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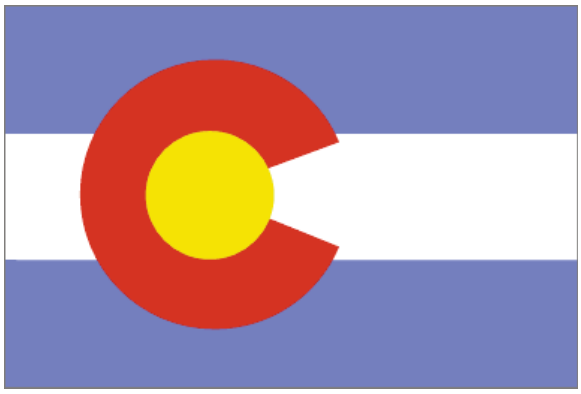

STATE OF COLORADO

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Nursing Facility Pay-for-Performance Application Review (For Applications Submitted 1/31/09)

June 30, 2009

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I. EXECUTIVE SUMMARY

The Colorado Department of Health Care Policy and Finance (The Department) made a transformational change in the way they reimburse nursing facility providers for performance in State Fiscal Year (SFY) 2009. The Department adopted a Pay for Performance (P4P) program, which offers financial incentives to providers that provide high levels of quality of life and quality of care. Public Consulting Group (PCG) was hired to review, evaluate, and validate applications from the nursing facilities that applied for the program by the January 31, 2009 deadline. This process included developing and implementing an application evaluation tool, finalizing nursing facility 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 facilities 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. These recommendations included the following items (in no particular order):

- Colorado may look to provide more detailed instructions with the application forms.
- Colorado may look to add supplemental forms for certain measures.
- Colorado may ensure provider Case-Mix is considered in scoring 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

The Department released a request for "Documented Quotes" (DQ) from qualified and experienced vendors to evaluate Pay-For-Performance applications and supporting documentation as submitted by nursing facilities in Colorado to determine whether each facility has met criteria and is eligible for additional reimbursement. Pursuant to HB 08-1114 the Department of Health Care Policy and Financing is required to reimburse nursing facilities in Colorado an additional per diem rate based upon performance. The Department developed performance measures to assess quality of life and care in each nursing facility, and needed to evaluate and validate that nursing facilities have implemented, and are in compliance with, performance measures as defined by the Department.

B. Goals of the Project

The Department had received forty-two (42) Pay-For-Performance applications which required review by June 30, 2009. In addition, the Department required on-site evaluations for no less than four (4) of these provider applicants. PCG responded to the DQ request and was awarded the project on June 8, 2009.

C. Major Deliverables

PCG was tasked with reviewing, evaluating, and validating whether nursing facilities 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 Colorado Nursing Facility Medicaid Pay-For-Performance program has twenty-seven (27) performance measures in the "domains" of "Quality of Life" and "Quality of Care". The reimbursement for these measures is based on points. A total of up to one-hundred (100) points are possible to be earned. The threshold for any reimbursement begins with scores of twenty-one (21) 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 facility chose which, and how many of these measures it applied for.

The Pay-For-Performance measures have been established in the Pay-For-Performance applications in two "domains": 1. "Quality of Life" and 2. "Quality of Care"

Within each "domain" are subcategory measures. On the application form, each of these subcategory measures is further described by definitions, minimum requirements description of the required documentation and the possible points for each subcategory measure. As the contractor, PCG is responsible for reviewing the applications and assigning the points merited for each measure contingent upon the review, evaluation and

validation that the subcategory measurement requirements have been documented and met.

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

- Reviewing, evaluating and validating applications from the nursing facilities that applied by the January 31, 2009 deadline to participate in the Pay-For-Performance program.

- Developing and implementing the evaluation tool that will be used to measure compliance with each Pay-For-Performance subcategory measure.

- Developing and maintaining a record file for each nursing facility that applies for the Pay-For-Performance program.

- Making the results of all evaluations and reports available to the Department for a period of five (5) years after the end of the contract resulting from the DQ.

- Developing template letters to inform the Department and the facilities about the results of its review, evaluation and validation of the Pay-For-Performance 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 facilities should have on-site visits and conducting four (4) on-site review and validations of the Pay-For-Performance Application and supporting documentation.

- Providing the final evaluation results of the Pay-For Performance applications to the Department by June 29, 2009 in a standardized format developed by the Contractor and approved by the Department, and

- Providing a report to the Department by June 30, 2009 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 state agency consulting engagements. 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 the following Subject Matter Experts (SMEs):

- Maureen Booth, a national expert on quality of care in long term care settings, who has worked closely with CMS and states.
- Roger Auerbach, a former Administrator of Oregon's Senior and Disabled Services Division, who has provided technical assistance to state grantees of CMS, and the U.S. Administration on Aging in addition to AARP, and
- 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 Subject Matter Experts (SMEs) was assisted by PCG Business Analysts and Consultants with backgrounds researching and analyzing "Pay for Performance" reimbursement structures. Team members included Keith Chernoff, Allison Ryan, Asher Cowan, 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 and Evaluation Tool

PCG developed a standardized, comprehensive methodology to review the forty-two Nursing Facility Pay for Performance (P4P) applications that were submitted to the Department of Health Care Policy and Financing (HCPF). During the week of June 15, 2009 through June 18, 2009, six reviewers worked at the Department offices to evaluate the applications. Working in this collaborative environment on Department premises allowed reviewers to develop an approach to evaluate applications and discuss ambiguous or contentious issues with Department staff to ensure uniformity in the reviews.

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. After entering in provider information, such as address, phone number, preparer name, etc., and the homes' self-reported scores, reviewers read each application and its supporting documentation in depth to evaluate and score the applications on each of the subcategory performance measures.

The database was designed to guide the reviewer through each minimum requirement and provide a "Yes" or "No" answer for each performance measure whether or not the applicant self-reported a score. The database contained a field for reviewer comments and reviewers added comments to it.

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

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.

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 two 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 reviewer examined the supporting documentation submitted in the application to answer "Yes" or "No" to the question, "Did the facility meet the minimum 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 reviewer entered a "Yes" response for all of the minimum requirements for a certain performance measure, the self reported score was confirmed. If the reviewer entered a "No" response to any of the minimum requirements for a particular performance measure, the self reported score was not confirmed.

The database was 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.
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, one home did not report a score for the neighborhoods/households measure, yet the application provided ample documentation that the home had neighborhoods. In situations like this a "Yes" score was assigned to the measure.

Reviewers discussed what evidence or supporting documentation an applicant needed in order to meet each minimum requirement. An effort was made to standardize what constituted an acceptable threshold for confirming points. Below are examples of standards adopted by the reviewers of the applications:

- In order to confirm points to an applicant for the "Care Planning" performance measure, samples of <u>both</u> an initial and quarterly care plan conference summary with a CNA signature must be included in the application.

- Reviewers used the CMS Online Survey Certification and Reporting (OSCAR) data to measure the statewide Medicaid occupancy average, which in December 2008 was reported to be 58.3%, per the Department's guidance. Applicants were measured against this percentage when evaluated for the 10% and 5% above statewide average Medicaid occupancy performance measure.

- To meet the requirements for Director of Nursing (DON) and Nursing Home Administrator (NHA) Retention performance measure, the DON and/or NHA had

to be employed in that particular role for at least three years. This disqualified applicants whose DON/NHA had been employed for at least three years, but had only held the DON/NHA position for less than three years.

Once the P4P applications were reviewed for all forty-two participating facilities, the individual application evaluation forms for each applicant were uploaded into a central Microsoft Access database.

After uploading all of the application evaluation forms into the central database, a report was run that summarized the applications scores by Facility Name, Application Reviewer, Available Points, Self-Reported Score, and Reviewer Score. The results of this report were used to assure the quality of the process. Reviewers cross-referenced each applicant's self-reported score from the application to what was entered into the database. More detailed reports for each applicant were checked against the application evaluation forms to make sure that the reviewer's score matched the "Yes" and "No" answers given for each of the minimum requirements, with the understanding that a "No" response for any minimum requirement resulted in no points awarded for that performance measure.

The application reviews were further checked to ensure points were awarded only once. for each "either/or" performance measure. For example, Staff Retention Rate and Staff Retention Improvement are measures for which an applicant can receive points for either but not for both.

An outlier check was made on those measures that almost every self-reported score was confirmed. For example, on both the performance measures of "External Community" and "Living Environment" only two providers were not confirmed points. As a group, reviewers discussed these four situations to be sure the scoring of them was correct.

At least three measures produced a difficult and broad array of disparate information: staff retention and turnover, continuing education, and consistent staff assignments. One reviewer was designated to check the scores of each these again to ensure that reviewers were consistent across homes.

IV. REVIEW OF PERFORMANCE MEASURES

A. Overview of Performance Measures

Pursuant to HB 08-1114 the Department is required to reimburse nursing facilities 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.

A Pay-For-Performance 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.

Calculation of the Per Diem Rate Add-On
0 – 20 points = No add-on
21 – 45 points = $1.00 per day add-on
46 – 60 points = $2.00 per day add-on
61 – 79 points = $3.00 per day add-on
80 – 100 points = $4.00 per day add-on

Approximately 190 nursing homes participated in the Medicaid program in 2007. The average number of days of Medicaid occupancy for these 190 homes was approximately 18,900 days.[2] The average home that scored 50 points on the pay for performance measures would thus receive an additional $2.00 a day in reimbursement or $37,872.[3]

To be eligible for participation a home must not have had substandard deficiencies, as defined by the State Operations Manual (SOM), on an annual, complaint or any other

[1] 10 CCR 2505-10 Section 8.443.12
[2] This figure was obtained by calculating the number of Medicaid days from the 190 cost reports submitted during 2007.
[3] This generalization is qualified by the provision of 8.443.12 6. Which reads "If the expected average rate add-on for those facilities 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 facility rate prior to add-on payments."

Colorado Department of Public Health and Environment survey.[4] In addition, the home must participate annually in a resident/family satisfaction survey that is developed, recognized, standardized and administered by an entity external to the home. The home must report its response rate and a summary report must be made publically available along with the home's State Survey results.

[4] The State Operations Manual (SOM) is published by the Centers for Medicaid and Medicare Services. Retrieved on _June 20, 2009 from http://cms.hhs.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf

B. Summary Report Chart Showing Scores of Homes

The following two tables show a summary of scores by home and by performance measure:

Provider#:	Facility Name:	Points Available	Self-reported Score	Reviewers Score
77105753	Amberwood Court CC	100	65	52
30576016	Berkley Manor Care Center	100	85	57
71787267	Brookshire House	100	69	61
37605216	Broomfield Skilled Nrsg & Rehab	100	54	42
79475744	Castle Rock CC	100	113	68
42988268	Christopher House	100	74	74
05650338	Clear Creek CC	100	61	61
05652607	Colorow	100	82	76
05655394	Columbine Manor Care Center	100	71	55
05650833	Columbine West Hlth & Rehab	100	64	59
82159815	CSV - Fitzsimons	100	65	53
05654223	CSV Bruce McCandless	100	84	84
05653274	CSV Homelake	100	56	47
73422070	Denver North CC	100	87	85
05653423	Fairacres Manor	100	62	50
00122777	Forest Street Compassionate CC	100	30	32
05652714	Hallmark Nursing Center	100	77	56
42402069	Harmony Pointe Nursing Center	100	76	78
05652623	Heritage Park Care Center	100	69	39
15526755	Highline Rehab & Care Community	100	61	28
05651245	Holly Heights Nursing Center	100	95	89
05655147	Holly Nursing Care Center	100	73	69
05651401	Julia Temple Center	100	75	65
05652334	Larchwood Inns	100	86	77
05651328	LCC Evergreen	100	64	64
05652995	LCC Littleton	100	69	46
05651377	LCC Longmont	100	65	57
05650742	LCC Pueblo	100	62	60
05653290	LeMay Ave Health & Rehab	100	57	55
05651294	North Shore Health & Rehab	100	69	58
26554739	North Star Community	100	66	48
16433548	Paonia Care & Rehab	100	70	50
54603528	ParkView Care Center	100	74	42
05652508	Rowan Community	100	85	76
05652615	San Luis CC	100	96	75
16876334	Sierra Healthcare Community	100	81	54
05654058	Trinidad State NF	100	73	46
08858721	Uptown CC	100	80	71
05651468	Valley View HCC	100	84	76
05655824	Valley View Villa	100	86	68
05655709	Villa Manor Care Center	100	81	75
05651575	Western Hills HCC	100	74	36

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	39	29	10	26%
Flexible and Enhanced Bathing	41	27	14	34%
Daily Schedules	38	33	6	16%
End Of Life Program	39	32	7	18%
Resident Rooms	41	40	1	2%
Public and Outdoor Space	39	37	4	10%
Overhead Paging	38	27	11	29%
Neighborhoods/Households	34	27	8	24%
50% Consistent Assignments	5	5	1	20%
80% Consistent Assignments	37	21	16	43%
Internal Community	35	33	2	6%
External Community	40	40	0	0%
Living Environment	41	39	2	5%
Volunteer Program	41	36	5	12%
Care Planning	33	22	11	33%
Career Ladders/Career Paths	38	33	5	13%
Person-Directed Care	34	27	7	21%
New Staff Program	39	29	10	26%
+2 Continuing Education	8	5	3	38%
+4 Continuing Education	8	3	5	63%
+6 Continuing Education	24	18	7	29%
Quality Program Participation	37	36	1	3%
High Risk Pressure Ulcers	20	17	3	15%
Chronic Care Pain Score	16	15	2	13%
Physical Restraints	22	21	1	5%
10% Medicaid	17	19	2	12%
5% Medicaid	11	2	9	82%
Staff Retention Rate	36	36	1	3%
Staff Retention Improvement	6	2	4	67%
DON Retention	21	19	2	10%
NHA Retention	27	24	3	11%
Employee Satisfaction Survey	36	34	2	6%

**# of Nursing Home with Score Confirmed includes cases where points were substantiated with documentation but the nursing home did not self report score*

