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State of Colorado

Department of Health Care Policy and Financing
Nursing Home Pay for Performance Application Review and Evaluation

2010

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I. EXECUTIVE SUMMARY

The Colorado Department of Health Care Policy and Financing (the Department) is now in the second year of the Pay for Performance (P4P) program. Once again, Public Consulting Group (PCG) was hired to review, evaluate, and validate applications from the nursing homes that applied for the program for FY 2009 and FY 2010. This process included developing and implementing an application evaluation tool, finalizing nursing home scores, and making recommendations to the Department for improving the program and process.

Managing culture change is a challenging task. Colorado has approached this program thoughtfully and with multiple layers of stakeholder input. Oversight board members responsible for implementing the program included the Ombudsman, nursing home providers, the Department, Colorado Foundation for Medical Care, and the state nursing homes contract auditor. The P4P program implemented by Colorado is thoughtful, ambitious, and fully embraces culture change and a model of resident-centered care.

The operation of the P4P program requires increased and improved reporting by providers. PCG's review identified numerous areas of focus for the Department to consider. For this task, PCG developed a database which documented each assessment of the application measures. From this comprehensive review, a list of recommendations was developed to improve the application and the program. Section VIII of the report includes specific recommendations for each performance measure. For example, these recommendations included the following items:

- Colorado may look to include a checklist in the application form.
- Colorado should consider making the captioning of pictures mandatory as evidence with the application mandatory for many criteria.
- Colorado may consider developing a website reporting of P4P outcomes and scoring data.
- Colorado may improve training and education on the P4P program.

The P4P nursing homes which were visited as part of this project were supportive and liked the program indicating that the assessment contributes to quality of life in homes and successfully encourages homes to change their culture. Each of the recommendations listed above would further strengthen the system and ultimately improve consumer outcomes. The Department has made significant strides with the implementation of the P4P program and should continue to fund and support the program for the improvement of resident care and outcomes for many years to come.

II. INTRODUCTION

A. Purpose of Project

In May 2010, the Department sought quotations from qualified and experienced vendors to conduct reviews to evaluate and validate whether nursing homes that applied for additional reimbursement under the P4P program have implemented, and are in compliance with, performance measures as defined by the Department.

The Department wishes to foster a person-centered and directed model of care in a home-like environment for Colorado's nursing home residents. Under HB 08-1114, an additional per diem rate based upon performance was to be paid to those nursing home providers that provide services resulting in better care and higher quality of life for their residents effective July 1, 2009. Using this per diem add-on methodology, nursing homes could apply for the P4P program quarterly. Under SB 09-263, additional payments to nursing homes for the Pay-For-Performance program are paid a supplemental payment rather than a per diem payment effective July 1, 2009. This change requires nursing homes to apply for the Pay-For-Performance program annually, by January 31, as all supplemental payments for the year must be calculated prior to the July 1 rate-setting date. The Department received, in total, forty-eight (48) applications from the 4/30, 7/31 and 10/31 quarterly deadlines. After October 31, 2009, applications were only accepted for the annual application deadline of January 31. The Department received ninety-eight (98) applications at the January 31, 2010 deadline. Based upon the application receipt date, applications shall be evaluated either under the 2009 application criteria or the 2010 application criteria.

B. Goals of the Project

There are two groups of applications to be reviewed, evaluated and validated. The first group includes applications received by quarterly deadlines of April 30, 2009, July 31, 2009 and October 31, 2009 (P4P 09 Applications). The Department received forty-eight (48) P4P 09 Applications. These applications will be reviewed, evaluated and validated using the original application, Colorado Nursing Homes P4P Application (P4P 09). The rate effective date for these providers is July 1, 2009. The second group includes applications received November 1, 2009 through January 31, 2010. These applications will be reviewed, evaluated and validated using the revised application, Colorado Nursing Homes Pay-For-Performance (P4P) Application (P4P 10). The rate effective date for these providers is July 1, 2010.

C. Major Deliverables

PCG was tasked with reviewing, evaluating, and validating whether nursing homes that applied for additional reimbursement related to the Pay-For-Performance program have implemented, and are in compliance with, performance measures, as defined by the Department, that provide high quality of life and high quality of care to their residents.

The P4P measures have been established in the application in two domains:

1. Quality of Life; and
2. Quality of Care.

The P4P 09 program has twenty-seven (27) performance measures in the domains of Quality of Life and Quality of Care. The P4P 10 has thirty (30) performance measures in the domains of Quality of Life and Quality of Care. The reimbursement for these measures is based on points. A nursing home may earn a total of up to one hundred (100) points. The threshold for any reimbursement begins with scores of forty-six (46) points or higher. Forty-nine (49) points are possible for the Quality of Life domain and fifty-one (51) points are possible for the Quality of Care domain. Each nursing home chooses which and for how many of these measures it applies.

Within each domain are sub-category measures. On the application forms, each of these sub-category measures is further described by definitions, minimum requirements, required documentation and the possible points for each sub-category measure. The Contractor's review of these applications shall assign the points merited for each measure contingent upon the review, evaluation and validation that the sub-category measurement requirements have been documented and met.

Specifically, the Department required that the contractor is responsible for the following:

- The Contractor shall review, evaluate and validate applications submitted by nursing homes that applied between February 1, 2009 and January 31, 2010 to participate in the P4P program. The review process will be accomplished in two (2) parts. The first part applies to nursing homes that applied by the October 31, 2009 quarterly deadline, P4P 09. The second part applies to nursing homes that applied between November 1, 2009 and January 31, 2010, P4P 10.
- Developing and implementing the evaluation tool that will be used to measure compliance with each P4P subcategory measure.
- Developing and maintaining a record file for each nursing home that applies for the P4P program.
- Making the results of all evaluations and reports available to the Department for a period of six (6) years after the end of the contract resulting from the DQ.
- Developing template letters to inform the Department and the homes about the results of its review, evaluation and validation of the P4P application and supporting documentation review.
- Developing the reporting mechanisms and any other ancillary documents and systems to successfully implement this program.
- Holding weekly meetings with the Department to ensure that the work is progressing appropriately.

- Making recommendations to the Department for which homes should have on-site visits and conducting review and validations of no less than 10% of the P4P Application and supporting documentation.
- Providing the final evaluation results of the P4P applications to the Department in a standardized format developed by the Contractor and approved by the Department, and
- Providing a report to the Department by June 30, 2010 detailing the Contractor's experience with this project and submitting recommendations to the Department for continuing and improving this project that might be used in a future solicitation process.

D. Project Team

PCG assembled a team of nationally recognized Subject Matter Experts (SMEs) in long term care policy and planning for this effort. The project was directed by Sean Huse, an experienced manager in Colorado for Medicaid over the past 7 years. Mr. Huse managed the project with Les Hendrickson, a national expert on long term care reimbursement policy and planning. In addition to the two project managers the team was supported by Amy Elliot, of the Pioneer Network, a national leader in the work on models of resident or person-directed care in nursing homes.

This team of project managers and SMEs was assisted by PCG Business Analysts and Consultants with backgrounds researching and analyzing P4P reimbursement structures. Team members included Joe Weber, Asher Cowan, Jonathon Hover, Garrett Abrahamson, Jheanell West, and Rebecca Smith. PCG believes this staffing approach is balanced and thoughtful and represents the knowledge and experience necessary to successfully accomplish the Department multiple objectives.

III. APPROACH

A. Assessment of Applications

PCG drew on the experience gained while reviewing last year's 2009 P4P applications to develop a standardized approach for reviewing the current year's forty-eight (48) additional 2009 applications and ninety-eight (98) 2010 applications that were submitted to the Department. During the period of May 28, 2010 through June 11, 2010, PCG's team of reviewers worked together to evaluate the applications. Working together in this collaborative environment allowed reviewers the opportunity to discuss ambiguous applications and develop a uniform approach to the reviews.

To maintain a consistent, equitable evaluation of all of the applications across the team of reviewers, a strict interpretation of the definition, minimum requirements, and required documentation for each performance measure as described in the respective application year's published P4P application was adopted. Reviewers took the position that the application was a request for state and federal reimbursement for nursing home services and the application was equivalent to a cost report form.

Each performance measure was broken down into one or more specific minimum requirements based on the language in the application. Reviewers examined the supporting documentation submitted in each provider's application to answer "Yes" or "No" to the question, "Did the home meet the minimum requirement?" To gain points on a measure, the provider needed to show the required documentation for each minimum requirement. The required documentation differed depending on the application year. The original 2009 application had less detailed instructions regarding required documentation types for each measure and was open to a significant amount of interpretation. To ensure that applications were scored consistently, reviewers debated ambiguous documentation and made sure to apply decisions to all application materials. The 2010 application included much more detail for each measure, often listing types of required documentation such as narratives, pictures, policy documents, and testimonials. Also, the application included specific instructions on calculating values for measures such as staff retention rate and continuing education that clarified much of the confusion that occurred on 2009 applications. When documentation was listed as required, each piece had to be present in order to meet the requirement. Reviewers did, however, exercise judgment in reviewing documentation provided. For example, if there was no explicit statement that staff members assist with resident room decoration, but pictures show various paint colors, wall hangings, and large pieces of personal furniture, the reviewer would assume that the nursing home staff assisted with the process.

In all cases, a literal definition of the minimum requirements was applied. If, for example, the requirement is for 12 hours or more of continuing education, it means 12 hours or more and answers of 11.99 or less do not meet the requirement. If the care planning requirement calls for

"Sample initial and quarterly documentation…", then both initial and quarterly documentation had to be present to meet the requirement.

In some cases, if no supporting documentation was included in the section designated for a particular performance measure, the reviewer searched the other sections in the application to see if documentation could be found elsewhere that would meet the minimum requirement. If the application showed that the minimum requirement for a measure was in fact met, then a "Yes" answer was assigned to the measure regardless of whether or not the home claimed a score for that measure. For example, if a home did not report a score for the neighborhoods/households measure, yet the application provided ample documentation that the home had neighborhoods then the review would assign a "Yes" score to the measure. Also, for performance measures containing an option for multiple point levels, such as the +2, +4, or +6 continuing education, reviewers would change the number of points awarded when appropriate. For example, if the provider applied for +6 continuing education, but the documentation only showed +4, the reviewer would say "No" to +6 and add a "Yes" to +4.

B. Evaluation Tool

Last year, PCG developed a Microsoft Access database as an evaluation tool to store information, self-reported scores, and application evaluations for each provider that submitted an application. This evaluation tool was updated and redesigned to meet the needs of reviewing the new group of 2009 applications and the 2010 applications. A separate database was developed for each group of applications.

After entering in provider information, such as address, phone number, preparer name, etc., reviewers entered in the homes' self-reported scores. It is important to note that self-reported scores were entered exactly as provided, even when the homes awarded themselves partial points or points for both options of an either/or measure. Then, reviewers read each application and its supporting documentation in depth to evaluate and score the applications on each of the subcategory performance measures.

As previously mentioned the measures were broken down into one or more minimum requirements and reviewers would assign a "Yes" or "No" to each as appropriate. The databases contained a field for reviewers to add comments pertaining to any of the minimum requirements or the decision that was made. Each measure also had a final, "Overall," minimum requirement that was only marked a "Yes" if all individual requirements were marked "Yes." The points for the measure would only be assigned when this final "Overall" was a "Yes," in line with the methodology of not assigning partial points for a measure.

A "No" response for any of the minimum requirements resulted in no points being awarded by the reviewer for that performance measure. For instance, with the minimum requirements for an applicant to receive the available points for "Enhanced Dining," the reviewer would need to see back-up documentation that all of the following requirements were met:

1. Menu options must be more than the entree and alternate selection
2. These options should include input from a resident/family advisory group
3. The residents have input into the appearance of the dining atmosphere
4. Residents have access to food at any time and staff are empowered to provide it

The databases were designed so that the total score being accumulated by the applicant was not apparent to the reviewer. This ensured that the supporting documentation for each minimum requirement for each performance measure was evaluated independently without knowledge of cumulative point thresholds.

After all of the applications in each batch had been evaluated, summary reports could be run showing nursing home scores, as well as detailed reports by nursing home showing all scores and reviewer comments for each minimum requirement.

C. Quality Assurance

Throughout the evaluation process, steps were taken to ensure the quality of reviews. The discussions between reviewers on ambiguous aspects of documentation allowed for a standardized approach to scoring the large number of applications. Also, the databases were designed to guide the reviewer through each performance measure, documenting his or her decision on each minimum requirement during the review.

Once the data was input, multiple checks were run on the information to ensure no anomalies were present. One check was to identify any instances where a reviewer gave all "Yes" responses on a performance measure, but a "No" on the "Overall" for the measure. Similarly, a check was performed to find any instances where a reviewer gave a "No" for any of the minimum requirements on a performance measure, but a "Yes" on the "Overall" for the measure. Any records in question were checked by a second review of the provider's documentation.

During the site visits, reviewers took notes about their findings with regard to specific performance measures. While no new documentation was accepted, reviewers identified instances where documentation may have been misinterpreted in the original evaluation of an application, and after speaking with nursing home staff, it was deemed appropriate to change the scoring based on what was originally provided. For example, a training sign-in sheet for "Bathing Without a Battle" that was not identified as such. Also, any situations where reviews were seemingly inconsistent on a performance measure were noted. Upon returning from the visits, all reviewer comments and binders were checked a second time with regard to those performance measures noted to ensure accuracy.

IV. REVIEW OF APPLICATIONS AND PERFORMANCE MEASURES

A. Overview of Performance Measures

Pursuant to HB 08-1114 the Department is required to reimburse nursing homes in Colorado an additional per diem rate based upon performance.[1] The payment is made to support policies that create a resident-centered and resident-directed model of care in a home-like environment for Colorado's nursing home residents.[2]

A P4P program is one way the Department can provide an incentive payment rewarding Colorado nursing homes that provide high quality of life and quality of care to their residents. The program is designed to be financially appealing to providers, simple to administer, contain easily accessible data to determine compliance, and is built around measures that are important to nursing home residents, families and consumers. The measures are centered on two "domains", "Quality of Life" and "Quality of Care".

Each measure has assigned points that, when totaled, will determine the amount of additional reimbursement per patient day. The following table shows the amount of the per diem add-on that can be obtained for 2010.

Calculation of the Per Diem Rate Add-On
0 –45 points = No add-on
46 – 60 points = $1.00 per day add-on
61 – 79 points = $2.00 per day add-on
80 – 100 points = $3.00 per day add-on

Approximately 187 nursing homes participated in the Medicaid program in 2008. The average number of days of Medicaid occupancy for these 187 homes was approximately 18,718 days.[3] The average home that scored 50 points on the P4P measures would thus receive an additional $1.00 a day in reimbursement or $18,718.[4]

[1] 10 CCR 2505-10 Section 8.443.12.
[2] See the SB 06131 Pay for Performance Subcommittee Report and Recommendations for discussion of the rationale behind performance measure selection. Retrieved on June 30, 2010 from http://165.127.10.10/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1224913928031&ssbinary=true
[3] See Med 13 reports for 2008. Retrieved on June 30, 2010 from http://mslccolorado.com/(S(v53vaxmtbfgktu45hj40re3c))/DatePortal.aspx?report=MED13CostReportSummary&fileType=XLS&yearList=2008,2007,2006,2005,2004,2003,2002,2001,2000
[4] This generalization is qualified by the provision of 8.443.12 6. Which reads "If the expected average rate add-on for those homes receiving an add-on payment is less than five-tenths of one percent of the statewide average per diem rate (prior to rate add-ons), the above table rates will be proportionately increased or decreased in order to have an expected average Medicaid add-on payment equal to five-tenths of one percent of the average nursing home rate prior to add-on payments."

The measures used in the pay for performance program changed in six noteworthy ways from 2009 to 2010:

The first change was the addition of explanatory detail to measures to help homes understand what the measure is directed at how to provide better documentation. Significant detail was added to the ten measures of Enhanced Dining, Flexible and Enhanced Bathing, End of Life, Resident Rooms, Public and Outdoor Space, Overhead Paging, Internal Community, External Community, Person-Directed Care, and New Staff Program.

The second change was the specification of minimum requirements. The 2010 application quantified requirements that previously had not been quantified:

- Daily Schedules was changed to require four resident testimonials and four care plans associated with same residents;
- Overhead Paging was changed to require two testimonials by non-management staff and two testimonials from residents,
- Neighborhoods/Households was changed to require testimony from four residents or family members;
- Internal Community was changed to require testimonials from three non-management employees and three residents or family members;
- Living Environment was changed to add testimonials from three residents and photographs;
- Care Planning was changed to add a sample of ten initial and ten quarterly reports, and
- New Staff Program was changed to include testimonials from four staff.

The third change was the specification of how information should be presented for three measures: Consistent Assignments, Continuing Education, and Staff Retention. Appendices were added showing precisely how data for these three measures should be presented. These appendices made significant improvements to these three measures. Each measure involves the quantitative comparison over time of staffing information and in 2009 homes had considerable difficulty in organizing this information.

The fourth change was in the Quality of Care measures. Two new measures, Falls and Urinary Tract Infections (UTI), were added, scores on the measure were changed and the points on the measures were changed. The rationale for keeping High-Risk Pressure Ulcers, Chronic Care Pain and Physical Restraints while adding Falls and Urinary Tract Infection is contained in state documents. The October 2009 profile of nursing home clients shows the focus and tracking that the Department of Health Care Policy and Financing is conducting in regard to these measures.[5]

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http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251604605694&ssbinary=true

A fifth change was the addition of a Staff Influenza Immunization measure giving credit if 60% or more of staff had received an influenza immunization.

The sixth change was a redistribution of points across the performance measures.

The cumulative impact of these changes resulted in a much improved application form and the state staff and members of the public that made them should be justifiably proud of the improvements. Reviewers observed that with these improvements the application itself is almost a manual or set of instructions on how to implement cultural change in a home. While reviewers did not quantify their observation, it is clearly the case that homes are learning and implementing new culture change efforts by reading the application.

The performance measures for FY 2009 are shown below. They are divided into two general domains, Quality of Life and Quality of Care.

DOMAIN: QUALITY OF LIFE	DOMAIN: QUALITY OF CARE
Subcategory: Resident-Directed Care	**Subcategory: Quality Of Care**
Enhanced Dining	12 hours Continuing Education
Flexible and Enhanced Bathing	14 Hours Continuing Education
Daily Schedules	16 Hours Continuing Education
End Of Life Program	Quality Program Participation
Subcategory: Home Environment	**Subcategory: Nationally Reported Quality Measures**
Resident Rooms	High Risk Pressure Ulcers
Public and Outdoor Space	Chronic Care Pain Score
Overhead Paging	Physical Restraints
Neighborhoods/Households	
Subcategory: Relationships with Staff, Family, Resident, and Community	**Subcategory: Home Management**
50% Consistent Assignments	10% Medicaid above state average
80% Consistent Assignments	5% Medicaid above state average
Internal Community	
External Community	
Living Environment	
Volunteer Program	

DOMAIN: QUALITY OF LIFE	DOMAIN: QUALITY OF CARE
Subcategory: Staff Empowerment	**Subcategory: Staff Stability**
Care Planning	Staff Retention Rate
Career Ladders/Career Paths	Staff Retention Improvement
Person-Directed Care	Director of Nursing Retention
New Staff Program	Nursing Home Administrator Retention
	Employee Satisfaction Survey

The performance measures for FY 2010 are shown below. As done in FY 2009, they are divided into two general domains, Quality of Life and Quality of Care. Those performance measures that were added in the FY 2010 application are highlighted.

DOMAIN: QUALITY OF LIFE	DOMAIN: QUALITY OF CARE
Subcategory: Resident-Directed Care	**Subcategory: Quality Of Care**
Enhanced Dining	12 hours Continuing Education
Flexible and Enhanced Bathing	14 Hours Continuing Education
Daily Schedules	16 Hours Continuing Education
End of Life Program	Quality Program Participation
Subcategory: Home Environment	**Subcategory: Nationally Reported Quality Measures**
Resident Rooms	Falls
Public and Outdoor Space	High Risk Pressure Ulcers
Overhead Paging	Chronic Care Pain
Neighborhoods/Households	Physical Restraints
	Urinary Tract Infection
Subcategory: Relationships with Staff, Family, Resident, and Community	**Subcategory: Influenza Immunization for Staff and Residents**
50% Consistent Assignments	Staff Influenza Immunization
80% Consistent Assignments	
Internal Community	**Subcategory: Home Management**
External Community	10% Medicaid above state average
Living Environment	5% Medicaid above state average

DOMAIN: QUALITY OF LIFE	DOMAIN: QUALITY OF CARE
Volunteer Program	
Subcategory: Staff Empowerment	**Subcategory: Staff Stability**
Care Planning	Staff Retention Rate
Career Ladders/Career Paths	Staff Retention Improvement
Person-Directed Care	Director of Nursing Retention
New Staff Program	Nursing Home Administrator Retention
	Employee Satisfaction Survey

B. Pre-Requisites for Participation

The Code of Colorado administrative regulations at 10 CCR 2505 8.443.12 at 2.a. and 2.b. set two prerequisites for applying for the P4P add-on to the per diem:[6]

> 2.a. No home with substandard deficiencies on a regular annual, complaint, or any other Colorado Department of Public Health and Environment survey will be considered for P4P
>
> 2.b. The home must perform a resident/family satisfaction survey. The survey must (a) be developed, recognized, and standardized by an entity external to the home; and, (b) be administered on an annual basis with results tabulated by an agency external to the home. The home must report their response rate, and a summary report must be made publically available along with the home's State's survey results

Both the 2009 and 2010 applications required the same prerequisites.

