# Colorado Department of Health Care Policy and Financing

## 2023 Nursing Facility Pay for Performance Application Review

### Data Report

June 2023

PUBLIC CONSULTING GROUP

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# INTRODUCTION & APPROACH

Colorado started the Nursing Facility Pay for Performance (P4P) Program on July 1, 2009, per *10 CCR 2505 section 8.443.12*. The Department of Health Care Policy and Financing (the Department) makes supplemental payments to nursing home throughout the State based on the achievement of performance measures around quality of life and quality of care for each participating home's residents. Nursing homes complete a P4P Application which consists of quality of life and quality of care measures with various points assigned to the fulfillment of each measure, totaling 100 points per application. There are minimum requirements and criteria within each performance measure that a home must meet to receive the points for a specific measure.

Public Consulting Group LLC (PCG) was contracted by the Department to review, evaluate, and validate nursing home applications for the 2023 P4P program. PCG utilized a specially developed web-based portal to collect application submissions. This was the fifth year in which the P4P online application system portal was used, and this year's portal included enhanced functionality to improve the user interface.

The application submission deadline was February 28, 2023. For the 2023 program year, there were 126 submitted applications. Once all applications were received, PCG began the application review process. This process included: conducting internal trainings for the review team; reviewing submitted scores, documentation, and appendices/tools for each home; conducting quality assurance reviews; conducting on-site validation reviews; generating review results reports; notifying providers of their results; and conducting an appeals process.

This year's process also included the sixth iteration of the "preliminary review" which afforded homes the opportunity to resubmit missing or incorrect documentation before the final review commenced. Overall, this process has proven to be very successful as many homes received points that they may not have been able to obtain in previous years.

The following pages highlight the results and analysis from the application review process for the 2023 P4P program year.

# 2023 P4P APPLICATION SCORING AND ANALYSIS

## PREREQUISITES

As in previous years, nursing homes had to meet certain prerequisite criteria to be eligible for participation in the P4P program. These prerequisites have remained consistent over the course of the program, with slight modifications to the submission requirements:

1) **Colorado Department of Public Health and Environment (CDPHE) Survey:** A home was not eligible to participate in the program if it had substandard deficiencies documented during the previous calendar year. Utilizing CMS data, PCG confirmed that all participants met the CDPHE prerequisite requirement:

   *"Substandard quality of care means one or more deficiencies related to participation requirements under 42 CFR 483.13, resident behavior and home practices, 42 CFR 483.24, quality of life, or 42 CFR 483.25, quality of care, that constitute either immediate jeopardy to resident health or safety (level J, K, or L); a pattern of or widespread actual harm that is not immediate jeopardy (level H or I); or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm (level F)."*

   PCG analyzed substandard deficiencies data from Calendar Year (CY) 2022 and found that eleven facilities had a total of 11 tags that disqualified them from the 2023 application. Two of these facilities had participated in the P4P program in a prior year and were not eligible to submit in 2023. One of these homes submitted an application and was notified that their home's substandard deficiency tag made them ineligible to participate in the program.

2) **Resident/Family Satisfaction Survey**: A home must include a survey that was developed, recognized, and standardized by an entity external to the home, and is administered on an annual basis. Additionally, facilities had to report their average daily census for CY2022, the number of residents/families contacted for this survey, the number of residents/families who responded to this survey, the name of the vendor conducting the survey, who administered the survey, and how the survey was administered.

   The web portal required providers to submit this survey information prior to completing the remainder of the application. Table 1 displays the data collected for this prerequisite for the 126 participating nursing facilities.

   - Across the facilities who completed the P4P application, the average daily census values ranged from 25 to 161, with a median of 70 and a program average of 72.
   - The number of residents/families contacted ranged from 11 to 1,834, with a median of 58 and an average of 107.
   - The number of residents/families responded ranged from 3 to 1,271, with a median of 45 and an average of 62.
   - The survey response rate ranged from 6% to 132%, with a median of 88% and an average of 75%.
   - The most used vendors were Pinnacle Quality Insight, Activated Insights, NRC Health, and CORTEX.

**Table 1 – Prerequisite: Resident/Family Satisfaction Survey Data**

| Home Name | Average Daily Census for CY2022 | # of residents/ families contacted | # of residents/ families responded | Response Rate |
|---|---|---|---|---|
| Adara Living | 151 | 162 | 154 | 95% |
| Allison Care Center | 56 | 194 | 22 | 11% |

| Home Name | Average Daily Census for CY2022 | # of residents/ families contacted | # of residents/ families responded | Response Rate |
|---|---|---|---|---|
| Arborview Senior Community | 101 | 469 | 140 | 30% |
| Arvada Care and Rehabilitation Center | 47 | 31 | 31 | 100% |
| Autumn Heights Health Care Center | 75 | 84 | 41 | 49% |
| Avamere Transitional Care and Rehabilitation- Malley | 92 | 134 | 132 | 99% |
| Belmont Lodge Health Care Center | 70 | 50 | 50 | 100% |
| Bent County Healthcare Center | 51 | 46 | 33 | 72% |
| Berkley Manor Care Center | 63 | 25 | 23 | 92% |
| Berthoud Care and Rehabilitation | 61 | 58 | 58 | 100% |
| Beth Israel at Shalom Park | 119 | 200 | 120 | 60% |
| Boulder Canyon Health and Rehabilitation | 104 | 96 | 24 | 25% |
| Briarwood Health Care Center | 79 | 52 | 44 | 85% |
| Brighton Care Center | 64 | 130 | 129 | 99% |
| Broadview Health and Rehabilitation Center | 76 | 53 | 57 | 108% |
| Brookside Inn | 112 | 124 | 121 | 98% |
| Bruce McCandless CO State Veterans Nursing Home | 53 | 38 | 37 | 97% |
| Cambridge Care Center | 75 | 272 | 55 | 20% |
| Castle Peak Senior Life and Rehabilitation | 36 | 38 | 39 | 103% |
| Cedars Healthcare Center | 82 | 39 | 39 | 100% |
| Centre Avenue Health & Rehab | 82 | 38 | 35 | 92% |
| Centura Health- Medalion Health Center | 96 | 41 | 30 | 73% |
| Cheyenne Mountain Center | 135 | 82 | 63 | 77% |
| Christian Living Communities Suites at Someren Glen Care Center | 86 | 37 | 35 | 95% |
| Christopher House Rehabilitation and Care Community | 67 | 81 | 71 | 88% |
| Clear Creek Care Center | 61 | 221 | 57 | 26% |
| Colonial Health and Rehabilitation Center | 68 | 40 | 40 | 100% |
| Colorado State Veterans Nursing Home- Rifle | 51 | 56 | 56 | 100% |
| Colorado Veterans Community Living Center at Homelake | 40 | 41 | 41 | 100% |
| Colorow Care Center | 55 | 248 | 58 | 23% |
| Columbine West Health and Rehab Facility | 85 | 36 | 35 | 97% |
| Cottonwood Care Center | 66 | 81 | 42 | 52% |
| Cottonwood Rehabilitation and Healthcare | 33 | 30 | 25 | 83% |
| Creekside Village Health and Rehabilitation Center | 81 | 61 | 55 | 90% |
| Crestmoor Health and Rehabilitation | 70 | 54 | 48 | 89% |
| Crowley County Nursing Center | 35 | 46 | 33 | 72% |
| Denver North Care Center | 74 | 82 | 69 | 84% |
| Desert Willow Health and Rehabilitation Center | 70 | 37 | 42 | 114% |
| Devonshire Acres | 70 | 71 | 63 | 89% |

| Home Name | Average Daily Census for CY2022 | # of residents/ families contacted | # of residents/ families responded | Response Rate |
|---|---|---|---|---|
| E Dene Moore Care Center | 38 | 30 | 9 | 30% |
| Eagle Ridge of Grand Valley | 54 | 65 | 31 | 48% |
| Eben Ezer Lutheran Care Center | 74 | 76 | 35 | 46% |
| Elevation Health and Rehabilitation Center | 54 | 35 | 28 | 80% |
| Elk Ridge Health and Rehabilitation Center | 46 | 28 | 37 | 132% |
| Englewood Post Acute and Rehabilitation | 70 | 44 | 36 | 82% |
| Evergreen Nursing Home | 67 | 11 | 11 | 100% |
| Fairacres Manor, Inc. | 105 | 404 | 57 | 14% |
| Falcon Heights Health and Rehabilitation Center | 74 | 48 | 48 | 100% |
| Forest Ridge Senior Living, LLC | 67 | 108 | 108 | 100% |
| Forest Street Compassionate Care Center | 50 | 46 | 33 | 72% |
| Fountain View Health and Rehabilitation Center | 79 | 47 | 47 | 100% |
| Good Samaritan Society - Fort Collins Village | 37 | 55 | 33 | 60% |
| Good Samaritan Society- Loveland Village | 79 | 80 | 65 | 81% |
| Harmony Pointe Nursing Center | 89 | 302 | 60 | 20% |
| Highline Rehabilitation and Care Community | 112 | 397 | 132 | 33% |
| Holly Heights Care Center | 93 | 94 | 67 | 71% |
| Holly Nursing Care Center | 25 | 126 | 29 | 23% |
| Horizons Care Center | 36 | 43 | 6 | 14% |
| Irondale Post Acute | 84 | 46 | 46 | 100% |
| Julia Temple Healthcare Center | 118 | 36 | 36 | 100% |
| Junction Creek Health and Rehabilitation Center | 77 | 41 | 40 | 98% |
| Juniper Village- The Spearly Center | 121 | 1834 | 1271 | 69% |
| Kiowa Hills Health and Rehabilitation Center | 58 | 22 | 23 | 105% |
| La Villa Grande Care Center | 81 | 46 | 44 | 96% |
| Larchwood Inns | 64 | 133 | 51 | 38% |
| Life Care Center of Aurora | 90 | 186 | 74 | 40% |
| Life Care Center of Colorado Springs | 68 | 34 | 33 | 97% |
| Life Care Center of Evergreen | 52 | 21 | 21 | 100% |
| Life Care Center of Greeley | 56 | 50 | 37 | 74% |
| Life Care Center of Littleton | 97 | 124 | 67 | 54% |
| Life Care Center of Longmont | 115 | 220 | 85 | 39% |
| Linden Place Health and Rehabilitation Center | 71 | 60 | 63 | 105% |
| Littleton Care and Rehabilitation Center | 33 | 14 | 14 | 100% |
| Lowry Hills Care and Rehabilitation | 77 | 40 | 18 | 45% |
| Mantey Heights Rehabilitation and Care Center | 56 | 36 | 34 | 94% |
| Mapleton Post-Acute Rehabilitation | 63 | 22 | 22 | 100% |
| Mesa Manor Center | 66 | 53 | 15 | 28% |

