NURSING HOME BOARD OF DIRECTORS AGENDA

County of Champaign, Urbana, Illinois
Monday, July 29, 2013 – 6:00pm

In Service Classroom, Champaign County Nursing Home
500 S. Art Bartell Road, Urbana

CHAIR: **Catherine Emanuel**
DIRECTORS: **Peter Czajkowski, Lashunda Hambrick, Josh Hartke, Mary Hodson, Gary Maxwell, Robert Palinkas**

ITEM

I. CALL TO ORDER

II. ROLL CALL

III. APPROVAL OF AGENDA

IV. PUBLIC PARTICIPATION

V. NEW BUSINESS – STRATEGIC PLANNING SESSION
Review Market/Environmental Changes

Strategic Objectives (Areas of Focus)
1. Medical Management
2. Nursing Management
3. Outcomes Measure
4. Financial Performance

X. ADJOURNMENT

To: Board of Directors
Champaign County Nursing Home

From: Scott T Gima
Manager

Date: July 24, 2013

Re: Strategic Planning Session

Over the past few months, there have been a few strategic planning related background documents have been distributed and discussed. The following is a summary of those documents and I have also attached copies with this memorandum.

1. 2011 Strategic Objectives Updated May 2013 – Discussed at June BOD Meeting
2. Quality Metrics – Discussed at June BOD Meeting
3. Environmental and Market Changes – Discussed May 2013 BOD Meeting

At the June meeting, I categorized the strategic objectives into four main areas of focus:

1. Medical management
2. Nursing management
3. Outcomes measures
4. Financial performance

The Strategy Planning Session should focus on identifying the individual strategies within each of these four areas. Some of these strategies were included in the 2011 Strategic Objectives and others have been reviewed in the documents listed above. I plan on providing a short review which will lead into the discussion of the individual strategies.

CCNH Continuing Strategic Objectives
Fiscal 2011 Update – August 2011
Updated – May 2013

Quality of medical services

a. Integrate Medical Director into daily operations at CCNH; move as many residents as possible to direct supervision by Medical Director (consolidate medical direction.

The goal is to get Dr. Thakkar to care for as many residents as possible. With consolidated medical direction, CCNH is in a better position to not only manage the care process, but also to advance it, particularly in terms of reducing unnecessary hospitalizations and of doing a better job of managing chronic conditions within the nursing home.

There is no cost to this initiative beyond the existing contractual obligation to Dr. Thakkar ($1,800 per month).

Status July 2011: We need to re-direct our efforts. Dr Thakkar is still functioning as Medical Director. His interests in gerontology appear to have waned as he has elected to head in a new specialty direction. We are not making sufficient progress increasing the number of patients under his care nor is it likely that we will. The current number of residents that he sees is 28.

Status May 2013. On November 1, 2011, Dr. Thakker was replaced with Dr. Fola Oluwehinmi, who went by Dr. Fola. Unfortunately Dr. Fola will be moving to Maryland in June. Dr. Fola had been an advocate of improving medical management and has been supportive of CCNH's internal efforts to improve care and reduce readmissions. With the support of Dr. Fola, discussions between CCNH and Carle Clinic have resulted in the appointment of Dr. Suma Peter as the new Medical Director of CCNH. Dr. Peter is board certified in geriatric medicine and has been with Carle Clinic since 1998.

Dr. Peter is the Geriatric Department Chair and is involved with teaching at University of Illinois and is an advocate of evidence based practice and its application in the long term care setting. Dr. Peter prides herself in ensuring the right client to provider mix is provided at Champaign County Nursing Home. Dr. Peter's Geriatric Medicine department provides three physicians and 1.5 Nurse Practitioners to provide resident care at Champaign County. There are plans to add another fulltime Nurse Practitioner in July.

Dr. Peter describes herself as being highly involved with Quality Measures in her role as a Medical Director. Dr. Peter has already assisted Champaign County Nursing Home in securing weekly rounding services of the Carle Wound Care program and specifically Dr. Li who has already started seeing residents on site.

b. Develop a sub-acute service or its equivalent

Advancing our capabilities in rehab will require a physician with rehabilitation skills, i.e., a physiatrist or the equivalent. This physician will serve as rehab director; compensation for administrative services will likely be in the range of $1,500 - $2,000 per month. On the clinical side, the rehab director will attend patients, will see them once weekly while they are receiving rehab care, and provide a higher level of service than what CCNH is currently able to provide. (Patients have the right to be followed in rehab by their own physicians in the event they do not want to be care for by the rehab director.)

