

2010 – 2011 REPORT

FOCUS ON EXCELLENCE

Performance Improvement for Oklahoma's Nursing Homes

Submitted to:

Oklahoma Health Care Authority

by

Prepared By



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Synopsis

Focus on Excellence has completed its fourth year of measurement. From the initial period in June 2007, there has been an increase from 266 participating facilities to 291 facilities in 2011; 95% of all contracted SoonerCare nursing facilities are enrolled and participate in this voluntary program. The Pacific Health Policy Group, independent consultants, compared pay-for-performance initiatives in the U.S. and concluded:

“Oklahoma’s system stands-out among its state counterparts as being among the most comprehensive in scope. The (incentive-based, voluntary) strategy worked.... Oklahoma has achieved, through a voluntary system, what others like Georgia and Iowa accomplished by mandating participation.”

Quality in a nursing home does not rise above the quality of its staff; quality is greatly affected by staff tenure and stability. In 2007, the collective CNA turnover in the nursing homes participating in Focus on Excellence Program stood at 126%. Since then, homes have cut turnover by 15 percentage points, to 111%.

The claim for an expanding core of stable, caring, and committed staff is also demonstrated in clinical success. Incidence of nursing-home-acquired catheters, pressure ulcers, and physical restraints as well as unplanned weight loss and falls has markedly declined, some rather quickly.

In keeping with the growth of the Focus on Excellence program, occupancy in participant nursing homes has slightly improved over time. Three other stakeholder groups have each separately reached an identical conclusion. Residents (care receivers), staff (caregivers), and families (bill payers), have, in 196,114 mailed-in responses, affirmed a high regard for their caregivers and expressed high satisfaction with the care the resident receives. For four years their satisfaction trend line has not lost ground, it has moved forward in one direction: upwards.

The data contains much more information: hidden patterns and sub themes, feats of excellence and cases of substandard performance; all these deserve to be teased out. However, we should not miss the central message that the data conveys. That message was presaged in what the Pacific Health Policy Group reported when Focus on Excellence was still in its infancy.

“Oklahoma’s program is one of the most holistic and comprehensive. Notably, Focus on Excellence is the only program to measure satisfaction from three viewpoints – the resident, family, and employee. Focus on Excellence also compares favorably to CMS Nursing Home Compare in terms of its comprehensiveness and freshness of data. Oklahoma is also a leader in seeking to make comparative data available to consumers in a user-friendly format. Only CMS and one other state have attempted anything similar... Of the seven examined, only two have Web sites that offer consumers information in the form of star-ratings based on quality measures: Minnesota and Oklahoma. Pay-for-performance systems such as Focus on Excellence represent the future for Medicare and Medicaid.”

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RECOMMENDATIONS

In examining the data over the life of the project, several conclusions and associated recommendations can be made.

It is clear from the data and associated trends that measurement and management of satisfaction elements has had a positive impact on the delivery of quality care in Focus on Excellence participating facilities. A continuation of key quality measurements is recommended to ensure continued focus on overall quality and quality improvement. Although there are many areas that have experienced significant improvement and are now maintaining high levels of performance, there are still areas that have significant room for improvement. For these areas, a focus on the underlying components and associated issues is recommended. For example, despite improvement overall, a persistent phenomenon for nursing homes nationwide and in Oklahoma is the reality that certified nursing assistants (CNAs), the largest occupational group with the most direct contact with nursing home residents, are the least satisfied with their work experience. This suggests that a focused and creative effort to strengthen engagement of these frontline caregivers represents both a continued need and a primary opportunity for continued improvement. In recent years, a number of approaches have demonstrated value, including peer mentoring programs, employee engagement measurement, culture change artifacts, and creative use of new training technology, which goes beyond skills training and compliance issues and focuses on workplace relationships and team building.

In addition to the continuation of measurement of the vital elements included in the current program, focused attention on new and innovative measures of nursing home quality is also recommended. As the long-term care landscape changes and evolves, the industry is changing to reflect an increased need to evaluate and measure those practices that relate to providing a person-centered care approach. The emergence of more specific dimensions of culture

change in nursing home environments is making it possible for organizations to specifically define metrics that can be attached to financial incentives.

Now is the opportune time to consolidate the Focus on Excellence base, make structural refinements, and win public recognition and support.

OKHCA and My InnerView (MIV), have built a functioning model of evidence-based approach in long-term care; hundreds of organizations pool data every month, share the findings, and use them to seek higher ground. This early success has brought visibility, earned admiration, and evoked some skepticism.

As a frontrunner, Focus on Excellence faces a new challenge that requires a multi-pronged response. First, consider raising the quality bar high enough that “Excellence” is set up as a goal and truly means what it implies—a lofty goal that strives for the best. The quality bar must be raised in degrees; excellence must stay within reach; clear milestones should recognize the progress an organization makes toward the goal.

Second, consideration should be given to recasting the scoring methodology appropriately, weighted to recognize different levels of achievements. Not merely the level of performance, but as well, the progress a nursing home makes from a low starting point.

Third, the incentive system could be tiered to reward and recognize those organizations “excelling” from those organizations that are “above average.” Incentives should not ignore the motivating potential of personal ambition and professional pride that are not satisfied with monetary incentives, but with public recognition.

Redefining excellence and tweaking the system to recognize true merit and reward progress toward excellence can help confront cynicism and scrutiny.

Redefining excellence and tweaking the system can help to recognize true merit and reward progress. It promotes collegiality among committed providers where superior performers mentor those who need a helping hand; those with outstanding records are celebrated as exemplars and become mentors of mentors.

An early warning was reported when the Pacific Health Policy Group cautioned:

“Many stakeholders, including providers, have concerns about the integrity of the process and the potential for results to be skewed by submission of inaccurate information. There is no evidence that more than a small number of providers have submitted erroneous data. However, the perception of problems among stakeholders is widespread and, left unaddressed, could lead to a drop in confidence, and participation, in the program.”

The problem lies in the weak links in the system. The program is a system built on strict scientific principles and sophisticated methodology where self-reporting of data is linked to incentives. It expects a high professional code to guide behavior.

A starting point for OKHCA and MIV is ensuring integrity at data collection.

- Remind the participating nursing homes that data integrity lays at the heart of the program. Inform them that data-integrity verification is built into the system.
- At data entry, set up alerts when data input does not meet set parameters and benchmarks, or fails other crosschecks.
- Subject submitted data to rigorous statistical and comparative tests.
- Establish a partnership with government agencies, CMS, nursing home chains, and vendors of software for clinical and personnel documentation. Strike agreements that permit access to specified data of nursing homes and remotely retrieve real time data.

Review metrics for relevancy. In a changing healthcare landscape, metrics should be reviewed for continued inclusion and others should be considered for addition.

The long-term care landscape is shifting; conceptual and technical innovations are opening doors to new possibilities.

- Review the satisfaction survey questionnaires based on evolving information needs of the program and understanding the clients' needs to drive improved quality.
- Review other reported measures. Seek ways to minimize and simplify self-collection and transmission of data. Add measures of excellence and of culture change.
- Reconfigure and refine formulas. Substitute the basis of the compliance score with CMS or other more precise weighting scales and create new aggregated indicators and scales to measure devoted care, compassionate approach, quality of the workplace, manager responsiveness, stress, and other key concepts. Construct new measures of wellness (of residents and staff), quality of end-of-life care, of commitment of staff and families, of innovation in programs and practices, and of business success.
- Simplify data collection at the nursing home level. Build in flags to reject or to warn when erroneous or anomalous data are entered.
- Upgrade templates for data collection and reporting on the Web. Aim at simplicity, elegance, clarity, and appeal.

Provide a solid initiation to newly joined nursing homes. Provide other members opportunities for continual learning, to keep abreast of developments and for professional growth.

Performance assessment programs begin to lose traction when the focus is solely on measurement vs. measurement and associated improvement. It is recommended that assistance be provided to participating nursing homes to gain a more complete

understanding of the goals, operation of the program, and how to improve.

- Design a curriculum to impart the principles and practice of evidence-based path to excellence.
- Build on the quality performance measures currently used in the program. Staff these learning programs with star performers drawn from the participants and with the best of MIV's roster of teachers. Offer sessions at strategic locations around the state, at times most convenient for the attendees. Use a variety of teaching methodologies, including webinars.

Such an educational initiative will indirectly serve other purposes, laying the foundation for a peer-mentoring system within a community of professionals, all on an evidence-based journey to excellence.

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 fourth year in June 2011.

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 that 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

From the inception of the program, My InnerView (MIV), a division of National Research Corporation (NASDAQ: NRCI), collected and managed data for Focus on Excellence. Resident/Family Satisfaction and Resident Quality of Life were assessed semi-annually through surveys sent to facility residents and their families. Data on Employee Satisfaction and System-wide Culture Change were gathered through surveys sent out semi-annually to employees. Scores for these metrics represented weighted averages of the four response categories on My InnerView’s satisfaction surveys. An average score was calculated by assigning the following values:

- Excellent = 100
- Good = 66.7
- Fair = 33.3
- Poor = 0

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

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

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STAR RATINGS

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.

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.)

PARTICIPATION

In mid-2007, 266 nursing homes in Oklahoma had joined the Focus on Excellence Program. At the end of June 2011, participation totaled 291, an increase from 83% to 95% of all the nursing homes in the state. The Focus on Excellence Program challenges participating nursing homes to show positive change across departments, as well as understand data, measurement practices, and data tools. These requirements can occasionally frustrate their early steps toward evidence-based quality improvement. Once past the initial 18-to-24 month adoption, typical in implementation of new evidence-based quality improvement programs, participating nursing homes that failed to submit data fell from 79 to 30, a 60% plus improvement (Table 1). This positive trend suggests that the incentives and value of the information have had a beneficial effect.

