

FOCUS ON EXCELLENCE

Performance Improvement for
Oklahoma's Nursing Homes

2008–2009 ANNUAL REPORT

Submitted to

**Oklahoma Health
Care Authority**

by



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Synopsis

Focus on Excellence has completed its second full year. As of June 2009, ninety-five percent (95%) of all contracted SoonerCare nursing facilities were enrolled and participating in this voluntary program.

With eight quarters of data in hand, evidence has emerged of incremental improvements in resident/family satisfaction, quality of life, employee satisfaction, system-wide culture change, staff turnover, clinical outcomes and direct care hours.

Improvements in staff turnover, clinical outcomes and direct care hours during the first two years of *Focus on Excellence* (FOE) are especially noteworthy. Turnover among nursing assistants averaged 127% over the second year of the program, down from 149% in the first year. The turnover rate among nurses dropped from an average of 76% during the first year to 68% in the second year.

Each of the *Focus on Excellence* clinical performance measures has shown improvement since the baseline (third quarter of 2007). The percentage of residents without physical restraints has shown the greatest improvement, from 93.2% at the baseline to 97.0% at the most recent assessment (second quarter of 2009). Over this same period, average direct care hours has increased from 3.35 to 3.55.

Though these trends are quite positive, continued progress is needed because turnover rates are still high by national norms, and comparable gains have yet to be achieved in terms of improvements in staff retention or state survey compliance.

Recommendations

Based on the program experience to date, we recommend that the following enhancements be made in *Focus on Excellence* during the near term.

- First, incentives should be created not only to reward facilities that reach or exceed fixed targets, but also reward facilities that show significant improvements in performance over time. Since the strongest predictor of current performance is past performance, this enhancement would help align payment incentives to sustain full engagement with the program from all nursing facilities (not just the best performers at a given point in time).
- Second, since star ratings are updated quarterly, the *Focus on Excellence* Web site should be upgraded to afford visitors an opportunity to view historical data showing facility performance over time. As more data become available, it would be beneficial to offer consumers

information about performance measures trended over time.

- Third, initiate a collaborative process with stakeholders to introduce differential weighting of *Focus on Excellence* performance measures based on strength of correlation to overall performance and consumer perceptions of value.
- Fourth, adopt regulatory system outcome thresholds to define prerequisites for continued facility eligibility for payment incentives.

The Oklahoma Health Care Authority has recently arranged for an independent evaluation by the Pacific Health Policy Group of the *Focus on Excellence* program structure and processes. This evaluation is expected to yield further useful recommendations for refining and targeting *Focus on Excellence* in light of the experience to date and constructive input from Oklahoma agencies, providers and consumers.

Overview

Focus on Excellence is a voluntary incentive-based performance system for Oklahoma skilled nursing facilities created by action of the Oklahoma Legislature and administered by the Oklahoma Health Care Authority. Implemented on July 1, 2007, *Focus on Excellence* has recently completed its second year.

The goal of this program is threefold: (1) enable the value-based purchasing of nursing home care by the Oklahoma Health Care Authority, (2) improve provider performance through timely feedback and easy comparison with peer performance, and (3) inform consumer choices when seeking long-term care. Performance assessment is based on a set of metrics in 11 areas:

- Resident/Family Satisfaction
- Quality of Life
- Employee Satisfaction
- System-wide Culture Change (Level of Person-Centered Care)
- CNA/NA Turnover and Retention
- RN/LPN Turnover and Retention
- State Survey Compliance
- Overall Occupancy
- Clinical Outcomes
- Direct Care Hours
- Medicaid Occupancy and Medicare Utilization

NOTE: In the *Focus on Excellence* program and throughout this report, all performance metrics (except staff turnover) are stated in the positive so that higher scores always denote better performance. For example, clinical outcomes such as pressure ulcers and falls are calculated as residents without these conditions (as opposed to the incidence or prevalence of these conditions). Similarly, our measure for direct care staff “stability” combines staff retention rates with the proportion of staff who do not turn over within a given period.

In addition to providing a more balanced and comprehensive assessment of performance and program quality than regulatory compliance alone, these performance metrics are designed to support continuous evidence-based improvement practices among nursing homes by aligning payment incentives with quality to optimize value for consumers and payers.

Sources of data

My InnerView (MIV), a division of National Research Corporation (NASDAQ: NRCI), collects and manages data for *Focus on Excellence*. Resident/Family Satisfaction and Resident Quality of Life are assessed semi-annually through surveys sent to facility residents and their families. Data on Employee Satisfaction and System-wide Culture Change are gathered through surveys sent out semiannually to employees. Scores for these metrics represent weighted averages of the four response categories on My InnerView’s satisfaction surveys. An average score is calculated by assigning the following values: Excellent = 100; Good = 66.7; Fair = 33.3; Poor = 0.

On a monthly basis, facilities provide administrative data on workforce and clinical measures directly to My InnerView through the company’s online data portal. The Oklahoma Health Care Authority furnishes My InnerView with Medicare and Medicaid utilization data as well as individual facility staffing data.

Through My InnerView’s Web-based tool, facilities have the ability to track their performance over time, compare it against peer performance on a statewide and nationwide basis, and identify priority areas and opportunities for improvement.

Star ratings for consumers

Consumers have access to facility performance ratings through the *Focus on Excellence* Web site (<http://www.oknursinghomeratings.com>). On the Web site, facilities are given “star ratings” on ten assessment areas and an overall star rating. A facility can receive up to five stars for performing well in each area compared to its peers.

The number of stars is calculated based on quintile rankings. The bottom 20% within each assessment area gets one star; the next 20% gets two stars; the next 20% gets three stars; the next 20% gets four stars; and the top 20% gets five stars. The appendix summarizes statewide percentile ranks used to determine the number of stars assigned to each facility during 2008. These ratings are updated quarterly as new data are gathered.

Calculation of the number of stars awarded for State Survey Compliance uses a slightly different algorithm. Facilities with no citations get five stars. For facilities that have at least one citation, an index is created based on the number and severity of care-related citations. These facilities are ranked based on the index, and the top quartile receives four stars; the next quartile receives three stars; the next quartile receives two stars; and the bottom quartile receives one star.

The overall star rating is based on the total number of incentive points that a facility earns. A facility with one or two points receives one star; a facility with three or four points, two stars; a facility with five or six points, three stars; a facility with seven or eight points receives four stars; and a facility with nine or ten points, five stars. (The measure related to Medicaid Occupancy and Medicare Utilization is used only to calculate payment incentives, so it does not affect the star rating.)

Incentive points for quality

Monetary incentives to improve performance under *Focus on Excellence* take the form of added payments for services provided to SoonerCare recipients.

Facility performance on each metric is converted into an overall performance index. Currently, if a facility scores above the 50th percentile (median) on an index, it is awarded one incentive point. A facility can receive up to ten points, one point for each assessment area. My InnerView has recommended that the levels of performance required to earn additional payments be gradually raised over time in line with performance improvements documented through *Focus on Excellence*.

This methodology for awarding points has established a baseline for facility performance in each metric area. Using this baseline, OHCA plans to award points according to established performance standards beginning in the third year of the program. Knowing fixed targets in advance will help providers further focus their quality improvement efforts. Fixed targets are also easier for consumers to understand.

Incentive points for State Survey Compliance are already awarded based on fixed rather than comparative performance thresholds. Points for this metric are calculated as follows. Points are awarded to facilities that meet one of two conditions: (1) a facility has no citations; or (2) a facility with one or more citations has no deficiencies worse than an “D” (in terms of scope and severity) in a care-related area and it has no deficiencies worse than an “E” (in terms of scope and severity) in a non-care related area.

Increasing participation

Participation in Oklahoma’s *Focus on Excellence* program is voluntary. However, participation has increased continuously during the program’s first two years. The number of participating facilities has grown from 266 at the start of the program to 290 in the second quarter of 2009, a 9% increase. As of June 2009, 95% of all licensed nursing homes in Oklahoma were participating in the program. More facilities have also been providing complete data (*TABLE 1*). Consequently, fewer facilities are failing to earn incentive points as a result of missing data.

FACILITY PARTICIPATION

QUARTER	PARTICIPATING	NO. NOT REPORTING	% NOT REPORTING
Q3 2007	266	79	30%
Q4 2007	266	73	27%
Q1 2008	275	60	22%
Q2 2008	274	46	18%
Q3 2008	282	57	20%
Q4 2008	283	37	13%
Q1 2009	291	34	12%
Q2 2009	290	20	7%

TABLE 1

Increasing response rates

Satisfaction survey response rates have also shown continuous improvement. Four waves of survey data have been collected and analyzed for resident/family satisfaction and employee satisfaction. During the first wave of resident/family satisfaction surveys (fourth quarter of 2007), a total of 15,380 surveys were sent out and 6,504 surveys were returned to achieve an overall response rate of 42%. The number of surveys sent out in the most recent surveys (second quarter of 2009) has increased modestly to 16,425, but the number

of surveys returned showed a substantial increase to 10,286. This increase has lifted the overall response rate to 63%.

Employee response rates have also increased since the first employee satisfaction surveys (fourth quarter of 2007). At that time, 18,454 surveys were sent out, and 9,757 surveys were returned for a 53% overall response rate. During the most recent wave of employee satisfaction surveys (second quarter of 2009), 19,243 surveys were sent, and 15,113 were returned for an overall response rate of 79%. The greatest increase in response rates happened between the first and second wave of surveys as providers were becoming familiar with the survey process (FIGURE 1).

AVERAGE RESPONSE RATES RESIDENT/FAMILY AND EMPLOYEE SURVEYS

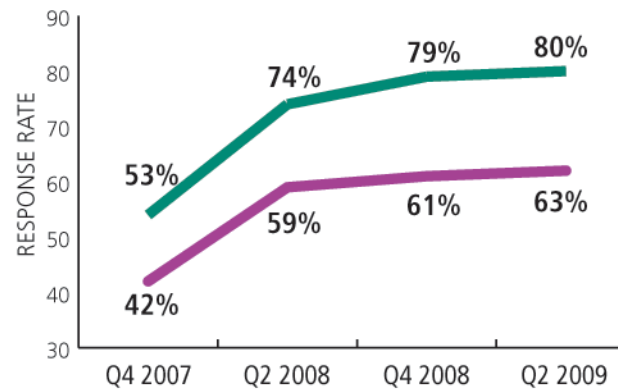


FIGURE 1

RESIDENT/FAMILY SATISFACTION

Resident and Family Satisfaction scores are derived from 14 items about quality of nursing care, meals, laundry, cleanliness and global satisfaction. In addition to completing the survey, two conditions must be met for a facility to receive incentive points or earn a star rating: (1) a facility's overall response rate on the survey must be at least 30%; and (2) for surveys mailed out to family members, the mailing address must be correct 65% or more of the time.