The rehab director bills for clinical services, which are distinct from administrative duties. The primary payer is Medicare. Facilities that have employed this approach report better use of therapy and significant improvements in relationships with residents and their families.

Status July 2011: Dr McNeil is on board as Rehab Director. She is overseeing rehab services beginning with the development of a new rehabilitation program quality assurance and improvement initiative. Dr. McNeil is working in concert with Andrew, Karen, and our rehab coordinator Nicole to develop a set of quality indicators that will give us an ongoing sense of the effectiveness of our therapy department. Data beginning July 1st will be collected and reviewed at least monthly. Quality indicators include measuring the timeframe from admission to therapy evaluation to therapy treatment, progress toward patient goals, and the accuracy of discharge planning done at admission. In addition, we are making overtures to improve our relationships with the Christie Clinic and with Provena. This has been slow going initially.

Status May 2013. We have tried to mirror the metric that Health Alliance Medicare Advantage has been utilizing in tracking their client progress through their stays at Champaign County Nursing Home and Health Alliance currently provides quarterly dashboard information and feedback as well as information about our ranking in comparison to our competitors. We are seeking to target objective measures on admission and discharge that can provide a measurement of success or a metric to compare outcomes to establish therapy goals for skilled rehabilitation stay at Champaign County Nursing Home.

Marketing

Develop state-of-the-art dementia program; position CCNH as market leader in dementia (programming, media, community education, client service)

a. Move dementia marketing to the community through education and support groups

CCNH is off to a good start rejuvenating its dementia program. Gail Shivers has taken on a significant increase in responsibility and has been equal to the challenge. One of operational difficulties is that the understanding of the disease progression. In some cases, families are reluctant to see their residents transferred from the dementia program to the general unit. This dilemma presents an immediate opportunity to educate families about the disease and a broader opportunity to do the same thing in the community at-large.

Speaking to civic church groups seems to be a logical starting point to experiment with marketing the CCNH dementia program. Education about what to expect in dealing with dementia, the disease progression, and how the CCNH program responds to the different levels of dementia can prepare the way for better family experiences at CCNH. More to the point, though, this type of education should position CCNH as the first top-of-mind response in the community's dementia options.

There is no additional cost to do this. We do need to develop presentation materials and identify support resources for Gail.

Status July 2011: No progress on the specific objective. Gail has been involved in training staff and in dealing with turnover on the dementia unit. She has made good progress in building a team that is much improved in that they are dedicated to dementia care. CCNH's dementia program was in need of a sea change. Gail also has been qualified as an MDS Coordinator, a process which took several months. She participates in the Alzheimer's Support Group. We have scheduled September as the month for Gail to start her public speaking.

Status May 2013. Champaign County Nursing Home continues to hold a monthly community support group at Brookens Building. Website items have been reviewed and plans have been made to update pictures and add pertinent information about program. We extended invitations to Champaign County Auxiliary members for presentations in the community. Administration and Marketing have been participating in collaborative with community based service providers such as Health Alliance and Community Foundation of East Central Illinois and are taking part in opportunities to be visible in the community and discuss the services provided at Champaign County Nursing Home.

Human resources

Advance the skill level of CCNH supervisors through management development and on-the-job experience; specific emphasis shall be placed on verbal and written communication skills, documentation of events worthy of either discipline or recognition, and consistent, even-handed enforcement of CCNH policies.

The department managers continue to receive training and education on supervision, communication, and documentation. Costs are built in to the CCNH operating budget. Manuals, webinars, and seminars targeted to the needs of the long-term care industry have been successful. Performance improvement plans have also been employed.

Status July 2011: Probationary and annual evaluations are a much better reflection of employee work performance than we had seen prior to this effort. The volume of discipline, unrelated to absenteeism, is significantly lower as managers are developing stronger work teams as a result of improved hiring processes. The employee recognition committee continues to work on creative ways to recognize employees doing a great job. Most recently giving a stack of poker chips to managers to give out when an employee makes a resident smile. Those poker chips can be redeemed for snacks and drinks. There is still significant work to do in this area.

