CMS Nursing Home Five Star Rating System

Discussion Guide

Meeting with the Centers for Medicare and Medicaid Services

January 22, 2009

The Alliance for Quality Nursing Home Care, The American Health Care Association, and The Association of Homes and Services for the Aging share the Administration's commitment to help consumers make educated decisions about nursing homes, based on the best data possible. We strongly support ensuring that accurate, understandable information about nursing homes is available to the public. While we concur with the concept of a quality rating system as a useful consumer tool, the Nursing Home Five-Star Rating System, as currently designed and implemented by the Centers for Medicare & Medicaid Services (CMS), is seriously flawed.

CMS' repeated statements that imperfections in the quality rating system will be addressed in "phase II" are unacceptable. If this rating system is truly for the benefit of consumers, it must be right the first time. The government owes that to both the public and to providers. The use of flawed data as the base of this tool can only discredit the tool itself and undermine the good and correct intent of CMS.

IMMEDIATE ACTIONS NEEDED

I. Multi-Dimensional vs. Uni-Dimensional Rankings

- Revisit the concept of using multi-dimensional ratings vs. the current use of a composite rating in addition to the individual domains.

- Elimination of the composite rating will allow for continued in-State data comparison to
  account for variability in implementation.

II. Predetermined Percentage Assignment of Stars vs. Clear Report of Facility's Performance

- Eliminate the pre-determined percentage assignment of facilities to star rankings (e.g., for survey rankings, 10% of facilities will receive five stars; 70% will receive four, three, or two stars; 20% will receive one star). In its place, establish a more appropriate initial distribution of rankings for each component.

III. Quality Measures

- Revisit inclusion of Quality Measures (QMs) in the calculation of a facility's Five-Star rating.

IV. Staffing

- Revisit the methodology for case mix adjustment
- Provide transparency in the current case mix adjustment methodology. Facilities cannot replicate and/or understand how ratings were calculated.
- Establish a national policy allowing submission of corrected 671 forms.
- Include all direct care staff, including therapists, in the staffing calculation.
- Use the same time period for case mix adjustment as that used for obtaining staffing data, i.e., the risk adjustment methodology must be applied to the same two-week timeframe used for completion of 671.
- Revise the CMS 671 form to reflect current practice, permitting clear reporting of universal workers, advanced nurse practitioners, etc.
- Amend the system to rank staffing at 5 stars if the expected CMI staffing is equal to or greater than what is recommended in the CMS time study.

V. Survey and Certification

- Establish a standardized process for survey data review requests and submission of corrected information.
- Establish a standardized and timely process for correction of errors, e.g., duplication of standard and complaint survey deficiencies; outdated survey information, including 'old' surveys and deficiencies that have been resolved or modified under IDR or appeal, to include that posted data found to be in error will be 'taken down' from the Nursing Home Compare site until corrections can be effected.
- Revisit the weighting structure related to use of complaint survey data to account for state variability in self-reporting requirements.

VI. Additional Issues to be Resolved

- Maintain the provider preview component and the Helpline for the duration of the 5-Star process.
- Develop and implement a formal appeals/correction process for the Five Star Rating System and inform all nursing facilities of the process.
- Clarification is required on how the system handles missing or clearly bad data, e.g., a quality measure with insufficient observations in the denominator or bad

staffing data. It may be preferable to have missing and bad data generate an "UNKNOWN" indicator that could be fixed rather than be calculated resulting in an inaccurate estimate.

- "The system is predicated on all nursing homes producing the same and a uniform product – i.e. long stay bed days. This is not true for many providers and the existing system has nothing that helps capture quality from the perspective of the post-acute world."
- Include resident satisfaction information. The long-term care survey is a snapshot – the residents reporting on satisfaction live in the facility 24/7.

FINDINGS / SUPPORTING INFORMATION

I. Multi-Dimensional vs. Uni-Dimensional Rankings

Continued use of the composite star-ratings is both inappropriate and misleading. Providing individual ratings within the respective domains and by State will allow consumers to reach decisions based on their particular needs.

