



Long Term Care Coordinating Council

Regular Meeting

April 11, 8, 2012

10:00 am

RIDOT Training Center Conference Room

(RIDOT Maintenance Headquarters)

360 Lincoln Avenue

Warwick, RI 02888

Minutes

Owen Heleen	Cynthia Conant-Arp
Bonnie Larsen	Katie Ryan
Bonnie Sekeres	Maureen Maigret
Maria Barros	Catherine Taylor
Liz Boucher	Gwen Reeve
Joan Kwiatkowski	Craig Stenning
Jim Nyberg	Deanna Casey
Michelle Szylin	Holly Garvey
Jenn Bergeron	Cathy Cranston
Jen Reid	Donna McGowan
Kathleen Heren	Virginia Burke
Ray Rusin	Emmanuel Falck
Maria Laferriere	Roberta Merkle

1. Call to Order

- a. The Chair called the meeting to order at 10:05 am.

2. Approval of minutes

- a. The minutes from last month's meeting were approved unanimously.

3. Announcement

- a. The Chair mentioned the recent passing of June Gibb's and shared the information for her services.

4. Report of Nursing Home Deficiencies Monitoring, Ray Rusin, Department of Health

- a. There were ten full surveys and five follow-ups. Two were standard; one was a complaint. Two were widespread potential for harm and triggered consequences under the federal definition for substandard care.
- b. Pawtuxet, Heberts, and Parkview being monitored. Parkview received a monitoring visit and Heberts received a full survey and did not have actual harm.
- c. Pawtuxet has been a special case and has been monitored. They found significant clinical care issues throughout and some actual harm. The Director issued an ordered stating it was their intent to close the facility. CMS had reached the end of their process and decertified them effective April 13th.
- d. Since then, DOH and The Alliance have been monitoring daily and there have been two investigations following up on complaints. Sun Healthcare, which owns Pawtuxet, decided to bring in Genesis (7 facilities in the state). They started on March 26th and made the recommendation that the home couldn't be turned around in time for deadlines. They decided to voluntarily close and seek alternative ownership. The Director entered a consent agreement with them. They will submit a closure plan. DOH, DHS and the Long-term Care Ombudsman, the facility – they will all be involved with the closure scheduling process.
- e. Kathy Heren – the families were told it would be permanent yesterday. There are 78 residents there currently. They are worried they'll lose their Medicare and Medicaid since the facility will be closing. There's also concern that their options will be greatly limited given their Medicaid status. May be able to start placements as soon as this weekend.
- f. Ray Rusin – they are visiting daily and swapping off on compliance visits with the Alliance. The facility has been quieter and more adept at identifying their own problems and getting back into compliance.
- g. Kathy Heren – Medication was 27% error rate, lab work not being followed up on, finger sticks issues.
- h. Ray Rusin – The Hillside experience prompted changes in statute and we've been more aggressive in holding facilities feet to the fire when there's a problem.
- i. The Chair asked about the comment about whether families didn't have awareness of the kinds of problems...
- j. Ray Rusin – there were no less than 6 letters ordered to go to families. There is a fairly rapid rate of turnover. We've been notifying families any time there is immediate jeopardy. On federal Nursing Home Compare there are public reports. The facilities also have to post them and make them available to the public.
- k. Kathy Heren – they aren't as accessible as they should be.
- l. Ray Rusin – Family awareness was a problem. The survey report wasn't taken when it was brought to the meeting. It is clinically based.

