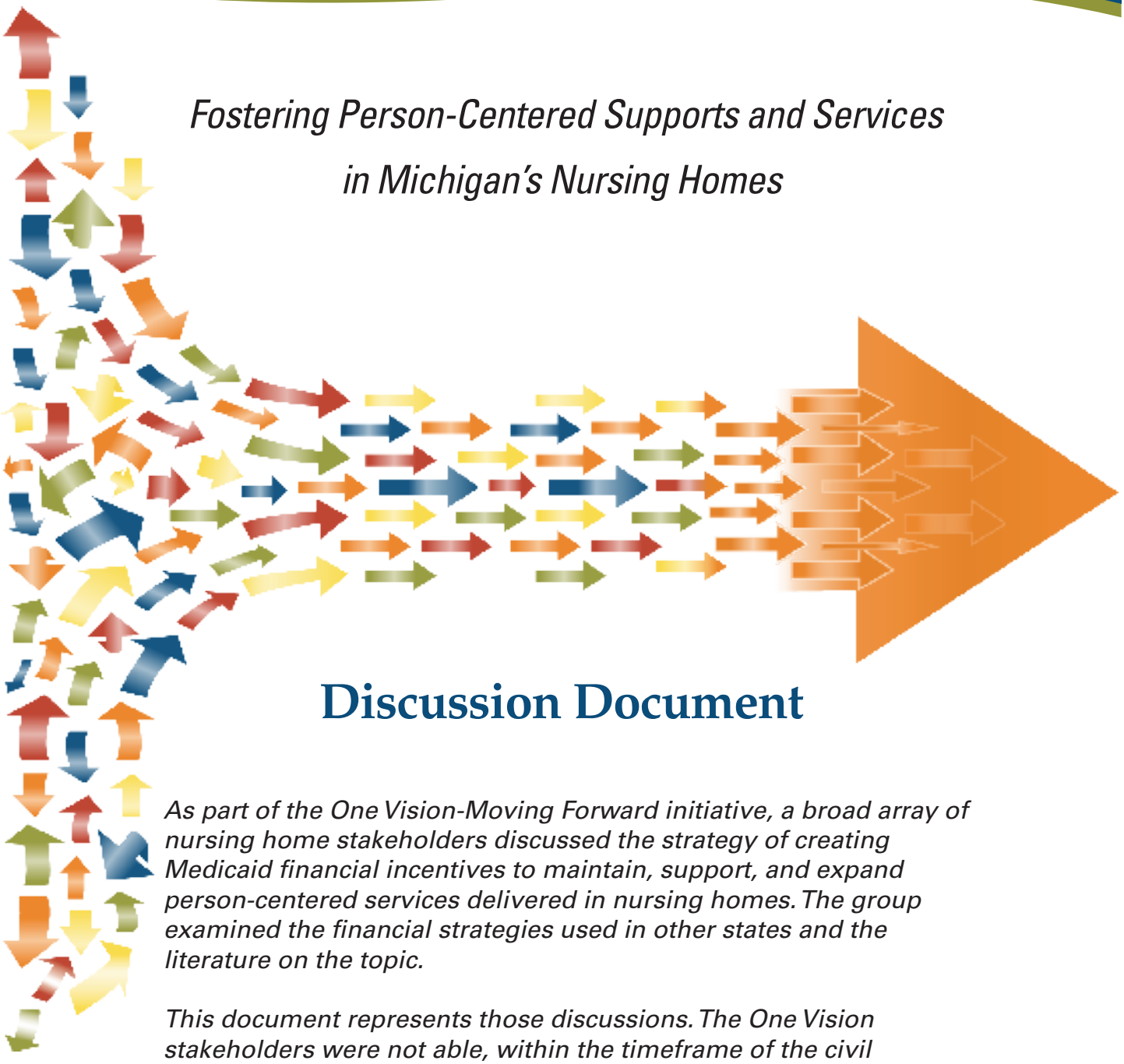
One Vision: Moving Forward

Fostering Person-Centered Supports and Services in Michigan's Nursing Homes



Discussion Document

As part of the One Vision-Moving Forward initiative, a broad array of nursing home stakeholders discussed the strategy of creating Medicaid financial incentives to maintain, support, and expand person-centered services delivered in nursing homes. The group examined the financial strategies used in other states and the literature on the topic.

This document represents those discussions. The One Vision stakeholders were not able, within the timeframe of the civil monetary grant funding, to reach consensus on the appropriateness of these specific strategies or the need for financial incentives.

The document does not represent the consensus recommendations of the One Vision stakeholders. It is being published to share what the One Vision stakeholders learned and discussed.