Vince Mor, Ph.D., Professor & Chair, Department of Community Health, Alpert Medical School at Brown University, and member of the CMS Technical Expert Panel for the Five Star Quality Rating system, in his [draft] "Commentary for Centers for Medicare and Medicaid Services Proposed 5-Star Rating System for Nursing Homes" (7/13/08) voices strong support for the use of a multi-dimensional vs. a uni-dimensional system:

- *"Creating a uni-dimensional 5 star rating system for health care providers like hospitals would seem to ignore why it is that the patient wants this service. In response to an inquiry as to which is the best hospital in an area, it is most likely that the response would be "for what?" Picking the best hospital overall and only then determining that the purpose of the hospitalization is for obstetric delivery versus open heart surgery would seem to be ridiculous, but that is precisely what we are requesting when we ask individuals to select a nursing home based upon a single 5 star rating system."*
- *"Even among the short and long stay residents, there are groups of patients with different needs. A global 5 star rating system would result in an 'average' across these very different needs, likely not being compatible with any."*
- *"Indeed it would not be an exaggeration to say that creating a uni-dimensional quality ranking system may do more harm than good, even if it is implemented with the intention of making ongoing modifications to it in the future. Precisely because creating a 5 star rating system combines uncorrelated measures results in a mix of homes that are good on some things and bad on others at all moments of the score distribution, such a system loses potentially meaningful differentiation across the individual component scores."*
- *"Admitting sicker and more frail patients presents facilities with a population that is at increased risk of experiencing negative outcomes like infections, incontinence, pressure ulcers, etc. To the extent that facilities' acuity levels are correlated with any of the indicators of quality, facilities admitting more impaired patients are disadvantaged in any rating system, particularly a global 5 star rating system precisely because the impact of the correlation between acuity and quality is additive across all measures as they are summed to create the global measure."*

- *"…making quality comparisons of facilities on the basis of staffing levels that are not adjusted for the acuity of residents served could lead to fallacious conclusions about the home, to say nothing of the need to set staffing standards that are reasonably informed by resident acuity."* (For example: A high acuity resident with a left ventricular assist device would not be captured on the MDS because there are no fields to capture that type of acuity. RUGS levels don't look at the extent of the acuity.)

Brown University examined the OSCAR records for all free-standing nursing homes in the United States and ranked facilities in their respective markets based on this data. In only two of every six cases did the average facility remain in the top or bottom quartile. There is simply too much volatility.

Elimination of the composite rating will allow for continued State-by-State data comparison to account for variability in implementation, and more clearly demonstrate individual facility performance.

II. Predetermined Percentage Assignment of Stars vs. Clear Report of Facility's Performance

The rationale for assigning the 5-star rating to the upper 10% of facilities and the 1-star to the bottom 20% is unclear. As designed, this pre-determined assignment of stars results in arbitrary rankings (as opposed to "rating" as used in the CMS title for this system) of facilities and can automatically preclude reflection of an accurate rating, e.g., under the current design all facilities do not have equal potential to achieve a 5-star ranking.

Facility ratings are currently based on group performance and they are subject to frequent change. These fluctuations in ratings may occur without any change in a facility's individual performance. This is in direct contrast to other consumer rating systems, such as those for restaurants and hotels, where the ratings obtained are based upon variables within the control of the entity (e.g., price, quality of food, service, or décor), rather than being dependent upon changes that occur with other local and national establishments.

III. Quality Measures

- Quality Measures cannot be used to rank facilities. The QMs were never intended to be used to rank facilities – this is a conclusion that is supported by the developers of the QMs; independent analyses; and by CMS itself:

- As reported on www.hhs.gov

"The current quality measures have been chosen because they can be measured and don't require nursing homes to prepare additional reports. They are valid and reliable. However, they are not benchmarks, thresholds, guidelines, or standards of care."

- MDS Quality Measure/Indicator Report

"QM/QIs are not definitive measures of quality of care, but are "pointers" that indicate potential problem areas that need further review and investigation. These data, at a nursing home level, are used by State survey agencies to target survey and quality monitoring activities. The data are also shared with the facilities; each facility receives a report of its own data, as well as its statewide data. This report can be used by the facility as a tool to rate its performance compared to the state and to target areas of care for improvement".

