TABLE OF CONTENTS

1 EXECUTIVE SUMMARY
3 AMERICAN HEALTH CARE ASSOCIATION MEMBERS
11 TRENDS IN QUALITY
16 REFERENCES
17 DATA SOURCE DESCRIPTIONS
EXECUTIVE SUMMARY

The American Health Care Association (AHCA) and National Center for Assisted Living (NCAL) is the nation’s premier association of long term and post-acute care providers. Together, the organization represents more than 12,000 non-profit and proprietary skilled nursing care centers, assisted living communities, sub-acute centers, and homes for individuals with intellectual and developmental disabilities. This report focuses on all skilled nursing care centers (SNCCs) nationally, including both our members as well as non-members. By delivering solutions for quality care, the Association aims to improve the lives of the millions of frail, elderly and individuals with disabilities who receive long term or post-acute care in our member centers each day.

The annual AHCA Quality Report uses mostly government data to provide an overview of the latest trends in quality for the skilled nursing care sector. The report also highlights member centers’ efforts to improve quality care through specific programs and initiatives.

THE CHANGING LONG TERM CARE POPULATION

Skilled nursing care centers (SNCCs) serve individuals who have increasingly complex medical conditions and extensive needs for care and support, as demonstrated by measures of both physical and cognitive function. In an analysis concentrating on five activities of daily living (bathing, bed mobility, transfer, toilet use and eating), nearly all (95 percent) individuals who enter a center for a Medicare-covered, post-acute stay require assistance with four or five of these activities. Among long-stay residents at centers for at least one year, 86 percent need that same level of assistance. In addition, almost two-thirds (61 percent) of long-stay residents have dementia (AHCA Quality Report, 2013).

In response to the increasing level of dependence of individuals entering SNCCs, the profession has increased the hours provided for direct nursing care. From 2009 through 2014, direct care nursing hours per resident day have steadily increased at all levels of nursing staff. Additionally, the percent of SNCCs receiving the top ratings of four or five stars in the staffing component of the Centers for Medicare & Medicaid Services (CMS) Five-Star Quality Rating System has steadily increased since 2009. Five years ago, 40 percent of centers received four or five stars on the staffing component, compared to 56 percent of centers in 2014.

OBJECTIVE MEASURES OF QUALITY CARE

On a national level, we also see quality improving steadily. In recent years, there have been across-the-board improvements in almost all the quality measures generally used in this field. The proportion of centers receiving the highest rating (i.e., five stars) on the CMS Five-Star Quality Rating System scale has increased from 13 percent in 2009 to 28 percent in 2014. However, starting in early 2015, CMS plans to rebase the scoring for the Five-Star Quality Rating System, which will result in an abrupt change, with a decrease in the proportion of centers receiving four or five stars and an increase in those receiving one or two stars. This will occur not because of a change in quality but due to CMS’ rebasing of the scoring cut points in order to force the distribution of star ratings back to an earlier time period. Thus, we will not be able to compare trends prior to 2015 once CMS rebases the rating thresholds.

In early 2012, the Association launched the Quality Initiative, a member-wide challenge to meet specific, measurable targets in four distinct areas: hospital readmissions, staff stability, customer satisfaction and the off-label use of antipsychotic medications. Since the launch of the initiative, members have demonstrated meaningful improvements in quality care for the two goals that we are able to measure using national data sets: rehospitalization and antipsychotic use.

AHCA members have reduced hospital readmissions by 14.2 percent (18.3 percent in 2011 to 15.7 percent in 2014). In that same time period, member centers reduced the off-label use of antipsychotic medications by 21.1 percent (23.7 percent in 2011 to 18.7 percent in 2014). National data on turnover and satisfaction is not yet available to adequately evaluate these two goals.

The AHCA/NCAL National Quality Award Program, based on the Baldrige framework for performance excellence, seeks to recognize those centers that embrace a broad and systematic approach to improving the overall quality of their organizations. By enhancing business practices and implementing strategic approaches to quality care, members commit to long term systematic changes in their centers. Centers that have earned awards at the Silver and/or Gold level consistently outperform other centers in objective quality metrics.

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1. Skilled Nursing Care Centers (SNCCs) is the same as Skilled Nursing Facilities (SNFs). For the purpose of this report, SNF is only utilized to refer to government programs and legislation.
2. At the time of publication, CMS had not announced the new changes to the Five-Star Quality Rating System.
A PROFESSION CENTERED ON QUALITY OUTCOMES

In addition to our Quality Initiative and Quality Award Program, AHCA has supported national policy changes to improve quality in long-term care. In the past year, AHCA supported the passage of the IMPACT Act of 2014 (H.R. 4994; Pub.L. 113–185) that will standardize the clinical assessments used across all post-acute providers, and require hospitals to provide consumers with information on the quality of post-acute providers prior to discharge from the hospital. In addition, AHCA supported the passage of the Protecting Access to Medicare Act of 2014 (H.R. 4302; Pub.L. 113–93) that will implement a 2 percent withhold of Medicare payments to all SNCCs that can be earned back based on a center’s rehospitalization rates. Both statutes also call for greater transparency with public reporting on numerous new quality measures related to post-acute care, including rehospitalization rates, discharges back to the community and improvement in functional outcomes.