- m. The Chair added that there are terms of art that make it hard to understand – i.e., what we need to worry about and what we might not have to worry about.
- n. Ray – one of the purposes is to give them people to call.
- o. Kathy Heren – Sun Bridge Healthcare kept saying they would get better. Genesis made an honest attempt to fix it, but it didn't work out. Some have been placed, some have gone to the hospital and of those, some chose not to return.
- p. Virginia Burke – if they lost Medicare certification, can a new owner still operate it as a nursing home?
- q. Ray – once it is rescinded it comes back to the Department. Sunhealth has made a formal appeal as to the decertification. The Director understands the demographics and that there will be a continued need for nursing home facilities into the future. This is a community based facility and loved ones want to have a local option for their family members.
- r. Joan Kwiatkowski – Could these beds get put into the culture change pool? Or, perhaps a new nursing home might have to represent the new model of culture change?
- s. Ray - Only if those beds went into that pool. Owners can put a limited number or all beds on hold before closing.
- t. The Chair asked if it was in fact closing and if so, what the status of the beds would be.
- u. Ray Rusin – They're voluntarily closing the facility, and technically the beds disappear unless they make an appeal. Last time it was an order telling us (DOH) not to take the beds back.
- v. The Chair asked whether the license had been revoked or not.
- w. Ray – the licensure status is pending. So long as there are residents there the license is pending.
- x. The Chair – is there a required date by when they have to be moved out?
- y. Ray – On April 13, 2012, Medicare stops paying. Medicaid has to protect people until they've been placed.
- z. Kathy – It's 45 days
- aa. Ray – that's the target date. We've never taken that long.
- bb. That Chair – please help us with this process. Say on May 22nd, the last patient leaves.
- cc. Ray – I will ask for that license.
- dd. The Chair – they've indicated they'll voluntarily hand it over?
- ee. Ray – No. They've indicated they'll voluntarily close.
- ff. Jim Nyberg – so they could say no to handing over the license?
- gg. Ray – Yes. It could become legal at that point.
- hh. Jim Nyberg – Every facility is important but we have been talking about rebalancing and stabilizing occupancy and so this may present an opportunity to do that. As Joan mentioned, if it reverts back to DOH, and we need them in the future, there is an option to do that.
- ii. Virginia Burke – there are other facilities in that neighborhood, aren't there?

- jj. Kathy Heren – some people chose it because they could walk there. Sunnyview is usually full, Avalon, which is small, has been rated so well that you cannot get in, others are limited in taking new residents.
- kk. The Chair – With respect to the report - two with widespread and one with pattern of harm; what are the next steps?
- ll. Ray – Reviews and follow-ups, and then they go into the monitoring system which is every 2-3 months where we take closer looks at the problems we saw. Cortland place is in the “lower tier” of performers. Pawtuxet was a special focus facility and so we will have to pick a new special focus facility. We have to choose one. They’ll get surveyed every 6 months instead of every 12 months.
- mm. Kathy Heren – we have volunteers in and out of the problematic facilities.
- nn. The Chair wrapped up the conversation by adding that there is an opportunity here to think about what the purpose of those beds going forward; is this a chance for a culture change, is there an opportunity to blend those two together? This is a chance to have that conversation.

5. Discussion of Ongoing Innovations Across the Long Term Care System and Opportunities Moving Forward

- a. The Chair opened the conversation by explaining that health homes and shared living will be addressed later on, but they are still relevant, we just will not be addressing them today.
 - i. Joan and Liz will begin with PACE. Dual opportunities from the federal government. This is a population where our federal government is looking for innovation and we are looking as well as we focus on quality of care.
- b. Joan Kwiatkowski: CMS’s initiatives are really encouraging long-term care providers to rethink how they behave and who they partner with. Hospital relationships are natural, but it’s not uncommon for hospitals to even own home care agencies. We’re talking about going beyond that model. Pace began 6 years ago – its payment structure is capitated where it meets Medicare and Medicaid dollars, and must take care of all the health care needs of its patients – its all in the care plan and PACE is obligated to pay for that.
- c. PACE can contract with community providers, but PACE remains the payer. Recently, CMS encouraged home and community based providers to think about bundled payment as a way to manage their business.
- d. Three initiatives: Care transitions, which identifies coaches in the hospitals to assist with the discharge planning. They are paraprofessionals. We’ve submitted a plan to do coaching within Lifespan hospitals. This is targeting patients who are more likely to be readmitted. This is somewhat familiar given Healthcentric’s work on this.
- e. Then there is bundled payment – a few groups in RI are submitting an application here.

