Colorado Department of Health Care Policy and Financing

2021 Nursing Facilities Pay for Performance Application Review

Recommendations Report

June 2021

PUBLIC CONSULTING GROUP

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1. INTRODUCTION

Public Consulting Group LLC (PCG) was contracted by the Department of Health Care Policy and Financing (the Department) to review, evaluate, and validate nursing home applications for the 2021 (calendar year 2020) Pay for Performance (P4P) program. This Recommendations Report is supplemental to the 2021 P4P Data Report, which includes final scores, historical data analysis, and a measure-by-measure data breakdown. This report provides analysis and recommendations for the P4P Program application and process to help ensure continuous program improvement. Considerations for the Department to implement in the P4P Program are based on:

- Observations and feedback throughout the application creation and review process,
- Research into Centers for Medicare and Medicaid Services (CMS) initiatives,
- Other states' P4P programs, and
- A literature review of best practices.

Each section offers specific details on the focus areas identified above and provides recommendations related to the findings and observations.

2. P4P PROGRAM REVIEW

Since its implementation in 2009, the Colorado P4P Program has continuously evolved to ensure that nursing facilities consistently strive to provide high quality care to its residents. Each year, the Department has implemented changes to the application and submission process with the aim of improving clarity, increasing participation, easing administrative burden and encouraging nursing facilities to improve on key quality measures in Colorado. Revisions to the 2021 application included improvements in measures, minimum requirements, and scoring from the previous application period as well as modifications to the application in light of COVID-19 and the impact it had on nursing facilities.

To promote program participation and aid the provider submission process, PCG developed a web portal which has been used by nursing facilities to complete and submit applications. The 2021 application cycle marked the fifth year a web portal was used to collect provider submissions. The experiences and feedback from the previous year informed enhancements to the web portal application, aimed at improving user experience from both the applicant and reviewer perspective.

Each P4P application year is unique, therefore this section reports on the following:

- Noted observations throughout the review process,
- Feedback collected from the Department on the application and review process, and
- Analysis of the final scores and measure analysis.

From the information collected above, PCG has outlined opportunities for further application, process, and program refinement.

COVID-19

COVID-19 had a significant impact worldwide and the P4P program was no exception. Persons living in communal settings are at high risk for COVID-19 due to the infectiousness of the disease. Elder adults and those with co-morbidities are at high risk for poor outcomes from COVID-19. Nursing facilities participating in P4P program combine risk factors, serving elder adults or those with co-morbidities in a communal setting.

Due to the high-risk nursing home residents faced, nursing homes had to quickly adapt and implement infection control procedures to mitigate the risk posed to residents. Infection control procedures affected homes' ability to meet some criteria in the P4P application. For example, quality of life aspects such as dining, personal care, volunteering had to be altered to prevent the spread of COVID-19. The 2021 P4P

program was modified, understanding the challenges homes faced in calendar year 2020 with regulatory and operational challenges.

The following changes were made to the 2021 P4P program application in response to COVID-19.

Measure 1: Enhanced Dining

- Adjusted 1.1 – Provide a detailed narrative describing your enhanced dining program. Given the adjustments that had to be made in your home and to your infection control plan in response to regulatory requirements/guidance, provide a narrative describing how you accommodated including input from resident/family advisory groups.
- Removed 1.4- Evidence that these options included input from a resident/family advisory group such as resident council or a dining advisory committee that takes into account the cultural, ethnic and religious needs of the resident population.
- Adjusted 1.6 - Given the adjustments that had to be made in your home and to your infection control plan in response to regulatory requirements/guidance, provide a narrative describing your policies/processes to ensure that residents have access to food 24/7.
- Adjusted 1.8 – Provide a narrative describing your food safety practices. Please include any adjustments that had to be made due to COVID-19.

Measure 2: Enhanced Personal Care

- Adjusted 2.1- Given the adjustments that had to be made in your home and to your infection control plan in response to regulatory requirements/guidance, provide a narrative describing how you still made efforts to accommodate residents' preferences with their personal care (including oral care).
- Adjusted 2.6- Given the adjustments that had to be made in your home and to your infection control plan in response to regulatory requirements/guidance, provide a narrative describing how bathing was accommodated. Include details on staff training and resident education.
- Adjusted 2.7- Given the adjustments that had to be made in your home and to your infection control plan in response to regulatory requirements/guidance, provide a narrative describing how oral care was accommodated. Include details on staff training and resident education.

Measure 3: End of Life Program

- Adjusted 3.1- Given the adjustments that had to be made due to COVID-19, provide a narrative on how your facility is approaching the end of life program including how you maintained support between residents, families, hospices, and systems to accommodate religious/ spiritual preferences around end of life wishes (virtually, telephonically, etc.).
- Removed 3.2 - Documentation of four (4) residents' individual wishes and how you honored them. If the facility does not have four (4) instances of how you have honored past residents, include documentation of how you plan to honor current residents' individual wishes.
- Adjusted 3.3 - Provide a narrative on how you are supporting your staff regarding end of life programming as a result of the impacts of COVID-19.
- Adjusted 3.4 - Provide two (2) signed testimonials from non-management staff describing end of life planning at your home including details on staff education and support given.

Measure 4: Connection and Meaning

- Adjusted 4.1- Given the adjustments that had to be made in your home and to your infection control plan in response to regulatory requirements/guidance, provide a narrative on how you have adjusted opportunities for connection and meaning amongst residents.
- Adjusted 4.2- Provide four (4) examples that demonstrate how you maintained connection and meaning within your home during the COVID-19 pandemic.

- Adjusted 4.3- Provide two (2) testimonials from non-management staff members on how your facility provided connection and meaning to your residents during the COVID-19 pandemic.

Measure 5: Person-Directed Care Training (CMS, HCPF)

- Adjusted 5.1- Given the adjustments that had to be made in your home and to your infection control plan in response to regulatory requirements/guidance, provide a narrative detailing your efforts to prepare and support your staff around person-directed care. Provide two specific examples of how this was accomplished (this can be informal training, education, communication, etc.).
- Removed 5.2- Annual training objectives for your person-directed care curriculum that specify how the curriculum considered the community assessment in defining the training objectives.

- Removed 5.4- A list of person-directed care trainings.

Measure 6: Trauma - Informed Care (CMS, HCPF)

- Removed 6.2- Submit training objectives and proof of actual trainings for your staff on trauma-informed care. Resources:
    - https://www.samhsa.gov/nctic/trauma-interventions
    - https://alamedacountytraumainformedcare.org/caregivers-and-providers
    - You may also find additional resources from your local mental health center
- Removed 6.3- Cite the evidence-based resources used during the trainings referenced in Measure 6.2.
- Removed 6.5- Provide an example of trauma informed care.
- Created 6.3- Complete the Trauma and Stress Types Tool.
    - Note: The tool will require homes to mark applicable trauma/stress experienced in the home. It will not require supporting documentation. Please refer to the Trauma and Stress Types Tool attached.

Measure 7: Daily Schedules and Care Planning (CMS, HCPF)

- Adjusted 7.1- Given the adjustments that had to be made in your home and to your infection control plan in response to regulatory requirements/guidance, provide a narrative describing your approach to care planning and daily schedules. Please include any efforts in accommodating residents' preferences with their daily schedules.
- Removed 7.2- Four (4) signed resident testimonials that prove implementation of the resident's choices, preferences and daily schedules.
- Removed 7.3- Four (4) care plans. Documentation must identify that residents and/or responsible party along with direct care staff participate and are present in developing an individual's care plan that documents the resident choices. Evidence that clearly identifies the participants and corresponding job titles.
- Removed 7.4- The same four (4) resident care plans and testimonials must be submitted with the application.
- Removed 07.5- Four (4) signed testimonials from staff who attended and participated in the care planning process.

Measure 8.1: Physical Environment – Appearance

- Adjusted 8.1.2 - Provide photographic support within the last 2 years from items discussed in your narrative and the items described below. We understand that your common areas' appearance may have been altered due to COVID-19 regulations. Photographs must be captioned.

Measure 9: QAPI (CMS) - Based on a Quality Measure

- Adjusted 9.1- Provide a narrative describing your QAPI for infection control that includes:
    - The problem statement,
    - Intended goals,
    - Tools/processes utilized,
    - Final outcomes,
    - Why the project is important, and
    - How this improves the quality of life and quality of care for residents or staff.
    - Include documented data trends through the duration of the project.
- Removed 9.2- Document the process on how the home is kept informed of the project and its progress for each element mentioned in Measure 9.1.
- Removed 9.3- Describe the process implemented to ensure that all staff, residents and their families are aware of and have the opportunity to support the QI project.
- Removed 9.4- Provide examples of how residents and staff supported the project.

Measure 10: Consistent Assignments

- Adjusted 10.1- Given the adjustments that had to be made in your home and to your infection control plan in response to regulatory requirements/guidance, potential staffing shortages, and limited contact, provide a narrative describing your process for maintaining consistent assignments.
- Removed 10.2- Monthly staffing schedules for Nurses, CNAs and Housekeeping for three (3) consecutive months that demonstrates consistent assignments. This is defined as staff scheduled to work with the same group of residents at least 80% of their scheduled shifts.
- Removed 10.3- Three (3) staff testimonials and three (3) resident and/or family testimonials that reflect the existence of consistent care assignments.
- Removed 10.4- If you are unable to qualify for points for Consistent Assignments based upon the above minimum requirements, but you have performed a QAPI project in 2020 for Consistent Assignments, you are able to earn one (1) QAPI recovery point by submitting a narrative of the QAPI project that includes how Consistent Assignments is addressed, the problem statement, baseline data, intended goals, tools/processes utilized, and final outcomes.

Measure 11: Volunteer Program

- Adjusted 11.1- We understand that the pandemic may have affected your normal volunteer program. Given the adjustments that had to be made in your home and to your infection control plan in response to regulatory requirements/guidance, provide a narrative on how you have maintained volunteer opportunities at your facility.

Measure 12: Staff Engagement

- Adjusted 12.1- Given the adjustments that had to be made in your home and to your infection control plan in response to regulatory requirements/guidance, provide a narrative on how are you continuing to ensure staff are engaged and maintaining as manageable of a work-life balance. Provide a specific example of how you supported staff with their stress and trauma related to COVID-19.
- Removed 12.3- Evidence of the existence of staff programs that foster development and engagement through participation. This may include a staff group, spontaneous activities and unique benefits that support your staff. Documentation must include four (4) testimonials from staff on empowerment opportunities.
- Removed 12.4- One (1) example per quarter of staff support or engagement unrelated to the typical policies and benefits package of the provider.

