

2014

State Uses Financial Incentives To Fund Nursing Home–Initiated Quality Improvement Projects Through Competitive Bidding Process, Leading to Better Care

Valerie Cooke

Greg Arling

T. Lewis


Kathleen Abrahamson

Priscilla Arling

Butler University, parling@butler.edu

See next page for additional authors

Follow this and additional works at: http://digitalcommons.butler.edu/cob_papers

 Part of the [Health and Medical Administration Commons](#), [Organizational Behavior and Theory Commons](#), [Performance Management Commons](#), and the [Training and Development Commons](#)

Recommended Citation

Cooke, Valerie; Arling, Greg; Lewis, T.; Abrahamson, Kathleen; Arling, Priscilla; Davila, H.; and Mueller, C., "State Uses Financial Incentives To Fund Nursing Home–Initiated Quality Improvement Projects Through Competitive Bidding Process, Leading to Better Care" (2014). *Scholarship and Professional Work - Business*. Paper 223.

http://digitalcommons.butler.edu/cob_papers/223

This Article is brought to you for free and open access by the College of Business at Digital Commons @ Butler University. It has been accepted for inclusion in Scholarship and Professional Work - Business by an authorized administrator of Digital Commons @ Butler University. For more information, please contact fgaede@butler.edu.

Authors

Valerie Cooke, Greg Arling, T. Lewis, Kathleen Abrahamson, Priscilla Arling, H. Davila, and C. Mueller

Policy Innovation Profile

State Uses Financial Incentives To Fund Nursing Home–Initiated Quality Improvement Projects Through Competitive Bidding Process, Leading to Better Care

Innovation

[What They Did](#) | [Did It Work?](#) | [How They Did It](#) | [Adoption Considerations](#) | [More Information](#)

Snapshot

Summary

Authorized in 2006 by the State legislature, Minnesota's Performance-Based Incentive Program funds nursing home–initiated quality improvement projects for 1 to 3 years through increases of up to 5 percent in the operating per diem rate charged to Medicaid and private-pay residents. Funding decisions are made through a competitive bidding process administered annually by the Department of Human Services, with recommendations from a review committee. Program staff provide support to nursing homes during and after the application process. Nursing homes that do not achieve project-specific performance targets can lose up to 20 percent of the incentive payments. The program has engaged a high proportion of Minnesota nursing homes in quality improvement activities; meaningfully improved the quality of nursing home care; and had a positive impact on quality improvement processes, teamwork, and communication within nursing homes.

Evidence Rating [\(What is this?\)](#)

Moderate: The evidence consists primarily of

comparisons of trends in performance on a composite measure of quality between nursing homes that participated in PIPP and those that did not. Additional evidence includes qualitative feedback from project leaders and staff at participating facilities about various aspects of the program and its impact.

Date First Implemented

2007

The first round of incentive payments began in October 2007.

Problem Addressed

Nursing home care remains suboptimal, and historical efforts by States to improve it (e.g., regulations, sanctions) have generally not worked. Although new approaches such as pay-for-performance (P4P) programs might help, relatively few States have pursued these strategies. Those trying P4P have met with mixed success, primarily due to local environmental and cultural issues that impede success, a general lack of resources within nursing homes, and a tendency for facilities to focus on targeted metrics to the detriment of other aspects of quality.

- **Suboptimal quality, despite efforts to improve it:** The U.S. Government Accountability Office has found that one-fourth of the country's 16,000 nursing homes have serious deficiencies that cause actual harm to residents or place their health and safety at risk.¹ These problems persist in spite of numerous attempts by policymakers to improve the quality of nursing home care through traditional methods such as regulations and sanctions for safety/quality violations.²
- **Unrealized potential of P4P:** States are in an ideal position to enact P4P programs within nursing homes, yet very few have done so. In most States, Medicaid is the single largest payer for nursing home services, and

State governments play a large role in setting Medicaid payment rates for nursing homes. State governments also generally have access to a wide range of data on the quality of nursing home care through a variety of standard assessment tools.^{3, 4} States that have enacted P4P have generally had limited success,^{1, 4, 5, 6, 7, 8} as many nursing homes lack the requisite tools, resources, or organizational culture to improve care. Some nursing home leaders remain skeptical of the return that can be generated on investments in quality improvement (QI). Finally, even when nursing homes respond to P4P incentives, they may focus exclusively on the targeted performance metrics and shift resources away from other important aspects of quality.⁶