Colorado Department of Public Health and Environment Survey Prerequisite

PCG reviewers were supplied with a definition of a substandard deficiency and used the Colorado Department of Public Health and Environment (CDPHE) website at http://www.cdphe.state.co.us/hf/ncf/index.html to check on homes. The upper left hand corner of the webpage provides search choices. The CDPHE database contains a list of Colorado nursing homes and the results of surveys and complaint investigations. PCG staff looked up each home in the CDPHE database and identified any deficiency that CDPHE assigned to the home that fit the definition of substandard and occurred within the time frame specified. For the

[6] http://www.sos.state.co.us/CCR/Rule.do?deptID=7&deptName=2505,1305 Department of Health Care Policy and Financing&agencyID=69&agencyName=2505 Medical Services Boar&ccrDocID=2921&ccrDocName=10 CCR 2505-10 8.400 MEDICAL ASSISTANCE - SECTION 8.400&subDocID=50025&subDocName=8.443 NURSING HOME REIMBURSEMENT&version=20

2009 applications the quarter the application was submitted for was used to find the most recent survey prior to the submittal date, and for 2010 the survey closest to January 2010 was deemed to be the most recent survey. All of the homes submitting applications met this prerequisite.

Resident/Family Satisfaction Survey

This prerequisite measure was defined in the P4P application as "Survey must be developed, recognized, and standardized by an entity external to the home. The acceptable verification said that the "Resident/family satisfaction surveys must have been conducted and tabulated between January 1 and December 31 of the previous year. A Summary Report, identifying vendor completing, must be attached to this application and made available to the public along with the home's State Survey Results". The 2010 application instructions were unchanged from the 2009 application instructions.

As in the review of last year's 2009 applications, some homes supplied the full copy of the survey whereas others only supplied cover pages of the survey. Reviewers gave credit to those homes that only supplied the cover pages, reasoning that these were evidence that the survey had been completed.

A review of the second round of 2009 applications showed nine of forty-eight applications, or 19%, did not contain a family survey. Twenty-nine of the ninety-eight 2010 applications, or 30% did not contain a family survey. Three of the homes visited during the site visits commented that they had done family surveys but these were not included with the documentation when the application was submitted. As in the previous review of 2009 applications, persons preparing the application did not notice the survey prerequisite and the requirement to submit evidence that the survey had been completed.

The tables below identify those homes that did not submit documentation of a completed resident/family satisfaction survey.

2009 Nursing Homes without Documentation of a Resident/Family Satisfaction Survey

Provider Number	Nursing Home Name
05650114	University Park CC
05650841	Aurora Care Center
05650890	Cherry Hills HCC
05652748	CSV - Rifle
05656269	St. Paul HC
13086863	Eagle Ridge of Grand Valley
35057335	Cedars Healthcare Center
41978765	Pikes Peak Care & Rehab
58301747	Mantey Hgts Rehab & Care Ctr

2010 Nursing Homes without Documentation of a Resident/Family Satisfaction Survey

Provider Number	Nursing Home Name		Provider Number	Nursing Home Name
00122777	Forest Street Compassionate CC		05652953	Sable Health Care Center
05652615	San Luis Care Center		05652961	Elms Haven Care Center
05653001	Life Care Center of Greeley		05653365	Eben Ezer Lutheran Care Ctr
05655709	Villa Manor Care Center		05656343	Walsh Healthcare Center
19005296	San Juan Living Center		13086863	Eagle Ridge of Grand Junction
00685046	Regent Park Nursing & Rehab		16876334	Sierra HC Community
05650114	University Park CC		27580547	Mountain View CC
05650338	Clear Creek Care Center		37605216	Broomfield Skilled Nursing & Rehab
05651260	Good Sam - Ft. Collins		41978765	Pikes Peak Care & Rehab
05651377	Life Care Center of Longmont		54603528	Parkview Care Center
05651567	Briarwood		55754244	Cambridge CC
05651880	The Valley Inn		58301747	Mantey Heights Care & Rehab C
05652334	Larchwood Inns		73787868	Rehab & Nursing Ctr of the Rockies
05652664	Westwind Village		85608742	Namaste Alzheimer Center
05652748	CSV - Rifle			

C. 2009 Scores and Discussion

Summary Chart Showing Scores of Homes

The following table provides a summary of the self-reported and reviewers' scores by home

Provider Number	Facility Name	Points Available	Self-Reported Score	Reviewers Score
63934272	Allison Care Center	100	79	61
96339349	Alpine Living Center	100	63	56
05650841	Aurora Care Center	100	49	48
83606041	Bear Creek Care & Rehab	100	68	64
05652169	Bethany Healthplex	100	84	70
05651567	Briarwood HCC	100	76	46
55754244	Cambridge Care Center	100	65	63
47333723	Camellia Health Care Center	100	62	45
05652631	Canon Lodge Care Center	100	68	43
35057335	Cedars Healthcare Center	100	86	37
99474743	Cherrelyn HCC	100	67	43
05650890	Cherry Hills HCC	100	48	29
75951274	Cheyenne Mtn Care & Rehab	100	62	41
05652748	CSV – Rifle	100	56	31
05652250	Devonshire Acres	100	82	67
05654702	Doak Walker Care Center	100	72	68
13086863	Eagle Ridge of Grand Valley	100	100	44
05652961	Elms Haven CC	100	63	54
05650080	Exempla CO Lutheran Home	100	77	67
99000792	Four Corners Health CC	100	58	55
05653464	Frasier Meadows Hlth Care Ctr	100	66	60
50709348	Garden of the Gods Care Ctr	100	62	44
05653571	Hildebrand Care Center	100	60	58
05652672	Horizon Heights	100	89	80
05652722	LCC Westminster	100	75	61
05653001	Life Care Center of Greeley	100	63	53
58301747	Mantey Hgts Rehab & Care Ctr	100	78	47
46279865	Mesa Manor Rehab CC	100	62	43
38305828	Monaco Parkway Hlth & Rehab	100	65	58
27580547	Mountain View CC	100	71	26
76173712	Pearl Street Health & Rehab	100	54	49
41978765	Pikes Peak Care & Rehab	100	77	56
05652839	Pine Ridge Extended CC	100	72	68
05652953	Sable Care	100	69	58
19005296	San Juan Living Center	100	76	71
05651534	Sandalwood Manor	100	93	78
05655543	SE Hospital LTC	100	85	78
72008041	Skyline Ridge Nursing Rehab	100	63	48
96731591	Spring Creek Health Care	100	62	56
13359240	Springs Village CC	100	50	9
05656269	St. Paul HC	100	90	68
05651880	The Valley Inn	100	76	57
05650114	University Park CC	100	73	65

Provider Number	Facility Name	Points Available	Self-Reported Score	Reviewers Score
89157231	Vista Grande Inn	100	63	57
69607532	Walsenburg Care Center	100	57.5	38
05652664	Westwind Village	100	77	69
80636217	Wheatridge Manor NF	100	81	52
71956000	Yuma Life CC	100	55	53

Changes to Self-Reported Scores

The following table provides a summary of the number of homes with self-reported, confirmed, and not confirmed scores for each measure.

Performance Measure Description	# of Nursing Homes with Self-Reported Score	# of Nursing Homes with Score Confirmed*	# of Nursing Homes with Score Not Confirmed	% of Score Not Confirmed
Enhanced Dining	44	24	20	45%
Flexible and Enhanced Bathing	41	31	10	24%
Daily Schedules	41	33	8	20%
End Of Life Program	43	30	13	30%
Resident Rooms	48	47	1	2%
Public and Outdoor Space	43	36	7	16%
Overhead Paging	34	13	21	62%
Neighborhoods/Households	28	9	19	68%
50% Consistent Assignments	7	3	4	57%
80% Consistent Assignments	43	37	6	14%
Internal Community	34	29	6	18%
External Community	43	41	2	5%
Living Environment	46	44	2	4%
Volunteer Program	44	38	6	14%
Care Planning	35	27	8	23%
Career Ladders/Career Paths	46	38	8	17%
Person-Directed Care	28	20	10	36%
New Staff Program	40	26	14	35%
+2 Continuing Education	12	4	8	67%
+4 Continuing Education	8	6	4	50%
+6 Continuing Education	25	20	5	20%
Quality Program Participation	39	35	5	13%
High-Risk Pressure Ulcers (5.5 or less)	18	13	5	28%
High-Risk Pressure Ulcers (>5.5 but <=7.2)	11	10	2	18%
Chronic Care Pain Score (2 or less)	17	17	1	6%
Chronic Care Pain Score (>2 but <=2.7)	4	2	2	50%
Physical Restraints (1 or less)	20	19	2	10%
Physical Restraints (>1 but <= 2)	5	3	3	60%
10% Medicaid	24	16	11	46%
5% Medicaid	6	2	5	83%
Staff Retention Rate	39	33	6	15%
Staff Retention Improvement	21	7	14	67%
DON Retention	16	15	1	6%
NHA Retention	22	21	1	5%
Employee Satisfaction Survey	41	36	7	17%

** The number of Nursing Homes with Score Confirmed includes cases where points were substantiated with documentation but the nursing home did not self report score.*

Discussion of Each Performance Measure

The following section includes a detailed discussion of each performance measure included in the FY 2009 application. The following discussion on these performance measures focuses only on those FY 2009 applications submitted during the second submission phase. Additionally, as recommendations based on the FY 2009 application have already been made and implemented with the FY 2010 application, no further recommendations have been provided on this application.

Sub Category: Resident Directed Care
Measures in this subcategory include Enhanced Dining, Flexible and Enhanced Bathing, Daily Schedules, and End of Life Program. Reviewers assessed each application and supporting documentation to validate compliance with designated minimum requirements.

ENHANCED DINING	
DEFINITION	The application states that the Definition/Minimum Requirement(s)/ Required Documentation for Enhanced Dining are: "Menus that include numerous options, menus developed with resident input. The dining atmosphere reflects the community. Residents have access to food 24 hours/day, and staff is empowered to provide food when resident desires it. Minimum requirement(s) with supporting documentation: Menu options must be more than the entree and alternate selection. These options should include input from a resident/family advisory group. The residents have input into the appearance of the dining atmosphere. Residents have access to food at any time and staff is empowered to provide it."
REVIEWER COMMENTS	Reviewers found that most nursing homes self-reporting provision of supplementary food items for residents provided sufficient supporting evidence. Common methods of documentation included supplying menus that explicitly state additional options are available upon request, handouts informing residents of additional food options, or photos of kitchens and pantries that were open for resident access. Most homes included minutes from resident and family councils or examples of resident participation. Reviewers noted common reasons for denying a nursing home credit for this measure, which included: homes not including menus, homes including menus but with only the main entrée and just one alternative, no resident council meeting minutes showing resident input into the atmosphere or food, or no photos of the dining areas. Finally, only a few nursing homes did not provide adequate documentation of 24 hour access to food. Photos of pantries or kitchens with narratives supplied the most credible evidence to support this measure.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 44 Number of homes with score confirmed: 24 Number of homes with score not confirmed: 20 Percent of score not confirmed: 45%

FLEXIBLE AND ENHANCED BATHING	
DEFINITION	The application states that the Definition/Minimum Requirement(s)/ Required Documentation for Flexible and Enhanced Bathing are: "Bath schedules are flexible to meet the residents' desires, options for bathing are provided, and the physical bathing environment is enhanced. Minimum requirement(s) with supporting documentation: Residents are interviewed about choices regarding time, choice of care giver, and type of bath. Bathing Without a Battle education is completed. Bathing atmosphere includes home décor."
REVIEWER COMMENTS	Reviewers noted that the majority of homes included narratives of the bathing program supported by questionnaires regarding residents' bathing preference or copies of care plans documenting resident participation in the choice of timing and type of bath. Reviewers noted that some homes did not provide sufficient documentation to verify that the bathing atmosphere for residents supported a home-like environment. The narrative of the application may have stated that home décor existed; however, the statement was not sufficient validation. The most persuasive forms of documentation for this requirement included photographs of the bathing environment and/or purchase receipts of items to support a home-like, comfortable atmosphere (e.g. towel warmers, candles, whirlpool tubs). The second most common reason that homes did not receive points for this measure was that there was no evidence that residents were given a choice in bathing times or caregivers. Sufficient documentation for this would have included resident surveys or questionnaires that ask for resident input into their bathing schedule. Another requirement that some homes did not validate well was the completion of "Bathing Without a Battle" education, and several homes did not supply sufficient documentation. In most instances of unsubstantiated claims, nursing homes either did not include mention of "Bathing Without a Battle" or only mentioned it in the narrative without including additional documentation. Homes that provided the most compelling evidence included

FLEXIBLE AND ENHANCED BATHING		
	documentation of "Bathing Without a Battle" in-services with staff sign-in logs or listings of the number of staff completing the training.	
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: Number of homes with score confirmed: Number of homes with score not confirmed: Percent of score not confirmed:	41 31 10 24%

DAILY SCHEDULES	
DEFINITION	The application states that the Definition/Minimum Requirements for the Daily Schedules measure are: "Residents are assisted in determining their own daily schedules and participate in developing their care plans. Minimum requirement(s) with supporting documentation: Residents are interviewed about choices regarding their routine, respecting daily choices and changes as they occur. Residents if able, families if available, and/or direct care staff participates in developing an individual's care plan."
REVIEWER COMMENTS	In evaluating the two requirements, several nursing homes did not provide sufficient documentation to support that residents are interviewed regarding choices in routine, and other homes did not supply documentation to verify resident, family and/or staff participation in care plans. For those homes that did substantiate claims, the best documentation included copies of surveys recording resident choices in key preferences for daily routines (e.g. waking, sleeping, dining, bathing) and acknowledgement by the home through care plans or narratives that daily schedules were organized to support these preferences. To evaluate participation in care planning, reviewers considered the totality of supporting documentation including resident care plans provided to illustrate the "Care Planning" measure. In most cases, evidence of resident, family or staff participation was available in these sections. The majority of nursing homes that did not satisfy this requirement did not include any documentation supporting the claims that residents and/or family members have input into their care plans, or only provided a brief narrative of the activity.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 41 Number of homes with score confirmed: 33 Number of homes with score not confirmed: 8 Percent of score not confirmed: 20%

END OF LIFE PROGRAM	
DEFINITION	The application states that the Definition/Minimum Requirements for the End of Life Program measure are: "The home has developed a program advocating for residents' participation in their own end-of-life care, providing regular opportunities for re-evaluation of these wishes, and respecting these wishes when end of life is imminent. Minimum requirement(s) with supporting documentation: Advance Directives are reviewed quarterly and as needed. A program includes: an individual's preferences, wishes, expectations, a plan for honoring those that have died, and a process to inform the community of such death."
REVIEWER COMMENTS	In evaluating the two requirements, reviewers found that the majority of homes that did not receive points did not provide sufficient evidence showing that Advance Directives were reviewed quarterly or as needed. In the majority of these cases, although reviewers assessed the entire application including care plan conference summaries, examples of quarterly reviews were not provided by the home. Homes may have provided brief narratives claiming to review Advance Directives quarterly, but additional documentation was not included in the application. Some homes also did not submit sufficient evidence of a process to honor those who have died. Conversely, many of the nursing homes were able to provide substantive evidence of end-of-life programs, such as "Butterflies are Free." Homes also included copies of programs for memorial ceremonies and remembrances of residents as validation, and photographs of memorial displays.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 43 Number of homes with score confirmed: 30 Number of homes with score not confirmed: 13 Percent of score not confirmed: 30%

SUB CATEGORY: HOME ENVIRONMENT

Measures in this subcategory include Residents Rooms, Public and Outdoor Space, Overhead Paging and Neighborhoods/Households. Reviewers assessed each application and supporting documentation to validate compliance with designated minimum requirements.

RESIDENT ROOMS	
DEFINITION	The application states that the Definition/Minimum Requirements for the Resident Rooms measure are: "Resident rooms have been redesigned/rearranged to enhance privacy, promote personalization and individual needs. Minimum requirement(s) with supporting documentation: Residents/families are encouraged to bring own home and room décor. The home will assist in personalization of an individual's room with such things as pictures, clocks, lamps, room color, etc."
REVIEWER COMMENTS	In assessing the requirements for resident rooms, reviewers found that only one home that did not provide evidence that residents were encouraged to personalize spaces with their own belongings or that the nursing home assisted residents in these efforts. Most applications included photographs of residents' rooms and/or logs of belongings that residents moved from their homes. In most cases, the amount and variety of home décor, e.g. pictures, dressers, and furniture, led reviewers to presume that the home assisted in moving and rearranging rooms to accommodate residents' preferences.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 48 Number of homes with score confirmed: 47 Number of homes with score not confirmed: 1 Percent of score not confirmed: 2%

PUBLIC AND OUTDOOR SPACE		
DEFINITION	The application states that the Definition/Minimum Requirements for the Public and Outdoor Space measure are: "Available public and outdoor spaces are designed for stimulation, ease of access, and activity. Minimum requirement(s) with supporting documentation: Public spaces that allow for residents to remain as independent as possible such as laundry and cooking pantry areas. These spaces should be comfortable and accommodating without clutter and free of visible medical equipment storage."	
REVIEWER COMMENTS	In evaluating the documentation to support public spaces that allow resident independence, reviewers found that several homes were unable to provide sufficient validation of this measure. The most common reason for homes not receiving points was that homes did not provide any or enough pictures of public and outdoor spaces that show how residents are able to remain independent. For those homes that did provide sufficient documentation, photographs were the best evidence of a resident-directed, transformed environment.	
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: Number of homes with score confirmed: Number of homes with score not confirmed: Percent of score not confirmed:	43 36 7 16%

OVERHEAD PAGING	
DEFINITION	The application states that the Definition/Minimum Requirements for the Overhead Paging measure are: "Overhead paging has been turned off and used only in emergencies. Minimum requirement(s) with supporting documentation: Overhead paging is limited to emergency use only. Needs to be observed or confirmed by the residents and staff."
REVIEWER COMMENTS	Reviewers found that homes did not provide adequate documentation to verify that the home limited paging to emergency use only. In certain cases, nursing homes would state that paging was only used for emergencies in the narrative, but written correspondence from leadership to staff would include instances of overhead paging outside of emergencies (such as phone calls from physicians). Reviewers did accept as supporting documentation, written policies, quotes, logs for in-services on the discontinued use of overhead paging, and photos or invoices of alternative systems. The most common reason for homes not receiving points and most challenging requirement for this measure was the requirement that the discontinued use of overhead paging was observed or confirmed by residents and staff. In many instances, homes failed to provide this confirmation; only providing documentation from staff, but no observations from residents that overhead paging had been turned off.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 34 Number of homes with score confirmed: 13 Number of homes with score not confirmed: 21 Percent of score not confirmed: 62%

NEIGHBORHOODS/HOUSEHOLDS	
DEFINITION	The application states that the Definition/Minimum Requirements for the Neighborhoods/Households measure are: "Physical environment has been designed or re-designed to create neighborhoods/households. Minimum requirement(s) with supporting documentation: Each neighborhood/household has its own unique identity as established by the individuals residing and working in the neighborhood/household."
REVIEWER COMMENTS	Although the single requirement for this measure was that each neighborhood/household has its own unique identity, homes did not provide adequate documentation to validate this activity. The most common reason for homes not receiving points for this measure was that the reviewers did not see evidence that the "neighborhoods" were uniquely identified. It appeared that the homes had only named different hallways and didn't differentiate them in any other way. Homes that did substantiate this measure included photographs of unique neighborhood characteristics, e.g. murals, newsletters, activities, and parties, or minutes of neighborhood meetings documenting resident input. In other instances, reviewers were able to verify this measure by evaluating the totality of supporting documentation. For example, staffing schedules used to validate the Consistent Assignment measure often designated staff schedules by neighborhood.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 28 Number of homes with score confirmed: 9 Number of homes with score not confirmed: 19 Percent of score not confirmed: 68%

SUB CATEGORY: RELATIONSHIPS WITH STAFF, FAMILY, RESIDENT, AND COMMUNITY

Measures in this subcategory include 50% or 80% Consistent Assignments, Internal Community, External Community, Living Environment, and Volunteer Program. Reviewers assessed each application and supporting documentation to validate compliance with designated minimum requirements.