- As reported by CHSRA (www.chsra.wisc.edu)

"Quality Performance Thresholds or Standards

Performance thresholds or standards are used to identify facilities with potential quality of care problems, by setting a level above which a facility's performance is considered suspect. Thresholds can be either absolute or relative. Absolute thresholds define a single number, above which facility QI scores are considered suspect. Relative thresholds are set relative to the distribution across the peer group facilities, e.g., the 75th percentile, the 90th percentile, the mean plus two standard deviations. The selection of peer group can have a dramatic impact on the setting of a threshold, and the consequent likelihood that a facility will be identified as having a potential quality problem related to any given QI.

The choice of a threshold affects the number of QIs for which a facility exceeds the threshold, the resources required to investigate potential quality problems, and the comparative standing of different facilities. Regardless of how the threshold is determined, it has implications for the cost and resources required of the regulatory survey process. The lower the threshold, the greater the number of facilities that will be identified for review. The implications are similar when QIs are used for internal facility quality improvement.

Based on our original QI development and validation, we have used a state (peer group) specific threshold of the 90th percentile, for most QIs. A few QIs are treated as sentinel events, so that any occurrence is cause for investigation.

Target Efficiency

This issue involves the specificity and sensitivity of the QI, in particular the likelihood of a false positive, i.e., that the QI will identify a resident or a facility for whom the QI flag is not ultimately found to represent a problem with the quality of care. Minimizing the number of false positives and false negatives is a critical concern, since each one decreases both the effectiveness and the efficiency of the quality monitoring process. False positives also may promote an erroneous perception of a quality of care problem for a facility, where no such problem exists. Using too strict a QI definition, however, may result in the opposite problem, failing to identify quality problems that in fact exist.

Based on our development and validation work however, we have chosen to use fairly simple measures, rather than those that we believe have the greatest target efficiency. This decision is based on several considerations. First, the more target efficient QIs are often difficult to interpret, due to their complex definitions. Second, use of more target efficient QIs may result in an exclusion of cases that are a result of poor quality of care, but that do not meet all of the conditions set forth in the complex QI definitions, thereby resulting in an increase in false negatives. Third, the use of complex definitions to increase target efficiency also may result in increased error. Specifically, any error that results from the first component of a complex definition can be multiplied as the remainder of the definition compounds the error. Finally, the use of the QIs in the monitoring process can take advantage of the regulatory survey or internal facility review as a source of immediate verification, detecting false positives.

The important general point with respect to target efficiency is that the more likely the case that the indicator itself is to be used to render decisions on quality of care without follow-up or verification, the more important is the target efficiency of that indicator."

- The original design and validation work conducted by CHSRA represents the foundation for the current reality of the QI/QMs and the following key points must be recognized:

1. The QI/QMs were designed for simplicity of definition and use, rather than target efficiency. The less "target efficient" the measures, the less reliable for use in rendering decisions on quality of care without follow-up or verification. The premise being that facility staff (or surveyors) will conduct a more comprehensive and thorough review to determine if a problem exists. The measures were not designed as a stand alone ranking of quality.

2. With the exception of the three sentinel events, the original QIs were validated at the 90th percentile rank, meaning the lowest ten percent of the state peer group.

This means that a measure was likely to represent a quality of care concern only if it was found to be in the bottom 10% of the state peer group. And even then, a comprehensive review of the patient population would underscore any determination of whether poor quality of care existed or whether the ranking was primarily due to a unique population of patients that might skew the data.

It simply cannot be proposed that the design, intent, or validation of the original QI data set could support extracting a handful of Nursing Home measures from the complete set and stratification of this group into quintiles for the purpose of measuring quality of care. Furthermore, implying that one quintile represents better or worse quality of care than another is simply unfounded – this is certainly the case for the top four quintiles. Additionally, under the current methodology of Five-Star, even the bottom 10% were lumped together with the next 10% into an aggregate 20% quintile rendering even that quintile inconclusive without further onsite verification and investigation. Third, onsite review of the patient population (review of charts and assessment of residents) must occur before any determination of quality of care can be made regardless of the percentile rank of any measure.

