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Top Stories

Eligibility Criteria for 24-Hour Customized Living Described at DHS Videoconference

In an Oct. 25 videoconference, staff from the Minnesota Department of Human Services described DHS' policy for eligibility for the 24-hour customized living service package, which will be formally issued in a November departmental bulletin.

Although in previous videoconferences, DHS staff had indicated that conditions such as recent vision loss and inability to self-preserve were likely to be included as eligibility criteria for the 24-hour service package, after additional analysis, DHS staff has decided that these conditions will not be used as eligibility criteria. Instead, in addition to the three statutory eligibility criteria already in place--intermittent assistance with toileting or transferring, cognitive or behavioral issues and a medical condition that requires clinical monitoring--DHS says those EW clients receiving "medication management" and needing at least 50 hours of direct service during a month would qualify to have their services come under the 24-hour customized living rate cap. The time spent in medication management can count toward the 50 hours of direct service.

Interestingly, at both the morning and afternoon videoconferences, DHS staff said that the eligibility changes to the 24-hour package were not made as cost-savings measures. Instead, DHS staff said these changes were made to get better accountability for the use of EW funds as part of their program integrity effort. MHHA notes that DHS did book savings related to these changes to the 24-hour package, based on the assumption that fewer EW clients would qualify for services under the higher rate cap and, as a result, their service costs would be reduced.

DHS staff indicated that DHS does not expect extensive documentation related to the 50 hours of service that a client must need to qualify, but that counties/lead agencies should estimate the time needed to provide the client with all needed and authorized services, including the time spent by staff in medication management. No definition of medication management was included in the DHS handout, but MHHA assumes it will probably include any or all of the following: medication set-ups, medication reminders, assistance with self-administration of medications, medication administration and central storage of medications. The November bulletin is expected to provide additional detail on this new eligibility criterion.

For those clients whose services must fall within the lower, customized living rate cap, DHS staff indicated that they will be simplifying the customized living rate caps. Currently, outside of the Twin Cities metro area (geographic group 3), counties could choose to either use the customized living rate cap for their geographic group or the higher statewide average rate cap. Some counties in groups 1 and 2 have chosen to use their geographic group rate cap rather than the higher statewide average rate cap. DHS has now decided to eliminate the rate caps for geographic groups 1 and 2, leaving just two rate caps for customized living--the group 3 rate caps for the metro area counties and the statewide rate caps for all remaining counties. For non-metro counties that have been using either the group 1 or 2 rate caps, this change to the statewide cap will increase the rate cap for a Case Mix A client from \$71 to \$97 per month. The rate cap for counties in the metro area--group 3--continues to be higher than the statewide average rate cap. The current rate caps are found in DHS Bulletin #07-25-05 found at <http://tinyurl.com/2y2ksc>.

According to statements made at the videoconference, DHS is changing its interpretation of one of the statutory eligibility criteria for 24-hour customized living concerning special treatments and medical conditions requiring clinical monitoring. The November bulletin will provide a more clear explanation of these changes, and will describe some accompanying changes that are going to be made to the Long-Term Care Consultation assessment form for EW clients to make the language in the assessment form consistent with the revised policy.

The final decision about the "other" criteria that qualify an EW client for the 24-hour service package was made after DHS analyzed May and October data on EW customized living and 24-hour customized living clients, their assessed needs, and the information provided by counties about the needs of clients who had been under the 24-hour package but did not meet the eligibility requirements added by DHS in a waiver amendment in 2006 and conforming 2007 legislation. In the sample October data, DHS did a detailed analysis of 634 EW Case Mix A clients authorized for either customized living or 24-hour customized living. Looking at the assessment information for these 634 clients, DHS evaluated the types and amounts of services that their assessed needs would require. DHS staff found that 250 of the 634 (39.3 percent) met the statutory criteria for needing assistance with toileting, 10 were dependent in transferring, and four met the statutory criteria for clinical monitoring. Altogether, slightly more than 41 percent of the 634 EW clients met the statutory criteria for 24-hour customized living.

Further analysis showed that 373 of the 634 EW Case Mix A clients had significant needs for assistance in medication

management. DHS staff found that even if an additional criterion related to the need for medication management was added, 105 people from the sample, or 21 percent would still not meet the eligibility requirement for 24-hour customized living. In determining that the additional criteria for eligibility for 24-hour customized living would be a need for medication management and a need for 50 hours/month of direct service, DHS staff estimated that if an EW client needed less than 50 hours a month of service, the needed services could be covered under the lower, customized living rate cap. More information from the analysis of May and October EW data is found in the handout available at <http://www.mhha.com/inc/data/Handout-EWCLSPowerpointOct 25.pdf>

Although in previous videoconferences, DHS staff has indicated that there would probably be an "exceptions" process to address any particular client needs that cannot be adequately addressed under the 24-hour criteria. At the October videoconference, DHS staff reversed their earlier statements, saying that they do not plan on an "exceptions process." However, they did repeat earlier statements that individual EW client always have the right to appeal decisions about their services and they also seemed to indicate a willingness to consider additional information as this new policy is implemented.