- Removed 12.5- A written narrative of a program that includes staff mentoring and/or buddy system for new staff.
- Remove 12.6- Documentation of at least a 70% response rate for your Staff Satisfaction Survey. Include the scoring results for an "Overall Satisfaction" question.
- Removed 12.7- If you are unable to qualify for points for Staff Engagement based upon the above minimum requirements, but you have performed a QAPI project in 2020 for Staff Engagement, you are able to earn one (1) QAPI recovery point by submitting a narrative of the QAPI project that includes how Staff Engagement is addressed, the problem statement, baseline data, intended goals, tools/processes utilized, and final outcomes.

Measure 13: Transitions of Care: Admissions, Transfer and Discharge Rights (CMS, HCPF)

- Removed 13.2- Submit the staff education and training objectives for Options Counseling that has occurred in your building in 2020. (resources about Transition Services: https://www.colorado.gov/pacific/hcpf/transition-services)"

Measure 15: Reducing Avoidable Hospitalizations (CMS, HCPF)

- Adjusted Measure 15 to award all facility 3 points. The measure was noted that requirements would be reinstated for the 2022 application.

Measure 18.1: Antibiotics Stewardship/Infection Prevention & Control (CMS) - Documentation

- Adjusted 18.1.2- Provide a narrative of how you maintained infection control in your facility including how you trained staff, implemented the infection control plan, etc.

Measure 18.2: Antibiotics Stewardship/Infection Prevention & Control (CMS) - Quality Measures

- Adjusted Measure 18.2 to pay for reporting.

Measure 20: Staff Retention Rate

- Adjusted Measure 20 to pay for reporting.
- Adjusted 20.1- Submit your staff retention rate (excluding NHA and DON). Supporting documentation must pertain to January 1 - December 31, 2020.
- Removed 20.3- Do not enter points for both the Staff Retention Rate AND Staff Retention Improvement categories above. Only three (3) points may be obtained for one of these categories
- Removed 20.4- If you are unable to qualify for points for Staff Retention Rate / Improvement based upon the above minimum requirements, but you have performed a QAPI project in 2020 for Staff Retention Rate / Improvement, you are able to earn one (1) QAPI recovery point by submitting a narrative of the QAPI project that includes how Staff Retention Rate / Improvement is addressed, the problem statement, baseline data, intended goals, tools/processes utilized, and final outcomes.

Measure 22: Nursing Staff Turnover Rate (CMS)

- Adjusted 22.1- Use the Staff Turnover Calculation tool to calculate your nursing staff turnover rate for calendar years 2019 and 2020. A termination is defined as any person who is no longer employed by the home for any reason.
- Removed 22.2- If you are unable to qualify for points for Nursing Staff Turnover Rate based upon the above minimum requirements, but you have performed a QAPI project in 2020 for Nursing Staff Turnover Rate, you are able to earn one (1) QAPI recovery point by submitting a narrative of the

QAPI project that includes how Nursing Staff Turnover Rate is addressed, the problem statement, baseline data, intended goals, tools/processes utilized, and final outcomes.

For 2022, the following changes are being recommended for the P4P application.

Measure 1: Enhanced Dining

- Adjust 1.1- Add into narrative, "how you are transitioning back to communal dining and how you have accommodated including input from resident/family advisory groups in the reintroduction of communal dining."
- Adjust 1.8- Provide "evidence" of food safety.
- The points available for this measure has been increased from 2 to 3.

Measure 2: Enhanced Personal Care

- Revert fully to pre-COVID measure.

Measure 3: End of Life Program

- 3.2- Reimplement pre-COVID measure.
- Adjust 3.3- Add language into narrative for how the facility has made an effort to make resident wishes known to staff.

Measure 4: Connection and Meaning

- Adjust 4.1- Add language to narrative on how the facility is working to reintroduce connection and meaning. Additionally, include details on any promising practices/opportunities that were implemented during the pandemic that you have decided to keep.
- Adjust 4.3- Add requirement for four resident testimonials and two non-management staff.

Measure 5: Person-Directed Care Training (CMS, HCPF)

- Adjusted 5.1- Add language to narrative about any practices/processes the facility would maintain that were implemented during COVID. Additionally, include details on any promising practices/opportunities that were implemented during the pandemic that you have decided to keep.
- 5.4- Reimplement pre-COVID measure
- Rename from "Person-Directed Care Training" to "Person-Directed Care Programming & Training"

Measure 6: Trauma - Informed Care (CMS, HCPF)

- Adjust 6.2- Provide a narrative on how you are using data and information around known trauma from your Facility Assessment, other assessments done in the home, or other means to influence programming and staff training. In your narrative, include a specific example.
- Adjust 6.3- Provide a narrative on how you are using data and information around known trauma from your Facility Assessment, other assessments done in the home, or other means to recognize trauma, develop an approach, and alter a care plan for residents. In your narrative, include a specific example.
- Reimplement 6.4 and 6.5 pre-COVID measures.
- Increase the points available for this measure has been from 4 to 5.

Measure 7: Daily Schedules and Care Planning (CMS, HCPF)

- Adjust 7.2, 7.3, and 7.4- Two examples/testimonials for each.

Measure 8.1: Physical Environment – Appearance

- Adjust 8.1.1- Removed reference to photos from the “last two years” and added language to ask about the impacts of social distancing and how the facility is reintroducing a de-institutionalized, homelike environment.

Measure 8.1: Physical Environment – Noise Management

- Add 8.2.4- Provide a narrative including minimum of two examples of your facility's approaches towards improving sleeping environments (e.g. policies, night owl wings, lighting options, and noise management).

Measure 9: QAPI (CMS) - Based on a Quality Measure

- Reimplement pre-COVID measure.

Measure 10: Consistent Assignments

- Adjust 10.1- Add details into narrative about the process for moving towards consistent assignments, identifying challenges and any best practices you will keep that were implemented during COVID.
- Adjust 10.2- Three total testimonials in total with at least one of each (resident and staff)
- Reinstate QAPI recovery point.

Measure 11: Volunteer Program

- Adjust 11.2, 11.3, and 11.4- Two examples of each are required.
- Adjust 11.3 and 11.4- Adjust language that “evidence” of events is required.

Measure 12: Staff Engagement

- Reimplement 12.3, 12.4, and 12.6 pre-COVID measures.
- Reimplement 12.5 pre-covid measure and additionally ask what the facility’s new buddy system and staffing looks like given the adjustments that had to be made due to COVID.
- QAPI recovery point has been reinstated.

Measure 13: Transitions of Care: Admissions, Transfer and Discharge Rights (CMS, HCPF)

- Reimplement 13.2 pre-COVID measure

Measure 14: Vaccine Education

- Adjust 14.1- Provide a detailed narrative describing your home’s educational efforts on the following three vaccinations for both residents and staff:
    - Pneumococcal
    - Influenza
    - COVID-19
- Increase the points available for this measure from 1 to 2.
- Rename this measure from “Vaccination Data” to “Vaccine Education”.

Measure 15: Reducing Avoidable Hospitalizations (CMS, HCPF)

- Remove the measure. Reimplement in 2023 and will have CY2021 as the baseline year.
- This measure was worth three points. Redistribute one point to each of the following measures:
    - Enhanced Dining

  - Trauma-Informed Care
  - Vaccinations

Measure 16.2-8: Nationally Reported Quality Measures Scores (CMS)

- Revert quality measures to pre-COVID scoring metrics with 5 points per QM.

Measure 18.2: Antibiotics Stewardship/Infection Prevention & Control (CMS) - Quality Measures

- Adjust 18.2.1 & 18.2.2 – These were previously one measure that should be split into two separate, single point measures.
- Add a QAPI recovery point for both UTI and Catheter.
  - To earn the QAPI recovery point, you must have performed a QAPI project related to all areas of 18.2.1 or 18.2.2 for which you did not qualify for points. For example, if you did not qualify for either, there must be a QAPI for both Catheter and UTI. If you did not qualify for UTI but did qualify for Catheter, there only needs to be a QAPI related to UTI and vice versa.

Measure 20: Staff Retention Rate

- Reimplement 20.1's requirement for a minimum rate to receive points. Facilities must demonstrate a retention rate of at least 60% or improvement in their retention rate. In the 2020 application, the improvement threshold was 5% which has now been removed.
- Reinstate QAPI recovery point.

Measure 22: Nursing Staff Turnover Rate (CMS)

- Reinstate 22.1's requirement for a minimum rate to receive points. In the 2020 application, the minimum turnover rate was 56.6%. The 2022 application minimum rate is 60% or demonstrated improvement.
- Reinstate QAPI recovery point.

Measure 23: Behavioral Health Care

- Add 23.2- Submit documentation of the process for accessing supports through the RAE for behavioral health and substance abuse for your residents.

2.1 P4P APPLICATION

Minimum Requirements Specificity and Standards

The 2021 application cycle resulted in slightly more appeals for requirement interpretation than in past years. Partly, this was due to new or modified measures and minimum requirements. Particularly with COVID-19, multiple measures switched from providing data to a narrative approach about processes. With new and/or changed measures, homes submitted materials that did not meet all requirements. Areas for increased clarity are discussed below.

Measure 1-Enhanced Dining received multiple appeals. Particularly, appeals revolved around minimum requirement 1-4 and the use of the facility assessment to inform menu options. Homes were not awarded points if they did not reference the facility assessment and how data from it was used to proactively inform menu options. While some homes did not reference the facility assessment directly, they did reference the demographic makeup of the home and how that informed menu options. The Department agreed that met the intent of the minimum requirement and awarded points.

Recommendation 1: Review minimum requirements for areas where the intent of the minimum requirement can be expanded upon to provide homes alternative ways of meeting the minimum requirement. For Measure 1 Enhanced Dining, modify language to include "how the home uses the facility assessment to proactively develop menu options that reflect the resident population seen in the home."

For *Measure 6-Trauma - Informed Care,* minimum requirements 1 and 2 were commonly appealed. For minimum requirement 6-1, the data reporting period was shifted from what a version of the application published earlier. Homes were notified of the reporting date change, the version was updated on the Department's website, and the portal date was correct. However, homes using older versions of the application to compile their application missed these notices. Therefore, there were multiple appeals. The Department allowed resubmission of the data during the appeals process to encompass the correct period, however, in the future, dates can be further highlighted to homes. For minimum requirement 6-2, there were multiple appeals due to the fact the narrative provided did not speak to changes the home implements after reviewing trauma data of the home. In the future, the requirements can be further broken out (such as with bullet points) to clearly identify narrative requirements.