Table 1

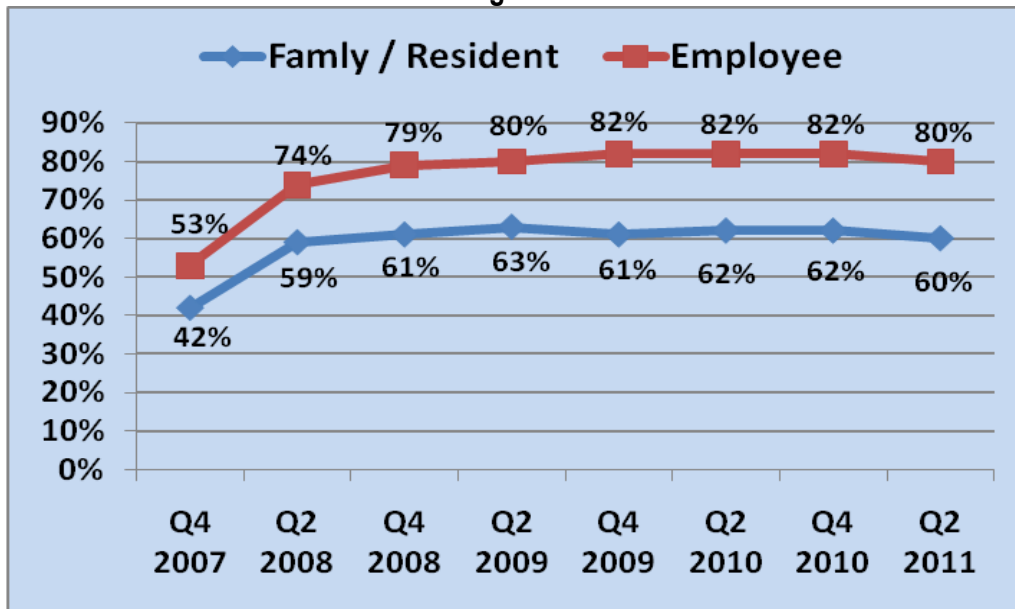
Quarter	Participants	# Not Rptng
Q3 2007	266	79
Q4 2007	266	73
Q1 2008	275	60
Q2 2008	274	46
Q3 2008	282	57
Q4 2008	283	37
Q1 2009	291	34
Q2 2009	290	20
Q3 2009	290	13
Q4 2009	291	15
Q1 2010	293	23
Q2 2010	293	19
Q3 2010	292	29
Q4 2010	294	30
Q1 2011	291	27
Q2 2011	291	30

RESPONSE RATES

Satisfaction survey response rates have steadily improved since program inception in 2007, leveling at 60% participation and 80% participation for family/resident satisfaction and employee satisfaction

respectively. On an annual basis, the voice from over 20,000 residents and their families, as well as over 32,000 employees is heard (Figure 1).

Figure 1

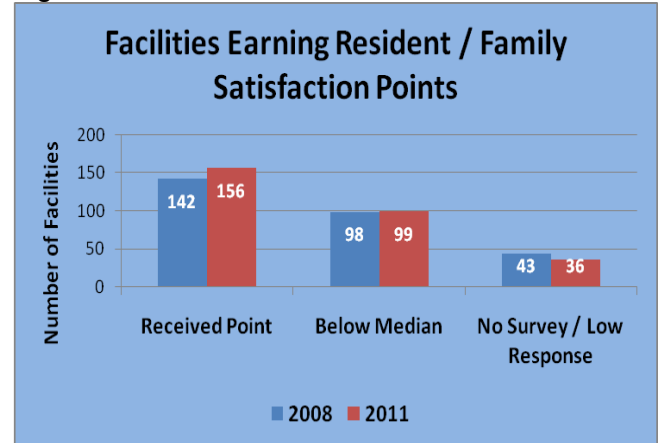


RESIDENT AND FAMILY SATISFACTION

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.

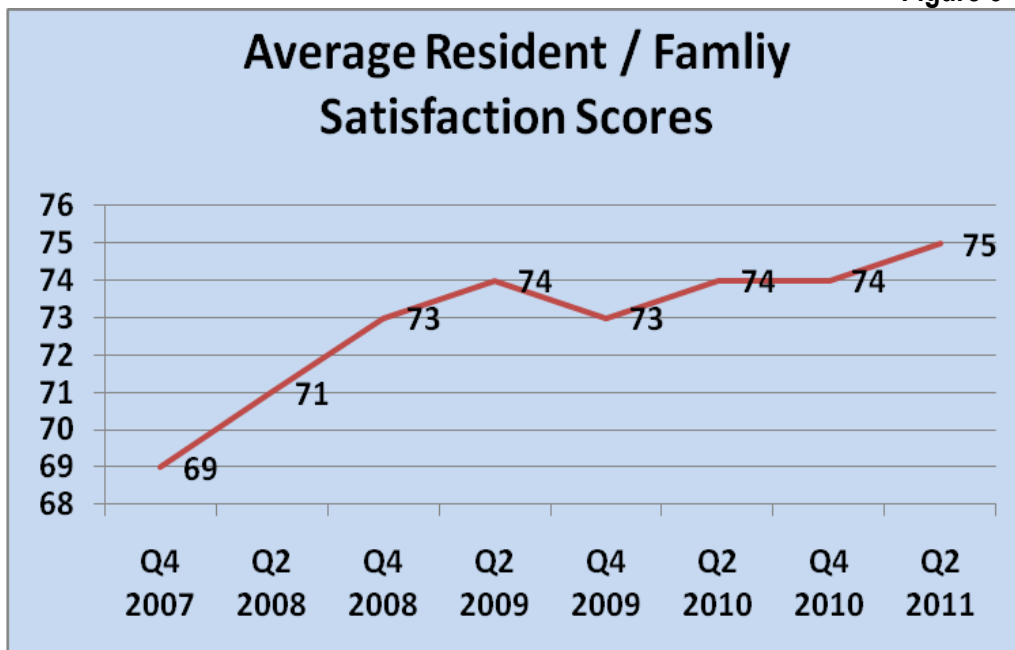
As facilities gained experience administering these surveys, fewer facilities failed on this metric due to a lack of participation, low response rates, or providing incorrect mailing addresses. In 2007, 68 facilities did not meet the criteria, while only 36 facilities did so for the final measurement period in Q2 2011. In addition, we've seen a 10% increase in the number of facilities receiving points since 2008 (Figure 2).

Figure 2



Over the four years of the program and across eight survey periods, average scores have increased from 69 in 2007, to its highest score of 75 in 2011 (Figure 3), evidence of improving performance on the part of participating nursing homes in the Focus on Excellence Program. Understanding why and what is driving this overall improvement is important.

Figure 3



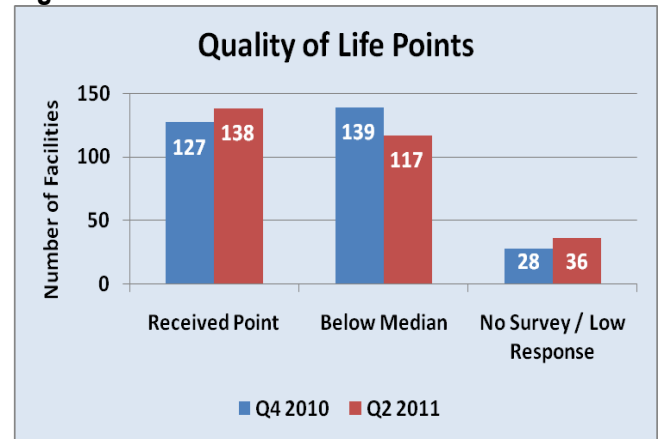
QUALITY OF LIFE

The 14 areas surveyed by MIV comprise 3 categories of nursing home life—Quality of Life, Quality of Care, and Quality of Service.

The Quality of Life score is derived of 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.

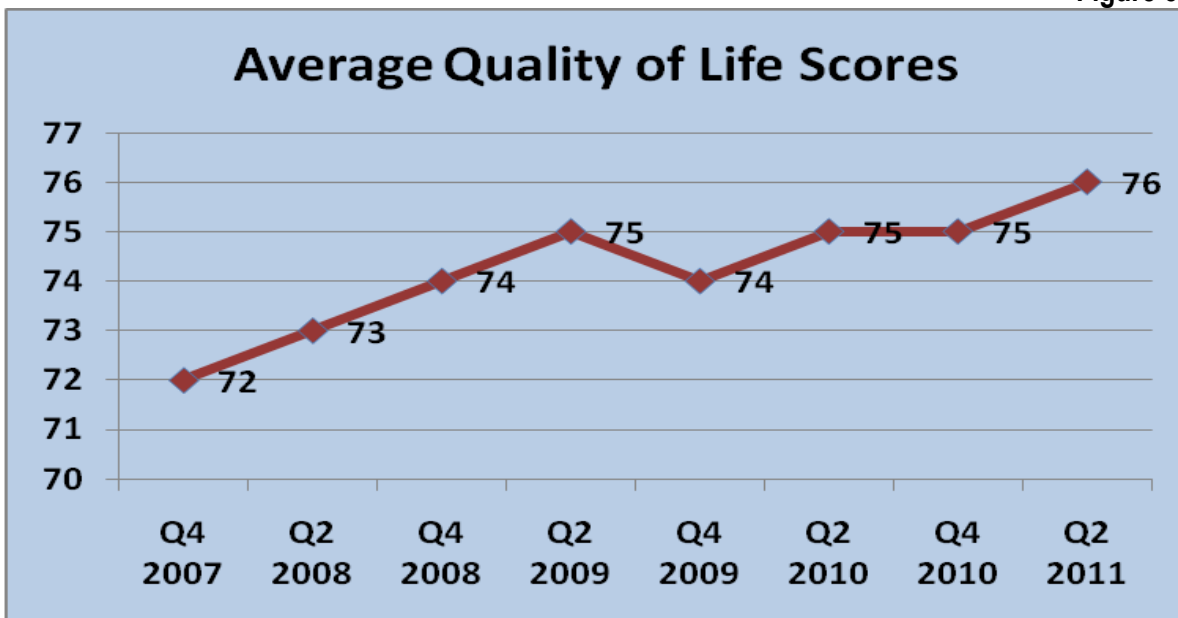
In Q2 2011, a total of 138 facilities received points for Quality of Life, up from the prior period in Q4 2009 (127), yet slightly lower than we saw in the first period at 142. In addition, 117 scored below the median and only 36 facilities missed the incentive point due to poor response rates, too many incorrect addresses or by not participating in the survey altogether, up slightly from Q4 2009 (Figure 4).