As facilities gain experience administering these surveys, fewer facilities are failing on this metric due to a lack of participation, low response rates or providing incorrect mailing addresses. For example, 68 facilities failed to meet these criteria during 2007, while only 31 facilities did so for the most recent wave of surveys conducted in the second quarter of 2009 (FIGURE 2).

Viewed across the four waves of surveys conducted during the

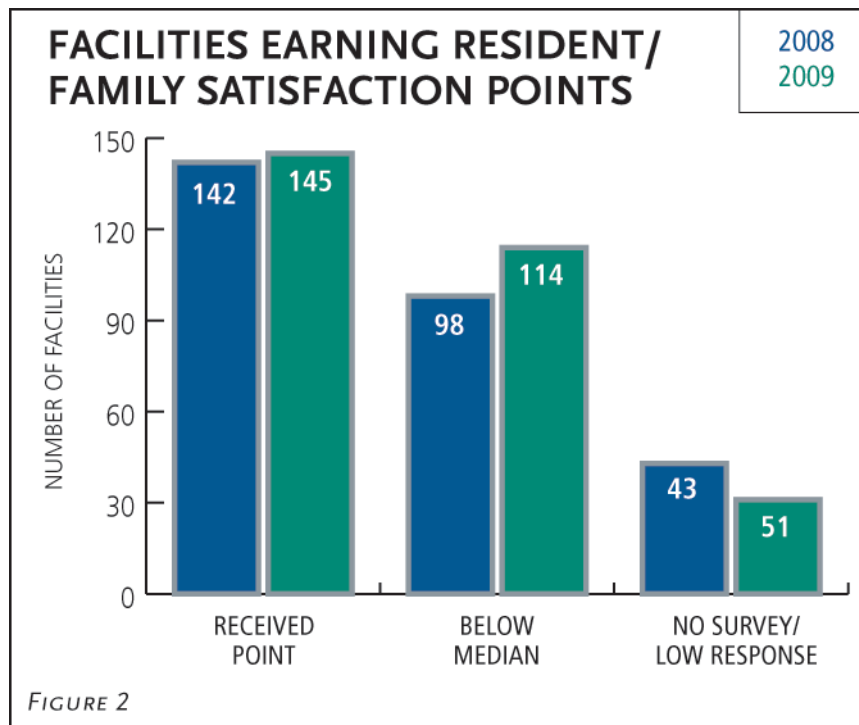


FIGURE 2

program's first two years, average scores have increased over time. The average increased from 69 in the baseline survey to 74 in the most recent wave of surveys. This improvement (see FIGURE 3) constitutes evidence that family and resident satisfaction are

improving over time. However, further analysis is needed to identify what factors underlie these changes.

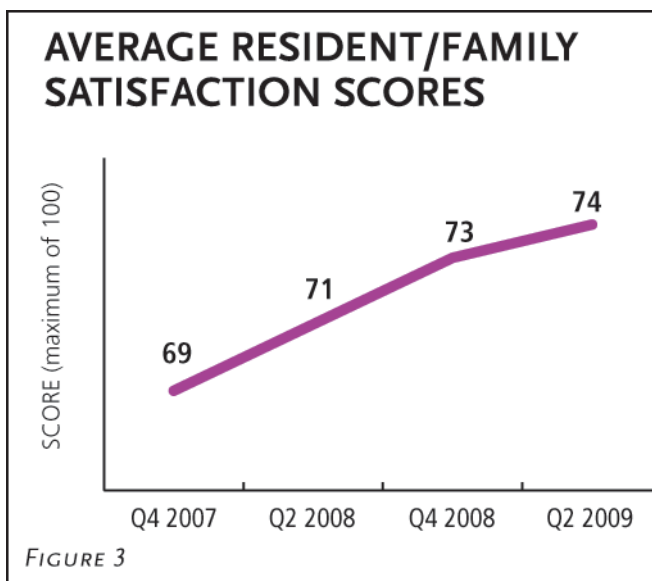


FIGURE 3

QUALITY OF LIFE

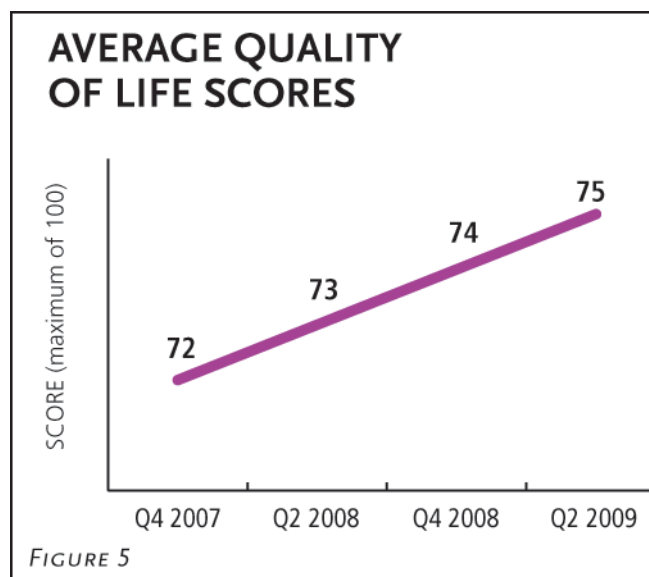
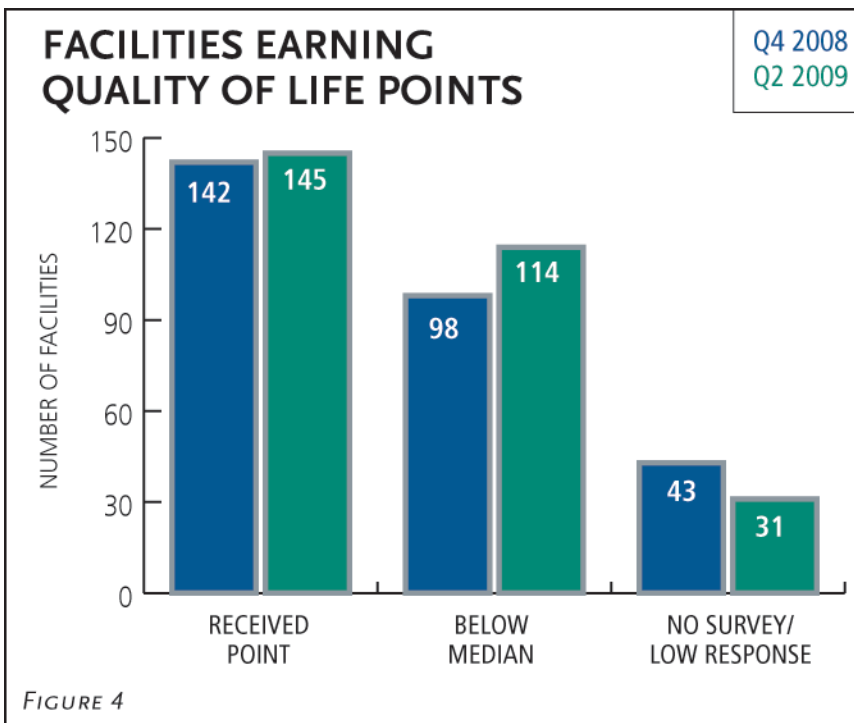
The Quality of Life score is derived from the ten items comprising the quality of life subscale that is part of the resident/family satisfaction survey. Quality of Life measures such things as the respect shown by staff, having one's privacy respected and meeting the resident's choices and preferences.

A total of 98 facilities scored below the median in the final quarter of 2008 while 114 facilities scored below the median in the second quarter of 2009. This increase in facilities scoring below the median is primarily a reflection of improved participation. In the second wave of surveys, only 31 facilities missed the incentive point due to poor response rates, too many incorrect addresses or not participating in the survey altogether is down from 43 facilities in the first wave (FIGURE 4).

In 2009, Quality of Life scores were higher than the previous wave of surveys in 2008. Comparing results

of surveys conducted in the fourth quarter of 2007 with the most recent wave of surveys in the second quarter of 2009, the average quality of life score increased from 72 to 75 (FIGURE 5).

Further analyses are warranted to identify what factors underlie these changes over time.



EMPLOYEE SATISFACTION

Employee Satisfaction is measured using 21 items on the employee satisfaction survey. This measure includes items related to things such as the quality of training, work environment, supervision, management and global satisfaction. About half of the participating facilities were given incentive points on this metric during 2008. A similar proportion earned incentive points in 2009.

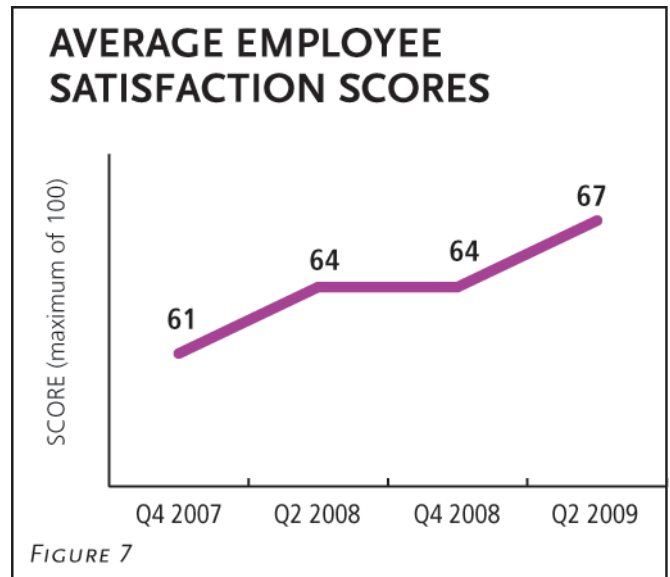
The number of facilities not getting incentive points due to lack of participation or poor response rates dropped from 67 in 2007 to 33 in 2009 (FIGURE 6). A larger proportion gets higher scores and a smaller proportion gets lower scores in 2009 compared to 2008.