Recommendation 2: Review minimum requirements for areas where requirements such as time frames or talking points can be highlighted or more easily identified. For minimum requirement 6-2, change to

"Provide a narrative on:

- ***How you are using data and information around known trauma from your Facility Assessment, other assessments done in the home, or other means to influence programming and staff training.***
- ***Include a specific example of how you are using the data and information about known trauma."***

Measure 11-Volunteer Program continued to receive appeals similar to previous years. For minimum requirement 11-2 states "Documentation of four (4) distinct events where residents have given to others or to their home, i.e. home service project, fundraisers for a home member, resident involvement in charity events, resident to resident volunteer projects, etc." While most facilities provide documentation such as pictures, some facilities only provide a summary. The intent is to have facilities provider more concrete evidence, which can be more clearly identified. Additionally, some facilities reference using the documentation provided for 11-2 as the testimonials submitted for 11-4. The Department and P4P Committee should decide whether the testimonials may apply as the documentation for two minimum requirements.

Recommendation 3: Review documentation requirement language to specify stronger documentation requirements such as images, signed testimonials, sign-in sheets, or other documentation that clearly confirms the event took place. Decide with the P4P Committee's input as to whether documentation, such as testimonials, can be utilized for two minimum requirements.

For *Measure 21-DON and NHA Retention,* documentation is required. However, facilities are often confused as to what documentation they should provide. It is recommended that documentation should not be required, or instructions should be more specific in what documentation to include, such as proof of hire date.

Recommendation 4: Clarify or remove documentation requirements for Measure 21.

For *Measure 22-Nursing Staff Turnover Rate* the measure requires documentation, however, the type of documentation is not specified which led to questions from facilities, as well as preliminary findings. It is recommended that documentation should not be required, or facilities should be instructed to upload their

nursing staff roster. Additionally, there is an error if there are more < 90-day terminations than staff present at the end of the calendar year. This should be fixed as this is situation that could occur.

Recommendation 5: Clarify or remove documentation requirements for Measure 22.

New Measures

The last year has brought heightened attention to diversity and equity for minorities. CMS has posted a request for information to collect feedback on ways it can increase health equity for patients through policies and the value-based purchasing process.[1] This is an area the Colorado P4P program has discussed measuring but has not finalized methodology for.

Within the last year, the Department and PCG has brainstormed some ways to measure equity within nursing homes in Colorado. Colorado's Hospital Quality Incentive Program (HQIP) currently has measures related to equity of patient care within hospitals. The table below provides a side-by-side comparison of HQIP equity measures and a potential P4P counterpart. .

Table 1. HQIP and P4P Equity Measure Comparison.

HQIP Measure	Nursing Home P4P Recommendation
Does the hospital's system accurately document self-identified race, ethnicity, and primary language? How does your hospital ensure that patients understand why race, ethnicity, and language data are being collected?	Provide a narrative on your home's process for collecting and documenting self-identified race, ethnicity, and primary language. Include examples of how patients are informed on why race, ethnicity, and language data is being collected.
Does the hospital provide system-wide staff education and training on how to ask demographic intake questions?	Provide evidence of staff education and training on how to ask demographic intake questions.
Are race, ethnicity, and language data accessible in the electronic medical record?	Provide a census of race, ethnicities, and languages spoken of residents in your home.
Does the hospital evaluate non-English language proficiency (e.g. Spanish proficiency) for providers who communicate with patients in languages other than English?	Provide your home's policies and procedures for evaluating non-English language proficiency (e.g. Spanish proficiency) for caregivers who communicate with patients in languages other than English. Provide a census of the demographic breakdown of your staff. Include a narrative on how your staff reflects the patient community served.
Does the hospital educate all staff (e.g. inpatient, outpatient, community-based) on interpreter services available within the healthcare system?	Provide your home's policies and procedures for accommodating patients with a primary language other than English.
Does the hospital provide staff-wide education on: i. Racial and ethnic disparities and their root causes? ii. Best practices for shared decision making?	Provide evidence of your home's training on: • Racial and ethnic disparities and their root causes, and • Best practices for shared decision making. Include learning objectives from the training.

[1]https://www.federalregister.gov/documents/2021/04/15/2021-07556/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities

HQIP Measure	Nursing Home P4P Recommendation
Does the hospital ensure that providers and staff engage in best practices for shared decision making?	Provide three (3) examples of how staff engaged in best practices for shared decision making.
Does the hospital engage diverse patient, family, and community advocates who can represent important community partnerships on quality and safety leadership teams?	Provide a narrative on how your home ensures your resident council and quality and safety leadership teams are reflective of the diversity in your home's resident and staff populations. Include at least 1 (one) example of a strategy used. Provide a narrative on how your home engages community advocacy organizations around care best practices for diverse patient populations.
Does the hospital provide staff-wide education on implicit bias?	Provide evidence of your home's training on implicit bias.
Does the hospital provide convenient access to health records without delay (paper or electronic), at minimal to no fee to the patient, in a clear and simple format that summarizes information most pertinent to patient care and wellness?	N/A
Does the hospital have a mechanism for patients, families, and staff to report inequitable care and episodes of miscommunication or disrespect?	Describe your home's mechanisms for patients, families, and staff to report inequitable care and episodes of miscommunication or disrespect. Provide evidence of communication to patients, families, and staff about mechanisms to report inequitable care and episodes of miscommunication or disrespect.
Does the hospital have a process to ensure a timely and tailored response to each report of inequity or disrespect?	Provide your home's policies and procedures for investigating reports of inequitable care and episodes of miscommunication or disrespect.
Does the hospital have discharge navigation and coordination systems post discharge to ensure that patients have appropriate follow-up care and understand when it is necessary to return to their health care provider?	N/A
Does the hospital provide discharge instructions that include information about what danger or warning signs to look out for, whom to call, and where to go if they have a question or concern?	N/A
Does the hospital provide discharge materials that meet patients' health literacy, language, and cultural needs?	Include in Measure 13: Transitions of Care: Admissions, Transfer and Discharge Rights (CMS, HCPF) Provide four (4) examples of discharge plans that meet patient's health literacy, language, and cultural needs.
Does the hospital have initiatives in place to build a culture of equity, including systems for reporting, response, and learning similar to ongoing efforts in safety culture?	Provide evidence of your home's initiatives to increase equity awareness and sensitivity for residents and staff.

HQIP Measure	Nursing Home P4P Recommendation
Does the hospital have a process in place for the regular reporting and monitoring of metrics (process and/or outcome) stratified by race and ethnicity and disseminate the information internally to staff and leadership? This could take the form of a dashboard, regularly distributed reports or other reporting and monitoring tools.	Provide evidence that your home periodically reviews care outcomes of patients by race and ethnicity.
Does the hospital implement quality improvement projects that target disparities in healthcare access, treatment, and outcomes?	If you are unable to qualify for points for Equity in Care based upon the above minimum requirements, but you have performed a QAPI project in 2021 for Equity in Care, you are able to earn one (1) QAPI recovery point by submitting a narrative of the QAPI project that includes how Equity in Caret is addressed, the problem statement, baseline data, intended goals, tools/processes utilized, and final outcomes.
Does the hospital consider the role of race, ethnicity, language, poverty, literacy, and other social determinants of health, including racism at the interpersonal and system-level when conducting multidisciplinary reviews of morbidity and mortality, and other clinically important metrics?	N/A
Does the hospital have a checkbox on the review sheet: Did race/ethnicity (i.e. implicit bias), language barrier, or specific social determinants of health contribute to the morbidity (yes/no/maybe)? And if so, are there system changes that could be implemented that could alter the outcome?	N/A

Additionally, PCG conducted literature reviews for exploration into how to measure equity outcomes in nursing homes. Campbell et al (2016) analyzed quality of life deficiencies in nursing homes with low, medium, medium-high, and high concentration of racial/ethnic minority residents.[2] The definitions of low, medium, medium-high, and high concentration can be found below:

Table 2. Minority Resident Concentration and Categorization in Nursing Home Equity Study.

Category	Percent Concentration of Minority Residents
Low	<5%
Medium	5%-15%
Medium-high	15%-35%
High	≥35%

[2] Campbell, L.J., Cai. X., Gao, S., & Li, Y. (2016). Racial/ethnic disparities in nursing home quality of life deficiencies, 2001 to 2011. *Gerontology and Geriatric Medicine.* https://doi.org/10.1177/2333721416653561

Rizzuto and Aldridge (2018) examined racial disparities in hospice outcomes.[3] They reviewed:

- Hospital admissions,
- Emergency department visits, and
- Hospice disenrollment after hospice enrollment.

Johnson (2013) reviewed racial and ethnic disparities in palliative care. [4]They measured:

- Satisfaction of care as reported by family members,
- Satisfaction of communication,
- Access to pain management, and
- Knowledge about advance directives.

Li and Cai (2015) used social engagement as the primary measure of demographic disparities.[5] They are used the covariates of:

- Age,
- Gender,
- Marital status,
- Difficulties in activities of daily living,
- Cognitive performance scale score,
- Hearing ability,
- Vision ability,
- Presence of adequate communication abilities, and
- Presence of certain diseases.

Social engagement was measured using a social engagement score developed by Mor et al. (1995).[6] The score is calculated by a six-item social engagement scale using Minimum Data Set (MDS) data. The six items were:

1. At ease interacting with others,
2. At ease doing planned or structured activities,
3. At ease doing self-initiated activities,
4. Able to establish own goals,
5. Able to pursue involvement in life of facility, and
6. Able to accept invitations into most group activities.

Hefele et al. (2017) used eight long-stay quality measures to evaluate demographic disparities in care.[7] The eight measures are:

1. Weight loss,
2. High-risk pressure ulcers,

[3] Rizzuto, J., & Aldridge, M. D. (2018). Racial Disparities in Hospice Outcomes: A Race or Hospice-Level Effect?. Journal of the American Geriatrics Society, 66(2), 407–413. https://doi.org/10.1111/jgs.15228
[4] Johnson K. S. (2013). Racial and ethnic disparities in palliative care. *Journal of palliative medicine*, *16*(11), 1329–1334. https://doi.org/10.1089/jpm.2013.9468
[5] Li, Y., & Cai, X. (2014). Racial and ethnic disparities in social engagement among US nursing home residents. *Medical care*, *52*(4), 314–321. https://doi.org/10.1097/MLR.0000000000000088
[6] Mor, V., Branco, K., Fleishman, J., Hawes, C., Phillips, C., Morris, J., & Fries, B. (1995). The structure of social engagement among nursing home residents. *The journals of gerontology. Series B, Psychological sciences and social sciences*, *50*(1), P1–P8. https://doi.org/10.1093/geronb/50b.1.p1
[7] Hefele, J. G., Ritter, G. A., Bishop, C. E., Acevedo, A., Ramos, C., Nsiah-Jefferson, L. A., & Katz, G. (2017). Examining Racial and Ethnic Differences in Nursing Home Quality. *Joint Commission journal on quality and patient safety*, *43*(11), 554–564. https://doi.org/10.1016/j.jcjq.2017.06.003

3. Low-risk pressure ulcers,
4. Incontinence,
5. Depressive symptoms,
6. In restraints daily,
7. Experienced a urinary tract infection, and
8. Urinary tract functional decline.

