DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 15-25-NH

DATE: **February 13, 2015**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: MDS / Staffing Focused Surveys Update

Memorandum Summary

FY2014 Pilot Surveys: In 2014, Centers for Medicare & Medicaid Services (CMS) and five volunteer States piloted a focused survey to assess MDS coding practices and its relationship to resident care in nursing homes.

- A report on the findings from the pilot is attached.

Nationwide Expansion: We subsequently announced that we would expand the MDS focused surveys to all States and include a review of nursing home staffing. This memo provides an update on the pilot and the status of the expansion of these surveys including:

- Training for the next surveys will begin in early April 2015.
- States will need to assign a minimum of three surveyors to be trained.
- Training and surveys will be rolled out in two phases with Regions and States assigned to one of two groups.
- Deficiencies identified during the surveys will result in relevant citations and enforcement actions.

Background

In 2014, the CMS, together with five volunteer States, piloted a short-term focused survey to assess Minimum Data Set, Version 3.0 (MDS 3.0) coding practices and its relationship to resident care in nursing homes. We appreciate the work of the five States that volunteered to conduct these surveys and provide us with useful feedback (MD, PA, VA, IL, and MN). Each of the five States dedicated at least two surveyors to the effort, plus the State Resident Assessment Instrument (RAI) Coordinator. Each State completed five Surveys which were each conducted over approximately two days. Attachment A provides a report of the findings from the pilot.

After completing the pilot, CMS announced we would expand these surveys to be conducted nationwide in 2015. The surveys are also being conducted in conjunction with CMS' efforts strengthen the *Nursing Home Five-Star Quality Rating System* (see press release at http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-10-06.html).

Nationwide Expansion

Based on the experiences in the five volunteer States, we revised the survey structure and processes (e.g., worksheets) to improve the usability, scalability, and effectiveness of the survey. The surveys will continue to assess compliance with 42 CFR 483.20 (Resident Assessment), and other applicable regulations that are identified during the investigatory process. Additionally, the surveys will include a review of nursing home staffing to help CMS assess how staffing levels may fluctuate throughout the year.

These surveys will be rolled out in two phases with Regions and States assigned to one of two groups. In February, CMS will inform Regional Offices and States regarding the group to which they are assigned. Each phase will begin with training. Regions and States will also need to identify a point of contact (POC) to be the primary recipient of information pertaining to these surveys. A sample of nursing homes will be surveyed in each State. We will work with States to identify the specific facilities to be surveyed. In addition, CMS may work with a contractor to supplement States' efforts to conduct surveys. More details will be conveyed to States as the training gets underway.

Surveyor Training

The surveys are designed to be conducted by two surveyors over approximately two days. The first phase of surveyor training will begin in early April 2015. States will need to allocate at least three surveyors to complete the training (e.g., two primary surveyors and one alternate). At least one of the onsite surveyors must be a Registered Nurse. Regional Offices should allocate at least one individual to complete the training and serve as a point of contact for States and CMS Central Office. Training will be provided via recorded webinars so surveyors will be able to complete their training at a time that fits within their schedule. The total time needed for training is expected to be approximately four hours, as the training for this focused survey builds on the training and experience that surveyors already possess. Support will also be provided for questions and technical assistance for surveyors throughout the training and survey period. States may allocate more than three surveyors to the training; however, at least one of the individuals trained should be a supervisor. Additionally, in contrast to the pilot, these surveys do not need to be conducted by State RAI Coordinators. We restructured the survey so that it would not be dependent on the use of State RAI Coordinators in every survey. Such restructuring enables the survey to be more scalable and decreases the burden on States.

We have received requests from nursing homes for materials or methods on how to prepare for these surveys. Information regarding methods for accurate completion of MDS assessments is found in the MDS RAI Manual. Additionally, Appendix PP of the SOM provides guidance on how to comply with the regulations listed above. Therefore, States and Regional Offices should refer providers to these resources for these types of inquiries. There are no new regulations involved in these surveys. The focus of the survey is on nursing home compliance with existing and long-standing regulations.

Enforcement in Accordance with Existing CMS Policy and Regulations

Deficiencies identified during the surveys will result in relevant citations and enforcement actions in accordance with normal and existing CMS policy and regulations. In the event that additional care concerns (beyond the MDS and staffing foci of this focused survey) are identified

during on-site reviews, those concerns will be investigated during the survey or, if immediate investigation is not possible, registered with the SA as a complaint for further review.