Overall, scores have increased from the baseline through the most recent round of surveys.

The average employee satisfaction score in the second quarter

of 2009 was 67, up from 61 in the fourth quarter of 2007 (FIGURE 7).



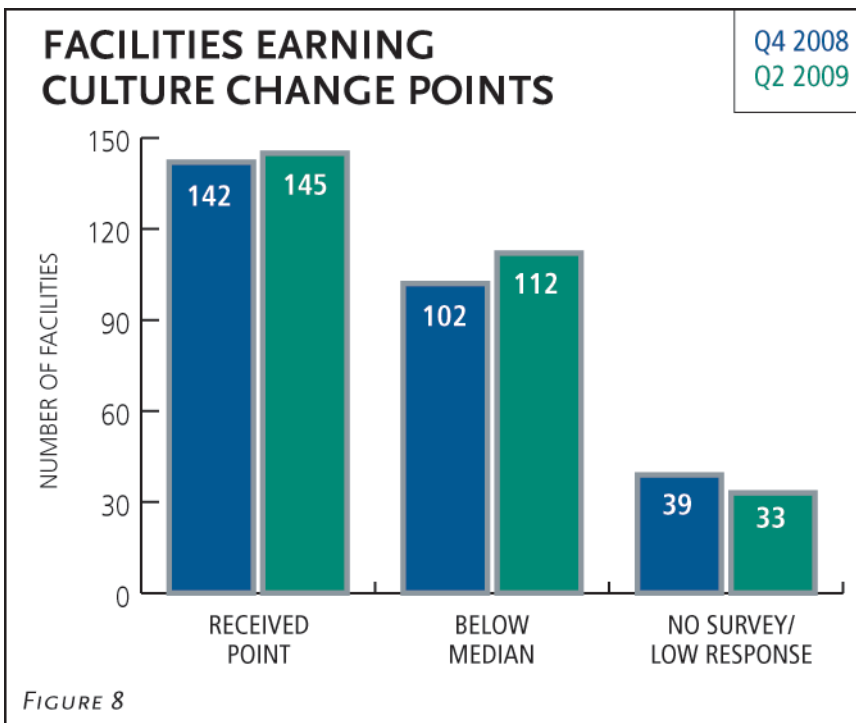
SYSTEM-WIDE CULTURE CHANGE (LEVEL OF PERSON-CENTERED CARE)

Culture change is a term used to describe the growing movement to introduce new operational practices aimed at transforming the nursing facility environment as much as possible from an "institution" to "home." The System-wide Culture Change metric includes 17 items related to organizational and leadership practices, innovation, quality management, resident directedness and other areas. Because these questions are included in the employee survey, the overall pattern of missing data due to non-participation and low response rates are identical to that for employee satisfaction surveys (FIGURE 8).

The distribution of System-wide Culture Change scores shows improvement between baseline and follow-up assessments. A higher proportion of facilities receive higher scores and a lower proportion receives lower scores in 2009

than 2008. Further evidence for improvement can be found in the increasing average culture change scores across quarters. The score increased from 65 at the baseline assessment in the fourth quarter of

2007 to 73 at the most recent assessment in the second quarter of 2009 (FIGURE 9).



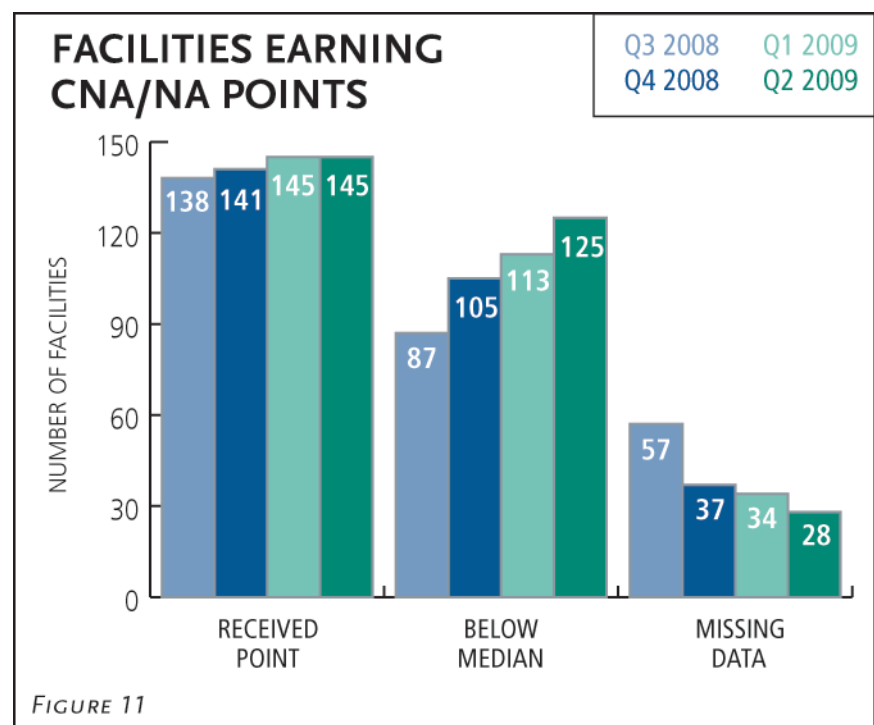
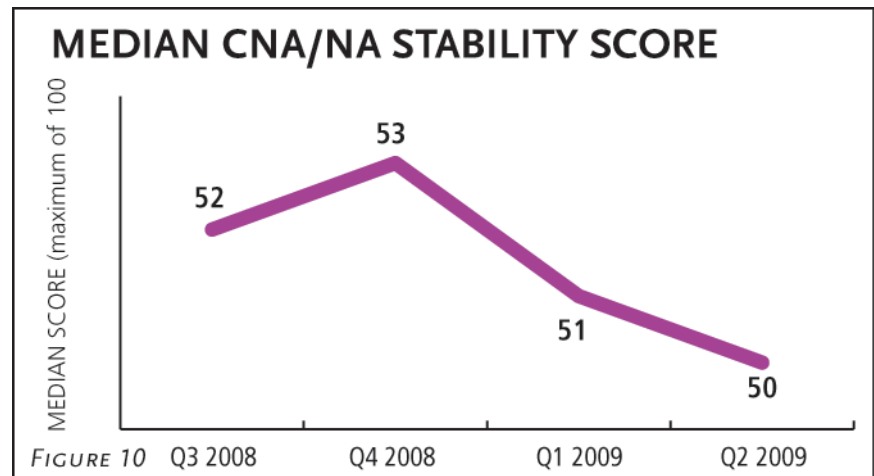
CNA/NA AND RN/LPN STABILITY

Turnover and retention among CNAs/NAs (certified nursing assistants/nursing assistants) and RNs/LPNs (registered nurses/licensed practical nurses) are direct measures of workforce performance. These measures have been shown in research to predict a facility's performance in many other areas.

Turnover measures the percentage of CNAs/NAs or RNs/LPNs who leave the facility during a given period. Monthly data are collected via My InnerView's portal and annualized to calculate an annual turnover rate for each group. Retention is the percentage of CNAs/NAs or RNs/LPNs who have been employed at the facility for at least one year at the end of each month. This number is calculated for a quarter by averaging monthly retention rates.

Turnover and retention are combined into a single overall metric called stability because these measures are strongly correlated. Measures of stability are calculated separately for CNAs/NAs and for RNs/LPNs.

The median score on CNA/NA stability over four quarters in 2008 and 2009 represents the threshold above which a facility receives an incentive point on this metric. In



aggregate, there is very little change on stability across four quarters (FIGURE 10). Average stability among CNAs/NAs ranges from a low of 50 to a high of 53 — suggesting that small improvements on this measure can yield additional incentive points.

There is a gradual decrease in the number of facilities with missing data over time, so there is clear evidence that reporting of this metric is improving (FIGURE 11). These data suggest that facilities are becoming more engaged in *Focus on Excellence*

as they gain experience using My InnerView's Web-based portal to submit data on a monthly basis.

The mean RN/LPN stability score shows a similar four-quarter fluctuation with a low median of 51 and a high of 52 (FIGURE 12). The number of facilities with missing data on RN/LPN stability also shows a steady decline across quarters, further indicating that more and more facilities participating in *Focus on Excellence* are using My InnerView's portal to submit monthly metrics on nurse turnover and retention (FIGURE 13).

In aggregate, Oklahoma facilities are improving both RN/LPN and CNA/NA stability scores over time, albeit very incrementally. This can be seen by comparing the average stability scores (not median scores depicted in Figures 10 and 12) for both groups across all eight quarters (FIGURE 14). Although the overall increases are small, they are significant considering stability scores reflect two separate measures. These improvements may indicate that facilities are achieving more consistent ranks on turnover and retention scores. These data also highlight the fact that RNs/LPNs generally have lower rates of turnover and higher rates of retention than CNAs/NAs. Stability measures nationally tend not to exhibit short term volatility, but may be subject to labor market