However, multiple studies cite difficulties measuring intra-home disparities due to sample size. Few studies complete an intra-home racial equity analysis. Studies used large (often national) data sets and analyzed racial and ethnic outcomes or grouped homes into broader categories to gain the sample size necessary to determine whether racial and ethnic barriers were noted in care. For Colorado, using regional groupings for data analysis and awarding homes points based on region or state performance may be required due to sample sizes.

Recommendation 6: Review ways to begin measuring racial equity within nursing homes in Colorado.

CMS is also seeking input on potential quality measures around digital quality.[8] Measures would seek to improve measurement, transparency, and reporting of data. Previous versions of the Colorado P4P Recommendations Report have noted the difficulties in data collection for homes that do not want to complete tools or submit data in formats that can be easily analyzed. This seems to be a concern nationwide and is an area that the Colorado P4P program can explore.

Recommendation 7: Explore with the P4P Committee adding measures related to digital data collection and reporting.

2.2 APPLICATION PROCESS

Web Portal

As mentioned above, this was the fifth year that the entire P4P application was completed, submitted, and reviewed via an online web portal. To build upon the overall success of the online system application last year, enhancements were made to further promote efficacy. It was noted from the 2020 application that facilities have turnover of home administrations or other executive leadership. Homes would miss out on important announcements, such as score release letters as well instructions for the appeal process. Therefore, this year homes had the option of adding a secondary contact who was included on all communications for the home.

Further system development can be considered to streamline the application and review process. The following improvements can be made to enhance the current application:

- Requiring tool competition in the portal instead of allowing for equivalent documentation uploads from the Excel application. Documents that are uploaded do not have their data easily accessible for analysis.
    - Add an import from Excel capability to streamline data collection and upload.
- Add the Federal Provider Number for all homes to assist in analysis with federal data sets.

Recommendation 8: Continue to monitor user experience with the application web portal to identify common issues experienced by the nursing home facilities and reviewers. Develop a user experience tracker/log to quantify issues. Enhancements to the web portal can lessen administrative burden and streamline the application and review process.

[8]https://www.federalregister.gov/documents/2021/04/15/2021-07556/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities

Recommendation 9: Have homes provide their Federal Provider Number to uniquely identify homes and increase efficiency in analyzing homes' performance in federal data sets.

Preliminary Review Process

This year's review process included a preliminary application review which included identifying instances in which a home may have unintentionally failed to upload a document, or uploaded reports for the incorrect reporting periods. The nursing home would then be given the opportunity to update their application before the final review period commenced. The preliminary review timeline is purposefully brief to ensure adequate time for comprehensive reviews. Within a week after the submission of applications, notifications are sent to facilities with preliminary review findings. Facilities then have one week to upload the corrected documentation for measures specified in their preliminary review findings report. New documentation outside of what was requested in the preliminary review findings is not allowed. The preliminary review, as indicated by its name, is not a comprehensive review and is only meant to catch clear instances of application oversight. It remains each nursing home's responsibility to review their application for completeness and accuracy prior to final submission.

Overall, the preliminary review had at least one finding for 40 facilities, thus giving nursing facilities the chance to resubmit their application with the appropriate documents and earn points that otherwise would have been lost. This was the fourth year a preliminary review was conducted. Homes completed the process by having their application rolled back, uploading the correct documentation, and resubmitting their application. Previously, a major hurdle for the preliminary reviews was getting in contact with facilities. In some cases, the contacts listed in the portal were no longer at the facility and emails were undeliverable. PCG addressed by adding a secondary or management contact field for facilities who was included on communications. This reduced the number of uncontacted facilities. However, some homes who did not list a secondary contact and had turnover were still unable to be reached. In the next application year, there should be a greater marketing campaign to have all homes list a secondary contact.

Recommendation 10: Educate and encourage all homes to provide a secondary or management contact to serve as an extra point of contact and ensure program communication is received by homes.

Score Letters

Beginning with the 2021 application, the score letter release process was modified. In previous years, PCG emailed each home a letter with their score and detailed score report. This year, both were generated in the portal. Therefore, homes would log into the portal and review their score letter and detailed report. This helps homes keep record of their score letter as they are housed in portal and stay with the facility, regardless of administrator or other staff changes. The continuity helps the home better monitor their performance from year to year. However, with the release of this new feature, there was an issue with the score letter displaying the home's total score reflecting only the score for the quality-of-life domain. While the score letters were generated correctly in the staging site, once moved to production, an error occurred. In the future, PCG will implement a robust quality control process in the generation of score letters in the portal to ensure scores are accurately reported.

Recommendation 11: Implement a robust quality control process in the generation of score letters in the portal.

Appeals Process

Over the years, the appeal process has not had explicit instructions, which has caused confusion amongst homes who would like to contest their scores. The current template provides the following instructions for submitting an appeal:

Applicants can contest the results of the application evaluation. Applicants have from the date this letter is received until May 31, 2021 to review the results of your P4P application and inform the Department in writing if you believe the documentation submitted with your application was misinterpreted. Per P4P application instructions, application packets as received are considered complete. No post receipt addendums or additional information will be accepted. After May 31, 2021, the opportunity to change your score will expire and your evaluated score will be considered final.

To help increase clarity, the score letter should include language on how to submit an appeal, the content required to submit an appeal, and the timeframe for a decision.

Recommendation 12: Include in score letter detailed information on how to submit an appeal, the content required to submit an appeal, and the timeframe for a decision.

2.3 PROGRAM DEVELOPMENT AND PARTICIPATION

There was a slight increase in program participation between 2021 and 2020. In 2021, 129 facilities submitted applications compared to 125 in 2020.

There were 16 facilities that did not reapply in 2021 that applied in 2020. Seven of the homes had disqualifying tags that did not make them eligible to participate. The reasoning for why the other some homes did not choose to apply this year is unclear. To gain insight into the decrease in participation, the Department could distribute a short survey to obtain clear reasons why these nursing facilities did not participate. This may be an opportunity for the Department to expand outreach and consider feedback that would encourage greater participation statewide.

Conversely, 20 homes that did not apply in 2020 applied in 2021. Four of the homes had tags in 2020 that disqualified them from participation. Similarly, the reasoning why some homes chose to apply beginning this year, particularly with the difficulties homes faced due to COVID, is unknown. The Department could distribute a short survey to obtain clear reasons what motivated homes to participate.

Recommendation 13: Reach out to nursing facilities that have created an account on the web portal but did not submit an application in the 2021 P4P program or nursing facilities that did not reapply for the program. Reach out to homes who the 2021 P4P program was their first time participating. Engage these homes through a short survey and follow up as necessary to collect information around barriers and motivations to participation.

3. CMS SNF REVIEW

CMS continues to promote initiatives and innovations to improve quality of care at skilled nursing facilities (SNF). CMS began the Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP), which was authorized by Section 215 of the 2014 Protecting Access to Medicare Act (PAMA), in fiscal year (FY) 2019. PAMA includes details about the readmission measures for the program, how facilities will be scored, the performance standards and periods, how facilities can review their scores, and how performance will be reported to the public. The SNF VBP's goal is to support improved clinical outcomes and experiences for skilled nursing facility patients. This program rewards participating skilled nursing facilities based on measures associated with hospital readmissions.

Specifically, CMS measures:

- Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM): "This measure estimates the risk-standardized rate of unexpected hospital readmissions within 30 days for people with fee-for-service Medicare who were inpatients at PPS, critical access, or psychiatric hospitals and for any cause or condition."[9]

The risk-adjusted readmission rate is determined by calculating the standardized risk ratio, then using the standardized risk ratio to calculate a facility-level standardized readmission rate.[10] The standardized risk ratio is the dividend of the predicted number of readmissions and the expected number of readmissions if the same patients were treated at an average facility. The standardized risk ratio is then multiplied with the mean rate of readmission in the population to calculate the facility-level standardized readmission rate.

There are nuances for what is considered as a readmission. For the predicted number of readmissions, hospital readmissions that occur after discharge from the nursing facility, but within the 30-day proximal hospitalization are included. Readmissions identified as planned readmissions or observation stays are excluded. For the expected number of readmissions, stays where the patient has one or more intervening post-acute care admission within the 30-day window, had multiple nursing facility admissions within the 30-day window, or has a gap greater than 1 day between hospitalization discharge and nursing facility admission are excluded. Also excluded are nursing facility stays where the patient did not have at least 12 months of fee for service Part A Medicare enrollment before the hospitalization discharge, where the patient was discharged from the skilled nursing facility against medical advice, or if the principal diagnosis of hospitalization was for cancer, rehabilitation care such as fitting of prostheses and adjustment of devices, or pregnancy. Nursing facility stays where the data is missing or problematic with respect to variables used for rate calculation can also be excluded.

CMS provided a fact sheet[11] regarding SNFRM that provides further insight on how the measure will be used in this program:

- "Hospital readmissions will be identified through Medicare claims. This means that SNFs do not have to report any additional data to CMS,
- Unplanned admissions are identified using a modified version of the CMS Planned Readmissions Algorithm,
- The SNFRM is adjusted to account for patient differences, such as comorbidities, when comparing facility readmission rates, and

[9] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html
[10] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/Top-10-thingst o know-about-SNFRM.pdf
[11] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/Top-10-thingst o know-about-SNFRM.pdf

- CMS will propose to replace the SNFRM with the SNF 30-Day Potentially Preventable Readmission Measure (SNFPPR) in future rulemaking."

All SNFs that are paid under the SNF Prospective Payment System (SNF PPS) will be eligible to receive incentive payments under the SNF VBP. The incentive payments are funded by a two percent reduction in the adjusted Federal per diem rate paid to SNFs for the fiscal year. Sixty (60) percent of this withheld amount represents the total available funding for the incentive payments.[12] Nearly all Colorado P4P SNFs are participating in the SNF VBP.[13]

The Fiscal Year (FY) 2019 program evaluated Calendar Year (CY) 2017 (January 1-December 31, 2017) data using CY15 (January 1-December 31, 2015) as the baseline period. The FY2020 program evaluated FY2018 (July 2017-June 2018) data using FY2016 (July 2016-June 2016) as the baseline. The FY2021 used FY2017 (July 2017-June 2017) as the baseline. The FY2022 program is projected to use FY2018 data. CMS utilizes the SNFRM to evaluate if there was any improvement between the evaluated fiscal year and baseline fiscal year. SNFs receive a score based on both their improvement and achievement between the baseline and performance year. CMS uses these scores to develop incentive multipliers. SNFs that earn higher scores receive higher incentive payments than lower performing peers. SNFs with performance scores that are ranked in the lowest 40 percent nationally receive payments at a rate lower than they would have without the SNF VBP.[14]

For the FY2021 program, the national average performance score was 33.14 points. Colorado facilities performed slightly above average with an average performance score of 43.53 points. Nearly a quarter of the facilities from Colorado fell within the national 40th percentile, receiving a lower payment rate than without the VBP program. The P4P application has a measure around reducing avoidable hospitalization; however, it was not required in the 2021 P4P application due to COVID-19 and its effects on hospitalization. In the future, creating a measure to focus on hospital readmission improvement may initiate processes to increase qualification and reimbursement under the SNF VBP program.

