

Virginia Medicaid Nursing Facility Pay for Performance Reimbursement Program



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Executive Summary - Nursing Facility Pay-For-Performance (NF P4P) Proposal

1. Introduction and Overview

DMAS makes the following NF P4P proposal with recommended options for the 2008-2010 biennial budget as required by Item 302.MMM of the 2007 Appropriation Act. This proposal is consistent with recommendations of the Governor's Health Reform Commission developed by the Quality, Transparency, and Prevention (QTP) workgroup. DMAS also convened an Advisory Committee, which helped to shape these recommendations.

More and more health care payers (commercial, Medicare, Medicaid) incorporate quality care as one of the criteria used in reimbursement methodologies. This "value-based purchasing" movement links pay to performance. A number of state Medicaid programs are developing pay for performance programs for nursing facility reimbursement because Medicaid is the largest single payer for nursing facility care. In Virginia, Medicaid recipients represent over 65% of all the bed days in the Commonwealth's 275 Medicaid certified nursing facilities. Because DMAS is the primary payer, a quality incentive program has the potential to have a major impact on the quality of care for all nursing facility residents.

2. Measuring NF Performance

A NF P4P program needs to answer the following questions:

- What criteria to use to measure performance?
- How to score providers on these criteria?
- How to link the scores to quality payments?

Criteria

The Advisory Committee recommendations of performance measures were chosen because these measures are necessary to ensure high quality resident care while addressing major quality systems improvements for residents. The measures described below were chosen by the Committee as the initial set of measures incorporated in the NF P4P Program. The committee agreed that survey deficiencies should play a small part. The advisory committee did not make a final recommendation on the weights of the other criteria.

Advisory Committee Recommendations on Performance Measures.			
Weight	Criteria	Details	Comments
TBD	Quality Indicators	MDS Long Stay Measures <ul style="list-style-type: none"> • high risk residents with pressure ulcers • residents with catheter • residents physically restrained • residents whose mobility worsened • residents who needed more help with Activities of Daily Living (ADLs) 	<ul style="list-style-type: none"> • Independently calculate measures rather than use CMS measures on NH Compare. • Use methodologies developed by University of Minnesota and CHSRA. • Consider additional measures. • Consider alternative measures (My Innerview). • Many hospital-based nursing homes will not have many long stay patients.
TBD	Resident Quality of Life	<ul style="list-style-type: none"> • Resident satisfaction survey • Family satisfaction survey 	<ul style="list-style-type: none"> • Need to contract for surveys. • Determine how to administer surveys.
TBD	Staffing	<ul style="list-style-type: none"> • Employee satisfaction survey • Employee retention rate 	<ul style="list-style-type: none"> • Advisory Committee did not recommend staffing hours per bed day as criteria. • Need to contract for surveys. • Need to collect retention rate data.
10%	Survey deficiencies	Three levels of compliance <ul style="list-style-type: none"> • no deficiencies • substantial compliance • not in compliance 	<ul style="list-style-type: none"> • Work with VDH to use available data.
0%	Avoidable hospitalizations		<ul style="list-style-type: none"> • Under development.

DMAS is committed to further work to develop a measure of avoidable hospitalizations. DMAS will continue to research other criteria, particularly criteria that reward innovation, modernization and culture change in furnishing resident care. The Advisory Committee and DMAS feel that additional work is necessary to develop and test quality indicators.

Scoring System

DMAS recommends that the scoring system of the NF P4P program should reward top performers and encourage other performers to improve. The Advisory Committee discussed various proposals. Some proposals attempted to combine both goals in a single scoring system. Other proposals would establish separate scoring for performance and improvement.

Provider representatives noted that low performing nursing facilities frequently have multiple problems. If one goal is to encourage low performing nursing facilities to improve, provider representatives recommend that the improvement incentive be substantial. Performance incentives could be limited to just the best 20% to 50% of nursing homes, but the Advisory Committee considered it important that most nursing homes feel they have a stake in the NF P4P program. To set the bar too high to qualify for at least a small quality incentive payment could act as a disincentive to improve quality, because a quality incentive payment may be unrealistic.

If there was a clear definition of quality performance, then performance could be based on achieving fixed standards. For the most part that is not the case. For

performance payments, therefore, DMAS would recommend using a relative scoring system that ranks the performance of all nursing homes. Relative scoring is based on realistic standards while still motivating facilities to improve, as long as there is room for improvement. It allows the bar to move from year to year. The one exception is for survey deficiencies that should be based on three levels based on absolute criteria.

Quality improvement on the other hand should probably be measured from an initial baseline performance for each nursing facility rather than from period to period.

DMAS and the Advisory Committee have expressed a desire to continue to explore options for providing quality incentives before making a final recommendation.

3. Implementation Recommendations

Phased Implementation

DMAS recommends that a P4P program be implemented in three phases: development, public reporting and pay for performance. Note that development also continues during the public reporting and pay for performance phases. The length of time for each phase is flexible but the following is one possible implementation plan:

Present-December 31, 2008 – Development

January 1, 2009- July 31, 2009 – Continued Development and Public Reporting Pilot

July 1, 2009 – Pay for Performance and Public Reporting

Assuming that DMAS contracts for this work effective July 1, 2008, the contractor would have six months for development before the Public Reporting pilot starts.

Public Reporting

In order to increase transparency between consumers and nursing care facilities, efforts should be made to publicly report performance scores collected through the Pay-For-Performance initiative. DMAS may work with Virginia Health Information (VHI) to display scores, rankings, or other performance data collected that allows consumers to compare nursing home facilities across the range of quality measures. While VHI is one option, it may be more efficient to include public reporting in a comprehensive contract if DMAS contracts for NF P4P.

DMAS also recommends public reporting as one of the implementation phases. The report card will test the criteria and the scoring. DMAS recommends that the report card be in place for at least six months prior to beginning the P4P phase.

Public reporting of nursing facility quality information has consequences for nursing facilities who have few or no Medicaid recipients. The Advisory Committee recommended that all nursing facilities have the opportunity to participate in the

public reporting and that facilities providing comparable quality of care should be ranked at the same level regardless of their level of participation in the Medicaid program.

Payment Timing

Most programs make annual quality incentive determinations. As a result there can be substantial lag between performance and reward. The amount of time needed to collect the data and calculate the scores also affects the lag. At least one program proposes to collect data and calculate scores quarterly and make quarterly quality incentive determinations with just one quarter lag on most of the criteria. While some criteria can be calculated quarterly (or more frequently), other criteria (survey deficiencies, for example) can only be calculated annually.

However, some criteria that could be calculated quarterly may be unstable not because of a true change in performance, but because of the imperfections of the measurement methodology. The frequency of calculations also has a minor impact on administrative resources needed.

DMAS believes it is premature to make a final recommendation on timing, though it would like to try semiannual performance periods.

Ongoing Development and a Standing Advisory Committee

While this report covers many aspects of a NF P4P program, more development is necessary. The Advisory Committee did not feel informed enough to make recommendations on some issues and wanted the flexibility for its recommendations to evolve based on more research and experience.

DMAS believes that it is important to maintain some flexibility to finalize the program and, just as importantly, revise it as needed. DMAS recommends that the Advisory Committee that assisted with this report be reconvened on a quarterly basis to review development of the program and to give feedback on its implementation. DMAS recommends that it report annually on the development and implementation of the NF P4P program, including any revisions it has implemented or proposes to implement.

Contracting

Implementation of the nursing facility pay for performance program will require additional resources for the following activities

- Data collection and calculations
- Employee and resident/family surveys
- Public reporting
- Coordination

In order to effectively run this program, DMAS strongly recommends that it contract out this activity in addition to dedicating one FTE to the program. DMAS should procure through a competitive bidding process a vendor to develop, implement and manage a tiered nursing home reimbursement system based on quality measures previously discussed. The contractor will design a turnkey solution based on these recommendations and in consultation with DMAS and the advisory committee.

At a minimum, DMAS would have to contract out individual components through a competitive bidding process such as employee and resident surveys and possibly the public reporting.

Voluntary Program

The Health Reform Commission has recommended that the program be voluntary. A successful program, however, needs to have broad participation. Participation depends on incentives. Some incentives/disincentives built into the program include

- Only participating nursing facilities are eligible for a quality payment
- Only participating nursing facilities receive satisfaction survey data and other feedback for quality improvement
- If a nursing facility does not participate, the public reporting mechanism would indicate that there is no data on this nursing home

While DMAS is concerned about excessive burdens on NFs in providing data, provider representatives on the Advisory Committee believe that NFs will be willing to provide data if the program is well designed.

Given the desire for a voluntary program but also the need for broad participation, the advisory committee recommended a monetary participation incentive at the beginning of the program. This incentive would not be connected to performance scores. To the extent that the program relied on the submission of new data, this incentive helps offset the cost to nursing facilities. A participation incentive, if utilized, would most likely be phased out after the first year.

4. Evaluation

DMAS recommends that an independent evaluation be contracted for at the end of the first three years of the program. DMAS and/or its contractor should report annually on the program, including any proposed revisions.

5. Budget

Administrative Funds

Administering a nursing home pay for performance program, especially during development and the first few years, will require additional administrative resources. DMAS recommends a minimum of one FTE to coordinate the program, assuming that

a substantial portion of the program will be contracted. DMAS recommends a total of \$762,834 (\$381,417 GF). in administrative funds for this program in FY09.

Participation Incentive Payments

If there is a participation incentive, DMAS recommends a participation incentive of 25 cents per Medicaid bed day or \$1.5 million (\$750,000 GF) in FY2009 if 95% of nursing facilities participated. For a nursing facility with 100 Medicaid occupied beds, this would mean a \$9,000 annual increase in reimbursement for one year.

Quality Incentive Payments

In the first year of quality incentive payments, DMAS recommends a quality incentive pool equal to 1% of base reimbursement in the prior year, equivalent to \$10.8 million (\$5.4 million GF) in FY09. Incentive programs are not effective unless the funding is stable. Stable funding, therefore, is just as important as the amount. The timing of this funding depends on the implementation schedule. Assuming that the quality incentive pool is distributed semiannually and the program performance period starts on July 1, 2009, approximately \$5.4 million (\$2.7 million GF) in funding will be needed in FY10. Funding needed will be higher in future bienniums. Provider representatives recommended a minimum of 3% of base reimbursement as an effective quality incentive program.

Evaluation

DMAS estimates that an evaluation will cost approximately \$200,000 (\$100,000 GF), but this cost will not be incurred for several years.

Low Cost Alternatives

DMAS strongly recommends the proposed plan, but recognizes that there may be competing budget priorities. Ways to reduce costs include

- Delay the implementation of the quality incentive payments
- Eliminate or reduce the participation incentive
- Eliminate or delay the number of criteria for which new data would need to be collected (for example, employee and resident/family surveys)
- Reduce the administrative cost

Some of these low cost alternatives, however, could affect stakeholder support.

1. Introduction and Overview

Nursing Facility Pay-For-Performance (NF P4P) has the potential to improve care to all Nursing Facility residents. The current reimbursement methodology does not consider quality directly in determining reimbursement. Virginia Medicaid recipients represent over 65% of all the bed days in the Commonwealth's 275 Medicaid certified nursing facilities. Because DMAS is the primary payer, a quality incentive program has the potential to have a major impact.

1.1 Budget Amendment

DMAS prepared this report in response to Item 302.MMM of the 2007 Appropriation Act.

Item 302.III. the Department of Medical Assistance Services shall develop a pay-for-performance proposal for Medicaid nursing homes. The proposal shall include the types of information that will be used to measure quality, the structure of the per diem reimbursement plan (including the quality indicators that will be used and any payment levels based on performance). To the extent feasible, the proposal shall also explain how any quality indicators and measures may be adjusted to account for differences between nursing homes, the types of residents served, and improvement over time. The department shall submit this proposal with recommended options and amounts of funding, as a request for the 2008-10 biennial budget.

This report is intended to provide detail to support the proposal the agency has submitted.

1.2 Health Reform Commission

Governor Kaine created the Health Reform Commission in July 2006 to develop a health reform agenda for his Administration. The Quality, Transparency and Prevention Workgroup of the Health Reform Commission recommended that DMAS implement a NF P4P program and made the following recommendations.

Recommendation 1:

The Governor should require the Nursing Home P4P program include the use of meaningful metrics linked to quality improvements that balance both absolute and relative scales, as appropriate. The program should begin as voluntary program and the proposed measurement system should be pilot tested. Non-

financial incentives should be used during the pilot-test before transitioning effective program components to a financial reward system.

Recommendation 2:

The Governor, through the Secretary of Health and Human Resources, should require the Nursing Home P4P program incorporate, at a minimum, MDS, staffing, satisfaction, and survey criteria into the measurement components for quality. Additionally, the Governor should also require the Nursing Home P4P program be updated, modified, and improved over time to include additional metrics targeting specific areas the Commonwealth would like to address, such as avoidable hospitalization rates.

Recommendation 3:

The Governor should require that funding for the Nursing Home P4P program come from new monies and that the program incorporate both financial and non-financial incentives. Overall, efforts should be made to reward innovation, modernization and culture change that promote quality in resident care.

Recommendation 4:

The Governor, through the Secretary of Health and Human Resources, should require the Nursing Home P4P program be evaluated and monitored regularly to assess effectiveness, with an annual report due to the Secretary of Health and Human Resources.

Recommendation 5:

Quality performance scores should be made publicly available through a website or other accessible means in order to increase transparency between consumers and nursing facilities and also provide consumers with an additional tool to compare and select nursing facilities. DMAS should discuss with VHI options for including such data as part of the information portal recommended in the transparency report.

The full Commission recommended that implementing a NF P4P program be a tier one priority. The full Commission report is available at http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingMats/FullCouncil/Health_Reform_Comm_Final_Report.pdf

1.3 Advisory Committee

DMAS convened an advisory committee of stakeholders to help develop a proposal. The advisory committee included representatives from nursing home associations and individual providers, the Virginia Department of Health, the Virginia Health Quality Center, advocacy groups and DMAS. The list of advisory

committee members is in Appendix 1. The Advisory Committee met five times between May and September.

1.4 Nursing Home Quality Activities of the Centers for Medicare and Medicaid services (CMS)

The Centers for Medicare and Medicaid Services (CMS), the federal agency responsible for administering the Medicare and Medicaid programs, has several activities that support nursing home quality, consistent with CMS quality initiatives for physicians, hospitals, MCOs and other health care providers.

1.4.1 Nursing Home Compare

CMS has an extensive nursing facility quality program and has developed the Nursing Home Compare website as part of CMS' ongoing commitment to use public reporting to improve the quality of care available in the nation's nursing homes. Nursing Home Compare is not a report card, but much of the quality information developed by CMS has been used in report cards and P4P programs.

Nursing Home Compare provides demographic information, quality measures, health and safety survey results and staffing ratios on individual nursing homes. Four databases with this information are also available for download. More information on Nursing Home Compare is in Appendix 2.

1.4.2 Quality Improvement Organizations

CMS also funds Quality Improvement Organizations (QIO) in each state. The contracted QIO in Virginia is the Virginia Health Quality Center (VHQC). Staff from VHQC participated on the Advisory Committee and presented information on the current Advancing Excellence in America's Nursing Homes campaign. Information on the Advancing Excellence campaign is included in Appendix 3. The Advisory Committee recommends that the Medicaid NF P4P program be consistent with the goals of the Advancing Excellence campaign.

1.4.3 Medicare Demonstration Program

CMS is developing a Medicare NF P4P demonstration. While CMS has not yet implemented this demonstration, the June 2006 Final Design Report, Quality Monitoring for Medicare Global Payment Demonstrations: Nursing

Home Quality-Based Purchasing Demonstration, prepared by the CMS contractor Abt Associates is the single best source of information on designing a NF P4P program.

1.5 Other State Medicaid NF P4P Programs

DMAS reviewed a number of Medicaid NF P4P programs in other states. The chart below summarizes some of these programs, including the proposed CMS Medicaid Demonstration. Additional information on these programs is in Appendix 4. No state has a long track record and there has been little evaluation of the success of these programs.

	MDS-Based Measures	Staffing Measures (resident to staff ratios, staff turnover and retention, and employee satisfaction)	Quality of Life Measures (resident satisfaction, resident interviews)	Survey Deficiencies	Other
CMS Proposed Medicare Demonstration (Abt Associates)	20%	30%	0%	20%	30% (Reductions in potentially avoidable hospitalizations)
Iowa (eff. 2002)	0%	25%	16%	25%	33% (efficiency measures)
Kansas (eff. 2005)	0%	44%	0%	22%	33% (efficiency measures)
Minnesota (Revised proposal eff. October 1, 2007)	35%	35%	20%	10%	0%
Texas (2001-2002)	50%	0%	0%	50%	0%
Oklahoma (eff. 2007)	10% (Alternative Quality Indicators)	40%	20%	10%	10% (Level of Person-Centered Care) 10% (Medicaid Occupancy and Medicare Utilization)

Some states have grant programs to reward or promote nursing facility quality instead of or in addition to statewide P4P programs. North Carolina and Vermont have programs to promote better staffing in nursing facilities. In Minnesota, nursing facilities can propose quality improvement programs for funding by the Medicaid agency. In Kansas, the Medicaid agency gives monetary awards for outstanding nursing facilities. In Virginia, DMAS has developed a strategic plan to implement a quality improvement program using civil money penalties. This program would complement the NF P4P program discussed in this report.

2. Measuring NF Performance

2.1. NF P4P Criteria

There is no single measure that can accurately measure nursing facility performance. As a result, all programs use a combination of quality measures. A review of the literature and other NF P4P programs proposed or implemented revealed that there are five basic types of performance measures for a NF P4P program:

1. Quality measures,
2. Staffing,
3. Resident/Family Quality of Life,
4. State survey inspections, and
5. Potentially avoidable hospitalizations,

The Advisory Committee used the charts in Appendix 5 as the basis for its discussion. This section documents DMAS research and the Advisory Committee discussion on NF P4P criteria. DMAS and the Advisory Committee feel that additional work is necessary to develop and test quality measures and a scoring system.

2.1.1 Quality Measures

CMS and others have invested substantial resources in developing “quality measures” or “quality indicators” using resident assessment data that nursing facilities are already required to report to CMS. CMS uses various methods to risk adjust the quality measures. For example,

the quality measure may exclude those who have recently been admitted since the nursing home may have admitted someone with a specific condition. Also certain conditions may increase the risk and they are calculated separately.