Fostering Person-Centered Supports and Services in Michigan's Nursing Homes

Introduction

In 2010, the Michigan Department of Community Health authorized an innovative project, *One Vision: Moving Forward,* to harness the energies of a broad array of nursing home stakeholder organizations—residents, providers, state agencies, culture change advocates, and workers.[1] Using civil monetary penalty funds the state collects from Michigan nursing homes, the stakeholder group was charged to resolve questions and remove barriers to residents experiencing person-centered supports and services (PCSS) in the more than 400 nursing homes.[2]

For the first time ever, these organizations were asked to work through a facilitated consensus process[3] that required each organization to stand up and be counted by "supporting," "standing aside," or "blocking" the action at hand.[4]

This paper contains the initial ideas of the One Vision: Moving Forward stakeholder group to embed person-centered measurements into the Michigan Medicaid nursing home payment system. Two key areas are the focus for these person-centered measurements: resident experiences and staffing practices. Both are described in detail below.

The One Vision stakeholders agreed to explore actualizing person-centered services by acknowledging person-centered practices with Medicaid monetary awards.

Why Create Medicaid Financial Incentives

Medicaid *financial* incentives can serve important and desirable public policy outcomes. Those desired outcomes include:

[1] Appendix A is a list of the *One Vision Moving Forward* organizations and their representatives
[2] To learn about all of the *One Vision Moving Forward* activities and products, go to www.PHInational.org/OneVision.
[3] PHI-Michigan developed the proposal and served as the process facilitator.
[4] Appendix B is the Consensus definition and process used by One Vision Moving Forward.

- To support, encourage, and recognize the delivery of PCSS to residents of Michigan nursing homes.[5]
- To actualize the state policies outlined in "Definition, Core Values/Principles and Essential Elements of the Person-Centered Planning Process for Long Term Care Supports & Services, Settings, and Programs" adopted by the Department of Community Health (MDCH) in 2009 and the Department of Licensing and Regulatory Affairs (LARA) in 2013.[6]

A financial incentive program can support other laudable outcomes as well. For example:

- Medicaid Managed-Care Organizations (MCOs) could use the payment recommendations to set contracting or payment schedules for Michigan Health Link, the state's integrated care demonstration for people who are eligible for both Medicare and Medicaid. This could be helpful for nursing home providers as well as other provider networks serving dually eligible beneficiaries.
- The performance data collected to measure the success of PCSS—resident satisfaction, staff retention, staff training and other indicators--would be useful to:
    - ✓ People who are selecting a nursing home,
    - ✓ People looking for employment in a nursing home, and
    - ✓ Homes that want to share with customers more data on their performance similarly to how some homes currently tout their Medicare "5 star" performance.

The financial incentive proposals presented here have limitations and do not attempt to resolve all questions related to the quality of care in Michigan's nursing homes. For example, these proposals are not meant to assure compliance with state or federal minimum operating or regulatory standards for nursing homes. Different systems are designed to address those standards and resident experiences. The One Vision

[5] One Vision stakeholders are mindful of the high participation rate of homes in past Medicaid programs that have offered financial rewards to homes for performance. Also, Medicaid has and will implement quality holdbacks for Medicaid managed-care organizations serving both younger people and the new MI Health Link serving Medicare and Medicaid beneficiaries.

[6] Appendix C: The "Definition, Core Values/Principles and Essential Elements of Person Centered Planning Process for Long Term Care Supports & Services, Settings and Programs" adopted by MDCH and LARA.

stakeholders, while working on those issues, want financial incentives to serve different purposes and policy goals.[7]

In addition, this paper is limited in scope. It outlines why Michigan might consider creating a Medicaid financial incentive program focused on PCSS for nursing homes and it proposes metrics to be used to earn the incentives. To design and implement a financial incentive program, however, more detailed work, analysis, and modeling is needed. Next steps must include:

- Collecting baseline data on the proposed metrics for assessing resident experiences and the staffing components outlined below, and
- Defining specific measurements or benchmarks that earn additional Medicaid payments.

Background

Person-centered supports and services (PCSS) and why they matter

With PCSS, a facility is driven by resident preferences and needs. Supports and services are built around an individual's capacity to engage in activities that promote community life and that honor that individual's autonomy, preferences, choices, abilities, and purposeful living. At its core, a PCSS approach within a nursing home means that the culture is not designed around a "medical model" or built on the needs and priorities of the provider/owner or the facility staff. Daily operations, events, and treatments are set to resident preferences and rhythms, not the facility or staff's needs or preferences. The goal is for resident choices to trump institutional schedules. Residents are not seen or treated as "the feeder" or "the quad" but rather are well-known as the unique individuals they are. Gone are the assumptions that senility or cognitive impairments or living more than 60 years or use of a nursing home or other long-term supports and services correlates directly to loss of opinions, preferences, or all control.[8]

[7] Several stakeholder organizations expressed interest in developing new, different systems to address sustained compliance with minimum state and federal nursing home standards.