For the FY2021 program, CMS limited changes to what is required by statute.[15] The limited changes were in recognition of COVID-19 and the impact it had on SNFs. Changes include a 2.2% market based. Additionally, a provider's status as a urban or rural facility is defined as what is designated by the Office of Management and Budget. There is a 5% cap on any decreases to a provider's wage index. CMS is also modifying the ICD-10 code mappings for payment groups, which became effective October 1, 2020. Lastly, CMS is finalizing statute so that it reflects previously finalized policies, updating the 30-day Phase One Review and Correction Deadline. There were no changes made to the performance measures, scoring policies, or payment policies.

For the FY2022 program CMS has proposed the following changes:[16]

- Increase payment rates by 1.3%,
- Rebase and revise the SNF market basket by using a 2018-based SNF market basket to update the PPS,

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[12]https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE18003.pdf
[13]https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBPPublicReporting-Oct-2017.xlsx
[14]https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE18003.pdf
[15]https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2021-payment-and-policy-changes-medicare-skilled-nursing-facilities-cms-1737-f
[16]https://www.federalregister.gov/documents/2021/04/15/2021-07556/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities

- Reduction in rates due to a new blood clotting factor exclusion from SNF consolidated billing,
- Change in ICD-10 code mappings related to of sickle-cell disease, esophageal conditions, multisystem inflammatory syndrome, neonatal cerebral infarction, vaping-related disorder, and anoxic brain damage,
- Adopting a claims-based measure around healthcare-associated infections hospitalization and COVID-19 vaccination coverage among healthcare personnel,
- Updating the denominator for the Patient-Post Acute Care (PAC) quality measure,
- Updating number of quarters used for public reporting due to exceptions in reporting from COVID-19, and
- Suppressing the SNF 30-day all-cause readmission measure for the FY2022 year due to COVID-19.

Recommendation 14: ***Continue to monitor the performance of Colorado P4P facilities in the FY2021 SNF VBP.***

Recommendation 15: Since preventable hospital readmissions are the primary focus in SNF VBP, reevaluate how hospital readmissions are currently scored in the Colorado P4P program.

4. OTHER STATES REVIEW

Colorado's P4P program is well established and its collaboration throughout the year with nursing home administrators is conducive to continuous improvement. Still, it can be useful for the Department to stay informed of other state's P4P-like programs. This section provides the Department with updates on other state's programs and include a summary of findings from the previous five P4P Recommendation Reports that are still relevant and may be instructive for any program changes.

TEXAS

As reported last year, Texas's Quality Incentive Payment Program (QIPP) had no proposed changes for QIPP program's fourth year. However, due to COVID-19 some modifications were made due to a lack of MDS data. Performance requirements related to MDS quality measures were waived effective March 1, 2020 to August 31, 2020.[17] The program also waived the Quality Assurance and Performance Improvement Validation reports that were required monthly under Component One of the program.[18]

For next year's QIPP program, the following changes have been proposed:

- Component 1: Metric requiring facilities holds a monthly QAPI to pursue an outcome as defined in a performance improvement plan (PIP).
- Component 2: Metric for facilities who maintain four additional hours of registered nurse (RN) staffing coverage per day, beyond the CMS mandate.
- Component 2: Metric for facilities who maintain eight additional hours of RN staffing coverage per day, beyond the CMS mandate.
- Component 2: Metric for facilities who have a PIP for workforce development and includes a self-directed plan and monitoring outcomes.
- Component 3: Including the following CMS MDS metrics:
  - N015.03. Percent of high-risk residents with pressure ulcers, including unstageable pressure ulcers.
  - N031.03 Percent of residents who received an antipsychotic medication.
  - N035.03 Percent of residents whose ability to move independently has worsened.
  - N024.02 Percent of residents with a urinary tract infection.
- Component 4: Metric for facilities who have an active infection control program that includes strategies to increase outcomes related vaccination rates and antibiotic stewardship.[19]

OKLAHOMA

In 2019, Oklahoma implemented a P4P program, which replaced it previous Focus on Excellence program. The P4P program measures 4 MDS measures:

- N029.02 – Percentage of long-stay residents who lose too much weight,
- N015.03 – Percentage of long-stay residents with high risk/unstageable pressure ulcers,
- N024.02 – Percentage of long-stay residents with a urinary tract infection, and
- N031.03 – Percentage of long-stay residents who received an antipsychotic medication.[20]

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[17]https://www.hhs.texas.gov/services/health/medicaid-chip/provider-information/quality-incentive-payment-program-nursing-homes
[18]https://www.hhs.texas.gov/services/health/medicaid-chip/provider-information/quality-incentive-payment-program-nursing-homes
[19]https://www.hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/qipp/qipp-final-quality-metric-packet-fy-2022.pdf
[20] https://oklahoma.gov/ohca/individuals/pay-for-performance.html

Homes must meet or exceed the national averages for the measure and show a 5% or better relative improvement from baseline each quarter. Facilities submit their facility adjusted score and CASPER report quarterly for payment.

SUMMARY OF PREVIOUS INFORMATION COLELCTED ON OTHER STATES' PROGRAMS

Minnesota

On January 1, 2016, Minnesota Legislature authorized a new system for nursing facility reimbursement rates, which the Department of Human Services calls the value-based reimbursement system. Under the value-based system, DHS sets facility reimbursement rates based on the cost of providing care to residents. Although the new system ties a facility's rate to its costs, DHS will not reimburse the facility for unlimited costs; a facility's rate will only reflect its care-related costs up to a limit. If a facility's care-related costs are greater than its limit, the facility's rate would not reflect the portion of the costs more than the limit. As with previous systems, facilities' rates are case-mix adjusted—facilities receive higher rates to care for more-resource intensive patients.

Within the value-based reimbursement system, Minnesota has implemented payments and rewards for high quality nursing facilities. Currently, DHS and the legislature have attempted to improve and reward nursing facility quality using three main strategies. First, DHS encourages facilities to improve their quality of care by publishing the Minnesota Nursing Home Report Card system. Second, the new value-based reimbursement system sets a limit on a facility's care-related reimbursement rate, and this limit is tied to the facility's quality score. Third, DHS operates two incentive programs that reward facilities who undertake quality improvement projects with rate increases.

The Minnesota Nursing Home Report Card

The Minnesota nursing home report card provides patient quality profile data of the nursing facilities in Minnesota based on three separate data sources. The first is a survey of residents in every facility on the quality of the nursing home and is conducted by a private contractor. The second are state inspections by the Minnesota Department of Health and the third are quality indicators that DHS derives from the comprehensive assessments and inspections conducted by MDH. These assessments are then broken down into (8) different quality measures so that patients can use the scores provided to make accurate choices. These quality measures include:

- Resident Quality of Life
- Family Satisfaction
- Clinical Quarterly Indicators
- State Inspection Results
- Hours of Direct Care
- Staff Retention
- Use of Temporary Nursing Staff
- Proportion of Beds in Single Rooms

Quality in the Value-based Reimbursement System

The value-based reimbursement system, effective January 1, 2016, builds a quality component into the operating payment rate by placing limits on care-related rates using a facility's quality score. For example, a facility with a higher quality score is subject to higher limits. These quality scores are calculated using the department's nursing facility quality profiles and are measured on a scale between 0-100. Fifty points of the score are based on a facility's quality indicator score which are derived from the Minimum Data Set's comprehensive assessments conducted at the facility. Forty points of the score comes from the, "resident quality of life score" from the survey of the facility's residents. The last 10 points come from the facility's, "state inspection results score."

Incentive Programs: PIPP and QIIP

DHS administers two programs that offer facilities time-limited rate adjustments to implement projects that improve the quality and efficiency of care. The Nursing Home Performance-based Incentive Payment Program (PIPP) awards rate increases on a competitive basis and is available to a limited number of facilities each year. In contrast, the Quality Improvement Incentive Program (QIIP) is a broader program that is open to any facility reimbursed under Medical Assistance.

PIPP has been offered since July 1, 2006 and has allowed facilities to apply for a time-limited rate increase in exchange for implementing a program designed to increase the quality of the facility. There is a competitive application process to see which facilities receive the funding as individual facilities or a collaboration of multiple facilities can apply. Facilities can request up to a 5 percent increase in their current payment rate. These facilities will receive the extra funding as long as they maintain projected program outcomes. Some of these programs DHS has provided funding for include improvement in employee recruitment and retention, reduce the rate of falls among residents, and improve residents dining experiences.

QIIP is a more recent incentive program authorized by the 2013 Legislature which went into effect on October 1, 2015. In contrast to PIPP, this program eliminates the competition and allows all facilities to take part in a rate increase. To participate in the process, a facility only needs to select a single quality indicator and work to improve that measure. These quality measures are split up into 38 individual measures and a facility may pick from a list of 26 “quality indicators” or 12 “quality of life domain scores.” The rate increase is determined of the amount of improvement seen in the selected quality measure relative to the previous year. The goal is to improve rates by one standard deviation.

Georgia

Georgia’s Department of Community Health (DCH) operates a P4P program with collaboration from nursing home providers, and consumer groups to raise the quality of care for the 40,000 Georgia citizens who live in the state’s nursing facilities. Similar to OHCA, DCH used nursing home performance information through My InnerView, a software and service for nursing facilities to monitor performance and quality measures and determine the quality incentive payments. My InnerView has research showing that state nursing facilities that take place in the statewide quality initiative achieve results, such as reducing resident falls, the use of physical restraints, and antipsychotic medications, as well as a reduction in staff turnover rates.