Status May 2013. The number of union grievances has fallen dramatically. The last grievance predates January 2012. This reduction is due to a combination of factors, including communication between management/supervisors and union. There is still more work that can be done to improve the quality of management and supervision. An employee satisfaction survey was conducted early in 2013 and the results are being tabulated. The feedback will be used to develop areas of focus including management/supervisory issues.

We have introduced QM action plans to union and received buy in for our initiatives for improvement and they have shown support for change in our systems and processes to improve quality. The union steward's expectations of the unionized staff have shifted to expecting high levels of performance and output and adherence to policy and procedures established at Champaign County Nursing Home.

Improve IDPH regulatory position

CCNH shall receive no citations under F 323 (Accidents & Supervision).

Status July 2011: So far, so good

Status May 2013. Recent surveys in 2012 and 2013 have been significantly better than in previous years. There have been no F323 tags in 2012 and 2013.

Customer Service

a. **Commit to Quality program continues**

Commit to Quality, with its department-specific measurement system, has been moved into CCNH's daily operating routine. Recent experience indicates that some measures might be more effective if monitored more often. For example, only a small percentage of rooms were inspected under Environmental Services; CCNH might have better customer satisfaction results if a higher number – say 25 percent – of all rooms were inspected. Commit to Quality is off to a good start and will respond to adjustments throughout the year.

Status July 2011: Our Commit to Quality effort grew significantly with the addition of management work teams in the dining process and neighborhood assignments. Additionally, our rehabilitation Quality effort is launched effective July 1st and we will spend the next 2-3 months working with our physician Rehabilitation Director to refine our rehab programs.

Status May 2013. Over the past two plus years, significant work has been focused on addressing Medicare readmissions. All readmissions are reviewed to determine cause and possible interventions that can be used to prevent future similar readmissions. Staff education and inservicing on the INTERACT program to aid nurses and CNAs to identify early signs, symptoms and changes in behavior that may be indicators of a change in condition. This work has been done in conjunction and support of Carle Foundation Hospital and Dr. Fola.

Administration and Marketing have been participating in collaborative with community based service providers such as Health Alliance on readmissions in their Medicare Advantage sector and have been able to provide a standardized service list that was provided to all physician's within the Carle group who might have contact with our resident population.

Dr. Fola and Susan Suttle NP have been involved with skills training and communication to also impact readmission rate. The second phase of Collaborative with Health Alliance will involved skill enhancement as well as a key work group goal. Carle Emergency Department physician Dr. Knight will be involved with direct staff trainings in long term

care settings as well as local EMS educational opportunities also willing to assist in the educational efforts identified by the collaborative work group.

b. **Pinnacle scores at 4.5 or better each month**

There is not much to add to develop this objective. CCNH is not where it should be. Department managers are being evaluated on their ability to provide good customer experiences.

Status 2011: This objective has received major emphasis so far this year. In particular, management is determined to improve the dining experience. The dining room setting has been improved and the management staff is assisting in the meal service. April scores jumped nicely; May's retreated; June was better at 4.2. CCNH remains far too inconsistent in customer service but the line managers are getting the idea and are energized.

Status May 2013. Pinnacle scores have been consistently below 4.5. Dining service and lost personal laundry have been the two most common issues over the past few months. Dining service changes planned to take effect June 17th. Beverage and soup and salads offered as a first course and then tables to be served restaurant style from main kitchen area and served by dietary staff. Laundry is to meet with new admission early in admission to determine who will be doing laundry and if their clothing needs to be marked. The Maintenance Director is working on system to bag new laundry such as a different color on admission to decrease opportunities for lost clothing.

Training/education for clinical coding skills; organize nursing to function without the MDS Coordinator position

Most skilled nursing homes employ MDS Coordinators. These positions are usually filled by RNs with special certification in the Resident Assessment Instrument. Their coding skills represent a specialty that is in high demand but in short supply. CCNH is like most other homes in this regard in that it is holding its breath until the MDS Coordinator turns over.

The MDS Coordinator is not a required position. Clinical skills are required in order to understand the relationships built into the Minimum Data Set (MDS). However, nurses with a good working knowledge of the MDS should be able to do the job provided that CCNH employs the logic checks available with the CareWatch software. Organizing the work flow to concentrate around the Unit Manager rather than the MDS Coordinator becomes the immediate task at hand.

There is no program development cost to this initiative, but it is clearly longer in horizon and dependent upon being able to stay the course in re-organizing nursing documentation activities.

