey process, including “composition of the survey team, surveyor qualifications, and the ability of the organization to provide continuing surveyor training,” “comparability of survey procedures,” “[the] organization’s procedures for monitoring noncompliance,” “[the] adequacy of staff,” “[agreement] to provide HCFA with a copy of the most current accreditation survey.” HCFA can require a validation survey of accredited providers, on a sampling basis or “... in response to substantial allegations of non-compliance.” (42 CFR 488.7). Although HCFA would receive each nursing homes’ accreditation survey, it could not release the survey or any supporting information to the public unless these materials related directly to an enforcement action (Sections 401.126 and 401.133). With a deeming option in place, enforcement remains HCFA’s responsibility. In answering comments on the proposed rules on deeming, HCFA noted that “we are authorized to accept the accreditation organization’s survey as our own in imposing sanctions.” The accrediting organizations are expected only to enforce “requirements for quality assurance and for assuring resident protection.”¹¹³

2.5.3.2 *Comparability*

The HCFA and JCAHO survey processes differ on a number of counts:¹¹⁴

- HCFA surveys facilities on an annual cycle. JCAHO surveys are conducted every three years.
- HCFA surveyors grade each deficiency in two dimensions; a) scope (from isolated to widespread) and b) severity (from no actual harm/minimal potential harm to immediate jeopardy to resident health and safety). JCAHO surveyors score adherence to standards using a five point scale, from substantial compliance to non-compliance - a software package, using weights and various adjustments to control the impact of individual standard scores on the facility’s score, converts standard-specific scores into an overall facility-specific score that ranges from 100 (substantial compliance) to 0 (noncompliance).

¹¹³ 42 CFR 61824 (November 23, 1993).

¹¹⁴ See Chapter 10, “Comparison of HCFA Enforcement and JCAHO Follow-Up.”

- HCFA's scope/severity scoring system links to specific categories of enforcement responses. Depending on the seriousness of the noncompliance, a variety of remedies may be imposed immediately or held as a threat if correction is not achieved by a certain point. For deficiencies that are isolated and have caused no harm with potential for minimal harm, facilities are not required to submit a plan of correction (POC). For all other deficiencies, however, facilities must generate a POC and conform to HCFA's dates for correcting deficiencies. JCAHO responses are to accredit (with commendation, with or without Type I recommendations, or on conditional or provisional bases) or to deny accreditation.
- Facilities cited for deficiencies by HCFA are required to correct deficiencies by a "date certain," within at most three months from the survey. HCFA usually conducts a revisit to verify compliance. Facilities with Type I recommendations from the JCAHO are typically allowed six months to demonstrate improved performance. Verification is normally based on receipt of a written progress report from the facility.
- Both HCFA and JCAHO report that a majority of facilities have deficiencies that need correction (66 percent and 75 percent from July 1996 through June 1997, respectively) and that most of them correct deficiencies within prescribed time frames.¹¹⁵ In 1996, JCAHO denied accreditation to only one facility (of 722 surveyed). HCFA and State survey staff doubted the validity of OSCAR data on remedies imposed, and there appears to be extensive variability among States in the quality and completeness of enforcement tracking information.
- Between standard surveys, HCFA may conduct investigations in response to complaints from State LTC ombudsmen or from the public. JCAHO uses random surveys (on a sample of 5 percent of accredited facilities) and unannounced surveys if staff become aware of serious problems within the three-year accreditation cycle.

LEAP offers an alternative to JCAHO accreditation. It is informative to contrast JCAHO's accreditation process with LEAP, which "requires an annual, unannounced survey for all LTC facilities seeking accreditation."¹¹⁶ This reflects the belief of LEAP's founder that "the quality of facility services is so highly dependent on the management team and direct care staff that the nature of the LTC industry is constantly changing so that "all it takes is a change in administration or management to quickly turn a good facility into a poor one."¹¹⁷

An intensive observational study of the JCAHO survey process reports that surveyors spend little time assessing quality of life issues or observing clinical treatments. Based on observations of

¹¹⁵ Chapter 11.

¹¹⁶ Chapter 4

¹¹⁷ *Idem*.

complete accreditation surveys in four facilities, investigators concluded that, although surveyors were well-trained and thoroughly professional (“masters-prepared with experience as directors of nursing and/or administrators in long term care”), little time was spent with residents (the numbers of residents surveyed ranged from one to six) and no time was spent observing clinical care delivery. Only one surveyor reviewed charts against direct observation of resident status. Surveyors were free to design their own protocols (with suggestions found in the JCAHO’s *Complete Guide to the Survey Process*). JCAHO software, accessed onsite through surveyor laptop computers, did not force complete coverage of all standards; surveyors could choose which standards to address. In addition, surveyors did not always enter all discrepancies that were discussed with facility management. Investigators concluded that, despite the high level of professionalism of JCAHO surveyors and their commitment to the consultative function of the JCAHO process, “. . . the standard JCAHO survey does not collect sufficient information regarding a LTC facility’s compliance with HCFA’s Requirements for LTC Facilities.”¹¹⁸

LEAP surveys resemble JCAHO surveys, with three important differences. First, LEAP surveyors are expected to “interview residents, staff, family members, and legal representatives” and to review a random sample of clinical charts. Second, the automatic scoring software the LEAP surveyors use onsite has scope and severity dimensions that map readily to HCFA’s system.¹¹⁹ Third, as mentioned earlier, LEAP accreditation surveys are conducted on a more frequent cycle (i.e., annually).

2.5.3.3 Capacity

Critics have argued that JCAHO cannot handle the volume of annual surveys that would be required to implement deeming for nursing homes. Freida Gorrecht, testifying for the National Citizens Coalition for Nursing Home Reform, noted a lack of JCAHO State and regional capacity.¹²⁰ In numbers and geographic distribution, based on information provided by JCAHO and HCFA, HCFA maintains a larger current capacity (6,000 to 7,000 surveyors) than JCAHO (70 LTC surveyors, of a total of 570 all of whom report to the JCAHO central office).¹²¹ A capacity constraint may be truly binding if, when activity levels for an organization increase, the unit costs of supporting those activities increase as well. JCAHO informants estimated that expanding from a current base of from 800 to 1,400 annual LTC accreditation surveys to 1,100 to

¹¹⁸ See Chapter 7, “Observational Study of the JCAHO LTC Survey Process.”

¹¹⁹ Chapter 4.

¹²⁰ Special Committee on Aging, p 59.

¹²¹ See Chapter 6 of this report, “Comparison of HCFA and JCAHO Surveyor Training.” Information from HCFA in this chapter reflects group interviews with HCFA surveyors, as well as targeted interviews of informed respondents. JCAHO surveyors were unable to participate in the study, so that information on JCAHO training reflects only targeted interviews of officials.

2,000 surveys could be accomplished at the current fee structure, adding 3 to 6 full-time equivalent (FTE) surveyors and from 2 to 4 accreditation specialists. Above 2,000 surveys, JCAHO estimates that substantial additional survey staff (14 to 20 FTEs), as well as accreditation specialists and central office management would be required, with a strong probability of increased fees.¹²² Information on LEAP's capacity to accept deeming authority is not yet available; this program plans to initially "confine accrediting activities to a narrow geographic area and low visibility until they are certain their system runs as smoothly as possible."¹²³

Whatever the case, any limits on JCAHO's ability to field sufficient surveyor capacity under deeming would probably be short run in nature. Over the long run, JCAHO could be expected to hire and train more LTC surveyors to address the requirements of increased activity, as needed.

Relative to JCAHO requirements (which reflect practice among most accrediting organizations), Federal training and experience requirements are minimal, with considerable discretion left to the States. HCFA's minimum requirements for background specify that one member of the multi-disciplinary survey team be a registered nurse; beyond this, States have flexibility to hire "generalists, sanitarians... nurses, pharmacists, social workers, dieticians."¹²⁴ In contrast, JCAHO requires a masters or advanced degree and at least five years experience in LTC management. Standard training techniques (e.g., role playing) are used in both programs. JCAHO requires a one-week refresher training session each year; the States vary in whether or how much follow-up training is made available. LEAP requires "that their surveyors have three years minimum LTC experience in management or three years as a Federal/State surveyor."¹²⁵

2.5.3.4 *Validity - Comparison of JCAHO and HCFA Surveys*

Some recent evidence suggests that JCAHO's survey process overlooks serious quality deficiencies that HCFA's surveys uncover.¹²⁶ In a comparison of 179 HCFA and JCAHO surveys completed within 3 months of each other, investigators found that "...only 28 percent of the surveys in the sample were found to be relatively comparable, [in the sense that] similar problems were identified by both organizations or because there were no significant problems identified by

¹²² See Chapter 11, "Comparative Analysis of HCFA and JCAHO Survey Costs."

¹²³ Chapter 4

¹²⁴ Chapter 6.

¹²⁵ Chapter 4

¹²⁶ See Chapter 8, "Comparative Analysis of HCFA and JCAHO Survey Results."

either group.”¹²⁷ Investigators further grouped surveys that failed tests of comparability according to whether these failures compromise the JCAHO’s ability to provide reasonable assurance that accredited facilities meet Medicare regulations.

1. Of least concern regarding “reasonable assurance,” *in about 19 percent of the sampled cases, HCFA found isolated deficiencies (i.e., limited to a small number of residents) that JCAHO did not find.*
2. Of greater concern, *for 46 percent of the sample, HCFA found relatively severe problems affecting patterns (and potentially all) residents, with “potential for adverse impact on numerous residents” but no determination of substandard quality of care (SQC). JCAHO did not report these deficiencies.*
3. Most troubling was the finding that *in 7 percent of cases, HCFA found facilities “... providing substandard quality of care and (causing) actual harm to residents.” JCAHO reported no such problems in these facilities, despite documented histories of past problems, and in two instances awarded facilities in this category Accreditation with Commendation.*

Investigators concluded that “JCAHO accreditation may be comparable to HCFA certification in facilities where there are no serious problems.” However “[it] is questionable whether the JCAHO process, as currently applied in most cases, is capable of uncovering serious quality of care and quality of life deficiencies that have the potential to severely compromise resident health, safety, and/or psychosocial well-being.”

2.5.3.5 Validity - Comparison of JCAHO and “Gold Standard” Surveys¹²⁸

Abt’s study, described above, compared the results of JCAHO and HCFA surveys and found a troubling portion of surveys where HCFA identified a serious problem that was not identified by the JCAHO survey. Another approach to validity is to compare the JCAHO survey with a concurrent “gold standard” survey conducted by independent experts. Consistent with the IOM recommendations on nursing home quality, University of Colorado (CU) researchers have developed a survey utilizing resident-centered and outcome process indicators with consideration for case mix. As part of this evaluation, CU researchers conducted 14 surveys concurrently with

¹²⁷ Note: The study selected a sample of 200 facilities that fit the 3 month window and other study criteria. Because the focus of this study was to determine whether the JCAHO process provides reasonable assurance than noncompliance with HCFA regulations will be identified, it was decided that the 127 facilities that were surveyed first by JCAHO would automatically be included in the sample so that, to the extent possible given the other sampling criteria, JCAHO survey results would not be confounded by a recent HCFA survey. Hence, nearly two thirds of the original sample were facilities surveyed first by JCAHO. The final sample was reduced somewhat because the HCFA-2567 reports were not readily available.

¹²⁸ See Chapter 10 for a full discussion of the CU and JCAHO surveys.

JCAHO surveys between September 8, 1997, and November 14, 1997. The sites were randomly selected by CU with some effort to maximize variation in the JCAHO surveyors, geographic regions, and some representation of facilities with hospital-based, subacute, and dementia units. Primary data from the Minimum Data Set assessment, nursing home records, observations, and interviews of staff and residents were collected on 1088 residents over the course of this project. These data were configured into a number of quality of care indicators covering 17 domains which could then be “mapped” to a comparable JCAHO standard. The analysis consisted essentially of “tests of agreement” for each domain and across domains (i.e., an overall facility level score) between the JCAHO and CU survey.

CU researchers found moderate agreement between the JCAHO and CU surveys for quality in the domain of personal environment and fair agreement in the domains of restraints, pain, and rehabilitation. However, in 10 quality domains they found that the JCAHO survey was not sensitive to important quality of care issues detected by the CU survey. These included: nutrition; function; falls; continence; psychotropic medications; personal care; deaths; pressure sores; contractures; and behavioral problems. The quality of care problems identified in the CU survey were resident-level outcome and process problems that were detected both because of their prevalence in the facility and the severity of the problems noted in individual cases. When quality of care indicators were aggregated to the facility level, the CU survey identified 4 facilities with significant quality problems, while JCAHO surveyors accredited all 14 facilities (scores of 80 percent or above). Furthermore, two of these four facilities, including the worst one according to the CU survey, ranked in the top four JCAHO surveys.

In addition to the comparative analysis, the larger reports presents summaries of some very disturbing findings of specific cases that were reviewed because the CU researchers believed that the selected cases demonstrate the validity of the quality problems. The CU analysis required clinicians to decide whether poor outcomes were justified by the resident’s underlying health conditions or the facility’s attempts to avoid adverse outcomes. These examples of disturbing findings include three deaths that were found in closed records for the admissions sample. In all cases there was lack of attentiveness to patient signs and symptoms by skilled nurses, despite resident complaints or ample evidence of a health problem. While in many cases a nursing home death is justified because aggressive intervention is neither warranted nor wanted, some are not. Other examples related to situations where rehabilitation was inadequate, resident function declined substantially, skin was not protected, no attempt was made to prevent incontinence episodes, restraints were used excessively or incorrectly, psychotropic medications were used without a supporting diagnosis or without review, residents were malnourished and receiving no nutritional supplements, new pressure sores occurred because immobilized residents had no protection, pain was not treated, and residents did not receive morning care or were dressed in nightshirts.

It can be argued that the comparison between JCAHO survey findings and CU’s “gold standard” survey is unreasonable. It may not be realistic to expect any operational survey - JCAHO’s or

HCFA's, for that matter - to compare favorably with a survey conducted by independent experts as part of a research study. Ideally, the HCFA survey would have been conducted at the same time as the CU and JCAHO surveys so that we could make a three-way comparison of findings. However, time, resource, and logistic constraints precluded this study design. While this three-way comparison did not occur for all 14 facilities, there was 1 facility where the HCFA survey occurred at the same time and 3 others where the HCFA survey occurred within the prior 6 weeks of the CU and JCAHO surveys. Despite the fact that HCFA findings may have been addressed to some extent in facilities where the HCFA survey was completed several weeks prior to the CU and JCAHO surveys, there were a number of similarities between the CU survey findings and the HCFA findings. In one facility, problems related to nutritional supplementation and rehabilitation were identified in both surveys. In a second facility both CU and HCFA found problems with residents' personal care, including grooming and cleanliness, and both surveys found problems with pressure sores. Nutrition, pressure sores, and the personal environment were found as problems in a third facility by both HCFA and CU surveys. In the final facility, the personal environment was identified as a problem in both surveys. Similarities between the HCFA and the JCAHO surveys across all four facilities consisted only of the finding related to the personal environment. The citations in the HCFA survey were based upon observations of residents, use of charts, and staff interviews. HCFA citations referenced individual resident outcomes and process of care. This suggests a stronger relationship between the CU survey and HCFA findings because domains such as pressure sores, nutrition, and personal care are emphasized in these surveys in contrast to the JCAHO survey.

At the same time, the HCFA survey did not identify problems that were found in the CU survey in three domains. First, in all four facilities the CU surveyors identified problems with the use of psychotropic medications including lack of an appropriate diagnosis and no reevaluation including attempted dose reductions, particularly for benzodiazepines. Second, problems with unrecognized pain that were prevalent in two facilities were not identified in the HCFA survey. Third, two issues related to skilled nursing care leading to deaths that were found in the CU survey were not detected by HCFA. Although this comparison is based on only four facilities, the CU researchers noted that these findings "suggest that HCFA should consider their process for reviewing quality in these three areas and whether further guidelines are required."

These problems with the HCFA survey notwithstanding, the CU study found that survey findings identified by JCAHO were more likely to be facility-level processes and procedures, or resident-level assessment process without a link to outcomes. As noted above, the HCFA citations referenced individual resident outcomes and process of care. Their conclusion appears reasonable: "Thus, providing deemed status to the Joint Commission would take a step away from the current focus on outcomes and processes of care at the resident level and a step backward in time relating to survey activities. For these reasons, the JCAHO survey does not appear to be an appropriate substitute for the HCFA survey."

2.5.3.6 Accountability

There is no disputing critics' contention that accrediting organizations are not fully accountable to the public. Recently, under pressure from the Federal government and consumer advocates, JCAHO surveys have been made available to regulators. As Schlossberg and Jackson point out, however, "Public access to meaningful JCAHO survey data is virtually nonexistent."¹²⁹ Only accreditation reports for home health agencies are subject to full public disclosure; full survey reports for other provider types are released only "to the extent that information is related to an enforcement action."¹³⁰ JCAHO "Performance Reports" are available to the public on request, but present only highly aggregated information (aggregate performance scores, counts of Type I recommendations), and neither present the surveyors' recommendations nor identify the specific deficiencies cited.

Legal remedies are available but are time consuming and prohibitively expensive for the average citizen. Accrediting organizations frequently emphasize the peer review function they perform, and peer review materials have been held by the courts to be privileged, since the peer review process is assumed to be directed toward self-improvement. However, the courts "may be persuaded to authorize disclosure of JCAHO accreditation reports on the grounds that the JCAHO acts more as a regulator than a peer review entity."¹³¹ Judgments on challenges to the secrecy of accreditation findings are made on a case-by-case basis. Therefore, despite many years functioning as a quasi-regulatory body in the Medicare hospital program, the JCAHO remains protected from full disclosure by legislation and judicial rulings.

2.5.3.7 Effectiveness

The sections above, particularly the validity analyses, raise serious doubts about the capability of the JCAHO survey to secure compliance. However, the adequacy of problem identification that is addressed in the validity analyses is only part of the story. Ultimately, we need to know the end result - i.e., the effectiveness of the HCFA and JCAHO in protecting health and safety of nursing home residents. Essentially, we need to know the impact on resident outcomes. Unfortunately, we have no way to access this issue for JCAHO. For the HCFA survey, this issue is addressed in a recent empirical analysis of resident status outcomes (i.e., physical restraints, pressure sores, and incontinence) that may be linked to the new HCFA survey and enforcement provisions that were recently implemented, effective on July 1, 1995. To control for confounding variables (e.g., case-mix) and to investigate whether resident status improvements can be linked to the enforcement

¹²⁹ Schlossberg, C. and Jackson, S. "Assuring quality: the debate over private accreditation and public certification of health care facilities." *Clearinghouse Review*. November 1996. p 711.

¹³⁰ 42 CFR Sections 401.126(b)(2) (1992)

¹³¹ Schlossberg and Jackson, op. cit., p 712.

regulation, a quasi-experimental study design was implemented that takes advantage of the staggered timing of the new regulation

This analysis is discussed at greater length in Chapter 17. The results offer suggestive evidence that the new enforcement regulation (i.e., new HCFA survey and enforcement provisions implemented as of July 1995) was effective in improving resident status outcomes. At the area office level, the new enforcement regulations are associated with a 9 to 10 percent reduction in bladder and bowel incontinence rates. There also is some evidence at the facility level that the new enforcement regulation had a very small, negative effect on the rate of physical restraint use.

These findings suggest that some nursing homes took steps after the new enforcement regulation was implemented. Although the nature of these steps is unclear, a recent survey of nursing home administrators provides some support for the conclusion that the response to the enforcement regulation may have been the desired one, i.e., that administrators responded by improving the processes of care.¹³² Surveys of a random sample of 720 nursing homes indicated that administrators “are generally satisfied with the accuracy of the HCFA survey process,” and that “the current HCFA enforcement and remedy system is an important factor in improving resident care.” Several respondents specifically mentioned responding to HCFA surveys by “reducing the use of restraints, reducing the inappropriate use of psychotropic drugs, increasing staff training, and strengthening internal quality assessment.” Respondents agreed that the new survey was more “focused on resident outcomes.”¹³³

More focused interviews with a smaller number of selected nursing home providers support these findings and reveal differential responses that reflect the relative severity of deficiencies and remedies.¹³⁴ For deficiencies that were not severe or widespread, administrators were likely to reinforce and implement more consistently policies already in place. For severe and widespread problems, administrators “implemented new procedures and systems for resident assessment.” Among administrators of facilities that had received remedies, there was substantial agreement that the “loss of the ability to train nursing assistants was a very punitive result.” Allowing for self-report bias, both qualitative and quantitative data tell the same story: positive changes in care processes have followed implementation of the new survey process and the new enforcement regulation.

Although there are no data that permit a comparison of JCAHO and HCFA with respect to the resident outcome measures discussed above, we have conducted an analysis of what might be viewed as an intermediate aspect of effectiveness, namely processes of enforcement that may

¹³² See Chapter 16.1, “Results of a Survey of Long Term Care Providers.”

¹³³ *Idem*.

¹³⁴ See Chapter 16.

occur between problem identification by the survey (either JCAHO or HCFA) and resident outcome.¹³⁵ Resources for this study included HCFA's SOM and JCAHO's Comprehensive Accreditation Manual for Long Term Care (CAMLTC), as well as telephone conversations with key informants at HCFA, JCAHO, and State agencies, and data supplied by HCFA and JCAHO. The approach of each system was found to be fundamentally different. In the HCFA process, substantial compliance with all participation requirements is mandatory. HCFA's strategy is to impose sanctions that compel providers to comply with Federal requirements or risk losing Federal payments. Facilities typically have 90 days to correct deficiencies and avoid sanctions. Onsite revisits are usually made to assess compliance. By contrast, JCAHO requires that to gain accreditation, a facility must demonstrate "overall compliance with the standards, not necessarily compliance with each standard." The JCAHO strategy is to motivate providers to make improvements. Facilities may have up to a year or more to demonstrate improvement, and JCAHO relies primarily on written progress reports from the facilities to demonstrate that deficiencies are corrected.

Despite this evidence, there are no data available to determine how important the enforcement component of the new system is in securing compliance, compared to the effects of the reformed survey and citation process itself.¹³⁶ HCFA continues to cite well over half of all nursing homes for deficiencies at severity levels of potential for minimal harm or worse. However HCFA data on enforcement may be misleading, because all providers subject to remedies have to be notified even if, once corrections are made, no remedies are imposed. Notification, imposing of remedies and follow-up are not tracked by some States, so that Federal data may understate the frequency of enforcement remedies.

2.5.3.8 Summary of Evidence

HCFA's rules for deeming nursing homes and other institutional providers (except HHAs) require comparability of public and private survey processes, but do not require public access to survey results of accrediting organizations. Critics of deeming have challenged deeming on other grounds as well, including the capacity of accrediting organizations to carry out regulatory duties, the validity of survey processes in identifying deficiencies, and the effectiveness of accreditation in protecting health and safety and improving the quality of care. Evidence on these points presented in this chapter includes:

- HCFA surveys are more frequent, more stringent in specifying steps required after a deficiency is identified, and are scored according to more focused criteria (scope and severity of identified problems) than the JCAHO surveys. LEAP provides an alternative to JCAHO accreditation that, at least in frequency of surveys, more nearly resembles HCFA's system.

¹³⁵ A comparison of HCFA and JCAHO enforcement and follow-up is presented in Chapter 10.

¹³⁶ For a comparison of HCFA enforcement and JCAHO follow-up procedures, see Chapter 10.

- JCAHO surveyors spend little time reviewing charts or interviewing residents. The LEAP approach appears to be more resident-centered than JCAHO's.
- HCFA's capacity to conduct surveys, determined by numbers and geographic disposition of surveyors, clearly exceeds JCAHO's capacity, but JCAHO would be able to take on a modest expansion of work without additional staff, and could clearly gear up to address a substantial expansion, given time.
- JCAHO's (and LEAP's) minimum skill and experience requirements are generally higher, and certainly more uniform, than HCFA's, which allow States considerable flexibility in setting these standards.
- Direct observation suggests that JCAHO surveyors overlook some quality deficiencies that HCFA surveyors uncover. This discrepancy appears largest in facilities where serious quality deficiencies exist. This does not mean that HCFA surveyors find deficiencies without difficulty. In particular, determining which problems are avoidable, taking risk factors into account, assessing "highest practicable levels" of functioning, and assessing severity continue to be difficult for HCFA surveyors.
- The public has access to highly aggregated findings from JCAHO surveys. However, these findings do not include specific survey results or recommendations.
- Although specific evidence showing that accreditation leads to quality improvement in nursing homes is not yet available, trends in certain outcome measures suggest that implementation of HCFA's new enforcement regulation in July 1995 may have encouraged improvements in care processes. Perceptions of nursing home administrators surveyed about the new process support this view.
- The role of enforcement alone, apart from the reformed survey and citation process itself, in securing desired results remains unexplored, because available data reflect reporting of sanctions and follow-up that varies in quality and completeness among the states.

2.6 Benefits and Costs of Deeming

Privatizing part or all of nursing home regulation has implications both for providers and residents, captured in the net benefits of costs of alternative models. Although a rigorous comparison of benefit cost ratios for alternative regulatory models cannot be made, largely because valid comparative data on benefits are not yet available, it is informative for considering policy options to compare net costs of the accreditation and traditional survey models.

2.6.1 Defining Benefits and Costs of Deeming

The *net benefits* of choosing one or another survey option are clearly best measured by the improvements in quality of care and quality of life that Medicare nursing home residents would achieve in excess of those they would have achieved under option(s) not chosen. Benefits could accrue to both Medicare and non-Medicare residents. An ideal measure of net benefit would capture improvements traceable to clinical and non-clinical activities *under the control of the nursing home*, after *adjusting for relative risk* at admission.

In fact, current knowledge does not provide much guidance on how to link outcome measures to care processes to measure “preventable” problems, and risk adjustment tools are not well-developed or widely applied in nursing homes. Moreover, there simply are no controlled studies of how alternative survey/enforcement systems affect quality.¹³⁷ Therefore, most available measures are intermediate products of the survey process; for example, how many and what kinds of deficiencies government and JCAHO surveyors detect. Until research provides a valid comparison of the effectiveness of accreditation and certification survey processes, there is no way to compare benefits.

The *net costs* of choosing among survey options can be most simply estimated by comparing the expenditures incurred by agencies that conduct surveys. In principle, others outside the agency incur costs related to surveys that, in practice, cannot readily be measured. Nursing home staff may spend more or less time preparing for and dealing with a HCFA or a JCAHO survey. LTC ombudsmen may play a more extensive role in one or the other model. However, there is little available evidence for differential survey burden, and so the cost estimates used in this discussion reflect only agency expenditures.

2.6.2 Net Costs

For a range of assumptions about unit survey costs, the percentage of nursing homes that achieve deemed status, and facilities’ success in passing along the costs of accreditation surveys to Medicare, *Medicare should save from \$2 million to nearly \$37 million annually if HCFA allows deemed status for accredited nursing homes*.¹³⁸ Under the most likely assumptions (unit costs at the current average, 14 percent of facilities choose the deeming option, and 54 percent of survey costs passed on to Medicare), Medicare should save \$9.3 million, representing about 9.6 percent of the total certification budget for fiscal year 1998.

¹³⁷ Jost (1983) cites work conducted before 1980 that found little evidence of an association between JCAHO accreditation and other measures of quality in hospitals. No such studies have reported on quality measures in accredited nursing homes.

¹³⁸ Except where indicated, the information in this section comes from Chapter 8 of this report, “Comparative Analysis of HCFA and JCAHO Survey Costs.”

Based on 1996 data provided by HCFA and JCAHO, a standard HCFA nursing home survey is estimated to cost \$2,758 more than the average fee charged for a JCAHO LTC general survey (\$8,972, compared to \$6,214).¹³⁹ However, costing an entire HCFA survey “package,” including a standard/extended survey, complaint survey and follow-up/revisit, the discrepancy increases to nearly \$6,800 (\$13,008, compared to \$6,214). This does not mean that, with the implementation of deemed status for nursing homes, HCFA would save the full cost difference on each survey or survey package. The net costs or savings of deeming depend on several factors.

First, Medicare’s share of the costs of deeming depend in part on how nursing homes shift costs among payers. Under the traditional survey system, States expend budgets, partly financed by the Federal government, to conduct surveys; providers pay nothing. Under deeming, providers pay fees to JCAHO, and attempt to pass the costs through to Medicare, Medicaid, private insurers and residents and their families. Since facilities will probably be able to shift only part of JCAHO fees to Medicare (in proportion to their Medicare business, which currently averages less than 10 percent of total expenditure on care), deeming should reduce Medicare’s share of survey expenses and increase the share of other payers. Medicaid’s share cannot increase substantially, unless higher payment rates are approved. Instead, high occupancy rates in most nursing homes should facilitate cost shifting toward private payers, without loss of business.

Second, provider enthusiasm for deeming may not be as widespread as some advocates believe. Experience with deeming of Medicare HHAs suggests that providers may balk at the expense of surveys. By August 1996, only 3 percent of Medicare-certified HHAs had received deemed status. In addition, the 8 percent of all nursing homes that JCAHO currently accredits tend to be located in urban areas of the Northeast. Unit costs of HCFA’s standard survey range among the States, from near \$2,000 to nearly \$30,000. If nursing homes that elect the accreditation option are concentrated geographically, the net effects on program costs could vary substantially from predictions based on national averages. For 83 percent of nursing homes queried in a recent survey, deeming should be an option in the Medicare program. Facilities belonging to a chain were more likely to favor deeming, as were facilities in the Northeast. In addition, 87 percent of facilities currently not accredited by the JCAHO reported that they would be somewhat or very likely to seek accreditation under a deeming option.¹⁴⁰

¹³⁹ LEAP’s projected fees appear to be lower than JCAHO fees, though the average fee will depend on the size of the facilities that LEAP surveys. In addition to a \$150 application fee, a facility with from 51 to 100 beds would pay an accreditation fee of \$2,500, plus surveyors’ travel expenses. (Chapter 4, this report) The base fee (for the average JCAHO-accredited facility of 139 beds) is currently \$4,035. (Chapter 11, this report).

¹⁴⁰ For a more complete discussion of attitudes toward accreditation and deemed status, see Chapter 16 of this report, “Results of a Survey of Long Term Care Providers.” These results should be treated cautiously. It was not always clear that respondents were entirely clear on their current accreditation status. The frequency of accreditation reported in the survey was 19 percent compared to JCAHO data that show approximately 12 percent of nursing homes are JCAHO accredited.

Third, the savings estimates reported here assume no change to the JCAHO process under deeming and no efficiency gains or losses under the proposed new system. Technology and policy changes are already changing the nature of JCAHO's procedures. Once the ORYX system is fully operational, JCAHO fees could rise to cover the increased costs of surveying *and* monitoring quality indicators. Should HCFA require increased survey frequency and revised content (to make the JCAHO survey better reflect Medicare participation requirements), the costs of deeming to providers (and to the Medicare program) could increase. Finally, large increases in survey volume (over 1,400 surveys per year) implied by some deeming scenarios might lead to short-term increases in fees, as JCAHO adds full-time surveyors and management staff. JCAHO staff saw no likelihood of lower fees based on scale economies from growth in survey volume. In contrast, HCFA predicts some reductions in survey costs in the near future, reflecting improvements in program efficiency.

With respect to this latter factor of efficiency, it should be noted that there is tremendous State variation in survey costs, from a low of \$2,414 for New Hampshire to a high of \$29,831 for Michigan (fiscal year 1996). This great variation in unit costs per LTC surveys among States naturally leads one to ask what factors may account for these variations. Following general economic theory of cost, one would expect unit costs to be influenced by: volume and type of surveys provided, unit costs of inputs (e.g., wages and other input prices), and other variables which may affect the level of fixed costs or the way LTC survey services are organized. A key component of fixed costs and survey organization would be the number of FTE LTC surveyors on staff in each State. Unfortunately, the small data set permitted only a very limited analysis. Nevertheless, this analysis indicated that unit cost per standard survey is correlated only slightly with the average number of hours per survey and not correlated with any of the remaining variables examined: number of substandard deficiencies, number of SNF and NF facilities, number of SNF and NF beds, number of survey (all types), and number of FTE LTC surveyors. The sources of this variation unexplained by normal cost factors are unknown.

Most importantly, it should be noted that cost analysis did not take into account differences in the technical content or procedures of the LTC survey conducted by HCFA and JCAHO. As we have seen from the discussion above, the results of the two surveys are vastly different and there are serious doubts as to whether the JCAHO survey sufficiently protects the health and safety of nursing home residents. While the costs of the HCFA survey are higher, the "benefits" appear to be much greater as well. If the results of a JCAHO and HCFA survey were roughly comparable, there might be some reason to take into consideration higher costs for no or marginal improvements in benefits. However, at some level when it comes to vast differences in the capacity of the two surveys to protect health and safety, as has been found in this study, the cost differences are irrelevant.

2.7 Summary and Conclusions: The Future of Medicare Nursing Home Quality Regulation

As long as the Federal government has regulated nursing homes, providers have argued for (and consumers have rejected) delegating some of this authority, through deeming, to accrediting organizations. This chapter, supported by research findings presented later in the report, does not finally settle the question of whether deeming would harm or help the average level of quality in nursing homes. However, it does review some important evidence on how Federal and private survey structure and processes differ. This evidence, together with estimates of the costs of the two programs, may inform the debate over whether to allow deeming for nursing homes. Major points in the discussion are summarized in the next section.

2.7.1 Summary

Medicare's survey and certification program for nursing homes is part of a larger quality assurance/improvement program that includes provider QA, private accreditation, other public programs (ombudsman and other consumer advocacy programs) and, more recently, Federal efforts to combat fraud and abuse. Proposals to delegate some regulatory authority to private organizations by accepting accredited providers as "deemed" to be in compliance with Medicare's LTC requirements have gained momentum since HCFA's new survey went into effect. Currently, the most likely organization to be granted deeming authority would be JCAHO.

Proponents of deeming, while admitting the need to protect consumers against poor care, argue that the current system is bureaucratic and inflexible and is not sufficiently targeted to the few nursing homes that need regulatory control. They contend that nursing home management is better positioned now than several years ago, by virtue of gains in education and experience, to benefit from the educative, consultative model that accrediting organizations provide. In the majority of facilities, according to proponents, this model will promote quality improvement.

Opponents of deeming dispute the proponents' view that there are few "bad" nursing homes, pointing to widespread deficiencies and arguing that, despite gains in education levels, management of nursing homes is, for the most part, not yet professional. The uneven history of JCAHO accreditation in other sectors, particularly hospitals which are presumably guided by clinical professionals, is cited to suggest that professionalism is not a guarantee of commitment to quality. Opponents also point to lack of public access (and severe limits on government access) to the accreditation process, a fatal flaw, in their view, in the argument for privatizing a regulatory function.

Accreditation involves setting standards and then judging whether applicants for accreditation have met those standards. Private standard setting for regulatory purposes has consistently received support in Congress and in the courts. However, a review of the content of JCAHO and HCFA standards shows that the JCAHO would have to change several standards to provide

reasonable assurance that Medicare participation requirements would be met. JCAHO standards remain heavily weighted toward structure, while HCFA's standards have embraced a more resident-centered focus. There is currently no public access to JCAHO's standard setting process.

In applying standards, HCFA and JCAHO again differ in processes used to determine and ensure compliance. HCFA surveys are more frequent, more stringent in defining steps to be taken to correct deficiencies, and scored according to more focused criteria (scope and severity) than JCAHO. HCFA surveyors spend more time reviewing charts and interviewing residents than JCAHO surveyors. JCAHO surveyors are generally held to higher standards of education and experience than HCFA surveyors. JCAHO surveyors seem to miss serious deficiencies that HCFA surveyors capture, though HCFA surveyors appear to have difficulty applying many of the requirements of the new survey process (such as taking into account residents' risk status). Public access to accreditation survey findings is severely limited. Although there is limited evidence that the new HCFA survey process may be effective in improving quality of care, there is, as yet, no comparable research on JCAHO effects.

Data show that, by authorizing deeming for nursing homes, Medicare may save from \$2 million to nearly \$37 million annually, depending on assumptions about unit costs and the percent of facilities that choose the deeming option. Based on 1996 data, a standard HCFA nursing home survey is estimated to cost nearly \$3,000 more than the average JCAHO LTC facility fee. Under deeming, moreover, it is likely that facilities will shift more of the cost of the survey process onto private payers. There is considerable uncertainty regarding the percent of facilities that might opt for deeming. Fewer than 5 percent of HHAs have chosen deeming. However, administrators of over 85 percent of nursing homes not currently accredited state that they would apply should deeming be made available.

In an assessment of the appropriateness of accreditation as a substitute for direct government regulation, Eleanor Kinney observes that "(clearly) the trend in the Medicare program is toward use of private accreditation to determine compliance with Medicare requirements for all healthcare institutions but with better oversight by HCFA." At the same time, noting that "... the services involved [in LTC] are fundamentally different (from medical care), Kinney suggests that "[the] more vulnerable, dependent and mentally compromised the patients are, the greater the danger that these patients might be endangered if regulatory oversight of the safety and quality of their care is limited."¹⁴¹ This skepticism, grounded in the conviction that nursing homes are "different" and more prone by their nature to quality problems is persistent. Fed periodically by media reports of horrific nursing facility practices, it will probably remain the most durable barrier against privatizing regulation in this industry.

¹⁴¹ Kinney, *op. cit.*, p 62.

3.0 HISTORY OF ACCREDITATION AND DEEMED STATUS IN HOSPITALS AND HOME HEALTH CARE

3.1 Introduction

This chapter presents a brief history of accreditation in hospitals and home health agencies and describes the role of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in each area. Resources for this chapter were identified by searching the Medline and Healthstar databases on combinations of the following keywords: hospital, accreditation, JCAHO, legislation, standards, quality assurance, home health care. Abt staff followed up on relevant citations from each publication. Additional information and materials were supplied directly from JCAHO and Community Health Accreditation Program (CHAP).

3.2 History of Accreditation in Hospitals

Until the twentieth century most health care was home-based. Hospitals existed primarily as charitable institutions where consumers who were destitute could receive care without paying for services.¹⁴² By the late nineteenth century, with the development of scientific advances such as anesthesia, antisepsis and surgery, hospitals began to change. As facilities offered more technical services, they became safer and more attractive to middle class consumers who could pay for care.¹⁴³

With new technology came increases in hospital costs. In response, hospitals began to charge for their care and to permit physicians who practiced within the hospital to charge for their services. All of this led to rapid growth. The number of hospitals increased from 178 in 1873 to 4,359 in 1909.¹⁴⁴

At the same time, specialty practices like surgery were becoming more common so that physicians relied increasingly and in greater numbers upon the hospital environment to provide services. As more medical professionals recognized the poor state of hospital conditions, for patients and physicians, they pushed for improvements.¹⁴⁵

¹⁴² Jost, T.S. "Medicare and the Joint Commission on Accreditation of Healthcare Organizations: A Health Relationship?" *57 Law and Contemporary Problems*, 15, 16, (1994). Kinney, E.D., "Private Accreditation as a Substitute for Direct Government Regulation in Public Health Insurance Programs: When Is It Appropriate?," *57 Law and Contemporary Problems*, 47, 50 (Autumn 1994).

¹⁴³ Jost, op. cit.

¹⁴⁴ Idem.

¹⁴⁵ Kinney, op. cit.

The first organized efforts to improve the quality of hospital care were private and voluntary.¹⁴⁶ The American College of Surgeons (ACS), founded in 1912, set out to standardize hospital care and established a committee to study the improvement of hospital standards. In January 1916, they received a grant from the Carnegie Foundation to develop hospital standards. In 1919, the ACS formally established the Hospital Standardization Program (HSP), which existed until it was superseded by the Joint Commission on Accreditation of Hospitals (JCAH) in 1951.¹⁴⁷

The ACS documented the need for hospital standardization when it surveyed 671 facilities in 1919 and found only 89 that met their minimum requirements. As interest in hospital standardization increased, the HSP attempted to identify efficiently organized hospitals and to audit hospital progress towards compliance with their minimum standards. Between 1926 and 1941, their Manual for Hospital Standardization was revised seven times and grew from 18 to 110 pages.¹⁴⁸

The ACS met with opposition from individual physicians, who perceived the HSP as a threat to the freedom of their medical practice. The American Medical Association (AMA), which represented a broad range of physicians, opposed the ACS as well and threatened to establish its own hospital accreditation program in 1918. Tension between the two groups was ongoing, reflecting what Jost described as “the differences between the elite and well-paid hospital-based surgeons of the AMA and the poorer community-based general practitioners of ACS.”¹⁴⁹ The American Hospital Association (AHA) and the Catholic Hospital Association, on the other hand, supported the HSP.¹⁵⁰

In 1946, the Hospital Survey and Construction Act, known as the Hill-Burton Act, made Federal funds available for hospital construction and changed the nature of hospital regulation. Federal funds were denied to any State that did not require hospital compliance with minimum standards of maintenance and operation. In response to the Hill-Burton Act, the AHA, with the assistance

¹⁴⁶ McGeary, M.G.H. “Medicare Conditions of Participation and Accreditation for Hospitals.” in *Medicare: A Strategy for Quality Assurance Volume II Sources and Methods*. Washington, DC: National Academy Press, 1990.

¹⁴⁷ Davis, L. *Fellowship of Surgeons: A History of the American College of Surgeons*, 1960. Jost 1994, op. cit. Kinney, op. cit. McGeary, op. cit.

¹⁴⁸ Davis, op. cit. Jost, op. cit.

¹⁴⁹ Jost, op. cit.

¹⁵⁰ Idem.

of the American Public Welfare Association, developed a model licensing law upon which most State laws are based.¹⁵¹

By 1951, the ACS was struggling to meet the demands of accrediting thousands of hospitals on its own. After much discussion, especially with the AHA and the AMA, it joined with the American College of Physicians (ACP), the AHA, and the AMA to form the Joint Commission on Accreditation of Hospitals (JCAH). As described by McGeary, "The JCAH carried on the ACS principles for improving health care in hospitals based on the consensus of health professionals, and confidential on-site surveys that involved education and consultation as well as evaluation."¹⁵²

By 1961, the Joint Commission began to hire its own surveyors rather than use ACS and AMA staff, and in 1964 JCAH began to charge a fee for inspections. By 1965, the Joint Commission was already accrediting 60 percent of the country's hospitals with 66 percent of the beds.¹⁵³ It then expanded its scope, assuming responsibility for nursing home accreditation and adding commissioners to represent the American Nursing Home Association and the American Association of Homes for the Aging. JCAH also added a program to accredit psychiatric facilities in 1960 and rehabilitation facilities in 1967.¹⁵⁴

Accreditation remained a private, voluntary program; however, the Joint Commission took on a major role in the regulation and financing of public health care with the passage of Medicare legislation in 1965. Under authority of Section 1865 of the Social Security Act, hospitals accredited by the Joint Commission were automatically "deemed" to meet all health and safety requirements for participation in Medicare except the utilization review requirement, the psychiatric hospital special conditions, and the special requirements for hospital providers of long-term care services.

As a result of this deemed status, most hospitals participating in Medicare did so by meeting the standards of an organization governed by representatives of health providers themselves. As enacted, the Medicare program also prohibited the Department of Housing, Education and Welfare (HEW, now HHS) from adopting standards higher than those of the JCAH.¹⁵⁵

According to McGeary, drafters of Medicare legislation did not want to create a national licensure program with federal inspectors. They knew the problems associated with both the State

¹⁵¹ Jost, *op. cit.* Kinney, *op. cit.*

¹⁵² McGeary, *op. cit.*

¹⁵³ *Idem.*

¹⁵⁴ Jost, *op. cit.* McGeary, *op. cit.*

¹⁵⁵ *Idem.*

licensure systems and the Joint Commission program. Aware of the variability of State licensure standards and recognizing that several thousand small rural or proprietary hospitals (one third of the nation's bed supply) were not in JCAH's voluntary accreditation program, legislators outlined a program that provided both options: hospitals could be certified by State inspection agency or accredited by JCAH.¹⁵⁶

There was also great political pressure to deliver Medicare benefits quickly and universally, and to involve as many hospitals as possible. President Johnson had a large political stake in Medicare and believed its success depended on maximum access from the beginning of the program. To achieve that, the government needed cooperation from hospitals and physicians. Use of the Joint Commission was instrumental in securing the necessary cooperation. Reliance on the JCAH was also strongly supported by the AHA.¹⁵⁷

As awareness about the JCAH role in the Medicare program grew, controversy mounted. By the early 1970s, the National Welfare Rights Organization and a number of other consumer groups met with JCAH and presented demands for more patient rights and consumer participation in the accreditation process. Consumer groups also sued HEW, challenging the delegation of authority to a private body was in violation of the Constitution.¹⁵⁸ The JCAH was also criticized in the media, most notably for accreditation of several large hospitals (San Francisco General Hospital and DC General Hospital) despite serious problems and complaints.¹⁵⁹ In 1970 and 1971, a bill introduced by Senator Edward Kennedy to establish an independent federal commission for accreditation further challenged the role of the JCAH.¹⁶⁰

The Joint Commission responded to consumer pressure by adding a preamble to its standards recognizing patient's rights and incorporating public information interviews into the accreditation process. However, the JCAH continued to identify itself as a consultant to the medical care industry and rejected the role of regulator.

Additional complaints surfaced in the annual report on Medicare of the Health Insurance Benefits Advisory Council (HIBAC). Issued July 1969, the report stated that the Council "found reason for concern that the JCAH standards are not applied with the frequency of inspection and range of

¹⁵⁶ McGeary, *op. cit.*

¹⁵⁷ Kinney, *op. cit.* Jost, *op. cit.*

¹⁵⁸ Jost, *op. cit.* McGeary, *op. cit.*

¹⁵⁹ Bogdanich, W., "Small Comfort: Prized by Hospitals, Accreditation ides Perils Patients Face," *Wall Street Journal*, October 12, 1988, sec. 1, p.1, col. 6.

¹⁶⁰ Jost, *op. cit.*

inspector skills necessary to assure a high degree of effectiveness” and that “the JCAH standards in some cases impose an undesirably low ceiling” on Medicare health and safety standards.

Congress responded to these concerns through the Social Security Amendments of 1972 which permitted HEW: to promulgate hospital standards exceeding JCAH accreditation standards; to validate JCAH accreditation by State inspections performed randomly and in response to substantial complaints; and to decertify accredited hospitals that failed to comply with Federal regulations. As a result of the legislation, pressure from consumers eased, but tension between the JCAH and HEW seemed to increase. For example, in their report to Congress on the 1976 validation surveys, HEW identified wide discrepancies between the JCAH and State surveys.

Despite criticisms, the JCAH dominated hospital regulation. Only the emergence of Professional Standards Review Organizations (PSROs) in 1972 challenged the JCAH’s position.¹⁶¹ The PSRO legislation established a quality and utilization peer review program for Medicare and Medicaid financed hospital care wholly independent of JCAH. The program even duplicated some of JCAH’s quality audit procedures.¹⁶²

After having long been accused of focusing on physical and administrative structures (the capacity to deliver care), rather than the actual quality of patient care, the JCAH increased its emphasis on quality of patient care in the early 1970s. The JCAH began to require outcome-oriented hospital quality review programs and developed a specific system, the Performance Evaluation Procedure for Auditing and Improving Patient Care (PEP), that hospitals use to meet this standard.

In 1977 and 1978 JCAH reorganized to eliminate internal accountability problems. Accreditation councils, set up in the mid 1960s had functioned with increasing autonomy, creating administrative and managerial problems and accreditation staff functioned under a dual authority, responding to both the accreditation councils and to JCAH management. To eliminate these problems, JCAH abolished the accreditation councils and established the PTAC system of four Professional Technical Advisory Committees, including representatives of health care organizations and members of the JCAH.

Members of the PTACs and JCAH staff develop the standards upon which accreditation decisions are based. Standards are then approved by the Board of Commissioners. The Board is also advised by a Policy Advisory Committee (PAC) composed of representatives of the PTACs, organizations involved in the provision of health related services, and other individuals.¹⁶³

¹⁶¹ Idem.

¹⁶² Jost, op cit McGeary, op. cit.

¹⁶³ Joint Commission on Accreditation of Healthcare Organizations. 1996 *Accreditation Manual for Hospitals*. Oakbrook, IL: JCAHO. Jost 1994, op. cit

By the late 1970s and early 1980s relations between the JCAH and HEW improved. A 1979 GAO Report supported a continued JCAH role in Medicare certification. The report was critical of HEW and concluded that State survey results were less reliable and had less impact than JCAH. HEW validation regulations issued in 1980 emphasized reconciling discrepancies between JCAH and State inspection reports more than monitoring JCAH performance. In 1981, the Reagan Administration even proposed permitting the JCAH to certify nursing homes for participation in Medicare and Medicaid.¹⁶⁴ By 1983, however, HCFA and Congress agreed to postpone virtually all changes in the regulations until a committee appointed by the Institute of Medicine studied the issues and reported its recommendations.¹⁶⁵

A shift from prescriptive to performance-oriented standards began at the JCAH in 1978. The board replaced a numerical medical audit requirement with a new quality assurance standard that mandated an ongoing, hospital-wide program to identify and solve problems. This new standard was approved in 1979 and implemented in 1981.¹⁶⁶

In 1981, the new quality assurance chapter of the manual had one standard: "There shall be evidence of a well-defined, organized program designed to enhance patient care through the ongoing objective assessment of important aspects of patient care and the correction of identified problems." A hospital governing body was to hold medical staff responsible for establishing quality assurance mechanisms. In 1984, uniform language for monitoring and evaluation of quality and appropriateness of care was added to each of 14 chapters on specific clinical services and required characteristics of acceptable processes for carrying out the standard were listed.

The early 1980s marked several changes at the JCAH. In 1982, the first public member began serving on the Board of Commissioners, and the accreditation cycle for hospitals changed from two to three years. By 1985, the JCAH introduced implementation monitoring so that certain (QA) standards could be surveyed and recommendations made without the lack of compliance affecting accreditation decisions. According to the JCAH, this gave hospitals the time required for learning and allowed for education of surveyors.

Since 1970, the JCAH had developed accreditation programs for additional health services of organizations delivering long term care, ambulatory health care, home care, hospice care, mental health care, and managed care. Thus it changed its name to Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in 1987.

¹⁶⁴ General Accounting Office. *The Medicare Hospital Certification System Needs Reform*. HRD-79-37 Washington, DC: GAO. 1979. Jost, op. cit.

¹⁶⁵ Institute of Medicine. Committee on Nursing Home Regulation. *Improving the Quality of Care in Nursing Homes*. Washington, D.C.: National Academy Press. 1986.

¹⁶⁶ McGeary, op. cit.

In 1994, JCAHO developed two initiatives: the Public Disclosure Policy and the Random Survey Process. Under the Public Disclosure Policy, the JCAHO agreed to release organization-specific performance reports of any health care organization it accredited. Information released to the public included performance area scores and national comparative information. Previously, only the surveyed organization had access to this information and disclosure was at their discretion. The Random Survey Process is a system where approximately 5 percent of accredited organizations are chosen for review, at the JCAHO expense, approximately 18 months after a previous survey. This process was implemented to help ensure and monitor performance between regular accreditation surveys.

3.3 Missions of JCAHO

The mission of JCAHO is to improve the quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations. The purposes of JCAHO, as stated in its by-laws are:¹⁶⁷

- (a) to establish standards for the operation of hospitals and other health-related facilities and services;
- (b) to conduct survey and accreditation programs that will encourage members of the health professions, hospitals, and other health-related facilities and services voluntarily to:
 - (1) promote high quality of care in all aspects in order to give patients the optimum benefits that medical science has to offer,
 - (2) apply certain basic principles of physical plant safety and maintenance, and of organization and administration of functions for efficient care of the patient,
 - (3) maintain the essential services in the facilities through coordinated effort of the organized staffs and the governing body of the facilities,
- (c) to recognize compliance with standards by issuance of certificates of accreditation; and
- (d) to conduct programs of education and research and publish the results thereof.

Most States rely on JCAHO accreditation, in whole or part, for licensing health care institutions.¹⁶⁸ While its hospital accreditation program is its oldest and best known, JCAHO has

¹⁶⁷ Jost, T. S. "The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care and the Public Interest," *Boston College Law Review* xxiv (4) (1983): 835-923.

¹⁶⁸ Schlosberg, C. and Jackson, S. "Assuring Quality: The Debate over Private Accreditation and Public Certification of Health Care Facilities." *Clearinghouse Review*, November 1996. Stieber, J.; Wolfe, S.M. *Who's Watching Our Hospitals?* Public Citizen's Health Research Group, August 1994.

similar programs in ambulatory care, long-term care, psychiatric facilities, home care programs, and health care networks. The JCAHO also offers a variety of products and services including publications, educational materials, technical assistance, and consulting services. Fees account for about 70 percent of the JCAHO revenues; the remainder come from the sale of publications and educational services.¹⁶⁹

From the early 1950s, the Joint Commission emphasized structure (resources) standards in its monitoring activities. This trend changed in the 1970s when the PSROs were established which emphasized process (procedures) in the evaluation of medical care delivered to Medicare patients. This emphasis was also adopted by Peer Review Organizations (PROs), the successors of PSROs, in the early 1980s.¹⁷⁰

In 1986, HCFA published a report on mortality rates of the nation's hospitals based on Medicare reimbursement data that prompted a shift towards outcomes management and led in part to the JCAHO's Agenda for Change, launched in 1987. The Accreditation Manual for Hospitals began its transition to standards that emphasize performance improvement concepts in 1992. This transition was completed in 1994 with the publication of the 1995 Accreditation Manual for Hospitals.

3.3.1 The Hospital Survey and Accreditation Process

The JCAHO is a private, nonprofit corporation that accredits 17,760 health care institutions, 5,155 of them hospitals.¹⁷¹ Hospitals accredited by the JCAHO are surveyed at least once every three years. Usually, the survey team includes a hospital administrator, a physician, and a nurse. Surveys typically last three days and facilities are notified of the survey date in advance. While onsite, surveyors review written documents (e.g., reports of performance-improvement activities) and other evidence of performance in patient care and organization functions and interview key staff. The hospital survey review process is summarized in Exhibit 3.1.

At the conclusion of the survey, surveyors score applicable standards on a scale from one to five, with one indicating substantial compliance and five indicating noncompliance. These scores are then aggregated using complex algorithms to reach an accreditation decision. Another set of rules is then applied to determine whether the hospital should be accredited and at what level. These three sets of decision rules (surveyor scoring of items on the report form, aggregation of

¹⁶⁹ McGeary, op. cit.

¹⁷⁰ Al-Assaf, AF. "Healthcare outcomes management and quality improvement" in *J R Soc Health*. 1996 Aug; 116(4): 245-52.

¹⁷¹ Joint Commission on Accreditation of Healthcare Organizations. Internal newsletter supplied by Sharon Weidenback. Oakbrook Terrace, IL: JCAHO. October 1997.

individual surveyor scores into summary scores on accreditation grid sheet, and rules used to make non accreditation and contingency decisions) were adopted in response to complaints about variations in surveyor judgment and are subject to constant review and periodic revision by the JCAHO.

Six types of accreditation decisions are possible. The percentage of hospitals currently accredited at each of those levels is listed below. Additional information regarding conditions that lead to each type of decision is presented in Exhibit 3.2.

Most hospitals are accredited with contingencies that must be resolved through further written reports or onsite inspections. Generally, less than one percent of the hospitals surveyed are denied accreditation.

Exhibit 3.1

1996 Survey Process in Brief

The **survey process is initiated** when a hospital applies for an accreditation survey, or is due for its triennial survey. If you are already accredited, you will be asked to update information on file at the Joint Commission to help in survey planning. Six weeks before the survey, your hospital will be assigned a liaison at the Joint Commission who is responsible for coordinating the review of your application and finalizing an individualized on-site survey agenda. This should help facilitate scheduling your staff members' participation in appropriate survey activities. Your liaison will also be available to answer questions throughout the survey cycle.

In most instances, the **survey team** will be composed of an administrator, nurse, and physician. In smaller hospitals, the survey team will include two surveyors, usually a nurse and a physician. In addition, depending on your hospital's service configuration, there may be other specialized surveyors addressing such areas as long term care, home care, or ambulatory care services. One surveyor will be designated as the "team leader." This surveyor is responsible for coordinating on-site survey activities and communicating with your staff members about survey issues.

Following the **opening conference**, your staff will be asked to orient the survey team to your hospital's approach to performance improvement. This is an opportunity for you to showcase your hospital's program to measure, assess, and improve your performance of the important functions outlined in this manual.

After this activity, the surveyors will **review key documents** that you have been asked to make available. These documents will focus on performance—minutes, reports of performance-improvement activities, measurement data, and other evidence of your performance of patient care and organization functions.

The **interactive portion** of the survey will follow. On the first day there is emphasis on surveyors visiting patient care settings in your hospital—the places where your patients actually receive care and services—for example, inpatient units, anesthetizing locations, operating rooms, and ambulatory care settings. During these visits, the team interacts with managers, direct care providers including members of the medical staff, other hospital staff, and patients. While each surveyor is responsible for interviewing designated members of the staff and visiting designated settings, the team will integrate their findings to assess compliance levels.

At the **conclusion** of the survey, the survey team members will meet to integrate their findings. They will also produce a preliminary report of these findings, and the potential impact on your hospital's accreditation decision. This preliminary report will be the basis of the leadership exit conference that the members of the team will conduct with hospital leadership prior to their departure.

Certain **on-site findings** will be reviewed at the Joint Commission central office following the survey. Accreditation findings that raise specific issues are reviewed by the Joint Commission's Accreditation Committee,* which then reaches a final accreditation decision.

* The Accreditation Committee is a committee of the Joint Commission's Board of Commissioners responsible for determining accreditation decisions.

Exhibit 3.2

Table 1. Types of Accreditation Decisions

Type of Decision	Conditions That Lead to This Type of Decision
<p>Accreditation with Commendation This is the highest accreditation decision, awarded to an organization that has demonstrated exemplary performance.</p>	<p>An organization is eligible for accreditation with commendation if (1) the summary grid score for all applicable services is 90 or higher, and (2) no follow-up monitoring has been assigned. <i>Note: The summary grid score on the decision grid for pathology and clinical laboratory services, if applicable, will currently not impact an accreditation with commendation decision. However, if an organization is assigned any type I recommendations as a result of its laboratory services survey, it will not be eligible for accreditation with commendation.</i></p>
<p>Accreditation This decision indicates that an organization is in overall compliance with applicable standards. Accreditation is awarded either with or without type I recommendations. A type I recommendation(s) is a recommendation or a group of recommendations that must be resolved within a specified period of time or the organization risks losing its accreditation.</p>	<p>An organization in this category demonstrates overall compliance with the applicable standards, but needs improvement in a specific area(s) to achieve overall compliance with standards in that area. In most of these cases, such improvement will be monitored through the assignment of some kind of follow-up monitoring, such as a focused survey or written progress report (WPR).</p>
<p>Conditional Accreditation This decision indicates that multiple substantial standards compliance deficiencies exist in an organization. Correction of deficiencies, which serve as the basis for further consideration of continuing accreditation, must be demonstrated through follow-up survey.</p>	<p>An organization is conditionally accredited: (1) when the survey results in the assignment of follow-up monitoring in many areas, indicating that the organization's overall performance is marginal; and (2) when an organization has not corrected type I recommendations in the time frames specified. Organizations with this accreditation status are required to develop a plan of correction, have it approved by the Joint Commission, and demonstrate sufficient improvement in a follow-up survey within six months. After the follow-up survey, the organization will either be accredited (with or without type I recommendations) or not accredited.</p>

Exhibit 3.2 (Cont.)

Table 1. Types of Accreditation Decisions (continued)

Type of Decision	Conditions That Lead to This Type of Decision
Provisional Accreditation	An accreditation decision that results when an organization has demonstrated substantial compliance with the selected structural standards surveyed in the first of two surveys conducted under the Early Survey Policy. The second survey is conducted approximately six months later to allow the organization sufficient time to demonstrate a track record of performance. Provisional accreditation status remains until the organization completes this second, full survey.
Not Accredited	An accreditation decision that results when an organization has been denied accreditation, when its accreditation is withdrawn by the Joint Commission, or when it withdraws from the accreditation process. This designation also describe any organization that has never applied for accreditation.

accreditation with commendation	12%
accreditation	4%
accreditation with type I recommendation	82%
conditional accreditation	<1%
provisional accreditation	1%
not accredited	<1%

3.4. Criticisms of Private Accreditation

The Joint Commission has faced opposition since its own founding and the founding of its predecessor, the ACS. Criticisms have come from its members, clients, and consumers, as well as

from State and Federal governments. The following section describes major complaints of privatized accreditation in general and JCAHO in particular.

3.4.1 Consumer Groups and the Media

Consumer groups and journalists challenged the role of the Joint Commission in determining participation in the Medicare program almost as soon as the legislation was passed in 1965. Consumer groups charged this was an improper delegation of legislative power and consumer groups presented JCAH with demands for patient rights and consumer participation in the accreditation process.¹⁷² Some groups sued HEW arguing that delegation of Medicare certification to the private sector was unconstitutional, and legislation was introduced to establish Federal accreditation commissions.¹⁷³

In 1969, the HIBAC advisory group to the Social Security Administration on the implementation of Medicare criticized JCAHO's standards and inspection process in its first report. Its criticisms included: standards that were too low; an inspection cycle too infrequent (every two years at that time); and surveyors too narrowly focused. The council recommended that the Secretary of HEW be given authority to set standards higher than the JCAH and that State agencies be given authority to inspect accredited hospitals.

