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: June 24, 2008, 1029 S. Fourth Street, Springfield

Attending: Bill Bell (HFS), Janice Cichowlas (IDoA), Bill Dart (HFS), Petie Hunter (AARP), Bonnie Lockhart (Illinois Foundation for Quality Health Care), Phyllis Mitzen (HMPRG, co-chair), Nancy Nelson (AARP), Sally Petrone (IDoA), Dan Rappoport (IDoA), Renee Razo (CIAA), Lester Robertson (Sunny Acres Home/IHCA), Maria Schmidt (Alzheimer's Association), and Kevin Taylor (Illinois Council on Long-term Care). By phone: Tim Thomas (SEIU), Myrtle Klauer (Co-Chair), and Steve Wolf.

Presenters: Debbie Belt (Health Care Council of Illinois) and Bonnie Lockhart (Illinois Foundation for Quality Health Care)

Motion to approve minutes: Maria, second by Sally Petrone

OASAC is determining the benchmarks against which it can measure it's progress. One of the issues has to do with quality. At our June 3 meeting the NH workgroup requested presentations on two QI programs now available to Illinois nursing homes.

"Road to Excellence" by Debbie Belt (www.roadtoexcellence.org)
This program is a collaboration between three nursing home associations; Illinois HealthCare Association; Illinois Council on Long Term Care, and Life Services Network.

Road to Excellence was rolled out in November, 2006. They looked at the QA tools to assure that it is effective and up to date and will improve on the current QA program. It is based on the national QI program but is specific to Illinois, targeting three issues considered to be of most interest to Illinois consumers:

- Wound management
- Pain management
- Customer/client satisfaction

Road to Excellence is optional. If a nursing home belongs to one of the three associations, there is no fee to participate. If they do not belong to an association, there is a fee to cover the cost of administering the program. To date there are 350-400 facilities participating out of a potential pool of the 850 nursing homes in Illinois. Some non-affiliated nursing homes have chosen to pay a fee and participate.

The public can access the site to see newsletters, press releases and background information about the survey, and a list of the participating facilities. Members enter their findings via the website. The program encourages that customer satisfaction surveys, family satisfaction surveys and employee satisfaction surveys be completed yearly. The goal is to have happy residents/employees who share success stories. CMS developed the protocols. The "Star" curriculum is used to help facilities set their goals. Only facilities have access to the "Star" data.

Each facility sets their own goal (wound, high-risk resident goals). The goal overall is that the numbers will improve. In Illinois, second quarter 2007, there were 16% high risk residents with pressure ulcers (4 points above national average). Pain management was at 5-6% in Illinois (4% nationally--number of residents identified as experiencing pain divided by total number of residents.) It's about 16-18 months since protocols were put in place for pain management.

The baseline on pain management has some glitches. Initially some patients do not report pain, e.g. chronic arthritis pain. They are working to standardize the reporting about pain. It is expected that at first the reporting of pain will go up with education, but it should standardize down the road. The issue of chemical restraints vs. management of pain is a sensitive subject.

Bonnie Lockhart explained that the Ninth Scope of work at CMS begins in the fall, and it will zero in on pressure ulcers and physical restraints and will target specific homes.

The hope is that this initiative will lower the Illinois average for pressure sores and pain.

"Illinois Foundation for Quality Health Care" by Bonnie Lockhart

(www.ifqhc.org)
OBRA 1987, initiated nursing home reform in the US. The culture change movement started 10-15 years ago. In 2002, the Nursing Home Quality Initiative began which included nursing homes and home health agencies. They identified 2 quality measures (see Nursing Home Compare website: www.medicare.org), in 2004 they added 10 more measures. In 2005 they focused on setting targets to decrease pressure points, restraints, pain, and depression. In 2006, CMS initiated Advancing Excellence in America's Nursing Homes, a two year quality campaign which has now been extended indefinitely. Based on NHQI and "Quality First", there are 8 targeted goals:

1. Reducing high risk pressure ulcers
2. Reducing the use of daily restraints
3. Improving pain management for longer term nursing home residents
4. Improving pain management for short stay, post-acute nursing home residents
5. Establishing targets for improving quality via the STAR (Setting Targets—Achieving Results)
6. Assessing resident and family satisfaction with quality of care
7. Increasing staff retention, and
8. Improving consistent assignment of nursing home staff, so that residents regularly receive care from the same caregivers.

Sixteen percent (16%) of nursing homes in Illinois have signed up. This national campaign has a web page for consumers/families, including the general public. The "Road to Excellence" is a state campaign. To be a part of "Road to Excellence", you have to be a part of "Star". "Advancing Excellence" is a national program. Bonnie indicated that Nursing Homes, Nursing home staff and consumers are encouraged to sign up and participate in the program.
(www.nhqualitycampaign.org/star_index.aspx?controls=consumer)

Discussion:

It was noted that in the staff satisfaction survey, money was third on the list next to self-respect and dignity, and to have a voice in what is going on.

Where is the best place for Illinois consumers to look for information on nursing homes? Perhaps it is "Nursing Home Compare."

Chicago Public Radio is currently trying to rank the Nursing Homes in Illinois to create a list from top to bottom.

Sally reported that the Ombudsman bill passed and is awaiting the Governor's signature. It would be effective July 1, 2009.