Status July 2011: One Unit Manager recently received her MDS coding certification, the RAC-CT, and we can begin to move forward on this objective. The Unit Managers

participating in the project require specialized training to be able to lead clinical teams through the data collection and coding process. The training is significant and only offered periodically, making the test process slow. Over the coming months we will train and practice completing the MDS without the MDS Coordinator to see if we can decentralize the entire process.

Status May 2013. One MDS coordinator position has been vacant for over two years. A couple of internal nurses have voiced interest in the position, but neither has taken or completed the certification course. Currently we have a prn RN that is completing the certification course and there are plans to begin on the job training for this position. Training is a significant management commitment for someone without prior experience as it is a responsibility that has a direct impact on Medicare and Medicaid reimbursement.

Improve financial position

a. **Cash**
b. **ADC**
c. **Payer mix**
d. **Profitability**

These objectives are circular in that CCNH's financial position depends upon payer mix, volume, and payment. If we have the volume and mix right, we'll be profitable; if we resolve the IGT deal, we'll have the cash.

Status July 2011: The results for the fiscal year-to-date are disappointing. Census for the first quarter was at our target level of 195; for the second quarter (March-April-May) it tanked. Census started re-building in late June and has been in the high 180s – but still below our target level. During this period of low census, expenses have been well controlled. Net income through June is $(73,100) excluding the extraordinary settlement payment.

Payer mix has stabilized at 36 percent Pvt Pay, 53 percent Medicaid, and 11 percent Medicare. This is a good mix, but CCNH cannot deliver the performance we want with low census and with low Medicare.

Because a resolution to the IGA is imminent, CCNH is likely to finish the fiscal year in a profitable position and with much improved cash flow.

Status May 2013. The current census is at 179-180, which has all indications of a cyclical event and not a permanent trend. Census reached an all time high in the winter of 2012. Medicare census has been strong in 2012 and so far in 2013, the average Medicare census is above 2012 average levels.

The payer mix is currently averaging 57 percent Medicaid, 33 percent private pay and 10 percent Medicare.

Cash position has been stable, hovering around $1 million. It is not a large balance, but outstanding payables have been paid down significantly to an average of 60 to 90 days versus up to 12 months at the end of 2011.

The new RUGs IV Medicaid reimbursement methodology that will begin in January of 2014 will result in a needed revenue infusion. MPA is working with LSN and the County Nursing Home Association to assure preservation of the county nursing home IGT program in the MMAI managed care program.

New Initiatives

Institute a regulatory compliance program

That the regulatory environment is becoming more complex is a given. Under the Deficit Reduction Act of 2005, facilities with more than $45 million in Medicaid receipts are required to have compliance plans in place; CCNH does not meet this requirement yet, but it is close. The recent health reform legislation requires compliance plans of all providers; they are to be in place by 2013. It is unlikely that this requirement is removed.

The primary purposes of a compliance plan are to assure the governing body that management is taking prudent steps to:

Secure the privacy of protected health information
Reduce the risk of identity theft
Record clinical documentation accurately and in accord with resident needs
Submit claims for services that are accurate
Train and educate the workforce on fraud & abuse and its detection/prevention
Provide a protected format for employees to report suspected incidents of fraud
Identify areas needing improvement and implement corrective action

Information technology plays a pivotal role in developing compliance skills. Medicare claims involve two separate forms – the MDS and the Uniform Billing Form 04. The UBWatch software provides a ready format for matching up the information in the UB04 and the MDS and screening for inconsistencies. Actually getting usable information from our current IT vendor, MDI, to make UBWatch functional is proving to be difficult. We continue to work towards a resolution.

Medicaid claims are census-based, for now. However, reimbursement is moving towards a needs-based system. Eventually, clinical documentation and billing data will need to match. Right now, CCNH checks for accurate Medicaid census counts, accurate resident claim numbers, and timely submittals of the MDS, without which reimbursement denials can result.

One of the goals of a compliance program is to reduce work processes to the minimum essential steps necessary to accomplish the work and to provide a basis for auditing its effectiveness. Standardizing procedures among several homes – in this case County homes – also provides for stronger reviewability, for better ability to replicate results, and for a common support group.

The cost of implementing a compliance plan can range from $75,000 to $100,000 if a facility elects to implement and supervise the program on its own. MPA is working on a shared format for compliance programs where the cost is reduced considerably to a range of $35-$40k.