What They Did

[Back to Top](#)

Description of the Innovative Activity

Through the Performance-Based Incentive Program (PIPP), the Minnesota Department of Human Services (DHS) funds nursing home–initiated QI projects for 1 to 3 years through increases of up to 5 percent in the operating per diem rates charged to Medicaid and private-pay residents. Funding decisions are made through a competitive bidding process administered each year by DHS, with recommendations from a review committee. DHS staff support nursing homes during and after the application process. Nursing homes that do not achieve project-specific performance targets can lose up to 20 percent of their incentive payments . Key program elements are detailed below:

- **Annual release of request for proposal (RFP):** Each fall, DHS releases an RFP that describes program goals and requirements. The RFP specifies guidelines related to the projects, including the need for proposed projects to be based on an extensive examination of

data and analysis of the underlying root cause(s) of quality problems. Although the RFP remains fairly similar from year to year, program administrators sometimes make changes to encourage or discourage particular types of projects. For example, in the first year, DHS staff revised the RFP to emphasize the need for projects to address underlying systemic quality issues after many nursing homes proposed investments focused more on technology and equipment (e.g., wireless call systems) relating to a particular aspect of quality. Also during the first several years, relatively few nursing homes proposed projects focused on improving quality of life (QOL). In response, program leaders began sharing trends in performance on QOL measures through the RFP, and inserted language encouraging nursing homes to develop projects focused on addressing QOL-related challenges, such as relationships, autonomy, mood, and engaging in meaningful activities.

- **Provider-initiated proposals based on local environment:** Following the guidelines in the RFP, nursing home leaders and staff have roughly 3.5 months to develop proposals (due in mid-February). Nursing homes propose projects based on the local environment and facility-specific needs, which ensures submitted ideas are likely to work and unlikely to face major barriers to implementation. Nursing homes can request between 1 and 3 years of funding. In many cases, multiple nursing homes join together to submit a proposal, with the typical year resulting in roughly 35 new project proposals involving approximately 100 facilities.
- **Proposal development support:** DHS staff proactively support nursing homes throughout the proposal development process. PIPP's QI coordinator (a registered nurse) hosts full-day workshops and webinars that bring together nursing home representatives involved in proposal development, and provides one-on-one consultations with these individuals, typically by phone. During these

interactions, the coordinator teaches nursing home representatives how to evaluate data and conduct root-cause analysis to identify important quality problems and strategies for addressing them. The coordinator also assists in reviewing and editing draft proposals throughout the 3.5-month period. As an additional source of support, DHS recently launched a mentoring program to partner representatives of facilities that have been successful in securing PIPP funding with those preparing proposals for the first time.

- **Committee review and recommendations:** A review committee assumes responsibility for reading and assessing each application. The committee includes representatives from the State QI organization and the Minnesota Department of Health (which regulates health care providers), along with the director of nursing from a nursing home facility, a former nursing home administrator, a geriatric nurse practitioner, an ombudsman for older Minnesotans, and two DHS staffers. Three committee members read each proposal, scoring and evaluating it using a standard rubric. The entire committee comes together for a full day to discuss the relative merits of the proposals and make funding recommendations. During this meeting, the readers of each proposal provide a brief summary of their assessment, and then the full group discusses and makes a recommendation on each proposal.
- **Final determination by DHS:** PIPP program leaders within DHS make the final determination based on the committee's recommendations. They often fund all committee-recommended projects, and in some cases also approve additional projects if financial resources are available. In some situations, program staff go back to a nursing home to suggest and assist with revisions to its proposal, often to tighten the focus; the committee usually decides to fund the proposal after these changes are made. In a typical year, DHS funds approximately 30 applications, usually involving about 100 facilities. A review of the first 4 years of the

program found that most facilities that won project approval (140 out of 174) focused on improving clinical aspects of care, such as reducing falls, managing pain, improving mobility, addressing incontinence, improving skin care. Other popular target areas included technology (done by 33 facilities), psychological well-being (28), care transitions (27), culture change (14), art therapy and recreation (13), and staff training (11).²