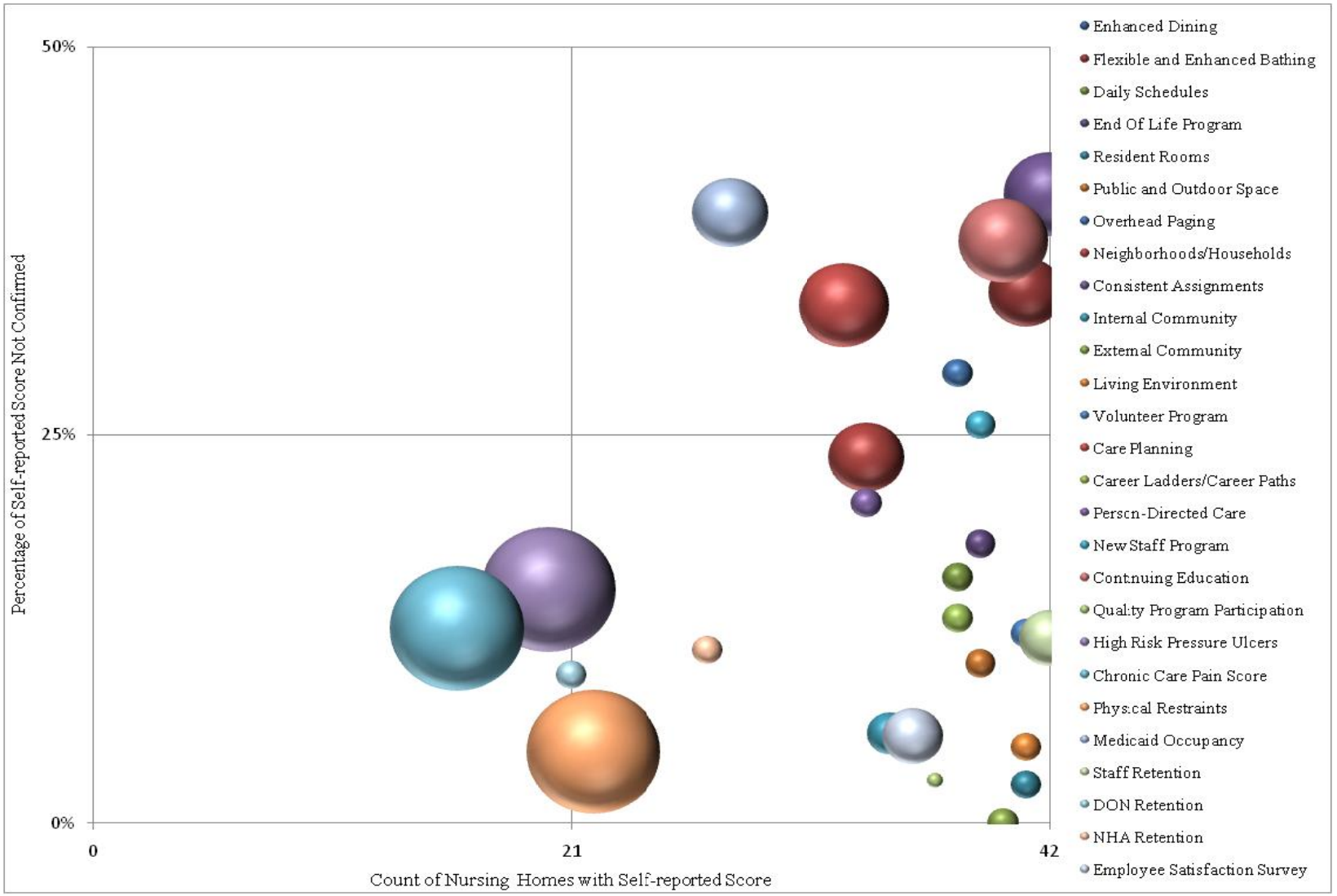
C. Changes to Self-Reported Scores

The graph below illustrates by performance measure the relationship of the number of nursing homes who self-reported a score and the percentage of those nursing homes where the score was not confirmed by the reviewers. The percentage of self-reported scores which were not confirmed is plotted on the vertical axis and was derived by dividing the number of scores not confirmed by reviewers into the number of homes which self-reported a score. Plotted on the horizontal axis is the count of nursing homes which self-reported a score for each performance measure. The size of the bubble indicates the points available for each performance measure. For example, Physical

Restraints has 9 possible points and thus is one of the biggest bubbles. Quality Program Participation has the smallest bubble with 1 possible point.

Most of the performance measures fall in the lower right quadrant of the graph. This means that most of the performance measures had more than 21 nursing homes self-reporting a score and less than 25% of the time the documentation did not confirm the score. High Risk Pressure Ulcers and Chronic Care Pain Score are the only two performance measures where fewer than 21 nursing homes self-reported a score.

There were 7 performance measures where reviewers did not confirm the self-reported score more than 25% of the time. These bubbles fall in the upper right quadrant on the graph below. Interestingly, these same 7 performance measures correlated with the performance measures which generated the most conversation and questions while reviewing the applications. Consistent Assignments, Continuing Education, and Flexible and Enhanced Bathing all fell in this quadrant with 40 or more nursing homes applying for the points and the score was not confirmed more than 34% of the time. Medicaid occupancy had 28 nursing homes self-reporting a score and 39.29% of them were not confirmed in the documentation. Care Planning, Overhead Paging, and New Staff Programs were the remaining performance measures which fell into the upper right quadrant on the graph.


50%
25%
0%
Percentage of Self-reported Score Not Confirmed
0
21
42
Count of Nursing Homes with Self-reported Score
Enhanced Dining
Flexible and Enhanced Bathing
Daily Schedules
End Of Life Program
Resident Rooms
Public and Outdoor Space
Overhead Paging
Neighborhoods/Households
Consistent Assignments
Internal Community
External Community
Living Environment
Volunteer Program
Care Planning
Career Ladders/Career Paths
Person-Directed Care
New Staff Program
Continuing Education
Quality Program Participation
High Risk Pressure Ulcers
Chronic Care Pain Score
Physical Restraints
Medicaid Occupancy
Staff Retention
DON Retention
NHA Retention
Employee Satisfaction Survey

D. Pre-Requisites for Participation

Colorado administrative regulations at 8.443.12 at 2.a. and 2.b. set two prerequisites for applying for the pay for performance add-on to the per diem:

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

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.hfemsd1.dphe.state.co.us/hfd2003/srch.aspx to check on homes. The CDPHE provides 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. Results were checked by state staff. All of the homes submitting applications met this prerequisite.

Resident/Family Satisfaction Survey
This prerequisite measure was defined in the pay for performance application as "Survey must be developed, recognized, and standardized by an entity external to the facility. Must be administrated on an annual basis with results tabulated by an agency external to the facility." The "Acceptable Verification of the Pre-Requisite Requirement" is "Resident/family satisfaction surveys must have been conducted and tabulated between September 1 and August 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 facility's State Survey Results."

A review of the documentation showed that twenty-four homes submitted such a survey. The others did not. 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 the cover pages were evidence that the survey had been collected even if complete copy of the survey was not submitted.
Reviewers found examples of cover pages that said "Summary" on the top of them. In this situation, it seemed reasonable that a home could submit the cover pages and believe

it was complying with the prerequisite. Information on which homes submitted the survey can be found in the table describing results for the individual homes.

Validation of this prerequisite would be easier if the state clarified whether it wanted evidence that a survey had been done or wanted a copy of all pages of the report. For example, the state might change the wording of the prerequisite to state that "A complete copy of all pages of the survey report identifying vendor completing, must be attached to this application and made available to the public along with the facility's State Survey Results."

E. Discussion of Each Performance Measure

The performance measures are shown below. They are divided into two general domains, Quality of Life and Quality of Care. Each domain has subcategories as shown below.

DOMAIN QUALITY OF LIFE	DOMAIN QUALITY OF CARE
Subcategory Resident-Directed Care	**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	**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	**Facility Management**
50% Consistent Assignments	10% Medicaid above state average
80% Consistent Assignments	5% Medicaid above state average
Internal Community	
Subcategory: Relationships with Staff, Family, Resident con't.	**Staff Stability**
External Community	Staff Retention Rate
Living Environment	Staff Retention Improvement
Volunteer Program	Director of Nursing Retention
	Nursing Home Administrator Retention

DOMAIN QUALITY OF LIFE	DOMAIN QUALITY OF CARE
Subcategory Staff Empowerment	Employee Satisfaction Survey
Care Planning	
Career Ladders/Career Paths	
Person-Directed Care	
New Staff Program	

Each measure is discussed below. Its definition is presented. Reviewer comments about it are made, summary scores of homes on the measure are presented, and then recommendations for improving it are suggested.

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 are 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 are empowered to provide it."
REVIEWER COMMENTS	Reviewers found that all 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. For the requirement describing input from a resident/family advisory group, only one home was unable to provide sufficient documentation to substantiate this activity. Most homes included minutes from resident and family councils or examples of resident participation. Conversely, input from residents into the appearance of the dining atmosphere was the most difficult requirement for homes to substantiate, and ten nursing homes did not provide sufficient documentation. Resident council meetings or photos of the dining areas that included narratives of the residents' input are examples of well formulated documentation. 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: 39 Number of homes with score confirmed: 29 Number of homes with score not confirmed: 10 Percent of score not confirmed: 26%
RECOMMENDATIONS	The inclusion of resident input into decisions regarding the appearance of the dining atmosphere was a challenging objective for homes to demonstrate. To ameliorate this issue, a revised Pay-for-Performance application might include a description of what a "dining atmosphere" is and provide examples of acceptable supporting documentation such as resident council minutes or narratives. For example, minimum documentation could require at least two examples of resident participation in the dining atmosphere corroborated by council minutes or signed resident testimonials. Photographs are also compelling and credible evidence of person-directed dining, and homes should be encouraged to provide photo documentation along with specific examples of transformations to the dining environment.

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. A requirement that homes did not validate well was the

	completion of "Bathing Without a Battle" education, and ten 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 documentation of Bathing Without a Battle in-services with staff sign-in logs or listings of the number of staff completing the training. In addition, eight homes did not provide sufficient documentation to verify that the bathing atmosphere for residents supported a home-like environment. As with the Bathing Without a Battle requirement, 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).
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 41 Number of homes with score confirmed: 27 Number of homes with score not confirmed: 14 Percent of score not confirmed: 34%
RECOMMENDATIONS	Some homes omitted Bathing Without a Battle education and a bathing atmosphere with home décor supporting documentation. To assist homes, a revised P4P application might outline specific verification methods such as in-service logs for Bathing Without a Battle and documentation of the frequency of trainings. Similar to the Enhanced Dining measure, home décor can be verified with photographs of the environment. With one exception, reviewers accepted pictures of the shower/bathing area. Homes should be encouraged to provide photographs and to retain receipts of expenditures to include in the P4P application. Another suggestion that might help homes is to break this measure up into three sections and assign points to each. Three of the four homes visited indicated that Bathing Without a Battle criteria did not apply to their patient

	population as Bathing Without a Battle is most appropriate for dementia patients. As currently conceived a home which met all minimum requirements except Bathing Without a Battle is treated the same as a home that did not meet any. Therefore the Department might consider awarding points on individual minimum requirements.

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 participate in developing an individual's care plan."
REVIEWER COMMENTS	In evaluating the two requirements, six nursing homes did not provide sufficient documentation to support that residents are interviewed regarding choices in routine, and four 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 left this section blank or only provided a brief narrative of the activity.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 38 Number of homes with score confirmed: 33 Number of homes with score not confirmed: 6 Percent of score not confirmed: 16%

RECOMMENDATIONS	While a detailed narrative of a process to respect residents' choices in daily schedules (supported by additional documents) was acceptable, reviewers did not consider brief, unsubstantiated narratives to be valid documentation. To dissuade homes from submitting a minimal narrative, a revised P4P application might encourage homes to better document the linkages between resident choice and care planning, for example, resident testimonials that prove the implementation of resident preferences. Simply asking residents is not sufficient, there needs to be proof that something was done.

End of Life Program

DEFINITION	The application states that the Definition/Minimum Requirements for the End of Life Program measure are: "The facility 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 Advance Directive requirement was not difficult to validate if it was included on quarterly care planning notes although eight homes did not provide sufficient evidence. 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. Conversely, nursing homes were able to provide substantive evidence of end-of-life programs. Programs such as "Butterflies are Free" were cited frequently and homes 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: 39 Number of homes with score confirmed: 32 Number of homes with score not confirmed: 7 Percent of score not confirmed: 18%
RECOMMENDATIONS	The most common issue in validating this issue was the absence of Advance Directives in care plans and quarterly reviews. To circumvent this issue in the future, a revised P4P application might request that homes provide copies of Advance Directives with signatures indicating quarterly review or quarterly care plans documenting this review. Since nursing homes excelled at providing evidence of an End of Life program to respect individual preferences, the current application's description of this requirement was interpreted with little difficulty.

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 facility 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 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: 41 Number of homes with score confirmed: 40 Number of homes with score not confirmed: 1 Percent of score not confirmed: 2%
RECOMMENDATIONS	A revised application might include a recommendation for photographic documentation of the personalization of resident rooms. Opinions of reviewers confirm that photographs are a validation of a home's efforts for this measure. However while photographs are useful, the validation problem for reviewers is to figure out if the one to five pictures presented in the application are representative of all rooms.

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 four homes were unable to provide sufficient validation of this activity. In most cases, homes either did not provide descriptions or photos, or the photographs were of landscaped outside spaces that did not suggest any special measures inside the home for residents. For the requirement of comfortable and clutter free spaces, three nursing homes did not provide any documentation, photographic or otherwise, that the environment supported this requirement. 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: 39 Number of homes with score confirmed: 37 Number of homes with score not confirmed: 4 Percent of score not confirmed: 10%
RECOMMENDATIONS	Reviewers thought that photos have to be supplemented with other information. As with resident rooms, the problem with relying on photos is their selective nature. Photographs of interiors were difficult to interpret since only the large common areas were usually photographed. Homes presented photos of what they would put in their advertising. Areas around nursing stations and corridors were not provided. There is little documentation of how institutional looking interior spaces are. The primary recommendation to assist homes in validating public and outdoor space requirements is for the state to provide insight into the type of information requested.