Time frame for implementation should be by mid-2011 or as soon as operating abnormalities with the current IT vendor are rectified.

Status July 2011: This program is on track and ready to implement pending resolution of the IGA.

Status May 2013. CCNH's corporate compliance program work began in September of 2012. There are six stages in the implementation. Work continues on stage 3, development of policies and procedures and stage 5, training and education. Full implementation is scheduled for the fourth quarter of 2013.

Develop protocols for providing more advanced nursing care for congestive heart failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD); work with local hospitals to institute the protocols at CCNH.

The current industry environment drives this objective as it focuses on better management of chronic disease at the SNF level. Readmissions to the hospital are being targeted by CMS and bundled reimbursement is on the horizon. Under bundled reimbursement, CMS would reimburse the hospital for all services associated with a Medicare episode of care. If skilled nursing services were part of the Medicare episode, the nursing facility would be paid by the hospital, not by the Medicare program as is currently the case. In the same thought process, if the hospital is at risk for an episode of care, it will seek to have that care provided in the least costly setting – for example, outpatient rather than inpatient, skilled rather than hospital inpatient. Under bundled payment, cost will emerge very quickly as a driving factor.

Low-tech chronic diseases are good candidates for evaluation in a skilled setting. Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD) are two prime diseases where CCNH might be able to make a difference for the hospitals. There are sure to be more.

Program implementation requires, first, an approved protocol. Dr. Thakkar is working with us on that now. A major factor in his review is how CCNH should integrate its services with the hospital. Second, clinical staff may need to be trained in new techniques involving IV medication administration, electrocardiograms, and blood gases. Third, some clinical testing equipment will likely be required to do some basic blood analysis and cardiac testing; any equipment investment is budgeted not to exceed $50k.

Status July 2011: Protocols are finished

Status May 2013. Protocols have been in place since 2011. Getting consistent adherence to the protocols by staff and medical staff is an ongoing issue.

Issues/Problems

Poor collaboration/communication with hospital
Poor identification of changes in condition or signs and symptoms
Poor internal communication between staff and/or between shifts
Poor communication with medical providers
Poor follow-up – interventions or results of interventions

Operational Strategies

Identify resident with a high risk of re-hospitalization – Existing Residents and New Admissions
Potential for complications
Likelihood of change
High risk factors
Acute conditions
Sub-acute conditions

Admission process
Identify co-morbidities
Review hospital care plan
Collaboration with hospital personnel
On-site assessment
- Co-morbidities
- Medication review
- Preparation and needs

Develop A Better Relationship/Partnership with Hospitals
Communication of patient care/condition/medications
Collaboration on strategies

Internal Strategies
Statistics – <30 day readmission rate
Identify root causes of transfer.
Identify common threads in avoidable hospitalizations
- Staffing levels, specific staff members, specific days, shifts, times of the day.
  Skills training needs

Education/tools to identify subtle changes in resident
Communicates less than usual
Need more help with ADLs
Participation in activities is less
Eating less
Agitated or nervous
Confused, drowsy

Change in skin color
Change in output
Changes in breathing patterns

Tools to communicate changes to doctors.
What is the situation
What is the background
What is the assessment or observation of the problems
What is the request or need?

Tools to elicit quality documentation and support critical thinking skills (PIE)
Problem
Subjective
Objective
Intervention
After assessment/observation
Plan/what was done about it
Evaluation/follow-up
What is the outcome?

Clinical Strategies/Daily Clinical Routine
Knowledge of conditions and medication regimen
Communication with staff
Communication with resident
Daily rounds
Discharge planning

Case Management Approach
No One is Managing the Care of Each Resident?