The Association also supported the President’s action to strengthen the Five-Star Quality Rating System by adding new measures (e.g., rehospitalization, discharges back to the community, antipsychotic use, staffing turnover and retention) and verifying the accuracy of the information used to calculate the measures in the Five-Star Quality Rating System.

In addition, AHCA developed several new quality measures that were submitted to the National Quality Forum (NQF) for endorsement, with plans for additional measure development in the coming years. The first measure submitted to NQF, PointRight® Pro 30™, is a 30-day SNF rehospitalization measure that received endorsement in 2014.

AHCA members safely reduced the off-label use of antipsychotic medications between Q4 2011 and Q2 2014.
AMERICAN HEALTH CARE ASSOCIATION MEMBERS

The American Health Care Association (AHCA) represents a diverse group of SNCCs across the United States. AHCA and its sister organization, the National Center for Assisted Living (NCAL), also represent assisted living communities and homes for persons with intellectual and developmental disabilities. This report focuses on the skilled nursing care sector.

As of March 2014, AHCA membership includes 9,296 or 59.4 percent of the 15,663 SNCCs across the nation. Our members are a combination of for-profit, not-for-profit and government centers. AHCA’s membership includes 68.5 percent of the nation’s for-profit centers, 37.9 percent of the not-for-profit centers and 40.8 percent of the government-owned centers (Table 1.1).

### TABLE 1.1

<table>
<thead>
<tr>
<th>NATIONAL PROFILE OF SKILLED NURSING CARE CENTERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Total Number of Centers</td>
</tr>
<tr>
<td>Number of For-Profit Centers</td>
</tr>
<tr>
<td>Number of Not-for-Profit Centers</td>
</tr>
<tr>
<td>Number of Government Centers</td>
</tr>
<tr>
<td>Number of Centers Owned by Multi-Facility Organizations*</td>
</tr>
<tr>
<td>Number of Independently Owned Centers*</td>
</tr>
<tr>
<td>Number of Urban Centers</td>
</tr>
<tr>
<td>Number of Rural Centers</td>
</tr>
<tr>
<td>Average Occupancy</td>
</tr>
<tr>
<td>Average Number of Beds per Center</td>
</tr>
</tbody>
</table>

Source: The Centers for Medicare & Medicaid Services (CMS) CASPER Data, March 2014; AHCA CRM Membership, as of March 2014.

*Based on the CMS definition of multi-facility and independently owned. A Multi-Facility Organization is an organization that owns two or more long term care facilities. The owner may be an individual or a corporation. Leasing of facilities by corporate chains is included in this definition. All others are defined as independent facilities.

Nationally, 69.6 percent of all SNCCs are located in urban settings and 30.4 percent are located in rural settings. Members tend to have a slightly lower average number of beds per center, at 105.6, than non-member centers, which have an average of 109.9 beds per center. However, members have slightly higher average occupancy than non-members, at 86.2 percent, compared to 84.2 percent (Table 1.1).
AHCA QUALITY INITIATIVE AND ACTIVITIES

The Association is committed to quality improvement and encourages its members to participate in quality improvement efforts, including the AHCA Quality Initiative, LTC Trend Trackers<sup>®</sup>, the AHCA/NCAL National Quality Award Program, and Advancing Excellence.

AHCA Quality Initiative

AHCA announced its Quality Initiative in February 2012 and set four specific, measurable goals with a target date to accomplish them. They include:

- **Safely Reduce Hospital Readmissions**: By March 2015, safely reduce the number of hospital readmissions within 30 days during a SNCC stay by 15 percent.
- **Safely Reduce the Off-label Use of Antipsychotics**: Among long-stay residents by 25 percent by December 2015 and 30 percent by December 2016.<sup>3</sup>
- **Increase Staff Stability**: By March 2015, reduce turnover among nursing staff (RN, LPN/LVN, CNA)<sup>4</sup> by 15 percent.
- **Increase Customer Satisfaction**: By March 2015, increase the percentage of customers who would recommend the center to others up to 90 percent.

The Quality Initiative embraces and supports the triple aim of improving the patient care experience, improving the health of populations and reducing the per-capita cost of health care.

**Safely Reduce Hospital Readmissions**

Hospital readmissions from SNCCs have potentially negative impacts on the physical, mental and emotional well-being of individuals. The high number of readmissions has been identified by policymakers as a key opportunity to reduce health care costs and improve quality of care. This past year Congress passed the AHCA-supported SNF Value Based Purchasing (VBP) legislation that imposes a 2 percent withhold on all SNF Part A payments, of which between 50–70 percent may be earned back based on a center’s rehospitalization rates (H.R. 4302; Pub.L. 113–93). This aligns nursing centers with the Hospital Readmission Reduction Program that levies a payment penalty to hospitals for high readmission rates.