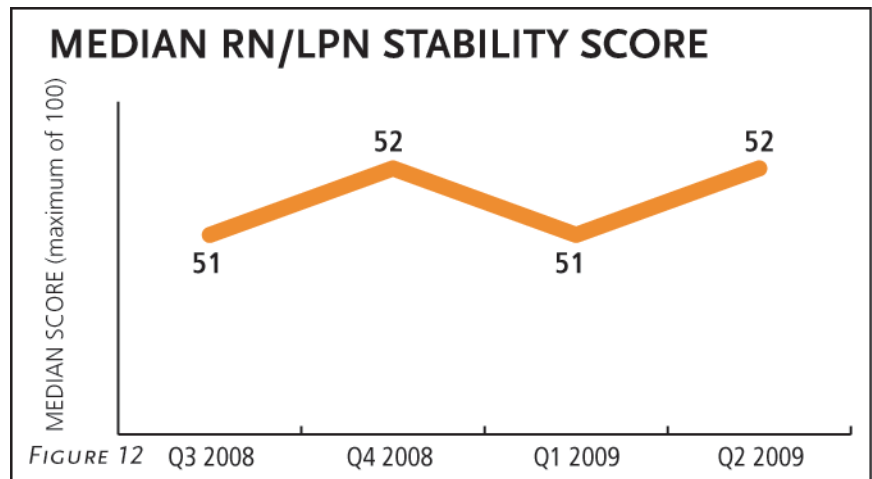


FIGURE 12 Q3 2008 Q4 2008 Q1 2009 Q2 2009

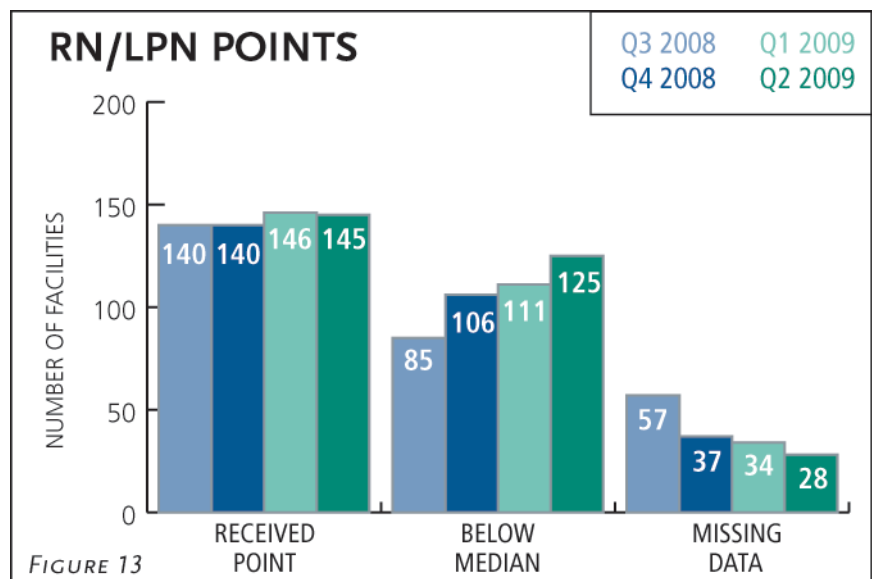


FIGURE 13

and other local conditions which can influence changes at the margin on a temporary basis. Hence no hard inferences are warranted regarding the affects of FOE incentives on this metric at this stage of the program.

Because the algorithm used to calculate stability scores combines several metrics and assigns equal weights to

retention and turnover, the stability score can mask real differences in the rate of turnover and retention between CNAs/NAs versus RNs/LPNs.

Stability scores are highly correlated with turnover and retention rates. However, they are not identical to the unadjusted or "raw" data describing turnover and

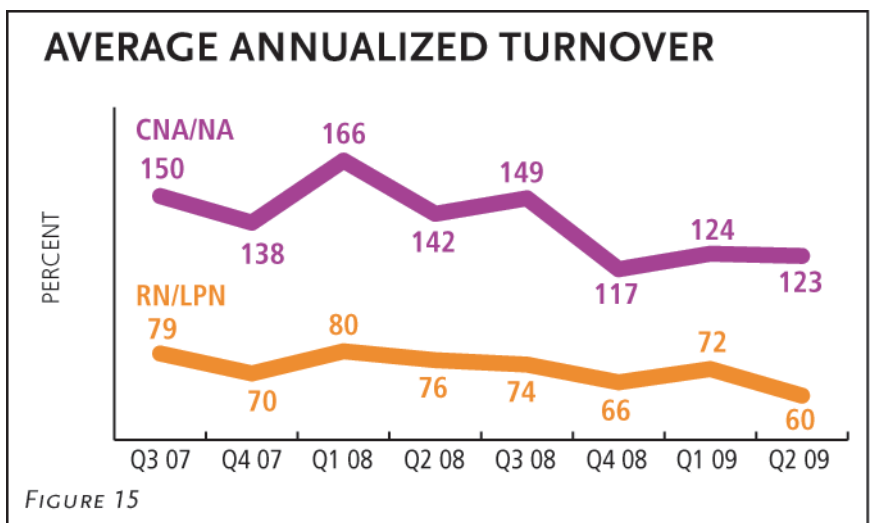
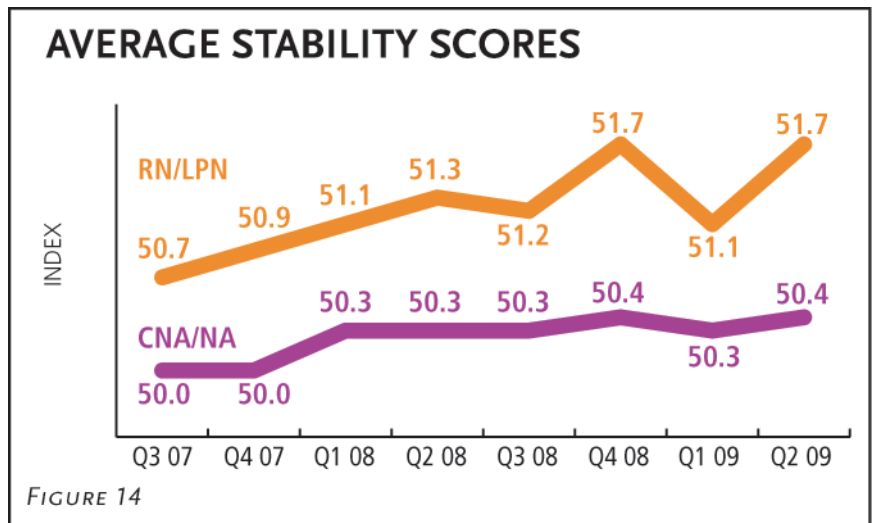
retention. The actual reported rates of turnover and retention are described below using “raw” (i.e., unadjusted) data.

There is substantial movement in average turnover rates over time especially among CNAs/NAs. Turnover peaked during the third assessment (166% during the first quarter of 2008) and dropped to a low in the sixth assessment (117% during the fourth quarter of 2008). Turnover among RNs/LPNs does not fluctuate as much, and turnover rates are consistently much higher among CNAs/NAs than RNs/LPNs. Turnover has decreased for both groups, however. Month over month turnover decreases between the third quarter of 2007 and the second quarter of 2009 (FIGURE 15). Average turnover is lower in the second year among both CNAs/NAs (149% in year one and 127% in year two) and RNs/LPNs (76% in year one and 68% in year two).

TURNOVER AND RETENTION

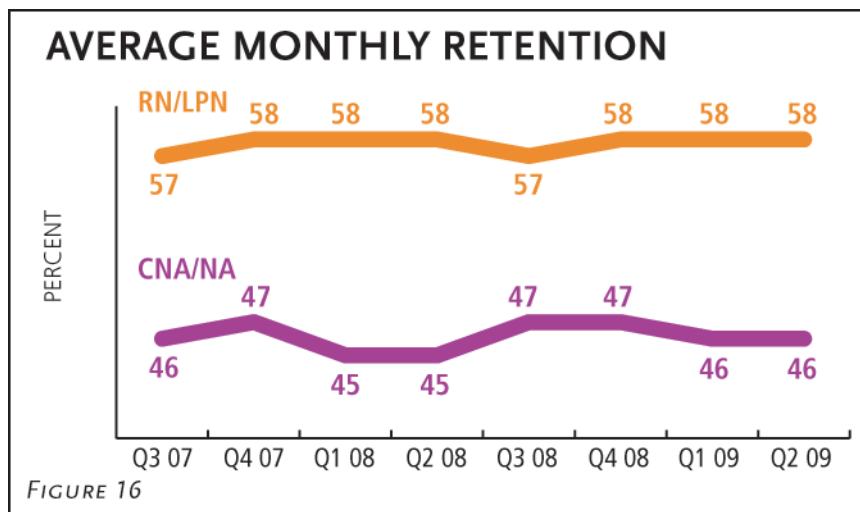
Retention rates among CNAs/NAs and RNs/LPNs (FIGURE 16) remain far more stable over time compared to the dramatic fluctuations seen in turnover rates. Thus, retention rates have not exhibited the same degree of improvement as turnover rates. These

findings suggest that there is a committed core group of nursing staff who have been employed by the facility for at least one year. This pattern holds true across all eight quarters, and is resonant with national data. Much of the turnover that is reported may be concentrated outside of this core group of more experienced and committed employees. The proportion of



staff who have been working at the facility for at least one year is greater among RNs/LPNs (averaging 58% across eight quarters) than among CNAs/NAs (averaging 46%).

As noted earlier, research shows that workforce performance predicts performance in many other areas. These data underscore the fact that there has been some improvement in turnover and little or no improvement in retention of nursing staff from baseline to the most recent quarter. Ongoing



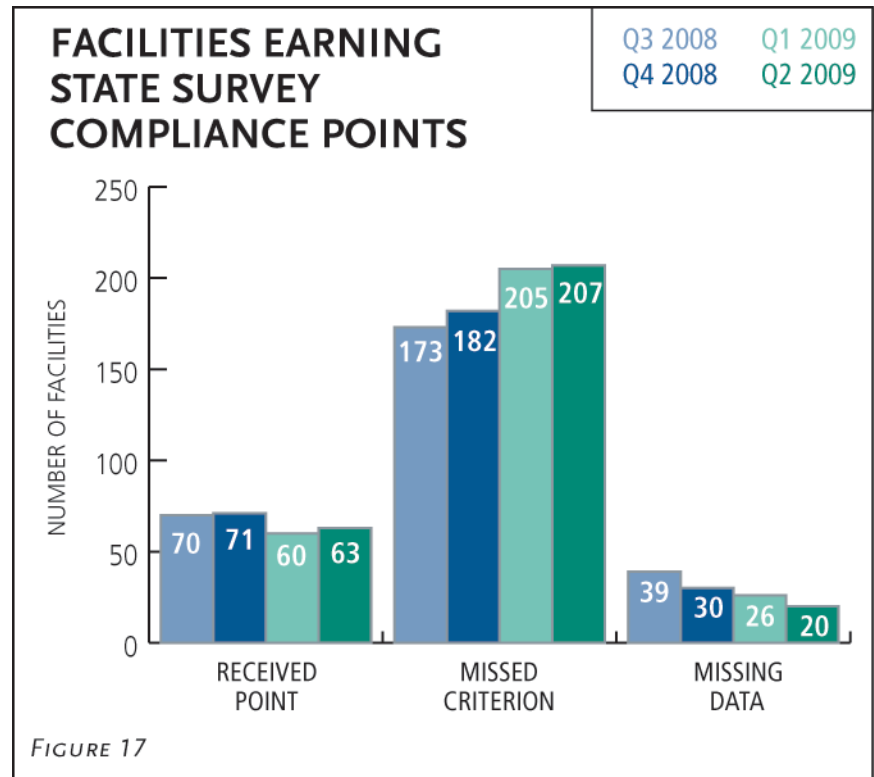
opportunities for improvement in this area are clearly evident

for both professional and paraprofessional nursing staff.