During the videoconference, DHS staff also discussed transportation reimbursement under Elderly Waiver and Alternative Care. DHS staff has been providing extra education to clarify that eligible transportation costs can often be paid by EW and AC on top of the monthly service package rate for home care services. DHS emphasized that "medical transportation" is a covered Medicaid State Plan service (applicable to EW but not AC) and that is should never be authorized under EW. Costs of State Plan medical transportation do not count toward the individual's EW budget cap and is not added to a provider's customized living/24-hour customized living service agreement. More information is found in the handout available at <http://www.mhha.com/inc/data/TransportationPowerpointOct252007.pdf>.

For more information, contact Mary Youle at myoule@mhha.com.

MHHA Summarizes Recent Class F Survey Information

MHHA has recently completed an analysis of 48 Class F surveys posted from January-early October 2007 on the Minnesota Department of Health (MDH) web site. Of these MDH surveys, 15 (31 percent) were follow-up surveys with providers that had previously received deficiencies. MHHA found that the vast majority of providers are still doing a good job of meeting the requirements, with 30 percent of regular surveys and 60 percent of follow-up surveys being deficiency-free. The average number of deficiencies for all 48 surveys was 2.29. In the follow-up surveys in which deficiencies had not been corrected, MDH imposed fines ranging from \$300 to \$2,900.

For the 48 surveys analyzed, frequently cited deficiencies were:

- Fourteen deficiencies concerned incomplete service plans. Service plans were often cited for contingency plans being omitted or incomplete, frequency of supervision not identified, and no identification of the staff that would perform various services.
- Nine deficiencies indicated that the RN was not supervising clients' services or that the supervision was not performed within the required timeframe (within 14 days after initiation of services and at least every 62 days thereafter).
- Eight providers were cited because they did not train or competency test all unlicensed staff on tasks they were performing or did not document that this was completed.
- Six providers received deficiencies because they had not completed the vulnerable adult assessment and/or had not developed (and implemented) an individual abuse prevention plan based on the assessment.

Recent information provided by MDH indicates that the Case Mix Review Section has now surveyed 487 or 84.7 percent of the 575 Class F licensees since these surveys began in June 2004. In May 2005, the Case Mix section also began surveying the 424 Class A "licensed only" providers, and to date 121 or 28.54 percent of those providers have been surveyed. MDH staff also evaluates providers' compliance with the 2006 assisted living requirements. Compliance with the assisted living requirements seems to have been quite good, as MDH has only sent out 3 warning letters concerning violations with 857 housing-with-services establishments identifying themselves as assisted living providers.

In the survey data provided by MDH based on all deficiency findings for Class F providers since June 2004, following are the top twelve categories of deficiencies:

- Contents of service plan (4668.0815, subp. 4)
- Services that require supervision by RN (4668.0845, subp. 2)
- TB screening (4668.0065, subp. 1)
- Evaluation; documentation (4668.0815, subp. 1)
- Re-evaluation (4668.0815, subp. 2)
- Medication records (4668.0855, subp. 9)
- Nursing assessment and service plan (4668.0865, subp. 2)
- Nursing assessment and service plan and medications (4668.0855, subp. 2)
- Performance of routine procedures (4668.0825, subp. 4)

- Prescriber's order required (4668.0860, subp. 2)
- VAA abuse prevention plans (626.557, subd. 14 (b))
- Modifications (4668.0815, subp. 3)

Class F survey results are posted at <http://tinyurl.com/2472z8>. Class A licensed only survey results (which MHHA has not yet analyzed) are found at <http://tinyurl.com/3yxxzj>. For more information, contact Mary Youle at myoule@mhha.com.

CMS Announces Timeline for MDS 3.0

The Centers for Medicare & Medicaid Services on Thursday announced its preliminary timeline for the long-awaited version 3.0 of the MDS. How long have providers waited? CMS circulated a draft version of MDS 3.0 for comment in January 2003--nearly five years ago. CMS's announcement came during the SNF Open Door Forum, and the agency promised that MDS 3.0 would be fully implemented by Oct. 1, 2009.

CMS indicated that it would post a timeline for the implementation process in December. In January, they plan to host an SNF Open Door Forum to discuss the content of the new assessment form. CMS will produce a draft of the specifications--i.e., the instructions that will be in a revised Resident Assessment Instrument Manual--by October 2008. The following year will be devoted to finalizing the MDS 3.0 and training providers on its content and use.

