

Natalie Highsmith—welcome

Sheila Lambowitz—we are in for “real treat”—we will introduce a new program—special 90 minute call. Nothing is more important than quality—Thomas Hamilton will explain this new program after a few brief announcements...

Briefly discussed

- Emergency procedures for MC coverage due to disasters in Iowa
- DME bidding system—7/1/08—begins—visit website for most recent info & educational articles

Quality care 5 *** rating system discussion—led by Thomas Hamilton**

Introduction of 5***** development team—Mary Pratt, Cindy Gronke, Joan Simmons, Carla Mcgregor, Ed Mortimer, Gene Scott

Purpose of this ODF—to provide the opportunity for you to learn about OUR thought process

- 3 methods will be used for stakeholders to communicate thoughts/responses/comments of proposed new system:
 1. e-mail to bettercare@cms.hhs.gov provide feedback to CMS by July 23rd if possible
 2. this ODF
 3. limited stakeholder communication/feedback meetings

Goal of rating system—we want to improve info given to consumers—info will come from 3 data sources—survey (3 years), QM (19), and staffing info (on website now)

Consumers have more info now—we added info on “special focus” facilities—But what information do consumers have about GOOD facilities—these are greater in number— wouldn't consumers also benefit from knowing this?? What is the best way to devise the rating system? We will take questions now...

Q & A from phone-in participants

Tim Vino—KY—we tried a rating system—problematic—minimum licensure requirements do not show QUALITY –is there a shift in CMS's strategy? (TH)—provide a window into quality and extent of compliance—get a sense in degree of quality—we agree do not show entire picture—we will not communicate that this should be a decision making tool...we ought to be careful how to use this info appropriately—many states have taken a leadership role in this, with their own rating systems—survey and QM and satisfaction surveys ; Gannett had a rating system based on survey—we are trying to get a more uniform approach to a rating system and would welcome feedback on this

Terry Sullivan—using same info it already has up on website—we are not informing public with more information, we are simplifying information—not real quality information—these do NO measure quality...am uncomfortable with stars for basic compliance...quality is more like pressure sores healed, not # of pressure ulcers; # of restorative programs, not # of bedfast residents; increase in ADLs, not decrease in ADLs; customer satisfaction surveys, pioneer practices like fine dining—these better indicate high quality—turnover not staffing levels should be looked at –this better reflects quality...or turnover of QI/QA nurses...am uncomfortable using OLD info types when

we could be more creative...

(TH) suggested turning around the QM's to the positive!!! And would like feedback on this!!!

Robin Fetters—SC—from a 58 bed facility—QM cannot be measured—how will this be handled?? Feel system is based on minimum versus high quality offered...is there a way to earn "extra credit" in areas of culture change...**(TH)**--"good ideas" open to suggestions how to measure these...looking for Dec 2008 start, as well as development agenda for future...this dialogue may form this process and move this agenda along...WHAT IS THE FORMULA? We don't know yet...will consider public comments and statistical analysis...to look at best balance to show most info

Beth Baker—writer about culture change...consumers want to know what facilities offer this and if better quality of care is a result—how are you going to get to this?? **(TH)**—this is important...we want to collect info/stats on this...where are we now? There is a tool developed—an "artifact tool"—we need real measures to show indicators of implementation and need ideas of how to collect information on other facility specialty programs ...??webbased system where NH would enter info about specialty services—some states already have this info on state website for emergency preparedness...vents, etc.

Deborah Zahr—KS—laudable goal to provide meaningful information...but...how did you determine what categories to select?? Resident/customer satisfaction MUST be included...plans to add on? **(TH)**—building on work to validate QM—like Mary Pratt and Gene Scott are doing...building on this foundation...consumers find staffing useful..."survey has objective 3rd party individuals looking at compliance"...customer satisfaction surveys done by many facilities—as a part of facility COI plan...using an external program may cause unintended effects, and we don't know if different surveys can be compared...we are considering many factors, including cost...need more info one facility customer is the MA/MC program itself—a deficiency means that the customer is not satisfied...this is of great concern to a facility...

Jim Leich—Indiana Homes and services for the aged—state surveys really vary---how is this going to be taken into account? **(TH)**—in 3 ways—management side—NH play a role in IDR or appeal process; also Federal 5% validation surveys...done within 60 days and compare results, bring differences to attention of state survey agency who then tries to fix systemic problems; there are limitations to this...can also set up a statistical method to control variation...also include complaint investigations---200,000 data points to consider; "grade on the curve"---?? compare within state only to moderate/minimize the state-to-state variations??...we want to assure a fair rendering of the information

Mara Hinkle—Genesis--in terms of QM...have you considered the effect of MD 3.0 on these? Has this been considered? Superior performance can not be shown using this methodology...**(TH)**—no deficiencies over time CAN show superior performance—this is a remarkable achievement...3.0...looking at...we will to figure out a way appreciate this...**Mary Pratt**—we are analyzing this now—use old, scrap, then make new---must be a dynamic process...change for the better...will be changes with 3.0...