STATE SURVEY COMPLIANCE

Nursing facilities are regulated by the Oklahoma State Department of Health for compliance with Oklahoma's Nursing Home Care Act and federal Medicare and Medicaid program certification requirements. As part of the regulatory process, each facility is surveyed to assess compliance with federal and state regulations. In the historical sense, regulatory compliance is a long-standing measure of nursing home quality that has existed for many decades.

The State Survey Compliance metric is based on the number and types of deficiencies that are weighted for scope and severity. Across all four quarters of year two, most facilities did not receive an incentive point on this measure (*FIGURE 17*). This result attained in part because the algorithm for calculating thresholds was based on a fixed performance parameter as opposed to a relative performance threshold that



was used for other metrics. Nevertheless, fewer facilities failed to get an incentive point due to missing data over time. These trends may reflect growth in facility participation across quarters rather than worsening regulatory performance, per se. Following incremental increases in the number of facilities receiving incentive points on this

metric during year one, the number of facilities that received a point decreased in the third quarter of 2008.

Excluding facilities with missing data, the number of facilities receiving incentive points on state survey compliance remains stable between 23% and 29% of the total participating facilities in the second year.

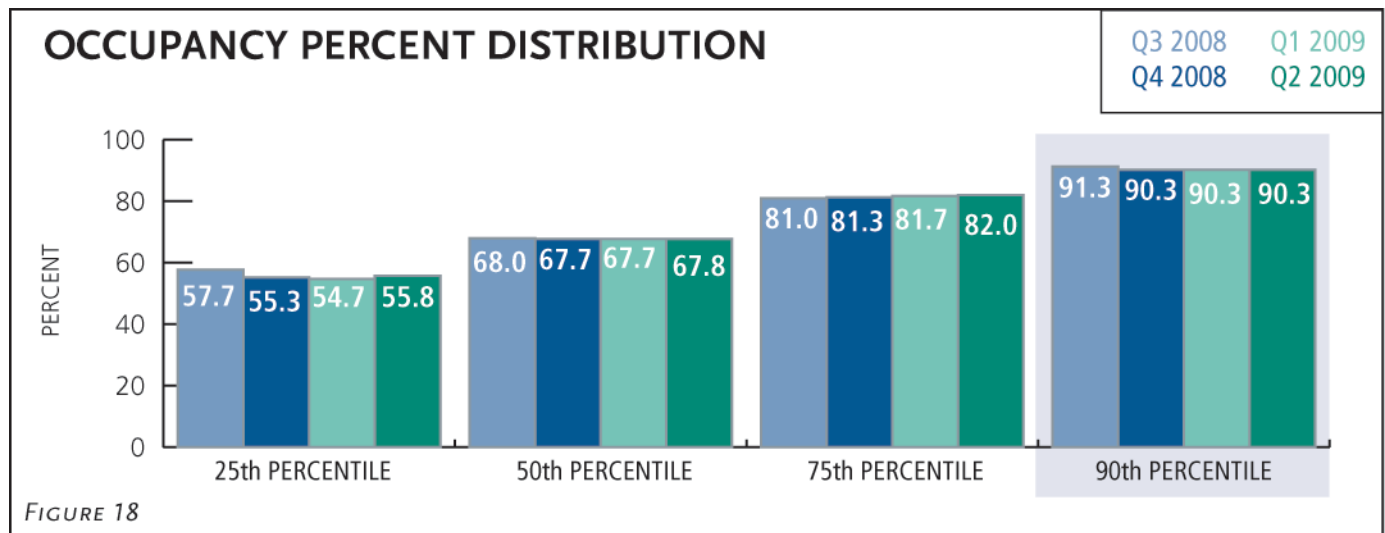
OVERALL OCCUPANCY

Occupancy data are provided to My InnerView on a monthly basis by each facility. This metric reflects the percentage of facility beds that are not left empty during the month.

No incentive points are granted based on occupancy rates because occupancy is a major driver of facility revenues. In other words, there are strong financial incentives for facilities to maintain high occupancy rates without additional

incentive points. From the perspective of the Medicaid program as a major purchaser of services, occupancy is an indicator of efficiency since fixed costs are lower on a per diem basis when spread over more days of service. From the consumer's perspective, occupancy is important because it is correlated with other measures of quality. Accordingly, each facility receives a star rating based on occupancy which appears on the consumer Web site. Percentile rankings of occupancy scores across four

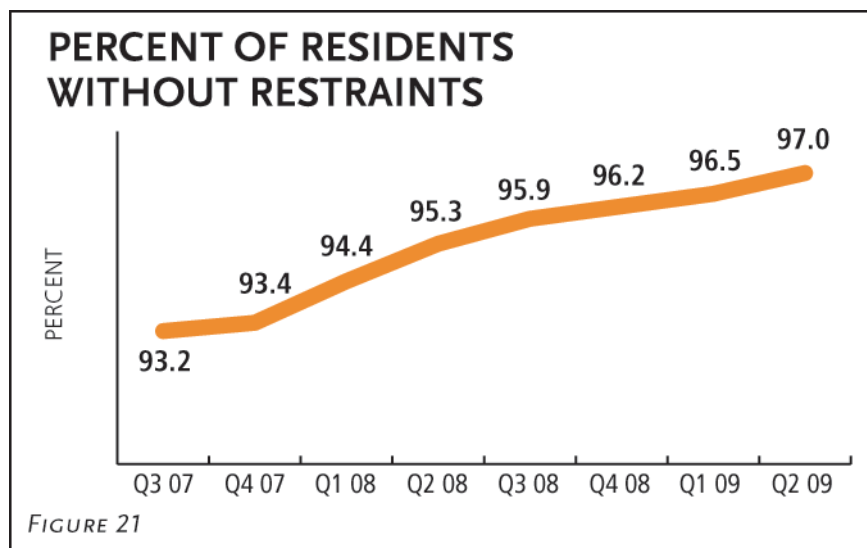
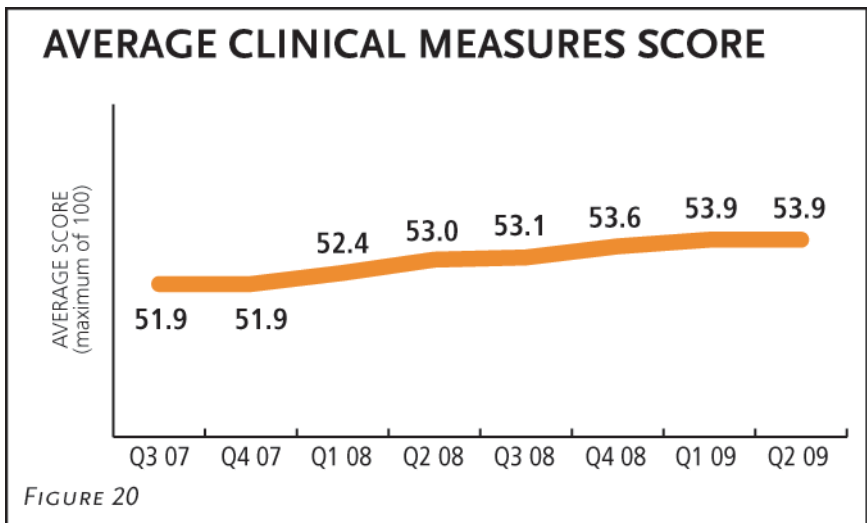
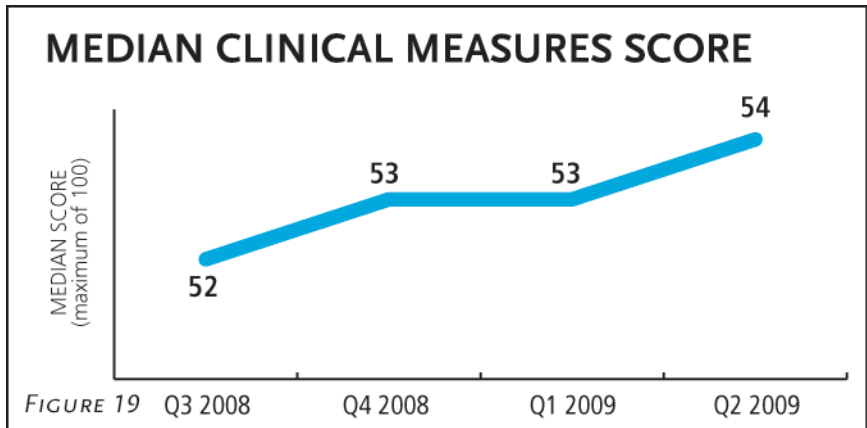
quarters are shown (FIGURE 18). The 90th percentile (or top 10%) is shown for reference since these are the best performers. There is tremendous variation on this measure across Oklahoma facilities. To the extent that variations might be due to differential demand for services, as for example between urban and rural locations, rather than efficiency or quality, this measure could be reexamined to determine its continued suitability as a performance measure.



CLINICAL OUTCOMES

Clinical outcomes are directly related to the quality of care provided. The extent that a facility minimizes falls, prevents residents from needing catheterization, reduces physical restraints, provides for nutritional support, and prevents pressure sores reflects the effectiveness of clinical processes. Although clinical outcomes are aggregated into a composite score for assigning incentive points, each clinical outcome is given a separate star rating on the OHCA consumer Web site. Though clinical outcomes are not presently adjusted for the relative acuity and "case mix" by either the Oklahoma Medicaid payment formula or *Focus on Excellence*, the use of multiple and aggregated clinical outcomes for FOE is believed to represent a reasonable basic measure of the quality of nursing and rehabilitative care provided by facilities.