In 2007, 78 percent of facilities applying to the program received incentive payments.[21] In 2009, DCH continued the incentive fee program for nursing facility providers who met specific criteria for quality measures, adding a 1 percent additional increase to the incentive payment through legislative mandate that began in FY 2010. Over 89 percent of all facilities participating in the program were awarded the incentive fees.[22]

California

California’s Quality Accountability Supplemental Payment Program (QASP) has been in operation since 2014 due to the passage of SB 853.10. The State also refers to the QASP program as the Quality Accountability Program for Skilled Nursing Facilities. The California Department of Public Health (CDPH) partners with the California Department of Health Care Services (DHCS) to implement QASP. To help

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21 https://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit_1210/3/39/167346932FY09AnnualReportredu.pdf

22 https://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit_1210/3/39/167346932FY09AnnualReportredu.pdf

DHCS issue incentive payments, CDPH's Center for Health Care Quality assesses and scores each facility's quality of care for its residents. For State Fiscal Year 2017, CDPH and DHCS established new quality measures and point allocations for QASP evaluations. Due to CMS's 2018 removal of the worsening pressure ulcer status quality measure, California is creating their own pressure ulcer measure to be incorporated.[23] New measures and point allocations are subject to change in each State Fiscal Year. Currently, QASP's quality measures are broken down into two categories: Measurement Areas and Quality Measures. In the Measurement Area, the subcategories include Pressure Ulcer Measurement Area, Immunizations Measurement Area, and 30-Day All-Cause Readmission. In the Quality Measure category, Staff Retention, Control of Bowel/Bladder: Long Stay, and Pneumococcal Vaccination: Short Stay are some of the subcategories. Compared to pay for performance programs in other states, QASP is much narrower in focus. However, QASP designates $81 million in Quality payments and $9 million in Improvement payments.[24] In other words, QASP rewards yearly improvement in facilities.

Recommendation 16: Explore dedicating funds for rewarding nursing facilities who show an improvement in their application scores. This would be a modification of California's structured payment program. Specific to Colorado, the Department could potentially provide a financial incentive for homes who score 0-20 points, thus not meeting the threshold to receive any per diem add on. These homes may be discouraged from applying. Some amount of financial incentive to encourage the home to continue building its program to meet P4P measures may increase program participation in future years.

New York

New York has participated in a nursing facility pay for performance program since 2008.[25] Currently, the state's program is referred to as the Nursing Home Quality Initiative (NHQI). NHQI is an annual quality and performance evaluation project that focuses on improving the quality of care for residents in Medicaid-certified nursing facilities across the state of New York. The current NHQI is based on the previous calendar year's performance and is worth 100 points. Nursing facilities are awarded points for quality and performance measures in the components of Quality, Compliance, and Efficiency. Specific deficiencies cited during the health inspection survey process are also incorporated into the results. The points for all measures are then summed to create an overall score for each facility. Facilities are ranked into quintiles based on their overall scores. Quintile one represents the top-performing facilities while quintile five represents the lowest-performing.

The New York State Department of Health website contains information and results for each year of the NHQI. After downloading from the website, the quintile ranking documents contain the following worksheets: nursing facilities in each of the five quintiles, nursing facilities with certain deficiencies cited during the health inspection survey process, and nursing facilities that are excluded from the NHQI for various reasons. Nursing facilities with certain deficiencies are ineligible for ranking, and homes are excluded from the NHQI program if they are:

- Non-Medicaid facilities
- Designated by CMS as a Special Focus Facility at any time during 2015 or 2016, prior to the final calculation of the 2016 NHQI
- Specialty facilities
- Specialty units within a nursing home
- Continuing Care Retirement Communities

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[23] https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/CDPHCASpecificPressureUlcersF1.pdf

[24] http://www.cahf.org/Portals/29/QCHF/2017/QASP%20DON.pdf?ver=2017-02-08-112725-853

[25] http://www.ltccc.org/publications/documents/LTCCCP4Preportfinal08.pdf

- Transitional Care Units

Utah

In Utah, the Nursing Facilities Quality Improvement Incentive (QII) Program is the state's pay for performance program.[26] Based on performance each year, QII uses general fund money to award performance. In total, the QII program has three components-QII(1), QII(2), and QII(3). QII(1) and QII(2) are two independently scored components. QII(1) ensures that quality programs are implemented at the facilities. QII(2) provides incentive for facilities to improve the environment for the residents. QII(2) categories include Patient Life Enhancing Devices, Clinical Software/Hardware, Improved Dining Experience, and Patient Bathing Systems. Scores in either QII(1) or QII(2) are not reliant on the score in the other component.

The final component, QII(3)'s score relies on the previous two components. Specifically, to earn all the points for the QII(3) component, a facility must complete all of the QII(1) forms and at least one QII(2) form. QII(3) ensures resident choices are available. To apply for QII consideration, providers must submit cover forms with checklists and supporting documentation to Utah's Department of Health Medicaid Reimbursement Unit. A complete QII application package includes: Application, Spreadsheet, Invoice(s), Proof of Payment, and a PDF for each incentive and email submission. QII is the longest running program out of the reviewed states, in operation since 2004. Utah has not completed much analysis to relate the resident satisfaction level to the QII payments over the years, however the State meets annually with representatives in the Nursing Facilities industry for input on what works and does not work for providers. Also, funding is 100 percent from the state's general funds.

26 http://health.utah.gov/medicaid/stplan/NursingHomes/QI/UHCA_April_2017_Presentation.pdf

5. BEST PRACTICES

In our review of best practices this year, PCG focused on best practices related to the new best practices measure introduced in the 2021 P4P application. Like the previous section, PCG reviewed Recommendations Reports from the previous five years to identify if any information was still relevant today.

SUPPORTING STAFF WITH END-OF-LIFE CARE

COVID-19 devested many nursing homes with high incidence of mortality. This can take a large toll on the mental health of staff. The 2021 application sought information on how homes supported their staff with the loss of residents. Multiple homes noted their provided some form of grief counseling, either through utilizing licensed clinical staff, or using outside resources. A home noted they created a memorial board, where staff could post comments and express themselves.

CONNECTION AND MEANING OPPORTUNITIES

Connection and meaning opportunities were especially limited during 2020 with increased social distancing and isolation requirements. However, connection and meaning are important for the wellbeing of nursing home residents. Many homes noted buying tablets to help residents connect and communicate with loved ones. Homes also noted creating activity carts, distributing things that residents could do in their rooms. While residents could not leave the home, some homes had staff collect resident wishes, either from the store or take out food requests, and went to purchase them. This kept residents more engaged with the community outside the home.

CONSISTENT ASSIGNMENTS STAFF ENGAGEMENT

COVID-19 created many staff shortages due to the need to quarantine and isolation guidelines. With the high-risk population nursing homes serve, homes had to especially careful to ensure staff did not bring and spread COVID-19 within the home. Homes used two primary methods to maintain consistent assignments—block booking agency staff to maintain some consistency, or cross training and pulling administrative staff to help perform duties. Homes found unique ways to shift work to address staffing needs and provide residents with familiar faces.

STAFF ENGAGEMENT

Staff engagement was difficult during 2020 as health care workers faced unprecedented challenges. One aspect of the 2021 P4P application sought to gain information on how homes kept staff engaged beyond regular opportunities. Some homes noted that due to shortages of items in grocery stores, homes allowed employees to buy groceries and toiletries from the home's food vendor. Additionally, homes provided incentives like free meals, gift cards, and COVID bonuses to help keep staff engaged.

SAFE ENVIRONMENT

Maintaining a safe environment, particularly preventing falls, is important and measured in multiple quality scores. Homes had unique best practices such as putting grip tape on high-use areas by elders. Additionally, one home described their process of using a fall scene tool. Staff members are encouraged to paint a picture of the fall scene and from there, greater analysis is completed on things that could be changed to prevent the fall.

PAIN MANAGEMENT

The opioid epidemic highlighted the need to increase non-pharmacological approaches to reducing pain. Homes were asked to provide their best practices on reducing resident pain, prior to prescribing medication. The most common results were heat therapy/heat packs, cold therapy/cold packs, re-positioning residents, encouraging residents to move and exercise, massage, music therapy, distraction, and providing a warm bath.

PREVENTION OF ABUSE AND NEGLECT

This year, the P4P application asked for best practices on how homes reduce abuse within the home including, but not limited to patient-to-caregiver, patient-to-patient, and caregiver-to-patient. Homes noted strategies ranging from anonymous reporting stations available, providing staff with adequate time and space for breaks, and looking for trends in staff who are calling out of shifts.

Recommendation 17: Innovation is an important part of P4P programs. A best practice sharing mechanism for Colorado facilities can provide new ideas especially in times where best practices are not readily established.

SUMMARY OF PREVIOUS INFORMATION COLLECTED

Literature Reviews

A recently published paper found that utilizing a smart watch-based communication system could improve call response times.[27] While this is a prototype study, the authors found a 40 percent reduction in response time to call lights to bedrooms, 58 percent reduction in response type to bathrooms, and a 29 percent reduction in response time to bed exit alarms. Further evaluation needs to be completed on efficacy and logistical barriers for implementation, but this is a novel idea that can improve the quality of care for patients.

Improving staffing ratios is another method of improving quality of care found in the literature. There is a strong positive impact on outcomes with increased nursing staff. However, staffing levels should also consider acuity of residents. CMS does include acuity staffing in their five-star rating methodology (discussed in the next section); however, a study notes that this methodology also underestimates needed staffing levels. Reviewing CMS's methodology, adjusting it to become more accurate, and rewarding facilities that meet or improve their staffing ratios may be a way to promote quality of care in Colorado.

Indiana

Indiana had some updates to their VBP program. Indiana's VBP program for nursing facilities has a maximum per diem add-on of $14.30 as of 2011. Scores to obtain a per diem add on are based on survey inspections, staffing, and quality of life measures. Indiana updated their scoring system for FY19-20. Scoring factors are their weights are:

- 30% determined by long-stay measures from CMS 5-star quality,
- 55% from health inspection domain of CMS 5-star quality,
- 10% from staffing domain (PBJ data) of CMS 5-star quality, and
- 5% for Advance Planning Certification.

Beginning in July 2020, these scores will be updated and determined by the following:

- 60% determined by long-stay measures from CMS 5-star quality,
- 25% from health inspection domain of CMS 5-star quality,
- 10% from staffing domain (PBJ data) of CMS 5-star quality, and
- 5% for Advance Planning Certification.

As of July 2013, the add-on formula is:

Per Diem Add-on = $14.30 ((84 – Total Quality Score) X $0.216667)

[27] https://www.ncbi.nlm.nih.gov/pubmed/31099184

Alabama

The Alabama Nursing Home Association conducts an annual showcase where homes around the state present best practices they developed to improve the quality of care or quality of life for residents. Related to quality of care, one home created an onsite dental program where a local dentist and hygienist provide services onsite.[28] The facility reported a reduction in risk of oral infection and risk of weight loss. They also reported a reduction in transportation costs and extra staff time required to transport residents. Residents do not pay out of pocket, rather, the facility uses Incurred Medical Expense billing to reduce the resident's financial liability to the facility. The facility then receives an increase in Medicaid dollars for the cost of the dental care, resulting the residents receiving dental care while the facility sees no impact to its revenue. Another best practice highlighted by the program was related to quality of life. A facility developed an activity to help individuals with dementia express themselves.[29] Twice a week, themed activity stations are set up with familiar music and activities, such as costume jewelry and blocks of wood. The facility notes that residents feel happier and useful.