CMS highlighted some of the changes in the MDS 3.0. These include:

- More focus on resident preferences and choices,
- More focus on returning the resident to the community (i.e., discharge potential),
- Assessment of pressure ulcers that are healing, and
- Standardized tools for assessing and measuring pain, depression, and delirium.

These changes obviously will require some new sections and items in the MDS. What is less clear, however, is how much change there will be in the current sections and items that will remain in the MDS.

The implementation of the MDS 3.0 will require a significant amount of training for providers, so that their staff can use the new version accurately and appropriately. Facility budgets will need to provide for training--and possibly quite a bit of training, depending on how extensive the changes are.

The changes could also affect the two major reimbursement systems that are based on the MDS--the Medicare SNF payment rates based on the Medicare RUG classifications and the Medicaid payment rates based on the MA RUG classifications. Each system may have its unique problems.

On the Medicare side, CMS might need to publish a new RUG system, and because of the federal requirements for notice and comment periods, it might not be possible to publish the Medicare SNF rates in order to implement them on Oct. 1, 2009. CMS usually publishes the SNF rates around Aug. 1.

The problem on the Medicaid side could be even worse. The MA RUG classifications are established in state law, and the legislature will adjourn before the end of May, 2009. If the MDS 3.0 isn't finalized in time, the legislature might not be able to change the reimbursement classifications to fit the MDS 3.0.

The two reimbursement systems may be able to adjust their classifications fairly smoothly, provided that there is a good crosswalk that does not have ambiguous links between items scored on the 2.0 and 3.0 versions. Depending on how well the MDS 3.0 will fit the current reimbursement classes, however, there may be a need to change the weights for the RUGs classes. CMS presumably may have the technical capability to implement new weights for the SNF RUG classes at the same time as the implementation, but it is less likely that state Medicaid programs will be able to act as quickly.

MHHA will alert members to new developments as they occur. For further information, contact Darrell Shreve at dshreve@mhha.com.

Care Centers, Assisted Living Have Large Impact on State's Economy

Minnesota's nursing homes, assisted living facilities and residential mental health facilities have a substantial impact on the state's economy, according to new figures from Transform 2010, a state initiative to prepare Minnesota for the "age wave." The Department of Human Services shared data with MHHA showing that statewide, providers create 120,000 jobs and contribute more than \$2.6 billion to the state's economy.

The state's figures show that healthcare jobs comprise 14.5 percent of the state's total workforce, with projections for a 2715 percent growth (95,500 jobs) created through 2014.

Physician assistants and home health aides lead the list of projected new jobs with increases estimated at 53.7 and 51.7 percent respectively. RNs (28 percent) physical therapists (23.4 percent) and occupational therapists (24.3 percent) also will see large growth in numbers.

The state estimates that the state's population of individuals age 65 and older will reach 1.3 million by 2030. The 85-plus population will be 163,000 by that year. The report concludes that the demand for workers in long-term care will only

increase as the population ages and this in turn will increase the economic impact long-term care provides to Minnesota. To access the fact sheets, click here <http://www.mhha.com/inc/data/economicimpactstatewide-p1of2.pdf> and <http://www.mhha.com/inc/data/economicimpactstatewide-p2of2.pdf>.

Latest QM Scores in QIO Group Continue Improvement

Last Thursday, Stratis Health, the QIO for Minnesota, released its latest data on quality measures. The data compare the scores on new pressure ulcers for high risk residents, restraint use, pain management, and depression at the national and state levels and the 53 care centers that are part of Stratis Health's technical assistance group. Stratis Health works closely with these care centers (and encourages them to work with each other), providing resources, information and assistance.

The data below compare the first quarter of 2007 (the most recent data) with the second quarter of 2004 (which is the benchmark quarter for the federal evaluation of Stratis Health).

On the measure for the enhanced QM score for high-risk pressure ulcers, the technical assistance group lowered its incidence from 9.67 to 6.32--a reduction of more than one third. During this time the statewide score dropped from 9.15 to 7.61, while the national score moved from 13.74 to 12.81. Thus Minnesota scores much better than the nation, but the technical group has shown even better improvement.

On the measure for the enhanced QM score for restraint use, the technical group dropped its incidence from 4.19 down to 1.69--a reduction of about 60 percent. The statewide score dropped from 4.58 to 2.65, an impressive improvement in itself. The national score dropped from 7.50 to 5.63, again much less than the improvement in Minnesota and very much less than the technical group's.