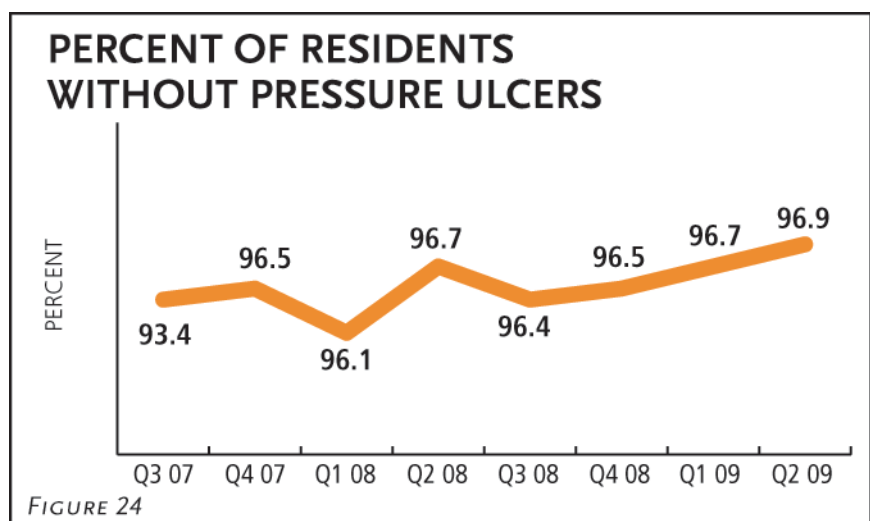
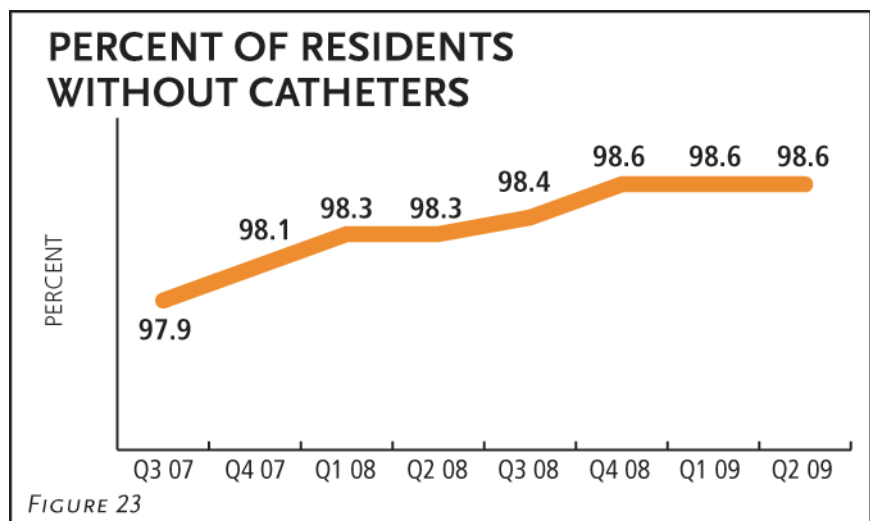
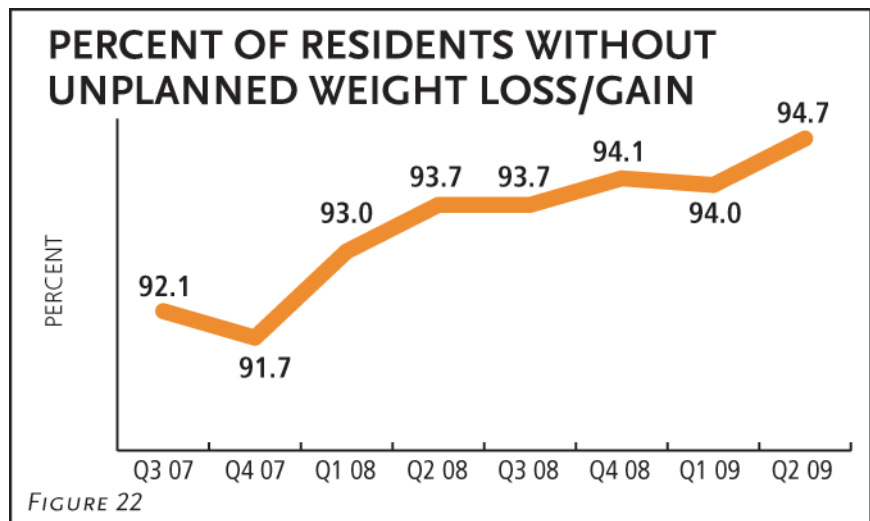
The median score for the composite clinical performance score across four quarters is shown (FIGURE 19). There are incremental improvements in clinical performance over time. The average clinical measures scores in FIGURE 20 (not median scores depicted in Figure 19) improve steadily over the eight assessments shown (third quarter of 2007 through the second quarter of 2009).



The clinical outcomes metric, like workforce stability, is a composite metric that combines provider rankings for each of the five clinical outcomes. Improvements in the overall clinical performance score may indicate that providers are achieving more consistent ranks across all five outcomes.

Further evidence for improved performance can be seen in the individual clinical outcomes (FIGURES 21–25). Each of the five outcomes has demonstrated improvement since the baseline assessment (third quarter of 2007). The most noticeable improvements in terms of percentage point gains were in the percent of residents without restraints and the percent of residents without unplanned weight loss/gain. At the baseline assessment, the average facility had 93.2% of residents without restraints. During the most recent assessment (second quarter of 2009), 97.0% of residents were without restraints, representing a 3.8 percentage point improvement. Over the same period, average number of residents without unplanned weight loss/gain improved from 92.1% to 94.7%, a 2.6 percentage-point improvement.

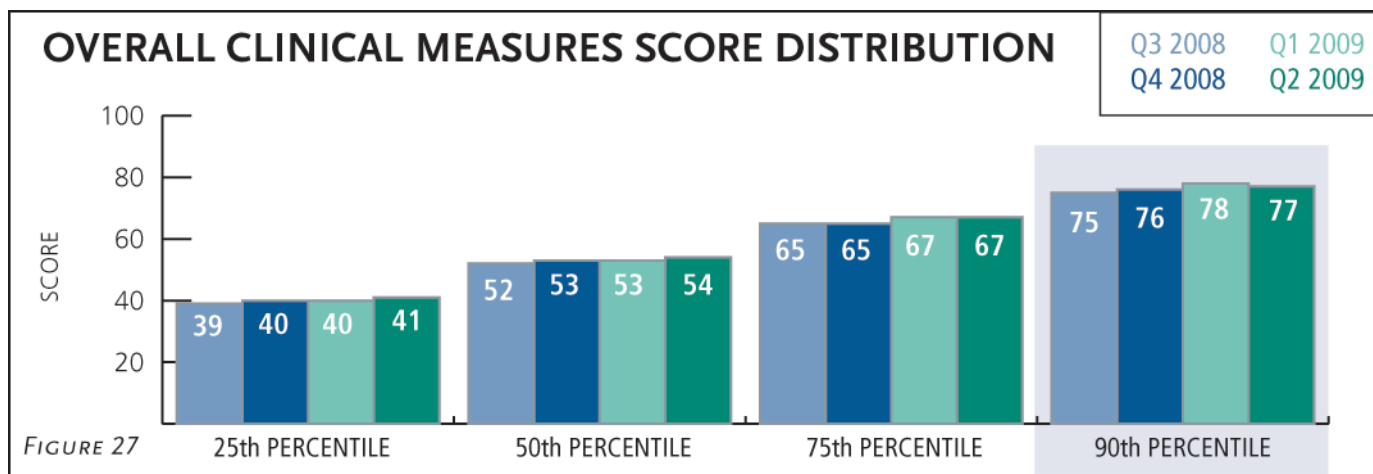
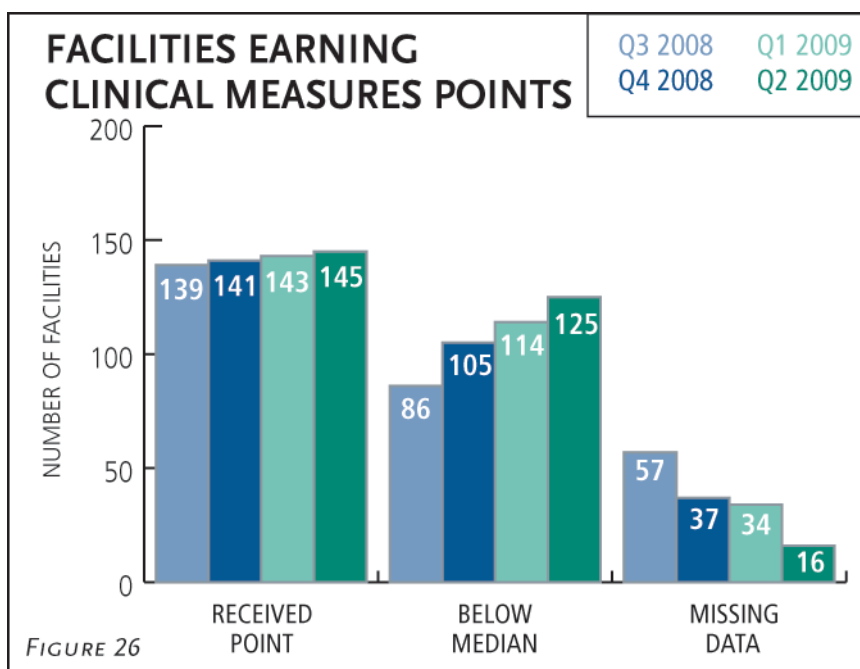
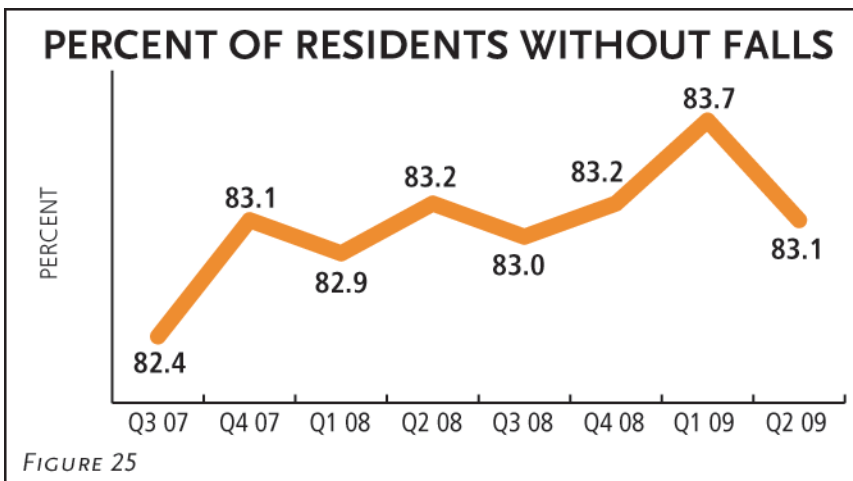
Facilities submit clinical data directly to My InnerView through its Web portal, so the decreasing number of missing data reflects greater participation over time (FIGURE 26).