| Home Name | Average Daily Census for CY2022 | # of residents/ families contacted | # of residents/ families responded | Response Rate |
|---|---|---|---|---|
| Mesa Vista Healthcare DBA Boulder Post Acute | 140 | 547 | 51 | 9% |
| Mountain Vista Health Center | 97 | 78 | 78 | 100% |
| North Shore Health and Rehab Facility | 91 | 34 | 33 | 97% |
| North Star Rehabilitation and Care Community | 64 | 80 | 62 | 78% |
| Orchard Valley Health and Rehabilitation Center | 63 | 52 | 51 | 98% |
| Park Forest Care Center, Inc. | 78 | 57 | 66 | 116% |
| Parkview Care Center | 62 | 72 | 55 | 76% |
| Pelican Pointe Health and Rehabilitation Center | 71 | 66 | 75 | 114% |
| Pikes Peak Center | 161 | 81 | 81 | 100% |
| Poudre Canyon Health and Rehabilitation Center | 68 | 47 | 47 | 100% |
| Prestige Care Center of Fort Collins | 42 | 42 | 3 | 7% |
| Prestige Care Center of Morrison | 110 | 120 | 20 | 17% |
| Pueblo Center | 94 | 83 | 79 | 95% |
| Regent Park Nursing and Rehabilitation | 40 | 121 | 74 | 61% |
| Rehabilitation and Nursing Center of The Rockies | 63 | 63 | 58 | 92% |
| Rehabilitation Center at Sandalwood | 84 | 250 | 211 | 84% |
| Ridgeview Post Acute Rehabilitation Center | 94 | 45 | 45 | 100% |
| Rio Grande Rehabilitation and Healthcare Center | 40 | 39 | 35 | 90% |
| River Valley Rehabilitation and Healthcare Center | 44 | 45 | 24 | 53% |
| Riverbend Health and Rehabilitation Center | 74 | 67 | 71 | 106% |
| Rowan Community, Inc | 58 | 62 | 42 | 68% |
| Sierra Rehabilitation and Care Community | 87 | 101 | 72 | 71% |
| South Platte Health and Rehabilitation Center | 49 | 48 | 45 | 94% |
| South Valley Post Acute Rehabilitation | 96 | 60 | 60 | 100% |
| Southeast Colorado Hospital LTC Center | 39 | 39 | 22 | 56% |
| Spanish Peaks Veterans Community Living Center | 71 | 76 | 41 | 54% |
| Spring Village Care Center | 76 | 44 | 44 | 100% |
| St Paul Health Center | 105 | 294 | 119 | 40% |
| Sterling Living Center | 47 | 32 | 34 | 106% |
| Suites at Clermont Park Care Center | 54 | 36 | 36 | 100% |
| Summit Rehabilitation and Care Community | 96 | 59 | 40 | 68% |
| Sundance Skilled Nursing and Rehabilitation | 51 | 17 | 17 | 100% |
| The Green House Homes at Mirasol | 86 | 188 | 75 | 40% |
| The Katherine and Charles Hover Green Houses, Inc. | 47 | 48 | 42 | 88% |
| The Peaks Care Center | 53 | 92 | 85 | 92% |
| The Valley Rehabilitation and Healthcare Center | 53 | 49 | 27 | 55% |
| The Villas at Sunny Acres | 143 | 96 | 96 | 100% |
| Trinidad Rehabilitation and Healthcare Center | 71 | 71 | 71 | 100% |

| Home Name | Average Daily Census for CY2022 | # of residents/ families contacted | # of residents/ families responded | Response Rate |
|---|---|---|---|---|
| University Heights Rehab and Care Community | 85 | 285 | 16 | 6% |
| Uptown Health Care Center | 70 | 243 | 64 | 26% |
| Valley Manor Care Center | 60 | 68 | 41 | 60% |
| Valley View Health Care Center Inc. | 52 | 187 | 42 | 22% |
| Vista Grande Rehabilitation and Health Care | 58 | 51 | 49 | 96% |
| Walsh Healthcare Center | 27 | 27 | 25 | 93% |
| Washington County Nursing Home | 38 | 57 | 26 | 46% |
| Western Hills Health Care Center | 89 | 47 | 45 | 96% |
| Westlake Care Community | 61 | 148 | 66 | 45% |
| Westlake Lodge Health and Rehabilitation Center | 67 | 60 | 53 | 88% |
| Wheatridge Manor Care Center | 56 | 235 | 48 | 20% |

## PRELIMINARY REVIEW PROCESS

The preliminary review's purpose is to identify instances in which a home may have unintentionally failed to submit a document or provided data from the incorrect reporting periods. If issues were identified, the nursing home would be given the opportunity to update their application and submit new or updated documentation before the final review period began. The preliminary review, as indicated by its name, is not a comprehensive review; therefore, it is only meant to catch clear instances of application oddities. It remains each nursing home's responsibility to review their application for completeness and accuracy prior to submission. Preliminary reviews focused on identifying the following instances:

**1)** A nursing home submitted an application, but did not upload the required pre-requisite supporting documentation;
**2)** A nursing home applied for a measure by assigning a self-score, but did not have at least one uploaded document for this measure; and,
**3)** A nursing home uploaded CASPER reports as requested by a minimum requirement, but the reports were not for the correct time periods.

PCG was able to identify homes missing documentation through a system extract, but the CASPER reports were manually reviewed and tracked when they were determined to be for the incorrect periods. Subsequently, PCG informed nursing homes if their preliminary review resulted in findings and rolled back the nursing homes' applications. PCG reported the specific finding(s) and directed the homes to access their application, upload documents as necessary, and resubmit their application within five business days of the notification. Participants could only upload documents pertaining to the preliminary review findings and were not allowed to change any of their initially submitted scores.

As a result of the preliminary review process, PCG identified 62 nursing homes that had at least one finding. The 2023 application saw fewer preliminary review findings compared to 2022. Last year, there were 129 findings across 78 homes. Below is a breakdown of this year's findings by number and type.

- There was a total of 94 findings in the preliminary review across 62 homes.
- 28 homes did not upload the proper prerequisite documentation.
- There were 32 total findings related to a self-scored measure with missing documentation.
- 34 homes had issues with their CASPER reports being improperly uploaded (either not at all, to the wrong measure, or with incorrect dates).

PCG ensured re-submitted applications adhered to the guidelines of the preliminary review period. At the conclusion of the preliminary review process, PCG closed the application portal and began conducting comprehensive reviews.

## APPLICATION RESULTS OVERVIEW

A total of 126 nursing homes submitted an application and were scored for the 2023 P4P program year. It should be noted that 127 nursing homes applied for the 2023 P4P program, but 4 homes were disqualified because they did not submit pre-requisite resident and family satisfaction surveys and 1 home was disqualified because they had a substandard deficiency tag. Four homes uploaded all documentation but did not complete the Confirmation/Submission tab on the P4P portal. Their applications were scored during the appeals process. The final breakdown of scoring based on the Per Diem Add-On groupings, is as follows:

**Table 2 – Score & Per Diem Overview**

| Points Achieved | Per Diem Add-On | # of Homes | Percentage |
|---|---|---|---|
| 0-20 | None | 1 | 1% |
| 21-45 | $1.00 | 18 | 14% |
| 46-60 | $2.00 | 24 | 19% |
| 61-79 | $3.00 | 49 | 39% |
| 80-100 | $4.00 | 34 | 27% |
| | **Total** | **126** | **100%** |

Table 3 below includes this same payment analysis for the past five years.

- In the past four years, there was an increase in the number of applicants receiving the $3.00 and $4.00 per diem add-on. This year there was an 8% decrease in the number of homes receiving the $4.00 per diem add-on compared to 2022.
- Overall, there was a shift back towards the $1.00 and $2.00 buckets in 2022 and 2023, as many of the application criteria were reinstated. In 2021 the application criteria were adjusted to a more narrative-based approach which allowed homes to apply for more measures than they would have in the past.

**Table 3 – Per Diem Historical Analysis**

| Per Diem Add-On | 2019 Homes | % | 2020 Homes | % | 2021 Homes | % | 2022 Homes | % | 2023 Homes | % |
|---|---|---|---|---|---|---|---|---|---|---|
| None | 0 | *0%* | 2 | *2%* | 0 | *0%* | 3 | *3%* | 1 | *1%* |
| $1.00 | 17 | *12%* | 10 | *8%* | 0 | *0%* | 12 | *10%* | 18 | *14%* |
| $2.00 | 30 | *22%* | 15 | *12%* | 16 | *12%* | 9 | *8%* | 24 | *19%* |
| $3.00 | 54 | *39%* | 51 | *40%* | 56 | *43%* | 51 | *44%* | 49 | *39%* |
| $4.00 | 37 | *27%* | 47 | *38%* | 57 | *44%* | 40 | *35%* | 34 | *27%* |
| **Total** | **130** | | **138** | | **126** | | **115** | | **126** | |

Table 4 shows the final nursing home Self Scores and Reviewer Scores for each home for the 2023 P4P program year.

- In 2023, the Self Scores ranged from 21-98 and the Reviewer Scores ranged from 7-95.