In 1969 and 1970, the JCAH came under fire from consumer groups and the media for accrediting major urban hospitals (e.g., Boston City, San Francisco, and DC General hospitals) despite extensive publicity about serious problems.¹⁷⁴ The fact that historically so few hospitals have lost accreditation status is frequently cited as demonstrating the ineffectiveness of JCAH accreditation. In addition, some consumer groups consider industry self-regulation to be inherently unacceptable. In a 1996 publication for example, Public Citizen faults JCAHO in several areas.¹⁷⁵

- JCAHO is subject to inherent conflicts of interest due to its governance, funding, and multiple roles. JCAHO is directly funded and controlled by the industry it monitors and subject to conflict of interest. As educational consultant and regulator, JCAHO's paying customers look to it for standard-setting, consultation/advice, and good grades, but State and Federal governments depend on JCAHO to protect the public from substandard hospital care.

¹⁷² Kinney, op. cit. Jost 1993, op. cit.

¹⁷³ Jost 1993, op. cit.

¹⁷⁴ Bogdanich, W., "Small Comfort: Prized by Hospitals, Accreditation hides Perils Patients Face," *Wall Street Journal*, October 12, 1988, sec. 1, p.1, col. 6.

¹⁷⁵ Dame, L., and Wolfe, S.M. *The Failure of "Private" Hospital Regulation: An Analysis of the Joint Commission on Accreditation of Healthcare Organizations' Inadequate Oversight of Hospitals*. Washington, DC: Public Citizen's Health Research Group (July 1996).

- As a private entity, JCAHO is not bound by same standards of public accountability and has been historically secretive about deficiencies uncovered
- JCAHO surveys are announced too far in advance and conducted too infrequently.
- The public and hospital customers ultimately pay the bulk of survey costs.

While the JCAHO has agreed to share more information with the government and the public, consumer groups point to several problems with the current information disclosure system. According to Public Citizen, the JCAHO's standards and scoring systems could be weakened with little or no public awareness. The group notes that grid scores have increased steadily since 1989 and that detailed data regarding performance is not available to the public. The JCAHO also notifies organizations of any requests for performance information and provides them with the requestor's name and address.

3.4.2 Hospitals

Hospitals have not been entirely satisfied with JCAHO performance either. Criticism from physicians, the AHA, and the AMA have been described above. The AHA also released a report critical of JCAHO's hospital survey process, primarily because of its high cost.¹⁷⁶ More recently, in 1990 and 1991 surveys, hospital CEOs expressed concern regarding vague and inconsistently interpreted standards, unqualified inspectors, delays in processing survey reports, and difficulty understanding survey reports.¹⁷⁷

Hospitals became increasingly vocal in 1994, complaining about JCAHO's proposals for using clinical indicators and for publishing hospital ratings, and about the quality of the survey process.¹⁷⁸ At St. Mary-Rogers Memorial Hospital in Rogers, AR, the survey process amounted to direct expenses of about \$168,000 a year for survey fees, manuals and educational programs, plus indirect expenses of administrative and employee time. Arkansas does not have deemed status, so State surveyors looked at the same things the JCAHO had reviewed, according to Sister Sharon Therese Zayac, the hospital's president. And the hospital did not have to pay State surveyors.¹⁷⁹

In addition, representatives of hospitals in Arkansas, Louisiana, and Tennessee voiced concerns about the JCAHO appearing more interested in pleasing the public than in meeting the

¹⁷⁶ Burma, D. "AHA Criticizes JCAHO," *Modern Health care*, September 29, 1989, p.5

¹⁷⁷ Burma, D. "JCAHO Gets Better Grands from Chief Execs," *Modern Health Care*, May 13, 1991, p 7, and "JCAHO Continues to Labor Under Criticism," *Alcoholism and Drug Abuse Week*, April 18, 1990, p 4

¹⁷⁸ Burma, D. "JCAHO Hits a Wall with Plan on Indicators," *Modern Health Care*, March 14, 1994, 30, and Burma, D. "AHA Taking a Closer Look at Accreditation," *Modern Health Care*, April 18, 1994, p 3

¹⁷⁹ Bergman, R. "The trials of accreditation," in *Hospitals and Health Networks*. 1994 Sep 5, 68(17):42-6, 49.

expectations of hospitals that pay for accreditation services. The Health Care Association of New York State, Albany, also called on the JCAHO for better dialogue, noting its concern over duplication in the collection of data by the State and JCAHO. According to Carolyn F. Scanlan, the association's executive vice president, some hospitals are considering dropping the accreditation process because it has become cumbersome and time-consuming to meet both surveillance functions. (New York does not have a deemed status relationship for State licensure)

Hospitals also criticized the JCAHO for changing its standards too often and complained that such an ongoing series of changes complicated survey preparation. Their main concern was the amount of money and time that goes into preparing for the survey: complying with standards, paying employees, attending educational programs, and purchasing publications and other accreditation materials. Seven State hospital associations (Arkansas, California, Florida, New York, Ohio, Texas, and Wisconsin) even formed an informal coalition in 1994 to share information about alternatives, such as accreditation by other organizations or direct inspections by Federal or State health officials.¹⁸⁰

3.4.3 State and Government Agencies

State survey agencies report both advantages and disadvantages of relying on JCAHO accreditation for licensure. According to Public Citizen, in a recent survey of State licensure agencies, 37 States reported benefits and 9 States reported more than one benefit; 45 States reported drawbacks and 26 reported more than one drawback. Benefits reported included: cost savings, national uniformity of standards, and reduction of duplication in surveys. Drawbacks frequently reported included: the infrequency of JCAHO surveys, loss of input and oversight control by the States, failure of JCAHO to ensure that standards were met, and JCAHO's educational (as opposed to regulatory) approach to certification.¹⁸¹

JCAHO has also been criticized for its inability to deal with regulatory concerns other than quality (e.g., utilization review), and for a lack of leadership in assuring access or cost control.¹⁸² In addition, JCAHO has rarely denied or revoked accreditation and has appeared weak in enforcing environmental and life safety code standards.¹⁸³

¹⁸⁰ Burma, D., and Morrissey, J. "Federal takeover fears sparked attack on JCAHO." *Modern Healthcare*, December 19-26, 1994, p 2.

¹⁸¹ Dame, op. cit.

¹⁸² Jost 1993, op. cit.

¹⁸³ HCFA, op. cit.

3.5. Support for Private Accreditation

As Dennis O'Leary, M.D., JCAHO President explained in a recent article,¹⁸⁴ private-sector organizations can:

- gain easier access to the expertise that they need to develop state-of-the-art, contemporary standards and outcomes measures;
- help foster improved performance while many regulatory processes bar surveyors from helping organizations improve and want them to inspect only;
- perform the process faster than government agencies, which find themselves bogged down in red tape and bureaucratic requirements; and
- avert political pressure.

Then former Director of HCFA's Health Standards and Quality Bureau, Thomas Morford, acknowledged advantages held by private entities at a congressional hearing:¹⁸⁵

Private sector organizations don't need to issue proposed rules, final rules, et cetera, to deal with everybody in the country who has a better idea. They can go and pretty much set standards that are the state of the art. That is a big encumbrance for the government. We will never match private sector standards vis-a-vis the state of the art. That is why deeming in general terms is a fairly good notion.

3.5.1 JCAHO Standards and Expertise

JCAHO continuously revises its standards and works with hospitals to ensure they are fully understood and implemented. Jost argues that the quality of JCAHO's standards is superior to HCFA's conditions of participation:

HCFA's standards, created in 1966 at the time Medicare was established, were based on then-existing JCAH standards and considered structural aspects of quality almost exclusively. In 1977, HCFA updated these standards. Draft regulations were published in 1980 and again in 1983, after a change in administration. HCFA published final regulations in 1986 and has not revisited them since. As evidenced by this history, updating federal provider conditions of participation has been a difficult and time-consuming process. HCFA is subject to the notice and comment constraints of the Administrative Procedure Act and has been subject to scrutiny from the Office of Management and Budget. By contrast, the Joint Commission amends its standards regularly.

¹⁸⁴ Bergman, op. cit.

¹⁸⁵ Jost 1994, op. cit.

McGeary found that JCAHO accreditation provided positive incentives that could motivate hospitals to improve. He also described a high level of expertise among JCAHO staff and noted the JCAHO surveyors tend to have better clinical credentials and make more consistent decisions than State surveyors.¹⁸⁶

Arguments also exist that JCAHO provides survey and certification services at a lower cost than HCFA could.¹⁸⁷ To the extent, for example, that JCAHO can draw on expertise of its member groups for assistance in formulating and interpreting standards, it may avoid some costs that HCFA would incur in operating a regulatory program.¹⁸⁸

3.5.2 Hospitals

While consumer groups describe JCAHO as a self-regulating body, hospitals have often viewed it as a troublesome regulator.¹⁸⁹ Jost has described the unique role of JCAHO as what he calls a "cross-regulator."

The power, wealth, and status of the Joint Commission are dependent upon its continued recognition by the public in general and the federal and State government in particular as an acceptable regulator. The Joint Commission has thus increasingly come to resemble other private standard-setters, which pursue their own interests as guarantors of quality to some extent independent of the more narrow interests of their sponsoring organizations.

Jost cites the JCAHO policy of performing unannounced inspections on 5 percent of accredited facilities annually as evidence of this role. The policy enhances the JCAHO's legitimacy as regulator, but runs counter to the interests of its accredited institutions. JCAHO has also modified its information disclosure policy and made other recent reform-motivated changes, such as prohibiting smoking in hospitals.¹⁹⁰

Jost also points out that JCAHO is more useful in institutions such as hospitals, where physicians are heavily involved, and the intermediate producer "cross-regulation" aspects of JCAHO counterbalance its self-regulatory aspects. For facilities like nursing homes, however, where

¹⁸⁶ The training of JCAHO and HCFA surveyors is discussed in Chapter 6.

¹⁸⁷ The validity of these arguments in the nursing home setting is discussed in Chapter 11, "Comparative Analysis of HCFA and JCAHO Survey Costs."

¹⁸⁸ McGeary, *op. cit.*

¹⁸⁹ Burma 1989, *op. cit.* Bergman, *op. cit.*

¹⁹⁰ JCAHO 1997, *op. cit.* Fiore, M.C. "Smoke-Free Hospitals: A Time for Universal Action," 102 CHEST 1317, 91992.

physician involvement is minimal, the JCAHO represents pure self-regulation and provides less protection for consumer interests.

3.5.3 State and Government Agencies

Jost described the efficiency of JCAHO operations and the cost savings associated with self regulation.

JCAH can get by with minimal inspection programs because the bulk of standards enforcement is achieved through physicians and administrators within the hospital. As JCAH standards promote the self-interest of physicians and hospitals, they are largely self-enforcing

In 1979, the GAO Report documented this efficiency and noted that State validation inspections cost on average \$150 more than JCAH accreditation surveys. At the same time, the standards seem to minimize regulatory inefficiencies because JCAH analyzes its regulations for cost effectiveness, and attempts to allow hospitals maximum flexibility in applying standards.¹⁹¹ The same tendency may be less likely to be found in a government regulator.

In 1991, HCFA estimated that it would cost \$59 million and require 722 additional full-time employees for it to assume responsibility for surveying all hospitals (including those currently granted deemed status) for Medicare compliance. HCFA would have to hire, train, and maintain a staff of costly professionals, including physicians, nurses, and attorneys, to formulate and enforce program standards. Under Medicare amendments adopted in 1990 that bar user fees for survey and certification purposes, HCFA would have to absorb all these costs itself. Since Medicare currently pays for only about 27 percent of the cost of hospital care, most of the cost of JCAHO certification is borne by other payers.

State survey agencies regularly survey a sample of JCAHO-accredited hospitals to validate their findings. HCFA must report the results of its validation surveys to Congress annually. The report for fiscal years 1991 and 1992 found (as it had in previous reports) that "in general, Joint Commission accreditation does, in fact, provide reasonable assurance that accredited hospitals meet federal requirements. [However there are some concerns about accredited hospitals maintaining compliance with the Medicare conditions of participation at the midpoint of their accreditation cycles]."¹⁹² The report concluded that, "accredited hospitals have few problems meeting Medicare conditions of participation other than the life safety code...Generally, the

¹⁹¹ Affeldt, J.E., Roberts, J.S., and Walczak, R.M. "Quality Assurance: Its Origins, Status, and Future Decisions-A JCAH Perspective." *Evaluation and the Health Professions*. 6:245-255, 1983

¹⁹² Health Care Financing Administration. Chapter X. Report on Medicare Validation Surveys for Hospitals Accredited by the Joint Commission on Accreditation of Healthcare Organizations (FY 91 and FY 92), pp 60-86.

percentage of hospitals placed under State agency monitoring following regular sample validation surveys has been decreasing over the years, demonstrating the increased equivalency between the Joint Commission and Medicare survey process.”¹⁹³

While the JCAHO is not widely recognized as a strong enforcer, historically HCFA enforcement has been no more aggressive. For example, not one of the 35 percent of accredited hospitals that received termination notices from HCFA during the validation process in fiscal year 1992 was in fact terminated from Medicare. In addition, facilities that have had their accreditation revoked by JCAHO have on occasion subsequently been certified to participate in Medicare by HCFA after a State survey.¹⁹⁴

3.6 Accreditation in Home Health

3.6.1. Introduction

The home health field encompasses a wide variety of organizations and services. More than 118,500 providers deliver home care services to some seven million individuals. These include: 9,120 Medicare-certified home health agencies (HHAs); 1,857 Medicare-certified hospices; and 7,897 HHAs, home care aide organizations and hospices that do not participate in Medicare (NAHC). Non-certified home care agencies and hospices often do not provide skilled nursing care and are not eligible for participation in Medicare.

Home care is a rapidly growing field in health care. Of the 9,120 Medicare-certified home health agencies, 43.3 percent are proprietary agencies and 27.1 percent are hospital-based agencies. The chart in Exhibit 3.3 from the National Association for Home Care shows how these organizations have grown faster than any others since the late 1960s.

As more sophisticated high-technology equipment and therapies can be used safely in the home, as efforts to reduce costs associated with hospital care continue, and as patients opt for care in the home setting when possible, demand for home care services is expected to continue to increase. More than 5 million elders in America are moderately to severely disabled and in need of assistance with personal care and activities of daily living. By the year 2000, this number is projected to reach 7.2 million, with subsequent increases to 10.1 million by 2020 and 14.4 million by 2050.¹⁹⁵ The number of new workers in home care, attempting to met the needs of the rapidly

¹⁹³ Idem.

¹⁹⁴ Jost 1993, op. cit. McGeary, op. cit.

¹⁹⁵ Applebaum, R. and Phillips, P. "Assuring the Quality of In-home Care: The 'Other' Challenge to LTC." *Gerontologist* 30 (4): 440, 1990.

expanding frail, homebound, elderly population, continues to grow faster than any other segment of health care delivery in the United States.¹⁹⁶

Exhibit 3.3

Number of Medicare-Certified Home Care Agencies, by Auspice, 1967-1995

Year	FREESTANDING AGENCIES						FACILITY-BASED AGENCIES			TOTAL
	VNA	COMB	PUB	PROP	PNP	OTH	HOSP	REHAB	SNF	
1967	549	93	939	0	0	39	133	0	0	1,753
1975	525	46	1,228	47	0	109	273	9	5	2,242
1980	515	63	1,260	186	484	40	359	8	9	2,924
1985	514	59	1,205	1,943	832	4	1,277	20	129	5,983
1990	474	47	985	1,884	710	0	1,486	8	101	5,695
1991	476	41	941	1,970	701	0	1,537	9	105	5,780
1992	530	52	1,083	1,962	637	28	1,623	3	86	6,004
1993	594	46	1,196	2,146	558	41	1,809	1	106	6,497
1994	586	45	1,146	2,892	597	48	2,081	3	123	7,521
1995*	575	40	1,182	3,951	667	65	2,470	4	166	9,120

Source: HCFA, Center for Information Systems, Health Standards and Quality Bureau
*Revised from previous Basic Statistics About Home Care

VNA: Visiting Nurse Associations are freestanding, voluntary, nonprofit organizations governed by a board of directors and usually financed by tax-deductible contributions as well as by earnings.

COMB: Combination agencies are combined government and voluntary agencies. These agencies are sometimes included with counts for VNAs.

PUB: Public agencies are government agencies operated by a state, county, city, or other unit of local government having a major responsibility for preventing disease and for community health education.

PROP: Proprietary agencies are freestanding, for-profit home care agencies.

PNP: Private not-for-profit agencies are freestanding and privately developed, governed, and owned nonprofit home care agencies.

OTH: Other freestanding agencies are agencies that do not fit one of the categories for freestanding agencies listed above.

HOSP: Hospital-based agencies are operating units or departments of a hospital. Agencies that have working arrangements with a hospital, or perhaps are even owned by a hospital but operated as separate entities, are classified as freestanding agencies under one of the categories listed above.

REHAB: Refers to agencies based in rehabilitation facilities.

SNF: Refers to agencies based in skilled nursing facilities.

from: National Association for Home Care

HHAs offer a multiplicity of services including the provision of medical equipment (e.g., ventilators), personal care and social support (e.g., bereavement) services, and hospice services. Medicare requires that the beneficiary be homebound and need skilled nursing, physical or speech therapy on an intermittent basis. Patients who meet qualifications are also eligible for ancillary services, such as occupational therapy, medical social service, home health aides, visits by medical interns or residents, medical supplies, rental of medical appliances, including durable medical equipment and prosthetic devices. Most services are delivered for a limited time (two-four

¹⁹⁶ Hankwitz, P. "Quality Assurance in Home Care." *Clinics in Geriatric Medicine*, Vol. 7, No. 4. November 1991.

months) and subject to renewal every 60 days (not meant as substitute for long-term care). These guidelines generally serve as model for home care benefits offered by private insurers.¹⁹⁷

Some States have programs, usually funded by Medicaid, that serve as alternatives to nursing home or institutional care. For example, home bound patients may receive maintenance treatment for chronic illness under New York State's Nursing Home without Walls program. Other services may be national, State or local and include Meals on Wheels or chore services. There are also high-tech home care services, spearheaded by manufacturers such as Upjohn and Baxter Travenol, that involve the provision of materials or equipment and a range of other services.¹⁹⁸

3.6.2. History

Organized home care in the United States dates back to the 19th century.¹⁹⁹ Visiting nurses provided early home care services and were often funded by philanthropic women. Programs were sometimes linked to social missions and focused on public health and disease prevention.²⁰⁰ This model continued through the early 20th century, when physician home visits became more common, but technology and treatments were limited. The first hospital-based home care program, "a hospital without walls," was established in 1947 at Montefiore Hospital in New York city to provide therapeutic care to patients in their homes through a team of nurses, therapists, and physicians. This program combined two parallel systems of home care: physicians' house calls and visiting nurses' care.²⁰¹

As hospitals became more high tech, the range of services that could be provided at home became more limited. At the same time, the physician shortage during and immediately after World War II made home visits less efficient. Rates for a home visit by a physician were not commensurate with those for in-hospital or office visits, so physician involvement declined. Currently, physicians play a minor role in home health care, often with little or no involvement, other than providing necessary signatures.²⁰²

¹⁹⁷ Koren, M.J. "Home Care - Who Cares?" *New England Journal Of Medicine*. Vol. 314, No. 14. April 3, 1986.

¹⁹⁸ Idem

¹⁹⁹ Kinney, op. cit.

²⁰⁰ Buhler-Wilkerson, K. "Public Health in Nursing: In Sickness or in Health". *American Journal of Public Health* 1985, 75:1155-61.

²⁰¹ Koren, op. cit.

²⁰² Koren, op. cit. General Accounting Office. *Medicare Home Health Services, A difficult program to control*. Washington, DC: GAO. 1981. National Association for Home Care. *1997 National Home Care and Hospice Directory 9th ed.*, Washington, DC: NAHC.

After the enactment of the Medicare and Medicaid programs in 1965, which included home health as a covered benefit, most States adopted their home health agency licensure statutes. The Medicare program required participating HHAs to comply with HHA Conditions of Participation, and the Medicaid program required HHAs to be licensed under State law. Most States require HHAs to meet quality standards as a condition of licensure only if the agency provides skilled nursing services. In general, State licensure of HHAs tends to be undeveloped and narrow in coverage with inconsistent or lax enforcement.²⁰³

When the Reagan administration ushered in the new prospective payment policy for hospitals in the early 1980s, public opinion about the quality of health care was low. Consumers believed that prospective payment contained incentives to discharge patients “quicker and sicker” into the community where the risks of poor quality continuing care services were greater and the checks and balances for safety and quality taken for granted in the hospital were totally absent.²⁰⁴

Consumer uproar over deteriorating quality of home care services prompted the House Select Committee on Aging to release a report in 1986 prepared by the American Bar Association entitled: *The Black Box of Home Care Quality*. Problems cited in the report included:

- Worker nonappearance, tardiness, or failure to spend the necessary time;
- Inadequate or improper performance of duties;
- Failure to perform duties;
- Attitudinal problems (insensitivity, disrespect, intimidations, abusiveness);
- Theft or financial exploitation; and
- Physical injury (intentional and accidental).

With the enactment of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), Congress approved more stringent quality controls for HHAs participating in Medicare. New Medicare conditions of participation addressed factors affecting quality assurance in the home by adding new patient rights protections, minimum training standards for home health aides, annual unannounced inspections, and stiff enforcement provisions.²⁰⁵

Some HHAs implemented their own quality assurance programs and sought private voluntary accreditation by JCAHO or the National League of Nursing's Community Health Accreditation Program (CHAP). CHAP's accreditation program for home care dates back to the 1960s, and the Joint Commission began accrediting hospital-based HHAs in the late 1970s.

²⁰³ Kinney, op. cit.

²⁰⁴ Mitchell, M. “Nursing's Legacy of Leadership.” *Nursing and Health Care*. June 1992.

²⁰⁵ Mitchell, op. cit. Micheletti, J. and Shala, T. “Evolving Quality Assurance Initiatives in Home Healthcare.” *Nursing Management*. August 1989.

In the mid-1980s, HCFA agreed to “deem” accreditation by both the National League of Nursing and the Joint Commission as compliance with Medicare standards. HCFA deferred recognition because Congress mandated changes in the Medicare Conditions of Participation for HHAs as well as the survey and certification procedures for HHAs. In 1991, HCFA proposed revisions in the Medicare Conditions of Participation for HHAs.

In May 1992, HCFA issued a notice granting “deemed” status to HHAs accredited under the CHAP standards of the National League of Nursing. A year later in June 1993, HCFA issued a final notice providing that JCAHO-accredited HHAs would be deemed to comply with the Medicare Conditions of Participation.²⁰⁶ Both notices provided that private accreditation would be pursuant to an unannounced survey and contained other provisions to enhance government oversight.

3.6.3 CHAP Background

Since the early 1960s, the National League of Nursing (NLN) had cosponsored with the APHA an accreditation program for home care, which at that time was dominated by visiting nurse associations and public health nurses. As the home health industry expanded in the early 1980s, the league noted problems in the existing system: home health aides were inadequately trained and agency supervision was sometimes lax. In 1986, they submitted an application for deemed status to the Federal government for the League’s Division of Accreditation for Home Care and Community Health.

According to Mitchell, NLN representatives planned to create a subsidiary corporation that would pull together powerful interests from the home care industry as well as the broader health care community. They sought to include a strong consumer and purchaser presence to distinguish the NLN accrediting body from other accrediting bodies, especially the physician-dominated Joint Commission, which was opposed to the inclusion of consumer input in the process at that time.²⁰⁷ On October 30, 1986 the NLN Board of Directors authorized the establishment of the League’s first separate subsidiary organization, the Community Health Accreditation Program. Carolyn Davis, former administrator of HCFA, was selected as the chair. Davis came up with the name for the new organization and helped shape the agenda, including a strategy that would confront the most pressing concern of the consumer community: public disclosure.²⁰⁸

Initially CHAP’s consumer approach threatened the status quo. The traditional view of accreditation was that standards should be established by the medical profession, not consumers

²⁰⁶ Kinney, *op. cit.*

²⁰⁷ Mitchell, *op. cit.*

²⁰⁸ *Idem*

or nurses, and that accreditation results were privileged information, not subject to public scrutiny. CHAP also required outcome measures that many people were not familiar with, and many home care organizations were uncomfortable with annual, unannounced visits.²⁰⁹ Resistance also came from those with opposing philosophies about quality who viewed the importance of the government's role in ensuring minimum standards as essential.

OBRA '87 included a moratorium on deemed status for 6 months. The AARP, Senators John Heinz and Bill Bradley, and Congressmen Pete Stark and Henry Waxman felt the Reagan Administration was not assuming its proper role in assuring quality in home care and wanted more time to study the situation thoroughly. The administration was wary of pursuing deemed status unless it had evidence of AARP's support.²¹⁰

In the summer of 1987, the league was awarded a \$1.2 million grant from the W.K. Kellogg Foundation to develop consumer-oriented outcome measures to be incorporated into the accreditation process. With the grant CHAP developed an outcomes-based data management system called Benchmarks for Excellence in Home Care. The purpose of the grant was: 1) to define empirically sound quality outcome measures using consumer input; 2) to develop a system to assess quality holistically; and 3) to incorporate the process into CHAP accreditation.

According to Mitchell, around this same time CHAP was informed that the Joint Commission was telling home care agencies that if they accepted referrals from a JCAHO-accredited hospital, they must also be JCAHO accredited. After a meeting between CHAP and JCAHO, JCAHO President Dennis O'Leary promised to address the matter.

CHAP's deemed status outcome was delayed by the presidential election and appointment of new HCFA administrator until on May 29, 1992 CHAP received deemed status and final notice was published in *Federal Register*. As described by Mitchell, CHAP leadership was motivated by: a health care system in desperate need of change, consumer needs that could not continue to go unmet, and the need for nursing's voice to be heard.

3.6.3.1 CHAP Accreditation Process

CHAP has been accrediting home and community-based healthcare since 1965. The purpose of the overall accreditation process is rooted in public disclosure, which enables consumers to make more fully informed decisions about their home and community care services and providers. Public disclosure also serves to raise overall standards in the industry. CHAP's philosophy is founded on the premise that the only way to assure the availability of quality community-based healthcare services and products is through voluntary commitment and that the accreditation

²⁰⁹ Idem

²¹⁰ Idem

process should be a mechanism for distinguishing such a commitment from minimal performance standards.

The accrediting process is participative and instructive, creating an ongoing, consultative relationship between agency management staff and CHAP administration and site visitors. Accreditation involves on-site expert clinical and management consultation. There is a three-year accreditation cycle, with each cycle requiring a full self-study and site visit. Accreditation fees are based on a sliding scale according to an agency's gross revenues.

The four steps of CHAP's accreditation process are described briefly below.

Step I:	Application
Step II:	Self-Study
Step III:	Site Visit
Step IV:	Board of Review

After completing the application form and sending appropriate fees, an agency receives a self-study preparation guide. The self-study is an internal assessment which can take an organization up to six months to prepare. It focuses on the four key principles of the CHAP process: structure and function, quality, resources, and long-term viability. Materials required include: mission statement, business plan, resumes, financial reports, sample clinical record, and verification of training for aides.

A survey team then conducts an unannounced site visit. Team size and duration of the visit vary depending on the size and scope of the agency. A typical five-day visit includes interviewing, reviewing documents and policies, performing clinical record reviews, and conducting home visits.

Clients are questioned about their knowledge of care and asked questions required of Medicare (e.g., state hotline number for complaints). Telephone surveys are also conducted for discharged clients and other individuals to determine their satisfaction with an agency.

Site-visitor findings, recommendations, and commendations are reviewed by the CHAP Board of Review at regularly scheduled meetings. The board is composed of community, home, public healthcare providers, experts and consumers. Three accreditation decisions are possible:

- *Full accreditation*, with or without required actions or recommendations;
- *Deferred accreditation*, pending receipt of additional information or a focused site visit to re-examine areas of concern; and
- *Denial* or withdrawal of accreditation.

CHAP-defined actions include commendations, recommendations, and required actions. Commendations are exceptional findings based on organizational strengths that the agency can use as a basis for strategic planning (and also useful for press releases and agency publications). Recommendations are suggestions the agency can use for operational improvements that will be referenced in subsequent visits. Required actions are items that need specific action and are reexamined at a focused visit or through an interim report, depending on the nature of the action. For Medicare deficiencies, a plan of correction is required within 10 days of receipt of the notification. For CHAP actions, a 60-day plan of correction is usually recommended for issues related to quality of care and a 90-day plan for paperwork issues.

3.6.4. JCAHO Background

In 1986, the Joint Commission initiated a home care project team to revise and broaden the home care standards and develop a survey process for the objective assessment of the quality of services provided by community-based and hospital-based home care organizations. The result was the establishment of the JCAHO home care accreditation program in 1988. The program's mission is to improve the quality of organized care services offered in the patient's home.²¹¹

HCFA evaluated JCAHO's capability to assure that home health agencies met Medicare conditions of participation prior to granting deemed status and a GAO report commenting on that evaluation was published in 1992. According to the GAO report:

HCFA compared its conditions of participation with JCAHO standards and examined JCAHO survey procedures, qualification requirements for surveyors, surveyor training programs, procedures for notifying home health agencies of survey results, and time frames for conducting follow-up visits if deficiencies are found.

As a result of its review, the GAO found that HCFA's evaluation was proper and that the issues HCFA believed needed to be resolved before approving deeming authority were resolved with JCAHO to the satisfaction of both organizations. In response to HCFA's concerns, JCAHO made the following revisions:

- JCAHO agreed to notify HCFA of any HHA that receives accreditation but opts not to be surveyed annually;
- JCAHO reduced the time it takes to conduct follow-up visits to HHAs with significant problems; and
- JCAHO agreed to conform its decision rules to HCFA requirements (e.g., an extended survey would be performed when even one condition of participation was not met).

²¹¹ Popovich, M. "On Accreditation of Healthcare Organizations: the ABCs of Accreditation". *Home Care Provider*. Vol 1, No. 1. February 1996.

In September 1993, HCFA found JCAHO standards and a modified survey process to be consistent with Medicare and Medicaid requirements for HHAs. As a result, these agencies can achieve Medicare certification by gaining accreditation through annual, unannounced JCAHO surveys. The home care program has grown to be the second largest for JCAHO, with approximately 6,000 accredited organizations.²¹²

3.6.4.1 JCAHO Accreditation Process

JCAHO offers different types of surveys depending on an organization's accreditation status and each has specific requirements. If an agency is eligible for Medicare or Medicaid certification, they may choose to participate in either a Medicare survey conducted by the State agency or a modified JCAHO accreditation survey. For deemed status surveys, JCAHO conducts unannounced surveys and surveyors are required to conduct more home visits and review additional patient records.

JCAHO home care surveys are conducted by home care professionals with administrative and clinical experience in the delivery of home care, including RNs, pharmacists, and respiratory therapists. Licensure in one of those three areas is required of all surveyors. Minimum requirements also include a bachelors degree (masters preferred) and five years experience in home care, with three years in a managerial or administrative role. The background and experience of the surveyor assigned to an agency depend upon the agency's structure and the nature and volume of services provided.

Components included in a survey of a home care organization include:

- Management and staff interviews;
- Home visits to current patients (typically, surveyors will select patients and conduct three to five home visits on a two-day survey);
- Documentation review, including administrative and clinical policies, personnel procedures, training and education materials, governing body bylaws or charter, pharmacy dispensing records (if applicable) and patient education materials;
- Random record review of current and discharged patients representing a variety of diagnostic categories, services provided, and branch offices (if applicable), and professional disciplines involved in care; and
- A review of equipment and pharmacy (if applicable).

JCAHO surveys usually begin with an opening conference when the surveyor explains the purpose of the survey, how it will be conducted, and the proposed schedule. The surveyor can answer

²¹² Idem

agency questions then or during daily briefings designed to review survey findings. Results are presented at a leadership exit conference upon completion of the survey to give agencies an opportunity to discuss and respond to survey findings. In addition, education conferences, interactive conferences between the surveyor and agency staff, are included in each survey based on a standards-related topic identified as an area for improvement.

Survey fees are based on the type and volume of services an organization provides, and the number of offices included in the survey. The survey and accreditation decision processes are based on an organization's demonstration of compliance with the standards as stated in the 1997-98 Comprehensive Accreditation Manual for Home Care. The standards are framed as performance objectives and emphasize actual performance over the capacity to conform. Standards include both patient care and organizational functions, as presented in Exhibit 3.4.

Exhibit 3.4
JCAHO 1997-98 Home Care Standards

Patient-Focused Functions	Organization Functions
rights and ethics	improving organization performance
assessment	leadership
care, treatment, and service	environmental safety and equipment management
education	management of human resources
continuum of care and services	management of information
	surveillance, prevention, and control of infection

To translate an organization's performance scores for the standards into an accreditation decision, JCAHO uses aggregation rules and decision rules designed to ensure that accreditation decisions are fair, reliable, and consistent. Once an agency has been surveyed and scores assigned to reflect performance in each standard, these scores are consolidated using the aggregation process.

Aggregation rules are formulas used to consolidate the scores of those standards assigned to a performance area (e.g., Nutrition Care). Aggregation rules are not based on averaging or summing groups of scores. Instead, each standard is weighted so that some carry more weight than others. JCAHO uses these aggregation rules to weight standards and their scores. Most standards do not lead to type I recommendations by themselves. They must be grouped with other standards that are also scored in less than significant compliance.

Twenty-six performance area scores are entered on the Accreditation Decision Grid using a five-point scale with one indicating substantial compliance and five indicating no compliance. Accreditation decisions are made by applying JCAHO decision rules to the aggregated scores on the decision grid. These decision rules are designed to ensure that the accreditation decision represents an organization's overall performance. Agencies are awarded one of the following categories of accreditation:

Accreditation with commendation. Awarded if the organization has no type I recommendations on the written report, no scores of 4 or 5 reflected on the grid, and an overall grid score of 90 or above.

Accreditation. May be contingent on the organization addressing type I recommendations found during the survey within a specific time period. A type I recommendation may be made when a score of 3, 4, or 5 is given for any standard. This is the most common accreditation decision.

Provisional accreditation. Applies if the organization opts to use Option I of the early survey option and meets the initial standards requirements.

Conditional accreditation. Given if the organization is not in substantial compliance with most of the home care standards, but is considered capable of resolving identified problems.

Preliminary non accreditation. An accreditation decision that is assigned to an organization when it is found to be in significant noncompliance with home care standards or when its accreditation is preliminarily withdrawn by JCAHO for other reasons (for example, falsification of documents) prior to the determination of the final accreditation decision.

Not accredited. Rendered by the Accreditation Committee when survey findings indicate that the organization demonstrates minimal compliance or noncompliance with most of the key home care standards.

Current accreditation levels are listed below:

accreditation with commendation	20%
accreditation	14%
type I accreditation	60%
conditional accreditation	4%
non accreditation	2%
provisional accreditation	<1%

3.6.5 Monitoring Quality/Accreditation

Home care includes health and human services and can draw upon the talents of a multidisciplinary range of professionals, paraprofessionals, and family members. Environmental variations in the home setting frequently lead to creative and flexible approaches to managing care. Personal care and household help are often provided by family members and overall plans of care may be carried out with efforts of patient, family and friends.²¹³

Any patient receiving care in a private home, out of the public's view, is vulnerable to substandard treatment or abuse, especially the frail, elderly, physically disabled, cognitively impaired, or those who live alone.²¹⁴ In addition, some conflict of interest seems inherent in the process: most referrals to home care programs are by nurses or social workers who may work for the agency to which they refer patients.²¹⁵

Quality assurance activities in home care are in an early stage compared to existing quality assurance developments in acute care hospitals or nursing homes, and monitoring this broad spectrum of care provided in the home setting is challenging.

JCAHO and CHAP recently initiated a cooperative accreditation agreement designed to reduce duplicate evaluations of home care organizations. Under this agreement, JCAHO agreed to recognize CHAP's survey findings in lieu of its own for surveys of integrated delivery systems and health plans. CHAP and JCAHO are also considering extending this cooperative arrangement to hospital-based home care agencies.

As described by CHAP Interim President and Chief Operating Officer Theresa Ayer in a recent JONA article:

While CHAP and the Joint Commission still maintain unique approaches to accreditation, this collaborative process has revealed a set of goals and outcomes shared by both organizations. Providers that are part of an integrated organization will continue to have the freedom to choose between two different philosophies of accreditation. Now they can also count on industry recognition, regardless of their choices.²¹⁶

²¹³ Hankwitz, op. cit.

²¹⁴ Idem

²¹⁵ Koren, op. cit.

²¹⁶ JONA. "Consider This...Community Health Accreditation Program and Joint Commission Announce Cooperative Agreement." *JONA*. Vol. 26, No. 12. December 1996.

4.0 CATALOG OF ACCREDITATION ENTITIES

4.1 Purpose of Catalog

To determine the potential of private accreditation and deemed status for long term care (LTC), it is necessary to understand the nature of accreditation and deeming and the current and future capacities for those functions. This chapter catalogs existing health care accreditation entities, identifying their key features and components, including similarities and differences with the HCFA regulatory process. The catalog identifies lessons learned from the processes of existing accreditation entities: 1) the Long-term Care Evaluation and Accreditation Program (LEAP); 2) the National Committee for Quality Assurance (NCQA); 3) the Rehabilitation Accreditation Commission (CARF); 4) the Community Health Accreditation Program (CHAP); 5) Accreditation Commission for Home Care (ACHC); and 6) the National PACE Association (NPA)'s future accreditation for PACE sites. Findings are summarized in Exhibit 4.1.

4.2 Methodology

Abt Associates interviewed representatives from each of the organizations currently involved in accreditation and deemed status for health care, including: Beth Klitch, President of LEAP; Eileen McKenna, Accreditation Program Manager for NCQA; Christine McDonell, Director of the Medical Rehabilitation Division for CARF; Theresa Ayer, President, and Bernard Rose, Business Manager, for CHAP; Tom Cesar, President, and Cynthia Layton, VP Accreditation Services for ACHC; and Joanne Kipnis, Accreditation Associate for NPA. In addition to conducting key informant interviews, Abt collected and reviewed documents from these entities, including accreditation manuals, standards, guidelines for surveyors, and promotional and conference materials. This activity specifically focused on identifying: existing accreditation and survey processes and their comparability/compatibility with the HCFA process; costs associated with accreditation; surveyor training and eligibility requirements; and follow-up and enforcement for noncompliance.

4.3 Existing Accreditation Entities

4.3.1 Long-term Care Evaluation and Accreditation Program

4.3.1.1 Background

The Long-term Care Evaluation and Accreditation Program (LEAP) is an accreditation program for LTC facilities developed by Survey Solutions, Inc., a consulting firm headquartered in Columbus, Ohio, which has been in operation for about three years. An interview with Survey Solutions' president, Beth Klitch, provided Abt with a perspective of LEAP's origin and the inception of its accreditation process.

Exhibit 4-1: Accreditation Entities*

	JCAHO	LEAP	NCOA	CARF	CHAP	ACHC
Address	1 Renaissance Blvd Oakbrook Terrace, IL 60181	1200 Chambers Rd. Suite 400, Columbus OH 43212	2000 L St., NW, Suite 500 Washington DC, 20036	4891 E Grant Road Tucson, AZ 85712	350 Hudson Street New York, NY 10014	3325 Executive Drive, Suite 150 Raleigh, NC 27609
Contact	Margaret Van Amringe Mariana Grachek M J Hampel and others	Beth Klitch President (604)488-1280	Eileen McKenna Accreditation Prgm. Manger (202) 995-3500	Christine McDonnell, Dir Medical Rehab Div (520) 319-3024	Bernard Rose Business Manager (212) 989-9393	Cynthia Layton VP Accreditation Services (919) 872-8609
Organizations Accredited	Long term care organizations, hospital- based psychiatric and substance abuse org Home care org Ambulatory care org Pathology and clinical laboratory services Health care networks	Long Term Care Facilities	(HMOs, managed behavioral healthcare organizations, credentialing verification organizations)	Medical rehabilitation programs Employment services programs Community support services programs Alcohol and other drug programs Mental health programs and behavioral health rehabilitation programs	Home and community-based health care organizations	Multi-service home care agencies/skilled services In-home aide programs Home medical equipment companies Pharmacy IV programs Hospices Women's healthcare products and services
Accreditation Statistics	15,797 orgs	1,963 LTC	275 Org (7/97)	14,061 Programs (8/97) 1,723 Org	350 Org (9/97)	54 Org (10/97)
# of Accredited Entities		Begin November 1997, 200 on wait				
Types of Accreditation Decisions	1) Accreditation with commendation 2) Accreditation-high acclaim 3) Conditional accreditation 4) Provisional accreditation 5) Not accredited	1) Accreditation- highest acclaim 2) Accreditation-high acclaim 3) Accreditation- acclaim 4) Not accredited	1) Full accreditation 2) 1-year accreditation 3) Provisional accreditation 4) Denial of accreditation	1) 3-year accreditation 2) 1-year accreditation 3) Provisional accreditation 4) Denial of accreditation	1) Deemed accreditation 2) Full accreditation 3) Deferred accreditation 4) Denial of accreditation	1) Full accreditation 2) Deferred accreditation 3) Denial of accreditation
% Granted Accreditation	99% All Others	85-90% should achieve the lowest level	94% Accredited (7/97)	98% Accredited (1995)	99% Accredited (7/97) 90% Deemed accreditation	36% Full accreditation (10/97) 64% Deferred accreditation
Eligibility Requirements	JCAHO has applicable standards Process for assessing quality of services Located in U S or territories	Must have provided long term care to residents for at least 12 mo as located in the U S or one of its territories	Be in operation for at least 18 months Be located within the US or one of its territories in compliance with applicable federal, state, and local laws & regulations, incl licensure Have a defined benefits package Have a process implemented to monitor, evaluate and improve the quality of care	Facility must have developed and implemented for a minimum of 6 mo. an interdisciplinary rehabilitation program The facility must be tracked for six months before the first survey using the Standards	Offer for > services Nursing Social work OT, PT, or speech therapy Respiratory therapy Homemaker and home health aide Hospice Management services Pharmacy Home medical equipment Infusion therapy	Facility must have been actively operating for at least 18 months and/or provide site services for no less than 4 months Have served a minimum of four clients prior to submitting an application Operate within the US and its territories

Survey Process		Surveyor Requirements		Minimum of three years experience in a long term care setting (led surveyor or mgmt)		Must be credentialed health professionals if applicable, holds a licence Has an in-depth understanding of quality improvement and managed care		Must have experience in a health-related field Must be referred Must have experience in rehabilitation three out of the last seven years		Must be masters prepared Usually RN with 5+ experience in home health		Must have at least 5 years experience in management/supervision Must have experience in the licensure or accreditation process for the specific se vice area surveyed	
5 yrs facility administrator or 5 yrs Director of Nursing	70 LTC	154	260, 230 M D s 30 RNs	1,000	50 Total 30 Active	20							
Varies	1 LTC	2 (facility with 51-100 beds)	2 at min (1-admin & 1-clinical) 5-6 surveyors (4-M D s and 2- master-level RNS)	2, depending on size and complexity	Determined on size and complexity	Determined on size and complexity							
RNs	RNs Specialists (dieticians, administrative, etc.)	RNs Specialists (dieticians, administrative, etc.)	Physicians Nurses Managed care experts	Administrative surveyors Program surveyors, clinicians	Administrative site visitors/clinical site visitors	Home health trained Surveyor HME or HMC/RRT Physical Therapist Hospice trained surveyors							
Resurvey every 3 years Announced	Resurvey Annually Unannounced	Resurvey Annually Unannounced	Resurvey annually and every 3 years Announced	Resurvey annually and every 3 years Announced	Resurvey every 3 years HHA that have had a change in ownership, are in business less than three years, or were cited with a condition-level deficiency Unannounced - deemed Announced - full accreditation	Resurvey every 3 years Announced							
2-3 days	2 days (facility with 51-100 beds)	3-5 days	3-5 days	2 days	6-7 days	2 days, depending on the # of service provided, volume of clients, # of programs, size of agency, and # of branch locations							
Varies	\$2,500 (facility with 51-100 beds), plus \$150 - app fee and surveyors expenses	Base fee of \$33,500 for plan w/ <50,000 members Re-accreditation review base fee \$15,000 Plus \$7,500 app fee	Base fee of \$3,500 for plan w/ <50,000 members Re-accreditation review base fee \$15,000 Plus \$7,500 app fee	\$3,500	\$7,100 for a fac w/revenue > \$500,000 Plus \$1,500 app fee	Base fee for all surveys/ categories is \$2,500, additional charges depend upon the size number of							
OR > Y (begins 12/97)	Quality Indicator Reports	HEDIS 3.0	HEDIS 3.0	Each program is required to have an outcomes measurement system	Benchmarks for Excellence	Outcomes of service delivery is reviewed during the on-site survey							

Prior to starting Survey Solutions, Inc., Ms. Klitch served as State Survey Director in Ohio from 1989 to 1992. She spent three years trying to improve Ohio's survey process and embarked on many pilot projects for HCFA until her tenure ended with a gubernatorial change. She founded Survey Solutions, Inc. to continue her work with LTC quality improvement. The company started as a consulting and educational firm aimed at demonstrating methods to properly assure quality in LTC facilities. Because of Klitch's past experience, she recognized the importance of being able to come back to a facility periodically to ensure that recommended changes were implemented correctly and sustained. Klitch sensed a great deal of frustration among providers, consumers, and vendor communities with the Federal survey framework, and as a result, Survey Solutions put a great deal of effort into conceptualizing how to "build a better mousetrap," i.e., a better way to measure the multiple dimensions of quality in a consistent manner.

LEAP has incorporated statistically sound methodologies into the survey process. One of the main goals in developing the system was to insure that LEAP surveyors were measuring multiple dimensions of quality and were doing so in a sound, consistent way that would minimize charges of surveyor inconsistency and subjectivity. Numerous LEAP methods and processes try to limit surveyor discretion; the idea is not to overrule their surveyors' professional judgment, but, by defining the tasks carefully, defining the documents surveyors should be looking for and the observations they should be making, and even structuring how observations are recorded, to enhance the chances of objectively measuring the facility's performance and limit the introduction of any surveyor biases.

Survey Solutions incorporated several tactics to evaluate and ensure quality as part of its accreditation process, including extensive reviews of the literature on quality in diverse fields (including auto manufacturing, Malcolm Baldrige awards, etc.) to determine common themes and to obtain a multidimensional view of quality services. Eventually, Survey Solutions staff elected to use David Zimmerman's quality indicators (QIs) as a basis for ongoing monitoring of accredited facilities because it was believed that the Zimmerman QIs were widely used and validated by years of research. Over time, additional QIs may also be developed and incorporated into the LEAP process. In addition, LEAP staff believed it was important to incorporate a consumer component, which resulted in the development of a customer satisfaction survey that asks residents and/or their representatives about their perceptions of quality.

The product of this research is LEAP's multidimensional accreditation process, which employs annual, onsite accreditation visits; the facility's mandatory periodic submission of QI performance data; and the facility's annual fielding of the LEAP-approved customer satisfaction survey.

4.3.1.2 Accreditation and Capacity

LEAP began conducting accreditation surveys in late November 1997. As of late January 1998, 11 surveys had been completed, with an additional 20 to 40 applicants with surveys scheduled. Of the original 11 facilities, 5 were granted some level of accreditation, 1 was denied accreditation,

and 5 decisions were in process at the time Abt made its inquiry. Jennifer Sparks, LEAP's Director of Research and Evaluation, explained that LEAP's statistical scoring model was designed to ensure that approximately 85 to 90 percent of the facilities will achieve at least the lowest level of accreditation.

During their initial phase of operations, Survey Solutions plans to confine the LEAP program to a narrow geographic area until the company is certain the system runs as smoothly as possible. In the future, Survey Solutions expects that LEAP accreditation will be accepted by managed care organizations to satisfy NCQA accreditation requirements to credential and monitor all providers in their network. Also, Survey Solutions expects that, should some States or even HCFA authorize deemed status for LTC facilities, the LEAP program would be an ideal candidate for accreditation based on the general requirements for deeming in health care.

Survey Solutions staff are still working out the details of plans to publicly release information about future LEAP-accredited facilities. At a minimum, Survey Solutions plans to require facilities to post and make available the survey reports and will maintain a website that will post accreditation status and scores, and may eventually post summary reports from accredited facilities.

4.3.1.3 Standards

LEAP has 50 standards organized into seven Conditions of Accreditation, covering administration, professional services, environment, residents' rights, quality of life, assessments, and quality of care. At one point, Survey Solutions considered incorporating more standards into the process. However, after assessing quality measurement systems in other industries, the company found that one hallmark of good systems was that they were simple and easily understood by the regulator and the regulated. Survey Solutions also sought to keep LEAP simpler than JCAHO or HCFA's systems, which have both received criticism for their complexity. Klitch perceived from her experience that one problem with a greater number of standards was that surveyors find it difficult to determine how to cite a problem (under which regulatory group, or tag) and often take a single fact pattern and cite it as numerous deficiencies. Such individual discretion is contrary to LEAP's philosophy and could be problematic. Because of this, Survey Solutions approached the development of LEAP standards with simplicity as the foremost goal, as well as developing a sense of systems in the scoring and observational process, in an attempt to forestall the problem of "which tag do we name?"

When developing standards, Klitch and her colleagues also looked at the OSCAR database for deficiency patterns -- frequencies, most common tags, etc. In addition, they spoke to surveyors and looked at survey reports. Survey Solutions plans to evaluate, change, and update the LEAP standards on an ongoing basis. The company anticipates numerous changes in the first year as it learns by implementing the process and will work on enhancing it after completing the first rounds of 200 to 300 surveys. The LEAP website will be used to disseminate updated standards.

The LEAP standards are cross-walked to both JCAHO and HCFA's because it was anticipated that as a start-up program, staff would often be asked how LEAP compares to JCAHO's accreditation standards. The crosswalk also serves to assure the public that all Medicare regulations could be captured within LEAP's 50 standards.

4.3.1.4 Accreditation Process

Any facility that has provided LTC services to residents for at least 12 months and is located within the U.S. or any of its territories is eligible to apply for LEAP accreditation. The accreditation process involves the submission of an initial facility application followed by an Onsite Review Process within 90 days of receipt. The facility pays a \$150 application fee along with one-third of the total accreditation fee. The accreditation fee is determined by the number of beds in a facility. For example, a facility with 51 to 100 beds would have an accreditation fee of \$2,500, plus surveyors' travel expenses. Survey Solutions plans to be able to provide facilities with an estimate of expenses, but has not set a specific limit on travel expenses. Standardized travel policies will include maximum per diem rates.

The Onsite Review Process is conducted by a minimum of two surveyors and lasts at least one day, but the number of surveyors and the length of their stay also depends on the number of beds in a facility. At least one of the surveyors is always a Registered Nurse. LEAP surveyors are required to have a minimum of three years of management experience in LTC or three years as a Federal/State surveyor, and must be appropriately credentialed for their profession. The determination to use either facility or survey experience as a criterion for employment was based on the assessment that professionals of each type bring a different set of skills to the process, and that these skills will be complementary. Surveyors are also required to attend LEAP training and pass a written examination. There are currently 39 full-time surveyors, 40 weekend/part-time surveyors, and 75 specialists (licensed professionals with specific expertise, such as dietitians and pharmacists).

Surveyors prepare for the survey by reviewing the LEAP application forms and facility-prepared documents submitted with the application. These documents include the prior-year survey and OSCAR data. The LEAP application has information regarding a facility's history and QIs. During off-site preparation, the surveyors also predetermine a random sample of residents to be reviewed based on the QI data that the facility provides with its application. To aid in off-site preparation, LEAP also purchases OSCAR data quarterly on CD-ROM.

The Onsite Review involves four tasks: opening conference; sample selection; review process; and decision-making and closing conference. Upon arriving at the facility, LEAP surveyors will hold an opening conference with facility representatives to introduce themselves, explain the LEAP accreditation process, and confirm the expected duration of the onsite review. Surveyors will then tour the facility looking for evidence regarding quality of life and environmental issues and possible areas of accident hazards. During the review process, surveyors will review facility

compliance with the seven Conditions of Accreditation. LEAP has an Onsite Review Document Checklist that details the documents that the facility must have ready and available during the visit. These documents include, but are not limited to:

- Medical records of sampled residents
- Employee personnel records
- Copies of staff licenses
- Closed records of former residents
- Documentation of in-service training
- Administrative documents of the governing body
- Documentation of staff emergency preparedness drills

The team will examine clinical records of a random sample of residents and review activities, dining rooms, kitchen area, and medication administration. The LEAP surveyors will also interview residents, staff, family members, and legal representatives. After concluding the review of the facility, they will meet for approximately two hours to discuss their findings. During this time, the LEAP staff will prepare a preliminary report regarding the findings, including scoring estimates, which will be presented at the closing conference.

4.3.1.5 Scoring

The LEAP survey teams have scoring software on their lap top computers so that they input their findings and the computer automatically calculates the survey score. The scores are aggregated by standards into a Range of Harm classification grid, which LEAP has crosswalked to the HCFA scope and severity grid scores, as illustrated:

Actual Harm	3 Corresponds to HCFA Scope and Severity of G, H, J, or K	4 Corresponds to HCFA Scope and Severity of L or I
Potential Harm	1 Corresponds to HCFA Scope and Severity of A,B,D, or E	2 Corresponds to HCFA Scope and Severity of C or F
	Limited	Systemic

The grid's design was intended to simplify decision-making by placing scope and severity determinations in categories that surveyors can easily and consistently identify. Survey Solutions believes that most surveyors can make consistent decisions between actual harm or the potential for harm, and between individual/limited problems and systemic problems.

The LEAP program also offers surveyors decision-making trees for assessing: pain management, depression treatment; pressure sores; use of physical restraints; and use of siderails. This documentation was adapted from review of the latest clinical journals with the goals of presenting the information in a way that will help the surveyors systematize, manage how they think, and improve their consistency.

Throughout the onsite review, during the closing conference, and for 15 days after receipt of the LEAP scores, a facility may supply additional information, submit documentation, write a letter, or telephone the LEAP central office to rebut the findings and scores. A LEAP manager who was not involved in the reviews will evaluate the information supplied. If a facility does not agree with the accreditation decision, it may attach a separate sheet to the onsite review results stating its disagreement with the scores.

4.3.1.6 Accreditation Decisions

There are three possible accreditation decisions based on the scoring. They are:

- **Accreditation with Highest Acclaim:** The facility has amassed at least 90 percent of the points possible in each of the seven Conditions of Accreditation.

- **Accreditation with High Acclaim:** The facility has amassed at least 85 percent of the points possible in each of the seven Conditions of Accreditation.
- **Accreditation with Acclaim:** The facility has amassed at least 80 percent of the points possible in each of the seven Conditions of Accreditation.

LEAP may withhold, refuse to grant, or withdraw accreditation at any time if a facility fails to meet its standards. LEAP's main emphasis is to "hold a big stick," i.e., the threat of loss/denial of accreditation. Currently, there are no intermediate responses planned. The philosophy articulated by Klitch is "follow all the rules or you'll lose the LEAP stamp of approval," which will be particularly important to facilities that need to maintain accreditation to stay in a managed care network.

LEAP also requires accredited facilities to notify them of any significant HCFA sanctions within 15 days. On receipt of such information, LEAP will decide whether the situation requires an onsite visit or can be managed with a "wait and see" approach (to see what the outcome of the HCFA process is). Klitch reported that LEAP does not yet have a planned channel for complaints. Survey Solutions is still examining this issue and exploring several alternatives (e.g., the State, the ombudsmen, etc.). While not wanting to avoid legitimate complaints, the company also does not want to open LEAP to frivolous complaints. If the LEAP program becomes aware of a legitimate situation at an accredited facility, LEAP may initiate an onsite review at the facility's expense.

4.3.1.7 *Quality Indicator Reports*

A component of the LEAP philosophy is the recognition that a lot of things determine quality or indicate an absence of quality that are not always easily measured through an annual onsite survey. Therefore, accredited facilities will be required to provide LEAP with QI Reports monthly. (Facilities need to obtain their own software to generate their QI data using the software package of their choice. For those who do not already have QI software or do not know how to obtain it, Survey Solutions will probably recommend AHCA's *Facilitator* package.) LEAP will send back reports benchmarking facilities' performance on a quarterly basis to: 1) other accredited facilities; and, 2) their own histories of performance. LEAP will also send aggregated reports on its accredited facilities' performance to offices of nursing home chains and to managed care organizations.

4.3.2 **National Committee for Quality Assurance**

4.3.2.1 *Background*

Established in 1991 as a spin off of the Group Health Association of America (GHAA), the National Committee for Quality Assurance (NCQA) is a non-profit organization headquartered in

Washington, D.C. When this report was written, the current NCQA president, Margaret O’Kane, was working at GHAA on developing a peer review process for health plans. Because of the potential for conflict of interest in the association monitoring its members, the activity became independent and received its initial funding from GHAA and the Robert Wood Johnson Foundation. At that point, a group of experts and stakeholders (e.g., consumers, employers, insurers, health plan representatives) was assembled to develop a set of standards and design an accreditation process for managed care. Presently, NCQA is governed by a Board of Directors that includes employers, consumers, labor representatives, health plans, quality experts, regulators, and representatives from organized medicine and is dedicated “to assessing and reporting on the quality of managed care plans.” NCQA’s two main activities are accreditation and performance measurement, using the Health Plan Employer Data and Information Set (HEDIS). NCQA offers its services to managed care plans, including health maintenance organizations (HMOs), managed behavioral health care organizations, management service organizations, and credential verification organizations.

Accreditation was NCQA’s first core program, followed by the development of HEDIS in 1993. These two programs have differing methodologies in their assessment of a managed care plan. Accreditation examines a plan’s structure and processes; HEDIS examines performance measures as evidence of the results the plan actually achieves. In the future, NCQA plans to integrate these two programs, but currently, accreditation and HEDIS have no bearing upon each other. According to Eileen McKenna, Accreditation Program Manager, the majority of health plans report HEDIS data annually, but these reports are not reviewed for purposes of monitoring accredited plans. However, many plans that choose to pursue NCQA accreditation use HEDIS measures as evidence of compliance with standards, which are reviewed as part of the survey process. NCQA is moving in the direction of ongoing monitoring of accredited plans through HEDIS and incorporating more performance measurement into the accreditation process.

4.3.2.2 *Accreditation Statistics*

NCQA accreditation assesses how well a health plan manages its clinical and administrative systems to continuously improve health care for its members. There are four major accreditation statuses awarded to managed care plans seeking NCQA’s stamp of approval: full accreditation; one-year accreditation; provisional accreditation; and denial of accreditation. An organization can also be classified as “under review,” “initial decision pending,” or “initial review scheduled.” Full accreditation is awarded to plans with “excellent” programs for continuous quality improvement (CQI) that meet all NCQA standards. This status is in effect for three years. One-year accreditation is granted to plans that have “well established” CQI programs and meet NCQA standards. These plans are provided with specific recommendations. After a year, the plan is resurveyed to determine if it has progressed enough in problem areas to be in full compliance with NCQA standards and expectations. If so, the plan is eligible for full accreditation. A plan can receive provisional accreditation for one year if it has “adequate” CQI and meets some of the standards. The plan must demonstrate “significant improvement” before it can qualify for higher

levels of accreditation. A plan is denied accreditation if it demonstrates a "low level" of compliance with the standards and does not have an "adequate" CQI program.

Accreditation decisions - for individual plans and total distributions - appear in NCQA's *Managed Care Organization Accreditation Status List*. This report is released in hard copy monthly and is also available on the NCQA website. The report shows levels of compliance met in each of the substantive areas and, as a benchmark, also shows average performance across all accredited plans. According to the July 15, 1997, report, there were a total of 275 accreditation decisions: 136 full accreditation, 104 one-year accreditation, 15 provisional, 16 denied, and 4 under review. In addition, there were 7 initial decisions pending and 52 initial reviews scheduled. NCQA has no specific plans for targeted growth, but there are about 600 managed care organizations in operation that may seek accreditation at some point. A representative from NCQA also stated that in the future NCQA would like to be responsive to Provider Service Organizations in addition to HMOs, further expanding the potential pool of applicants.

4.3.2.3 Standards

NCQA has more than 50 standards, each focusing on an important aspect of the health plan. The standards fall into six different categories: quality improvement; physician credentials; members' rights and responsibilities; preventative health services; utilization management; and medical records. The quality improvement category accounts for 35 percent of a plan's score. It stipulates that the organization must have a quality improvement plan that is organized, comprehensive, and accountable to the organization's top level. Standards on physician credentials, which account for 25 percent of the plan score, require that the plan verify provider credentialing information such as license, malpractice history, hospital privileges, DEA certification, etc. These standards also require the plan to conduct a structured review of provider offices prior to contracting. Standards included in the members' rights and responsibilities category, which accounts for 10 percent of the plan's score, require the plan to have written documentation that recognizes member's rights such as their right to voice grievances and receive information about the plan. Preventative services, which accounts for 10 percent of the score, mandates that the plan develop "specifications," clinical policies, or practice guidelines for the use of preventative services. NCQA also requires that the plan communicate this information to providers and patients and present to NCQA a yearly performance report of the plan's delivery of two services chosen from a list developed by NCQA. Utilization management standards, accounting for 10 percent of the score, seek to ensure that the managed care organization has an organized system for utilization management; that review decisions are made by "qualified medical professionals;" that the managed care organization has a written utilization management protocol based on "reasonable scientific evidence;" and that there is an "adequate appeals process." The remaining 10 percent of the score is based on medical record standards. NCQA supplements its review of quality management with a sample of ambulatory care records to assess both the quality of

documentation and quality of care. All of these standards are the basis of the accreditation process.