On the measure for the enhanced QM score for pain, the technical group started out in 2004 at 7.36--above the statewide figure of 6.70 and also the national figure of 6.23. The most recent data, however, show the technical group (4.40) and the state (3.55) now both below the national score (4.53).

On the measure for the enhanced QM for depression, the technical group and the state were both well above the national score in 2004, and they both are still well above the national score. None of the three scores moved very much. The measure itself has been subjected to some criticisms, and Stratis Health staff mentioned that CMS has dropped depression from their evaluation of the QIO.

For Medicare-certified home health agencies, the hospitalization rate for the technical assistance group has dropped about one percentage point since the baseline in 2004, while the state and national hospitalization rates have increased two and one points, respectively. The technical assistance group is still higher than the other groups, but not by as much.

On the measure of improvement in administration of oral medications, the technical group of HHAs improved their management rates by 4.5 percent, compared to one percent for the state and three percent for the nation. The national rate (42 percent) is still higher than the state (35 percent) and the technical assistance group (34 percent).

Overall, the data clearly demonstrate that the efforts of Stratis Health and its two technical assistance groups have paid dividends--most of the outcome measures have improved more than those at the state and national levels. MHHA congratulates Stratis Health and its participating care centers and home health agencies.

For further information, contact Darrell Shreve at dshreve@mhha.com or Marilyn Reiersen, Stratis Health, at 952-853-1815 or mnpro.mreiersen@sdps.org.

Moratorium Application Information Available

As previously reported in *Monday Mailing*, the Minnesota Department of Health received 16 applications for the current Moratorium Exceptions Process. The following table contains information on the projects submitted for consideration:

FACILITY	CITY	PROJECT TYPE	TOTAL COST
Aitkin Health Services	Aitkin	Renovation	\$3,957,949
Ambassador Good Samaritan	New Hope	Renovation	\$7,888,293
Assumption Home	Cold Spring	Renovation/Replacement/Upgrade	\$8,160,000
Battle Lake Good Samaritan	Battle Lake	Renovation	\$3,211,572
Good Shepherd Lutheran Home	Sauk Rapids	Renovation/Replacement	\$15,850,000
Golden Living Center Meadow Lane	Benson	Relocation	\$11,353,718
LifeCare Medical Center (formerly Roseau NF)	Greenbush	Replacement	\$5,288,269

Mankato House Health Care Center	Mankato	Renovation/Replacement	\$4,015,455
Martin Luther Manor	Bloomington	Renovation	\$13,072,000
Oak Hills Living Center	New Ulm	Renovation	\$6,322,670
Park River Estates Center	Coon Rapids	Conversion/Renovation/Upgrade	\$2,295,000
Penninghom Health Services	Thief River Falls	Relocation	\$13,984,962
Pioneer Retirement Community	Fergus Falls	Replacement	\$21,873,000
Prairie View Health Care Center (formerly Tracy NH)	Tracy	Relocation	\$2,965,903
Rice Care Center	Willmar	Replacement	\$13,665,040
Sholom Home West	St. Louis Park	Renovation	\$7,004,096

The annual Medical Assistance cost of the projects has not yet been calculated. Public hearings on the proposals will take place in early December. For further information, contact Lori Meyer at lmeyer@mhha.com.

State Agencies Hear First Hand about 'Staffing Collapse' in Southern Minnesota

Over 20 nursing facility administrators and directors of nursing gathered earlier this month at **Mapleton Community Home** in Mapleton, to discuss the "staffing collapse" that has occurred in their region of the state--especially with licensed staff. **Deb Barnes**, Administrator of Mapleton Community Home, organized the meeting that included Val Cooke and Bob Held, from the Minnesota Department of Human Services and Darcy Miner and Sue Winkelman, from the Minnesota Department of Health.

Despite all of their efforts and creativity, facilities in this area are struggling with acute staffing shortages. In response, Barnes contacted local State Sen. Julie Rosen (R-Fairmont) and began organizing the meeting with DHS and MDH. "Together we care for over 600 elderly persons, and the [staffing shortage] is a crisis," Barnes told the agency representatives in attendance. "We need your help."

Participants outlined the many steps they have taken to cover shifts and attract new employees including adjusting shifts, disallowing or limiting vacations, allowing children in the workplace, and automating certain functions. Some commented that even pool staff is generally unavailable without a 2-4 week notice. Others commented on their dependence on overtime and double shifts. One facility shared that they had 4-5 people with 140 hours in a single pay period. Other challenges that were raised included: 1) Delays in processing criminal background checks for new employees; 2) Lack of available CNA training and test out slots; and 3) The huge increase in paperwork that pulls licensed staff off the floor and away from resident care.