**Table 4 – 2023 Application Final Score Summary**

| Home Name | 2023 Self Score | 2023 Final Score |
|---|---|---|
| Adara Living | 87 | 85 |
| Allison Care Center | 80 | 56 |
| Arborview Senior Community | 83 | 80 |
| Arvada Care and Rehabilitation Center | 84 | 81 |
| Autumn Heights Health Care Center | 80 | 53 |
| Avamere Transitional Care and Rehabilitation- Malley | 85 | 82 |
| Belmont Lodge Health Care Center | 73 | 65 |
| Bent County Healthcare Center | 88 | 77 |
| Berkley Manor Care Center | 73 | 67 |
| Berthoud Care and Rehabilitation | 89 | 82 |
| Beth Israel at Shalom Park | 85 | 83 |
| Boulder Canyon Health and Rehabilitation | 98 | 69 |
| Briarwood Health Care Center | 80 | 61 |
| Brighton Care Center | 85 | 76 |
| Broadview Health and Rehabilitation Center | 80 | 65 |
| Brookside Inn | 95 | 95 |
| Bruce McCandless CO State Veterans Nursing Home | 82 | 81 |
| Cambridge Care Center | 91 | 71 |
| Castle Peak Senior Life and Rehabilitation | 88 | 65 |
| Cedars Healthcare Center | 61 | 61 |
| Centre Avenue Health & Rehab | 56 | 50 |
| Centura Health- Medalion Health Center | 88 | 79 |
| Cheyenne Mountain Center | 89 | 83 |
| Christian Living Communities Suites at Someren Glen Care Center | 75 | 68 |
| Christopher House Rehabilitation and Care Community | 92 | 84 |
| Clear Creek Care Center | 91 | 79 |
| Colonial Health and Rehabilitation Center | 38 | 34 |
| Colorado State Veterans Nursing Home- Rifle | 86 | 69 |
| Colorado Veterans Community Living Center at Homelake | 54 | 54 |
| Colorow Care Center | 84 | 78 |
| Columbine West Health and Rehab Facility | 84 | 79 |
| Cottonwood Care Center | 88 | 85 |
| Cottonwood Rehabilitation and Healthcare | 91 | 85 |
| Creekside Village Health and Rehabilitation Center | 22 | 22 |
| Crestmoor Health and Rehabilitation | 88 | 62 |
| Crowley County Nursing Center | 83 | 52 |
| Denver North Care Center | 81 | 77 |
| Desert Willow Health and Rehabilitation Center | 85 | 72 |

| Home Name | 2023 Self Score | 2023 Final Score |
|---|---|---|
| Devonshire Acres | 84 | 77 |
| E Dene Moore Care Center | 83 | 63 |
| Eagle Ridge of Grand Valley | 73 | 49 |
| Eben Ezer Lutheran Care Center | 81 | 76 |
| Elevation Health and Rehabilitation Center | 93 | 57 |
| Elk Ridge Health and Rehabilitation Center | 51 | 36 |
| Englewood Post Acute and Rehabilitation | 80 | 74 |
| Evergreen Nursing Home | 21 | 7 |
| Fairacres Manor, Inc. | 90 | 84 |
| Falcon Heights Health and Rehabilitation Center | 76 | 56 |
| Forest Ridge Senior Living, LLC | 85 | 66 |
| Forest Street Compassionate Care Center | 97 | 68 |
| Fountain View Health and Rehabilitation Center | 71 | 58 |
| Good Samaritan Society - Fort Collins Village | 46 | 39 |
| Good Samaritan Society- Loveland Village | 33 | 24 |
| Harmony Pointe Nursing Center | 94 | 93 |
| Highline Rehabilitation and Care Community | 92 | 75 |
| Holly Heights Care Center | 90 | 84 |
| Holly Nursing Care Center | 92 | 92 |
| Horizons Care Center | 90 | 46 |
| Irondale Post Acute | 93 | 93 |
| Julia Temple Healthcare Center | 94 | 92 |
| Junction Creek Health and Rehabilitation Center | 71 | 46 |
| Juniper Village- The Spearly Center | 88 | 66 |
| Kiowa Hills Health and Rehabilitation Center | 42 | 34 |
| La Villa Grande Care Center | 42 | 31 |
| Larchwood Inns | 82 | 64 |
| Life Care Center of Aurora | 72 | 46 |
| Life Care Center of Colorado Springs | 38 | 35 |
| Life Care Center of Evergreen | 50 | 50 |
| Life Care Center of Greeley | 88 | 70 |
| Life Care Center of Littleton | 82 | 68 |
| Life Care Center of Longmont | 60 | 27 |
| Linden Place Health and Rehabilitation Center | 81 | 72 |
| Littleton Care and Rehabilitation Center | 93 | 93 |
| Lowry Hills Care and Rehabilitation | 83 | 73 |
| Mantey Heights Rehabilitation and Care Center | 74 | 56 |
| Mapleton Post-Acute Rehabilitation | 27 | 25 |
| Mesa Manor Center | 87 | 80 |

| Home Name | 2023 Self Score | 2023 Final Score |
|---|---|---|
| Mesa Vista Healthcare DBA Boulder Post Acute | 77 | 67 |
| Mountain Vista Health Center | 94 | 82 |
| North Shore Health and Rehab Facility | 78 | 63 |
| North Star Rehabilitation and Care Community | 78 | 64 |
| Orchard Valley Health and Rehabilitation Center | 26 | 26 |
| Park Forest Care Center, Inc. | 85 | 82 |
| Parkview Care Center | 93 | 80 |
| Pelican Pointe Health and Rehabilitation Center | 56 | 48 |
| Pikes Peak Center | 86 | 83 |
| Poudre Canyon Health and Rehabilitation Center | 73 | 54 |
| Prestige Care Center of Fort Collins | 83 | 46 |
| Prestige Care Center of Morrison | 92 | 41 |
| Pueblo Center | 88 | 85 |
| Regent Park Nursing and Rehabilitation | 75 | 62 |
| Rehabilitation and Nursing Center of The Rockies | 90 | 48 |
| Rehabilitation Center at Sandalwood | 80 | 80 |
| Ridgeview Post Acute Rehabilitation Center | 95 | 68 |
| Rio Grande Rehabilitation and Healthcare Center | 90 | 84 |
| River Valley Rehabilitation and Healthcare Center | 92 | 54 |
| Riverbend Health and Rehabilitation Center | 67 | 60 |
| Rowan Community, Inc | 90 | 80 |
| Sierra Rehabilitation and Care Community | 85 | 66 |
| South Platte Health and Rehabilitation Center | 66 | 50 |
| South Valley Post Acute Rehabilitation | 96 | 89 |
| Southeast Colorado Hospital LTC Center | 65 | 50 |
| Spanish Peaks Veterans Community Living Center | 89 | 86 |
| Spring Village Care Center | 45 | 23 |
| St Paul Health Center | 80 | 74 |
| Sterling Living Center | 73 | 44 |
| Suites at Clermont Park Care Center | 88 | 70 |
| Summit Rehabilitation and Care Community | 87 | 87 |
| Sundance Skilled Nursing and Rehabilitation | 65 | 65 |
| The Green House Homes at Mirasol | 82 | 76 |
| The Katherine and Charles Hover Green Houses, Inc. | 89 | 62 |
| The Peaks Care Center | 56 | 27 |
| The Valley Rehabilitation and Healthcare Center | 79 | 76 |
| The Villas at Sunny Acres | 82 | 79 |
| Trinidad Rehabilitation and Healthcare Center | 95 | 95 |
| University Heights Rehab and Care Community | 98 | 84 |

| Home Name | 2023 Self Score | 2023 Final Score |
|---|---|---|
| Uptown Health Care Center | 86 | 33 |
| Valley Manor Care Center | 91 | 79 |
| Valley View Health Care Center Inc. | 88 | 82 |
| Vista Grande Rehabilitation and Health Care | 85 | 52 |
| Walsh Healthcare Center | 88 | 61 |
| Washington County Nursing Home | 75 | 31 |
| Western Hills Health Care Center | 84 | 27 |
| Westlake Care Community | 83 | 68 |
| Westlake Lodge Health and Rehabilitation Center | 64 | 46 |
| Wheatridge Manor Care Center | 86 | 65 |

Table 5 displays data summarizing the P4P program's final scores from the past 5 years. As homes have become more familiar with the application process, the average Self Score has increased. It should be noted that the 2021 application criteria were adjusted to a more narrative-based approach which allowed homes to apply for more measures than they would have in previous years and as such should be viewed as an outlier. The 2022 and 2023 data are aligned with prior years.

**Table 5 – Scoring Historical Analysis**

| Statistic | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Average Self Score | 75 | 77 | 86 | 79 | 78 |
| Average Reviewer Score | 66 | 70 | 75 | 69 | 64 |
| **Avg. Difference (Reviewer minus Self Score)** | **-9** | **-7** | **-11** | **-10** | **-14** |

## APPLICATION MEASURES ANALYSIS

The 2023 P4P application consisted of 25 measures, separated into two domains and nine subcategories:

| Domain: Quality of Life |
|---|
| ***Resident Directed Care*** |
| 1. Enhanced Dining |
| 2. Enhanced Personal Care |
| 3. End of Life Program |
| 4. Connection and Meaning |
| 5. Person-Directed Care Training |
| 6. Trauma – Informed Care |
| 7. Daily Schedules and Care Planning |
| ***Community Centered Living*** |
| 8.1 Physical Environment – Appearance |
| 8.2 Physical Environment – Noise Management |
| 9. QAPI |
| ***Relationships with Staff, Family, Resident and Home*** |
| 10. Consistent Assignments |
| 11. Volunteer Program |
| ***Staff Empowerment*** |

| |
|---|
| 12. Staff Engagement |
| ***Quality of Life*** |
| 13. Transition of Care – Admissions, Transfer and Discharge Rights |
| 14. Equity |
| 15. Isolation Protocols |
| **Domain: Quality of Care** |
| ***Quality of Care*** |
| 17. Reducing Avoidable Hospitalizations |
| 18. Nationally Reported Quality Measures Scores (18.1- 18.9) |
| 19.1 Best Practices – Safe Physical Environment |
| 19.2 Best Practices – Pain Management |
| 19.3 Best Practices – Prevention of Abuse and Neglect |
| 20.1 Antibiotics Stewardship/Infection Prevention & Control – Documentation |
| 20.2 Antibiotics Stewardship/Infection Prevention & Control – Quality Measures |
| ***Home Management*** |
| 21. Medicaid Occupancy Average |
| ***Staff Stability*** |
| 22. Staff Retention Rate/Improvement |
| 23. DON and NHA Retention |
| 24. Nursing Staff Turnover Rate |
| ***Behavioral Health*** |
| 25. Behavioral Health Care |

The remainder of this section provides analysis of the scoring for each specific measure. Table 6 is a summary of the measure-by-measure analysis that follows. Table 6 displays the following for each measure:

- The total number of nursing homes that applied for the measure in 2023;
- the number of nursing homes that received points last year (2022) for the measure, applied for the same measure in 2023, but did not receive points in 2023;
- the number of nursing homes that applied for the measure in 2023, but did not receive points; and,
- the percentage of nursing homes that applied for the measure in 2023 but did not receive points.