For questions on this memorandum related to the MDS / Staffing Focused Survey, please email MDSFORSandC@cms.hhs.gov and consult with your CMS Regional Office.

Effective Date: Immediately. The information contained in this memorandum should be communicated with all survey and certification staff (including the State RAI Coordinator), their managers and the State/Regional Office training coordinators within 30 days of this memorandum. More information will be communicated directly with States shortly on the specifics of the next steps for implementing these surveys.

/s/
Thomas E. Hamilton

Attachment- MDS Staffing Focused Surveys Pilot Findings

cc: Survey and Certification Regional Office Management

Memorandum

US Health – Health Policy

Date January 22, 2015

To CMS

From Abt Associates

Subject MDS 3.0 Focused Survey Pilot Results

Executive Summary

This memo describes the results of the MDS 3.0 Focused Survey Pilot that was conducted during June and July 2014 in 25 nursing homes in the US. One goal of the pilot study was to evaluate adherence to MDS 3.0 reporting requirements, including the requirement to have an RN conduct or coordinate the assessments, and adherence to the required timelines for assessments. A second goal was to evaluate the agreement between the MDS 3.0 assessments and the resident's medical record. These comparisons were supplemented with observations of residents and interviews with nursing home staff and/or residents. In the event the resident medical record did not match the MDS 3.0 assessment, surveyors were prompted to evaluate compliance with related regulations.

The information from the survey worksheets from the 25 Pilot surveys was compiled into a dataset and overall trends in MDS 3.0 reporting among the Pilot facilities were evaluated. In addition, the surveyors who participated in the Pilot were asked to provide input and suggestions for enhancements to the MDS 3.0 Focused Survey process, worksheets, and training through completion of an on-line questionnaire.

While the Pilot results indicate relatively high levels of compliance related to registered nurse (RN) coordination and assessment timing requirements, there is room for improvement in MDS 3.0/medical record agreement in four of seven clinical conditions reviewed, including: 1) the severity of injury associated with falls; 2) pressure ulcer status; 3) restraint use; and 4) late loss activities of daily living (ADL) status. Review of these four clinical conditions showed levels of disagreement between the resident's medical record and their MDS 3.0 assessment of 15 to 25 percent. For example:

- 25% of MDS 3.0 assessments reviewed for falls showed disagreement between the MDS 3.0 and the medical record;
- 18% of MDS 3.0 assessments reviewed for pressure ulcers showed disagreement between the MDS 3.0 and the medical record;
- 17% of MDS 3.0 assessments reviewed for restraints other than side rails showed disagreement between the MDS 3.0 and the medical record; and

- 15% of MDS 3.0 assessments reviewed for late loss ADLs (including bed mobility, toileting, transfer, and eating) showed disagreement between the MDS 3.0 and the medical record.

Further, the disagreement that was found was concentrated in a small number of pilot facilities and States.

The findings from the MDS 3.0 Focused Survey Pilot should be interpreted with caution. The results of the Pilot are not generalizable to all nursing homes in the U.S. as the sample of nursing homes included in the Pilot was not fully representative of the nation's nursing homes. Further, the participating s volunteered to be in the pilot and the State Survey Agency (SSA) Directors had some discretion in choosing facilities for participation in the focused surveys. Additionally, the surveyors who conducted the pilot surveys were also specifically selected for the Pilot, and were accompanied onsite by the State RAI Coordinator, adding a level of MDS competency that might not be available in a larger roll-out of the focused survey process. In addition, each survey team was accompanied on their first survey by a CMS staff member and a CMS consultant who provided technical assistance to the surveyors and ensured that the survey protocol was being implemented as intended and the survey worksheets were being correctly completed.

Overview of the MDS 3.0 Focused Survey Pilot

Five volunteer States were chosen to participate in the Pilot, with two to three surveyors from each State conducting the survey at five facilities in their State. A total of 25 facilities were included in the Pilot. By reviewing the facilities' medical records and MDS 3.0 assessments, interviewing residents and staff, and observing residents, the Pilot surveyors were able to record and analyze the agreement of the facilities' MDS 3.0 assessments with information in the resident's medical records. Additionally, compliance with OBRA assessment timing and completion/coordination requirements was evaluated.