50% OR 80% CONSISTENT ASSIGNMENTS	
DEFINITION	The application states that the Definition/Minimum Requirement(s)/ Required Documentation for the 50% or 80% measure are: "50% of the time (using Advancing Excellence Methodology) staff is consistently assigned to the same resident(s)…OR… Minimum requirement(s) with supporting documentation: Staff assignment for a previous, consecutive 8 week period".
REVIEWER COMMENTS	Reviewers did see a few applications that used the Advancing Excellence format for calculating the consistency of staff assignment. Providers needed to include daily or monthly schedules for a previous, consecutive eight week period in order to back up a self-reported score for 50% or 80% consistent assignments. These schedules needed to include both staff name and assigned neighborhood/unit to establish that the same staff was assigned to the same residents. This performance measure was difficult to judge because of the inconsistency in the calculation of consistent assignment percentage. Some applications included the minimum requirement of eight weeks of consecutive staff schedules, but the provider did not calculate the percent of consistent assignments. More than one provider simply copied daily staff schedules and in the narrative claimed a consistent staff schedule, but did not present any analysis. In this case, reviewers looked for general consistency in staff names assigned daily to each neighborhood/unit, and then randomly selected a sample of staff members to test the percent of their time that they were consistently assigned. This attempt at validation introduced inconsistency in the scoring of applications. The major reason providers received a "No" response was for failing to include a full eight weeks of <u>consecutive</u> schedules. Others were denied the claim of 50% or 80%

50% OR 80% CONSISTENT ASSIGNMENTS	
	consistency in assignments because the sample of staff schedules was not representative of all staff, for example, providing information for only four staff members. Others provided schedules, but received a "No" because it wasn't clear that the staff was assigned to the same residents every day. Testimonials from residents/staff about the consistency of assignments were deemed to be insufficient supporting documentation by reviewers. Reviewers responded "Yes" to any applicant that provided eight weeks of daily schedules for a full range of staff and documented how their minimum required percentage was arrived at, assuming that they met the 50% or 80% thresholds.
PERFORMANCE MEASURE REVIEW STATISTICS	<u>50% Consistent Assignments</u> Number of homes with self-reported score: 7 Number of homes with score confirmed: 3 Number of homes with score not confirmed: 4 Percent of score not confirmed: 57% <u>80% Consistent Assignments</u> Number of homes with self-reported score: 43 Number of homes with score confirmed: 37 Number of homes with score not confirmed: 6 Percent of score not confirmed: 14%

INTERNAL COMMUNITY	
DEFINITION	The application states that the Definition/Minimum Requirement(s)/ Required Documentation for Internal Community are "Regular neighborhood community meetings or learning circles to promote a sense of community and spontaneous activities. Minimum requirement(s) with supporting documentation: Sample weekly meeting minutes and documentation of spontaneous activities."
REVIEWER COMMENTS	Monthly schedules with neighborhood meetings and learning circles were often included as supporting documentation, but a monthly schedule alone was insufficient. Spontaneous activities were difficult to document. Some applicants included spontaneous activity logs, pictures of spontaneous activities like computer use or board games, or a detailed narrative and anecdotal evidence. If no evidence of spontaneous activities was found in the Internal Community section of the application, reviewers looked at the remainder of the documentation that spontaneous activities occurred at the home, for example, pictures of tables with puzzles on them. The most common reason for homes not receiving points for this measure was if they did not provide adequate documentation of spontaneous activity or weekly meeting minutes.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 34 Number of homes with score confirmed: 29 Number of homes with score not confirmed: 6 Percent of score not confirmed: 18%

EXTERNAL COMMUNITY	
DEFINITION	The application states that the Definition/Minimum Requirement(s)/ Required Documentation for External Community are: "External community invited, informed and involved in the life of the home. Minimum requirement(s): Sample monthly documentation of a variety of external community participation in addition to the regularly scheduled activity programming groups."
REVIEWER COMMENTS	Reviewers looked for calendars with external activities, flyers that advertised external community participation, and/or pictures as acceptable supporting documentation. The documentation needed to prove that these types of activities and interactions with the external community were occurring monthly in addition to the regularly scheduled activities. If no evidence of external community involvement was found in the External Community section of the application, the remainder of the documentation was looked at to see if these events occurred.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 43 Number of homes with score confirmed: 41 Number of homes with score not confirmed: 2 Percent of score not confirmed: 5%

LIVING ENVIRONMENT	
DEFINITION	The application states that the Definition/Minimum Requirement(s)/ Required Documentation for Living Environment are: "Plants, pets, or children have been introduced to develop a living environment. Opportunity exists, as chosen by the resident and as much as possible, for connection with the world including but not limited to nature, gardens, animals, children, crafts, music, art and technology as indicated by residents' majority/individual preferences. Minimum requirement(s) with supporting documentation: Three opportunities as listed above."
REVIEWER COMMENTS	Pictures of resident interaction with children, animals, plants, etc. were the most common form of supporting documentation provided by applicants. Reviewers accepted monthly calendars of activities. If no documentation was found in the Living Environment section of the application, the remainder of the documentation was checked to see that these opportunities existed.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 46 Number of homes with score confirmed: 44 Number of homes with score not confirmed: 2 Percent of score not confirmed: 4%

VOLUNTEER PROGRAM	
DEFINITION	The application states that the Definition/Minimum Requirement(s)/ Required Documentation for Volunteer Program are: "Formalized volunteer program exists to allow for the provision of resident-specific activities and visits. Minimum requirement(s): Written policy and documentation of hours of visits."
REVIEWER COMMENTS	Reviewers looked for both the written policies and documentation of hours in order to award a "Yes" response. Simply stating that a volunteer program was in place, submitting a blank volunteer log-in sheet, or providing no evidence of volunteer hours of visits resulted in a "No" response.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 44 Number of homes with score confirmed: 38 Number of homes with score not confirmed: 6 Percent of score not confirmed: 14%

SUBCATEGORY: STAFF EMPOWERMENT

Measures in this subcategory include Care Planning, Career Ladders/Career Paths, Person-Directed Care, and New Staff Program. Reviewers assessed each application and supporting documentation to validate compliance with designated minimum requirements.

CARE PLANNING	
DEFINITION	The application states that the definition/Minimum Requirement(s)/ Required Documentation for Care Planning are: "Certified Nursing Assistant(s) is involved in care planning and care conferences. Minimum requirement(s) with supporting documentation: Sample initial and quarterly documentation of attendance and participation."
REVIEWER COMMENTS	Review of the documentation showed two common deficiencies in the supporting documentation. First, applicants did not submit both initial and quarterly care plans. The most typical situation was that only quarterly documentation was provided even though the requirement required both. Second, nursing homes submitted proof of care conferences with signatures of direct care staff in attendance; however it was not clear whether the direct care staff in attendance included CNAs. In these cases, other sections of the supporting documentation were cross referenced to substantiate the points.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 35 Number of homes with score confirmed: 27 Number of homes with score not confirmed: 8 Percent of score not confirmed: 23%

CAREER PLANS/CAREERS LADDER	
DEFINITION	The application states that the Definition/Minimum Requirement(s)/ Required Documentation for Career Plans/Careers Ladder are: "Home has systems in place to promote and support staff advancement. Minimum requirement(s) with supporting documentation: Written program."
REVIEWER COMMENTS	In this review, acceptable supporting documentation included nursing home policy and procedures for staff advancement, tuition reimbursement, promoting internally and posting open positions. In some cases, testimonials were included of employees who had advanced at the nursing home; however this was not enough to substantiate their score. The most common reason for a home not receiving points for this measure was that they did not include a written policy in there supporting documentation.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 46 Number of homes with score confirmed: 38 Number of homes with score not confirmed: 8 Percent of score not confirmed: 17%

PERSON-DIRECTED CARE	
DEFINITION	The application states that the Definition/Minimum Requirements for the Person-Directed Care measure are: "Home supports and has systems in place to provide formal training on person-directed care to all staff. Minimum requirement(s): Submit annual training objectives, agenda and lists of attendees. If you are an Eden Registered Home in good standing as verified by the Eden Alternative organization, you automatically meet this requirement."
REVIEWER COMMENTS	Reviewers found that some homes did not provide sufficient validation for this requirement. In these cases, nursing homes claimed that person-directed training occurred, but only provided evidence of clinical or organizational training and not annual objectives, an agenda, and list of attendees for training in person-directed care. In other instances, training was limited to less than an hour in an agenda for a P4P in-service training, and no annual objectives or plans for future person-directed training were included.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 28 Number of homes with score confirmed: 20 Number of homes with score not confirmed: 10 Percent of score not confirmed: 36%

NEW STAFF PROGRAM	
DEFINITION	The application states that the Definition/Minimum Requirement(s)/ Required Documentation for New Staff Program are: "Staff members are involved in recruitment, orientation and mentoring of new staff. Minimum requirement(s) with supporting documentation: Written program.
REVIEWER COMMENTS	If nursing homes were missing one requirement of the three (recruitment, orientation, and mentoring of new staff), their self-reported score was not substantiated. In this review, acceptable supporting documentation included policies and procedures for orientation, recruitment, mentoring of new staff, position descriptions that contained mentoring duties and forms provided new staff members identifying their mentor.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 40 Number of homes with score confirmed: 26 Number of homes with score not confirmed: 14 Percent of score not confirmed: 35%

SUBCATEGORY: QUALITY OF CARE

Measures in this subcategory include Continuing Education, Quality Program Participation, and three Nationally Reported Quality Measures: High Risk Pressure Ulcers, Chronic Care Pain Score, and Physical Restraints. Reviewers assessed each application and supporting documentation to validate compliance with designated minimum requirements.

CONTINUING EDUCATION	
DEFINITION	Homes could receive 2, 5 or 6 points for their continuing education programs. Two points could be attained for documenting 12 hours of average continuing education, 5 points for 14 hours of average continuing education and 6 points for 16 hours. The application states that the Definition/Minimum Requirement(s)/Required Documentation for the +2 Continuing Education measure are "Documentation 12 hours on average caregiver/ staff person (Social Services/Activities/RN's/LPN's/C.N.A's) Continuing Education per year…OR… **Minimum requirement(s) with supporting documentation:** Full list of staff and training hours". The documentation requirements are the same for the +4 Continuing Education measure and the +6 Continuing Education measures except that 14 and 16 average hours are required respectively.
REVIEWER COMMENTS	As with the consistent staffing measure, this was a difficult set of measures to evaluate because of the disparate documentation submitted. The best documentation was summary data showing how the average number of hours was computed supplemented by sign-in sheets for specific classes showing staff attendance compared to the number of staff at the home. Problems in validating the information provided arose because homes did not state how the average hours per employee was calculated, did not show total staff at the home, or when calculations of reviewers could not substantiate calculations of the home. Some homes presented class lists of persons who attended education, but had no sign-in signatures. Homes also provided a wide range of documentation for what they believed was continuing education, including documentation of routine staff meetings. Reviewers accepted classes put on by providers to educate their staff,

CONTINUING EDUCATION		
	but were instructed not to accept what appeared to be routine staff meetings as continuing education.	
PERFORMANCE MEASURE REVIEW STATISTICS	<u>+2 Continuing Education</u> Number of homes with self-reported score: Number of homes with score confirmed: Number of homes with score not confirmed: Percent of score not confirmed: <u>+4 Continuing Education</u> Number of homes with self-reported score: Number of homes with score confirmed: Number of homes with score not confirmed: Percent of score not confirmed: <u>+6 Continuing Education</u> Number of homes with self-reported score: Number of homes with score confirmed: Number of homes with score not confirmed: Percent of score not confirmed:	 12 4 8 67% 8 6 4 50% 25 20 5 20%

QUALITY PROGRAM PARTICIPATION	
DEFINITION	The application states that the Definition/Minimum Requirement(s)/Required Documentation for the Quality Program Participation is "Participation in Advancing Excellence in America's Nursing Homes or a successor quality program **Minimum requirement(s) with supporting documentation:** List of goals that the home is participating in."
REVIEWER COMMENTS	The most common reason for homes not receiving points for this performance measure was that they did not provide sufficient supporting documentation showing participation in Advancing Excellence in America's Nursing Homes or similar program.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 39 Number of homes with score confirmed: 35 Number of homes with score not confirmed: 5 Percent of score not confirmed: 13%

HIGH RISK PRESSURE ULCERS	
DEFINITION	The measure called High Risk Pressure Ulcer scores is one of three nationally reported quality measures. These are all scored in term of percentages of residents. The application states that the Definition/Minimum Requirement(s)/Required Documentation for the High Risk Pressure Ulcer score is a score of 5.5 percent of residents or less to obtain nine points, and a score of greater than 5.5 percent but less than or equal to 7.2 percent of residents is worth 2 points.
REVIEWER COMMENTS	This is an objective national measure and most homes simply provided documentation from the national websites. Scores of all nursing homes are maintained by the Centers for Medicare and Medicaid Services (CMS) and placed on their website. This site can be used to search for particular homes and see a display of the percentage of residents on different quality measures.
PERFORMANCE MEASURE REVIEW STATISTICS	<u>Score of 5.5 or less</u> Number of homes with self-reported score: 18 Number of homes with score confirmed: 13 Number of homes with score not confirmed: 5 Percent of score not confirmed: 28% <u>Score greater than 5.5 but less than or equal to 7.2</u> Number of homes with self-reported score: 11 Number of homes with score confirmed: 10 Number of homes with score not confirmed: 2 Percent of score not confirmed: 18%

CHRONIC CARE PAIN SCORE	
DEFINITION	The measure called Chronic Care Pain Score is one of three nationally reported quality measures. These are all scored in term of percentages of residents. The application states that the Definition/Minimum Requirement(s)/Required Documentation for the Chronic Care Pain Score is a score of 2.0 percent of residents or less to obtain nine points, and a score of greater than 2.0 percent but less than or equal to 2.7 percent of residents is worth 2 points
REVIEWER COMMENTS	This is an objective national measure and most homes simply provided documentation from the national websites. Scores of all nursing homes are maintained by the Centers for Medicare and Medicaid Services (CMS) and placed on their website. This site can be used to search for particular homes and see a display of the percentage of residents on different quality measures.
PERFORMANCE MEASURE REVIEW STATISTICS	<u>Score of 2.0 or less</u> Number of homes with self-reported score: 17 Number of homes with score confirmed: 17 Number of homes with score not confirmed: 1 Percent of score not confirmed: 6% <u>Score greater than 2.0 but less than or equal to 2.7</u> Number of homes with self-reported score: 4 Number of homes with score confirmed: 2 Number of homes with score not confirmed: 2 Percent of score not confirmed: 50%

PHYSICAL RESTRAINTS	
DEFINITION	The measure called Physical Restraints is one of three nationally reported quality measures. These are all scored in term of percentages of residents. The application states that the Definition/Minimum Requirement(s)/Required Documentation for the Physical Restraints Score is a score of 1.0 percent of residents or less to obtain nine points, and a score of greater than 1.0 percent but less than or equal to 2 percent of residents is worth 2 points.
REVIEWER COMMENTS	This is an objective national measure and most homes simply provided documentation from the national websites. Scores of all nursing homes are maintained by the Centers for Medicare and Medicaid Services (CMS) and placed on their website. This site can be used to search for particular homes and see a display of the percentage of residents on different quality measures.
PERFORMANCE MEASURE REVIEW STATISTICS	<u>Score of 1.0 or less</u> Number of homes with self-reported score: 20 Number of homes with score confirmed: 19 Number of homes with score not confirmed: 2 Percent of score not confirmed: 10% <u>Score greater than 1.0 but less than or equal to 2.0</u> Number of homes with self-reported score: 5 Number of homes with score confirmed: 3 Number of homes with score not confirmed: 3 Percent of score not confirmed: 60%

SUBCATEGORY: HOME MANAGEMENT

Measures in this subcategory include 10% and 5% above statewide average Medicaid occupancy. Reviewers assessed each application and supporting documentation to validate compliance with designated minimum requirements.

10% OR 5% MEDICAID	
DEFINITION	The P4P measures reward more points to homes that take care of a higher average percentage of Medicaid residents. The application states that the Definition/Minimum Requirement(s)/Required Documentation for the 10% Medicaid measure are "Medicaid occupancy 10% or more above statewide average. **Minimum requirement(s) with supporting documentation:** Copy of Certification Page of Med 13" A home that had a Medicaid occupancy rate 10% or more above the statewide average could attain 5 points on this measure. A home that had a Medicaid occupancy rate 5%, but less than 10%, above the statewide average could attain 2 points.
REVIEWER COMMENTS	The application instructions contain no definition of how the statewide Medicaid occupancy percentage shall be calculated. The latest data from the state is for cost reports that were submitted in 2007. The statewide Medicaid occupancy rate based on annualized 2007 data is 61.98%. Instead of using this 2007 figure, reviewers choose to use OSCAR data for December 2008. The OSCAR data is a federal data collection effort that collects data uniformly on nursing homes. The OSCAR data is shown in the Appendices. In the snapshot data for December 2008, Colorado is shown as having a statewide Medicaid percentage rate of 58.3%. Reviewers choose to use the December 2008 data because it was a standardized, uniformly collected count that was done closer in time to when the applications were submitted. The most common reason for a home not receiving points for this measure was that their Medicaid occupancy rate was below the statewide average. Homes were also denied points for the 10% category but given points in the 5% measure when their Medicaid occupancy was not greater than 10% but still greater than 5%.

10% OR 5% MEDICAID		
PERFORMANCE MEASURE REVIEW STATISTICS	10% Medicaid	
	Number of homes with self-reported score:	24
	Number of homes with score confirmed:	16
	Number of homes with score not confirmed:	11
	Percent of score not confirmed:	46%
	5% Medicaid	
	Number of homes with self-reported score:	6
	Number of homes with score confirmed:	2
	Number of homes with score not confirmed:	5
	Percent of score not confirmed:	83%

SUBCATEGORY: STAFF STABILITY

Measures in this subcategory include Staff Retention Rate, Staff Retention Improvement, DON Retention, NHA Retention, and Employee Satisfaction Survey. Reviewers assessed each application and supporting documentation to validate compliance with designated minimum requirements.

STAFF RETENTION RATE	
DEFINITION	The application states that the Definition/Minimum Requirement(s)/ Required Documentation for the Staff retention rate measure is: Staff retention rate (excluding NHA and DON) at or above 55%. Minimum supporting documentation for staff stability subcategory: Staff name, position and hire date or home developed retention report.
REVIEWER COMMENTS	The staff retention rate was an especially problematic performance measure to calculate and score. Different methods were used by homes to calculate the retention rate. These findings showed that the definition of retention rate and the methodology used to calculate it varied greatly. Below is a description of different methodologies used in calculating staff retention rates: **Remaining / Total** The most common methodology was a calculation of the number of employees that began the year and remained employed through the end of the year divided by the number of employees that began the year. This method seemed to be the most accurate and straightforward. **Average Monthly** The average monthly methodology was a calculation of the total number of terminations divided by the monthly average number of employees. The output of that calculation is the turnover rate. The retention rate is then calculated by subtracting the turnover rate from 1. This method allows for potentially wide variations in the outcome of the retention rate. The application provided no definition as to how a staff retention rate was to be calculated. The reviewers accepted reasonable methodologies and confirmed percentages through their own calculations of the supporting documentation.

STAFF RETENTION RATE	
	Consequences of Using Different Methodologies The following examples illustrate how slight reasonable sounding differences in the applications of these two most common methodologies can result in different percentage calculations. Using Average Monthly Methodology 1. A home starts the year with 100 employees. a. During the year, 50 employees discontinue working for the home for various reasons. b. The home backfills all 50 positions, and hires additional employees giving them a monthly average of 150 employees. c. The turnover rate in this methodology would be 50 / 150 = .333 = 33.3% d. The retention rate is therefore 1 - .333 = .667 = 66.7% e. This home would be judged to have met the 55% retention rate threshold and would receive the 4 points available. Using Remaining / Total Methodology 2. The same home starts the year with 100 employees a. During the year, 50 employees discontinue working for the home for various reasons. b. The home backfills all 50 positions, and hires additional employees giving them a monthly average of 150 employees. c. The retention rate in this case would simply be the number of employees that began the year that are still on staff, (50) divided by the number of employees that began the year, (100), or 50 / 100 = .50 = 50% d. This home would be judged to have missed the 55% retention rate threshold and would not receive the 4 points available. The above examples illustrate the bias in the different retention rate calculation methodologies. In this example, the home receives or fails to receive points entirely based

STAFF RETENTION RATE		
	on which method they choose. These findings are not surprising given national studies showing the absence of uniformity in calculations of nursing home staff turnover.[7]	
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: Number of homes with score confirmed: Number of homes with score not confirmed: Percent of score not confirmed:	39 33 6 15%

[7] Castle, N. (2006), *Measuring Staff Turnover in Nursing Homes*, Gerontologist Vol. 46 pp. 210-219 Retrieved on June 27, 2009 from http://gerontologist.gerontologyjournals.org/cgi/content/abstract/46/2/210

STAFF RETENTION IMPROVEMENT	
DEFINITION	The application states that the Definition/Minimum Requirement(s)/ Required Documentation for Staff Retention Improvement are: "A 5% improvement on staff retention rate per year for homes with less than 75% retention rate. Homes with 75% retention rate or greater must remain consistent from year to year." Minimum supporting documentation for staff stability subcategory: Staff name, position and hire date or home developed retention report."
REVIEWER COMMENTS	Nine homes claimed for both measures, but this was an "either/or" provision, and therefore points could not be awarded for both measures. In cases like this, points were awarded for the measure that had the most adequate supporting documentation. In most cases the documentation provided did not adequately support the homes' claim of a 5% improvement; it simply stated the retention rate for one year, but did not give the rate for the previous year.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 21 Number of homes with score confirmed: 7 Number of homes with score not confirmed: 14 Percent of score not confirmed: 67%

DON RETENTION	
DEFINITION	The application states that the Definition/Minimum Requirement(s)/ Required Documentation for Director of Nursing Improvement are: "DON Retention of three years or more. Minimum supporting documentation for staff stability subcategory: Staff name, position and hire date or home developed retention report."
REVIEWER COMMENTS	This performance measure was straight forward. Points were given to homes that provided the name, and hire date of the DON. Some homes provided excellent supporting documentation including hire dates and time cards dating back at least three years. Reviewers accepted statements from homes stating the date of hire of the DON. One home that applied for this measure did not receive points because the DON had not been at that position in the home for the required three years.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 16 Number of homes with score confirmed: 15 Number of homes with score not confirmed: 1 Percent of score not confirmed: 6%

NHA RETENTION	
DEFINITION	The application states that the Definition/Minimum Requirement(s)/ Required Documentation for NHA Retention are: "NHA retention rate of three years or more. Minimum supporting documentation for staff stability subcategory: Staff name, position and hire date or home developed retention report."
REVIEWER COMMENTS	This performance measure was straight forward. Points were given to homes that provided the name, and hire date of the NHA. Some homes provided excellent supporting documentation including hire dates and time cards dating back at least three years. Reviewers accepted statements from homes stating the date of hire of the NHA. One home that claimed for this measure did not receive points because the NHA has not been in the position for the required three years.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 22 Number of homes with score confirmed: 21 Number of homes with score not confirmed: 1 Percent of score not confirmed: 5%

EMPLOYEE SATISFACTION SURVEY	
DEFINITION	The application states that the Definition/Minimum Requirement(s)/ Required Documentation for Employee Satisfaction Survey are: "Externally developed, recognized, and standardized employee satisfaction survey conducted on an annual basis, with at least 35% response rate total. Minimum supporting documentation for staff stability subcategory: Staff name, position and hire date or home developed retention report."
REVIEWER COMMENTS	The employee satisfaction survey performance measure did not pose difficulties in reporting or scoring. Most providers who claimed for this measure provided sufficient supporting documentation with their claim. My Innerview and Associates Satisfaction Survey were two programs/companies that homes used to prove that the survey was externally developed. Homes did not receive points for this measure if they did not provide supporting documentation that verified that a survey was done, that a survey was externally developed, or that a sufficient number of employees participated in the survey.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 41 Number of homes with score confirmed: 36 Number of homes with score not confirmed: 7 Percent of score not confirmed: 17%

D. 2010 Scores and Discussion

Summary Chart Showing Scores of Homes

The following table provides a summary of the self-reported and reviewers' scores by home.