**Table 6 – Score by Measure Analysis**

| Measure | Total Homes Applied in 2023 | Homes Received Points in 2022, Applied in 2023 but Did Not Receive Points | Homes Applied but Did Not Receive Points in 2023 | % of Homes Applied and Did Not Receive Points | |
|---|---|---|---|---|---|
| **1. Enhanced Dining** | 113 | 14 | 44 | 39% | **(A)** |
| **2. Enhanced Personal Care** | 106 | 9 | 26 | 25% | **(A)** |
| **3. End of Life Program** | 106 | 14 | 27 | 25% | **(A)** |
| **4. Connection and Meaning** | 120 | 6 | 12 | 10% | **(A)** |

| Measure | Total Homes Applied in 2023 | Homes Received Points in 2022, Applied in 2023 but Did Not Receive Points | Homes Applied but Did Not Receive Points in 2023 | % of Homes Applied and Did Not Receive Points | |
|---|---|---|---|---|---|
| **5. Person-Directed Care Training** | 113 | 5 | 20 | 18% | **(A)** |
| **6. Trauma – Informed Care** | 104 | 14 | 27 | 26% | **(A)** |
| **7. Daily Schedules and Care Planning** | 107 | 11 | 20 | 19% | **(A)** |
| **8.1 Physical Environment – Appearance** | 113 | 6 | 17 | 15% | **(A)** |
| **8.2 Physical Environment – Noise Management** | 106 | 15 | 35 | 33% | **(A)** |
| **9. QAPI** | 88 | 8 | 22 | 25% | **(A)** |
| **10. Consistent Assignments** | 117 | 4 | 9 | 8% | **(A)** |
| **11. Volunteer Program** | 103 | 12 | 30 | 29% | **(A)** |
| **12. Staff Engagement** | 92 | 16 | 36 | 39% | **(A)** |
| **13. Transition of Care – Admissions, Transfer and Discharge Rights** | 104 | 17 | 33 | 32% | **(A)** |
| **14. Equity** | 88 | 0 | 8 | 9% | |
| **15. Isolation Protocols** | 121 | 0 | 8 | 7% | |
| **16. Vaccination Data** | 124 | 6 | 8 | 6% | |
| **17. Reducing Avoidable Hospitalizations** | 86 | 0 | 8 | 9% | **(B)** |
| **Quality Measure – 18.1.1 (Narrative)** | 117 | 5 | 7 | 6% | |
| **Quality Measure – 18.2** | 71 | 5 | 12 | 17% | |
| **Quality Measure – 18.3** | 68 | 3 | 8 | 12% | |
| **Quality Measure – 18.4** | 66 | 5 | 11 | 17% | |
| **Quality Measure – 18.5** | 59 | 3 | 9 | 15% | |
| **Quality Measure – 18.6** | 62 | 4 | 11 | 18% | |
| **Quality Measure – 18.7** | 69 | 5 | 11 | 16% | |
| **Quality Measure – 18.8** | 71 | 3 | 10 | 14% | |
| **Quality Measure – 18.9** | 82 | 3 | 7 | 9% | |
| **19.1 Best Practices – Safe Physical Environment** | 122 | 2 | 3 | 2% | |
| **19.2 Best Practices – Pain Management** | 120 | 0 | 1 | 1% | |
| **19.3 Best Practices – Prevention of Abuse and Neglect** | 119 | 2 | 5 | 4% | |
| **20.1 Antibiotics Stewardship/Infection Prevention & Control - Documentation** | 113 | 18 | 40 | 35% | |

| Measure | Total Homes Applied in 2023 | Homes Received Points in 2022, Applied in 2023 but Did Not Receive Points | Homes Applied but Did Not Receive Points in 2023 | % of Homes Applied and Did Not Receive Points | |
|---|---|---|---|---|---|
| **20.2 Antibiotics Stewardship/Infection Prevention & Control - Quality Measures** | 109 | 9 | 14 | 13% | |
| **21. Medicaid Occupancy Average** | 84 | 1 | 8 | 10% | |
| **22. Staff Retention Rate/Improvement** | 94 | 9 | 19 | 20% | **(A)** |
| **23. DON and NHA Retention** | 74 | 7 | 25 | 34% | |
| **24. Nursing Staff Turnover Rate** | 95 | 2 | 9 | 9% | **(A)** |
| **25. Behavioral Health Care** | 108 | 7 | 23 | 21% | |

*Note that for this year's application analysis:*

- *(A) Indicates that this measure was adjusted in 2021 due to the impacts of COVID and normal measure requirements were implemented for 2022 and continued in 2023.*
- *(B) This measure was not evaluated in 2022 as COVID-related hospitalizations created outlier data. It was reimplemented in 2023.*

Using this analysis, the PCG review team highlighted common insufficiencies across all applications that led to a reduction in the reviewer score from the self-score for each measure. PCG has provided common reasons for why homes were not awarded points by the reviewer.

The following sections break out each measure, showing a summary of the percentage of homes that applied and received points for each measure. It is important to note that the percentage awarded is based on the number of homes that applied for that specific measure and not all 126 homes that submitted an application. A table showing historical percentages for homes that received points is also provided for each measure.

## 1. Enhanced Dining

| Enhanced Dining - Awarded % | | | |
|---|---|---|---|
| **2019** | **2020** | **2021** | **2022** |
| 83% | 86% | 47% | 65% |

| 2023 | |
|---|---|
| Homes Applied | 113 |
| Applied % | 90% |
| Homes Awarded | 69 |
| Awarded % | 61% |

The minimum requirements of the Enhanced Dining measure ask for homes to demonstrate that menus and dining atmosphere are created with resident input and that residents have access to food 24 hours a day. Additionally, homes were asked to detail how their dining program includes both communal and in-room dining options. The below list displays the primary reasons homes most frequently lost points and is

not exhaustive. It should be noted that homes may have missed points across multiple of the measure's minimum requirements.

- 22 homes also failed to correctly provide survey information – they either failed to submit anything, submitted questions without responses, submitted only responses, or submitted internal surveys.
- 16 homes were not awarded points for this measure, as they did not provide a description of both communal and in-room dining options.
- 17 homes also lost points by not providing evidence regarding how residents provide input into the appearance of the dining atmosphere.
- 9 homes lost points for not describing how resident information from the Facility Assessment is used to develop menu options.

## 2. Enhanced Personal Care

| Enhanced Personal Care - Awarded % | | | |
|---|---|---|---|
| **2019** | **2020** | **2021** | **2022** |
| 87% | 93% | 74% | 72% |

| 2023 | |
|---|---|
| Homes Applied | 106 |
| Applied % | 85% |
| Homes Awarded | 81 |
| Awarded % | 76% |

The goal of the Enhanced Personal Care measure is to ensure that personal care schedules are flexible and meet residents' desires and choices. Additionally, homes were asked to provide evidence of staff training for enhanced bathing and oral care.

- 23 homes lost points for this measure because they failed to mention oral care.
- 15homes did not provide documentation about staff training. These homes often failed to provide concrete evidence aside from a narrative description.
- 10 homes missed points for not providing sufficient evidence demonstrating residents are interviewed about choices regarding time, caregivers, and type of bath.

## 3. End of Life Program

| End of Life Program - Awarded % | | | |
|---|---|---|---|
| **2019** | **2020** | **2021** | **2022** |
| 83% | 91% | 76% | 86% |

| 2023 | |
|---|---|
| Homes Applied | 106 |
| Applied % | 85% |
| Homes Awarded | 80 |
| Awarded % | 75% |

The minimum requirements for the End of Life Program ask for a detailed narrative that identifies individual preferences, spiritual needs, wishes, expectations, specific grief counseling, and a plan for honoring those

that have passed and a process to inform the home. Homes were required to provide documentation of how the home honored the wishes of four residents.

- 12 homes lost points for not providing specific examples of how residents were honored or providing less than 4 examples.
- 10 homes missed points for not providing 2 signed testimonials from non-management staff describing end of life planning. Commonly only 1 testimonial was provided.
- 7 homes failed to mention how they were preparing or training staff for End of Life programming.

### 4. Connection and Meaning

| Connection and Meaning - Awarded % | | | |
|---|---|---|---|
| **2019** | **2020** | **2021** | **2022** |
| 87% | 92% | 94% | 85% |

| 2023 | |
|---|---|
| Homes Applied | 120 |
| Applied % | 96% |
| Homes Awarded | 108 |
| Awarded % | 90% |

Connection and Meaning strives to ensure that each home is unique based on the needs and preferences of its residents. Homes must provide support for connection and meaning through companionship, spontaneity, variety, and opportunities for residents to give and receive care for each other.

- 12 homes did not provide the required number of testimonials by residents/family members and staff. The minimum requirement specified 2 testimonials must be from residents or family members and 2 testimonials must be from non-management staff.
- 1 home also did not provide 4 examples demonstrating connection and meaning in the home.

### 5. Person-Directed Care Training

| Person-Directed Care Training - Awarded % | | | |
|---|---|---|---|
| **2019** | **2020** | **2021** | **2022** |
| 89% | 88% | 88% | 80% |

| 2023 | |
|---|---|
| Homes Applied | 113 |
| Applied % | 90% |
| Homes Awarded | 94 |
| Awarded % | 83% |

Person-Directed Care Training is designed to ensure that each home has systems in place to provide training on person-directed care to all staff. Person-directed care promotes and empowers decision making and choices by residents.