AHCA is measuring progress of this goal using the PointRight<sup>®</sup> Pro 30™ rehospitalization metric, which has been endorsed by the National Quality Forum (NQF). This is an all-cause measure of 30-day readmissions from the SNCC setting that is risk-adjusted using 33 demographic and clinical factors to achieve comparability across centers, which is available at ahcancal.org/research. It is calculated using Minimum Data Set (MDS) 3.0 data from a 12-month period.

**FIGURE 1.1**

AVERAGE REHOSPITALIZATION RATE—AHCA MEMBERS

![Graph showing average rehospitalization rates for AHCA members from 2011 Q4 to 2014 Q2.](image)

Source: CMS MDS data based on PointRight<sup>®</sup> Pro 30™ measure.

Note: AHCA membership as of October 2014.

From the baseline period of the fourth quarter of 2011 through the second quarter of 2014, AHCA members have reduced hospital readmissions by 14.2 percent (18.3 percent in 2011 to 15.7 percent in 2014) (Figure 1.1). During this period, 50.5 percent of AHCA member centers have already achieved the three-year goal of a 15 percent reduction. As a result, members have successfully avoided a total of 38,011 hospital readmissions in the first two years of this initiative. Figure 1.2 shows the change in rehospitalization rates by state from 2011 to 2014. Twenty-four states have already achieved an average 15 percent reduction in rehospitalization rates.

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3. Updated September 2014.
4. RN: registered nurse; LPN/LVN: licensed practical nurse/licensed vocational nurse; CNA: certified nursing assistant.
Safely Reduce the Off-Label Use of Antipsychotics

Studies have demonstrated that antipsychotic medications provide only a small benefit for a limited set of individuals with dementia, but pose a large risk of adverse events (Ballard, Waite, & Birks, 2006; Maher et al., 2011). In 2012, the Centers for Medicare & Medicaid Services (CMS) launched the National Partnership to Improve Dementia Care in Nursing Homes, which AHCA supported, setting the goal of a 15 percent reduction. That goal was achieved as of the end of 2014. In September 2014, CMS along with AHCA and others set new goals to continue reducing the use of antipsychotic medications in nursing centers by 25 percent in 2015 and 30 percent in 2016, as compared to the original 2011 baseline period.

The progress on this goal is measured using the CMS quality measure on the prevalence of off-label use of antipsychotic medications in SNCCs for long-stay residents, which is published on Nursing Home Compare. Member centers have seen a steady decrease in the use of antipsychotics from 2011 to 2014 (Figure 1.3). Overall, AHCA members have achieved an average 21.1 percent decrease in the use of antipsychotic medications, with 57.0 percent exceeding the initial 15 percent reduction goal. As a result of these efforts, about 32,400 individuals in AHCA member centers are no longer receiving these medications.
Figure 1.4 shows the average change in off-label use of antipsychotics in each state from 2011 to 2014 compared to the goals set for 2014, 2015 and 2016. Overall, 43 states have exceeded the 2014 goal of a 15 percent reduction and 16 states have already achieved the 2015 goal, of which nine states also have achieved the 2016 goal of a 30 percent reduction compared to their 2011 baseline rates.

**REDUCTION IN OFF-LABEL USE OF ANTIPSYCHOTICS**

As of 2014, 43 states have exceeded the 2014 goal of a 15 percent reduction. Nine states have achieved the 2016 goal of a 30 percent reduction compared to their 2011 rates.

**Increase Staff Stability**

Studies have found that higher levels of turnover in SNCCs are associated with lower quality of care (Castle & Anderson, 2011). The largest national source of nursing care center turnover and retention data is the Nursing Facility Staffing Survey conducted by AHCA. The survey is distributed to all nursing care centers in the United States, regardless of AHCA membership, and measures turnover and retention from the prior year. Survey responses can be submitted electronically or via hard copy. More than 4,000 SNCCs participated in the most recent survey, reporting data for calendar year 2013. This survey measures turnover by dividing the number of staff who left (voluntarily or otherwise) in a given year by the total number of current employees at the end of the calendar year. Retention is measured by dividing the number of employees who have worked in the center for at least 12 months by the total number of employees at the end of the calendar year.