The assertion by Dr. C. Teigland that the measures are primarily driven by the types of residents admitted rather than the quality of care delivered is valid [see below].

*****See attached: *5-Star Quality Measures—Are they risk adjusted to "level the playing field" and allow fair/accurate comparisons across facilities?* Christie L. Teigland, Ph.D., Director of Health Informatics Research, New York Association of Homes and Services for the Aging (NYAHSA) and EQUIP for Quality®

- Additional Quality Measure Concerns/Issues:

  - Current methodology results in facilities that accept short-term and high acuity residents being penalized in the rankings. Higher acuity and shorter lengths of stay decrease the number in the denominator for the Quality Measures increasing volatility. Facilities with shorter lengths of stay are judged mainly on their long term patients and not on the outcomes of their main business, post acute rehabilitation. Facilities are penalized within the Star rating system for increasing acuity and shortening lengths of stay.

    Example –One facility consistently maintains a higher M2 census than another (68% versus 33%) which lowers the denominator for the Quality Measures creating higher volatility within the measures. Facility A received only 8 deficiencies on their last standard survey (below the state average of 9.1). Facility B received 13 deficiencies on their last standard survey. Facility A had a Quality Indicators Survey (QIS) which relies heavily on Critical Elements that evaluate quality processes. Facility A received 2 stars for Quality Measures and Facility B received 4 stars. M2

census and higher acuity appears to have negatively impacted Facility A's Quality Measures rating.

Most Quality Measures are prevalence indicators. If a center is skilled in caring for complex pressure ulcers and the wound is not completely healed within 90 days the center is unfairly penalized once again for admitting highly complex patients. With the advent of MDS 3.0, Quality Measures should account for variances in types of patient populations and reflect fairly on both chronic and post acute providers.

IV. Staffing

- CMS recognizes the limitation of the current staffing data in its caveat on the website: "An Important Caution: These numbers are based on information provided by the nursing home and are not checked for accuracy. They represent nursing staff levels for a two-week period prior to the time of the state inspection. Because the numbers are not checked and nursing staff levels may have changed since the last state inspection, you should be cautious when interpreting the data."

- The continued use of the current staffing information perpetuates the problems with Nursing Home Compare: consumers have no option but to make a quality judgment based on information that is explicitly acknowledged by CMS to be substantially flawed, i.e., that has not been verified and that could be outdated.

- Staffing data used as the calculation baseline is an average of 9.4 months old.

- Staffing data provided by the facility on the 671 form uses an arbitrary 2 week period snapshot at a point in time which may or may not be an accurate reflection of the average staffing levels. This methodology is not appropriate for the purpose of providing the public with information regarding staffing levels.

- The PPD obtained from the 671 is case mix adjusted with data that is taken from a different time period. Staffing data that was obtained from a 2 week time period, which is on average 9.4 months old, is adjusted with current RUG data. Methodologically this creates numerous inaccuracies.

- The case mix adjustment methodology has not been disclosed to the public, making it difficult for facility staff to understand how the scores were derived and how to, e.g., work to change their scores. Information in the CMS Technical User's Guide (December, 2008), does not include information such as "Hours Expected" and "Hours National Average", needed to complete the

formula. It becomes particularly difficult to interpret when reported OSCAR HPPD's vary and the resulting 5 Star staffing rating does not reflect this variation. It appears that the case mix adjustment may be applied against the overall population which, in a high acuity facility, may bias the acuity calculation for chronic patients and affect the rating for the staffing component.

Example - The OSCAR data from Facility A show that the most recent standard survey publicly reported the facility's HPPD at 4.25. This 4.25 represented a 4 Star rating on Nursing Home Compare for staffing. Conversely Facility B's OSCAR data shows a 4.35 HPPD, but only rates 2 Stars for staffing. Medicare/managed care (M2) census is normally a good indicator of average acuity and admission/discharge rates in a facility. Facility A's average M2 census is 50.5% while Facility B's average M2 census is 33% for 2008, making Facility A appear to have a higher acuity and admission/discharge rate. Given case mix adjustment of the staffing rates, it would be expected that Facility A would have a lower star rating that Facility B due to the overall lower HPPD and the appearance of higher acuity.