During their stay in a nursing home, residents are assessed by the home staff. This assessment is called a Minimum Data Set (MDS) Assessment and is performed at admission, quarterly, annually and whenever the resident experiences a significant change in status. This extensive assessment includes many items such as: diagnosis; the ability to do certain tasks such as get in and out of bed, walking, eating, bathing, toileting, etc; clinical conditions such as the presence of sores, wounds or cuts on the body; use of certain types of medications; dehydration; mental functioning; and certain cares and treatments provided to the resident. CMS contracts with the Virginia Department of Health to collect this data in Virginia.

CMS reports 14 long stay quality measures and five short stay quality measures on CMS compare using MDS data. Abt Associates, however, only recommended using five long-stay quality measures and three short stay quality measures for the Medicare NF P4P Demonstration. Abt only recommended quality measures that are valid and reliable, are under the nursing home's control, have good statistical performance and reflect important societal values. DMAS recommends using the five long stay quality measures recommended by Abt. They are

- High risk residents with pressure ulcers
- Residents with catheter
- Residents physically restrained
- Residents whose mobility worsened
- Residents who needed more help with ADLS

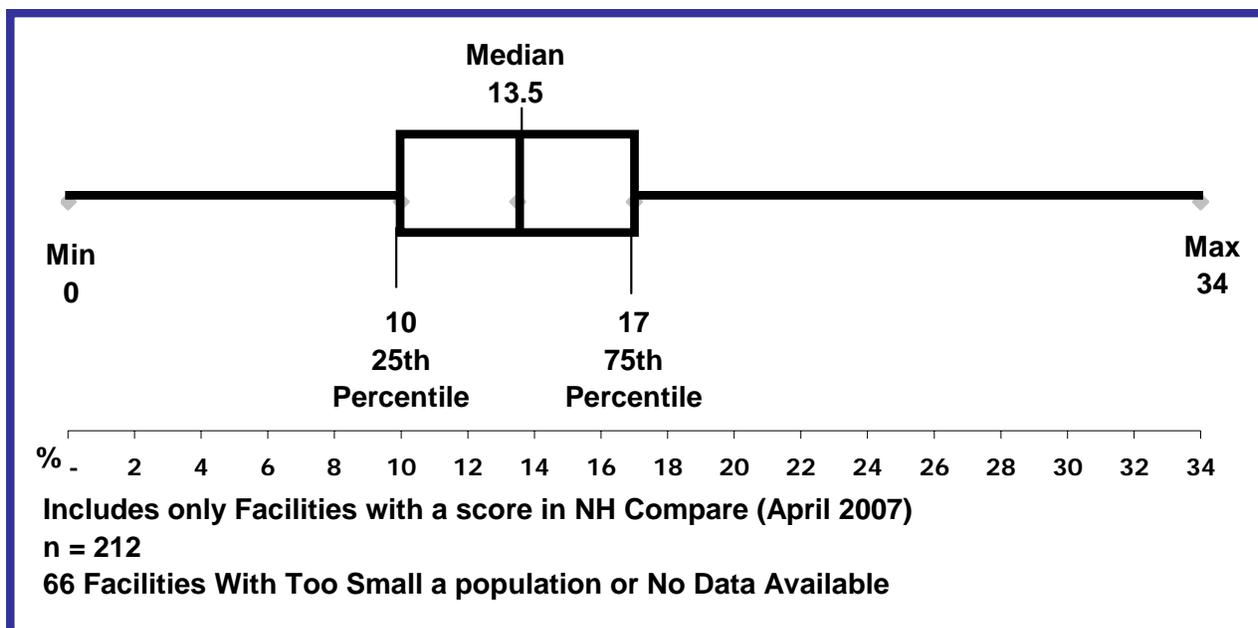
The long stay measures are more important for Medicaid covered services. The short stay measures, while important, are more relevant to Medicare covered services.

The Advisory Committee was interested in other measures that could also be included:

- Residents with moderate to severe pain
- Residents with unplanned weight loss
- Residents with falls

Below are box charts with summary information on Virginia nursing facility scores on the five selected long stay quality measures from April 2007 Nursing Home Compare. Also included is information on the pain measure. Appendix 6 includes detailed scores by nursing facility based on a sample scoring proposal derived from the scoring method used by Minnesota.

Figure 1: Percent of High-Risk Long-Stay Residents Who Have Pressure Sores.



The interpretation of this figure is that half of the nursing facilities had less than 13.5% of residents with pressure sores and half of the nursing facilities had more than 13.5% of residents with pressure sores. One quarter of the facilities had less than 10 percent of residents with pressure sores and another quarter had more than 17% of residents with pressure sores. The lowest score among all nursing facilities was 0% of residents with pressure sores and the highest score was 34% of resident with pressure sores. Other figures should be interpreted in a similar manner.

Figure 2: Percent of Long-Stay Residents Who Have Moderate to Severe Pain

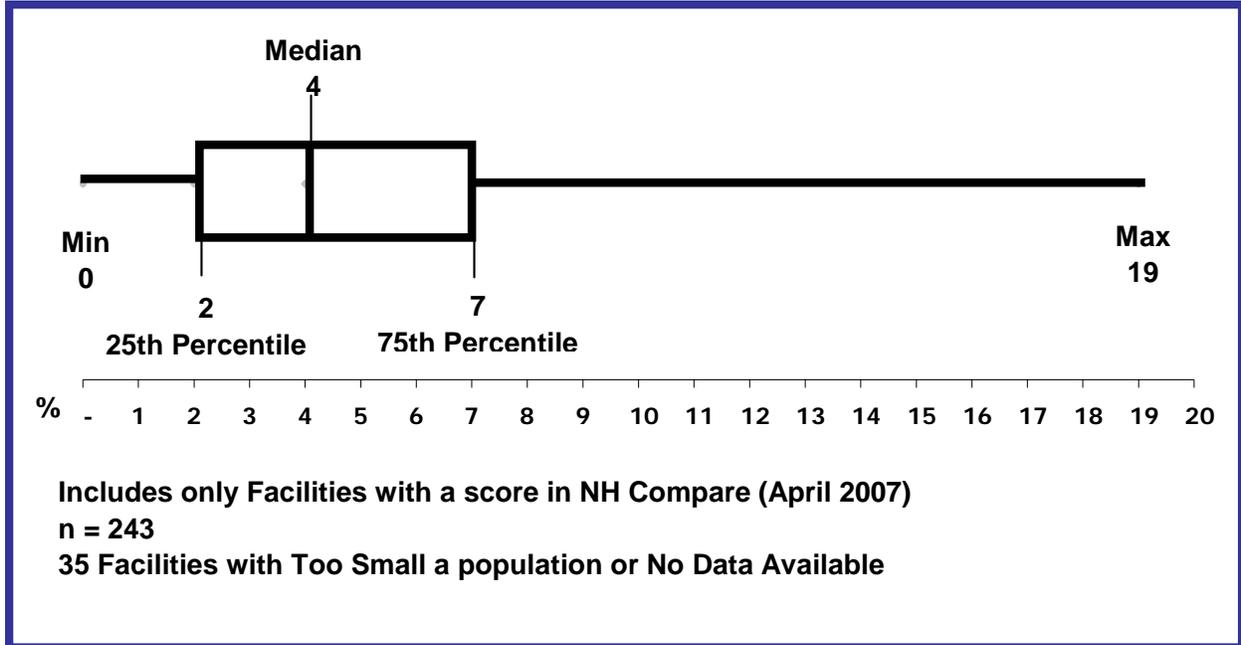


Figure 3: Percent of Long-Stay Residents Who Have/Had a Catheter Inserted and Left in Their Bladder

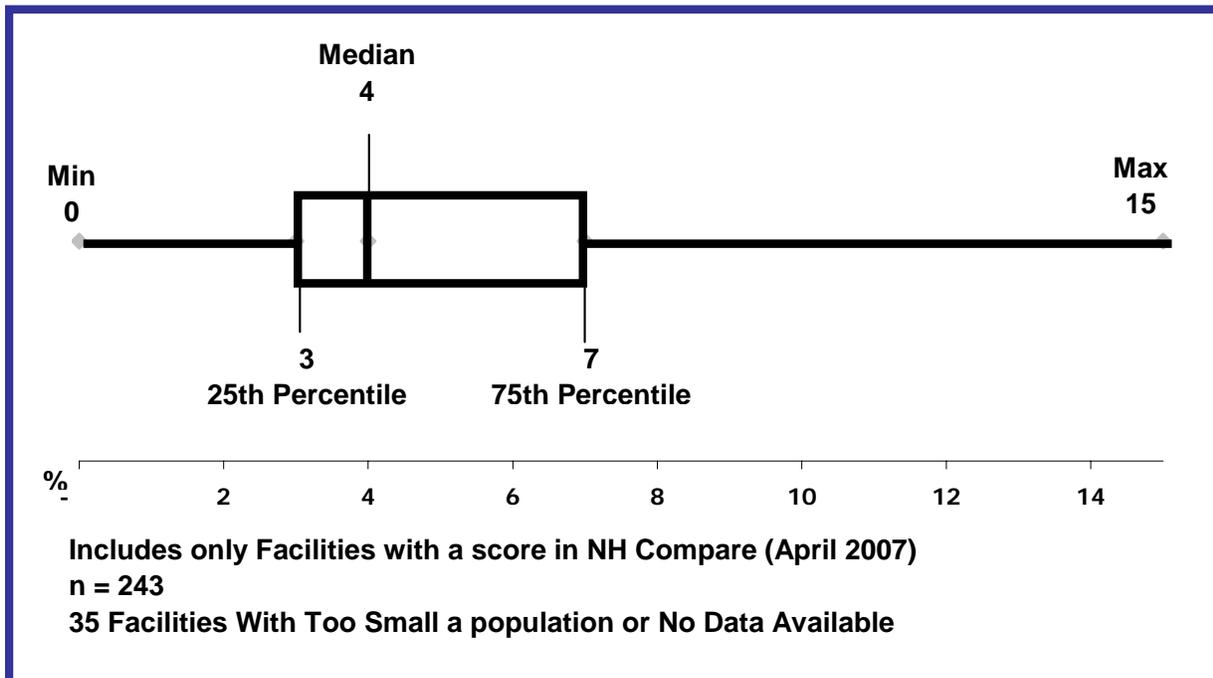


Figure 4: Percent of Long-Stay Residents Who Were Physically Restrained

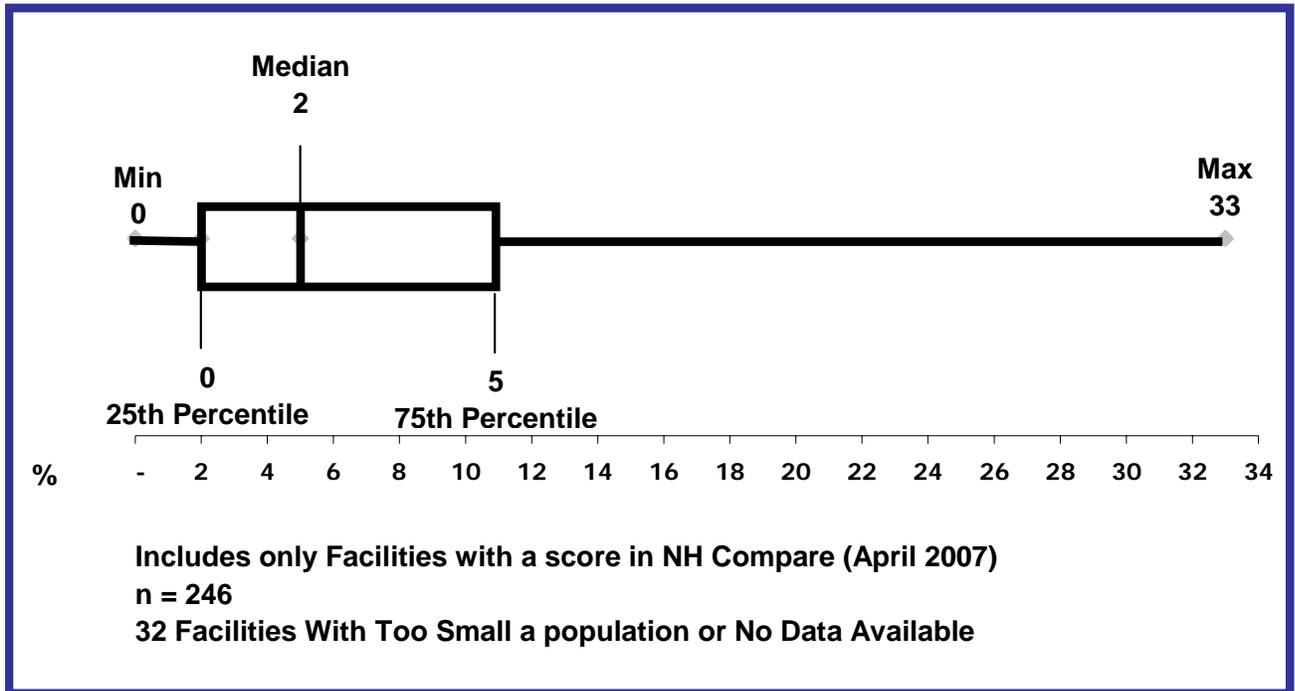


Figure 5: Percent of Long-Stay Residents Whose Ability to Move About In and Around Their Room Got Worse

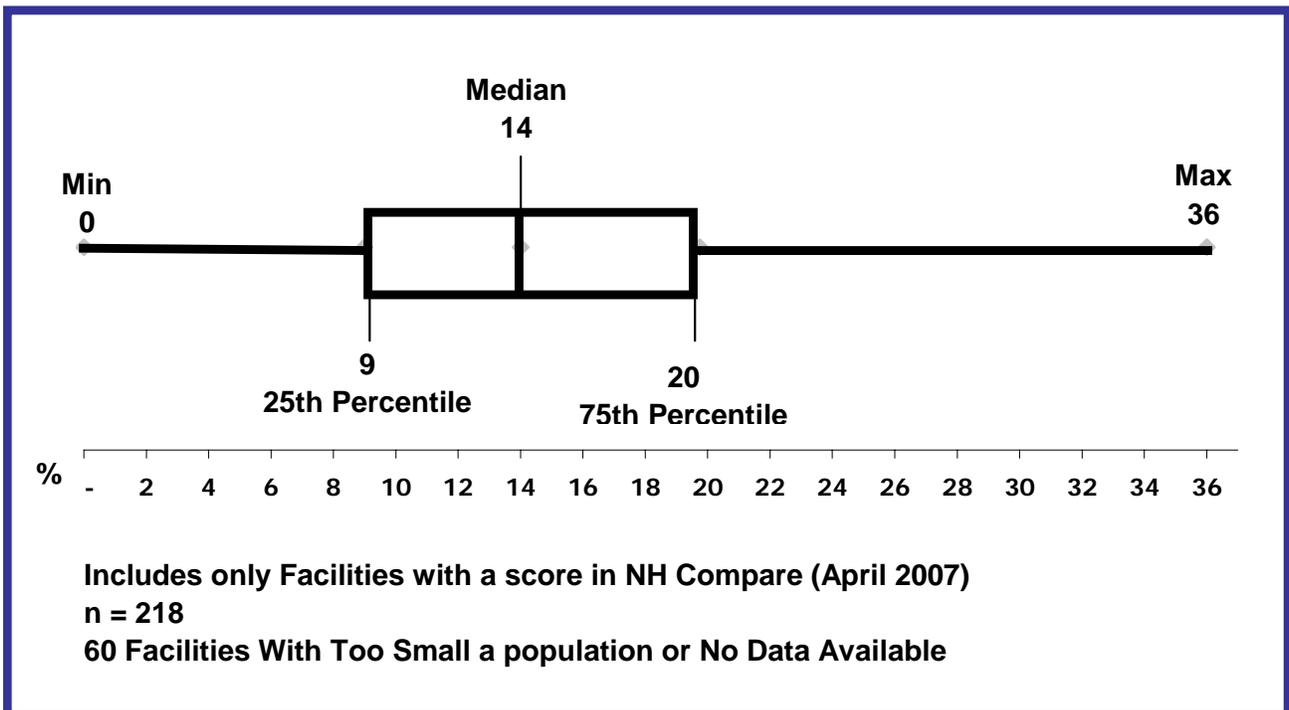
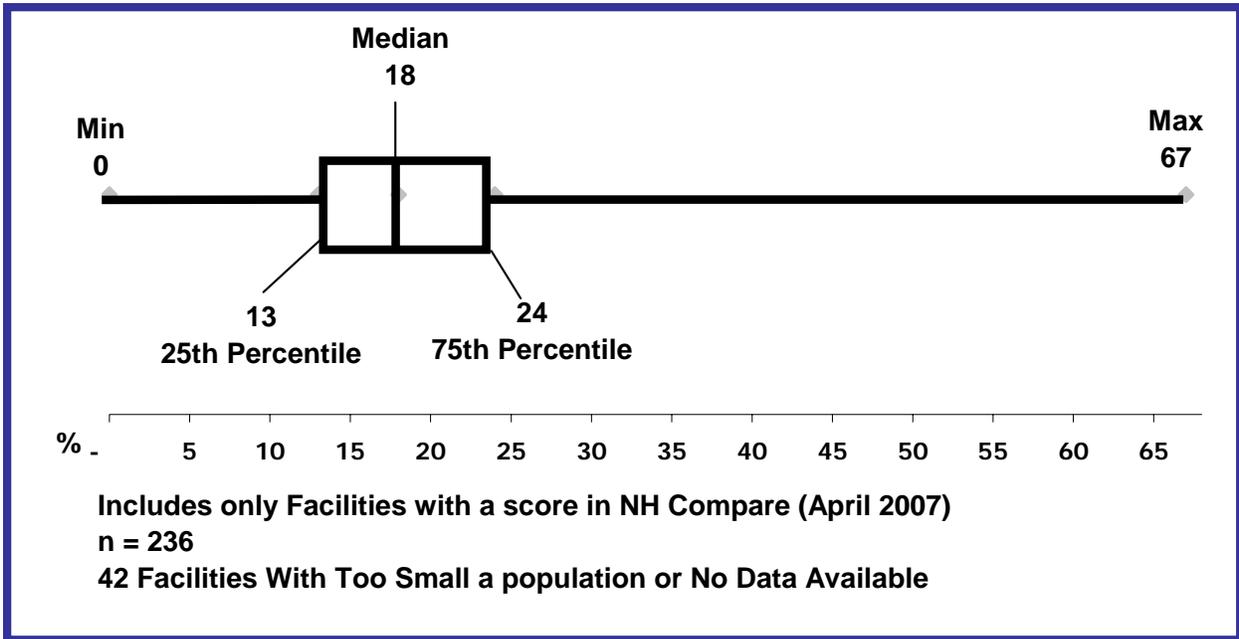


Figure 6: Percent of Long-Stay Residents Whose Need for Help With Daily Activities Has Increased .