- **Contract specifying incentives, performance targets, and requirements:** For each approved project, DHS negotiates a formal contract with the nursing home that addresses the following:
 - **Incentive payments built into per diem rates:** DHS provides no upfront funding for the approved QI projects. Incentive payments of up to 5 percent are built into the operating per diem rate (i.e., not the facility or property charge) charged to the Minnesota Medicaid program and to residents who pay for nursing home care on their own. By law in Minnesota, private insurers pay the same rate as the Medicaid program, and hence nursing homes also charge the incentive payment to these payers for residents who have private insurance. (The incentive payment does not get charged to Medicare.) For the typical 100-bed facility, the 5-percent increase in the operating per diem rate equates to roughly \$65,000 a year. Each contract specifies the maximum percentage increase that the nursing home can charge (between 0 and 5 percent); 80 percent of the increase is contingent on implementing and executing the approved project, while 20 percent is contingent on achieving agreed-to performance targets, as discussed in the subbullets below.
 - **Negotiated performance targets:** Each contract lists the specific quality metrics the project is expected to influence, along with agreed-to performance targets for each over time. Targets generally come from measures reported on

Minnesota's nursing home report card, including risk-adjusted clinical indicators or resident QOL and satisfaction scores. In some cases, measures cover other aspects of nursing home quality, such as satisfaction of family members. The targets are set at levels thought by both parties to be realistic and achievable given the nursing home's current performance and available resources. Because it takes time before a project is fully implemented and begins to have an impact, performance measurement may continue for a year or more after the incentive payments end.

- **Financial penalties for not meeting targets:** The contract details financial penalties for not meeting the specified targets, typically giving DHS the ability to reduce future per diem rates by up to 20 percent of the incentive payment. In other words, a nursing home that initially received a 5-percent increase in the per diem rate could lose one-fifth of that increase (one percentage point) if it does not meet the performance targets set for that project in any given year. Before administering this penalty, DHS typically works with and supports the underperforming nursing home, with the goal of helping it take corrective action that will allow the targets to be met in the near future. Only after these efforts fail are penalties typically enforced.
- **Requirements for ongoing, active participation:** The contract requires nursing homes to "actively participate" in the approved project and details specifically what it means to meet this requirement each year. For example, requirements might specify that the nursing home establish a core project team that meets regularly, establish a data collection system and a process for reviewing that data, develop and implement training programs, and periodically provide the State with information on the project's status and impact.

Context of the Innovation

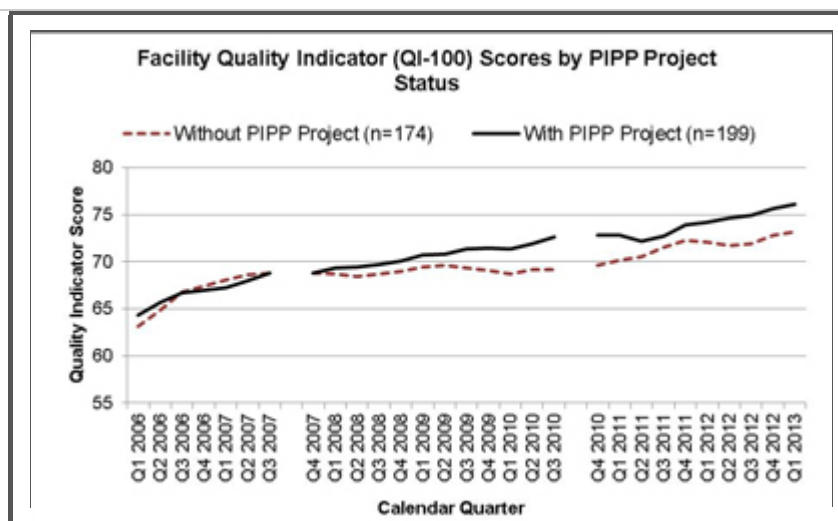
The Minnesota DHS provides Minnesotans (particularly vulnerable residents) with a variety of services intended to help them live as independently as possible. These services are offered in partnership with counties, tribes, nonprofit entities, and other organizations. Although the vast majority of services are provided by these partners, DHS sets policies and directs the payments for many of the services delivered, often working under the direction of the Governor and/or State legislature. DHS is the largest State agency, administering roughly a third of Minnesota's budget. The agency's biggest expense is providing health care coverage for low-income Minnesotans.