- There is a general and widespread lack of clarity and understanding of 671 definitions, leading to inaccurate completion of 671.
- The 671 form is archaic technologically. It must be laboriously completed by hand or with a typewriter rendering it more vulnerable to entry errors and also slowing the process of completion at the facility.
- The categories and definitions on the 671 are becoming increasingly outdated and not illustrative of current practice and staffing patterns in nursing facilities--this is especially the case regarding universal workers or the Shahbaz concept of the Greenhouse model, among others; "this makes it difficult for facilities to capture the actual direct care hours they residents receive "credit" for, according to the report of our state survey representative…"
- The calculation does not reflect all direct care staff and the changing acuity of residents. The primary care providers in a skilled nursing facility 20 years ago were the nurses and nursing assistants. However, as diagnosis related groupings pushed more patients out into skilled centers earlier there is a greater need for true post acute rehabilitation services and advanced practice nursing.

Examples: (1)"Physician Extenders. Research has shown that registered nurse practitioners improve quality of care within a facility. Although [we] contract for full time (40 hours per week) nurse practitioners in many of [our] facilities, these hours are captured under medical extender and are not reflected in the 5 Star rating. (2) Therapy Services. An increased post acute census has led to a higher level of therapy services and a greatly expanded therapy staff. Residents receive the benefit of an increased number of therapy hours which are reported on the 671, but are also not a

part of the 5 Star rating. Some of [our] facilities have as many as 30 plus full time therapist providing seven day a week therapy services."

Example: "If the DON is on vacation, she can't be counted on the 671 form. This may trigger the default to 'data unavailable' regarding the 5-Star rating system.

- State surveyors, in general, do not review the 671 for accuracy or completion during their visit.
- The ability to correct 671 data is variable and problematic. The state agency has little or no involvement with the 671 once it has been uploaded to CMS. Facilities have no way of knowing whether their data has been pulled by CMS at any point for any reason - there is no notification from either the State Agency or CMS. If a facility identifies a problem, there is no clear path as to how it gets corrected. It is assumed the Helpline will be eliminated at some point (already not open daily) leaving the facility with little recourse for inquiry.

V. Survey and Certification

Inconsistencies in Survey Results

*See attached for interstate inconsistencies: Geographic Survey Discrepancies, as prepared by PointRight.

*See attached for an example of intrastate survey inconsistencies: Pennsylvania data analysis, as prepared by Presbyterian Senior Living.

Duplicate Deficiencies

The calculating of health inspections is based on the Online Survey and Certification Reporting (OSCAR) data. Complaints and standard surveys that occur on the same date may not appear that way in the OSCAR data. Standard survey data can be bundled with the life safety survey which may be greater than 30 days before or after the actual standard survey date.

Example – "OSCAR data shows that the standard survey for Facility A was completed on 8/14/08. This was actually the date of the life safety survey. The standard survey occurred on 6/26/08 with a complaint survey. Eight total deficiencies were cited for the standard and complaint survey (7 on standard and 1 for the complaint). All eight of the deficiencies appear under the complaint on 6/26/08 and for the standard on 8/14/08.

- *Example - "We were successful yesterday in reaching the "helpline" and after 35 minutes of calculating our survey ratings on the phone, it appears that CMS "double counted" deficiencies for years of the ratings: 2006 and 2007. It*

appears that deficiencies that emerged during a regular survey which also included a complaint investigation were double-counted, i.e., the deficiencies counted under the health survey, were counted again under a complaint survey."

Closed Facilities Remain on Nursing Home Compare

Nursing facilities that are closed continue to be posted on Nursing Home Compare. The erroneous inclusion of these facilities in the peer ratings thereby impacts the position and ratings of other facilities.

Example - Tennessee : "This Facility is a SFF and has been for a while. CMS and TDH decertified the Facility as of 12/29/08. Note that they have a 5 of 5 for their quality measure outcomes.