Quality measures continue to be refined through recommendations from the National Quality Forum, a voluntary standard setting, consensus-building organization representing providers, consumers, purchasers and researchers.

There have been quality and timeliness issues with the quality measures reported on Nursing Home Compare and available on the database. It may be beneficial for DMAS to calculate the scores itself.

Moreover, the University of Minnesota has developed techniques that improve the ability to report scores for some nursing facilities. Based on a recent download, approximately 12 to 24 percent of nursing facilities in Virginia did not have a score for one of the five quality measure either because data was not available or the number of residents is too small to report.

Other organizations, specifically the University of Minnesota and the Center for Health Systems Research and Analysis have developed additional MDS-based quality measures that could be considered.

My InnerView, an applied research company working with long-term care facilities to promote quality and the contractor for the Oklahoma NF P4P program, has developed six clinical outcome measures based on

data reported periodically by nursing facilities. The data is not adjusted for case mix or other criteria.

- Residents without falls
- Residents without antipsychotic meds
- Residents without acquired catheters
- Residents without acquired physical restraints
- Residents without unplanned weight loss/gain
- Residents without acquired pressure sores

Valid outcome measures similar to the quality measures described in this section should be an important component of a NF P4P program. However, Medicaid covered nursing facility services include less medical services and treatments than Medicaid covered hospital care. Unlike hospitals, nursing facilities are long-term residences, hopefully “homes” for the residents, and other criteria are needed to measure performance related to non-medical components of nursing facility services.

2.1.2 Nursing Facility Staffing

Staffing in nursing facilities is considered a critical component in the ability of a nursing facility to deliver quality care. Some states (North Carolina and Vermont) have built quality improvement programs around improving staffing using a model developed by Better Jobs Better Care. The Advisory Committee considered three kinds of staffing measures:

- Employee satisfaction
- Retention/turnover
- Staffing levels

The Advisory Committee recommended that the NF P4P program include employee satisfaction and retention as criteria to measure staffing. It would be very difficult to consistently deliver quality care without a satisfied staff. Employee satisfaction is currently being used in the new Oklahoma NF P4P program.

It is also hard to deliver quality care if new staff is constantly being hired to replace existing staff. Retention and turnover are two facets of the same issue and can be combined in a quality measure. However, the Advisory Committee thought it more important to retain quality staff than try to prevent turnover. There will always be some level of turnover in low wage work done by nursing assistants who provide the

majority of direct care in a nursing facility. Some turnover is acceptable as long as continuity of care can be maintained by a dedicated cadre of staff. Iowa, Kansas and Oklahoma use retention and or turnover as a component of their NF P4P program and Abt Associates recommends that Medicare include a retention measure in the Medicare NF P4P Demonstration program.

The Advisory Committee did not recommend staffing levels be included in the NF P4P program. While staffing is important, a numerical number is not a guarantee of the quality of care and the alternative measures chosen would be more targeted to aspects of staffing that relate directly to quality care. At least one member of the Advisory Committee, however, suggested that staffing levels be reconsidered as a component. She suggested a minimum level and "consistent staffing," though it was not clear how to measure consistent staffing.

There is evidence that low nurse staffing levels compromise quality of care and that higher staffing levels in nursing homes have been found to be associated with fewer hospitalizations, fewer infections, fewer pressure ulcers, less skin trauma, less weight loss, decreased resistance to care, and higher levels of functional status. Above certain levels, however, higher levels of staffing have little impact on quality.

Many state NF P4P programs (Texas, Iowa, Kansas, Minnesota) and the proposed Medicare demonstration use staffing levels as a performance measure. They measure total nursing hours per resident day, registered nursing hours per resident day and/or other auxiliary service hours per resident day. Most programs case mix adjust the hours per resident day and some give different weighting to different levels of care. One program gives a lower weight for agency staff. Agency or temp staff is better than no staff, but not as good as staff that is familiar with the residents and their needs.

DMAS presented staffing level information to the Advisory Committee based on the DMAS wage survey.

2.1.3 Resident Quality of Life

Many nursing facilities utilize resident and/or family satisfaction survey tools to evaluate the quality of life in the nursing facility. The nursing facility is the home of the resident, not just a medical facility. Satisfaction surveys measure the non-medical component of quality.

Nursing home satisfaction represents a multidimensional collection of issues related to various aspects and experiences of the particular group responding. In most cases it is the resident completing the survey, but many surveys also include family satisfaction components. There are a number of resident and family surveys in use or under development that were constructed for a variety of purposes – for nursing home selection, for quality improvement initiatives, for public reporting and as a component to adjust reimbursement rates (e.g., provide care-related payment incentives). A number of these instruments have undergone extensive development and testing.

Many nursing facilities already use satisfaction surveys and some use multiple satisfaction surveys as management tools. However, in order to use a satisfaction survey in a scorecard or NF P4P program, all nursing facilities would have to use the same tool. Currently, about 120 Virginia nursing homes use some or all of the survey components offered by My InnerView, a commercial survey instrument, as a quality improvement tool.

The advisory committee also considered family surveys either separately or as a proxy for non-responsive residents. There was some disagreement whether all residents could be validly surveyed due to their mental or physical disabilities and whether family members could be adequate proxies. Family members may have congruent interests with the resident, but they may also have other interests. Their experiences are also going to be different than the experience of residents. For example, family members do not experience the nursing facility in the middle of the night. Consumer representatives strongly recommended that every effort be made to survey residents directly. They recommended that family members be surveyed separately.

A related issue is whether to use written surveys or interviews. Most organizations use written surveys for residents and family members; however, there is a limited response rate to written surveys by residents with mental or physical disabilities. The survey firm Vital Research made a presentation to the Advisory Committee about its capability to use interviews to directly survey residents and about the techniques it employs to get a high response rate, even from residents with mental or physical disabilities. A number of states have contracted for interview surveys.

There is a concern that surveys conducted via direct interview could be costly or disruptive in the nursing facility. However, achieving robust response rates is important in obtaining results that are meaningful.

Many survey organizations can provide management feedback and action plans to improve nursing facility quality. It would be an added benefit if the NF P4P also provided quality feedback from the resident/family satisfaction surveys in addition to its use as a quality measurement criteria.

Iowa, Minnesota and Oklahoma use resident/family satisfaction surveys. Of these three, Minnesota uses interview surveys. Ohio also uses statewide interview surveys for public reporting even though Ohio currently does not have a NF P4P program. Abt Associates recommended that CMS continue to research surveys as a potential component of a Medicare NF P4P Demonstration program.

2.1.4 Deficiencies from State Survey Inspections

All nursing homes that participate in Medicare or Medicaid must have a certification survey on a regular basis (on average once every 12 months) to ensure that they meet certain federal requirements. However, if the nursing home is performing poorly, the State inspectors may conduct more frequent inspections. In addition, the State also investigates complaints about nursing home care.

There are a total of 190 different requirements (categorized into 17 major areas e.g., nursing, physical environment, kitchen/food service, quality of care, quality of life, resident behavior; nursing home practices, etc.). The surveys provide a snapshot of a nursing home's quality of care at the time of the survey. When a nursing home fails to meet a specific requirement, the nursing home receives a letter deficiency based on scope and severity. See the chart below.

Table 2: Scope and Severity of Deficiencies from State Survey Inspections

Severity	Scope		
	Isolated	Pattern	Widespread
Immediate jeopardy to resident harm or safety	J	K	L
Actual harm that is not immediate jeopardy	G	H	I
No actual harm but potential for more than minimal harm	D	E	F
No actual harm with potential for only minimal harm	A	B	C

Abt Associates recommended that deficiencies related to resident behavior and nursing home practices, quality of life or quality of care and in the shaded area of the chart be considered substandard care.

Survey deficiencies may be used in two ways in the design of a P4P program:

1. As a screening measure that would disqualify any nursing home that, in the evaluation period, received a citation for substandard quality of care. This screening criterion would help to ensure that homes with otherwise good performance would not receive any performance payment as a result of the serious quality of care issues identified by surveyors.
2. As part of a nursing home's performance scores. The information on the Nursing Home Inspections database contains health inspections that determine whether its nursing homes meet the minimum Medicare and Medicaid quality and performance standards. The State conducts inspections, on average about once a year, of each nursing home that participates in Medicare and/or Medicaid. Data contained in the Nursing Home Inspections database include the current and previous two health and fire safety inspections for each nursing home.

The Virginia Department of Health recommended that survey deficiencies have a relatively small weight in the total and that only the most recent annual survey be used. The survey process emphasizes those not performing at the minimum required level, but do not necessarily measure high quality. While complaints are an important part of the overall survey process, using complaint surveys in the NF P4P program may skew the playing field, because they include "nuisance" complaints. Additional work needs to be done to determine which deficiencies to include and how to develop a score.

2.1.5 Rate of Potentially Avoidable Hospitalizations

The most common reasons for hospitalization for nursing home residents are infections, falls and fractures, and cardiovascular events. The leading cause of morbidity and death of nursing home residents is pneumonia, a common nursing home acquired infection. In studies commissioned by CMS and conducted by Abt Associates Inc. in 2005 and 2006, careful management of ambulatory care-sensitive conditions (e.g.,

congestive heart failure, chronic obstructive pulmonary disease, diabetes mellitus, urinary tract infections and pneumonia) may reduce hospitalizations and that as many as 36 percent of emergency department transfers and 40 percent of hospital admissions were inappropriate. Studies also suggest that for some conditions there is no significant difference in outcomes between residents treated in nursing homes and those hospitalized. Furthermore, a resident transferred to a hospital may be worse off than if he/she remained in the nursing home.

This is considered a desirable criterion because it directly measures quality and represents the success or failure of multiple systems in the nursing facility. DMAS intends to continue research. While Abt Associates has recommended this measure for the Medicare NF P4P Demonstration program, it has not fully developed the calculations needed to create this score.

One Advisory Committee member cautioned that the scoring of this measure not be a disincentive to appropriate hospitalization. The approach that Abt recommended is to set a hospitalization floor so that nursing homes don't have an incentive to reduce hospitalization below the floor.

2.1.6 Culture Change

Both the Health Reform Commission and the Advisory Committee were very interested that the NF P4P program promotes culture change. The simplest definition of culture change is making the care more resident-centered and home-like and less institutional. One of the challenges of using culture change in a NF P4P program is measuring culture change. The Oklahoma NF P4P program proposes to measure culture change using the employee survey protocol. Culture change may also be reflected in the resident surveys. DMAS will continue to research culture change either as a direct or indirect component of the NF P4P program.

2.2 Scoring System

2.2.1 Individual Criteria Score

The Advisory Committee did not discuss this in detail, because it is difficult to do so in a vacuum. It is necessary to review actual scoring protocols applied to real data.

Each criteria or component of criteria needs to be scored. This is true regardless of whether the purpose is public reporting or NF P4P.

There are several options for scoring. One option is just to present the raw score for each criteria. Option two is to present the raw score with benchmarks. Option three is to convert results into a "grade" (points, stars, etc.). The benchmark or grade can be determined based on absolute scores or relative scores. Examples of relative benchmarks or grades are the median, average, 80th and 20th percentile, etc.

Public reporting can use any of the three options (or a combination). A P4P program has to use option three. Below are four examples.

CMS uses option one for staffing levels published in Nursing Home Compare. CMS publishes the number of nursing hours per resident per day without any benchmarks.

CMS uses option two for the quality measures published in Nursing Home Compare. CMS publishes an average for the state and the nation for each quality measure along with the NF score.

Minnesota uses option three by awarding up to five stars for each criteria in its report card based on a ranking of facilities for each criteria. Individuals can also get raw scores. Minnesota uses the same scoring system for its NF P4P program.

Iowa also uses option three for its NF P4P program but it awards zero, one or two points for each criteria (some criteria have a maximum of one point) based on meeting absolute criteria established for the program. Iowa doesn't publish a scorecard.

There is not much research information validating absolute scores and there seems to be sufficient room for improvement that DMAS would recommend using relative benchmarks or scores to measure quality for most criteria (except possibly survey deficiencies). Using a relative scoring system means that the scoring is based on realistic standards while still motivating facilities to improve, as long as there is room for improvement.

Appendix 6 shows a relative scoring system for six quality measures using Virginia nursing home data downloaded from CMS Nursing Home Compare in April 2007. This scoring system is similar to what Minnesota uses. Any facility with a score at the 20th percentile or better (the best

quality rate) received the maximum points for that quality measure. Any facility with a score at the 90th percentile or worse (the low quality rate) received no points for that quality measure. Points were evenly distributed for scores between the best quality rate and the low quality rate. In this example, the total possible score for each quality measure was 16.67 and for all measures combined was 100. The highest score received was 93.1. The lowest score received was 11.9.

Minnesota then uses the mean and standard deviations to assign stars from one to five based on the following:

- 5 Stars Mean plus 1½ standard deviations
- 4 Stars Mean plus ½ to 1½ standard deviations
- 3 Stars Mean plus or minus ½ standard deviations
- 2 Stars Mean minus ½ to 1½ standard deviations
- 1 Star Mean minus 1½ standard deviations

Measuring quality improvement, however, may be different. Improvement needs to be measured against a baseline. Decisions on how to score improvement can be delayed until later.

Consumers are going to have different needs. For some, a simple, easy to understand scoring system such as one based on five stars is ideal. Others will want to have more detail. A reporting system could have the flexibility to allow both. A pay for performance plan ultimately has to have a specific score.

Additional work needs to be done in the area of scoring. Once the criteria have been selected and raw scores calculated, DMAS can model different scoring methods for review by the Advisory Committee.

2.2.2 Overall Score and Incentive Payments

All NF P4P programs combine scores into one overall score based on weights assigned to each criteria to determine the quality incentive payment. The Advisory Committee agreed that the weight for survey deficiencies should be low, 10%. The Advisory Committee recommended that weights for other criteria not be assigned yet.

When the overall score is determined, the final scoring decision is where to draw the line for reimbursement purposes. Most programs have at least two levels of payment, some have more. Most payment plans by design limit quality incentive payments to at least those in the top half, sometimes a more limited group.

DMAS presented the following option involving multiple tiers to the Advisory Committee. Under this option, the lowest performing facilities would receive no payment, but all other facilities would receive some payment. Each successive tier would receive an increasing portion of the quality incentive pool.

1. Top Performer’s Tier: The top twenty percent (20%) of facilities equally divide forty percent (40%) of the net pool of quality incentive dollars.
2. Standard Performer’s Tiers: The next three tiers (20% of nursing homes in each tier) would receive an increasing portion of the quality incentive dollars, 10% for the second tier, 20% for the third tier and 30% for the fourth tier.
3. Low Performer’s Tier: The lowest twenty percent (20%) would receive no P4P dollars.

If there was a 1% quality incentive pool, and the funding was distributed based on the scoring option above, the per diem increases in FY09 would be

Nursing Facility Tier	Per diem quality incentive payment (FY09)
Five Stars	\$3.38
Four Stars	\$2.54
Three Stars	\$1.69
Two Stars	\$0.85
One Star	\$0.00

To set the bar too high to qualify for at least a small quality incentive payment could act as a disincentive to improve quality, because a quality incentive payment may be unrealistic. Having relatively small ranges means that a nursing home with a reasonable effort would have a realistic chance of moving to a higher tier and conversely a nursing home that did not make a reasonable effort to improve quality would have a risk of moving to a lower tier.

The Advisory Committee discussed the merits of this proposal, but thought that they should consider additional options. Some were concerned that the incentives for a poor performing nursing facility with only one or two stars was not sufficient. However, doubling all the incentives by doubling the funding may increase the highest incentives more than reasonable.

An option would be to have separate scoring structures for high quality and quality improvement. The CMS demonstration proposes to have two measurement scales for quality and improvement but to base reimbursement only on one or the other. For quality and improvement payments, CMS proposes payments for those NFs in the top 20% with higher payments for those in the top 10%.

Most states do not have a direct incentive for improvement. Of course, a nursing facility that improves may qualify for a payment that it didn't previously qualify for or qualify for a higher payment than last time. Oklahoma intends to include a payment for improvement, but not until the program has at least one year of experience.

3. Implementation Issues

3.1 Phased Implementation

There are three phases to implementing the NF P4P program.

The first phase is development. DMAS has made substantial progress in development during the last year and much of that work has been shared with the Advisory Committee. But additional development work remains to be done. Subject to approval in the budget, DMAS intends to develop an RFP for a contractor with a target contract date of July 1, 2008. In the meantime, other development tasks include:

- Research quality measure calculations using MDS data,
- Develop scoring methods for survey deficiencies in conjunction with VDH,
- Model different scoring and payment plans,
- Research options for reporting nursing facility performance scores with VHI and Senior Navigator,
- Survey nursing facilities on employee retention in conjunction with DMAS annual wage survey, and
- Research avoidable hospitalization calculations.

The contractor at a minimum will be responsible for an annual survey of residents/family and employees that will need to be fielded soon after the contract starts. After the contractor begins, DMAS will need to merge its development efforts with the contractor's development efforts and finalize the initial criteria and scoring in conjunction with an advisory committee. DMAS and

the contractor will need to communicate program details to nursing facility providers prior to implementing phase two.

Phase two is public reporting. While public reporting is a goal in itself, public reporting also will test the scoring to be used in the P4P phase. DMAS wants to have the flexibility to modify criteria or the weight based on experience. DMAS recommends that public reporting should be in place for at least six months before the P4P phase begins. The target date for phase two is January 1, 2009.

Phase three is the P4P program. The target date to implement the NF P4P phase is July 1, 2009. Meeting this schedule depends on results during the earlier phases and on the resources dedicated to implementing the NF P4P program.

In the P4P phase, there is a "performance" period used to measure performance. Scoring won't be completed and the incentive won't be paid until sometime after the conclusion of the performance period. As a result, the "incentive" lags the performance. The Advisory Committee recommends a lag as short as possible. The length of the lag depends on two factors: the length of the performance period itself and the amount of time it takes to gather the data and calculate the performance scores.