- f. Finally, the readmission to hospitals initiative – helping nursing homes create internal systems to avoid readmissions.
- g. The whole piece here is the idea that as a business, you need to think differently about who you partner with and how much control you can have where.
- h. Liz Boucher: Bundled payment initiative through the Innovations grants – this is an intensive program, and they’ve received a lot of applications, particularly as folks aren’t ready for ACO’s but are open to working on bundled payments.
- i. Carelink is pursuing a post-acute model that will involve some partnership with hospitals because there’s a need to link with MS-DRG. This helps us develop an effective post-acute plan of care. The nursing homes have to work with hospitals --but specialists and primary care too. Choose one diagnosis and specify how many days that care will last. A target price gets selected and if care cost comes in under that, all partners share in that savings. CMS would be reimbursed by us for care that goes over that amount. We understand this is where the system is going and will help us understand what works in terms of collaboration in care.
- j. The Chair asked how quality will be measured?
- k. We demonstrate quality measure and CMS has their own metrics too. If we say the period is 90 days long, CMS will monitor for an additional 30 days. Any additional costs that might come up may be wrapped into that bundle.
- l. Maureen Maigret – have you selected one DRG? Also, how do you decide the point in time the patient is “in the bundle”
- m. Liz Boucher – CHF. When the patient enters one of our partners, its 30 days post-acute care. It’s still tied to a hospital stay.
- n. Maureen Maigret – is CareLink going to do anything on transitions?
- o. Kathy Heren – how does the patient come into the bundle?
- p. Joan Kwiatkowski– if you have CHF and get services through the network. A PACE patient or someone who goes into a nursing home or home care agency within our network agencies, then within 30 days of a hospitalization because of CHF, then 30 days post-acute care, we start their bundled payment model of care. If they’re in one of our organizations they can opt-in to this bundled payment. If they then want to go somewhere that’s not within the facilities participating, then they wouldn’t...
- q. Payments start being shared across instead of by a per diem arrangement. This is an exercise in understanding what would happen if CMS changed their system into bundled payment.
- r. The Chair – when you say there are 4 categories, and you’re applying for the post-acute one, I’m assuming all of the bundled payment models will span the system: home care, long-term care, primary care. Will you participate in other bundled payment applications? Is it just a Medicare demonstration?
- s. Joan Kwiatkowski – It’s considered an Innovation and its just Medicare.

- t. Maureen Maigret – if they're duals then they're "in"?
 - u. Joan Kwiatkowski – Yes. This is bundled services for care, not custodial.
 - v. The Chair – this raises the opportunity of the duals and their care. That is somewhere we have not yet ventured except through the PACE program, but there are opportunities there and we have to decide at the state level which ones we want to take on.
6. Owen Heleen: Powerpoint presentation available upon request.
- a. Maureen Maigret – OneRecovery would require people to have a computer? Are you going to be helping with that? Training?
 - b. Owen – Yes, although not providing the computers. We're also looking into mobile phones and applications to help that. An application, for example, that might tell you where the nearest AA meeting is to your location? These can help reduce some of the stigma.
 - c. Maureen Maigret – are you doing anything specific with the assisted living residences?
 - d. Owen Heleen – nothing specific, but certainly there's an opportunity there.
 - e. Catherine Taylor – I really appreciate the Providence Center's emerging focus on elders. Inmates, people with HIV, people with developmental disabilities that we've not historically thought about in terms of growing older are emerging populations, and its great that you've begun working on that. Also, when we start our work on a state plan for Alzheimer's, we know that the diagnosis of Alzheimer's can be a risk factor for suicide.
 - f. Kathy Heren – how do you protect the confidentiality of OneRecovery?
 - g. Owen Heleen – you can go in under a user name – you can be as confidential as you want.
 - h. Kathy Heren – When someone comes into the emergency room and lies about a drug or alcohol addiction condition, but its clear they're going through withdrawal?
 - i. Owen Heleen – we're in early stages of a partnership trying to blend expertise. It is a merging of two cultures issues, but we have good early experiences, it's just that the entrée part takes a long time.
 - j. Kathy Heren – are you targeting homes you'd like to work with or going through the agencies?
 - k. Owen – We have had some early conversations, but none that I can yet identify.
 - l. Kathy Heren – I want to make sure that anything that goes into the nursing home is working with what is already there.
 - m. Owen – As do we, and we want to figure out what we've learned and can learn before going forward.
 - n. Kathy Heren – we either have no psychiatric care or too much.
 - o. Owen – I think we are on the same page and want to serve the patient.
 - p. Maria Barros asked about minorities and language barriers – many patients are identified or diagnosed with depression or risk of suicide and some have seen a doctor but go untreated. Last year, we had 10 suicides in the Cape Verdian community and nothing has been done about it yet. In

June, we're trying to present information about dementia and Alzheimer's and depression. The issue is accessing care. If they call The Providence Center – are there options for people?