In 2013, median turnover rates for all staff and direct care staff were lower than in 2011. Additionally, median turnover rates for the direct care staff categories of RN, LPN and CNA were lower in 2013 than 2011 (Table 1.2).
TABLE 1.2
AHCA MEMBER MEDIAN TURNOVER RATES

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Staff</td>
<td>45.1%</td>
<td>45.2%</td>
<td>40.6%</td>
</tr>
<tr>
<td>Direct Care Staff</td>
<td>50.0%</td>
<td>51.4%</td>
<td>44.4%</td>
</tr>
<tr>
<td>RN</td>
<td>50.0%</td>
<td>50.0%</td>
<td>44.4%</td>
</tr>
<tr>
<td>LPN</td>
<td>36.8%</td>
<td>37.5%</td>
<td>30.8%</td>
</tr>
<tr>
<td>CNA</td>
<td>51.9%</td>
<td>52.4%</td>
<td>45.8%</td>
</tr>
</tbody>
</table>

Source: Nursing Facility Staffing Survey conducted by AHCA.
Note: AHCA membership as of October 2014.

In 2013, median retention rates also improved for all staff, direct care staff, LPNs and CNAs from those in 2011, and stayed the same for RNs (Table 1.3).

TABLE 1.3
AHCA MEMBER MEDIAN RETENTION RATES

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Staff</td>
<td>71.5%</td>
<td>71.0%</td>
<td>73.1%</td>
</tr>
<tr>
<td>Direct Care Staff</td>
<td>68.7%</td>
<td>67.8%</td>
<td>70.0%</td>
</tr>
<tr>
<td>RN</td>
<td>66.7%</td>
<td>66.7%</td>
<td>66.7%</td>
</tr>
<tr>
<td>LPN</td>
<td>75.0%</td>
<td>74.1%</td>
<td>76.0%</td>
</tr>
<tr>
<td>CNA</td>
<td>68.3%</td>
<td>67.5%</td>
<td>69.6%</td>
</tr>
</tbody>
</table>

Source: Nursing Facility Staffing Survey conducted by AHCA.
Note: AHCA membership as of October 2014.

Increase Customer Satisfaction

Measuring customer satisfaction enables SNCCs to gain essential insight into their performance in offering quality of care and quality of life from the perspective of the individuals they serve and their families. There is no single customer satisfaction survey that is consistently used in the long term and post-acute care field. As there is no one commonly used survey, AHCA lacks the data to allow measurement of progress on this goal across all members.

To address this, AHCA’s Customer Experience Committee—in conjunction with Dr. Nicholas Castle from the University of Pittsburgh—has developed the CoreQ, a set of three questions for long-stay residents and family members and an additional fourth question for individuals discharged following short-stay rehabilitation care.

These two questionnaires along with the resulting quality measure (percent of respondents who are satisfied) have been pilot tested and validated. AHCA is in the process of submitting the measure based on the CoreQ questionnaire to NQF for endorsement. Several satisfaction vendors are also adding these questions to their questionnaires, which will allow for national benchmarking in the future.

CoreQ Questions and Rating Scales

CoreQ—Short-Stay Discharge

1. In recommending this facility to your friends and family, how would you rate it overall?
   ① Poor  ② Average  ③ Good  ④ Very Good  ⑤ Excellent

2. Overall, how would you rate the staff?
   ① Poor  ② Average  ③ Good  ④ Very Good  ⑤ Excellent

3. How would you rate the care you receive?
   ① Poor  ② Average  ③ Good  ④ Very Good  ⑤ Excellent

4. How would you rate how well your discharge needs were met?
   ① Poor  ② Average  ③ Good  ④ Very Good  ⑤ Excellent

CoreQ—Long-Stay Residents and/or Long-Stay Family Members

1. In recommending this facility to your friends and family, how would you rate it overall?
   ① Poor  ② Average  ③ Good  ④ Very Good  ⑤ Excellent

2. Overall, how would you rate the staff?
   ① Poor  ② Average  ③ Good  ④ Very Good  ⑤ Excellent

3. How would you rate the care you receive?* 
   ① Poor  ② Average  ③ Good  ④ Very Good  ⑤ Excellent

*The question for family members is “How would you rate the care your family member received?”
AHCA PROGRAMS TO ADVANCE PERFORMANCE

AHCA provides its members resources to help improve the quality of care they provide. Two of these are highlighted below.

LTC Trend Tracker

LTC Trend Tracker™ is an exclusive web-based tool for members that allows them to access key information that can help their organizations succeed (Figure 1.5.). It offers important metrics not found elsewhere such as an MDS-based, risk adjusted readmissions measure (PointRight® Pro 30™), discharge back to the community and length of stay measures. Additionally, members can use prediction tools to identify changes to their Five-Star Quality Rating System performance, search for Resource Utilization Group (RUG) information and keep track of their quality improvement. LTC Trend Tracker™ allows the creation of custom reports, and offers member centers options to choose their peer group comparisons so that they can individualize analysis to meet their performance improvement needs.

FIGURE 1.5
INFORMATION AVAILABLE ON LTC TREND TRACKER

- Survey History
- Resident Characteristics
- Staffing Information
- AHCA Post-Acute Measures
- CMS Five-Star Rating

AHCA/NCAL National Quality Award Program

The AHCA/NCAL National Quality Award Program is a progressive, three-step program based on the nationally recognized Baldrige Performance Excellence criteria. Members can apply for recognition at the Bronze, Silver and Gold levels. As an organization progresses through the levels, applicants must showcase a more detailed and comprehensive demonstration of systematic quality performance and organizational effectiveness.