[8] For more discussion of person-centered and person-directed services and culture change, go to the federally funded Advancing Excellence in America's Nursing Home campaign and the Pioneer Network.

Research, though in the early stages, shows that adding financial incentives to Medicaid payment systems results in stronger culture change outcomes such as "resident-directed care and activities."[9]

Development of MDCH/LARA person-centered values and principles

In 2005, Governor Granholm appointed the Long-Term Supports and Services (LTSS) Advisory Commission to assist the MDCH in implementing and monitoring the Medicaid Long-Term Care Reform Task Force recommendations. Their charge was to discuss changes to state policies and to review and comment on a statewide plan for long-term supports and services.[10] The first recommendation of the Long-Term Care (LTC) Reform Task Force was to "Require and implement Person-Centered Planning Practices throughout the LTC continuum and honor the individual's preferences, choices, and abilities."[11]

Among the first workgroups created by the LTSS Commission was Person-Centered Planning, which was co-chaired by an advocate for people with disabilities and the executive director of an organization providing residential and in-home LTSS. After months of work and discussion, the Commission fully endorsed the workgroup's recommended "Definition, Core Values/Principles and Essential Elements of the Person Centered Planning Process for Long Term Care Supports & Services, Settings and Programs." As indicated in Appendix B, these concepts were accepted as policies for MDCH in April 2009. LARA similarly accepted the concepts in 2013.

An online training module was created in 2012 by another LTSS Commission workgroup, facilitated by the Michigan Office on Services to the Aging, for all MDCH employees to understand and explore PCSS.

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[9] Miller, Looze, et al. "Culture Change Practices in U.S. Nursing Homes: Prevalance and Variation by State Medicaid Reimbursement Policies," *The Geronotolgist*, March 2013.
[10] Michigan Executive Order 2005-14
[11] The Task Force Final Report can be found at:
http://www.michigan.gov/documents/miseniors/Final_LTC_Task_Force_Report_344103_7.pdf

Work of One Vision--Moving Forward

One Vision: Moving Forward sought to identify and resolve questions and obstacles related to the implementation of person-centered practices and other culture change initiatives in Michigan's nursing homes and to develop resident, family, and staff surveys intended to measure and support culture change and the integration of person-centered practices across the state.

This initiative was conceived and facilitated by Michigan-based staff of PHI. *The* One Vision*:* Moving Forward coordinators facilitated a framework for consistent, productive conversation, where providers, consumers, staff, and government agencies could spend time co-creating a forward-thinking, quality person-centered experience.

The initiative's design required the engagement of a wide range of stakeholders and the production of all project deliverables through a consensus framework. The participating stakeholder group included state agencies, worker associations, culture change champions, provider associations, and resident advocates, encouraging the alignment of stakeholder interests and person-centered efforts across the state.

The ultimate goal of One Vision: Moving Forward is to improve the likelihood of holistic, person-centered care delivery for Michigan's nursing home residents by removing barriers and obstacles to culture change and person-centered care. In addition to this discussion paper, which is the product of the stakeholders' consideration of a Medicaid financial incentive payment program, deliverables for the entire initiative included:

- A consensus framework to resolve challenges and obstacles to the delivery of person-centered care;
- Recommended solutions to challenges and obstacles outlined in "clarification" and "best practice" documents; and
- Development of resident, family and staff satisfaction surveys to support person-centered practices and culture change.

All these products and tools can be found at www.phinational.org/OneVision.

Financial incentives in Medicaid reimbursement systems

Federal Medicaid laws authorize a state to provide financial incentives to nursing homes that "provide the highest quality care to residents":

> ***(F) Incentives for high quality care***
> *In addition to the remedies specified in this paragraph, a State may establish a program to reward, through public recognition, incentive payments, or both, nursing facilities that provide the highest quality care to residents who are entitled to medical assistance under this subchapter. For purposes of section 1396b (a)(7) of this title, proper expenses incurred by a State in carrying out such a program shall be considered to be expenses necessary for the proper and efficient administration of the State plan under this subchapter. 42 USC 1396r(h)(2)F)*

Michigan has twice used the federal authority to provide Medicaid financial incentives to nursing facilities. With the leadership of Speaker of the House Bill Ryan, homes were awarded additional Medicaid funds for better clinical outcomes (no in-house development of pressure ulcers) and other kinds of domains such as an active resident or family council. The program operated in the mid to late 1980s.