Most state Medicaid NF P4P programs use a performance period of a year. If it takes a while to put all the data together, nursing facilities do not receive "the performance incentive" until more than a year after the performance period began. Members of the Advisory Committee were concerned that the timing of the incentive payment be more closely linked to the performance.

The Oklahoma Medicaid NF P4P program proposes to have quarterly performance periods. There are two concerns about quarterly performance periods. The first is potential volatility in some of the data. Many criteria are measured at a point in time or may represent short-term issues. It may be more accurate to average scores over several periods. While some criteria can be measured quarterly (for example, quality measures) or even more often, other criteria can only be measured once a year or even less often. Resident/family and employee surveys are typically done once a year. Federal surveys of nursing facilities are usually performed every 9 to 15 months, and sometimes longer. The same score can be used more than once but creating performance scores with the same data multiple times may give the impression that performance remains the same when the results reflect the fact that the data source has not been updated.

DMAS would like to consider a semiannual schedule. DMAS already uses semiannual case mix adjustments in its nursing facility reimbursement

methodology. Case mix adjustments use the same MDS data that would be used to calculate quality measures. If the NF P4P phase is implemented on July 1, 2009 based on semiannual performance measures, the first performance payments would be paid in the first half of 2010, prior to the end of the next biennial budget.

Initial implementation of the NF P4P phase involves calculating performance payments, but not improvement payments. Baselines need to be established before improvement payments can be calculated. DMAS recommends that at least one year of data be used as the baseline. Based on the target implementation dates in this report, the first performance period used to measure improvement will be July 1, 2010 through December 31, 2010.

Some consumer representatives expressed disappointment at the length of the proposed implementation of quality incentive payments, but agreed that it is more important to do it right rather than fast. The Health Reform Commission also recommended that the program be "pilot tested." DMAS does not believe that the quality incentive payments can be implemented any sooner, and cautions that the implementation could be slowed by results during the development and public reporting phase and/or by the lack of resources.

3.2 Ongoing Development and an Advisory Committee

While this report covers many aspects of a NF P4P program, more development is necessary. The Advisory Committee did not feel informed enough to make recommendations on some issues and wanted the flexibility for its recommendations to evolve based on more research and experience. Some of the issues that the Advisory Committee did not make recommendations on are

- Criteria details
- Weighting of criteria
- Public reporting details
- Incentive payment and improvement payment structure(s)

DMAS can learn from the experience of other states but only a few states have any experience with NF P4P programs and few have performed rigorous evaluations of their programs. Programs in Minnesota and Oklahoma have evolved both during the development phase and after initial implementation. Implementation plans have been revised based on experience.

DMAS believes that it is important to maintain some flexibility to finalize the program and, just as importantly, revise it as needed. DMAS recommends that the Advisory Committee that assisted with this report be reconvened on a

quarterly basis to review development of the program and to give feedback on its implementation.

DMAS will recommend a final plan and any revisions to the Governor and the General Assembly prior to implementation. The recommendations will be made in consultation with its contractor, if used, and the Advisory Committee. DMAS also will use the state regulatory process to promulgate emergency and final regulations as appropriate to implement and revise the program.

3.3 Contracting

DMAS strongly recommends that it procure through a competitive bidding process a vendor to develop, implement and manage the NF P4P program. The contractor will develop and implement a program based on these recommendations and in consultation with DMAS and the Advisory Committee.

A NF P4P program is very complex and will require significant resources, based on a mix of skills, to implement. Contracting provides the best opportunity to get the right level of resources and mix of skills to implement a successful program. Use of performance criteria in a contract may facilitate implementation of the NF P4P program in a timely manner because a contractor can devote the right resources to completing the task. If DMAS is not able to contract the total NF P4P program, it may affect the implementation timetable proposed above.

Even if the budget does not authorize DMAS to contract for developing and implementing the total NF P4P program, DMAS will need to contract individual components through a competitive bidding process.

Using an independent contractor for resident/family and employee surveys increases the level of confidentiality and independence necessary for reliable results. While DMAS has a lot of experience using data (for example, to calculate quality measures from MDS data), it has almost no experience as an organization in fielding satisfaction surveys.

DMAS may also need to contract for public reporting. While DMAS has a web site for agency information, creating and updating information on NF performance would be very challenging to implement on its own. VHI and Senior Navigator are possible partners in this area, but even they would likely need additional resources to implement the public reporting phase of the NF P4P program.

3.4 Voluntary

The Health Reform Commission recommended that the NF P4P program be voluntary but that it be designed to encourage facility participation by providing strong financial incentives. A successful program needs to have broad participation.

DMAS notes that the NF P4P program has both financial and non-financial incentives built into the program:

- Only participating nursing facilities are eligible for a participation or quality incentive payment,
- Only participating nursing facilities receive satisfaction survey data and other feedback for quality improvement, and
- Non-participating facilities could not be included in the public reporting if there is no available data.

To the extent that NF P4P incentive payments are weighted by Medicaid days, nursing facilities with low Medicaid participation would not receive significant financial incentives. The provider representatives on the Advisory Committee felt that most nursing facilities would want to participate, even those with relatively low Medicaid participation. Provider representatives also recommended that non-Medicaid facilities have the opportunity to participate in the public reporting component of the program.

However, the reporting burden on nursing facilities is a potential disincentive to participation. Participation in resident/family and employee satisfaction surveys was mentioned by provider reps as a particular burden even for those who already use satisfaction surveys. DMAS would need to select a standard survey tool for statewide use. Some nursing facilities already use one, two or even three surveys for various purposes and this survey could be a different instrument from one they already use. Even with the state paying for the survey, cooperating with the administration of the survey demands scarce resources in the nursing facility. There may also be other data reporting requirements in addition to currently available data.

Both the Health Reform Commission and the Advisory Committee recommended a participation incentive to encourage maximum participation in the program. DMAS recommends a participation incentive equal to \$0.25 per Medicaid bed day to be paid for one year to nursing facilities who participate in the resident/family and employee survey and other data reporting requirements. Given the proposed implementation schedule, these payments would be made from July 1, 2008 through June 30, 2009.

4. Evaluation

DMAS intends to continually review and update the program and report annually. In addition, DMAS feels that it is important to do an independent evaluation. The Health Reform Commission also recommended this.

There has been limited evaluation of existing NF P4P programs. This is not surprising since most programs are relatively new. DMAS is not aware, however, of any evaluations being planned except for the Medicaid demonstration program, which has been delayed. Medicare is proposing to put nursing facilities into a control group and a demonstration group.

Before its NF P4P program was discontinued, Texas did a formal evaluation to determine if the program accurately measured quality performance and determined that it did. Texas only used survey measures and MDS-based quality measures to determine quality but was considering adding additional measures.

In addition to evaluating whether the program accurately measures quality, it would be important to evaluate whether the NF P4P program acts as a positive incentive to improve quality either overall or for a subset of nursing facilities. DMAS would also want to know the relative impact of non-financial and financial incentives, including the size of the financial incentive.

An evaluation would not be completed until after the program was in operations for several years. DMAS, however, may want to contract for this evaluation at the beginning so that the evaluation could be designed.

5. Budget

There are three components of a budget proposal for NF P4P program.

- Administering the program
- Provider Payments
 - Participation Incentive Payments
 - Quality Incentive Payments
- Independent Evaluation

The timing of each component varies. DMAS will incur administrative costs first for developing, implementing and managing the NF P4P program, prior to making any provider payments. The independent evaluation would be an administrative cost incurred only after several years of experience with provider payments.

Due to the complexity of the NF P4P program, DMAS has recommended contracting for its administration beginning in FY09, including the cost of resident/family and employee satisfaction surveys and public reporting of NF performance. In addition, DMAS recommends one additional FTE in FY09 to manage the contract and to assist with data that DMAS has. The administrative cost is itself a significant, but necessary, investment. DMAS has estimated an administrative cost of \$762,834 (\$381,417 GF) in FY09.

There are two types of costs associated with provider payments. The first cost is the proposed participation incentive, payable in FY09. Assuming 95% participation, the total cost of a participation incentive equal to \$0.25 per Medicaid bed day would be \$1.5 million (\$750,000 GF).

The most significant cost of a NF P4P program is the quality incentive payments to nursing facilities. DMAS presented to the Advisory Committee a payment plan based on funding equal to 1% of base reimbursement, equivalent to \$10.8 million (\$5.4 million GF) in FY09. Provider representatives on the Advisory Committee, however, believe that in order to provide sufficient incentive, the funding for provider quality incentive payments should be 3% to 5% of base reimbursement.

In support of the higher payments, provider representatives note that Medicaid reimbursement overall only covers 93% of Medicaid allowable cost, though this percentage varies significantly by individual provider. Provider representatives also noted that incentives for poor performing facilities to improve need to be significant since poor quality is often linked to financial problems.

DMAS recommends initial funding equal to 1% of base reimbursement in the prior year and an additional 1% of base reimbursement when payments for improvements are implemented. Due to the phased implementation, however, there would only be a small cost for provider payments in the 2008-10 biennium. Assuming that the quality incentive pool is distributed semiannually and the program performance period starts on July 1, 1009, approximately \$5.4 million (\$2.7 million GF) in funding will be needed in FY10. Cost would significantly increase in the 2010-12 biennium.

The Governor and the General Assembly could increase the funding either initially or after several years of experience. A decision on additional funding could be dependent on the independent evaluation. Additional funding would be justified if the evaluation indicates that the program is working to improve quality and that higher incentives are likely to further increase quality.

DMAS has noted that the provider payments could have an unintended inflationary impact, because the reimbursement methodology is tied to provider costs. If providers increase expenditures to maintain or improve quality, it will increase their reimbursement in the following year, subject to the ceilings. In addition, over time

this could also increase the median cost per day, which would increase the ceilings over what they would have been, since the ceilings are a percentage of median cost. DMAS intends to adjust for this inflationary impact unless directed not to. The inflationary impact could be considered a positive side effect of the NF P4P program in that it is an indirect result of increased spending on quality.

The Advisory Committee also emphasized the importance of stable funding for provider payments. Incentive programs are not effective unless the funding is stable. Stable funding is as important as the amount. Also, funding for the NF P4P program should not come at the expense of base reimbursement. The Health Reform Commission recommended that funding would be in addition to current reimbursement.

The final component of the budget for a NF P4P program is an independent evaluation. DMAS recommends that this be done after three years of program operation and estimates that it will cost \$200,000 (\$100,000 GF).

The Advisory Committee discussed budget alternatives to reduce the cost. The program (and associated costs) could be phased in more slowly without affecting the ultimate objective. DMAS could do more of the program internally, except satisfaction surveys, rather than contract out the whole project. Doing more of the project internally is likely by itself to slow the phase in.

The participation incentive could be reduced or eliminated but that could affect participation. Charging nursing facilities to offset the cost of the surveys would most likely reduce participation, even though this would be an allowable cost that DMAS would reimburse. Eliminating satisfaction surveys would reduce the cost but would eliminate a key criteria according to the Advisory Committee. The program could start with criteria based on currently available data or new data that could be collected at low cost, however, and add satisfaction surveys at a later date.

APPENDIX 1 – Pay-For-Performance Advisory Committee Members

Name	Agency/Organization
Madge Bush	AARP of Virginia
Bob Gerndt	Bedford County Nursing Home (VANHA)
Linda McCauslin	Medical Facilities of America (VHCA)
Dan Estes	Mission Texas Corporation (VHCA)
Aryana Khalid	Office of the Secretary of Health & Human Resources
Joani Latimer	State Long-Term Care Ombudsman
Dana Parsons	Virginia Association of Non-Profit Homes for the Aging (VANHA)
Hobart Harvey	Virginia Health Care Association (VHCA)
Chris Bailey	Virginia Hospital and Healthcare Association (VHHA)
Bruce Robertson	Sentara Nursing Homes (VHHA)
Connie Kane	Virginia Department of Health
Betty Hudnall	Virginia Department of Health
Mary Huynh	Virginia Department of Health
Janet Lynch/Carla Thomas	Virginia Health Quality Center
Al Shrieves	Virginia Health Services (VHCA)
Kathy Pryor	Virginia Poverty Law Center
Michael Tweedy	Department of Planning and Budget
Cindi Jones	DMAS
Terry Smith	DMAS, Long-Term Care
William Butler	DMAS, Long-Term Care
Carla Russell	DMAS, Provider Reimbursement
Diane Hankins	DMAS, Provider Reimbursement
William Lessard	DMAS, Provider Reimbursement
Scott Crawford	DMAS

APPENDIX 2 - Nursing Home Compare

The data on the Nursing Home Compare website describes nursing home characteristics, quality measures, inspection results, and nursing staff information and the information by nursing home is available on databases that can be downloaded. The data come from two sources: CMS' Online Survey, Certification, and Reporting (OSCAR) database for everything but quality measures and the Minimum Data Set (MDS) for quality measures.

2.1 Nursing Home Characteristics

The information in the CMS OSCAR database contains demographic data that is prepared by each nursing home at the beginning of the regular State inspection. It is reviewed by nursing home inspectors, but not formally audited to ensure data accuracy.

2.2 Nursing Home Quality Measures

CMS notes that the quality measures have four intended purposes:

1. to give information about the care at nursing homes to help choose a nursing home for yourself or others,
2. to give information about the care at nursing homes where an individual or family member already live,
3. to get interested parties to talk to nursing home staff about the quality of care, and
4. to give data to the nursing home to help them with their quality improvement efforts.

The current quality measures have been chosen because each can be measured and do not require nursing homes to prepare additional reports. The measures are valid and reliable and show ways in which nursing homes differ from one another. The quality measures have been independently validated and are based on the best research currently available. A benefit derived from reporting these quality measures is the ability for nursing homes to concentrate efforts to improve their percentages.

Some MDS items used to calculate the quality measures consider the resident's condition during previous days prior to the assessment date. This data is used to develop quality measures shared in CMS' Nursing Home Compare website. The following table provides the quality measures and the observation or "look back" time frames listed on the Nursing Home Compare site.

Quality Measures	MDS Observation Time Frame *
Percent of Long-Stay Residents Given Influenza Vaccination During the Flu Season	October 1 thru March 31
Percent of Long-Stay Residents Who Were Assessed and Given Pneumococcal Vaccination	Looks back 5 years
Percent of Long-Stay Residents Whose Need for Help With Daily Activities Has Increased	Looks back 7 days
Percent of Long-Stay Residents Who Have Moderate to Severe Pain	Looks back 7 days

Table 3: CMS Nursing Home Compare Long-Stay Measures and Observation Time Frame.	
Quality Measures	MDS Observation Time Frame *
Percent of High-Risk Long-Stay Residents Who Have Pressure Sores	Looks back 7 days
Percent of Low-Risk Long-Stay Residents Who Have Pressure Sores	Looks back 7 days
Percent of Long-Stay Residents Who Were Physically Restrained	Looks back 7 days
Percent of Long-Stay Residents Who are More Depressed or Anxious	Looks back 30 days
Percent of Low-Risk Long-Stay Residents Who Lose Control of Their Bowels or Bladder	Looks back 14 days
Percent of Long-Stay Residents Who Have/Had a Catheter Inserted and Left in Their Bladder	Looks back 14 days
Percent of Long-Stay Residents Who Spent Most of Their Time in Bed or in a Chair	Looks back 7 days
Percent of Long-Stay Residents Whose Ability to Move About in and Around Their Room Got Worse	Looks back 7 days
Percent of Long-Stay Residents with a Urinary Tract Infection	Looks back 30 days
Percent of Long-Stay Residents Who Lose Too Much Weight	Looks back 30 days

Table 4: CMS Nursing Home Compare Short-Stay Measures and Observation Time Frame.	
Quality Measures	MDS Observation Time Frame *
Percent of Short-Stay Residents Given Influenza Vaccination During the Flu Season	October 1 thru March 31
Percent of Short-Stay Residents Who Were Assessed and Given Pneumococcal Vaccination	Looks back 5 years
Percent of Short-Stay Residents With Delirium	Looks back 7 days
Percent of Short-Stay Residents Who Had Moderate to Severe Pain	Looks back 7 days
Percent of Short-Stay Residents With Pressure Sores	Looks back 7 days

*When multiple MDS items with more than one "look back" timeframes are used to calculate the measure, this table displays the longest "look back" timeframe.

2.3 Nursing Home Inspections

Survey deficiency data is recorded in the CMS Online Survey Certification and Reporting (OSCAR) system. The information on the Nursing Home Inspections database contains health inspections that determine whether its nursing homes meet the minimum Medicare and Medicaid quality and performance standards. The State conducts inspections, on average about once a year, of each nursing home that participates in Medicare and/or Medicaid. However, if the nursing home is performing poorly, the State inspectors may conduct more frequent inspections. In addition, the State also investigates complaints about nursing home care. Data contained in the Nursing Home Inspections database include the current and previous two health and fire safety inspections for each nursing home. The deficiencies can be categorized into two types, annual health inspection and annual fire safety inspections; and, complaint inspections. Deficiencies are

identified during a nursing home's annual health or fire safety inspection whereas complaint deficiencies are identified before or after the annual inspection. The database lists the alphabetic code for the severity of each deficiency, representing the combination of the scope and the level of harm.

2.4 Health Inspections

During the nursing home inspection, the State looks at many aspects of quality including resident care processes, staff/resident interaction, and the environment. The inspection team interviews a sample of residents and family members about their life within the nursing home, and interviews caregivers and administrative staff, and reviews clinical records.

The inspection team consists of trained inspectors, including at least one registered nurse. This team evaluates whether the nursing home meets individual resident needs. In addition, fire safety specialists evaluate whether a nursing home meets standards for safe construction. When an inspection team finds that a home does not meet a specific regulation, it issues a deficiency citation.