The impetus for PIPP came from State leaders, who had long been interested in promoting nursing home quality. The State had previously sponsored a few small incentive programs, including bonus payments based on overall quality scores. In the mid-2000s, the Governor proposed development of a more comprehensive program to promote nursing home quality through financial incentives. In response, DHS developed the framework for PIPP, and the State legislature formally approved funding for PIPP in 2006.

Did It Work?

[Back to Top](#)

Results



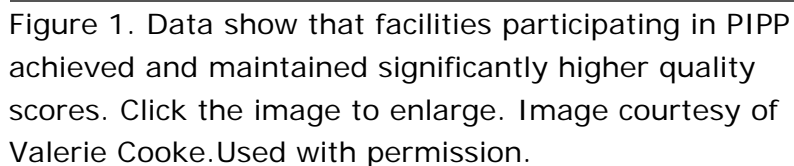


Figure 1. Data show that facilities participating in PIPP achieved and maintained significantly higher quality scores. Click the image to enlarge. Image courtesy of Valerie Cooke. Used with permission.

The program has engaged a high proportion of Minnesota nursing homes in QI activities; meaningfully improved the quality of nursing home care; and had a positive impact on quality improvement processes, teamwork, and communication.

- **Broad participation:** In the program's first 5 years, nearly three-quarters (74 percent) of the State's nursing homes had either participated in a project or applied to the program. During this period, DHS approved 89 projects involving 199 facilities.
- **Higher quality, sustained over time:** Both qualitative and quantitative data show that PIPP has led to significant, sustained improvements in the quality of nursing home care in Minnesota, as outlined below:
 - **Vast majority meeting performance targets:** During the first four rounds of funding, 95 percent of the funded projects (63 out of 66) met their performance targets. Only three projects (conducted at four facilities) did not meet the targets and consequently lost a portion of their project funding.²
 - **Better performance scores:** As depicted in Figure 1, before implementation of PIPP, the quality of care (as measured by the QI-100, a weighted average of 23 measures) in the 174 Minnesota nursing homes that later participated in PIPP was similar to that of the 199 facilities that did not. In both groups, scores had been trending upward at similar rates over time, likely due to introduction of a statewide nursing home quality report card in 2005. During the 4-year period after implementation (2007 to 2010), QI-100

scores improved significantly in nursing homes that participated in PIPP, while remaining flat among those that did not. After 2010, scores in both participating and nonparticipating facilities increased at similar rates, with participants maintaining significantly higher scores throughout this period—i.e., the quality gap persisted and remained stable.² (Program leaders suspect that the launch of other initiatives to improve nursing home quality may account for the upward trajectory among nonparticipating nursing homes during this period.) A separate analysis of individual clinical quality indicators revealed a significant improvement by PIPP project facilities in both targeted and nontargeted areas of care.⁹

- **Reports of sustained improvement from project leaders:** In a survey, 42 percent of project leaders felt that their PIPP-funded QI projects had a very significant, positive impact on quality in the areas targeted. They also reported that the projects are having a lasting impact that extends beyond the end of PIPP funding. Because project leaders developed concrete plans for sustainability as part of the proposal writing and implementation process, they can now point to specific project components that have remained in place after funding ended and to specific quality improvements and organizational changes that have been sustained.
- **No evidence of falloff in nontargeted measures:** Participating facilities did not experience declines in performance scores for individual quality indicators, including those not targeted by the improvement projects. (As alluded to above, these scores often improved.) This finding suggests that participating nursing homes did not divert their attention away from aspects of quality not targeted by the program.²
- **Positive impact on QI processes, teamwork, communication, and staff-resident relations:**

Project leaders and staff at participating nursing homes report that the program has allowed them to pay more attention to and increase use of evidence-based practices, data collection and analysis, and systems-level approaches to QI. They believe the project has helped to improve staff teamwork and communication and has enhanced relationships between nursing home staff and residents/family members.² In surveys, a high proportion of participating providers believe the program has increased frontline staff involvement in QI activities (38 percent), stimulated new QI ideas (35 percent), encouraged collaboration with other facilities (33 percent), encouraged leaders to be bold and take risks (33 percent), and improved organizational culture (32 percent).⁹

Evidence Rating *(What is this?)*

Moderate: The evidence consists primarily of comparisons of trends in performance on a composite measure of quality between nursing homes that participated in PIPP and those that did not. Additional evidence includes qualitative feedback from project leaders and staff at participating facilities about various aspects of the program and its impact.