- 12 homes failed to describe in their narrative how their Facility Assessment is used to define training objectives.
- 6 homes missed points for not clearly identifying their Mission/Vision statement.
- There were 3 instances of homes losing points due to providing person-direct care training documentation dated outside of CY2022.

### 6. Trauma Informed Care

| Trauma Informed Care - Awarded % | | | |
|---|---|---|---|
| **2019** | **2020** | **2021** | **2022** |
| 88% | 95% | 45% | 83% |

| 2023 | |
|---|---|
| Homes Applied | 104 |
| Applied % | 83% |
| Homes Awarded | 77 |
| Awarded % | 74% |

Trauma Informed Care rewards homes for identifying residents with a strong potential for, or known past trauma, and providing education to their staff on trauma-informed care. Homes were required to submit training objectives and proof of actual training regarding trauma-informed care. In 2023, there was a newly introduced minimum requirement related to trainings and initiatives around current trauma experienced in the home related to grief management, coping mechanisms, compassionate care, managing trauma-related stress, and building resilience in staff and residents.

- 9 homes lost points for not submitting proof of actual trauma-informed care trainings or training objectives for staff.
- In 2021, there was a newly introduced standard on how the home was utilizing the facility assessment to develop trauma informed care training/programming. While we have seen overall improvement in addressing this minimum requirement, 12 homes missed points by not addressing the facility assessment or providing an example demonstrating how it was used to influence staff training or a resident's care plan.
- 11 homes failed to describe initiatives and training related to current trauma experienced in the home. The minimum requirement asks homes to specifically describe training related to grief management, coping mechanisms, compassionate care, managing trauma-related stress, building resilience in staff and residents.

### 7. Daily Schedules and Care Planning

| Daily Schedules - Awarded % | | | |
|---|---|---|---|
| **2019** | **2020** | **2021** | **2022** |
| 87% | 92% | 91% | 83% |

| 2023 | |
|---|---|
| Homes Applied | 107 |
| Applied % | 86% |
| Homes Awarded | 87 |
| Awarded % | 81% |

Daily Schedules and Care Planning rewards homes that allow residents to determine their own daily schedules and participate in developing their care plan. Homes were asked to provide signed resident testimonials, staff testimonials, and care plans that demonstrated resident input.

- 13 homes missed points related to providing care plans. Homes either provided only one care plan or provided care plans that did not pertain to the two residents who submitted testimonials for an earlier minimum requirement.
- 11 homes lost points as they failed to provide the correct number of resident or staff testimonials.

## 8. Physical Environment

The Physical Environment measure was split out into two sub-measures in 2019 which evaluate criteria around each homes' ability to create a home like environment through its appearance and noise management.

### 8.1 Physical Environment - Appearance

| Physical Environment (8.1) – Awarded % | | | |
|---|---|---|---|
| **2019** | **2020** | **2021** | **2022** |
| 88% | 94% | 97% | 88% |

| 2023 | |
|---|---|
| Homes Applied | 113 |
| Applied % | 90% |
| Homes Awarded | 96 |
| Awarded % | 85% |

Measure 8.1 indicates that the home must strive to create a home-like environment that wholistically reflects the community. Much of the criteria in this measurement involves providing photographs of the home to demonstrate the de-institutionalization of the physical environment and providing a narrative describing how this environment is being reintroduced due to the impacts of social distancing.

- 8 homes lost points because their photographs did not contain captions, as specified by the minimum requirement.
- 6 homes failed to provide photographs of items discussed in their narrative, or the items listed in the minimum requirements, such as common spaces and nursing stations.
- 4 homes did not provide any photographic support and did not meet the minimum requirement's criteria.

### 8.2 Physical Environment – Noise Management

| Physical Environment (8.2) – Awarded % | | | |
|---|---|---|---|
| **2019** | **2020** | **2021** | **2022** |
| 76% | 90% | 87% | 88% |

| 2023 | |
|---|---|
| Homes Applied | 106 |
| Applied % | 85% |
| Homes Awarded | 71 |
| Awarded % | 67% |

Measure 8.2 indicates that excess noise must be eliminated by decreasing the usage of alarms of all types except those necessary to fulfill life safety code and other state or federal mandates. Homes must provide examples of their approaches towards improving sleeping environments.

- 26 homes did not meet the minimum requirements for this measure as they either failed to provide evidence of an evaluation or action plan to reduce patient disruptions or provide a plan/policy speaking to the reduction of extraneous noise.
- 4 homes did not provide two examples of their home's approaches toward improving sleeping environments.
- 4 homes did not include their current policy for absence of overhead paging.

## 9. QAPI

| QAPI - Awarded % | | | |
|---|---|---|---|
| **2019** | **2020** | **2021** | **2022** |
| 84% | 87% | 91% | 81% |

| 2023 | |
|---|---|
| Homes Applied | 88 |
| Applied % | 70% |
| Homes Awarded | 67 |
| Awarded % | 76% |

The QAPI measure asked that homes provide a narrative describing an identified Quality Measure that needs improvement within their home.

- 16 homes lost points because they did not address all components listed in the minimum requirements. Baseline data, tools/processes utilized, and data trends were areas commonly missed.
- 9 homes did not describe the process on how the home is kept informed of the project and its progress.
- 8 homes also failed to mention how staff, residents, and families are aware of and can support the project.

## 10. Consistent Assignments

| Consistent Assignments - Awarded % | | | |
|---|---|---|---|
| **2019** | **2020** | **2021** | **2022** |
| 84% | 94% | 86% | 93% |

| 2023 | |
|---|---|
| Homes Applied | 117 |
| Applied % | 94% |
| Homes Awarded | 108 |
| Awarded % | 92% |

The Consistent Assignments measure asked homes to describe their process for maximizing consistent assignments.

- 8 homes lost points in this measure for either not providing the required number of testimonials or providing testimonials that did not address the existence of consistent care assignments.
- 3 homes did not provide a narrative describing their home's process for maximizing consistent assignments.

### 11. Volunteer Program

| Volunteer Program - Awarded % | | | |
|---|---|---|---|
| **2019** | **2020** | **2021** | **2022** |
| 86% | 91% | 41% | 75% |

| 2023 | |
|---|---|
| Homes Applied | 103 |
| Applied % | 82% |
| Homes Awarded | 73 |
| Awarded % | 71% |

This measure places an emphasis on developing a thriving volunteer program between external community members and residents living in the home to bring purpose and meaningful activity into one's life. Homes were asked to provide evidence of volunteer opportunities for residents and for external individuals.

- In 2021, emphasis was placed on providing "evidence" for events that were occurring in the home, which led to more homes losing points that year. In 2022 and 2023, far fewer homes lost points for this reason.
- 17 homes lost points for either not providing evidence at all or not providing evidence for the specified number of examples of volunteer opportunities.
- 16 homes failed to submit their written volunteer policy.
- 7 homes did not provide two testimonials from residents participating in two different projects. These homes either did not submit any testimonials, only provided one testimonial, or provided two testimonials regarding the same project.

## 12. Staff Engagement

| Staff Engagement - Awarded % | | | |
|---|---|---|---|
| **2019** | **2020** | **2021** | **2022** |
| 76% | 85% | 92% | 80% |

| 2023 | |
|---|---|
| Homes Applied | 92 |
| Applied % | 74% |
| Homes Awarded | 56 |
| Awarded % | 61% |

The Staff Engagement measure is designed to ensure that each home has systems in place to promote and support staff in their personal and professional development as well as their engagement in the home. Homes were also asked to describe how they adjusted their infection control plan in response to regulatory requirements.

- 18 homes lost points for not including 4 testimonials from staff on empowerment opportunities.
- 17 homes lost points as they did not meet the requirements for the Staff Satisfaction Survey. Responses that did not qualify either did not include an Overall Satisfaction question, did not demonstrate at least a 70% response rate, or were dated outside of CY2022.
- 13 homes did not provide quarterly examples of staff engagement events. Homes who lost points typically submitted too few examples or did not specify when events occurred.
- 6 homes lost points as they failed to describe adjustments to their staff mentoring and/or buddy system programs.

## 13. Transitions of Care: Admissions, Transfer and Discharge Rights

| Consistent Assignments - Awarded % | | | |
|---|---|---|---|
| **2019** | **2020** | **2021** | **2022** |
| 73% | 89% | 91% | 80% |

| 2023 | |
|---|---|
| Homes Applied | 104 |
| Applied % | 83% |
| Homes Awarded | 71 |
| Awarded % | 68% |

In Measure 13, points are awarded to homes who increase community and resident awareness of transition options.

- 25 homes lost points related to the Facility Characteristics Casper Report. Sixteen of these homes submitted the Quality Measure Casper Reports instead of the Facility Characteristics Report. The other homes either did not submit any report or submitted a report from the wrong measurement period.
- 13 homes did not provide proper documentation of staff education and training objectives for Options Counseling that occurred in 2022.

- 7 homes did not include the name and contact information of the individual at the local agency responsible to be the liaison between the nursing care center and agency for community placement referrals.

## 14. Equity

| Equity - Awarded % | | | |
|---|---|---|---|
| **2019** | **2020** | **2021** | **2022** |
| n/a | n/a | n/a | n/a |

| 2023 | |
|---|---|
| Homes Applied | 88 |
| Applied % | 70% |
| Homes Awarded | 80 |
| Awarded % | 91% |

Measure 14 (Equity) is a new measure in the 2023 application. Points are awarded to homes who provide evidence of training on areas such as racial and ethnic disparities and their root causes, best practices for shared decision making, implicit bias, ageism/ableism, and gender identity/sexual orientation equity, as well as providing evidence of your home's initiatives to increase equity awareness and sensitivity for residents and staff.

- 6 homes lost points if they did not submit proof of any training related to equity. Homes who were not awarded points submitted documentation such as definitions, policies, or training unrelated to equity.
- 3 homes lost points for failing to provide evidence regarding the home's initiatives to increase equity awareness.