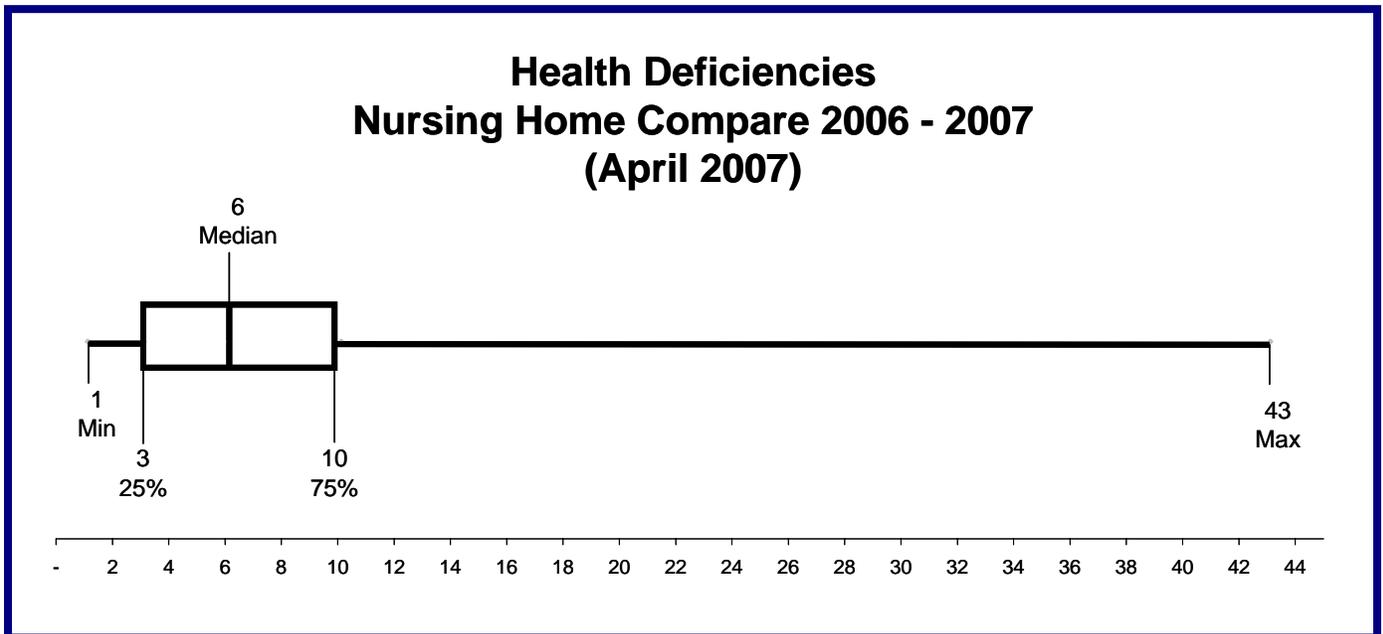
Many regulatory standards are examined that cover a wide range of aspects of resident life, from specifying standards for the safe storage and preparation of food to protecting residents from physical or mental abuse or inadequate care practices.

The total number of nursing homes with health inspections in calendar years 2006 through 2007 was two hundred forty-two (242.) Virginia results indicate that four (4) facilities received five (5) health deficiencies greater than or equal to H in calendar years 2006 and 2007. The total number of health deficiencies reported during this time-frame was 1,787.

The eight (8) HEALTH deficiency categories used are:

- Mistreatment Deficiencies
- Quality Care Deficiencies
- Resident Assessment Deficiencies
- Resident Rights Deficiencies
- Nutrition and Dietary Deficiencies
- Pharmacy Service Deficiencies
- Environmental Deficiencies
- Administration Deficiencies

Figure 7: Health Deficiencies Reported on Nursing Home Compare (April 2007).



Fire Safety Inspections

The Fire Safety inspection covers a wide range of aspects of fire protection, including construction, protection and operational features designed to provide safety from fire, smoke, and panic. When an inspection team finds that a nursing home does not meet a specific regulation, it issues a deficiency citation.

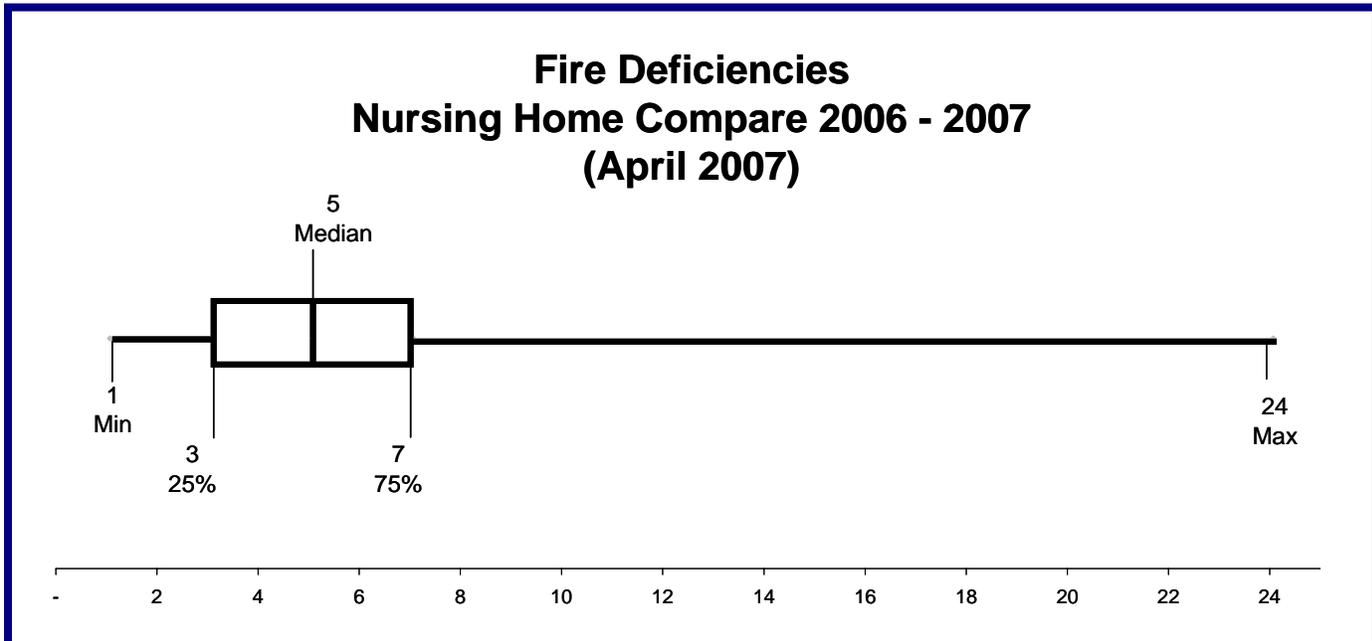
The total number of nursing homes with Fire Safety inspections in calendar years 2006 through 2007 was one hundred ninety (190.) Virginia results indicate that four (4) facilities received six (6) fire safety deficiencies greater than or equal to severity level H. The total number of fire safety deficiencies reported in calendar years 2006 and 2007 was 1,031.

The nineteen (19) FIRE SAFETY deficiency categories used are:

- Building Construction
- Interior Finish
- Corridor Walls And Doors
- Vertical Openings
- Smoke Compartmentation and Control
- Hazardous Area
- Exit and Exit Access
- Exits and Egress
- Illumination And Emergency Power
- Emergency Plans And Fire Drills
- Fire Alarm Systems
- Automatic Sprinkler Systems
- Smoking Regulations
- Building Service Equipment
- Furnishings and Decorations

- Laboratories
- Medical Gases and Anesthetizing Areas
- Electrical Deficiencies
- Miscellaneous

Figure 8: Fire Deficiencies Reported on Nursing Home Compare (April 2007).



Resident Complaints

Resident complaints are also investigated by the investigation team which can result in citations and penalties.

Nursing Home Staffing

CMS collects staffing data from its state survey agency that represents the nursing home's nursing staff hours for a two-week period prior to the time of the state inspection. CMS converts the nursing staff hours reported by the nursing home into the number of staff hours per resident per day. Total nursing staff hours per resident per day, RN, LPN/LVN and CNA hours per resident day are reported in the download database. The calculation of hours per resident per day is the average amount of hours worked divided by the total number of resident days. The information is reviewed by nursing home inspectors, but not formally audited to ensure data accuracy.

Improvements in the collection of nursing home staffing data are planned in FY 2007. CMS will:

- (a) complete the analysis of what would be required for a reporting system that is based on payroll data transmitted electronically to CMS,
- (b) design a payroll database extract system for use in the Nursing Home Value-Based Purchasing Demonstration,
- (c) initiate a feasibility study of the national use of the payroll database extract, and
- (d) improve the comprehensiveness of the staffing information on NHC by collecting information on staff turnover and retention.

Action steps related to collecting information derived from payroll data are part of a longer term strategy to improve accuracy of the data compared to the current Online Survey, Certification, and Reporting (OSCAR)-based system. Collection of information on staff turnover will provide a broader range of information to consumers. (2007 Action Plan for *Further Improvement of* Nursing Home Quality (September 2006))

APPENDIX 3 - Advancing Excellence in America’s Nursing Homes

The *Advancing Excellence in America’s Nursing Homes* campaign is designed to complement what your facility may already be doing as part of Quality First, the Nursing Home Quality Initiative (NHQI), or work with your local Quality Improvement Organization (QIO). The campaign brings these initiatives together along with consumer support, new resources, and more ways to help foster continuing quality improvement for your residents and staff.

While your participation in the campaign may not change your current focus and efforts if you are already committed to Quality First or working with the QIOs, joining the campaign is not automatic—**sign up today at www.nhqualitycampaign.org**.

Goal / Aspect of the campaign	Advancing Excellence in America’s Nursing Homes	Quality First (AHCA, AAHSA, The Alliance)	Nursing Home Quality Initiative (CMS)**	Culture Change*	AMDA-F LTC Quality Improvement Study
Voluntary participation	X	X		X	X
Reduce incidence of pressure ulcers	X	X	X		X
Reduce use of restraints	X	X	X		
Reduce pain in long-stay residents	X	X	X		X
Reduce pain in short stay residents	X	X	X		X
Set targets for clinical quality improvement	X		X		X
Measure resident and / or family satisfaction and incorporate into care plan	X	X	X	X	
Measure staff turnover and develop plans to improve staff retention	X	X	X	X	
Adopt “consistent assignment” of CNAs	X			X	

* Nursing home culture change concepts, moving from an institutional care to individualized/patient-centered care will, in many instances, positively impact the quality of clinical care in a variety of areas for nursing home patients.

** While participation in quality data reporting (Nursing Home Compare) for the NHQI is not voluntary, working with the Virginia Health Quality Center to improve quality of care is a voluntary initiative, and is highly encouraged.

APPENDIX 4 - A Description Of Various NF P4P Programs

4.1 Iowa

Iowa's Nursing Home Pay-For-Performance program began in 2002 and uses ten (10) accountability measures to award points that can earn nursing facilities additional dollars per resident day. Iowa's program does not currently use any MDS-based quality indicators (QIs), because at the time their system was implemented, the quality indicators were relatively new and were not considered for inclusion. In order for a nursing home to qualify for additional Medicaid reimbursement based on accountability measures, it must achieve a minimum score of 3 points out of the 12 maximum available points. Additional Medicaid reimbursement will be available in the following amounts:

0 – 2 points	No additional reimbursement	\$0 per day
3 – 4 points	1% of the direct care and non-direct care medians	\$.95 per day
5 – 6 points	2% of the direct care and non-direct care medians	\$1.91 per day
7 or more points	3% of the direct care and non-direct care medians	\$2.86 per day

Scores are calculated on each facility's data compared to established criteria. Listed below are brief descriptions of each measure and the criteria required to achieve the measure.

Measure #1. Deficiency Free Survey – Based on the latest annual survey completed on or before December 31, 2001 and any subsequent surveys completed between the annual survey date and December 31, 2001. Point value equals 2.

Measure #2. Substantial Compliance with Survey - Based on the latest annual survey completed on or before December 31, 2001 and any subsequent surveys completed between the annual survey date and December 31, 2001. Point value equals 1.

Measure #3. Nursing Hours Provided – Based on a nursing facility's case mix adjusted nursing hours per patient day. For nursing facilities with nursing hours per patient day at or above 3.204 hours (50th percentile) and below 3.691 hours (75th percentile), the point value is equal to 1. For nursing facilities at or above 3.691 hours, the point value is equal to 2.

Measure #4. Resident Satisfaction – Measured using the Resident Opinion Survey – Form 470-3890. Nursing facilities with an average score of 4.066 (50th percentile) or greater receive 1 point.

Measure #5. Resident Advocate Committee Resolution Rate – Nursing facilities that have a resident advocate committee resolution rate of 60% or greater receive 1 point.

Measure #6. High Employee Retention Rate – Nursing facilities that have an employee retention rate of 72.7273 (50th percentile) or greater receive 1 point.

Measure #7. High Occupancy – Nursing facilities with occupancy at or above 95% receive 1 point.

Measure #8. Low Administrative Costs and Low Utilization of Contracted Nursing – Nursing facilities with per patient day administrative costs of \$10.82 (50th percentile) or less and no contracted nursing (50th percentile) receive 1 point.

Measure #9. Special Licensure Classification – Nursing facilities with units licensed for the care of residents with chronic confusion or dementing illness (CCDI units) receive 1 point.

Measure #10. High Medicaid Utilization – Nursing facilities with Medicaid utilization at or above 50.41% receive 1 point.

In addition, nursing homes are awarded one or two points based on nursing hours per resident day (for RNs, LPNs, rehabilitation nurses, nurse aides, and contracted nursing services). Homes receive one point for staffing that falls between the 50th and 75th percentile and two points if staffing is at or above the 75th percentile. Homes can receive one point if their staff retention rate is more than 72.73 percent. A case mix index based on Resourced Utilization Group (RUG-III) is used to adjust for differences in resident acuity.

4.2 Kansas

In 2002, the Kansas Department on Aging (KDOA) developed the Promoting Excellent Alternatives in Kansas (PEAK) Nursing Homes initiative to promote “culture change” in nursing homes through recognition and education. The PEAK initiative uses a two-prong approach, recognizing nursing home providers which have made innovative changes in the way long-term care is delivered and educating those who are desirous of creating change. Innovations in the domains of resident control, staff empowerment, home environment, and community involvement are recognized annually by KDOA. Education is provided through a contract with Kansas State University's (KSU) Galichia Center on Aging to develop and produce culture change resources for nursing homes.

The Nursing Home Quality and Efficiency Outcome Incentive Factor is a component of the Kansas Medicaid nursing home rate setting methodology. The quality and efficiency factor was implemented on July 1, 2005 to provide a monetary incentive for favorable outcomes in the following areas: direct care staffing; operating costs; direct care staff turnover; staff retention; total occupancy; Medicaid occupancy; and, Medicaid certification survey results. Thirty-eight percent of the nursing home providers received a quality incentive factor of \$1.00, \$2.00 or \$3.00 in their Medicaid per diem rate.

4.3 Minnesota

Minnesota's original and current proposed "value-based" reimbursement (VBR) system includes several staffing measures. The current proposed system has reduced the staffing component – the staffing level measure was dropped altogether, staff retention was increased to 25 percent; staff turnover increased to 15 percent and pool use increased to 10 percent. In the original proposed system, staffing measures accounted for 63 percent of nursing homes' score with MDS indicators only 14 points out of the total possible 100. The current proposed system has brought these two measures more in balance with staffing accounting for 50 percent of the payment and MDS-based indicators 40 percent. In both systems, staffing remains much more heavily weighted than survey deficiencies, which count for a maximum of only 10 points (Minnesota, DHS, 2004). The staffing level performance measure is adjusted for case mix using the nursing home's average case mix index under the RUG-III system used by the state.

4.4 Texas

Under Texas' Performance-Based Add-On (PBAO) program (2001 – 2002), fifty (50) percent of a nursing home's per diem add-on payment was based on performance on the MDS quality indicators. The other 50 percent was based on survey compliance. Texas used twenty-four (24) Center for Health System Research and Analysis (CHRSA) Quality Indicators to determine resident outcomes. Two indices were used to describe resident outcomes: 1) Potential Advantages Score that reflected the number of QIs in which a nursing home appears to have better resident outcomes than 90 percent of Texas homes and 2) Potential Disadvantages that reflected the number of QIs in which a nursing home appears to have worse resident outcomes than 90 percent of Texas homes. The Texas PBAO program was discontinued due to a State budget shortfall.

4.5 Oklahoma

Oklahoma Health Care Authority's Focus on Excellence Program will use regularly-collected nursing home performance data to award "star" ratings and additional incentives included in a home's Medicaid payment rates. Both the star ratings and Medicaid payment rates will be recalculated every 90 days. The Focus on Excellence program was designed to accomplish three purposes: (1) enable additional Medicaid payments to nursing homes that meet or exceed any of ten separate performance targets; (2) provide information to support a public star rating system for use by consumers in evaluating homes; and (3) to give providers the technology and tools to set and meet their own quality improvement goals and compare their performance to homes across the state and the nation. Primary management responsibility for the program was awarded to My InnerView, Inc., the national quality data management firm selected by the Authority as its contractor through a competitive process conducted in November 2006.

APPENDIX 5 - Measure Types Used In Nursing Home Pay-For-Performance Payment Systems

Resident Outcomes (MDS Quality Measures)

General Description and Rationale for Inclusion: During their stay in a nursing home, residents are assessed by the facility staff. This assessment is called a Minimum Data Set (MDS) Assessment and is performed at admission, quarterly, annually and whenever the resident experiences a significant change in status. This extensive assessment includes many items such as: diagnosis; the ability to do certain tasks such as get in and out of bed, walking, eating, bathing, toileting, et.; clinical conditions such as the presence of sores, wounds or cuts on the body; use of certain types of medications; dehydration; mental functioning; and certain cares and treatments provided to the resident.