Figure 4



For 2011, Quality of Life Score steadily improved from its initial score of 72 in 2007, achieving 75 in Q2 2009. Since that time, the score has held steady through Q4 2009 and now peaking in 2010 at 76, a four point improvement in the four year period (Figure 5).

Figure 5



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.

In Q2, 2011, 176 facilities received point for Employee Satisfaction—the highest number to date. In addition, the number of facilities not getting incentive points due to lack of participation or poor response rates dropped from 67 in 2007 to 22 in Q2 2011 (Figure 6).

Overall, the average Employee Satisfaction Score has steady climbed each year, increasing from 61 in Q4 2007 to 68 in Q2 2011 (Figure 7).

Figure 6

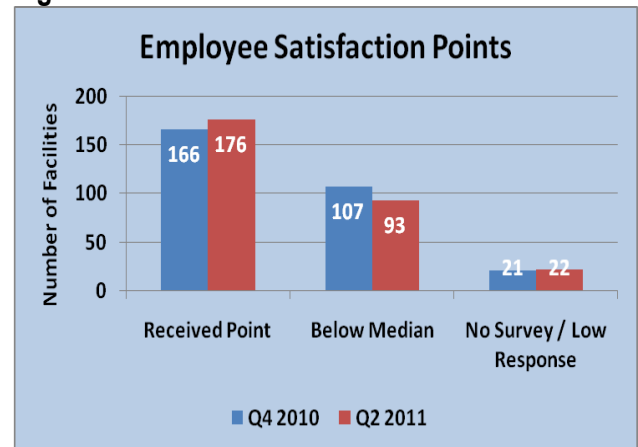


Figure 7



SYSTEM-WIDE CULTURE CHANGE

Culture change is a term used to describe operational practices aimed at transforming the nursing facility environment as much as possible from an “institution” to a “home.” The System-wide Culture Change metric includes 17 items related to organizational and leadership practices, innovation, quality management, resident directedness, and other areas. Fifty-six percent of participating facilities receive incentive points (Figure 8).

The distribution of System-wide Culture Change scores shows improvement between baseline and follow-up assessments. 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 74 at the most recent assessment in the second quarter of 2011 (Figure 9).

Figure 8

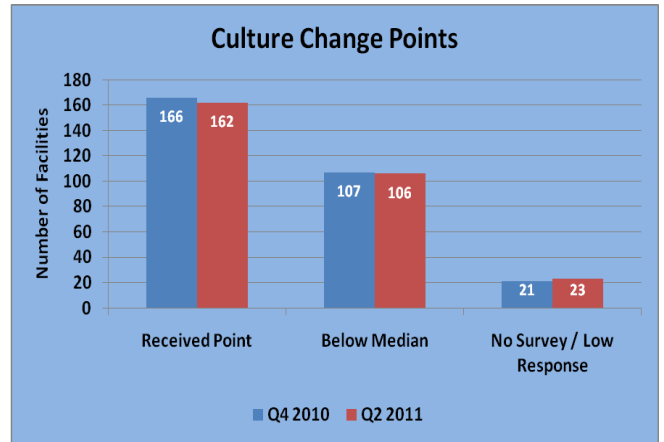
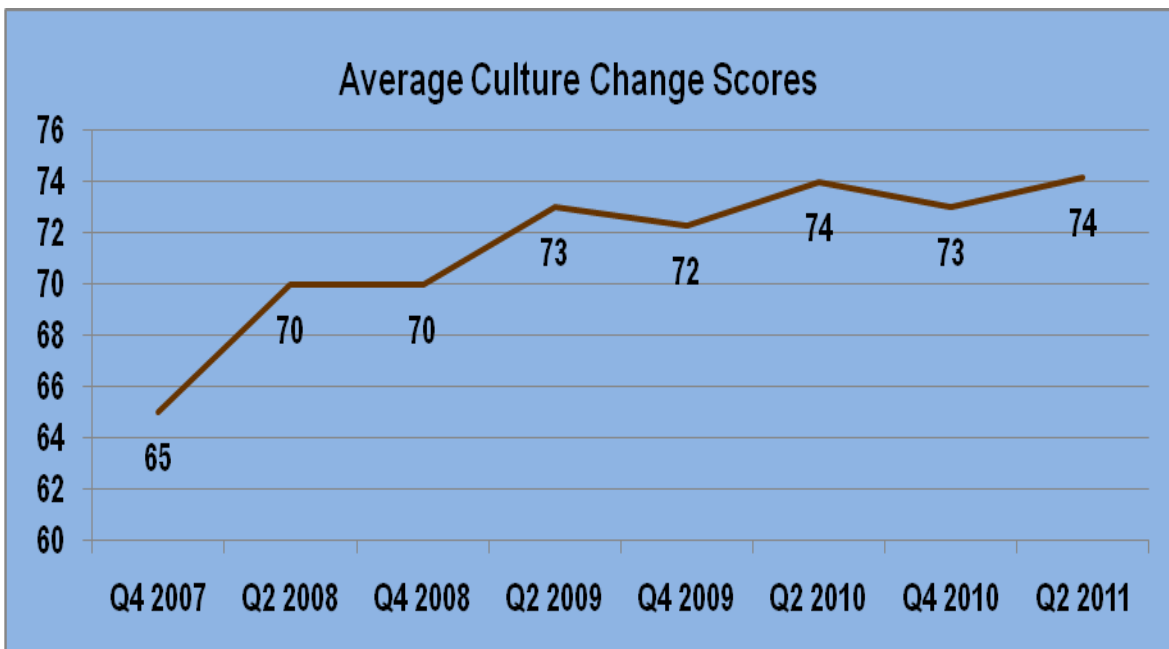


Figure 9



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.

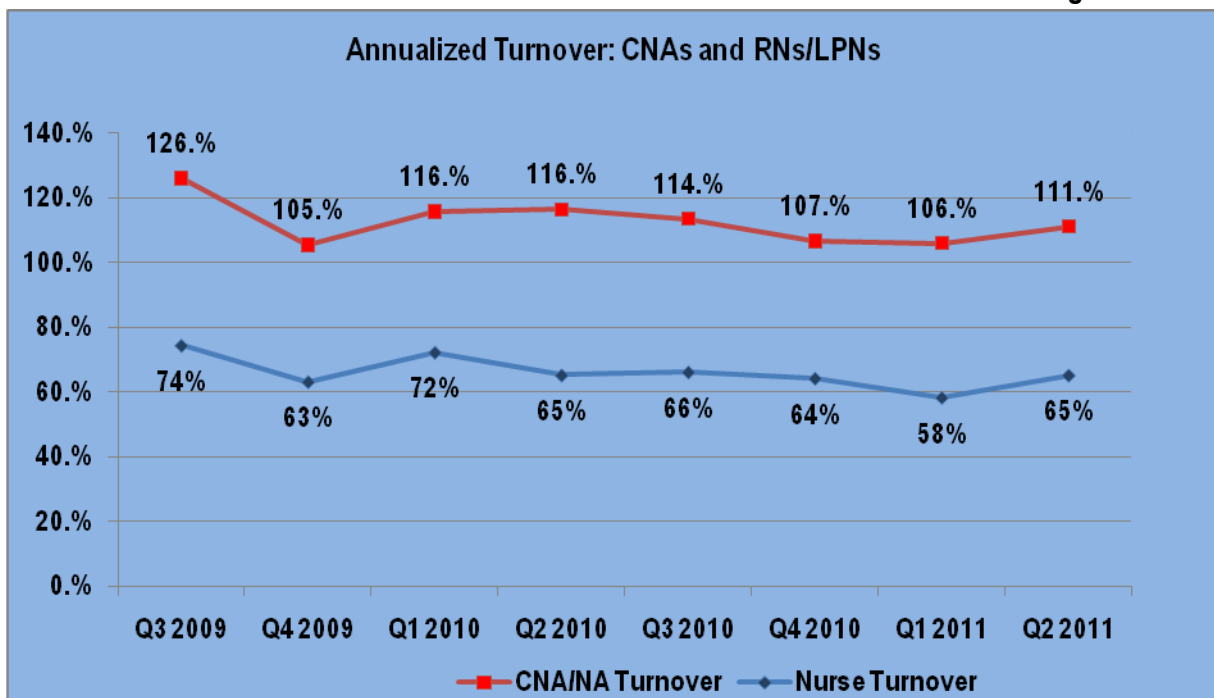
Turnover measures the percentage of CNAs/NAs or RNs/LPNs who leave the facility during a given period. Monthly data are collected via My InnerView's portal and annualized to calculate an annual turnover rate for each group. Retention is the percentage of CNAs/NAs or RNs/LPNs who have been employed at 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.

Understandably, admission into a nursing home causes transfer trauma in many residents. Being uprooted from family and from familiar surroundings, having to be physically separated from relatives and friends, and now living under one roof with strangers, all these factors make a resident insecure and to yearn for continuity and consistency. Instability in the ranks of caregivers adds to resident trauma.

Annualized turnover CNAs stood at 126% for CNAs in 2007 and has reduced to 111% by mid 2011. Similarly, 74% of nurses left their job in 2007, lowered to 65% by the end of June 2011 (Figure 10).