A standards committee comprised of a variety of stakeholders including consumers, purchasers, and lawyers meet quarterly or biannually to review, revise, or accept new standards. The standards are updated at least annually, at which time there can be minor changes or large-scale revisions. All annual revisions are provided to all accredited plans. The last revisions were completed in 1997.

4.3.2.4 Accreditation Process

According to NCQA's *Administrative Policies and Procedures*, before an organization seeks NCQA accreditation, it must meet a number of requirements:

6. The managed care organization must have a process implemented to monitor, evaluate and improve the quality of care provided to its members. It must also provide access to necessary clinical information for its members.
2. The managed care organization must provide or arrange to provide the following services through an organized delivery system to enrolled members:
 - Defined benefits package including: adult medical and surgical, pediatric medical and surgical, obstetrics, mental health, and preventative health services.
 - Services in a setting that include ambulatory and inpatient sites.
3. The managed care organization must be:
 - In operation for at least 18 months;
 - Located within the US or one of its territories;
 - In compliance with applicable Federal, State, and local laws and regulations, including requirements for licensure.
 - Operating without discrimination on the basis of sex, race, creed, or national origin.
4. The managed care organization must be willing to:
 - Release to NCQA information that NCQA deems pertinent.
 - Hold NCQA harmless from any claims the organization may have relating to the NCQA accreditation survey, all review and reconsideration processes, and any determinations made by NCQA relating thereto;
 - Abide by the terms of the NCQA Application for Accreditation Survey contract, the Administrative Policies and Procedures, Accreditation and Appeal Procedures, the Standards, and all other published NCQA policies.

An organization that meets the eligibility requirements begins its process for accreditation by submitting a signed Application For Accreditation Survey (legal contract), a completed Preliminary Information Form, a signed Fraudulent Information document, and an application fee of \$7,500. The balance of the survey fee must be paid 30 days before the survey date.

The survey fee is based on a NCQA fee structure that may change from time to time and is based on the size and complexity of the surveyed organization. A base fee of \$33,500 is charged for organizations with fewer than 50,000 members. For organizations with more than 50,000, the base fee is \$33,500 plus \$.10 per member in excess of 50,000. Another base fee of \$21,000 is charged for all accreditation re-reviews. The fee may increase from initial estimates based on the findings of the Preliminary Information Form and discussion with the health plan.

Before the onsite survey, the organization is advised by NCQA to complete ample site visit preparation. First, NCQA advises that the plan comprehensively review all NCQA standards. Before the survey date, the organization should also have documentation accessible. Prior to the survey, NCQA also requires a list of primary care providers for chart selection and preassessment information. The preassessment information is used by the survey team and includes overview of the organization's size, scope, structure, and operations.

The minimum survey team includes one physician surveyor and one administrative surveyor. On average, there are five or six people per team (four medical doctors and two master-level registered nurses). The composition and size of the team depends on the size and complexity of the organization. When this report was written, there were approximately 230 physician surveyors, who are generally medical directors or directors of quality assurance at HMOs or managed behavioral health plans. In addition, there were over 30 registered nurse surveyors. All surveyors must be credentialed, and if applicable, licensed, have an understanding of quality improvement and managed care, and have no direct financial relationship with the managed care organization under review. NCQA surveyors also attend a training program called "*Moving to Quality*," which is intended to teach them about the quality standards. NCQA also offers its surveyors continuing education programs and has staff available for one-on-one training. Each surveyor is required to be retrained annually.

The onsite survey normally lasts three to five days. Upon arrival, the team conducts an initial meeting in which the managed care organization has an opportunity to give a brief overview of the plan. The surveyors then assess compliance with each standard onsite and use scoring guidelines to assign a level of compliance (full, significant, partial, minimal, none) with each standard. NCQA's assessment of compliance with these standards includes, but is not limited to, review of written documentation, observations, interviews with staff, review of medical records, and assessment of member service systems, including provisions for complaints, grievances, member education, and member surveys. The survey ends with a summation conference. Typically in attendance from the organization are the chief executive officer, medical director,

chair of the quality improvement committee, quality improvement director, utilization management director, and member and provider relations director.

4.3.2.5 Accreditation Decision Process

Survey data are compiled into a preliminary/draft survey report that lists each standard and provides feedback to the provider. This report is then submitted to NCQA, where it is reviewed and edited by a senior staff member who can overrule surveyor decisions and can send back inquiries for more information. The report then goes to the Review Oversight Committee (ROC), which is composed of about nine members, primarily health plan medical directors who are also surveyors. The ROC makes the ultimate accreditation decision based on the scoring guidelines. (The process to this point averages about 120 days. NCQA's goal is to reduce the time to 90 days.) The plan then has the right to appeal the decision within 30 days. If the plan appeals, it goes to the Reconsideration Committee (which consists of six members--medical directors, NCQA staff, and surveyors). After an accreditation decision has been granted, NCQA has no formal process for enforcement during the one or three year period in which the organization is accredited. However, based on reports of problems at an accredited plan, NCQA can initiate a discretionary review at the plan's expense or go so far as revoking an accreditation decision.

4.3.3 Rehabilitation Accreditation Commission

4.3.3.1 Background

The Rehabilitation Accreditation Commission (CARF) is an internationally-recognized accrediting body whose mission is "to promote quality in rehabilitation services." Founded in 1966 and headquartered in Tucson, Arizona, CARF serves as an "accountability advocate" for persons with disabilities and others in need of rehabilitation. CARF accredits individual programs within an organization. Throughout its history, CARF has established standards and an accreditation process for rehabilitation services in spinal cord injury, brain injury, pain management, and occupational therapy programs including inpatient and outpatient services. CARF has also accredited employment and community support services, alcohol and other drug programs, and mental health, psychosocial, and behavioral health programs. In 1996, CARF released its first standards for care outside of the institutional setting to develop an accreditation process for home and community-based rehabilitation programs.

4.3.3.2 Accreditation Decisions and Statistics

Three types of accreditation statuses may be granted to programs seeking CARF accreditation: three-year accreditation, one-year accreditation, and provisional accreditation. To receive three-year accreditation, an organization must meet each of the Accreditation Principles, Criteria, and Conditions and show "extensive" fulfillment of the appropriate standards. Programs that receive three-year accreditation should have "established" programs, "adequate" personnel, and

documentation that clearly indicates an established pattern of high quality services that will be likely to be maintained. These organizations are given a "Quality Improvement Plan" detailing recommendations for the facility, and this is reviewed upon the next survey. A decision for one-year accreditation indicates that the program shows major deficiencies in meeting some of the applicable standards; however, this status indicates that there is evidence of the organization's ability to improve. If the deficiencies have been corrected at the one-year survey, the facility is given three-year accreditation. Finally, provisional accreditation is given to facilities that were awarded a one-year accreditation and at their resurvey did not demonstrate correction of their deficiencies. A facility is only allowed one one-year accreditation decision before receiving provisional accreditation. If the facility does not demonstrate improvement during its year end survey under provisional accreditation, it does not receive accreditation.

Currently CARF releases only information on accreditation status (i.e., services the program is accredited for and accreditation status). According to CARF's *Count of Accredited Programs/Sites - August 1, 1997*, there were 14,061 accredited programs. This represents 2,723 organizations with accredited programs and 6,897 sites with accredited programs. The majority of their accredited programs were in employment services and community support services. In 1995, 87 percent of those surveyed received three-year accreditation, 11 percent received one-year accreditation, and 2 percent were not accredited. As of July 1, 1998, CARF will be releasing a summary of findings. CARF is in the process of developing a way to present this information in an easy to understand, meaningful graphic form.

4.3.3.3 Present Collaboration and Future Capacity

NCQA and JCAHO recognize CARF accreditation in their network accreditation processes. In addition, as of January 1997 a combined CARF/JCAHO survey is offered to freestanding rehabilitative hospitals as an alternative to their separate selection of either CARF or JCAHO evaluation. In these facilities CARF and JCAHO conduct concurrent surveys that include provisions for joint activities including document review, observation, daily briefing, interviews, and exit conference. Each accrediting body renders its own accreditation decision based on its standards and decision process, issues its own report, and charges its customary fee. There are plans to move toward a less expensive and more integrated alternative for providers. Also, as of August 1, 1998, JCAHO will recognize CARF accreditation of programs located within facilities seeking JCAHO accreditation. In this case, these already CARF accredited programs will not need to be re-surveyed by JCAHO. With regard to CARF seeking deemed accreditation status for Medicare from HCFA, Christine McDonell, National Director for Medical Rehabilitation Division, stated that CARF has been "steered away." However, CARF does have plans to put in an application for deemed status for CORFs (Comprehensive Outpatient Rehabilitation Facilities)

4.3.3.4 Standards

CARF's existing standards are the product of 31 years of involvement and development by providers, consumers, and purchasers of services. The standards were not derived from a research base, but rather, represent a "national consensus standard." They define the expected inputs, processes, or outcomes of services for people with disabilities and others in need of rehabilitation.²¹⁷ CARF has a separate standards manual and interpretive guidelines for medical rehabilitation, employment services, community support services, alcohol and other drug programs, mental health, and psychosocial rehabilitation programs. For example, in all medical rehabilitation programs, the organization must demonstrate to a survey team the organization's conformance with standards and its approaches in the following areas:

- Philosophy and Mission
- Governance
- Organizational Structure and Management
- Fiscal Management
- Planning
- Personnel and Personnel Development
- Health, Physical Plant, and Transportation
- Rights of the Person Served
- Intake Management
- Orientation
- Individual Program Planning
- Discharge/Transition Planning and Implementation
- Records of Persons Served
- Program Evaluation
- Assessing the Quality of Services Provided to the Persons Served
- Analysis and Utilization of Information

Standards are updated every two to three years. The Board decides when and which standards will be updated. The process is extensive, involving feedback from the various stakeholder groups (which are referred to as "fields") such as consumers, providers, and payors. A National Advisory Committee is convened, consisting of approximately 20 members representing all rehabilitation fields. This group establishes a consensus on what the standards should be addressing. The CARF staff then formulates the actual standards. The advisory committee convenes again to review and edit the standards developed by the CARF staff. Then a Field Review Document (draft standards) is circulated to all of the fields and to the Board for response, following which the revised standards are finalized and approved by the Board. The entire process takes approximately 18 months. New manuals are disseminated in January and go into effect in July. All programs (accredited or not) must purchase the new manuals if they want them.

²¹⁷ See CARF's 1997 Standards Manual and Interpretive Guidelines for Medical Rehabilitation.

4.3.3.5 Accreditation Process

A facility that has implemented an interdisciplinary rehabilitation program for a minimum of six months is eligible to begin the CARF survey process by purchasing the appropriate Standards Manual. The organization must then go through a period of self-evaluation using the standards as CARF requires that the organization must track use of the standards for six months prior to the survey. When an organization feels it has adequately met CARF standards, it can submit an application fee as well as eight written policies (input from persons served, accessibility, outcomes, rights, health and safety, human resource development, leadership, legal requirements, and financial planning and management) as part of a complete application. CARF then reviews the application and determines the number of days and the number of surveyors required for the site survey and informs the organization at least 30 days before the survey. The average survey length is two days, with an average of two surveyors per team. The average cost of the survey is determined by the number of surveyors and the length of the survey. An average survey cost is \$3,800.

CARF currently has approximately 1,000 surveyors who are considered part-time employees. All of CARF'S surveyors work full-time at CARF accredited programs. There are two types of surveyors, administrative and program surveyors (split about 50-50). Administrative surveyors are generally vice presidents, chief executive officers, and administrators, and about 98 percent also have some type of clinical background. Program surveyors are clinicians including physicians, therapists, etc. There is no formal degree requirement, but each surveyor is chosen by referral and must have worked three out of the prior seven years in a rehabilitation program.

Surveyors go through an initial five day training session, with two days devoted to reviewing the standards from the perspective of interacting with an organization and discussing the process of survey, followed by a simulated survey on the third day. Surveyors then conduct a minimum of two internship surveys with a mentor within the first six months. They are evaluated based on those two surveys, and it is determined whether they need additional supervision. CARF also requires its surveyors to take a formal continuing education course a minimum of once every three years. Surveyors are also provided with additional training materials on an ongoing basis through literature, tapes, newsletters, etc.

When the survey team arrives at the organization, it begins the site visit with an orientation conference with representatives from the organization including governing body, administration, staff, and whomever the organization invites. The organization provides an overview of its operations. After that, the survey team is given a tour of the facility. The rest of the day is spent observing activities, interviewing staff and persons served, and reviewing medical records and other documentation. The documentation includes fiscal reports as well as administrative records. The following day(s) is an extension of the previous day's activities, but ends with an exit conference with the same persons who attended the opening meeting. The conference's purpose is to provide the organization with immediate feedback and recommendations for improvement.

At this time, the organization can question or comment on any of the survey team's findings and provide additional evidence demonstrating compliance with the standards.

The survey team compiles its scores and report its findings in a survey report. The current scoring for standards is binary: either in compliance or out. However, a scaled scoring system (from 1 to 4) is being piloted, but probably will not be implemented until approximately 2000. The pilot will involve surveyors scoring on a scale that will aggregate to a total score. In addition to the scoring, the survey report includes commendations, suggestions, and recommendations. Based on this, the Board then makes final accreditation decisions. The organization is notified of the decision and receives a written report detailing any recommendations. The program then has 90 days to submit to CARF a Quality Improvement Plan outlining the actions that will be taken in response to the survey report. CARF has the option to rescind accreditation decisions if organizations fail to respond to the survey reports.

4.3.4 Community Healthcare Accreditation Program

4.3.4.1 Background

The Community Healthcare Accreditation Program (CHAP) is a consumer-driven organization aimed at setting high standards and ensuring quality for home and community-based organizations. As a subsidiary of the National League for Nursing, CHAP has been accrediting various types of facilities including home health care agencies, community nursing centers, durable medical equipment companies, infusion therapy companies, pharmacies, and home health care aide programs for the past 30 years. CHAP is governed by a Board of Directors whose members include consumers, insurers, business leaders, health care professionals, and representatives from HMOs.

4.3.4.2 Types of Accreditation and Statistics

In 1992, the Federal government approved CHAP's standards for Medicare deemed status for certification of the following services:

- Community Health/Public Health
- Community Nursing Centers
- Community Rehabilitative Centers
- Home Care Aide
- Home Health Paraprofessional Services
- Home Health Professional Services
- Home Infusion Therapy
- Home Medical Equipment
- Home Pharmacy Services
- Hospice
- Private Duty Nursing Services
- Supplemental Staffing

Facilities seeking deemed status for the first time receive an unannounced site visit as part of the initial accreditation process. If the facility is awarded full accreditation without deficiencies, the

unannounced resurvey will be in three years. If the facility has reported deficiencies, then the unannounced survey is performed annually. For deemed accreditation, CHAP submits the necessary Medicare COPs forms to State and Federal agencies. This is different than the CHAP survey form, which is generated solely for the agency/provider. The CHAP survey report is not submitted to States routinely with the certification forms, but States do have the option to receive a copy of the report. According to CHAP's Business Manager, Bernard Rose, States have the option of applying enforcement actions based on the CHAP report, although this rarely happens. States also have the right to conduct their own survey of an agency at any time, for example, in response to a complaint.

Facilities not seeking deemed status accreditation may fall into one of three accreditation categories: primary full accreditation, deferred accreditation, or denied accreditation. For facilities seeking a renewal of accreditation, possible decisions are renewal of accreditation, notice of formal warning, or withdrawal of accreditation. Full accreditation is awarded when the facility has adequately met all of CHAP's standards. If a facility is found to have deficiencies in meeting some of CHAP's standards, CHAP requires various follow-up actions that are based on the degree of the problem. These include: requiring progress reports (every 30, 60 or 90 days or every 6 months); and focused site visits. These actions can be used in combination, and are combined if a facility is put on warning. Presently, CHAP has approximately 350 accredited providers, of which 90 percent have deemed accreditation. The President of CHAP, Theresa Ayer, also added that 99 percent of all facilities seeking accreditation receive some sort of accreditation because CHAP is primarily a consultative process and emphasizes a facility's self-evaluation.

There are no real differences in survey process between deemed accreditation and full accreditation. The only difference exists relative to the paperwork that follows the survey -- with deemed accreditation, CHAP files the necessary paperwork (related to Medicare COPs) with the State and Federal (Regional Offices) agencies. One point made by CHAP is that it does not want providers to view CHAP accreditation as a mechanism for circumventing a denial of certification from HCFA. Occasionally a provider that has not passed a HCFA survey will come to CHAP seeking deemed accreditation. Depending on the circumstances, CHAP may find that the facility qualifies for accreditation (if some time has passed and problems found previously by HCFA have been corrected, for instance), but in that case, CHAP will not submit the paperwork for deemed status on behalf of the facility.

4.3.4.3 Public Disclosure

Information about CHAP-accredited facilities is disclosed to the public and is free. Information regarding details such as the agency's strengths and weaknesses on their last survey can be given over the telephone. If more detailed information is required, a written request must be submitted. CHAP will then release a summary report that tells how the agency was scored for conditions met and not met. In addition, all CHAP facilities are required to post an 800 number that consumers

can call for information and to register complaints. The agency is also required to post a number for the State's complaint office. CHAP does not receive many calls from consumers wanting general information, but they do receive calls from corporations and managed care groups wanting detailed survey information.

4.3.4.4 Present Collaboration and Future Plans

CHAP is an expanding organization. In August 1996, JCAHO began to recognize and accept CHAP's accreditation findings and decisions regarding home care organizations when surveying integrated delivery systems and health plans. In addition, CHAP plans to seek deemed status for accredited hospices. CHAP would like to double its number of accredited facilities within 2 years, although its business plan assumes only a 5 percent rate of growth per year for the next 2 years.

4.3.4.5 Standards

CHAP's standards are published in their *Standards for Excellence*. Several types of standards are offered: Core Standards; Public Health Standards; Home Health Standards; and Home Care Aide Services Standards. There are 44 Core Standards. In addition, CHAP has 27 Professional, 23 Paraprofessional, 41 Hospice, 30 Infusion Therapy, 27 Home Medical Equipment, and 25 Pharmacy standards. The four basic principles of all of the CHAP standards are:

- The organization's structure and function consistently support its consumer-oriented philosophy and purpose.
- The organization consistently provides high-quality services and products.
- The organization has adequate human, financial, and physical resources, effectively organized to accomplish its stated purpose.
- The organization is positioned for long-term viability.

Standards are updated on an ongoing basis. When this report was written, CHAP was in the process of updating its home health standards, which were last updated in 1993. Revised standards were slated to become effective January 1998. The process of updating the standards can take up to two years, after which HCFA must then review the updated material. CHAP-accredited facilities receive the updated standards and self-study manual free of charge. Facilities seeking accreditation must purchase the standards. CHAP-accredited agencies are also now being invited to participate in the week-long continuing education course that was previously only for surveyors.

4.3.4.6 Accreditation Process

An organization can apply for accreditation if it offers at least one of the following services:

- Nursing
- Social Work
- Occupational Therapy
- Respiratory Therapy
- Homemaker
- Home Health Aide
- Hospice
- Management Services
- Infusion Therapy
- Public Health Nursing
- Community Nursing Center
- Physical Therapy
- Speech Therapy
- Nutrition Counseling
- Pharmacy
- Home Medical Equipment

CHAP's accreditation process resembles the others in that there is a period of self-evaluation and an organizational profile submitted with the application. The organizational profile includes an overview of the services offered, number of branches and subsidiaries, annual client visits, and gross revenue. The application fee of \$1,500 is submitted with the application. This fee is deducted from the overall accreditation fee, which depends on the size and scope of the facility. For example, an organization with revenue of \$8 million will have a fee of \$7,100. The announced survey (for those seeking full accreditation) or the unannounced survey (for those seeking deemed status) is conducted between 30 and 45 days following the receipt of the application and signed contract. The survey normally lasts six to seven days, but the length depends on the facility's size and complexity. The number of surveyors per team depends on the agency's profile and also depends on the services the agency provides.

CHAP has a total of 50 surveyors, 30 of whom are currently active. Most surveyors are hired as part-time employees, but about 10 are full time. A prospective surveyor is eligible only if masters prepared. Most surveyors are registered nurses with at least five years of home health experience. CHAP has both administrative and clinical surveyors, though the majority are clinical. CHAP surveyors are required to participate once a year in a week-long continuing education course developed by CHAP. This course covers the standards in detail, interpretation of the standards, application of the standards, Medicare certification, Medicare COPs, requirements for documentation, etc. CHAP has plans to expand this course to a two-week session.

The onsite survey process also closely resembles other accreditation programs. The survey opens with a preparatory conference and tour of the facility and branch offices. Surveyors then spend time documenting evidence of compliance with the standards by reviewing documentation such as service records, policies, procedures, personnel records, and minutes. They also interview board members, management, administrative staff, the financial officer, clinical staff, support staff, program directors, and committees. In addition, CHAP surveyors select clients for home visits and telephone interviews. The survey ends with an exit consultation with representatives of the organization. The surveyors' comments and recommendations are reported to the CHAP Board

of Review. A decision is made within two to four months of the site visit. If the facility is seeking deemed status, the CHAP Board of review submits the Medicare COP report to the proper State agency. The State still has the final authority to approve or disapprove the certification.

Depending on the accreditation outcome, the facility can have no required follow-up actions and be resurveyed in three years or require follow-up to demonstrate correction of deficiencies and be resurveyed in one year. CHAP also has existing channels to field complaints about already accredited CHAP facilities. All incoming complaints are documented and go directly to the Senior Vice President for Accreditation, who determines how to handle the complaint. For serious situations (adverse impact on patient care), CHAP visits the agency within 24 hours. For less serious complaints, CHAP gathers information, calls the agency to discuss the situation, and follows up. Complaints usually do not involve an onsite visit.

4.3.4.7 *Gold Seal Services*

In addition to accreditation, CHAP offers Gold Seal Services which includes its outcomes measurement software program and expert consultation services. In 1989, CHAP received a grant from the W.K. Kellogg Foundation to develop a consumer-oriented outcomes measurement program for home care. CHAP collected data from home care consumers, home care managers, and home care staff and formed a research database and test site for the development of the data collection tools. The product of this effort is the *Benchmarks for Excellence in Home Care* Program. CHAP's new program established outcome measures by focusing on crucial measures of home care excellence: Clinical Operations, Organizational Planning, Financial Systems, and Risk Management, and Customer Satisfaction. Within these areas, the project defined 11 outcomes that characterize an excellent home care organization. Tools have been devised to measure to what extent an agency has met these outcomes. CHAP markets this program to facilities as a tool and a basis for self-evaluation of quality improvement. The facility will receive the software that will track its outcomes data and measure them relative to industry standards. This software is mainly sold to providers (both accredited and those seeking accreditation) and some educational institutions.

In addition, CHAP surveyors provide expert consultation. To avoid conflict of interest, surveyors do not provide Gold Seal services to an agency that they survey. Currently, about seven CHAP surveyors are part of the Gold Seal program, although in the future, CHAP will be hiring a separate group of consultants whose only role will be to provide Gold Seal services (i.e., they will not also be surveying agencies). This is in attempt to clearly delineate the roles of consultants from those of surveyors. The Gold Seal Services are designed to help organizations prepare for accreditation. The fees for these services are established based on the scope of work required.

4.3.5 Accreditation Council for Home Care

4.3.5.1 *Background*

The Accreditation Commission for Home Care, Inc. (ACHC) is an independent, private, non-profit corporation established in 1986. ACHC is based in Raleigh, North Carolina, and was founded by the North Carolina Association for Home Care, Inc. It was developed in response to providers' concerns regarding quality, community-based health care services and the need for an alternative to accreditation. The former accreditation options had been criticized for their costliness and lack of applicability to the needs of durable medical equipment dealers, respiratory therapy suppliers, and home infusion companies.

4.3.5.2 *Types and Number of Accreditation*

ACHC accredits multi-service home care agencies/skilled services, in-home aide programs, home medical equipment companies, pharmacy IV programs, women's health care products, and hospices. According to Cynthia Layton, Vice-President of Accreditation Services, as of October 1997, there were 54 accredited home care providers. ACHC offers four types of accreditation: accreditation with commendation; full accreditation; deferred accreditation; and denial of accreditation. Accreditation with commendation is awarded to organizations with survey scores of 95 percent or above. Full accreditation is awarded to an organization when the overall survey score and each service area score is within a passing range of 85 percent or above. An organization will receive a deferral of accreditation if any individual service area score is within the 70 to 84 percent range. The deferral may be for an agreed upon 30, 60, or 90 day time frame. After the time frame expires, another survey is done at the organization's expense. If the surveyors find that the organization is in compliance with applicable standards for the service area and now has a passing score for the service, then a Certificate of Accreditation is issued. Accreditation decisions are recognized for three years, after which the organization must reapply for renewal. When this report was written (fall of 1997), 36 percent of those seeking accreditation were awarded either full accreditation or accreditation with commendation; 64 percent were granted a deferral for accreditation.

4.3.5.3 *Expected Future Growth*

Because of expected growth in the home care industry, ACHC is targeting 1996 to 1998 as a timeframe for the completion of its national expansion. It would like to have at least 100 facilities accredited by the end of 1997. This will coincide with plans to gain recognition from JCAHO for its network accreditation program. This status is already recognized by the Community Health Accreditation Program (CHAP). This status would provide that payors requiring either of these accreditations would be able to accept ACHC accreditation instead. ACHC is recognized by 20 State and regional payor plans, including several Blue Cross-Blue Shield plans. In addition to

private payors, ACHC is seeking Medicare deemed status from HCFA. An application has been submitted along with revisions to its current standards.

4.3.5.4 Standards

According to informational materials from ACHC, its standards were developed by providers for providers in the home care industry. The product is criteria that are “high in quality, reasonable in application, and user friendly in language.” Currently, there are 86 standards, which serve as the foundation of the ACHC accreditation process and are found in the *Accreditation Resource Manual*. The standards address issues such as organization and administration, program/service management, personnel, fiscal management, client care coordination, infection and safety control, nursing services, therapy services, infusion nursing services, clinical respiratory services, pharmacy services, medical social services, and home medical equipment services. There are six standards manuals available: Multi-Service (certified and non-certified home health), Infusion (infusion add-mix; IV nursing), Home Medical Equipment (HME), Hospice, In-Home Aide (PCS), and Women’s Healthcare Products and Services. According to President Tom Cesar, ACHC’s recently revised standards are scheduled to be introduced in January 1998.

4.3.5.5 Accreditation Process

Organizations must meet certain requirements in order to apply for accreditation. The organization must be actively providing in-home and/or alternative site service in the U.S. or its territories for no less than four months and have served a minimum of four clients. In addition, the organization must agree to grant ACHC full access to all records (both patient and personnel) necessary to ascertain the degree of compliance with the standards. Finally, the organization must agree to pay fees in accordance with the Accreditation Price Lists payment plan and be willing to submit a completed application.

After meeting all of the eligibility requirements, an organization begins the accreditation process by purchasing the applicable *Accreditation Resource Manual*. The organization is asked to prepare for accreditation by using the standards to determine levels of compliance and making changes to assure substantial adherence to policies, internal processes, and performance. After ample preparation time, the organization submits an application form, fee, and a Preliminary Evidence Report (PER). The PER is designed to inform ACHC of the organizations’ matching of policies and procedures to standards and evidence documenting the standards. The PER is forwarded to the assigned surveyors who conduct a Desk Review of the organization. During the Desk Review, the surveyors identify survey topics and focus and draw a preliminary sample of patients for a record review from a list provided by the organization.

The facility is scored on its presentation of policies and procedures and provision of evidence of its function during the survey. Evidence of the functioning of the organization’s policies and procedures is considered by ACHC as the more important of the two and is weighted accordingly.

ACHC emphasizes that it not only looks for structure and process, but also for strong evidence that the organization's intentions have been carried through.

ACHC has a variety of types of surveyors. There are home health trained surveyors, as well as home medical equipment, pharmacist, and hospice trained surveyors. All ACHC surveyors have at least five years of experience, one of which must be management/supervision as well as experience in licensure or an accreditation process. When this report was written, ACHC had 20 contracted surveyors and was planning to hire more for future growth. The selection of surveyors for an organization depends on the type of organization and the types of services the organization provides.

The onsite survey typically lasts a couple of days but depends on the number of services provided, volume of clients, number of programs, size of agency, and number of branch locations. These factors also contribute to the cost of the survey. However, the base fee for all survey categories is \$2,500, with additional charges for size and complexity. Each site survey involves a review of personnel files, client records, budgetary information, policies and procedures, quality initiative plan, and operational and service delivery outcomes. Interviews are conducted with the staff and clients.

The survey process begins with an entrance interview with the leader/executives of the organization. The first day normally involves clarification of documents previously received by the survey team, review of the organization's existing contracts, interviews with staff, an initial review of client and personnel records, and a selection of clients to be interviewed. The staff interviewed usually consists of leaders/executives of the organization, the quality improvement coordinator, and program supervisor. The second day involves interviews with the clients and additional staff including case managers, service supervisors, and an intake worker who describes the organization's services to the public. The latter days are also reserved for review of documented outcomes of quality improvement activities and a review of staff meetings, Board meetings, and planning session minutes. The survey is concluded with an exit interview with representatives of the organization.

Accreditation decisions will be made by the Review Committee according to the survey results. ACHC retains the right to release announcements of accreditation status. ACHC plays an "advisory role" with its accredited organizations rather than one of enforcement. However, if ACHC hears about compliance problems in any of its accredited organizations, it may review the organization at the organization's expense and has the option to withdraw accreditation.

4.3.6 The National PACE Association

In 1996, the National PACE Association (NPA) received funding from the Robert Wood Johnson Foundation to develop a national accreditation program for the Program of All-inclusive Care for the Elderly (PACE). The NPA was formed in June 1994 to expand health service to the frail

elderly through the PACE model, a community-based alternative to nursing home services for the elderly. NPA's aim is to insure the integrity of the PACE model. With the anticipated growth of the PACE model in the future, it is important to the NPA to have a consistent and comprehensive external regulatory mechanism.

Initially, NPA established a working group of NPA staff and health care professionals from PACE sites. NPA is guided by a National Accreditation Advisory Committee comprised of experts in accreditation and quality assurance, and Federal and State policy makers and foundation representatives. The working group's first objective was to create model standards and performance measures for use by PACE sites and then to establish a national accreditation process.

In August 1997, NPA finished its first draft of the model standards and performance measures. The finalized version is to be completed by the end of 1997. The NPA wanted to address not only issues of structure and process within the standards, but to focus on outcomes as well. NPA refined and incorporated an existing PACE quality assurance activity, PACE Protocol, and CHAP standards for the establishment of its process and structural elements. Structural standards include organizational capacity, staffing, and financial reserve requirements. Process standards include the interdisciplinary team process, responsiveness in addressing changes in participants' (patients') conditions, and participant involvement in treatment planning. Proposed outcome standards were also part of the submitted draft. They include participant and family satisfaction, disenrollment rate, mortality rate, and changes in functional status.

The final task facing the NPA is to establish a national accreditation process. NPA plans to base its program on a review of literature on various accreditation processes and an evaluation of the experiences of other accrediting bodies. A proposed approach includes an application, self-study, site visit, potential accreditation decisions, and requirements to maintain accreditation. The site visit is to be done by trained industry volunteers resulting in a "peer review" model. The surveyor's purpose will be to observe the functioning of the site as well as to provide consultation. The final accreditation decision will be made by an accreditation commission or committee. Design of this process is scheduled to be completed and piloted in 1998.

4.4 Comparisons with the Federal Regulatory Process

Major differences between private accreditation processes and the Federal process include: 1) overall philosophy and approach to surveys; 2) frequency of surveys; 3) surveyor requirements and training; and 4) public information disclosure and public participation in the process.

4.4.1 Philosophy

Each of the accrediting entities reviewed as part of this catalog has roots deep within the industry and communities it serves. During the origination of all these accreditation programs, the

organization invited feedback and input from groups representing consumers, health care professionals, and the future accreditation-seeking facilities. This is evident in the approach that the NPA has chosen to formulate its accreditation program. From the outset, it recognized the importance of including both consumer and industry voices. For some organizations, this partnership is always present, as is the case with NCQA's Standards Committee and CARF's National Advisory Committee whose members include representatives from all sectors affected by accreditation.

Because of this partnership, for the most part these accreditation programs are not viewed as standards enforcement entities, but as an experienced helping hand. Virtually all of the accrediting agencies, in addition to surveying facilities, offer consulting and educational services over and above those provided while surveyors are on site. For example, the key informants and all the promotional materials from CHAP heavily accentuate its consultative approach. CHAP has invested a great deal of effort in its Benchmarking software and recently has begun to invite its accredited facilities to participate in a week-long course about its revised standards. CARF also prides itself on being a consultative body. Providers can get free technical assistance via telephone and e-mail and receive information about CARF-sponsored conferences and educational meetings, which they can attend for a fee. CHAP also offers facilities one-on-one consulting services. For 15 percent of the accreditation fee, a managed care organization can choose to have a pre-survey conducted by NCQA, which is consultative in nature and does not result in an accreditation decision, one year prior to applying for accreditation. In the future, LEAP plans to develop a separate consultative program aimed at trying to improve quality in its facilities. The future program will be manned by accreditors cross-trained as consultants, with protections against conflicts of interest incorporated.

Another manifestation of an advisory rather than inspection orientation is the mandatory period of self-study required of most organizations before an onsite survey. The accrediting organizations take pains to ensure that facilities seeking accreditation know exactly what to expect and what is needed to receive a favorable decision. NCQA goes as far as to provide interview tips. CARF also holds an introductory three-day seminar called "CARF 101" to assist providers in preparing for accreditation. By contrast, States' surveyors are expressly barred from acting in a consultative role while conducting Medicare/Medicaid surveys. The Federal view is that an individual cannot wear both hats at once - inspector and consultant - and objectively fulfill the role of regulator.

4.4.2 Frequency of Surveys

With the exception of the LEAP accreditation cycle, the other organizations may grant an accreditation decision resulting in a three-year survey cycle. Most programs offer an alternative accreditation decision that requires a re-survey after one year for facilities that do not meet the standards at a level qualifying them for full, three-year accreditation, but such decisions tend to be made less frequently. Accreditation statistics at NCQA, CARF, and CHAP, all of which offer alternative decisions, show an accreditation rate of over 90 percent. ACHC is the only

accreditation program reviewed that reported a relatively low rate of facilities receiving an initially successful accreditation. They reported a 36 percent rate of facilities receiving full accreditation (3 year survey); the other 64 percent is given a deferral of accreditation due to a lack of compliance with standards. The deferral is for 30, 60, or 90 days, after which another survey is done. Also, with the exception of facilities seeking LEAP or CHAP deemed status accreditation, facilities are informed of the coming survey at least 30 days in advance.

The LEAP program is the exception regarding survey cycles. LEAP requires an unannounced annual survey for all LTC facilities seeking accreditation. LEAP developers decided to conduct unannounced surveys to maintain the integrity of the process and prevent facilities from trying to “get ready” for the survey. LEAP intends to vary its survey cycle for individual facilities with the goal of visiting approximately annually, though it does not plan to release to the public a specific cycle that would increase predictability to facilities. Because LEAP developers believe that the quality of facility services is so highly dependent on the management team and direct care staff, there are no plans to extend the survey cycle (i.e., to allow surveys every two or three years for good facilities) because of the belief that all it takes is a change in administration or management to quickly turn a good facility into a poor one.

State surveys of LTC facilities are conducted, on average, every 12 months with a survey interval as great as 15 months for an individual nursing home being permissible so long as the State maintains, at a minimum, the 12 month survey average for all nursing homes. The State may survey any nursing home as frequently as it feels is necessary to insure compliance with program requirements and the safety and well-being of residents. Anecdotal information from consumer advocate groups and ombudsmen suggests that States’ surveys fall within predictable patterns, however, a statistical analysis of this charge is addressed in Chapter 18 of this report.

4.4.3 Surveyor Requirements and Training

A major discrepancy between the Federal and private accreditation programs are requirements for surveyors. HCFA requires that surveyors successfully complete a Federal training course and a minimum qualifications test within their first year of employment as a surveyor; however, HCFA has not established any more specific qualifications, leaving these requirements to the discretion of individual States. Accordingly, there is no assurance of educational or experiential uniformity. In addition, States may use one pool of surveyors to survey multiple types of facilities, so that a LTC surveyor may not necessarily have any previous professional experience in the LTC setting.

Private accreditation entities have clear and enforced minimum requirements for surveyor eligibility. NCQA and CHAP have education requirements for, at the minimum, masters-prepared professionals. NCQA also has credentialed physicians acting as surveyors. The rest of the organizations require a minimum amount of experience in the management of health care organizations for surveyors in their applicable fields. For example, LEAP requires that surveyors have three years minimum LTC experience in management or three years as a Federal/State

surveyor. LEAP, as in the Federal program, requires that surveyors attend a training and pass a written examination.

Like HCFA, most private accreditation programs require their surveyors to attend an initial training session. A possible difference in training, however, is the continuing education and mandatory retraining offered by private accreditation entities to their surveyors. NCQA offers, in addition to their mandatory annual training session "*Moving to Quality*," continuing education programs and one-on-one training. CARF has a formal continuing education program required a minimum of once every three years and also offers literature, tapes, and newsletters. CHAP has plans to lengthen their mandatory annual continuing education session to two weeks. There is no federally-mandated continuing education required for State surveyors, and State requirements vary.

4.4.4 Public Information and Participation

One issue of great concern, particularly to consumer advocates, residents, and their representatives is the issue of disclosure of survey findings. This issue is in some respects directly related to the philosophy of the accrediting body. As stated earlier, most see themselves in a consultative role rather than as a regulatory enforcement entity, and since the accrediting body is paid by its accredited organizations, there may be some hesitancy to take what could at times be an adversarial role. However, clearly some accrediting bodies have shown a willingness to disclose information and make findings available to the public, going so far as to discuss the possibility of posting findings and scores on internet websites and establishing policies to administer the release of information in response to public requests.

Federal regulations require that LTC facilities post State survey results in a location accessible to the public and inform residents that they have a right to review these results. Survey findings are also available upon request from the State survey agency and at the Social Security district office that the facility is located in.

An additional issue related to accountability to and involvement with the public is the process of developing and revising standards that accredited facilities or organizations must meet. The Federal regulatory process, often criticized for its lack of speed, does allow for public scrutiny of and involvement in the rulemaking/standard setting process, allowing for the submission of public comment on any proposed regulation. Prior to making any changes to Federal regulations, the proposed regulatory language must be printed in the Federal Register, and a comment period must follow. Before the regulations may be finalized, the agency (in the case of health care providers, HCFA) must review these comments and address them in a subsequent issue of the Federal Register, either incorporating the public feedback into the regulation or providing a justification for the failure to do so. Private accrediting bodies are not bound by any such processes providing for public input into changes in their standards; hence, the critics charge that accrediting bodies are not accountable to the public. While many of these organizations do solicit

feedback from stakeholder groups and advisory committees, decisions as to which groups will be represented in the process remain at the discretion of the accrediting body.

5.0 CONTENT ANALYSIS OF JCAHO STANDARDS AND HCFA REGULATIONS FOR LTC

The purpose of this content analysis is to determine whether there is a reasonable assurance that the accreditation process of a national accrediting body, specifically, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), meets the Medicare participation requirements for skilled nursing facilities as set forth in the Social Security Act (the Act) and implemented through the HCFA State nursing home survey process. Section 1865(a) of the Act requires that this reasonable assurance exist as a prerequisite for granting deeming authority to an accrediting body. It is not the aim of this analysis to judge if the JCAHO standards are equal to or better than every specific participation requirement as implemented in the HCFA regulations and survey process.

For this content analysis, the JCAHO and HCFA sets of standards and regulations were initially analyzed in a point-by-point comparison. The next step was to identify patterns or themes in the discrepancies in the language used in the two different systems. The analysis of the language used in the JCAHO standards and in the HCFA requirements demonstrated several key distinctions in the coverage and intended application of the two systems. This analysis includes discussion of: discrepancies in the language used in the HCFA requirements and in the JCAHO standards; the effect these discrepancies have in the determination of reasonable assurance; and conclusions regarding these discrepancies.

The discussion on discrepancies in the language of the two systems is detailed in several subtopics:

- Comparable subject matter and intended application between the two systems as evidenced by similar JCAHO standards and HCFA regulations;
- JCAHO standards have an intended application in a broader clinical domain or dimensions of resident care than the corresponding HCFA regulations;
- JCAHO standards are more restricted in domain as indicated in the intent and do not include a significant dimension of resident care that is included in the HCFA regulations;
- JCAHO standards that do not have a corresponding match in the HCFA regulations.

The term “intent” is used in describing the discrepancies between the two systems. Both the JCAHO manual and the HCFA State Operations Manual (SOM) use the term “intent,” which JCAHO defines as a brief explanation of a standard’s rationale, meaning, and significance.

The analysis of the discrepancies between the terms used in the JCAHO standards and the HCFA regulations then led to the identification of six areas of concern in the JCAHO accreditation

standards. These differences were sufficient to cast doubt on a reasonable assurance that the JCAHO standards meet the Medicare participation requirements. These six areas are:

1. Safeguarding and protection of the individual's rights.
2. Description of residents' special needs.
3. Qualifications of a social worker, activities director, and dietitian.
4. Lack of clarity regarding use of medications.
5. Subsequent actions required by the HCFA regulations following poor resident outcomes which are not explicitly stated in JCAHO standards.
6. Provision of physician services.

If the JCAHO standards in the above areas were to be revised so their intended application in areas of resident care would more closely resemble the language and intended application of the HCFA requirements, those steps would lead to a concurrence between the language in the JCAHO and HCFA systems. Were changes made in the JCAHO standards, they would give greater confidence that the JCAHO standards would meet the participation requirements as applied in the HCFA survey process.

However, the analysis of the language must be accompanied by an analysis and consideration of the implementation of the standards, including the JCAHO's scoring guidelines and survey procedures. Under separate research tasks, data were collected through observations of the JCAHO accreditation visits and through comparisons of HCFA survey results with the JCAHO accreditation team decisions. Findings of those studies are discussed in Chapters 7 and 8 of this report.

5.1 Organization of the Report

This report is organized in the following manner.

Section 5.2 provides background information on the two different systems -- the JCAHO standards for long term care organizations, and the HCFA requirements for the long term care survey and certification process. The overall tone and quality of the survey as implemented by each system is identified.

Section 5.3 describes analysis methods used for the content analysis.

Section 5.4 contains the findings from the analysis. The first section in the findings (5.4.1) highlights the differences between the HCFA survey and the JCAHO accreditation site visit. For a more detailed discussion of the JCAHO process, see Chapter 7, which presents findings from an observational study. The differences between the two systems provide essential background information that is pertinent to this more detailed content analysis of the standards and regulations.

Section 5.4.2 summarizes the content analysis and comparison of the JCAHO long term care survey standards and HCFA's long term care regulations. The sources used were the JCAHO Comprehensive Accreditation Manual for Long Term Care (CAMLTC) 1996 and the HCFA Long Term Care Survey SOM Transmittal 273/274 July 1995.

Section 5.4.3 focuses on the effect of discrepancies between the two systems on the desired outcome that facilities accredited by the JCAHO meet the Medicare participation requirements. Section 5.4.4 contains a summary of the findings.

Section 5.5 contains conclusions regarding the noted discrepancies between the two systems. The appendices contain detailed comparisons of the individual JCAHO standards and the associated HCFA requirements.

5.2 Background

Entities that provide health care services to Medicare and Medicaid beneficiaries operate under provider agreements with HCFA for Medicare and with the State Medicaid Agencies for Medicaid. To enter into these agreements, the entity must be certified by a State survey agency as complying with the conditions of participation (COPs) or, for nursing homes, participation requirements, set forth in Federal law and regulations. Health care services providers are regularly surveyed to assess compliance with the COPs or participation requirements.

Section 1865(a) of the Act allows that, under a certain condition, providers may be exempt from the routine surveys conducted by State survey agencies to determine compliance. The necessary condition is that the provider must be accredited by a national accrediting entity which has been granted deemed status by the Secretary of Health and Human Services. The Secretary would have to find that the process implemented by the national accrediting organization provides a reasonable assurance that Medicare COPs, or, if this provision were to be implemented for nursing homes, participation requirements, are met in the manner that HCFA would have required (Federal Register 56 (172):43929). If the accrediting entity is recognized as providing this reasonable assurance, then providers accredited by the accrediting body are considered "deemed" to meet Medicare COPs and/or requirements.

5.3 Analysis Methods

This report compares the more than 500 updated JCAHO standards that became effective for accreditation purposes on January 1, 1996, with the HCFA requirements (referred to as F Tags) that are listed in SOM Transmittal No. 274, dated June 1995. The crosswalk of the HCFA F Tags and the JCAHO standards is listed in Appendix A1. The JCAHO CAMLTC 1996 was used to identify the initial crosswalk of JCAHO standards to the corresponding HCFA F Tags.

In the analysis of the two systems, it was not necessary or possible to perform a word-by-word comparison to determine if the JCAHO and HCFA standards are directly matched. The goal was to evaluate whether the JCAHO accreditation requirements as they would be implemented would provide reasonable assurance of meeting all of the Medicare participation requirements.

Although the HCFA Procedures and Probes included in the interpretive guidelines and the JCAHO examples are used in practice with the HCFA regulations and the JCAHO standards, respectively, they were not the focus in this analysis. The following rules were applied in the analysis of the two systems:

5.3.1 Statements of Inclusion and Exclusion

1. Inclusion of standard/regulation + intent of standard/regulation

JCAHO: The point of comparison was the statement of the standard and the intent of the standard as written in the JCAHO CAMLTC.

HCFA: The point of comparison was the statement of the regulation in the HCFA SOM and the statement of intent that corresponds to each regulation.

2. Exclusion of the illustrative statements in both systems

JCAHO: The JCAHO manual also includes statements referred to as "Intent of the standards for Dementia Special Care Units" and "Intent for Subacute Programs." The JCAHO manual further identified examples of implementation for the standards and examples of evidence of performance for the standards. The examples of implementation offer various strategies, activities or processes that can be used to comply with the standards. They are not requirements. For that reason, they were not used as the basis for comparison to the statements of HCFA regulations.

HCFA: The HCFA regulations also include guidelines, procedures and probes and notes, that accompany the statements of some regulations. These additional statements are listed as guidance to surveyors. The interpretive guidelines define or explain the relevant statutes and regulations and do not impose any requirements that are not otherwise set forth in the statute

or regulations. Therefore, the clarifications in the interpretive guidelines are not the point of comparison to the JCAHO standards.

3. Further point of exclusion

JCAHO has standards for and conducts surveys of long term care organizations, including subacute programs and dementia special care units. The HCFA survey process does not apply separate statements of intent in the survey process to dementia units or special care units. Not all long term care organizations or nursing homes have a dementia unit or a subacute unit, so the tailored statements of intent for those two types of units would not be applicable to all organizations or facilities. Long term care organizations have the option to seek accreditation for their subacute programs and special care units. Those intent statements that were tailored to dementia and subacute units were therefore not included in the focus of the comparison of the JCAHO standards and the HCFA regulations.

In instances where one JCAHO standard was not immediately comparable to one F Tag, related and closely corresponding JCAHO standards were analyzed to determine whether the accreditation standards and the related Intent Statements provide a reasonable assurance of compliance with Medicare requirements.

When a JCAHO standard was not identified as directly related to a HCFA regulation, which raised the question of whether the Medicare participation requirements would be met, the next step was to refer to the scoring guidelines that are routinely used by the JCAHO surveyors. The scoring guideline is not a standard as such, but conveys the application of the standard and illustrates the expectations of JCAHO in meeting the standard. If the JCAHO surveyor uses the scoring guidelines and decides that a particular standard has only been partially or minimally met, or if there is noncompliance, then the survey team provides recommendations. The facility undergoing the accreditation must respond to the recommendation with a correction of the inadequacy within a specified time period.

5.3.2 Strategy to Compare Standards and Regulations

The initial point of comparison was the identification of selected regulations that were considered to be key areas in the HCFA Long Term Care Survey process. These were the F Tags included in regulatory groupings 483.13 (Resident Behavior and Facility Practices), 483.15 (Quality of Life), and 483.25 (Quality of Care). If a nursing home fails to meet these requirements and the scope and severity of the noncompliance is sufficient, a determination of substandard quality of care (SQC) is made. The list of the F Tags within the regulatory groupings 483.13, 483.15, 483.25 is included in Appendix A2. The selected HCFA F Tags were compared in subject matter and intent to the corresponding JCAHO accreditation standards.

The analysis approach was to begin with those standards that define quality of life and quality of care directly, and then move to tiers of standards with less immediate impact on quality of care or quality of life issues.

The next tier for comparison was the deficiencies that were most often cited in surveys of skilled nursing facilities as reported in OSCAR Report 20, Comparison of Deficiency Patterns in Frequency of Occurrence Sequence, Deficiency Listings for Skilled Nursing Facilities (run on February 27, 1997). The list of these most frequently cited F Tags is included in Appendix A3. Analysis of this group served to determine if JCAHO standards exist that are comparable to these frequently cited HCFA F Tags to provide reasonable assurance that Medicare participation requirements would be met in these critical areas through the JCAHO process.

The third tier of JCAHO standards for comparison to the HCFA F Tags were those pertaining to resident assessment and care planning. Finally, the remaining JCAHO standards and corresponding F Tags were reviewed. If JCAHO standards did not have a closely corresponding HCFA regulation, several standards were checked to identify similarities to the HCFA regulations. The point-by-point comparison of HCFA F Tags with JCAHO standards is included in Appendix A4.

5.4 Findings

5.4.1 Differences Between the HCFA Survey and JCAHO Accreditation Processes

Distinct assumptions and related language used in the JCAHO standards and in the HCFA regulations delineate the contrasting purposes of these two systems. The JCAHO standards are written as performance focused standards; that is, the standards are developed to evaluate organization performance that is aimed at continuously improving resident care outcomes. The standards are written in a way that the surveyor would request to see evidence that a process exists or that procedures or policies describe how the facility personnel are expected to perform. The standards are grouped in two major sections - Resident Focused Functions and Organization Functions. The use of the word "functions" as a categorical term conveys that the JCAHO standards are conceived of as ongoing work, including the processes and activities of the long term care organizations. The term "long term care organization," which conveys an administrative structure that includes the interaction of various systems, is consistently used. The standards are generally short statements that separate specific elements into distinctly numbered standards (e.g. lights and temperature, recreational needs, environmental needs, oral health needs). They are written as performance markers for what is done and how well it is done within the facility. Related performance measures are included to improve the organization's performance. The JCAHO (CAMLTC) includes "examples of evidence of performance" which focus on the demonstration that the elements of the system, including the actors (facility staff), are in place to perform. Examples of evidence of performance include: interviews with leaders and staff, job

descriptions, policies and procedures, and organizational charts.²¹⁸ Clearly the focus is on process and presentation of policies and procedures as indicated in the JCAHO accreditation manual which states, “an organization must have a method for assessing and improving important functions and work processes and their outcomes.”²¹⁹

In contrast, the HCFA regulations define resident outcomes as evidence of services delivered and as the basis for the survey process. The focus on outcomes is specified in the SOM used by the State surveyors. The language used in the regulatory guidelines is more directive than “evidence of performance” and actually defines terms used, (e.g., “significant change,” “resident decline” and “improvement”) as well as identifying what constitutes accurate assessments. HCFA regulations specify that resident-focused outcomes are expected to occur within a certain time limit or should not exceed a threshold, (e.g., 5 percent change in 30 days). In the HCFA guidelines, the use of terms such as “The facility must provide,” “The facility is responsible for...” places the obligation on the facility to meet regulations. The obligatory tone is more rigorous than that used in the JCAHO framework, which merely suggests improving performance.

The wording selected by each system conveys the dissimilar underlying assumptions of these systems. The JCAHO standards identify existing evidence that a facility is working towards achievement of standards and has established quality improvement policies and procedures. The HCFA regulations define expected resident outcomes based on the provision of services. The JCAHO CAMLTC specifies that the 1996 JCAHO standards are a substantial revision from the 1992 standards, and are to be more resident-centered, performance-focused standards. As stated in the intent of a standard on improving organization performance, “All of the functions and processes that are identified in the manual affect resident outcomes.”²²⁰ The shift represents an effort by JCAHO to maintain comparability between the JCAHO standards and the HCFA regulations. While this intentional shift is evidently a move away from the evaluation of specific departments, it does not achieve total comparability, as is explained below.

The HCFA regulatory language explicitly refers to observable or measurable outcomes with more consistent emphasis on residents’ rights, resident assessment, and indications of harm or risk to residents than is found in the JCAHO standards (described in the sections below).

The HCFA regulations and the JCAHO standards were designed to serve two distinct purposes. HCFA is authorized to carry out enforcement and impose related remedies, including civil money penalties, for noncompliance with HCFA regulations, while JCAHO strives to achieve and

²¹⁸ JCAHO, 1996 Comprehensive Accreditation Manual for Long Term Care. Oakbrook Terrace, IL. JCAHO p. 411.

²¹⁹ *Idem*, p. 70.

²²⁰ JCAHO, *op. cit.*, p. 357.

maintain professional standards among its accredited organizations. As an enforcement option, JCAHO may withhold accreditation of a facility that does not acceptably meet its performance standards. It is important to note that the JCAHO is financially dependent upon the accreditation fees paid by providers seeking to attain and/or maintain accreditation. The implications of the different enforcement options available to the two organizations are analyzed in Chapter 10. While there are similarities between the HCFA long term care survey and certification process and the JCAHO accreditation visit, there are significant differences, including: the frequency of visits (HCFA surveys are on average conducted annually, with an allowed interval between surveys of up to 15 months, provided that the overall statewide average interval between surveys is at most only 12 months. JCAHO's accreditation visits are conducted on a three year cycle.); the imposition of penalties (HCFA may impose penalties for deficiencies according to their scope and severity, while JCAHO may withhold accreditation.); and a means to ensure correction of deficiencies within a selected time period (HCFA regulations explain a policy for re-visits). Furthermore, there are differences in the composition of the survey team and the length of time the survey team is onsite in the facility.

HCFA's nursing home survey process is required by statute to be outcome oriented. The interval between surveys and the specifics of the process are detailed in the SOM. HCFA specifies the system to ensure that deficiencies identified during a survey are corrected.

The JCAHO survey is also carried out according to specific procedures. The JCAHO accreditation visitors may decide to recommend accreditation, to recommend accreditation with corrective action, or to withhold accreditation.

The processes of the JCAHO accreditation site visit and the HCFA survey process when taken in their entirety contain similar components. But, the two systems differ in significant dimensions, specifically the duration of the visit and the time frame for the plan of correction. The duration of JCAHO's onsite visit is not as clearly delineated as HCFA's. The SOM includes guides for completion of numerous tasks during the survey with an expectation of the length of a standard and an extended survey. The HCFA process also specifies the time frame required for the plan of correction with the assumption that facilities will complete changes by a certain date.

5.4.2 Content Analysis of Individual JCAHO Standards and HCFA Regulations

5.4.2.1 Evidence of Domains That Are Comparable Between the Two Systems as Indicated in Similar Subject Matter and Intended Application of the JCAHO Standards and HCFA Regulations.

There are 69 instances in which the HCFA regulations and the related JCAHO standards are quite comparable in subject matter and intended application. Of these, 46 were actually very similar in the language and selection of terms. The following comparisons are illustrative of these similarities.

HCFA Tags F221 & F222 -- Use of physical and chemical restraints
JCAHO-- RI.2.6, TX.8, TX.8.1

Both systems refer to a resident's right of freedom from physical and chemical restraints and deem restraints necessary only if a medical symptom warrants them after a comprehensive assessment is made and only after risks and benefits are addressed.

HCFA Tag F241 -- Dignity
JCAHO -- RI.2, RI.2.1, RI.2.1.1

The HCFA regulation focuses on dignity, which is further defined as activities and providing care in a manner and in an environment that enhance self-esteem and self-worth in full recognition of the resident's individuality. Exemplars listed in the guidelines closely resemble specifics listed in the Intent of related JCAHO standards.

HCFA Tag F280-- Comprehensive Care Plan
JCAHO -- TX.1.2.1, TX. 1.2.2, TX.1.2.5, TX. 1.2.6, TX.3.1, TX.6.1

HCFA requires the care plan to be written within 7 days after assessment is completed as does TX 1.2.6 which states that the care plan is to be developed no later than one week after comprehensive assessment is completed. The HCFA tag refers to reviewing and revising the plan and TX.3.1 refers to evaluating the resident's response. The F Tag specifies that the care plan must be developed by an interdisciplinary team as does TX 1.2.1. However, the HCFA regulation indicates that family involvement is desirable, while JCAHO standards make no such recommendation.

HCFA Tag F353 -- Nursing Services
JCAHO-- HR.2, HR.2.1, HR.2.1.1, HR.2.1.2, HR.2.1.3, HR.2.1.4, HR.2.1.5, HR.2.1.6, HR.2.1.7, HR.2.1.8, HR.2.1.9, HR.2.3, HR.2.4, HR.2.5

The HCFA F Tag 353 specifies that there must be sufficient nursing staff to meet the resident's needs and to allow staffing of an RN for eight consecutive hours, seven days a week. The JCAHO standards state similarly that an RN supervise care on the day shift seven days a week and that nursing personnel are sufficient to meet the residents' comprehensive needs.

HCFA Tag F427 -- Pharmacy Services
JCAHO -- TX.4.2.2, LD.2.2.4, HR.2, HR.2.1, HR.2.1.1, HR.2.1.2, HR.2.1.3, HR.2.1.4, HR.2.1.5, HR.2.1.6, HR.2.1.7, HR.2.1.8, HR.2.1.9

Both systems list similar requirements for the services of a licensed pharmacist to provide consultation and oversee recordkeeping and reconciliation of controlled drugs.

Appendix A4 contains the comparisons of the remaining JCAHO standards and HCFA regulations that are similar in subject matter and intended application. However, under each of the three regulatory groupings where substandard care may be cited (483.13, 483.15 and 483.25), there are instances where JCAHO standards and HCFA F Tags are not similar. These examples include F Tags 223-225, F 243, F313-324.

5.4.2.2 Evidence That JCAHO Standards Have an Intended Application in a Broader Clinical Domain or Dimensions of Resident Care than the Corresponding HCFA Regulations

The following examples illustrate that in certain resident-focused domains, the JCAHO standards are broader in their intent than are the HCFA regulations. There are three patterns in which JCAHO standards have more extensive coverage than HCFA regulations:

1. Use of prescriptive language in the JCAHO standards related to the services that an organization might provide;
2. Use of an additional term that extends what was defined in the HCFA certification requirement;
3. Inclusion of an additional status area or other dimension, such as the combination of one clinical focus for resident care with other resident care components.

Use of prescriptive language in the JCAHO standards related to the services that an organization might provide.

HCFA Tag F243 -- Participation in resident and family groups
JCAHO -- RI.2.9, RI.2.15, RI.2.16, TX1.6.7- Adds language to require establishment of such group and provides for a more appropriate forum in some settings as well as resident advocate

HCFA specifically addresses the resident's and the family's right to participate in resident and/or family groups, and the facility's responsibility to provide space to meet, a staff person to assist, and to respond to written requests from such group. JCAHO TX.1.6.7 provides for a family council (similar purpose as family groups), and response to resident grievances as in F243. JCAHO uses stronger language and refers to the facility's obligation to establish a resident council in settings where such council is suitable. In addition, the JCAHO standard RI.2.16 identified that where a resident council is not a suitable forum (Intent for dementia

special care units and subacute programs suggest that the resident council may not be appropriate in these settings.), the organization must provide a resident representative or advocate for addressing grievances.

HCFA Tag F245 -- Participation in other activities

JCAHO -- RI 2.9 Adds language that allows residents to organize activities

HCFA regulation refers to the resident's right to participate in social, religious and community activities. The guidelines give specific mention to activities outside the facility and the need to support involvement in them. HCFA addresses protection of the rights of residents who are not involved in such activity. JCAHO language adds the right of residents to organize such activities and also mentions the right to refuse to participate.

Use of an additional term that extends what was defined in the HCFA certification requirement.

HCFA Tag F272 -- Comprehensive Assessment

JCAHO-- PE.1, PE.1.1, PE.1.1.1, PE.1.1.2, PE.1.1.3, PE.1.1.4, PE.1.1.5, PE.1.1.5.1, PE.1.1.6, PE.1.1.7, PE.1.1.8, PE.1.1.9, PE.1.1.10, PE.1.1.11, PE.1.1.12, PE.1.2, PE.1.2.1, TX 4, TX 4.1

JCAHO standards provide for the assessment of the resident's spiritual needs and also an assessment of pain as part of the comprehensive assessment. JCAHO also assesses the resident's response to stress of the illness process. The language in the HCFA regulation does not specifically address these areas. The regulations do not refer to a resident's spiritual needs or frame the illness response as a stressful experience.