The program is a member of the Alliance for Performance Excellence, an association of the 33 recognized Baldrige-based award programs in the nation. The AHCA/NCAL program is the largest of these programs, with a volume of applications that exceeds the combined total of all the other 32 programs and the National Baldrige program. From 2010–2013, the state and national Baldrige programs received a total of 691 applications; whereas, in the same timeframe, the AHCA/NCAL Quality Award Program received 3,946 applications.

As of the 2014 award cycle, 2,988 members have achieved the Bronze Award, 365 members have achieved the Silver Award, and 24 members have achieved the Gold Award. These members are well suited to meet the forthcoming regulatory requirements of Quality Assurance and Performance Improvement (QAPI), mandated for implementation in SNCCs by the Affordable Care Act (ACA), due to the parallels that exist between the criteria of the Quality Award Program and the five elements of QAPI. Both QAPI and the Quality Award Program utilize a systematic approach to organizational performance and focus on leadership, responding to staff and customers, and demonstrating results (Kaldy, 2013).

Research demonstrates that AHCA/NCAL Gold and Silver Quality Award recipients have better outcomes than other AHCA members. For instance, Silver and Gold Award recipients from 2012–2014 have lower rates of readmissions and antipsychotic use (Figures 1.6 and 1.7).
FIGURE 1.6
TREND IN AVERAGE RISK-ADJUSTED REHOSPITALIZATION RATE FOR SILVER AND GOLD QUALITY AWARD RECIPIENTS AND ALL OTHER MEMBERS

Source: CMS MDS data based on PointRight® Pro 30™ measure.

FIGURE 1.7
TREND IN AVERAGE RATE OF OFF-LABEL USE OF ANTIPSYCHOTICS FOR SILVER AND GOLD QUALITY AWARD RECIPIENTS AND ALL OTHER MEMBERS

Source: CMS Nursing Home Compare (one quarter average).
Silver and Gold recipients also have better performance on CMS’ Five-Star Quality Rating System than other AHCA/NCAL members. For instance, in 2014 35.9 percent of Silver and Gold recipients from 2012–2014 had a 5-star rating compared to 29.8 percent of other members (Figure 1.8).

Lastly, on average Silver and Gold recipients (2012–2014) also tend to have a higher occupancy rate than other AHCA/NCAL members. This serves as evidence that a focus on quality can translate into better business outcomes. In the first quarter of 2014, Silver and Gold recipients (2012–2014) had an average occupancy rate of 86.1 percent compared to the 82.6 percent occupancy rate of other members (Figure 1.9).
SKILLED NURSING CARE CENTER QUALITY MEASURES

Skilled nursing care center (SNCC) quality measures are calculated by the Centers for Medicare & Medicaid Services (CMS) based on clinical information collected at the bedside by nurses and other clinicians using a standardized assessment tool—the Minimum Data Set (MDS). The current quality measures are available on Nursing Home Compare (www.medicare.gov) for all Medicare- and/or Medicaid-certified SNCCs in the United States starting from the fourth quarter of 2011. There are five short-stay quality measures and 13 long-stay quality measures.

All the quality measures except for one—long-stay residents who are incontinent of bowel and bladder—are showing improving trends from the fourth quarter of 2011 to the second quarter of 2014 (Table 2.1). Lower numbers indicate better quality for all quality measures except for the four vaccination measures. Some changes are quite large and correspond with national quality improvement efforts. For instance, the percent of long-stay residents who receive an antipsychotic medication for off-label use has decreased to 19.8 percent in the second quarter of 2014 from 23.9 percent in the fourth quarter of 2011, corresponding to CMS’ National Partnership to Improve Dementia Care in Nursing Homes and AHCA’s Quality Initiative. Likewise, the instance of individuals with a urinary tract infection has decreased from 7.8 percent to 5.8 percent from the fourth quarter of 2011 to the second quarter of 2014, corresponding to the Department of Health and Human Services’ (HHS) National Action Plan to Prevent Health Care Associated Infections and the Agency for Healthcare Research and Quality’s (AHRQ) effort to reduce catheter-associated infections.