- q. Owen Heleen – We have some multi-cultural capacity, but its not near enough. We're working hard on this and are seeking foundation help on this. Because this is a fundamentally orally-driven care service, then language is critical.
 - r. Maria Barros – The tool that you reference; the Columbia Suicide Risk tool is that geared toward adults?
 - s. Owen – I believe its been tested off the community.
 - t. Bonnie Sekeres – For seniors living in the community, what kind of referral do you need to have and what is your reimbursement through Medicare or does it have to be private?
 - u. Owen – We serve everybody irregardless of their ability to pay. Most services don't require referral.
 - v. Craig Stenning – Medicare doesn't provide a lot of the mental health services.
 - w. Owen – The co-pays are an issue.
 - x. Craig Stenning – Community health centers are required within 40 days to provide an appointment. Because of the global waiver and CNOMS, those who don't meet the definition of chronic and persistent mental health issue may not qualify under the program for reimbursement.
7. Money Follows the Person, Transitions & Diversion: Presentation was given by Michelle Szylin and Jenn Bergeron from EOHHS and is available.
- a. From April to December: awarded in July and were approved to provide services. Saw the first transition in November. We had 6 in 2011.
 - b. In this year, we have 14 active enrollees and 2 MFP staff.
 - c. We're working on building up the systems and supports currently to make sure this is a successful process.
 - d. We have a supplemental grant with ADRC system to fund additional staffing and focus on long-term care services counseling in community and facility settings. We will also have discharge planners.
 - e. We have a steering committee focusing on areas of concern: housing, rebalancing and reinvesting, marketing and outreach (focused on enrollment), accessing behavioral health solution, recruitment and involvement.
 - f. Working on staffing up, working on DEA sister agency relationships – with BHDDH too. We're also working on how to report critical incidences.
 - g. MFP is also part of nursing home transitions.
 - h. We have 358 referrals and 109 have been transitioned. 48 are MFP and 95 are NHTP (don't qualify for MFP).
 - i. Most went home: 13 went home with home and community based services. One person went to assisted living.

- j. NHTP: 70 have returned home and 3 returned home and are case managed by DEA. 3 went home on personal choice, 2 shared living, 1 to PACE and 6 have passed away.
 - k. Diversion: Through ConnectCare Choice. 57 ER diversions, 11 hospital, and 5 nursing home diversions.
 - l. NHTP – on the 95, what was the most frequent reason they couldn't do the MFP?
 - m. Answer: a lot is the nursing home stay – they haven't stayed long enough.
 - n. Chair: this is the issue with housing. We'll keep you longer so you lose your home and then spend more to recreate your home.
 - o. Maureen Maigret – it used to be longer.
 - p. 50 are waiting – of the 83 that have gone home, can we track what kind of services are they receiving?
 - q. They've gone home on the global waiver with typical services, but mostly CAN.
 - r. Joan Kwiatkowski – The Adult Supportive Housing regulations?
 - s. Ray – there is a draft set of regulations.
 - t. Maureen Maigret – Michelle, the restrictions under MFP relate to assisted living.
8. Legislative Update - Lindsay McAllister
- a. Given the short amount of time remaining, Lindsay provided a brief run-down of the legislation slated for action in the coming weeks. She mentioned that the Complete Streets bill had passed in the Senate and was held in Municipal Government committee on the House side last week. She also mentioned that the MOLST bill was having a hearing in the Senate that day, as was the nursing home reimbursement package. The home Care rights and findings bill was also up for a hearing that day.
 - b. It was mentioned that the Medicaid buy-in legislation would be up for a hearing at the end of the month in House finance.
 - c. Maureen Maigret – the SSI bill will be coming up as well – the 25th.
9. No Public Comment was offered.
10. The meeting was adjourned at 11:32 am.