



State of Illinois
Rod R. Blagojevich, Governor
Illinois Department on Aging
Charles D. Johnson, Director

Older Adult Services Advisory Committee

Nursing Home Conversion Work Group

Date: July 24, 2007

Location: Illinois Health Care Association, Springfield

Attending: Myrtle Klauer (co-chair), Phyllis Mitzen (co-chair), Bill Dart, John Echert, Bob Greene, Matt Hartman, Bonnie Lockhart, Scott Musser, Sally Petrone, Renne Razo, Lester Robertson, Terry Sullivan, Kevin Taylor, Enrique Unanue and Steven Wolf

Guest Speaker: (via pre-conference call) Patricia Snyder, Director, Nebraska Health Care Association.
Attending: Bill Dart, John Echert, Phyllis Mitzen and Terry Sullivan

Guest Speaker: Bob Seiffert, former State Medicaid Director, Nebraska

Pre-conference Guest Speaker: Pat Snyder

Pat Snyder ran nursing homes for many years prior to becoming Executive Director at the Nebraska Health Care Association (NHCA), giving her credibility with her constituency.

Nebraska developed its program in the 1990's. They realized that most of their Medicaid funding went to nursing homes. They were over bedded, and had a good handle on nursing home residents with low acuity. The state wanted to get in line with the rest of the nation. The NHCA and State Medicaid Department worked in partnership on the issue. Their goals were to:

- Create alternative living arrangements
- Reduce the number of nursing home beds
- Offer more services in less costly settings

Nebraska is primarily rural and alternative services are not financially feasible. They decided to provide incentives for nursing homes to convert to:

- Medicaid assisted living
- Respite care
- Adult Day Services

They converted 967 nursing home beds to 967 assisted living beds. Over 5 years decreased nursing home utilization by 2000 people.

Pat said nursing homes haven't figured out that they are in the business of giving care and services -- not necessarily in a facility, but they need a business model that is feasible. Rural areas can't sustain homecare programs. The end result is to build a system of services with a fiscally sound model.

(continued on next page.)

They developed criteria for assisted living, which nursing homes must meet in order to receive a grant:

- Safety — not accept people who have conditions that might result in repeat hospitalizations (falling, medication mismanagement, etc.)
- Must provide private room or apartment

Nursing homes had to change their philosophy from two-bed to single-bed occupancy option. Their incentive for taking \$30 less per day as assisted living was the declining market. Beds couldn't be sold for what the nursing homes had valued them. Value of property as assisted living was greater than if it remained a nursing home.

A demographic study of the state was conducted. It found that 17 counties had out-migration of elderly people. They talked to parents of disabled children who were willing to use nursing homes in their area for health care rather than go to a hospital far away (aunt lives in the N. H., uncle works there). Parents were also willing to send their children to local nursing homes to live.

However, it is hard to get people to change their business model: OT, PT, Rehab. One reason is that the Medicaid payment rate is so low that they needed to build a private market to compensate.

Results:

One total facility conversion (from 2 nursing homes)

Nursing homes converted wings

Isolated from the nursing home

Different entrance and staff

Nebraska pays nursing homes at the assisted living levels for people with low acuity. This is a financial burden on the nursing homes, and the assisted living rates aren't keeping up with costs.

Guest Speaker: Bob Seiffert

Nebraska looked at various states prior to creating their model:

- Virginia — used the MDS to compare service costs in nursing homes vs. HCBS
- Oregon and Washington — primary model is small group homes, locally owned. (The 12-member task force rejected this model, too many facilities to insure quality.)
- Team of state employees spent time in Washington and Oregon to examine their model.
- Used New Hampshire model (legislation?)

Nebraska developed a 15-20 year plan for out-of-home care.

In 1990's, private sector was demonstrating that assisted living was a successful model.

The state noted that most nursing facilities in small towns were brick with pitched roofs, built at the edge of town, could expand and still look nice.

They had to determine the numbers, so they collected demographic data:

- Mapped out all of the nursing homes in the state
- MDS data
- Demographic changes

Data they collected:

- They had a formalized reporting system to track the number of beds
- County by county tracking of people 75+
- Percentage of people using nursing homes
 - If high percentage, assumed there were not enough hcbs services
 - Less utilization of nursing homes in Lincoln and Omaha, probably due to more hcbs available

Intergovernmental Transfer Funds, available to states in the mid '90's, gave Nebraska total control over the program, and how the money was to be spent. They decided to give small grants to the nursing homes for architectural studies and larger grants for the project. It was an out-right award, with a ten-year contractual agreement. The rate per resident for ten years is 95% of nursing home rate.

40% of the apartments must be held for Medicaid eligible residents. This is hard to enforce, but you don't want nursing homes to hold beds for private pay people.

How is it doing now? They find that areas where there were small conversions, the projects are struggling. People are moving to larger towns where there is better access to medical care.

Questions have been raised in Nebraska about whether it is government's role to do this? Bob felt that this is an open question, but that government had an incentive/obligation to reduce nursing home beds and create alternative housing.

Nebraska now has a baseline Assisted Living program. They are asking if AL can accommodate higher levels of care. Do they want to have small group homes that can accommodate higher levels of need?

They used a two-step process:

- 1) Team of state and others reviewed the proposal
- 2) Made recommendations to the Advisory Committee

They had limited success with providing respite and Adult Day Services. Unfortunately ADS is not getting used.

Q: Would your program have been successful if there were no IGFT? (by Terry Sullivan)

A: It wouldn't have happened. The stars were aligned. You need some carrot and some leverage; control over the process in service development. You don't want failures and need to keep the costs down.

Bob is very enthused about the AL model. Due to lack of availability, people have bypassed subsidized housing and gone into AL.

They have built NO new nursing home beds in ten years. They find there is no demand in the market place. It is hard to know if any will be needed in the future.

Average Nursing home rate = \$100-120/day

Average AL rate= \$2,300/month

This results in a savings to Medicaid. The savings goes to GRF. The AL operates under a standard 1915 HCBS waiver

Q: What MDS data did you use? Which fields were targeted? (by Enrique Unanaue)

A: In Nebraska there is a definition for each code.

Implications for work group:

- We need a report on Enhanced Transition, Money Follows the Person, Choices for Care. Invite Wayne Smallwood.
- Nebraska put a lot of thought into what might be a sustainable conversion. They collected a lot of data to help them make decisions.
- What do people in nursing homes need now and how can we get this information?

Next steps:

- 1) Agree on the goals of this workgroup in the OAS process
- 2) Paul Bennett to report on his findings
- 3) Shelly Ebbert report on the Enhanced Transition findings
- 4) Wayne Smallwood report on SLF

Next Meeting:

September 25, 2007, 10:30 a.m. - 2:30 p.m. at the Illinois Health Care Association.