

# Government Focus on Quality of Care Highlights Need for Greater Director Involvement in Quality Assurance<sup>1</sup>

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Improving quality and preventing adverse events of care in post-acute settings, including skilled nursing homes (SNFs) and hospices, continues to be a major focus of the Office of Inspector General (OIG), the Centers for Medicare and Medicaid Services (CMS), and the Department of Justice (DOJ.) Recent OIG reports stress lack of sufficient oversight and enforcement as a factor that has contributed to poor care in such settings. Not surprisingly, members of Congress have read the OIG reports, and in an April 2, 2014 letter to CMS, Administrator Marilyn Tavenner and Senators Charles Grassley and Bill Nelson look for changes to the survey and certification process. Taken together, the OIG reports and Congressional inquiry underscore the need for medical directors to become more involved in their organizations' quality assurance programs.

Senator Grassley, Ranking Member of the Senate Committee on the Judiciary, and Senator Nelson, Chair of the Senate Special Committee on Aging, trace their concern about SNF quality of care to two OIG reports, *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries*<sup>3</sup>, and *Medicare Nursing Home Resident Hospitalization Rates Merit Additional Monitoring*<sup>4</sup>. Drawing on the findings of these reports, the Senators want to work with CMS "to improve the survey and certification process to improve patient care and to identify problems earlier, so that CMS can work with facilities to address them before they compromise patient care."

It is too early to tell how CMS will respond to the Senators' inquiry about changes to the survey and certification process. We do know, however, that CMS and the Agency for Healthcare Research and Quality (AHRQ) are committed to raising awareness of nursing home safety issues and seeking ways to reduce resident harm using methods similar to those used to promote hospital safety efforts. CMS has advised the OIG that it will instruct state agency surveyors

to review nursing home practices for identifying and reducing adverse events.

Now is a good time for medical directors to assume a more proactive role in their organizations related to quality assurance, particularly in those areas that the government has identified as being problematic. According to the OIG Adverse Events report, in Fiscal Year 2011, approximately 22% of Medicare beneficiaries experienced preventable adverse events during their stay at a SNF. The OIG extrapolated that these events cost Medicare about \$2.8 billion for hospital treatment for harm caused by SNFs<sup>5</sup>. Of those events, the OIG determined that 59% were clearly or likely preventable: 37% of events were related to medication; 37% of events were related to resident care; and 26% of events were related to infection. The consequences of those events varied in scope with 79% of the adverse events resulting in a prolonged SNF or hospitalization, 14% requiring intervention to sustain the resident's life and 6% contributing to or resulting in the resident's death.

The OIG's Compendium of Priority Recommendations<sup>6</sup>, released in March 2014, is a good resource to review for understanding how the OIG would like CMS to improve the survey and certification process and the quality of care provided by SNFs. Citing a prior report that found that Medicare paid approximately \$5.1 billion for a sample of 2009 stays in which SNFs did not meet quality-of-care requirements, the OIG identified significant problems with inappropriate care planning and discharge planning. Specifically, the OIG found that for 37% of stays, SNFs did not develop care plans that met requirements or did not provide services in accordance with care plans. For 31% of stays, SNFs did not meet discharge planning requirements. Other areas of poor quality care related to wound care, medication management, and therapy. Areas of special concern for the OIG also include inadequate resident monitoring,

failure or delay of necessary care, and atypical antipsychotic drug use.

In neither the Adverse Events nor the Resident Hospitalization reports did the OIG consider whether the alleged problems they found were episodic or systemic. Regardless of this shortcoming, by focusing on data within their own facilities, medical directors can help administration analyze patterns and trends. Working within the privileged environment of their Quality Assurance and Assessment Committee, medical directors can assume a leadership role in conducting root causes analyses of identified risk areas. Beginning this process now will better position the SNF for the increased scrutiny that is guaranteed to follow in the aftermath of the recent OIG reports on quality of care.

Although CMS has yet to issue regulations clarifying the parameters of an effective Quality Assurance and Performance Improvement (QAPI) Program, based on these reports and recommendations, CMS is likely to require that the QAPI Program address the reduction of preventable adverse events in SNFs. In fact, CMS guidance on QAPI states that QAPI incorporates the existing Quality Assessment and Assurance regulation which requires facilities to track, investigate and try to prevent adverse events. CMS has also indicated that when nursing facilities promote a systematic, comprehensive, data-driven approach to care, this very well may prevent adverse events from occurring.

As the person responsible for the implementation of resident care policies within the SNF, medical directors are integral to detecting and preventing adverse events. To date, many SNFs have failed to take full advantage of the value that medical directors can bring to their quality assurance endeavors. The recent OIG reports and the Congressional letter to CMS should serve as a wake-up call to all SNFs to engage their medical directors in a more integrated and thoughtful approach to quality assurance. ■

1. This article does not offer specific legal advice, nor does it create an attorney-client relationship. You should not reach any legal conclusions based on the information contained in this article without first seeking the advice of counsel.  
2. Ms. Sanders is a Principal and Chair of the national health law practice of Post & Schell, P.C. She may be reached at psanders@postschell.com and 717-612-6027  
3. OIG, *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries*, OEI-06-11-00370 (Feb. 2014)  
4. OIG, *Medicare Home Resident Hospitalization Rates Merit Additional Monitoring*, OEI-06-11-00370 (Feb. 2014)  
5. The sample consisted of only 653 beneficiaries who had SNF stays of 65 days or less.  
6. OIG, *Compendium of Priority Recommendations*, (March 2014). See also, OIG 2014 Workplan and OIG 2014-2018 Strategic Plan.