Kathy Hamlin—QM not always indicative of good quality, or poor quality; why are we rolling this out when the survey situation is not settled? Staffing is a snapshot...how can this be better represented?? QM can be indicative of year old info...how often will this be updated?? Is the 5 star rating dynamic or not?? **(TH)**—QM—would be interested in your thoughts...which ones are useful/valid??; QIS survey—this should improve consistency, then could relax statistical controls...over many years...for the near future, we will place emphasis in expanding/improving the QUALITY and consistency of QIS before we expand the actual program...re: complaint surveys on NH compare—we include actual findings, not number of complaint surveys...re: staffing—we have looked at this info, and it is reasonably consistent with continual reporting...Gene Scott is looking at a way to extract info using payroll info—we do want a way to look at turnover...update at least quarterly...dynamic exchange of information—KH—we want to see it updated frequently

Bonnie Zabell—Wisconsin—we developed a P4P program in Wisc—but then had no \$\$ to actually implement...first determination from professional group (consumers, QIO, ombudsman, surveyors, DN's, ADM, many others...) who developed program—cannot use survey or QM to measure quality; survey deficiency does not really define the QUALITY issue...why it happened is a bigger issue. In our state, there is not always a choice for placement—d/c workers find an open bed...no opportunity for consumer choice, no matter how much info is out there...**(TH)**—P4P is different than a quality rating system...there is also a term called “value based purchasing”...we would like to know what system you developed if survey and QM were not used...we are looking if each QM has “integrity”—QM for DU has countervailing influence—RUG levels and payment; we want to be sure to put in other cautions the consumer must consider; eg, distance, how often family can visit.....important consumer considerations

Allison Herschell—Michigan campaign for quality care—concern that staffing and QM are self-reported...is there checking that will be done?? **(TH)**—we want to select those QM with more integrity...we can check staffing with payroll, if we question the staffing...we have built in more edits into reporting system...we ask states to follow up if discrepancy

Mary Phillips—IOWA—we are a state with many small community based NH—average person wants to go to home close to them...the consumer may look at special focus facilities information and understand that. But consumer will look at the “5 star rating” in the same way it is used to rate hotels (not quality, but AMENITIES)—a 5 star small home in Iowa will be “normal”—it will not be like a 5 star hotel with an Olympic pool!!—the stars mean nothing—like AAA—how do you plan to educate public?? This is NOT the same as a hotel rating system...how will you accommodate small “normal” facilities who provide normal, good care?? **(TH)**—we may want to pay attention to this...**Mary Pratt**—I am looking at this from a consumer point of view...5 star AAA ratings...**(TH)**—we need to connect more with the consumer groups...like NCCNHR—direct these questions to them...they are important...and ask them how to best educate the public

Rhonda Richards—has consumer testing been done about NH compare or other systems like the proposed star system?? We also do not want all homes to have “3 star ratings”—need clear distinctions if possible...will consumers see how the system is composed?? How can a Special focus facility have 2 star rating in the example given on the web?...would expect to see many more 1 star facilities since number of special focus is limited...**(TH)**—we have a 5 star rating for

Part D plans which is working...NH have a "leg up" as they "have 3rd party trained individuals who measure quality objectively"...we will have info on website, will need consumer feedback how best to display this—consumers can control amount of info they can drill down to...we left the example you gave for discussion...**(TH)**---(...continues, kind of thinking out loud)...there should there be a way to show slow improvement or slow decline in quality—the trendline...is there a way to display for consumers? This could make a difference to consumers—give some thought to this...look forward to AARP feedback.

Virginia Mosely—certain types of patients in hospital-based facilities will always have pain mgmt. issues due to the type of patients...staffing levels WILL ALWAYS be higher and different due to mix of patients and fewer beds, we have a much higher acuity...but this higher staffing level does not necessarily mean BEST care or better care than the SNF who have MANY LOC...staff is spread across LOCs **(TH)**—good point. **CMS person** (didn't catch name)—yes, staffing...we need to develop way to look at this...maybe pull out these facilities—we agree that may reduce consumer confusion

Sue Mathewson—CARF accreditation agency--we accredit facilities based on standards for "person centered" nursing homes...we make good use of satisfaction survey feedback...must look carefully at survey responses given questions about staff responsiveness, decision making allowed by residents and "value" of services provided...and...How are survey results tied to CQI in specific NH?? "You should look at 3rd party accreditation processes used in various states...like Florida"

Rose Ireland—Texas Assoc of Homes and Services for the aged—what is the cost of this 5star program? Where can I find this? Is it publicly available? **(TH)**—(made unrelated comment re: deficiencies in IDR or under appeal) –we do not record on website until completed...Cost—general program to be absorbed in our normal budget. We do have a special budget for contractors, who may do special research or website design—can provide this information publicly...e-mail me and ask me the question

Carl Garber—Alaska—I agree with comments made re: lack of value of survey findings...will there be a statistic of # of deficiencies per patient day? This is one way to "normalize" or "standardize" number of deficiencies—**(TH)**—we are looking at this...give us your feedback

Sheila—the Encore audio will available at 1-800-642-1687---conf ID 50249977—available for one week from today—688 participants on today's call—next--SNF ODF call—July 31st.