<table>
<thead>
<tr>
<th>TABLE 2.1</th>
<th>QUALITY MEASURE RATES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2011 Q4</td>
</tr>
<tr>
<td>Percent of Long-Stay Residents Who:</td>
<td></td>
</tr>
<tr>
<td>Receive an Antipsychotic Medication for Off-Label Use</td>
<td>23.9%</td>
</tr>
<tr>
<td>Have a Pressure Ulcer (High Risk)</td>
<td>7.0%</td>
</tr>
<tr>
<td>Are Physically Restrained</td>
<td>2.4%</td>
</tr>
<tr>
<td>Have Increasing Symptoms of Depression or Anxiety</td>
<td>7.2%</td>
</tr>
<tr>
<td>Experience One or More Falls with Major Injury</td>
<td>3.4%</td>
</tr>
<tr>
<td>Have Moderate to Severe Pain</td>
<td>12.5%</td>
</tr>
<tr>
<td>Have Weight Loss</td>
<td>7.2%</td>
</tr>
<tr>
<td>Experience Increased Dependency in ADLs</td>
<td>16.8%</td>
</tr>
<tr>
<td>Have an Indwelling Urinary Catheter</td>
<td>4.3%</td>
</tr>
<tr>
<td>Are Incontinent of Bowel or Bladder (Low Risk)</td>
<td>41.5%</td>
</tr>
<tr>
<td>Have a Urinary Tract Infection</td>
<td>7.8%</td>
</tr>
<tr>
<td>Are Assessed and Appropriately Given the Seasonal Influenza Vaccine</td>
<td>91.0%</td>
</tr>
<tr>
<td>Are Assessed and Appropriately Given the Pneumococcal Vaccine</td>
<td>94.0%</td>
</tr>
</tbody>
</table>

| Percent of Short-Stay Residents Who: | | | | |
| Are Started on an Antipsychotic Medication for Off-Label Indication | 3.0% | 3.0% | 2.7% | 2.4% |
| Have Moderate to Severe Pain | 23.1% | 22.5% | 19.6% | 18.8% |
| Have One or More Pressure Ulcer(s) That Are New or Worsening | 2.1% | 1.7% | 1.3% | 1.0% |
| Are Assessed and Appropriately Given the Seasonal Influenza Vaccine | 80.6% | 83.1% | 84.6% | 84.4% |
| Are Assessed and Appropriately Given the Pneumococcal Vaccine | 80.6% | 82.1% | 83.2% | 82.9% |

Source: CMS Nursing Home Compare quality measure data (MDS 3.0), three quarter average.
1. 2011 Q4 was the first quarter in which MDS 3.0 based quality measures were available.
FIVE-STAR RATING

The CMS Five-Star Quality Rating System was incorporated into CMS’ Nursing Home Compare web-based consumer information system in 2008. The system provides a rating from one star (lower quality) through five stars (higher quality) for each of the following areas: health inspections, staffing and quality measures, as well as an overall aggregate rating combining all three areas. From 2009 to 2014, the proportion of SNCCs receiving five stars has increased from 13 percent to 28 percent. At the same time, the proportion of SNCCs receiving one star has decreased from 21 percent to 9 percent (Figure 2.1). However, starting in early 2015 CMS plans to rebase the scoring for the Five-Star Rating System, which will result in an abrupt change with a decrease in the proportion of SNCCs receiving four or five stars and an increase in those receiving one or two stars. This will occur not because of a change in quality but due to CMS’ rebasing of the scoring cut points.

Starting in July 2012, CMS set and maintained cut points to achieve each level of star rating. Knowing the cut points to achieve the rating allowed SNCCs to set targets for improvement and resulted in dramatic improvements, as seen in Figure 2.2, consistent with the academic literature on the power of setting targets to drive improvement in healthcare.

REGULATORY COMPLIANCE MEASURES

Federal law requires that SNCCs that are Medicare- and/or Medicaid-certified comply with the requirements that are present in 42 CFR Part 483, Subpart B. To assess this compliance, SNCCs are inspected by state surveyors who are contracted by CMS. These inspections are conducted unannounced annually and are referred to as “standard surveys.” Each Medicare- and/or Medicaid-certified center is required to have a standard survey conducted at least once every nine to 15 months. If a complaint is lodged against the nursing center or the SNCC self-reports a potentially bad outcome (e.g., a fall), a focused survey, referred to as a “complaint survey,” may also be conducted at a separate time from the standard survey. A citation is given to the center during a survey if it fails to comply with any of the 174 different regulatory requirements, referred to as “F-tags.” Each citation is rated based on the scope of the deficiency (e.g., how common the deficiency is) and its severity (e.g., how much potential or actual harm may occur). Certain citations are classified as Substandard Quality of Care (SQC). These citations are for deficiencies in the regulatory categories of resident behavior and center practices, quality of life or...
quality of care that are also rated as more severe, such as immediate jeopardy; or a pattern of widespread actual harm; or a widespread potential for more than minimal harm. Points are assigned for each deficiency, which CMS uses to calculate a survey score that is used in the Five-Star Quality Rating System (Table 2.2).