There were also ideas on how to bring about relief, including: 1) Elimination of rate equalization to generate additional revenue for wages and benefits; 2) Reviewing state-specific regulations and eliminate overlap with federal requirements; and 3) Providing additional resources for "essential access facilities" in need of staff.

MHHA has contacted agency staff regarding next steps in addressing the issues raised at this meeting. Members experiencing similar staffing challenges are encouraged to contact Kari Thurlow at kthurlow@mhha.com or Lori Meyer at lmeyer@mhha.com.

At the State Capitol

MHHA Members Testify at House Nursing Home Working Group Hearing

Late last week, the House Nursing Home Working Group held a hearing at **Twin Valley Living Center** in Twin Valley. Four Representatives on that working group attended the hearing, which also was attended by numerous providers, including more than one who traveled more than 100 miles to provide testimony.

The MHHA members in attendance stressed to the working group that the recent nursing home rate increases have been too low to provide adequate pay increases for staff, and have worsened the financial circumstances of facilities that have been spending their reserves to provide quality care.

Mary Krueger of **Glenwood Retirement Village** testified that she recently lost a valuable RN to a hospital that can pay \$7 more per hour and that this year her average CNA is receiving an hourly wage increase of only 18 cents per hour because of the small rate increase provided by the state.

Barry Robertson of **Fair Meadow Nursing Home** in Fertile told the legislators that because of the rate freeze and relatively low increases that have followed it, his employees have received an average wage increase of less than 1 percent per year over the last five years. He also testified that if the underfunding of nursing home care continues, some providers won't be around to provide care before too much longer.

Janet Green of **Ecumen** told the working group that the employees of nursing homes deserve a living wage, and that currently the rates paid by the state do not allow providers to pay appropriate wages to their staff. She also pointed out that nursing homes contribute a lot economically to rural communities, and that state support for those homes is crucial to keeping them viable.

Rep. Larry Hosch (D-St. Joseph) wrapped up the hearing by saying that the providers in attendance had made a strong case for the need to address funding for nursing homes. He encouraged all those in attendance to continue contacting their representatives, senators, and the governor to inform them of the need to fix the problems with nursing home funding.

Members with questions about the House Nursing Home Working Group should contact Kari Thurlow at kthurlow@mhha.com.

News Briefs

Record-Breaking Attendance at the MHHA/MHCA 2007 Assisted Living and Home Care Conference



More than 160 people attended the 2007 Assisted Living and Home Care Conference, and gave the program high marks, with many suggesting that more time was needed for the important topics suggested.

The keynote, "Working in Four Part Harmony? Singing a Multi-Generational Tune," provided a high energy start to the day when Valerie Halling, Mayo Clinic, Angela Jackson, Mayo Clinic, and April Sutor, United Way of Olmsted County (pictured above) role-played the four generations that providers may have in their workforce. They will also make a presentation at the MHHA Institute for Older Adult Services on Thursday afternoon, Feb. 7.

With humor, music, raps and costumes, the three presenters demonstrated the differences in how the generations behave and interact. Participants said it was "a great starter session" and "the multi-generational presentation was the best I've heard--most helpful." Speakers and participants talked about the keynote throughout the day.

Rave reviews were also heard for other seminars that covered topics such as incontinence, dementia care and several legal topics. Five early-bird roundtable discussions also drew participants to lively discussions of home care surveys, Elderly Waiver customized living, medication set-ups, MSHO and service plan agreements.

The Assisted Living and Home Care Conference is jointly sponsored each year by MHHA and the Minnesota HomeCare Association. For more information, contact Mary Youle at myoule@mhha.com.

MDH Covers Range of Topics at LTC Issues Meeting

The Minnesota Department of Health hosted the latest Long-Term Care Issues Committee Meeting on October 16. Representatives from MDH provided a number of updates and responded to issues raised by committee members. The following is a brief summary of this meeting.

- **Commissioner Magnan:** The new commissioner of health will officially start on Oct. 31.
- **Freedom to Breathe Act:** MHHA's Lori Meyer sought clarification on a potential conflict between the new law's focus on eliminating secondhand smoke from the workplace and a care center's obligation to supervise smoking for a resident who cannot smoke safely. Darcy Miner will discuss this issue with the MDH Environmental Health Division and report back.
- **QIS System:** MDH surveyors will begin being trained on the new QIS survey system in early January, 2008. Surveyors will be trained in groups over the next three years. The first group will include 8 surveyors (one from each district), 2 supervisors and 2 program managers. Their training will include one week of classroom instruction, 2-3 mock surveys, followed by 6 surveys of record. This first round of surveyor training is expected to be completed by the end of February. Only one other round of surveyor training will be scheduled prior to the end of the federal fiscal year (9/30/08). Once trained in QIS, a surveyor cannot conduct a survey under the current survey method. This may pose

some challenges for MDH, but Darcy Miner indicated that they will be able to keep up their survey workload. As a result, providers may notice an increase in the number of surveyors that are not their normal surveyors.