Arizona

The Arizona Health Care Cost Containment System (AHCCCS) has implemented a VBP model to financially reward providers. These providers must meet or exceed specific benchmarks to receive payment. Benchmarks are focused on specified quality and cost measures.[30] Arizona's 2016 VBP initiative included five measures, two of which were considered utilization measures, and three that were considered clinical care quality measures. Specific goals included reducing the rate of readmission within 30-days to below 20 percent and also reducing emergency department utilization to below 20 percent. Arizona's 2018 VBP model includes two clinical care quality measurements that are that are focused on improving pneumococcal vaccination rates and influenza vaccination rates.[31] This model allows select AHCCCS-registered providers to meet the two clinical care quality measures to receive a VBP Differential Adjusted Payment. The purpose of these payments is to reward the providers that have proven their commitment to improving patient experiences, improving members' health, and reducing cost of care. These adjusted payments will represent an increase in the current fee-for-service rates.

Ohio

In May 2017, Ohio's State Plan Amendment (SPA) 17-004 was approved to provide enhanced payment rates for nursing facilities that provide services to ventilator-dependent individuals. The payment is based on a per-diem payment rate for ventilator-dependent individuals in nursing facilities that participate in the Ohio Department of Medicaid (ODM) nursing facility ventilator program. The per-diem rate equals 60 percent of the statewide average of the total per Medicaid day payment rate for long-term acute care hospital services for the prior calendar year. The enhanced payment may be reduced by a maximum of five percent if the nursing home's numbers of ventilator associated pneumonia (VAP) episodes exceed the maximum number of VAP episodes determined by ODM for two consecutive quarters.[32] Ohio requires managed care plans to pay the fee for service (FFS) rate, which enables them to pass the enhance payment on to the providers.

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[28] https://anha.org/uploads/web/Crowne-Mobile-BP-2017.pdf
[29] https://anha.org/communicating-with-people-unable-to-speak-2/
[30] https://www.azahcccs.gov/AHCCCS/Initiatives/PaymentModernization/valuebasedpurchasing.html
[31] http://www.integratedcareresourcecenter.com/PDFs/ICRC_VBP_in_Nursing_Facilities_November_2017.pdf
[32] https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OH/OH-17-004.pdf

New York

New York's Nursing Home Quality Initiative (NHQI) Methodology was updated in March 2017 and is comprised of three components: the Quality Component, the Compliance Component and the Efficiency Component. The Quality Component is calculated using MDS 3.0 data from the 2016 calendar year, NYS employee flu vaccination data and nursing home cost report data to determine the percentage of contracted and/or agency staff utilized and the rate of staffing hours per day. The Compliance Component comprises CMS' five-star quality rating for health inspections, timely submission of nursing home certified cost reports, and timely submission of employee influenza immunization data. Lastly, the Efficiency Component stems from potentially avoidable hospitalization data.[33] Notably, the recently enacted State Fiscal Year (SFY) 18-19 budget included new initiatives that will impact New York's nursing facilities. The Department of Health will reduce Medicaid revenue to a residential health care facility in a payment year by two percent to the lowest performing Nursing Homes. The two percent reduction will apply if in each of the most recent payment years, the facility was ranked in the lowest two quintiles of facilities based on NHQI performance and was ranked in the lowest quintile in the most recent payment year.

Kansas

The P4P Program in Kansas provides nursing facilities with the opportunity to earn up to $9.50 per diem add per day. The program has two distinct per diem add on measure sets. There is the Quality and Efficiency Incentive Factor, which includes quality of care performance measures. This incentive factor is determined by three outcomes: case mix adjusted nurse staffing ratio, staff turnover and Medicaid occupancy. The per diem add on opportunity for this incentive is up to $5.50. Then there is the PEAK 2.0 Incentive Factor, which includes measures related to person-centered care. For the PEAK Incentive, there are six levels that a home may fall within in adopting person-centered care. Each level is tied to a per diem amount, ranging from $0.50 - $4.00. Accordingly, the per diem add on for the PEAK Incentive can be as much as $4.00.

Minnesota

There are two nursing home incentive-based payment programs in Minnesota. The Performance-based Incentive Program and the Quality Improvement Incentive Payment Program. The former rewards quality improvement through a competitive program that provides an increase in rates of up to 5 percent for up to three years. The nursing facilities assume 20 percent of risk for outcomes on projects they initiate, thus they are guaranteed 80 percent of the state funding. The Quality Improvement Incentive Program allows nursing facilities to choose areas of focus in any quality indicator or quality of life domain. The homes then set improvement goals by one standard deviation over the course of the review year and also must be in at least the 25th percentile. Financial incentives may be as much as $3.50 per resident day. It should be noted that nursing facilities generally do not completely meet their goal and thus receive a prorated per diem. This has ensured that the maximum allowable per diem of $1.75 in the state's funding is not exceeded.

[33] https://www.health.ny.gov/health_care/medicaid/redesign/nhqi/2017/docs/methodology.pdf

6. CMS 5-STAR RATING DATA REVIEW

At the national level, CMS has a rating system to allow consumers, families, and caregivers to compare nursing facilities. CMS has acknowledged the difficulty of developing a rating system that addresses all considerations that consumers and families may have when deciding on a nursing home. The rating system described below is meant to be one source of information that should be considered with other factors to best inform a decision on a nursing home for an individual.

CMS employs a 5-star rating system, as such, overall ratings range from one star to five stars, with more stars indicating better quality. As described by CMS, the 5-star ratings are based on the three components listed below. Each component gets its own rating, then an overall rating is determined.

1) Health inspections: this includes reviewing information from the three most recent onsite inspections that include standard and complaint surveys.
2) Staffing: this includes reviewing information regarding the average number of hours of care provided to each resident each day by nursing staff.
3) Quality measures (QMs): this includes reviewing the four most recent quarters of data available for 16 different physical and clinical measures for nursing home residents.

Using the three components, CMS assigns the overall 5-star rating in these steps:

Step 1: Start with the health inspections rating.

Step 2: Add 1 star if the staffing rating is 4 or 5 stars and greater than the health inspections rating. Subtract 1 star if the staffing rating is 1 star.

Step 3: Add 1 star if the quality measures rating is 5 stars; subtract 1 star if the quality measures rating is 1 star.

Step 4: If the health inspections rating is 1 star, then the overall rating cannot be upgraded by more than 1 star based on the staffing and quality measure ratings.

Step 5: If a nursing home is a special focus facility, the maximum overall rating is 3 stars.

Table 3, below, displays each applicant's CMS 5-star rating in additional to their P4P application self-score and the final review score. Out of the 129 applications received, 0 (0%) had a 0-star rating, 6 (5%) had a 1-star rating, 34 (27%) had a 2-star rating, 21 (16%) had a 3-star rating, 27 (21%) had a 4-star rating, and 41 (31%) had a 5-star rating. It can be determined that a 1 or 2-star rating did not deter facilities from applying for the 2021 Pay for Performance program.

Table 3. CMS 5-Star Rating Data with 2021 P4P Scores.

Facility Name	2021 Self Score	2021 Final Review Score	5-Star Rating
Allison Care Center	82	70	4
Alpine Living Center	89	81	3
Amberwood Court Rehabilitation and Care Community	86	76	5
Applewood Living Center	89	81	2
Arborview Senior Community	88	84	2
Arvada Care and Rehabilitation Center	81	72	5
Aspen Living Center	90	85	2
Autumn Heights Health Care Center	91	82	3

Facility Name	2021 Self Score	2021 Final Review Score	5-Star Rating
Avamere Transitional Care and Rehabilitation-Brighton	87	81	4
Avamere Transitional Care and Rehabilitation-Malley	86	81	3
Bear Creek Center	86	73	4
Belmont Lodge Health Care Center	71	58	3
Bent County Healthcare Center	92	78	5
Berkley Manor Care Center	81	71	3
Berthoud Living Center	83	69	4
Beth Israel at Shalom Park	91	87	5
Boulder Manor	94	87	2
Briarwood Health Care Center	71	54	4
Brookshire House Rehabilitation and Care Community	88	74	4
Brookside Inn	90	81	5
Broomfield Skilled Nursing and Rehabilitation Center	87	78	3
Bruce McCandless CO State Veterans Nursing Home	90	80	4
Cambridge Care Center	94	77	4
Casey's Pond Senior Living LTC	88	88	4
Castle Peak Senior Life and Rehabilitation	95	70	5
Cedarwood Health Care Center	94	81	2
Centennial Health Care Center	85	83	5
Centura Health- Medalion Health Center	81	74	3
Cherry Creek Nursing Center	95	94	3
Cheyenne Mountain Center	88	75	2
CHI Living Communities - Namaste Alzheimer's Center	81	58	3
Christopher House Rehabilitation and Care Community	93	90	2
Clear Creek Care Center	79	73	5
Colonial Columns Nursing Center	90	82	4
Colorado State Veterans Nursing Home - Fitzsimons	63	53	3
Colorado State Veterans Nursing Home- Rifle	81	66	5
Colorado Veterans Community Living Center at Homelake	81	69	5
Colorow Care Center	88	80	5
Columbine West Health and Rehab Facility	81	63	5
Cottonwood Care Center	83	85	2
Cottonwood Inn Rehabilitation and Extended Care Center	95	52	5
Denver North Care Center	90	75	4
E Dene Moore Care Center	91	61	5
Eagle Ridge of Grand Valley	84	76	2