Inclusion of an additional status area or other dimension.

HCFA Tag F314 -- Pressure sores

JCAHO TX 2.4, PI.3.1 Resident outcome is a bigger domain in resident care.

The related JCAHO standards are broader in intent. The JCAHO standard 3.1 is quite general and refers to collecting data on resident care. The text of PI.3.1 is "The organization collects data on important processes or outcomes related to resident care and organization functions." It is implicit that the prevention of pressure sores is one such important outcome related to resident care.

F314 is found within TX.2.4 as the standard reads "Residents receive care to prevent complications of immobility." When the intent of this standard is read, the terms are that interventions should prevent complications of immobility of which pressures is one, along with contractures and incontinence. F Tag 314 is citable as substandard care and is also one of the most frequently cited F Tags in the long term care survey process of skilled nursing facilities.

HCFA Tag F253 -- Housekeeping and maintenance.

JCAHO RI.2.11 -- Adds dimensions of supportive environment that preserves dignity.

Housekeeping and maintenance are specifically addressed in F253, while the JCAHO standard refers to a supportive environment that preserves dignity. The JCAHO intent mentions seven other dimensions including cleanliness, home-like environment, and space. The terms housekeeping and maintenance are not explicitly addressed by the JCAHO standards but would be inferred in the intent of the JCAHO standard. However, HCFA details specific requirements for cleanliness and maintenance that are missing in JCAHO.

5.4.2.3 JCAHO Standard Is More Restricted in Domain as Indicated in the Intent and Does Not Include a Significant Dimension of Resident Care That Is Included in the HCFA Regulations

There are at least three categories where JCAHO standards do not have the same coverage as stated by the HCFA regulations. The terms used in the JCAHO standards reflect a less detailed or less specific approach. The examples are identified in several patterns:

1. HCFA regulation emphasizes resident outcome while the JCAHO standard is process-centered;
2. HCFA regulation is more inclusive of resident status areas or care needs;
3. HCFA regulation includes terms focused on resident outcome that are not explicitly stated in the JCAHO standard.

HCFA regulation emphasizes resident outcome while the JCAHO standard is process-centered.

HCFA Tag F279 -- Comprehensive Care plans

JCAHO -- RI.2.17, PE.3, TX.1.2.1, TX. 1.2.2, TX.1.3, TX.1.3.1, TX.1.4, TX.1.4.1, TX.1.4.2

F279 specifies that the care plan must describe services designed to meet the resident's highest practicable well-being with consideration to the resident's right to refuse treatment. The JCAHO standards address the refusal of treatment and identify that goals are to be individualized and measurable. The JCAHO standards address who is to provide the services and the frequency of services which is implicit in the F Tag. While the overall subject matter is quite similar, the F Tag clearly emphasizes resident-focused outcome of meeting the resident's highest practicable well-being, in contrast to the JCAHO emphasis on the activity of identifying and measuring goals.

HCFA regulation more inclusive of resident status areas or care needs;

HCFA Tag F250 -- Social Services

JCAHO-- TX 1.6, TX 1.6.1, TX.1.6.2, TX.1.6.3

HCFA F Tag 250 addresses specifically medically-related social services that would enhance the total health of the individual resident; and the facility's responsibility to assist in obtaining such services from outside sources that are not provided by the facility. Examples include (but are not limited to) obtaining adaptive clothing, legal assistance, dental/denture care, and counseling. The HCFA guidelines are extensive in covering the full range of services that should be available or sought out from other sources. The related JCAHO standards address, in title, psychosocial needs that would be met by spiritual, mental health, and therapeutic recreational services. However, the JCAHO intent, including intent for dementia special care units, focuses on spiritual services and the requirement of the facility to allow for spiritual fulfillment and does not detail other potentially important social services.

HCFA regulation includes terms focused on resident outcome that are not explicitly stated in the JCAHO standard.

HCFA Tag F370, F371 -- Food procurement, preparation, storage
JCAHO - TX 5.5

The intent of the HCFA regulation is to prevent food borne illness, as food borne illness is identified as potentially fatal to nursing home residents. The statement of intent for the JCAHO standard is to ensure food and nutrition products are safely stored. The JCAHO focus is on methods, which is not the same as the focus on residents which is stated in the HCFA intent. The HCFA regulation states that food must be procured from approved sources. These regulations address procurement of safe food and storage, preparation, and distribution of food to prevent food borne illnesses. The corresponding JCAHO standard states that foods and nutrition products should be stored and prepared under proper conditions, but does not detail procurement of safe food nor does it define specific distribution requirements for food, including holding temperatures (which is delineated in the HCFA guidelines).

The HCFA guidelines are more explicit as to the storage and separation of foods when stored than are the JCAHO statements. The JCAHO intent statement refers to protecting food and nutrition products from contamination and spoilage, which is consistent with the JCAHO performance emphasis assuming that a means for protecting food should be in place. For this standard the JCAHO examples were included and these words were "the kitchen staff monitors refrigerator temperatures." The corresponding HCFA guidelines are very specific in identifying that "potentially hazardous foods must be subject to continuous time/temperature controls in order to prevent ... growth of micro-organisms" and cold/hot temperatures are listed, which is consistent with the HCFA regulatory and enforcement function that would find conditions citable if continuous controls to prevent contamination were not in place.

JCAHO lacks definition of safety and hazard surveillance and includes infection control in this discussion; where HCFA is quite specific in its definition of “accident hazards”, which includes faulty equipment and hazardous cleaning materials. HCFA addresses infection control in other regulations. The intended application is generally the same, but finding specific compliance guidelines is difficult in the JCAHO language, which is not unexpected given the emphasis on facility performance.

5.4.2.4 JCAHO Accreditation Standards That Do Not Have Corresponding Regulations in the HCFA Long Term Care Survey Process

There are three categories of JCAHO standards that do not have a direct correspondence in individual HCFA regulations. These are: (1) specific standards that are included under a limited number of functional areas; (2) standards that relate directly to the quality improvement process within the long term care organization, and (3) standards that are applicable only to practices and resident care in subacute and dementia units.

5.4.2.4.1 Functional Areas Containing Specific JCAHO Standards That Do Not Have Directly Corresponding HCFA Regulations

The following areas that are included in the JCAHO standards do not have close counterparts in the HCFA regulations. These JCAHO standards are representative of performance-based, functionally organized standards. The differences in the two systems are again very apparent just in the highlights of the topics of the standards that focus on structures, processes, and systems.

Resident Rights and Organizational Ethics

- RI.4.1 The organization’s code of ethical behavior addresses marketing practices.
- RI. 4.2 The organization’s code of ethical behavior addresses the relationship of the organization and its staff with other health care providers, educational institutions, and payers.

Continuum of Care

- CC.7 The organization uses a process for resolving denial of care issues to meet resident’s ongoing care and discharge needs.

Treatment

- TX.4.6 Pharmacy Services are available at all times.

Leadership

- LD.2.2 The organization plans for services to meet identified resident needs consistent with its mission.
- LD.2.6 The leaders and appropriate staff participate in decision-making structures and processes. (The leaders are defined as the organization's owners, chief executive officer, other senior managers, leaders of the licensed independent practitioners.)

Education of Residents

- PF.5 The organization plans for and supports the provision and coordination of resident education.

5.4.2.4.2 Continuous Improvement Processes Evident in the JCAHO Accreditation Process But Not Covered in HCFA Regulations

Improving Organization Performance

- PI.2 New or redesigned processes well.
- PI.3.4 The organization collects data about staff views regarding performance and improvement opportunities.
- PI.3.6 The organization collects data from quality-control activities.
- PI.4.1 The assessment process uses appropriate statistical techniques.
- PI.4.2 The organization compares data about its processes or outcomes.
- PI.4.3 The organization initiates intensive assessment when it detects or suspects undesirable variation in performance.
- PI.4.3.1 All confirmed transfusion reactions are intensively assessed.
- PI.4.3.2 All significant adverse drug reactions are intensively assessed.

5.4.2.4.3 Standards That Are Applicable Only to Practices and Resident Care in Subacute and Dementia Units

Organizations seeking certification of these specialty units must initially meet the requirements for accreditation of long term care organizations. HCFA regulations do not specify variations in the overall statement of the regulation that would selectively pertain to special units. Examples of the type of JCAHO standards that are written for subacute programs but not stated in HCFA regulations include:

Care and Treatment of Residents

- TX.12 A preanesthesia assessment of the patient is performed before anesthesia.
- TX.13 An assessment determines the appropriateness of procedures.

5.4.3 Effects of Discrepancies on the Determination of Reasonable Assurance

The preceding sections have identified that the features of the JCAHO and HCFA survey processes diverge significantly in underlying organization as well as philosophically. The discrepancies in language and in the selected terms that have been described have underscored that the HCFA approach is resident-outcome focused and the JCAHO is focused on organization-performance outcomes.

The point-by-point comparison discussed in the preceding section served as a means to identify if any discrepancies between the two systems were sufficient to cast doubt on the reasonable assurance of the JCAHO system. After that initial comparison, the differences identified between the systems were evaluated and it was determined that sufficient discrepancies exist between the JCAHO standards and the HCFA regulations so as to cast doubt upon the assurance that the Medicare participation requirements would be met. There are six areas where the JCAHO standards diverge from the HCFA regulations, either in the subject matter of the statement or in the intent, so as to cast doubt on a reasonable assurance that the Medicare participation requirements are met:

1. Safeguarding and protection of the individual's rights.
2. Description of resident's special needs.
3. Qualifications of a social worker, activities director, and dietitian.
4. Lack of clarity regarding use of medications.
5. Subsequent actions required by the HCFA regulations following poor resident outcomes which are not explicitly stated in JCAHO standards.
6. Provision of physician services.

5.4.3.1 *Safeguarding and Protection of the Individual's Rights*

The following examples demonstrate HCFA's attention to safeguarding and protecting of the rights of individual residents, which is addressed to some extent in the JCAHO approach. However, the HCFA regulations consistently focus on the resident in the statement of the regulation or in the regulation intent. This focus is not conveyed in the JCAHO standards. This difference would likely be significant so as to cast doubt on a reasonable assurance of meeting Medicare participation requirements in the application of the JCAHO standards.

HCFA Tag F156: (JCAHO: RI.2.12, RI.2.15, RI.2.19, RI.2.22, RI.4, CC.2.3)

HCFA Tag F167, F168 : (JCAHO: RI.1, RI.1.1, RI.2.3)

HCFA Tag F174 (JCAHO: RI.2.3, RI.2.11, RI.2.14)
HCFA Tag F516 (JCAHO IM.2, IM.2.1, IM.2.2, IM.2.3)

The language in the F Tags pertaining to residents' rights is far more explicit in five HCFA regulations (F156, F167, F168, F174, F516) than are corresponding statements in JCAHO standards. This is indicated in F156, which specifies that residents must be informed before and at the time of admission as well as during a stay in the facility of the facility services and related charges. In addition, F Tag 156 specifies the resident must be informed of rights at time of admission that include protection of personal funds, addresses of state advocacy groups, how to apply for Medicare benefits, the right to file a complaint, and the right to accept or refuse medical treatment. The JCAHO standard, CC.2.3 refers only to the residents and their families receiving sufficient information to make decisions about care. The standard does not define what is "sufficient" but the intent statement refers to charges for services. The corresponding JCAHO standards, RI.2.12, RI.2.15, and RI.2.19 refer to the resident's right to delegate management of personal affairs, to have complaints heard and when possible, resolved, to communicate with providers, and to formulate advance directives. On the point of advance directives, the language in the standards and in the regulations is similar. But, the HCFA regulatory language specifically refers to services, related charges, and to a "written description of legal rights."

Similarly, F167 and F168 refer to the residents' rights to access and examine federal or state survey results and to receive information from client advocacy groups. The corresponding JCAHO standards refer only to residents' involvement in their care and to a "right to privacy and security." The JCAHO standard language is not explicit on the two points of access to survey results and to advocacy groups.

Clearly, the HCFA regulation F174 is explicit in the resident's rights to private telephone calls and to retaining personal property. The JCAHO standard RI.2.3 is broad in referring to privacy and security. While the intent of the JCAHO standard indicates accommodation to residents including auditory privacy, the language in the standard is not as specific as the HCFA regulation. The JCAHO standard RI.2.11 refers to the environment but not specifically to the retention of personal property. Clearly the intent of the HCFA regulations is the safeguarding of personal rights and property that is not made explicit in the JCAHO standards.

HCFA F Tag 516 refers to maintaining the safety and confidentiality of the resident's records. The corresponding JCAHO standards do not refer to the resident but are similar in focus on the safeguarding of information.

5.4.3.2 *Description of Residents' Special Needs*

HCFA makes specific statements as to residents' special needs that are not found in JCAHO standards. The result of this difference between the two systems casts doubt on reasonable assurance that the JCAHO standards meet the Medicare participation requirements.

HCFA Tag F328 Special Needs.

JCAHO: TX.2.1, TX.4.9, TX.4.9.1, TX.4.9.2, TX.4.9.3, TX.4.9.4, TX.4.9.5, TX.4.9.6, TX.4.9.7, TX.4.9.8, TX.4.9.9.

F 328 is quite specific about the definition of special needs and the facility's responsibility in providing for residents. The JCAHO language in TX.2.1 refers globally to resident's needs. JCAHO language in TX.4.9 is specific to medication administration and lacks comprehensive language regarding special needs and certification standards.

HCFA Tag F320

JCAHO: TX.1.6, TX.1.6.1, TX.1.6.2, TX.1.6.3

F320 addresses assessment and maintenance of psychosocial health, while the JCAHO standards refer to the provision of services to meet psychosocial needs, without directly addressing assessment, maintenance, or care planning. JCAHO does not focus on the maintenance of health.

5.4.3.3 *Qualified Social Worker, Activities Director, and Dietitian*

The following HCFA F Tags specify the qualifications (education, training, and experience) of different staff positions: social worker, activities director, and dietitian. The intended application of these regulations appears to be to protect the residents by stipulating that services must be provided by qualified individuals. The JCAHO standards are not as specific relating to the qualifications of individuals to fill these positions. The terms in the JCAHO standards list the comprehensive needs of residents that are expected to be met by an adequate number of qualified staff. This is a different approach from HCFA regulations and may have substantial effect on services provided to the residents, as to cast doubt that the Medicare participation requirements are met.

HCFA Tag F251- Regulation specifies employment of full-time, qualified social worker.

JCAHO: HR.2, HR.2.1, HR.2.1.1, HR.2.1.2, HR.2.1.3, HR.2.1.4, HR.2.1.5, HR.2.1.6, HR.2.1.7, HR.2.1.8, HR.2.1.9, HR.2.2, HR.2.2.1, HR.2.2.2, HR.2.2.3, HR.2.2.4, HR.2.2.5, HR.2.2.6, HR.2.2.7, HR.2.2.8, HR.2.2.9

HCFA F 251 states a facility with more than 120 beds must employ a qualified social worker on a full-time basis. JCAHO standards HR.2 through HR.2.1.9 refer to adequate staff to meet

residents' needs and list nine areas of resident needs which include social service. The term adequate refers to staff size and composition. JCAHO standards HR.2 through 2.2.9 define qualified staff to meet the residents' needs, one of which is social service. The JCAHO standard intent states that the organization should check, when relevant, "education and training in accordance with applicable law and regulation and organization policy."

The HCFA regulation explicitly states the level of education and experience that is required of a social worker. Although the statement of intent for the JCAHO standards indicates that a social worker should have special training related to the patient population served,²²¹ the level of education, training, and experience is not specified.

HCFA Tags F248 & F249 - Employment of activities director.

JCAHO: CC.3, TX.2.6, TX.2.6.1, TX.2.6.1.1, HR.2, HR.2.1, HR.2.1.1, HR.2.1.2, HR.2.1.3, HR.2.1.4, HR.2.1.5, HR.2.1.6, HR.2.1.7, HR.2.1.8, HR.2.1.9
JCAHO: HR.2.2, HR.2.2.1, HR.2.2.2, HR.2.2.3, HR.2.2.4, HR.2.2.5, HR.2.2.6, HR.2.2.7, HR.2.2.8, HR.2.2.9

Both the HCFA regulations and the JCAHO standards address activity programs appropriate to the individual resident's needs, interests, and capabilities. HCFA additionally lists specific qualifications, experience, and training required for the activities program director. These HCFA regulations refer only to the position of activities director and refer to other staff separately.

The related JCAHO standards 2.1.1 through 2.1.9 and HR.2.2.1 through HR.2.2.9 list residents' needs, one of which is recreational. The JCAHO standard HR.2.1 refers to an adequate staff to meet all of the listed needs and HR.2.2 refers to qualifications of staff necessary to meet the residents' needs. The JCAHO standards do not separate the qualifications, training, and experience that are specifically required of an activities director. The inclusion of recreational needs as one of nine areas and the mention of staff to meet those needs do not convey the same importance placed on the activities that are provided in a nursing facility that is specific in the HCFA regulation.

HCFA Tags F361 & F362 - Employment of qualified dietitian.

JCAHO: LD.2.2.4, HR.2, HR.2.1, HR.2.1.1, HR.2.1.2, HR.2.1.3, HR.2.1.4, HR.2.1.5, HR.2.1.6, HR.2.1.7, HR.2.1.8, HR.2.1.9, HR.2.2, HR.2.2.1, HR.2.2.2, HR.2.2.3,, HR.2.2.4, HR.2.2.5, HR.2.2.6, HR.2.2.7, HR.2.2.8, HR.2.2.9)
F362: HR.2, HR.2.1, HR.2.1.1, HR.2.1.2, HR.2.1.3, HR.2.1.4, HR.2.1.5, HR.2.1.6, HR.2.1.7, HR.2.1.8, HR.2.1.9, HR.2.2, HR.2.2.1, HR.2.2.2, HR.2.2.3, HR.2.2.4, HR.2.2.5, HR.2.2.6, HR.2.2.7, HR.2.2.8, HR.2.2.9)

²²¹ JCAHO, *op. cit.*, p. 485.

Adequate staffing to meet the nutritional and dietary needs is addressed in F360. JCAHO is less comprehensive in intended coverage and less specific than the HCFA requirements. HCFA Tag F361 states criteria to define “qualified” by registration or through education, training, and experience. HCFA Tag F361 mandates utilization of a “qualified” dietitian for all residents’ nutritional needs, while JCAHO mentions a dietitian only in the context of “subacute” programs.

5.4.3.4 Lack of Clarity Regarding Use of Medications

Medicare requirements may not be met by the current JCAHO standards as evidenced by the following discussion of medication.

HCFA Tag F329, 330, 331
JCAHO- TX.4, TX.4.1, TX.4.13.2

F329 addresses the use of psychotropic drugs with specific parameters and standards. JCAHO standards refer to antipsychotic drugs, not psychotropic drugs. In the JCAHO standards that are similar to F 330 and 331, JCAHO continues to use “psychotropic” as though it is interchangeable with antipsychotic. The HCFA F Tags make a clear distinction between the two and their uses: Psychotropic medications include several classes: antidepressants, neuroleptics (also called antipsychotic agents), antianxiety agents, other drugs that affect the mind including those that modify mental activity. Antipsychotic drugs refer to the neuroleptic agents that block receptors in the central nervous system.

5.4.3.5 HCFA Regulations Assure Actions Following Poor Resident Outcomes That Are Not Required by JCAHO

The following discussion describing poor resident outcomes addressed by HCFA but not specifically mentioned by JCAHO could lead to noncompliance with Medicare participation requirements if survey by the current JCAHO standards were to replace the HCFA survey.

HCFA Tag F282
JCAHO TX.2., HR.2.2., HR.2.2.1, HR.2.2.2, HR.2.2.3, HR.2.2.4, HR.2.2.5, HR.2.2.6, HR.2.2.7, HR.2.2.8, HR.2.2.9

Both the HCFA regulations and the JCAHO standards require that qualified (licensed, certified) persons are involved with the care plan. However, HCFA addresses outcomes that JCAHO does not. Per the HCFA regulations, if an outcome is not met then it must be evaluated to determine if it is due to failure to meet professional standards of practice. Questions to assist in this probe are also included. The intended application of this HCFA F Tag is to assure that services being provided meet professional standards of quality, which are the accepted standards of clinical practice per specific disciplines. The intent of the JCAHO

standards are that the organization checks the qualifications of employees to meet the comprehensive needs of the residents. The JCAHO intent does not coincide with the resident-focused outcome that is clearly stated in the guidelines for the HCFA F Tag.

5.4.3.6 JCAHO Less Comprehensive in Provision of Physician Services

Reasonable assurance of meeting participation requirements would be in doubt if the following JCAHO standard were used in place of the HCFA F Tag.

HCFA Tag F389

JCAHO TX 1.5.1.1

Regarding obtaining physician's services, JCAHO's standard is less comprehensive in intended application than the corresponding HCFA regulation. F389 assigns responsibility to the facility to "provide or arrange for provision of physician services [including resident transportation for emergency treatment] 24 hours a day." JCAHO merely requires that an attending physician "designates an alternate physician whom the organization can contact. . . ." The outcome of this F Tag would assure that a resident be transported for emergency services if necessary. In contrast, the JCAHO standard only dictates that a system should be in place to contact a physician as needed.

5.4.4 Section Summary

The evidence cited casts doubt that nursing homes accredited using the JCAHO standards would meet the Medicare participation requirements, but this finding must be interpreted in its context. The point-by-point comparison between JCAHO and HCFA and the review of the findings of that comparison was focused on the statements of the regulations and the statements of intent. This does not convey the total process of the JCAHO survey. This essential next step, to consider how these JCAHO standards might actually be applied in practice, will lead to one of two results: (1) In practice, the JCAHO standards are implemented so as to provide a reasonable assurance that facilities that are accredited through the JCAHO meet Medicare participation requirements; or (2) In practice, the JCAHO standards are not implemented in a manner sufficiently similar to the HCFA regulations so as to provide the reasonable assurance that facilities that are accredited through the JCAHO meet Medicare participation requirements. Given that the point-by-point comparison led to findings that the JCAHO approach is performance oriented rather than resident focused, this would likely lead to the implementation of the survey process as a series of checks for existing procedures, policies, and indicators of the facility level of performance. That focus would differ from HCFA's.

Whether the JCAHO accreditation process provides a reasonable assurance that Medicare participation requirements are met should not be determined solely on the basis of a point-by-point comparison of the JCAHO standards and the HCFA regulations. Further analysis has been

conducted by Abt Associates Inc. and the findings of those separate analyses should be considered to review all aspects of the JCAHO accreditation program.

5.5 Conclusions Regarding Discrepancies

The following conclusions are based on the initial comparison of the language used in the JCAHO standards and HCFA F Tag requirements.

The focus of each of the two systems is sufficiently different that the standards and regulations are not consistently comparable on a point by point basis. A single HCFA F Tag often corresponds to more than one JCAHO standard and, in some cases, to as many as 27 or 28 standards. The JCAHO standards are written as levels of performance, generally stated in systems-focused terms, that the long term care organization is expected to accomplish. The HCFA regulations as stated in F Tags are expressed in terms of the evidence or the occurrence of a resident-focused outcome or the care or service that is required. The differences in the words and terms used in the JCAHO standards and in the HCFA regulations are sufficiently different to confound the comparison of the one system to another.

To provide reasonable assurance of compliance with Medicare participation requirements, the JCAHO standards would have to focus on outcomes, which is a departure from the systems oriented performance goals that presently exist. In particular areas, the JCAHO standards are more general or less specific than the HCFA regulatory language:

1. Specific terms and related measures (e.g., temperatures, weights) to identify compliance are not now explicitly stated in the JCAHO standards.
2. The intent of the HCFA regulations broadens many of the individual standards from JCAHO's individual statements of need areas into more comprehensive terms such as resident status areas.
3. Several very encompassing or global JCAHO standards have subsumed more than one HCFA regulation and at a high level of abstraction have lost specificity.

The JCAHO standards as they are presently written do not consistently use terms that show protection of various rights of the individual that are specified in the HCFA regulations - the right to be informed, to right to be provided with options, the right to be made aware of survey results and of advocacy groups, the right to be assured of access to emergency services. Three JCAHO standards exemplify that some standards do, of course, refer to the right of the resident to a quality of life that supports independent expression, the right to considerate care, and the right to personal freedom. However, the HCFA regulations consistently reflect resident-focused rights and resident-focused outcomes; whereas the overall pervasive theme evident in the statements of the JCAHO standards is the organization's levels of performance.

6.0 COMPARISON OF HCFA AND JCAHO SURVEYOR TRAINING

6.1 Introduction

This chapter outlines the long term care (LTC) surveyor training requirements of the Health Care Financing Administration (HCFA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) based on information and materials collected directly from staff at each organization. Contacts made in preparing this report include:

<u>HCFA</u>	<u>JCAHO</u>
Mary Beth Ribar	Joyce Faulkner
Vic Santoro	Jackie Streid
Karen Schoeneman	

Because hiring and training of LTC surveyors occurs at the State level, HCFA was unable to provide comprehensive information regarding surveyor training for this report. In an effort to capture more information about individual State experiences, Abt staff conducted group interviews with approximately 20 surveyors attending the HCFA LTC BASIC Training Session in September 1997 for this report. Another 57 training session attendees volunteered to complete a brief questionnaire regarding their experience as surveyors. A copy of the surveyor questionnaire and summary of responses are attached as Appendix B.

Abt staff requested an opportunity to administer the same questionnaire to JCAHO surveyors. However, JCAHO headquarters staff was not able to respond to this request within the time constraints for this report. Information included here is based solely on comments and materials supplied by JCAHO headquarters staff.

6.2 Background and Experience

6.2.1 HCFA

HCFA surveyors are hired by the States according to individual State policies. These are State civil service jobs and, according to Karen Schoeneman at HCFA central office, qualifications vary greatly from State to State. Some States hire generalists, such as sanitarians who are paid less because they do not have clinical backgrounds. Most States have some combination of surveyors with different backgrounds (nurses, pharmacists, social workers, dietitians, and sanitarians). HCFA estimates there are currently 6,000 to 7,000 surveyors throughout the country.

As summarized in the State Operation Manual (SOM), Federal regulations require that:

- Surveys be conducted by a multi disciplinary team of professionals, at least one of whom must be a registered nurse (RN);

- Surveyors be free of conflicts of interest,²²² and
- Surveyors successfully complete HCFA-approved training and pass Module A of the Surveyor Minimum Qualifications Test (SMQT).

Because States make individual hiring decisions, minimum requirements regarding surveyor qualifications and training are determined on a State-by-State basis. However, HCFA offers States guidance in the SOM as follows:

- Consider using more than one RN for facilities with a large proportion of residents with complex nursing or restorative needs;
- Include social workers, registered dietitians, pharmacists, activity professionals, or rehabilitation specialists, when possible; and
- To the extent practical, utilize team members with clinical expertise and knowledge of current best practices that correspond to the resident population's assessed needs, the services rendered in the facility, and the type of facility;
- In addition to members of individual disciplines routinely included as members of the survey team, consideration should be given to the use of individuals in specialized disciplines who may not routinely participate as team members. These individuals would be available to assist the survey team when specific problems or questions arise. Consultants in these suggested disciplines include, but are not limited to, physicians, physician assistants, nurse practitioners, physical, speech, and occupational therapists, dieticians, sanitarians, engineers, licensed practical nurses, social workers, pharmacists, and gerontologists.
- Surveyors in training must be accompanied onsite by a surveyor who has successfully completed the required training and testing. While it is desirable that all survey team members be fully qualified, HCFA recognizes that trainees must be given opportunities to perform survey functions so that they can achieve fully qualified status. Participation in actual surveys is a valuable and integral part of a training program. In fact, in the orientation program designed for newly employed surveyors, HCFA recommends that three weeks be spent in the field as part of the training.

The majority of surveyors who completed the Abt questionnaire had nursing backgrounds and 68 percent identified themselves as RNs. Their experience was not necessarily gained at nursing facilities, however, nor is LTC experience specifically required by HCFA. About half of the survey respondents reported they had worked as a LTC nurse for more than four years. Approximately 23 percent indicated they had more than four years experience as a director of nursing (DON) in a LTC facility. A summary of the experience reported by questionnaire respondents is presented below in Exhibit 6.1.

²²² Conflicts of interest may arise when public employees use their positions for private gain (monetary or otherwise) or to secure unfair advantages for outside associates. For example, the surveyor (or an immediate family member) cannot be an employee or recent employee of the facility and cannot have any financial interest or ownership interest in the facility. Nor can an immediate family member be a facility resident.

Exhibit 6.1
Questionnaire Results: Surveyor Experience

position	# of respondents (total = 57)	average years experience
DON	13	4.7
RN	29	4.4
Nursing Assistant	4	3.8
Social Worker	4	5.3
Dietician	4	8.7
Administrator	1	5
Other	9	4.5

Levels of education varied among respondents: 35 percent reported having an associates degree, 33 percent held bachelors degrees, and 23 percent held masters. One surveyor held only a high school diploma and the remainder reported some "other" education. Ten of the 57 questionnaire respondents, or 17.5 percent, reported no previous nursing home experience.

6.2.2 JCAHO

JCAHO employs a total of about 570 surveyors, and 70 of those survey LTC facilities. All surveyors report directly to supervisors at JCAHO central office. According to Joyce Faulkner, Head of Surveyor Recruitment and Orientation at JCAHO, LTC surveyors are typically former DONs or administrators. Minimum requirements are masters or advanced degree and five years experience at a management level in a LTC facility (e.g., DON or administrator). According to JCAHO, surveyors are usually hired with more than the minimum required experience.

6.3. Initial Training

6.3.1 HCFA

According to Mary Beth Ribar, surveyors are required to attend LTC BASIC Training after they have completed a State orientation and gained some survey experience. No specific amount of field work time is required. Training lasts one week and includes reviews of and exercises in the following areas:

- The rationale for and the basic elements of the survey and certification process;
- The skills of observation, interviewing and decision making and their application to the survey tasks;

- The content and intent of the regulations; and
- The technical knowledge and surveyor skills needed to perform within the legal framework of the certification process.

In group interviews and questionnaire responses, surveyors reported having little and sometimes no contact with HCFA regional staff for training purposes. Generally, States require some initial classroom instruction combined with individual review of manuals or other materials. Surveyors then often work with preceptors in the field for a brief period. State training programs vary widely, however. In group interviews, surveyors reported training experiences that ranged from no formal training in one State to eight weeks in another.

In one State, for example, a surveyor stated that she started work on a Friday and was out onsite on Monday. This surveyor had been working for almost one year with no formal training in the standards and no apparent initial supervision by a preceptor. Another surveyor from the same State was trained under a new six-month preceptor program, but reported having very little interaction with the preceptor. Conversely, another State surveyor received eight weeks of training that included lecture, classroom instruction, review of manuals, and then testing. All new surveyors in that State were also assigned peer advisors and tutors to help them prepare for the SMQT.

Supervision and evaluation of new surveyors' performance varies widely across States as well. In interviews, some surveyors reported having formal State evaluations after three to six months in the field, however, most surveyors relied on informal feedback from other surveyors, supervisors, and/or preceptors to monitor performance.

Impressions of the preceptor system and its utility varied and several individuals had suggestions for improvements. These included:

- Selecting preceptors based on level of interest and commitment to providing supervision and mentoring, not just years of experience;
- Compensating preceptors for their service; and
- Standardizing the systems in place across States.

Abt's surveyor questionnaire asked respondents to indicate the mode of training received in each of the following subjects:

- State Agency Surveyor Training Orientation Program
- SOM #274 Survey Process
- SOM #273 Enforcement
- Principles of Documentation
- MDS/RAI Training
- Laptop Survey Software

The majority of surveyors reported receiving a combination of formal classroom training and self-study from a manual or written guidelines for all subjects listed above except survey software. Some 30 percent of new surveyors said they received no training on this component. More than half the surveyors responding reported that they received classroom instruction in every subject except Principles of Documentation. For training on Principles of Documentation, 67 percent of the surveyors relied on self-study from a manual or written guidelines and videos. Responses for each subject area are summarized below in Exhibit 6.2.

Exhibit 6.2
HCFA Surveyor Training Modes

Subject	Self-study from manual, written guidelines, video	Formal classroom training or field study at State agency
State Agency Surveyor Training Orientation Program	54%	75%
SOM #274 Survey Process	65%	72%
SOM #273 Enforcement	53%	60%
MDS/RAI Training	49%	68%
Principles of Documentation	67%	56%
Laptop Survey Software	31.5%	53%

Note: 30% of surveyors reported receiving no software training.

Overall, questionnaire respondents indicated that they felt the formal training received since being hired as a surveyor, including the Basic Training course, was adequate. Surveyors rated training for the following three areas most highly:

- The objectives of the orientation tour;
- The criteria and process used in selecting the resident sample, and
- How to conduct a quality of care assessment.

Surveyors selected the following four areas most frequently for additional training:

- How to use the laptop survey software;
- How to document negative findings to support a statement of deficiencies; and
- How to assess the appropriateness of physical restraints and psychoactive medications.

Additional comments from HCFA training attendees focused on their mission as advocates for the resident population and facilitators of change in the industry. Some surveyors expressed frustration with the long hours and low pay associated with their work. Others described feeling pressured by State agencies that require enormous amounts of evidence when citing facilities for fear of going to court.

6.3.2 JCAHO

JCAHO provides standardized LTC surveyor training to all new hires in a two-week training session that covers the standards, Joint Commission policies and procedures, and computer training. Surveyors practice skills by role playing interview sessions, conducting practice surveys, and giving presentations of 30 to 60 minutes on topics of their choice.

Because the JCAHO focuses on improving facility performance, surveyors also serve as educational consultants in the field and are prepared to share information with each organization they survey. Surveyors often make presentations to facilities at lunch so that most staff are able to attend. The educational component of survey work is incorporated into new surveyor training. According to Jackie Streid, a JCAHO educator, the training is an integrated process that combines learning the standards with practicing computer skills and other surveyor skills (e.g., interviewing, observing, presenting). An agenda from the August 1997 training session is included as Appendix B.

Following training at JCAHO central office, surveyors complete a preceptorship while working in the field for their first four surveys. Surveyors use this phase to observe and learn from their mentors while experienced surveyors have an opportunity to monitor and provide feedback on new surveyor performance.

6.4 Continuing Education

6.4.1 HCFA

State variations are also found in continuing education requirements and resources available to surveyors in the field. State requirements for continuing education are mixed, and some States do not require any ongoing training or education.

In group interviews, most surveyors stressed the importance of continuing education since they are expected to enter facilities as experts and to present at conferences and training programs. Many described their frustration with an overall lack of support for continuing education. State budgets have minimal funds available for reimbursing surveyors for CEUs. In addition, few surveyors were even allowed time off to attend continuing education programs without sacrificing personal or vacation time. Some suggested HCFA should develop minimum standards for all States to address the problem.

Although each State system operates separately, surveyors from all States indicated in group interviews that they could contact supervisors by telephone for assistance with any problems encountered in the field.

6.4.2 JCAHO

JCAHO conducts a one-week training session each year and requires all surveyors to attend. This is a refresher course, separate from the initial training offered to new hires. In addition, all surveyors report to two associate directors at JCAHO central office. According to Joyce Faulkner, surveyors can call upon these supervisors anytime they have questions they cannot answer in the field. Surveyors are also supplied with materials and manuals during their initial training. In addition, JCAHO holds surveyor teleconferences twice a year and routinely broadcasts voicemail and e-mail messages to surveyors.

6.5 Evaluation

6.5.1 HCFA

All surveyors must pass the SMQT. If a surveyor does not pass section B, described below, the surveyor is limited to general observations and group interviews. The SMQT covers the knowledge, skills, and abilities (KSAs) identified by an advisory panel of survey agency directors or their representatives. They include:

- Knowledge of laws, regulations, and interpretive guidelines
- Knowledge of the LTC facility survey process, procedures, and forms
- Knowledge of sampling procedures
- Knowledge of factors affecting environmental quality
- Knowledge of assessment and resident care plans
- Knowledge of medical, nursing, and rehabilitative care
- Knowledge of resident rights and quality of life issues
- Knowledge of nutritional and dietary service principles and practices
- Knowledge of drug therapies and drug administration principles and practices
- Knowledge of LTC facility records
- Knowledge of sanitation and infection control procedures
- Observational skill
- Skill in communicating, interviewing, and relating to others
- Skill in documentation
- Skill in integrating information
- Skill in evaluating the significance of information
- Knowledge of gerontology
- Investigatory skill
- Skill in analyzing information

Module A covers all the areas above, while module B covers all but “knowledge of sampling procedures.” The nature of the questions vary in each module, however. For example, questions in module A that concern “skill in documentation” relate to documenting quality of life, or the environmental aspects of dietary services. Questions in module B that concern the same KSA relate to documenting quality of care, medications, or the clinical aspects of dietary services. In all cases, the test covers federal, not State requirements.

All questions are multiple choice, each of which has four answer choices. Some questions test straightforward knowledge, others present survey situations and ask surveyors to apply their knowledge. The SMQT requires approximately 5 hours of testing and administration time.

No additional testing or ongoing performance evaluations are required, however, these may be conducted at the State level. State requirements regarding surveyor testing and evaluation vary.

6.5.2 JCAHO

JCAHO evaluates surveyors’ skills during initial training, through preceptorship, and in annual performance reviews. New surveyors’ understanding of the standards is tested during initial training by requiring each surveyor to present a chapter learned in training to the group. According to Jackie Streid, this reflects each individual’s comprehension of the material covered. The actual amount of material presented is limited, however, since each presentation cannot be comprehensive.

Preceptors provide feedback on new surveyor performance by completing the evaluation form included as Appendix B. Preceptee evaluations forms assess surveyor skills and abilities in the following areas:

- Knowledge of the standards
- Report preparation
- Time management
- Education/consultation
- Knowledge of special policies and procedures
- Conference skills
- Data gathering
- Personal skills (e.g., listening, team player)

Among personal skills, evaluators are asked to assess the JCAHO surveyor’s “ability and willingness to be flexible in accepting new ways of meeting the intent of the standard and to adjust the schedule to meet the needs of the facility.” This is worth noting because it reflects one of the major philosophical differences between JCAHO and State surveyors and contrasts sharply with

comments from HCFA training session attendees regarding their role as advocates for nursing home residents.

JCAHO surveyors are evaluated on an ongoing basis using a combination of methods including:

- Self appraisals;
- Feedback on survey reports;
- Revision requests (disputes initiated by facilities);
- Timeliness of survey report submissions;
- Frequency of manually overriding computer-generated standard scores;
- Facility-completed evaluation forms (each organization has an opportunity to provide feedback on their surveyor's performance);
- Random post-survey phone calls;
- Peer evaluations (e.g., when a LTC surveyor accompanies a subacute surveyor); and
- Direct observation.

Annual performance reviews include input from surveyors and supervisors. Surveyors' knowledge and skills are assessed and rated as: EE, exceeds expectations; FM, fully meets and sometimes exceeds target level; or NI needs improvement. A description of the specific knowledge and skills required of surveyors and a surveyor performance assessment form are provided in Appendix B.

6.6 Summary

Although individual State requirements vary, reports from new surveyors attending the 1997 HCFA LTC BASIC Training indicate that surveyors are not required to have advanced degrees or management level experience to be hired. In some States, no previous LTC experience is required. Most surveyors report a background in nursing, but not necessarily in a LTC setting. The JCAHO reports higher minimum qualifications for surveyors: a master's or advanced degree plus five years of experience in a long term facility at the management level, typically as a DON or administrator.

HCFA and JCAHO both offer an initial training session for new surveyors. Following their initial training, JCAHO surveyors complete a preceptorship for the first four surveys. Feedback on JCAHO surveyor performance in the field is collected on an ongoing basis through a variety of mechanisms, including evaluations completed by providers. Formal performance reviews and updated training sessions are conducted annually. State training programs vary widely. Many offer preceptorship programs, but surveyor reaction to the effectiveness of these programs was mixed. No continuing education is required of HCFA surveyors, and few States support it. HCFA surveyors must take and pass the SMQT. No additional assessments are required; however, most surveyors reported getting feedback on performance from peers and supervisors.

7.0 OBSERVATIONAL STUDY OF THE JCAHO LONG TERM CARE FACILITY SURVEY PROCESS

7.1 Background/Overview

This chapter describes the observational study of the Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) long term care (LTC) facility survey process. The main purpose of the observational study was to develop an understanding of the JCAHO's process, and to assess the comparability of the JCAHO process to the Federal survey and certification process for LTC facilities. The observation protocol included a review of investigatory techniques utilized by JCAHO surveyors, a limited evaluation of the consistency of the implementation of the process across surveys, and interviews with surveyors regarding preparation for the survey, data collection tools utilized, and decision-making about survey outcomes.

7.1.1 Organization of the Chapter

The following sections describe the questions to be addressed through the observational study, followed by a description of the methodology and facility sample, review of findings, discussion, and conclusions regarding the JCAHO LTC survey process and its compatibility with HCFA's goals and initiatives in LTC quality monitoring.

7.1.2 Questions to Be Answered

Two general areas to be addressed in the observational study include: 1) what are the components of the JCAHO survey process and how are these components implemented by surveyors? and 2) does the process adequately evaluate HCFA's primary areas of concern in long term care facilities, such as the quality of life experienced by Medicare beneficiaries residing in such facilities? Examples of our questions regarding the JCAHO survey process and its outcomes included:

- Do JCAHO surveyors employ comparable investigation techniques to those required by the HCFA process?
- Are there components of the JCAHO survey process that HCFA might consider utilizing in the Federal survey process?
- Is there evidence that the JCAHO process affects provider behavior differently than the Federal survey process; for example, is there evidence that the JCAHO process of quality review creates lasting change in provider operations?

Examples of our questions regarding whether the JCAHO process addresses HCFA's areas of chief concern included:

- Is the JCAHO survey process compatible with the goals of the HCFA quality monitoring process for long term care facilities?
- Does the standard JCAHO survey obtain sufficient information regarding a LTC facility's compliance with HCFA's Requirements for LTC Facilities (42 CFR 483)?
- Are quality of life issues considered in the selection of sample residents for review or interview?
- Which of the staff interviews include discussions about quality of life? What specific issues related to quality of life are discussed with staff?
- How much time do surveyors spend observing staff-resident interaction, resident activities or non-interviewable residents?

7.1.3 Methodology

A total of four survey observations were conducted between March and October 1997. Observations were carried out by two-person teams, each led by a senior Abt Associates staff member with a background in nursing and experience conducting Federal LTC certification surveys. An observational protocol was developed which included a series of interview questions for each surveyor observed, and a worksheet for recording observations during the survey. The worksheet prompted Abt staff to note both the duration of each survey task, and whether certain HCFA LTC requirements were addressed during interviews or other investigational activities. The Federal requirements of highest interest were grouped into general areas of HCFA concern, such as resident rights, quality of life, and quality of care; all of which contain individual requirements which lead to substandard care determinations (e.g., residents' right to be free from physical restraints, dignity, accommodation of needs, provision of necessary care for highest practicable level of well being). Abt staff also observed certain structural components of the JCAHO survey; for example, did the surveyor obtain information regarding the availability of sufficient nursing staff or specialized rehabilitative staff? A copy of the observational worksheet is included in Appendix C.

7.1.4 Facility Sample

The original plan for sampling called for onsite observations of facilities that differed in size, ownership type, and type of facility (e.g., hospital-based); this was discussed with the Joint Commission, who reported that these variables were not available prior to scheduling surveys. M.J. Hampel, Service Integrator and LTC survey scheduler at the JCAHO, requested that the Abt team members provide her with our available dates for survey observation and any other preferences; she then scheduled the surveys and informed us as to their dates and locations. Other preferences the Abt team expressed were to observe long term care and subacute surveys

scheduled prior to June 1997 for full accreditation surveys and to observe surveys at facilities located on the east coast (in order to minimize travel expenses). It is important to note that the JCAHO scheduler then selected the facilities and the surveyors that we were to observe.

We observed a total of 4 surveys between March and October 1997 in the following states: Florida, Maryland, New Jersey, and Massachusetts. All facilities surveyed were members of chain corporations and were over one hundred beds in size. The types of surveys observed were as follows: combined long term care and subacute; subacute-only, and long term care-only. Two of the four surveys were initial accreditation surveys; the third was a subacute survey conducted in a facility already JCAHO accredited for long term care; and the fourth was a triennial survey. The combined long term care/subacute survey was conducted by two surveyors; all others were conducted by one JCAHO surveyor. Time spent onsite amounted to three days, with the exception of the subacute-only survey which consisted of two days onsite.

7.1.5 JCAHO Surveyors

Four of the five JCAHO surveyors observed worked part-time for the JCAHO, one worked intermittently. Part-time surveyors generally conduct two surveys per month. All were masters-prepared nurses with experience as directors of nursing (DONs) and/or administrators in long term care; the two subacute care surveyors currently work in subacute facilities when they are not conducting surveys for the JCAHO. The others work as LTC facility consultants when not conducting JCAHO surveys. In this capacity, they provide consultation to LTC facilities preparing for JCAHO accreditation surveys by going onsite to train facility staff on the JCAHO standards, on implementing continuous quality improvement processes, and on managing information. Both surveyors and JCAHO leadership staff interviewed stated that this private consulting work presents no conflict of interest between providers and the Joint Commission and that JCAHO policy prohibits accreditation surveys to be conducted by any surveyor who has formerly consulted with the facility to be surveyed.

7.2 Findings/Discussion

Though Abt Associates staff made every attempt to observe only the *process* as it was being conducted by each surveyor, rather than to observe and make our own judgments about the facilities' delivery of care, it is important to point out some general information about the surveys and their overall outcomes. All surveys observed resulted in recommendations for Joint Commission accreditation with Type I recommendations. All were relatively uneventful; that is, neither JCAHO surveyors nor Abt observers noted any flagrant noncompliance with the HCFA substandard care requirements of most interest (e.g., use of physical restraints, abuse, dignity, accommodation of needs). Our general observations of the surveyors themselves were that all conducted themselves professionally and exhibited expertise in long term care nursing, all provided consultation and education to facility staff during the surveys; and all readily sought further guidance from the JCAHO when necessary. Despite the high degree of professionalism

displayed, all surveyors appeared (and admitted to being) pressed for time to complete all components of the LTC accreditation survey in the allotted three days. In elaborating on the difficulty of completing survey tasks in the required timeframe, surveyors described working late hours in their hotel rooms to complete documentation of findings because they did not have enough time during the work day to do so. Several of the surveyors interviewed stated that the three day timeframe was too short to thoroughly cover all accreditation standards. One surveyor expressed some apprehension about the new JCAHO policy which dictates that all future surveys--even combined LTC/subacute surveys--will now be conducted by just one surveyor.

The conduct of the surveys was similar in many ways: all surveyors had preset agendas which had been negotiated with the facility administrators and all spent the mornings of the second and third day of survey in review of findings from the previous day(s) and in verification of the agenda with facility management. The majority of work performed by the surveyors was in meetings with staff and review of documents; these activities generally took place in conference rooms located near the main entrances of the long term care facilities. There was one exception to this. One surveyor spent much of her time in a conference room located in the center of the facility she surveyed. This location required her to walk through resident care areas each morning, unlike the other surveyors.

The following discussion describes our findings regarding the investigational techniques utilized by JCAHO surveyors and the average time spent on target areas of interest such as quality of life. Areas of comparability are highlighted as well as descriptions of variations in survey implementation or survey outcomes. In order to provide a frame of reference for discussion of the compatibility of the JCAHO and Federal survey and certification processes, we have made some direct comparisons between the JCAHO process as observed and the Federal survey protocols and surveyor guidelines found in the State Operations Manual (SOM)²²³.

7.2.1 Investigatory or Data Collection Techniques Utilized and Comparison to Federal Survey and Certification Processes

7.2.1.1 Staff Interview

All JCAHO surveys observed were characterized by the use of direct questioning of staff as the primary mode of investigation. All surveyors conducted interviews of facility leaders such as the administrator, director of nursing, and medical director(s). All surveyors interviewed department heads, as well (admissions, social services, activities, dietary, human resources). Some surveyors informally interviewed staff on the units to ask about life safety and hazardous materials issues.

²²³ Department of Health and Human Services, Health Care Financing Administration. State Operations Manual, Revision 274. June 1995.

The use of interview as the primary investigatory technique is consistent with the JCAHO survey processes described in “The Complete Guide to the Survey Process: Long Term Care, Subacute Care and Dementia Units.”²²⁴ This guide informs facilities to expect some element of staff interview in each survey activity. This instruction differs significantly from the Federal survey and certification processes described in the SOM.²²⁵ Guidance found in §2714 instructs surveyors that, though they may need to interview the Administrator and DON, they should “not disrupt the facility by protracted interview of all the staff”.

7.2.1.2 Resident/Family Interview

Surveyors varied in their approach to selection of a sample of residents to interview, in the number of residents and/or families interviewed, and in the information ascertained from resident/family interview. The number of residents interviewed during the four surveys ranged from one to six residents. Most surveyors chose a convenience sample to interview, based upon which patients were in their rooms and noted by staff to be “interviewable” and available to speak with during their tours of the units. Types of information elicited from residents involved the quality of the food and the care received at the facility. Surveyors of subacute programs also were responsible for contacting, by telephone, during offsite hours, 5 patients discharged in the last 30 days from the subacute units by telephone during off-site hours. Abt staff were not able to sit in on these calls, but were informed by one subacute surveyor that the interviews take approximately 5 minutes per call.

This approach to resident interview differs from the Federal survey and certification process most notably in that it lacked emphasis or a sense of priority in the JCAHO surveys observed. Comparatively, the Federal process views resident and family interviews as integral components of the quality of life review, and formalizes the process with a specific sampling framework and interview protocol. The SOM instructs surveyors to interview at least 5 percent of residents, or a range from 1 to 7 residents, depending on the size of the facility. Given the size of the 4 facilities observed (greater than 100 beds each), a minimum of 5 resident interviews at each facility would have been conducted by State or Federal surveyors, as compared with the 3 residents on average interviewed during the accreditation surveys observed.

7.2.1.3 Observation

Abt staff shadowed the JCAHO surveyors as they toured the facilities, and made note of all tasks that involved the use of observation skills to note life safety issues, the environment of care, staff

²²⁴ Joint Commission on Accreditation of HealthCare Organizations, *The Complete Guide to the Survey Process: Long Term Care, Subacute Care, and Dementia Units*. 1997.

²²⁵ Department of Health and Human Services, Health Care Financing Administration. *State Operations Manual*, Revision 274. June 1995. Section 2714.

treatment of residents, or care delivery (such as observation of treatments). Our findings are as follows:

- All surveyors conducted a life safety inspection, in which fire walls, exit signs, accessibility of corridors, and other areas were assessed.
- All surveyors attended an interdisciplinary team meeting and observed staff-to-staff and staff-to-resident interaction in the care planning process.
- Three of the five surveyors noted privacy and dignity issues such as homelike rooms and privacy curtains when touring the units.
- Two of the five surveyors noted staff treatment of residents during observation of a meal and during tours of the units.
- None of the surveyors observed clinical care delivery such as treatment of wounds, tracheotomy care, or removal of restraints.

The most striking difference between the observed JCAHO surveys and the HCFA survey protocols was the absence of time devoted to care observation or staff treatment of residents. The JCAHO survey process does call for the investigation of resident care and treatment areas through observation of “care, treatment, and services being provided,” however, we witnessed little time devoted to “observation” of these issues.²²⁶ The SOM, on the other hand, instructs surveyors to spend time in Task 5, Information Gathering, on observing residents and caregivers during care and treatment, at meals, and at various times of the day. Surveyors are also directed to “Devote as much time as possible during the survey to doing observations and conducting formal and informal interviews...”²²⁷ The Federal survey and certification guidelines emphasize these as priority areas for survey, in a manner in which the five JCAHO surveyors observed did not.

7.2.1.4 Documentation Review

All surveyors spent some amount of time in reviewing documents such as facility policies and procedures, open and closed medical records, personnel records and minutes from meetings. Most document review was conducted in a conference room in the presence of some facility staff. For example, most surveyors reviewed facility policies while interviewing department heads, and

²²⁶ Joint Commission on Accreditation of HealthCare Organizations, *The Complete Guide to the Survey Process: Long Term Care, Subacute Care, and Dementia Units*. 1997. (p. 75).

²²⁷ Department of Health and Human Services, Health Care Financing Administration. *State Operations Manual*, Revision 274. June 1995. (p.21).

some reviewed the personnel records with the assistance of Human Resource and other facility staff.

The JCAHO survey process for open medical record review suggests a 10 percent sample; however, the number of records reviewed varied over the surveys we observed. Open medical record review was performed at the nursing stations on the resident units by four of the five surveyors. Surveyors varied in their selection criteria for the open record sample. All stated that they try to get a “mix” of residents at the facility, and all selected some residents to review based upon tours of the units and discussions of special needs with staff. What one surveyor considered a “special needs” patient seemed to vary across surveyors. For example, while one LTC surveyor requested a record for a resident on restraints, another subacute care surveyor defined special needs patients as those requiring heavy care, rehabilitation, and those who were younger in age than other patients.

Only one surveyor described a routinized approach to selecting the sample, and said that she did this in order to “cover all the [JCAHO] standards”. She requested one record for each of the following issues: new admissions, rehabilitation, urinary tract or other infections, psychotropic drugs, long term residents, residents with weight loss, and behavioral problem residents. She then reviewed these records with each relevant staff member (e.g., dietary for residents with weight loss, physical therapy for those residents receiving rehabilitation) during their interview in order to elicit some summary-level information about the residents and to provide the staff members with feedback on her review. Her sampling framework was consistent with information found in the *JCAHO Guide to the Survey Process*.

For four of the five surveyors, the open record review was comprised of verifying the presence of specific items, such as the date of admission or the presence of a history and physical performed by the physician. Only one surveyor spent time reviewing resident assessments against care plans and nursing or therapy notes, to see that plans matched resident condition and/or were implemented. That same surveyor was the only one who reviewed records against observations of resident status to determine whether highest practicable levels of well being or ADL function were attained or maintained (42 CFR 483.25) by the facility.

Though the JCAHO process as observed and the Federal survey and certification process both involve medical record and other document review, the JCAHO process varied by surveyor and followed no clear investigatory path. This is different from the Federal survey and certification process, which calls for a formal sampling method, intended to capture a casemix-stratified sample of residents for review. The components of the resident review are dictated by the SOM and include not only an assessment of the presence of certain information in the medical record, but an evaluation of resident function and examination of care planning goals and implementation of those goals.

7.2.1.5 Data Collection Tools

Four of the five surveyors utilized some written protocols to prompt them in addressing JCAHO standards during staff interviews. These surveyors stated that they create their own worksheets and data collection protocols to facilitate the survey process. The worksheets we reviewed varied in format and content, and were a combination of interview questions, JCAHO standards, and medical record audit sheets. We discussed the use of survey protocols with the Joint Commission, who did point out that the recently published *Guide to the Survey Process* contains sample survey agendas and examples of questions surveyors might ask, which may be used by surveyors in preparation for their long term care surveys²²⁸. JCAHO also confirmed that surveyors were not required to use any particular survey worksheet when documenting survey findings. The one surveyor who did not use any worksheets or interview guides stated that she has a good memory and did not feel that she needed additional paper [to complete the survey].

There is little comparison between the JCAHO process and the Federal survey process in this regard; State and Federal surveyors are instructed to document all findings on pre-designed survey worksheets for each information-gathering task. Examples of the survey worksheets are: the roster/sample matrix (HCFA-802), the resident review worksheet (HCFA-805), and the quality of life assessment worksheets (HCFA-806A, B and C).

7.2.2 Time Spent on Particular Activities

As stated earlier, the JCAHO surveys observed were characterized by the use of direct questioning of staff as the primary mode of investigation. In attempts to quantify how much time was spent engaged in this type of activity, we have combined the minutes spent over all surveys on the following interviews: performance improvement, administrative, nursing and medical leadership, admissions/social services, activities, human resources/staff development, and rehabilitative services. Across all surveys, these areas of investigation were comprised entirely of direct interview, and always took place in a non-patient care area such as a conference room or department head's office. Over the four observations, JCAHO surveyors spent an average of 5.5 hours on these interviews (of the roughly 22 hours spent onsite).

In terms of time spent in resident or family interview, the time spent by individual surveyors ranged from under 5 minutes to 15 minutes per resident, and from under 5 minutes to 90 minutes total time spent over the course of all surveys.

Time spent in observation of the environment of care varied from no time spent to 1¼ hours spent. All surveyors spent about 2 hours each in touring the buildings as part of the life safety

²²⁸ Joint Commission on Accreditation of HealthCare Organizations, *The Complete Guide to the Survey Process: Long Term Care, Subacute Care, and Dementia Units*. 1997.

inspection. Again, no time was spent by any surveyor in observing staff render care or treatment to residents.

Review of open medical records averaged about 1½ hours on the four surveys. The least amount of time spent was 30 minutes; the most was just over 2 hours. Other documentation review, such as closed medical record review, was either not observed or interspersed with interviews and thus not separately measured.

7.2.3 Decision Making

The decision-making process utilized in a JCAHO survey is somewhat complex, due to the aggregation rules imbedded in the JCAHO's survey software, and the presence of "capped" standards, which the JCAHO uses to allow facilities time to become accustomed to having to comply with those standards. In this study, we therefore attempted to follow informally the thought process behind surveyors' decisions, by discussing with surveyors their thoughts about facility compliance with JCAHO standards, and by sitting in on the daily debriefings in which surveyors would to present findings to facility management from the previous day of survey. We found some degree of variation in the standards noted and/or mentioned to facility management or to the Abt team with those that were actually cited in the accreditation recommendation. When asked about the apparent discrepancies, surveyors offered various explanations. Most surveyors were observed to informally discuss or point out potentially isolated issues to facility staff. Some applied judgement as to whether the facility would act upon recommendations in the absence of written presentation of findings, and expressed confidence that this would indeed happen. These surveyors therefore did not find it necessary to document all findings or recommendations. Other surveyors stated that findings do not always "score" when entered into the laptop computer program. Some examples of the types of preliminary findings that surveyors shared with Abt observers and facility managers but did not result in citations or recommendations include:

- Lack of evidence of restraint reduction;
- Identification and tracking of infection control issues;
- Presence of infection control risks;
- Behavioral and psychotropic monitoring;
- Measurable care planning goals;
- Failure to obtain a physicians signature for verbal orders within 72 hours; and
- Failure of care plans to articulate advance directives.

The software program does not require surveyors to systematically review all JCAHO standards when documenting findings. The program allows surveyors to skip to standards they wish to document and score, and to ignore the remainder of the standards. Again, some surveyors had created survey worksheets to prompt them to address all resident-focused and organization functions required by the JCAHO; others did not utilize such tools.

Other observations of the JCAHO decision-making process include the documentation of findings and decisions, and the potential impact of the JCAHO review team on the survey decisions made by onsite surveyors. It was clear during our observations of all surveys and discussions with surveyors that the documentation of findings of a long term care survey via the survey software was a laborious process. Surveyors spent anywhere between 45 minutes to 3 hours onsite in documenting survey findings prior to conducting exit conferences with facility management. Many described hours of off-site computer documentation in addition to the onsite preparation. One surveyor admitted that it was so difficult to complete the survey within the required 3-day timeframe that she hoped not to discover any problems in the facility, due to the documentation burden and additional investigation that would be required. This additional burden was described as necessary to offer enough evidence for the recommendations to be acted upon by the JCAHO review committee, which is located at the Joint Commission headquarters and reviews all survey findings and makes decisions regarding the adequacy of the evidence used to support the surveyors' findings and recommendations. According to the surveyors interviewed, the committee also evaluates surveyor performance through this review. Three of the five surveyors expressed some discomfort with this review process. One surveyor also described some uneasiness with being evaluated by the facilities she surveys. Facilities undergoing JCAHO accreditation surveys complete performance evaluations of their JCAHO surveyor, and this evaluation is heavily weighted in the surveyor performance review system. This surveyor expressed some misgiving that such a system could allow her to objectively assess compliance with quality standards while being evaluated as a customer service representative of the accrediting organization.

7.3 Conclusions

Though the Abt Associates project team did gain firsthand experience and understanding of the JCAHO LTC survey process through these onsite observations, any conclusions drawn must be tempered by the small sample size and its limited generalizability. We do, however, believe that we observed enough of the Joint Commission process to conclude the following:

- The strength of the process lies in the professionalism and qualifications of the survey staff;
- Some areas of HCFA concern are addressed in the JCAHO survey;
- There are areas of the process which are not comparable to the Federal survey and certification process which may be of concern to HCFA; and
- Finally, the implementation and outcomes of the accreditation process vary by surveyor.

We found the five surveyors exceptionally professional and knowledgeable about long term care, both in the administrative and clinical care aspects of this provider setting. All have hands-on experience in management of LTC or subacute facilities, and bring to their jobs a realism about staff and residential life in a facility. Each surveyor displayed a commitment to "customer service" for the Joint Commission customers, i.e., the facilities. This philosophy contrasts with the HCFA approach, which is based on the view of the resident/beneficiary as the "customer." This JCAHO

outlook is evidenced by the degree of consultation and education administered throughout the surveys observed. Additionally, all surveyors exhibited a willingness to reconsider evidence and to listen to facility explanations for issues which may have been identified as areas of concern or noncompliance with JCAHO standards.