In the course of the MDS 3.0 Focused Survey Pilot, State surveyors evaluated:

1) Facility compliance with the regulatory requirement related to an RN conducting or coordinating MDS 3.0 assessments,
2) Timeliness of OBRA Admission, Quarterly and Annual, and Significant Change in Status assessments, and facility compliance with the requirement to initiate a Significant Change in Status Assessment as appropriate,[1] and
3) Agreement of the MDS 3.0 and the resident's medical record using a series of worksheets that prompted surveyors to compare MDS 3.0 assessments to the resident's medical record and, in some cases, to their (surveyor) observations of the resident and interviews with staff and/or residents.

To identify facilities for participation in the Pilot, Abt Associates conducted a targeting analysis to preliminarily identify facilities within the five volunteer States based on their quality measure trends over time. CMS provided State Survey Agency (SSA) Directors in the five volunteer States with a list of possible facilities to be included in the Pilot. SSAs were given some discretion in choosing from among the targeted facilities to accommodate the geographic preferences of the survey teams. In order to ensure that the survey could be conducted in two days, an attempt was made to only include facilities with 120 beds or less in the Pilot. However, this was not possible in all cases, although most facilities in the Pilot had fewer than 120 beds. Alternate facilities were selected (when possible) if a targeted facility was larger than 150 beds.

The Pilot process was documented in a detailed study protocol that included instruction on: 1) off-site survey preparation; 2) procedures for entrance to a Pilot facility; 3) conducting an entrance conference with facility staff; 4) touring the facility and obtaining direct observation of residents and staff; 5) collection of documents from facility staff; 6) daily team meetings; 7) general guidelines for validating the agreement of the MDS 3.0 assessment with the resident's medical record; 8) determining compliance with specific (related) regulations; 9) survey team decision making; and 10) conducting an exit conference.

Pilot surveyors were trained on the full survey protocol through during a 90 minute webinar training session that aimed to ensure the pilot surveyors ability to understand the types of assessments reviewed during the Pilot study, understand why the Assessment Reference Date (ARD) is critical in determining the clinical information captured on the MDS 3.0, understand the coding instructions for those items included in the Pilot study, and understand the criteria for a Significant Change in Status Assessment (SCSA) and how it relates to the assessment process.

[1] A significant change assessment is required for any resident with a new onset of conditions and/or treatments, such as a newly developed pressure ulcer, a major injury as a result of a fall, the initiation of an indwelling catheter, etc.

For each facility in the Pilot, the sample for review of a given clinical condition was capped at ten residents. Additionally, some of the clinical conditions being evaluated required review of only the most recent MDS 3.0 assessment, whereas evaluation of other conditions required review of all MDS 3.0 assessments completed in the preceding 90 days. Because of variability in clinical conditions within a given facility (e.g., low or no restraint use) and the worksheet design leading to a portion of assessments vs. all assessments being evaluated for certain conditions, the sample sizes for each of the clinical conditions evaluated in the Pilot varied across facilities. For example, while the RN coordination evaluation included 1,027 MDS 3.0 assessments, the evaluation of restraint use included only 47 MDS 3.0 assessments.

For evaluation of ADL agreement in the Pilot, the ten most recent OBRA-required assessments for residents still residing in the facility were utilized by the surveyors. For all other clinical conditions for which MDS 3.0 agreement was evaluated (falls with major injury, pressure ulcers, indwelling catheters, antipsychotic medications, urinary tract infections [UTIs], and restraints other than side rails), administrative and front-line nursing staff report provided the basis for each sample. Surveyor observation augmented the staff report for identification of restraints, and surveyors reviewed incident reporting information to augment the listing of resident falls with major injury. The coding active diagnoses that serve as exclusions for the indwelling catheter and antipsychotic medication quality measures was also validated during the Pilot for residents evaluated for those conditions.

In the event noncompliance with MDS 3.0 requirements was identified during the Pilot, the surveyors were prompted to evaluate compliance with related clinical regulations (e.g., unnecessary medications and/or quality of care may have been evaluated if errors in coding antipsychotic medications were identified) and the Quality Assessment and Assurance (QAA) regulation.