	This may include the inclusion of photos of the environment plus other information. Since some homes included photographs of traditional landscaping as the only form of support, descriptions of environments might include the expectation that photos include residents in the spaces or resident testimonials of using the environment to maintain independence.

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 two 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. A far more challenging requirement for this measure was the requirement that the discontinued use of overhead paging was observed or confirmed by residents and staff. In twelve instances, homes failed to provide this confirmation. In most cases, homes provided documentation from staff, but did not include observations from residents that overhead paging had been turned off.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 38 Number of homes with score confirmed: 27 Number of homes with score not confirmed: 11 Percent of score not confirmed: 29%

RECOMMENDATIONS	Reviewers found that the most common issue in validating the Overhead Paging measure was the requirement for staff **and** resident confirmation that systems were turned off and used only in emergencies. The minimum requirements for the application should be changed to state that if a home says it does not have an overhead paging system, then no further documentation is necessary. This measure could be validated upon site visits.

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, eight homes did not provide adequate documentation to validate this activity. In most of these cases, nursing homes only included documentation that neighborhoods had been "named" by residents or staff, and reviewers did not view this documentation as evidence of a unique identity. The P4P application is clear in saying that the quality of life program must be in place at the time of the P4P application. Some documentation had the impression that the homes were having meetings to create neighborhoods two weeks before the application was due. 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: 34 Number of homes with score confirmed: 27 Number of homes with score not confirmed: 8 Percent of score not confirmed: 24%
RECOMMENDATIONS	For this measure, reviewers assessed the expectation for a "unique" identity at a higher threshold than just "naming" neighborhoods. To not veer from resident/staff participation in smaller environments as a catalyst for resident-directed quality, a revised P4P application could include an expanded definition of neighborhoods/households to include resident participation and additional requirements of documentation (e.g. neighborhood meeting minutes, testimonials from residents that explicitly discuss neighborhoods, staffing schedules by neighborhoods). This type of clarification could help to avoid misinterpretation by nursing homes. For example, one application claimed points for this measure, but stated that the 100+ residents voted not to be divided into neighborhoods, and the home remained one "big" neighborhood. This veers from the intent of the measure and could be avoided with further clarification in the application.

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 consistent assignment percentage calculations. 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 never presented any analysis of how the mass of paper was analyzed. In this case, reviewers looked for general consistency in staff names assigned daily to each neighborhood/unit, and then randomly selected one or two staff to test the percent of their time they were consistently assigned. This attempt at validation introduced inconsistency in the scoring of applications. Other applications presented summary staff schedules like grids on a single page showing which staff worked where

	when. These summary pages would typically have 6-8 letter abbreviations in the boxes of the schedule. None of these summary schedules contained a glossary of what the letters meant and the use of letters varies across homes. The major reason providers received a "No" response was for failing to include a full eight weeks of consecutive schedules. Others were denied the claim of 50% or 80% consistency in assignments because the sample of staff schedules was not representative of all staff, for example, providing information for only four staff. 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.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 42 Number of homes with score confirmed: 26 Number of homes with score not confirmed: 17 Percent of score not confirmed: 40%
RECOMMENDATIONS	In the future the Department might consider providing additional guidance stating that the documentation for the eight consecutive weeks must cover all staff who worked, specify that the calculations used to arrive at the percentage be clearly documented and contain suggested formats that providers could use to present the information.

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	Reviewers looked for both of these requirements to respond "Yes" to a provider that self-reported a score for this performance measure. Monthly schedules with neighborhood meetings and learning circles were also 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 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.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 35 Number of homes with score confirmed: 33 Number of homes with score not confirmed: 2 Percent of score not confirmed: 6%
RECOMMENDATIONS	In the future the Department might consider clarifying examples of spontaneous activity documentation.

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 facility. 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. For instance, if

	an applicant submitted documentation of a volunteer program and volunteer hours, this was acceptable evidence of external community.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 40 Number of homes with score confirmed: 40 Number of homes with score not confirmed: 0 Percent of score not confirmed: 0%
RECOMMENDATIONS	Reviewers found the judgment of this performance measure to be straightforward, and have no recommendations for improvement to External Community.

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: 41 Number of homes with score confirmed: 39 Number of homes with score not confirmed: 2 Percent of score not confirmed: 5%
RECOMMENDATIONS	Reviewers found the judgment of this performance measure to be straightforward, and have no recommendations for improvement to Living Environment.

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: 41 Number of homes with score confirmed: 36 Number of homes with score not confirmed: 5 Percent of score not confirmed: 12%
RECOMMENDATIONS	In the future the Department might consider making the application be more explicit in its requirement of both a written volunteer policy and documentation of volunteer hours.

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 and initial documentation was not, even though the requirement called for 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 CNA(s). 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: 33 Number of homes with score confirmed: 22 Number of homes with score not confirmed: 11 Percent of score not confirmed: 33%
RECOMMENDATIONS	To assist applicants, the Department should remind applicants and emphasize that supporting documentation must include initial and quarterly care plans where the CNA's attendance is clearly identified.

Career Plans/Careers Ladder

DEFINITION	The application states that the Definition/Minimum Requirement(s)/ Required Documentation for Career Plans/Careers Ladder are: "Facility 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 if no written policy and procedures were provided in supporting documentation.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 38 Number of homes with score confirmed: 33 Number of homes with score not confirmed: 5 Percent of score not confirmed: 13%
RECOMMENDATIONS	There are no recommendations.

Person-Directed Care

DEFINITION	The application states that the Definition/Minimum Requirements for the Person-Directed Care measure are: "Facility 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	In evaluating the documentation to support annual objectives, an agenda, and list of attendees for training in person-directed care, reviewers found that seven 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. 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: 34 Number of homes with score confirmed: 27 Number of homes with score not confirmed: 7 Percent of score not confirmed: 21%
RECOMMENDATIONS	To encourage homes to more thoughtfully implement a training program, a revised P4P application could include acceptable forms of training (e.g. Bathing Without a Battle, Consistent Assignment) while delineating this type of training from traditional clinical or organizational training. The application could also encourage homes to document the amount of training with a minimum threshold (e.g. one hour monthly) to receive points for the measure. Two homes claimed participation in the Eden Alternative program; however their participation could not be confirmed by contacting Eden Alternative.

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 who their mentor was.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 39 Number of homes with score confirmed: 29 Number of homes with score not confirmed: 10 Percent of score not confirmed: 26%
RECOMMENDATIONS	To assist applicants, the Department should emphasize that nursing homes must show proof of staff involvement in all three areas, recruitment, orientation, and mentoring of new

	staff. Additionally, the Department could consider clarifying the definition of "written program" to include examples such as an orientation program agenda for new employees, policies on staff involvement in recruitment such as referral bonus programs, and established mentoring programs.

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 person who attended education, but had no sign-in signatures. Homes also provided a wide range of what they thought was continuing education. Some providers submitted

	documentation including routine staff meetings. Reviewers accepted classes put on by providers to educate their staff, but were instructed not to accept what appeared to be routine staff meetings as continuing education.
PERFORMANCE MEASURE REVIEW STATISTICS	These performance statistics are different from other measures because they combine all three continuing education measures. Number of homes with self-reported score: 38 Number of homes with score confirmed: 26 Number of homes with score not confirmed*: 12 Percent of score not confirmed: 32% *One home received more points than it self-reported in its application because the documentation justified a higher number of hours.
RECOMMENDATIONS	Requirements for this measure could be improved by specifying what information needs to be provided, for example, lists of classes and attendees, other continuing education courses taken by employees, lists of all staff, and the method the home used to calculate the average number of hours. The Department could develop a form so that providers knew what information to enter. A second improvement would be to specify what constitutes continuing education.

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 facility is participating in."
REVIEWER COMMENTS	There are no reviewer comments.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 37 Number of homes with score confirmed: 36 Number of homes with score not confirmed: 1 Percent of score not confirmed: 3%
RECOMMENDATIONS	Reviewers found the judgment of this performance measure to be straightforward.

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 at http://www.medicare.gov/NHCompare/Include/DataSection/Questions/ProximitySearch.asp. 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	Number of homes with self-reported score: 20 Number of homes with score confirmed: 17 Number of homes with score not confirmed: 3 Percent of score not confirmed: 15%
RECOMMENDATIONS	Reviewers found the judgment of this performance measure to be straightforward. The full CMS wording for this measure is "Percent of high-risk long-stay residents who have pressure sores." The measure apparently focuses on long-term residents. On the other hand, there is a perception that the measure is unfair to homes with a high proportion of sub-acute residents that might have increased admissions with pre-existing pressure ulcers. The Department might consider explaining how it came to choose this measure and why it is appropriate as a measure of performance. Future applications may be pre-populated with Nursing Home Compare data by the Department.

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 at http://www.medicare.gov/NHCompare/Include/DataSection/Questions/ProximitySearch.asp. This site can be used to search for particular homes and see a display of the percentage of residents on different quality measures. Of the three quality measures employed in Colorado's Pay-for-Performance application, chronic care pain is the only measure with little support for correlation with resident-directed care. The lack of findings is likely the result of extreme variation in pain measurement across homes. In fact, the chronic pain indicator is routinely the subject of debate, and at least one researcher has argued that the CMS scores under-estimate true pain measurements in nursing homes.[5]
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: 2 Percent of score not confirmed: 13% *One home was given points, but did not self-report a score.
RECOMMENDATIONS	Reviewers found the judgment of this performance measure to be straightforward. What is not clear about this measure is its applicability to homes with a higher percentage of sub-acute residents. Homes with a high proportion of sub-acute residents might have more persons with chronic pain because of their illness and post

[5] Rahman, A. (2005, March-April), *Debate Looms on CMS Use of Pain Measure in Nursing Homes*, Aging Today, Vol. 26, p. 3 see retrieved on June 27, 2009 from http://www.asaging.org/at/at-262/Forum_Debate_Looms_On_CMS.cfm

	operative condition yet this measure is worth nine percent of the total pay for performance points. Future applications may be pre-populated with Nursing Home Compare data by the Department.

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 at http://www.medicare.gov/NHCompare/Include/DataSection/Questions/ProximitySearch.asp. 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	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%
RECOMMENDATIONS	Reviewers found the judgment of this performance measure to be straightforward. Future applications may be pre-populated with Nursing Home Compare data by the Department.

Subcategory: Facility 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% Medicaid

DEFINITION	The pay for performance 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 of the statewide average could attain 5 points on this measure.
REVIEWER COMMENTS	The home submitting applications did send in their Med 13 forms. The issue of validating them was to determine what the statewide Medicaid occupancy was. The application instructions contain no definition of how this percentage shall be calculated. The latest data from the state is for cost reports that were submitted in 2007. Data from 2008 cost reports is not available. 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 choice of this measure made it easier for homes to qualify for points under this measure.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 17 Number of homes with score confirmed*: 19 Number of homes with score not confirmed: 2 Percent of score not confirmed: 12%

	*Four nursing homes received points that did not self-report a score. However their Med 13 showed they qualified using this measurement of occupancy.
RECOMMENDATIONS	Reviewers found the judgment of this performance measure to be straightforward. The Department may consider establishing a statewide occupancy rate to be used with each application period.

5% Medicaid

DEFINITION	The pay for performance 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 5% Medicaid measure are "Medicaid occupancy 5% 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 5% or more of the statewide average could attain 2 points on this measure
REVIEWER COMMENTS	The home submitting applications did send in their Med 13 forms. The issue of validating them was to determine what the statewide Medicaid occupancy was. The application instructions contain no definition of how this percentage shall be calculated. The latest data from the state is for cost reports that were submitted in 2007. Data from 2008 cost reports is not available. 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 choice of this measure made it easier for homes to qualify for points under this measure.

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:	11 2 9 82%
RECOMMENDATIONS	Reviewers found the judgment of this performance measure to be straightforward. The Department may consider establishing a statewide occupancy rate to be used with each application period.	

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 facility 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. The methods used by the homes ranged from those that were clear and easy to follow, to others that were vague, difficult to follow, or completely non-existent. 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, variations of which were used by 14 homes, 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, which was used by 5 homes, 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. **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 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.[6]
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 36 Number of homes with score confirmed: 36 Number of homes with score not confirmed: 1 Percent of score not confirmed: 3%
RECOMMENDATIONS	The Department might help providers by providing a template or form that documents how the retention rate should be calculated.

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 facilities with less than 75% retention rate. Facilities 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 facility developed retention report."
REVIEWER COMMENTS	Few providers claimed for this performance measure. Most providers claimed for the staff retention rate of 55% or above. Two 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. There were also cases where homes claimed for this

[6] 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

	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: 6 Number of homes with score confirmed: 2 Number of homes with score not confirmed: 4 Percent of score not confirmed: 67%
RECOMMENDATIONS	State more clearly that the Staff Retention Rate, and the Staff Retention Improvement measures are an "either/or" measure. Homes can be eligible for only one measure, but not both.

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 facility 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. Some homes that claimed for this measure did not receive points. The most common reason was that the current DON had not been in that position for more than three years, but had been working at the home for over three years. The DON had been promoted to that position within the last three years, and had therefore not been the DON for three years. Consequently, no points were awarded.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 21 Number of homes with score confirmed: 19 Number of homes with score not confirmed: 2 Percent of score not confirmed: 10%

RECOMMENDATIONS	Reviewers found the judgment of this performance measure to be straightforward.

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 facility 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. Some homes that claimed for this measure did not receive points. The most common reason was that the current NHA had not been in that position for more than three years, but had been working at the home for over three years. The NHA had been promoted to that position within the last three years, and had therefore not been the NHA for three years. Consequently, no points were awarded.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 27 Number of homes with score confirmed: 24 Number of homes with score not confirmed: 3 Percent of score not confirmed: 11%
RECOMMENDATIONS	Reviewers found the judgment of this performance measure to be straightforward.