Though some areas of HCFA concern were addressed during the surveys observed, we conclude that the standard JCAHO survey does not collect sufficient information regarding a LTC facility's compliance with HCFA's Requirements for LTC Facilities. All JCAHO surveyors asked some questions of facility management about notices of resident rights and facility services, all looked to some degree at the use of physical restraints, and all discussed patient assessment and care planning in the facilities surveyed. However, the focus of the Joint Commission survey process as implemented on the observational surveys was not on determining whether care plans matched resident condition and/or were implemented, or that highest practicable levels of well being or ADL function were attained or maintained (42 CFR 483.25) in the facilities. There was minimal time spent by surveyors on assessing the quality of life experienced by residents in the facilities surveyed. The largest number of residents interviewed in any survey was 6 residents, (and this in a 114 bed LTC facility). Meal observations or observations of resident care being rendered were not high priority areas, as evidenced by the little to no time spent by surveyors in these investigational activities.

Time spent onsite was insufficient to obtain enough information to evaluate care delivery and facility practices. JCAHO surveyors interviewed expressed real concern about their ability to evaluate all accreditation standards in the 3-day timeframe allotted for survey. One surveyor noted that she gained comfort in the fact that the State would also survey every facility she accredits for two reasons: 1) she is not always comfortable that she has thoroughly reviewed the facility in her short time onsite; and 2) she finds value in that additional level of facility oversight.

The investigational techniques and tools utilized by JCAHO surveyors vary, as do the decision-making processes which drive the outcomes of the accreditation survey. The majority of surveyors observed created their own interview protocols and audit tools to facilitate implementation of the survey; however, these tools varied in their scope, and were not consistently completed during our observations. The decision-making process observed during the surveys was inconsistently implemented, as some findings were reported in the accreditation recommendation and some were not. The survey software takes away some of the subjective judgment of the surveyor by aggregating the grid scores, however, the software does not require surveyors to address each JCAHO standard. Therefore, surveyors may or may not complete a uniform, comprehensive accreditation survey while onsite.

8.0 COMPARATIVE ANALYSIS OF HCFA AND JCAHO SURVEY RESULTS

8.1 Introduction

This study activity, comparing the results of HCFA and JCAHO surveys for a sample of long term care facilities, was designed to assess whether the application of the JCAHO survey process can be expected to provide reasonable assurance that long term care facilities accredited by the JCAHO may also be assumed to be in substantial compliance with all of the Medicare requirements for long term care facilities. While other components of this involved detailed analyses of the JCAHO standards, the JCAHO survey process, comparisons of surveyor qualifications and training, comparisons of enforcement and follow-up options available to JCAHO and HCFA, this activity focuses on survey outcomes. The activity is intended to determine whether, irrespective of the structure of an evaluation system and the survey processes used to arrive at a conclusion, the end results of the HCFA and JCAHO survey processes are similar in their determinations about a facility's degree of compliance with regulations and/or standards.

8.2 Sample

8.2.1 Sample Selection

JCAHO supplied Abt Associates with a file containing some limited demographic data on all long term care facilities accredited by JCAHO as of February 5, 1997 (a total of 1,517 facilities). This listing was matched by Abt to HCFA's OSCAR database, which contains information on all federally-certified long term care facilities. JCAHO and HCFA each have their own separate systems of unique identifiers for their facilities (an HCO number and a Medicare Provider Number, respectively), neither of which is contained in both databases. Therefore, JCAHO and HCFA records could be matched only on the basis of name and address. Of a total of 1,517 JCAHO accredited facilities listed in the JCAHO database, matches were found in the OSCAR database for 1,232, or 81 percent of the JCAHO facilities. While there were a number of minor data problems detected during the matching process (e.g., several duplicate records were located in the JCAHO database), the sizeable number of accredited facilities for which no matches could be located in the OSCAR database led to an investigation of possible explanations and a search for commonalities among the non-matching facilities.

Initial review of the list of unmatched facilities showed that they are virtually all hospital-based. In addition, 47 percent are Veteran's Administration facilities, which are not surveyed by the States and would thus not be expected to be found in the OSCAR database. In an attempt to determine whether there was a single explanation for the remaining facilities, phone calls were made to a random sample of 10 providers on the list to inquire about their certification status. Nine of the ten hospitals contacted indicated that they own and operate nursing homes that are physically separate from the hospital. JCAHO policy is to accredit these nursing homes for Long

Term Care as a component of the hospital's accreditation and to list them under the hospital name in the JCAHO database. HCFA, on the other hand, surveys these nursing homes as independent entities and lists them in the OSCAR database by the nursing facility name. Because the nursing facilities are at separate addresses and operate under separate names from that of the hospitals, they could not be identified through the matching of the JCAHO and OSCAR files based on name and address. The tenth provider indicated that the facility previously included a skilled nursing unit but that it was closed approximately two years ago. Therefore, the provider would not be expected to be found in current OSCAR data. With a pattern of responses among nine out of ten providers, the most likely explanation for a large proportion of the unmatched facilities appears, then, to be the former example - freestanding long term care facilities owned and operated by hospitals. There is no reason to believe that the omission of these facilities from the sample for this study would bias the results.

The comparison sample of 200 facilities was selected in a multi-stage process from the group of facilities with matching records in the JCAHO listing and the OSCAR database. Since the JCAHO accreditation survey occurs once every three years rather than annually, the sample first was reduced to the group of facilities with both JCAHO and HCFA surveys that occurred after July 1, 1995 in order to include only surveys conducted since the implementation of the new enforcement regulation. There were 610 records that met this criterion.

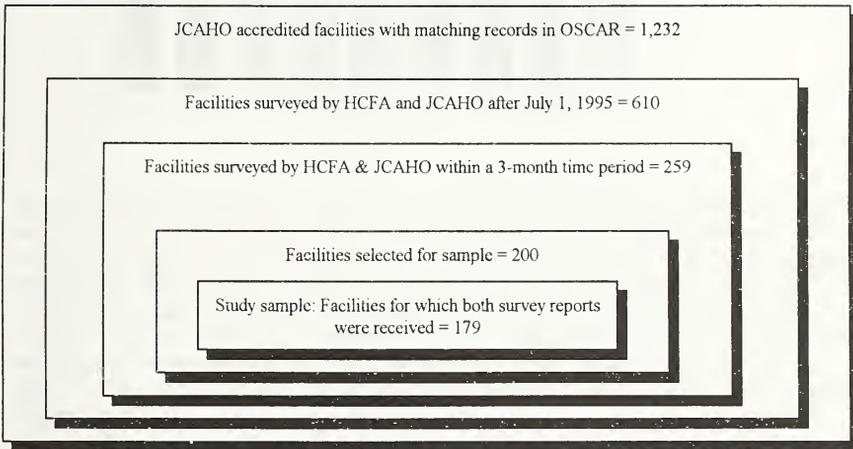
One-to-one comparison of HCFA and JCAHO survey reports is complicated by the fact that the presence of each organization's surveyors in the facility at different points in time raises the question of whether the two survey processes may be reasonably expected to identify similar issues, given that the facility itself may have undergone significant changes during the time period between the two surveys. The decision was thus made to limit the sample to surveys conducted no more than three months (90 days) apart in order to minimize the likelihood of drastic differences in the facilities themselves. Limiting the sample to facilities that were surveyed by both HCFA and JCAHO within a three-month time period yielded a total of 259 facilities. Of these facilities, 127 were surveyed first in time by JCAHO and then subsequently by HCFA, while the remaining 132 were surveyed first by HCFA.

Because the focus of this study was to determine whether or not the JCAHO process provides reasonable assurance that non-compliance with HCFA regulations will be identified, it was decided that the 127 facilities that were surveyed first by JCAHO would automatically be included in the sample so that, to the extent possible given the criteria for sample selection defined above, JCAHO survey results would not be confounded by a recent HCFA survey. The remaining 73 facilities needed to complete the sample of 200 were selected from among the facilities surveyed first by HCFA. This portion of the sample selection was completed in a two-step manner. First, one-half (36) were selected at random. The remaining one-half (37) were selected based on the results of their HCFA and JCAHO surveys, in an effort to ensure sufficient representation in the sample of facilities with significant problems identified on their HCFA surveys. Those selected were: (1) facilities with the most divergent survey results, based on JCAHO accreditation status

and HCFA severity rating; (2) facilities HCFA determined to have been providing substandard quality of care; and (3) facilities with the greatest number of deficiencies cited by HCFA.

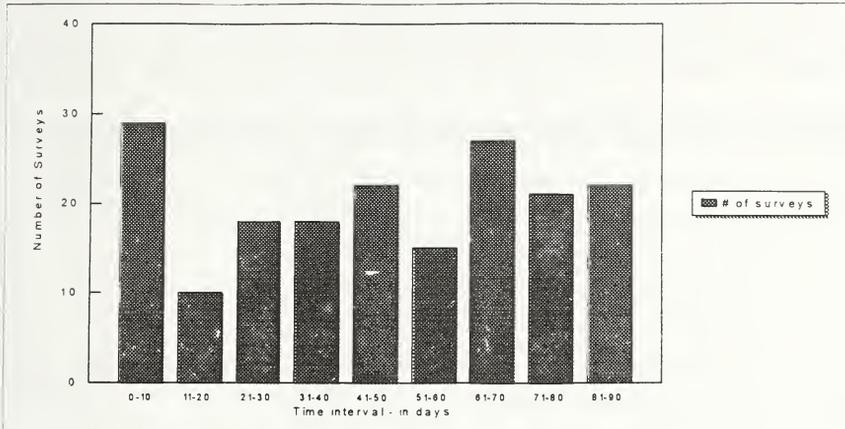
The complete JCAHO survey reports and HCFA 2567 reports for the 200 facilities selected were requested from JCAHO and HCFA. Abt received all 200 JCAHO reports, but only 186 corresponding 2567's. Of those 186 reports, seven were reports for surveys conducted on dates other than those requested, placing them outside the 3-month window needed for inclusion in the sample. The facilities for which Abt received either no 2567, or a 2567 for a survey other than the one requested, were excluded from the sample, leaving a total of 179 surveys that were compared for this task. The strategy used to arrive at the study sample is also depicted in Exhibit 8.1.

Exhibit 8.1 Sampling Strategy



As defined by the sampling criteria, the time intervals between the HCFA and JCAHO surveys reviewed ranged from 0-90 days. The mean time span between surveys in our sample was 46.7 days and the median was 48.5 days. As can be seen from the distribution of time intervals for the sample shown in Exhibit 8.2 below, the sample does not appear to be skewed toward either extreme, though the highest frequency for a single 10-day window was seen in the interval of 0-10 days.

Exhibit 8.2 Time Intervals Between Surveys



In order to determine whether the differences in time intervals between the HCFA and JCAHO surveys in the sampled facilities might be a significant factor in explaining differences in the two sets of survey results, a test of association between the time interval and the degree of divergence in the results was conducted. The results of each HCFA and JCAHO survey were categorized on a scale of 1 through 4 (from best to worst), based on the JCAHO accreditation decision and the severity level of the highest HCFA deficiency cited. The absolute difference between these two rankings was used as a measure of divergence between the two sets of survey results for each facility. Using the multinomial, ordered logit model, regression analysis was employed to observe the amount of variation in the difference between rankings (taken as the dependent variable) which could be explained by the variation in the time interval between surveys (the independent variable). The results of this analysis showed no statistically significant association between the two variables, with a Chi-squared value of 0.05, which is well below the critical value of 3.841 necessary to render the association statistically significant. This finding is further corroborated by the very low R^2 value of 0.010.

8.2.2 Generalizability of Findings

Some opponents of private accreditation and deemed status as a means for assuring compliance with Federal regulation for nursing homes argue that any conclusions drawn about the broader applicability of accreditation based on currently accredited facilities are not generalizable to the universe of nursing homes because the JCAHO accredited segment of the population is a unique, self-selecting subset of facilities that is not representative of the industry as a whole. Some argue

that only facilities providing higher than average quality services seek and are willing to pay for accreditation. Based on anecdotal evidence, Abt derived a number of working hypotheses regarding facility characteristics that might be expected to be associated with the likelihood of JCAHO accreditation. The factors that were hypothesized as potentially being associated with the likelihood of JCAHO accreditation were delineated into several domains, as shown in Exhibit 8.3.

Exhibit 8.3 Factors Expected to Be Associated with Likelihood of JCAHO Accreditation

Domain	Factor
General Facility Attributes	profit status
	multi-facility (chain) or independent
	payor mix
	freestanding or hospital-based
	categorized as SNF, SNF/JF, or NF
Location	urban or rural
	distribution by State
Quality	# of deficiencies on most recent survey
	scope/severity ratings on most recent survey
	medication error rate
Special Services Provided	# of special care beds for:
	AIDS
	Alzheimers
	Huntington's
	dialysis
	disabled children
	ventilator-dependent
	head trauma
	hospice
	specialized rehab
Resident Profile/Acuity	% of residents completely dependent in ADL's:
	bathing
	dressing
	transferring

Domain	Factor
	toileting
	eating
	% of residents:
	with catheters
	incontinent of bladder
	bedfast
	restrained
	independently ambulatory
	with dementia
	with pressure sores
	receiving IV therapy, parenteral nutrition, or transfusion
	receiving respiratory therapy
	receiving tube feedings
	receiving specialized rehab
	had at least 1 skilled nursing or rehab service in last week
receiving psychoactive medications	

These hypotheses were tested by comparing the population of JCAHO accredited facilities that Abt was able to match to OSCAR data with the non-JCAHO accredited certified facilities. In addition, the representativeness of the 179-facility study sample of the population of JCAHO accredited facilities and of all certified facilities was assessed based on a subset of the factors listed above.

8.2.2.1 Comparison of JCAHO-Accredited Facilities with All Other Certified Facilities

JCAHO-accredited facilities differ from facilities that are not JCAHO-accredited along a variety of characteristics. In many cases, however, these differences are quite small in magnitude. Exhibit 8.4 below presents descriptive statistics on payor mix, location, quality, special services, and resident characteristics for JCAHO-accredited and non-accredited nursing homes. The proportions and means were tested for statistically significant differences across the two samples.

Exhibit 8.4 Nursing Home Characteristics by JCAHO Accreditation Status

	JCAHO-Accredited (N = 1,232)	Not Accredited by JCAHO (N = 15,144)
<i>Payor Mix:</i>		
% Medicaid Residents***	56%	62%
% Medicare Residents***	19%	14%
% Other Payor Residents	24%	25%
<i>Location, Size and Type of Facility:</i>		
Urban***	78%	64%
% Located in Northeast***	41%	17%
% Located in South	22%	33%
% Located in West*	12%	14%
% Located in Central***	25%	36%
Mean Residents Per Facility***	105.5	86.9
Multi-Facility Organization***	56%	52%
Hospital-Based***	30%	12%
<i>Quality:</i>		
Medication Error Rate*** ²²⁹	.85	.00
Mean # of Deficiencies on Most Recent Survey***	4.3	5.1
% with Highest Scope/Severity Rating of G or worse on Most Recent Survey***	23%	26%
<i>Special Services Provided:</i>		
AIDS Beds Per Resident	.40%	.20%
Alzheimer's Disease Beds Per Resident	7.9%	5.6%
Huntington's Disease Beds Per Resident	.04%	.04%
Dialysis Beds Per Resident	.01%	.08%

²²⁹ A comparison of medication error rates across facilities may be inappropriate because different facilities can have different error potential. The medication error rate is based on the number of medication passes observed by the surveyors, which may vary across facilities.

	JCAHO-Accredited (N = 1,232)	Not Accredited by JCAHO (N = 15,144)
Disabled Youth Beds Per Resident	.44%	.36%
Ventilator Dependent Beds Per Resident***	.56%	1.8%
Head Trauma Beds Per Resident**	.61%	.21%
Hospice Beds Per Resident	.22%	.44%
Rehabilitation Beds Per Resident***	3.6%	2.0%
<i>Resident Characteristics:</i>		
%Residents Totally Dependent for Bathing**	44%	41%
% Residents Totally Dependent for Dressing***	41%	37%
% Residents Totally Dependent for Transferring**	32%	29%
% Residents Totally Dependent for Using Toilet**	38%	35%
% Residents Totally Dependent for Eating**	23%	20%
% Residents with Catheters*	9.2%	7.7%
% Residents Incontinent of Bladder	49%	49%
% Residents Restrained	18%	17%
% Residents Bedfast	9%	8%
% Residents with Dementia**	38%	41%
% Residents with Pressure Sores	8%	7%
% Residents Receiving IV Therapy, Parenteral Nutrition or Blood Transfusion	2%	2%
% Residents Receiving Respiratory Therapy	9%	7%
% Residents Receiving Tube Feeding***	9.3%	6.3%
% Residents Receiving Special Rehabilitation***	24%	19%
% Residents Received at least One Skilled Nursing/Rehab Service Visit during Past Week***	44%	36%
% Residents Receiving Psychoactive Medications	42%	44%

Notes: Proportions tested using two sample proportions test based on normal distribution

Means tested using two sample t-test with unequal variances

Two sided p-values

*** indicates p-value ≤ .01

** indicates p-value > .01 & ≤ .05

* indicates p-value > .05 & ≤ .10

Beds Per Resident ratios were created by dividing total beds by total number of residents.

(i.e. # AIDS beds in facility/total residents in facility = AIDS beds per resident)

Northeastern region includes CT DC DE MA MD ME NH NJ NY PA RI VT

Southern region includes AL AR FL GA KY LA MS NC OK SC TN TX VA WV

The descriptive statistics indicate that JCAHO-accredited facilities have higher percentages of Medicare residents and lower percentages of Medicaid residents compared to those not JCAHO-accredited. Both groups of nursing homes have similar proportions of residents with other payment sources (i.e. private insurance, out-of-pocket). Surprisingly, JCAHO-accredited nursing homes are more likely than non-accredited nursing homes to be not-for-profit or government owned. JCAHO facilities are more likely than non-JCAHO facilities to be classified as a SNF/NF. (see Exhibits 8.5 and 8.6) JCAHO facilities also are significantly more likely than non-JCAHO facilities to be large, hospital-based, and located in a northeastern, urban area. Non-JCAHO nursing homes tend to be smaller and located in southern States.

Exhibit 8.5 Profit Status by JCAHO Accreditation Status

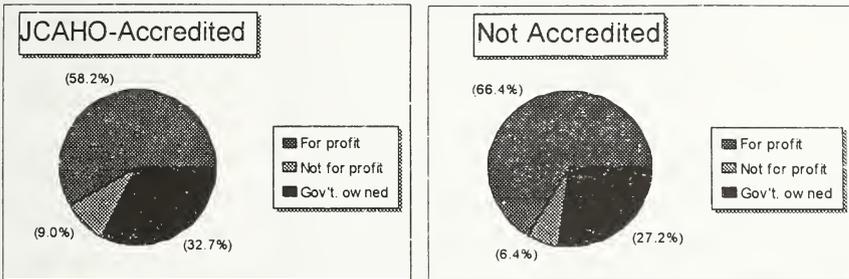
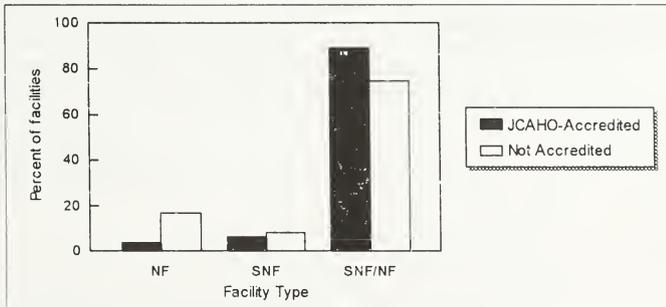


Exhibit 8.6. Facility Type by JCAHO Accreditation Status



On average, JCAHO-accredited nursing homes perform slightly better than non-JCAHO nursing homes in the HCFA survey process. JCAHO facilities average 4.2 deficiencies on the most recent survey compared to a mean of 5.1 deficiencies in the non-JCAHO group. JCAHO facilities also are less likely than non-JCAHO facilities to have received a scope/severity rating of G or higher on their most recent survey. Although the descriptive statistics demonstrate that JCAHO nursing homes have a significantly higher medication error rate compared to non-JCAHO nursing homes, for both groups this medication error rate is quite low. The distribution of highest scope/severity rating on the most recent survey for JCAHO and non-JCAHO facilities is illustrated in Exhibits 8.7 and 8.8.

Exhibit 8.7 Differences in Highest Scope/Severity Rating by JCAHO Status

	JCAHO Accredited	Not JCAHO Accredited
% With No Deficiencies***	24%	21%
% With Highest Score of A	4%	4%
% With Highest Score of B	3%	4%
% With Highest Score of C***	3%	5%
% With Highest Score of D*	14%	12%
% With Highest Score of E	23%	21%
% With Highest Score of F	7%	8%
% With Highest Score of G	19%	20%
% With Highest Score of H	3%	4%
% With Highest Score of I***	.1%	.8%
% With Highest Score of J	0%	.1%
% With Highest Score of K	0%	.2%
% With Highest Score of L	.1%	.1%

Notes: 99 facilities were omitted from this analysis because they had non-missing scope/severity ratings and zero deficiencies. The scope/severity distribution for this group was similar to that of the population. The exclusion of these facilities, therefore, probably did not affect the results.

Proportions tested using two sample proportions test based on normal distribution

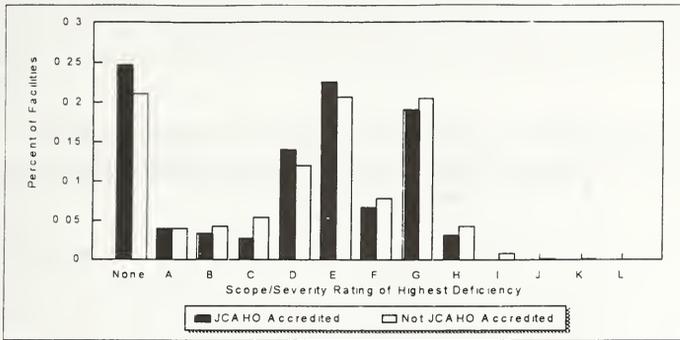
Two sided p-values

*** indicates p-value $\leq .01$

** indicates p-value $> .01$ & $\leq .05$

* indicates p-value $> .05$ & $\leq .10$

Exhibit 8.8 Comparative Distribution of Highest Deficiencies



JCAHO facilities and non-JCAHO facilities appear to offer similar specialized care services, even though JCAHO nursing homes care for more totally dependent residents. JCAHO facilities and non-JCAHO facilities share similar bed/resident ratios for AIDS, Alzheimer's disease, Huntington's disease, dialysis, hospice and disabled youth. Compared to the non-JCAHO nursing homes, however, JCAHO-accredited facilities have higher proportions of residents totally dependent in eating, bathing, dressing, and other activities of daily living.

The preceding discussion was based on descriptive statistics rather than a formal model. The decision to seek JCAHO accreditation can be modeled as an observed, binary choice. Presumably, some unobserved, normally distributed dependent variable underlies this process (i.e. net benefits gained from JCAHO accreditation). In this situation, a simple probit model can be used to learn more about the determinants of JCAHO accreditation. Compared to the descriptive statistics, this approach has the advantage of being able to control for potentially confounding independent variables.

Many of the variables listed in Exhibit 8.4 are highly correlated with each other. In particular, the resident characteristics are very highly positively correlated. Additionally, the payor characteristics tend to share a strong, negative relationship. For example, nursing homes with high proportions of Medicare residents tend to have low proportions of Medicaid residents. To prevent serious multicollinearity problems in the analysis, a sub-set of the variables in Exhibit 8.4 were included as independent variables in the probit model. The dependent variable is a 0/1 variable indicating whether or not the nursing home is accredited by JCAHO.

It is important to note that the quality indicators listed in Exhibit 8.4 initially were excluded from the analysis because they are potentially endogenous. In this context, endogeneity refers to the possibility that the decision to seek JCAHO accreditation both affects quality and is affected by

quality. If an endogenous variable is included as a covariate, regression estimates are biased and inconsistent. Because a formal test for endogeneity is not conducted in this analysis, models were estimated both with and without the quality indicators as covariates. Both sets of estimates are presented in Exhibits 8.9 and 8.10 but only the models *without* quality covariates are discussed in this section.

**Exhibit 8.9 Dependent Variable -- Accredited by JCAHO (Binary Variable)
Probit Estimates (without potentially endogenous quality covariates)**

	coefficient (standard error)
% Medicare Residents	-.094 (.107)
Urban	.221*** (.041)
Not-for-Profit	.001 (.073)
Government	-.118*** (.042)
Hospital Based	1.06*** (.058)
Multi Facility Organization	.302*** (.036)
Skilled Nursing Facility	-.151 (.108)
Skilled Nursing Facility/Nursing Facility	.413*** (.068)
Located in South	-.677*** (.046)
Located in West	-.706*** (.055)
Located in Central	-.541*** (.043)
Total # Residents in Facility	.002*** (.000)
AIDS Beds Per Resident	.291 (.220)
Alzheimer's Disease Beds Per Resident	.021** (.010)

	coefficient (standard error)
Huntington's Disease Beds Per Resident	1.18 (1.78)
Dialysis Beds Per Resident	-6.21 (5.76)
Disabled Youth Beds Per Resident	.021 (.089)
Ventilator Dependent Beds Per Resident	.252*** (.097)
Head Trauma Beds Per Resident	.959*** (.305)
Hospice Beds Per Resident	-.155 (.316)
Rehabilitation Beds Per Resident	.033 (.046)
% Residents Dependent for Using Toilet	.318*** (.100)
% Residents Bedfast	-.444*** (.157)
% Residents with Pressure Sores	.272 (.221)
% Residents Received at least One Skilled Nursing/Rehab Service Visit during Past Week	.067 (.063)
% Residents Receiving Psychoactive Medications	.005 (.091)
% Residents Ambulatory	-.874*** (.139)
Pseudo R2	.13

Notes: *** indicates p-value \leq .01

** indicates p-value $>$.01 & \leq .05

* indicates p-value $>$.05 & \leq .10

Beds Per Resident ratios were created by dividing total beds by total number of residents.

(i.e. # AIDS beds in facility/total residents in facility = AIDS beds per resident)

Northeastern region includes CT DC DE MA MD ME NH NJ NY PA RI VT

Southern region includes AL AR FL GA KY LA MS NC OK SC TN TX VA WV

Western region includes AK AZ CA HI ID NM NV OR UT WA

Central region includes CO IA IL IN KS MI MN MO MT ND NE OH SD WI WY

**Exhibit 8.10 Dependent Variable -- Accredited by JCAHO (Binary Variable)
Probit Estimates w/ Potentially Endogenous Quality Covariates**

	coefficient (standard error)
% Medicare Residents	-.102 (.107)
Urban	.225*** (.041)
Not-for-Profit	-.002 (.073)
Government	-.122*** (.042)
Hospital Based	1.06*** (.058)
Multi Facility Organization	.304*** (.036)
Skilled Nursing Facility	-.153 (.108)
Skilled Nursing Facility/Nursing Facility	.417*** (.069)
Located in South	-.664*** (.047)
Located in West	-.667*** (.058)
Located in Central	-.523*** (.044)
Total # Residents in Facility	.002*** (.000)
AIDS Beds Per Resident	.292 (.219)
Alzheimer's Disease Beds Per Resident	.021** (.010)
Huntington's Disease Beds Per Resident	1.18 (1.79)
Dialysis Beds Per Resident	-6.22 (5.81)

	coefficient (standard error)
Disabled Youth Beds Per Resident	.021 (.090)
Ventilator Dependent Beds Per Resident	.252*** (.097)
Head Trauma Beds Per Resident	.944*** (.306)
Hospice Beds Per Resident	-.161 (.317)
Rehabilitation Beds Per Resident	.033 (.046)
% Residents Dependent for Using Toilet	.325*** (.100)
% Residents Bedfast	-.450*** (.157)
% Residents with Pressure Sores	.306 (.221)
% Residents Received at least One Skilled Nursing/Rehab Service Visit during Past Week	.063 (.063)
% Residents Receiving Psychoactive Medications	.003 (.091)
% Residents Ambulatory	-.872*** (.139)
Total Number of Deficiencies in Last HCFA Survey	-.006** (.003)
Medication Error Rate	.001 (.004)
Pseudo R2	.13

Notes: *** indicates p-value<=.01

** indicates p-value>.01 & <=.05

* indicates p-value>.05 & <=.10

Beds Per Resident ratios were created by dividing total beds by total number of residents.

(i.e. # AIDS beds in facility/total residents in facility = AIDS beds per resident)

Northeastern region includes CT DC DE MA MD ME NH NJ NY PA RI VT

Southern region includes AL AR FL GA KY LA MS NC OK SC TN TX VA WV

Western region includes AK AZ CA HI ID NM NV OR UT WA

Central region includes CO IA IL IN KS MI MN MO MT ND NE OH SD WI WY

Overall, the probit models confirm the descriptive statistics findings presented in Exhibit 8.4. Nursing home location, type of facility, and size are powerful determinants of JCAHO accreditation status. Controlling for other factors, larger facilities located in northeastern urban centers have a higher probability of seeking JCAHO accreditation compared to smaller nursing homes located in rural areas and in other regions of the country. Hospital-based, skilled nursing facility/nursing facility and multi-facility status variables also are excellent predictors of JCAHO accreditation. After controlling for a variety of characteristics, for profit status and Medicare caseload are not significantly related to the JCAHO accreditation decision. Government-owned facilities, however, are less likely than others to seek JCAHO accreditation.

The availability of specialized bed services generally has no significant impact on the likelihood of JCAHO accreditation. Only two specialized bed services -- head trauma and ventilator -- are significantly related to JCAHO accreditation. Both of these services are positively associated with accreditation, suggesting that nursing homes with high proportions of severely disabled residents are more likely than others to seek JCAHO accreditation. Other evidence supported this hypothesis. Resident characteristics that indicate disability (i.e. % residents dependent in ADL's, % residents receiving skilled nursing or rehab visits) also are positively associated with JCAHO accreditation.

Both the descriptive statistics and the regression analysis presented in this section support several hypotheses about the determinants of JCAHO accreditation. First of all, JCAHO-accredited nursing homes tend to be larger, hospital-based facilities with residents that require relatively intensive care. Compared to non-JCAHO nursing homes, the accredited facilities are more likely to be located in urban areas and in the northeastern part of the country. The descriptive statistics indicate statistically significant, small differences in HCFA survey performance between JCAHO and non-JCAHO facilities.

8.2.2.2 Comparison of Sampled Facilities to JCAHO-Accredited Facilities and to All Other Certified Facilities

Another objective of this section was to assess the representativeness of the 179 nursing homes in the survey comparison task sample by comparing sample facilities to two other groups of facilities: (1) all certified facilities (N = 16,376); and (2) all JCAHO accredited facilities with matching records in OSCAR (N = 1,232). To ensure validity of the statistical tests, the comparison was conducted between mutually exclusive samples. Descriptive statistics are displayed below in Exhibits 8.11 and 8.12.

Exhibit 8.11 General Nursing Home Attributes by Sample

	Certified Nursing Home Population - Sample (OSCAR 1996) (N = 16,197)	Sample (N = 179)
% Medicaid Residents	61%	57%
% Medicare Residents	14%	19%
% Other Payor Residents	25%	24%
% Located in Northeast***	19%	34%
% Located in South***	32%	23%
% Located in West	14%	13%
% Located in Central	35%	31%
Mean Residents Per Facility***	88.0	113.1
Mean # of Deficiencies on Most Recent Survey**	5.0	6.2
Highest Scope/Severity Rating on Most Recent Survey was G or Worse	26%	30%
Urban***	65%	82%

Notes: Proportions tested using two sample proportions test based on normal distribution

Means tested using two sample t-test with unequal variances

Two sided p-values

*** indicates p-value $\leq .01$

** indicates p-value $> .01$ & $\leq .05$

* indicates p-value $> .05$ & $\leq .10$

Exhibit 8.12 General Nursing Home Attributes by Sample

	JCAHO-Accredited - Sample (N = 1,053)	Sample (N = 179)
% Medicaid Residents	56%	57%
% Medicare Residents	19%	19%
% Other Payor Residents	25%	24%
% Located in Northeast***	43%	34%
% Located in South	22%	23%
% Located in West	12%	13%
% Located in Central**	23%	31%
Mean # Residents Per Facility*	104.2	113.0
Mean # of Deficiencies on Most Recent Survey***	4.0	6.2
Highest Scope/Severity Rating on Most Recent Survey was G or Worse***	21%	30%
Urban	77%	82%

Notes: Proportions tested using two sample proportions test based on normal distribution

Means tested using two sample t-test with unequal variances

Two sided p-values

*** indicates p-value \leq .01

** indicates p-value $>$.01 & \leq .05

* indicates p-value $>$.05 & \leq .10

Compared to all other certified nursing homes, facilities included in the study sample are larger, more likely to be located in the Northeast and more likely to be located in urban areas.

Unsurprisingly, nursing homes included in the study sample have higher numbers of HCFA deficiencies than all facilities. As described earlier, facilities with high numbers of deficiencies were over sampled.

The sampled nursing homes also were compared to all other JCAHO-accredited facilities. Again, the nursing homes in the sample tend to have more deficiencies. In this case, however, the sample facilities are less likely than all JCAHO facilities to be located in the Northeast. Otherwise, as in the previous comparison, the two groups have quite similar characteristics.

The comparison between the analysis sample and the two larger nursing home samples revealed that, in general, the analysis sample reasonably represents the population of nursing homes. The study sample's higher level of HCFA deficiencies can be explained by the sampling strategy. It also is not surprising that Northeastern facilities are over-represented in the analysis sample

compared to the entire universe of certified facilities, the analysis sample contains only JCAHO-accredited facilities which were more likely than others to be located in the Northeast. It is not clear, however, why the geographical distribution of the sampled nursing homes varies somewhat from the remainder of the JCAHO-accredited facilities. Nevertheless, it is unlikely that these relatively small differences in geographical distribution will have important implications for the comparison of survey results.

8.3 Methods

Data were abstracted from the HCFA and JCAHO survey reports by three Abt staff members on the basis of the protocol attached as Appendix D. For each facility, the abstractor recorded the JCAHO accreditation decision, the type of follow-up required to demonstrate compliance with Type I recommendations, and the summary grid score. Each standard for which the facility received a Type I or a Supplemental recommendation was recorded, along with:

- the score assigned to the standard and the corresponding grid element score,
- the types of supporting documentation listed by the surveyors in the survey report,
- the number of residents affected and sample size on which the recommendation was based (when this information was provided in the evidence), and
- a brief summary of the evidence of non-compliance found in the survey report.

The abstractor also indicated whether the standard referenced was specific to subacute programs or dementia units.

A similar process was followed for data abstraction from the HCFA 2567 forms. The abstractor recorded:

- The HCFA tag number cited,
- The scope and severity of the deficiency,
- The supporting documentation and sample size noted in the survey report, and
- A brief description of the deficiency.

In addition, the abstractor noted whether or not the deficiency fell into the regulatory groupings of Resident Behavior and Facility Practices, Quality of Care, or Quality of Life, which have the potential to generate a finding of substandard quality of care (SQC), and whether or not, based on the scope/severity rating, the deficiency did, indeed, result in a finding of substandard quality of care.

JCAHO has crosswalked its standards to the HCFA long term care regulations. The crosswalk is contained in the 1996 Comprehensive Accreditation Manual for Long Term Care (CAMLTC). This crosswalk served as the basis for determining equivalent HCFA tags for standards resulting in recommendations in the JCAHO survey reports. As also noted in the content analysis of

standards, although the standards and F-tags are crosswalked, the equivalence is not of a one-to-one relationship. JCAHO standards may be more or less comprehensive than any one HCFA F-tag to which they are crosswalked, so that the issues described in the JCAHO survey report supporting evidence may or may not be similar to those on the HCFA 2567, despite the existence of a crosswalk to an equivalent HCFA tag. In cases where standards and tags were equivalent based on the crosswalk, they were listed in the comparison section of the abstraction protocol. In reviewing and categorizing the survey results however, the abstractor made determinations about the actual similarity of findings based on the summaries of evidence provided.

Conversely, there were cases where the JCAHO standard was not crosswalked to a specific HCFA F-tag, but the evidence provided in the survey report characterized an issue similar to a deficiency cited by HCFA. This may have occurred due to variances in surveyor decision making allowed for within the two processes. For example, in a facility failing to appropriately assess, care plan for, and treat residents with pressure sores, one group of surveyors may have described the problem as one of assessment and care planning, which the other group of surveyors may have chosen to list it under the care area of pressure sores. On a weekly basis, these types of instances were discussed by the abstractors and the Project Director as a group and decisions were made on a case-by-case basis as to whether the findings were similar despite the lack of a direct crosswalk between the standard and the tag.

All completed survey abstraction protocols were reviewed by an Abt analyst, who categorized and grouped them on the basis of overall similarities and differences noted. The categories employed were developed through discussion between the abstractors and the Project Director regarding the patterns noted in the data abstraction process. In order to assess inter-rater reliability for the categorization process, a second individual, who is familiar with the data by way of participation in the abstraction process, also categorized a sample of 10 of the surveys. The two individuals categorizing these 10 surveys achieved 90 percent agreement.

In addition to the qualitative comparison based on categorization of the degree of similarity between survey results, the patterns of citation (expressed as frequencies of recommendations or citations for specific standards/tags) and the types of supporting documentation mentioned by surveyors in their descriptions of evidence of non-compliance were examined to aid in further characterizing the differences between the two processes and their outcomes.

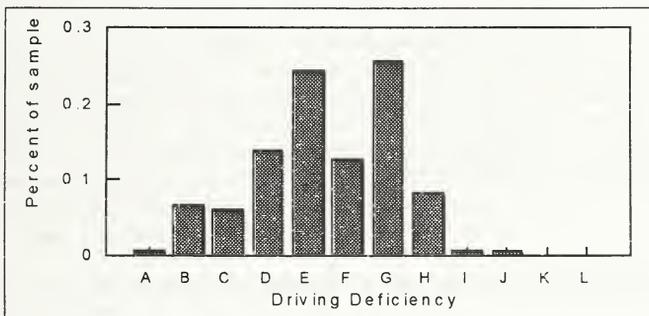
8.4 Findings

8.4.1 Overview

The findings presented herein represent the review of 179 surveys containing a total of 1280 HCFA deficiencies, 2170 JCAHO standards cited for Type 1 Recommendations and 1080 JCAHO standards cited for Supplemental Recommendations, each of which was abstracted for inclusion in the analysis. JCAHO surveys tended to have a relatively high number of standards

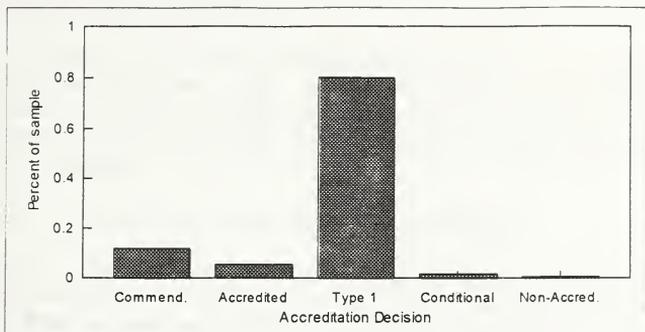
cited per survey, on average, as compared to average numbers of deficiencies on the HCFA surveys. This, however, appears to be more a function of the methods the two organizations' surveyors use in recording findings than it is a reflection on outcomes. Many JCAHO standards are narrowly focused or filter down from a broad topic to sub-sections that are increasingly narrower. Often, a single fact pattern demonstrating non-compliance is used to cite multiple standards that are all inter-related. While HCFA surveyors may also cross-reference information and cite a single issue at multiple tag numbers, the number of tags cited in this manner is generally far less than on JCAHO surveys, on average. The number of standards cited for Type 1 Recommendations for surveys in our sample ranged from 0 to 116, with an average of 10.85 per survey. There were generally fewer standards cited in connection with Supplemental Recommendations, ranging from 0 to 74 and averaging 5.4 per survey. The sampled HCFA surveys averaged 6.4 deficiencies per survey, with a range of 0 to 30.

Exhibit 8.13 HCFA Driving Deficiency Distribution (in review sample)



The distributions of HCFA driving deficiencies and of JCAHO Accreditation Decisions were also calculated and are shown in Exhibits 8.13 and 8.14.

Exhibit 8.14 JCAHO Accreditation Decision Distribution (in review sample)



As can be seen from the above distribution, the vast majority (80 percent) of JCAHO surveys reviewed resulted in a determination of Accreditation with Type 1 Recommendations. This distribution roughly approximates the overall distribution of JCAHO Accreditation Decisions for 1996. There are virtually no objective measures by which this category of accreditation may be further delineated to create a more meaningful distribution that could be more closely aligned with the HCFA scope and severity ratings. An attempt was made to delineate the category of Accreditation with Type 1 Recommendations into subgroups based on the type of follow-up action required. This yielded the distribution shown in Exhibit 8 15.

Exhibit 8.15 Types of Follow-Up Required for Facilities Accredited with Type 1 Recommendations

Follow-up Required	Number of Facilities	Percent of Facilities
6-month written progress report	117	81.2
1-month written progress report	2	1.4
1-month and 6-month written progress reports	20	13.9
6-month written progress report and focused survey	2	1.4
1-month plan of correction and focused survey	3	2.1

Because this distribution is dominated by one category of follow-up action (six-month written progress report), it was decided to focus primarily on the qualitative aspect of the analysis to derive conclusions about comparative survey outcomes rather than to attempt to map the JCAHO

categories deficiencies to the HCFA categories of deficiencies, resulting in a quantitative comparison that would be largely artificial.

The data collected for this task permitted comparison and contrast of several additional overall patterns noted in each of the two processes. The two primary areas where marked differences were noted were: 1) the issues or problem areas that each of the two processes identified and recorded; and, 2) the types of documentation cited in the survey reports as the basis for decisions regarding non-compliance.

8.4.1.1 Most Frequently Cited Deficiencies and Standards

Frequencies were calculated of the HCFA regulations and JCAHO standards that the sampled survey reports listed as out of compliance. The regulations/standards most commonly identified through each of the two processes are shown in Exhibits 8.16 and 8.17 below. It is interesting to note that, although the sample of surveys reviewed for this task was not specifically designed to be representative of all HCFA surveys, all of the deficiencies listed below are also among the most frequently cited by HCFA nationally.

Exhibit 8.16: HCFA Most Commonly Cited Deficiencies in Sampled Facilities

Frequency (% of surveys including this citation)	F-Tag Number(s)	Regulation
32	371	The facility must store, prepare, and distribute food under sanitary conditions.
28	272	The facility must make a comprehensive assessment of a resident's needs.
28	279	The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.
24	221	The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.
21	241	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.
19	323	The facility must ensure that the resident environment remains as free of accident hazards as possible.
19	314	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable.
19	309	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.
17	246	A resident has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.
16	312	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.
16	324	The facility must ensure that each resident receives adequate supervision and assistive devices to prevent accidents.

Exhibit 8.17 JCAHO Most Common Type 1 Recommendations in Sampled Facilities

Frequency (% of surveys including citation)	Standard Number(s)	Standard
24	PF.2.2	The care planning process incorporates information from the resident's assessment about his or her education needs. This education includes explaining the resident's and family's responsibilities in the resident's care.
23	PE.1.1.9	[The initial assessment of each resident includes] the resident's dental status and oral health, including the condition of the oral cavity, teeth, and tooth-supporting structures; the presence or absence of natural teeth or dentures; and the ability to function with or without natural teeth or dentures.
21	PE.1.1.10	[The initial assessment of each resident includes] the resident's pain, including its origin, location, severity, alleviating and exacerbating factors, and current treatment and response to treatment.
19	EC.1.8	A management plan addresses medical equipment.
18	HR.6.1.1	Credentials are verified
18	HR.6	All individuals permitted by law and the organization to practice independently are authorized to do so through a defined process.
18	LD.2.8	A systematic process is used for credentialing licensed independent practitioners.
17	HR.6.1	The organization adopts uniformly applied credentialing criteria to licensed independent practitioners applying to provide resident care or treatment under the organization's auspices.
14	EC.1.4	A management plan addresses security.
13	PI.3.2.2	The organization collects data about the appropriateness of care.

The majority of the JCAHO standards listed above (with the exception of PF 2.2, EC.1.4 and PI.3.2.2) are also among those JCAHO surveyors most frequently score out of compliance on a national basis, indicating that the citation patterns observed in the study sample are not atypical.

8.4.1.2 Documentation Utilized in Assessment of Compliance

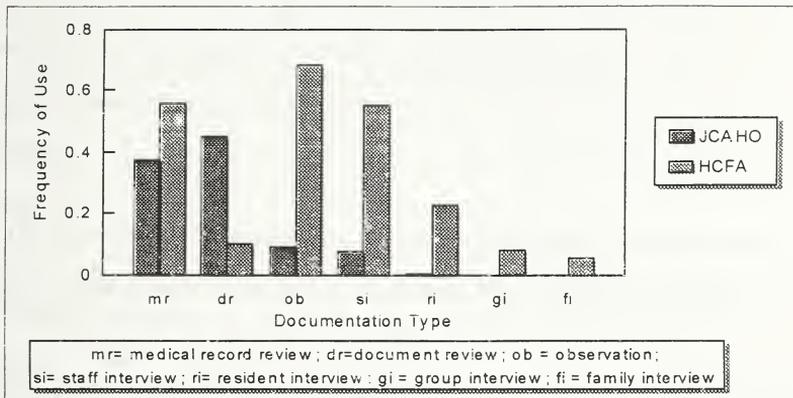
Patterns of documentation noted in comparing the two groups of the survey reports were also very different. The documentation used by both organizations in assessing facility compliance with regulations and standards can generally be categorized into seven types:

- 1) Medical record review
- 2) Review of other documents (policies, procedure manuals, personnel records, etc)
- 3) Observation
- 4) Staff interview
- 5) Individual resident interview
- 6) Resident group interview

7) Family interview

Surveyors may base their evidence of non-compliance on one or any combination of these different types of supporting documentation. The JCAHO and HCFA processes differ substantially in the types of documentation most commonly used, as can be seen from the distributions in Exhibit 8.18 below.

Exhibit 8.18 Frequency of Documentation Types Used in Support of Deficiencies and Type 1 Recommendations



Differences were also noted in the number of different types of documentation the two groups of surveyors use in support of a citation. HCFA surveyors, on average, cite 2.2 types of documentation per deficiency, while JCAHO surveyors cite one.

8.4.2 Categorization of Results of One-to-One Comparison

The data abstracted from each facility survey were reviewed and categorized first into one of two groups based on whether or not the findings of the two surveys were generally similar or different. Fewer than one-third of the survey comparisons were determined to be similar in terms of the outcomes of the two survey processes. The remaining surveys differed in a number of ways, which were further grouped into four categories of differences. Each category of similarity or difference is discussed briefly below, illustrated by examples from the survey reports and abstracts.

8.4.2.1 Similar Findings

8.4.2.1.1 No Significant Problems Identified by Either Survey

Approximately 14 percent of the facilities in the sample appeared, based on analysis of both their HCFA and JCAHO survey reports, to have been in substantial compliance with the HCFA regulations and JCAHO standards. They received Accreditation with Commendation, Accreditation, or Accreditation with Type 1 Recommendations from JCAHO and minimal HCFA deficiencies, with none rated higher than level C on the scope/severity grid. While the specific issues noted on site by JCAHO and HCFA differed, the types of problems identified seemed likely to have little potential for any significant adverse impact on the residents, and therefore, the overall outcome of each survey was the same, i.e., a determination that the quality of care being provided by the facility was, at a minimum, acceptable and in accordance with expectations, or at best, providing exceptional care and services.

Examples:

Facility A:

JCAHO - Accredited with Commendation, no Type 1 or Supplemental Recommendations.

HCFA - One deficiency in Dietary Services, for improper food temperatures, assigned a scope/severity rating of C.

Facility B:

JCAHO - Accredited with Type 1 Recommendations, four Type 1 Recommendations, each scored a 3, in human resources and information management; two Supplemental Recommendations scored a 2, for lack of sufficient weekend activities and dust on linen carts.

HCFA - Three deficiencies, each rated a B, in dietary services for problems with sanitary food storage, and physical environment for insufficient privacy curtains in several rooms and lack of an exhaust vent in the janitor's closet.

8.4.2.1.2 Similar Problems Identified by Both Surveys

A second category of surveys, also representing about 14 percent of the sample, showed some degree of similarity in specific findings or in the overall determination of quality of services being provided. While some of the surveys in this group had findings of more significance than those in the previous category, the majority of the deficiencies still fell within the substantial compliance severity level and most included no citations at a severity level any higher than potential for harm.

The exception to the overall pattern of minimal problems in this group is the subset of sampled surveys that resulted in Conditional Accreditation (three surveys) or Non-Accreditation (one

survey) by JCAHO. In these four cases, both HCFA and JCAHO detected multiple, serious problems related to compliance with the standards/regulations. In each case, there were some specific findings on these HCFA and JCAHO surveys that were similar in nature and some that were not. The key finding with regard to these four surveys, however, is that, viewing the survey outcomes as a whole, the determinations of the two surveying bodies were similar. Joint Commission made determinations of non-compliance that resulted in adverse decisions for facilities that displayed clear quality problems. It must be noted, however, that these four surveys amount to only two percent of the overall sample reviewed and only 0.4 percent of all facilities surveyed by JCAHO in 1996 received decisions of Conditional or Non-Accredited.

Examples:

Facility C:

JCAHO and HCFA both noted problems with unsanitary conditions in food storage and preparation areas, including food spills, debris on utensils and surfaces, and improper cleaning and sanitizing of dishes. The deficiency was assigned a HCFA/scope/severity rating of B and a JCAHO score of 3.

Facility D:

JCAHO and HCFA surveyors both identified non-compliance with regard to the use of restraints. JCAHO indicated that restraints found to be in use for 3 of 5 sampled residents were inconsistent with documentation in their medical records and assigned the standard a score of 3. HCFA found that 4 of 22 residents lacked appropriate assessment for restraint use, indication for use, and assessment for gradual restraint reduction. HCFA determined the scope/severity to be an E.

8.4.2.2 *Findings Differ*

For the remaining surveys in the sample (approximately 72 percent of the total), it was determined that the JCAHO findings were dissimilar from the HCFA findings. In each of these facilities, HCFA identified deficient practices posing the potential for harm or having caused actual harm to residents that were not detected by the JCAHO surveyors. These surveys were grouped into four sub-categories based on the levels of scope/severity of findings on the HCFA surveys that were not identified by JCAHO, including:

- 1) HCFA findings indicate potential for harm or actual harm, but at isolated levels of scope
- 2) HCFA findings of pattern or widespread potential for harm, not in the SQC regulatory groups
- 3) HCFA findings in SQC regulatory groups, but at lesser scope than required for a finding of SQC

4) HCFA findings of SQC and actual harm

8.4.2.2.1 HCFA Findings Indicate Potential for Harm or Actual Harm, but at Isolated Levels of Scope

For this group of surveys, representing about 19 percent of the overall sample, quality problems having caused actual harm to residents or having the potential for harm were detected on the HCFA survey but were not noted by JCAHO. However, it is important to note that the HCFA findings were for isolated levels of scope -- affecting only one or two residents. Other deficiencies noted on these surveys were at the level of substantial compliance.

Examples:

Facility E:

JCAHO - Accredited with Type 1 Recommendations, facility received three Type 1 Recommendations in the areas of: (1) assessment, for failing to complete required oral assessments and pain assessments; (2) medication use, for failing to consistently document resident response to pain medications; and (3) resident-specific data and information, for failing to identify progress toward nursing care goals in monthly nursing summaries. The facility received no Supplemental Recommendations.

HCFA - Survey identified six deficiencies, all rated scope/severity level D. The facility was cited for: (1) failure to care plan appropriately for two residents; (2) failure to provide services in accordance with the care plans for two residents; (3) failure to provide appropriate adaptive equipment to allow one resident to eat independently; (4) failure to provide recommended adaptive equipment to maintain range of motion and prevent contractures for one resident; (5) failure to address one resident's agitation, aggressive and self-abusive behavior; and (6) failure to ensure adequate supervision of two residents to prevent accidents.

Facility F:

JCAHO - Facility Accredited (no Type 1 Recommendations). Facility received four Supplemental Recommendations: (1) medical histories and physicals not completed within the required time frame; (2) resident care plan had an essential, critical goal that was not measurable; (3) the transfer agreement in the contract book was outdated and there was no systematic process for keeping contracts up to date; and (4) 30-day re-orders in records were not dated.

HCFA - The facility received four deficiencies, three of which were assigned a scope/severity level of D: (1) one resident did not receive assistance during meals per the resident's care plan; (2) two residents requiring assistance with ADL's did not receive necessary services to maintain grooming and hygiene; and (3) one resident did not receive needed assistance and supervision to prevent accidents. The fourth deficiency was rated at a scope/severity level of G and was issued

for the failure to provide needed services to maintain or increase range of motion and prevent further decrease.

8.4.2.2.2 *HCFA Findings of Pattern or Widespread Potential for Harm, Not in the SQC Regulatory Groups*

This group of surveys each contained at least one HCFA finding identified as having the potential for harm at a scope of pattern or widespread (rated a scope/severity of E or F) that was not identified on the JCAHO survey. The findings of E or F for surveys in this category however, are limited to deficiencies outside the regulatory groups that carry the potential for a determination of substandard quality of care. These citations generally include issues such as administration, physical plant, dietary services, and resident assessment. Other deficiencies on these HCFA surveys were at the levels of substantial compliance or isolated scope. This category represented about 16 percent of the sample.

Examples:

Facility G:

JCAHO - Accredited with Type 1 Recommendations. The facility received four Type 1 Recommendations for, (1) failure to develop interim care plans; (2) credentialing process for independent practitioners that was limited to license verification; (3) lack of management plans for security and medical equipment, and (4) failure to implement a complete credentialing process. The facility also received Supplemental Recommendations in the areas of the Medical Director's written responsibilities and staff training in performance improvement.

HCFA - The facility received seven deficiencies, two of which were rated a scope/severity of F: (1) failure to store food under sanitary conditions in a walk-in freezer; and (2) failure to secure drugs and biologicals in a locked, permanently affixed compartment directly supervised by authorized personnel. The facility was also cited for failure to post information about Medicare and Medicaid benefits, failure to ensure resident privacy, and failure to administer medications as ordered (all at scope/severity of A), and for failure to protect resident dignity and to adequately supervise the physical therapy room to prevent accidents (at scope/severity of D).

Facility H:

JCAHO - Facility Accredited with Type 1 Recommendations. The facility received four Type 1 Recommendations and one Supplemental Recommendation. Type 1's were in the areas of: (1) assessment - oral assessments not completed within the required time period and incomplete pain assessments; (2) care planning - care plans did not contain individual care and treatment goals; (3) leadership - no facility authorization for the several independent practitioners to practice; and (4) credentialing - lack of an appropriate process. A Supplemental Recommendation was received for the lack of a family and visitor council.

HCFA - The HCFA survey resulted in four deficiencies, two of which were at the scope/severity level E: (1) failure to provide sanitary conditions for food storage and preparation, and (2) failure to consistently verify CNA certification with the State registry. The remaining two deficiencies were for: (1) failure to complete the Resident Assessment Instrument for one resident (scope/severity A), and (2) failure to consistently carry out unannounced disaster drills (D).

8.4.2.2.3 HCFA Findings in SQC Regulatory Groups, but at Lesser Scope than Required for a Finding of SQC

This group of surveys contained HCFA findings not identified by JCAHO that had the potential to result in a determination of substandard quality of care based on the regulatory groupings cited, but did not because the surveyors determined that the scope of the deficiencies were limited to a pattern, rating them an E on the grid (just outside the SQC determination). This was the largest single category of surveys contained in the comparison sample, representing 30 percent of the total surveys reviewed.

Examples:

Facility I:

JCAHO - Accredited with Type 1 Recommendations. JCAHO issued 12 Type 1 Recommendations as a result of this survey: (1) physician orders for implementation of advance directives were not obtained in a timely manner (cited three times - under resident rights, information management, and resident rights for the subacute program); (2) assessments were not comprehensive; (3) some care plan goals were not measurable or lacked timeframes (cited twice - for long term care and subacute); (4) the subacute program was indistinguishable from traditional skilled nursing with regard to mission and philosophy; (5) subacute assessments failed to include patient and family needs, psychosocial factors, spiritual needs, oral health, pain, and activities; (6) no defined requirement for physician visits to subacute residents; (7) no drug-food interaction counseling provided to subacute residents; (8) incomplete documentation on credentialing and privileging for subacute (cited twice - under leadership and human resources), and (9) social service documentation did not include interventions, outcomes, or progress to goals. The facility received supplemental recommendations in the areas of planning and providing care, directing services, resident-specific data and information, and continuum of care.

HCFA - The facility received nine deficiencies, four of which were at scope/severity level E: (1) residents were restrained without documentation of medical necessity, evaluations, or trials of less restrictive measures; (2) CNA's were employed prior to receiving clearance from the State abuse registry; (3) cognitively impaired residents were not engaged in meaningful activity; care plans failed to identify activity preferences or customary routines; (4) care plan approaches for maintaining and/or improving ADL functioning were not implemented. Five additional deficiencies were cited: (1) staff did not knock prior to entering resident rooms (S/S = C); (2) snacks were not served in a timely manner during the day and not offered throughout the facility

at bedtime on a regular basis (S/S = F); (3) the pharmacist did not report all irregularities to physicians (S/S = F); (4) physicians did not act on consultant pharmacist's reports (S/S = F); and (5) drugs were not stored in locked compartments permitting only authorized access.

Facility J:

JCAHO - Accredited with no Type 1 or Supplemental Recommendations.

HCFA - The HCFA surveyors, assessing the facility three days after the JCAHO, cited six deficiencies, including one in the SQC regulatory groups at a scope/severity of E, for the failure to provide residents with limited range of motion the needed treatment and services to prevent further decline and increase range of motion. Also in the SQC regulatory groups, but cited at isolated scope (D), were: (1) the failure to assist residents with meals as required, and (2) the failure to prevent a resident from repeatedly leaving the facility unsupervised (a total of 48 times). Additional deficiencies cited were in the areas of failure to protect privacy by exposing residents during bathing and transfer (E), failure to post survey results, and failure to use appropriate infection control procedures during incontinence care.

8.4.2.2.4 HCFA Findings of SQC and Actual Harm

The final category in the sample, representing about 7 percent of the surveys reviewed, includes surveys with findings of substandard quality of care, most at the severity level of actual harm (scope/severity ratings of F, H or I) by HCFA. While this proportion may be slightly overstated due to the intentional selection into the sample of facilities with divergent survey results, it should be noted that the majority of surveys in this category (and all of the examples listed below) were not selected under this criterion, but under one of the other two selection methods employed for the study (i.e., they were surveyed by JCAHO prior to HCFA, or they were selected at random from among facilities surveyed by HCFA first).

The care issues noted by HCFA on these surveys were not detected by JCAHO during their accreditation surveys. Because this is the category of findings that raises the most concern as to whether the JCAHO process provides reasonable assurance that an accredited facility is in compliance with Medicare regulations, additional documentation was obtained for review of these cases, including OSCAR reports providing the three-year deficiency histories of the facilities, and HCFA 2567 forms providing the results of re-visit surveys to determine whether the facilities had corrected their deficiencies in a timely manner (prior to the re-visit).

Facility K: The facility was surveyed by HCFA less than three weeks prior to survey by the JCAHO.

JCAHO - The facility was accredited with commendation, receiving a summary grid score of 99. They received one Supplemental Recommendation, scored a 2, in the area of Resident-Specific

Data and Information, for failing to document resident response to discharge education in the medical record of one resident.

HCFA - The survey resulted in 18 deficiencies, four of which were rated a scope/severity level of H: (1) failure to provide needed social services for 11 of 28 sampled residents, including interventions to reduce the incidence of resident- and visitor-to resident abuse and to provide assistance to residents and staff in understanding resident behavior in the context of emotional needs; (2) failure to conduct assessments of causal/risk factors, potential complications, and restorative potential with regard to restraint usage, bladder incontinence, ADL's, falls, and weight loss for 20 of 28 sampled residents; (3) failure to develop care plan interventions for 15 of 28 residents to address medical and psychosocial needs including goals for mental health services treatment, restraint use and resident safety, abuse, restorative needs, refusal to ambulate, and social isolation; and (4) failure to properly supervise 7 of 28 residents assessed as at risk for falls, resulting in multiple falls, some of which caused injury to residents.

In addition, the facility received four citations at scope/severity level E: (1) failure to protect resident rights by obtaining consent for DNR orders for 6 residents from family members despite the residents' being aware, alert, and capable of independent decision-making; (2) failure to fully inform 4 of 4 residents of the risks of refusal of treatment; (3) failure to demonstrate that 13 of 20 restrained residents had been appropriately assessed for restraint use and that restraints in place were needed to treat medical symptoms; (4) 13 of 13 care plans for residents receiving mental health interventions failed to meet professional standards of quality and contained no measurable goals or timeframes.