Figure 10



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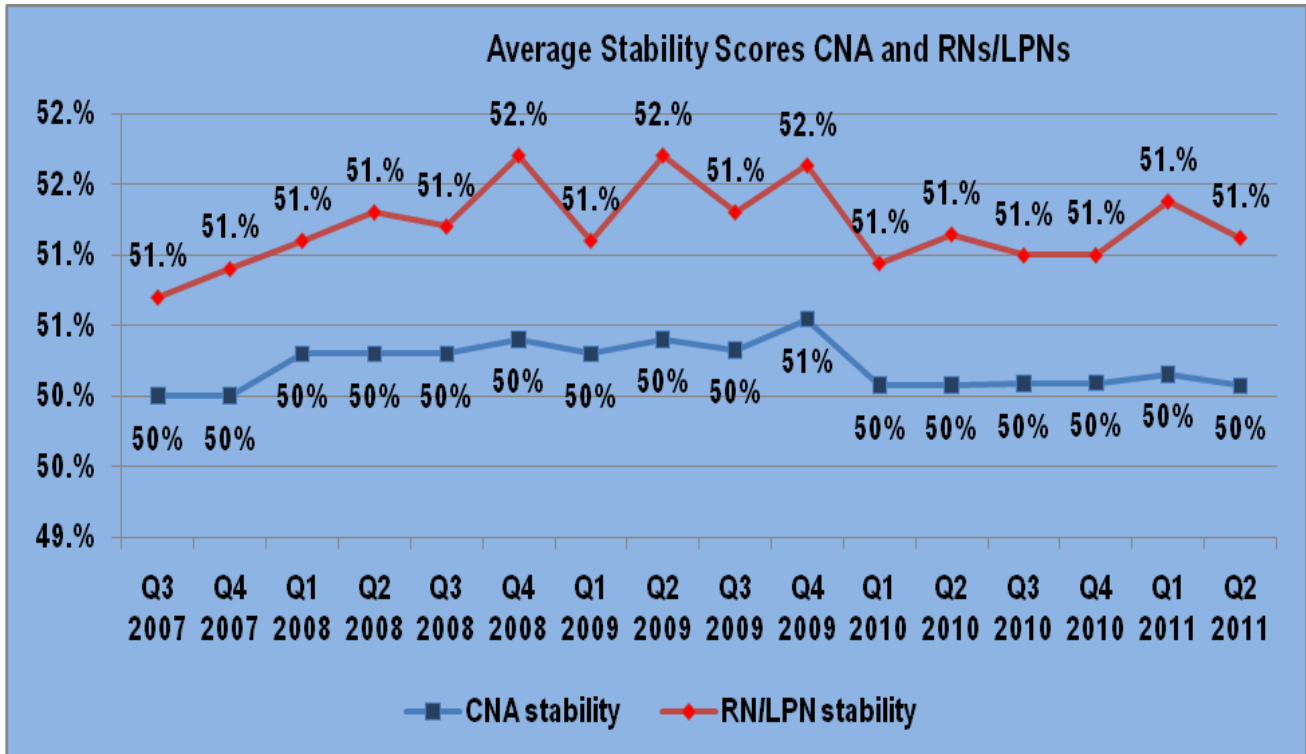
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The improvement in these two metrics contributes to the positive trend in stability.

Some patterns emerge in the data. While still high, the turnover rate among CNAs is moving in the right direction. Despite the high number of CNAs turning

over, nearly half of their ranks are stable year after year (Figure 11). This stability amidst turnover has been observed in other analyses. It indicates that although many CNAs come and go, nursing homes succeed in maintaining a large core of stable CNAs that prevent the erosion of quality.

Figure 11

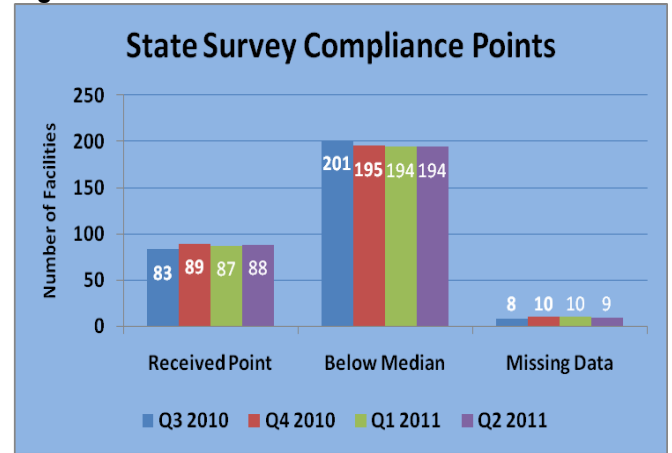


STATE SURVEY COMPLIANCE

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.

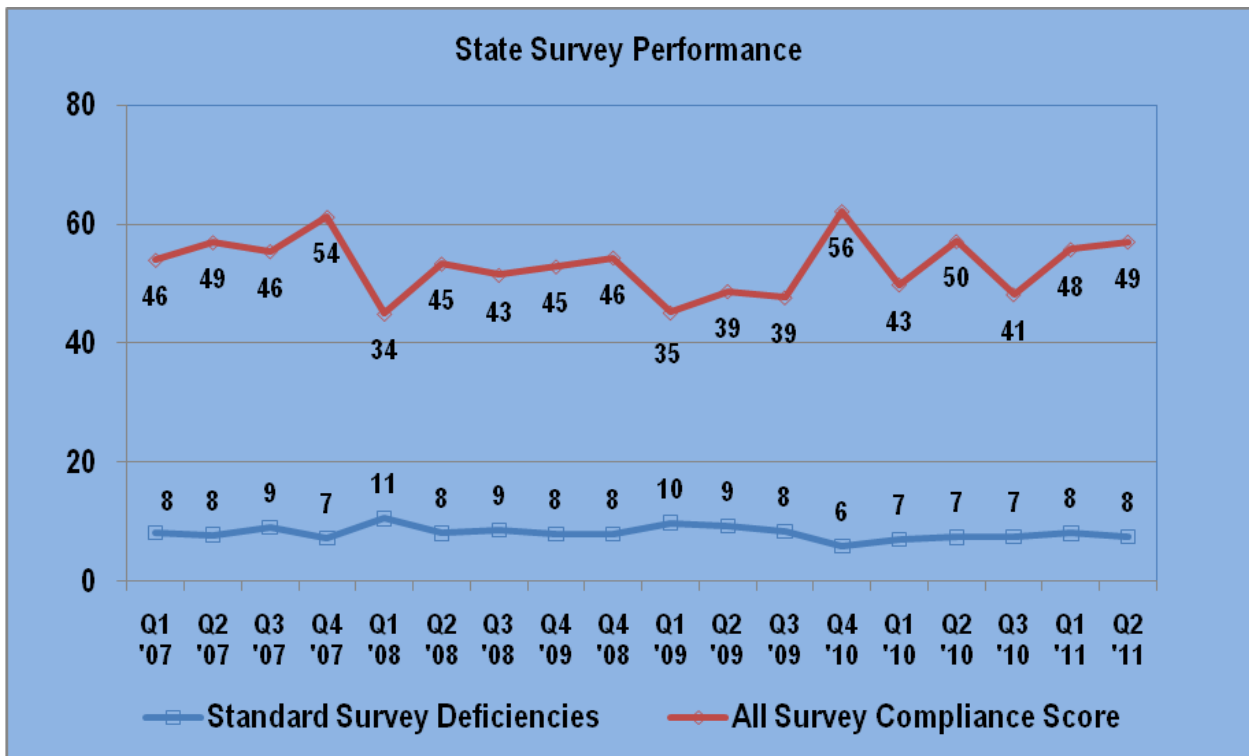
The State Survey Compliance metric is based on the number and types of deficiencies that are weighted for scope and severity. Across the final four quarters of measurement, most facilities did not receive an incentive point on this measure (Figure 12).

Figure 12



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. However, facilities receiving points has increased from 60 to 88 in the most recent period.

Figure 13



OCCUPANCY

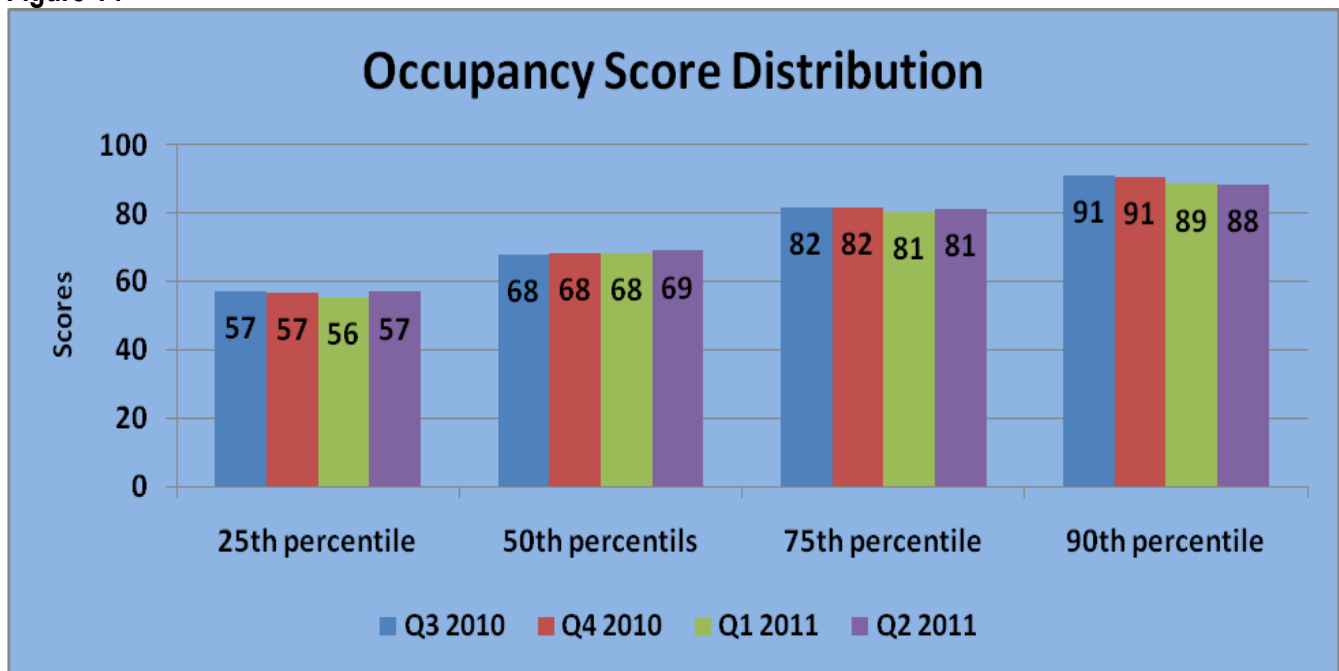
Occupancy data are provided to My InnerView on a monthly basis by each facility. This metric reflects the percentage of facility beds that are not left empty during the month.