Provider Number	Facility Name	Points Available	Self-Reported Score	Reviewers Score
63934272	Allison CC	100	76	64
96339349	Alpine Living Center	100	80	50
77105753	Amberwood Court	100	81	72
03604250	Applewood Living Center	100	61	51
83603041	Bear Creek Care & Rehab	100	77	69
11434317	Belmont Lodge HCC	100	54	44
30576016	Berkley Manor CC	100	70	68
05651567	Briarwood	100	63	22
71787267	Brookshire House	100	74	74
37605216	Broomfield Skilled Nursing & Rehab	100	63	49
55754244	Cambridge CC	100	71	51
47333723	Camellia HCC	100	71	68
05652631	Canon Lodge	100	69	67
79475744	Castle Rock CC	100	100	90
35057335	Cedars Health Care Center	100	57	30
54454735	Cedarwood HCC	100	48	50
00565034	Centura Health -Medalion HC	100	57	41
56375867	Cherry Creek Nursing Centr	100	51	44
75951274	Cheyenne Mountain Care & Rehab	100	52	46
42988268	Christopher House	100	73	54
05650338	Clear Creek Care Center	100	74	69
05654793	Colonial Columns NC	100	64	55
05652607	Colorow Care Center	100	76	76
05650833	Columbine West Health & Rehab	100	52	52
05654223	CSV - Bruce McCandless	100	70	81
82159815	CSV - Fitzimons	100	74	64
05653274	CSV - Homelake	100	91	81
05652748	CSV - Rifle	100	64	32
73422070	Denver North CC	100	82	82
05652250	Devonshire Acres	100	68	43
05654702	Doak Walker	100	78	76
13086863	Eagle Ridge of Grand Junction	100	79	66
05653365	Eben Ezer Lutheran Care Ctr	100	61	45
05652961	Elms Haven Care Center	100	69	63
05650080	Exempla Colorado Lutheran Home	100	81	72
05653423	Fairacres Manor	100	68	68
00122777	Forest Street Compassionate CC	100	61	36

Provider Number	Facility Name	Points Available	Self-Reported Score	Reviewers Score
99000792	Four Corners HCC	100	65	67
34432850	Ft. Collins HC Center	100	57	34
50709348	Garden of the Gods CC	100	47	25
05655410	Glen Ayr Health Center	100	42	7
05651260	Good Sam - Ft. Collins	100	52	49
05652714	Hallmark Nursing Center	100	65	10
42402069	Harmony Pointe NC	100	93	84
15526755	Highline Rehab	100	76	76
05653571	Hildebrand Care Center	100	76	61
05651245	Holly Heights Nursing	100	89	87
05655147	Holly Nursing CC	100	76	76
05652672	Horizon Heights	100	77	69
77678737	Jewell Care Center	100	61	42
11651016	Kenton Manor	100	58	53
05652334	Larchwood Inns	100	72	51
05653290	Lemay Avenue Health & Rehab	100	59	52
75482282	Life Care Center of Evergreen	100	71	60
05653001	Life Care Center of Greeley	100	79	57
05651377	Life Care Center of Longmont	100	67	30
05650742	Life Care Center Pueblo	100	64	54
05652722	Life Care of Westminster	100	76	52
58301747	Mantey Heights Care & Rehab C	100	70	60
46279865	Mesa Manor Rehab CC	100	50	45
27580547	Mountain View CC	100	71	55
85608742	Namaste Alzheimer Center	100	72	49
05651294	North Shore Health & Rehab	100	67	60
26554739	North Star Community	100	88	83
16433548	Paonia Care & Rehab	100	57	47
54603528	Parkview Care Center	100	79	79
76173712	Pearl Street Health & Rehab	100	52	38
41978765	Pikes Peak Care & Rehab	100	86	59
05652839	Pine Ridge	100	58	63
11271868	Pioneer Health Care	100	50	45
60052279	Pueblo Care & Rehab Ctr	100	42	41
00685046	Regent Park Nursing & Rehab	100	45	17
73787868	Rehab & Nursing Ctr of the Rockies	100	99	0
05652508	Rowan Community	100	84	84
05652953	Sable Health Care Center	100	49	34
19005296	San Juan Living Center	100	79	62
05652615	San Luis Care Center	100	88	72
05651534	Sandalwood Manor	100	62	40
16876334	Sierra HC Community	100	88	88
96731591	Spring Creek HC	100	58	50

Provider Number	Facility Name	Points Available	Self-Reported Score	Reviewers Score
05656269	St. Paul HCC	100	92	47
41328582	Sunset Manor	100	56	39
05652789	The Peaks Care Center	100	62	55
05651880	The Valley Inn	100	65	23
05650114	University Park CC	100	91	19
08858721	Uptown Health Care Center	100	88	73
05651468	Valley View HCC	100	90	90
65533763	Valley View Villa	100	68	46
05655709	Villa Manor Care Center	100	83	76
89157231	Vista Grande Inn	100	64	55
69607532	Walsenburg Care Center	100	34	13
05656343	Walsh Healthcare Center	100	63	56
05652581	Washington County Nursing Home	100	62	50
05652664	Westwind Village	100	81	69
80636217	Wheatridge Manor NH	100	68	64
71454241	Woodridge Park Nrsing & Rehab	100	48	46
70601577	Woodridge Terrace Nrsg & Rehab	100	42	33
71956000	Yuma Life Care Center	100	70	66

Changes to Self-Reported Scores

The following table provides a summary of the number of homes with self-reported, confirmed, and not confirmed scores for each measure.

Performance Measure Description	# of Nursing Homes with Self-Reported Score	# of Nursing Homes with Score Confirmed*	# of Nursing Homes with Score Not Confirmed	% of Score Not Confirmed
Enhanced Dining	90	65	25	28%
Flexible and Enhanced Bathing	78	58	20	26%
Daily Schedules	79	59	21	27%
End Of Life Program	85	66	20	24%
Resident Rooms	96	88	9	9%
Public and Outdoor Space	86	75	11	13%
Overhead Paging	79	64	16	20%
Neighborhoods/Households	61	35	26	43%
50% Consistent Assignments	15	13	2	13%
80% Consistent Assignments	80	70	10	13%
Internal Community	62	46	16	26%
External Community	91	85	8	9%
Living Environment	91	76	15	16%
Volunteer Program	90	82	9	10%
Care Planning	61	52	10	16%

Performance Measure Description	# of Nursing Homes with Self-Reported Score	# of Nursing Homes with Score Confirmed*	# of Nursing Homes with Score Not Confirmed	% of Score Not Confirmed
Career Ladders/Career Paths	94	79	15	16%
Person-Directed Care	62	39	23	37%
New Staff Program	79	55	24	30%
+2 Continuing Education	11	4	8	73%
+4 Continuing Education	10	7	3	30%
+6 Continuing Education	64	46	18	28%
Quality Program Participation	87	80	9	10%
Falls (13.1 or less)	38	36	4	11%
Falls (>13.1 but <=15.2)	15	12	3	20%
High-Risk Pressure Ulcers (5.1 or less)	29	22	8	28%
High-Risk Pressure Ulcers (>5.1 but <=7.1)	18	16	3	17%
Chronic Care Pain Score (1.2 or less)	25	21	6	24%
Chronic Care Pain Score (>1.2 but <=2.3)	13	13	3	23%
Physical Restraints (0)	29	24	5	17%
Physical Restraints (1.7 or less)	21	16	6	29%
UTI (5.3 or less)	31	27	4	13%
UTI (>5.3 but <=6.7)	9	5	4	44%
Staff Influenza Immunization	78	71	7	9%
10% Medicaid	61	26	36	59%
5% Medicaid	16	14	12	75%
Staff Retention Rate	89	86	5	6%
Staff Retention Improvement	8	2	6	75%
DON Retention	35	27	8	23%
NHA Retention	45	41	5	11%
Employee Satisfaction Survey	73	62	11	15%

Discussion of Each Performance Measure

The following section includes a detailed discussion of each performance measure included in the FY 2010 application. Where applicable, changes from the FY 2009 application to the FY 2010 application have been noted. Additionally, any recommendations for the enhancement of a performance measure have been included with the description of that measure.

SUB CATEGORY: RESIDENT DIRECTED CARE

Measures in this subcategory include Enhanced Dining, Flexible and Enhanced Bathing, Daily Schedules, and End of Life Program. Reviewers assessed each application and supporting documentation to validate compliance with designated minimum requirements.

ENHANCED DINING	
DEFINITION	Menus that include numerous options, menus developed with resident input. The dining atmosphere reflects the community. Residents have access to food 24 hours/day, and staffs are empowered to provide food when resident desires it. Dining atmosphere is defined as the table settings, table cloths, lighting, music, servers and dining style (restaurant, salad bar, menu, and buffet).
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	Menu options must be more than the entree and alternate selection. These options should include input from a resident/family advisory group such as resident council or a dining advisory committee. The residents have input into the appearance of the dining atmosphere. Residents have access to food at any time and staffs are empowered to provide it. Supporting documentation can be resident signed testimonials, resident council minutes, minutes from another advisory group or a narrative and photographs of changes in the dining atmosphere.
APPLICATION CHANGES IN 2010	The 2010 application added clarification to both the definition and supporting documentation requirements. A definition of "dining atmosphere" was added and examples of supporting documentation were added. The number of points associated with this measure increased from 2 in 2009 to 3 in 2010.
REVIEWER COMMENTS	This measure has four distinct requirements. Homes that did not receive credit typically did not provide documentation that addressed all four requirements. The most frequent reason that points were not assigned on this measure was that the requirement of resident input was not documented. Nineteen of the twenty five homes that did not receive points for this measure had weak or non-existent documentation for this requirement. Onsite home visits confirmed that changes to the 2010 P4P application that further define the dining environment and provide examples of supporting documentation (including a narrative, resident testimonials and photographs) provide a more representative picture of the enhanced dining experience in the home.

ENHANCED DINING	
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 90 Number of homes with score confirmed: 65 Number of homes with score not confirmed: 25 Percent of score not confirmed: 28%
RECOMMENDATIONS	There are no recommendations for this performance measure based on the 2010 application.

FLEXIBLE AND ENHANCED BATHING	
DEFINITION	Bath schedules are flexible to meet the residents' desires and choices. Options for bathing are provided, and the physical bathing environment is enhanced and provides dignity for the resident.
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	Residents are interviewed about choices, regarding time, choice of caregiver, and type of bath. "Bathing Without A Battle" education is completed. Bathing atmosphere includes home décor. Documentation includes photographs of the decor, receipts associated with the enhancements, in-service logs or certificates of education on enhanced bathing experiences for residents including choice in type of bath, schedule and caregiver. Use and documentation of "Bathing Without a Battle" video is required.
APPLICATION CHANGES IN 2010	The definition was changed in 2010 to include the concept that the bathing experience provides dignity for the resident. The documentation requirements were amplified and the requirement that the "Bathing Without a Battle" video is required was emphasized. The number of points associated with this measure decreased from 5 in 2009 to 3 in 2010.
REVIEWER COMMENTS	The most frequent reason that a home did not receive credit was for not providing documentation as to the completion of "Bathing Without a Battle" training. Twelve of the twenty homes that did not receive credit for the flexible and enhanced bathing measure did not have documentation regarding "Bathing Without a Battle."
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 78 Number of homes with score confirmed: 58 Number of homes with score not confirmed: 20 Percent of score not confirmed: 26%
RECOMMENDATIONS	The clarifications regarding types of documentation for the measure improved the number of homes confirmed in 2010. However, documentation of use of "Bathing Without a Battle" continues to be a reason for denial. Although all homes should have access to the video through CMS, the Department might consider providing additional information on "Bathing Without a Battle" in the application or more detailed expectations of proper documentation such as orientation materials or training logs.

DAILY SCHEDULES	
DEFINITION	Residents are assisted in determining their own daily schedules and participate in developing their care plans.
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	Residents are interviewed about choices regarding their routine, respecting daily choices and changes as they occur. Documentation for the application should include detailed narratives of the process used to identify and include resident choices in the daily routine. Documentation must include 4 resident testimonials that prove implementation of the resident's choices, preferences and daily schedules. Residents if able, families if available, and/or direct care staffs participate in developing an individual's care plan that document the resident choices with resident or family signatures on the care plan. The same 4 resident care plans and testimonials must be submitted with the application.
APPLICATION CHANGES IN 2010	The definition was unchanged, but the documentation changed in two ways. First, more examples of what constitutes documentation were provided and second, new requirements were added. The new requirements include four resident testimonials to document that resident preferences were taken into account. Also the care plans of the same residents had to be submitted. The number of points associated with this measure increased from 2 in 2009 to 3 in 2010.
REVIEWER COMMENTS	The most frequent reason that points were not assigned for this measure was that four resident testimonials and/or their corresponding care plans were not submitted. Based on resident interviews, the more rigorous documentation requirements are appropriate to assure that all aspects of resident preference for the daily schedule are observed.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 79 Number of homes with score confirmed: 59 Number of homes with score not confirmed: 21 Percent of score not confirmed: 27%
RECOMMENDATIONS	The more rigorous expectations for documentation in the 2010 application may have resulted in more homes with unconfirmed implementation of this measure. However, the reviewers found that use of 4 resident testimonials and care plans was not unreasonable for a home. A potential

DAILY SCHEDULES	
	recommendation for a revised P4P application is to bold "same resident care plans and testimonials" in the application to further highlight this requirement.

END OF LIFE PROGRAM	
DEFINITION	The home has developed a program advocating for residents' participation in their own end-of-life care, providing regular opportunities for re-evaluation of these wishes, and respecting these wishes when end of life is imminent.
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	Advance Directives are reviewed quarterly and as needed. The application includes documentation with signatures indicating the quarterly review of the advance directives on the care plan or on separate forms. A program includes: an individual's preferences, wishes, expectations, a plan for honoring those that have died, and a process to inform the community of such death.
APPLICATION CHANGES IN 2010	The only difference from 2009 to 2010 is the specification that the documentation must include signatures on the care plan, or separate form, showing that advance directives are reviewed.
REVIEWER COMMENTS	There were two documentation requirements. First, that advance directives be reviewed and second that the home has a program that structures end of life experiences. Homes that did not get points assigned to them usually missed one of these requirements. Reviewers did find an issue of homes using different care planning forms that do not identify whether the care plan review is done quarterly or monthly or less frequently.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 85 Number of homes with score confirmed: 66 Number of homes with score not confirmed: 20 Percent of score not confirmed: 24%
RECOMMENDATIONS	To clarify the measure for providers, a revised P4P application may request providers to clearly identify that Advance Directives are done quarterly or more often via dates on the form, and/or ask homes to choose a minimum threshold of residents and supply reviews for a year to demonstrate quarterly compliance.

SUB CATEGORY: HOME ENVIRONMENT

Measures in this subcategory include Residents Rooms, Public and Outdoor Space, Overhead Paging and Neighborhoods/Households. Reviewers assessed each application and supporting documentation to validate compliance with designated minimum requirements.

RESIDENT ROOMS	
DEFINITION	Resident rooms have been redesigned/rearranged to enhance privacy, promote personalization and individual needs.
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	Residents/families are encouraged to bring own home and room décor. The home will assist in personalization of an individual's room with such things as pictures, clocks, lamps, room color, etc. Documentation to support this requirement should include a detailed narrative of the process used to individualize resident rooms and photographs of resident rooms with their own belongings and/or logs of belongings that residents moved from their homes.
APPLICATION CHANGES IN 2010	The definition of the resident room measure remained the same, but documentation examples were expanded upon so it was easier to understand what could be provided as documentation.
REVIEWER COMMENTS	The requirements open with the sentence that "Resident and families are encouraged to bring their own home and room décor." The word "encouraged" presented occasional interpretation difficulties in the context of reading the home's policy. For example, when does a reasonable policy of limiting what a resident can bring have the appearance of restricting or limiting resident choice in décor? The most common reasons for not assigning points were that documentation of home assistance to residents was weak and some visual documentation was not persuasive. That said, over 90%, received credit for this measure.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 96 Number of homes with score confirmed: 88 Number of homes with score not confirmed: 9 Percent of score not confirmed: 9%
RECOMMENDATIONS	The problem with visual documentation is that the pictures that are presented are not randomly selected and may represent the very best in the home rather than the average.

RESIDENT ROOMS	
	The state might consider suggesting that all rooms in a unit or part of a home be selected or a minimum number of rooms be selected to ensure a more representative selection.

PUBLIC AND OUTDOOR SPACE	
DEFINITION	Available public and outdoor spaces are designed for stimulation, ease of access, and activity.
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	Public spaces that allow for residents to remain as independent as possible such as laundry and cooking pantry areas. These spaces should be comfortable and accommodating without clutter and free of visible medical equipment storage. Documentation should include a narrative of the process used for the de-institutionalization of public and outdoor spaces. Documentation should include photographs of public spaces, indoor and outdoor, that provide the opportunity for residents to remain independent or enjoy normalcy such as personal laundry, cooking/pantry areas, small areas for socialization. Also provide photographs to support ease of access to outdoor areas that include areas of socialization, gardening, or exercising. Documentation of uncluttered areas and lack of visible medical equipment should include photos of hallways, nurse's stations/areas and common areas.
APPLICATION CHANGES IN 2010	The requirements section was substantially expanded to provide examples of what constituted documentation.
REVIEWER COMMENTS	Homes that did not receive credit had photographs that were not persuasive; they did not show much of the home or what was in the pictures did not appear to document the measure. Interviews with providers during site visits illustrated the importance of this measure to represent the overall environment for residents and staff. Descriptions of the public and outdoor space noted that staff also enjoys these spaces or included examples of staff and residents enjoying activities (picnics, barbecues, gardening).
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 86 Number of homes with score confirmed: 75 Number of homes with score not confirmed: 11 Percent of score not confirmed: 13%
RECOMMENDATIONS	The requirements appear to provide ample illustrative examples of what should be shown in the photographs. To clarify the measure and assist in application review, a revised P4P application might ask providers to include captions with the photographs identifying the public and outdoor spaces and examples of the use of the space by residents and staff.

OVERHEAD PAGING	
DEFINITION	Overhead paging has been turned off and used only in emergencies.
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	Overhead paging is limited to emergency use only. Needs to be observed or confirmed by the residents and staff. Documentation must include testimonials of at least two non-management employees and two residents or family members that overhead paging is limited only to emergency use. Emergency use is a resident or staff member requiring immediate assistance or in case of fire or disaster- real or drills.
APPLICATION CHANGES IN 2010	The definition of the overhead paging measure was retained but the requirements of its documentation were expanded to include "testimonials" by two staff and two residents that overhead paging was used only in emergency situations. A definition of "emergency use" was also added to the documentation requirements.
REVIEWER COMMENTS	Homes that did not receive credit for this score usually had testimonies or policies that clearly indicated that the overhead paging system was used for non-emergencies. One home visited by PCG had repeated non-emergency use on the day of the visit, even though its application said the paging was used for only emergency uses. Interviews with providers during onsite visits indicate that discontinuing overhead paging has significantly enhanced operations. Through alternative communication, management is better able to audit the answering of call-lights. Most systems also indicate to staff the order that calls were made and staff members are better able to address resident needs in an orderly fashion. Providers also report that the lack of constant beeping has increased productivity.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 79 Number of homes with score confirmed: 64 Number of homes with score not confirmed: 16 Percent of score not confirmed: 20%
RECOMMENDATIONS	Onsite visits confirmed the importance of methodically corroborating this measure through testimonials in the application review process. As a result, reviewers found the rigorous minimum documentation for this performance measure to be appropriate and have no further recommendations.

NEIGHBORHOODS/HOUSEHOLDS	
DEFINITION	Physical and social environment has been designed or re-designed to create neighborhoods/households.
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	Documentation should include photographs of different neighborhood/household décor, signage. Also include minutes of resident/staff neighborhood/household meetings. Also include testimony from at least 4 residents or family members that explicitly discusses neighborhood/households, and invitations to neighborhood/household social events.
APPLICATION CHANGES IN 2010	The two examples of documentation were added along with required testimonies from four residents or family members.
REVIEWER COMMENTS	There were two main reasons why homes did not get scores assigned on this measure; there was no documentation provided of any physical differences in the locations within a home and the absence of testimony about the functioning of neighborhoods within the home. Based on site visits, there seems to be an issue with the interpretation of this performance measure. Providers either reported that neighborhoods/households are not conducive to the layout of their home or applied for points just for "naming" neighborhoods.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 61 Number of homes with score confirmed: 35 Number of homes with score not confirmed: 26 Percent of score not confirmed: 43%
RECOMMENDATIONS	Even with the increased 2010 documentation requirements, homes seem to be misinterpreting or not understanding this measure, evidenced by 43% of the scores not being confirmed. To further clarify for homes, a revised P4P application may include further definition of neighborhoods/households as noted in a Stage Model of Culture Change (Grant & Norton, 2003). In addition, if rewarding person-directed environmental transformations is the goal of the measure, the definition could be expanded to include alternative environmental changes such as eliminating nurses stations or increasing the number of private rooms (or the Neighborhoods/Households measure could be reweighted to reflect fewer points and an additional measure could be added to reflect environmental

NEIGHBORHOODS/HOUSEHOLDS	
	transformations not currently represented in the application).

SUBCATEGORY – RELATIONSHIPS WITH STAFF, FAMILY, RESIDENT, AND COMMUNITY

Measures in this subcategory include 50% or 80% Consistent Assignments, Internal Community, External Community, Living Environment, and Volunteer Program. Reviewers assessed each application and supporting documentation to validate compliance with designated minimum requirements.