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 facility 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. The only reasons for homes to not receive points for this measure was 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. There was one case where a home had a 34.96% participation in the survey. Points were not awarded to this home because the minimum requirement was to have 35% participation.
PERFORMANCE MEASURE REVIEW STATISTICS	Number of homes with self-reported score: 36 Number of homes with score confirmed: 34 Number of homes with score not confirmed: 2 Percent of score not confirmed: 6%
RECOMMENDATIONS	Reviewers found the judgment of this performance measure to be straightforward.

V. ON-SITE REVIEWS

A. Selection of Homes to Review

Reviewers discussed with the Department the best methodology for choosing the four facilities at which to conduct on-site reviews. Administrative regulations at 8.443.12 4. state that "Facilities 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 random selection of four facilities would be appropriate since all had an equal probability of verification risk. The only non random criteria for choosing the four facilities was that they were located within a sixty-mile radius of the metro Denver area to make site visits feasible for the reviewers. Participating facilities were assigned numbers 1-42, and then a random generator was used to pick the numbered facilities. Of the first four numbers randomly generated, two facilities were disqualified for being located outside the sixty-mile radius. After randomly generating two more numbers, the following four facilities were chosen for an on-site review:

- Colorado State &Veterans Nursing Home - Aurora
- Life Care Center of Littleton - Littleton
- Lemay Avenue Health & Rehab Facility – Fort Collins
- Uptown Healthcare Center – Denver

B. Methods used to Review Homes

The visits to the four nursing homes involved two distinct phases. In each case a tour of the building was undertaken and a meeting with administrative staff was held. 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
- use of an overhead paging system
- presence of animals, birds, fish and plants
- memorial areas in remembrance to former residents and
- evidence of neighborhoods

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.

The reviewers learned new and different information from each of the four 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 four 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. 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.

i. General Comments

- Consideration of Provider Case Mix - Providers generally indicated a desire for flexibility in P4P scoring based on the characteristics of the resident population served. Providers varied considerably in the type of resident and care provided. The profiles of their residents range from a population of at least 75% veterans to a home that catered to a higher sub-acute population of local affluent residents with an average stay of 30 days, to a home with a younger, often impoverished and homeless population of residents requiring psychiatric care for long periods of time.

- Partial Credit - Providers generally expressed a desire for partial credit awarded for measures. The populations of the homes vary, as indicated above. The view seemed to be that if you took a measure like bathing and break it up into separate measures a home can customize its efforts to fit its needs. Given the concerns with variations in care provided to residents offered, partial credit is seen as a solution to provider choices to invest in measures that were more applicable to their own business needs.

- Quality Measures –Providers noted that the thresholds for chronic pain and pressure ulcers would be impossible to achieve given the proportion of their residents that are sub-acute. Moreover, paying persons to have residents with lower pain and pressure ulcers could actually create a perverse incentive to deny admissions of residents with either of those issues. Providers agreed that restraints were representative, but other measures of quality of care should be considered to replace chronic pain or pressure sores. Some of the measures suggested included: activities, weight loss and falls. They also commented that the disparity of points awarded for these measures was too wide.

- Timeframe of Application - Providers were confused by the continuing education and staff retention timeframes since the application did not specify timeframes for these measures. Providers also varied in the length of time they had to work on the application. Some started in January and hurriedly did it while others started in the early Fall. One obtained help from an outside advisor and others did not.

- Providers indicated that a description of the review process would be helpful – Providers mentioned that an understanding of the type of reviewer would be instrumental in preparing explanations for supporting documentation. For example, a nurse reviewer would easily comprehend schedules used as supporting documentation for consistent assignment, but non-clinical reviewers would likely need accompanying descriptions of the methodology behind preparing schedules or more complete descriptions of schedule layouts.

- Type of Narrative and Describing the Process - Providers noted the tricky nature of describing their process through the documentation. As one provider noted, “We are

expected to create home and engagement, but it's difficult to show engagement and relationships from a paper application." Providers noted that it would be helpful to have templates for narratives including expected length and types of description for each section, and guidance on the amount of evidence needed in each sub-heading (e.g. 3 photos, care plans for 2 residents).

- Other Provider Comments - In general, providers were supportive and liked the program saying the Pay-for-Performance assessment contributes to quality of life emphases in homes and is successfully encouraging homes to change their programs. One provider noted that, "This is the right way to go and it is appropriate to reward these measures." Another provider expressed an interest for the state to take this process a step further. For example, many measures in the application call for interviewing residents about choices and preferences, but implementation of these choices and preferences are not a minimum requirement. This home felt that homes that go above and beyond by actually implementing resident choices and preferences should be rewarded for doing so.

ii. Comments on Application Measures

- Dining - The point score on dining was commented on by providers. At two points it seemed low to them given the importance of food in persons' lives. It is regarded as just as important as bathing if not more so. As one administrator said, there are three important times in a person's day: breakfast, lunch and dinner.

- Flexible and Enhanced Bathing – Providers were unclear how relevant Bathing Without a Battle is for residents without dementia. For example, one provider noted that, although the home used the Bathing Without a Battle education as a resource, residents in the home did not typically experience dementia and were willing to take baths. As a result, the provider does not invest significant resources in regular Bathing Without a Battle training. Another provider noted that with a younger population often working though drug and alcohol addiction, much of the work with bathing at is geared towards promoting self-esteem to reintegrate residents back into the community. In this case, Bathing Without a Battle was also a resource, but bathing was more about sensitivity than working with residents with dementia. Some providers felt that Enhanced Bathing was appropriately rated highly at 5 but other important measures are rated at only a 2. Another provider felt that implementation of resident interviews should be a requirement for the full 5 points. If implementation was not a requirement, they felt that it was only worth about 2 points.

- Daily Schedules - One home rated this measure higher than Enhanced Bathing because of the lack of relevance of the Bathing Without a Battle education to their population. Another home commented that implementation of resident interviews should be a minimum requirement.

- End of Life Program - One provider noted that the review of Advance Directives is a product of the MDS review process, and the other requests for documentation on an individual's preferences are more reflective of resident-directed care.

- Public and Outdoor Space - One provider said they were unclear on how many photos or what type to include.

- Overhead Paging – One home expressed the belief that many homes, including it, are making this change based on the P4P application. The administrator indicated that the change was wonderful and should be worth more points.

- Neighborhoods/Households – Two homes made the point that explained that the "neighborhoods" concept had different applicability depending on whether you are talking about sub-acute or long-stay residents. Social programming differs depending on what group you are talking about. At one home, a long-term neighborhood might have a cooking group, but the short-term acute residents have a recuperation/renewal group)

- Consistent Assignment - Providers were unclear on the type of documentation expected. Specifics were needed regarding the level of staff assignments; whether it is considered a consistent assignment if they are always assigned to the same neighborhood, or do staff need to be assigned to the same residents. One provider commented that more points should be given for consistent assignments of 80% or more, and there should be more levels of points given as the percentage drops to the minimum of 50%.

- Internal Community - From a sub-acute perspective, one provider noted that tools such as learning circles would not work with their short-stay residents who are interested in rehabilitating to get back home. Again, the process is different for long-stay residents, but this is a small % of one provider's community.
  Two providers had impressive Wellness Programs for residents and staff (e.g. Massage, Yoga, Reiki.

- External Community, Living Environment and the Volunteer Program - One provider viewed these measures as an opportunity to show that "Life Happens Here" and would value these higher. One provider noted that volunteers, while present at the home, are less likely to volunteer service in a more psychiatrically based home.

- Care Planning - A provider again noted differences for a sub-acute population and explained that the sheer numbers of admissions from a short-stay perspective would make it difficult to pull CNA's from the floor for every initial care conference, although CNA's are typically present for long-stay conferences. Providers were

unsure of the amount of documentation required by the application, e.g. how many different residents and how many care plans.
Providers felt that, while important, this measure was rated disproportionately high compared to others in the sub-heading.

- Person-Directed Care - This heading requires more clarification training type.

- Continuing Education - It was time consuming for the providers to pull together the documentation. One provider requested a standardized document from the Department and would adjust processes to fill it out on an ongoing basis. Another said he was unsure why continuing education was in the performance measure since at the state already required at least eight hours for aides. Another provider thought that all staff should be included in this average including administrators. This provider also thought that this measure should take into account that employees are hired throughout the year and employees hired towards the end of the year will have had less of an opportunity to accumulate hours of continued education and will therefore bring down the overall average.

- Staff Retention Rate - This performance measure was difficult for providers to pull together. The directions were very vague as to what needed to be included in the report and/or supporting documentation. They had questions as to what employees should be included, what method of calculation should be used, what supporting documentation should be included, and whether or not to include temporary and part time employees.

VI. COLORADO P4P PARTICIPATION ANALYSIS

The data below is from the 2008 archived nursing home compare database that the Centers for Medicare and Medicaid Services maintains. It is not 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.

Table 1 below shows a distinct difference in the average size of homes that did not and did submit a pay for performance application.

Table 1 Average Number of Certified Beds in Colorado Homes that did not and did make a P4P Application

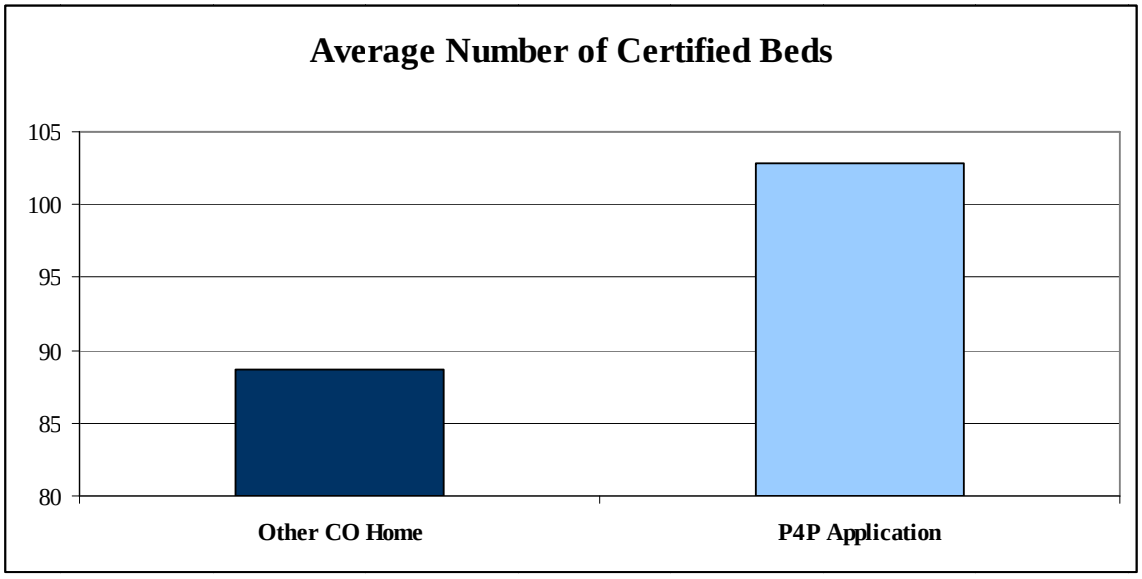


Table 2 below shows a distinct difference in the average Medicaid occupancy of homes that did not and did submit a pay for performance application.

Table 2 Average Medicaid Occupancy in Colorado Homes that did not and did make a P4P Application

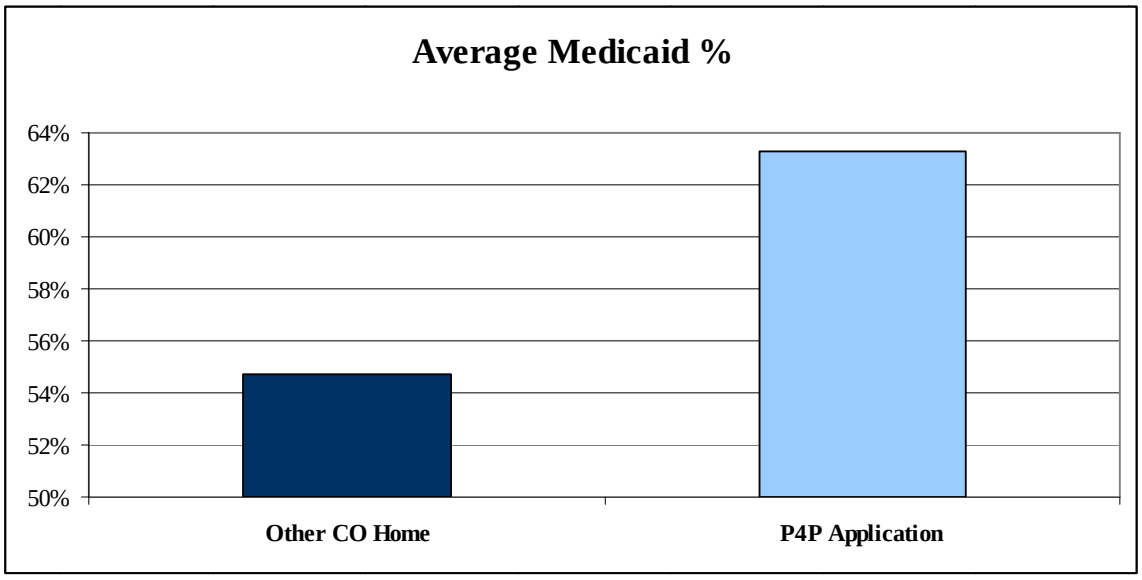


Table 3 below shows a distinct difference in the average number of deficiencies of homes that did not and did submit a pay for performance application.