The results of the individual survey worksheets were compiled into a dataset, and by analyzing these data, overall trends in MDS 3.0 timing and agreement among the Pilot facilities was evaluated. While the Pilot results shows relatively high levels of compliance related to registered nurse (RN) coordination and MDS 3.0 timing requirements, there is room for improvement in MDS 3.0 agreement with the medical record, especially in the reporting of the severity of injury associated with falls, late loss activities of daily living (ADL) status, pressure ulcer status, the presence of certain diagnoses, restraint use, and the use of antipsychotic medications. The Pilot results also indicate that disagreement between the MDS 3.0 and the resident's medical record were concentrated in a small number of States and facilities, rather than being uniformly distributed across the surveyed States and facilities.

It is important to note that the results of the MDS 3.0 Focused Survey Pilot are not generalizable to all nursing homes, as the sample of nursing homes included in the Pilot was not representative of U.S. nursing homes. Only 25 facilities were surveyed as part of the Pilot, representing a small fraction of the country's approximately 16,000 nursing homes. Slightly more than 1,000 MDS 3.0 assessments were reviewed during the pilot, compared to approximately 1.6 million assessments that are conducted and submitted to CMS every month. Further, CMS solicited volunteer States to conduct the Pilot, and those States, including Minnesota, Maryland, Virginia, Pennsylvania, and Illinois, are not representative of all States in the US.

Analysis of MDS 3.0 Focused Survey Pilot Results

For evaluation of RN participation in MDS 3.0 assessments, 6 of the 1,027 (0.6%)[2] MDS 3.0 assessments reviewed documented a failure of a registered nurse to conduct or coordinate the assessment as required. Thus, with less than 1% of assessments indicating a failure in this area, there is no sign of widespread lack of RN involvement in the assessment process. While it is true that any identified noncompliance represents a departure from CMS's standards related to resident assessment, this very low rate indicates that there is little reason for CMS to focus on RN Coordination as an area of concern, assuming future rounds of the MDS 3.0 Focused Surveys indicate this same result.

In the evaluation of assessment timing, 23 of the 1,027 (2.2%)[3] MDS 3.0 assessments reviewed documented failure of the facility to comply with OBRA-required assessment scheduling requirements for Admission, Significant Change in Status, Annual, and Quarterly assessments. Failures of the facility to initiate the assessment and/or complete the assessment in a timely manner are included in these instances. While the overall rate of compliance with OBRA MDS 3.0 assessment timing requirements is high, issues were identified in three of the five States in the pilot. Six facilities (or 24% of the total) were noted to have instances of noncompliance with OBRA assessment timing.

Evaluation of the agreement of MDS 3.0 assessments reveals some assessment areas where there is a high rate of agreement between the assessment and the resident's medical record, as well as assessment areas where there is a significant need for more analysis. The raw percentages of disagreement are listed in Table 1 below. In this table, the numerator is the number of assessments that were not in agreement with information in the medical record, and the denominator represents the total number of assessments reviewed in the particular assessment area.

Table 1: MDS Accuracy Issues, by Assessment Area

Numerator/ denominator	Percent Disagreement	Assessment Area
8/47	17.0%)[4]	Failure of facility staff to accurately reflect the status of the resident related to **restraint use other than side rails**
18/218	8.3%[5]	Failure of facility staff to accurately reflect the status of the resident related to the **presence of pressure ulcers**
40/218	18.3%[6]	Failure of facility staff to accurately reflect the status of the resident related to **pressure ulcer stage**
13/218	6.0%[7]	Failure of facility staff to accurately reflect the status of the resident related to **worsening of pressure ulcer status** since prior assessment or last admission/entry

[2] This represents the sum of all "No" responses from Question 3 on Worksheets 5, 6, 7, 10, and 11, Question 4 on Worksheet 8, and Question 2 on Worksheet 9.
[3] This represents the sum of all "No" responses from Question 4 on Worksheets 5, 6, 7, 10, and 11, Question 5 on Worksheet 8, and Question 3 on Worksheet 9, as well as "No" responses to the second part of Question 8 on Worksheet 5, Question 9 on Worksheets 6 and 9, Question 10 on Worksheets 7 and 11, and Question 7 on Worksheet 10.
[4] Sum of all "No" responses from Q6 on Worksheet 5.
[5] Sum of all "No" responses from Q5 on Worksheet 6.
[6] Sum of all "No" responses from Q6 on Worksheet 6.
[7] Sum of all "No" responses from Q7 on Worksheet 6.