## 15. Isolation Protocols

| Isolation Protocols - Awarded % | | | |
|---|---|---|---|
| **2019** | **2020** | **2021** | **2022** |
| n/a | n/a | n/a | n/a |

| 2023 | |
|---|---|
| Homes Applied | 121 |
| Applied % | 97% |
| Homes Awarded | 113 |
| Awarded % | 93% |

Measure 15 (Isolation Protocols) is a new measure in the 2023 application. Homes were awarded points if they provided a narrative addressing how patients in isolation can communicate with families and staff, maintain connection, provide input into care and food preferences, access mental health resources, and stay active.

- 7 homes lost points because they did not address all components listed in the minimum requirement. Most commonly homes failed to address how residents were able to connect with others or if staff wore name tags to ensure residents could communicate.
- 1 home did not submit any documentation for this measure and was not awarded points.

### 16. Vaccination Data

| Vaccination Data - Awarded % | | | |
|---|---|---|---|
| **2019** | **2020** | **2021** | **2022** |
| n/a | n/a | 96% | 95% |

| 2023 | |
|---|---|
| Homes Applied | 124 |
| Applied % | 99% |
| Homes Awarded | 117 |
| Awarded % | 94% |

This measure looks to gain insight into homes' educational efforts around vaccinations.

- Most homes were able to meet the minimum requirements of this measure, however, 9 homes lost points because they did not provide specific details on each vaccination.

### 17. Reducing Avoidable Hospitalizations

| Reducing Avoidable Hospitalizations - Awarded % | | | |
|---|---|---|---|
| **2019** | **2020** | **2021** | **2022** |
| 82% | 86% | 0% | 0% |

| 2023 | |
|---|---|
| Homes Applied | 86 |
| Applied % | 69% |
| Homes Awarded | 78 |
| Awarded % | 91% |

This measure was not evaluated in 2021 and 2022 due to COVID-related hospitalizations and was reimplemented in 2023. However, there was a delay in receiving data from CMS and the American Health Care Association (AHCA) needed to independently validate long stay hospitalization data. The Department decided to award the full 3 points to all homes who applied for Measure 17 and who met all the minimum requirements for 17-2 and 17-3.

- 7 homes did not receive points because they did not complete or upload the Reducing Avoidable Hospitalization Tool.
- 1 home failed to upload 4 cases demonstrating why individuals were hospitalized or discharged and did not receive points.

- 2 homes did not upload documentation that addressed all components needed to qualify for the QAPI recovery point.

## 18. Nationally Reported Quality Measures Scores 18.1-18.9

Because there are a range of scores for measures 18.2-18.9, the "Homes Awarded" data below correspond to homes awarded a particular point value, regardless of which point value they applied for. Please note that the Awarded Percentages can be greater than 100% as some homes' Reviewer Score for a Quality Measure may fall into a different bucket than their Self Score. Additionally, year-over-year comparisons are not provided for measure 18.2-18.9 as the Quality Measures change each year.

### QM Narrative (18.1)

| QM Narrative - Awarded % | | | |
|---|---|---|---|
| **2019** | **2020** | **2021** | **2022** |
| 95% | 96% | 99% | 99% |

| 2023 | |
|---|---|
| Homes Applied | 117 |
| Applied % | 94% |
| Homes Awarded | 110 |
| Awarded % | 94% |

The Quality Measure Narrative allows homes the opportunity to earn one point for providing a narrative that addresses their three lowest quality measures.

- All 7 homes who lost points either did not upload the required narrative or failed to clearly explain their three lowest quality measures.

### High Risk Resident with Pressure Ulcers (18.2)

| 2023 | | | | | |
|---|---|---|---|---|---|
| **Statistic** | **Overall** | **+4** | **+3** | **+2** | **+1** |
| Homes Applied | 71 | 28 | 18 | 16 | 9 |
| Applied % | 57% | 22% | 14% | 13% | 7% |
| Homes Awarded | 59 | 26 | 15 | 13 | 5 |
| Awarded % | 83% | 93% | 83% | 81% | 56% |

The bullets below show the number of homes that received a different Reviewer Score than their Self Score:

- 3 homes received more points than they applied for.
- 14 homes received fewer points than they applied for.

### Residents with One or More Falls with Major Injury (18.3)

| 2023 | | | | | |
|---|---|---|---|---|---|
| **Statistic** | **Overall** | **+4** | **+3** | **+2** | **+1** |
| Homes Applied | 68 | 35 | 5 | 9 | 19 |
| Applied % | 54% | 28% | 4% | 7% | 15% |

| | | | | | |
|---|---|---|---|---|---|
| Homes Awarded | 61 | 30 | 4 | 7 | 20 |
| Awarded % | 90% | 86% | 80% | 78% | 105% |

The bullets below show the number of homes that received a different Reviewer Score than their Self Score:

- 2 homes received more points than they applied for.
- 11 homes received fewer points than they applied for.

**Residents who Received Antipsychotic Medications (18.4)**

| 2023 | | | | | |
|---|---|---|---|---|---|
| **Statistic** | **Overall** | **+4** | **+3** | **+2** | **+1** |
| Homes Applied | 66 | 24 | 4 | 22 | 16 |
| Applied % | 53% | 19% | 3% | 18% | 13% |
| Homes Awarded | 56 | 18 | 4 | 22 | 12 |
| Awarded % | 85% | 75% | 100% | 100% | 75% |

The bullets below show the number of homes that received a different Reviewer Score than their Self Score:

- 1 home received more points than it applied for.
- 13 homes received fewer points than they applied for.

**Residents with Depression Symptoms Medications (18.5)**

| 2023 | | | | | |
|---|---|---|---|---|---|
| **Statistic** | **Overall** | **+4** | **+3** | **+2** | **+1** |
| Homes Applied | 59 | 31 | 6 | 7 | 15 |
| Applied % | 47% | 25% | 5% | 6% | 12% |
| Homes Awarded | 52 | 28 | 5 | 7 | 12 |
| Awarded % | 88% | 90% | 83% | 100% | 80% |

The bullets below show the number of homes that received a different Reviewer Score than their Self Score:

- 5 homes received more points than they applied for.
- 11 homes received fewer points than they applied for.

**Low Risk Residents Who Lose Control of Bowel/Bladder (18.6)**

| 2023 | | | | | |
|---|---|---|---|---|---|
| **Statistic** | **Overall** | **+4** | **+3** | **+2** | **+1** |
| Homes Applied | 62 | 31 | 6 | 9 | 16 |
| Applied % | 50% | 25% | 5% | 7% | 13% |
| Homes Awarded | 51 | 23 | 7 | 8 | 13 |
| Awarded % | 82% | 74% | 117% | 89% | 81% |

The bullets below show the number of homes that received a different Reviewer Score than their Self Score:

- 0 homes received more points than they applied for.
- 13 homes received fewer points than they applied for.

**Residents Who Lose Too Much Weight (18.7)**

| 2023 | | | | | |
|---|---|---|---|---|---|
| **Statistic** | **Overall** | **+4** | **+3** | **+2** | **+1** |
| Homes Applied | 69 | 40 | 7 | 9 | 13 |
| Applied % | 55% | 32% | 6% | 7% | 10% |
| Homes Awarded | 59 | 33 | 8 | 6 | 12 |
| Awarded % | 86% | 83% | 114% | 67% | 100% |

The bullets below show the number of homes that received a different Reviewer Score than their Self Score:

- 2 homes received more points than they applied for.
- 14 homes received fewer points than they applied for.

**Residents Whose Need for Help w/ Daily Activities Has Increased (18.8)**

| 2023 | | | | | |
|---|---|---|---|---|---|
| **Statistic** | **Overall** | **+4** | **+3** | **+2** | **+1** |
| Homes Applied | 71 | 43 | 5 | 8 | 15 |
| Applied % | 57% | 34% | 4% | 6% | 12% |
| Homes Awarded | 61 | 37 | 4 | 7 | 13 |
| Awarded % | 86% | 86% | 80% | 88% | 87% |

The bullets below show the number of homes that received a different Reviewer Score than their Self Score:

- 0 homes received more points than they applied for.
- 12 homes received fewer points than they applied for.

**Residents Whose Ability to Move Independently Worsened (18.9)**

| 2023 | | | | | |
|---|---|---|---|---|---|
| **Statistic** | **Overall** | **+4** | **+3** | **+2** | **+1** |
| Homes Applied | 82 | 60 | 2 | 14 | 6 |
| Applied % | 66% | 48% | 2% | 11% | 5% |
| Homes Awarded | 79 | 55 | 3 | 15 | 6 |
| Awarded % | 96% | 92% | 150% | 107% | 100% |

The bullets below show the number of homes that received a different Reviewer Score than their Self Score:

- 7 homes received more points than they applied for.
- 10 homes received fewer points than they applied for.

**19. Best Practices**

In this measure, points are awarded to communities who provide a narrative detailing their best practices pertaining to safe physical environment, pain management, and prevention of abuse and neglect. Communities had to provide two examples of each best practice to meet the minimum requirements. This measure was implemented in 2021.

### 19.1 Best Practices –Safe Physical Environment

| Best Practices –Safe Physical Environment (19.1) – Awarded % | | | |
|---|---|---|---|
| **2019** | **2020** | **2021** | **2022** |
| n/a | n/a | 98% | 98% |

| 2023 | |
|---|---|
| Homes Applied | 122 |
| Applied % | 98% |
| Homes Awarded | 119 |
| Awarded % | 98% |

Facilities were asked to provide a narrative detailing how their home maintains a safe physical environment to prevent falls.

- Most facilities were able to meet the minimum requirements of this measure, however, 3 homes lost points because they failed to describe two examples of how their facility maintains a safe physical environment to prevent falls.

### 19.2 Best Practices – Pain Management

| Best Practices – Pain Management (19.2) – Awarded % | | | |
|---|---|---|---|
| **2019** | **2020** | **2021** | **2022** |
| n/a | n/a | 99% | 98% |

| 2023 | |
|---|---|
| Homes Applied | 120 |
| Applied % | 96% |
| Homes Awarded | 119 |
| Awarded % | 99% |

Facilities were asked to provide a narrative on their homes' non-pharmacological approaches to pain management.

- Most facilities were able to meet the minimum requirements of this measure; however, 1 home did not include two examples of non-pharmacological approaches to pain management.