Seven additional deficiencies were of limited scope (rated scope/severity of G), affecting one to three residents, and were in the areas of abuse, assessment, care planning, and quality of care (ADL's, incontinence care, nutritional status, and unnecessary drugs). Two deficiencies were rated D, for problems with staff treatment of residents and accommodation of needs, and one deficiency received a rating of A, for failure to inform residents of the bed-hold policy prior to transfer.

Review of the facility's OSCAR report indicated that several of the areas cited on this survey were repeat deficiencies that also appeared on the prior year's survey. Specifically, the repeat deficiencies were in the areas of accommodation of needs, comprehensive assessments, comprehensive care plans, provision of services in accord with residents' care plans, and supervision for the prevention of accidents. Three of these repeat citations were among those deficiencies rated a scope/severity of H on the survey reviewed.

A re-visit survey to assess correction of the deficiencies identified was conducted approximately 60 days following the certification survey, at which time the facility was determined to be in substantial compliance.

Facility L: The facility was surveyed by JCAHO approximately one month prior to the HCFA survey.

JCAHO - The facility was accredited with Type 1 Recommendations and received a summary grid score of 78. They were required to submit a plan of correction within one-month on 17 recommendations and were to receive a follow-up survey approximately four months following JCAHO's receipt of the plan of correction. The facility was surveyed for both long term care and subacute accreditation. Nine of the Type 1 Recommendations were for long term care standards and the remaining eight were for subacute services standards.

Long term care Type 1 Recommendations were made in the areas of (1) incomplete and undated restorative nursing assessments; (2) lack of documentation that residents with catheters were assessed for continued use and that catheters were changed monthly as ordered; (3) failure to address residents' educational needs in plans of care; (4) incomplete management plans for safety and emergency preparedness and lack of a management plan for security; (5) lack of a security management program; (6) no evidence of safety committee activities over the previous year; (7) smoking area not environmentally separate from resident care areas; (8) failure to consistently document response to restorative nursing care; and (9) accumulation of debris, lint, and dust in linen storage and medical supply storage areas

Subacute Type 1 Recommendations were made for: (1) failure to complete assessments within 48 hours of admission; (2) failure to perform quality control checks on glucometer each day of use; (3) failure to review care plans every two weeks for first quarter after admission; (4) failure to document attempts at less restrictive measures for residents in wrist restraints; (5) duties and responsibilities of the Medical Director were not delineated in policies and procedures or in written agreements; (6) personnel files did not contain current performance evaluations or copies of current licenses; (7) credentialing was not accomplished until the second day of the survey; and (8) plans of care did not address goals found in the medical record and records lacked bi-weekly social service progress notes during the first three months of admission.

Supplemental Recommendations were made in the areas of care planning, life safety code issues, and orientation and training on glucometer quality monitoring. While the facility clearly did not receive a flawless JCAHO survey, problem areas noted were primarily administrative and paper-oriented, related to documentation, assessment, record-keeping, and policies and procedures rather than to outcomes of care.

HCFA - The survey resulted in 12 deficiency citations, two of which were assigned a scope/severity of H and placed the facility in SQC. These deficiencies were both in the quality of care regulatory grouping. The first was for failure to provide grooming and personal hygiene care for six of 14 residents unable to care for themselves. Examples recounted in the supporting evidence include completely dependent residents who are incontinent of bladder and bowel left on soiled bed linens and incontinent pads, for one to three hours. Residents were also observed with

dried fecal matter under their fingernails and on other parts of their bodies. The second level H deficiency was for the failure to promote healing of pressure sores and prevent new ones from developing. Seven of 18 sampled residents had pressure sores, five of whom were not provided with appropriate care. Surveyors observed failure to turn and reposition residents appropriately and to make use of available pressure-relieving devices. Several newly-developed pressure sores were noted during the course of the survey.

In addition, one deficiency, for insufficient hot food temperatures, was assigned a scope/severity of F, and two were rated E: (1) failure to preserve residents' dignity for 6 of 21 sampled residents by staff speaking inappropriately harshly, failing to respond to call lights, failing to provide incontinence care to wet residents before meals, and disregarding residents' expressed choices related to music and care preferences; and (2) failure to use the State-mandated version of the RAI to complete resident assessments. The facility also received seven citations at isolated levels of scope (D or G) in the areas of ensuring operable call lights are in reach, significant change assessments, care planning, ensuring resident is not catheterized unless medically necessary, providing treatment to prevent UTI and restore bladder function in catheterized residents, and providing a system to ensure the accuracy of facility-performed lab testing.

Based on information provided by the State agency, the deficiencies at this facility were corrected on re-visit. The OSCAR report indicates, however, that on the subsequent annual survey (which is the most current for this facility) several of the same deficiencies were cited: ADL care for dependent residents, proper treatment to prevent and heal pressure sores, and appropriate treatment for incontinent residents.

Facility M: The facility was surveyed by HCFA approximately two and one-half months prior to the JCAHO survey and the HCFA re-visit was conducted approximately one week before the JCAHO survey.

JCAHO - The facility received Accreditation with Commendation, achieving a summary grid score of 97. Supplemental Recommendations, each scored a 2, were issued in the areas of: (1) failure to make complete pain assessments; (2) care plan goals not measurable and team members to provide care were not identified; and (3) effectiveness was not documented for medications given PRN (i.e., as needed).

HCFA - Surveyors cited 14 deficiencies, one of which was assigned a scope/severity of H, resulting in a determination of SQC. This deficiency was for the failure to provide appropriate care to 6 of 6 residents to prevent the development of avoidable pressure sores. Surveyors determined from medical records that not all residents at risk for skin breakdown were appropriately assessed and also observed that residents were not turned and pressure-relieving devices were not applied in accord with residents' plans of care.

Five additional deficiencies were assigned a scope/severity rating of E: (1) assessments failed to address needs in the areas of communication, psychosocial issues, ADL's, fall prevention, and incontinence; (2) care plans were not comprehensive, particularly with regard to skin care; (3) appropriate treatment and quarterly evaluations not provided to residents with limited range of motion; (4) inadequate staff to dress residents and transfer them out of bed; and (5) inadequate personal and oral hygiene care provided to dependent residents.

Remaining deficiencies were at lower levels of scope/severity and included citations in the areas of refusal of transfer (D), notification of transfer (D), urine odors and soiled surfaces throughout the building (B), peeling paint and marred walls (B), initial assessments not conducted within 14 days of admission (D), lack of a medical diagnosis indicating need for a catheter (D), improper food temperatures (B), and problems with functioning of exhaust fans and refrigerators (B).

A number of these deficiencies had been corrected prior to the revisit, however citations remained in several areas, though they were often assigned lower scope/severity ratings than on the annual survey. These areas of continuing non-compliance were: resident assessment (E), comprehensive care planning (E), and pressure sores (G). Five additional deficiencies were also cited during the re-visit, including: (1) failure to ensure privacy and confidentiality of medical records (D); (2) failure to investigate allegations of abuse (D); (3) discharge planning (D), supervision to prevent accidents (G), (4) unnecessary drugs (D), and (5) in-service education requirements for nurse aides (E).

Review of the facility's OSCAR report indicated that several of the citations on the annual survey and the re-visit are in domains that have been problematic for the facility in the past, as evidenced by citations on surveys conducted in prior years. The regulations the repeatedly failed to demonstrate compliance with were:

- Privacy and confidentiality - cited on two prior surveys
- Safe, clean, homelike environment - cited on two prior surveys
- Housekeeping and maintenance services - cited on three prior surveys
- Comprehensive assessment - cited on two prior surveys
- Comprehensive care plans - cited on three prior surveys
- Discharge planning - cited on two prior surveys
- Treatment to heal and prevent pressure sores - cited on three prior surveys
- Range of motion treatment and services - cited on two prior surveys
- Unnecessary drugs - cited on one prior survey
- Palatable food - cited on one prior survey

Facility N: The facility was surveyed by JCAHO approximately two weeks prior to HCFA survey.

JCAHO - The JCAHO survey resulted in a decision of Accreditation with Type 1 Recommendations. The facility received a summary grid score of 84 and was required to submit a written progress report on 13 Type 1 Recommendations within six months. The facility was surveyed for both long term care and subacute accreditation. The Type 1 Recommendations made for the subacute program were restatements of the same issue cited for long term care. Type 1 Recommendations were: (1) failure to make accurate and complete assessments during the time periods required and in response to changes in condition as required; (2) failure to appropriately monitor and calculate new rates of contractures; (3) improper storage and monitoring of drugs; (4) dietary issues including failure to care plan for nutritional needs, dusty air vents over food preparation area and improper handling of food, and failure to re-assess resident's nutritional needs subsequent to weight loss; (5) failure to have a documented and defined credentialing process (two recommendations issued - one under leadership the other under credentialing); (6) improper storage of flammable materials; (7) failure to properly document discharge summaries; and (8) infection control practices, including improper storage of urine and body fluid specimens and improper food handling procedures. The subacute program received Type 1 Recommendations based on the same evidence for nutrition care, credentialing, and infection control. The facility also received Supplemental Recommendations for urine odors noted in the facility and for utilizing staff performance evaluations that were generic and not based on individual job descriptions.

HCFA - The facility was cited for 27 deficiencies by the HCFA surveyors, seven of which were assigned scope/severity level H and placed the facility in the category of SQC. These deficiencies were: (1) mistreatment and neglect of residents, based on 2 of 19 dependent residents observed by surveyors lying in urine and feces for hours at a time; (2) failure to determine causes of unknown injuries and to report incidents as required for 6 of 21 residents; (3) failure to respect resident dignity, as demonstrated by 14 examples, affecting 9 of 19 residents, of exposure of resident body parts, failure to respond to call lights, rough handling of residents by staff, and masks worn by staff when not necessary or indicated; (4) failure to provide social services for 5 residents experiencing depression, grief, disturbances regarding treatment, and issues of dealing with restraints; (5) failure to provide appropriate care (turning, pressure-relieving devices, proper incontinence care) to 5 of 19 residents, resulting in the development or exacerbation of pressure sores; (6) failure to supervise and care plan appropriately for 6 of 21 residents, resulting in falls, bruises, and skin tears; and (7) failure to accommodate 9 residents' needs and preferences, including food preferences, bathing schedules, and requests for warmer blankets and gowns.

Four additional deficiencies received scope/severity ratings of H, but were outside the SQC regulatory groupings: (1) failure to notify physicians of injuries and deteriorations in condition requiring the attention of a physician for 5 residents; (2) failure to complete significant change assessments following marked declines for 2 residents; (3) failure to care plan for all identified needs and to establish measurable goals (13 examples); (4) inadequate staff to respond to resident needs including turning, changing diapers, and supervision to prevent injury.

Other deficiencies were at lesser levels of scope/severity. Eight were assigned level E: (1) failure to inform residents of potential side effects of psychoactive medications; (2) use of chemical restraints for convenience, i.e. to prevent residents from crawling out of bed; (3) inaccurate assessments; (4) failure to follow facility procedures for providing quality care to help residents achieve their highest practicable well-being (examples included care of dialysis patients, assessments following falls, pressure sore care, etc.); (5) failure to maintain a safe environment by storing hazardous materials in areas accessible to residents and failing to prevent slippage and falling hazards such as pooled water and boxes on the floor; (6) failure to prevent significant medication errors; (7) absence of a contract with dialysis providers serving residents; and (8) incomplete medical record documentation. The remaining deficiencies were all determined to be scope/severity level B and included the areas of resident rights regarding personal property, consent and free choice, activities for high and low functioning residents, urine and fecal odors, medication error rates, and provision of evening snacks.

Revisit information was not available for this facility at the time the interim report was being prepared, however review of the OSCAR report indicated that thirteen of the citations listed in the survey reviewed were repeated on the following annual survey (which is the most current one for this facility). The citations that appeared again on the subsequent survey were: residents' rights to be informed of their health status and medical condition, dignity, accommodation of needs, activities, social services, safe, clean, comfortable and homelike environment, comprehensive assessments, comprehensive care plans, quality of care to achieve highest practicable well-being, treatment to heal and prevent pressure sores, supervision to prevent accidents, sufficient nursing staff, and clinical records meeting professional standards. Two of these deficiencies - for dignity and sufficient nursing staff - were cited at a level H of scope/severity on the most recent survey.

8.5 Conclusions

8.5.1 Differences in Focus of Most Commonly Cited Issues

As can be seen from the comparison of the citations found in the highest frequencies in the sample, the types of problems identified during HCFA and JCAHO surveys are very different. This is largely a function of the two sets of standards themselves, which lead the surveyors to focus on different objectives. The most commonly cited deficiencies on HCFA surveys are largely resident-focused and outcome-based, addressing care and services the facility is required to ensure that each resident receives and the type of living environment the facility is expected to provide. In fact, of the 11 regulations listed in Table 3, five fall within the Quality of Care regulatory grouping and two within the Quality of Life grouping. Of the remaining four, one relates to dietary services, two to resident assessment and care planning, and one to resident rights.

The JCAHO standards with which facilities are most often found out of compliance are generally administrative, dealing with the presence or absence of required systems, policies, procedures, and

documentation. Four of these standards deal with the credentialing of licensed independent practitioners providing services within the facility, three address aspects of resident assessment and care planning, two relate to requirements that facilities have specific systems in place governing the environment of care (management plans for security and medical equipment), and one deals with performance improvement.

These patterns of citation call attention to the overall differences between the HCFA and Joint Commission standards and the differing philosophies that they represent. The JCAHO standards appear to be designed based on the philosophy that a facility that develops appropriate policies and procedures, hires qualified staff and provides them with appropriate, ongoing training, and practices techniques of performance improvement will necessarily provide high quality care to each of its residents. That is to say, the JCAHO standards and process focus on facility-level systems, without necessarily providing for an independent assessment of how those systems work in practice and whether, in a particular facility, they are sufficient to result in the best possible resident-level outcomes. The standards and process are designed to take a “top-down” look at a facility and to focus on the leadership and direction of the organization.

The HCFA regulations and survey process, on the other hand, look at a facility more from a “bottom-up” approach, assessing whether the end result of a facility’s practices is quality service provision to residents and positive outcomes -- the achievement of each resident’s “highest practicable well-being.” For example, under the HCFA regulations, it is not sufficient to have properly written skin care protocols, documented in-service training sessions on skin care for all direct care staff, and documentation in the medical record stating the residents are assessed for risk of skin breakdown. While all of these steps are important in achieving good outcomes, the most relevant question from the perspective of the HCFA regulations is: “Is the facility staff providing the necessary care and treatment to each resident to prevent the development and promote the healing of avoidable pressure sores?” The focus is on the outcome of the care provided to each resident.

8.5.2 Differences in Evidence Used in Determining Compliance

The differences in the standards and philosophies of the two organizations discussed above necessarily lead to differences in the types of evidence of compliance or non-compliance that the two groups of surveyors gather while on site. As can be seen in Exhibit 8.19, JCAHO surveyors’ primary sources of information about a facility (in descending order) are document review, medical record review, observation, staff interview, and resident interview. Within the sample of surveys reviewed, there were no reports that indicated Type 1 Recommendations were issued by JCAHO on the basis of resident group or family interviews. Also, on average, JCAHO surveyors indicate on survey reports that the non-compliance cited is based on one source of evidence. The JCAHO surveyors’ information-collection strategy, however, follows logically from the focal point of the standards - the assessment of the presence or absence and the appropriateness of

facility systems, as reflected in policy documents and clinical records and in the descriptions of the operation of basic systems by facility staff and leadership.

HCFA surveyors, on the other hand, are more likely to reference multiple sources of information in presenting their evidence (on average, 2.4 per deficiency). The most often-referenced evidence of non-compliance on the HCFA surveys reviewed was surveyor observation, followed by (in descending order): staff interview, medical record review, resident interview, document review, group interview, and family interview. These data-collection approaches, like those primarily used by JCAHO, follow from the focus of the regulations. Non-compliance with HCFA regulations is determined based on whether or not each resident (or each resident for whom the particular regulation is applicable if it relates to some subset of the resident population) received the services and whether the services provided were of acceptable quality and in accord with professional standards. Scope and severity of a deficiency is then determined by assessing whether or not the failure to meet the requirements resulted in harm to a resident or residents and the severity of that harm. Determination of these facts may require a combination of the methods listed above and may be impossible to make at all through a review of documents or records alone - particularly for issues relating to quality of life. Therefore, the HCFA surveyor relies more on his/her own observations in the facility and interviews with staff and residents.

8.5.3 Comparability of Results

As indicated in the description of findings from the one-to-one survey comparison, only 28 percent of the surveys in the sample were found to be relatively similar - either because similar problems were identified by both organizations or because there were no significant problems identified by either group. The remainder of the sample was found to have had different outcomes on each of the two surveys. Those surveys were grouped into four categories of difference based on the HCFA survey results, each of which has different implications in the determination of whether the JCAHO accreditation process provides reasonable assurance that accredited facilities have met all of the Medicare regulations.

The first group, where the HCFA findings of deficiencies not identified by JCAHO were of isolated scope, does not necessarily indicate that the criterion of reasonable assurance is not met. Because each survey is, by necessity, a snapshot in time and determinations are based on the sample of residents selected at that time for review, one cannot reasonably expect that two organizations surveying at different points in time would both select an identical sample and detect problems that affected only one or two residents in a facility. While the HCFA regulations stipulate that a facility must ensure full compliance with all conditions for *each* resident, determinations of deficiency with isolated scope are largely a function of sample selection and the somewhat random nature of onsite observations. As such, even if the comparison were being made between two HCFA surveys conducted at different points in time, identical determinations would not necessarily be expected to result. The likelihood of the two processes - HCFA and JCAHO - discovering the same problems in a facility that affect limited numbers of residents or

particular categories of residents might be increased somewhat if JCAHO were to make its resident sampling procedures more explicit and to modify them to more closely mirror the HCFA sample selection protocols.

The following two categories include HCFA surveys with findings at the scope and severity levels of E and F, indicating that problems exist that affect at least a pattern of residents and in some cases, potentially all residents in a facility. It is these findings that begin to raise concerns about the degree to which one can say with confidence that a JCAHO accredited facility may be assumed to be in compliance with the HCFA regulations. While the deficiencies identified on surveys in this category have not yet caused actual harm, the degree of non-compliance with regulations was determined to have the potential for adverse impact on numerous residents. Particularly for surveys in the second of these two categories, where the deficiencies fell within the SQC regulatory groupings, the failure of JCAHO to identify the issues found by HCFA calls into question whether this system is capable of ensuring residents sufficient protection from inappropriate facility practices that reflect poor quality of care or are detrimental to quality of life.

Likewise, the final category of survey results, those in which HCFA determined facilities to be providing substandard quality of care and to have caused actual harm to residents, leads to even greater doubt that the criterion of reasonable assurance of compliance with Medicare regulations can be met by the JCAHO accreditation process. The facilities in question all appear, based on their OSCAR reports, to have problematic histories, with many of the same deficiencies appearing repeatedly on surveys from year to year, indicating that the HCFA findings on the sampled surveys are unlikely to be atypical for these facilities. Two of these facilities were awarded Accreditation with Commendation by JCAHO, indicating that the JCAHO surveyors regarded them to be providing exceptional care. While the remaining two facilities received Type I Recommendations, the problems identified were primarily administrative, policy- and procedure-oriented and not directly related to the types of egregious care practices and quality of life violations noted by the HCFA surveyors. Therefore, even if the facilities were to achieve correction of all the JCAHO-identified deficiencies, there is no guarantee that residents would be protected from the types of violations cited by HCFA.

The results of this comparison indicate that JCAHO Accreditation may be comparable to HCFA certification primarily in facilities where there are no serious problems and as such, may be appropriate as a replacement for certification surveys for facilities that have a proven track record of good performance and have demonstrated that they have consistently achieved some minimum level of quality. It is questionable, however, whether the JCAHO process, as currently applied in most cases, is capable of uncovering serious quality of care and quality of life deficiencies that have the potential to severely compromise resident health, safety, and/or psychosocial well-being. The findings of this study indicate that in over 50 percent of the surveys reviewed (the last three categories of differences), significant problems were identified by HCFA that the Joint Commission failed to detect, resulting in these facilities receiving JCAHO Accreditation. Therefore, accreditation in its present form may not be an acceptable replacement for HCFA

certification in all facilities, as this seems unlikely to provide sufficient protection for the rights of all Medicare beneficiaries to quality health care services.

9.0 COMPARISON BETWEEN THE JOINT COMMISSION ACCREDITATION SURVEY AND A CONCURRENT NURSING HOME QUALITY SURVEY

9.1 Background

The purpose of this study is to determine whether the Joint Commission (JCAHO) accreditation survey identifies important quality of care deficiencies detected in a concurrent quality assessment. This concurrent quality assessment conducted by University of Colorado researchers (CU) is based on recommendations from the Institute of Medicine's (IOM) committee on nursing home regulation (IOM, 1986), the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), and the HCFA survey procedures published in the State Operations Manual. If the JCAHO accreditation findings are consistent with a quality assessment that uses these principles, even if the survey activities differ, then it supports granting of deemed status. However, if quality problems detected by a rigorous quality assessment based upon these principles are not detected in the JCAHO survey, doubts about the appropriateness of deemed status are raised.

9.1.1 CU Survey Development

The HCFA requirements and survey process have undergone evolution since the 1986 IOM report and OBRA '87 nursing home reform legislation. However, the major tenets underpinning the IOM's recommendations remain central to the survey process. These tenets include: (1) use of resident-centered outcome and process indicators; (2) comparisons with norms; (3) use of uniform and reliable data; and (4) consideration of case mix. The focus of the HCFA survey has been shifted to resident-centered outcome and process indicators (tenet #1) with particular emphasis on certain case mix groups (tenet #4). However, comparisons with norms (tenet #2) using the minimum data set (MDS) as a source of uniform data (tenet #3) is conducted only in selected States with fully computerized MDS data.

The survey used by CU for comparison purposes in this study was developed and used initially to evaluate the consistency and validity of the revised HCFA survey process in the 1991 Nursing Home Survey Evaluation conducted by Abt Associates and CU. This survey was designed to assess quality of care in nursing homes and not other areas such as quality of life, administrative structure/organization, and physical plants. However, there is some overlap in these areas because quality of care can be influenced by these other attributes of nursing home care. In the CU survey, the four underlying tenets of the IOM recommendations for quality assessment were rendered operational in the following ways:

- (1) Resident-Centered and Outcome Process Indicators: Quality indicators were selected from approaches used in extant research on nursing home quality assessment. These included outcome measures based on changes in status occurring between two time points and process measures relating to specific services provided to individual residents. Quality indicators were

then chosen for quality of care domains (e.g., functional maintenance, incontinence, restraint use) that pertain to specific requirements in the Federal regulations.

- (2) Comparison with Norms: The standard used for comparative purposes was based on norms for over 50 facilities contributing to a national data base previously obtained using this quality assessment tool. The comparisons involved a random census sample, a random admission sample, and case-mix stratified samples totaling more than 80 residents per facility.
- (3) Uniform and Reliable Data: To assure that uniform, reliable data were collected, nurse researchers followed a specific protocol for abstracting information from the MDS and resident charts, interviewing staff, and observing residents. The information was recorded using defined categorical responses rather than open-ended description so that identical information was available on every resident.
- (4) Consideration of Case Mix: Several approaches were used to take facility case mix into consideration. First, samples of residents at risk for specific problems were selected for analysis in addition to a random sample. Second, residents for whom a specific indicator was inappropriate because of some comorbid condition were excluded from analyses using that indicator. Third, a second stage of review was conducted to assess specific cases and determine whether patient characteristics were the cause of the poor outcome, thus rendering the outcome justifiable.

9.1.2 Quality Domains

Over 80 quality indicators representing 17 quality of care domains are included in the CU survey. Validity of the quality of care domains and indicators included in the CU survey is strongly supported by extant literature on measurement of nursing home quality and the consensus of clinicians experienced in nursing home care who assisted in selecting these indicators. For example, fundamental quality of care issues in nursing homes such as nutrition,²³⁰ performance in activities of daily living (ADLs),²³¹ and occurrence of falls²³² are assessed using indicators that have received substantial attention in the literature. Outcomes and care related to incontinence are important due to the prevalence of incontinence among nursing home residents, and CU includes several indicators used in related work.²³³ Quality indicators related to prevention of

²³⁰ Silver et al., 1988; Tayback et al., 1990; Fries et al., 1997

²³¹ Zimmerman, 1991; Mukamel, 1997

²³² Tinetti et al., 1989; Norton et al., 1997

²³³ Crooks et al., 1995; Schnelle, 1990; Hawes et al., 1997; Schnelle et al., 1997

pressure sores and contractures among immobilized patients have also been used extensively in other studies.²³⁴

The use of physical and chemical restraints was one of the major foci of OBRA '87. Thus, CU includes quality indicators relating to use of psychotropic drugs²³⁵ and the use of physical restraints.²³⁶ Provision of personal care, including dressing and grooming residents daily, was also emphasized in OBRA '87, and thus included in the CU survey. Recognition and treatment of pain is another important issue affecting quality of life for nursing home residents that was included as a quality domain.²³⁷

Several domains relate to the shorter-term, subacute care increasingly being provided in nursing homes. One important domain that CU investigates for new admissions is rehabilitation in terms of improved functional status and community discharge.²³⁸ A second domain relates to acute hospitalization,²³⁹ while a third domain relates to unexpected death in nursing homes.²⁴⁰ As one of the major causes of hospitalization and death, infection is also a critical quality issue in nursing homes and therefore included in this survey.

9.1.3 Survey Comparisons

Some discrepancies might be expected when comparing the results of two completely independent quality assessments. Nevertheless, if one quality assessment detects quality problems that are prevalent and of an apparent severity to cause harm, these should generally be identified in some form by a second assessment. When the CU survey findings in 40 facilities were compared with the concurrent HCFA survey in 1992, agreement was moderate across multiple domains.²⁴¹ The strongest agreement occurred for quality indicators in the domains of incontinence, personal care, restraint use, maintaining function, use of neuroleptics, and nutrition. The HCFA survey was less likely to identify quality problems related to functional rehabilitation of new admissions, pressure sores, and use of other psychotropic medications. The evaluation resulted in recommendations to

²³⁴ Bergstrom et al., 1996; Morris et al., 1997

²³⁵ Avorn et al., 1989; Shorr et al., 1994; Harrington et al., 1992

²³⁶ Siegler et al., 1997; Evans et al., 1997; Hawes et al., 1997

²³⁷ Ferrell et al., 1990; Fries et al., 1997

²³⁸ Schnelle et al., 1995; Kramer et al., 1997

²³⁹ Irvine et al., 1984; Mor et al., 1997

²⁴⁰ Hotzman et al., 1996

²⁴¹ Kramer, 1996

render the process more consistent and sensitive to selected quality concerns. The extent to which the HCFA survey process has changed since 1992 in terms of consistency and sensitivity to quality problems is not known.

Using several HCFA surveys that were, by coincidence, conducted in close proximity to CU surveys in this current project, CU attempted some qualitative comparisons with HCFA surveys. The major objective in this report, however, is to determine if the JCAHO and CU surveys detect the same quality problems. If different, the CU results will be valuable in understanding the types of quality problems that are detected by JCAHO and those that are not.

9.2 Methods

9.2.1 Sampling

9.2.1.1 Facility Sampling

Fifteen CU surveys were conducted concurrently with JCAHO surveys between September 8, 1997 and November 14, 1997. The sites were randomly selected from a list of full and initial scheduled surveys provided by JCAHO staff each month. CU purposefully over sampled by 3 to 5 sites each month and then selected those sites that promoted maximum variation in the JCAHO surveyors and geographic regions. CU also selected at least one facility each month that was a hospital-based unit; one or two facilities that had a dementia unit, and one facility that had a subacute unit. This sampling strategy allowed CU to include roughly the same proportion of hospital-based, subacute, and dementia units in the survey sample as the JCAHO included over the same time period. One facility was dropped from the analysis after completing the concurrent survey because the CU research team used the site primarily for surveyor training. The 14 JCAHO/CU surveys included in this analysis were conducted by 12 different JCAHO surveyors in 11 different States.²⁴² Three of the facilities were hospital-based, four facilities had subacute units, and five facilities had dementia units.

Once the facility sample was selected each month, introductory letters were mailed out to the facility administrators briefly explaining the project and CU's activities onsite, and asking for the cooperation of the facility staff. The facilities were then contacted by the JCAHO long-term care director to confirm their willingness to participate in this project. Once a facility administrator agreed to participate, a coordinator from the CU research team contacted the administrator to address any questions he/she had regarding the needs of the CU surveyors while onsite. Of the approximately 25 facilities contacted, only 2 facilities indicated they would not participate in the CU survey. Additional facilities were dropped from the sample due to changes in the scheduled JCAHO visit or conflicts with the CU survey teams' schedules.

²⁴² Facilities surveyed were located in the following states: California, Illinois, Indiana, Iowa, Michigan, New York, Ohio, Pennsylvania, Tennessee, Texas and Wisconsin.

9.2.1.2 Resident Sampling

Data were collected on 1088 residents over the course of this project. At each facility, the CU survey teams²⁴³ selected from three samples of residents: long stay random sample, tracer group samples, and admission random sample. In the long-stay sample, 40 residents currently residing in the facility for a minimum of 105 days were randomly selected from a census list provided by the facility. Residents who were in the facility for less than 105 days were excluded from this long-stay sample because such residents had not been in the facility long enough to obtain two time points for outcome assessment using MDS data. Additional residents were added to the sample as needed in order to include up to 20 residents in each of 2 tracer groups, pressure sores and psychotropic medications (i.e., anti-psychotics, benzodiazepines, and sedative/hypnotic medications). Although the analysis included four different tracer groups, the other two conditions (incontinence and nutrition/weight loss) appear with sufficient prevalence in a random sample. The total number of residents in the long-stay sample was 570, or an average of 41 residents per facility.

In order to examine short-term outcomes relating to both rehabilitation and death, an admission sample was also included in the CU survey. Quality relating to rehabilitation and death is difficult to evaluate using a census sample because many of the residents who improve in function or who die tend to have shorter stays and are not in the facility on the day of the site visit. Without an admission sample, a surveyor cannot determine which facilities discharge substantial numbers of residents who improve in function in contrast to facilities that rehabilitate and discharge very few admissions. Additionally, deaths cannot be found in a census sample. Thus, CU selected another 40 residents from a list of all residents admitted to the facility 3 to 15 months prior to its visit. The total number in the admission sample is 518, or an average of 37 residents per facility. Some of the smaller facilities in the sample did not have 40 new admissions within the specified time frame.

9.2.2 Data Collection

Once the selected residents were identified, data on residents in the sample were collected using instruments developed for this survey.²⁴⁴ Using strict study protocols, data were obtained from the MDS, the chart, nursing staff interviews, and resident observation. All information was entered into laptop computers onsite and used to calculate quality indicator variables or profiles

²⁴³ Each survey team consisted of two RNs with ten or more years in long-term care and/or advanced degrees (Master's/PhD) in health care. Five RNs were recruited and trained by the research team prior to the first site visit and all the CU surveys were then conducted by pairs of these five individuals.

²⁴⁴ Staged Quality of Care Survey Manual, 1997

(QUIPs).²⁴⁵ Based on the input data, the survey program calculated scores for up to 80 quality indicators, excluding those residents for whom the indicator was not appropriate. For example, the indicator "decline in locomotion" was calculated by comparing locomotion at admission with locomotion at 90 days; residents with a terminal illness and those completely dependent in locomotion at admission were excluded from this calculation.

The incidence rate of adverse outcomes for each quality indicator in the facility was then compared to national norms previously obtained from over 50 long-term care facilities across the country. Quality indicators in which the facility had a rate of adverse outcomes that exceeded the normative standard were then identified in a Quality Indicator Profile report for the surveyors.²⁴⁶ The program then identified individual residents who had experienced the adverse outcomes related to these identified quality indicators. Using Individual Resident Reports,²⁴⁷ the CU surveyors were able to further investigate the potential quality problems at the individual resident outcome level using charts, staff interviews, and resident observations.

Upon completion of the individual resident investigation, the surveyors indicated which of the triggered adverse outcomes identified in the Individual Resident Reports were justified and which were not justified. A justified outcome was defined as an outcome beyond the control of the facility (i.e. resulting from resident characteristics), while a not justified outcome indicated the problem was the result of facility care or lack thereof. After all the investigations were completed at a facility, scores for each quality indicator identified as a potential problem were calculated by the survey team and recorded on the Facility Summary Report.²⁴⁸ A score of "0" was given if all the residents investigated for a potential quality indicator problem were marked justified. A score of "1" was given if at least one not justified mark was received but no actual harm occurred, and a score of "2" was given in those cases where at least one not justified mark was received and *actual* harm occurred.

Although both the CU and the JCAHO surveyors were on site at the same time, no information was shared between the two teams regarding findings and results. The two survey teams entered the facility on the same day; however, the surveys frequently ended on different days. The CU survey took 2.5 to 3.5 days to complete. Once the CU survey was complete, the data were compiled in Denver using Microsoft Access. Upon completion of the JCAHO survey, the JCAHO surveyor sealed the preliminary report in a confidential envelope and mailed the report

²⁴⁵ Appendix E

²⁴⁶ Appendix E

²⁴⁷ Appendix E

²⁴⁸ Appendix E

directly to the project manager in Denver. JCAHO then provided CU with a final report on each facility²⁴⁹ once the preliminary report had been reviewed for clarity and consistency.

9.2.3 Analysis

The terminology used to describe the JCAHO and the CU surveys differs substantially. 'Standards of performance' refers to the most basic elements or variables used by JCAHO in evaluating a facility, while 'quality indicators' refers to the most basic elements or variables used by CU in evaluating a facility. The CU quality indicators all relate to 1 of 17 quality domains discussed in the background section. As mentioned in the preceding section, at the completion of the CU survey the quality indicators identified as potential problems were all scored as either 0 (no problem), 1 (problem), or 2 (severe problem). For those quality indicators that were not triggered, meaning the facility did not fall outside the normative standard for adverse outcomes, 0 (no problem) was automatically assigned.

The comparison of JCAHO and CU survey results then involved five analytic steps:

1. Scoring JCAHO standards of performance
2. Mapping JCAHO standards of performance that were comparable to CU quality domains
3. Mapping JCAHO standards of performance that were not comparable to CU quality domains
4. Tests of agreement in comparable domains
5. Comparison of facility rankings

Each of these steps is described below.

9.2.3.1 *Scoring JCAHO Standards of Performance*

The JCAHO reports given to the CU research team contained two components that were used in this analysis: the Long Term Care Accreditation Services Accreditation Decision Grid, and the listing of Type 1 and Supplemental Recommendations. The Decision Grid included a score for each of 32 grid elements, or categories of performance standards, and an overall facility score based upon these grid elements.²⁵⁰ The Recommendations section contained a detailed listing of all performance standards for which the facility received a score of 3, 4 or 5 which indicates

²⁴⁹ The final report for one facility was unavailable at the time of this report

²⁵⁰ Appendix E

partial, marginal, or unsatisfactory compliance respectively.²⁵¹ In order to render the JCAHO and CU scoring scales comparable, the JCAHO scores were collapsed into a 3 point scale where 1 and 2 were set equal to 0 (no problem), 3 and 4 were set equal to 1 (problem) and 5 was set equal to 2 (severe problem).

9.2.3.2 Mapping Comparable Standards

The CU quality indicators are grouped by content into 17 different categories, or quality domains. For example, the quality indicators regarding new restraints, physical restraints, highly restrictive restraints, no reevaluation of restraints, and restraint applied backwards are grouped under the domain, entitled "restraints."

CU mapped the JCAHO standards of performance to these same 18 domains using all the information available. For each standard of performance receiving a score of 3 or higher, the Recommendations section in the JCAHO report included the text of the standard, the score for the standard, and the surveyors' comments explaining the scoring decision. Because any single standard could be used to identify problems in multiple domains, the content of the surveyors' comments were used in conjunction with the standard to identify the appropriate domain for each specific citation. For example, the standard PE.1 refers to the assessment of each resident's physical, functional, psychosocial, and nutritional status, and in one report was scored unsatisfactory. Through the use of the surveyors' notes, it was clear that the unsatisfactory score resulted from the lack of a pain assessment. This particular citation was then mapped to the Pain domain. Standards pertaining to structure, process, or outcome of care were included in the same domain as long as the citation was relevant to the content of that particular domain. The domains to which CU quality indicators and JCAHO standards of performance were assigned is presented in Exhibit 1.

²⁵¹ JCAHO standards of performance are scored on a scale of 1-5 where 1 = substantial compliance; 2 = significant compliance; 3 = partial compliance; 4 = minimal compliance; and 5 = noncompliance. For further information on JCAHO accreditation scores, see 1996 Comprehensive Accreditation Manual for Long Term Care, Joint Commission, 1996.

EXHIBIT 9.1

Comparable Domain Mapping.

Domain	CU Variables	Comparable JCAHO Standards/Description
Nutritional Status	Syringe feeding	PE 1.4: Lack of initial assessment/time frame
	No supplements	PE 1.1.8: Lack of initial assessment
	Extended NG feed	IM 7.3.1.1: Documentation of care and treatment
	Tube fed/losing weight Weight loss	TX 5.4: Administer food/nutrition products
ADLs	Locomotion decline	TX 2.4, 5: Care/prevent complications of immobility
	Toileting decline	PE 1.1.4: Evaluation of rehab status
	Eating decline	
	Dressing decline	
Falls	Falls with fracture	TX 2.3: Safe from accident/injury
Infection Control	Urinary tract	PE 1.1.4: Lack of initial assessment
	Skin	IC 1, 1.1, 1.1.1, 1.1.6,
	Respirator	2, 4, 5, 6, 6.1: Process to reduce risk of infection
		LD 2.2.2: Process to ensure care needs are met
Continenence	Continenence decline	PE 1.1.4: Lack of initial assessment
	Skin decline	
	Use of catheter	
	Voiding schedule	
Psychotropic Medications	Benzodiazepines	TX 4.12.2: Process to monitor psychotropic use
	Sedatives/hypnotics	
	Antipsychotics	
	Excess dose	
	No supporting diagnosis No attempt at reduction	
Personal Care	Unclean/ungroomed	HR 2.1.2: Staff positions for nursing care needs
	Not dressed	
Restraints	New restraint	PI 3.2.3: Process for collecting data
	Physical restraint	TX 8: System for restraint-free environment
	Highly restrictive	TX 8.1: System to address use of restraints
	No reevaluation	IM 7.2.12: Medical record includes diagnostic and therapeutic orders
	Restraint backwards	
Pain	Untreated	PE 1.1.10: Lack of assessment and response
	Unrecognized	

<u>Domain</u>	<u>CU Variables</u>	<u>Comparable JCAHO Standards/Description</u>	
MDS Completion	Missing 1+ items Missing >30% items	IM 7.2.11: IM 7.3.1.1:	Documentation process and outcome Documentation of care and treatment
Rehabilitation	Community discharge Dressing Locomotion Toileting Eating PT/OT	TX 6.1:	Care plan guides provision of rehabilitation services
Emergent Care	Hospitalization in last 30 days Hospitalization in 90 days	CC 5: TX 2.1: PE 2:	Discharge based on assessed needs Appropriate services and interventions Reassessment related to treatment or significant change
Mortality	Deaths	TX 7-7.3: TX 2.1: PE 2:	Care of dying Appropriate services and interventions Reassessment related to treatment or significant change
Pressure Sores	Prevalence Relief bedding Skin care assessment Stage 3 or 4 ulcer Two-stage decline	TX 2.4: PE 1.1.6: PE 2:	Care to prevent complications of immobility Assessment/integumentary needs Reassessment related to treatment or significant change
Personal Environment	Structured activities Odor in facility Safety Personal environment	EC 1.1: EC 2.11: EC 5: RI 2.11: TX 2.6.1: TX 4.9.2 PE 1.1.7 HR 2.2.7	Compliance with Life Safety Code Maintaining safety elements Non-smoking policy Preserves dignity and self-image Lack of structured activities Medication safety and accuracy No assessment of activities needs Qualified staff to meet recreational needs
Contractures	Prevalence Unprotected	TX 2.4:	Care to prevent complications of immobility
Behaviors	Wandering Physical abuse decline	PE 1.1.2:	Assessment of mental and cognitive status

To ensure unbiased domain assignment, each JCAHO report was mapped by two different research assistants on the CU team who had been blinded to the facility name as well as the CU survey results. In those cases where the two reviewers disagreed on the mapping assignment, the research analysis team met to obtain consensus on the interpretation of the JCAHO citation.

9.2.3.3 Mapping the Remaining Standards

Many of the JCAHO citations did not map to any of the 17 domains identified by CU. The comparable domains, by definition, pertain only to the quality of care areas assessed during the CU concurrent survey. An additional 14 domains were identified based upon the remaining JCAHO citations and pertain largely to the written documentation of processes, a range of human resource issues, the education of residents, and a variety of structural environment concerns. Exhibit 9.2 lists the domains and associated JCAHO standards/citations that were not comparable to the CU domains. The last column in the exhibit gives the number of facilities that received a score of 3 or higher in each domain.

EXHIBIT 9.2 Cited JCAHO Standards that Map to Incomparable Domains.

<u>Domain</u>	<u>Content of the JCAHO Standards that are Mapped to the Domain Involve:</u>	<u>Number of Facilities with a Citation in This Domain</u>
Structural Environment	Compliance with the Life Safety Code; management plans must address security, emergency preparedness, medical equipment, and utility systems	4
Admission Policies and Procedures	Pre-admission process includes defining the types of residents admitted	1
Assessment (signatures)	Attending physician completes a history and physical exam within 72 hours	1
Assessment (MD)	Initial assessment of a resident's relevant past medical history and status, including current diagnosis, physical status; resident's status must be reassessed at regular intervals; vital signs are assessed during medication administration; the attending physician must visit the resident at least once during the initial 30 days; provision and response to medical care must be documented	6
Assessment (oral and dental)	Lack of objective criteria in comprehensive oral assessments	1
Assessment (spiritual)	Failure to assess resident family's coping strategies and support systems; failure to assess a resident's spiritual needs	2
Care Planning	Care is planned by a team of all appropriate health professionals; interdisciplinary team uses a coordinated approach to identify, integrate, and prioritize care needs; services are provided to meet resident's psychosocial needs, including a family and visitor council	3
Education	Continuing education maintains and improves staff competence; care planning incorporates residents' educational needs; resident education includes counseling on potential food-drug interactions and other nutritional and oral needs	3
Instrument Quality Control	Medical equipment is maintained and inspected; medical equipment management plan is implemented; staff performing tests receive specific training and orientation and demonstrate satisfactory competence; appropriate quality control and test records are maintained	2

Medications (non-psychotropics)	Significant adverse drug reactions are intensively assessed; every dose of medication administered is documented; housekeeping and maintenance maintain a sanitary, orderly, and comfortable interior	2
Human Resources (MD)	Providers practicing independently are authorized through a defined process; organization adopts uniformly-applied credentialing criteria	5
Human Resources (others)	Leaders ensure that the competence of all staff members is assessed, maintained, demonstrated, and improved continually; organization supports self-development and learning for all staff; orientation process provides initial job training and assesses each staff member's abilities to perform specific job duties; organization regularly collects aggregate data on competence patterns and trends to identify staff learning needs	7
Documentation	Medical record documentation contains treatment and response to care	1
Resident Council Attendance	Residents have a right to a Resident Council	1

9.2.3.4 Tests of Agreement

In order to compare the results by domain, a CU and a JCAHO domain score was calculated for each of the 17 comparable domains by facility. After compiling the CU quality indicators by domain, the domain was scored based on the worst (highest) indicator score. For example, if a facility received a score of 1 for the quality indicator significant weight loss, and a score of 2 for failure to provide nutritional supplements for underweight residents, the Nutrition domain would be scored as a 2. Similarly, the JCAHO score for a domain was based on the worst standard of performance score within that particular domain.

Agreement between the two surveys was examined for each domain by tabling the number of facilities where both surveys agreed, the number of facilities where CU identified a problem and JCAHO did not, and the number of facilities where JCAHO found a problem and CU did not. A Cohen's Kappa statistic was calculated indicating the prevalence of agreement based on a dichotomous score for each domain (0 = no problem; 1, 2 = problem).

9.2.3.5 Facility Rankings

To compare the survey results across domains, an overall facility level score was calculated for the CU surveys. The JCAHO surveys already included an overall score that reflected the percentage of points obtained out of the possible points that could have been obtained (0 to 100 percent), using the grid element scores in the accreditation report.²⁵² To calculate the CU score, each of the 17 domain scores, ranging from 0 to 2, was utilized: a score of 2 resulted in 0 points, a score of 1 resulted in 1 point, and a score of 0 resulted in 2 points for that domain. Hence, a total of 36 points were possible and the overall facility score was set equal to the percentage of points actually obtained at each facility (0-100%). Based on the overall scores, each facility was ranked from best to worst according to the CU results and according to the JCAHO results. The rankings were then compared using a Spearman's rank correlation coefficient.

²⁵² Joint Commission, 1996

9.3 Results

9.3.1 Quality Comparison Within Domains

The results of the comparison between CU and JCAHO findings for each of the comparable quality of domains is presented in Exhibit 9.3. For the 17 comparable domains, the exhibit shows the number of facilities where a quality problem was identified by surveyors. The first column shows the number of facilities in which both the JCAHO and CU reported a problem, the second column shows the number of facilities in which neither survey identified a problem, and the third and fourth columns show the number of facilities in which the survey results differed. The last column is the value of the Cohen's Kappa statistic indicating the extent of agreement, ranging from -1 denoting complete disagreement to +1 denoting perfect agreement. In several instances (10 of the 17 domains), a statistical comparison is not possible because of insufficient variation in the scores: either the JCAHO surveyors or CU surveyors did not identify a problem in any of the facilities. Except in the case of emergent care, where neither survey identified quality problems, the lack of variation represents very poor agreement because quality problems were detected by one survey and never by the other.

EXHIBIT 9.3 Comparison of CU and JCAHO Survey Findings by Domain Across 14 Facilities.

Domain	Agreement Between CU and JCAHO Surveys				Cohen's Kappa (Kappa value)*
	CU Problem/ JCAHO Problem	CU No Problem/ JCAHO No Problem	CU Problem/ JCAHO No Problem	JCAHO Problem/ CU No Problem	
Nutrition	2	6	5	1	0.14
ADLs	0	6	8	0	†
Falls	0	11	3	0	†
Infection	0	10	0	4	†
Continence	0	7	6	1	-0.14
Psychotropic Meds	1	3	9	1	-0.09
Personal Care	1	8	5	0	0.19
Restraints	1	10	2	1	0.28
Pain	2	6	3	3	0.26
MDS Complete	0	11	3	0	†
Rehabilitation	1	9	4	0	0.24
Emergent Care	0	14	0	0	†
Mortality	0	10	4	0	†
Pressure Sores	0	10	4	0	†
Environment	4	6	3	1	0.43
Contracture	0	8	6	0	†
Behaviors	0	9	5	0	†

†Indicates that the statistic cannot be computed due to lack of variation in scores, in one of the surveys.

*Cohen's Kappa ranges from -1 denoting complete disagreement to +1 denoting perfect agreement. A Kappa value of less than 0 denotes poor agreement, 0 to .20 denotes slight agreement, .21 to .40 denotes fair agreement, and .41 to .6 denotes moderate agreement (Kramer and Feinstein, 1981).

The first column of Exhibit 9.3 indicates that in relatively few instances both CU and JCAHO identified a problem; however, they were much more likely to agree that a facility did not have a problem as indicated Column 2. As shown in the third column, CU identified problems in many domains where JCAHO surveyors did not detect a problem. This was particularly true in relation to nutrition, functional maintenance in ADLs, continence, use of psychotropic medications, personal care, contractures, and behavior. Pressure sores and deaths also represent areas of marked difference in that JCAHO surveyors never identified problems in these domains. The fourth column indicates that JCAHO was more likely to find problems related to infection control and that with respect to pain, JCAHO and CU surveyors found problems in some different facilities as well as agreeing upon findings in other facilities. Overall, the strongest agreement occurred in the domain of quality of the environment while fair agreement occurred in relation to restraint use, pain, and rehabilitation.

To illustrate the quality problems identified by the CU surveyors but not detected in the JCAHO survey, Exhibit 9.4 contains examples based upon the CU review activities. The first three examples in Exhibit 9.4 relate to deaths, all of which were investigated upon detection in the admission sample. In the first facility in the exhibit, four deaths were identified and three of them were considered justified, i.e. care in the facility was appropriate in view of the patient's condition. However, as depicted in the first case of unjustified death, skilled nursing care was inadequate in response to a notable patient finding leading to an unanticipated death.

Other examples in Exhibit 9.4 relate to quality indicators in other domains that were identified by CU surveyors but were not found by JCAHO surveyors. In all cases, the prevalence of these quality problems exceeded the normative standards, as represented in the second column, which prompted the review of individual cases. Thus, these quality indicators are important because of the prevalence of the problems in the facility combined with the severity as illustrated by these examples.

Exhibit 9.5 provides examples of quality problems detected by JCAHO surveyors. The first three examples are in the domains that are comparable to the CU survey and the remainder are in the domains that JCAHO evaluates but are not included in the CU quality domains. In general, the JCAHO survey problems relate to facility procedures or policies; documentation issues related to the assessment of the resident; environment findings; or care planning issues. Thus, very little similarity exists in the nature of the quality problems identified by CU and JCAHO.

EXHIBIT 9.4 Examples of Quality Issues Identified by CU.

Domain

<u>Quality Indicator</u>	<u>Prevalence and Norms</u>	<u>Examples of Unjustified Quality Issues</u>
Mortality		
Death	# Deaths in Sample = 4 Justified = 3 Unjustified = 1	Resident admitted to the nursing home from the emergency room with diagnosis of lumbar strain and history of ETOH abuse. Resident had previously resided in the community and required supervision only for ADLs on admission. There was no documented change in condition for three months. On 12/17, nursing notes indicate a physician call was made for resident complaint of joint pain. A physician visit was made that day. No new orders or progress notes to indicate a change in condition. On 12/18, there was a note of blood on the tissue when resident used the bathroom. The patient was questioned regarding presence of hemorrhoids and responded "yes". There was also a note, "c/o of abdominal pain, v.s. within normal limits". No documented follow-up. The next nursing note was on 12/20 by the night nurse who wrote, "found by nurses aide, stiff and cold, with coffee ground emesis around mouth".
Death	# Deaths in Sample = 2 Justified = 1 Unjustified = 1	Resident admitted to the nursing home on 6/26 following a hospitalization for UTI and sepsis. Resident was febrile on admission and it was noted that she was alert, oriented and easily falls asleep. Resident fell from bed on 6/28, was placed in a soft waist restraint, and a psychotropic drug was ordered. The care plan did not include reference to the UTI, the monitoring of antibiotic effect, or the monitoring of fever. Antibiotic was started on 6/30. Nursing notes did not include notation of a febrile condition until 7/1 when Tylenol was given. There was sporadic and infrequent charting on the resident condition. Intake and output was not recorded although there was an order to encourage intake. Nursing action started when resident became lethargic, resulting in unresponsiveness. Family then requested only comfort measures and patient expired after one month.

Quality Indicator

Prevalence and Norms

Examples of Unjustified Quality Issues

Death
Deaths in Sample = 4
Justified = 3
Unjustified = 1

Resident admitted one year prior with dementia and COPD. On 4/18/97, nurse noted swelling in feet and ankles. Daughter told nurse "it happens occasionally and there is nothing the doctors can do". According to notes, resident and daughter declined to see the physician at that time. No evidence that the nurse notified the physician. Last note of 4/18 reads "will monitor swelling". Next entry on 4/25, "resident in bed, c/o shortness of breath with 1+ edema extremities and feet, lungs with decreased breath sounds". Oxygen given, no physician notification documented. On 4/29, notes indicated resident found in room "very agitated and diaphoretic" and resident stated, "I feel funny, what's wrong with me?" Nurse reassured her she "was ok." Again, no physician notification documented. Next entry on 5/2, resident found on floor in room at side of bed. Physician was notified but by log book only. DPOA was called. On 5/4, physician was called with resident c/o's fatigue, skin color pale. Telephone order for lab work obtained. Nursing notes indicate increasing edema left leg but no notification of this to physician. Second notification to physician on 5/6, edema 4+, resident c/o's of weakness and fatigue. No lab results as lab had no record of blood draw. Lab reordered by physician, but no visit. Resident had UTI and antibiotic initiated. There was occasional charting of vital signs throughout this period. Notes of 5/7 indicate "shortness of breath, ankle edema 2+ with mottling, breath sounds decreased, diaphoretic". Nurse called DPOA first. Notes appear to indicate physician was called by the DPOA. Telephone order to transfer to hospital for evaluation. Admitted with acute CHF and aspiration pneumonia. Readmitted to nursing home on 5/15 with "slurred speech and receiving oxygen". On 5/16 am note indicates resident did not void on the midnight shift. No further evaluation of voiding or notification to physician. On 5/16 8pm, resident not responding to pain stimuli, nurse attempted to start IV but unsuccessful. Another attempt made to start IV at 11pm but unsuccessful. Physician and DPOA notified. Nurse "found living will in chart that said resident did not want IVs". Resident expired in nursing home on 5/17 at 1:30am.

Rehabilitation

Lack of Rehabilitation in Dressing, Locomotion, Toileting
Dressing
Prevalence = 69%
Norm = 53%
Locomotion
Prevalence = 67%
Norm = 47%
Toileting
Prevalence = 69%
Norm = 58%

Resident admitted from home with new CVA, received three months of physical therapy and was ambulating with two assist 60 feet on discharge. MDS indicates resident continued to require extensive assistance for dressing and toileting needs. No evidence that dressing or toileting needs were addressed by therapy. No monitoring of resident functional status after therapy discharge. Nurses notes and care plan did not reflect any restorative nursing program. Notes indicated resident was in recliner average of five hours per day and was walked to bathroom only.

ADLS

Severe Locomotion Decline
Prevalence = 7%
Norm = 4%

Long stay resident with rehab aide note in June 1997 stated, "resident independent". No further restorative notes. Chart indicates resident was actively involved in activities at this time. In September 1996, resident was not coming to activities, staying in room in bed, frequent falls and exhibiting aggressive behavior. Resident was on Atarax for anxiety since 1995 with no reassessment. Resident's function declined from independence in locomotion to requiring assistance in a three-month period. No assessment of decline in the record.

<u>Quality Indicator</u>	<u>Prevalence and Norms</u>	<u>Examples of Unjustified Quality Issues</u>
Severe Eating Decline	Prevalence = 4% Norm = 2%	Resident admitted in May 1997 for rehabilitation following a hip fracture. Resident was independent in eating on admission but required extensive assist by August 1997. Resident became depressed following the fracture, decreased eating and fluid intake, low sodium levels, and increased confusion. Depression was never evaluated or treated
Contracture Unprotected Contracture	# in Sample = 7 Justified = 1 Unjustified = 6	Hand contractures observed, skin on skin, unprotected, no skin program in place.
Incontinence No Timed or Prompted Voiding Schedule	Prevalence = 82% Norm = 36%	Resident with CVA, dementia, history of falls; incontinent with no assessment of bladder function; no documentation of a program to keep patient dry or attempts at rehabilitation for toileting needs; incontinent on floor several times and did experience a fall as result of urine on floor. The charge nurse indicated that there were no residents on the floor who were on a management program but it was a program they planned to put into place soon.
Restraints No Re-evaluation of Restraint Use; Highly Restrictive Restraint Use	Prevalence = 88% Norm = 39% Prevalence = 13% Norm = 11%	Resident admitted in July 1996 with diagnosis of severe dementia. Fall assessment in January 1997, "soft waist restraint provided for safety from falls, attempts to get up from chair, fidgeting, attempts to go to bathroom." This documentation was repeated as justification on all following restraint assessments. No new documentation existed that resident was high risk for falls. Care plan approaches included offering activities and assisting to bathroom. No evidence in record that either of these approaches were followed by the nursing staff. Another mentioned approach to discourage resident from getting up was to ignore resident.
Psychotropic Medications No Sedative-Hypnotic Reduction	Prevalence = 100% Norm = 24%	Resident with anxiety and depression, on Vistaril at bedtime since 9/96 with no documentation as to attempt to reduce or discontinue. Pharmacy drug treatment regimen review present but no assessment related to use of Vistaril.
No Antipsychotic Supporting Diagnosis	Prevalence = 22% Norm = 14%	Resident had pain assessment completed with note that resident expressed pain by anger and agitation. On March 1997, a note indicated resident was to receive Vicodin every four hours for tooth pain. Resident received Haldol on a routine basis for agitation with no supporting diagnosis. No dental intervention until October 1997.
Nutrition Underweight and No Supplements	Prevalence = 28% Norm = 16%	Long stay resident, weight 84-86 pounds past six months; Stage II pressure ulcer present for one year. No evaluation of enhanced nutritional needs in relation to weight and skin integrity. Received routine snacks only.

<u>Quality Indicator</u>	<u>Prevalence and Norms</u>	<u>Examples of Unjustified Quality Issues</u>
Pressure sore Presence of Pressure Ulcer	Prevalence = 90% Norm = 19%	No pressure sore present on July 1997 admission. Developed pressure sores on each heel since admission. No evidence of turning program or any heel protection.
Pain Untreated Pain	# in Sample = 1 Justified = 0 Unjustified = 1	Patient admitted in October 1996 with an assessment of "rotted teeth." Resident nonverbal but on interview, the floor nurse stated she believed the resident had pain due to the tooth condition. The nurse also reported that the resident's husband was told by the dentist at time of admission that she was not a candidate for extractions at that time. A dental consult on admit stated "no treatment unless pain or swelling develop." Resident received water/peroxide swabs to mouth daily which nurse interpreted as a method of pain relief. Resident received an aspirin a day but not ordered for pain. No apparent follow-up to initial dental consult or documented pain assessments by staff.
Personal Care Resident Unclean/ Ungroomed	# in Sample = 4 Justified = 0 Unjustified = 4	One resident was observed in a soiled worn nightshirt; nails were dirty and long; hair was unclean and uncombed, oral care not given. One resident had refused morning care the day of observation because of a recent fall but her nails were dirty and her hair was long and stringy.
Resident Not Dressed	# in Sample = 3 Justified = 1 Unjustified = 2	One resident noted in dining room with two nightshirts on, one frontward and one backward. One resident was not adequately dressed to prevent exposure of private area.

EXHIBIT 9.5: Examples of Quality Issues Identified by JCAHO Surveyors.

<u>Domain</u>	<u>JCAHO Standard</u>	<u>Comments</u>
Nutrition	Care and Treatment of Residents TX 5.4	Food is not consistently served at proper temperatures because of equipment problems. The situation is being addressed.
	Assessment PE 1.4	The nutritional assessment was lacking in 10 of 12 subacute records. In one instance, the patient had a secondary diagnosis of hypokalemia
Infection Control	Infection Control IC 1.1-1.1.1	There is lack of documentation concerning the infection control process. Oversight of the infection control process is isolated and does not include participation and communication with relevant staff

<u>Domain</u>	<u>JCAHO Standard</u>	<u>Comments</u>
	IC 6-6.1	There is lack of coordination between the infection control processes and the organization's PI process. The IC data is not collected, analyzed, and synthesized with risk reduction procedures.
Pain	Assessment PE 1.1.10	There is no documentation of the following parameters being assessed for pain: alleviating factors, exacerbating factors, current treatment, and response to treatment. Pain assessments do not include exacerbating factors, no chart reviewed found evidence of pains' causes or factors that make pain worse.
Human Resources-Physicians	Human Resources HR 6.1.1	Two of five credential files did not have evidence of primary source verification provided by a JCAHOAHO agency as stated in the organization's policy or evidence of competency. The only information was the presence of a current license and malpractice insurance.
Human Resources-Others	Human Resources HR 3.2	The facility regularly utilizes a staffing agency to supplement the CNA staffing. The agency does not provide evidence of the CNA's orientation nor does the facility provide the same orientation to the agency CNA's as is provided to the facility's employees.
Assessment-Signatures	PE 1.4.1	It was noted during review of six open long-term care medical records, that the record of a resident admitted on 10/25/97 with a diagnosis of terminal breast cancer contained a medical history and physical completed by the consulting oncologist, but not signed off by the admitting/attending physician at time of this survey 10 days after admission.
Assessment by Physician	Assessment PE 1.4.1	There is no documentation of a medical history being completed within five days before admission or 72 hours after admission in three out of eight open and two out of six closed medical records reviewed.
	Management of Information IM 7.3.5	No progress notes have been recorded in one of 14 open medical records reviewed. The medical record indicated the resident had been regularly taken to the physician's office by family members.
Structure Environment	Environment of Care EC 1.5	The hazardous materials management plan did not include performance standards to measure the effectiveness of the program and a process for annual evaluation of the objectives, scope, and effectiveness of the program.