The second program, Continuous Quality Improvement Program (CQIP), was driven by resident desires for choice and control within the facilities. During this 1990s initiative, homes were required to conduct resident surveys to determine how resident control and choice could be improved. Homes were then eligible for additional funding by acting on resident recommendations. About two years after implementation, the Colorado Medicaid program initiated a very similar program, Resident Quality Improvement Program, using many Michigan benchmarks and lessons.

In the last five years, sixteen states have operated Medicaid financial incentive programs or designed systems for implementation. Most have incorporated some form of resident feedback or satisfaction and staffing metrics along with a wide range of clinical measures.[12] The limited research on these systems concludes that:

- Payment systems that reward resident satisfaction and staffing metrics like those recommended here see better clinical outcomes (reduced pressure ulcers and urinary tract infections) and increase mobility, independence and activities.[13]

[12] "Value Based Purchasing in Skilled Nursing: A Discussion of Current Trends and Initiatives," by National Research Corporation, November, 2011. States focused on "staff stability/retention"—GA, KS, IA, MN, OH, OK, CO, UT, IN, and MD. States focused on "Customer Satisfaction"—GA, IA, MN, OH, OK, CO, UT, and MD. States focused on "Culture Change/Person-centered Care"—KS, IA, OK, CO, and UT.

[13] "Nursing Home Clinical Quality and State Medicaid Pay-for-Performance" by Buikas and Skira, August 14, 2013 http://ldi.upenn.edu/uploads/media_items/nursing-home-clinical-quality-and-state-medicaid-pay-for-performance-programs.original.pdf

- Operational changes in nursing homes that actualize PCSS result in
  - ✓ Improved customer and staff satisfaction,
  - ✓ Reduced staff turnover,
  - ✓ Improved occupancy rates, and
  - ✓ Improved operation margins.[14]

Discussion Item 1: Initial/Threshold Eligibility Standard for Nursing Home Participation

One Vision stakeholders agreed that 100 percent participation by facilities in a financial incentive program would be optimal to actualize PCSS. At the same time, One Vision stakeholders agree some yet-to-be-defined extremely poor services, actual harm, or fraud should prevent a nursing home from being eligible to receive "extra" payments from the state's Medicaid program.

Every state with a Medicaid financial incentive payment system has created a minimal threshold or prerequisite that relies on past regulatory history. Similarly, Michigan nursing homes should meet a "to-be-determined" level of compliance with state and federal minimum standards to be eligible to apply for the PCSS financial incentives.

Stakeholders are not looking for perfect compliance records. By the same token, homes with documented, severe challenges and failures in delivering essential basic services should not receive additional Medicaid funds designated for demonstrated quality. The One Vision stakeholders urge that this threshold compliance level be explored, modeled, and then defined in the implemented system.

Discussion Item 2: Metrics to Actualize Person-Centered Supports and Services in Michigan Nursing Homes

After reviewing other state payment systems and available literature, the One Vision stakeholders determined that the following metrics would be most relevant to promoting, encouraging, and recognizing PCSS in Michigan nursing homes:

[14] "Culture Change and Resident Centered Care in Nursing Homes Health Care Reform Act (HR 3590) National Demonstration Project on Culture Change" by the Pioneer Network, 2010. Also see, "Person-Centered Care for Nursing Home Residents: The Culture-Change Movement," *Health Affairs* Web First, by M. J. Koren, Jan. 10, 2010.

- **Resident ratings of their service experiences, including staff expertise, and**
- **Assessment of staffing practices, outcomes, and investments that exceed current minimum standards.**

One Vision stakeholders agree that resident assessment of their experiences must play a major role in judging the success of a home's attempts to deliver person-centered services and ultimately any financial awards. With survey tools and methodologies adapted to assess person-centeredness, a fair assessment of resident experiences—not family or staff—can and should impact the Medicaid payment system.

Similarly, One Vision stakeholders know that the facility's staffing practices and investments are critical to quality. The staffing components outlined below exceed current governmental minimum requirements and are hallmarks for quality nursing home operations. These quality hallmarks deserve promotion, encouragement, and recognition.

The absence of clinical measures—depression, falls, pressures ulcers, and others—is intentional. One Vision stakeholders agree that clinical services and improvements are highly dependent upon and will follow success with these resident and staffing focused metrics. A home is much more likely to produce quality clinical outcomes once these person-centered practices, particularly the staffing components, are in place and thriving.

Resident ratings of their supports and service experiences, including staffing

One Vision stakeholders want residents to be the ultimate judge of actualization of PCSS within Michigan nursing homes. Homes should be assessed, recognized, and rewarded based on resident—not family or surrogate—experiences. This principle requires the implementation of a process to solicit and analyze resident opinions. To that end, One Vision stakeholders created survey tools and methodologies designed to get a better picture of resident satisfaction with the level of resident choice and control in their facility.