Numerator/ denominator	Percent Disagreement	Assessment Area
		or reentry
1/132	0.8%[8]	Failure of facility staff to accurately reflect the status of the resident related to the **presence of an indwelling catheter**
21/132	15.9%[9]	Failure of facility staff to accurately reflect the status of the resident related to the **diagnoses of neurogenic bladder and/or obstructive uropathy**
21/136	15.4%[10]	Failure of the facility staff to accurately reflect the status of the resident related to the **late loss ADL status**. Late loss ADLs include bed mobility, toileting, transfer, and eating
24/94	25.5%[11]	Failure of the facility staff to accurately reflect the status of the resident related to the **level of injury sustained during a fall as a major injury**
11/218	5.0%[12]	Failure of the facility staff to accurately reflect the status of the resident related to the **use of antipsychotic medications**
7/218	3.2%[13]	Failure of the facility staff to accurately reflect the status of the resident related to **diagnoses of Tourette's syndrome, Schizophrenia, and Huntington's disease**

Activities of Daily Living

The rate of disagreement in late loss ADL status is an area of concern. At 15.4%, this represents approximately one in every seven cases of late loss ADLs being coded differently than would be expected based on information in the resident's medical record. As late loss ADL status is already included in the Five-Star Quality Rating System, these disagreements are directly affect facilities' QM ratings.

Restraints

While the Pilot surveyors identified relatively few restraints in use in the facilities included in the pilot, a disagreement rate of 17% is notable and additional guidance and education to ensure correct identification and coding of restraints seems warranted. What is particularly significant about this finding is that there were cases in which the medical record supported the MDS 3.0 assessment finding of there being no restraint in use; however, through surveyor observation and investigation, restraints were identified.

Pressure Ulcers

Three separate MDS 3.0 pressure ulcer items were evaluated for agreement with the medical record during the MDS 3.0 Focused Survey Pilot, including the presence, worsening, and staging of pressure ulcers. While all three of these areas showed significant disagreement between the MDS 3.0 assessment and the resident's medical record, the failure of facilities to accurately identify the pressure ulcer stage in

[8] Sum of all "No" responses from Q6 on Worksheet 7.
[9] Sum of all "No" responses from Q8 on Worksheet 7.
[10] Sum of all "No" responses from Q8 on Worksheet 9.
[11] Sum of all "No" responses from Q6 on Worksheet 10.
[12] Sum of all "No" responses from Q6 on Worksheet 11.
[13] Sum of all "No" responses from question 8 from worksheet 11.

18.3% of assessments reviewed is problematic. Based on review of Statements of Deficiencies from the surveys and the CMS consultant's experiences on-site during some of the pilot surveys, the errors in staging likely stemmed from a lack of an accurate clinical assessment of the pressure ulcers and failure of facility staff to accurately stage pressure ulcers in the clinical record.

Falls

By far, the largest area of disagreement in the Pilot study was with falls, particularly the level of injury resulting from the fall. Over 25% of the reviewed assessments (24 out of 94) indicated disagreement between the assessment and the resident's medical record in terms of the level of injury documented after a fall.

Evaluation of the distribution of MDS 3.0 disagreement across the five pilot States indicates that in many cases, particular types of disagreement were concentrated in one or a few States, rather than being distributed evenly across all Pilot States. Table 2 displays the MDS 3.0 Pilot results by State and shows that facilities in Minnesota account for the majority (55.6%) of total disagreement (among the pilot States) in reporting the presence of pressure ulcers, and also account for more than one- third (35%) of total disagreement in pressure ulcer staging. Facilities in Illinois showed the highest level of disagreement in coding late loss ADLs, with 24 percent of the assessments in IL found to disagree with information in the medical record. Similar trends are noted in the area of falls and falls with injury, where the majority of disagreements were found in the Maryland pilot facilities.

Disagreement between the MDS 3.0 assessments and information in the resident's medical record was also concentrated at the facility- level, although to a lesser degree than at the State- level. For example, approximately one-third of the total facilities with disagreement in late loss ADLs were located in Illinois, and 75 percent of the total facilities with disagreement in restraint use were located in Maryland. As such, actions taken to address coding disagreement should take into account that certain types of disagreement may be focused in particular States or in a small group of facilities within a State, rather than being evenly distributed among all nursing facilities. This may be due to differences in MDS education and training, to facility internal MDS audit practices, or to State-level MDS or casemix audit practices.