- **IIDR:** For 2007, the average number of IIDR requests is two per month. This is down from 3-5 per month previously.
- **Complaint Surveys:** CMS is looking at the MDH practice of not issuing a deficiency for a substantiated complaint if it has already been satisfactorily corrected.
- **Survey Revisits:** MDH has looked into how many of the random revisits required a second revisit. No concerns were raised by the results so MDH will continue with the random revisit policy.
- **Survey Team Consistency:** The median number of deficiencies per survey is currently 9. The state goal is for all surveys teams to be in the range of +/- 2 from the statewide median. For surveys completed between 10/1/06 through 9/30/07 there are three teams that are not meeting that goal: Statewide Team (14), Metro B Team (13), and Rochester Team (12). MDH has conducted a data analysis to look at survey consistency by economic district rather than survey team. The results currently showed consistency in the tags cited, except for restraint citations.

For further information contact Lori Meyer at lmeyer@mhha.com.

DHS Sends Disaster Application Form to Providers

The Minnesota Department of Human Services on Friday mailed the application form for disaster relief to providers in the southeastern Minnesota counties affected by the floods in August. The accompanying letter explains that the funds authorized in the special legislative session are to be used to reimburse for costs incurred related to evacuation, transportation and medical or remedial services provided to vulnerable residents necessary to assure the health and safety of Medical Assistance recipients. The affected counties are: Dodge, Fillmore, Houston, Olmsted, Steele, Wabasha, Jackson, and Winona.

Members may download the application form (PDF) by clicking on this link:

<http://www.mhha-apps.com/downloads/Flood%20Assistance%20Application.pdf>.

For further information, contact Kari Thurlow, Lori Meyer, lmeyer@mhha.com or Darrell Shreve, dshreve@mhha.com.

Safe Patient Handling Grant Application Now Online

The final version of Minnesota's safe patient handling grant application is now available on the Department of Labor web-site: http://www.doli.state.mn.us/safe_patient-handling.html.

Applicants must use this form to apply for a safe patient handling grant. The grant application will be available through 4:30 p.m. on Dec. 7. Grants will be awarded in January 2008. On the same web-site, you can also view the letter that will be sent to healthcare facilities summarizing the safe patient handling statute and grant program.

MHHA's district meetings this fall are featuring a program on safe patient handling with experts from the Minnesota Department of Labor and Industry on hand to assure you are:

- Aware of the new requirements facing your organization
- Recognize all new protocols and policies required for compliance
- Know what a safe patient handling committee should look like and do.

Participants receive training materials and information to bring back to your staff. Remaining district meetings are Oct. 30 for District G at the James J. Hill House, 240 Summit Ave., St. Paul, and Nov. 1, for District F, at Cabela's in Owatonna.

CMS Pressure Ulcer Project Demonstrates Success

The Centers for Medicare & Medicaid Services is spreading the word about a new study conducted in 35 care centers that showed a 69 percent reduction in new Stage III or Stage IV pressure ulcers.

"This project showed clinicians and managers that major improvement is possible, even for conditions affecting our most frail beneficiaries," said Barry M. Straube, MD, CMS chief medical officer and director of the Office of Clinical Standards and Quality. "The results will enable us to separate the serious pressure ulcers from the superficial ones, a change that will help beneficiaries and their families to see whether a nursing home has implemented the best practices available."

Participants in the study worked voluntarily with experts on process improvement and preventing pressure ulcers. The improvement materials used in this project are available to anyone interested in improving the care of bed sores, free of charge, on the Medicare Quality Improvement web site at: <http://www.medqic.org> (under the "Nursing Home" tab).

Members may also download the list of five improvement strategies that form the basis for the improvement efforts by clicking on this link: <http://www.mhha.com/inc/data/PressureUlcerImprovementStrategies.pdf>. The study also had two unexpected findings. The incidence of Stage II pressure ulcers did not decline, although these tend to heal fairly quickly and are not as serious for the residents. Also, the publicly reported quality measure for pressure ulcers remained unchanged for the facilities, which may reflect a problem with the quality measure and the MDS items on which it is based.

The study is reported in the October 2007 issue of the Journal of the American Gerontological Society. For further

information, contact Darrell Shreve at dshreve@mhha.com.

