Understanding the 5-Star Ratings and Quality Measures

Erica Holman, LMSW, LNHA, CDP
Evolucent Risk Management Consultant
Learner Objectives

- Describe the CMS 5-Star Rating system
- Define the relationship between the 5-Star Rating system and Quality Measures
- Explain how Quality Measures can improve 5-Star Ratings
What impact does it have?

- From a claims perspective Evolucent has identified a correlation between star rating and loss history.
- 4 and 5 star buildings tend to have fewer claims.
- 1 and 2 star buildings tend to have more claims with higher settlement amounts.
The 5-Star Rating System

- Provides consumers with Overall Quality Rating of one to five stars based on performance for three types of measures, each with its own five-star rating:
  - Health Inspections
  - Staffing
  - Quality Measures
The 5-Star Rating System

- In addition to the overall staffing, a five-star rating is separately displayed for RN staffing
Recent Changes to the 5-Star Rating

- Overall Five Star rating
  - No changes to methodology but changes to Staffing and Quality Measure (QM) components will impact your overall rating
- Survey component
  - No changes
- Staffing component
  - Changed how 3 and 4 star ratings are determined on Staffing component (remain 3-star if both nursing & DCS are 3-stars)
- Quality Measure component
  - Add two new quality measures (ST & LT antipsychotic use)
  - Reset the cut points to achieve each star rating
Health Inspection Scoring Rule

- Calculated based on points assigned to deficiencies
  - Current health inspection survey and the two prior surveys, AND
  - Deficiency findings from the most recent three years of complaints information and survey revisits
Health Inspection Scoring Rule

- Points are assigned according to scope and severity - more points = more serious, widespread deficiencies
- If substandard quality of care, additional points are assigned.
- If “past non-compliance” and severity is “immediate jeopardy” assigned points associated with a G-level deficiency.
- Deficiencies from Life Safety surveys are not included.
- Deficiencies from Federal Monitoring surveys are not reported on Nursing Home Compare or included in Five Star calculations.
Health Inspection Scoring Rule

- Repeat Revisits -
  - No points are assigned for the first revisit;
  - Points are assigned only for the second, third, and fourth revisits and are proportional to the health inspection score for the survey cycle.
Health Inspection Scoring Rule

- Failure to correct deficiencies by the first revisit results in additional revisit points assigned up to 85% of the health inspection score for the fourth revisit.

- CMS experience is that providers that fail to demonstrate restored compliance with safety and quality of care requirements during the first revisit have lower quality of care than other nursing homes.

- More revisits are associated with more serious quality problems.
Calculating Health Inspection Score

- Weighted deficiency score and number of repeat visits needed.
- Most recent period = weighting factor 1/2
- 13-24 months ago = weighting factor 1/3
- 25-36 months ago = weighting factor 1/6
Calculating Health Inspection Score

- To avoid potential double-counting, deficiencies that appear on complaint surveys that are conducted within 15 days of a standard survey (either prior to or after the standard survey) are counted only once.

- If the scope or severity differs on the two surveys, the highest scope-severity combination is used.

- Points from complaint deficiencies from a given period are added to the health inspection score before calculating revisit points, if applicable.
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<thead>
<tr>
<th>Severity</th>
<th>Scope</th>
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<tbody>
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<td>Immediate jeopardy to resident health or</td>
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Note: Figures in parentheses indicate points for deficiencies that are for substandard quality of care. Shaded cells denote deficiency scope/severity levels that constitute substandard quality of care if the requirement which is not met is one that falls under the following federal regulations: 42 CFR 483.13 resident behavior and nursing home practices; 42 CFR 483.15 quality of life; 42 CFR 483.25 quality of care.