Working with the National Research Corporation, the One Vision group revised the survey questions for the My Innerview resident, family, and staff surveys to dig deeper into person-centeredness. In addition, the stakeholder group developed new

methodologies for approaching and supporting residents in responding to the surveys. The recommended default methodology for soliciting responses is to approach and support each resident to complete the survey. The goal is to obtain 50 percent resident participation in the survey, a goal that the One Vision stakeholders believe is realistic.[15]

Our discussions concluded that financial incentive payments should be based in large measure on the resident experiences with, and opinions of, person-centeredness and staff services. We suggests further exploration of the following:

- Using the Michigan version of My Innerview survey tools, or similar tools with specific measures around person-centeredness and staff services, to survey nursing home residents.
- Including, in addition to markers for person-centeredness, the standard question related to "would you recommend this facility to family and friends" as part of any calculation of financial incentives.
- Using a survey methodology, such as approaching and supporting each resident in responding, in order to generate a minimum 50 percent participation rate.
- Requiring a threshold level of resident survey participation of at least 25 percent to encourage a full view of resident experiences and to support confidentiality of individual responses.

As outlined earlier, the One Vision stakeholders did not fully discuss every aspect of designing a process for determining eligibility for financial incentives. In the resident survey process, there are more issues to consider and design elements to test, including:

- Identifying other survey tools meet the requirements described above.
- Determining how frequently surveys can be conducted and incentives adjusted.
- Defining the benchmarks for incentive payments. For example, will the measurement be based on individual facility improvement? Or, must every home meet a specific score on the survey or a set of questions?

[15] The IV group did examine the face-to-face interview process used in Ohio and did not endorse that methodology, largely for cost and complexity considerations.

Staffing practices, outcomes, and investments exceed current minimum standards

To secure a positive set of experiences for nursing home residents, a home's staff is the most critical factor. Their attitudes, competencies, and skills are the building blocks to high-quality operations and personal and clinical outcomes. One Vision stakeholders discussed including, in addition to resident ratings of their experiences, facility staffing practices, outcomes, and investments that exceed the current minimum standards as a factor in determining Medicaid financial incentive payments. We strongly believe these staffing practices and investments will result in better clinical outcomes as well.

One Vision stakeholders discussed developing benchmarks for the following staffing elements to earn Medicaid financial incentives:

- Relational staffing or, as more commonly known, consistent staff assignment
- Staff retention rates
- Ongoing staff training beyond current minimum requirements
- Staff satisfaction
- Staffing levels calibrated to residents' preferences and needs

Again, the One Vision project and process did not attempt to fully delineate all the details of how to measure and analyze each of the five staffing elements. More discussion and modeling is needed to fully articulate an incentive payment structure. We are, however, convinced that these are the right staffing elements to focus on to promote, encourage, and recognize person-centered supports and services.

Current research indicates that being specific about the staffing elements to be measured is more likely to encourage homes to adopt these practices. Researchers hypothesize that "it may be that when culture change is specifically targeted in (financial incentive) programs, nursing homes (in addition to responding to financial incentives) may also have more certainty that practice implementation is compatible with regulatory oversight."[16]

Below we further explain each of the staffing elements we identified for additional payments.

[16] Culture Change from The Gerontologist, page 10 of 12.

Relational, or consistent, staff assignment means that each resident is supported by the same CNAs, licensed nurses, housekeepers, therapists, social worker, and other staff week in and week out. Staffing assignments are designed so residents and staff get to know each other and become comfortable. Traditional staffing models that rotate staff across wings and floors every week or month, as well as the mantra "do not get too close or personal with your patients," are abandoned.

> "Changing staff is like changing OB doctors right before you give birth…you've spent 9 months getting to know someone in the most intimate ways and then when it really counts some stranger who you know nothing about and knows nothing about you walks in the door and you're supposed to just accept that they can be trusted with the only thing we have…our life. Now you tell me, does that make any sense to you?"

There is broad agreement among both Directors of Nursing (DONs) and Certified Nursing Assistants (CNAs) that relational staffing improves care. One Vision stakeholders believe that this staffing practice is appropriate for all populations and care needs.