Focus on Excellence: Performance Improvement for Oklahoma's Nursing Homes

2008-2009 ANNUAL REPORT

The distribution of composite clinical outcomes score is shown (FIGURE 27). The 90th percentile (or top 10%) is highlighted. There is tremendous variation on the composite measure across Oklahoma facilities. However, these differences must be interpreted with caution because many of these differences may be due to selection bias (rather than real differences in clinical quality) since residents are not randomly assigned to facilities, and as mentioned above outcomes are not formally adjusted to reflect differences in resident acuity among facilities.



OKLAHOMA HEALTH CARE AUTHORITY

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Page 17

DIRECT CARE HOURS

Direct Care Hours are essentially measured as the ratio of staff hours to residents (or patients). These data are provided to My InnerView by the Oklahoma Health Care Authority. Nursing staff hours per resident day combines RN/LPN hours and CNA/NA hours into a single score that weights these two components equally. The adequacy of staffing as reflected in direct care hours per resident day can be an important indicator of the quality of care. Staffing levels among direct-care staff reflect the resources available to provide care.

Because staffing levels are a major component of operating costs, staffing ratios tend to remain fairly stable — varying within narrow ranges over time. The median staffing hours used to allocate incentive points across quarters are shown (FIGURE 28). This area has had consistent improvements since the baseline assessment (quarter three 2007). FIGURE 29 shows the improvement in average direct care

hours (not median hours shown in Figure 28). Average staff hours per resident day increase from 3.35 at baseline to 3.55 for the most recent quarter.

This change represents about 0.2 hours per resident day or an additional 12 minutes of staff time available for resident care each day.

MEDIAN STAFF HOURS PER RESIDENT DAY

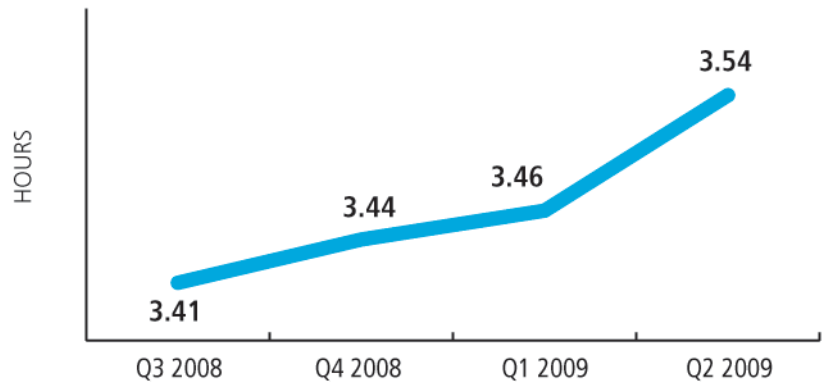


FIGURE 28

AVERAGE STAFF HOURS PER RESIDENT DAY

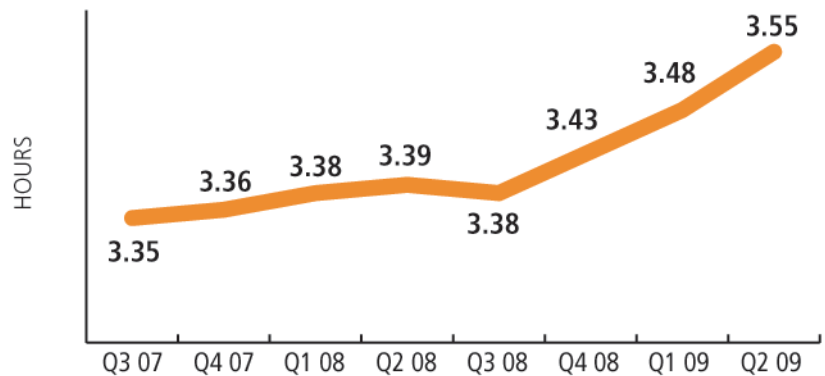


FIGURE 29

MEDICAID OCCUPANCY AND MEDICARE UTILIZATION

The Medicaid Occupancy and Medicare Utilization metric is calculated as the ratio of Medicare Part A days to Medicaid days. These data are provided by the Oklahoma Health Care Authority. This metric is used for incentive points. It is not used to determine a star rating on the OHCA consumer Web site.

The purpose of this metric is to incentivize provider utilization of Medicare. To be eligible for this payment incentive under FOE, a facility must have greater than 50% Medicaid occupancy and be above the median. The median score on this metric across four quarters is shown (FIGURE 30). FIGURE 31 shows that the average score for this metric (not the median shown in Figure 30) increased by 23% percent (from 0.084 at baseline to 0.103 at the most recent follow-up). Roughly half of the facilities participating in Focus on Excellence were awarded incentive points on this metric during each quarter (FIGURE 32).

MEDIAN PERCENT OF MEDICARE DAYS TO MEDICAID DAYS

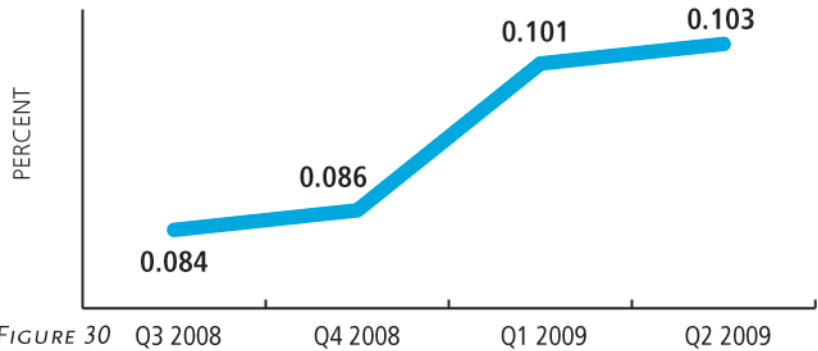


FIGURE 30 Q3 2008 Q4 2008 Q1 2009 Q2 2009

AVERAGE RATIO OF MEDICARE DAYS TO MEDICAID DAYS

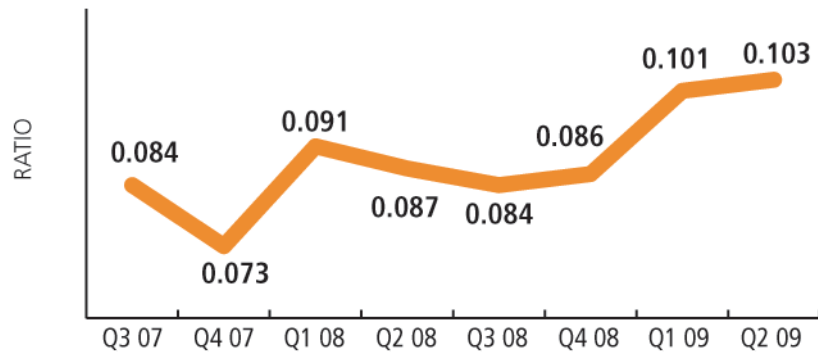


FIGURE 31

FACILITIES EARNING MEDICARE UTILIZATION POINTS

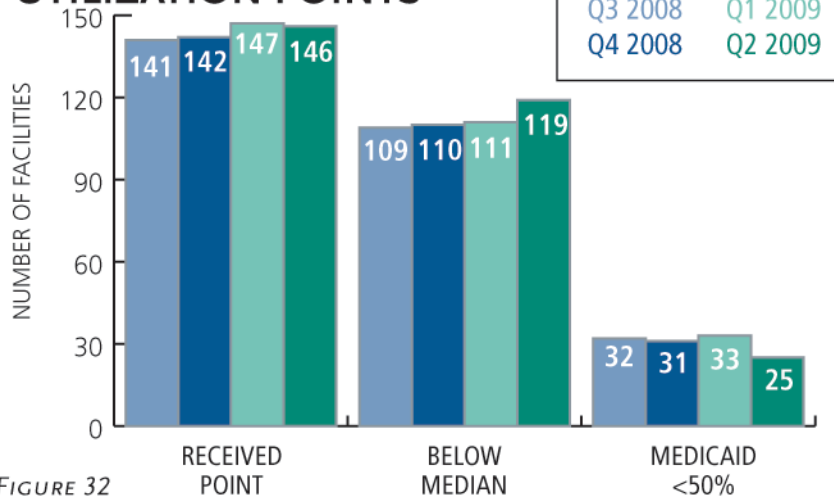


FIGURE 32

DISTRIBUTION OF STARS AND INCENTIVE POINTS OVER TIME

In general, the number of stars a facility receives in a prior quarter is a good predictor of how many stars a facility gets in the next quarter. That is, high-scoring facilities tend to stay high-scoring, and low-scoring facilities tend to stay low-scoring. This relationship becomes weaker over time because

incremental changes are seen on various performance metrics across multiple quarters.

Further analysis about the distribution of stars may be warranted as more data become available over time. The number of stars awarded has a fairly normal bell-shaped curve across all four quarters (*FIGURE 33*). This was true for the first four quarters of the program and has remained true into the second year. This

metric seems to have very good overall distributional characteristics. The number of incentive points awarded to a facility appears to be less stable than the number of stars across quarters, although top performers tend to remain the best in class over time. No facility was awarded 0 points across all four quarters, and fourteen facilities earned 10 points across all four quarters.