50% OR 80% CONSISTENT ASSIGNMENTS	
DEFINITION	50% or 80% of the staff is consistently assigned to the same resident(s).
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	Staff assignment for a previous, consecutive 8 week period. See instructions and work sheet at Appendix 2.
APPLICATION CHANGES IN 2010	The only change in the application from 2009 to 2010 was the creation of Appendix 2 as a template for all homes to include as part of the supporting documentation. This was done to create a uniform method for determining the percentage of consistent assignments.
REVIEWER COMMENTS	Reviewers looked to determine if the home provided staff assignments for a consecutive 8 week period and that either Appendix 2 or some similar summary was provided. In reviewing the documentation for this measure, the most common error that resulted in homes not receiving points was due to incomplete documentation. Homes were asked to complete Appendix 2 or documentation similar to this and did not do so. Homes were also denied points for including documentation from which it could not be clearly determined that it was for 8 consecutive weeks or for appropriate the staff. Reviewers also noted that Appendix 2 is set up for homes that follow a strict Day/Night Shift scheduling however not all homes schedule in this manner. As each home handles their nursing schedules differently, Appendix 2 should be flexible to accommodate these different scheduling patters.
PERFORMANCE MEASURE REVIEW STATISTICS	<u>50% Consistent Assignments</u> Number of homes with self-reported score: 15 Number of homes with score confirmed: 13 Number of homes with score not confirmed: 2 Percent of score not confirmed: 13%

50% OR 80% CONSISTENT ASSIGNMENTS	
	<u>80% Consistent Assignments</u> Number of homes with self-reported score: 80 Number of homes with score confirmed: 70 Number of homes with score not confirmed: 10 Percent of score not confirmed: 13%
RECOMMENDATIONS	The improvements to the confirmed score percentages from the 2009 to the 2010 application are substantive verification of the value of Appendix 2 as a documentation guide for homes. However, documenting variations in methods of scheduling from the day and evening designation in the 2010 application instructions is a legitimate concern for applicants. As a result, a revised P4P application could augment instructions to account for scheduling variations or provide a note describing potential ways to document non day/evening shifts for homes.

INTERNAL COMMUNITY	
DEFINITION	Regular neighborhood community meetings or learning circles to promote a sense of community and spontaneous activities.
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	Sample weekly meeting minutes and documentation of spontaneous activities. Documentation must include testimonials of at least 3 non-management employees and 3 residents/families of regular neighborhood community meetings and/or the use of learning circles to promote community, as well as evidence of spontaneous activities. Photographs of meetings, learning circles, and spontaneous activities must also be included.
APPLICATION CHANGES IN 2010	The biggest change in the application from 2009 to 2010 was in the required documentation. The 2010 application required additional documentation not required in the 2009 application, namely testimonials from 3 non-management staff and 3 residents/families.
REVIEWER COMMENTS	Reviewers looked for the application to include sample weekly minutes, documentation of spontaneous activities, testimonials from 3 non-management employees and 3 residents/families, and photographs of internal community in order to award the home points for this measure. Reviewers found that the most common issue surrounding this measure was the lack of complete supporting documentation, with the majority of homes failing to receive points due to a lack of the required 6 testimonials. Homes were also denied points for not including photographic evidence of the activities as required. Reviewers also noted that the documentation requirements call for sample weekly minutes however most homes documented monthly minutes. Through the site visits, it became apparent that most internal communities have attempted to conduct weekly meetings but have since moved to monthly meetings at the request of the residents. These homes noted that weekly meetings were poorly attended by residents and that attendance and participation in monthly meetings has been better. Interviews also indicated that residents meet with each other through community meetings and have the opportunity to

INTERNAL COMMUNITY	
	meet with and provide feedback to staff, but providers associated the measure with neighborhoods/households and did not apply for this measure.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 62 Number of homes with score confirmed: 46 Number of homes with score not confirmed: 16 Percent of score not confirmed: 26%
RECOMMENDATIONS	If the intent of the measure is to encourage a regular communication conduit between residents and staff, the Department might consider changing the wording to reflect different types of meetings of committees and eliminate the designation of weekly minutes from the required documentation and allow for any example of minutes (weekly, monthly, etc.), i.e. minutes of periodic meetings.

EXTERNAL COMMUNITY	
DEFINITION	External community invited, informed, and involved in the life of the home.
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	Sample monthly documentation of a variety of external community participation in addition to the regularly scheduled activity programming groups. Documentation may include calendars with external communities, flyers that advertise external community participation showing these types of activities and interactions with the external community are occurring monthly. Photographs of events and activities must also be included.
APPLICATION CHANGES IN 2010	The only changes from the 2009 to the 2010 application were in regards to the documentation requirements. The 2010 documentation requirements were more specific by asking for calendars, flyers, and photographs illustrating external community involvement.
REVIEWER COMMENTS	Reviewers looked for calendars with external activities, flyers that advertised external community participation, and pictures as acceptable supporting documentation. The documentation needed to prove that these types of activities and interactions with the external community were occurring monthly in addition to the regularly scheduled activities. Reviewers found that those homes that did not receive points for this measure failed to provide documentation that clearly illustrated the involvement of the external community. An example of this would be activity calendars that did not clearly highlight those activities that involved the external community. Those homes that received points in this category often included flyers that were sent to the external community announcing events for holidays, newspaper ads, and clearly marked activity calendars. Reviewers also found it helpful when homes included captions with the photographs to identify the activity and the external community involvement depicted in the picture.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 91 Number of homes with score confirmed: 85 Number of homes with score not confirmed: 8 Percent of score not confirmed: 9%

EXTERNAL COMMUNITY	
RECOMMENDATIONS	To clarify the measure and assist in application review, a revised P4P application might ask providers to include captions with the photographs identifying the activity and external community involvement.

LIVING ENVIRONMENT	
DEFINITION	Opportunity exists, as chosen by the resident and as much as possible, for connection with the world including but not limited to nature, gardens, animals, children, crafts, music, art and technology as indicated by residents' majority/individual preferences.
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	Documentation includes a narrative describing at least three opportunities as listed above, testimonials from 4 residents, and photographs identifying the living environment.
APPLICATION CHANGES IN 2010	The required documentation identified in the 2010 application is more explicit than in the 2009 application. The 2010 application required a narrative describing the three opportunities, 4 resident testimonials, and photographs identifying the living environment.
REVIEWER COMMENTS	Pictures of resident interaction with children, animals, plants, etc. were the most common form of supporting documentation provided by applications. Reviewers also looked for the 4 resident testimonials. Reviewers found that the most common error resulting in a home with a score not confirmed was the lack of testimonials included in the documentation. There were also some homes that included resident testimonials that did not speak to the living environment at the home. Reviewers also found that applications that included captions with the photographs provided for a more clear understanding of the relevance of the photograph to the measure. For example, one home utilized the same photographs for multiple measures.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 91 Number of homes with score confirmed: 76 Number of homes with score not confirmed: 15 Percent of score not confirmed: 16%
RECOMMENDATIONS	Captions should be included with the photographs to allow for a more clear understanding of the relevance of the photograph.

VOLUNTEER PROGRAM	
DEFINITION	Formalized volunteer program exists to allow for the provision of resident-specific activities and visits.
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	Documentation must include both a written volunteer policy and documentation of hours of visits.
APPLICATION CHANGES IN 2010	There were no changes to this performance measure from the 2009 application to the 2010 application.
REVIEWER COMMENTS	Reviewers looked for both the written policies and the documentation of hours in order for a home to receive points for this measure. A narrative stating that a volunteer program existed along with blank volunteer log-in sheets did not meet the requirements for this measure. Reviewers found that the two main reasons for a home not receiving points for this performance measure were the lack of a formalized volunteer program and the lack of documented volunteer hours. Onsite visits revealed that a home may not have included formal sign-in sheets because volunteers were asked to sign-in in the guest log intermixed with visitors. In this instance, the home provided descriptions of multiple programs and visits substantiated by an outside source.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 90 Number of homes with score confirmed: 82 Number of homes with score not confirmed: 9 Percent of score not confirmed: 10%
RECOMMENDATIONS	If sign-in sheets are the preferred documentation of volunteer hours, the Department might consider revising minimum requirements to include sign-in sheets.

SUBCATEGORY: STAFF EMPOWERMENT

Measures in this subcategory include Care Planning, Career Ladders/Career Paths, Person-Directed Care, and New Staff Program. Reviewers assessed each application and supporting documentation to validate compliance with designated minimum requirements.

CARE PLANNING	
DEFINITION	Certified Nursing Assistant(s) is involved in care planning and care conferences.
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	Sample of both ten initial and ten quarterly care plan attendance forms with clearly identified CAN participation in care plan meeting including signatures of CNA's.
APPLICATION CHANGES IN 2010	The change in the 2010 application for this performance measure is that the required documentation calls for 10 initial and 10 quarterly care plan attendance forms with CNA signatures whereas the 2009 application did not specify the amount of care plan attendance forms nor did it require the forms to be signed.
REVIEWER COMMENTS	Reviewers looked to ensure that samples of ten initial and ten quarterly care plan attendance forms were included with clearly identified CNA participation and signatures. Homes that did not receive points for this measure were found to have not included the required ten initial and ten quarterly care plans. Reviewers also found that some homes did not clearly indicate the frequency of the care plan reviews, however if the required 20 care plans were presented indicating CNA involvement, the points were granted.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 61 Number of homes with score confirmed: 52 Number of homes with score not confirmed: 10 Percent of score not confirmed: 16%
RECOMMENDATIONS	The improvements to the confirmed score percentages from the 2009 to the 2010 application are substantive verification of the value of clarifications to the minimum requirements in the 2010 application. To further clarify this measure the Department might consider asking homes to clearly identify the care plans as initial and quarterly.

CAREER LADDERS/CAREER PATHS	
DEFINITION	Home has system in place to promote and support staff advancement.
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	Written program or policy and procedures for staff advancement, tuition reimbursement if applicable, promoting internally, and posting open positions.
APPLICATION CHANGES IN 2010	The only change to the application in 2010 was that the minimum requirements specify the areas that need to be covered by the written program or policy.
REVIEWER COMMENTS	In this review, acceptable supporting documentation included nursing home policy and procedures for staff advancement, tuition reimbursement, promoting internally and posting open positions. Reviewers found that the most common issue in a home not receiving points for this measure was the lack of a written policy and procedure document. Some homes included a narrative and/or staff testimonials about the home's career ladders/paths however this was not sufficient documentation for this measure.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 94 Number of homes with score confirmed: 79 Number of homes with score not confirmed: 15 Percent of score not confirmed: 16%
RECOMMENDATIONS	Based on onsite visits, it is clear that this measure may favor corporate chains that are able to put more structured programs in place. To curtail this type of bias, it is a positive aspect of the 2010 application that it allows for more informal documentation such as promoting internally for those smaller, independent homes. Still, the minimum requirement of "Written program or policy and procedures for staff advancement" is not unreasonable for a home and fulfills verification of the measure. Thus, reviewers have no recommendation for improvements.

PERSON-DIRECTED CARE	
DEFINITION	Home supports and has systems in place to provide formal training on person-directed care to all staff.
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	Submit annual training objectives. Please include Mission and Vision statement regarding person-directed care, list of person-directed care training and any other pertinent documentation that supports person-directed care. If you an Eden Registered Home in good standing as verified by the Eden Alternative organization, you automatically meet this requirement.
APPLICATION CHANGES IN 2010	The 2010 application includes more specific requirements including the inclusion of Mission and Vision statements regarding person-directed care.
REVIEWER COMMENTS	In evaluating the documentation to support annual objectives, an agenda, and list of attendees for training in person-directed care, reviewers found that those homes that did not receive points failed to include all of the required documentation. These homes may have provided their Mission and Vision statements but no listing of person-directed care trainings. Reviewers also found that some documentation included a listing of all in-service trainings but did not clearly identify those trainings that were part of the person-directed care program. Providers visited commented that they were not sure what to submit for the measure. Interviews also indicated that providers are only associating this measure with Eden Alternative. Of the homes that received points for this measure, 13 were identified as an Eden Registered Home.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 62 Number of homes with score confirmed: 39 Number of homes with score not confirmed: 23 Percent of score not confirmed: 37%
RECOMMENDATIONS	The observation that fewer homes applied for, and successfully documented this measure, is evidence of opportunities for future growth and implementation of person-directed care in the 2011 P4P application process. Since fulfilling requirements for person-directed care may not be as concrete as other measures (e.g. overhead paging) and site visits indicated that homes may associate this

PERSON-DIRECTED CARE	
	measure with Eden Alternative trainings only, a revised P4P application could further clarify this measure to include investment in training or education for any of the P4P Quality of Life performance measures to include outside speakers, webinars, and/or conferences with documentation of staff participation. A revised P4P application could also further clarify that the Eden Alternative classification must be for the entire home and not individual staff.

NEW STAFF PROGRAM	
DEFINITION	Staff members are involved in the recruitment, orientation, and mentoring of new staff.
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	Documentation should include a written narrative of a program that includes staff involvement in all three areas – the recruitment, orientation, and mentoring of new employees. Documentation may also include new staff orientation program agenda, policies on staff involvement in recruitment such as referral bonus programs, and outline for mentoring program. Documentation should include testimonials from 4 staff about their involvement in new staff programs.
APPLICATION CHANGES IN 2010	Documentation requirements in the 2010 application were more specific than in the 2009 application. Homes are now required to include not only the narrative of the program but they must also include testimonials from 4 staff about their involvement in new staff programs.
REVIEWER COMMENTS	In this review, acceptable supporting documentation included policies and procedures for orientation, recruitment, mentoring of new staff, position descriptions that contained mentoring duties and forms provided to new staff members identifying their mentor. Testimonials from 4 staff members were also required in order to receive points for this measure. If documentation supporting any one of the three was not included, the self reported score was not substantiated. Reviewers found that the most common reason for a home not receiving points for this measure was the lack of staff testimonials.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 79 Number of homes with score confirmed: 55 Number of homes with score not confirmed: 24 Percent of score not confirmed: 30%
RECOMMENDATIONS	Reviewers found documentation to be reasonable. Since staff testimonials were the predominant reason for denial of this measure, the Department might consider moving the requirement for staff testimonials to immediately follow the written narrative as opposed to following optional measures (e.g. orientation, referral bonus) to further highlight this requirement in the application.

CONTINUING EDUCATION	
DEFINITION	Hours (on average) of caregiver/ staff person (Social Services/Activities/RN's/LPN's/C.N.A's) Continuing Education per year. This includes any education provided internally or externally that enhances the Quality of Care or Quality of Life of the resident, clinical training, leadership/management training or safety training. Included in Continuing Education would be In-Service Education, seminars, workshops and conferences. General Home Orientation not related to resident care or meetings related to general home information would not be considered. Homes could receive 2, 4 or 6 points for their continuing education programs: 2 points could be attained for documenting 12 hours of average continuing education, 4 points for 14 hours of average continuing education, and 6 points for 16 hours of average continuing education.
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	(1) Continuing Education Form completed for 20% of all employees in previous calendar year for the following job categories: Social Services, Activities, Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants. (2) Individual Continuing Education Tracking Forms for 20% of individual employees in each job category. (3) List of Continuing Education Provided in-house in previous calendar year.
APPLICATION CHANGES IN 2010	In the 2009 application the documentation required a "Full list of staff and training hours," and the amount of paper received made it difficult to calculate an average. In 2010 an appendix was included with the application that required Continuing Education statistics for 20% of employees in 5 job categories. The 2010 application also requires Continuing Education Tracking Forms for those 20% of employees, as well as a list of in-house Continuing Education provided. This change simplified and improved the measurement.
REVIEWER COMMENTS	Most homes that did not receive points for Continuing Education did not submit some or all of the necessary documentation, for example homes that only included in-service sign-in sheets, and others that did not include the Individual Continuing Education Tracking Forms for the 20% of employees selected for the Continuing Education Form.

CONTINUING EDUCATION	
PERFORMANCE MEASURE REVIEW STATISTICS	<u>+2 Continuing Education</u> Number of homes with self-reported score: 11 Number of homes with score confirmed: 4 Number of homes with score not confirmed: 8 Percent of score not confirmed: 73% <u>+4 Continuing Education</u> Number of homes with self-reported score: 10 Number of homes with score confirmed: 7 Number of homes with score not confirmed: 3 Percent of score not confirmed: 30% <u>+6 Continuing Education</u> Number of homes with self-reported score: 64 Number of homes with score confirmed: 46 Number of homes with score not confirmed: 18 Percent of score not confirmed: 28%
RECOMMENDATIONS	There are no recommendations for this performance measure based on the 2010 application.

QUALITY PROGRAM PARTICIPATION	
DEFINITION	Participation in Advancing Excellence in America's Nursing Homes or a successor quality program
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	List of goals that the home is participating in, printing from the Advancing Excellence Website.
APPLICATION CHANGES IN 2010	2010 application clearly states that the list of goals, in which the home is participating, must be printed from the Advancing Excellence Website
REVIEWER COMMENTS	The homes that did not receive points either included no documentation for this performance measure, or only included the registration page of the Advancing Excellence Website. This meant that the list of goals for the home was not included.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 87 Number of homes with score confirmed: 80 Number of homes with score not confirmed: 9 Percent of score not confirmed: 10%
RECOMMENDATIONS	There are no recommendations for this performance measure based on the 2010 application.

FALLS	
DEFINITION	One of five nationally reported quality measures scores from the CMS MDS website. A score of 13.1 or less received 5 points, while a score greater than 13.1, but less than or equal to 15.2 received 3 points.
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	Print and include scores from CMS MDS website for Quarter 2 (4/1/2009 to 6/30/2009) and Quarter 3 (7/1/2009 to 9/30/2009) of previous calendar year. Add scores (observed percent value) from Quarter 2 and Quarter 3 together and divide by 2 to calculate the average value to one decimal point
APPLICATION CHANGES IN 2010	Falls was added to the 2010 application in the Quality of Care sub-category of the Quality of Care domain.
REVIEWER COMMENTS	In most cases, homes that did not receive points for this performance measure did not include scores from both Quarter 2 and Quarter 3. In some instances, homes only included one quarter, while in others the home only considered their lowest score. Some homes included both quarters on the same report (April 1, 2009-September 30, 2009). This was accepted as adequate documentation.
PERFORMANCE MEASURE REVIEW STATISTICS	<u>Score of 13.1 or less</u> Number of homes with self-reported score: 38 Number of homes with score confirmed: 36 Number of homes with score not confirmed: 4 Percent of score not confirmed: 10% <u>Score greater than 13.1, but less than or equal to 15.2</u> Number of homes with self-reported score: 15 Number of homes with score confirmed: 12 Number of homes with score not confirmed: 3 Percent of score not confirmed: 20%
RECOMMENDATIONS	Application states in Appendix 4 (page 18) "Set your report dates (March 1 – November 30) of the previous year." This conflicts with selecting Quarter 2 and Quarter 3, and should be updated. It is not necessary to select both quarters individually, since both can be selected in a single date range (4/1/09-9/30/09).

HIGH-RISK PRESSURE ULCERS	
DEFINITION	One of five nationally reported quality measures scores from the CMS MDS website. A score of 5.1 or less received 5 points, while a score greater than 5.1, but less than or equal to 7.1 received 3 points.
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	Print and include scores from CMS MDS website for Quarter 2 (4/1/2009 to 6/30/2009) and Quarter 3 (7/1/2009 to 9/30/2009) of previous calendar year. Add scores (observed percent value) from Quarter 2 and Quarter 3 together and divide by 2 to calculate the average value to one decimal point
APPLICATION CHANGES IN 2010	The upper-level score was reduced from 9 to 5, and the necessary score was changed from 5.5 or less to 5.1 or less. The lower-level score was increased from 2 to 3, and the necessary score was changed from greater than 5.5 but less than or equal to 7.2 to greater than 5.1 but less than or equal to 7.1.
REVIEWER COMMENTS	In most cases, homes that did not receive points for this performance measure did not include scores from both Quarter 2 and Quarter 3. In some instances, homes only included one quarter, while in others the home only considered their lowest score. Some homes included both quarters on the same report (April 1, 2009-September 30, 2009). This was accepted as adequate documentation. During site reviews, homes expressed concerned about pressure ulcers stating that a large percentage of their population comes in with pressure ulcers and the home is therefore at a disadvantage with this performance measure. PCG reviewed the November 2004 National Nursing Home Quality Measures Users Manual and believes that the description of high-risk pressure ulcers in its Chapter 2 indicates that a short-term residents are not included in this measure.
PERFORMANCE MEASURE REVIEW STATISTICS	<u>Score of 5.1 or less</u> Number of homes with self-reported score: 29 Number of homes with score confirmed: 22 Number of homes with score not confirmed: 8 Percent of score not confirmed: 28%

HIGH-RISK PRESSURE ULCERS	
	Score greater than 5.1, but less than or equal to 7.1 Number of homes with self-reported score: 18 Number of homes with score confirmed: 16 Number of homes with score not confirmed: 3 Percent of score not confirmed: 17%
RECOMMENDATIONS	Application states in Appendix 4 (page 18) "Set your report dates (March 1 – November 30) of the previous year." This conflicts with selecting Quarter 2 and Quarter 3, and should be updated. It is not necessary to select both quarters individually, since both can be selected in a single date range (4/1/09-9/30/09).

CHRONIC CARE PAIN SCORE	
DEFINITION	One of five nationally reported quality measures scores from the CMS MDS website. A score of 1.2 or less received 5 points, while a score greater than 1.2, but less than or equal to 2.3 received 3 points.
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	Print and include scores from CMS MDS website for Quarter 2 (4/1/2009 to 6/30/2009) and Quarter 3 (7/1/2009 to 9/30/2009) of previous calendar year. Add scores (adjusted percent value) from Quarter 2 and Quarter 3 together and divide by 2 to calculate the average value to one decimal point
APPLICATION CHANGES IN 2010	The upper-level score was reduced from 9 to 5, and the necessary score was changed from 2.0 or less to 1.2 or less. The lower-level score was increased from 2 to 3, and the necessary score was changed from greater than 2.0 but less than or equal to 2.7 to greater than 1.2 but less than or equal to 2.3.
REVIEWER COMMENTS	In most cases, homes that did not receive points for this performance measure did not include scores from both Quarter 2 and Quarter 3. In some instances, homes only included one quarter, while in others the home only considered their lowest score. On this measure there were homes that did not score themselves correctly. It appears as though they were using the "Observed Percent Value" instead of the "Adjusted Percent Value." Some homes included both quarters on the same report (April 1, 2009-September 30, 2009). This was accepted as adequate documentation.
PERFORMANCE MEASURE REVIEW STATISTICS	<u>Score of 1.2 or less</u> Number of homes with self-reported score: 25 Number of homes with score confirmed: 21 Number of homes with score not confirmed: 6 Percent of score not confirmed: 24% <u>Score greater than 1.2, but less than or equal to 2.3</u> Number of homes with self-reported score: 13 Number of homes with score confirmed: 13 Number of homes with score not confirmed: 3 Percent of score not confirmed: 23%
RECOMMENDATIONS	Application states in Appendix 4 (page 18) "Set your report dates (March 1 – November 30 of the previous year." This

CHRONIC CARE PAIN SCORE	
	conflicts with selecting Quarter 2 and Quarter 3, and should be updated. It is not necessary to select both quarters individually, since both can be selected in a single date range (4/1/09-9/30/09). In addition, the application should more clearly state that the Adjusted Percent Value should be used for Chronic Care Pain Score. It is mentioned in Appendix 4, but needs to be highlighted or emphasized in some manner.