Table 3 Average Deficiencies in Colorado Homes that did not and did make a P4P Application

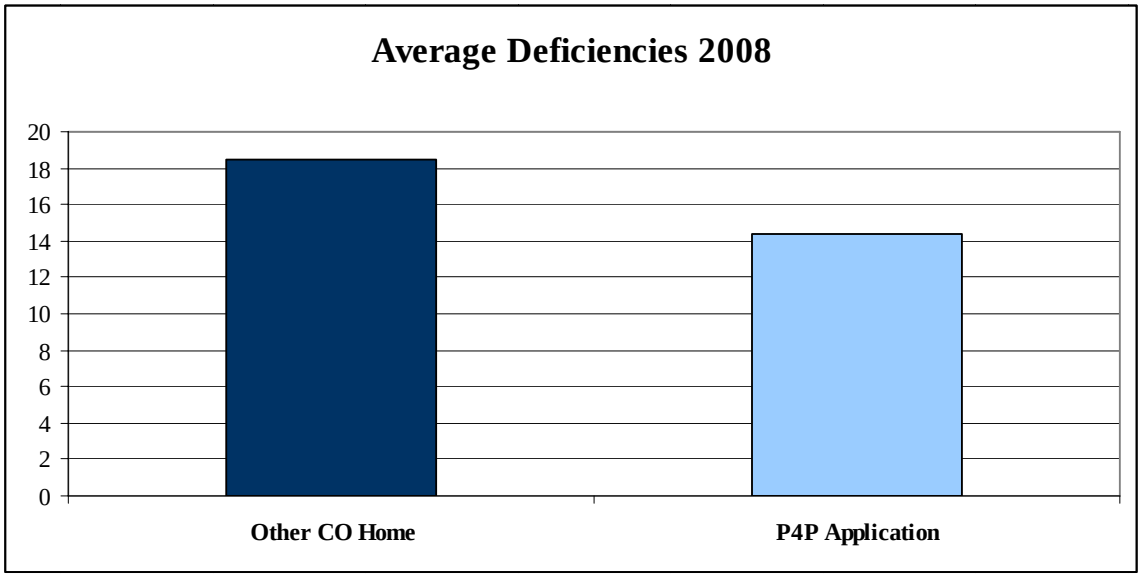
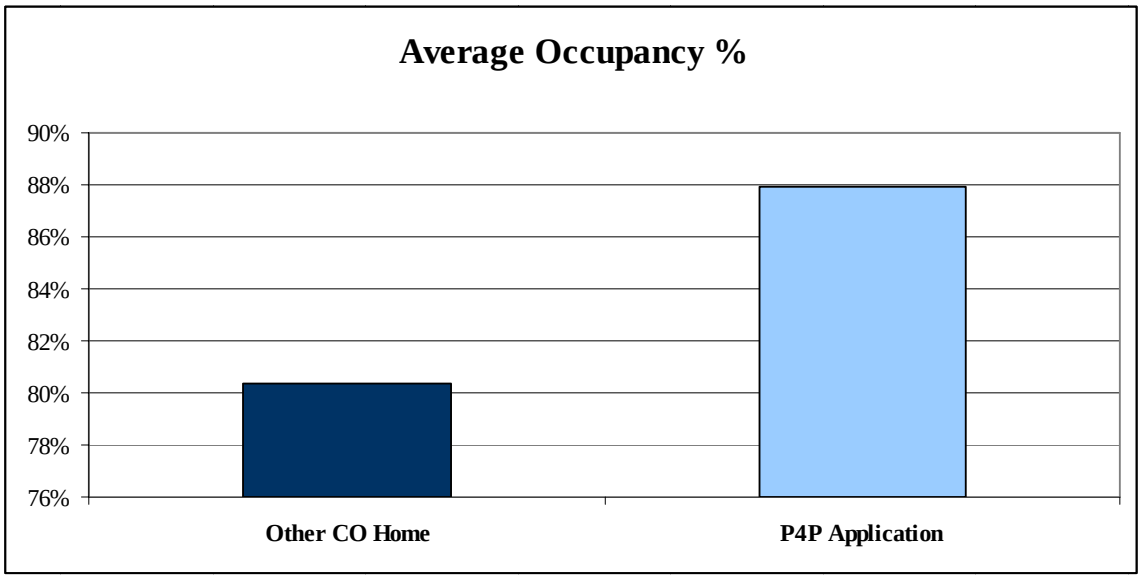


Table 4 below shows a distinct difference in the average occupancy of homes that did not and did submit a pay for performance application.

Table 4 Average Occupancy in Colorado Homes that did not and did make a P4P Application



Based on the tables above, it appears as if the 42 homes that submitted P4P applications were, on average, larger, and had total occupancy rates and higher Medicaid occupancy rates and fewer overall deficiencies.

VII. 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.

As the material in the table below shows, three of the really difficult measures to review were all quantitative measures: consistent staff assignments, continuing education, and staff retention. Homes responded in substantially different ways to each of these three often providing considerable amounts of paper but little analyses of what was on the paper. Fortunately there are steps that can be taken to help homes in the future around these three measures. The Department could help homes to document their answers in these three areas by developing one-page forms to use as a template.

Another prevalent problem in the reviews had nothing to do with the measures themselves. 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. The first round of applications has ended and PCG believes 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	The inclusion of resident input into decisions regarding the appearance of the dining atmosphere was a challenging objective for homes to demonstrate.	A revised Pay-for-Performance application might include a description of what a "dining atmosphere" is and provide examples of acceptable supporting documentation such as resident council minutes or narratives.
Flexible and Enhanced Bathing	The completion of Bathing Without a Battle education and a bathing atmosphere with	To assist homes, a revised P4P application might outline specific verification methods

Measure	Reason for Recommendation	Recommendation
	home décor were difficult requirements for some nursing homes to verify.	such as in-service logs for Bathing Without a Battle and documentation of the frequency of trainings. Reallocate points for Enhanced Dining, Enhanced Bathing, and Daily Schedules or award partial points based on individual requirements for each measure, so homes would still receive partial credit for Enhanced Bathing or other measures.
Daily Schedules	While a detailed narrative of a process to respect residents' choices in daily schedules (supported by additional documents) was acceptable, reviewers did not consider brief, unsubstantiated narratives to be valid documentation.	To dissuade homes from submitting a minimal narrative, a revised P4P application might encourage homes to better document the linkages between resident choice and care planning, for example, resident testimonials that prove the implementation of resident preferences.
End Of Life Program	The most common issue in validating this measure was the absence of Advance Directives in care plans or quarterly reviews.	A revised P4P application might request that homes provide copies of Advance Directives with signatures indicating quarterly review or quarterly care plans documenting this review. Another suggestion that might help homes is to break this measure up into two sections and assign points to each. As currently conceived there are two minimum requirements and a home has to meet both to get any points. Thus a home which met one is treated in the

Measure	Reason for Recommendation	Recommendation
		same category as a home that did not meet any. For example, each requirement could be assigned one point, so the total point score is unchanged. Move this requirement to the Care Planning section, because it is often a part of that documentation or revise the application to include an expected number of Advance Directives to clarify this for providers, or remove the Advance Directive requirement.
Resident Rooms		No recommendation.
Public and Outdoor Space	Reviewers thought that photos have to be supplemented with other information. As with resident rooms, the problem with relying on photos is their selective nature.	A revised application might provide suggestions to provider as to what supplemental information is acceptable.
Overhead Paging	Reviewers found that the most common issue in validating the Overhead Paging measure was the requirement for staff **and** resident confirmation that systems were turned off and used only in emergencies.	Future applications could request staff **or** some resident confirmation of discontinued use. Alternatively, the application could mandate a minimum threshold of observations (e.g. two staff and two residents) to clarify expectations for homes in the application process. It also may be helpful to concretely specify the parameters of "emergency use" for homes to decrease instances of misinterpretation in implementation of alternative communication systems.

Measure	Reason for Recommendation	Recommendation
Neighborhoods/Households	Some assertions that a home had neighborhoods seemed to be based on hurriedly held January meetings.	A revised P4P application could include an expanded definition of neighborhoods/households to include resident participation and additional requirements of documentation (e.g. neighborhood meeting minutes, testimonials from residents that explicitly discuss neighborhoods, staffing schedules by neighborhoods, signage.)
Consistent Assignments	The applications contained widely varying types of documentation ranging from copies of daily schedules to one page spreadsheets. Some homes documented how they are arrived at a percentage but many did not.	In the future the Department might consider providing additional guidance stating that the documentation must cover all staff who worked, specify that the calculations used to arrive at the percentage be clearly documented and contain suggested formats that providers could use to present the information.
Internal Community	The documentation of spontaneous activities was hard for some providers.	In the future the Department might consider clarifying the forms of spontaneous activity documentation that are acceptable. The revised application could include other examples of Internal Community, such as a Wellness Program, to allow providers more opportunities to score points.
External Community		No recommendation.
Living Environment		No recommendation.
Volunteer Program	Some providers did not present both policies and the	In the future the Department might consider making the

Measure	Reason for Recommendation	Recommendation
	documentation of volunteer hours.	application be more explicit in its requirement of both a written volunteer policy and documentation of volunteer hours.
Care Planning	The application often overlooked initial care plans and only included quarterly plans. At times it was not clear which staff person was the CNA.	To assist applicants, the Department should remind applicants and emphasize that supporting documentation must include initial **and** quarterly care plans where the CNA's attendance is clearly identified. The requirement for initial and quarterly reviews could be broken into three points apiece with three points for documentation of CNs involvement in initial planning and three points for documentation of involvement in quarterly planning.
Career Ladders/Career Paths		No recommendation.
Person-Directed Care	The majority of nursing homes that did not provide adequate documentation to support this measure clearly did not have systems in place to provide formal training on person-directed care to all staff.	To encourage homes to more thoughtfully implement a training program, a revised P4P application could include acceptable forms of training (e.g. Bathing Without a Battle, Consistent Assignment) while delineating this type of training from traditional clinical or organizational training.
New Staff Program	Homes did not show proof of staff involvement in all three areas. Rather only one or two areas were mentioned.	To assist applicants, the Department should emphasize that nursing homes must show proof of staff involvement in all three areas, recruitment, orientation, and mentoring of new staff. Additionally, the

Measure	Reason for Recommendation	Recommendation
		Department could consider clarifying the definition of "written program" to include examples such as an orientation program agenda for new employees, policies on staff involvement in recruitment such as referral bonus programs, and established mentoring programs with defined responsibilities
Continuing Education	Along with consistent staff assignments and staff retention, this was a difficult measure to review. Home provided documentation ranging from copies of courses to one page spreadsheets. Some homes did not document how their claims of average hours were arrived at. What constitutes continuing education was also varied. Some providers included routine staff meetings and others did not.	Requirements for this measure could be improved by specifying what information needs to be provided e.g. lists of classes and attendees, other continuing education courses taken by employees, lists of all staff, and the method the home used to calculate the average number of hours. It would make sense to develop a form so that providers knew what information to enter. A second improvement in the development of this measure would be to specify what constitutes continuing education.
Quality Program Participation		No recommendation.
High Risk Pressure Ulcers	There is a perception that the measure is unfair to homes with a high proportion of sub-acute residents that might have more persons coming to them from a hospital with pressure ulcers. Also, Nursing Home Compare data is publicly	The Department might consider explaining how it came to choose this measure and why it is appropriate as a measure of performance. Future applications may be pre-populated with Nursing

Measure	Reason for Recommendation	Recommendation
	available and could be integrated into the application by the Department.	Home Compare data by the Department.
Chronic Care Pain Score	There is a perception that the measure is unfair to homes with a high proportion of sub-acute residents that might have more persons coming to them from a hospital with chronic pain. Also, Nursing Home Compare data is publicly available and could be integrated into the application by the Department.	The Department might consider a review of this measure as there are other Nursing Home Compare measures that could be substituted for it such as the percent of long-stay residents who spend most of their time in bed or in a chair. Future applications may be pre-populated with Nursing Home Compare data by the Department.
Physical Restraints	Nursing Home Compare data is publicly available and could be integrated into the application by the Department.	Future applications may be pre-populated with Nursing Home Compare data by the Department.
Medicaid Occupancy	Homes utilized various baseline statewide occupancy rates to determine self-reported score.	The Department may consider establishing a standardized statewide occupancy rate to be used with each application period.
Staff Retention Rate	Along with consistent staff assignments and continuing education, this was a difficult measure to review. Home provided documentation ranging from copies of staff assignments to one page spreadsheets. Some homes did not document how their claims of staff retention were arrived at. As discussed in the Appendices, methods used by homes differed	The Department might consider establishing one method of calculation of calculating their staff retention rate and providing forms to help homes calculate their rate. Should the Department wish to do this, PCG would recommend the following formula: 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 merits of this formula are that it is clear and easy for homes to

Measure	Reason for Recommendation	Recommendation
		calculate. It is a simple calculation because it doesn't take into account new hires in the year including temporary and part time employees. It does not employ monthly average calculations and is easily documented; homes would simply need to provide a full staff list from the beginning of the year and end of the year.
Staff Retention Improvement	Some homes wished to be scored on both staff measures.	State more clearly that the Staff Retention Rate, and the Staff Retention Improvement measures are an "either/or" measure. Homes can be eligible for only one measure, but not both.
Director of Nursing Retention		No recommendation.
Nursing Home Administrator Retention		No recommendation.
Employee Satisfaction Survey		No recommendation.
Other Recommendations		
Instructions to Preparers	Some homes seemed to embellish their answers.	In future application instructions, the Department might consider reminding the preparer of the application that it is a claim for state and federal Medicaid reimbursement and must be filled out with same diligence and confirmation of fact expected with other Medicaid cost reports.
Develop Training Material	Applicants could use some ideas.	The state could develop a small 10-page guide that listed documentation ideas and provided sample forms.
Survey Prerequisite	The phrase "most recent" is	The words "most recent"

Measure	Reason for Recommendation	Recommendation
	vague.	could be better specified, for example by stating a specific date or saying most recent before the date of the application is due.
Time Frame of Review	Providers were confused by the continuing education and staff retention timeframes since the application did not specify timeframes for these measures.	The state might consider better definitions about data reporting periods to create uniformity in responses.
Case Mix	Providers indicated that some measures did not account for the differences in case-mix among residents (for example high pressure ulcers).	The state might consider changes which account for case-mix by home.