No incentive points are granted based on occupancy rates because occupancy is a major driver of facility revenues. 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 14).

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, for example between urban and rural locations, rather than efficiency or quality, this measure should continually be evaluated as to its suitability as a performance measure.

Figure 14

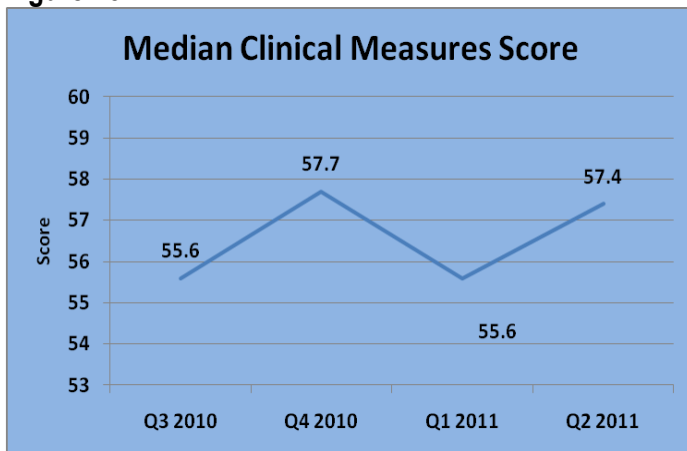


CLINICAL OUTCOMES

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.

The median and average score for the composite clinical performance score across the final periods are shown in figures 15 and 16 respectively

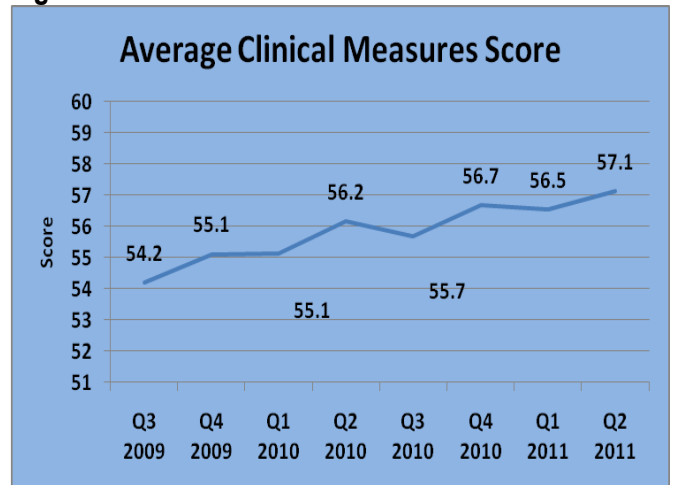
Figure 15



There are incremental improvements in clinical performance over time. The average clinical measures scores in Figure 16 improve steadily over the assessment periods.

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 suggest that providers have achieved more consistent performance across all five outcomes.

Figure 16



Further evidence for improved performance can be seen in the individual clinical outcomes (Figures 17 and 18). Four of the five outcomes have 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 weight loss/gain.

At the baseline assessment, the average facility had 93% of residents without restraints. During the most recent assessment over 98% of residents were without restraints, representing a five percentage point improvement. Over the same period, average number of residents without weight loss/gain improved from 92% to over 95%.

Facilities submit clinical data directly to My InnerView through its Web portal, as such, decreasing number of missing data reflects greater participation over time.

The distribution of composite clinical outcomes score is shown (Figure 19). 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.

The dominant pattern you discern incidence of the five clinical conditions—nursing home acquired pressure sores, residents losing unexpectedly lose

weight, residents under physical restraint, and residents with in-house acquired catheters—is that the score in four of the five indicators improve from the quarter Focus on Excellence was launched through June 2011.

In addition, the increase in the score for not using physical restraints is the steepest, followed by score for not letting residents lose weight. As well, little back sliding from quarter to quarter is observed.