The limited research on relational, or consistent, staff assignment finds that in homes that implement these staffing patterns:[17]

- Residents, families and CNAs are more satisfied
- Deficiencies findings are lower
- CNA turnover rates are reduced
- CNA absenteeism is reduced
- Of quality indicators, 10 of the 14 are better

Designing an element of the incentive plan to focus on a home's implementation of relational/consistent assignment will take further discussion. One Vision stakeholders want to promote a high level of consistent assignment, understanding that residents, particularly during an extended stay, will never be able to rely exclusively on a small number of staff. While the Advancing Excellence in America's Nursing Homes campaign has done groundbreaking work on relational assignment of CNAs, their

[17] Research findings related to relational or consistent staffing are drawn on the work of Nicholas Castle, Ph. D. University of Pittsburgh and are available from PHI's Midwest staff.

national benchmark of no more than "12 direct caregivers in one month" may not reflect the benchmarks needed by Michigan residents and homes.[18]

There are several issues to consider and design elements to test before implementation, including:

- Defining the level of dedicated assignments that will trigger a financial incentive.
- Determining how frequently assignments will be assessed (bi-weekly, monthly) and incentives adjusted (quarterly, semi-annually)?
- Defining the benchmarks for incentive payments. For example, will the measurement be based on significant improvement at the individual facility? Or, must every home meet a specific rate of dedicated staff for most residents?
- How are the various staff roles (CNAs, licensed nurses, etc.) calculated or weighted as part of the payment methodology? Are homes rewarded for having the consistent assignment of staff other than the CNAs?

Staff retention rates—that is, measurements of the percentage of veteran, experienced employees working in homes—have been used in other states deploying Medicaid financial incentive payments. Additionally, other states have rewarded the flip side of the staffing coin, reducing staff turnover. The Advancing Excellence campaign calls its focus on reducing turnover, "staff stability."[19]

All of the One Vision stakeholders acknowledge the real damage as well as missed opportunities in facilities with high turnover rates: care plans are rarely fully known or realized; residents are attended by "a parade of strangers"; and time and money[20] are spent on recruitment, screening, orientation, and training only to repeat as staff leave within the first six months of employment. Higher staff retention rates make relational

[18] For more information, tools, and research from the AE campaign on consistent staff assignments, go to https://www.nhqualitycampaign.org/goalDetail.aspx?g=CA#tab1

[19] For more information, tools, and resources on the Advancing Excellence goal of "staff stability," go to: https://www.nhqualitycampaign.org/goalDetail.aspx?g=SS

[20] "The Cost of Frontline Turnover in Long-Term Care," by Dorie Seavey, Ph.D, 2004 for the Better Jobs, Better Care Demonstration Project. http://phinational.org/sites/phinational.org/files/clearinghouse/TOCostReport.pdf

staff assignments easier to implement and improve the ability of staff to learn how best to support and serve residents.

The One Vision stakeholders discussed wanting to enhance the "positive" side of this coin—creating an organization that holds onto competent staff and leaders by rewarding the longevity of CNAs, licensed nurses, Directors of Nursing, and Administrators.

Among the issues to consider and design elements to test are the following:

- As a result of inadequate data on the retention rates of staff in these positions in Michigan homes, a baseline survey is likely needed to gauge current performance and to develop benchmark goals.
- Determining how frequently retention rates should be gathered (quarterly, semi-annually) and incentives adjusted (quarterly, semi-annually).
- Defining benchmarks for incentive payments. For example, is the measurement based on significant improvement in staff retention at the individual facility? Or, must every home meet a specific staff retention rate to receive the incentive payment?
- Determining how the various staff retention rates (CNAs, licensed nurses, etc.) are included, or weighted, as part of the payment methodology.

Ongoing staff training beyond current requirements is similarly important in actualizing high-quality, person-centered services in the state's nursing homes.[21] One Vision stakeholders discussed how training is necessary to serve people with chronic conditions that are managed rather than cured (e.g., dementia, Parkinson's, ALS, diabetes) as well as those people who seek rehabilitation after surgeries, strokes, brain injuries, and other incidents. All frontline caregiving staff, regardless of job titles, need to have access to the latest in treatments and approaches to effectively support and serve residents.

[21] For CNAs, 12 hours of continuing education are required annually. Licensed nurses and administrators must complete 25 and 36 hours, respectively, over two years periods tied to their license renewals. Michigan social workers must complete 45 hours within their 3 year licensing renewal frame.

Continued training of nursing home employees correlates to

- Improvement in job performance,[22] and
- Reductions in turnover rates.[23]

One Vision stakeholders discussed rewarding training programs with the following characteristics in any financial incentive program:

- Incorporate person-centered principles and values recommendations,
- Teach needed competencies,
- Use adult learner-centered methodologies, and
- *Exceed* current continuing education requirements for the engaged staff.

This measurement will likely be the hardest to define and quantify given the diverse training opportunities available to various staff, the relative effectiveness of different kinds of continuing or on-going education, the number of businesses who provide training services to nursing homes, and the wide array of topics that should and can be covered. There are many topics for discussion and approaches to be studied and modeled.