### TABLE 2.2
HEALTH INSPECTION SCORE: WEIGHTS FOR DIFFERENT TYPES OF DEFICIENCIES

<table>
<thead>
<tr>
<th>Severity</th>
<th>Isolated</th>
<th>Pattern</th>
<th>Widespread</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Jeopardy to Resident Health or Safety</td>
<td>J 50 points* (75 points)</td>
<td>K 100 points* (125 points)</td>
<td>L 150 points* (175 points)</td>
</tr>
<tr>
<td>Actual Harm That Is Not Immediate Jeopardy</td>
<td>G 20 points</td>
<td>H 35 points (40 points)</td>
<td>I 45 points (50 points)</td>
</tr>
<tr>
<td>No Actual Harm with Potential for More Than Minimal Harm That Is Not Immediate Jeopardy</td>
<td>D 4 points</td>
<td>E 8 points</td>
<td>F 16 points (20 points)</td>
</tr>
<tr>
<td>No Actual Harm with Potential for Minimal Harm</td>
<td>A 0 points</td>
<td>B 0 points</td>
<td>C 0 points</td>
</tr>
</tbody>
</table>

Note: Figures in parentheses indicate points for deficiencies that are for substandard quality of care. Shaded cells denote deficiency scope/severity levels that constitute substandard quality of care if the requirement that is not met is one that falls under the following federal regulations: 42 CFR 483.13 resident behavior and nursing home practices; 42 CFR 483.15 quality of life; 42 CFR 483.25 quality of care.

Table 2.3 shows that from 2009 to 2012, the average total number of survey citations in SNCCs steadily decreased and has since remained essentially unchanged through 2014. Similarly, the percent of SNCCs with citations at scope and severity level G or above, with SQC citations or with citations classified as posing immediate jeopardy (IJ) to residents also decreased from 2009 to 2012 and then remained essentially unchanged through 2014.

The percent of SNCCs that have had citation-free standard and complaint surveys has increased from 2009 to 2014, going from 6.2 percent to 8.3 percent (Figure 2.3). Because CMS fixes the distribution of SNCCs receiving one to five stars on the survey component in the Five-Star Quality Rating System, these improvements in deficiencies cited by CMS are not apparent in the 5-star ratings.

### TABLE 2.3
TRENDS IN SKILLED NURSING CARE CENTER CITATIONS

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Number of Deficiency Citations in Nursing Centers</td>
<td>8.8</td>
<td>8.3</td>
<td>7.8</td>
<td>7.0</td>
<td>7.3</td>
<td>7.2</td>
</tr>
<tr>
<td>Percent of Nursing Centers Cited at Level “G” or Above</td>
<td>25.2%</td>
<td>22.7%</td>
<td>21.7%</td>
<td>17.5%</td>
<td>17.6%</td>
<td>17.3%</td>
</tr>
<tr>
<td>Percent of Nursing Centers with Substandard Quality of Care Citations</td>
<td>7.1%</td>
<td>6.4%</td>
<td>6.1%</td>
<td>5.0%</td>
<td>5.1%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Percent of Nursing Centers with Immediate Jeopardy Citations</td>
<td>6.1%</td>
<td>5.3%</td>
<td>5.5%</td>
<td>4.2%</td>
<td>4.4%</td>
<td>4.5%</td>
</tr>
</tbody>
</table>

Source: CMS CASPER, March of each year. Standard and Complaint Health Survey Data.
Adverse events and patient safety issues are also an important quality metric gaining national attention in SNCCs. Table 2.4 reports on trends in specific citations for three safety-related deficiencies. In the six-year time period reported, the frequency of centers without a medication error citation steadily increased, with a small drop in 2014 to 90.3 percent. In other words, 90 percent of centers did not have a citation for medication error in 2014. However, the number of nursing centers free of citations for use of unnecessary drugs and infection control has dropped since 2009.

<table>
<thead>
<tr>
<th>TABLE 2.4</th>
<th>TRENDS IN SKILLED NURSING CARE CENTER SAFETY MEASURES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2009</td>
</tr>
<tr>
<td>Percent of Centers without a Medication Error Citation</td>
<td>88.9%</td>
</tr>
<tr>
<td>Percent of Centers without an Unnecessary Drug Citation</td>
<td>79.9%</td>
</tr>
<tr>
<td>Percent of Centers without an Infection Control Citation</td>
<td>79.3%</td>
</tr>
</tbody>
</table>

Source: CMS CASPER, March of each year. Standard and Complaint Health Survey Data.

WORKFORCE

The SNCC workforce consists of individuals from many professions, including CNAs, LPNs, RNs, nurses with administrative duties (ARNs), nurse practitioners, therapists, dietary staff, social workers, housekeeping personnel, social services staff, activity professionals and administrative workers. In 2013, SNCCs employed a total of 1,656,760 individuals (United States Department of Labor, Bureau of Labor Statistics, 2013).
SKILLED NURSING CARE CENTER STAFFING

CMS collects information on actual staffing hours worked during the two-week period prior to their unannounced annual survey inspection. CMS uses this data combined with data on the residents in each SNCC to calculate and report the hours per resident per day. During the period from 2009 through 2014, the direct care nursing hours per resident day have steadily increased at all levels of nursing staff (Figure 2.4). For instance, RN hours per resident day have increased from 0.32 in 2009 to 0.46 in 2014. This is a positive trend, as research has demonstrated that staffing is associated with the quality of care in SNCCs and correlates with the trends we see of improvements in survey deficiencies and quality measures. For instance, a 2011 study shows that every additional hour of CNA staffing per resident day is associated with a 10 percent decrease in the total deficiency score of a center. A six-minute increase is associated with a 3 percent decrease in the quality of care deficiency score. Conversely, a one-hour decrease in CNA staffing per resident day is associated with a 33 percent increase in quality of care deficiencies (Hyer et al., 2011).