APPENDIX A: COMPARATIVE STUDIES OF OTHER STATES' P4P PROGRAMS

Description of States

In PCG's experience, collecting information and observing how other state program can provide useful ideas. Given the short time of two weeks, PCG decided to try to get information on four of eight other states' pay for performance systems to gain insight about their operations. After discussion with Department staff, Georgia, Iowa, Kansas and Minnesota were selected. These states were selected because they were more likely to use a combination of quality of life and quality of care measures. Information was collected on them through a combination of internet research, a review of journal articles and telephone interviews. Below are the results of this work:

Georgia

Implementation Date: 2007

Program Description

- Goal: To promote successful measures to monitor quality and to raise the quality of care

- Operations: All nursing homes participate in the program by conducting self-improvement assessments. Georgia describes the Quality Initiative as a collaboration of the Department of Community Health and its partners in long-term care industry to promote successful measures to monitor quality indicators.[7]

Measures

Effective July 1, 2009, Georgia will use the following measures:

Non-Clinical Measures

- Most Current Family Satisfaction Survey Score for "Would you recommend this facility?" Percentage of responses either "excellent" or "good" to meet or exceed the state average of 85% combined. **Point Value is 1**
- Participation in the Employee Satisfaction Survey **Point Value is 1**
- Quarterly average for RNs/LVNs/LPNs Stability (retention) **Point Value is 1**
- Quarterly average for CNAs/NA Stability (retention) **Point Value is 1**

Clinical Measures

[7] Georgia Department of Community Health, (2007, March 14), *Georgia Nursing Home Incentive Model*. 2007. Retrieved on June 27, 2009 from http://www.ghca.info/DCH.pdf

- Percentage of High Risk Long-Stay Residents who have Pressure Sores. **Point Value is 1**
- Percentage of Long-Stay Residents who were Physically Restrained. **Point Value is 1**
- Percentage of Long-Stay Residents who have Moderate to Severe Pain. **Point Value is 1**
- Percentage of Short-Stay Residents who had Moderate to Severe Pain. **Point Value is 1**
- Percentage of Residents who have received Influenza Vaccine. **Point Value is 1**
- Percent of Low Risk Long-Stay Residents who have Pressure Sores. **Point Value is 1**

Scoring and Incentive

A facility is listed as eligible to receive an award:

- If the facility scores a minimum of 3 points with at least one from a clinical and one from a non-clinical measure, it will receive a 1% add-on to the routine service component of the facility's per diem. To score a point, the facility must exceed the statewide average.
- If the facility scores a minimum of 6 points, at least 3 from clinical and one from non-clinical, it will receive a 2% add-on to the routine service component of the facility's per diem. To score a point, the facility must exceed the statewide average.

However, if facilities do not generate enough data to report on the CMS website due to not meeting the minimum number of assessments for reporting, they will use a predetermined value based on Georgia values for that metric. There are also additional substitute data for both clinical and non-clinical measures, if there are not sufficient available data.

Data Sources

Employee retention data are available from cost reports. Clinical data are available from CMS reports, normally the MDS. Family Satisfaction Survey and Employee Satisfaction Survey are self-reported.

Changes since Initial Implementation

Two new clinical measures have been added: percent of residents who received influenza vaccine; and percent of low risk long-stay residents who have pressure sores. The new system now gives the opportunity for a 2% add-on; in 2007 there was only an opportunity for a 1% add-on. Scoring has remained similar.

Analysis

Adding an additional 1% to its add-on incentive program in just 2 years after implementation, when state budgets have been very challenged, demonstrates strong early support for this program. Although two measures have been added, they are MDS quality indicators which are already tracked and publicly reported. Georgia has given clear indication of what it believes important and has already increased the amount of the incentive add-on.

Iowa

Implementation Date: 2002

Program Description

- Goal: Achievement of multiple measures suggests that quality is an essential element in the facility's delivery of resident care.
- Operations: All facilities are required to participate except for the measure related to resident satisfaction.

Measures and Data Sources

- Deficiency-free survey. The survey includes the latest annual survey and any subsequent surveys, complaint investigations, or revisit investigations. If there are only "A" level deficiencies, the facility survey shall be deemed deficiency-free. **Point Value is 2**
- Regulatory compliance with survey. Facilities are considered to be in compliance if no on-site revisit is required for either recertification surveys or substantiated complaint investigations. **Point Value is 1** A facility that receives points for deficiency-free cannot receive these points in addition.
- Nursing hours provided. Includes RNs, LPNs, CNAs, rehabilitation nurses and other contracted nursing services hours normalized to remove variations associated with the facility cost report resident case mix. **Point Value is 1** for a facility that falls between the 50th and 75th percentile of per resident day hours and **2 points** if the facility is at or above the 75th percentile. The fiscal consultant calculates this measure from Form 470-0030, Financial and Statistical Report.
- Resident satisfaction. Facilities must achieve a 35% response rate on Form 470-3890, Resident Opinion Survey. **Point Value is 1** for facilities above the 50th percentile. The Department or its contractor decides which facilities meet this measure.
- Resident advocate committee resolution rate. Facilities must have a resolution rate of 60% on issues and grievances as certified by the office of the long-term care ombudsman. **Point Value is 1**.

- High employee retention rate. Facilities at or above the 50th percentile using Schedule 1 of Form 470-0030, Financial and Statistical Report. **Point Value is 1** as determined by the department's fiscal consultant.
- High occupancy rate. Occupancy rate is defined as the percentage derived by dividing total patient days, based on census logs, by total bed days available, based on licensed beds. The **point value is 1** if the rate is at or above 95% as determined by the fiscal consultant.
- Low administrative costs. A facility at or below the 50th percentile or percentage administrative costs to total costs shall receive **1 point** as determined by the fiscal consultant.
- Special Licensure Classification. A facility licensed for the care of residents with chronic confusion or a dementing illness shall receive **1 point**.
- High Medicaid Utilization. Utilization is defined by dividing total Medicaid days by total nursing facility days. A facility receives **1** point if it is at or above the 50th percentile as determined by the fiscal consultant.

Scoring and Incentive

- 3-4 points results in a 1% of direct care plus non-direct care cost component patient-day weighted medians multiplied by 80%, subject to a reduction (outlined below).
- 5-6 points results in a 2% of direct care plus non-direct care cost component patient-day weighted medians multiplied by 80%, subject to a reduction (outlined below).
- 7 or more points results in a 3% of direct care plus non-direct care cost component patient-day weighted medians multiplied by 80%, subject to a reduction (outlined below).
- The add-on is subject to reduction for the following:
    - 25% reduction in the add-on for each citation for actual harm at a G level
    - If the facility fails to cure the G level deficiency within the time allowed, it will receive no add-on for the year
    - If the facility receives an actual harm citation at the H level, it will receive no add-on for the year.

Changes since Initial Implementation

The measures have remained almost the same, except in 2002 there was a measure for utilization of contracted nursing. The scoring appears to be the same, but the incentives are at 80% of median rather than 100% of the median as they were in 2002. The reductions and forfeit of the add-on for citations of actual harm have been added. The 2009 Legislature has ordered a review and potential update of the program.

Analysis

Iowa's program is the oldest in continual operation. There have not been many changes since it was implemented, except to make sure that facilities receiving actual harm deficiencies on their survey get less or no quality add-on incentive. Since the legislature ordered a review and potential update for this program, there is certainly some dissatisfaction about the way this program has been operating.

Kansas

Implementation Date: 2005

Program Description

- Goal: To provide a monetary incentive for favorable outcomes
- Operations: All facilities are eligible to apply.

Measures and Incentives (Proposed for State Fiscal Year 2010)

- Case Mix Adjusted Staffing Ratio. Providers that maintain a case mix adjusted staffing ratio at or above the 75th percentile will earn a $1.00 per diem add-on. Providers which fall below the 75th percentile, but improve their staffing ratio by 10% or more, will earn a $.10 per diem add-on.
- Staff Turnover Rate. Providers that achieve a turnover rate at or below the 75th percentile will earn a $1.00 per diem add-on. Those who have a turnover rate greater than the 75th percentile, but reduce their rate by 10% or more, will receive a $.10 per diem add-on.
- Culture Change Survey. Providers that have completed the full Kansas Culture Change Instrument (KCCI) Survey will receive a $.15 per diem add-on.
- Medicaid Occupancy. Providers that have a Medicaid occupancy of 60% or more will receive a $.45 per diem add-on.

Changes since Initial Implementation

Kansas has recently proposed a change in the number of measures earning incentives and the amount of the incentives. It has eliminated "operating expense", "staff retention", "total occupancy" and "survey outcomes" from its quality measures and added participation in its full culture change survey. In addition, it used to have 3 tiers of add-on rates based on scoring points, as other states have done. The three tiers were a $1.00, $2.00 and $3.00 per diem add-on. Now providers can achieve a maximum of a $2.60 per diem add-on and a minimum of $.10 per diem add-on.

Analysis

This is probably the biggest reported program change for the four states. Elimination of the operating expense and total occupancy measures demonstrates a move away from "efficiency" measures, although the program is still called the Nursing Facility Quality

and Efficiency Incentive Factor. Kansas Department of Aging staff said that they eliminated these measures because they wanted to direct provider attention more towards quality of care outcomes. They eliminated the staff retention measure because there wasn't much difference between the list of homes with low turnover and those with high retention. Staff said they moved away from the point system to the per diem add-ons to directly reward providers for specific outcomes. The second tier add-on for both staffing ratio and staff turnover was added to reward improvement.

Finally, the KCCI survey was added because it had been tested for validity and reliability and matched the Department's focus on quality outcomes. Although staff did not address the elimination of the survey outcomes, they may either reflect dissatisfaction with it as a measure of quality or could be related to timing issues due to when the survey was conducted and when the per diem awards were calculated.

Minnesota

Implementation Date: 2006

Program Description

- Goals: Quality improvement, increased efficiency, rebalance long-term care.
- Operations: All facilities are eligible to participate in the program.

Measures and Data Sources

- Staff turnover. Based on number of nursing staff who left in a year, facilities receive **15 points** if the turnover rate is less than 20% and **proportional points** if the rate is between 20 and 70%.
- Staff retention. Based on the number of nursing staff still employed after a year, facilities receive **25 points** if retention is greater than 80% and **proportional points** for retention rates between 50% and 80%.
- Use of pool staff. Based on the amount of pool staff as a percentage of total nursing hours, facilities receive **10 points** if they use no pool hours and **proportional points** if their rates are 0 to 10% of total nursing hours.
- Quality Indicators (QI) from the MDS. Based on 24 indicators in care domains such as behavior or depression symptoms, incontinence, skin care, pain, psychotropic drugs, and nutrition, facilities can receive up to **40 points** based on the scoring on the selected QIs.
- Survey deficiencies: Facilities can receive **10 points** if all deficiencies were below an F level of severity and **5 points** if the highest deficiencies an F or G.

Scoring and Incentive

The Commissioner determines an operating payment rate for each facility. Then a ratio is derived by subtracting 40 from the point total and dividing by 60. For example, if a facility scored a 60 for quality points, 40 points would be subtracted from that 60 and would equal 20, which would then be divided by 60, which would equal .3333. That ratio would then be applied to the operating payment rate as the add-on. However, the maximum add-on is .3 percent.
Changes since Initial Implementation

The major change since implementation was the maximum quality add-on percentage. When the program began, there was a cap of 2.4%. That appears to have only lasted one year. The cap is now .3 %.

Analysis

Minnesota has made a dramatic reduction in the amount of the add-on incentive, although this is not surprising given the challenges of current state budgets. There was also mention in the literature reviewed that it will initiate a major resident satisfaction survey in the future, but an implementation date could not be confirmed nor could any incentive tied to that outcome be confirmed.

Chart comparing characteristics

Table Characteristics of State Pay for Performance Measures

State	Quality of Life Measures	Quality of Care Measures	Facility Management Measures	Scoring and Incentive
Georgia (state categorized its measures as clinical and non-clinical) **Effective July 1, 2009**	Facility recommended on family survey; Employee satisfaction survey completed; Nurse retention; Nurse assistant retention.	High Risk Long-Stay Pressure Sores; Low Risk Long-Stay Pressure Sores; Long-Stay moderate to severe pain; Short-Stay moderate to severe pain; Long-Stay Physically Restrained; Influenza Vaccine.	None	Each measure equals 1 point if above state average 1% add-on to routine service component if 3 points, at least 1 clinical and 1 non-clinical 2% add-on if 6 points, at least 3 clinical and 1 non-clinical
Iowa	Resident satisfaction; Resident advocate committee issue resolution rate	Deficiency-free survey; Regulatory compliance with survey; Nursing hours;	Occupancy rate; Low administrative costs; Medicaid	Deficiency-free survey & high nurse hours are 2 points; all others 1; 1% of direct care plus non-direct

State	Quality of Life Measures	Quality of Care Measures	Facility Management Measures	Scoring and Incentive
		Employee retention	utilization rate; Special licensure for chronic confusion or dementing illness	care cost component weighted medians multiplied by 80% for 3-4 points; 2% for 5-6 points; 3% for 7 or more; REDUCTION of 25% for each actual harm at G; No add-on if G level not timely cured; No add-on if actual harm at H level
Kansas **Effective State Fiscal Year 2010**	Kansas Culture Change Initiative (KCCI) Survey completed	Case-mix adjusted staffing ratio; Staff turnover rate	Medicaid occupancy	$1.00 per diem add-on for staffing above 75th percentile; $.10 add-on for providers that improve by 10% on staffing (can't get both); $1.00 per diem add-on for turnover below 75th percentile; $.10 add-on for provider that improve by 10% (can't get both); $.15 per diem add-on for doing KCCI Survey; $.45 per diem add-on for 60% Medicaid
Minnesota		Staff turnover (15 points maximum); Staff retention (25 points maximum); Use of pool staff (10 points maximum); Quality indicators from MDS (40 points max.); Survey		.3 % maximum of operating rate; Total points minus 40 divided by 60 is percentage add-on

State	Quality of Life Measures	Quality of Care Measures	Facility Management Measures	Scoring and Incentive
		deficiencies (10 if all deficiencies below F; 5 if none above G)		

Major Lessons and Application for Colorado

After reviewing the nursing facility pay for performance programs in other states, there are lessons learned that should be considered by Colorado as it moves forward with improving its own program.

1. Fewer measures can get providers focused on what is important to the State

Kansas, the state that has changed its program the most, eliminated four (4) of its measures because it wanted to focus provider attention on specific outcomes it believed were important. It now has only four (4) measures. Although Georgia recently added two (2) quantifiable MDS measures for a total of six (6), it has ten (10) measures. Iowa also has 10, while Minnesota has 5, but uses 24 quality indicators from the MDS. It will be interesting to see how Iowa redesigns its plan this year, as mandated by the legislature.