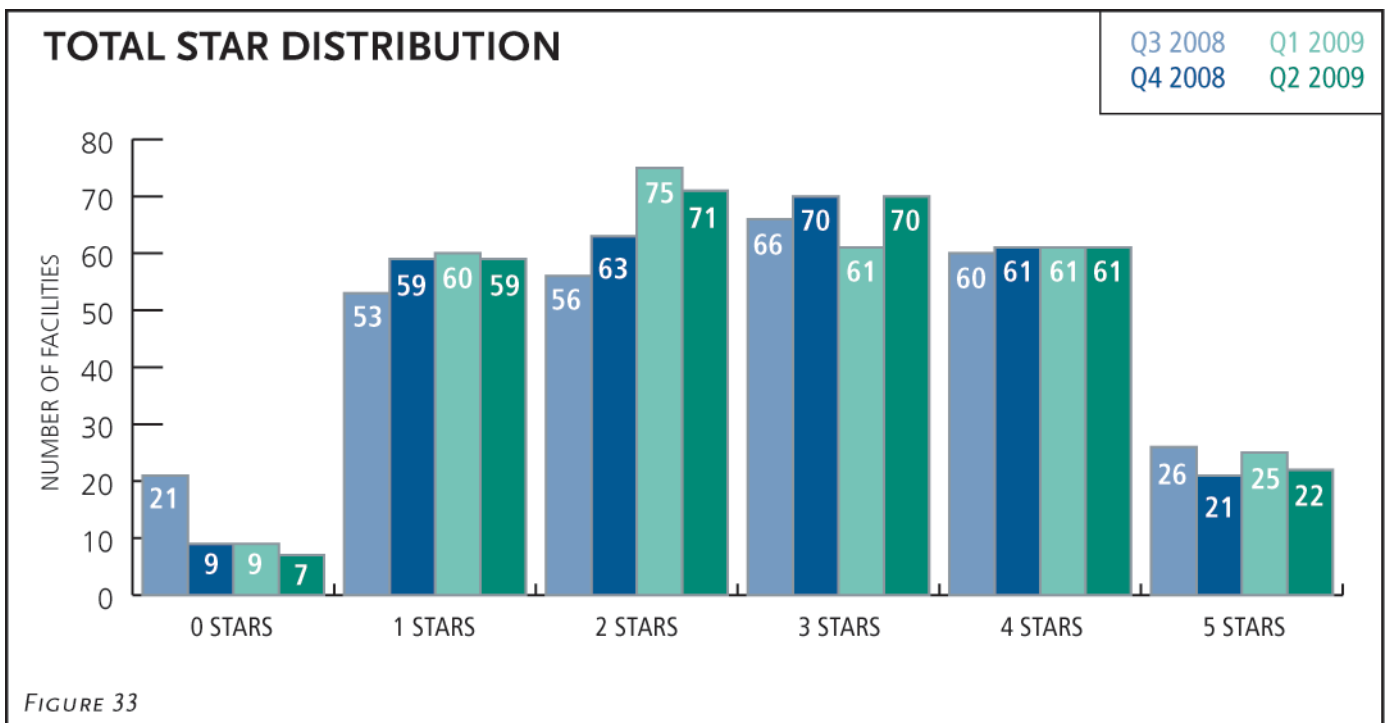


FIGURE 33

Conclusions and recommendations

Focus on Excellence is perhaps the most innovative and comprehensive effort to date of any state Medicaid program to leverage its purchasing power to align payment incentives to achieve higher quality in nursing homes. This program is also virtually unique in its effort to align payment incentives with public information provided via a dynamic consumer Web site. Oklahoma's approach to value-based purchasing is likely to create value for key stakeholders as it continues to integrate provider quality-improvement strategies with payment incentives and transparency in consumer-oriented information. In short, *Focus on Excellence* implements value-based purchasing using a unified policy framework and a well-aligned program design that addresses the needs of key stakeholder groups including consumers, payers and providers.

Because the program is still relatively new, *Focus on Excellence* has not yet been subjected to rigorous scientific evaluation. The ultimate value that this program provides to consumers, payers and providers remains to be seen. Nevertheless, several positive milestones have been reached during the first two years of this program, including broad-scale provider enrollment, and measurable improvement in performance on a majority of the FOE metrics. High levels of provider participation and data compliance in a voluntary program have been achieved and sustained in a relatively short period of time. Administrative arrangements have been largely problem-free during the early years of the program. The scope and frequency of data collection is rapidly accumulating actionable performance information that can be evaluated in future years to verify that program goals are being met. These efforts should go far in helping program managers make continuous refinements to this program to reinforce those goals going forward.

OHCA has recently elected to adopt a schedule of fixed performance targets that will become the criteria for earning reimbursement points in 2010. Over the near term, four additional enhancements are recommended to offer greater value for key stakeholders.

- New incentives should be created not only to reward facilities that reach fixed targets, but also reward facilities that show significant improvements in performance over time. Since the strongest predictor of current performance is past performance, this enhancement would help align payment incentives to encourage greater "buy-in" into the program. This new strategy would help sustain continued engagement of all nursing facilities in Oklahoma (not just the best performers at a given point in time).
- Since star ratings are updated quarterly, the OHCA Focus on Excellence Consumer Web site should be upgraded to afford consumers an option to view historical data showing facility performance over time — not just a snapshot of performance during the prior quarter. As more data become available, it would be beneficial to give consumers an optional view that includes information about past performance trended over time. This enhancement to the Web site would allow consumers to understand the consistency in facility performance, as well as any overall trends in facility performance across multiple quarters.
- Third, initiate a collaborative process with stakeholders to introduce differential weighting of performance measures based on strength of correlation to overall performance and consumer perceptions of value.
- Fourth, give consideration to using regulatory system outcome thresholds to define prerequisites for facility eligibility for payment incentives.

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Page 21

APPENDIX

For purposes of allocating star ratings to each facility on various performance metrics, facilities are ranked by their score on each metric. The 20th, 40th, 60th and 80th percentiles serve as benchmarks. Facilities with a score equal to or below the 20th percentile receive one star; facilities with a score between the 20th and 40th percentiles receive two stars; facilities with a score between the 40th and 60th percentiles receive three stars; facilities with a score between the 60th and 80th percentiles receive four stars; and facilities above the 80th percentile receive five stars. The following tables detail the benchmarks used to assign stars for each metric by quarter.

THIRD QUARTER 2008				
METRIC	PERCENTILE			
	20th	40th	60th	80th
Resident/Family Satisfaction	65.0	69.1	73.0	78.4
Quality of Life	67.2	71.2	75.1	79.4
Employee Satisfaction	56.0	61.3	66.2	71.7
Culture Change	60.9	67.2	73.4	79.0
CNA/NA Stability	27.0	43.0	58.0	73.0
RN/LPN Stability	26.0	44.5	57.5	75.0
Occupancy	53.0	63.5	74.3	85.0
Clinical Outcomes	37.0	49.0	57.5	67.5
Restrains	92.3	96.7	98.7	100.0
Unplanned Weight Gain/Loss	89.0	93.7	96.2	99.0
Catheters	97.0	98.5	99.7	100.00
Pressure Ulcers	94.7	96.3	97.3	98.7
Falls	78.2	81.5	84.0	88.5
Direct Care Hours	3.00	3.26	3.50	3.76

FOURTH QUARTER 2008				
METRIC	PERCENTILE			
	20th	40th	60th	80th
Resident/Family Satisfaction	65.6	70.4	74.2	79.4
Quality of Life	67.8	72.0	75.2	80.6
Employee Satisfaction	56.2	61.0	67.1	71.9
Culture Change	61.8	69.5	73.5	78.9
CNA/NA Stability	26.0	44.0	62.0	74.0
RN/LPN Stability	26.0	46.0	63.0	76.0
Occupancy	53.0	64.0	72.0	85.3
Clinical Outcomes	39.0	49.0	58.0	68.0
Restrains	93.0	97.0	99.0	100.0
Unplanned Weight Gain/Loss	90.7	94.0	96.7	98.7
Catheters	97.3	99.0	100.0	100.00
Pressure Ulcers	94.7	96.3	97.7	98.7
Falls	78.3	81.3	85.3	88.3
Direct Care Hours	3.06	3.29	3.54	3.83

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Appendix 1

APPENDIX

FIRST QUARTER 2009

METRIC	PERCENTILE			
	20th	40th	60th	80th
Resident/Family Satisfaction	65.7	70.5	74.2	79.2
Quality of Life	67.9	72.0	75.2	81.0
Employee Satisfaction	56.4	61.5	67.1	71.9
Culture Change	62.0	69.5	73.5	78.9
CNA/NA Stability	25.0	42.0	61.0	74.0
RN/LPN Stability	27.0	44.0	58.0	77.0
Occupancy	52.7	62.3	72.7	85.7
Clinical Outcomes	37.0	47.0	58.0	70.0
Restraints	93.7	97.0	99.3	100.0
Unplanned Weight Gain/Loss	89.7	94.0	96.3	98.7
Catheters	97.7	99.0	100.0	100.0
Pressure Ulcers	95.0	96.7	97.7	99.0
Falls	79.0	82.3	85.3	89.0
Direct Care Hours	3.11	3.34	3.56	3.84

SECOND QUARTER 2009

METRIC	PERCENTILE			
	20th	40th	60th	80th
Resident/Family Satisfaction	66.0	71.2	75.7	81.8
Quality of Life	67.8	72.2	76.7	82.1
Employee Satisfaction	58.6	64.6	69.3	74.0
Culture Change	63.9	71.0	76.0	82.1
CNA/NA Stability	28.0	44.0	58.0	76.0
RN/LPN Stability	28.0	43.5	59.0	76.0
Occupancy	52.7	62.3	73.3	85.8
Clinical Outcomes	37.0	49.0	58.0	70.0
Restraints	95.0	97.8	99.3	100.0
Unplanned Weight Gain/Loss	91.3	94.7	97.0	99.0
Catheters	97.3	99.0	99.7	100.0
Pressure Ulcers	95.0	96.7	97.8	99.0
Falls	78.7	82.0	85.3	88.7
Direct Care Hours	3.16	3.42	3.64	3.88

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Appendix 2