HUD Documents Recently Posted on the Web

HUD has noted the following documents that have recently been posted at <http://www.hudclips.org>:

- HUD published proposed rule regarding pet ownership in HUD-assisted housing for the elderly and persons with disabilities in order to conform the exceptions for animals that assist persons with disabilities to those that apply to HUD's public housing programs. The proposed rule was published in the Oct. 15, 2007, *Federal Register*. Comments are due Dec. 14.
- Form HUD-93104, Monthly Report of Excess Income, has been revised and posted at http://hudclips.org/sub_nonhud/cgi/pdfforms/93104.pdf. The form is to be mailed to: HUD Multifamily Excess Rental Income Payments, P.O. Box 105423, Atlanta, GA 30348-5423.
- The Operating Cost Adjustment Factors (OCAF) for 2008 were published in the Oct. 25, 2007 *Federal Register*. These factors are used for adjusting or establishing Section 8 rents under the Multifamily Assisted Housing Reform and Affordability Act of 1997 (MAHRA), as amended, and under the Low-Income Housing Preservation and Resident Homeownership Act of 1990 (LIHPRA) projects assisted with Section 8 Housing Assistance Payments. The factors are effective Feb. 11, 2008.
- The revised Index for HUD Handbook 4350.3 REV-1, *Occupancy Requirements of Subsidized Multifamily Housing Programs* is now posted at http://hudclips.org/sub_nonhud/cgi/pdfforms/43503IndHSGH.doc. It was revised Oct. 2007.

HUD also reports that the fax machine for the Multifamily Help Desk is back in service. EIV Coordinators may now submit their Coordinator Access Authorization Form (CAAF) requesting re-certification of their contract(s) and/or property(ies) by either faxing the completed CAAF to the Multifamily Help Desk at 202-401-7984 or by e-mail at Mf_Eiv@hud.gov.

Feds to Review States' Medicaid Waiver Programs in 2008

The U.S. Department of Health and Human Services Inspector General will be examining the extent to which states are complying with federal regulations related to the Medicaid waiver programs in 2008. The Assisted Living Director reports that the IG's 2008 work plan does not identify the states whose programs will be examined. Apparently waiver funds for adult day health services will also receive scrutiny.

In the past several years, the Minnesota Department of Human Services has put increasing attention on what they call "program integrity" for home and community-based waiver services. In the Oct. 25 videoconference on Elderly Waiver customized living, the 2007 changes to the customized living program were described as being part of the program integrity effort. For more information, contact Mary Youle at myoule@mhha.com.

House Passes National Affordable Housing Trust Fund Act

The U.S. House of Representatives recently passed the National Affordable Housing Trust Fund Act, a bill that could start the largest expansion in federal housing programs in decades. If passed, AAHSA says this bill would create a fund to produce, rehabilitate and preserve 1.5 million units of affordable housing over the next 10 years. The fund would also allocate \$800 million to states and local communities during the first year and \$1 billion annually thereafter. This bill's fate rests in the Senate's hands, and staff at the American Association of Homes and Services for the Aging have pledged to work hard to gain the necessary Senate support.

For more information, contact Alayna Waldrum at awaldrum@aahsa.org or 202-508-9476 or contact Nancy Libson at nlibson@aahsa.org or 202-508-9447.

SSA Announces 2008 COLA Increase

The U.S. Social Security Administration has announced that retirees will receive a 2.3 percent cost of living adjustment (COLA) increase in 2008. Social Security and Supplemental Security Income benefits increase automatically each year based on the rise in the Bureau of Labor Statistics' *Consumer Price Index for Urban Wage Earners and Clerical Workers* (CPI-W), from the third quarter of the prior year to the corresponding period of the current year.

The 2.3 percent Cost-of-Living Adjustment (COLA) will begin with benefits that nearly 50 million Social Security beneficiaries receive in January 2008. Increased payments to more than 7 million Supplemental Security Income beneficiaries will begin on Dec. 31.

Some other changes that take effect in January of each year are based on the increase in average wages. Based on that increase, the maximum amount of earnings subject to the Social Security tax (taxable maximum) will increase to \$102,000 from \$97,500. Of the estimated 164 million workers who will pay Social Security taxes in 2008, nearly 12 million will pay higher taxes as a result of the increase in the taxable maximum.

Information about Medicare changes for 2008 can be found at <http://www.cms.hhs.gov>.

America Medical Directors Looking for Art

The American Medical Directors Association Foundation will hold a silent auction at the AMDA Symposium in Salt Lake City featuring work by residents of long-term care facilities. They are soliciting paintings, drawings and hand-crafted items from facilities across the country.

Over the past two years, AMDA has collected and auctioned more than 200 items to help fund the foundation. For more information or to send digital photos of art, contact cdaniel@amda.com or call 410-992-3134. Artwork must be received by Dec. 31.

MHCA Offers Two Special Fall Events

The Minnesota HomeCare Association has two upcoming events that may be of interest to MHHA members.