5 separate units with a total of 243 beds
Dedicate a RN to each unit
Coordinates/Facilitiates/Communicates/Educates

Skilled Nursing Facility Metrics

Life Services Network of Illinois
May 1, 2013

Management Performance Associates

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Speaker

Scott Gima, RN, MHA

Vice President
Management Performance Associates
St. Louis, Missouri
stg@healthcareperformance.com
314-434-4227, x21

Points To Cover Today

- Managed Care – Medicare-Medicaid Alignment Initiative (MMAI)
- Quality Metrics

Medicare-Medicaid Alignment Initiative
Health Plan Reimbursement

- Health plans will be paid a capitated rate from CMS and the State for Medicare and Medicaid
- Capitated rate is $$ per member per month
- Rate is based on baseline spending in both Medicare and Medicaid programs and anticipated savings that will result from the integration and improved care management
- Savings percentage

Year 1	1 percent
Year 2	3 percent
Year 3	5 percent

Medicare-Medicaid Alignment Initiative
SNF Reimbursement Rates

- SNFs will be paid current Medicare and Medicaid rates
- Costs = Price x Utilization
- If the providers are paid their current rates, savings can only come from reducing utilization
- New incentives to reduce SNF services and/or costs

Medicare-Medicaid Alignment Initiative
Health Plan Incentive Pool

- Proposed Health Plan Incentive Pool Holdbacks
  - Year 1 1%
  - Year 2 2%
  - Year 3 3%
- Plans will receive a percentage of the holdback based on achieving pay for performance metrics established by the State and CMS
- CMS metrics required for all demonstration programs nationwide
- State specified withhold measures

Medicare-Medicaid Alignment Initiative - Recap
SNF Quality Measures – Years 2 and 3

- 30 day Readmission Rate
- Transitions of members from LTC to waiver services
  - Report the number of members moving from institutional care to waiver services
- Long Term Care residents of prevalence of pressure ulcers – stage II or higher

Medicare Medicaid Alignment Initiative
Network Adequacy

- For the first year of the demonstration (01/01/2014 to 12/31/14) Demonstration (Health) Plans will be required to offer contracts to all nursing facilities and SLFs
- After the first year , Plans may establish quality standards and may contract with only those providers that meet such standards, as long as providers are informed no later than 90 days after the start of the first year of the Demonstration

Metrics Used to Profile Skilled Nursing Facilities

Catholic Health Initiatives

73 hospitals in 19 states

- Length of stay
- 7- and 30- day readmission rates
- Functional independent measure (FIM) scores
- Patient and family satisfaction
- Emergency room visit rates
- Infection rates
- Interviews with primary care physicians, specialists and hospitalists

Kaiser Permanente Northwest

Northwest Oregon/Southwest Washington

- Patient satisfaction
- Readmission rates
- Functional independent measure (FIM) scores
- CMS 3 star rating or higher
- Emergency room transfer rates
- Low Medicare length of stay

The Methodist Hospital – Houston, TX

- Facility acquired pressure ulcers
- Unanticipated weight loss
- Restraint usage
- Dehydration
- Staffing levels
- State investigations
- Tenure of Administrator and Director of Nursing
- Medical Director qualifications
- Patient and family satisfaction

Satisfaction Surveys

- Resident/Family satisfaction surveys
  - "Would you recommend this facility to others?"
- Employee satisfaction surveys
  - "Would employees recommend the facility they work at to others?"

Functional Improvement Measures

- A standardized tool for describing functional status and improvement in functional status
- Used in inpatient rehab
- Scoring at admission and discharge
- Range from 18 (total dependence) to 126 (independent)

Functional Improvement Measures

- 18 measures – 13 motor items and 5 cognitive items
- Motor – eating, grooming, bathing, dressing (upper and lower), bladder management, bowel management, toileting, bed to chair transfer, toilet transfers, shower transfer, locomotion (walk or wheelchair), stairs
- Cognitive – comprehension, expression, problem solving, social interaction, memory

Functional Improvement Measures
Acute Stroke FIM Study - 2003

	Admission Mean (SD)	Discharge Mean (SD)
FIM Total	69.2 (27.4)	83.2 (25.7)
FIM Motor	43.8 (20.7)	55.9 (20.3)
FIM Cognitive	25.9 (10.7)	27.2 (9.5)