2. Using Financial and Statistical Reports, Facility Survey Data, Standardized Satisfaction Surveys and MDS quality indicators ease administration and add objectivity

All states are using data which they already collect whether they are cost reports used for rate-setting, statistical data on occupancy, staff turnover and training and facility survey results or data easily accessible from CMS. Iowa also uses a standardized Resident Opinion Survey. Kansas requires use of its Kansas Culture Change Instrument Survey. There continues to be "self-reported" data, but states are limiting that data to that which is most often regularly audited or subject to audit, like cost reports.

3. Rewarding facilities that are not the best, but have shown improvement, gives all facilities a chance to get rewarded for quality improvement

Kansas has adopted a new measure and a small incentive for facilities that have increased their staffing ratio by over 10%, but do not fall into the larger incentive category of being in the top 25% of facilities on that measure. Likewise, it has a small incentive for facilities that decrease their turnover by 10%, but do not fall into the larger incentive category of being in the top 25%. Although Colorado may choose different measures for smaller incentives or set the difference between the best and the "improving", this is an idea worth considering. Kansas already collects the data used to determine these smaller incentives.

4. Using a scoring system based on quantifiable data demonstrates objectivity to providers seeking an incentive

Almost all state measures are quantifiable, already reported and regularly audited. Although providers could complain about the measures chosen and the scoring methodology, it is harder to complain about data that is reportable and verifiable. With the potential for controversy with a new program and one that differentiates in payment, increasing objectivity should reduce causes for objections.

5. Using the severity of a deficiency on the facility survey as a measure would reinforce the survey as quality tool

Although the nursing facility survey is not the perfect tool to assess quality, it can be a good method to find patterns of inferior and inappropriate care. Iowa reduces the add-on or eliminates it based on severity of the deficiency. Minnesota uses its point system to adjust for severity of a deficiency. Rather than eliminate those facilities with substandard deficiencies from the quality performance payment, Colorado could consider using the severity of the deficiency to adjust or eliminate an incentive.

APPENDIX B: REVIEW OF QUALITY OF LIFE AND QUALITY OF CARE MEASUREMENT SETS

Appendix B looks at national data bases and other state programs to see what value such a look may have for Colorado.

To assist Colorado in its review of potential Quality of Life and Quality of Care measures, the following appendices were prepared:

Appendix B.1 – Quality of Life Measurement Sets looks at eight sets of questions that are available in the public domain for interviewing residents in nursing homes. Appendix B.1 presents general information about the sets. The sets can be examined to find other measures of quality of life that Colorado can consider using. These surveys provide a host of possible questions that can be asked of nursing home residents.

Appendix B.2 – Individual Quality of Life Measures by Instrument. This appendix takes a more detailed look at fourteen categories of questions that are in the eight sets of questions shown in Appendix B.1. For example, if you are interested in knowing what questions might be available to ask about activities of daily living then you can find that category in the table and see that two survey sets have questions about ADLs, CMS and CAHPS. Assignment of measures to a category was arbitrary given that that the different survey sets define categories differently. Colorado's measures are included to add a comparison within and across categories and measurement sets.

Appendix B.3 –CMS Quality of Care Measurements Set.

Culture

Appendix B.4 - Nursing Home Surveys for Assessing Culture. A separate but related measurement sets pertain to culture. The quality of life measures include aspects of a facility's culture related to person-centered care and a physical environment that respects resident privacy and comfort. But culture is more than that. There is a widespread presumption that a facility's leadership, open communication, and supportive work environment significantly impacts both the quality of care as well as a resident's quality of life.

Appendix B.4 describes two survey initiatives focused on culture. These differ from instruments and measures described in Appendices A, B.1, and B.2 in two important ways:

- They are intended to be completed by nursing home staff.
- They capture the culture in practice, not the external manifestations of physical environment or resident satisfaction.

Because of its connection to quality and patient safety, the Department might consider including a staff culture survey as a measure for enhanced reimbursement. Providers would be rewarded for investing in its completion and providing evidence on how findings are being used for improvement.

Vermont Gold Star Program

Appendix B.5 Vermont Gold Star Employment Program. Identifies the seven areas for which best practices have been developed in Vermont and the sub-components of each.

The Vermont Gold Star Program is in the public domain and can be obtained by request from the Vermont Health Care Association.

Several of the Department's measures pertain to how staff contribute significantly to a resident's quality of life and quality of care. To better understand how this issue could be addressed, information about the Vermont Gold Star Program is presented. As conceived by its sponsors at the Vermont Department of Disabilities, Aging and Independent Living in partnership with the Vermont Health Care Association, the Gold Star Program recognizes nursing homes that adopt an accepted best practice in their recruitment and/or retention approaches. While not a P4P program in Vermont, the concept could lend itself to potential enhanced payment.

APPENDIX B.1 -QUALITY OF LIFE MEASUREMENT SETS

Instrument	Purpose	Domains	Mode/Scale
MN Department of Human Services Resident Satisfaction Survey, 2007 http://www.health.state.mn.us/nhreportcard/mn_survey_instrument.pdf	Component of state's voluntary Nursing Facility Performance-Based Incentive Payment program. Intended to augment information contained on MDS.	Autonomy Comfort Customer satisfaction Dignity Environmental adaptation Food enjoyment Individuality Meaningful activity Mood Privacy Relationships Security Spiritual well-being	**Mode:** Interview of nursing home residents **Scale:** Mood questions - often, sometimes, rarely, never, don't know All others - generally agree; generally disagree; Don't Know
CMS Quality of Life (QOL) Assessment Resident Interview http://www.cms.hhs.gov/cmsforms/downloads/CMS806a.pdf	To provide data to consumers to better inform decisions; to assist nursing home quality improvement efforts	Room Environment Privacy Food Activities Staff ADL Decisions Medical Services	**Mode:** Interview of all residents at specified intervals during their stay **Scale**: open ended
MDS 3.0 (Scheduled for implementation 10/2010) http://www.cms.hhs.gov/nursinghomequalityinits/25_nhqimds30.asp	Increase the resident's voice by introducing more resident interview items as part of MDS assessment; serve as basis for care planning	Mood Daily Preference Activity Preference	**Mode**: Interview with each residents at required intervals **Scale**: Symptom presence; system frequency
Iowa Accountability Measures http://www.ime.state.ia.us/docs/ResidentOpinionSurveyRevised10-16-02.pdf	Completion of Resident Opinion Survey is required as part of qualification for additional Medicaid reimbursement	General	**Mode**: Resident self-report **Scale**: strongly agree, agree, neutral, disagree

Instrument	Purpose	Domains	Mode/Scale
			and strongly disagree
Kansas PEAK (Promoting Excellent Alternatives in Kansas) http://www.agingkansas.org/CultureChange/PEAK/PEAK%20Award%20Sample%20Application.pdf	Created to promote more social, non-traditional models of long-term care. Includes an educational component to support nursing homes in implementing progressive, innovative approaches to improving quality of life for those living and working in long-term care environments.	Domains related to QOL: Resident control, home environment, community involvement	**Mode**: Self report by nursing facility administration **Scale**: Yes/No; describe
CAHPS – Nursing Home https://www.cahps.ahrq.gov/content/products/NH/PROD_NH_Long-Stay_Resident_Instrument.htm	Developed by the Agency of healthcare Quality and Research to Assess the patient-centeredness of care; compare and report on performance; and improve quality of care.	Environment Care Communication and Respect Autonomy Activities	**Mode**: Resident Interview **Scale**: Yes/No format
Maryland Facility Family Survey http://mhcc.maryland.gov/consumerinfo/nhguide/satisfactionsurveystatewide2008.pdf	• Measures experience and satisfaction with the nursing home and care provided; • Compares experience and satisfaction measures among Maryland nursing homes; and • Compares between nursing homes in the same geographic region, of similar size, and for-profit or non-profit ownership.	Food and Meals Autonomy & Resident Rights Physical Aspects of the Nursing Home	**Mode:** Mail survey to person designated as the "responsible party" for residents with stays of 90 days or longer. **Scale**: Yes/no; numeric response
Vermont Gold Star Program http://www.vahhs.org/EventDocs/HCsummit05/Speaker%20Handouts/Mary%20Shriver_Laine%20Lucenti_attaining%20magnet%20status%20in%20hospitals_vts%20newest%20initiative.ppt	Recognition program jointly sponsored by state and nursing home association to improve workplace practices. Recognition makes facility eligible to win one of five annual $25,000 awards	Staff recruitment Orientation and training Staff levels Work hours Professional development and advancement Supervision, training and practice Team approach Staff recognition and support	

APPENDIX B.2 - QUALITY OF LIFE MEASURES BY INSTRUMENT

Domain	MN DHS	CMS QOL	MDS 3.0 (10.2010)	Iowa Accountability Measures	Kansas PEAK	CAHPS-NH	Maryland Family Survey	CO P4P
Comfort	Have you been too cold here	Do staff try to make facility homelike		Most of the residents have adjusted to the NH	Have efforts been made to reduce institutional noise	How would you rate how comfortable the temperature in the NH	In the last 6 mos., did the public areas look and smell clean	**Overhead paging has been turned off and used only in emergencies.**
	Are you in physical pain?	Is there anything that would make this facility more comfortable		The residents appear to be comfortable		How would you rate how clean the facility is	In the last 6 mos., did the resident's room look and smell clean	**Physical environment has been designed or re-designed to create neighborhoods/house holds.**
	Are you bothered by noise when you are in your room?	Is it generally quiet or noisy here; what about at night		Nursing home is clean		Is area around your room quiet at night	In the last 6 months, was the noise level around the resident's room acceptable	**Plants, pets, or children have been introduced to develop a living environment.**
		Is facility usually clean and free of bad smells		Housekeeping department does a good job		Are you bothered by noise during the day		
				There are no bad odors				
				The surroundings are comfortable				
Environment Adaptations	Is it easy for you to get around in your room by yourself	Do you enjoy spending time in your room			Are there distinct neighborhoods and environments and are they staffed	Can you reach the call button when you want		

Domain	MN DHS	CMS QOL	MDS 3.0 (10.2010)	Iowa Accountability Measures	Kansas PEAK	CAHPS-NH	Maryland Family Survey	CO P4P
Environment Adaptations (cont'd)	Are your personal items arranged so you can get them	Is there enough light for you			Are resident rooms, care areas and common areas less institutional and more home compatible?	Is there a pitcher of water you can reach by yourself		
	Can you get the personal items you want to use in your bathroom	Is the room temperature comfortable			Has the traditional nurses' work area been made to have a less institutional appearance			
	Do you take care of your own things as much as you want	If room changed, what was reason; did you have choice						
		Is there anything you would like to change about your room						
Privacy	Can you find a place to be alone when you wish	Are you able to have privacy when you want it	How important is it to use the phone in private			If you have visitors, can you find a place to visit in private	If resident desires private space for visits, is private space available	**Resident rooms are designed to promote enhance privacy, promote personalization and individual needs.**

Domain	MN DHS	CMS QOL	MDS 3.0 (10.2010)	Iowa Accountability Measures	Kansas PEAK	CAHPS-NH	Maryland Family Survey	CO P4P
Privacy (cont'd)	Can you make a private phone call	Do staff and other residents respect your privacy				Do staff make sure you have enough privacy when you dress, take shower or bathe	In the last 6 mos., was resident's privacy protected when the resident was dressing, showering, bathing or I a public area	
	Do you and your visitors get enough privacy	Do you have a private place to meet with visitors						
		Do you have a private place to make phone calls						
Dignity	Do the people who work here treat you politely	Do staff treat you with respect				How respectful are staff to you	In the last 6 mos., how often did the nurses treat the resident with courtesy and respect	
	Are you treated with respect here	Do you feel staff know something about you as a person						
	Do the people who work here handle you gently	Do staff treat you with respect						

Domain	MN DHS	CMS QOL	MDS 3.0 (10.2010)	Iowa Accountability Measures	Kansas PEAK	CAHPS-NH	Maryland Family Survey	CO P4P
	Do the people who work here respect your modesty							
Meaningful Activity	Are there things to do here that you enjoy	How do you find out about what activities are going on	How important is it to: • Have books, newspapers and magazines to read • Listen to music you like • Be around animals such as pets • Keep up with the news • Do things with groups of people • Do your favorite activities • Go outside to get fresh air when weather is good • Participate in religions services or practices	There are activities available to encourage thinking.	Do residents regularly engage in activities of their own choice and desire	Are there enough organized activities for you to do on weekends/weekdays		
	Are there things to do on the weekend that you enjoy	Are there activities on weekends		Chapel services are adequate	Is there a formal process for informing the community about activities at your home?			
	Do you help other people	Do you participate in activities; what kinds; do you enjoy them			Is there an established process in each neighborhood to encourage residents to participate in community activities, both inside and outside the home on a weekly basis			**Regular neighborhood community meetings or learning circles promote a sense of community and spontaneous activity.**

Domain	MN DHS	CMS QOL	MDS 3.0 (10.2010)	Iowa Accountability Measures	Kansas PEAK	CAHPS-NH	Maryland Family Survey	CO P4P
Meaningful Activity (cont'd)	Can you do hobbies that you enjoy here	Is there some activity that you would like to do that is not available here; have you talked to anyone about this; what was their response			Is there a formal volunteer program with recognition			**The external community is invited, informed and involved in the life of the facility.**
					Are there inter-generational programs scheduled regularly and frequently			**Opportunities exist 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.**
Food Enjoyment	Do you like the food here	How does your food taste		A variety of meals are provided	Do residents have choices regarding meals and mealtimes	How would you rate the food	How often did you help with eating or drinking because nurses or assistance were not available to help or made him/her wait too long	**Menus include numerous options**
	Do you enjoy mealtimes here	Are you served foods that you like to eat		The dietician is easy to talk with		Do you ever eat in the dining room; how did you enjoy your mealtime		**Menus are developed with resident input**

Domain	MN DHS	CMS QOL	MDS 3.0 (10.2010)	Iowa Accountability Measures	Kansas PEAK	CAHPS-NH	Maryland Family Survey	CO P4P
	Do they serve your favorite foods here	Are hot and cold foods served at temperatures that you like		Food is good tasting				**The dining experience reflects the community**
		Have you ever refused to eat something served to you; did the facility offer you something else		Food servers are pleasant				**Residents have access to food 24 hours/day and staff are empowered to provide food when resident desires it**

Domain	MN DHS	CMS QOL	MDS 3.0 (10.2010)	Iowa Accountability Measures	Kansas PEAK	CAHPS-NH	Maryland Family Survey	CO P4P
Autonomy	Can you go to bed at the time you want	Are you involved in making choices about your daily activities	Daily Preference: How important is it to: • Choose what clothes to wear • Take care of your personal belongings or things • Choose between a tub bath, shower, bed bath, or sponge bath • Have snacks available between meals • Choose your own bed time • Have your family or a close friend involved in discussions about your care	Residents get a change in roommate if they request.	Do residents have options in bathing methods and times	How well do staff listen to you		**Bath schedules are flexible to meet resident desires, options for bathing are provided, and the physical bathing environment is enhanced.**
	Can you get up in the morning at the time you want	Are you involved in making decisions about your nursing care and medical treatment			Do residents choose what to wear on a daily basis and are they encouraged to dress themselves	Can you choose time you go to bed		Residents are assisted in determining their own daily schedules and participate in developing their care plans.