Despite these and other challenges, the One Vision stakeholders are moved to support this element because of the need and thirst for knowledge, skills, and better ways to serve residents that is identified by and requested from frontline staff every day. A Medicaid financial incentive based on high-quality training has the potential to reshape the field by driving the creation and use of high-quality, effective training.

Staff satisfaction with the home's ability to operate a person-centered organization that delivers on the state's principles and values was also discussed as crucial to success in implementing PCSS. Using a tool such as the My Innerview staff survey tool adapted by this project, it is possible to solicit staff feedback and use this as an element in a financial incentive program. Moreover, surveying the staff bolsters the ability of a facility to deliver person-centered services and reach other benchmarks. One Vision

[22] "The Value of Geriatric Care Enhancement Training for Direct Service Workers," by Constance Coogle, *Gerontology and Geriatrics Education,* 2006.

[23] Pennsylvania Intra-Governmental Council on Long-Term Care, *Pennsylvania's Frontline Workers in Long-Term Care: The Provider Organization Perspective* (Jenkintown, PA: Polisher Research Institute. Also, Margaret A. Noel, Gregory L. Pearce, and Ronnie Metcalf, "Front Line Workers in Long- Term Care," *Journal of the American Medical Directors Association* (November/ December 2000).

stakeholders concluded that a well-crafted survey of all staff can inform strategies to improve retention, assist in implementing dedicated assignments, and identify training needs. We discussed:

- The use of the Michigan version of the staff My Innerview survey tool, which includes specific measures around person-centeredness and staff's ability to reach those goals.
- Including, in addition to markers for person-centeredness, the standard question related to "would you recommend this facility to family and friends" as part of any calculation of financial incentives.
- Requiring at least 60 percent participation in the staff survey to encourage a full view of staff experiences and to support confidentiality of individual responses.

Additional issues to consider and design elements to test, include:

- Identifying other survey tools that meet the requirements described above.
- Determining how frequently surveys will be conducted and incentives adjusted.
- Designing benchmarks for incentive payments. For example, is the measurement based on significant improvement at the individual facility? Or, must every home meet a specific score on the survey or a set of questions?

Staffing levels calibrated to assure the delivery of person-centered supports and services according to resident needs and preferences is the final element One Vision stakeholders discussed for determining Medicaid financial incentives. This element is the most complex of all that were considered and likely would require formidable changes in operations and policies.

An obvious truth is that PCSS are possible only when a sufficient number of brains, backs, hands, and feet are in the building. The actual amount of work and time needed from each staff person is dependent on the needs and desires of the residents on any given day.

Michigan's 40-year-old staffing level requirements[24] are largely irrelevant. The standards are not built off the defined needs or preferences of the residents but are built off of body counts within the home. Additionally, the numbers are so low that homes most often staff at higher levels, rarely falling below the requirements.

Nursing homes want and need to staff outside the traditional three shifts-a-day approach. It is hard to be "home-like" and build and support community in the three-shifts-a-day mindset required by the state law.

One Vision stakeholders discussed an incentive based on facility staffing patterns that respond directly to the cumulative long-term supports and services and health-related needs and preferences of the residents. Others might call this an acuity-based staffing system. We intentionally do not use the word "acuity" because that phrase does not include supports and accommodations that resident's desire to be engaged in the larger community and to live a full life.

We envision a dynamic system that schedules and deploys staff based on resident needs (e.g., baths, feeding assistance) and desires (e.g., a later breakfast in my room, dinner out with my grandchild) as identified in that facility's care plans. The facility's unique plan could abandon the shift framework or add occupational therapy aides or social workers. It is likely that this type of staff scheduling would be done with the assistance of a yet-to-be-identified or -developed software program that interfaces and analyzes care plan information with needed hours of staffing to deliver the planned supports and services. The group would recommend that the software program also be designed to facilitate relational, or consistent, staff assignments.

The stakeholders' goal is have a sufficient number of staff working with residents to deliver all the supports and services outlined in all the care plans in a dignified, respectful, highly competent manner. Michigan's staffing requirements and public reimbursements system do not support these kinds of staffing levels. The kind of financial incentive we envision would recognize those homes that make staffing level decisions based on the needs and desires of all residents, not some other kind of measure.

[24] 1 caregiving staff member to 8 residents on the morning shift; 1 to 12 on the afternoon shift; 1 to 15 on the afternoon shift. And an overall 2.25 hours of nursing/CNA staff time per resident per day.