Figure 17

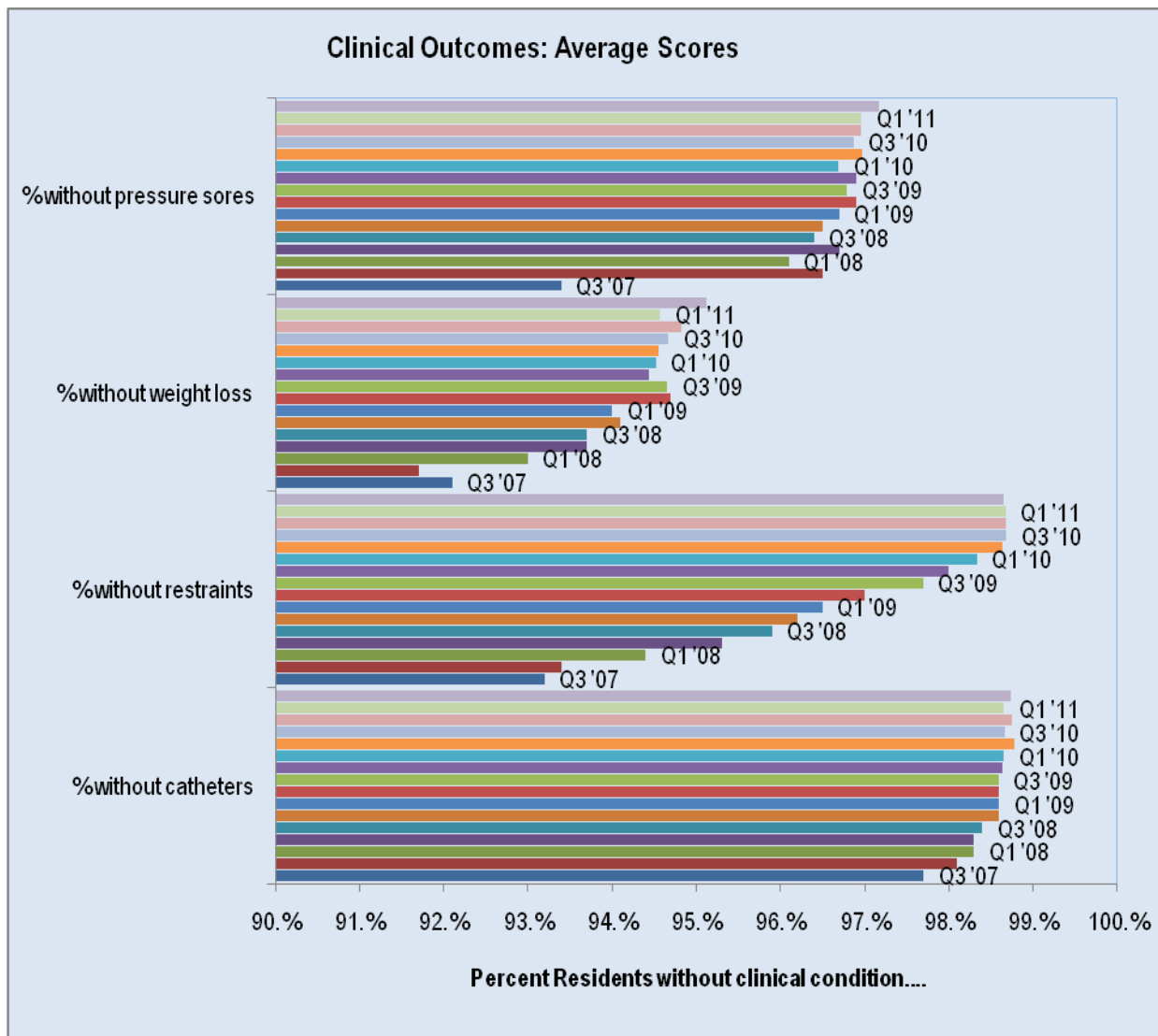


Figure 18

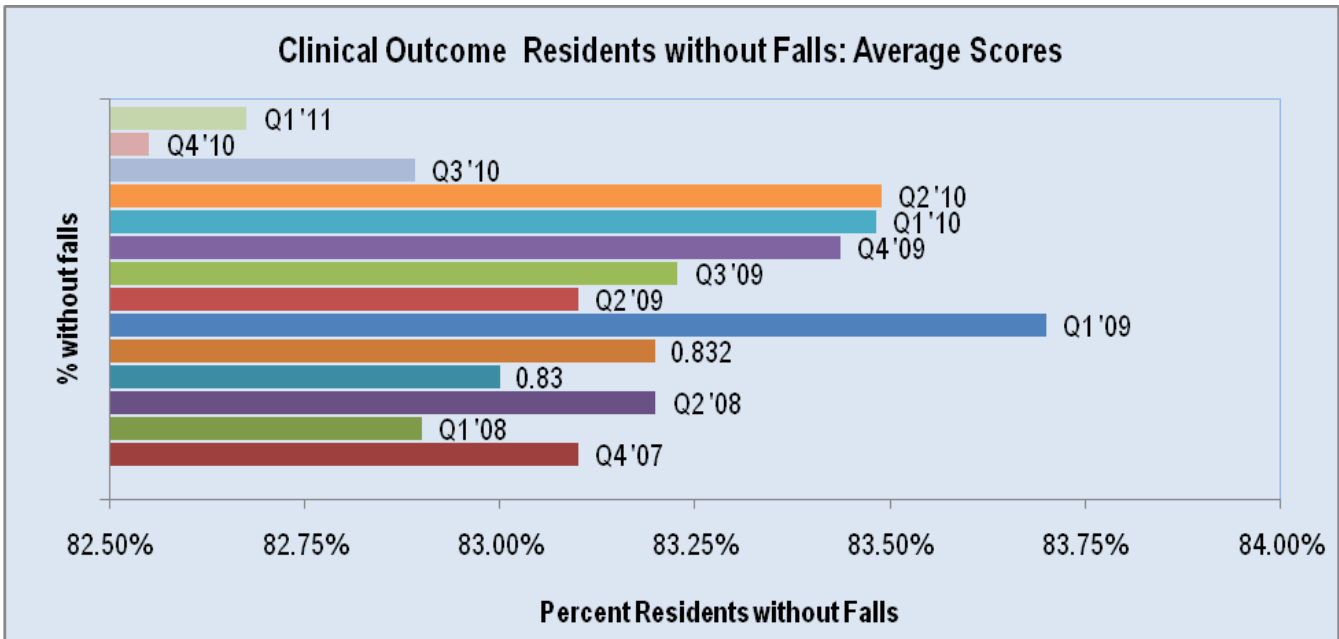
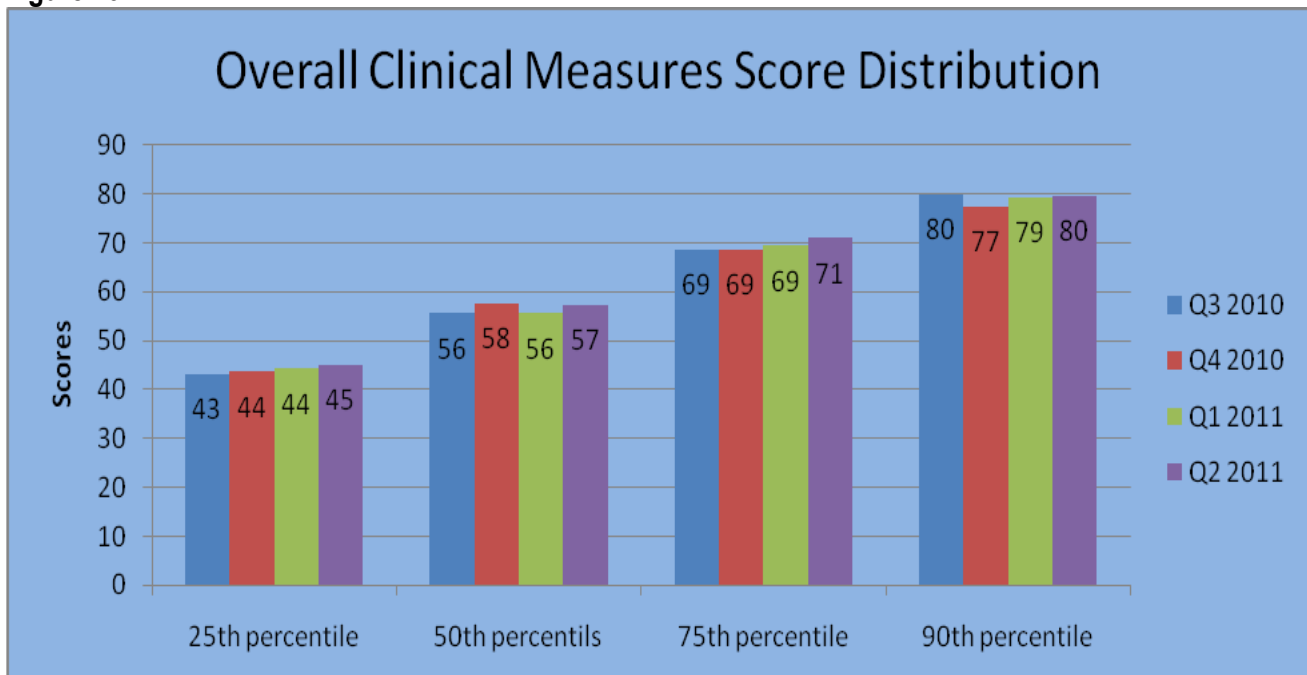


Figure 19



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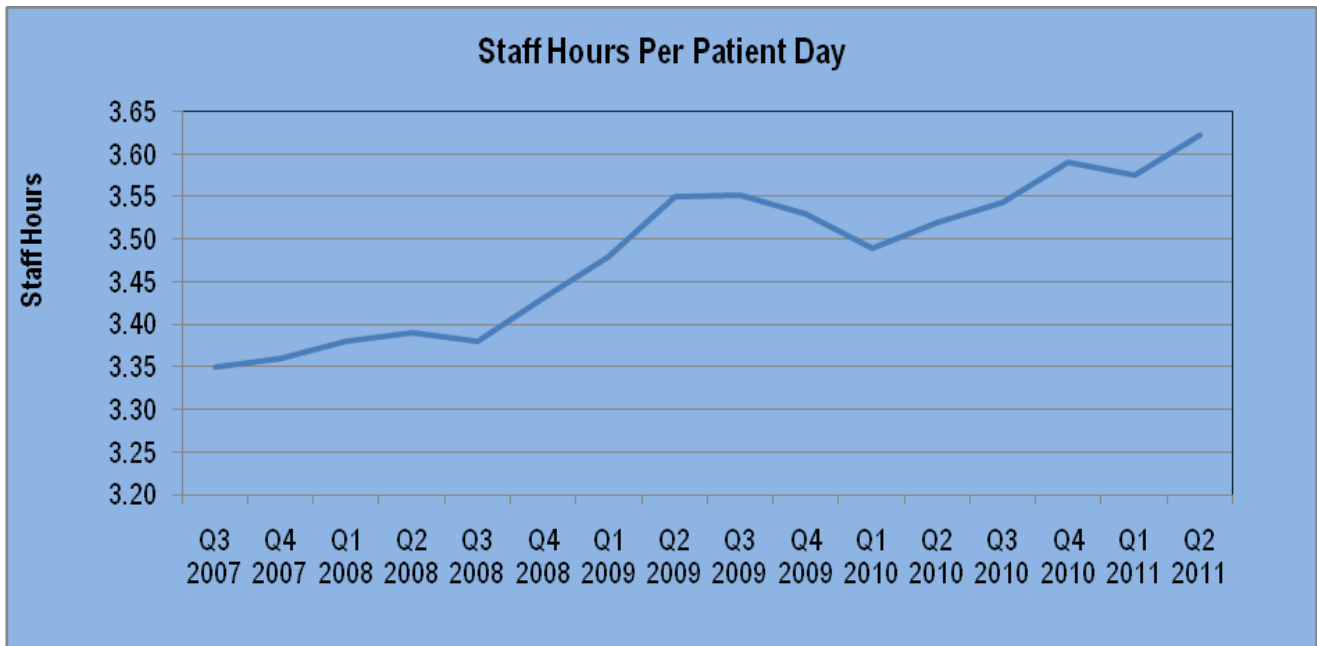
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DIRECT CARE HOURS

Direct Care Hours are 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

The nursing homes in the Focus on Excellence Program showed an average HPPD of 3.35 at the start of the program in 2007. In the following 40 months, HPPD inched upwards to 3.62 in mid-2011; the HPPD for all Oklahoma nursing homes was 3.5 in 2010

Figure 20



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 20). This area has had consistent improvements since the baseline assessment (Q3 2007).

INCENTIVES AND PERFORMANCE

Focus on Excellence uses a tiered-reimbursement system to award points to participating facilities that meet or exceed a specified level within the 11 areas, except for overall occupancy. The points determine a nursing home's rank among participating providers. You earn an incentive point if your score is in the upper half of all scores on each measure.

The state survey compliance awards the incentive point differently if the nursing home had no deficiency cited or had a deficiency of D level or less in a care-related area or had a deficiency of level E in a non-care related area.

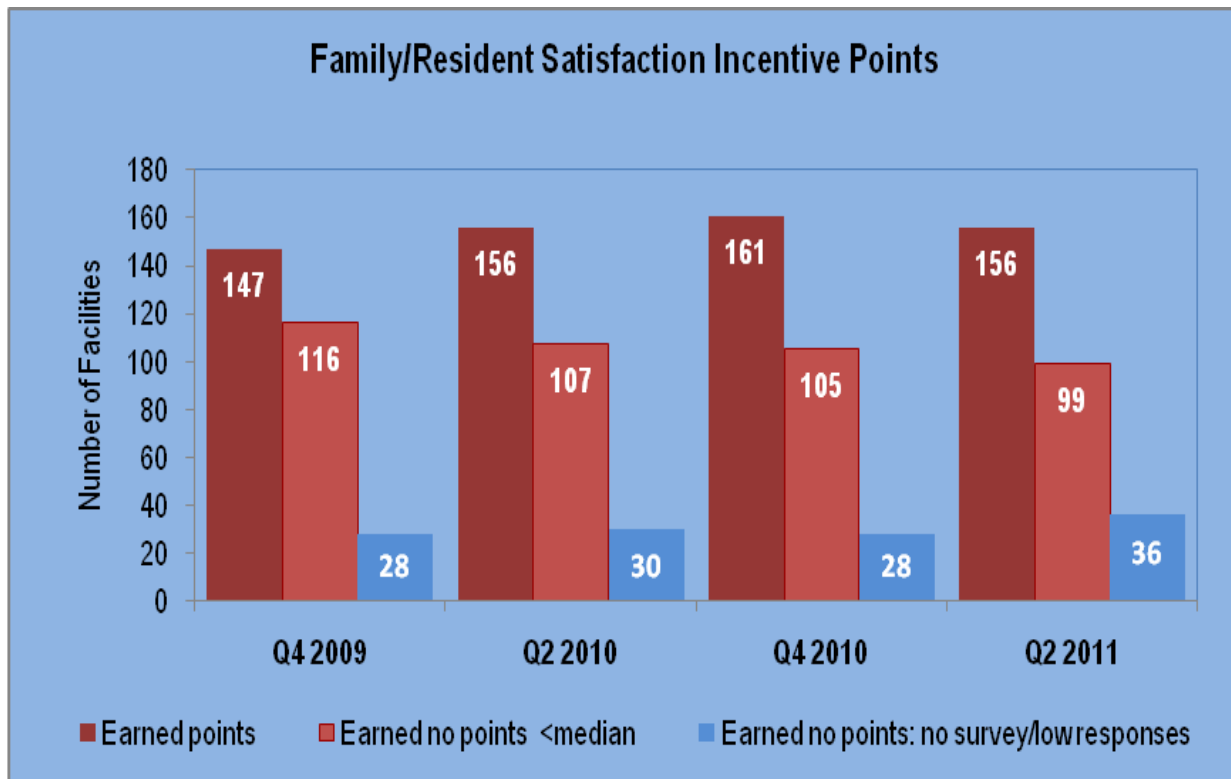
In addition to earning points for reimbursement, nursing homes receive a star rating on ten of the

11 measures based on one's rank among all participants. Overall occupancy is excluded from the incentive payment but included here. Medicaid, Medicare ratio is excluded here and included in incentive payment.