The staffing component of the Five-Star Quality Rating System is based on the number of RN hours per resident day and the number of total nursing hours per resident day (including RNs, LPNs and CNAs). The staffing measures are adjusted to account for variations in the acuity of residents in different nursing care centers (Abt Associates, 2013). As shown in Figure 2.5 the percent of nursing care centers receiving the top ratings of four or five stars in the staffing component has steadily increased since 2009. In 2009, 40 percent of centers received either four or five stars, compared to 56 percent that received those ratings in 2014. The converse trend of decreases in one and two stars also holds true. In 2009, 40 percent of centers had one or two stars, compared to only 25 percent in 2014.

Since 2009, the proportion of skilled nursing care centers receiving a 5-star rating in the staffing component has increased from 7 percent to 12 percent, an increase of more than 70 percent.
REFERENCES


Minimum Data Set (MDS) 3.0: The MDS is a comprehensive, standardized assessment instrument completed by the nursing center staff for every resident on admission and at regular intervals during each person’s stay. The assessment includes the resident’s physical, cognitive, emotional and clinical conditions and abilities; care needs; preferences; and life care choices. Nursing center staff use the assessment to develop a plan of care for each resident. Information collected using the MDS assessment is also used to determine payment rates for all Medicare stays and in many state Medicaid programs. The data are also used to generate quality measures. The data collected using the MDS is housed in a national database.

CMS Nursing Home Compare (Five-Star Quality Rating System): The overall 5-star rating includes the following domains: (1) health inspections, (2) direct care staffing and (3) MDS-based quality measures. The ratings are updated on a monthly basis with any new data generated as a result of recent annual, complaint and revisit health inspections, and on a quarterly basis with new quality measure data.

Health Inspections Domain: A health inspection score is calculated based on points assigned to deficiencies identified during a nursing center’s most recent and two prior annual health inspections, referred to as surveys, as well as any deficiency findings resulting from surveys conducted based on complaints over the most recent three years and during revisit surveys, conducted to verify resolution of previously identified deficiencies. More weight is placed on recent inspections in calculating a rating.

Staffing Domain: The staffing domain is based on two measures: (1) registered nurse hours per resident day and (2) total staffing hours per resident day. Total staffing hours include registered nurses, licensed practical nurses/licensed vocational nurses and certified nursing assistants. The rating is adjusted to account for the acuity of residents being served in the center. The data for this domain are derived from a report centers are required to complete and submit to state surveyors at the time of their annual health inspection.

Quality Measure Domain: The quality measure domain is based on nine of the 18 quality measures that are currently on the Nursing Home Compare website, which can be found at www.medicare.gov. These include seven measures specific to long-stay residents and two specific to short-stay residents. Quality measure data are updated quarterly in January, April, July and October. The nursing home quality measures are calculated using the MDS resident assessment data that nursing homes routinely collect about residents at specified intervals during their stay (see above description of MDS 3.0). These measures capture specific care processes and clinical outcomes.

Nursing Facility Staffing Survey: The survey is conducted annually by AHCA to collect retention and turnover information for all nursing center employees, including administrative and management, nursing, therapy, food services, housekeeping and maintenance, and social services and activities staff. All federally certified nursing homes in the nation are invited to participate in this survey, regardless of AHCA membership.

CMS Certification and Survey Provider Enhanced Reporting (CASPER): This database includes information on resident census, staffing, health and life safety deficiency citations, as well as complaint investigations for all Medicare- and Medicaid-certified nursing centers in the nation. Onsite inspections, referred to as standard surveys, are conducted by state agencies and are required by federal law for each nursing center. Each skilled nursing care center is surveyed every nine to 15 months, and each state agency must average 12 months between the surveys for all of the nursing centers in their state.

PointRight® Pro 30™: PointRight’s risk-adjusted measure of 30-day, all-cause reshospitalizations from skilled nursing facilities is calculated using data from MDS 3.0 assessments over a 12-month period. The reshospitalization measure was developed by PointRight, validated by Brown University and endorsed by the National Quality Forum. AHCA has adopted the measure for our use and for distribution to members. Admission assessments are used to generate the denominator (admissions from acute care hospitals) and 33 variables used in risk adjustment, while discharge assessments are used to determine the numerator (returns to the hospital).