Bed Reduction, Bill Bell (IDPH)

Bill distributed a chart of Long Term Care Facility Initial Licensure, 2000 – listing the names of facilities opened and the names of the facilities that were closed for each year from 2000 on. The handout is not finished due to the flood problems in Illinois.
Lester commented that the closures are primarily due to financial problems (such as slow/low payment).

The work group identified that we need data on:

- how many types of beds opened and closed each year.
- How many of the closed beds were part of a hospital?

The NH is required by statute to give notice of a closure to IDPH within 90 days—some close sooner, but they must notify IDPH within 90 days. Some closures occurred by IDPH directive. Occasionally there is an emergency closure where the provider simply walks away and IDPH has a procedure for dealing with this situation.

Maria said there is a one page document, the Health Facility Planning Boards Annual LTC Report, which might be helpful to this group. It is a self-reported survey so the info may not be accurate, according to Bill Bell. Bill Bell had a copy which he shared with Jan.

We know the number of licensed beds but we don't know the number of people in those beds. The occupancy rate is 78.2% statewide.

Do we want to do any work with the Health Facilities Planning Board's Task Force that is reviewing the work of the Planning Board? (Dave Carvallo would know the details.) Bill said there is some language we could offer to the Planning Board. Bill's subcommittee is still working on this. The Planning Board will be looking at long term care on July 14th. Bill's subcommittee will try to send something by email for consideration.

Bed Conversion, Kevin Taylor

The best way to get beds off the books is for nursing homes to be provided incentives to convert to a single bedroom, with a bed buyout program similar to the program in MN. Without a bed buyback program that is properly funded, it will be difficult to have a conversion process. This should be done with new money, not money that robs "Peter to pay Paul." It would mean that the Certificate of Need would be gone forever

Is there commitment in the Governor's office to do this? If the goal was to
buy out 1000 beds, you could compute over time the years it would take to have savings. The public health annual questionnaire asks about "set up" beds, which is a bed that is already set up, not just the room to set up a bed??? This is all self-reported.
Other states have not differentiated whether a bed is set up or not. There are licensed beds, empty beds, non-set up beds (no revenue for non-set up beds). Bankers said no problem with a good business plan but some loans are guaranteed by the NUMBER of beds. There is a difference of opinion on how bankers will look at the collateral of beds.

There are some loan documents that say that the borrower cannot borrow if there is a change in the number of beds until there is a reanalysis. Kevin stated that this is truly unexplored territory and if there is not a sufficiently funded revenue stream, this won't work.

The benchmark for nursing home value has always been on a per bed value (i.e., x $'s for 100 beds).

There are psychological and financial thresholds to get through. What type of a timeframe are we looking for? If the time frame is short, there is a higher dollar value. There are more closures than openings in Illinois. Occupancy has gone down slowly but it is stabilizing at around 80%. There is a threshold where it is no longer viable to establish a program, i.e. closures according to this theory will occur due to attrition

The homes that are profitable will remain profitable. The closures are homes that have had census problems all along. Lines of credit may only be 90 day loans, or possibly 120 days, as they understand the slow payment for Medicaid. The key for the bankers is a stabilized payment schedule, no matter how many days it is but it must be consistent.
It is difficult to project out the numbers for 5 years, 10 years, 20 years.

Another issue is how we get at the number of people who are 65+ with a primary diagnosis of mental illness. These people usually have possibly lower physical needs. Bill responded that there is a box checked on the MDS as to whether they have a "serious mental illness" but IDPH does not track this data currently.

MDS is done by quarterly reviews. In 2006, full MDS started to be done quarterly instead only being done annually.

CASPER data is not public. It is aggregated by facility and not aggregated by State.
Once a client is in the SLF, they don't continue doing the DON.

Where are we over/under bedded in the State? We should look at the data available from the NH Facilities Planning Board. Check their website. It shows, under the current criteria, which areas are over/under bedded.

Presentation, Maria Schmidt

Maria distributed the report: *NH Conversion Work Group Developing and Partnering with Community Services Subcommittee* (dated 6/24/08, 8:00 a.m.)

Subcommittee reviewed draft grant program rules. Rules/Statutory changes have addressed barriers to converting nursing home beds, but regulations were never drafted. Barriers to conversion must be addressed. For example: P. 3, State Statutory and Regulatory Impediments such as visiting hours, traffic through resident rooms, etc. "Life Safety Codes"

Regarding respite: Even for a respite stay, the feds require a full MDS. ADS does not require this and thus it has been a barrier for ADS being established in a NH. An overnight stay changes the status from ADS to nursing home, and an MDS assessment is required. So, respite can only be 23 hours. A separate entrance can possibly have some impact on the designations. But, then you have infectious control issues, etc. If a facility is only 65 -70% occupied, it helps to have another wing for other activities.

We discussed which barriers apply to each of the medical services listed? You could easily do "Telephone Consultation" but a congregate meal would have to be in a separate place due to infectious disease standards. Maria will send this to the full group for comment.

If the LTC facility is going to be part of the aging network and meet the identified needs of their community, the nursing home should be willing to convert to provide different types of services. The workgroup raised more questions:

- Under CCP, is there a prohibition to payment to a LTC facility?
- What are the incentives (vs barriers)?
- There are also issues of liability (license is on the line with liability issues).

No one is aware of national examples of nursing homes offering certain community services in the NH setting. Most take a hit on respite due to admin/paperwork costs.

NHs are providing respite in some parts of Illinois. Renee/Sally will report back about this next meeting.

Next Meeting

July 29, 2008, 10:30 a.m. to 2:00 p.m.