Stars are based on what quintile rank you score. Star-ratings are posted on the Focus on Excellence Nursing Home Ratings Web site and are accessible by consumers.

The following charts show, for select quarters from 2009 to 2011, the number of nursing homes in the following groups:

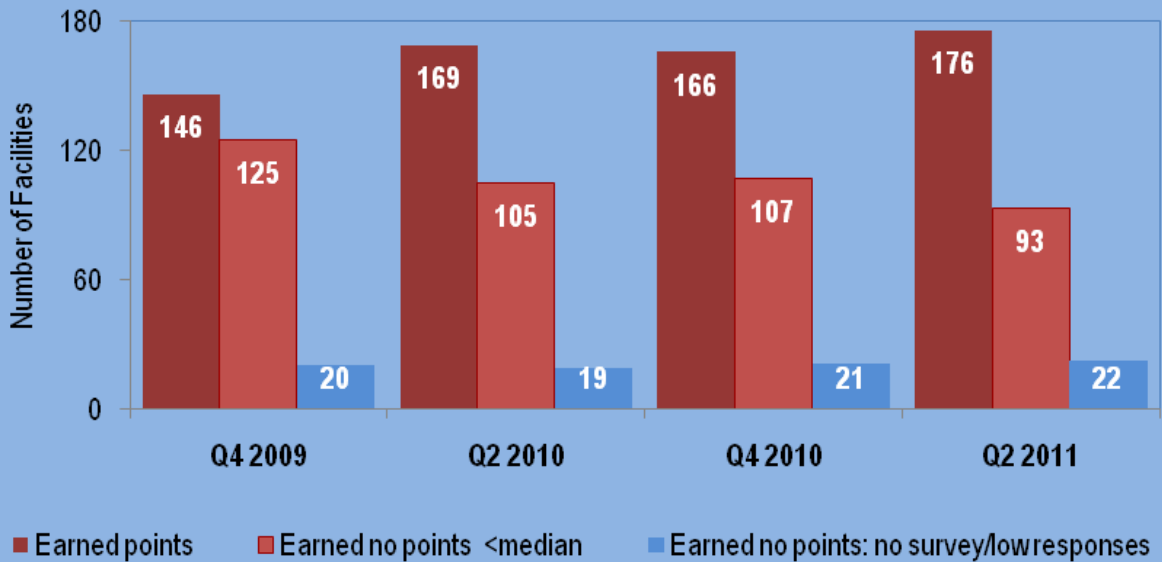
1. Nursing homes that earned incentive points
2. Nursing homes that did not earn incentive points
3. Nursing homes that did not earn incentive points because that activity was not performed.



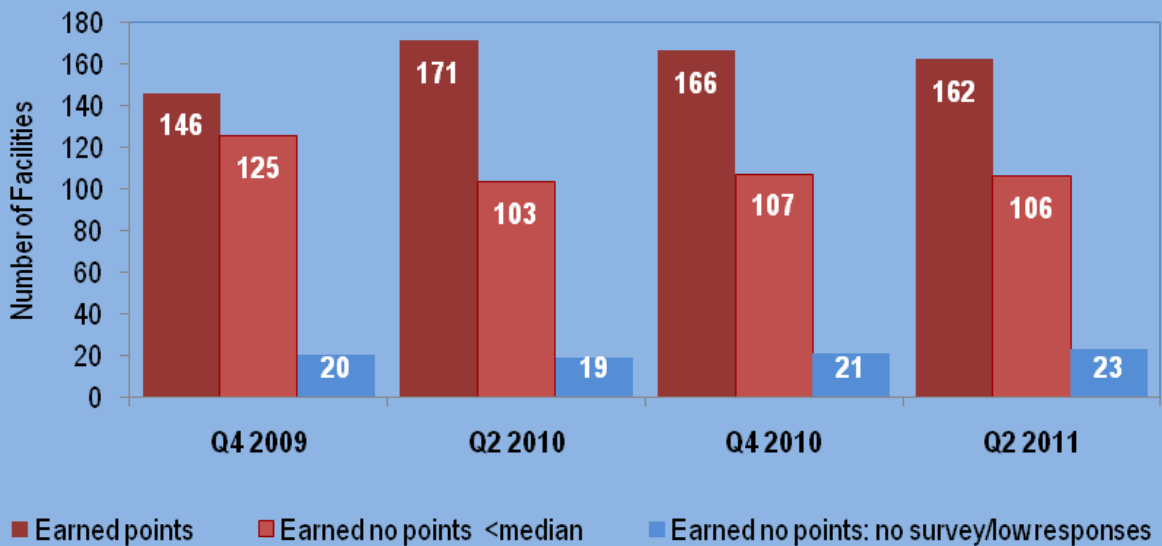
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Employee Satisfaction Incentive Points



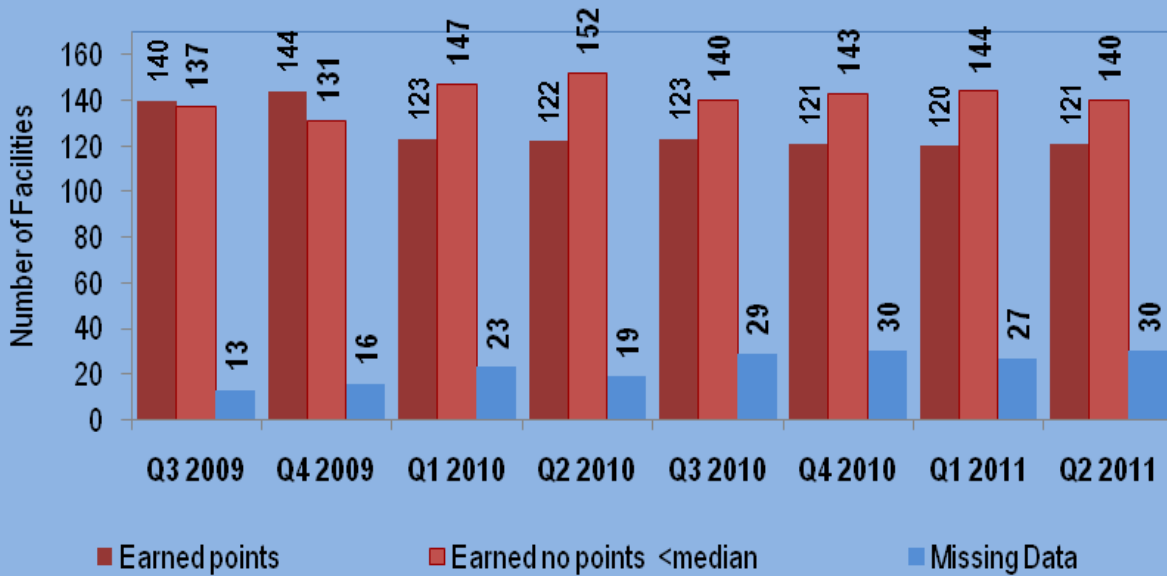
Culture Change Satisfaction Incentive Points



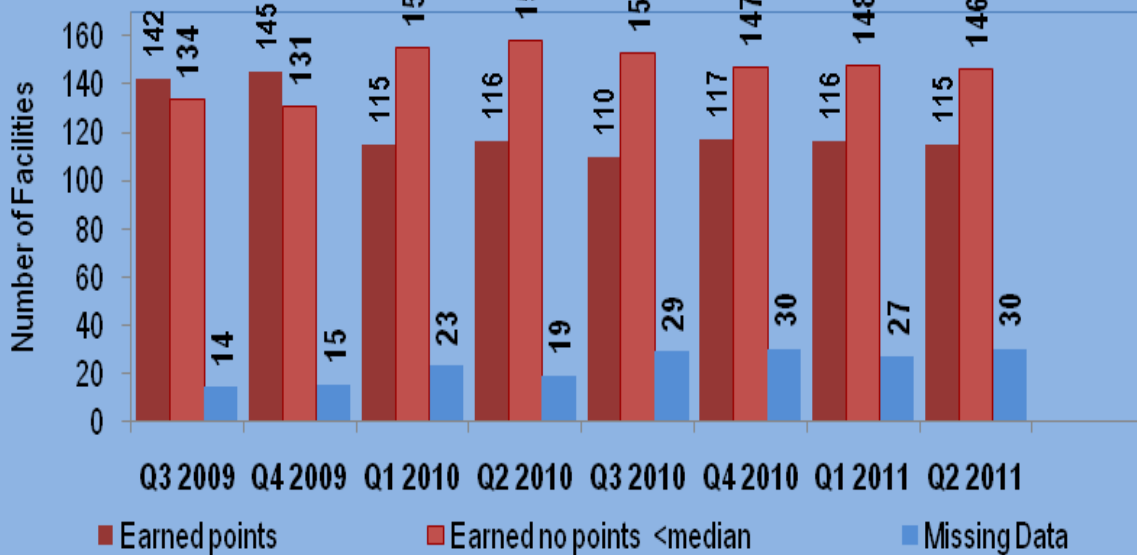
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CNA Incentive Points