Facility Name	2021 Self Score	2021 Final Review Score	5-Star Rating
Eben Ezer Lutheran Care Center	81	77	4
Elms Haven Center	88	72	2
Englewood Post Acute and Rehabilitation	81	76	5
Fairacres Manor, Inc.	87	82	4
Forest Ridge Senior Living, LLC	93	70	5
Forest Street Compassionate Care Center	88	67	2
Fort Collins Health Care Center	80	78	2
Four Corners Health Care Center	96	91	2
Glenwood Springs Health Care	80	64	1
Golden Peaks Center	88	69	2
Good Samaritan Society - Fort Collins Village	87	60	5
Good Samaritan Society- Bonell Community	88	79	3
Grace Manor Care Center	82	70	5
Hallmark Nursing Center	80	62	5
Harmony Pointe Nursing Center	98	90	3
Highline Rehabilitation and Care Community	89	85	5
Holly Heights Care Center	94	91	5
Holly Nursing Care Center	88	88	2
Horizons Care Center	82	74	3
Irondale Post Acute	95	84	2
Jewell Care Center of Denver	88	73	2
Julia Temple Healthcare Center	89	83	5
Juniper Village- The Spearly Center	94	65	2
Kenton Manor	92	90	2
Larchwood Inns	84	75	3
Lemay Avenue Health and Rehabilitation Facility	74	57	5
Life Care Center of Evergreen	50	49	5
Life Care Center of Greeley	85	61	5
Life Care Center of Littleton	83	77	5
Mesa Manor Center	85	76	2
Mesa Vista of Boulder	88	80	2
Minnequa Medicenter	94	82	2
Monaco Parkway Health and Rehabilitation Center	95	89	2
Monte Vista Estates, LLC	73	47	1
Mount St Francis Nursing Center	91	91	5
Mountain Vista Health Center	79	67	4
North Shore Health and Rehab Facility	80	70	4
North Star Rehabilitation and Care Community	88	82	3
Palisades Living Center	94	91	2
Paonia Care and Rehabilitation Center	87	81	4

Facility Name	2021 Self Score	2021 Final Review Score	5-Star Rating
Parkmoor Village Healthcare Center	94	91	1
Parkview Care Center	87	82	4
Pearl Street Health and Rehabilitation Center	91	84	2
Pikes Peak Center	89	80	2
Pine Ridge Extended Care Center	87	69	5
Pueblo Center	91	79	2
Regent Park Nursing and Rehabilitation	83	73	4
Rehabilitation and Nursing Center Of The Rockies	88	77	5
Rehabilitation Center at Sandalwood	84	79	5
Rio Grande Inn	88	70	3
River Valley Inn Nursing Home	63	52	4
Rock Canyon Respiratory and Rehabilitation Center	86	80	1
Rowan Community, Inc	96	89	4
San Juan Living Center	88	85	2
Sandrock Ridge Care and Rehab	86	86	4
Sierra Rehabilitation and Care Community	90	82	2
Sierra Vista Health Care Center	86	83	2
Skyline Ridge Nursing and Rehabilitation Center	94	54	5
Southeast Colorado Hospital LTC Center	91	81	4
Spanish Peaks Veterans Community Living Center	87	84	3
Spring Creek Health Care Center	86	83	2
St Paul Health Center	92	83	2
Sterling Living Center	79	76	1
Suites at Clermont Park Care Center	79	68	5
Summit Rehabilitation and Care Community	94	85	5
Sunset Manor	86	77	4
Terrace Gardens Health Care Center	95	88	2
The Gardens	64	51	3
The Green House Homes at Mirasol	87	77	5
The Pavillion at Villa Pueblo	93	52	3
The Valley Inn	94	82	5
The Villas at Sunny Acres	80	68	4
University Heights Rehab and Care Community	89	81	1
Uptown Health Care Center	94	70	4
Valley Manor Care Center	82	67	3
Valley View Health Care Center Inc.	88	84	4
Villa Manor Care Center	85	61	5
Vista Grande Inn	83	55	3
Washington County Nursing Home	85	64	2
Western Hills Health Care Center	62	50	5

Facility Name	2021 Self Score	2021 Final Review Score	5-Star Rating
Westlake Care Community	87	82	5
Wheatridge Manor Care Center	84	67	5
Willow Tree Care Center	62	51	5
Windsor Health Care Center	89	84	4
Yuma Life Care Center	91	88	5

Furthermore, looking at average final scores and (range) across the star ratings the average final application score for 1-star facilities is 73.2 (range: 47-91), 2-star facilities is 80.9 (range: 64-91), 3-star facilities is 71.9 (range: 51-94), 4-star facilities is 75.8 (range: 52-89), and 5-star facilities is 71.1 (range: 49-91). These can be found in Table 4. Based on this analysis, CMS 5-star rating is not necessarily a useful predictive indicator of success on the P4P application.

Table 4. 5-Star Ratings and P4P Score Average and Range.

5-Star Rating	P4P Score Average	P4P Score Range
1	73.2	47-91
2	80.9	64-91
3	71.9	51-94
4	75.8	52-89
5	71.1	49-91

7. RECOMMENDATIONS

A summary of the recommendations and considerations outlined in this report are as follows:

Recommendation 1: *Review minimum requirements for areas where the intent of the minimum requirement can be expanded upon to provide homes alternative ways of meeting the minimum requirement. For Measure 1 Enhanced Dining, modify language to include "how the home uses the facility assessment to proactively develop menu options that reflect the resident population seen in the home."*

Recommendation 2: *Review minimum requirements for areas where requirements such as time frames or talking points can be highlighted or more easily identified. For minimum requirement 6-2, change to*

"Provide a narrative on:

- *How you are using data and information around known trauma from your Facility Assessment, other assessments done in the home, or other means to influence programming and staff training.*
- *Include a specific example of how you are using the data and information about known trauma."*

Recommendation 3: *Review documentation requirement language to specify stronger documentation requirements such as images, signed testimonials, sign-in sheets, or other documentation that clearly confirms the event took place. Decide with the P4P Committee's input as to whether documentation, such as testimonials, can be utilized for two minimum requirements.*

Recommendation 4: *Clarify or remove documentation requirements for Measure 21.*

Recommendation 5: *Clarify or remove documentation requirements for Measure 22.*

Recommendation 6: *Review ways to begin measuring racial equity within nursing homes in Colorado.*

Recommendation 7: *Explore with the P4P Committee adding measures related to digital data collection and reporting.*

Recommendation 8: *Continue to monitor user experience with the application web portal to identify common issues experienced by the nursing home facilities and reviewers. Develop a user experience tracker/log to quantify issues. Enhancements to the web portal can lessen administrative burden and streamline the application and review process.*

Recommendation 9: *Have homes provide their Federal Provider Number to uniquely identify homes and increase efficiency in analyzing homes' performance in federal data sets.*

Recommendation 10: *Educate and encourage all homes to provide a secondary or management contact to serve as an extra point of contact and ensure program communication is received by homes.*

Recommendation 11: *Implement a robust quality control process in the generation of score letters in the portal.*

Recommendation 12: *Include in score letter detailed on how to submit an appeal, the content required to submit an appeal, and the timeframe for a decision.*

Recommendation 13: *Reach out to nursing facilities that have created an account on the web portal but did not submit an application in the 2021 P4P program or nursing facilities that did not reapply for the program. Reach out to homes who the 2021 P4P program was their first time participating. Engage these homes through a short survey and follow up as necessary to collect information around barriers and motivations to participation.*

Recommendation 14: *Continue to monitor the performance of Colorado P4P facilities in the FY2021 SNF VBP.*

Recommendation 15: *Since preventable hospital readmissions are the primary focus in SNF VBP, reevaluate how hospital readmissions are currently scored in the Colorado P4P program.*

Recommendation 16: *Explore dedicating funds for rewarding nursing facilities who show an improvement in their application scores. This would be a modification of California's structured payment program. Specific to Colorado, the Department could potentially provide a financial incentive for homes who score 0-20 points, thus not meeting the threshold to receive any per diem add on. These homes may be discouraged from applying. Some amount of financial incentive to encourage the home to continue building its program to meet P4P measures may increase program participation in future years.*

The recommendations have also been sorted into categories to allow for more efficient discussion and task delegation. The categories are application recommendations, portal recommendations, and programmatic recommendations. The sorted recommendations can be found in Table 5.

Table 5. Summary of Recommendations

Application	Portal	Programmatic
Recommendation 1: *Review minimum requirements for areas where the intent of the minimum requirement can be expanded upon to provide homes alternative ways of meeting the minimum requirement. For Measure 1 Enhanced Dining, modify language to include "how the home uses the facility assessment to proactively develop menu options that reflect the resident population seen in the home."* ***Recommendation 2:*** *Review minimum requirements for areas where requirements such as time frames or talking points can be highlighted or more easily identified. For minimum requirement 6-2, change to* *"Provide a narrative on:* • *How you are using data and information around known trauma from your Facility Assessment, other assessments done in the home, or other means to influence programming and staff training.* • *Include a specific example of how you are using the data and information about known trauma."* ***Recommendation 3:*** *Review documentation requirement language to specify stronger documentation requirements such as images, signed testimonials, sign-in sheets, or other documentation that clearly confirms the event took place. Decide with the P4P Committee's input as to whether documentation, such as*	***Recommendation 8:*** *Continue to monitor user experience with the application web portal to identify common issues experienced by the nursing home facilities and reviewers. Develop a user experience tracker/log to quantify issues. Enhancements to the web portal can lessen administrative burden and streamline the application and review process.* ***Recommendation 9:*** *Have homes provide their Federal Provider Number to uniquely identify homes and increase efficiency in analyzing homes' performance in federal data sets.* ***Recommendation 10:*** *Educate and encourage all homes to provide a secondary or management contact to serve as an extra point of contact and ensure program communication is received by homes.* ***Recommendation 11:*** *Implement a robust quality control process in the generation of score letters in the portal.*	***Recommendation 6:*** *Review ways to begin measuring racial equity within nursing homes in Colorado.* ***Recommendation 7:*** *Explore with the P4P Committee adding measures related to digital data collection and reporting.* ***Recommendation 12:*** *Include in score letter detailed on how to submit an appeal, the content required to submit an appeal, and the timeframe for a decision.* ***Recommendation 13:*** *Reach out to nursing facilities that have created an account on the web portal but did not submit an application in the 2021 P4P program or nursing facilities that did not reapply for the program. Reach out to homes who the 2021 P4P program was their first time participating. Engage these homes through a short survey and follow up as necessary to collect information around barriers and motivations to participation.* **Recommendation 14:** *Continue to monitor the performance of Colorado P4P facilities in the FY2021 SNF VBP.* ***Recommendation 15:*** *Since preventable hospital readmissions are the primary focus in SNF VBP, reevaluate how hospital readmissions are currently scored in the Colorado P4P program.* ***Recommendation 16:*** *Explore dedicating funds for rewarding nursing facilities who show an improvement in their application*

Application	Portal	Programmatic
testimonials, can be utilized for two minimum requirements. ***Recommendation 4:*** *Clarify or remove documentation requirements for Measure 21.* ***Recommendation 5:*** *Clarify or remove documentation requirements for Measure 22.*		*scores. This would be a modification of California's structured payment program. Specific to Colorado, the Department could potentially provide a financial incentive for homes who score 0-20 points, thus not meeting the threshold to receive any per diem add on. These homes may be discouraged from applying. Some amount of financial incentive to encourage the home to continue building its program to meet P4P measures may increase program participation in future years.*