Data Analysis Conclusions

The MDS 3.0 Focused Survey Pilot indicates that there is relatively little misreporting occurring in the areas of RN coordination and MDS 3.0 scheduling, but that there is room for improvement in MDS 3.0 assessment agreement with a resident's medical record, especially in the reporting of the severity and frequency of falls, late loss ADL status, pressure ulcer status, restraint use, and coding of certain diagnoses including UTI.

Table 2: MDS Validation Pilot Results by State

Presence of PUs	Total	PA	MD	VA	IL	MN
# assessments	218	44	44	32	58	40
# disagreements	18	3	4	0	1	10
# facilities w/ disagreements	11	3	3	---	1	4
% disagreement	8.3%	6.8%	9.1%	0.0%	1.7%	25.0%
% of total disagreements	100.0%	16.7%	22.2%	0.0%	5.6%	55.6%

Late Loss ADLs	Total	PA	MD	VA	IL	MN
# assessments	136	26	31	25	29	25
# disagreements	21	2	6	2	7	4
# facilities w/ disagreements	12	1	2	1	4	4
% disagreement	15.4%	7.7%	19.4%	8.0%	24.1%	16.0%
% of total disagreements	100.0%	9.5%	28.6%	9.5%	33.3%	19.0%

PU Stage	Total	PA	MD	VA	IL	MN
# assessments	218	44	44	32	58	40
# disagreements	40	5	12	1	8	14
Total # facilities w/ disagreements	14	4	4	1	1	4
% disagreement	18.3%	11.4%	27.3%	3.1%	13.8%	35.0%
% of total disagreements	100.0%	12.5%	30.0%	2.5%	20.0%	35.0%

Falls	Total	PA	MD	VA	IL	MN
# assessments	94	23	15	15	22	19
# disagreements	10	1	6	2	0	1
Total # facilities w/ disagreements	6	1	2	2	---	1
% disagreement	10.6%	4.3%	40.0%	13.3%	0.0%	5.3%
% of total disagreements	100.0%	10.0%	60.0%	20.0%	0.0%	10.0%

Worsening PU	Total	PA	MD	VA	IL	MN
# assessments	218	44	44	32	58	40
# disagreements	13	5	3	0	5	0
# facilities w/ disagreements	8	4	2	---	2	---
% disagreement	6.0%	11.4%	6.8%	0.0%	8.6%	0.0%
% of total disagreements	100.0%	38.5%	23.1%	0.0%	38.5%	0.0%

Falls w/ injury	Total	PA	MD	VA	IL	MN
# assessments	94	23	15	15	22	19
# disagreements	24	2	9	4	3	6
# facilities w/ disagreements	12	1	3	3	3	2
% disagreement	25.5%	8.7%	60.0%	26.7%	13.6%	31.6%
% of total disagreements	100.0%	8.3%	37.5%	16.7%	12.5%	25.0%

Dx Neuro bladder	Total	PA	MD	VA	IL	MN
# assessments	132	36	29	24	22	21
# disagreements	21	2	5	9	2	3
# facilities w/ disagreements	13	1	4	4	1	3
% disagreement	15.9%	5.6%	17.2%	37.5%	9.1%	14.3%
% of total disagreements	100.0%	9.5%	23.8%	42.9%	9.5%	14.3%

Restraint Use	Total	PA	MD	VA	IL	MN
# assessments	47	4	25	3	4	11
# disagreements	8	0	5	0	0	3
# facilities w/ disagreements	4	---	3	---	---	1
% disagreement	17.0%	0.0%	20.0%	0.0%	0.0%	27.3%
% of total disagreements	100.0%	0.0%	62.5%	0.0%	0.0%	37.5%

UTI	Total	PA	MD	VA	IL	MN
# assessments	182	43	42	25	46	26
# disagreements	32	6	5	2	6	13
# facilities w/ disagreements	12	2	3	2	1	4
% disagreement	17.6%	14.0%	11.9%	8.0%	13.0%	50.0%
% of total disagreements	100.0%	18.8%	15.6%	6.3%	18.8%	40.6%