NASHVILLE, TN 37207
Resident Council
Overall: 2 out of 5 stars
Survey: 1 out of 5 stars
Staffing: 2 out of 5 stars
Quality Measures: 5 out of 5 stars'

Uncorrected Informal Dispute Resolution (IDR) Results

Deficiencies that are modified as the result of IDR or appeal must be corrected within the OSCAR data base prior to posting. In the example below, it should be noted that although citations were removed or reduced in scope and severity per the notice received from the state, OSCAR data has not been updated *[as of 1/14/09].*

Example – "The facility requested an IDR of federal deficiencies from the January 11, 2008 standard survey. In a letter dated 3/6/08, two citations had been reduced in scope and severity. Both were reduced from a level G citation (20 points each for the health inspection score) to level D citations (4 points each). This would represent a total decrease in the health deficiency score of 32 points. OSCAR data still lists these two citations as level G's."

Additional Examples of Problems Identified by Providers

- Minnesota – “We noted that many of the facilities receiving 5 stars are Transitional Care facilities or hospital short-stay facilities which are staffed differently, get a different rate and have a much different population.”

- Connecticut - “For two days now we have been embroiled in a nightmare with our state DPH because there apparently has been a "glitch" in the uploading of our data, so that our rating in both staffing (where we have more than 4.6 hours of care pp/pday) and in inspections has defaulted to a 1-- the lowest rating.”

- Connecticut - “The staffing data is sufficiently problematic in Connecticut that the state agency has agreed to do a special conference call on the completion and submission of 671 forms. The state has acknowledged publicly that they have had problems with timely uploading of this information.”

- Connecticut - “Big facilities get lower scores! More than 90% of facilities of over 200 beds received 1 or 2 star rating while 95% of those facilities of 25-60 beds received 4 or 5 star ratings. Also, in CT we have been using the QIS for three survey cycles now. QIS is now statewide, but some facilities have yet to experience a QIS survey. The mix of traditional vs. QIS surveys which makes up the survey rating for everyone in our state has tended to skew the results.”

- QI Information -”That data always looks very skewed for really small homes. When the sample group is very small in number, each resident's data has a huge impact on the percentile ranking. Even one resident can swing the numbers so much that it looks like the home has a significant problem where none exists.

- ”Wisconsin – “Our facility is a small 28 bed sub-acute rehab facility located within a hospital in Janesville. The average LOS for our patients is 14/21 days. We received a 4 star overall quality rating: 5 star health inspection; 1 star quality measures; and 2 star staffing.

  We do not report measures for long term care patients because all of our patients are short term post acute. The CMS data indicates we have only reported information for 5 of the 19 quality measures.

  RN staffing is 4 stars yet my overall staffing is 2 stars. I assume that the difference is related to the case mix MDS distribution and/or QM's

  We are a rehab facility. It is unusual for our patients to have high ADL scores and high rehab needs. Our patients are returning to the community 95% of the time.”

- Texas – "We spent meaningful time with a reporter from our local paper before he wrote his article. The article ran the Saturday after Christmas and was awful. We had a bad survey experience in March, 2008. After spending money on legal counsel (money that that should have gone to direct care staff salaries) to appeal the survey results (in November CMS agreed with us and overturned an IJ and changed language in our "inspection report") our Regional survey team did not make the changes to the 2567 in a timely manner. As of last week we were still waiting for the revised 2567. So the information on the website was incorrect and we had nothing in writing to counter the information the reporter had obtained from CMS. Our efforts at transparency with the media and our attempts to reason and use common sense with surveyors have not produced encouraging results. We are working hard to keep staff morale high and communicate with our families our side of the story."

- "My major concern is that accuracy is assured on the website. I went to the CMS Nursing home compare and found that our facility did not have a resident council. Well, I was a bit surprised as we have had a council for over 20 years."

- "Less than a month ago when this came out we were 4 stars overall and 3 stars on inspections. We have had no surveys since then; on the 1/5/09 edition we are 3 stars overall and 4 stars on inspections. Our quality measures went from 2 stars to 1 star. We have generally the same population as a few weeks ago.