Resident Outcomes (MDS Quality Measures)		
Pros	Cons	Comments and Issues
<ul style="list-style-type: none"> • These are direct outcome measures. • MDS data is readily available. • Performance is in control of provider. 	<ul style="list-style-type: none"> • According to studies, only a small number are statistically valid and reliable. • Studies reveal contradictory findings with regard to the validity of some currently available MDS QMs. • Self-reported data where inconsistencies or misinterpretation of measures could exist. • DMAS does not currently extract all the MDS variables that might be used in calculating quality measures. 	<p><u>Selecting MDS-based Quality Measures</u> CMS currently posts 19 MDS-based quality measures (QMs) on its Nursing Home Compare web site available to the public (14 long-stay measures and 5 short stay measures). When Abt reviewed these quality measures for the Medicare NH P4P demonstration it recommended only 5 out of the 14 long-stay measures from the CMS Nursing Home Compare and 3 short-stay QMs proposed by another CMS contractor that met the following criteria:</p> <ul style="list-style-type: none"> ▪ Are valid and reliable. ▪ Are under the nursing home's control. ▪ Have good statistical performance. ▪ Reflect important societal values. <p>Abt recommended not using 8 long-stay measures and 4 short-stay measures on Nursing Home Compare for various reasons. Abt did not include pain with the other recommended MDS-based QMs because of concerns about differences across nursing homes in how they assess pain. Abt, however, has recommended further consideration of a long-stay and short-stay QM for pain.</p> <p>In contrast to the Abt recommended approach for the Medicare NH P4P demonstration (a few valid and reliable MDS items), Texas and Minnesota use a large number of MDS QMs. The cumulative results could still be valid and reliable. Texas Performance Based Add-On Program (2001 – 2002) used 24 QMs developed by the Center for Health Systems Research and Analysis (CHSRA) and combined above average scores with below average scores. Minnesota Value-Based Reimbursement, which was implemented 10-1-06, uses 23 QMs recommended from a variety of sources (UMN research team, CMS Nursing Home Compare, CHSRA, Brown University, Abt Associates).</p> <p><u>Selecting Change or Prevalence Measures</u> Some QMs measure change while others measure prevalence.</p> <p><u>Measuring Quality for Long-stay and/or Short-stay Residents</u> Since Medicaid recipients are primarily long-stay, it may not add value to develop criteria for short-stay residents and would complicate the calculation. Many Medicaid nursing homes are not dual-certified for Medicare residents. But some Medicaid nursing homes, particularly hospital-based nursing homes, primarily serve short-stay residents.</p> <p><u>Measurement Issues</u> Calculating many of the potential QMs, especially the most sophisticated ones are not straightforward. Many of them measure differences between recent quarters. Others exclude some assessments or risk-adjusted. DMAS does not currently extract all the MDS data needed to calculate the QMs as currently specified. Calculating them may be difficult to do in house. DMAS may be able to obtain them from CMS or some other source on a timely basis.</p> <p>Not clear whether MDS scores are measured once (at the end of the performance period) or multiple times (quarterly) and averaged.</p>

Staffing Levels

General Description and Rationale for Inclusion: There is strong evidence that low nurse staffing levels seriously compromise quality of care. Based on previous studies, higher staffing levels in nursing homes have been found to be associated with fewer hospitalizations, fewer infections, fewer pressure ulcers, less skin trauma, less weight loss, decreased resistance to care, and higher levels improved functional status. Several Pay-For-Performance programs (Iowa, Kansas, and Minnesota) use staffing-related performance measures. The two most frequently used are total nursing hours per resident day and turnover percentage for nursing staff.

Pros	Cons	Comments and Issues
<p>Nursing hours</p> <ul style="list-style-type: none"> • CMS reported a relationship between staffing (particularly RNs) and a variety of outcomes, including: <ul style="list-style-type: none"> – lower death rates, – higher rates of discharges to home, – improved functional outcomes, – fewer pressure ulcers, – fewer urinary tract infections, – lower urinary catheter use, and – less antibiotic use. ▪ Nurse staffing data available on annual nursing home wage survey and cost report. 	<ol style="list-style-type: none"> 1. Shortage of RNs, LPN, and CNAs currently exist. Problem is aggravated if shortage is unevenly distributed. 2. Data is self-reported and not currently audited. 3. Variations between facilities in the needs of residents (can adjust for). 4. There are very large differences in RN staffing levels for the two nursing home types, hospital-based and free-standing. 5. A small percentage of nursing facilities do not respond to annual survey. 6. Turnover or retention data not currently collected. 7. Many people feel that turnover has a major negative impact on quality but research has not definitely demonstrated a relationship between nursing home staff turnover and quality of care (Abt Associates). 	<p><u>Selecting Staffing Measures</u> <i>All but one program has used multiple staffing criteria.</i></p> <p>Abt recommends using RN hours per resident day, total nursing hours per resident day, and turnover percentage for nursing staff for the Medicare NH P4P demonstration. RN staffing levels may not be as important for Medicaid population as Medicare population. Minnesota Value-Based Reimbursement program includes weighted direct care staff hours per resident day (Minnesota also counts non-nursing direct care staff), direct care staff turnover, direct care staff retention, and use of temporary/pool staff. Iowa awards one or two points (out of a total of 12 possible) based on total nursing hours per resident day. Kansas uses direct care staffing, direct care staff turnover, staff retention. Texas Performance Based Add-On Program (2001 – 2002) did not use any staffing measures due to a lack of current and audited staffing information at the time but Texas has an alternative voluntary Direct Care Enhancement Program that provides additional funds for homes whose staffing levels exceed the state average.</p> <p><u>Measurement Issues</u> DMAS currently collects staffing on a calendar year basis or a provider fiscal year basis, which would be inconsistent with a program based on the state fiscal year.</p> <p>When combining different staff types, DMAS might consider weighting the different skill levels. Minnesota, for example, gives a weight of 1 for CNAs and higher weights to higher qualified staff. Abt recommends a lower weight for agency staff.</p> <p>Most programs case mix adjust the staffing results for each nursing home. DMAS could do that using nursing facility case mix scores.</p> <p>CMS found when examining ratios of nurses to residents that there was a pattern of incremental benefits of increased staffing until a threshold was reached at which point there were no further significant benefits with respect to quality when additional staff were utilized.</p> <p>May need to consider separate scoring if hospital based nursing homes are included.</p> <p>Turnover and/or retention data could be added to the annual nursing home wage survey.</p> <p>DMAS may need to begin to audit this. One way to do this would be to make sure that data reported on the wage survey is consistent with data reported on the cost report. It would mean asking NFs who do not have a 12/31 FYE to report the wage survey information in two periods.</p>

Survey Deficiencies

General Description and Rationale for Inclusion: All nursing homes that participate in Medicare or Medicaid must have a certification survey on a regular basis (on average once every 12 months) to ensure that they meet certain federal requirements. There are a total of 190 different requirements (categorized into 17 major areas e.g., nursing, physical environment, kitchen/food service, quality of care, quality of life, resident behavior; nursing home practices, etc.). The surveys provide a snapshot of a nursing home's quality of care at the time of the survey. When a nursing home fails to meet a specific requirement, the nursing home receives a letter deficiency based on scope and severity (see table below). Survey deficiency data is recorded in the CMS Online Survey Certification and Reporting (OSCAR) system. Survey deficiencies may be used in two ways:

3. As a screening measure that would disqualify any nursing home that, in the evaluation period, received a citation for substandard quality of care. This screening criterion would help to ensure that homes with otherwise good performance would not receive any performance payment as a result of the serious quality of care issues identified by surveyors.
4. As part of a nursing home's performance scores.

Pros	Cons	Comments and Issues																								
<ul style="list-style-type: none"> • CMS' survey represents the minimum federal requirements. These surveys evaluate the quality of care and services provided by nursing homes, as well as the nursing home's building, equipment, staffing, policies, procedures and finances. • Survey results should be easy to access. • Several other rating systems have been developed to rank nursing home performance based on survey deficiencies allowing for choices of this measurement type (American Health Care Association, 2003). <p style="text-align: center;">Used in all rating systems.</p>	<ul style="list-style-type: none"> • Scoring may be inconsistent among surveyors who assign a scope and severity rating for each deficiency. • Timing and posting of survey deficiency data results may not correlate with evaluation period. • Focus on the negative. 	<p><u>Selecting Survey Deficiency Measures</u> Abt recommends excluding any nursing home with substandard quality of care. According to Abt, shaded cells denote a deficiency level that constitute substandard quality of care if it involves a requirement related to resident behavior and nursing home practices, quality of life or quality of care. Nationally, about 25% of nursing homes have substandard quality of care using this standard. To measure performance, Abt recommends measuring all deficiencies using an escalating weighted scale (no points for A-C; 2-6 points for D-F, 10-30 for G-I; and 50-150 for J-L).</p> <table border="1" data-bbox="772 751 2032 922"> <thead> <tr> <th data-bbox="772 751 1430 781">Severity</th> <th colspan="3" data-bbox="1430 751 2032 781">Scope</th> </tr> <tr> <th data-bbox="772 781 1430 810"></th> <th data-bbox="1430 781 1577 810">Isolated</th> <th data-bbox="1577 781 1801 810">Pattern</th> <th data-bbox="1801 781 2032 810">Widespread</th> </tr> </thead> <tbody> <tr> <td data-bbox="772 810 1430 839">Immediate jeopardy to resident harm or safety</td> <td data-bbox="1430 810 1577 839" style="background-color: #cccccc;">J</td> <td data-bbox="1577 810 1801 839" style="background-color: #cccccc;">K</td> <td data-bbox="1801 810 2032 839" style="background-color: #cccccc;">L</td> </tr> <tr> <td data-bbox="772 839 1430 868">Actual harm that is not immediate jeopardy</td> <td data-bbox="1430 839 1577 868">G</td> <td data-bbox="1577 839 1801 868" style="background-color: #cccccc;">H</td> <td data-bbox="1801 839 2032 868" style="background-color: #cccccc;">I</td> </tr> <tr> <td data-bbox="772 868 1430 898">No actual harm but potential for more than minimal harm</td> <td data-bbox="1430 868 1577 898">D</td> <td data-bbox="1577 868 1801 898" style="background-color: #cccccc;">E</td> <td data-bbox="1801 868 2032 898" style="background-color: #cccccc;">F</td> </tr> <tr> <td data-bbox="772 898 1430 927">No actual harm with potential for only minimal harm</td> <td data-bbox="1430 898 1577 927">A</td> <td data-bbox="1577 898 1801 927" style="background-color: #cccccc;">B</td> <td data-bbox="1801 898 2032 927" style="background-color: #cccccc;">C</td> </tr> </tbody> </table> <p>Minnesota scores deficiencies on seventeen requirements considered directly important to quality care (physical restraints, chemical restraints, abuse, dignity, choice of activities and schedules, ADLs, maintain or improve physical abilities, pressure sores, catheters, bladder treatment, NG tubes, nutrition, hydration, drug prescribing, antipsychotic drug use, medication errors, sufficient staff). Minnesota determined two levels of compliance: all deficiencies below level E and 5 and all deficiencies below level H.</p> <p>Iowa determined two levels of compliance: "deficiency free" and "regulatory compliance" (no on-site revisit required). Kansas determined two levels of compliance: "deficiency free" and no substandard care deficiencies with no more than five total deficiencies. Texas determined three levels of regulatory compliance: deficiency-free, substantial compliance (no deficiency greater than C), minimum acceptable level of compliance (no deficiency greater than F). Texas also disqualified a nursing home with substandard quality of care (see Abt above).</p> <p><u>Measurement Issues</u> Every nursing home may not have a survey during the 12 month performance period. Can use the most recent survey, but at some point, the available surveys may be too old. May need to work with VDH/CMS. Some NFs will have additional complaint survey(s). Most programs also use complaint survey results since the last regular survey.</p> <p>Assume that DMAS would have access to survey deficiency data. Need to explore with VDH/CMS. If calculating an "average," must give point values to deficiencies. May want to weight survey deficiencies.</p>	Severity	Scope				Isolated	Pattern	Widespread	Immediate jeopardy to resident harm or safety	J	K	L	Actual harm that is not immediate jeopardy	G	H	I	No actual harm but potential for more than minimal harm	D	E	F	No actual harm with potential for only minimal harm	A	B	C
Severity	Scope																									
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No actual harm but potential for more than minimal harm	D	E	F																							
No actual harm with potential for only minimal harm	A	B	C																							

Avoidable Hospitalizations

General Description and Rationale for Inclusion: Nursing home residents are most commonly hospitalized for infections, falls and fractures, and cardiovascular events. Pneumonia, a common nursing home acquired infection, is the leading cause of morbidity, death, and hospitalization in nursing home residents. Studies suggest that careful management of ambulatory care-sensitive conditions (e.g., congestive heart failure, chronic obstructive pulmonary disease, diabetes mellitus, urinary tract infections and pneumonia) may reduce hospitalizations and that as many as 36 percent of emergency department transfers and 40 percent of hospital admissions were inappropriate. Studies also suggest that for some conditions there is no significant difference in outcomes between residents treated in nursing homes and those hospitalized. Furthermore, outcomes for nursing home residents transferred to the hospital may be worse than those who remain in the nursing home.

Pros	Cons	Comments and Issues
<ul style="list-style-type: none"> • Uses hospital claims data • Avoiding hospitalization is a positive benefit to NH residents. 	<ul style="list-style-type: none"> • Complex calculation matching hospitalizations to NH stays. • Nursing homes may avoid necessary hospitalizations. • Nursing homes may avoid sicker patients unless there is a risk adjustment. 	<p><u>Selecting Measures</u> Abt's recommendation for this measurement is based on the premise that the CMS demonstration is to be financed based on the reduction in certain Medicare expenditures achieved across participating homes in each state. Abt notes that the most direct method by which nursing homes can control Medicare expenditures is by reducing hospitalizations. Significantly reducing hospitalization may not save as much money for Medicaid as Medicare because Medicare is the primary payer for hospital care for dual eligible recipients. No other NH P4P plan includes similar criteria.</p> <p>Abt recommends using the list of ambulatory-care sensitive conditions that was developed by the Agency for Healthcare Quality and Research (AHRQ). The AHRQ list of ambulatory-care sensitive conditions was initially developed for community residents and not developed specifically for the nursing home population. These are hospitalizations that stem from medical conditions thought to be largely avoidable and/or manageable (e.g., dehydration, diabetes, congestive heart failure, COPD, urinary tract infection) if they are treated in a timely fashion with access to outpatient physician and other medical support services.</p> <p>Abt recommends separate measures for short-stay (Medicare covered days) and long-stay (Medicaid covered days), but a Medicaid pay-for-performance plan may focus only on long-stay.</p> <p><u>Measurement Issues</u> Need to case mix adjust.</p> <p>Do not give points for very low hospitalization so that nursing homes do not avoid necessary hospitalizations.</p> <p>May not be able to calculate this in house.</p> <p>Nursing home may have too few residents for the hospitalization performance measure to be calculated.</p>

Resident/Family Quality of Life Surveys

General Description and Rationale for Inclusion: Many nursing homes utilize resident, family, and employee satisfactions survey tools in their efforts to improve quality. Nursing home satisfaction represents a multidimensional collection of issues related to various aspects and experiences of the particular group responding (i.e., resident or family). There are a number of resident and family surveys in use (or under development) having been constructed for a variety of purposes – for nursing home selection, for quality improvement initiatives, for public reporting and as a component to adjust reimbursement rates (e.g., provide care-related payment incentives). A number of these instruments have undergone extensive development and testing. About 120 Virginia nursing homes use “My Inner View,” a commercial survey instrument, as a quality improvement tool.

Pros	Cons	Comments and Issues
<ul style="list-style-type: none"> Includes the resident and the resident’s family in a quality-based payment system. 	<ul style="list-style-type: none"> There is no currently available data source in Virginia. Difficult to audit. Resident satisfaction measures process. There is little evidence of a link between process measures and resident outcomes (Abt Associates). Resident surveys are already used by nursing home surveyors to identify possible deficiencies. 	<p><u>Selecting Measurement Criteria</u> Abt recommends consideration of two possible performance measures: nursing home use of resident assessment of care surveys and/or a performance measures derived from the Nursing Home CAHPS (Consumer Assessment of Health Plans Survey) survey once development and testing of this instrument is completed. Domains include global ratings on staff care and nursing home, getting needed care, getting care quickly, staff helpfulness/courtesy and staff communication.</p> <p><u>Minnesota Value-Based Reimbursement</u> program uses a resident satisfaction and quality of life interview on a variety of topics that include comfort, environmental adaptations, privacy, dignity, spiritual well-being, meaningful activity, food enjoyment, autonomy, individuality, security, relationships and mood. Trained interviewers employed by an independent contractor of the state interview a statistical sample of residents in each facility.</p> <p><u>Iowa:</u> Iowa uses a measure of resident satisfaction as an optional measure. Homes must be at or above the 50th percentile of resident satisfaction based on a Resident Opinion Survey (31 items/questions about staff, quality of life, housekeeping, and activities). Homes distribute the survey to their residents for completion and the surveys are returned to an independent entity that compiles the survey results and completes a state form.</p> <p><u>Measurement Issues</u> May be difficult to score nursing home use of resident assessment of care surveys.</p>

APPENDIX 6- Facility Specific Nursing Home Compare Quality Indicators (April 2007)

	Percent of High-Risk Long-Stay Residents Who Have Pressure Sores	Percent of Long-Stay Residents Who Have Moderate to Severe Pain	Percent of Long-Stay Residents Who Have/Had a Catheter Inserted and Left in Their Bladder	Percent of Long-Stay Residents Who Were Physically Restrained	Percent of Long-Stay Residents Whose Ability to Move About in and Around Their Room Got Worse	Percent of Long-Stay Residents Whose Need for Help With Daily Activities Has Increased	
Mean QI Rate	14.047	4.506	5.082	3.407	14.702	19.305	
Best Quality Rate = 20th Percentile	9.000	1.000	3.000	0.000	8.000	12.000	
Low Quality Rate = 90th Percentile	23.000	10.000	8.800	9.000	25.300	30.500	
Maximum Points	16.67	16.67	16.67	16.67	16.67	16.67	TOTAL
Nursing Home Name	Point Scale						