<u>Domain</u>	<u>JCAHO Standard</u>	<u>Comments</u>
Care Planning	Assessment PE 3	There is no consistent system found that alert appropriate team members of significant resident changes found on reassessments. One resident with a newly placed peg tube who also received dilantin did not have a coordination of the dilantin administration to allow absorption of the dilantin on an empty stomach. Neither dietary, nursing or pharmacy picked up the potential problem. Another resident with blood sugars from 400 to above 600 had no care plans addressing the problem.
	Care and Treatment of Residents TX 1.2.1	Nursing assistants were not included in the care planning team conferences.
Instrument Quality Control	Assessment 8.3	It was determined during review of quality control and test records for bedside glucose testing that testing two levels of control for each instrument on each day of resident testing is not done. The records that are kept document the result of the confidence strip.
Medications- Other Than Psychotropics	Improving Organization Performance- Assessment PI 4.3.2	Intensive assessment is not performed on all significant adverse drug reactions. No formal process is available in the facility to fully recognize adverse drug reactions. Allergic reactions are generically identified with no documentation of the specific reaction.
	Management of Information IM 7.2.19	In four of five medical records reviewed, there was documentation missing to indicate that all medications were given to the resident. For example, in one record, there was documentation missing for five medications given for a total of 20 dosages missing for the month of October.

9.3.2 Quality Comparisons at Facility Level

Exhibit 9.6 presents the results of the comparison of overall facility rankings. The first column identifies individual facilities, and the remaining columns show the overall score and ranking according to CU survey results and JCAHO survey results, respectively. JCAHO scores for the 14 facilities vary from a low of 80 to a high of 100; none of these scores were below the JCAHO score required for certification. In contrast, the CU scores range from 53 to 94; the lower scores clearly reflect quality problems throughout the facility. The Spearman's rank correlation coefficient is 0.240 for these 14 facilities. Although a weak association exists in the findings, the surveys do not agree on whether facilities have significant enough quality problems to deny certification.

EXHIBIT 9.6 Facility Scores and Ranks Across All Domains.

Facility	CU		JCAHOAHO	
	Score	Rank	Score	Rank
1	74	8+	86	13
2	65	13	87	12
3	71	10+	89	9.5†
4	74	8+	90	7.5†
5	94	1	91	4.5†
6	68	11.5†	93	4
7	53	14	95	3
8	88	3	100	1
9	82	5†	80	14
10	74	8†	89	9.5†
11	82	5†	98	2
12	68	11.5†	88	11
13	82	5†	90	7.5†
14	91	2	91	4.5†

†Indicates a tied rank represented by the average of the ranks that are tied.

To illustrate the differences in findings for specific facilities, CU described the cited problems for the three facilities that have the greatest disparity in ranks. Facility 6 (ranked 11.5), is tied for the 11th/12th lowest score among the CU surveys, but ranked fourth among the JCAHO surveys. The nature of the issues identified and cited were not comparable. For example, while the JCAHO identified a failure to assess pain and verify credentials, CU identified unjustified outcomes pertaining to new antipsychotic administration following admission to the facility, the death of a resident, functional decline of several residents, lack of nutritional supplements for two underweight residents, a case of an unprotected contracture, and improper use of benzodiazepines.

have detected? Third, to what extent does the JCAHO survey lend itself to detecting the types of problems identified in the CU survey and the HCFA survey?

While there is no simple and uniform definition of quality for nursing home care, consensus about how to measure it has been emerging over the last decade since the 1986 IOM report. As discussed in the background section, nursing home residents are entitled to care that maintains their function, nutritional status, personal hygiene and grooming, as well as care that prevents such problems as pressure sores, contractures, pain, and certainly unanticipated death to the extent that health care can prevent these occurrences. Finally, substantial emphasis has been placed on minimizing the use of physical restraints and chemical restraints or psychotropic medications. These indicators of quality have sufficient face validity in terms of quality of care and their relationship to quality of life for nursing home residents. However, the step from these constructs to precise measures or findings of poor quality care is a large one.

The CU survey reflects its belief that measuring quality requires a rigorous process beginning with sampling and evaluating both resident outcomes and the nursing home care processes that led to these outcomes. As argued by the IOM, CU uses uniform data, comparison with norms, and adjustment for case mix so that it does not unfairly identify quality problems in facilities merely because they admit residents who are more disabled and have greater health care needs. In fact, CU synthesizes information from multiple sources (i.e., observation, staff interview, the nursing home record, and the MDS for longitudinal information) to obtain the most accurate and comprehensive understanding of care. While the process may seem too systematic and rigid to some, these steps result in a final judgement made by expert nurses about specific cases. Clinicians decide whether poor outcomes were justified by the resident's underlying health conditions or the facility's attempts to avoid adverse outcomes. In this report, CU has chosen to provide summaries of specific cases that were reviewed because it believes the selected cases demonstrate the validity of the quality problems.

These examples include three deaths that were found in closed records for the admissions sample. In all cases there was lack of attentiveness to patient signs and symptoms by skilled nurses, despite resident complaints or ample evidence of a health problem. While in many cases a nursing home death is fully justified because aggressive intervention is neither warranted nor wanted, some are not. Other examples relate to situations where rehabilitation is inadequate, resident function declines substantially, skin is not protected, no attempt is made to prevent incontinent episodes, restraints are used excessively or incorrectly, psychotropic medications are used without a supporting diagnosis or without review, residents are malnourished and receiving no supplements, new pressure sores occur because immobilized residents have no protection, pain is not treated, and residents do not receive morning care or are dressed in nightshirts.

Ideally, the HCFA survey would have been conducted at the same time as the CU and JCAHO surveys so that a three-way comparison of findings could be conducted. While this did not occur for all 14 facilities, there was one facility when the HCFA survey occurred at the same time and three others where the HCFA survey occurred within the 6 weeks prior to the CU and JCAHO surveys. Despite the fact that HCFA findings may have been addressed to some extent in facilities

where the HCFA survey was completed several weeks prior to the CU and JCAHO surveys, there were a number of similarities between the CU survey findings and the HCFA findings. In one facility, problems related to nutritional supplementation and rehabilitation were identified in both surveys, in a second facility both CU and HCFA found problems with residents' personal care, including grooming and cleanliness, and both surveys found problems with pressure sores. Nutrition, pressure sores, and the personal environment were found as problems in a third facility by both HCFA and CU surveys. In the final facility, the personal environment was identified as a problem in both surveys. Similarities between the HCFA survey and the JCAHO survey across all four facilities consisted only of the finding related to the personal environment. The citations in the HCFA survey were based upon observations of residents, use of charts, and staff interviews. HCFA citations referenced individual resident outcomes and process of care. This suggests a stronger relationship between the CU survey and HCFA findings because domains such as pressure sores, nutrition, and personal care are emphasized in these surveys in contrast to the JCAHO survey.

At the same time, the HCFA survey did not identify problems that were found in the CU survey in three domains. First, in all four facilities the CU surveyors identified problems with the use of psychotropic medications including lack of an appropriate diagnosis and no reevaluation including attempted dose reductions, particularly for benzodiazepines. Second, problems with unrecognized pain that were prevalent in two facilities were not identified in the HCFA survey. Third, two issues related to skilled nursing care leading to deaths that were found in the CU survey were not detected by HCFA. Although this comparison is based on only four facilities, it suggests that HCFA should consider its process for reviewing quality in these three areas and whether further guidelines are required.

As illustrated in this report, survey findings identified by JCAHO were more likely to be facility-level processes and procedures, or resident-level assessment process without a link to outcomes. Through facility-level process review, JCAHO identified problems in infection control procedures that CU surveyors did not find because facilities did not have an atypically high rate of infection. The JCAHO findings related to oversight and coordination of infection control processes.

While some of the process findings relating to individual resident assessments led to identification of quality problems that were consistent with CU survey findings relating to both process and outcome, many others focused exclusively on documentation. The facility-level policies and procedures, which often related to human resources, have an important role in the survey process to ensure that proper hiring procedures are used and background checks are conducted to avoid staff who are either unqualified or malicious. Nevertheless, excessive focus on documentation, policies, and procedures is still one or more steps removed from resident process and outcomes, rendering the findings potentially misleading. It is possible for the books to look good and the care to be poor, and also the reverse.

With a quality assurance approach that focuses on facility processes and procedures, resident documentation, and the physical environment, the incentive for facilities is to put more resources into administration and documentation even if it results in fewer resources available for patient

care. Prior to OBRA '87, this was the criticism of the HCFA survey process -- that it overemphasized structure and documentation without enough of a focus on resident process and outcomes. Thus, providing deemed status to the JCAHO would represent a step away from the current focus on outcomes and processes of care at the resident level, backward in time relating to survey activities. For these reasons, the JCAHO survey does not appear to be an appropriate substitute for the HCFA survey.

10.0 COMPARISON OF ENFORCEMENT AND JCAHO FOLLOW-UP

10.1 Introduction

This chapter describes the enforcement process currently in place at the Health Care Financing Administration (HCFA) and the follow-up system used by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The approach of each organization is discussed and compared. Resources for this paper include HCFA's State Operations Manual (SOM) and the Joint Commission's Comprehensive Accreditation Manual for Long Term Care (CAMLTC). In addition, brief telephone interviews were conducted with staff at HCFA central and regional offices, and State agencies, as well as at the JCAHO central office. Data included in the report were supplied directly by HCFA and the Joint Commission. Contacts include the following:

HCFA Central Office: Nancy Archer
Cindy Graunke
Pat Miller

HCFA Regional Offices: Jay William Robertson, Boston
Theresa Bennett, Dallas
Al Harris, Kansas City
Peter Greuber
Kathy Devochek
Francine Lassiter, Seattle

State Agencies: Mike Politte and Doyle Young, Arkansas
Loretta Beard, Texas
Joyce Stockwell, Washington

JCAHO: Mark Dieden
Peggy Gaddis
Marianna Grachek
Carol Jewett
Kay Kruse
Chuck Mowl
Gail Weinberger

10.2 HCFA Enforcement Process

The HCFA survey and enforcement process is promulgated in the State Operations Manual (SOM) and Enforcement Regulations. Except in the case of State-operated facilities, the State agency (SA) has responsibility for conducting surveys and certifying compliance with Federal participation requirements, subject to HCFA's approval. The regional office (RO) certifies compliance at State-operated facilities.

The SA also recommends appropriate enforcement actions to the State Medicaid Agency (SMA) for Medicaid and the RO for Medicare. The SMA and RO then determine eligibility for participation in the Medicaid and Medicare programs (based on SA certification). Although enforcement authority remains with the SMA/RO, their actions are based on the recommendations of the surveying entity.

10.2.1 Types of Remedies

As stated in the SOM, “The broad array of statutory remedies that vary in form and severity recognize that there can be variations in impact posed by each violation of participation requirements.” HCFA enforcement regulations include both mandatory and optional components that attempt to ensure Federal requirements are always met while allowing some flexibility in determining specific enforcement responses. These responses, or remedies, are selected from appropriate categories, based on the seriousness of the deficiency, and a number of other factors including:

- The relationship of one deficiency to other deficiencies
- The facility’s prior history of noncompliance in general and with reference to the cited deficiency and
- The likelihood that the remedy selected will achieve correction and continued compliance. (e.g., If failure to spend money is the root cause of the facility’s noncompliance, then any CMP that is imposed should at least exceed the amount saved by the facility by not maintaining compliance.)

All enforcement remedies (optional and mandatory) are listed below.

Available Federal remedies include:

- Termination of provider agreement
- Temporary management
Facility management relinquishes control to a temporary manager (assigned by SA) and pays his/her salary.
- Denial of payment for all Medicare/Medicaid residents by the Secretary
- Denial of payment for all new Medicare/Medicaid admissions
- Civil monetary penalties (CMPs)
- State monitoring
Professional monitor identified by the SA oversees the correction of cited deficiencies as a safeguard against further harm to residents.
- Directed plan of correction (DPoC)
A plan which the State or RO develops to require a facility to take action within specified time frames. Differs from a traditional PoC in that an entity other than the facility develops it. Achieving compliance remains the provider’s responsibility.
- Directed in-service training

Facility staff must attend an in-service training program developed by well-established center of geriatric health services education.

- Alternative or additional State remedies approved by HCFA

Mandatory enforcement remedies include:

- Termination of provider agreement and
- Denial of payment for all new admissions.

All facilities with deficiencies other than those of isolated scope with the potential for no more than minimal harm must submit an acceptable plan of correction (PoC). However, a PoC is not considered an enforcement remedy.

According to the SOM, States are also required to deny or withdraw approval of the nurse aide training and competency evaluation program (NATCEP) for a period of two years if: a facility refuses to permit an unannounced State visit; an extended or partial extended survey is conducted (i.e., when substandard quality of care is identified); and if the facility has been subject to a CMP of \$5,000 or more, a denial of payment, the appointment of a temporary manager, termination, closure and/or transfer of residents; and if the facility requested and was granted a waiver of nurse staffing requirements.

Based on the seriousness of the deficiency and the facility's history, SAs determine which and how many remedies to recommend and forward the information to the RO/SMA. The RO/SMA then issues formal notice of the remedies to be imposed upon a provider and their effective dates. The remedy selection process is discussed further in the section below.

10.2.2 Deficiency Levels

Remedy selection is determined by the degree of seriousness associated with the cited deficiency. The national system for measuring the seriousness of deficiencies weighs both the scope and severity of the problem and assigns it a letter score (A-L). Each score then correlates with specific categories of enforcement responses. As illustrated in the scope and grid in Exhibit 10.1 below, the severity of remedies imposed increases with the severity of the deficiency cited.

After a survey team has identified noncompliance, the SA decides whether to recommend imposing remedies as soon as notification requirements are met or to give the provider an opportunity to correct. That decision is based on whether the facility is considered a poor performer. HCFA defines a poor performer as a facility that is cited for substandard quality of care on the current survey and substandard quality of care or immediate jeopardy on at least one of the previous two surveys. Facilities can also be considered poor performers if significant noncompliance is found during the current survey and the State chooses to use one of the following optional criteria:

- Level A deficiencies (other than SQC) were identified in one of the past two standard surveys;
- The facility has a history of substantiated complaints in the last two years; or
- The facility does not have a quality assurance program.

Exhibit 10.1
Scope and Severity Grid
 (with enforcement options)

	isolated	pattern	widespread
immediate jeopardy to resident health or safety	J category 3 (optional category 2 & 1)	K category 3 (optional category 2 & 1)	L category 3 (optional category 2 & 1)
actual harm that is not immediate jeopardy	G category 2 (optional category 1)	H category 2 (optional category 1)	I category 2 (optional category 1, temporary management)
no actual harm with potential for more than minimal harm that is not immediate jeopardy	D category 1 (optional category 2)	E category 1 (optional category 2)	F category 2 (optional category 1)
no actual harm with potential for minimal harm	A substantial compliance no poc no remedies, commitment to correct not on HCFA-2567	B substantial compliance poc	C substantial compliance poc

category 1
 directed plan of correction,
 State monitor,
 directed in-service training

category 2
 denial of payment for new admissions,
 denial of payment for all individuals imposed by HCFA,
 CMPs (\$50 - \$3,000)

category 3
 temporary management, termination
 optional :
 CMPs (\$3,050 - \$10,000)

Standardard quality of care (gray shading) = deficiency level F or higher for a deficiency in the regulatory groupings of Resident Behavior and Facility Practices (483.13), Quality of Care (483.25), or Quality of Life (483.15).

States are also free to consider criteria other than the national mandatory and optional criteria established.

The SA recommends remedies be imposed as soon as notification requirements are met for poor performers. For others, the SA sets a "date certain" by which the facility must be in substantial compliance or the SA will recommend that remedies be imposed. The date certain must be set within 90 days. In practice, however, HCFA has found that SAs allow facilities an average of 45 days to demonstrate compliance. When recommending any remedy, the SA notifies the RO/SMA of its choice of enforcement remedy and the timing for imposing it. According to the SOM, "Except in the most extraordinary circumstances, the RO/SMA accepts the SA's recommendation on the choice of remedy and the amount of a CMP."

Immediate jeopardy is defined as a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. Temporary management, termination, or both is required to address immediate jeopardy situations. As noted in the SOM, "While the use of other remedies in addition to temporary management or termination is allowed, the Act makes it clear that the enforcement action for noncompliant facilities with immediate jeopardy deficiencies is intended to be swift and lasting."

10.2.3 Enforcement Process

The enforcement process begins upon completion of the survey process. Providers are informed of initial survey findings at an exit conference and given an opportunity to discuss them and supply surveyors with additional information. Actions taken from then on depend upon the seriousness of deficiencies cited. In cases of immediate jeopardy, the SA notifies the facility, SMA and RO of its recommendations in writing by the second calendar day. The SMA/RO issue formal notification of remedies to the facility by the 21st day and the provider agreement is terminated or a temporary manager appointed if immediate jeopardy is not removed within 23 days. At day 23, if immediate jeopardy is removed, but the facility has not achieved substantial compliance, it may be given additional time (up to six months) to come into compliance. These are maximum time frames and remedies can be imposed sooner if notice is given as required. Required time periods for formal notice are summarized in Exhibit 10.2.

**Exhibit 10.2
Notification Requirements**

Immediate Jeopardy		No Immediate Jeopardy	
State monitoring	no notice	State monitoring	no notice
temporary management	2 days	termination	15 days
termination	2 days	remedies other than CMPs	15 days
remedies other than CMPs	2 days	CMPs	effective as of date noncompliance began, usually last day of survey
CMPs	effective as of date noncompliance began, usually last day of survey		

In cases where no immediate jeopardy exists and the facility is not a poor performer, the SA may opt to set a “date certain” by which the facility must be in substantial compliance. The SA may presume a facility to be in substantial compliance based on an acceptable PoC, as of a particular date specified in the PoC, and conduct a revisit later to verify compliance. If the facility is in compliance at the revisit, no remedies will be imposed. If the facility does not demonstrate substantial compliance at the revisit, SA recommends that remedies be imposed and the RO/SMA sends out formal notice to the provider imposing the remedies within three days.

The SA may opt to impose category 1 remedies as well as setting a date certain. In such cases, SAs may impose category 1 remedies themselves, on behalf of the RO/SMA, if the RO/SMA does not communicate disapproval within two days of the notice from the SA.

When no immediate jeopardy exists, the SA sends an initial notice to the provider within 10 days with copies to the SMA and RO, which includes:

- Deficiencies cited and Form HCFA 2567;
- Mandatory remedies imposed if provider fails to achieve substantial compliance;
- SA recommended remedies and effective dates*;
- Information regarding the plan of correction (POC) if applicable;
- Opportunity for informal dispute resolution; and
- Procedures to follow when provider alleges substantial compliance

*These remedies are not effective until formally imposed by RO/SMA.

The SMA/RO responds to SA recommendations within three calendar days and sends out formal notice to provider imposing remedies and effective dates. At minimum, mandatory denial of payment for all new admissions must be imposed and effective within three months from the last day of survey if facility has not corrected the deficiencies cited.

These steps are summarized in Exhibit 10.3.

Exhibit 10.3
Enforcement Actions and Time Frames

Immediate Jeopardy		No Immediate Jeopardy	
action taken	deadline	action taken	deadline
initial notification to provider (SA)	2 days	initial notification and 2567 to provider (SA)	10 days
SA forwards all documentation to RO/SMA	5 days	formal notification to poor performer (RO/SMA)*	13 days
notification of temporary management (HCFA/SMA)	5-8 days	provider may submit PoC and request informal dispute	20 days
formal notification of remedies (RO/SMA)	5-21 days	if no PoC submitted, SA notifies provider of recommended remedies (effective when notification requirements met)	20 days
Form HCFA 2567 sent to facility, RO/SMA	7-10 days	SA opts to set date certain by which provider must be in substantial compliance	20 days
Facility notified of effective date of CMP and temporary manager installed	10 days	SA accepts PoC with revisit conducted later to verify compliance if not in compliance at revisit, remedies imposed by RO/SMA within 3 days of revisit	20 days revisit by 70 days
Provider submits PoC to SA with 4 core elements	10 days after receipt of 2567	if deficiencies not corrected, mandatory denial of payment for all new admission imposed	3 months
formal notice of termination to facility that refused temporary manager or has not removed immediate jeopardy (HCFA/SMA)	10-21	if deficiency not corrected, termination imposed	6 months

Immediate Jeopardy		No Immediate Jeopardy	
action taken	deadline	action taken	deadline
initial notification to provider (SA)	2 days	initial notification and 2567 to provider (SA)	10 days
termination takes effect unless immediate jeopardy is removed	23 days		
additional time may be given to achieve substantial compliance (if immediate jeopardy removed)	6 months		

* SA may impose category 1 remedies on behalf of RO/SMA if disapproval is not communicated within 2 days of notice to RO/SMA.

Additional actions are taken when substandard quality of care is identified, including notification to attending physician of each resident found to have received substandard care and to the State board responsible for licensing the facility administrator. If substandard quality of care is found on three consecutive standard surveys, HCFA/SMA must deny payment for all new admissions as soon as possible, and impose State monitoring.

States are also required to deny or withdraw approval of the Nurse Aide Training and Competency Evaluation Program (NATCEP) for a period of two years when substandard quality of care is identified. Since facilities are prohibited from using untrained nurse aides, they must find and finance alternative training for employees during this period. The loss of nurse aid training is a consequence that currently affects about 12 percent of long term care facilities, according to HCFA.

In the case of category 1 remedies, the SA notifies RO/SMA of its recommendation to impose directed in-service training, DPoC, or State monitoring. If RO/SMA does not indicate disapproval within two calendar days of this notice, the SA sends letter to facility imposing category 1 remedies on behalf of RO/SMA. Termination is effective six months after survey date unless provider demonstrates substantial compliance.

Facilities have the option of challenging deficiencies. A request for informal dispute resolution (IDR) must be made in writing within the same 10-day period the provider has for submitting an acceptable PoC. An explanation of the IDR process accompanies the HCFA 2567. Methods of IDR vary by State and can include telephone conferences, written disputes, or in a face-to-face meetings.

Providers are informed of unsuccessful resolutions in writing. When successful, Federal regulations require the deficiency to be marked "deleted," signed and dated by a supervisor of the surveying entity. Any enforcement action imposed because of that deficiency should be rescinded.

and the provider has the option of requesting a clean (new) copy of the Form HCFA-2567, releasable only when the new PoC is provided and signed.

Any HCFA-2567 and/or PoC that is revised or changed as a result of informal dispute resolution, must be disclosed to the ombudsman. Once resolved, amended information should be entered into the OSCAR database.

Providers also have the right to appeal certification of noncompliance and request a hearing. Providers who waive their right to request a hearing receive a 35 percent reduction in the CMP amount. The enforcing authority also has the right to settle cases prior to a final decision. Regulations call for the State's conclusion about noncompliance to be upheld unless clearly erroneous.

10.3 JCAHO Follow-Up Process

The JCAHO accreditation process is articulated in the 1996 Comprehensive Accreditation Manual for Long Term Care (CAMLTC). Findings of non compliance and minimal compliance by a JCAHO surveyor are eligible for, and most require, follow-up. The follow-up process requires providers to demonstrate improvement in recommended areas within specified time frames. Rather than imposing sanctions, the Joint Commission Accreditation Committee may deny or delay accreditation to facilities that fail to meet their requirements.

10.3.1 Types of Recommendations

JCAHO surveyors can make two types of recommendations: supplemental and Type I. Supplemental recommendations are made for issues that require no formal follow up. Supplemental recommendations are noted on the organization's accreditation report and can affect a future accreditation decision if not dealt with appropriately by the next triennial survey.

To address insufficient or unsatisfactory standards compliance in a specific performance area, JCAHO makes Type I recommendations that must be resolved within specified time frames for an organization to maintain its accreditation. Progress is monitored through focused surveys (FOC), written progress reports (WPR), or both, at specified times during the accreditation cycle.

In general, providers are given two opportunities to demonstrate sufficient progress in any area assigned a type I recommendation: first and second generation. According to the CAMLTC, third generation type I recommendations are possible, but rarely assigned. JCAHO does not normally track the percentage of facilities that clear Type I recommendations after each generation, however, so they were unable to provide Abt with specific data.

This process is illustrated in the JCAHO flow charts attached as Appendix F. For example, after a surveyor identifies a problem, s/he assigns a first generation Type I recommendation requiring follow up in the form of a WPR or FOC. The facility is informed of the surveyors findings at the exit conference at the end of the survey and receives an Official Accreditation Decision Report

within 60 days. Depending on the nature of the problem, up to six months may be allowed for correction. If after six months, JCAHO determines the problem still has not been addressed, a second and third generation recommendation may be assigned until the organization demonstrates sufficient progress or is denied accreditation.

JCAHO monitors compliance improvement through written progress report or focused survey. JCAHO staff make the determination as to which method is more effective depending on the nature, severity and number of compliance problems in a given area. In most cases, providers can demonstrate improvement by submitting a WPR, normally due within one month or six months. The time allowed for submitting a WPR depends on the nature of the problem. One-month WPRs address critical issues and short time frame issues (e.g., controlled substances improperly handled). Six-month WPRs address deficiencies that require longer than one month to demonstrate compliance (e.g., no pain assessment on admission). In both cases, WPRs are assigned when compliance with relevant standards can be demonstrated through a written report. According to the CAMLTC, when a WPR is assigned to address second generation recommendations, it is usually due within one month.

Generally, grid element scores (discussed below) of 4 or 5, which indicate minimal or noncompliance, are considered most serious and may result in a focused survey. Usually, first generation focused surveys are scheduled within approximately six months and second generation focused surveys within approximately four months. In these cases, evidence of actual implementation and compliance is required to clear the Type I recommendations (e.g., verification of licensure for health care practitioners). In most cases a track record of successful implementation is also required (e.g., pain assessment procedures implemented and conducted successfully). A surveyor tours the facility, conducts interviews, reviews documents and other records to assess progress. Focus is on the specified standard, but may also address issues related to the subject, or situations that arise onsite.

According to the JCAHO, most organizations resolve Type I recommendations within one year. Technically, JCAHO policy allows up to three years. Deadlines can sometimes be extended to organizations in extenuating circumstances. For example, a surveyor may call a facility after six months to check on an over due progress report, find that it is nearly complete, and allow the organization another 10 days to submit it. If a new administrator has been hired, a 30-day extension may be granted. Although the JCAHO restricts extensions to 10-day periods in policy, surveyors can make exceptions in practice when confronted with common long term care issues like staff turnover.

Time lines for JCAHO follow-up actions are summarized in Exhibit 10.4.

Exhibit 10.4
Follow Up Actions and Time Frames

action taken	options and deadlines
Official Accreditation Decision Report to provider	60 days
1st generation type I recommendation	1-month WPR, 6-month WPR, 6-month FOC
2nd generation type I recommendation	4-month WPR or FOC
3rd generation type I recommendation	1-month WPR
supplemental recommendation (noted on accreditation report)	3 years can affect accreditation decision upon review at next triennial survey

10.3.2 Accreditation Levels

JCAHO staff evaluate survey results, surveyor recommendations, and other relevant information, such as documentation of compliance with the standards, documentation of plans to correct deficiencies, or evidence of recent improvements. Using scoring guidelines, accreditation rules, and decision rules, staff make a determination regarding accreditation. The level of accreditation awarded is based on the provider's performance as summarized in Exhibit 10.5.

Exhibit 10.5
Levels of Accreditation

DECISION	CONDITIONS
accreditation with commendation	summary grid score of 90 or higher and no follow-up monitoring
accreditation with or without type I recommendations (must be resolved within a specified period of time or organization risks losing accreditation)	<u>without follow-up</u> : overall compliance, vast majority of grid elements scored 1 or 2, and at most only one scored 3 <u>with follow-up</u> : needs improvement in specific area(s) to achieve compliance with standards in that area, usually indicated if grid elements scored 3, 4, or 5 and usually requires follow-up monitoring through focused survey or written progress report (WPR), depending on nature, severity, and number of compliance problems

DECISION	CONDITIONS
conditional accreditation multiple substantial standards compliance deficiency exists, correction must be demonstrated through follow up survey	survey results in assignment of follow-up monitoring in many areas indicating organizations' s overall performance is marginal or when an organization has not corrected type I recommendations in time frames specified. Organizations are required to develop a plan of correction, have it approved by Joint Commission and demonstrate sufficient improvement in follow-up survey within 6 months. (After follow-up survey, organization will be accredited (with or without type I recommendations) or not accredited.
provisional accreditation for organizations wishing to be accredited , but not ready for full evaluation (e.g., not operational for four months)	organization demonstrated substantial compliance with selected structural standards surveyed in the first early survey. Second survey is conducted approximately 6 months later to allow sufficient time for organization to demonstrate a track record of performance
not accredited	JCAHO denies or organization withdraws

JCAHO completed 722 long term care surveys in 1996. The percentage accredited at each level are listed below:

- Accreditation with commendation 17%
- Accreditation without Type I 5.8%
- Accreditation with Type I 75%
- Conditional accreditation 0.3%
- Provisional accreditation 1%
- Not accredited 0.1%

The majority (75 percent) of facilities accredited by the JCAHO received some type of follow up, another 23 percent will not be contacted until their next regular survey (unless included in the 5 percent of providers randomly sampled mid-cycle). Rarely was a facility conditionally accredited or denied accreditation

10.3.3 Process

The accreditation process involves three separate activities: the survey process, aggregation process and decision process. During the survey process, the surveyor holds daily briefings, and can even provide in-service to management and staff (if time permits) on topics related to problems identified. Before completing the survey, the JCAHO surveyor also holds an exit conference to present findings and discuss causes of compliance issues. This gives the surveyor an opportunity to recommend improvements and organizational leaders an opportunity to clarify issues and respond to recommendations.

The surveyor indicates compliance with JCAHO standards using a five-point scale where each score corresponds to a defined level of compliance:

- 1 = substantial compliance
- 2 = significant compliance
- 3 = partial compliance
- 4 = minimal compliance
- 5 = noncompliance
- n = not applicable

During the aggregation process, these scores are consolidated using aggregations rules that designate the weight each standard carries in the accreditation decision. According to the CAMLTC, this aggregation process accounts for the fact that standards are not of equal weight and provides a consistent system for reconciling their differing impacts into a single accreditation decision. This is worth noting because it reflects a significant difference between Joint Commission and HCFA systems. While JCAHO works hard to capture a facility's overall level of compliance, HCFA requires substantial compliance with each standard.

The aggregation system uses caps, sets, and critical numbers. A cap defines the maximum impact that a standard's score can have on the grid element score. Actual performance is captured and standard's impact on grid element score is limited. For example, if the cap for a specific standard is set at 3, the surveyor may score this standard at 5, but it will not have an impact greater than 3 on the grid element score. Standards may be capped at different scores. The grid reflects capped scores, while the Official Accreditation Decisions Report shows actual, standard-level scores. Caps are generally used when a new standard is introduced in order to allow time for facilities to become familiar with the requirements and develop a history of compliance.

An alphabetic set designation (A, B, C...) indicates the set to which a standard belongs. A standard is placed in set A when it addresses an issue so critical that the standard's score should directly and independently impact the grid element score. Set B or higher relates to standards that are grouped and need to be evaluated together. In addition, some standard scores are buffered, or capped, to limit their effect on grid element score.

Critical numbers, the number of standards scored at a certain level that will result in a particular score, indicate the point at which compliance problems exist and are used to help arrive at a set score. Critical numbers are unique to a set and are based on the specific content of the standards in that set. For example, in the Diagnostic Services grid element because of the expectations related to the standards in Set B, the critical number is set at 2. If two or more of the three items are scored 5, the score is 5.

JCAHO considers two pieces of information in the decision process: the grid element scores and summary grid score. The method for determining a single score for the grid element is graduated consolidation (individual standard scores to set scores to the grid element score). Aggregation

rules are applied to determine the score for each set within a grid element. Below are examples provided in the CAMLTC:

Set A: critical number for standards is always one because each standard in set A can affect the grid independently. Rule is: worst score of all the A standards, after applying caps, is the score for Set A.

Set B: Standards in Set B or higher affect grid in combination with one another, up to five “if/then” rules are applied and the set score is determined through a process of elimination.

The first “if” scenario that is true provides the score for the set.

In Diagnostic Services, for example, the following aggregation rules apply:

If 2 or more of 3 items are scored 5, the score is 5.

If 2 or more of 3 items are score 4 and/or 5, the score is 4.

If 2 or more of 3 items are scored 3,4, and/or 5, the score is 3.

If any of the 3 items is scored 2 or worse and none of above rules are met, score is 2

If all 3 items are scored 1, score is 1.

The grid element score is the worst of the scores listed.

Finally, the summary grid score is calculated using four steps:

step 1: Convert each grid element score into a numeric value, assigning the better scores more points.

Score 1 = 4 points

2 = 3

3 = 2

4 = 1

5 = 0

step 2: Add converted grid element scores.

step 3: Total the number of scored grid elements (those assigned a numeric code, Ps and Ns not counted) and multiply the result by 4. For example, if all grid elements on L.C. are scored, the number would be 128 (32 grid elements x 4 = 128).

step 4: Divide the sum of converted actual grid element scores (from step 2) by the total of the converted perfect grid element scores (from step 3) and multiply by 100. 100 = substantial compliance and 0 = noncompliance

To determine the accreditation decision from a completed decision grid, Joint Commission decision rules are considered sequentially, starting with worst-case scenario (not accredited) and ending with best (commendation). An accreditation decision is reached through process of elimination. The CAMLTC provides a flow chart of this process and is included as Exhibit 10.6. Additional flow charts that follow each type of accreditation decision are included in Appendix F.

JCAHO provides an Official Accreditation Decision Report to the facility within 60 days of the survey's completion. The organization then has 30 days from receipt of the report to notify JCAHO of its intent to contest any portion of the report and 20 days to notify JCAHO of intent to contest a decision to deny accreditation. If an organization does not challenge its survey report, JCAHO forwards a copy of the performance report which includes performance data summarized from the survey report and national comparative data placing the organization in perspective. On receipt, the facility has 30 days to submit an optional two-page commentary.

An organization that has been denied accreditation or assigned conditional accreditation can submit a written request for a hearing to the Joint Commission within 20 days of their receipt of the accreditation decision. The JCAHO president assigns three impartial individuals to an Appeal Hearing Panel to study original adverse decisions and determine its own independent recommendation. A Board Appeal Review Committee reviews the panel's findings at its next regular meeting and makes final decision regarding accreditation status.

10.4 Comparison of HCFA AND JCAHO Approaches

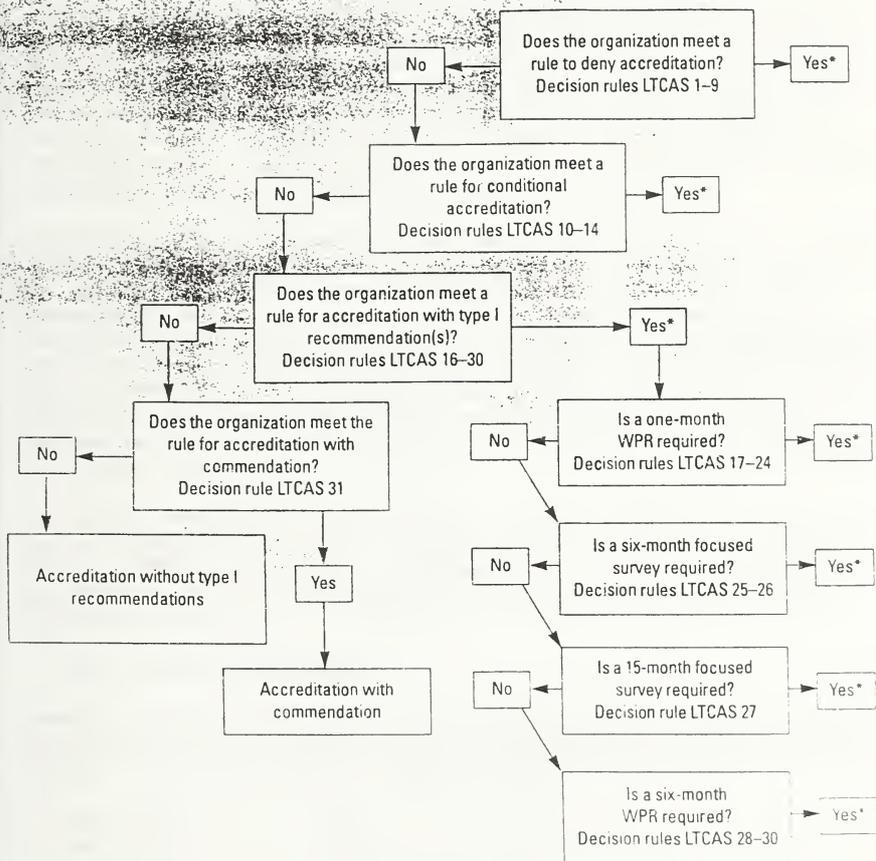
Although the goal of each process is for providers to achieve and maintain substantial compliance, the approach of each system is fundamentally different.

According to HCFA: "The new nursing home enforcement protocol/procedures are based on the premise that all requirements must be met and enforced." Substantial compliance with all conditions of participation is mandatory. It is HCFA's responsibility to ensure that facilities provide quality services and that residents' health and safety are protected. Their enforcement remedies attempt to guarantee compliance with Federal regulations. HCFA's strategy is to impose sanctions that compel providers to comply with Federal requirements or risk losing Federal payments.

According to the Joint Commission: "To gain accreditation, an organization must demonstrate overall compliance with the standards, not necessarily compliance with each standard."

JCAHO is less concerned with the letter of the law and more interested in overall performance. Accreditation is voluntary and JCAHO follow-up procedures reflect a cooperative approach to compliance. The JCAHO strategy is to motivate providers to make improvements and to avoid the costs associated with poor performance.

EXHIBIT 10.6



Note: Organizations surveyed under the Early Survey Policy will receive either provisional accreditation or no accreditation decision and will have to reapply for survey.

* See the flowchart poster packaged with this book for more information on the steps that follow an accreditation decision or assignment of follow-up monitoring (focused survey, written progress report, or plan for improvement)

10.4.1 Time Allowances

Most HCFA remedies require 2 days notice in cases of immediate jeopardy and 15 days notice when no immediate jeopardy exists. Unless the facility is a poor performer, they typically have 90 days to correct deficiencies and avoid sanctions. Once imposed, HCFA enforcement remedies remain effective until providers correct deficiencies or terminate. CMPs are effective from the date noncompliance began and providers must face termination if immediate jeopardy is not removed within 23 days of survey. Six months is the maximum time allowed for a facility to demonstrate compliance. In addition, the survey and certification process operates on an annual cycle so onsite visits are conducted with each provider at least every 15 months.

JCAHO issues an Official Accreditation Decision Report within 60 days of the survey. According to the CAMLTC, providers are generally given two opportunities to demonstrate progress in any area assigned a Type I recommendation: first and second generation. The majority of first generation follow up requirements allow six months for the provider to submit a WPR. If the six-month WPR fails to clear the recommendation, facilities may be allowed a second generation type I recommendation (FOC or WPR) and be given another four months or more to demonstrate improvement. By this time, one year has passed since the organization's survey. In rare cases, after failing to clear two rounds of type I recommendations, a facility can be conditionally accredited, rather than being denied accreditation. These facilities have an additional four months to demonstrate compliance.

The CAMLTC flow chart of this cycle is presented in Exhibit 10.7. Taking into account the 60-day notification period, follow up with the organization in this example can take anywhere from eight to 16 months after the initial survey identifying problem areas. The Joint Commission accreditation process operates on a triennial cycle and allows a maximum of three years for organizations to resolve type I recommendations.

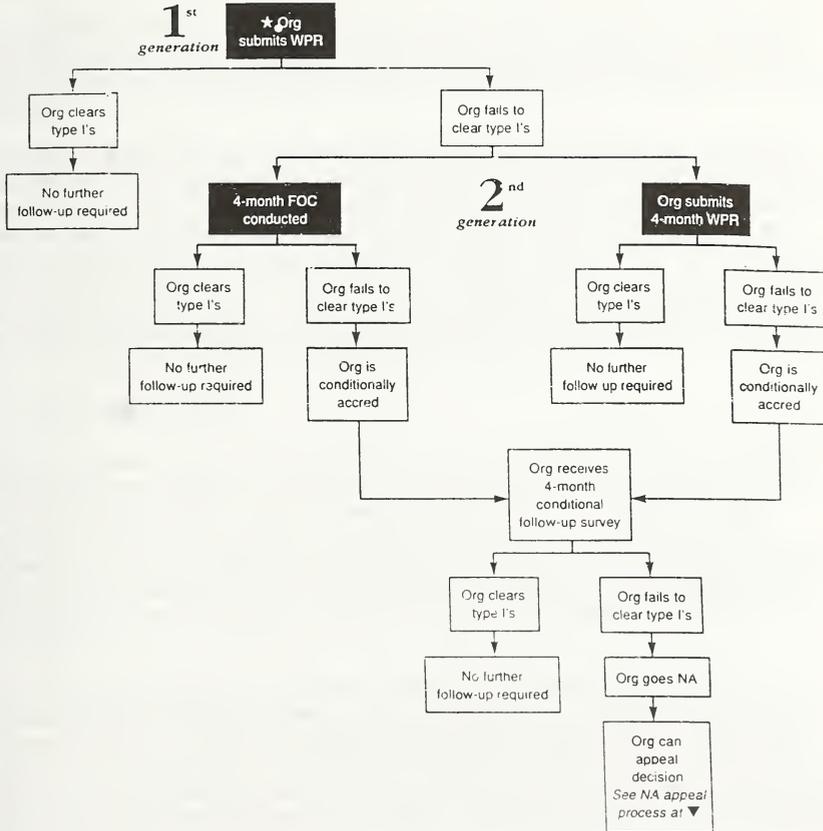
10.4.2 Verification of Compliance

According to the JCAHO, 722 long term care surveys were completed in 1996. Most of those (75 percent) resulted in accreditation with Type I recommendations and required some type of follow up. Type of follow-up required breaks out as follows:

6-month WPR	87%
1-month WPR	0.5%
6-month FOC	1.5%
1- and 6-month WPRs	11%
1-month WPR and 6-month FOC	0.1%

EXHIBIT 10.7

Accreditation with Six-Month WPR



The numbers above indicate that JCAHO relies primarily on written progress reports to demonstrate that deficiencies are corrected. The flow chart provided in Exhibit 10.7 illustrates the follow up provided to a facility accredited with a six-month WPR. This example represents the majority of JCAHO-accredited facilities in 1996. In this case, JCAHO required an onsite survey when compliance issues were not resolved after 10 months. At that time, an additional four-month period was available for the facility to demonstrate improvement through a follow-up survey. In addition, the Joint Commission's regular survey cycle is triennial, so no surveyor would return to the facility for another three years.

Although JCAHO policy calls for focused surveys when conditions warrant it, the data suggest that seldom occurs. There is an element of "benefit of the doubt" in acceptance of provider progress reports until the next triennial survey, when recommendations are looked at by JCAHO surveyors.

Conversely, HCFA surveyors tend to rely upon onsite revisits to verify facilities' compliance. According to HCFA requirements, revisits are optional for deficiencies that fall in the D, E, and F categories and have no substandard quality of care. However, State agency staff indicated they were not always comfortable conducting paper/desk reviews. States attributed their revisit policies to the nature of the most frequently cited deficiencies. If a provider was at fault for not having a full-time DON on staff, for example, they could provide documentation that one had been hired and the SA could do a desk review of their paperwork. If equipment needed to be purchased or repaired, surveyors could review invoices, etc. In most cases, however, deficiencies focused on quality of care issues that needed to be addressed onsite.

10.4.3 Public Disclosure

HCFA requirements regarding notification involve more than just the provider and surveying and enforcement entities. Whenever a facility has deficiencies that constitute substandard quality of care, the SA must notify the attending physician of each resident found to have received substandard quality of care as well as the State board responsible for licensing the facility administrator. In addition, substantiated cases of abuse, neglect, or misappropriation of resident property must be reported within 10 working days to individuals involved, applicable licensing authorities, and nurse aide registry. Notice is also given to general public of impending termination.

The SA must provide the State long term care ombudsman with information regarding deficiencies, reports of adverse actions, written responses from providers (PoCs), and of appeal requests and results. Information regarding cases involved in informal dispute resolutions is released to ombudsmen, but not entered into OSCAR until resolved. In phone interviews, SA reported relying on ombudsmen and the public to communicate problems at facilities between regular survey periods and help monitor compliance. This information exchange is an important part of that process.

Generally within 14 days, the SA, RO, or SMA can supply provider information to the public upon request and usually for a nominal fee. Information available to public upon request by SA, SMA, or HCFA for all surveys and certifications of SNFs and NFS includes:

- Eligibility for participation in Medicare/Medicaid program
- Official statement of deficiencies and acceptable POCs, both are spelled out in Form HCFA-2567 (individual names blacked out)
- Provider comments
- Statements that facility did not submit acceptable PoC or failed to comply with conditions of imposed remedies if appropriate
- Official notices of provider terminations
- Statistical data on provider characteristics
- Final appeal results
- Medicare and Medicaid cost reports
- Names of individuals with direct or indirect ownership interest in SNF or NF

Information that must be disclosed within 14 days of request includes:

- Statements of deficiencies (2567);
- Separate listings of any isolated deficiencies that constitute no actual harm, with potential for minimal harm; and
- Approved POCs (2567) which contain any provider response to deficiencies.

JCAHO sends a facility performance report and commentary provided by the facility to individuals upon request beginning 30 days after its receipt by the organization. No performance report is released if an organization is in the process of challenging an accreditation decision or survey report. JCAHO holds the report until the challenge is resolved.

According to the CAMLTC, JCAHO maintains confidentiality for providers on the following information received or developed during the accreditation process:

- Information regarding compliance with specific standards obtained from the organization before, during, or following the survey;
- All materials that may contribute to the accreditation decision (e.g., survey report forms);
- Written staff analyses and Accreditation Committee minutes and agenda materials; and
- The official accreditation report.

On request, the JCAHO discloses information regarding an organization's current accreditation status and accreditation history. However, standards compliance data is only released at the grid or grid element level. "Grid element level" is a performance area or topic, such as resident rights, that receives a discrete score on the accreditation decision grid. Since this data has undergone the JCAHO aggregation process, the information released will not show survey scores for each standard, rather it will present the organization's overall performance in each area.

According to the CAMLTC, the JCAHO may release organization-specific performance information to the public provided it meets the following conditions:

- Data are accompanied by an explanation of their source(s) or derivation, accuracy, reliability, and validity; appropriate uses, and limitations and potential misuses.
- Data are portrayed or described in an understandable context including comparisons with national or other statistically valid performance data.
- Standards-compliance data are at the grid or grid element level.
- Data from performance-measurements systems that are an integral part of the accreditation process are a summary of the most recent 12 months.
- The organization has had an opportunity to comment on them.

The JCAHO also notifies organizations of the names and addresses of parties who receive their performance information.

Under two circumstances, JCAHO also provides responsible Federal, State, or local government agencies with information: 1) when a surveyor identifies a serious situation that may jeopardize the safety of residents or the public, and 2) when an organization certified for participation in Medicare or Medicaid, or licensed to operate on the basis of its accreditation (as provided in statute or regulation) becomes conditionally accredited or not accredited.

10.5 Issues to Consider

This section discusses some concerns and limitations regarding the data available for this report. It reviews the reporting and tracking systems currently in place and addresses the issue of how compliance is monitored and ensured over time.

10.5.1 Data Reports

According to HCFA central office, 16,835 standard surveys were completed between July 1, 1996 and June 30, 1997. Of those, 11,276 (67 percent) had deficiencies of level D and higher. Most facilities (9,499) were in substantial compliance by the time of the revisit. HCFA's statistics seem to indicate that providers respond to the threat of potential sanctions and come into compliance before penalties are actually imposed. This was confirmed in telephone conversations with several regional and State representatives. In Boston and Kansas City, for example, staff indicated that most facilities comply by the time of the first revisit so that remedies are never actually imposed. Exhibit 10.8 below presents the number of remedies proposed and imposed between July 1, 1996 and June 30, 1997.

Exhibit 10.8
Survey Activity Report from OSCAR

Remedies	Proposed		Total Imposed	% Imposed
	Standard	Complaint		
Civil Monetary Penalty	3187	870	275	6.8%
Temporary Management	15	5	1	5%
Directed Inservice Training	3493	959	123	2.8%
State Monitoring	1415	458	50	2.7%
Denial of Payment for New Admissions	6109	1694	189	2.4%
Directed Plan of Correction	2080	343	31	1.3%
HCFA Approved Alternative State Remedy	136	18	2	1.3%
Termination	6680	1572	14	<1%
Denial of Payment for All Residents	47	10	0	0
Transfer of Residents/Facility Closure	1	0	0	0
Transfer of Residents	1	0	0	0.8

However, these data do not clearly show what happens from the time a remedy is proposed until it is actually imposed, disputed, or the facility achieves compliance. According to HCFA staff, the number of termination and denial of payment remedies proposed is misleading. Notification of possible termination and denial of payment for new admissions to providers is mandatory, even when providers are given an opportunity to correct deficiencies by the date certain. Those remedies are proposed in virtually all cases without expectation of actually being enforced. As one SA reported, "The number proposed doesn't matter. Most [facilities] comply by the revisit, so we're not tracking it." This report also raised concerns about the accuracy of OSCAR data if all States are not reporting information consistently.

Data available from the JCAHO were also limited. Abt was not able to obtain statistics on complaints, appeals, or actual time allowances for resolution of Type I recommendations because JCAHO does not regularly track this information. The Joint Commission surveyed a total of 722 facilities in 1996 and the majority of those facilities required some type of follow up (75 percent). In most of those cases (87 percent), follow up was required in the form of a six-month written progress report.

10.5.1.1 Tracking Enforcement Data

As Abt staff contacted HCFA regional and State offices for additional information on how enforcement data are tracked and reported, several other issues surfaced. States and ROs had questions regarding the accuracy of OSCAR data. Regional representatives reported that States do not always enter enforcement actions reliably, so that the information in the system may be incomplete or that there may be time lags for data entry. One State reported entering the information consistently, but found that the information was not always there when they extracted it back out. States also described a cumbersome reporting process that involved State and regional systems, in addition to OSCAR data requirements. One State pointed out, "so much notification is required, there are bound to be failures. Our regional office has good data, but it's not from OSCAR."

Reporting and tracking systems varied: notification letters were copied, forms were faxed, and/or data was shared with State licensure and HCFA regional offices. One region said they know States are directed by the SOM to send copies of initial letters to the RO, but that they don't require it. Instead they rely on data tracked through the survey system to identify poor performers. The RO explained that while that system was not always reliable, they had developed informal checks and made phone calls when they noticed problems with the data. Most problems encountered were attributed to new hires among data entry staff. Another region developed formal, written instructions to the States on the necessary documentation required in the long term care enforcement process.

Regional variations and additional reporting problems were found with tracking of complaints and IDRs. One State was unsure how IDRs were tracked, but suggested Abt contact facilities directly for complete information about informal dispute resolutions. Another State said the total number was not tracked, but changes to deficiencies resulting from IDRs were noted in the file.

Regional variations noted in several areas are difficult to capture, including frequency of IDRs and types of remedies imposed across States. In Oregon, for example, CMPs are reserved for the worst cases. In Washington State, Federal CMPs are never proposed. According to HCFA regional staff, this is because Washington has effective fines under their State licensure system and the process for enforcing them is less involved. So the State uses the same process that was in place before the Federal regulations.

According to Joyce Stockwell at the Aging and Adult Services Administration, Washington's State system is superior to the Federal enforcement regulations and allows the SA to act immediately. In cases of substandard quality of care, for example, a stop placement remedy is imposed without giving providers any notification or opportunity to correct. As a result, facilities cannot admit any residents, including private pay. Because the State has a parallel CMP enforcement system, imposing the optional Federal fines seems unnecessary. Stockwell reports that the State fines are more effective, the process is less cumbersome, and they are used to using it. When a moratorium was issued for a period and there were holds on the Federal CMP policy, Washington decided to go with the State system already in place.

While it may be true that no Federal CMPs are imposed in Washington, it is also true that the State is making use of that enforcement method under its State regulations. From October 1996 through September 1997, Washington reports 67 fines were imposed on facilities in the State for a total of \$154,300. However that information is not reported to HCFA central office.

Tracking enforcement actions is a complex process that requires coordination among the State, regional, and Federal systems. It is not always clear how information regarding enforcement at each level is shared or centralized. Abt collected reports Washington State and from the Kansas City Regional office for comparison with OSCAR data. These materials are attached for HCFA's review as Appendix F.

Because Joint Commission operates through one centralized office, tracking and reporting operations are simpler. Surveyors have one employer and one set of reporting requirements. In addition, all undergo an identical training process. According to Joint Commission staff, surveyors are supplied with laptops. As of 1997, all information is entered in the field and both electronic and hard copies of reports are sent to JCAHO central office where all information is maintained.

10.5.2 Monitoring Compliance

JCAHO uses random surveys and unannounced surveys to ensure continued compliance between their regular three-year surveys. Random sample surveys are midcycle, unscheduled surveys conducted on 5 percent of accredited organizations. One surveyor conducts each survey for one day and organizations receive 24-48 hours notice. JCAHO does not charge for random surveys. Continuous compliance is expected and JCAHO may survey an organization at any time with or without notice (in response to complaints, media coverage, etc.) at no charge.

In addition, Joint Commission may conduct unscheduled and unannounced surveys when staff become aware of potentially serious resident care or safety issues in an accredited organization at any point in the 3-year accreditation cycle. In such cases, JCAHO usually provides the organization with 24 to 48 hours advance notice of an unscheduled survey. No notice is provided for unannounced surveys conducted in response to a concern about: a substantial deterioration in clinical care; an immediate threat to resident care or safety, or credible allegations of falsified accreditation information. These surveys can include all services or only those areas where serious concern exists. Failure to permit unscheduled or unannounced surveys will be grounds for withdrawing accreditation. JCAHO does not charge for these surveys.

10.5.2.1 Complaints

HCFA monitors continued compliance between standard, annual surveys, by relying on the public complaint process and ombudsmen to keep informed of problems. Individual State plans describe procedures for processing complaints. The SA informs RO and/or SMA anytime certification requirements are out of compliance, but the State establishes written procedures and maintains

adequate staff to receive, investigate, and resolve complaints. States are also responsible for tracking complaint information until it is entered into OSCAR Complaint Subsystem.

HCFA's policy is that complaint investigations be unannounced and that immediate jeopardy situations get a response within 2 working days. Additional procedures apply in cases of resident neglect, abuse, and/or misappropriation of resident property. Most States prioritize incoming complaints into those that need immediate response and those that can wait until the next standard survey. If noncompliance is found, the same procedures apply as in regular surveys.

Comments made during phone interviews also indicated that there was a time lag in entering information regarding complaints into the system. In one State, complaints are handled by "local units," not the State survey agency. Sometimes these units referred cases to the State and they could be traced through the State system, but none of the information reached OSCAR. Unfortunately data regarding complaints was unavailable from the JCAHO.

10.6 Summary

Fundamental differences exist in the philosophies of each organization and are reflected in the approaches taken by HCFA and the JCAHO. HCFA emphasizes that compliance with all its requirements is mandatory and imposes (mandatory and optional) remedies when providers fail to correct deficiencies. Remedies are determined by the seriousness of the deficiency, as measured by its scope and severity. The JCAHO focuses on overall compliance and limits the effect of some standard scores on the facility's overall score. According to the CAMLTC, this aggregation process accounts for the fact that standards are not of equal weight and provides a consistent system for reconciling their differing impacts into a single accreditation decision.

Differences between HCFA's enforcement process and JCAHO's follow up procedures include:

- The time allowed to correct deficiencies;
- The methods used to verify correction of deficiencies; and
- The systems for implementing and tracking these activities.

Typically, a facility cited by HCFA surveyors corrects the deficiencies by the date certain, a maximum of three months. HCFA usually conducts a revisit to verify this compliance. A typical facility with Type I recommendations from the JCAHO is allowed six months to demonstrate improved performance and does so by submitting a written progress report.

HCFA reporting procedures have been described as cumbersome and questions surfaced regarding the accuracy of the data available. Problems were reported tracking enforcement actions that varied from State to State. Because Joint Commission surveyors report directly to their central office, these problems were not an issue and JCAHO staff report that regional variations do not exist.

Both HCFA and the JCAHO require immediate action in situations that may jeopardize the health and safety of residents. Both also have policies for releasing information to the public. HCFA also requires specific procedures be followed to inform the ombudsmen of deficiencies, and to notify attending physicians and appropriate licensing boards of cases involving substandard quality of care. SAs reported relying on these policies, and the monitoring activities of the public and the ombudsmen, to ensure continued compliance from facilities. The JCAHO monitors compliance between surveys by conducting random, unscheduled surveys on 5 percent of accredited providers.

While the data available are limited, reports from HCFA and JCAHO indicate that both find a majority of facilities have deficiencies that need to be corrected. The typical response from each is to allow facilities time to correct the problem on their own. HCFA and JCAHO both report that most providers correct deficiencies within the given time frames, so that HCFA does not terminate many facilities and the Joint Commission does not deny many facilities accreditation. Based on the data available for this report, the question of whether (and how) effective HCFA and the JCAHO are in achieving and maintaining lasting compliance among providers remains unclear.

11.0 COMPARATIVE ANALYSIS OF HCFA AND JCAHO SURVEY COSTS

11.1 Introduction

The proposed policy of accreditation/deemed status for long-term care (LTC) facilities may have several cost impacts. First, it may change the overall costs of the Medicare/Medicaid certification survey program depending on the relative efficiency with which public and private bodies implement LTC certification/deemed status surveys. Second, it may affect the size of the Health Care Financing Administration (HCFA) LTC survey budget depending on the new role played by HCFA in implementing LTC deemed status. Third, it may change the share of LTC certification/deemed status survey costs borne by public payers as LTC facilities shift the costs of accreditation/deemed status survey costs to a variety of public and private payers. Currently, the cost of surveying all nursing homes participating in the Medicare and Medicaid programs (approximately 17,000 facilities) is borne by the Federal and State governments and those facilities who elect voluntarily to also be accredited by JCAHO pay a fee for triennial survey conducted at their facility.

To make an initial assessment of the cost impacts of the proposed LTC accreditation/deemed status survey, the objectives of this chapter are to (1) compare LTC survey costs between HCFA certification surveys and JCAHO accreditation surveys; (2) estimate the net costs of accreditation/deemed borne by LTC facilities and how they might be passed on to public and private payers; and (3) estimate net budgetary impact of accreditation/deemed status for HCFA. The results of these analyses should be interpreted as approximate because much of the data was in a form more amenable to internal operational decisions at HCFA or JCAHO than to such an external review; neither institution had a cost accounting system that could generate directly comparable cost estimates. For example, specific line items could not be compared, nor could the various non-quantifiable non-survey activities of State agencies be costed out separately. This makes it very difficult to come to any precise conclusions about the relative efficiency of two survey organizations. More extended data collection and analysis would be needed to improve comparability of costs.

Importantly, the study does not account for differences in technical content or procedures of the LTC surveys conducted by the two organizations. We attempt to minimize differences in types of surveys compared by focusing on HCFA's standard/extended survey and JCAHO accreditation survey, but substantial differences still exist between these types of surveys. Cost estimates based on more comparable surveys can only be done once decisions have been made how to change private accreditation surveys to satisfy deeming policies. Other chapters in this report deal extensively with these technical issues.

After this introduction in Section 11.1, Section 11.2 explains the types and sources of data used for the analysis. Section 11.3 presents estimates of HCFA costs per LTC certification survey followed by an analysis of JCAHO costs per LTC accreditation survey in section 11.4. Section 11.5 uses the costs per survey estimated in the two previous sections and other data to examine the potential cost-shifting that may occur as survey costs are passed through LTC facilities to

other payers. Section 11.6 also uses the estimates of HCFA's cost per survey to approximate the net budgetary impact for HCFA from instituting accreditation/deemed status for LTC facilities. Finally, section 11.7 attempts to make some overall conclusions from the various cost analyses.

11.2 Data

11.2.1 HCFA Source of Data for Unit Cost Estimates

State-Level Costs: Every year, HCFA regional offices are given Medicare budget allocations to fund LTC and non-LTC survey activities. The regional offices negotiate with each State for State-specific budget amounts. Once a budget agreement has been reached, survey budget accounts are funded every quarter and State agencies can draw down this account by reporting expenditures on the HCFA 435 form and by reporting survey workload on the HCFA 434 form. These are then recorded in the OSCAR (On-line Survey Certification and Review) information system and the 670 database that documents all survey hours by type of work (e.g. pre-survey prep, survey work, post-survey work). OSCAR provides the data necessary for HCFA to estimate historical unit costs per survey for the nation and by State. HCFA periodically examines costs per survey to track general efficiency of the program and to identify high- and low-cost outliers.

Regional-Level Costs: Regional costs in support of LTC survey activities are not routinely reported as a separate program activity. In order to make approximate estimates of regional unit costs, the central offices of HCFA solicited data from regional offices on the direct and indirect costs associated with LTC survey activity. This information was not available in time to be included in the report.

Central Headquarters Costs: Not included in this round of analysis.

All basic data provided by HCFA are presented in several tables in Appendices J through M.

11.2.2 JCAHO Source of Data for Unit Cost Estimates

All cost and price information for JCAHO was provided and calculated by the Pricing Unit of JCAHO in response to specific questions posed by Abt technical staff. Ideally, it was hoped that the Joint Commission's cost data could be provided in a form directly comparable to HCFA cost estimates; however, JCAHO does not presently have a cost accounting system that is able to generate costs per survey according to the line items provided by HCFA; instead, JCAHO was able to disaggregate survey costs only into direct and indirect cost components.