How They Did It

[Back to Top](#)

Planning and Development Process

Key steps included the following:

- **Launching initial pilot project and reauthorizing program on a broader scale:** The 2006 legislation provided \$2.7 million in funding for a pilot project that began in October 2007. After the first year, the legislature voted to maintain the program and increase the money allotted to it, authorizing \$6.7 million in State funding each year.
- **Developing and refining the RFP:** Working with key stakeholders, program leaders at DHS created the

initial RFP and have subsequently refined it each year.

- **Ongoing performance monitoring:** The State maintains and continuously updates PIPP performance indicators. For example, after the recent approval of several projects that focused on reducing hospitalizations and improving care transitions, DHS staff developed and began tracking performance on new measures related to these areas.
- **Marketing and support to encourage nonparticipants:** DHS recently launched an initiative designed to attract nursing homes that have not yet participated in the program. The QI coordinator now conducts periodic day-long “boot camps” for representatives of these facilities. These sessions teach the skills and tools needed to identify high-potential QI projects (e.g., data collection, root-cause analysis), complete the RFP process, and successfully implement and execute the projects.
- **Expanding to home health and community-based organizations:** DHS is in the process of developing a similar program that will create incentives for home health agencies and other community-based organizations serving the elderly and individuals with disabilities. Launching this program has proven more challenging than was the case with nursing homes, as there are less data and fewer performance measures available to gauge the quality of services offered by these organizations.

Resources Used and Skills Needed

- **Staffing:** The program has one part-time administrator (who spends 20 to 25 percent of her time on PIPP), a full-time nurse who serves as the QI coordinator, and several administrative support staff who collectively represent roughly a quarter of a full-time equivalent employee. In addition, an information technology programmer spends some time on PIPP as part of larger responsibilities related to DHS quality programs. This position existed at DHS before PIPP began, and

this individual incorporates program-related work into regular job responsibilities.

- **Costs:** The annual program budget totals roughly \$18 million.

Funding Sources

The State of Minnesota provides \$6.7 million in funding to the program each year through the incentive payments added to the per diem rates. The Federal Government provides an equal amount through matching Medicaid funds. Private payers contribute the remainder (just under \$5 million), as Minnesota regulations require these payers to pay the same rates as those paid by Medicaid.

The Agency for Healthcare Research and Quality provided a grant (R1BHS018464) that covered the costs of a qualitative and quantitative evaluation of PIPP.

Tools and Resources

More information about PIPP is available

at: <http://www.dhs.state.mn.us>

[/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_136547](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_136547).

Adoption Considerations

[Back to Top](#)

Sustaining This Innovation

- **Ensure that performance targets remain relevant, achievable:** The measure(s) chosen to assess projects must be relevant—that is, the QI project being implemented must have a reasonable chance of influencing the measure(s). In addition, performance targets must be achievable, with adjustments made if they are not. For example, PIPP program leaders initially negotiated performance targets that required nursing homes to generate 10- to 20-percent improvements in QOL measures. They soon learned that this magnitude of improvement is simply not possible over a short period of time, and consequently

renegotiated the targets with the nursing homes.

- **Emphasize organizational and system-level change in funding decisions:** The program's long-term success depends on organizations being able to sustain improvements beyond the initial funding period. Consequently, the most successful projects will be those that address underlying organizational and cultural barriers to quality. Projects featuring one-time changes (such as the purchase of new equipment) or changes that do not relate to these systemic issues are less likely to have a lasting impact.
- **Adapt and adjust program over time:** PIPP's success is attributable in no small part to its flexibility, with target areas and performance measures being modified over time in response to external developments. For example, after the launch of major government initiatives to reduce unnecessary hospital admissions, program leaders tweaked the RFP to emphasize this area and subsequently directed funding to projects focused on reducing hospitalizations and improving care transitions. As part of this effort, they have developed new measures and collected data to monitor performance in these areas.
- **Provide support throughout process:** In surveys, leaders and staff within participating nursing homes emphasized the importance of providing technical training and other support throughout the application and implementation process, including training on QI methods for those with little experience in this area.⁹
- **Monitor and share performance data and success stories:** Surveys suggest that nursing homes value regular feedback on their progress toward established quality goals.⁹ In addition, legislators, consumers, and other key stakeholders will be more likely to remain engaged in and supportive of the program if they regularly see data that demonstrate its positive impact on nursing home quality.