### 19.3 Best Practices – Prevention of Abuse and Neglect

| Best Practices –Prevention of Abuse and Neglect (19.3) – Awarded % | | | |
|---|---|---|---|
| 2019 | 2020 | 2021 | 2022 |
| n/a | n/a | 99% | 98% |

| 2023 | |
|---|---|
| Homes Applied | 119 |
| Applied % | 95% |
| Homes Awarded | 114 |
| Awarded % | 96% |

Facilities were asked to provide a narrative on how they approach the prevention of abuse and neglect in their homes.

- Most facilities were able to meet the minimum requirements of this measure, however, 5 homes lost points because their narratives either did not describe reporting processes, address how they promote a safe culture, or include two examples.

### 20. Antibiotics Stewardship/Infection Prevention & Control

This measure was implemented in 2018 and then split out into two sub-measures for 2019. Points are awarded to communities who complete the CDC Infection Prevention and Control Assessment Tool for Long-term Care Facilities, who train staff on Antibiotic Stewardship, and who submit information on UTI and antibiotic use.

### 20.1 Antibiotics Stewardship/Infection Prevention & Control - Documentation

| Antibiotics Stewardship/Infection Prevention & Control (20.1) – Awarded % | | | |
|---|---|---|---|
| 2019 | 2020 | 2021 | 2022 |
| 68% | 86% | 69% | 84% |

| 2023 | |
|---|---|
| Homes Applied | 113 |
| Applied % | 90% |
| Homes Awarded | 73 |
| Awarded % | 65% |

This sub-measure rewards facilities for submitting Sections 1 through 3 of the CDC Infection Prevention and Control Assessment Tool. Facilities were also asked to provide a narrative of how they maintained infection control in their homes.

- 22 homes failed to complete all sections of the CDC tool, which is required for the P4P program to be awarded points. Section 3 was commonly missed.

- 10 homes submitted a newer version of the CDC tool which will be required in the 2023 application or a COVID-19 specific ICAR tool. A copy of the correct tool was linked in the measure's minimum requirements in the portal and provided to all homes via email ahead of submission to prevent homes from completing the wrong version. Homes that submitted the incorrect version were not awarded points.
- 8 homes missed points because they did provide both the name and qualifications of the infection preventionist.
- 4 homes did not provide the required narrative addressing how they maintain infection control in their home.

**20.2 Antibiotics Stewardship/Infection Prevention & Control – Quality Measures**

| Antibiotics Stewardship/Infection Prevention & Control (20.2) – Awarded % | | | |
|---|---|---|---|
| **2019** | **2020** | **2021** | **2022** |
| 85% | 83% | 97% | 94% |

| 2023 | |
|---|---|
| Homes Applied | 109 |
| Applied % | 87% |
| Homes Awarded | 95 |
| Awarded % | 87% |

This measure awarded points to facilities based on their completion of the Antibiotics Stewardship and Infection Prevention & Control Quality Measure Calculation Tool.

- 12 homes lost points because they did not meet the proper criteria of improving or being better than state average for both Casper Quality Measure Data on UTI (L) N024.02 and Catheter Inserted/Left in Bladder (L) N026.03. Homes that met criteria of improving or being better than the state average for at least one of the Quality Measures received one point.

**21. <u>Medicaid Occupancy Average</u>**

| | Medicaid Occupancy Average - Awarded % | | | |
|---|---|---|---|---|
| | **2019** | **2020** | **2021** | **2022** |
| <u>10%</u> | 93% | 88% | 96% | 92% |
| <u>5%</u> | 90% | 100% | 85% | 91% |

| 2023 | | | |
|---|---|---|---|
| | **Overall** | **10%** | **5%** |
| Homes Applied | 84 | 69 | 15 |
| Applied % | 67% | 55% | 12% |
| Homes Awarded | 76 | 63 | 13 |
| Awarded % | 90% | 91% | 87% |

Facilities may qualify for this measure if their home has Medicaid occupancy of at least 5% above statewide average. Facilities that qualified were asked to complete the Medicaid Occupancy Percentage Tool.

- For this measure, 7 facilities did not receive points because their Medicaid Occupancy average was below 72.3%.
- 1 home submitted Census data from 2023 and did not meet the minimum requirements, which specify to submit a census summary for 2022 calendar year.

### 22. Staff Retention Rate/Improvement

| Staff Retention Rate/Improvement - Awarded % | | | |
|---|---|---|---|
| **2019** | **2020** | **2021** | **2022** |
| 92% | 93% | 95% | 89% |

| 2023 | |
|---|---|
| Homes Applied | 94 |
| Applied % | 75% |
| Homes Awarded | 75 |
| Awarded % | 80% |

This measure awards points to facilities with a staff retention rate at or above 60% or a demonstrated improvement in their staff retention rate between CY2021 and CY2022.

- 12 homes did not highlight staff hired on or before January 1, 2022, on their payroll roster as specified in the minimum requirements.
- 5 homes did not meet the 60% staff retention requirement or demonstrate improvement in the staff retention rate between CY2021 and CY2022.
- 3 homes did not earn points as they did not complete the Staff Retention Calculator or attach a copy of the calculator.

### 23. DON/NHA Retention

| DON/NHA Retention - Awarded % | | | |
|---|---|---|---|
| **2019** | **2020** | **2021** | **2022** |
| 91% | 93% | 81% | 77% |

| 2023 | |
|---|---|
| Homes Applied | 74 |
| Applied % | 59% |
| Homes Awarded | 50 |
| Awarded % | 68% |

The minimum requirement for this measure is having the DON or NHA of a facility meet the three-year retention rate.

- 34 facilities did not receive the full 2 points on this measure as they did not meet the three-year retention requirement for either their DON and/or NHA or failed to complete the calculator.

### 24. Nursing Staff Turnover Rate

| Nursing Staff Turnover Rate - Awarded % | | | |
|---|---|---|---|
| **2019** | **2020** | **2021** | **2022** |
| 96% | 92% | 94% | 92% |

| 2023 | |
|---|---|
| Homes Applied | 95 |
| Applied % | 76% |
| Homes Awarded | 89 |
| Awarded % | 94% |

This is a measurement of Nursing Staff Turnover Rate. Facilities are asked to complete the Staff Turnover Calculation Tool and must report a rate below 60% or documented improvement between 2021 and 2022 to receive points.

- 8 facilities lost points as they either failed to upload supporting documentation or reported a turnover rate above 60%.

### 25. Behavioral Health Care

| Nursing Staff Turnover Rate – Awarded % | | | |
|---|---|---|---|
| **2019** | **2020** | **2021** | **2022** |
| n/a | n/a | 63% | 76% |

| 2023 | |
|---|---|
| Homes Applied | 108 |
| Applied % | 86% |
| Homes Awarded | 85 |
| Awarded % | 79% |

This is a measurement of Behavioral Health linkage for 2022. Homes were asked to submit the name and contact information of the individual at the Regional Accountable Entity responsible to be the liaison between their nursing home and RAE.

- 22 homes did not meet the minimum requirements for this measure as they did not specifically include the name of an individual at RAE in the documentation that they provided.

# ON-SITE REVIEWS

As part of the annual review process, the P4P Program requires that on-site visits be conducted for a sample of the participating facilities. This is pursuant to 10 CCR 2505 section 8.443.12 subsection 4, "The Department or the Department's designee will review and verify the accuracy of each facility's representations and documentation submissions. Facilities will be selected for onsite verification of performance measures representations based on risk."

## ON-SITE REVIEW SELECTION METHODOLOGY

After an initial review was completed for all facility applications, PCG conducted a risk methodology assessment to select nursing facilities for the proposed on-site reviews. The risk methodology consisted of multiple risk categories with varying weight on risk score. These risk categories and their weight on overall risk scores include:

- Reviewer Score vs. Self-Score Variance (30%)
- Year to Year Total Score Variance (20%)
- Unclear or Unorganized Documentation (10%)
- Calculation Errors in Application (10%)
- Newly Participating Nursing Homes (5%)
- Preliminary Review Findings (15%)
- Total Self Score (10%)

These risk categories were scored independently for each nursing facility that submitted a P4P application. All nursing homes were scored for each risk category as either High = 3 points, Medium = 2 points, or Low = 1 point. Then, each facility was assigned a total risk score using a weighted average of each risk category score.

PCG then divided the nursing facilities into three risk level groups (High, Medium, and Low) based on these total risk scores. Using a bell-curve distribution while analyzing the range of calculated risk scores, approximately 25% of facilities are in the High and Low risk level groups and approximately 50% of facilities are in the Medium risk group.

PCG then randomly generated five High, five Medium, and two Low risk facilities for the proposed 2023 on-site review process. This distribution allows PCG to verify review methodologies for nursing facilities at different risk levels and analyze how they compare. Consideration was also given to location across the State, ensuring different regions were covered as part of the selection process. In addition, nursing facilities that received an on-site review from 2019 to 2022 were not selected for a 2023 on-site review.

Based upon the described process, 12 (10%) homes were selected for an on-site review as shown in Table 7.

**Table 7 – Homes Selected for On-Site Review**

| Home Name |
|---|
| Colonial Health and Rehabilitation Center |
| Sundance Skilled Nursing and Rehabilitation |
| Cheyenne Mountain Center |
| Fountain View Health and Rehabilitation Center |
| Prestige Care Center of Fort Collins |
| Columbine West Health and Rehab Facility |
| Creekside Village Health and Rehabilitation Center |
| Juniper Village- The Spearly Center |
| Life Care Center of Longmont |

| |
|---|
| The Katherine and Charles Hover Green Houses, Inc. |
| The Peaks Care Center |
| Ridgeview Post Acute Rehabilitation Center |

## ON-SITE REVIEW FEEDBACK

### GENERAL FEEDBACK

- Homes who had participated in the program before and began data collection early in the reporting year had less confusion and were more successful in uploading data in the portal.
- Newer homes and newer administrators typically expressed they wished they had organized their documentation differently to align with minimum requirements.
- Staffing shortages have been a major challenge for both preparing this application and providing adequate care for residents.
- Most homes were appreciative of the training resources available and updates to the portal over recent years that made submitting the P4P application more straightforward.