Source: Centers for Medicare & Medicaid Services
Revisits Matter

Table 2
Weights for Repeat Revisits

<table>
<thead>
<tr>
<th>Revisit Number</th>
<th>Noncompliance Points</th>
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<tbody>
<tr>
<td>First</td>
<td>0</td>
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<tr>
<td>Second</td>
<td>50 percent of health inspection score</td>
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<tr>
<td>Third</td>
<td>70 percent of health inspection score</td>
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<tr>
<td>Fourth</td>
<td>85 percent of health inspection score</td>
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Note: The health inspection score includes points from deficiencies cited on the standard annual survey and complaint surveys during a given survey cycle.
Rating Methodology - Health Inspections

- Five-Star ratings on the health inspection domain are based on the relative performance within a state using these criteria:
  - Top 10 percent (lowest 10 percent for health inspection deficiency score) in each state receive a five-star rating.
  - The middle 70 percent of facilities receive two, three, or four stars, with an approximately 23.33 percent in each category.
  - The bottom 20 percent receive a one-star rating.
Can I Buy A Star? Staffing Domain

- Considerable evidence of a relationship between staffing levels and resident outcomes.

- CMS found a clear association between nurse staffing ratios and quality of care, identifying specific ratios of staff to residents below which residents are at substantially higher risk of quality problems.

- Plaintiff attorneys use the staffing ratings to “prove” home provides substandard care.
Staffing Domain

The rating for staffing is based on two case-mix adjusted measures:

- Total nursing hours per resident day (RN + LPN + nurse aide hours)
- RN hours per resident day
Staffing Domain

- Staffing measures are CMS form CMS-671 from CASPER.
- Resident census is based on the count of total residents from CMS-672 (Resident Census and Conditions of Residents).
- Specific fields that are used in the RN, LPN, and nurse aide hours calculations are:
  - RN hours: Includes registered nurses (tag number F41 on the CMS-671 form), RN director of nursing (F39), and nurses with administrative duties (F40).
  - LPN hours: Includes licensed practical/licensed vocational nurses (F42)
  - Nurse aide hours: Includes certified nurse aides (F43), aides in training (F44), and medication aides/technicians (F45)
Staffing Domain - FYI or CYA?

- CASPER staffing data include facility employees (full- and part-time) AND individuals under an organization (agency) contract or an individual contract.
- Does not include “private duty” nursing staff reimbursed by a resident or responsible party.
- *Also not included are hospice staff and feeding assistants.*
Case-Mix Adjustment (The short version)

- Expected hours are calculated by summing the nursing times (from the CMS Time Study) connected to each RUG category across all residents in the category and across all categories.

- The hours are then divided by the number of residents included in the calculations = “expected” number of hours for the nursing home.

- The “reported” hours are those reported by the facility on the CMS-671 form for their most recent survey, while the “national average” hours represent the unadjusted national mean of the reported hours across all facilities.
Scoring Rules

- RN and total nursing staff are given equal weight. For each of RN staffing and total staffing, a 1 to 5 rating is assigned based on a percentile-based method.
- For each facility, the overall Staffing Rating is assigned based on the combination of the two staffing ratings.
Facility ratings for overall staffing are based on the combination of RN and total nurse (RNs, LPNs, LVNs, and CNAs).

To receive a five-star rating, facilities must meet or exceed the five-star level for both RN and total staffing.

To receive a four-star staffing rating, facilities must receive at least a three-star rating on both RN and total nurse staffing and must receive a rating of four or five stars on one of these domains.
**Rating Methodology**

<table>
<thead>
<tr>
<th>RN rating and hours</th>
<th>Total nurse staffing rating and hours (RN, LPN and nurse aide)</th>
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<tbody>
<tr>
<td></td>
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*Note: Adjusted staffing values are rounded to three decimal places before the cut points are applied.*
Quality Measure Domains

Now it gets really exciting😊
Quality Measures

- QMs describe the quality of care provided in nursing homes and address a broad range of functioning and health status in multiple care areas.
- The QM domain is based on performance on a subset of 11 (out of 18) of the QMs.
- The measures were selected based on their validity and reliability, the extent to which facility practice may affect the measure, statistical performance, and importance.
Risk Adjusted values of QMs

- Catheter use
- Long-stay pain
- Short-stay pressure wounds

Risk adjusted QM score is a facility-level QM score adjusted for the specific risk for that QM in the nursing facility