Domain	MN DHS	CMS QOL	MDS 3.0 (10.2010)	Iowa Accountability Measures	Kansas PEAK	CAHPS-NH	Maryland Family Survey	CO P4P
Autonomy (cont'd)	Can you change things you don't like here	Do you participate in meetings where staff plan your activities and daily medical and nursing care			Do residents have ownership of their rooms as well as spaces to use	Can you choose what clothes you wear		**Facility 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.**
	Do the people who work here know what you are interested in and what you like	If you are unhappy with something, how do you let facility know; do staff listen to your requests and respond appropriately; if not able to accommodate your request, do they provide reasonable explanation			Do residents know they have the right to make choices and are they encouraged to do so; how can residents provide input	Can you choose what activities you do		**Facility supports and has systems in place to provide formal training on person-directed care to all staff.**
		Can you choose how you spend your day			Is input received from each resident for development of their plan of care			

Domain	MN DHS	CMS QOL	MDS 3.0 (10.2010)	Iowa Accountability Measures	Kansas PEAK	CAHPS-NH	Maryland Family Survey	CO P4P
		Have you ever refused care or treatment; what happened			Are daily schedules flexible and centered around resident choices			
Individuality	Do the people who work here know you as a person			The nursing staff understand how residents feel		How well do staff listen to you		**Formalized volunteer program exists to allow for the provision of resident-specific activities and visits.**
	Are people working here interested in the things you've done in your life			The staff care about the residents		How well do staff explain things in a way that is easy to understand		
	Do the people who live here know you as a person			Staff deals honestly with residents				
	Are your personal items safe here	Has any resident or staff member ever physically harmed you	How important is it to have a place to lock your things to keep them safe	Staff is safety conscious	Are there secured outdoor areas	How safe and secure do you feel?		

Domain	MN DHS	CMS QOL	MDS 3.0 (10.2010)	Iowa Accountability Measures	Kansas PEAK	CAHPS-NH	Maryland Family Survey	CO P4P
Security	Does your clothing get lost or damaged in the laundry	Has any resident or staff member ever taken anything belonging to you without permission		Residents' property is rarely stolen and if it, property is usually recovered				
	Do you feel safe and secure	Has a staff member ever yelled or sworn at you; did you report this; how did they respond						
Relationships	Do the people who work here ever stop by just to talk	Are staff usually willing to take the time to listen when you want to talk about something personal or a problem you are having		The aides like their jobs.				**Staff are consistently assigned to the same resident**
	Do you consider anybody who works here to be your friend	Do staff make efforts to resolve your problems		The staff communicates well with all concerned				
	Can you get help when you need it			The staff is patient				
				Housekeeping staff are pleasant to visit with				

Domain	MN DHS	CMS QOL	MDS 3.0 (10.2010)	Iowa Accountability Measures	Kansas PEAK	CAHPS-NH	Maryland Family Survey	CO P4P
Satisfaction	Do the people who work here listen to what you say			The nurses are well trained	Are resident satisfaction surveys conducted on an ongoing basis and are they analyzed for possible areas for improvement		From 1 to 10, how would you rate this facility	
	Do the people who work here explain your daily care			The aides know what they are doing when caring for residents			Would you recommend this facility to others	
	Do you consider any of the other people who live here a friend			Administration spends money wisely				
	Do the people who work here knock on your door and wait to be invited in			I am satisfied with: • Aide service • Dietary service • Nursing service • Housekeeping service • administration				

Domain	MN DHS	CMS QOL	MDS 3.0 (10.2010)	Iowa Accountability Measures	Kansas PEAK	CAHPS-NH	Maryland Family Survey	CO P4P
Satisfaction (cont'd)	Do the people who work here ever get angry with you							
	Would you recommend this nursing home to someone who needs care							
	Overall, what grade would you give this nursing home							
	Bored		In past 2 weeks, have you been bothered by any of the following: Little interest or pleasure in doing things Feeling down, depressed, hopeless Trouble falling or staying asleep;, sleeping too much Feeling tired or having little energy			How often do you feel : • Worried • Happy		
	Angry							
	Peaceful							
	worried							
	Interested in things							
	Sad							

Domain	MN DHS	CMS QOL	MDS 3.0 (10.2010)	Iowa Accountability Measures	Kansas PEAK	CAHPS-NH	Maryland Family Survey	CO P4P
Mood	Afraid		Poor appetite or over eating Feeling bad about yourself – or that you are a failure or have let yourself or your family down Trouble concentrating on things, such as reading the newspaper or watching TV Moving or speaking so slowly that other people could not have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual Thoughts that you would be better off dead, or of hurting yourself in some way					
	Lonely							
	Happy							
ADL's		Tailored based on MDS: Do you feel that you get the help you need				How gentle are staff when they're helping you		
		Does staff encourage you to do as much as you can for yourself?						

Domain	MN DHS	CMS QOL	MDS 3.0 (10.2010)	Iowa Accountability Measures	Kansas PEAK	CAHPS-NH	Maryland Family Survey	CO P4P
Medical Services		Did you choose your physician yourself		If requested, residents will get change in care		How well do staff help you when you have pain		
		Are you satisfied with the care provided by your physician				How quickly does staff come when you call for help		
		Can you see your doctor if you need to						
		Do you have privacy when you are examined by your physician at the facility						
		Does facility help you make doctor's appointment and help you obtain transportation						
		Can you get to see a dentist, podiatrist, or other specialist						
Other		Is there anything else you would like to talk about regarding your life here						

APPENDIX B.3 – CMS QUALITY OF CARE MEASUREMENT SET

Instrument	Purpose/Data Source	Quality of Care Indicators
CMS Quality Measures http://www.cms.hhs.gov/NursingHomeQualityInits/10_NHQIQualityMeasures.asp	**Purpose:** To provide public information on the care in nursing homes to improve decision making; to give data to nursing homes to help them with their quality improvement efforts **Data Source**: MDS Assessment Instrument	Percent of residents given influenza vaccination during the flu season (separate measures for long and short stay) Percent of long stay residents who were assessed and given pneumococcal vaccination (separate measures for long and short stay) Percent of residents whose need for help with daily activities has increased Percent of residents who have moderate to severe pain Percent of high risk residents who have pressure sores Percent of residents who were physically restrained Percent of residents who are more depressed or anxious Percent of low risk residents who lose control of their bowels or bladder Percent of residents who have/had a catheter inserted and left in their bladder Percent of residents who spent most of their time in bed or in a chair Percent of residents whose ability to more about in and around their room got worse Percent of residents with a urinary tract infection Percent of residents who lose too much weight Percent of short stay residents with delirium Percent of short stay residents who had moderate to severe pain Percent of short stay residents with pressure ulcers.

APPENDIX B.4 – NURSING HOME SURVEYS FOR ASSESSING CULTURE

Instrument	Purpose/Mode	Domains
Nursing Home Survey on Patient Safety Culture http://www.ahrq.gov/qual/nhsurvey08/nhdimensions.htm	**Purpose:** AHRQ sponsored the development of the *Nursing Home Survey on Patient Safety Culture* for use as: • a diagnostic tool to assess the status of patient safety culture in a nursing home. • an intervention to raise staff awareness about patient safety issues. • a mechanism to evaluate the impact of patient safety improvement initiatives.	Teamwork Staff compliance with procedures Training and skills Non-punitive responses to mistakes Handoffs Feedback and communication about incidents Communication openness Supervisory expectations and actions promoting resident safety Overall perceptions of resident safety

Instrument	Purpose/Mode	Domains
	• a way to track changes in patient safety culture over time. **Mode:** Designed to be administered to **all** employees in nursing home, ranging from nursing home administrators, physicians (M.D. or D.O.), physician assistants, and nursing staff to housekeeping, maintenance, and security staff. Methods for sampling staff provided.	Management support of resident safety Organizational learning
Commonwealth, Nursing Home Survey http://www.commonwealthfund.org/Content/Surveys/2007/The-Commonwealth-Fund-2007-National-Survey-of-Nursing-Homes.aspx	**Purpose:** Survey initially designed to examine the penetration of the culture change movement at the national level and measure the extent to which nursing homes are adopting culture change principles and practicing resident-centered care. Mode: Mailed survey to directors of nursing.	Care and resident-related activities directed by residents; Environment designed as a home Close relationships among residents, family members, staff, and community; Work that is organized to support and empower all staff to respond to residents' needs and desires; Management that allows for collaborative and decentralized decision-making Systematic processes that are comprehensive, measurement-based, and used for quality improvement

APPENDIX B.5 – VERMONT GOLD STAR EMPLOYMENT PROGRAM

Domain	Quality Sub-domains
Staff Recruitment and Practices	Community outreach and involvement Collaboration with other agencies Screen for successful employees Honest description of job duties and expectations Involve direct care workers in recruitment, interviewing
Orientation and Training Practices	Standardized orientation Regular follow up with new staff Hands-on training specific to required tasks and responsibilities Mentoring and support for new staff
Staffing Levels and Work Hours Practices	Stable, reliable hours Flexible scheduling Worker control over hours worked Overtime in not coercive, not pressured or frequently requested Safe work loads
Professional Development and Advancement Practices	Career lattices Cross disciplinary training Mentoring programs Training in specialized care Ongoing training opportunities on site or through financial support
Supervision: Training and Practices	Training for all supervisory staff Provide management staff with tools needed to succeed Accessible management and supervisory staff Demonstrated/model attitudes and behavior Treat each worker as important to achieving agency mission Specific, measurable job descriptions used to conduct performance reviews of supervisory staff
Team Approach Practices	Direct care worker involved in patient care planning Shared responsibility for patient care and outcome Permanent assignments to units or teams Regular, mandatory team building activities Regular meetings and communications to share information Staff involvement in problem solving and decision making

APPENDIX C - 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%
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%

State	Total Patients	Medicare	Medicaid	Other Payer
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%

Data Source: American Health Care Association

APPENDIX D – STAFF RETENTION RATE

This performance measure was the most difficult to score and had the widest range of supporting documentation of any of the measures. There should be clearer instructions on what documentation to include, what staff to include, and how to interpret the calculation of the staff retention rate. To illustrate the differences in interpretation, and how it can affect the scoring, see the following examples:

Example 1. This home calculated their staff retention rate by dividing the number of current employees divided by the total number of employees throughout the course of the year. They arrived at a calculation of 69/122 or 56.5%. Looking further at how they arrived at this calculation we discovered that their retention rate could have been significantly different if they had interpreted how to calculate the rate differently. Reviewing their employment data, we noticed that there are four different classifications of employees relevant to a staff retention report. They are:

1. Employees who began the year and remained employed through the end of the year, or, "remains"
2. Employees who began the year and did not remain employed through the end of the year, or, "began and left"
3. Employees hired within the year and remained employed through the end of the year, or, "stays"
4. Employees that were hired within the year but did not remain employed through the end of the year, or, "leavers"

In this example the home calculated their staff retention rate by adding the "remains" category to the "stays" category. This was then divided by the sum of all four categories. This method was different from most of the other methods used. The most common method used was taking the "remain" category, and dividing it by the sum of the "remain" and "began and left" category. If this home had used this method to calculate their retention rate, the formula would have be 45/ (45+21) or 45/66 = 68.2%. This is a significant difference from the 56.5% rate they arrived at using their calculation.

Example 2. Another home used the exact same calculation as the home in example 1. The formula they arrived at was 95/165 = 57.58%. When breaking down their employee listing file given as supporting documentation, there were 57 "remains," 50 "began and left," 37 "stays," 40 "leavers," and the rest were unclear as to what category they fill into. This home self-reported a score of 57.58% and therefore gave themselves the 4 points available for this measure. However, if this home had used the most common formula to calculate their retention rate, the formula would be: 57/(57+50) or 57/107 = 53.27%, and would not have received points for this measure.

<u>Recommendations:</u>
There needs to be clear guidelines on how to calculate the staff retention rate. There also needs to be clear direction on how to treat the four employee categories. The state should

also develop a form for facilities to fill out with the chosen formula. Every facility that used a variation of the above calculation method included the first two categories. The question is whether or not to include those employees hired within the year in the staff retention rate calculation. It is our recommendation that facilities not include employees hired within the year in the staff retention rate calculation for the following reasons:

1. The number of "leavers" may be artificially inflated by the amount of temporary or part time employees hired. Nursing homes will typically use part time and temporary employees to fill short term needs. It will also hire "seasonal" employees, for example, college students who work in a nursing home for the summer, but go back to school in the fall, and are therefore no longer employed by the home.
2. The staff retention rate should be a calculation of the number of staff that began the year relative to the number of those employees who remain employed through the end of the year.