AMELIA NURSING CENTER	16.670	11.100	13.800	9.300	0.000	14.000	64.870
APPOMATTOX HEALTH AND REHABILITATION CENTER	11.900	9.300	5.200	16.670	7.000	16.670	66.740
ARCADIA NURSING & REHAB CENT	10.700	11.100	10.900	5.600	10.200	13.100	61.600
ASHLAND CONVALESCENT CENTER	3.600	11.100	13.800	13.000	11.900	5.900	59.300
AUGUSTA MEDICAL CTR SKILLED CA	10.700	10.200	10.700	10.400	10.200	10.100	62.300
AUGUSTA NRSG & REHAB CTR	4.800	0.000	16.670	0.000	9.000	7.700	38.170
AUTUMN CARE OF ALTAVISTA	0.000	14.800	16.670	0.000	13.800	5.900	51.170
AUTUMN CARE OF GREAT BRIDGE	10.700	13.000	8.000	1.900	16.670	16.670	66.940
AUTUMN CARE OF MADISON	10.700	16.670	0.000	5.600	10.200	16.670	59.840
AUTUMN CARE OF NORFOLK	15.500	16.670	5.200	13.000	2.200	0.000	52.570
AUTUMN CARE OF PORTSMOUTH	11.900	5.600	5.200	0.000	1.300	11.300	35.300
AUTUMN CARE OF SUFFOLK	7.100	5.600	16.670	7.400	10.900	11.300	58.970
AVANTE AT HARRISONBURG	10.700	1.900	13.800	0.000	12.800	15.800	55.000
AVANTE AT LYNCHBURG	3.600	9.300	13.800	0.000	16.670	11.300	54.670
AVANTE AT ROANOKE	13.100	9.300	8.000	11.100	16.670	16.670	74.840
AVANTE AT WAYNESBORO	8.300	13.000	8.000	11.100	16.670	9.500	66.570
BAY POINTE MEDICAL & REHAB CEN	0.000	5.600	0.000	0.000	12.800	5.900	24.300
BAYSIDE HLT CARE CTR	10.700	10.200	10.700	10.400	10.200	10.100	62.300
BEACON SHORES NURSING & REHABILITATION	11.900	1.900	13.800	5.600	16.670	14.000	63.870
BEAUFONT HEALTH CARE CENTER	10.700	10.200	10.700	10.400	10.200	10.100	62.300
BEDFORD CO NURSING HOME	16.670	16.670	16.670	0.000	16.670	3.200	69.880
BELVOIR WOODS HEALTH CARE CENTER	10.700	9.300	5.200	16.670	0.000	3.200	45.070
BENJAMIN BORDEN HEALTH CENTER	10.700	16.670	16.670	16.670	7.000	13.100	80.810
BERKSHIRE HEALTH & REHABILITATION CENTER	8.300	7.400	8.000	14.800	12.800	9.500	60.800
BERRY HILL NURSING HOME	16.670	7.400	16.670	9.300	15.700	0.000	65.740
BETH SHOLOM HOME OF EASTERN VI	9.500	11.100	16.670	16.670	14.700	16.670	85.310
BETH SHOLOM HOME OF VIRGINIA	16.670	16.670	8.000	11.100	7.000	13.100	72.540
BEVERLY HEALTHCARE - FREDERICKSBURG	16.670	13.000	16.670	16.670	3.200	0.000	66.210
BEVERLY LIVINGCENTER -THE CEDARS	16.670	13.000	2.300	13.000	13.800	14.000	72.770
BEVERLY LIVINGCENTER-BATTLEFIELD PARK	9.500	16.670	16.670	13.000	10.900	14.000	80.740
BEVERLY LIVINGCENTER-PETERSBURG	13.100	11.100	16.670	9.300	16.670	16.670	83.510
BEVERLY LIVINGCENTER-SLEEPY HOLLOW	7.100	14.800	10.900	16.670	6.100	0.000	55.570
BIRMINGHAM GREEN	15.500	11.100	16.670	14.800	12.800	13.100	83.970
BLAND COUNTY NURSING & REHABILITATION	10.700	0.000	0.000	16.670	10.200	14.000	51.570

	Percent of High-Risk Long-Stay Residents Who Have Pressure Sores	Percent of Long-Stay Residents Who Have Moderate to Severe Pain	Percent of Long-Stay Residents Who Have/Had a Catheter Inserted and Left in Their Bladder	Percent of Long-Stay Residents Who Were Physically Restrained	Percent of Long-Stay Residents Whose Ability to Move About in and Around Their Room Got Worse	Percent of Long-Stay Residents Whose Need for Help With Daily Activities Has Increased	
Mean QI Rate	14.047	4.506	5.082	3.407	14.702	19.305	
Best Quality Rate = 20th Percentile	9.000	1.000	3.000	0.000	8.000	12.000	
Low Quality Rate = 90th Percentile	23.000	10.000	8.800	9.000	25.300	30.500	
Maximum Points	16.67	16.67	16.67	16.67	16.67	16.67	TOTAL
Nursing Home Name	Point Scale						
CENTER							
BLUE RIDGE NURSING CENTER INC	7.100	13.000	16.670	7.400	1.300	2.300	47.770
BLUE RIDGE REHAB CENT	9.500	11.100	13.800	9.300	9.000	11.300	64.000
BON SECOURS DEPAUL,TCC	10.700	10.200	10.700	10.400	10.200	10.100	62.300
BON SECOURS-MARYVIEW NURSING C	13.100	11.100	13.800	3.700	10.900	11.300	63.900
BOWLING GREEN HEALTHCARE CNTR	15.500	14.800	16.670	16.670	12.800	16.670	93.110
BRANDON OAKS NURSING AND REHABILITATION CENTER	10.700	5.600	5.200	13.000	3.200	7.700	45.400
BRIAN CENTER NURSING CARE/ALLEGHANY	10.700	0.000	0.000	11.100	11.900	15.800	49.500
BRIAN CENTER NURSING CARE/FINCASTLE	10.700	5.600	13.800	5.600	10.200	0.000	45.900
BRIAN CTR HLT & REHAB/SCOTT CO	13.100	16.670	0.000	0.000	10.200	6.800	46.770
BRIDGEWATER HOME , INC.	16.670	7.400	13.800	13.000	16.670	8.600	76.140
BRITTHAVEN OF KEYSVILLE	16.670	14.800	16.670	13.000	14.700	0.000	75.840
BURKE HEALTH CARE CENTER	10.700	11.100	0.000	14.800	0.000	9.500	46.100
CARRIAGE HILL REHAB AND NURSIN	10.700	13.000	13.800	0.000	9.900	8.600	56.000
CARRINGTON PLACE AT BOTETOURT COMMONS	10.700	10.200	10.700	10.400	10.200	10.100	62.300
CARRINGTON PLACE AT WYTHEVILLE - BIRDMONT CENTER	14.300	11.100	10.900	16.670	0.000	0.000	52.970
CARRINGTON PLACE OF CHESAPEAKE,LLC	9.500	11.100	10.900	1.900	16.670	16.670	66.740
CARRINGTON PLACE OF TAPPAHANNOCK	7.100	14.800	16.670	13.000	16.670	16.670	84.910
CARRINGTON,THE	14.300	16.670	10.900	3.700	14.700	8.600	68.870
CENTRAL VIRGINIA TRAINING CENT	16.670	16.670	8.000	16.670	10.200	10.100	78.310
CHASE CITY NURSING AND REHABILITATION CENTER	3.600	11.100	2.300	16.670	8.000	7.700	49.370
CHERRYDALE HEALTH CARE CENTER	15.500	9.300	13.800	16.670	5.100	3.200	63.570
CHESAPEAKE HEALTH AND REHABILITATION CENTER	8.300	13.000	2.300	11.100	10.900	11.300	56.900
CHESAPEAKE THE	16.670	7.400	5.200	16.670	10.200	14.000	70.140
CHILDRENS HOSPITAL	10.700	10.200	10.700	10.400	10.200	10.100	62.300
CLINCH VALLEY MEDICAL CENTER	10.700	10.200	10.700	10.400	10.200	10.100	62.300
COLISEUM PARK NURSING HOME	14.300	14.800	16.670	14.800	9.000	2.300	71.870
COLONIAL HEIGHTS HEALTH CARE C	11.900	14.800	13.800	16.670	16.670	16.670	90.510
COLONNADES HEALTH CARE CENTER	10.700	10.200	10.700	10.400	10.200	10.100	62.300
COMMUNITY MEM	8.300	9.300	13.800	16.670	10.900	16.670	75.640
CONSULATE HEALTHCARE OF WILLIAMSBURG	16.670	14.800	16.670	16.670	6.100	11.300	82.210
CONSULATE HEALTHCARE OF WOODSTOCK	8.300	14.800	13.800	7.400	6.100	16.670	67.070
COURTLAND HEALTHCARE CENTER	9.500	0.000	2.300	16.670	0.000	8.600	37.070
CULPEPER BAPTIST RETIRE COMMUN	10.700	10.200	10.700	10.400	10.200	10.100	62.300
CULPEPER HEALTH & REHABILITATION CENTER	16.670	16.670	13.800	16.670	2.200	9.500	75.510
EDGEMONT CENTER	10.700	16.670	16.670	9.300	10.200	0.000	63.540
EMPORIA MANOR LLC	13.100	16.670	16.670	7.400	13.800	16.670	84.310
EVERGREEN HEALTH AND REHAB	0.000	3.700	0.000	16.670	16.670	15.800	52.840
EVERGREENE NURSING CARE CENTER	10.700	9.300	16.670	0.000	0.300	0.000	36.970

	Percent of High-Risk Long-Stay Residents Who Have Pressure Sores	Percent of Long-Stay Residents Who Have Moderate to Severe Pain	Percent of Long-Stay Residents Who Have/Had a Catheter Inserted and Left in Their Bladder	Percent of Long-Stay Residents Who Were Physically Restrained	Percent of Long-Stay Residents Whose Ability to Move About in and Around Their Room Got Worse	Percent of Long-Stay Residents Whose Need for Help With Daily Activities Has Increased	
Mean QI Rate	14.047	4.506	5.082	3.407	14.702	19.305	
Best Quality Rate = 20th Percentile	9.000	1.000	3.000	0.000	8.000	12.000	
Low Quality Rate = 90th Percentile	23.000	10.000	8.800	9.000	25.300	30.500	
Maximum Points	16.67	16.67	16.67	16.67	16.67	16.67	TOTAL
Nursing Home Name	Point Scale						
FAIRFAX NURSING CENTER INC	0.000	14.800	5.200	5.600	0.000	0.000	25.600
FAIRMONT CROSSING	9.500	7.400	2.300	7.400	7.000	15.800	49.400
FRANCIS MARION MANOR	10.700	0.000	5.200	16.670	8.000	16.670	57.240
FRANCIS N SANDERS NURSING HOME, INC	10.700	10.200	10.700	10.400	10.200	10.100	62.300
FRANKLIN HLTH CARE CTR	16.670	0.000	16.670	16.670	5.100	7.700	62.810
FRIENDSHIP HEALTH AND REHAB CENTER	7.100	3.700	16.670	16.670	0.000	0.500	44.640
GAINESVILLE HEALTH AND REHABILITATION CENTER	10.700	10.200	10.700	10.400	10.200	10.100	62.300
GOLDEN LIVINGCENTER - BLUE RIDGE	14.300	11.100	13.800	16.670	2.200	14.000	72.070
GOLDEN LIVINGCENTER- MARTINSVILLE	11.900	13.000	2.300	14.800	2.200	9.500	53.700
GOLDEN LIVINGCENTER- PORTSMOUTH	7.100	14.800	13.800	14.800	5.100	4.100	59.700
GOLDEN LIVINGCENTER-ALLEGHANY	8.300	14.800	8.000	13.000	7.000	11.300	62.400
GOLDEN LIVINGCENTER-BAYSIDE OF POQUOSON	9.500	16.670	16.670	16.670	7.000	13.100	79.610
GOLDEN LIVINGCENTER-ELIZABETH ADAM CRUMP	16.670	16.670	8.000	14.800	13.800	16.670	86.610
GOLDEN LIVINGCENTER-ROSE HILL	14.300	13.000	13.800	16.670	7.000	6.800	71.570
GOLDEN LIVINGCENTER-SHENANDOAH VALLEY	16.670	14.800	16.670	5.600	12.800	14.000	80.540
GOODWIN HOUSE ALEXANDRIA	10.700	13.000	16.670	16.670	7.000	15.800	79.840
GOODWIN HOUSE BAILEY'S CROSSROADS	10.700	16.670	8.000	16.670	16.670	13.100	81.810
GRACE HEALTHCARE OF ABINGDON	9.500	1.900	5.200	3.700	1.300	16.670	38.270
GRACE LODGE	10.700	0.000	16.670	16.670	10.200	16.670	70.910
GRAYSON N&R CENTER	11.900	1.900	16.670	0.000	5.100	11.300	46.870
GREENSPRING VILLAGE	14.300	13.000	8.000	14.800	16.670	16.670	83.440
GREENSVILLE MANOR	7.100	16.670	0.000	16.670	10.200	5.900	56.540
GRETNA HEALTH CARE CENTER	16.670	9.300	13.800	16.670	14.700	11.300	82.440
HALIFAX REGIONAL HOSPITAL SNF	10.700	10.200	10.700	10.400	10.200	10.100	62.300
HANCOCK GERIATRIC TREATMENT CT	16.670	5.600	16.670	3.700	16.670	16.670	75.980
HANOVER HEALTH CARE CENTER	10.700	10.200	10.700	10.400	10.200	10.100	62.300
HARBOUR POINTE M & R CENTER	15.500	11.100	8.000	11.100	5.100	9.500	60.300
HARRISONBURG HLTH & REHAB CNTR	4.800	9.300	2.300	16.670	6.100	6.800	45.970
HEALTH CARE CENTER AT BRANDERM	10.700	16.670	16.670	13.000	16.670	13.100	86.810
HEALTH CARE CENTER LUCY CORR	13.100	16.670	10.900	16.670	12.800	13.100	83.240
HENRICO HEALTH & REHABILITATION CENTER	0.000	9.300	0.000	16.670	9.900	10.400	46.270
HERITAGE HALL - BROOKNEAL	10.700	5.600	16.670	16.670	0.000	5.000	54.640
HERITAGE HALL FRONT ROYAL	10.700	16.670	0.000	9.300	16.670	4.100	57.440
HERITAGE HALL - LAUREL MEADOWS	0.000	16.670	16.670	9.300	16.670	16.670	75.980
HERITAGE HALL BIG STONE GAP	16.670	0.000	8.000	7.400	6.100	8.600	46.770
HERITAGE HALL BLACKSBURG	7.100	7.400	5.200	13.000	16.670	0.000	49.370
HERITAGE HALL BLACKSTONE	16.670	16.670	5.200	11.100	13.800	11.300	74.740
HERITAGE HALL CLINTWOOD	10.700	14.800	2.300	16.670	16.670	16.670	77.810
HERITAGE HALL DILLWYN	6.000	13.000	16.670	16.670	11.900	16.670	80.910
HERITAGE HALL GRUNDY	0.000	5.600	0.000	0.000	16.670	7.700	29.970

	Percent of High-Risk Long-Stay Residents Who Have Pressure Sores	Percent of Long-Stay Residents Who Have Moderate to Severe Pain	Percent of Long-Stay Residents Who Have/Had a Catheter Inserted and Left in Their Bladder	Percent of Long-Stay Residents Who Were Physically Restrained	Percent of Long-Stay Residents Whose Ability to Move About in and Around Their Room Got Worse	Percent of Long-Stay Residents Whose Need for Help With Daily Activities Has Increased	
Mean QI Rate	14.047	4.506	5.082	3.407	14.702	19.305	
Best Quality Rate = 20th Percentile	9.000	1.000	3.000	0.000	8.000	12.000	
Low Quality Rate = 90th Percentile	23.000	10.000	8.800	9.000	25.300	30.500	
Maximum Points	16.67	16.67	16.67	16.67	16.67	16.67	TOTAL
Nursing Home Name	Point Scale						
HERITAGE HALL KING GEORGE	1.200	5.600	8.000	11.100	11.900	6.800	44.600
HERITAGE HALL LEXINGTON	10.700	16.670	13.800	5.600	14.700	14.000	75.470
HERITAGE HALL NRSG AND REHAB	15.500	14.800	5.200	11.100	16.670	3.200	66.470
HERITAGE HALL NURSING HOME /NA	9.500	11.100	8.000	0.000	16.670	16.670	61.940
HERITAGE HALL TAZEWELL	11.900	0.000	8.000	16.670	15.700	11.300	63.570
HERITAGE HALL VIRGINIA BEACH	8.300	7.400	8.000	0.000	10.200	16.670	50.570
HERITAGE HALL WISE	9.500	7.400	0.000	7.400	6.100	2.300	32.700
HERITAGE HALL-CHARLOTTESVILLE	8.300	9.300	8.000	13.000	15.700	16.670	70.970
HIGHLAND RIDGE REHAB CENTER	1.200	9.300	8.000	7.400	16.670	13.100	55.670
HIRAM W DAVIS MEDICAL CTR	16.670	16.670	10.900	0.000	10.200	10.100	64.540
HOLLY MANOR NURSING HOME	10.700	10.200	10.700	0.000	10.200	10.100	51.900
HOPEWELL HEALTH CARE CENTER	0.000	0.000	0.000	7.400	16.670	16.670	40.740
ILIFF NURSING HOME AND REHAB C	16.670	16.670	16.670	13.000	12.800	16.670	92.480
INOVA CAMERON GLEN CARE CNTR	16.670	5.600	0.000	14.800	11.900	16.670	65.640
INOVA COMMONWEALTH CARE CENTER	10.700	11.100	8.000	14.800	10.900	13.100	68.600
JAMES RIVER CONVALESCENT CENTE	0.000	9.300	16.670	14.800	16.670	14.900	72.340
JEFFERSON, THE	10.700	10.200	10.700	10.400	10.200	10.100	62.300
JOHNSON CNTR/FALCONS LANDING	10.700	10.200	10.700	10.400	10.200	10.100	62.300
KINGS DAUGHTERS COMM HEALTH	11.900	9.300	13.800	3.700	0.000	6.800	45.500
KING'S GRANT RETIREMENT COMMUN	10.700	10.200	10.700	16.670	10.200	10.100	68.570
KROONTJE HEALTH CARE CENTER	8.300	16.670	13.800	16.670	0.000	15.800	71.240
LAKE PRINCE WOODS, INC	10.700	14.800	0.000	16.670	10.200	16.670	69.040
LAKE TAYLOR HOSP	13.100	13.000	13.800	16.670	16.670	13.100	86.340
LANCASHIRE CONVALESCENT AND REHABILITATION CENTER	7.100	3.700	0.000	16.670	16.670	14.000	58.140
LAURELS OF WILLOW CREEK,THE	0.000	14.800	8.000	14.800	6.100	6.800	50.500
LEE NURSING AND REHAB CENTER	13.100	11.100	10.900	13.000	8.000	14.000	70.100
LEEWOOD HEALTHCARE CENTER	0.000	14.800	13.800	7.400	0.000	0.000	36.000
LEXINGTON COURT	11.900	13.000	0.000	14.800	14.700	15.800	70.200
LIFE CARE CENTER OF NEW MARKET	15.500	7.400	5.200	9.300	9.000	6.800	53.200
LITTLE SISTERS OF THE POOR	10.700	10.200	10.700	10.400	10.200	10.100	62.300
LOUDOUN NURSING AND REHAB CNTR	9.500	5.600	5.200	16.670	6.100	4.100	47.170
LOUISA HEALTH CARE CENTER	11.900	7.400	2.300	16.670	0.000	0.500	38.770
LOVINGSTON HEALTH CARE CENTER	16.670	16.670	16.670	16.670	7.000	10.400	84.080
LYNCHBURG HLTH & REHAB CNTR	10.700	0.000	16.670	11.100	11.900	10.400	60.770
MANASSES NURSING & REHABILITATION CENTER	13.100	13.000	16.670	14.800	12.800	6.800	77.170
MANOR CARE HEALTH SERVICES	10.700	13.000	2.300	16.670	11.900	14.900	69.470
MANOR CARE HEALTH SERVICES	0.000	11.100	13.800	5.600	15.700	16.670	62.870
MANOR CARE HEALTH SERVICES-ALEX	1.200	0.000	5.200	16.670	10.200	16.670	49.940
MANOR CARE IMPERIAL	15.500	11.100	5.200	14.800	10.900	14.900	72.400