Think of it as an estimate of the facility’s QM rate if facility had residents with average risk
Long-Stay QMs Used

- Percent of residents whose need for help with activities of daily living has increased
- Percent of high risk residents with pressure ulcers (sores)
- Percent of residents who have/had a catheter inserted and left in their bladder
- Percent of residents who were physically restrained
- Percent of residents with a urinary tract infection
- Percent of residents who self-report moderate to severe pain
- Percent of residents experiencing one or more falls with major injury
- Percent of residents who received an antipsychotic medication
Short-Stay QMs Used

- Percent of residents with pressure ulcers that are new or worsened
- Percent of residents who self-report moderate to severe pain
- Percent of residents who newly received an antipsychotic medication
Let’s talk a little more about QMs

- What makes these SO important?
- How SHOULD you be using them?
- HOW can they make QAPI meaningful?
- WHY are you using them?!
Where do they come from?

- **MDS assessment data**

  The MDS assessment data are converted to develop quality measures providing information showing how well SNFs are caring for residents’ physical and clinical needs.

- **MDS is not just a reimbursement assessment**, the accuracy of this information has a huge impact on the QM rating
How were they chosen

- Current quality measures were chosen because they can be measured and don't require additional reports.
- They are valid and reliable.
- CMS says they are *not* benchmarks, thresholds, guidelines, or standards of care. (Hmmmm - )
- Per CMS QMs are based on aggregate data and not on resident specific data, *and are not appropriate for use in a litigation action*. (Trust me, plaintiff attorneys will try!)
Why were the QMs chosen?

- The QMs were selected because they are important.
- They show ways in which nursing homes are different from one another.
- SNFs can improve their QM percentages.
- The quality measures have been validated and are based on the best research currently available.
QMs are dynamic

- That’s a fancy way of saying they will change
- CMS says QMs will continue to be refined
Calculating the Overall Rating

- Step 1 = Health Inspection Rating
- Step 2 = Staffing Rating; add 1-star for 4- or 5-star staff rating; subtract 1-star for 1-star staff rating
- Step 3 = Quality Measures; add 1-star for 5-star QMs; subtract 1-star for 1-star QMs
HOW do you make this information relevant and useful

- Use the data even if CMS says they are NOT benchmarks
- Assign champions to different areas
- THESE are the QAPI markers you should be addressing
  - Develop PIPs to improve outcomes
- 5-star in QMs will raise overall star rating
A quick overview to PIPs & improving QMs

- Does everyone use the QMs?
- How effectively are you using them?
- The following PIPs provide tangible examples that have been effective
WARNING - The following slides may cause eyes to glaze over...

- The slides are provided as your “take away” - an actual PIP
- Please ask questions!
Alarm Reduction Improvement Plan

- The FACILITY NAME uses personal alarms. The alarms have been mislabeled as “safety” and/or “protective” devices without evidence based research indicating improvement in fall rates while alarms are used. Alarms may be useful to alert staff once a resident has begun getting up and/or to alert/remind alert and oriented (or easily re-oriented residents) to request assistance. The facility will engage in a fall reduction and alarm elimination program.
Alarm Reduction Improvement Plan

Several actions may occur simultaneously and/or overlap but time frames should be established for completion/goal dates to keep the project moving forward.
Alarm Reduction Improvement Plan

- Form a work group to review alarm use and alarm reduction process (it is helpful to include CNAs and other disciplines to “think outside the box”).

- The work group should become the “experts” on alarm elimination - review research and data from sources such as Pioneer Network, MassPro, and other QIOs for ideas and successful examples of alarm elimination.

  - From the work group establish “Champions” for specific units/areas. The Champions act as cheerleaders, provide ideas, help with problem solving, etc.