11.3 Analysis of Cost per Survey for HCFA LTC Certification

11.3.1 Purpose of Unit Cost Analysis

The purpose of this analysis on the unit costs for LTC surveys by HCFA is to generate an estimate of HCFA's cost per survey for LTC certification to compare with the costs per survey for accreditation by JCAHO as a basis for making a preliminary assessment of the relative efficiency of each organization in conducting LTC surveys, and to use these unit cost estimates to calculate the net budgetary impact of accreditation/deemed status for HCFA. As part of the unit cost analysis, we attempt to understand variation in unit costs among States and what factors affect unit costs such as volume of surveys, types of surveys, and other regional factors, so that results are interpreted carefully and further calculations are done correctly. Ideally, analysis of the behavior of unit costs and efficiency would be done using fairly elaborate statistical techniques that use multiple regression analysis to estimate cost functions, but data limitations allow only simple statistical tests and basic descriptive analyses.

11.3.2 HCFA Unit of Analysis

HCFA conducts a wide variety of surveys. The main types include:

- Standard/extended surveys (120 hours + 16 travel hours)
- Complaint surveys (29 hours including travel)
- Follow-up/revisit surveys (19.2 hours including travel).

The cost accounting system in HCFA does not directly generate separate unit cost estimates for each type; but with the use of simple cost accounting techniques, estimates for the costs of each of these types of surveys can be made. Although complaint and revisit surveys are important for monitoring and enforcing certification requirements, the emphasis will be on unit cost for the standard LTC survey since this provides the first point of comparison with the future accreditation/deemed status survey.

11.3.3 HCFA Cost Components

Unit costs include both variable and fixed cost components. where variable costs are those costs that are directly related to volume of services provided, and fixed costs are those costs that remain stable across a relevant range of service volume. Examples of variable costs include survey personnel, travel, some training and other direct costs. Fixed costs include the indirect costs that cover items such as utilities and building maintenance. The distinction between fixed and variable costs is needed to be able to predict whether survey unit costs will change as volume of surveys change.

In addition, costs are incurred at the State, regional and central headquarters level. The State-level costs support most of the direct survey activity, whereas the regional offices and central headquarters costs support some direct survey activity, but support mostly administrative and

overhead activities for the program. This study was able to get full information on State-level costs. Because private accrediting bodies are not yet operating at a high enough volume level to justify opening regional offices, regional and central cost allocations are not included in these comparisons. Also, there is substantial difficulty in assigning central headquarters costs to LTC survey activities, and then assigning these costs down to regional and State survey activities.

11.3.4 HCFA State-Level Unit Costs - National Estimate

HCFA prepared the following costs estimates using the information extracted from the OSCAR system and the 670 database. For FY96, the full cost of a survey package which includes the standard/extended survey, the complaint survey and the follow-up/revisit survey is \$13,008 package as shown in Exhibit 11.1. According to HCFA, it is expected that these costs will fall below \$13,000 in 1998 because HCFA is continuously exploring ways to improve the efficiency of the survey process. These costs include salary/retirement/fringe, travel, training, other direct costs (communications, supplies, consultants, equipment, nurse aid registry, nurse aide training and competency evaluation program, unanticipated expenses resulting from the implementation of the enforcement regulation), and State-level indirect costs. Indirect cost rates and the costs they

Exhibit 11.1
National Average Unit Cost for LTC Survey Package
State-Level Component
HCFA, FY 1996

1) Salary/Retirement/Fringe	\$8,604
*standard/extended survey hours	\$5,937
*complaint survey hours.....	\$1,635
*fellow-up/revisit hours.....	\$1,032
2) Travel (non-salary travel costs)	\$509
3) Training	\$176
4) Other Direct Costs	\$1,883
5) Indirect Costs	\$1,836
TOTAL	\$13,008

Source: HCFA

Based on FY96 actual expenditures and norms for survey hours: standard (136 hours); complaint (29 hours); revisits (19.2 hours).

cover also vary by State, but in general the indirect cost component covers items such as office utilities and maintenance, telephone service, portion of salaries of higher administrative staff, and personnel activities such as payroll, and supplies.²⁵³

The unit cost of a survey package can be used to estimate the cost of a standard/extended survey. In collaboration with HCFA, it was determined that an appropriate cost allocation would be to take 69 percent of the unit cost for the survey package for all line items except indirect costs. The 69 percent represents the portion of labor costs for the standard survey out of total labor costs.²⁵⁴ Indirect costs would be estimated using the indirect cost rate of 16.4 percent of all other direct costs (16.4 percent of \$7,708). Exhibit 11.2 presents HCFA unit cost per standard survey which was estimated to be \$8,972 per standard survey (either initial or recertification survey).

Exhibit 11.2 National Average Unit Cost for LTC Standard Survey State-Level Component HCFA, FY 1996	
1) Salary/Retirement/Fringe	\$5,937
2) Travel (non-salary travel costs)	\$351
3) Training	\$121
4) Other Direct Costs	\$1,299
5) Indirect Costs	\$1,264
TOTAL	\$8,972
Source: HCFA	

²⁵³ Indirect cost rates are negotiated between the State Agencies and Division of Cost Allocation/DHHS.

²⁵⁴ From Figure 11.1: $\$5,937/\$8,604 = 69$ percent

11.3.5 HCFA Ranges in State-Level Unit Cost Estimates, By State

Since the national average unit cost per LTC standard survey for HCFA reflects unit costs across all the States, some understanding of unit costs for each State is helpful when comparing HCFA unit costs to those of JCAHO. As will be seen in section 11.4, JCAHO's annual volume of standard accreditation surveys is comparable to the number of HCFA certification surveys conducted for a large State, ranging from about 800 to 1,400 surveys per year. Most importantly, although the composition of costs for HCFA LTC surveys is rather stable across States (Exhibit 11.4), there is tremendous amount of variation in the level of unit cost among States.

To demonstrate this, two sources of data are examined. First, the composition of Medicare FY98 total budget allocations for LTC survey activities is presented by line item for each State (Appendix G). It is important to know that FY98 line item budget allocations represent what is proposed to States, but do not necessarily reflect actual expenditures by line item; nevertheless, it is believed that these budget allocations are indicative of the composition of costs.²⁵⁵ Second, the State-level unit costs used in this discussion are only rough estimates of unit costs because precise actual unit costs per type of survey are not typically calculated. These estimates were derived by HCFA by dividing the total LTC survey actual expenditures for all surveys in each State by the total number of standard surveys (initial and recertifications) in each State.²⁵⁶

11.3.5.1 State Variation in Composition of FY98 Total Budget Allocations Line Items

As shown in Exhibit 11.3, of the total Medicare FY98 budget allocations for LTC survey activity, on average 59.27 percent is allocated to salary/retirement/fringe, 3.84 percent is allocated to travel, 1.38 percent is allocated for training, 11.88 percent for other direct costs, 7.78 percent for additional special allocations and 15.84 percent for indirect costs. With the exception of a few outlier States, most States fall close to the average as shown by the distribution of States across percentiles (25 percent, 50 percent, 75 percent) in Exhibit 11.4.

²⁵⁵ States are allowed to shift survey resources among budget line items (e.g., salary, travel, training, other direct costs, etc.) within plus or minus 10 percent of original allocation. Actual expenditures are not monitored retrospectively.

²⁵⁶ For FY96 two unit cost estimates were available: one with the denominator based on standard (initial and recertification) surveys only, and one where the denominator included all types of surveys (initial, recertification, complaints and follow-up). Only the first is presented in this analysis of variations across States, but the results about variation of unit costs among States were similar for the second unit cost estimate.

**Exhibit 11.3 LTC Certification: Average Composition of State Allocations
(Based on 1998 Proposed Medicare State Allocations; Source: HCFA)**

**Exhibit 11.3 LTC Certification: Average Composition of State Allocations
(Based on 1998 Proposed Medicare State Allocations; Source: HCFA)**

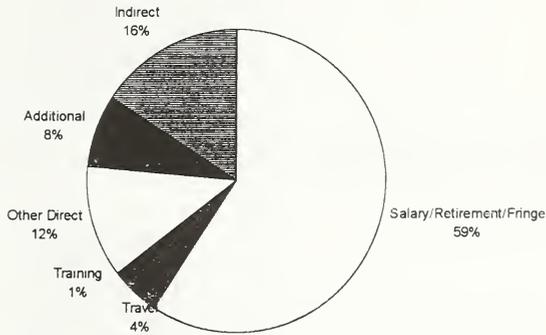


Exhibit 11.4. FY98 Proposed Medicare Budget Allocations, By State

Budget Line Item	25th Percentile	Median	75th Percentile
<i>Salary/retire/fringe</i>	53.97%	59.39%	65.24%
<i>Travel</i>	1.78%	3.69%	4.86%
<i>Training</i>	0.70%	1.41%	2.39%
<i>Other Direct Costs</i>	6.16%	8.10%	16.70%
<i>Additional Allocation</i>	6.18%	7.11%	8.51%
<i>Indirect Costs</i>	11.55%	14.95%	18.82%
<i>Total</i>	N.A.	100%	N.A.

Source: HCFA

11.3.5.2 State Variation in FY96 Estimated Unit Costs per LTC Survey

Costs per survey at the State-level were provided by HCFA and estimated by dividing actual total expenditures for LTC surveys in FY96 by the standard number of surveys. The results show tremendous variation across States. Costs per standard survey, shown in Exhibit 11.5, range from a low of \$2,103 (PR) to a high of \$29,831 (MI).

States at the high end of unit costs (50 percent above the national average, either estimate) include:

Louisiana	\$19,786 standard
New York	\$20,112 standard
New Mexico	\$20,523 standard
Colorado	\$21,076 standard
Alaska	\$21,863 standard
Delaware	\$22,708 standard
Oregon	\$24,029 standard
California	\$24,700 standard
Michigan	\$29,831 standard

States at the low end of unit costs (50 percent below the national average, either estimate) include:

Puerto Rico	\$2,103 standard
New Hampshire	\$2,415 standard
Pennsylvania	\$4,533 standard
North Carolina	\$5,679 standard
Vermont	\$6,377 standard
Connecticut	\$6,480 standard
Texas	\$6,520 standard
Arkansas	\$6,522 standard

Exhibit 11.5

FY1996 LTC Estimates of Total Unit Costs per Standard Survey in Ascending Order

State Name	FY96 Unit Cost per Standard Survey	
PUERTO RICO	\$2 103	
NEW HAMPSHIRE	\$2 415	
PENNSYLVANIA	\$4,533	
NORTH CAROLINA	\$5 679	
VERMONT	\$6,377	
CONNECTICUT	\$6 480	
TEXAS	\$6,520	outlined area
ARKANSAS	\$6,522	< 50% of average
OHIO	\$6,966	
MASSCHUSETTS	\$7,184	
KENTUCKY	\$7,775	
VIRGINIA	\$8,245	
RHODE ISLAND	\$9 614	
MAINE	\$10 829	
SOUTH CAROLINA	\$10 956	
ARIZONA	\$12 086	
GEORGIA	\$12,254	
IDAHO	\$12,395	
MARYLAND	\$12,396	
MISSISSIPPI	\$12 629	
TENNESSEE	\$12 930	
MINNESOTA	\$13,505	
Average	\$13,686	
KANSAS	\$13,927	
MONTANA	\$13,989	
SOUTH DAKOTA	\$14,032	
IOWA	\$14 061	
FLORIDA	\$14 154	
ILLINOIS	\$14 281	
WEST VIRGINIA	\$14,454	
ALABAMA	\$14 505	
NORTH DAKOTA	\$14,597	
NEBRASKA	\$14,786	
MISSOURI	\$14,981	
INDIANA	\$15 176	
OKLAHOMA	\$15 213	
UTAH	\$15,228	
WASHINGTON	\$16 825	
NEW JERSEY	\$17 618	
WISCONSIN	\$18,823	
WYOMING	\$18,950	
LOUISIANA	\$19 786	
NEW YORK	\$20 112	
NEW MEXICO	\$20,523	
COLORADO	\$21,076	outlined area
ALASKA	\$21,863	>50% of average
DELAWARE	\$22,708	
OREGON	\$24,029	
CALIFORNIA	\$24,700	
MICHIGAN	\$29,831	
VI D C NV HI	n a	

Source: HCFA. Actual Total FY96 LTC survey expenditures divided by no. std surveys

11.3.5.3 Factors Influencing State Variation in FY96 Estimated Unit Costs Per LTC Survey

The great variation in unit costs per LTC surveys among States naturally leads one to ask what factors may account for these variations. Following general economic theory of cost, one would expect unit costs to be influenced by: volume and type of surveys provided, unit costs of inputs (e.g., wages and other input prices), and other variables which may affect the level of fixed costs or the way LTC survey services are organized. A key component of fixed costs and survey organization would be the number of FTE LTC surveyors on staff in each State. To determine which factors are related to unit cost variation in a statistically significant way, ideally, one would want to estimate a cost function using ordinary least squares regression (OLS) where unit cost would be the (dependent) variable to be explained by several explanatory (independent) variables or those which are hypothesized to influence unit cost. Unfortunately, the small data set permits only limited regression analysis; therefore, findings are based primarily on simple correlation coefficients and simple regressions and visually presented using scatter diagrams.²⁵⁷

The analysis looks at the relationship of FY96 survey unit costs with the following explanatory variables from FY96:

Volume of services provided:

- # SNF + NF beds
- # SNF + NF facilities
- # of surveys (all types)

Type of survey:

- average # survey hours per survey
- # of substandard deficiencies in FY96

Unit costs of inputs:

- region (proxy for differences in wages and price levels in each region)

Other factors affecting fixed costs or organization:

- region
- # of FTE LTC surveyors

The simple correlation coefficients given in Exhibit 11.6 indicate that the HCFA unit cost per standard survey is correlated only slightly with the average number of hours per survey and not

²⁵⁷ The data set is limited by having only 49 points of observation and few variables to measure explanatory factors such as volume and type of services rendered, and unit costs of inputs. Simple correlation coefficients measure the linear association between two variables without controlling for the influence of other factors. Correlation coefficients range from -1.0 (perfectly negative relationship) to 0 (no relationship) to 1.0 (perfectly positive relationship). OLS or multiple regression identifies the statistical relationship of each explanatory variable to the dependent variable while controlling for the other explanatory variables included in the regression.

correlated with any of the remaining variables: number of substandard deficiencies, number of SNF and NF facilities, number of SNF and NF beds, number of surveys (all types), and number of FTE LTC surveyors. Visual representations of these results are given in several exhibits below

**Exhibit 11.6. Simple Correlation Coefficients
Between HCFA Unit Cost per Standard Survey and
Several Explanatory Variables**

Explanatory Variable	Correlation Coefficient
Ave. number of survey hours	0.364
no. substandard deficiencies	0.023
no. SNF + NF facilities	0.004
no. SNF + NF beds	0.032
no. surveys (all types)	0.084
no. LTC FTE surveyors	0.065

Volume: Exhibit 11.7, which lists State-specific HCFA unit cost per survey in ascending order of number of surveys conducted in FY96 in each State, shows that there is little, if any, relationship between volume of surveys and unit costs. Exhibit 11.8 provides a pictorial representation of this result. Exhibit 11.7 also indicates that it would be difficult to pick a unit cost estimate for HCFA standard certification survey that is comparable with JCAHO unit costs in terms of volume. JCAHO unit costs apply to a range of volume of about 800 - 1,400 LTC standard surveys per year. Exhibits 11.9 and 11.10 also show that there is no significant relationship of HCFA LTC standard survey unit cost with the number of LTC facilities (SNF + NF) or with number of LTC beds (SNF + NF).

Length of Surveys: Consistent with the simple correlation coefficient result, Exhibit 11.11 shows that there appears to be a slight relationship between unit costs and average number of hours per survey in FY96 per State: as average survey hours increase, so does the unit cost per survey. This is further confirmed in the regression analysis.

Costs of Inputs and other Regional Factors: Exhibit 11.12 indicates that in only one region, region 7 (IA, KS, MO, NE), are unit costs similar among States. In all other regions, unit costs per standard LTC survey vary substantially between States in the region.

Regression Analysis: Using ordinary least squares analysis, unit costs per standard survey were examined as a function of the volume of services, the number of substandard deficiencies, the

Exhibit 11.7

LTC Survey Estimated Unit Costs Ordered by Ascending Volume of Standard Surveys

State Name	1996 Standard Surveys	FY96 Estimated Unit Cost Per Std Survey	
PUERTO RICO	4	\$2,103	
ALASKA	17	\$21,863	
D C	20	n a	
DELAWARE	35	\$22,708	
WYOMING	39	\$18,950	
HAWAII	40	n a	
VERMONT	44	\$6,377	
NEVADA	46	n a	
NEW HAMPSHIRE	78	\$2,415	
NEW MEXICO	81	\$20,523	
IDAHO	83	\$12,395	
NORTH DAKOTA	87	\$14,597	
UTAH	92	\$15,228	
MONTANA	95	\$13,989	
RHODE ISLAND	97	\$9,614	
SOUTH DAKOTA	103	\$14,032	
WEST VIRGINIA	110	\$14,454	
MAINE	135	\$10,829	
ARIZONA	147	\$12,086	
OREGON	168	\$24,029	
SOUTH CAROLINA	173	\$10,956	
MISSISSIPPI	200	\$12,629	
COLORADO	204	\$21,076	
MARYLAND	215	\$12,396	
ALABAMA	216	\$14,505	
NEBRASKA	235	\$14,786	
CONNECTICUT	253	\$5,480	
VIRGINIA	265	\$8,245	
ARKANSAS	281	\$6,522	
WASHINGTON	287	\$16,825	
KENTUCKY	314	\$7,775	
TENNESSEE	334	\$12,930	
NEW JERSEY	338	\$17,618	
LOUISIANA	339	\$19,786	
OKLAHOMA	380	\$15,213	
GEORGIA	387	\$12,254	
NORTH CAROLINA	399	\$5,679	
MINNESOTA	405	\$13,505	
IOWA	430	\$14,061	
MICHIGAN	437	\$29,831	
WISCONSIN	439	\$18,823	
KANSAS	470	\$13,927	
INDIANA	552	\$15,176	
MASSCHUSETTS	574	\$7,184	
MISSOURI	581	\$14,981	
NEW YORK	616	\$20,112	
FLORIDA	627	\$14,154	
PENNSYLVANIA	801	\$4,533	
ILLINOIS	873	\$14,281	
OHIO	1032	\$6,966	outlined area
TEXAS	1290	\$6,520	JCAHO range
CALIFORNIA	1340	\$24,700	of volume, 1997
VIRGIN ISLANDS	n a	n a	

Source: HCFA. Actual Total FY96 LTC survey expenditures divided by no. std surveys

Exhibit 11.8

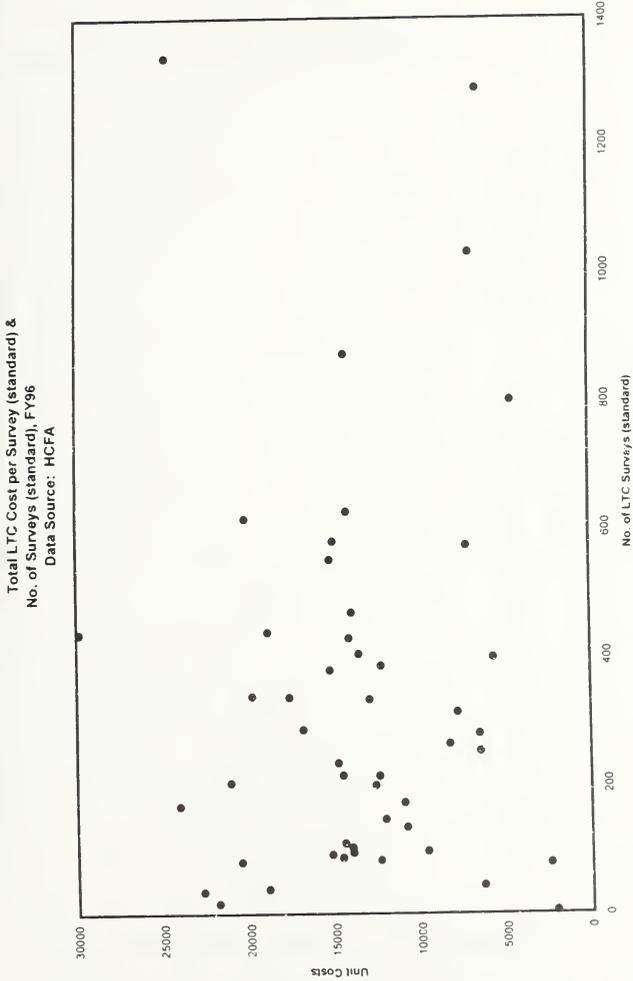


Exhibit 11.9

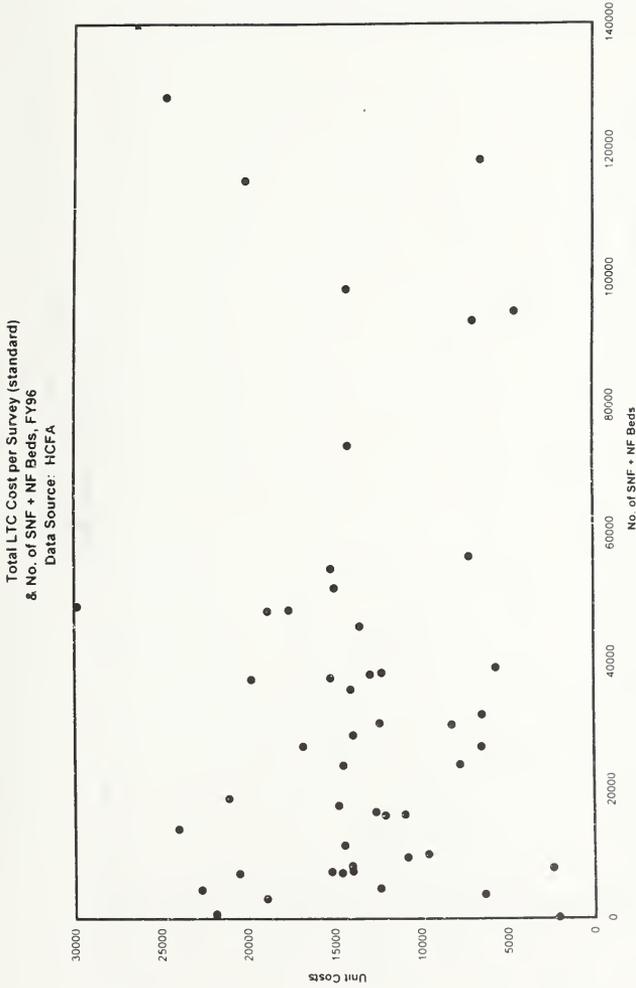


Exhibit 11.10

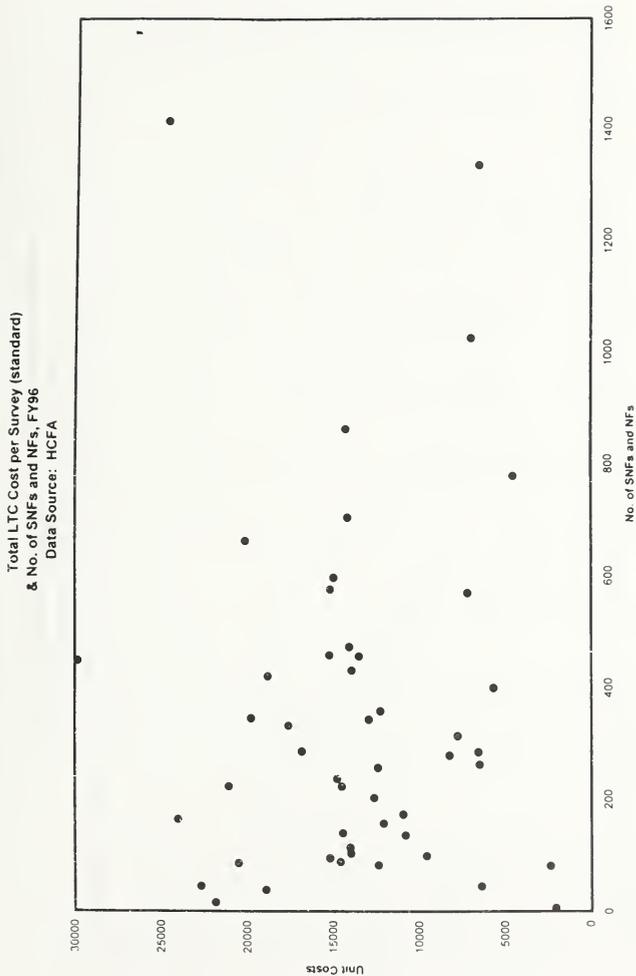


Exhibit 11.11

Total LTC Cost per Survey (Standard) & Average No. of Hours per Survey, FY 96
Data Sources: HCFA & U. of Wisconsin (1/97)

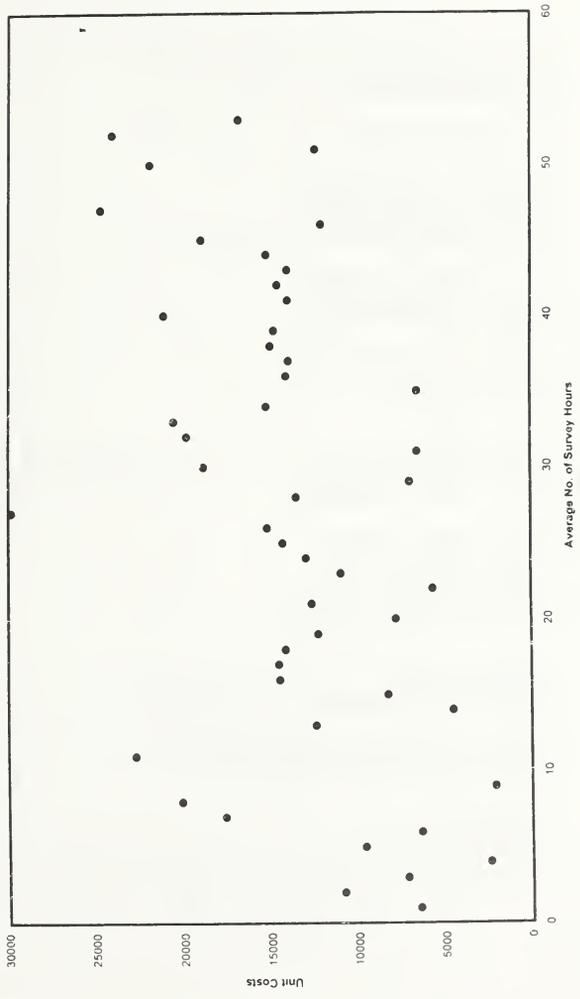


Exhibit 11.12

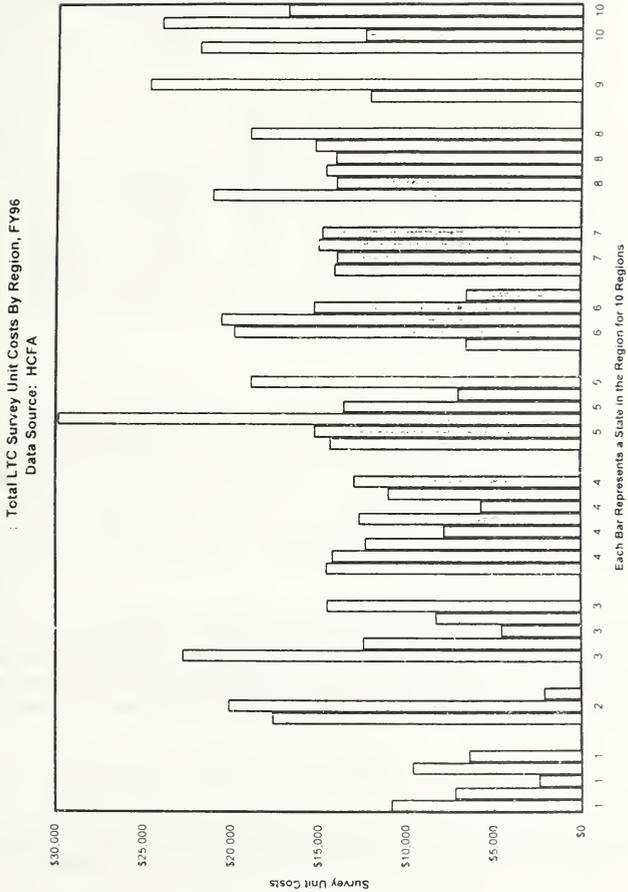


Exhibit 11.13

**Regression of Unit Costs per Standard Survey Explained by LTC Facilities
(SNF + NF), No. of Substandard Deficiencies, Average Survey Hours, and FTE Surveyors**

<i>Regression Statistics</i>					
Multiple R	0.370631779				
R Square	0.137367916				
Adjusted R Square	0.058946817				
Standard Error	5807.526789				
Observations	49				

ANOVA					
	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>Significance F</i>
Regression	4	236316922.4	59079230.59	1.751670383	0.155817268
Residual	44	1484004166	33727367.4		
Total	48	1720321088			

	<i>Coefficients</i>	<i>Standard Error</i>	<i>t Stat</i>	<i>P-value</i>
Intercept	5083.186528	3932.756768	1.292525022	0.202922034
Total SNF + NFs	-3.29388121	7.333443344	-0.449158881	0.65552169
No. Subst. Deficiencies	4.739848648	27.80355449	0.170476356	0.865417024
Avg Total Survey Hrs	82.38689356	33.61094426	2.451192473	0.018280563
No. of FTE Surveyors	4.212229946	8.974124014	0.469375054	0.641119294

Note: OLS Regression was also run using ln(unit costs), a typical transformation used in cost analysis. Similar results were obtained.

number of average hours per survey, and the number of FTE LTC surveyors. A few different regression models were tried to determine which measure of volume, if any, had a significant relationship with unit cost.²⁵⁸ All the regressions results were similar, in general, only a small portion (7 percent) of the variation in unit costs was explained by the explanatory variables and in all cases, the only statistically significant relationship was a positive relationship between unit costs and average number of survey hours. Exhibit 11.13 gives a representative sample of the regression results.

The results of both the correlation coefficients and the regressions are striking. They certainly lead one to ask what other reasons might help explain variation of unit costs across States. Perhaps allocations based on historical budgets may be imbedding practices, norms or other considerations that may or may no longer apply. Determinants of unit costs deserves further exploration.

11.3.5.4 *Qualifications to the Unit Cost Analysis*

A consistent theme in interviews with a variety of experts in LTC care on the issue of unit costs is that LTC survey departments do more than just conduct surveys. The unit costs presented above

²⁵⁸ With only 49 observations, the regression model had to be very parsimonious, including as few explanatory variables as possible.

focus on services and resources that can be quantified in the 670 database, such as survey hours by type of survey. But these databases do not record other services provided by LTC survey staff such as providing training for or implementing the Minimum Data Sets (MDS) or Resident Assessment Instruments (RAI) in LTC facilities, providing technical advice to facilities, and making various efforts to ensuring rectification of deficiencies (e.g., reviewing and monitoring plans for correction). HCFA unit costs per survey may be higher than those of JCAHO because HCFA unit costs may account for other non-quantifiable services. The extent to which this situation exists is difficult to measure.

11.3.6 Summary of HCFA Unit Cost Analysis

From the cost analysis, \$8,972 is the best estimate of HCFA's cost per standard survey for FY96. According to HCFA, it is expected that unit costs will fall in FY97 because improvements in efficiency are continually being explored. This cost estimate should be qualified in several respects:

- A. *Regional and Central HCFA Costs:* The figure of \$8,972 does not include regional and headquarters costs. Since the volume of JCAHO surveys is more equivalent to a large State without regional offices, making unit cost comparisons without including regional and central costs seems appropriate. However, if the number of accreditation/deemed status surveys conducted by JCAHO increases substantially, such that JCAHO chooses to establish regional support systems, then including a regional cost component would be appropriate.
- B. *Variation Across States in Resource Use:* Unit cost data for the States showed that there is substantial variation in the use of resources to conduct LTC surveys. This suggests that there is opportunity to look at States to identify 'best practices' and to potentially improve the efficiency of the survey program.
- C. *Other Services Rendered:* HCFA estimates of cost per survey are blurred by the fact that LTC units of State Agencies likely perform more than just surveys. They may be involved with training to implement the MDS's in LTC facilities, providing technical assistance related to certification and other activities.²⁵⁹ The extent to which these other services are provided is not well known such that the time and other resource costs associated with them cannot be precisely estimated; they are included in the unit cost estimates

11.4 Cost per Survey for JCAHO LTC Accreditation

11.4.1 Purpose of Unit Cost Analysis

The purpose of this analysis on the unit costs for LTC surveys by JCAHO is to generate an estimate of JCAHO's cost per survey for LTC certification to compare with the costs per survey

²⁵⁹ Some States feel that it is not appropriate to provide technical assistance

for accreditation by HCFA as a basis for making preliminary assessment of the relative efficiency of each organization in conducting LTC surveys, and to use the JCAHO unit cost estimate to calculate the costs of accreditation/deemed status faced by LTC facilities. As part of the analysis, we attempt to understand what influences the unit cost estimate, so that results are interpreted carefully and further calculations are done correctly. In particular, it is important to understand what the cost implications might be if demand for JCAHO accreditation/deemed status increased from current levels of about 800 per year to a range of about 1,100 - 1,400 or even 2,500 - 3,200 per year or more.

11.4.2 JCAHO Unit of Analysis

JCAHO conducts a wide variety of surveys. The key one for this analysis is the general long-term care accreditation survey for nursing homes. It can be supplemented by two additional surveys: accreditation of subacute units and dementia special care units. A facility may elect whether or not to opt for subacute accreditation. If so, the subacute survey may be conducted concurrently with general long term care survey or at a separate time and has additional costs associated with it. If the facility has a dementia special care unit, the dementia protocol is mandatory and is conducted concurrently with the general long term care survey.

11.4.3 JCAHO Cost Components

JCAHO does not presently use a cost accounting system that provides accurate composition of costs by line item (e.g. salary, training, travel, etc). However, using information on base rates and average fees, it is possible to make some estimates of direct and indirect cost components. JCAHO states that its base rate of \$4,035 covers all of the direct costs (e.g. salary, training, travel, other direct costs) of the surveys while the average fee per Long Term Care survey of \$6,214 covers all direct and indirect costs. This implies that approximately \$2,179 of the fee or about 35 percent of total fees accounts for indirect costs and any surplus above costs.

11.4.4 JCAHO Unit Cost Estimates

The Joint Commission's pricing structure is comprised of three components: a base fee, a variable patient volume fee and a survey price ceiling. For the current volume of 800 LTC accreditation surveys per year (average bed size is 139 beds), the base fee for the Long Term Care Accreditation program is currently \$4,035. The base fee very roughly approximates the direct costs associated with the conduct of the average duration of an LTC general survey. The patient volume portion of the survey fee is calculated using an average of the facility seeking accreditation's annual patient days for the past three years (\$0.523 per patient day above 5,000 patient days). Organizations with more patient days pay a proportionately larger survey fee, thus establishing a sliding scale based on patient volume. The survey price ceiling establishes a maximum price for each facility based on the number of surveyor days used in the conduct of the survey. The current average fee per LTC general survey has been \$6,214. The maximum fee for the general LTC accreditation survey, following the rules for the survey price ceiling for the largest LTC facilities, would theoretically be \$11,100 (3 day survey @ ceiling of \$3,700 per

surveyor day), but in reality highest costs have been around \$10,000 for the largest facilities. A summary of these cost estimates is presented in Exhibit 11.14.

Exhibit 11.14
Unit Cost Estimates for LTC General Accreditation Survey
(Current Volume: 800-1,400 LTC Surveys)
JCAHO, 1997

Base Rate:	\$4,035
Additional Patient Volume Fee: \$0.0523 per patient day over 5,000 patient days	sliding scale
Subacute Care Specialist (Optional)	\$2,650
1997 Average Fee per LTC General Accreditation Survey	\$6,214
Theoretical Survey Price Ceiling (3 days @ \$3,700 per surveyor day)	\$11,100
Source: JCAHO Pricing Unit	

11.4.5 JCAHO Ranges in Unit Costs for Additional Volumes

According to the JCAHO, the unit costs and fees given in Exhibit 11.14 would continue to hold for an increase of 300 to 600 surveys per year, or a total of 1,100-1,400 per year. The current fee structure would be able to absorb the additional surveyor manpower of approximately 3 to 6 FTE surveyors to conduct the additional surveys and approximately 2-4 accreditation specialists to schedule the surveys and process the accreditation reports.

The JCAHO expects, however, that unit costs would begin to increase when more than 1,400 surveys per year are required. For example, if 2,500 to 3,200 surveys per year were required, approximately 14 to 20 FTE surveyors would have to be hired. In order to train this many surveyors, additional staff in the JCAHO's surveyor training unit would also have to be hired. In terms of JCAHO Central Office staff to support the process, 6-8 accreditation specialists would have to be added. Additional management staff would also be necessary to manage the increased number of surveyors and accreditation specialist staff. The increase in fees would depend on the geographic proximity of the facilities.

11.4.6 Summary of JCAHO Unit Cost Analysis

JCAHO offers a wide variety of surveys, but for the purposes of this comparison, the general accreditation survey is most directly comparable to HCFA's certification survey. The average unit cost of \$6,214 of a JCAHO general accreditation survey applies to a range of volume from about 800 surveys to about 1,400 surveys per year. Above 2,500 surveys per year, JCAHO would expect costs of providing and administering general accreditation surveys to increase by a significant increment. The exact amount the increase in unit costs is not precisely known and would depend in part on the geographic proximity of the LTC facilities that request accreditation/deeming.

11.5 Cost Sharing of Accreditation/Deemed Status Survey Costs

If deemed status were introduced, the cost of paying for accreditation/deemed status surveys would shift from HCFA, Medicare, Medicaid and State Licensure budgets to the LTC facilities which must pay a private accrediting body.²⁶⁰ These costs will be passed through to Medicare, Medicaid, private insurers, and the patients themselves, or then absorbed by the LTC facility. This section attempts to shed light on how the burden of costs may change. It first looks at the costs of accreditation/deemed status surveys that LTC facilities would face. It then provides some information on what survey costs can be passed on to other public and private payers.

11.5.1 Accreditation/Deemed Status Survey Costs for LTC Facilities

One of the most critical components of the deeming policy that affects the costs faced by LTC providers when receiving accreditation/deemed status is the one that specifies the required cycle (annual, bi-annual, triennial) of accreditation/deemed status surveys. Traditionally, HCFA has called for deemed status surveys to occur in sync with the pre-existing certification cycle. In the case of Home Health Agencies (HHA), certification was an annual cycle. In contrast, HHA accreditation surveys were required every three years. As a result, the cost of receiving deemed status became three times as costly as receiving simple accreditation, a sizeable cost burden for a provider group that consists of relatively small organizations. Not surprisingly, the demand by HHAs for deemed status has been very small. HCFA experts believe that the high costs associated with annual survey cycles is a likely important explanation for low demand, although conclusive empirical studies do not exist to confirm this hypothesis. Exhibit 11.15 shows that less than 3 percent of Medicare-approved HHA had received deemed status by August 1996 and even

²⁶⁰ Since Medicare and Medicaid certification surveys are often the same as State licensure surveys, some of the survey costs are, or could be, covered by State licensure budgets. When JCAHO surveys qualify for deemed status, it is not clear how States would pursue licensure. Similarly, to the degree, that costs are shared between Federal and State budgets, it is not clear how State budgets would be effected. Not all States have State licensure budgets and it is not known to what extent State licensure budgets currently cover the costs of certification surveys. States with limited State licensure budgets may choose to accept deemed status in lieu of other licensure surveys.

by July 1997. These were conducted by either the Community Health Accreditation Program (CHAPs) or the Joint Commission (JC).

Exhibit 11.15. Percentage of Medicare-approved HHA with Accreditation/Deemed Status

	As of August 1996	As of July 1997
Total Medicare-approved HHA	9,310	10,426
Total accredited/deemed:	251 (2.6%)	273 (2.6%)
<i>CHAP accredited/deemed</i>	131	151
<i>JC accredited/deemed</i>	120 (includes 88 pending)	122

Source: HCFA

In October 1996, deeming policies for HHA were changed to allow a variable cycle for conducting accreditation/deemed status surveys. In general, those HHAs that received high marks on accreditation surveys were permitted to follow a three year cycle, while those HHAs with lower marks had to follow a more frequent cycle, which in the worst case was an annual cycle. CHAPs received permission to institute the variable cycle in November 1996 and the JCAHO followed in January 1997. It is too early to tell how the variable cycle will affect the demand for deeming by HHAs, but the expectation is that demand will increase.

If HCFA follows the same tradition with LTC facilities, LTC facilities will also face a tripling of survey costs when seeking deemed status, as shown in Exhibit 11.16. Using the JCAHO cost per survey for accreditation as an estimate of annual survey costs, the total survey cost burden over a three year period will increase from approximately \$6,214 without deeming to approximately \$18,642 with deeming. As explained earlier in section 4.0, JCAHO unit cost may even go up if volume increases substantially.

Exhibit 11.16. Costs of Accreditation With and Without Deeming for LTC Facilities

Item	Accreditation without Deeming	Accreditation with Deeming
Survey Unit Cost:	\$6,214	\$6,214 (may change depending on changes required by deeming policies)
Survey Cycle:	every 3 years	every year
Total cost every 3 years:	\$6,214	\$18,642

Source: Based on Discussions with HCFA Experts

11.5.2 Cost-Sharing with Medicare and Medicaid

11.5.2.1 Cost Sharing Before Proposed Deemed Status

At the State-level, current costs of LTC facility certification are shared by Medicare, Medicaid, and in some States by State licensure budgets. Cost-sharing of survey costs depends on the type of nursing home. According to HCFA, in 1997 there are about 17,000 LTC facilities of which 14,000 are 'duly participating' (accepting both Medicare and Medicaid), 1,500 are SNFs (Medicare only) and 3,000 are NFs (Medicaid only). In general, for 'duly participating' LTC facilities, Medicare pays 50 percent of survey costs, and Medicaid pays the remaining 50 percent. Of the Medicaid portion, 75 percent is paid by Federal Medicaid and 25 percent by State Medicaid. The survey costs for the 1,500 SNFs are paid entirely by Medicare and the survey costs for the 3,000 NFs are paid entirely by Medicaid. The share funded out of State licensure budgets is not precisely known, but it is small. Regional costs that support LTC survey activities come out of the HCFA Salary and Expense budget. Based on a weighted average of the SNF/NFs, SNF, and NF share of funding sources, overall Medicare pays about 46 percent of survey costs and Medicaid pays 54 percent of survey costs under existing survey policies that do not include deemed status. This excludes regional office costs.

11.5.2.2 Potential Cost Sharing After Proposed Deemed Status

Currently, Medicare Cost Report experts for hospitals and SNFs believe that Medicare reimbursement of LTC survey costs for accreditation/deemed status will likely follow the Medicare Cost Report regulations already set for hospitals, for which deemed status has existed for many years. Under deeming policies, hospital survey costs are allowable as administrative and general costs (HCFA Pub 15-2, Provider Reimbursement Manual, Part II, Section 3610) and are stepped-down to individual hospital services using a variety of allocation bases. This means that LTC survey costs would not be reimbursable dollar for dollar, but rather in proportion to the number of Medicare patient days. Since under deeming, LTC survey costs are expected to be

passed on to Medicare in proportion to the number of Medicare patient days, as is generally true for other LTC costs under Medicare Cost Report rules, a reasonable assumption is that for those facilities which pursue deemed status, survey costs will be shared among payers in a similar fashion as overall nursing home expenditures were distributed across payers in 1994-5.

In 1995, the source of funds for LTC expenditures (\$77.9 billion) for Nursing Home Expenditures included private funds (41.9 percent), Medicaid (46.5 percent), and Medicare (9.4 percent). Out-of-pocket payments accounted for most of private funds. The full breakdown for 1994-5 is given in Exhibit 11.17. The share of LTC spending from out-of-pocket sources has been falling, mostly offset by the rising share of Medicare spending.

**Exhibit 11.17. Nursing Home Care Expenditures
by Source of Funds: Calendar Year 1994-95**

Data Source: Health Care Financing Review/Fall 1996/Volume 18 (1): 208

Source of Funds	1994	1995
Total (billions)	\$72.4	\$77.9
Private Funds (&):	42.3%	41.9%
Out-of-Pocket Payments	37.1%	36.7%
Private Health Insurance	3.3%	3.3%
Other Private Funds	1.9%	1.9%
Public Funds:	57.7%	58.1%
Federal Funds	37.1%	37.6%
State and Local Funds	20.6%	20.5%
Medicare	8.2%	9.4%
Medicaid	47.2%	46.5%

Comparing cost-sharing trends in 1994-95 with the cost-sharing patterns for Medicare and Medicaid before deeming suggests that after the introduction of deeming, the Medicaid share of survey costs will decrease slightly from 54 percent to around 46 percent while the Medicare share will fall from 46 percent to around 9 percent. Private payers will increase their share from 0 percent to about 42 percent. These figures are summarized in Exhibit 11.18.

After 1998 or 1999, the potential to pass-through survey costs to Medicare on the Medicare Cost Report is likely to change, since HCFA is proposing to pay LTC facilities using prospective payment. When prospective payment is introduced, payment rules are expected to reimburse general administration costs using a flat per diem rate with a routine cost limit. If deeming policies are introduced before these prospective payments are set, survey costs will be built into the flat per diem rate. If deeming policies are introduced after these prospective payments are set, LTC facilities may try to negotiate an add-on per diem component that covers these survey costs.

In the case of Medicaid, State Medicaid programs have increasingly introduced prospective-type payments for nursing home costs, with varying degrees of cost containment incentives. As of 1996, all States except for 10 (CO, ID, IN, MD, MN, MT, NE, ND, OR, TN, UT) use some form of prospective reimbursement. The remaining 10 States generally base payments on historic costs trended forward. Other States such as Arizona, Florida, Hawaii, Illinois, Kentucky, Massachusetts, Michigan, Ohio, Oregon, Rhode Island, South Carolina, and Tennessee are in the process or already have applied managed care to Medicaid beneficiaries.²⁶¹

It is not clear how public costs will shift between Federal and State budgets. Of the Medicaid portion, Federal (75 percent) and State (25 percent) portions are assumed to remain the same; however, if States do not use deemed status to satisfy their own State LTC licensure requirements, they will have to pay for State licensure surveys out of their own State budgets.

Exhibit 11.18.
Estimated Cost-Sharing of LTC Survey Costs
Among Payers

Payor	Pre-Deeming Policy	Post-Deeming Policy
Medicare	46%	9%
Medicaid	54%	46%
Private	0%	42%
Other Govt	small but not known	3%

Assumes Medicare reimbursement for LTC facilities will follow Medicare Cost Reports already set for hospitals and therefore survey costs will be shared among payers in similar fashion as overall nursing home expenditures in 1994-95.

11.6 Net Costs of Accreditation/Deemed Status for HCFA

11.6.1 A Range of Estimates of Annual Cost-Savings

A preliminary estimate of the net impact of allowing deemed status for LTC facilities on the HCFA LTC survey budget can be calculated by looking at the incremental net cost-savings attributable to the change in deeming policies. Exhibit 11.19 shows three main factors that contribute to net cost-savings for HCFA from introducing deemed status.

²⁶¹ Anderson, A. *The Guide to the Nursing Home Industry: 1996*. HCIA Inc. Baltimore, MD, 1996.

Exhibit 11.19. Annual Net Cost - Savings for HCFA

Net Cost-Savings for HCFA Resulting from Deeming LTC Facilities =

Cost-savings: Direct reduction in HCFA survey costs when LTC facilities are surveyed by private accrediting bodies.

Minus

Cost-addition #1: Survey costs paid to private accrediting bodies that are passed-through back to government payers.

and

Cost-addition #2: Additional costs of implementing LTC validation surveys (analogous to hospital and HHA validation programs).

The proposed deemed status policy for LTC facilities would lead to cost savings for HCFA because some LTC facilities would no longer need to be surveyed by HCFA survey staff. However, some of the survey costs paid by LTC facilities to private accrediting bodies to receive deemed status could be shifted back to government as pass-through costs on Medicare or Medicaid cost reports or if imbedded in prospective payment rates. In addition, HCFA would likely establish a validation program to ensure the quality of surveying being done by private accrediting bodies.

Because of the uncertainty around what percentage of LTC facilities will actually seek deemed status, and the imprecision in estimates of costs per survey by HCFA and the JCAHO, a range of estimates for annual net cost-savings for HCFA is calculated to reflect a variety of scenarios that might occur. Key assumptions that are expected to affect the estimates of net cost-savings include: (1) number of LTC facilities receiving deemed status: a range of 14 percent to 50 percent of all LTC facilities is used; (2) the level of variable unit costs for HCFA standard surveys: a range of 10 percent above and below the estimate provided in Exhibit 11.2 is used; (3) the level of total costs per HCFA standard survey: a range of 10 percent above and below the estimate provided in Exhibit 11.2 is used; (4) unit cost per survey for JCAHO: a range of 10 percent above and below the 1997 average estimate provided in Exhibit 11.14 is used; and (5) the proportion of survey costs paid to private accrediting bodies that can be reimbursed by either Medicare or Medicaid: a range of 54 percent to 100 percent is used. The details of calculating cost-savings

and cost-additions are explained below using 'best guess' scenarios and the full set of estimates are presented in Exhibits 11.20-11.23 ('best guess' estimates are bolded and boxed).

The amount of cost-savings from a reduction in the number of HCFA certification surveys can be estimated using the formula shown in Equation 1:

$$\text{Equation 1: } \quad \text{HCFA cost-savings} = \text{net no. of LTC facilities receiving deemed status} * \text{HCFA variable cost per survey}$$

The net number of LTC facilities that receive deemed status from a private accrediting body depends on the total demand for accreditation/deemed status minus the number of LTC facilities that apply for deemed status but fail it. Those that fail fall back to HCFA responsibility to enforce certification. The formula for calculating the net number of LTC facilities receiving deemed status is given in Equation 2.

$$\begin{aligned} \text{Equation 2: } \quad \text{Net no. of LTC facilities receiving deemed status} &= && 2,389 \\ \text{projected LTC demand for deemed status} & && (14\% * 17,410 = 2,438) \\ \text{-- no. of LTC facilities failing deemed status} & && (2\% * 2,437 = 49) \end{aligned}$$

The projected total LTC demand for deemed status depends on a variety of factors and is difficult to predict without knowing the final content of deeming policies. For this reason, the sensitivity analysis will use a fairly wide range of values for the number of LTC facilities receiving deemed status (14 percent, 25 percent and 50 percent of all LTC facilities). Factors influencing LTC participation in deeming might include: price of accreditation/deemed status survey from private accrediting body, frequency of deeming surveys required, prior demand for accreditation, type of LTC facility (e.g. for-profit, not-for-profit, free-standing, hospital-based, independent, chain), State Medicaid reimbursement policies, degree of competition among nursing homes, likelihood of receiving deemed status, etc.. It is beyond this preliminary analysis to examine each of these factors, but some basic facts about demand patterns are already known and are helpful in producing a 'best guess'.

First, it is known that by mid-1997, JCAHO accredited a little less than 2,500 (or about 14 percent) of 17,410 LTC facilities. [Note: 2,500 is the cumulative total number of facilities that have gone through JCAHO accreditation. This is different than the number of annual surveys conducted per year, e.g., 800-1,400, referred to when discussing the relevant range of volume for unit cost estimates.] Approximately 62 percent of those accredited are freestanding, mostly within LTC chains, and the remaining 38 percent are hospital-based. According to the Joint Commission, the recent increase in demand for accreditation by the Joint Commission has been fueled primarily by managed care requirements as well as the implementation of well received Sub Acute Care standards. Second, it is also known from experience related to HHA deeming policies, (as explained in section 5.1), that there was a very low demand for deeming among HHAs (about 2.6 percent of all Medicare approved HHAs) because of the deeming policy that required HHAs to pay for surveys on an annual basis. If the LTC deeming policy also requires

annual surveys, one would expect demand for deemed status to remain at current low levels or potentially even fall. The Joint Commission acknowledges that demand for deemed status in LTC depends greatly on the required survey cycle. For these reasons, the 'best guess' estimate of LTC facilities receiving deemed status assumes the lowest value of 14 percent.

To calculate the net number of facilities receiving deemed status, one must take into account that not all LTC facilities that apply for deemed status from a private accrediting body will always receive it. Those facilities which receive provisional accreditation or lower status from the JCAHO do not qualify for deemed status. The Joint Commission's experience with LTC facilities indicates that about 2 percent of facilities which apply for accreditation would probably fail to receive deemed status (provisional or lower category of accreditation). These facilities would fall back on HCFA to be followed-up and eventually certified. This figure of 2 percent seems quite solid based on past experience and is used for all scenarios. To summarize, if 14 percent of LTC facilities seek accreditation (14 percent of 17,410 = 2,438) and if 2 percent of these fail to receive deemed status, then the net number of LTC facilities receiving deemed status would be about 2,389 facilities (98 percent of 2,438).

Under deeming, HCFA costs would probably not fall by the full LTC survey unit cost given in Exhibit 2 (\$8,972) because some of these costs remain fixed within a given range of survey services. A reasonable assumption is that the indirect costs that cover building maintenance, utilities and the like would not be affected by relatively small reductions in HCFA survey volume. HCFA would avoid only the direct survey costs (salary/retirement/fringe, travel, training, other direct costs) which amount to \$7,708 resulting in a total cost-savings of approximately \$18,411,730 (2,389 surveys @ \$7,708 per survey). This is shown in Exhibit 11.20. Because of imprecision of deriving unit cost estimates, and the potential for efficiency improvements projected by HCFA, the sensitivity analyses uses a margin of plus/minus 10 percent of the unit cost estimates provided in Exhibit 2.

As discussed in section 5.2, some of the costs of LTC surveys paid to private accrediting bodies may be shifted back to government payers when allowed under cost reports or imbedded in prospective per diem rates. According to Exhibit 11.18, about 54 percent of survey costs will borne by Medicare and Medicaid. This is used as the 'best guess' estimate, but LTC facilities may be able to negotiate larger reimbursement by government since these survey costs are specific requirements of Medicare and possibly Medicaid.²⁶² The sensitivity analysis uses a range of 54 percent, 75 percent and 100 percent. The JCAHO average fee for 1997 (\$6,214) is used as the 'best guess' estimate for what costs would be incurred by LTC facilities, but a plus/minus 10 percent margin is used to calculate a range of estimates. Equation 3 summarizes this calculation. With 14 percent of LTC care facilities receiving deemed status, and paying an average fee of \$6,214 of which 54 percent is reimbursed by government payers, government payers would still incur \$8,015,265 for LTC surveys (Exhibit 11.21).

²⁶² One justification for negotiating higher pass through rates is that the government requires MDS/ RAIs of all patients, not just Medicare patients.

Equation 3: *Government reimbursed deemed status survey costs:*
(Net no. of LTC facilities receiving deemed status
*@ JCAHO cost per accreditation survey) * pass-through percentage*
 $\$8,015,265 = (2,389 @ \$6,214 \text{ per survey}) * 54\%$

Cost-additions from implementing a LTC validation program for accreditation/deemed status surveys can be approximated using the formula shown in Equation 4:

Equation 4: *Cost of LTC validation program =*
*No. of validation surveys * cost per LTC validation survey*
(119 surveys) @ \$8,972 cost per survey = \$1,071,549

The existing HCFA hospital validation program that monitors the quality of hospital accreditation/deemed status surveys can be used to provide the basic model for estimating costs for an analogous program in LTC. The hospital validation survey is the same both in content and cost as the original Medicare/Medicaid hospital certification survey.²⁶³ A 5 percent sample of deemed hospitals is used to conduct validation surveys.²⁶⁴ For LTC facilities, this would mean conducting about 119 LTC validation surveys (5 percent of 2,389 deemed facilities) at a cost of \$8,972 (the cost of a standard LTC certification survey). The total cost of the LTC validation program would be \$1,071,549. The sensitivity analysis uses a range of plus/minus 10 percent of the cost of a standard LTC certification survey (Exhibit 11.22).

The hospital validation program is not funded out of a separate budget, but rather is funded out of the general survey budget for all non-LTC providers. This means that validation survey activities compete with other survey activities. If States have high numbers of complaints, or follow-ups/revisits in any given year, experience shows that the number of validation surveys conducted suffers because of lack of funds. Similar concerns might apply to LTC validation surveys. Sufficient funds would have to be set aside to ensure that the new LTC validation program is adequate and cost-effective.

The range of net cost-savings to HCFA from the proposed deemed status policy is presented in Exhibit 11.23. The estimates range from a low of \$2,248,438 to a high of \$36,637,230 and the

²⁶³ HCFA is currently re-inventing the hospital validation program that would include an onsite assessment of how each private accrediting body operationalizes its standards and survey procedures. The evaluation would consist of a two-person team (Federal and State surveyor) that would accompany the private accrediting body to evaluate its performance. It is hoped that this re-invention will strengthen the validation process. There is no official a priori expectation about what the impact on costs of the validation program will be, although some experts believe it will be budget neutral or slightly cost-saving.

²⁶⁴ The original hospital survey validation program includes a 5 percent random sample of all accredited facilities which implies a 15 percent sample of those facilities deemed in any given year since there is a 3-year accreditation/deemed status cycle. The hospital validation sample is selected by central HSQB offices, but in the future it is expected that regional offices will play a larger role in selecting the random sample

'best guess' estimate of \$9,324,915 is closer to the lowest estimate. In comparison to projected FY98 national Medicare Certification budgets of \$96,371,661, the 'best guess' net-cost savings attributable to the introduction deemed status for LTC facilities is about 9.6 percent of the total Medicare Certification budget.

11.6.2 Limitations of the Annual Net Cost-Savings Estimates

These estimates of annual net cost-savings should be interpreted with caution for two main reasons. First, as already mentioned, there is some uncertainty about the values for the key parameters used in the calculation. Of all the assumptions, perhaps the most difficult is to predict how many LTC facilities will seek deemed status. In addition, opportunities to pass-through survey costs back to government payers under proposed new prospective payment systems is not completely clear. Also, the report has already enumerated several factors that make it difficult to come up with precise costs per survey for HCFA or JCAHO.

The second main reason for interpreting the results with caution is that these calculations do not take into account the costs incurred by LTC facilities to prepare for accreditation/deemed status surveys. These may be substantial if the technical content of the certification survey is enhanced or if the survey cycle is annual.

11.7 Conclusions

As stated in the introduction, this cost analysis does not take into account differences in the technical content or procedures of the LTC surveys conducted by HCFA and JCAHO. To make survey unit costs somewhat comparable, the analysis focuses on HCFA's standard/extended survey and JCAHO general accreditation survey, but clearly substantial differences still exist between these types of surveys. More precise unit cost estimates of more comparable surveys can only be done once decisions have been made about how private accreditation surveys might have to change to satisfy deeming policies. In addition, cost comparisons are not able to factor out other non-quantifiable activities performed by State agency survey staff.

Survey unit costs of HCFA (\$8,972) are about \$2,700 more, or 43 percent more, than the average survey unit costs of JCAHO (\$6,214). Because the surveys themselves and cost components are not directly comparable as mentioned earlier, specific conclusions about relative efficiency are not made. The difference in unit costs may change when survey content and processes are adjusted to meet new deeming policies. Also, HCFA unit costs are also expected to fall in 1997. Since the annual volume of JCAHO LTC surveys is comparable to the volume provided by a single State, the cost comparisons do not include, on the HCFA side, any regional or headquarters costs. However, if JCAHO survey volumes increase substantially as a result of deeming, regional costs might have to be considered, particularly if JCAHO opened regional offices. JCAHO's survey unit costs and fees vary primarily by patient volume; a sliding scale is used to adjust fees for the size of the LTC facility. HCFA survey unit costs exhibit tremendous variation across States and there appears to be no clear set of factors that can explain this variation. Further investigation is needed to determine which States have 'best practices'.

A major factor in determining the demand for deemed status by LTC facilities is whether HCFA will require an annual or triennial cycle or something in between. Traditionally, HCFA has required that deemed status surveys occur in sync with the pre-existing certification cycle. LTC certification surveys occur, on average, once every year. This would imply a threefold increase in survey fees for those facilities wanting deemed status by a private accrediting body. This would likely inhibit some demand for deemed status. HCFA experts hypothesize that the annual cycle of survey fees for deemed status has been a major deterrent to applying for deemed status, although empirical evidence is not available to confirm this. The HHA industry provides a good example of this.

Deemed status may result in a substantial shift of survey costs from the government to private payers, assuming that the 1995 pattern of source of funds for LTC expenditures can be used to approximate cost-sharing. Medicaid's share will remain relatively stable at around 50 percent, but Medicare will drop from 46 percent to 9 percent and will be picked up by private payers where the share increases from 0 percent to 42 percent. The government share may decrease even further as new prospective payment reforms are introduced for LTC facilities.

Finally, the cost analysis suggests a wide range of estimates in the annual net cost savings that may accrue to HCFA from the proposed deeming policy, ranging from a low of \$2,248,438 to a high of \$36,637,230. The 'best guess' estimate suggests savings at the lower end of about \$9,324,915, which is about 9.6 percent of Medicare Certification allocations. This estimate is highly sensitive to demand projections. If deeming is put on an annual survey cycle, demand is likely to be low and cost-savings will be at the low end of the range of estimates.

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