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Mean QI Rate	14.047	4.506	5.082	3.407	14.702	19.305	
Best Quality Rate = 20th Percentile	9.000	1.000	3.000	0.000	8.000	12.000	
Low Quality Rate = 90th Percentile	23.000	10.000	8.800	9.000	25.300	30.500	
Maximum Points	16.67	16.67	16.67	16.67	16.67	16.67	TOTAL
Nursing Home Name	Point Scale						
MANOR CARE STRATFORD HALL	14.300	16.670	8.000	16.670	16.670	12.200	84.510
MAPLE GROVE HEALTH CARE CENTER	11.900	16.670	2.300	13.000	10.200	16.670	70.740
MARY WASHINGTON HLTH CTR	10.700	16.670	16.670	16.670	0.000	4.100	64.810
MEADOWVIEW TERRACE	11.900	16.670	13.800	16.670	9.000	4.100	72.140
MEDICAL CARE CENTERS	16.670	16.670	13.800	13.000	10.900	9.500	80.540
MIZPAH HEALTH CARE CENTER	10.700	5.600	16.670	5.600	6.100	13.100	57.770
MONTVUE NURSING HOME	16.670	0.000	16.670	14.800	8.000	16.670	72.810
MOUNT VERNON NURSING AND REHABILITATION CENTER	15.500	16.670	16.670	7.400	12.800	16.670	85.710
MOUNTAIN VIEW NURSING HOME	16.670	9.300	16.670	7.400	10.200	10.100	70.340
MOUNTAIN VIEW REGIONAL MEDICAL CENTER	16.670	0.000	0.000	0.000	10.200	10.100	36.970
NANSEMOND POINTE REHAB & HEALT	14.300	5.600	5.200	0.000	9.900	0.000	35.000
NEWPORT NEWS NRSG REHAB CENTER	10.700	13.000	2.300	13.000	0.000	1.400	40.400
NHC HEALTHCARE, BRISTOL	16.670	16.670	8.000	0.000	16.670	14.900	72.910
NORFOLK HEALTH CARE CENTER	13.100	14.800	10.900	16.670	1.300	5.900	62.670
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	10.700	13.000	13.800	16.670	10.200	16.670	81.040
OAK LEA NSG HOME	16.670	16.670	16.670	11.100	12.800	11.300	85.210
OAK SPRINGS OF WARRENTON	16.670	13.000	16.670	9.300	13.800	12.200	81.640
OAKWOOD MANOR BEDFORD MEM	13.100	16.670	16.670	7.400	4.100	14.900	72.840
OAKWOOD NSG & REHAB CNTR	10.700	5.600	16.670	16.670	10.200	10.100	69.940
ORANGE COUNTY NURSING HOME	16.670	14.800	13.800	16.670	12.800	0.500	75.240
OUR LADY OF HOPE HEALTH CENTER	10.700	10.200	10.700	10.400	10.200	10.100	62.300
OUR LADY OF PEACE INC	10.700	16.670	16.670	16.670	10.200	10.100	81.010
OUR LADY OF PERPETUAL HELP	10.700	10.200	10.700	10.400	10.200	10.100	62.300
OUR LADY OF THE VALLEY	8.300	13.000	10.900	16.670	10.900	3.200	62.970
PARHAM HEALTH CARE & REHAB CEN	0.000	9.300	2.300	14.800	3.200	8.600	38.200
PHEASANT RIDGE N & R	9.500	7.400	8.000	0.000	0.300	11.300	36.500
PINEY FOREST HEALTH CARE CENTE	0.000	16.670	2.300	16.670	8.000	7.700	51.340
POTOMAC CENTER GENESIS ELDERCA	1.200	14.800	16.670	16.670	6.100	0.000	55.440
PULASKI COMMUNITY HOSPITAL	10.700	10.200	10.700	10.400	10.200	10.100	62.300
PULASKI HLTH & REHAB CNTR	11.900	0.000	16.670	16.670	16.670	10.400	72.310
RADFORD NURSING AND REHAB	0.000	13.000	16.670	9.300	16.670	16.670	72.310
RALEIGH COURT HLTH CARE CNTR	15.500	16.670	16.670	13.000	7.000	6.800	75.640
RAPPAHANNOCK WESTMINSTER CANTE	10.700	16.670	0.000	5.600	10.200	5.900	49.070
REGENCY HLTH CARE CNTR	10.700	0.000	16.670	13.000	1.300	3.200	44.870
RICHFIELD RECOVERY & CARE CENT	16.670	13.000	13.800	13.000	15.700	16.670	88.840
RIDGECREST MANOR NURSING & REHABILITATION	9.500	0.000	0.000	7.400	15.700	6.800	39.400
RIVER POINTE REHAB HEALTHCARE	4.800	13.000	5.200	7.400	16.670	0.500	47.570
RIVER VIEW ON THE APPOMATTOX	2.400	14.800	16.670	14.800	6.100	7.700	62.470
RIVERSIDE CONVAL CENTER-MATHEW	0.000	0.000	13.800	5.600	12.800	5.000	37.200

	Percent of High-Risk Long-Stay Residents Who Have Pressure Sores	Percent of Long-Stay Residents Who Have Moderate to Severe Pain	Percent of Long-Stay Residents Who Have/Had a Catheter Inserted and Left in Their Bladder	Percent of Long-Stay Residents Who Were Physically Restrained	Percent of Long-Stay Residents Whose Ability to Move About in and Around Their Room Got Worse	Percent of Long-Stay Residents Whose Need for Help With Daily Activities Has Increased	
Mean QI Rate	14.047	4.506	5.082	3.407	14.702	19.305	
Best Quality Rate = 20th Percentile	9.000	1.000	3.000	0.000	8.000	12.000	
Low Quality Rate = 90th Percentile	23.000	10.000	8.800	9.000	25.300	30.500	
Maximum Points	16.67	16.67	16.67	16.67	16.67	16.67	TOTAL
Nursing Home Name	Point Scale						
RIVERSIDE CONVAL CENTER-SALUDA	6.000	14.800	8.000	0.000	16.670	8.600	54.070
RIVERSIDE CONVAL CTR -HAMPTON	7.100	14.800	5.200	14.800	16.670	5.000	63.570
RIVERSIDE CONVALESCENT CENTER-SMITHFIELD	13.100	16.670	16.670	16.670	16.670	11.300	91.080
RIVERSIDE CONVALESCENT CNTR WE	8.300	16.670	16.670	16.670	14.700	3.200	76.210
RIVERSIDE HEALTH & REHAB CNTR	0.000	11.100	16.670	16.670	7.000	13.100	64.540
RIVERSIDE REGIONAL CONVAL CNTR	13.100	11.100	16.670	7.400	12.800	8.600	69.670
RIVERSIDE TAPPAHANNOCK HOSPITAL	10.700	10.200	10.700	10.400	10.200	10.100	62.300
RIVERVIEW NURSING HOME	14.300	0.000	16.670	16.670	5.100	0.000	52.740
RJ REYNOLDS PATRICK CO MEM HOS	10.700	10.200	10.700	10.400	10.200	10.100	62.300
ROMAN EAGLE MEMORIAL HOME	16.670	16.670	13.800	14.800	0.300	6.800	69.040
RUXTON HEALTH AT THE MEADOWS	15.500	9.300	16.670	16.670	9.900	6.800	74.840
RUXTON HEALTH AT THE VILLAGE	8.300	14.800	2.300	16.670	12.800	11.300	66.170
RUXTON HEALTH OF ALEXANDRIA	7.100	7.400	10.900	14.800	0.000	3.200	43.400
RUXTON HEALTH OF LAWRENCEVILLE	2.400	16.670	16.670	11.100	16.670	11.300	74.810
RUXTON HEALTH OF STAUNTON	16.670	3.700	13.800	7.400	2.200	2.300	46.070
RUXTON HEALTH OF STRATFORD HILLS	3.600	16.670	8.000	14.800	16.670	12.200	71.940
RUXTON HEALTH OF WILLIAMSBURG	9.500	14.800	10.900	14.800	15.700	15.800	81.500
RUXTON HEALTH OF WINCHESTER	16.670	11.100	16.670	7.400	9.900	9.500	71.240
RUXTON HEALTH OF WOODBRIDGE	4.800	0.000	13.800	7.400	16.670	10.400	53.070
RUXTON OF WESTOVER HILLS HRC	14.300	16.670	13.800	11.100	6.100	12.200	74.170
SALEM HEALTH & REHABILITATION	15.500	0.000	13.800	9.300	0.000	0.500	39.100
SEASIDE HHC @ ATLANTIC SHORE	10.700	0.000	10.900	16.670	10.200	0.000	48.470
SENTARA NSG CENTER-WINDERMERE	16.670	16.670	13.800	1.900	15.700	16.670	81.410
SENTARA NSG CNTR CHESAPEAKE	3.600	11.100	16.670	11.100	16.670	16.670	75.810
SENTARA NURSING CENTER HAMPTON	10.700	7.400	13.800	16.670	14.700	16.670	79.940
SENTARA NURSING CENTER NORFOLK	7.100	14.800	10.900	14.800	15.700	8.600	71.900
SENTARA NURSING CENTER PORTSMO	6.000	14.800	16.670	13.000	5.100	12.200	67.770
SENTARA NURSING CENTER VA BEAC	15.500	5.600	16.670	14.800	16.670	14.900	84.140
SEVEN HILLS HCC	4.800	9.300	16.670	11.100	13.800	16.670	72.340
SHENANDOAH NURSING HOME	0.000	0.000	0.000	0.000	11.900	0.000	11.900
SHENANDOAH VLY WESTMINSTER-CANTERBURY	10.700	10.200	10.700	10.400	10.200	10.100	62.300
SHORE LIFECARE, INC	13.100	14.800	10.900	1.900	10.900	6.800	58.400
SHORE MEMORIAL HOSPITAL	10.700	10.200	10.700	10.400	10.200	10.100	62.300
SKYLINE NURSING AND REHABILITATION CENTER	8.300	14.800	16.670	0.000	0.000	1.400	41.170
SKYLINE TERRACE CONV HOME	16.670	0.000	13.800	16.670	10.200	7.700	65.040
SNYDER NURSING HOME	16.670	14.800	10.900	16.670	10.200	10.100	79.340
SOUTH BOSTON MANOR	13.100	7.400	8.000	9.300	16.670	14.000	68.470
SOUTH ROANOKE NURSING HOME INC	0.000	13.000	8.000	14.800	5.100	7.700	48.600
SOUTHAMPTON MEMORIAL HOSP	14.300	14.800	8.000	0.000	10.900	7.700	55.700
SOUTHSIDE REGIONAL MEDICAL CTR	10.700	10.200	10.700	10.400	10.200	10.100	62.300

	Percent of High-Risk Long-Stay Residents Who Have Pressure Sores	Percent of Long-Stay Residents Who Have Moderate to Severe Pain	Percent of Long-Stay Residents Who Have/Had a Catheter Inserted and Left in Their Bladder	Percent of Long-Stay Residents Who Were Physically Restrained	Percent of Long-Stay Residents Whose Ability to Move About in and Around Their Room Got Worse	Percent of Long-Stay Residents Whose Need for Help With Daily Activities Has Increased	
Mean QI Rate	14.047	4.506	5.082	3.407	14.702	19.305	
Best Quality Rate = 20th Percentile	9.000	1.000	3.000	0.000	8.000	12.000	
Low Quality Rate = 90th Percentile	23.000	10.000	8.800	9.000	25.300	30.500	
Maximum Points	16.67	16.67	16.67	16.67	16.67	16.67	TOTAL
Nursing Home Name	Point Scale						
SPRINGS NURSING CENTER, THE	10.700	1.900	8.000	0.000	4.100	14.900	39.600
SPRINGTREE HEALTHCARE & REHAB CENTER	1.200	13.000	10.900	16.670	9.900	14.000	65.670
ST FRANCIS NURSING CTR	7.100	9.300	0.000	14.800	14.700	14.900	60.800
STANLEYTOWN HLTH CARE CNTR	11.900	0.000	13.800	11.100	11.900	7.700	56.400
STRATFORD REHABILITATION CENTER	10.700	10.200	10.700	10.400	10.200	10.100	62.300
SUMMIT HEALTH & REHABILITATION CENTER	7.100	3.700	16.670	0.000	11.900	16.670	56.040
SUMMIT SQUARE	10.700	10.200	10.700	10.400	10.200	10.100	62.300
SUNNYSIDE PRESBYTERIAN RETIREMENT COMMUNITY	16.670	14.800	13.800	1.900	5.100	12.200	64.470
SW VA M H INST GERI TRT CTR	10.700	10.200	10.700	10.400	10.200	10.100	62.300
TANDEM HEALTH CARE OF NORFOLK	3.600	13.000	10.900	11.100	16.670	16.670	71.940
TANDEM HEALTHCARE OF WINDSOR	16.670	14.800	16.670	0.000	3.200	6.800	58.140
THE CONVALESCENT CENTER AT PATRIOTS COLONY	10.700	1.900	16.670	13.000	8.000	0.000	50.270
THE FOUNTAINS AT WASHINGTON HOUSE	10.700	10.200	10.700	10.400	10.200	10.100	62.300
THE LAURELS OF CHARLOTTESVILLE	10.700	5.600	8.000	0.000	16.670	13.100	54.070
THE LAURELS OF UNIVERSITY PARK	0.000	0.000	16.670	11.100	13.800	9.500	51.070
THE NEWPORT	10.700	10.200	10.700	16.670	10.200	10.100	68.570
THE ORCHARD	8.300	5.600	10.900	0.000	10.200	16.670	51.670
THE VIRGINIAN	10.700	10.200	10.700	10.400	10.200	10.100	62.300
THORNTON HALL	16.670	14.800	16.670	13.000	12.800	16.670	90.610
TRINITY MISSION FARMVILLE	0.000	9.300	5.200	16.670	15.700	0.000	46.870
TRINITY MISSION OF CHARLOTTESV	16.670	3.700	13.800	16.670	9.900	9.500	70.240
TRINITY MISSION OF HILLSVILLE	10.700	9.300	16.670	9.300	8.000	15.800	69.770
TRINITY MISSION OF ROCKY MOUNT	15.500	13.000	10.900	1.900	16.670	16.670	74.640
VA BAP HOSP DIV CEN	10.700	3.700	8.000	16.670	0.000	0.500	39.570
VA BEACH HEALTHCARE AND REHAB	4.800	14.800	13.800	9.300	13.800	11.300	67.800
VALLEY HEALTH CARE CENTER	10.700	5.600	8.000	11.100	16.670	13.100	65.170
VIRGINIA HOME	16.670	9.300	0.000	14.800	16.670	16.670	74.110
VIRGINIA VETERANS CARE CENTER	16.670	16.670	10.900	14.800	9.000	5.000	73.040
WADDELL NURSING AND REHAB CENTER	16.670	16.670	13.800	9.300	0.300	5.000	61.740
WALTER REED CONVALESCENT AND REHABILITATION CENTER	0.000	1.900	2.300	16.670	16.670	16.670	54.210
WARREN MEMORIAL HOSP LYNN CARE	9.500	0.000	16.670	14.800	5.100	8.600	54.670
WARRENTON OVERLOOK HEALTH & RE	9.500	11.100	13.800	14.800	5.100	10.400	64.700
WARSAW HEALTH CARE CENTER	16.670	13.000	8.000	16.670	0.000	0.000	54.340
WAVERLY HLTH CARE CNTR	13.100	16.670	8.000	16.670	7.000	12.200	73.640
WESTMINSTER AT LAKE RIDGE	10.700	5.600	16.670	13.000	9.900	15.800	71.670
WESTMINSTER CANTERBURY CHESAP	16.670	16.670	16.670	16.670	0.000	0.000	66.680
WESTMINSTER CANTERBURY BLUE RI	10.700	10.200	10.700	10.400	10.200	10.100	62.300
WESTMINSTER-CANTERBURY HOUSE	15.500	5.600	0.000	14.800	0.000	0.000	35.900
WESTMINSTER-CANTERBURY -LYNCHB	6.000	14.800	13.800	0.000	4.100	0.000	38.700

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Mean QI Rate	14.047	4.506	5.082	3.407	14.702	19.305	
Best Quality Rate = 20th Percentile	9.000	1.000	3.000	0.000	8.000	12.000	
Low Quality Rate = 90th Percentile	23.000	10.000	8.800	9.000	25.300	30.500	
Maximum Points	16.67	16.67	16.67	16.67	16.67	16.67	TOTAL
Nursing Home Name	Point Scale						
WESTPORT HEALTH CENTER	13.100	14.800	13.800	13.000	14.700	16.670	86.070
WESTWOOD CENTER	11.900	11.100	5.200	13.000	2.200	0.000	43.400
WOODBINE REHABILITATION & HEALTHCARE CENTER	0.000	11.100	5.200	13.000	0.000	2.300	31.600
WOODHAVEN HALL AT WILLIAMSBURG LANDING	10.700	10.200	10.700	10.400	10.200	10.100	62.300
WOODLANDS,THE	0.000	14.800	0.000	0.000	15.700	16.670	47.170
WOODMONT CENTER	0.000	16.670	8.000	0.000	16.670	16.670	58.010
WOODVIEW,THE	11.900	14.800	16.670	14.800	16.670	16.670	91.510
WYTHE CNTY COMMUNITY HOSP ECU	10.700	10.200	10.700	10.400	10.200	10.100	62.300
YORK CONVALESCENT CENTER	10.700	1.900	5.200	16.670	16.670	16.670	67.810

Methodology: Scores were taken from a download of the CMS Compare database in April 2007. A nursing home received a maximum score of 16.67 points if it had the "Best Quality Rate" or better. A nursing home received no points if it had the "Low Quality Rate" or worse. Points were evenly distributed for score between the "Best Quality Rate" and the "Low Quality Rate."

Cells where a mean rate was assigned because the facility did not have data are highlighted in black.

Hospital-based facilities are highlighted in grey.