Discussion Item 3: Funding Options to Develop and Actualize Incentive Payments to Facilities Delivering Person-Centered Supports and Services[25]

Funding is needed to both develop and actualize incentive payments to Michigan nursing homes delivering person-centered supports and services. The One Vision stakeholders discussed the following ideas regarding funding:

Incentive payments

Researchers report that "aggregate program payments (that) typically do not exceed 2 to 3 percent of overall Medicaid nursing home annual payments" are "sufficient to attract" participation by the state's homes and "to induce a desirable degree of focus on improvements." In this state, Medicaid's aggregate payments top out at $1.76 billion in FY 2013 and an appropriated $1.78 billion for FY 2013. Following the 2 to 3 percent pattern from other states, incentive payments would require a total amount of $35.6 million to $53.4 million, respectively. With the federal government contributing 66.54 percent of Medicaid nursing home payments, the state's portion of the overall incentive payments would be $12.3 to $18.5 million, based on the FY 2015 federal matching funds coming to the state's Medicaid program.[26]

One Vision stakeholders considered the possibility that the state portion of Medicaid incentive payments could come from the State Retainer $58.6 million in enhanced federal match secured through the Quality Assessment Payment from the state's nursing homes. These funds generated by nursing home residents and facilities are not currently earmarked for any long-term supports and services Medicaid program. Earmarking a percentage of those retained state funds (21 percent to 32 percent) to promote, encourage, and recognize PCSS could be a worthy public investment.

[25] It should be noted that the Executive Committee of the Health Care Association of Michigan decided after reading the Consensus Draft of this document, that financial incentives for person-centered supports and services within Michigan homes are not necessary. According the provider association, MI homes are implementing needed changes and best practices without changes in the reimbursement system discussed here.

[26] All these numbers were provided by MSA staff and staff of the Health Care Association of Michigan.

Development costs

As indicated throughout this discussion paper, much remains to be discussed, analyzed, and modeled to develop an incentive payments program that encourages and rewards the delivery of more PCSS in Michigan's 430 nursing homes.[27]

First, to develop effective metrics and benchmarks, baseline data on the metrics outlined above would need to be collected from almost all homes participating in the Medicaid program. No one knows how Michigan homes perform with regard to these metrics (retention, resident or staff satisfaction, etc.). That baseline data is necessary to inform policymakers and stakeholders so that incentive payments that sustain and grow PCSS are tied to realistic benchmarks. Organizations experienced in designing Medicaid nursing home payment methodologies could be engaged to evaluate the baseline data and model, field test, and adjust the metrics so that homes would understand the benchmarks and could succeed in reaching them.

Once a system is designed, training for residents and their families, facilities and their staffs, and state employees would need to be conducted to maximize the potential to deliver more and better PCSS through consistent assignment, staff retention efforts and other person-centered practices. Training topics could include how to achieve PCSS as well as how the incentive payments are achieved.

Additional time from the One Vision stakeholders and outside resources is needed to develop a credible incentive payments system. The One Vision stakeholders also discussed that the process outlined here for developing the incentive payments system would need to be collaborative, open and transparent in its collection and analysis of additional data, selection and calibration of metrics, and modeling of design elements.

One Vision stakeholders believe that the cost of developing a financial incentive payment program could be funded by the state's civil monetary penalty (CMP) funds. CMP funds have been used to support other projects designed to support person-centered services.[28] To the best of our knowledge, the fund currently contains $12.33 million. One Vision stakeholders firmly believe that the design work fits within the

[27] "A Pathway to Evidence-Based Quality Improvement, Public Transparency, and Value-Based Purchasing for Medicaid Long-Term Care Services," by National Research Corporation, May, 2013.

[28] Provider. (May, 2010). *Extra News Online: Culture Change in the States.* Retrieved May 3, 2010, from http://www.ahcancal.org/News/publication/Provider/ENOCultureChange.pdf.

permissible uses of the fund—"activities that will benefit residents."[29] Federal instructions on permissible CMP projects also list "culture change" activities, "staff stability" efforts, "start-up" activities, "workgroups" that study problems and change systems, "technical assistance for facilities implementing quality assurance programs," and "training in facility improvement" as acceptable projects. All of these permissible uses align with a Michigan CMP-funded development process for creating financial incentives for PCSS.

Participation and public disclosure

Public disclosure of the homes that participate in the incentive program along with their scores could be a strong catalyst for promoting PCSS. As discussed above, the One Vision stakeholders believe that sharing this information could also be useful to families looking for nursing home services, people looking for employment, and MCOs paying for services.

Conclusion

Research indicates that nursing homes respond positively to financial incentives of all kinds.[30] Michigan state departments have defined and endorsed the delivery of PCSS along the entire array of long-term services offered in Michigan.

[29] CMS Letter to State Survey Directors, Ref: S&C: 12-13-NH, December 11, 2011

[30] Norton, E. C. (1992). Incentive regulation of nursing homes. *Journal of Health Economics*, *11*, 105–128.