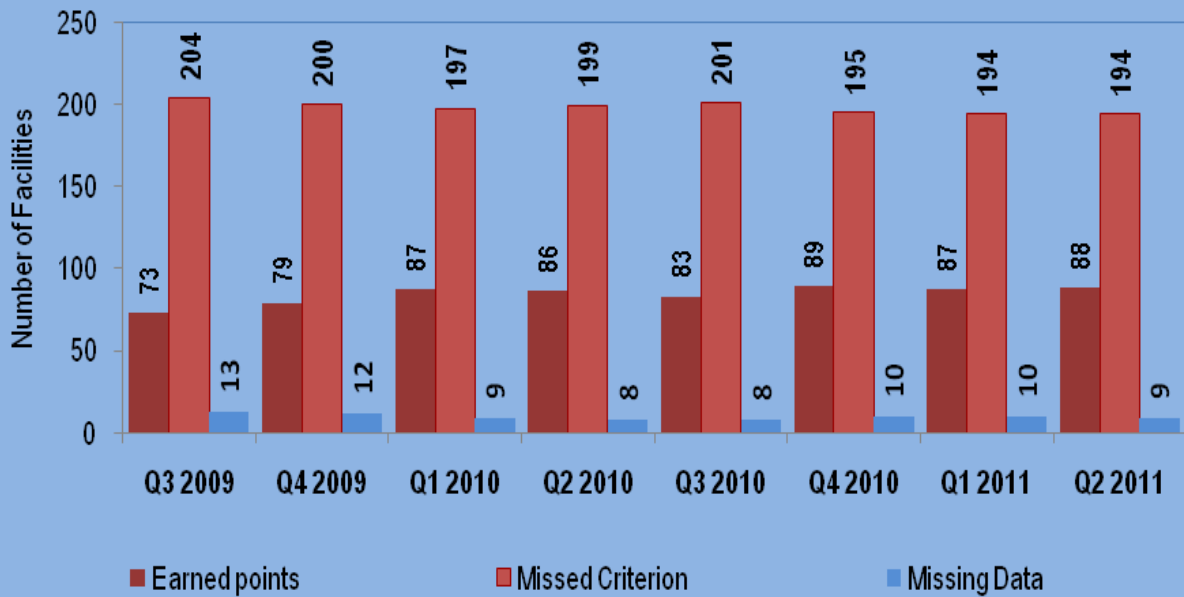
RN/LPN Incentive Points



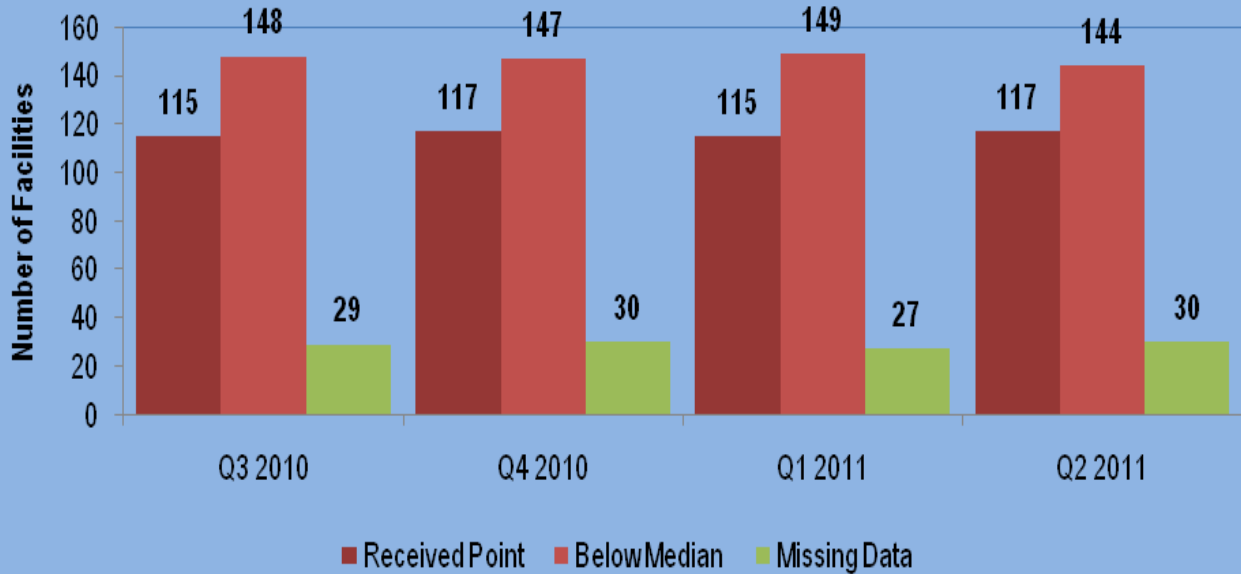
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State Survey Compliance Incentive Points

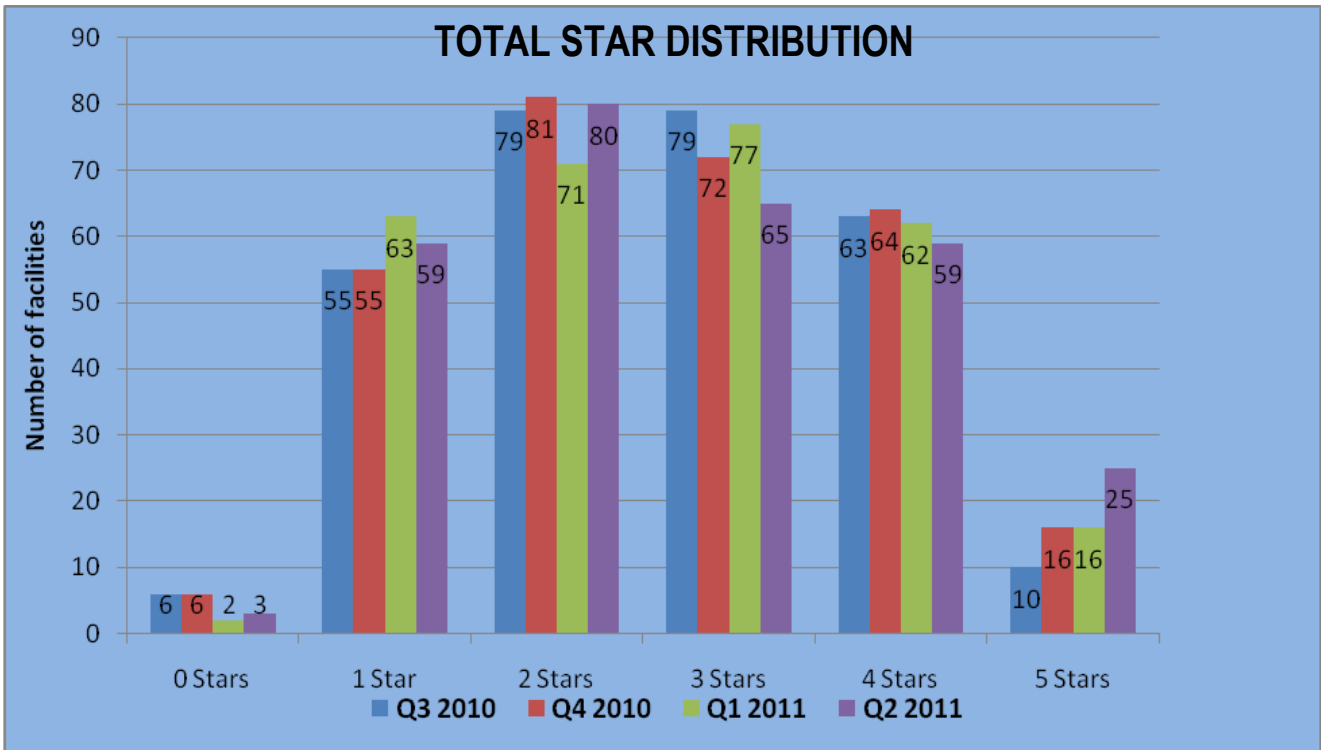
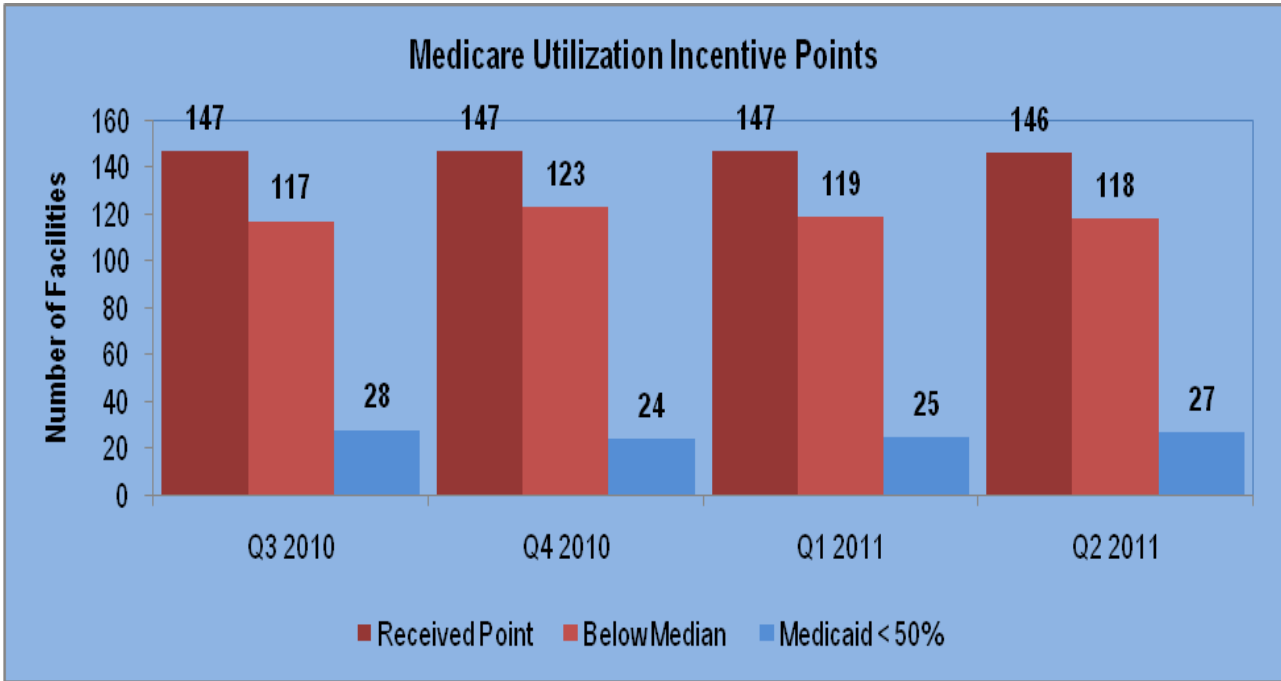


Clinical Measures Incentive Points



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