More Information

[Back to Top](#)

Contact the Innovator

Valerie Cooke

Project Director
Department of Human Services
Nursing Facility Rates & Policy
PO Box 64973
St. Paul, MN 55164-0973
(651) 431-2263
E-mail: valerie.cooke@state.mn.us

Innovator Disclosures

Ms. Cooke reported having no financial interests or business/professional relationships related to the work described in this profile other than the funders listed in the Funding Sources section.

References/Related Articles

Arling G, Cooke V, Lewis T, et al. Minnesota's provider-initiated approach yields care quality gains at participating nursing homes. *Health Aff (Millwood)*. 2013;32(9):1631-8. [[PubMed](#)]

Abrahamson K, Arling P, Arling G. A state-sponsored approach to quality improvement in nursing homes: insights from providers. *Annals of Long-Term Care: Clinical Care and Aging*. 2013;21(7):20-4.

Abrahamson, K, Davila H, Mueller C, et al. Examining the lived experience of nursing home quality improvement: the case of a multifacility falls reduction project. *J Gerontol Nurs*. 2013;39(9):24-30. [[PubMed](#)]

Footnotes

1. Improving the quality of nursing home care: the Wellspring Model. The Commonwealth Fund. October 2005. Available at:
<http://www.commonwealthfund.org/grants-and-fellowships/grants/2000/jan/promoting-quality-in-nursing-homes-the-wellspring-model>.
2. Arling G, Cooke V, Lewis T, et al. Minnesota's

- provider-initiated approach yields care quality gains at participating nursing homes. *Health Aff (Millwood)*. 2013;32(9):1631-8. [\[PubMed\]](#)
3. Castle NG, Ferguson JC. What is nursing home quality and how is it measured? *Gerontologist*. 2010; 50(4):426-42. [\[PubMed\]](#)
 4. Werner RM, Konetzka RT. Advancing nursing home quality through quality improvement itself. *Health Aff (Millwood)*. 2010;29(1):81-6. [\[PubMed\]](#)
 5. Arling G, Job C, Cooke V. Medicaid nursing home pay for performance: where do we stand? *Gerontologist*. 2009;49(5):587-95. [\[PubMed\]](#)
 6. Werner RM, Konetzka RT, Kruse GB. Impact of public reporting on unreported quality of care. *Health Serv Res*. 2009;44(2 Pt 1):379-98. [\[PubMed\]](#)
 7. Briesacher BA, Field TS, Baril J, et al. Pay-for-performance in nursing homes. *Health Care Financ Rev*. 2009;30(3):1-13. [\[PubMed\]](#)
 8. Werner RM, Konetzka RT, Polsky D. The effect of pay-for-performance in nursing homes: evidence from state Medicaid programs. *Health Serv Res*. 2013;48(4):1393-414. [\[PubMed\]](#)
 9. Abrahamson K, Arling P, Arling G. A state-sponsored approach to quality improvement in nursing homes: insights from providers. *Annals of Long-Term Care: Clinical Care and Aging*. 2013;21(7):20-24.

Contact the Innovator



Look for Similar Items by Subject

Nursing home

Aged adult (80 +
years)

Senior adult (65-79
years)

Medicaid

Frail elderly

Long-term care

Pay for
performance/incentive
s

Quality measurement,
benchmarking, data
feedback

Training, knowledge
management

Quality of life

Funding Sources

Agency for Healthcare
Research and Quality

State of Minnesota

Developers

Minnesota Department
of Human Services

Original Publication: 04/09/14

Original publication indicates the date the profile was first posted to the Innovations Exchange.

Last Updated: 06/04/14

Last updated indicates the date the most recent changes to the profile were posted to the Innovations Exchange.

Disclaimer: *The inclusion of an innovation in the Innovations Exchange does not constitute or imply an endorsement by the U.S. Department of Health and Human Services, the Agency for Healthcare Research and Quality, or Westat of the innovation or of the submitter or developer of the innovation. [Read Health Care Innovations Exchange Disclaimer.](#)*