PHYSICAL RESTRAINTS	
DEFINITION	One of five nationally reported quality measures scores from the CMS MDS website. A score of 0 received 5 points, while a score greater than 0, but less than or equal to 1.7 received 3 points.
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	Print and include scores from CMS MDS website for Quarter 2 (4/1/2009 to 6/30/2009) and Quarter 3 (7/1/2009 to 9/30/2009) of previous calendar year. Add scores (observed percent value) from Quarter 2 and Quarter 3 together and divide by 2 to calculate the average value to one decimal point
APPLICATION CHANGES IN 2010	The upper-level score was reduced from 9 to 5, and the necessary score was changed from 1.0 or less to 0. The lower-level score was increased from 2 to 3, and the score was changed from greater than 1.0 but less than or equal to 2.0 to greater than 0 but less than or equal to 1.7.
REVIEWER COMMENTS	In most cases, homes that did not receive points for this performance measure did not include scores from both Quarter 2 and Quarter 3. In some instances, homes only included one quarter, while in others the home only considered their lowest score. Some homes included both quarters on the same report (April 1, 2009-September 30, 2009). This was accepted as adequate documentation.
PERFORMANCE MEASURE REVIEW STATISTICS	<u>Score of 0</u> Number of homes with self-reported score: 29 Number of homes with score confirmed: 24 Number of homes with score not confirmed: 5 Percent of score not confirmed: 17% <u>Score greater than 0, but less than or equal to 1.7</u> Number of homes with self-reported score: 21 Number of homes with score confirmed: 16 Number of homes with score not confirmed: 6 Percent of score not confirmed: 29%
RECOMMENDATIONS	Application states in Appendix 4 (page 18) "Set your report dates (March 1 – November 30 of the previous year." This conflicts with selecting Quarter 2 and Quarter 3, and should be updated. It is not necessary to select both quarters individually, since both can be selected in a single date range (4/1/09-9/30/09).

UTI	
DEFINITION	One of five nationally reported quality measures scores from the CMS MDS website. A score of 5.3 or less received 5 points, while a score greater than 5.3, but less than or equal to 6.7 received 3 points.
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	Print and include scores from CMS MDS website for Quarter 2 (4/1/2009 to 6/30/2009) and Quarter 3 (7/1/2009 to 9/30/2009) of previous calendar year. Add scores (observed percent value) from Quarter 2 and Quarter 3 together and divide by 2 to calculate the average value to one decimal point
APPLICATION CHANGES IN 2010	UTI was added to the 2010 application in the Quality of Care sub-category of the Quality of Care domain.
REVIEWER COMMENTS	In most cases, homes that did not receive points for this performance measure did not include scores from both Quarter 2 and Quarter 3. In some instances, homes only included one quarter, while in others the home only considered their lowest score. Some homes included both quarters on the same report (April 1, 2009-September 30, 2009). This was accepted as adequate documentation.
PERFORMANCE MEASURE REVIEW STATISTICS	<u>Score of 5.3 or less</u> Number of homes with self-reported score: 31 Number of homes with score confirmed: 27 Number of homes with score not confirmed: 4 Percent of score not confirmed: 13% <u>Score greater than 5.3, but less than or equal to 6.7</u> Number of homes with self-reported score: 9 Number of homes with score confirmed: 5 Number of homes with score not confirmed: 4 Percent of score not confirmed: 44%
RECOMMENDATIONS	Application states in Appendix 4 (page 18) "Set your report dates (March 1 – November 30 of the previous year." This conflicts with selecting Quarter 2 and Quarter 3, and should be updated. It is not necessary to select both quarters individually, since both can be selected in a single date range (4/1/09-9/30/09).

STAFF INFLUENZA IMMUNIZATION	
DEFINITION	60% or greater immunization rate of staff. A 2006 RAND Study found that the nursing homes were 60% less likely to have a cluster of influenza-like illness cases if more than 55% of staff and more than 89% of residents were vaccinated for influenza
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	(1) Submit list of employees actively employed as of December 31 and note those who received the immunization. (2) Calculate the % of those staff receiving the influenza vaccine
APPLICATION CHANGES IN 2010	Staff Influenza Immunization was added to the 2010 application in the Quality of Care sub-category of the Quality of Care domain.
REVIEWER COMMENTS	Most homes that did not receive points did not include documentation for this performance measure. In one instance the home incorrectly calculated their percentage. In another, they provided an entire staff list and a "non-immunized list" (this home received points as it was assumed that the rest of the staff did receive the immunization).
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 78 Number of homes with score confirmed: 71 Number of homes with score not confirmed: 7 Percent of score not confirmed: 9%
RECOMMENDATIONS	There are no recommendations for this performance measure based on the 2010 application.

10% OR 5% MEDICAID	
DEFINITION	Medicaid occupancy 10% or more above statewide average received 5 points. Medicaid occupancy 5% or more above statewide average received 3 points.
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	Copy of Certification Page of Med 13
APPLICATION CHANGES IN 2010	No changes were made from the 2009 application to the 2010 application.
REVIEWER COMMENTS	Some homes reported the statewide Percent Medicaid Utilization average as 47.6%. One home included an email from the CO HCA calculating the percentage as Medicaid Census/Total Certified Beds. The Med 13, however, calculates the percentage as Medicaid Days/Total Days. Of those homes that were using the correct statewide average, some gave themselves points if their *percent change* was 5% or 10% above the statewide average. When calculating the 5% or 10% above the statewide average as a change in percentage points, these homes did not meet the threshold. There were also homes that did not include a copy of their Med 13 Certification Page; some submitted nothing, while others submitted an informal document stating their Percent Medicaid Utilization. Reviewers accepted documents submitted from a central office of a nursing home chain containing occupancy documentation, even though they were not the Med 13. It appeared that the individual nursing home did not have a copy of the cost report, and requested occupancy data from the home office.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 61 Number of homes with score confirmed: 26 Number of homes with score not confirmed: 36 Percent of score not confirmed: 59% Number of homes with self-reported score: 16 Number of homes with score confirmed: 14 Number of homes with score not confirmed: 12 Percent of score not confirmed: 75%
RECOMMENDATIONS	If possible, the statewide Percent Medicaid Utilization (as

10% OR 5% MEDICAID	
	calculated in accordance with the Med 13) average should be included in the application so that all homes are comparing themselves to the proper percentage. In addition, it should be specified that "10% above or more" and "5% above or more" refers to percentage points, not the percent change.

SUBCATEGORY: STAFF STABILITY

Measures in this subcategory include Staff Retention Rate, Staff Retention Improvement, DON Retention, NHA Retention, and Employee Satisfaction Survey. Reviewers assessed each application and supporting documentation to validate compliance with designated minimum requirements.

STAFF RETENTION RATE	
DEFINITION	The application states that the definition for staff retention measure is: Staff retention rate (excluding NHA and DON) at or above 55%.
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	Minimum supporting documentation for staff stability subcategory must include the following: 1. Complete Appendix 5 Staff Retention OR Staff Retention Improvement Form 2. Submit one of the following: a. January 1 payroll roster listing names of all employees **AND** December 31 payroll roster listing names of all employees with retained employees highlighted b. December 31 payroll roster listing names of all employees **AND** dates of hire, with employees hired on or before January 1 highlighted.
APPLICATION CHANGES IN 2010	The Department established a method of calculating the staff retention rate and provided a calculation worksheet, Appendix 5, to help homes calculate their rate. The formula included staff that began the year and remained employed through the end of the year divided by the number of staff that began the year. The calculation was simple because it did not take into account new hires in the year including temporary and part time employees. Also, it did not employ monthly average calculations and was easily documented; homes provided a full staff list from the beginning of the year and end of the year.
REVIEWER COMMENTS	The supporting documentation included was standard for most of the homes. The reviewers found that most of the homes that applied for this measure followed the instructions for the minimum requirements. Documentation included: January 1 payroll roster and December 31 payroll roster listing names of all employees with retained employees highlighted or December 31 payroll roster listing

STAFF RETENTION RATE	
	names of all employees AND dates of hire, with employees hired on or before January 1 highlighted. However, there were some instances where homes included supporting documentation but calculated the percentage incorrectly. In these cases, PCG calculated the percentage and applied the points as necessary. Additionally, some of the homes provided the correct documentation but did not include Appendix 5. PCG used the supporting documentation to validate the homes' claims. Other homes provided a turnover percentage which was used to determine the retention rate for the home.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 89 Number of homes with score confirmed: 86 Number of homes with score not confirmed: 5 Percent of score not confirmed: 6%
RECOMMENDATIONS	The narrative in the minimum requirements should reference Appendix 5 instead of Appendix 2. In addition, the Staff list does not have to be the exact run date from 1/1/2009-12/31/2009. Staff retention options should be reworded to accept staff list run dates within two weeks before or after the end of the year.

STAFF RETENTION IMPROVEMENT	
DEFINITION	The application states that the definition for Staff Retention Improvement is a 5% improvement on the staff retention rate per year for homes with less than a 55% retention rate. Homes with 55% retention rate or greater must remain consistent from year to year.
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	Minimum supporting documentation for staff stability subcategory must include the following: 1. Complete Appendix 5 Staff Retention OR Staff Retention Improvement Form 2. Submit one of the following: a. January 1 payroll roster listing names of all employees **AND** December 31 payroll roster listing names of all employees with retained employees highlighted b. December 31 payroll roster listing names of all employees **AND** dates of hire, with employees hired on or before January 1 highlighted.
APPLICATION CHANGES IN 2010	It is more clearly stated that the Staff Retention Rate and the Staff Retention Improvement measures are an "either/or" measure. Homes were eligible for one measure, not both.
REVIEWER COMMENTS	Most homes received credit for staff retention rate and not staff retention improvement even though they qualified for both. Points were awarded for the measure that had the most adequate supporting documentation. There were also cases where homes claimed for this performance measure, but did not supply adequate supporting documentation with the claim. In most cases the documentation provided did not adequately support the homes' claim of a 5% improvement. It merely stated the retention rate for one year, but did not give the rate for the previous year.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 8 Number of homes with score confirmed: 2 Number of homes with score not confirmed: 6 Percent of score not confirmed: 75%
RECOMMENDATIONS	The narrative in the minimum requirements should reference Appendix 5 instead of Appendix 2. In addition, the Staff list does not have to be the exact run date from 1/1/2009-12/31/2009. Staff retention options should be reworded to accept staff list run dates within two weeks before or after the end of the year.

DON RETENTION	
DEFINITION	The application states that the definition for DON retention is a rate of three years or more.
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	Minimum requirement must include name and hire date including date started in DON position.
APPLICATION CHANGES IN 2010	There were no application changes in 2010.
REVIEWER COMMENTS	The reviewers' observations were consistent for all homes that did not receive points. There were homes that submitted documentation for a DON, but did not provide the date of hire for the individual. Also, there were homes that submitted documentation that did not meet the minimum requirement but stated that they should receive points because the current DON previously held the same position at another home in Colorado. There were homes that simply provided a name, and date of hire of the DON and received points for the measure. Other homes had stronger documentation, for example an HR report to ensure that the DON was in the role at the start of employment.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 35 Number of homes with score confirmed: 27 Number of homes with score not confirmed: 8 Percent of score not confirmed: 23%
RECOMMENDATIONS	There are no recommendations for this performance measure based on the 2010 application.

NHA RETENTION	
DEFINITION	The application states that the definition for NHA retention is a rate of three years or more.
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	Minimum requirement must include name and hire date including date started in NHA position.
APPLICATION CHANGES IN 2010	There were no application changes in 2010.
REVIEWER COMMENTS	This performance measure was straight forward. Points were given to homes that provided the name, and hire date of the NHA. Some homes provided excellent supporting documentation including hire dates and time cards dating back at least three years. Reviewers accepted statements from homes stating the date of hire of the NHA. The most common reason that homes did not receive points was that the current NHA had not been in that position for more than three years. Some homes provided documentation that the NHA has been working at the home for over three years, but had only recently been promoted to that position. Additionally, there were homes that did not provide documentation to indicate the date started in NHA position. Consequently, no points were awarded.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 45 Number of homes with score confirmed: 41 Number of homes with score not confirmed: 5 Percent of score not confirmed: 11%
RECOMMENDATIONS	There are no recommendations for this performance measure based on the 2010 application.

EMPLOYEE SATISFACTION SURVEY	
DEFINITION	The application states that the definition of Employee Satisfaction Survey is: Externally developed, recognized, and standardized employee satisfaction survey conducted on an annual basis, with at least 60% response rate.
MINIMUM REQUIREMENT(S) WITH SUPPORTING DOCUMENTATION	Minimum supporting documentation for employee satisfaction survey should include a survey summary page with clearly identified response rate.
APPLICATION CHANGES IN 2010	There were no application changes in 2010.
REVIEWER COMMENTS	The employee satisfaction survey performance measure did not pose difficulties in reporting or scoring. Most providers who claimed for this measure provided sufficient supporting documentation with their claim. There were some homes that did not receive points for this measure because they did not provide supporting documentation that verified that a survey was done, that a survey was externally developed, or that a sufficient number of employees participated in the survey. Additionally, there were homes that provided supporting documentation that did not clearly confirm the employee response rate and did not meet the 60% minimum requirement.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 73 Number of homes with score confirmed: 62 Number of homes with score not confirmed: 11 Percent of score not confirmed: 15%
RECOMMENDATIONS	There are no recommendations for this performance measure based on the 2010 application.

V. YEAR TO YEAR COMPARISON ANALYSIS OF 2009 AND 2010 SCORES

PCG analyzed the scoring of providers across the first two years of the program. A total of 90 providers submitted applications in FY 2009, through the first and second round of application submissions. Of these 90 providers, 75 would go on to submit in FY 2010 and 15 would not. In FY 2010, 98 providers submitted applications, with 23 providers applying for the first time. All analysis performed by PCG of the year-to-year comparison was focused on the 75 providers with the two-year history in the program.

Submitted Applications by Fiscal Year

Providers	FY 2009	FY 2010
FY 2009 and FY 2010 Filing	75	75
FY 2009 Filing Only	15	0
FY 2010 Filing Only	0	23
Total	**90**	**98**

The intent of this review was to gain a better understanding of the program, scoring improvements made by individual homes, and improvements made to the self scoring and review adjustments. PCG's analysis yielded interesting findings about the first two years of the program that include:

- The average point decrease between the Self-Reported Score and the Final Score improved from 13.8 points in FY 2009 to 13.2 points in FY 2010 for the 75 homes completing applications in both years.
- For the 75 homes, the count with negative percent value changes from the Self-Reported Scores and Final Scores decreased from FY 2009 to FY 2010. As an example, only 4 homes had "no change" to their score in FY 2009. That total for the same group of homes increased to 11 in FY 2010.
- Overall, the 75 homes received an almost identical number of total points in the FY 2009 and FY 2010; there was only a 1% difference in total points. However, a high degree of variability existed among individual providers (Standard Deviation was 18.65 for points). PCG recommends performing some detailed reviews into some of the providers that had severe changes to their year to year scores.

The following tables provide further detail supporting the above findings.

Average Points by Fiscal Year

Scoring between the two fiscal years remained relatively consistent with an average score of 72.2 in FY 2009 and 71.9 in FY 2010 for Self-Reported Scores. The Final Scores were close as well at 58.3 for FY 2009 and 58.7 for FY 2010. PCG was encouraged to see that the scoring changes

brought on by its review improved slightly from FY 2009 to FY 2010, dropping from 13.8 to 13.2. A performance goal for future years is to tighten the difference in Self-Reported and Final scores which would indicate the providers have a greater understanding of the instructions surrounding the application.

Category	FY 2009	FY 2010
Avg. Pts - Self Reported	72.2	71.9
Avg. Pts. – Final Score	58.3	58.7
Avg. Pts. Change	13.8	13.2
St. Deviation of % Change	15%	20%

Average Point Changes between Fiscal Years

The average point changes between fiscal years also illustrated interesting results. Overall, providers improved their average final score by 0.4 points between FY 2009 and FY 2010. However, the variability in the scoring changes was high with 18.65 point change standard deviation. This illustrates that many providers had large positive or negative year-to-year point swings. The positive changes should be encouraged as they reflect positive movement in quality of life and care within homes. Conversely, the Department should discourage large negative year-to-year point swings of providers and may wish to follow up with a few of these homes to understand why the changes occurred.

Category	FY 2009 vs. FY 2010
Avg. Pt Change	0.4
Avg. Pt Change Standard Deviation	18.65

The table showing the self reported and final scores for each home can be found below.

FY 2009 and FY 2010 Count of Providers by % Point Change

A final analysis conducted by PCG was the count of percent changes in scores between Self-Reported Scores and Final Scores for homes. The graph indicates that there is less variability in FY 2010 than in FY 2009. The preferred trend would be a right curve shift in the graph. One encouraging example of this was the increase in the number of homes that did not have a score change. A total of 4 homes had "no change" to their score in FY 2009. That total for the same group of homes increased to 11 in FY 2010.

Self Report and Final Score Analysis by Home

On the page that follows is the FY 2009 and FY 2010 self reported and final scores for the 75 homes. The table compares the final scores between years for each home by point and percent change. Eleven homes had an increase in score greater than 33% and another eleven homes had a decrease of 33%.

Provider #	Facility Name	FY 2009 Self-Reported Score	FY 2009 Final Score	FY 2010 Self-Reported Score	FY 2010 Final Score	09 - 10 Change in Final Score	09 - 10 % Change in Final Score
15526755	Highline Rehab	61	28	76	76	48	171%
27580547	Mountain View CC	71	26	71	55	29	112%
54603528	Parkview Care Center	74	42	79	79	37	88%
26554739	North Star Community	66	48	88	83	35	73%
05653274	CSV - Homelake	56	47	91	81	34	72%
16876334	Sierra HC Community	81	54	88	88	34	63%
05652631	Canon Lodge	68	43	69	67	24	56%
47333723	Camellia HCC	62	45	71	68	23	51%
13086863	Eagle Ridge of Grand Junction	100	44	79	66	22	50%
77105753	Amberwood Court	65	52	81	72	20	38%
05653423	Fairacres Manor	62	50	68	68	18	36%
79475744	Castle Rock CC	113	68	100	90	22	32%
58301747	Mantey Heights Care & Rehab C	78	47	70	60	13	28%
71956000	Yuma Life Care Center	55	53	70	66	13	25%
80636217	Wheatridge Manor NH	81	52	68	64	12	23%
99000792	Four Corners HCC	58	55	65	67	12	22%
71787267	Brookshire House	69	61	74	74	13	21%
82159815	CSV - Fitzimons	65	53	74	64	11	21%
30576016	Berkley Manor CC	85	57	70	68	11	19%
05651468	Valley View HCC	84	76	90	90	14	18%
37605216	Broomfield Skilled Nursing & Rehab	54	42	63	49	7	17%
05652961	Elms Haven Care Center	63	54	69	63	9	17%
05650338	Clear Creek Care Center	61	61	74	69	8	13%
00122777	Forest Street Compassionate CC	30	32	61	36	4	13%
75951274	Cheyenne Mountain Care & Rehab	62	41	52	46	5	12%
05654702	Doak Walker	72	68	78	76	8	12%
05652508	Rowan Community	85	76	84	84	8	11%
05655147	Holly Nursing CC	73	69	76	76	7	10%
83603041	Bear Creek Care & Rehab	68	64	77	69	5	8%
42402069	Harmony Pointe NC	76	78	93	84	6	8%
05653001	Life Care Center of Greeley	63	53	79	57	4	8%
05650080	Exempla Colorado Lutheran Home	77	67	81	72	5	7%
41978765	Pikes Peak Care & Rehab	77	56	86	59	3	5%
05653571	Hildebrand Care Center	60	58	76	61	3	5%
63934272	Allison CC	79	61	76	64	3	5%
46279865	Mesa Manor Rehab CC	62	43	50	45	2	5%
05651294	North Shore Health & Rehab	69	58	67	60	2	3%
05652748	CSV - Rifle	56	31	64	32	1	3%
08858721	Uptown Health Care Center	80	71	88	73	2	3%
05655709	Villa Manor Care Center	81	75	83	76	1	1%
05652607	Colorow Care Center	82	76	76	76	0	0%
05652664	Westwind Village	77	69	81	69	0	0%
05651245	Holly Heights Nursing	95	89	89	87	-2	-2%
89157231	Vista Grande Inn	63	57	64	55	-2	-4%
73422070	Denver North CC	87	85	82	82	-3	-4%
05654223	CSV - Bruce McCandless	84	84	70	81	-3	-4%
05652615	San Luis Care Center	96	75	88	72	-3	-4%
05653290	Lemay Avenue Health & Rehab	57	55	59	52	-3	-5%
16433548	Paonia Care & Rehab	70	50	57	47	-3	-6%
75482282	Life Care Center of Evergreen	64	64	71	60	-4	-6%
05652839	Pine Ridge	72	68	58	63	-5	-7%
05650742	Life Care Center Pueblo	62	60	64	54	-6	-10%
96339349	Alpine Living Center	63	56	80	50	-6	-11%
96731591	Spring Creek HC	62	56	58	50	-6	-11%
05650833	Columbine West Health & Rehab	64	59	52	52	-7	-12%
19005296	San Juan Living Center	76	71	79	62	-9	-13%
05652672	Horizon Heights	89	80	77	69	-11	-14%
05652722	Life Care of Westminster	75	61	76	52	-9	-15%
35057335	Cedars Health Care Center	86	37	57	30	-7	-19%
55754244	Cambridge CC	65	63	71	51	-12	-19%
76173712	Pearl Street Health & Rehab	54	49	52	38	-11	-22%
42988268	Christopher House	74	74	73	54	-20	-27%
05656269	St. Paul HCC	90	68	92	47	-21	-31%
65533763	Valley View Villa	86	68	68	46	-22	-32%
05652334	Larchwood Inns	86	77	72	51	-26	-34%
05652250	Devonshire Acres	82	67	68	43	-24	-36%
05652953	Sable Health Care Center	69	58	49	34	-24	-41%
50709348	Garden of the Gods CC	62	44	47	25	-19	-43%
05651377	Life Care Center of Longmont	65	57	67	30	-27	-47%
05651534	Sandalwood Manor	93	78	62	40	-38	-49%
05651567	Briarwood	76	46	63	22	-24	-52%
05651880	The Valley Inn	76	57	65	23	-34	-60%
69607532	Walsenburg Care Center	57.5	38	34	13	-25	-66%
05650114	University Park CC	73	65	91	19	-46	-71%
05652714	Hallmark Nursing Center	77	56	65	10	-46	-82%

VI. ON-SITE REVIEWS

A. Selection of Homes to Review

Reviewers discussed with the Department the best methodology for choosing the homes at which to conduct on-site reviews. Colorado Code at 10 CCR 2505 section 8.443.12 4 states that "Homes will be selected for onsite verification of performance measures representations based on risk." In thinking about how to be guided by this regulation, it became apparent that the application itself did not contain a measurement of risk since the verification risk is the amount of discrepancy between material in the application and what is actually occurring in the home.