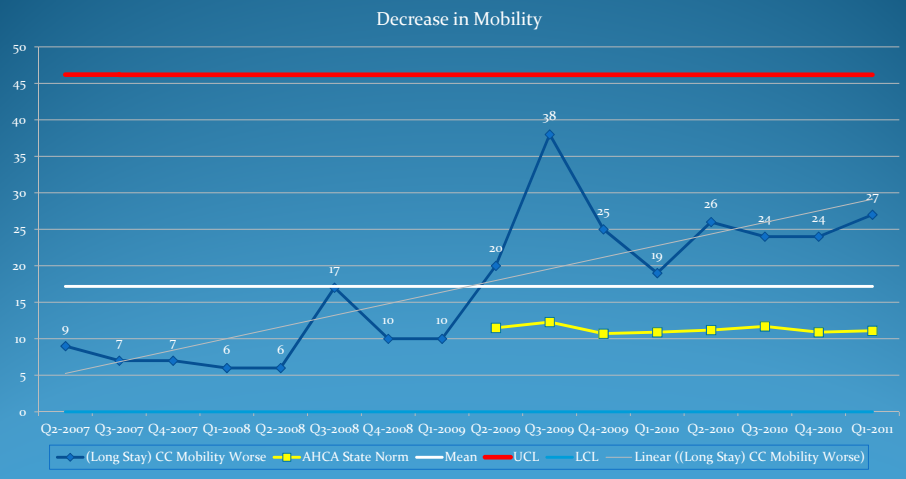
SNF To Do List – Readmission Metrics

- Do you know your readmission rates?
- Track monthly readmission rates
- Track source, timing and causes of readmissions
- Emergency room transfers

SNF To Do List – Quality Metrics

- Improve your 5-star rating
- If rating is low, communicate with health plans
  - Reasons for the low score
  - Action plan to improve
- Patient/family, employee, physician satisfaction surveys
  - Independent survey versus facility survey
- Objectively show improvement in resident functional status from admission to discharge by resident by diagnosis

Quality Measure Profile Example



Final Thought

Prove What You Do

Champaign County Nursing Home
Environmental/Market Changes
Discussed at May BOD Meeting
Summarized in June Management Update

1. Changing Environment
   a. Declining SNF census

   b. Alternatives to SNF placement has been a huge push by the Feds and State
      i. Assisted living
      ii. Supportive living
      iii. Home and community based services

   c. SNF case mix/acuity is increasing.
      i. SNFs losing higher functioning or more independent residents
      ii. SNFs are slowly turning into sub-acute care facilities

   d. Reimbursement rate cuts and/or smaller annual increases
      i. Medicare rate increases of 2 to 3% annually are gone
      ii. No substantial Medicaid rate increases. Illinois did increase Medicaid rate but as a direct result of the new bed tax, resulting in a small net increase in Medicaid revenue.
      iii. Expect little or no increases in rates. Illinois' new Medicaid RUG system will result in a rate increase.

   e. State and Federal Changes/Initiatives
      i. Feds – Affordable Care Act
         (1) A large number of Medicare payment initiatives
            (a) Bundled payments
            (b) Shared savings
      ii. State – Medicare Medicaid Alignment Initiative (MMAI) – dual eligible managed care.
         (1) Health plan will be paid a capitated rate (per member per month) to provide all health care services to the dual eligible recipient.
      iii. Focus of these initiatives
         (1) Eliminate fragmentation of payment system. Physicians, hospitals, SNFs, home health are paid separately
         (2) Improve care coordination. Fragmented payment system promotes a lack of care coordination between providers
         (3) Improve quality of care
         (4) Reduce Medicare and Medicaid spending
      iv. Overall goals are to use financial incentives to promote cost savings and improve the quality of care.

2. Initiatives that Directly Impact CCNH
   a. Medicare Medicaid Alignment Initiative (MMAI)
      i. Medicare (Feds) and Medicaid (Illinois) will contract with managed care health plans to provide health care services to individuals who qualify for Medicare and Medicaid.

ii. Providers including CCNH will contract with the health plans for both Medicare and Medicaid services. Medicare and Medicaid will no longer pay CCNH for services.
iii. Over half of CCNH's residents are dual-eligible.
iv. Illinois wants half of the dual eligibles in a managed care plan by January 2015. They would like to have all duals in a managed care plan by that date if possible.
v. The health plans are responsible for coordinating the care
vi. Health plans have financial incentives to reduce costs and improve quality of care
    (1) Incentives to move residents out of the nursing home
    (2) Incentives to reduce rehospitalization rates.

b. Christie Clinic Accountable Care Organization (ACO)
    i. Provides care to about 6,000 Medicare patients, not dual eligibles.
    ii. The ACO is responsible for coordinating services including, primary care, specialists, pharmacy, hospitals, rehab, behavioral services, home care, SNF, preventative care and wellness programs.
    iii. A shared savings program, where the payment system does not change but savings is expected by preventing unneeded care and emphasizing wellness and preventative care.