  - Champions are tireless advocates to improve residents’ quality of life.
Alarm Reduction Improvement Plan

- Begin education and informational blitz for residents, staff, and families on the plan to eliminate alarm use and WHY/HOW it might be an effective method to reduce falls, improve quality of life, and increase employee responsiveness (or other similar/pertinent sub-targets). Include but not limited to:
  - Alarms generally serve as an alert when someone has already fallen and often more than one (1) staff member goes to the alarm sound, removing staff from other residents.
  - Residents often restrict movement to limit alarm sound and risk increased debilitation and alteration in skin integrity.
  - Sleep cycle is disturbed with alarms in use.
  - Quality of life is (negatively) impacted with the noise.
Alarm Reduction Improvement Plan

- Generate list of residents using alarms include number in use (i.e. if a resident has more than one) and types of alarms.

- Using fall data establish fall patterns and trends; alarm in use and placed and relationship of residents with alarms and falls and residents without alarms and falls.
Alarm Reduction Improvement Plan

- Based on fall data, set a starting point (i.e. specific unit or hallway). The staff members working in this area must have the “buy in” and understand the intent (to reduce falls, eliminate alarms and increase time at the “bed side” versus running around for alarms). The starting area should be evaluated from the ground up for:
  - Acuity including functional dependence
  - Behavioral symptoms (on average)
  - Labor study
  - Staffing assignments and staffing ratios
  - Fall patterns
  - Recreational Therapy programming - may need to be adjusted to address times of falls
  - Waking and sleeping cycles; sleep quality study; hours of sleep (i.e. are residents in bed by 8:00 pm and up by 2:00 am?)
  - Medication regimen - are there medications that cause side effects of “jitteriness”, anxiety or sedation that could be more efficaciously administered in the evening and remain therapeutic?
    - Liberalize medication administration to more “home like” process - “upon rising 6:00 am - 10:00 am”.
Alarm Reduction
Improvement Plan

- Establish a priority list for alarm elimination such as:
  - No falls in last year, no unexpected movement - assess for fall risk & conduct risk benefit for alarm use.
  - Residents who detach alarms AND have falls - they are not reliably using the alarm so the INTENT for use is not being met.
  - Falls consistently with alarm activated (i.e. unobserved) and no falls when in events with staff or peers.
  - Remind the team, “Never say never” - there might be a resident benefitting from alarms - maybe someone with slight memory impairment that is “reminded” by the sounding alarm.

- Update fall risk assessments and care plans as moving through the alarm elimination process.
Alarm Reduction Improvement Plan

- Set benchmarking goals for BOTH fall reduction and alarm elimination. Set 30-, 60-, and 90-day reviews.

- Continue education and outreach; communicate improvements to residents, families and staff; display success on message boards and in newsletters.
Alarm Reduction Improvement Plan

- Evaluate outcomes critically - was the success due to, or in spite of, approaches and interventions to reduce falls and eliminate alarms.
  - Review fall rates at all parameters established
  - Evaluate if fall alarm has met success criteria
  - Present data to QAPI
- QAPI directs team to continue work or to revise methodology and reassess benchmarking. Determines:
  - Strengths and weaknesses of current process
  - If PIP should continue in present form. If not:
- Revise plan and rework
Purpose Statement: The home flags for pain on CASPER. The home wants to improve resident quality of life & survey outcomes.
1. As a short-term, immediate "fix" begin asking the MDS pain-related questions 1-2 weeks before the MDS is due. This will give the home the opportunity to address the resident’s statements about pain and provide interventions to address the pain prior to the ARD.

2. The Geriatric Pain website provides free, evidence based interventions to address pain. Information can be downloaded: http://www.geriatricpain.org/Content/Quality/QIProcess/Pages/QIOverviewProcess.aspx

3. Advancing Excellence also provides free information to develop a PIP on pain management: https://www.nhqualitycampaign.org/goalDetail.aspx?g=pain#tab2
References

- BetterCare@cms.hhs.gov This address can be used for comments & ideas as well as requesting a breakdown of your home’s current points


- Shephard, R. The Five-Star Quality Rating System. AANAC publication, September 2012.
THANK YOU!

If you have questions please feel free to contact us at:
Erica.Holman@Evolucent.care
Angie.Szumlinski@Evolucent.care
734.996.2700