After discussion, the Department and PCG decided that a selection of eleven homes would be appropriate since all had an equal probability of verification risk. Of these eleven homes, two would be selected for a review of the 2009 application, seven would be selected for the 2010 application, and two would be selected for a review of the 2009 and 2010 applications for a total of thirteen applications reviewed.

The selection of the homes included both random and purposive sampling. Prior to the selection of the sample, homes were first grouped into geographic regions to ensure that homes from across the state would be part of the sample. Within the geographic regions, homes were also categorized based on the application years that were submitted; 2009 only, 2010 only, or 2009 and 2010. One home was identified within each of the categories as having an unusual aspect to their scoring; be it a low reviewer score or a significant change in the score between the two application years, and was therefore selected for a site visit. The remaining homes were then randomly selected from these geographical areas in keeping with the methodology requirements of two homes from the 2009 only category, seven homes from the 2010 category, and two from the 2009 and 2010 category.

Based on the above criteria for selection, the following eleven homes were chosen for an on-site review:

- Alpine Living Center (2010) - Thornton
- Camellia Health Care Center (2010) - Aurora
- Cedarwood Health Care Center (2010) – Colorado Springs
- Colorado State &Veterans Nursing Home (2009) – Rifle
- Denver North Care Center (2010) – Denver
- Eagle Ridge of Grand Junction (2009, 2010) – Grand Junction
- Glen Ayr Health Center (2010) – Lakewood
- Good Samaritan – Ft. Collins (2010) – Fort Collins
- Monaco Parkway Health & Rehab (2009) – Denver
- Pikes Peak Care & Rehab (2009, 2010) – Colorado Springs
- Pueblo Care & Rehab Center (2010) – Pueblo

B. Methods Used To Review Homes

The visits to the eleven nursing homes involved two distinct phases. In each case a tour of the building was undertaken and a meeting with administrative staff was held. Those visits for the 2010 applications also included a third phase; interviews of two residents.

Home Tour

The purpose of the tour was to obtain a better idea of the physical plant and programs of the home. Reviewers focused on different measures when examining parts of the home. For example, when touring the sub-acute part of the home, reviewers were less interested in the personalization of resident rooms since the average resident may only reside in the room for nineteen days. Generally the reviewers used the tour to obtain verification of performance measures that could be visually observed. These included the:

- degree to which resident rooms were personalized;
- amount of institutional objects in hallways such as drug carts, lifts, and wheelchairs;
- home décor of the bathing area;
- presence of volunteers;
- presence of community groups;
- access of residents to food outside their main dining area;
- food choices on menus used in the dining room(s);
- use of an overhead paging system;
- presence of animals, birds, fish and plants;
- the presence of snack areas or other places where residents obtain food;
- memorial areas in remembrance to former residents; and
- evidence of neighborhoods.

Discussion with Staff

The meeting with administrative staff focused on the review of the application. The purposes of the review were to:

- learn how the application was put together,
    - why did the home apply?
    - when did the home start work on it?
    - did the home receive any help from any one in putting it together?;
- discuss each section of the application;
- learn why decisions were made to apply for some measures but not others;
- provide the administrative staff with the reviewers' reaction to the documentation;
- discuss the documentation with the home; and
- solicit opinions from the nursing home staff as to how to improve the process.

Resident Interviews

The addition of the resident interviews to 2010 site visits was done to accomplish two main goals:

- Obtain first-hand verification of the performance measures for the individual home. There are many components (e.g. bathing environment) that can be seen on a tour of the home, so the interview is an additional opportunity to assess process and outcomes.
- Assess any commonalities in findings of resident interviews from the cross-section of homes. This could be particularly valuable in providing additional insight into the overall efficacy of the P4P program from a resident perspective.

The reviewers learned new and different information from each of the eleven visits and this created a conceptual question for the reviewers. On the one hand, having complete or more accurate information implies a more accurate measurement of the homes' performance on the measures. On the other hand, it is not equitable for eleven randomly selected homes to have the opportunity to provide new information or supplement information provided.

The position that reviewers took on this question was guided by administrative regulation 8.443.13 4, which states that "Applications and supporting documentation as received will be considered complete. No post receipt or additional information will be accepted for that application." Reviewers then would not accept additional information, for example, material that had been accidently omitted from the application. If, however, the visit to the home showed reviewers had not correctly understood information that was already in the application, then that changed understanding was used to review the scoring of the measure.

C. 2009 and 2010 Site Visit Comments

The material presented below is the reviewers' interpretation of what providers were saying. Not all providers had comments on the same topic. Where possible the commentary below seeks to summarize what the main or common points are. The recommendations below are made by reviewers and may or may not be agreed with by the providers interviewed.

General Comments

- Examples of Best Practices – Providers noted that it would be helpful to view best practices in documentation and/or actual implementation of the measure. One 2009 applicant stated that certain performance measures (e.g. neighborhoods/households) were confusing and they were not sure how to implement the practice given their physical plant. A 2010 applicant said that they were still learning about the P4P process and trying to understand requirements for supporting documentation.

- Quality Measures and Consideration of Provider Case Mix – As with site visits in the initial 2009 P4P application review process, providers generally indicated that the scoring of the quality of care domain would be biased to favor homes that did not serve higher acuity populations. One 2009 applicant observed, "I specialize in high acuity wounds. I will always flag for pain and pressure ulcers." On a positive note, one home visited for a 2009 and 2010 application had previously been on the Centers for Medicare & Medicaid home watch list due to poor quality. The home has been working to improve the quality for the residents and is using the P4P application as guidance for focus areas of improvement. As a result, the home is no longer on the watch list or in danger of being closed.

- Application Submission – Providers indicated that the application was hard to find on the website and they had to research submission logistics. A provider visited for a 2010 application mentioned that it was difficult to find the address of where to send the application, and she ultimately drove quite a distance to deliver the documentation personally to Denver. Another provider for a 2009 site visit even noted that it would help to have "upload" capability for the application, so that the home can virtually deliver documentation.

- Recognition of Other Person-Directed Practice or Environmental Transformations – Providers on site visits indicated three areas that are contributing to person-directed care but not recognized in the current P4P application. The first, suggested by a 2010 applicant, is the removal of institutional nurses' stations.[8] The provider remarked that the removal of the station in tandem with the elimination of overhead paging created a more "homelike" atmosphere for residents and staff. Another person-directed transformation mentioned by providers was the use of technology. Reviewers observed the use of "Care Tracker" in two homes (2009 and 2010 applicants). Providers reported that the use of technology anecdotally improves care processes and reporting for the home while lowering costs. A final environmental transformation highlighted by providers was the use of private rooms. Both a 2009 and a 2010 applicant stressed that private rooms were the most resident-directed with little or no restrictions for residents' belongings. For example, residents in private rooms can even bring queen-sized beds from their home.

- Enhancements to Application Instructions – One provider visited for both 2009 and 2010 applications noted that the 2010 application was more detailed and easier to prepare. The same provider also noted that because there were now detailed documentation requirements for each performance measure, it would be helpful to have a checklist within the application that outlined the minimum requirements for each measure.

[8] A review of application indicates that at least three homes do not have nurse's stations: Two of the state veteran's homes, and another home in Greeley.

Comments on Application Measures

- Dining – Onsite home visits confirm that changes to the 2010 P4P application that further define the dining environment and provide examples of supporting documentation (including a narrative, resident testimonials and photographs) provide a more representative picture of the enhanced dining experience in the home. Resident interviews also supported that dining is a key component of their day and choice is important to their subsequent satisfaction. Residents stated that "You choose what you want. If you ask, someone will get you something else" and "They ask us what we want….Dining is the most important for me." Another resident mentioned that the food is so good that it is making him fat and that he enjoys bacon so they have provided him with more bacon. Another resident commented that the home does a good job of trying to incorporate everyone's needs however she understands that it is almost impossible in a nursing home to give everyone everything they want on a daily basis. She said that they have opportunities to get snacks and drinks throughout the day.

- Flexible and Enhanced Bathing – Onsite visits for 2009 and 2010 applications confirmed that documentation was representative of the environment. Homes were in varying states of implementation with some bathing environments completely renovated and others with more minor alterations. It was clear to reviewers after touring the home and speaking with providers that many changes (including paint and home decor) were incentivized by the P4P application. Resident interviews supported that the bathing process was not unpleasant. One resident stated that "They have temperature controls and I always have her turn it down, because I don't like to be warm." Reviewers also attempted to confirm that residents had choice in bathing times when a home had applied for the measure. For example, one resident commented that "It's always the same aid and she asks first." Another said, "I get to shower before breakfast." Another resident was very detailed describing how she bathes twice a week and tells the staff what time of day and how much help she needs.

- Daily Schedules – Based on resident interviews, the more rigorous documentation requirements are appropriate to assure that all aspects of resident preference for the daily schedule are observed. For instance, a 2010 application was denied for the measure and one of the residents interviewed in the home noted that "You have to get up at a certain time (between 6 and 7) for breakfast, but they ask when we want to go to bed." In other homes, resident interviews helped to corroborate verification of the measure. One resident explained that he has a great deal of freedom at the home and that he is able to leave the home to go out to a local shopping center with the understanding that "I just let them know where I am going and when I will be back." Other residents commented that there are activities but they can choose what they want to do. For residents in both 2009 and 2010 site visits, this included staying in their room (by choice) and reading books.

- End of Life – Reviewers noted that Advance Directive instructions are usually on care plans and some forms do not identify whether care plan review occurs quarterly, monthly or less frequently.

- Resident Rooms – Both 2009 and 2010 provider interviews indicated that private rooms are the most person-directed with little to no restrictions and that private rooms are better able to accommodate family to stay with residents in post-acute environments. Semi-private rooms have some restrictions based on available space. All residents interviewed indicated that they were able to personalize their space. One resident even stated that she used her winnings from Bingo to purchase decorations from the home's "Bingo Bazaar" which was described as a shopping area where residents can use their Bingo winnings to purchase different items. Resident interviews also supported the importance of a private and individualized space. One resident stated that "I've never been an activities person. I like to just spend the day in my room reading." Another said "My room is comfortable and a place that I like to be. My best friend lives next door."

- Public and Outdoor Space – Interviews with providers illustrated the importance of this measure for the overall environment. Descriptions of the public and outdoor space mentioned that staff also enjoys these spaces or included examples of staff and residents enjoying activities together (picnics, barbecues, gardening). Reviewers observed dynamic and creative use of outdoor spaces including rose gardens with raised beds the height of wheelchairs so that residents can pick and take roses back to their rooms and vegetable gardens that residents help to tend. Overall, residents interviewed also supported the importance of the outdoor spaces. After resident rooms, outdoor spaces were reported as the most utilized by residents. One resident commented "We love to go outside in our courtyards and we just had a picnic with staff at Cook Park." Another resident that was interviewed by reviewers had family members arrive for a picnic outside.

- Overhead Paging – Providers report that discontinuing overhead paging has significantly enhanced operations. Management is able to better audit the answering of call-lights through the non-overhead system. The system also indicates to staff the order that calls were made, so staff members can address resident needs in an orderly fashion. Both 2009 and 2010 applicants also report the lack of constant beeping has increased productivity. Providers asserted that paging was turned off in response to the P4P application. With one exception, resident interviews confirmed that paging was turned off for those homes that applied for the measure. Residents either were not aware that there was a pager or reported that it was only used for emergencies.

- Neighborhoods/Households – Based on site visits, there seems to be an issue with the interpretation of this performance measure. Providers either reported that neighborhoods/households are not conducive to the layout of their home or applied for points just for "naming" neighborhoods. Residents also were a bit confused by the

concept. Many residents categorized neighborhoods as "sticking together." One resident stated that she calls them units or halls.

- Consistent Assignment – Both 2009 and 2010 providers report the importance of consistent assignment for quality of care and life for residents. A 2010 provider reported that, when CNAs know residents' needs (in terms of wake/sleep, toileting, etc), it has significant impact on resident dignity. A 2009 applicant stated that they now have 0% agency use and "You can't maintain quality with agency. Nothing is consistent" resulting in cost savings for the home while improving quality of life. Resident interviews confirmed consistent assignment in those homes that applied for the measure with residents stating, "The same CNA's are with us the same time every day unless it is their day off. We miss them on their days off. We have our favorites." A resident's family member mentioned that "We know the staff and they are kind to everyone. That is most important to me as a family member."

- Internal Community – Onsite visits revealed that communities have monthly instead of weekly meetings. In addition, other comments from 2009 and 2010 visits indicated that providers did not feel that they met measure requirements, because they had not implemented neighborhoods/households. However, reviewers confirmed that residents meet with each other and also have substantive opportunities to meet with and provide feedback to staff through community meetings. This type of internal interaction may not be fully captured in the current wording of this performance measure.

- External Community – Both 2009 and 2010 visits confirmed the presence of vibrant programmatic implementation that engages the external community. For example, one home creates "Jazz at the Monaco" where professional jazz musicians volunteer to play for residents. Another home has created particularly interesting programs by leveraging proximity to Colorado State University (CSU) to engage students that need volunteer credits and professors interested in lecturing. Other homes from onsite visits were less creative in engaging the external community and may benefit from learning about other creative programs across the state.

- Living Environment – Onsite visits confirm that the testimonials from residents appear to be a successful addition to the 2010 application. Documented testimonials regarding the living environment (e.g. animals, gardening, computer and internet access) are representative of the areas that providers highlighted onsite.

- Volunteer Program – In a comment on the application, a 2009 provider indicated that volunteers had traditionally signed-in via the guest log. Thus, it was difficult for this provider to document hours of visits. However, reviewers also had the opportunity to observe that certain homes for onsite visits had very dynamic volunteer programs. For example, one home uses innovative methods including working with Volunteers of America and partnering with CSU and logged over 1,300 volunteer hours last year.

- Care Planning – Based on provider comments, this is a practice highly incentivized by the P4P application. One provider explained that it is initially a challenge to orient CNAs to the practice of attending care planning sessions but that it is ultimately a good practice that results in positive outcomes for residents and families. From a logistics standpoint, reviewers noted that homes use varying care planning forms that do not identify whether the care plan is done quarterly, monthly or less frequently.

- Career Ladders/Career Paths – Based on onsite visits, reviewers observed that this measure may favor corporate chains that are able to put more structured programs in place. Thus, it is good that the measure also allows more informal documentation such as promoting internally for those smaller, independent homes.

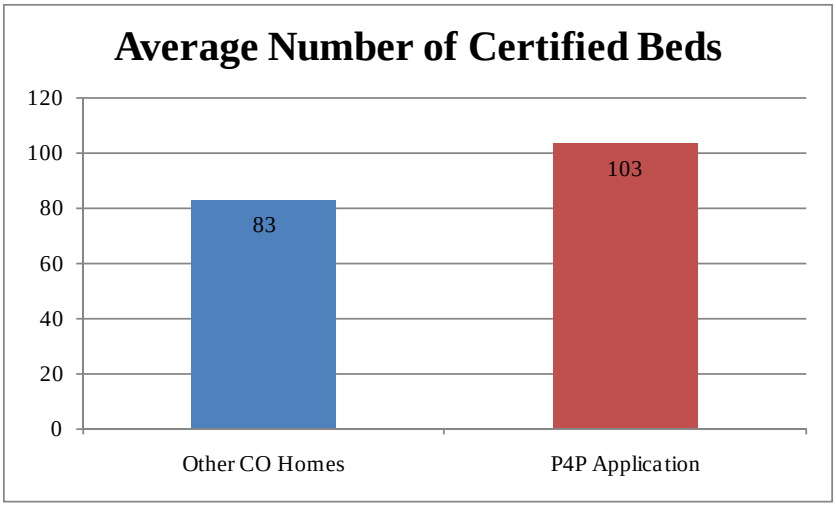
- Person-Directed Care – Onsite visit providers commented that they were not sure what to submit for the measure. Provider interviews also indicated that some providers are associating this measure with Eden Alternative only and not other forms of training.

VII. COLORADO P4P PARTICIPATION ANALYSIS

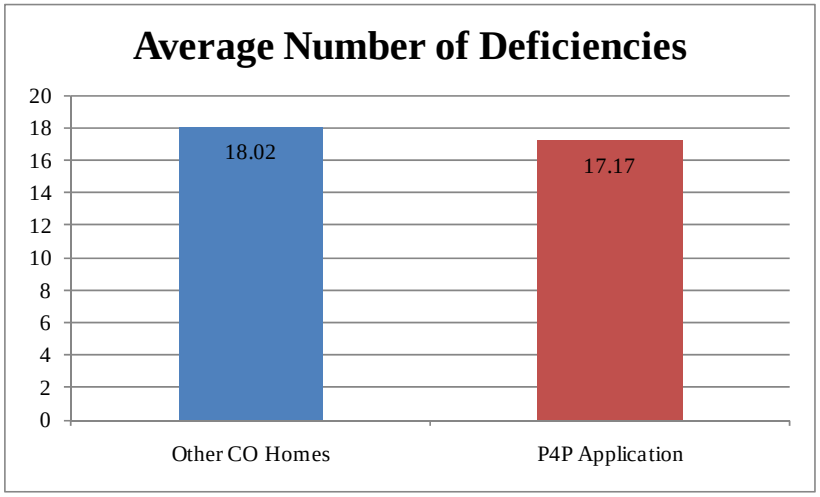
A. 2009 Participation Analysis

The data below is from the 2008 archived Nursing Home Compare database that the Centers for Medicare and Medicaid Services (CMS) maintain. Certain data including Medicaid occupancy is not publicly available on a CMS website, but was obtained directly from CMS staff by reviewers and used to examine differences between homes that applied for the P4P application and homes that did not. The P4P Application values include all 2009 applications submitted for the quarterly 2009 deadlines, including both last year's and the current year's reviews.

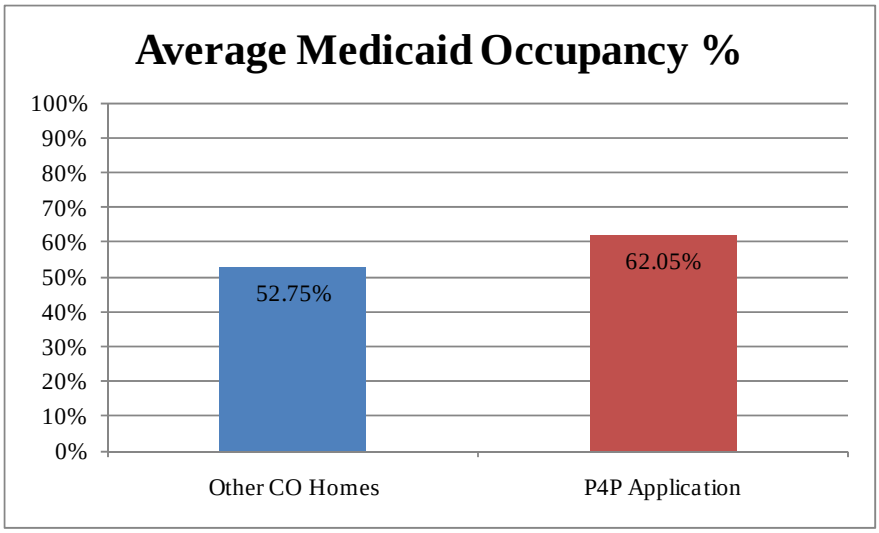
The table below shows that the average size of homes that submitted a P4P application was larger than of homes that did not.



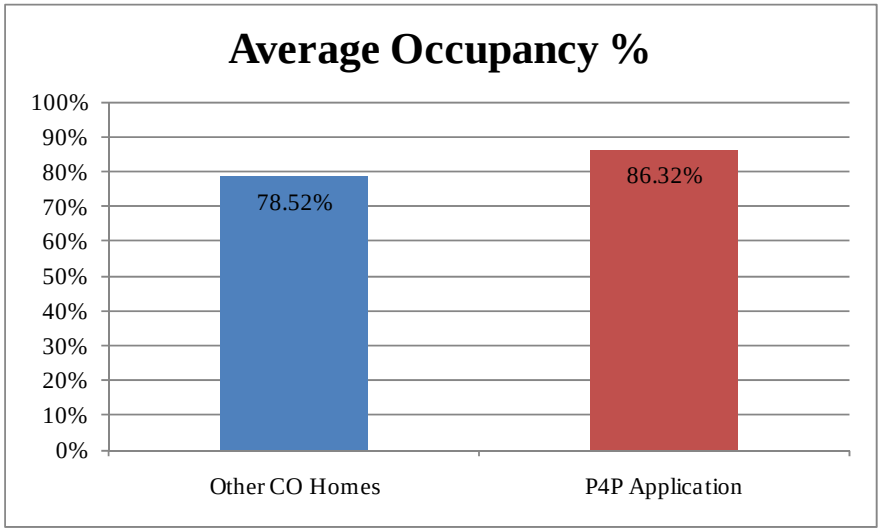
The table below shows that the average number of deficiencies found in homes that submitted a P4P application was less than in homes that did not.