  Also, we are penalized on the Quality Measures because we are a small facility averaging 45 residents. We admit a lot of pressure ulcers, many of our admits have altered mental status upon admission and we have a very small denominator so our percentage is whopping!!

  Fortunately, we are a fabulous facility both aesthetically and with a great care reputation so we have no census issues, but for us it's a matter of pride at present. It will be a different matter when the rating system starts to tie in with reimbursement…

  Another interesting fact- On the state website we are 5 stars in all rated categories. It's the same information."

- "We have been reviewing our rating. The survey data is flawed since they haven't removed the deficiencies we have had overturned at ALJ.
  1) The RN Staffing was based on a two-week snapshot when most of my RNs were on vacation (July) and we were staffing with LPNs.
  2) We are completely baffled as to why the QMs were poor, as our review shows we are good or better than benchmarks, both state and national. And the only one I flag is nine or more meds. We have determined that if you are a heavy acuity facility and do a lot of look-back capturing of hospital data, then this kills you on the QM for this.

The Catheter QM doesn't take into consideration the medical necessity vs. convenience. So if you are a high acuity facility, discharging most of your more independent people to AL, then you will trip this one just based on the fact that your people have heavier acuity.

For the residents newly coming from the hospital, if they had a catheter in the hospital, this would be captured on your lookback MDS. If you are a heavily skilled facility with a lot of skilled MDSs, this will look bad on your QIs.

Under pain, the QMs do not consider what the facility is administering or doing for the pain. It is only a 7-day lookback on the MDS; it may not be chronic pain. Another example if you have a lot of skilled residents with fractures, etc., then this would look terrible.

For mobility, it removes the information from their skilled stay to their long-term stay data, and doesn't take into consideration if their decline was related to a hospitalization. Delirium also has a 7-day lookback and can cover the hospitalization.

We have determined that we will now have to just do a comprehensive full MDS after residents' skilled stay is done for this to be accurate, because otherwise every skilled resident will count against us due to acuity. Our MDS nurse of 30 years was not doing this because she felt that most didn't meet the significant change criteria and they were returning to prior level of functioning. The IFMC nurse or the surveyors never had a problem with this interpretation."

- "When the average age of our residents is 85 years old, is it not reasonable to expect that at some point in time, there will be deterioration that leads to death. Is this not a natural occurrence in the dying process? How do you separate out what is reality or what is facility acquired? How is that determination made through the survey process?"

- Maine - Does the 5-star system also inform the public if/when the citations were determined to have been corrected? I know it differs from state to state, but in Maine, we always have a follow-up visit after our allegation of compliance is completed, so cited issues are verified to be corrected. I cannot continue with a deficient practice - there are many safeguards in place to prevent it (and rightfully so). Therefore, citations from 2004-2007 are really irrelevant.

  In terms of quality, we just finished a 3-year pilot project with our QIO. We were chosen due to our reputation as being a leader in innovative care practices. In the area of pain management, we completely renovated our program. With accolades from the QIO, we are now much more effective in addressing pain; the QIO sent copies of our program to other facilities. However, the more you look for pain, the more you find. Our QI pain rates increased rather than decreased. Are our residents in more pain? I don't think so - we're just more aggressive in

identifying it. Our residents are better cared-for; what's more important - resident care or numbers?"

- Maine – "More data on the system's inaccuracies: 2 nursing homes in Maine were rated in the 5-star system, even though they have been closed for a year. They received 1 and 3 stars."

- California – "We are a 5 star rated facility in California. We have had 3 perfect surveys in 5 years. And, like many, many others, I also disagree with the methodology, rollout, etc. with the 5 star ratings. We only scored a 2 of 5 in staffing, but yet had 3 perfect surveys. So, is CMS telling us and many others we need to spend more of their money on staffing to achieve the same results? It seems to me that our roles/jobs are to run an efficient facility without any sacrifices. So, I feel our "charge" is to train and teach the resident to be as independent as possible and to achieve the highest level of quality of care and quality of life as the resident desires."