### MEASURE-SPECIFIC FEEDBACK

- One home expressed their frustration with needing to add data line by line into the Reducing Avoidable Hospitalizations Tool.
- A home explained that they are better preparing for the equity measure by pursuing Telligen trainings and hope to earn points next year.
- Some homes missed points because they read the measure descriptions, instead of focusing on each of the minimum requirements.
- One home found it difficult to meet P4P measures with infection control protocols. They specifically cited enhanced dining, as they no longer offer food 24/7.

### PORTAL-SPECIFIC FEEDBACK

- Homes that have been participating for several years have found the portal to be easier to use each year. Many explained that the application changes training is helpful.
- One home suggested the portal should have a notification if a home tried to apply for a minimum requirement but did not upload documentation to the minimum requirement. They had missed points because of missing documentation.
- There were several criteria where a user forgot to attach the correct or all the documentation. They recommend having a better system making sure each measure is accounted for. This is related to the above bullet.

### RESIDENT FEEDBACK

- Overall, residents had positive things to say about the facilities they were living in. At many facilities, residents expressed that staffing issues often led to long wait time to receive care. No significant concerns were identified during the on-site reviews.

# APPEALS

Nursing homes were given the opportunity to submit an appeal request after they received their score notification letter and accompanying reports. The appeals process gives each applicant the opportunity to review the evaluation of their P4P application score and to inform the Department in writing if they believe the documentation submitted with their P4P application was misinterpreted, resulting in a different score than their self-score. Providers had from May 1 – May 31 to submit an appeal request. All appeal requests were required to be submitted through a specifically designed Microsoft Form.

The Department received 20 appeals as part of the 2023 review process. Table 8 provides the number of appeals received in previous years.

**Table 8 – Appeals Historical Data**

| Year | Number of Appeals |
|---|---|
| 2019 | 16 |
| 2020 | 20 |
| 2021 | 24 |
| 2022 | 16 |
| 2023 | 20 |

Once an appeal was received, the PCG team reviewed the appeal and reevaluated the documentation submitted in the initial application. After reviewer evaluation, PCG provided appeal review recommendations to the Department, who would then make the final decision for each appeal. The Department provided each nursing facility who submitted an appeal with an Appeal Review Report, which detailed findings and any scoring changes as a result of the appeal.

Table 9 provides information on the specific facilities that appealed, their pre- and post-appeal scores, and the point difference after the appeal review.

- The 20 homes appealed a total of 53 measures, 34 were approved.
- On average, facilities appealed measures worth 9 points and were awarded 14 points. However, this figure is skewed as 3 homes appealed all measures due to submission errors but had to select Measure 1 due to limitations on the Microsoft Form used. These homes were awarded a large number of points, averaging an updated score of 59 points. The median number of points awarded to all homes was 5 points.

**Table 9 – 2023 Appeals Summary**

| Facility Name | Initial Reviewer Score | Final Reviewer Score | Difference After Appeal |
|---|---|---|---|
| Pueblo Center | 74 | 82 | 8 |
| Mesa Manor Center | 75 | 80 | 5 |
| Skyline Ridge Nursing and Rehabilitation Center | 0 | 0 | 0 |
| Castle Peak Senior Life and Rehabilitation | 0 | 65 | 65 |
| Beth Israel at Shalom Park | 77 | 80 | 3 |
| Rio Grande Rehabilitation and Healthcare Center | 77 | 81 | 4 |
| Julia Temple Healthcare Center | 84 | 89 | 5 |
| Rehabilitation Center at Sandalwood | 77 | 80 | 3 |

| Facility Name | Initial Reviewer Score | Final Reviewer Score | Difference After Appeal |
|---|---|---|---|
| St Paul Health Center | 56 | 74 | 18 |
| Arborview Senior Community | 77 | 80 | 3 |
| Prestige Care Center of Morrison | 0 | 41 | 41 |
| Westlake Care Community | 58 | 65 | 7 |
| Spanish Peaks Veterans Community Living Center | 78 | 86 | 8 |
| Adara Living | 77 | 82 | 5 |
| Highline Rehabilitation and Care Community | 0 | 72 | 72 |
| Life Care Center of Littleton | 59 | 68 | 9 |
| Arvada Care and Rehabilitation Center | 73 | 81 | 5 |
| The Katherine and Charles Hover Green Houses, Inc. | 59 | 59 | 0 |
| Westlake Lodge Health and Rehabilitation Center | 45 | 46 | 1 |
| Sierra Rehabilitation and Care Community | 39 | 66 | 27 |

## APPEALS DETAILS

Table 10 below shows the number of appeals that were received, approved, and denied for each measure.

**Table 10 – Appeal Details by Measure**

| Measure | # Approved | # Denied | Total |
|---|---|---|---|
| Measure 1: Enhanced Dining | 4 | 3 | 7 |
| Measure 3: End of Life Program | 1 | 0 | 1 |
| Measure 5: Person-Direct Care Training | 3 | 1 | 4 |
| Measure 6: Trauma-Informed Care | 3 | 0 | 3 |
| Measure 8.2: Physical Environment - Noise Management | 1 | 1 | 2 |
| Measure 9: QAPI | 1 | 0 | 1 |
| Measure 11: Volunteer Program | 1 | 1 | 2 |
| Measure 12: Staff Engagement | 3 | 0 | 3 |
| Measure 13: Transitions of Care - Admissions, Transfer, and Discharge Rights | 2 | 4 | 6 |
| Measure 16: Vaccination Data | 1 | 0 | 1 |
| Measure 17: Reducing Avoidable Hospitalizations | 7 | 0 | 7 |
| Measure 18: Nationally Reported Quality Measures Scores | 1 | 1 | 2 |
| Measure 20.1: Antibiotic Stewardship/Infection Prevention & Control - Documentation | 2 | 1 | 3 |
| Measure 20.2: Antibiotic Stewardship/Infection Prevention & Control - Quality Measures | 0 | 1 | 1 |
| Measure 21: Medicaid Occupancy Average | 1 | 2 | 3 |
| Measure 22: Staff Retention Rate | 2 | 0 | 2 |

| Measure | # Approved | # Denied | Total |
|---|---|---|---|
| Measure 23: DON and NHA Retention | 1 | 1 | 2 |
| Measure 25: Behavioral Health Care | 0 | 3 | 3 |
| **Grand Total** | **34** | **19** | **53** |

The most common measures for appeals were Measure 1 (Enhanced Dining), Measure 5 (Person-Direct Care Training), Measure 13 (Transitions of Care – Admissions, Transfer, and Discharge Rights), and Measure 17 (Reducing Avoidable Hospitalizations).

**Measure 17 had seven appeals – seven were approved.** Many of the appeals in Measure 17 (Reducing Avoidable Hospitalization) were related to the pending score for 17-1. There was a delay in receiving data from AHCA and CMS, which prevented the independent review of the long stay hospitalization data. The Department decided to award all homes who applied for the measure and who met all of the minimum requirements for 17-2 and 17-3 the full 3 points for Measure 17. All four homes who appealed the pending score were included in the 74 homes who were awarded the full 3 points.

**Measure 1 had seven appeals – four were approved.** Most appeals for Measure 1 (Enhanced Dining) were missing information in the narrative section around communal and in-person dining options. Three homes that appealed Measure 1 were appealing all measures; however, due to the nature of the Microsoft Form being used, selecting all measures was not an option.

**Measure 13 had 6 appeals – two were approved.** Most of the appeals from Measure 13 (Transitions of Care) were related to CASPER Report MDS 3.0 Facility Characteristics. Some homes did not upload the report or uploaded the report to Measure 18 (Quality Measure). There was one instance of a home missing the name of the individual at the local agency responsible to be the liaison between the nursing care center and agency for community placement referrals.

**Measure 5 had 4 appeals – three were approved.** There were two instances of homes submitting combined mission and vision statements, which were both approved as the measure language did not explicitly specify the statements needed to be separate. One appeal was denied as the narrative provided did not address how the facility assessment influenced person directed care training.

Overall, 20 facilities appealed a total of 53 items. Measures 1, 5, 13, and 17, described above, were the only measures with more than four appeals. Generally, appeals were approved when a facility was able to provide further clarification around the location of certain pieces of documentation and criteria. Appeals were usually denied when a facility was unable to demonstrate that they had provided documentation that met the application requirements in their initial submission package or attempted to submit additional documentation during the appeals process.

# OTHER ANALYSIS

## MEASURE 22 – STAFF RETENTION

This tool collects data for each facility's staff retention. To qualify for points, the facility must demonstrate a staff retention rate greater than 60% or a rate above 40% with an improvement in the rate from the previous year. Table 10 below shows the aggregated 2020 application (78 homes), 2021 application (77 homes), 2022 application (66 homes), and 2023 application (85 homes) data for providers that reported figures in the portal's tool. The retention statistics decreased by 3% in 2021. This decrease was expected due to the impacts that COVID had on nursing home staffing. This year's rate remained consistent with the 2020 and 2022 application.

**Table 15 – Staff Retention Tool Analysis**

| Statistic | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|
| Staff Retention Rate | 69.8% | 66.6% | 70.7% | 71.1% |

## MEASURE 24 – NURSING STAFF TURNOVER

This tool collects data around the turnover rate of each applicant's nursing staff. Historically, to qualify for points, the facility must demonstrate a rate below 56.6% or a documented improvement (lower rate) between the current and previous year. However, in 2021, these criteria were removed, and facilities were awarded points for reporting the data. A termination is defined as any person who is no longer employed by the home for any reason. Table 11 below shows aggregated 2020 (75 homes), 2021 application (69 homes), 2022 application (66 homes), and 2023 (85 homes) data from providers that used the portal's tool. Overall, there was a sharp increase in the nursing staff turnover rates compared to 2022. The 2023 rate was more similar to the 2021 rate.

**Table 16 – Nursing Staff Turnover Tool Analysis**

| Statistic | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|
| Nursing Staff Turnover Rate | 58.2% | 64.6% | 58.8% | 64.4% |
| % of Terminations for Employees with <90 Days on the Job | 28.1% | 31.0% | 27.5% | 27.0% |

PCG and the Department will continue to monitor and analyze this information in the future to identify any industry trends.