The table below shows that the average Medicaid occupancy in homes that submitted a P4P application was higher than in homes that did not.



The table below shows that the average occupancy in homes that submitted a P4P application was higher than in homes that did not.

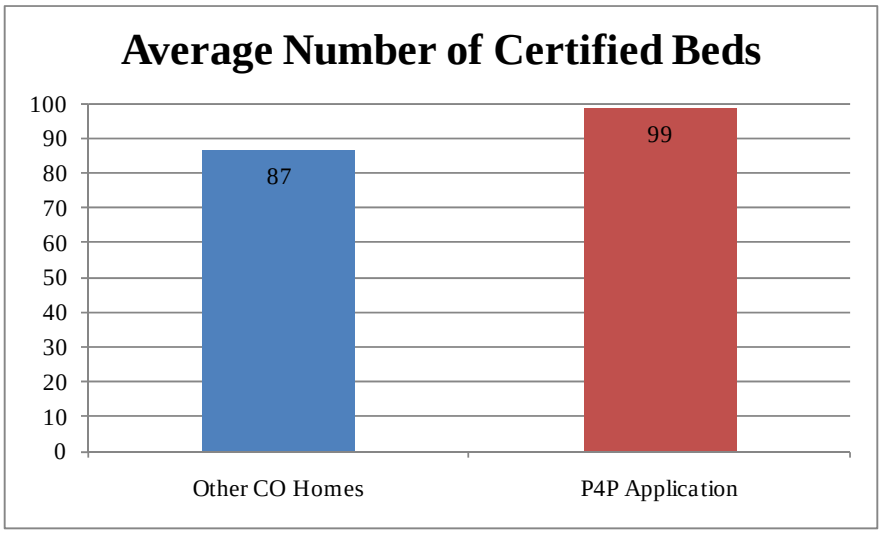


Based on the tables above, it appears as if the 90 homes that submitted 2009 P4P applications were, on average, larger, had fewer deficiencies, and had higher Medicaid and overall occupancy rates.

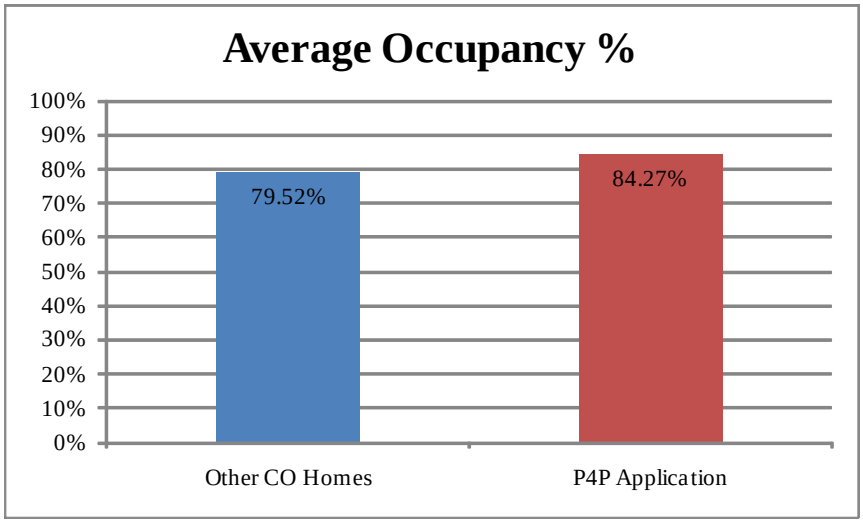
B. 2010 Participation Analysis

The data below is from the 2009 archived Nursing Home Compare database that the Centers for Medicare and Medicaid Services (CMS) maintain. The data was obtained from Nursing Home Compare by reviewers and used to examine differences between homes that applied for the P4P application and homes that did not. Certain data including Medicaid occupancy is not publicly available on a CMS website, and the Average Medicaid Occupancy and Average Deficiency charts could not be presented because of an unavailability of data at this time. The P4P Application values include all 2010 applications submitted for the January 31, 2010 deadline.

The table below shows that the average size of homes that submitted a P4P application was larger than of homes that did not.



The table below shows that the average occupancy in homes that submitted a P4P application was higher than in homes that did not.



Based on the tables above, it appears as if the 98 homes that submitted 2010 P4P applications were again, on average, larger and had a higher overall occupancy rate. However, the difference on each measure between the average values for homes that submitted P4P applications and those that did not appears to have shrunk in 2010 compared to 2009.

VIII. SUMMARY OF RECOMMENDATIONS

The table below summarizes the recommendations developed during the application review and home visits. There is a point of view that says the best performance measures to use are those that are quantifiable e.g. developed from cost reports, or those that are standardized across states such as the CMS Nursing Home Compare data. As this review of performance measures shows, significant experiences such as dining, bathing, and living in a home with more resident-centered activities do not admit to ready quantification, however, they are essential performance measures and can be consistently reviewed.

A prevalent problem in the reviews had nothing to do with the measures themselves but rather that homes did not follow the directions in the applications and omitted documentation called for in the minimum requirements.

What is apparent from the reviews of the applications and home visits is that the performance measures have successfully stimulated homes to change their culture. PCG believes that the application was greatly enhanced with the changes made from FY 2009 and FY 2010, and the reviewers hope that the suggestions below will strengthen and simplify the ability of homes to apply in the future and support the Department as its use of these measures evolves.

Measure	Reason for Recommendation	Recommendation
Enhanced Dining		No recommendation
Flexible and Enhanced Bathing	The most frequent reason that a home did not receive credit was for not providing documentation as to the use of Bathing without a Battle.	Although all homes should have access to the video through CMS, the Department might consider providing additional information on Bathing without a Battle in the application or more detailed expectations of proper documentation such as orientation materials or training logs.
Daily Schedules	The most frequent reason that points were not assigned for this measure was that four resident testimonials and/or their corresponding care plans were not submitted.	A potential recommendation for a revised P4P application is to bold "same resident care plans and testimonials" in the application to further highlight this requirement.
End Of Life Program	The most frequent reason that points were not assigned for	To clarify the measure for providers, a revised P4P

Measure	Reason for Recommendation	Recommendation
	this measure was that four resident testimonials and/or their corresponding care plans were not submitted.	application may request providers to clearly identify that Advance Directives are done quarterly or more often via dates on the form, and/or ask homes to choose a minimum threshold of residents and supply reviews for a year to demonstrate quarterly compliance.
Resident Rooms	The problem with visual documentation is that the pictures that are presented are not randomly selected and may represent the very best in the home rather than the average.	The state might consider suggesting that all rooms in a unit or part of a home be selected or a minimum number of rooms be selected to ensure a more representative selection.
Public and Outdoor Space	Homes that did not receive credit had photographs that were not persuasive. Either the photographs did not appear to show much of the home or what was in the pictures did not appear to document the measure.	To clarify the measure and assist in application review, a revised P4P application might ask providers to include captions with the photographs identifying the public and outdoor spaces and examples of the use of the space by residents and staff.
Overhead Paging		No recommendation.
Neighborhoods/Households	Based on site visits, there seems to be an issue with the interpretation of this performance measure. Providers either reported that neighborhoods/households are not conducive to the layout of their home or applied for points just for "naming" neighborhoods.	To further clarify for homes, a revised P4P application may include further definition of neighborhoods/households as noted in a Stage Model of Culture Change (Grant & Norton, 2003). In addition, if rewarding person-directed environmental transformations is the goal of the measure, the definition could be expanded to include alternative environmental

Measure	Reason for Recommendation	Recommendation
		changes such as eliminating nurses stations or increasing the number of private rooms (or the Neighborhoods/Households measure could be reweighted to reflect fewer points and an additional measure could be added to reflect environmental transformations not currently represented in the application).
Consistent Assignments	Documenting variations in methods of scheduling from the day and evening designation in the 2010 application instructions is a legitimate concern for applicants.	In the future the Department might consider augmenting instructions to account for scheduling variations or provide a note describing potential ways to document non day/evening shifts for homes.
Internal Community	Reviewers noted that the documentation requirements call for sample weekly minutes however most homes documented monthly minutes. Through the site visits, it became apparent that most internal communities have attempted to conduct weekly meetings but have since moved to monthly meetings at the request of the residents. These homes noted that weekly meetings were poorly attended by residents and that attendance and participation in monthly meetings is better.	The Department might consider changing the wording to reflect different types of meetings of committees and eliminate the designation of weekly minutes from the required documentation and allow for any example of minutes (i.e. minutes of periodic meetings)
External Community	Reviewers found that those homes that did not receive points for this measure failed	To clarify the measure and assist in application review, a revised P4P application

Measure	Reason for Recommendation	Recommendation
	to provide documentation that clearly illustrated the involvement of the external community.	might ask providers to include captions with the photographs identifying the activity and external community involvement.
Living Environment	Reviewers found that applications that included captions with the photographs provided for a more clear understanding of relevance of the photograph the measure	Captions should be included with the photographs to allow for a more clear understanding of the resident connection.
Volunteer Program	Onsite visits revealed that a home may not have included formal sign-in sheets because volunteers were asked to sign-in in the guest log intermixed with visitors. In this instance, the home provided descriptions of multiple programs and visits substantiated by an outside source.	If sign-in sheets are the preferable documentation of volunteer hours, the Department might consider revising minimum requirements to include sign-in sheets.
Care Planning	Care plans forms vary and do not always identify timing.	To further clarify this measure the Department might consider asking homes to clearly identify the care plans as initial and quarterly.
Career Ladders/Career Paths		No recommendation.
Person-Directed Care	Many providers either did not apply or did not meet measure requirements. Providers commented that they were not sure what to submit for the measure. Interviews also indicated that providers are associating this measure with Eden Alternative and not other forms of training.	The observation that fewer homes applied for, and successfully documented this measure, is evidence of opportunities for future growth and implementation of person-directed care in the 2011 P4P application process. Since fulfilling requirements for person-directed care may not be as concrete as other measures (e.g. overhead paging) and site visits indicated that

Measure	Reason for Recommendation	Recommendation
		homes may associate this measure with Eden Alternative trainings only, a revised P4P application could further clarify this measure to include investment in training or education for any of the P4P Quality of Life performance measures to include outside speakers, webinars, and/or conferences with documentation of staff participation.
New Staff Program	Reviewers found that the most common reason for a home not receiving points for this measure was the lack of staff testimonials.	Since staff testimonials were the predominant reason for denial of this measure, the Department might consider moving the requirement for staff testimonials to immediately follow the written narrative as opposed to following optional measures (e.g. orientation, referral bonus) to further highlight this requirement in the application. Recruitment is the most difficult requirement to document. Either it should be dropped from the performance measure or more description should be supplied as to what qualifies as adequate documentation.
Continuing Education		No recommendation
Quality Program Participation		No recommendation
Falls		Application states in Appendix 4 (page 18) "Set your report dates (March 1 – November 30) of the

Measure	Reason for Recommendation	Recommendation
		previous year." This conflicts with selecting Quarter 2 and Quarter 3, and should be updated. It is not necessary to select both quarters individually, since both can be selected in a single date range (4/1/09-9/30/09).
High Risk Pressure Ulcers		Application states in Appendix 4 (page 18) "Set your report dates (March 1 – November 30) of the previous year." This conflicts with selecting Quarter 2 and Quarter 3, and should be updated. It is not necessary to select both quarters individually, since both can be selected in a single date range (4/1/09-9/30/09).
Chronic Pain		Application states in Appendix 4 (page 18) "Set your report dates (March 1 – November 30) of the previous year." This conflicts with selecting Quarter 2 and Quarter 3, and should be updated. It is not necessary to select both quarters individually, since both can be selected in a single date range (4/1/09-9/30/09). In addition, the application should more clearly state that the Adjusted Percent Value should be used be used. It is mentioned in Appendix 4, but should be highlighted.

Measure	Reason for Recommendation	Recommendation
Physical Restraints		Application states in Appendix 4 (page 18) "Set your report dates (March 1 – November 30) of the previous year." This conflicts with selecting Quarter 2 and Quarter 3, and should be updated. It is not necessary to select both quarters individually, since both can be selected in a single date range (4/1/09-9/30/09).
UTI		Application states in Appendix 4 (page 18) "Set your report dates (March 1 – November 30) of the previous year." This conflicts with selecting Quarter 2 and Quarter 3, and should be updated. It is not necessary to select both quarters individually, since both can be selected in a single date range (4/1/09-9/30/09).
Staff Influenza Immunization		No recommendation
10% or 5% Medicaid	Homes used a statewide Medicaid Utilization rate that was calculated incorrectly.	If possible, the statewide Percent Medicaid Utilization (as calculated in accordance with the Med 13) average should be included in the application so that all homes are comparing themselves to the proper percentage. In addition, it should be specified that "10% above or more" and "5% above or more" refers to percentage points, not the percent change.
Staff Retention Rate		The narrative in the

Measure	Reason for Recommendation	Recommendation
		minimum requirements should reference Appendix 5 instead of Appendix 2. In addition, the Staff list does not have to be the exact run date from 1/1/2009-12/31/2009. Staff retention options should be reworded to accept staff list run dates within two weeks before or after the end of the year.
Staff Retention Improvement		The narrative in the minimum requirements should reference Appendix 5 instead of Appendix 2. In addition, the Staff list does not have to be the exact run date from 1/1/2009-12/31/2009. Staff retention options should be reworded to accept staff list run dates within two weeks before or after the end of the year.
DON Retention		No recommendation
NHA Retention		No recommendation
Employee Satisfaction Survey		No recommendation
Other Recommendations		
Provide Recommendations of Best Practices	Visits to onsite providers indicated that it would be helpful to view best practices in documentation and/or actual implementation of the measure. Reviewers also noted examples of best practices that resulted in higher quality for the home at a cost savings.	An ancillary (yet beneficial) outcome of the pay-for-performance process for Colorado is the amassing of best practices. In particular, many practices are improving resident quality while saving the organization money (examples from onsite visits include dining, external community and volunteer practices). It would be

Measure	Reason for Recommendation	Recommendation
		beneficial to the state, nursing homes, and residents to share these practices for more wide scale adoption. This could be done via the website, examples in the application or through communication from state provider organizations.
Application Submission	Providers indicated that the application was hard to find on the website and they had to research submission logistics.	More clearly state submission logistics at the top of the application under the application deadline and/or allow homes to upload or send the application and supporting documentation virtually.
Recognition of Other Person-Directed Practice or Environmental Transformations	Providers indicated that other person-directed practice or environmental transformations occurring in homes are significant but not captured in the current application.	In the future, the Department may revisit the application to consider including other person-directed transformations such as eliminating nurses' stations, use of technology and percentage of private rooms.
Prerequisites	Homes did not include the Family/Resident Survey. From onsite interviews it became clear that homes did not notice the prerequisites on the first page.	Include prerequisites in the same design as the rest of performance measures.
Photograph Captions	Reviewers had a difficult time identifying the relevance of some photographs provided.	Require that photographs included in the documentation have captions to clearly identify the relevance of the photograph.
Training and Education	During onsite visits, homes noted that they would benefit from a formal training about the P4P process and application.	Develop an annual training program for the P4P process and application.
Electronic Submittal (CDs	Some homes that sent CDs	A best practice noticed of

Measure	Reason for Recommendation	Recommendation
and USBs)	and USBs scanned all documentation into one file that was very difficult to identify pages were documentation a particular performance measure.	other submittals was to create separate folders for each performance measure with clearly labeled files within each folder.
Requirement Checklist	Homes did not include all pieces identified as required documentation within individual measures. From onsite interviews it became clear that homes were overlooking sections of the performance measure narratives.	Develop a comprehensive checklist that identifies the mandatory and optional requirements discretely.

APPENDIX A – MEDICAID OCCUPANCY DATA

2009 Medicaid Occupancy Data

Nursing Facility Patients by Payor - Percentage of Patients
CMS OSCAR Data Current Surveys, December 2008

State	Total Patients	Medicare	Medicaid	Other Payer
US	1,412,414	14.00%	63.50%	22.50%
AK	616	10.20%	74.00%	15.70%
AL	23,205	14.30%	68.70%	17.00%
AR	17,753	11.70%	69.20%	19.10%
AZ	12,201	13.20%	62.80%	24.00%
CA	103,487	13.50%	65.40%	21.10%
CO	16,464	11.90%	58.30%	29.80%
CT	26,819	15.40%	66.20%	18.30%
DC	2,437	8.80%	81.90%	9.30%
DE	3,999	16.80%	56.20%	27.00%
FL	71,833	20.00%	57.60%	22.50%
GA	35,254	11.70%	72.70%	15.60%
HI	3,840	10.00%	70.00%	20.00%
IA	26,292	7.50%	47.40%	45.10%
ID	4,522	15.90%	59.00%	25.10%
IL	76,282	14.40%	62.10%	23.50%
IN	39,536	16.10%	61.60%	22.20%
KS	19,301	9.20%	52.80%	38.00%
KY	23,233	15.20%	66.10%	18.70%
LA	25,875	11.70%	73.70%	14.60%
MA	43,684	13.60%	63.20%	23.20%
MD	25,243	16.20%	60.80%	22.90%
ME	6,591	16.80%	65.40%	17.80%
MI	40,224	17.60%	63.20%	19.20%
MN	31,056	10.40%	56.20%	33.40%
MO	37,510	12.60%	60.60%	26.80%
MS	16,246	13.40%	76.90%	9.60%
MT	5,137	11.00%	58.00%	31.00%
NC	38,025	15.70%	66.90%	17.30%
ND	5,847	6.90%	54.80%	38.20%
NE	12,899	11.10%	51.60%	37.30%

State	Total Patients	Medicare	Medicaid	Other Payer
NH	6,953	14.90%	63.80%	21.20%
NJ	45,946	17.10%	62.70%	20.20%
NM	5,695	13.20%	61.10%	25.70%
NV	4,724	16.00%	58.40%	25.60%
NY	110,836	13.10%	70.60%	16.30%
OH	81,395	13.90%	62.60%	23.50%
OK	19,518	11.10%	66.40%	22.50%
OR	8,113	13.20%	61.70%	25.20%
PA	79,710	11.70%	62.90%	25.50%
RI	7,955	9.10%	64.90%	25.90%
SC	17,004	16.10%	64.40%	19.50%
SD	6,528	7.70%	56.70%	35.60%
TN	32,288	15.20%	65.90%	18.90%
TX	90,385	14.40%	63.40%	22.30%
UT	5,456	18.40%	53.30%	28.30%
VA	28,279	17.60%	59.70%	22.70%
VT	2,992	14.40%	67.10%	18.50%
WA	18,760	16.20%	59.70%	24.00%
WI	32,325	14.20%	60.10%	25.70%
WV	9,710	13.80%	72.50%	13.70%
WY	2,431	12.60%	60.10%	27.30%

Source: American Health Care Association

2010 Medicaid Occupancy Data

Nursing Home Patients by Payor - Percentage of Patients
CMS OSCAR Data Current Surveys, December 2009

State	Total Patients	Medicare	Medicaid	Other Payer
US	1,401,295	14.10%	63.60%	22.20%
AK	633	11.70%	76.80%	11.50%
AL	23,186	13.30%	69.20%	17.50%
AR	17,801	11.00%	69.10%	19.90%
AZ	11,908	13.80%	63.70%	22.60%
CA	102,700	13.90%	66.50%	19.60%
CO	16,288	11.90%	58.00%	30.10%
CT	26,253	14.90%	66.10%	19.00%
DC	2,531	10.60%	80.10%	9.30%
DE	4,256	16.40%	56.90%	26.70%
FL	71,657	20.40%	57.80%	21.90%
GA	34,794	12.00%	72.40%	15.60%
HI	3,841	11.00%	70.30%	18.80%
IA	25,814	7.60%	47.40%	45.00%
ID	4,419	16.50%	60.90%	22.70%
IL	75,546	14.50%	62.40%	23.10%
IN	39,190	16.40%	61.30%	22.30%
KS	19,029	10.10%	53.40%	36.40%
KY	23,318	15.50%	65.80%	18.70%
LA	25,077	11.90%	73.80%	14.30%
MA	43,215	14.00%	63.20%	22.70%
MD	25,011	17.20%	60.40%	22.40%
ME	6,485	16.10%	65.70%	18.10%
MI	40,188	17.80%	62.60%	19.70%
MN	30,073	10.40%	56.00%	33.70%
MO	37,588	13.10%	60.90%	26.00%
MS	16,294	14.40%	75.70%	9.90%
MT	5,077	10.90%	57.20%	31.90%
NC	37,587	15.30%	67.40%	17.20%
ND	5,777	7.30%	53.70%	39.00%
NE	12,627	11.60%	51.70%	36.70%
NH	6,941	13.90%	64.50%	21.60%

State	Total Patients	Medicare	Medicaid	Other Payer
NJ	45,788	17.70%	63.00%	19.40%
NM	5,569	12.10%	61.40%	26.50%
NV	4,699	16.10%	60.60%	23.30%
NY	109,867	12.50%	72.00%	15.50%
OH	80,185	13.30%	62.70%	24.10%
OK	19,209	11.20%	66.60%	22.20%
OR	7,708	12.90%	60.90%	26.20%
PA	80,562	11.60%	62.30%	26.10%
RI	8,040	9.70%	64.90%	25.40%
SC	17,148	16.30%	63.70%	20.10%
SD	6,476	8.10%	55.90%	35.90%
TN	31,876	15.30%	65.20%	19.50%
TX	90,534	14.80%	63.00%	22.10%
UT	5,358	17.80%	53.50%	28.60%
VA	28,392	18.00%	60.50%	21.50%
VT	2,980	15.10%	66.40%	18.50%
WA	18,188	17.00%	59.80%	23.20%
WI	31,619	13.60%	60.20%	26.20%
WV	9,613	13.40%	73.20%	13.40%
WY	2,380	10.90%	59.80%	29.20%

Source: CMS OSCAR Form 672: F75 - F78