On Nov. 8-9, the 2007 Public Policy Conference will be held at Crowne Plaza in Brooklyn Center. It features Joanne Disch, chair of the AARP National Board of Directors, Sen. Linda Berglin, Minnesota's nurse legislators and Raymond Swisher, manager of Medicare Advantage, CMS.

On Nov. 29-30 is Performance Based Leadership Certificate Program - Module I. It will be held at the Ramada Mall of America " Bloomington. This two day program focuses on Human Resource Practices and Employment Law Overview for Home Health Care. Participants will learn to apply the framework for understanding the daily operations, policies and procedures relating to human resources in home care organizations.

For more information, contact Paulette Sorenson, Education Programs Director, Minnesota HomeCare Association, at 651-635-0923 or psorenson@mnhomecare.org.

November is National Alzheimer's Awareness Month; Stickers Help Raise Funds

Help raise funds and awareness to fight Alzheimer's disease and related disorders by giving employees an opportunity to purchase stickers and dress "Casual for a Cause." The Alzheimer's Association sticker is a round, lime green sticker with "Casual for a Cause!" and the Association logo in dark purple, and shows people that the wearer has joined in the fight against Alzheimer's. Proceeds raised benefit the Alzheimer's Association Minnesota - North Dakota. For more information, call 952-857-0532.

Consumer Groups Assail Medicare Part D

In an article published Oct. 24, Consumers Union and Medicare Rights Center called for older adults and persons with disabilities to have the option of choosing prescription drug coverage through the original Medicare program. The groups said the change would "eliminate the consumer exploitation that plagues the current Medicare Part D drug benefit run by private insurance companies."

"The Best Medicine: A Drug Coverage Option Under Original Medicare," is available online at <http://www.consumersunion.org/> or <http://www.medicarerights.org/TheBestMedicine.pdf>.

The report cites studies that find the current Medicare drug benefit available only through private plans is unnecessarily costly, has coverage gaps, is unstable and leaves consumers vulnerable to marketing fraud because of the number of plans offering such divergent benefit packages.

Legislation to give consumers a Medicare-run drug option has been introduced today by Sen. Richard Durbin (D-IL) and Reps. Marion Berry (D-AR) and Jan Schakowsky (D-IL). The Medicare Prescription Drug Savings and Choice Act would utilize price negotiation and the best evidence about the safety and effectiveness of drugs to give older adults and people with disabilities the choice of a stable, consistent and affordable drug coverage plan.

Consumers Union (CU), publishes Consumer Reports, is an independent, nonprofit testing and information. Medicare Rights Center (MRC) offers health care information and assistance in the United States for people with Medicare.

Member News

Member News

Lutheran Care Center and Bridgeway Estates now managed by HSI; Ecumen names new trustees; and Health Service Innovations names two new staffers. Read more in this week's Member News, http://www.mhha.com/index/Member_News. Send your news to Barbara Averill at baverill@mhha.com.

Association News

'Last Call' for MHHA Awards Nominations

Don't delay... send in your nomination for the MHHA Spring Awards program by Nov. 7. Entries postmarked on or before that date will be accepted for judging.

Please review the nomination booklet each member facility received in the mail, or go to MHHA.com and click on "About MHHA" and "Awards and Recognition" to see more about the awards categories. A complete nomination brochure is available at <http://www.mhha.com/inc/data/2008springawardsprogrampacket.pdf>. Extra copies of the nomination brochure also will be available at MHHA district meetings.

For more information, contact Barbara Averill at baverill@mhha.com.

Don't Miss it: CEOs and Board Leadership Training Program is Nov. 17

MHHA will present a powerful workshop on Nov. 17 with a focus on building stronger alignments between board effectiveness and organizational effectiveness. The *Mission Possible: Aligning Governance Effectiveness with Organizational Effectiveness* workshop will take place at Boutwells Landing, Oak Park Heights, with registration beginning at 8:30 a.m. and programming continuing until 3:30 p.m., <http://www.mhha.com/inc/data/846700.pdf>. The fee for MHHA members is \$195 for a team of CEO and board leader. Additional board members are welcome for \$75 fee per person. The program is open to nonmembers at \$275 per team of two and \$125 for each additional board member.

Watch your mail for the brochure for this important workshop or go to MHHA.com and click on "Events." For further information, contact Heidi Simpson at hsimpson@mhha.com.

Quality Indicators Survey Process Phone Seminar is Nov. 9

MHHA is launching a series of essential educational offerings to coincide with the rollout of the Quality Indicators Survey (QIS) process in Minnesota. The series begins with a phone seminar on Friday, Nov. 9, from 9:30 to 11 a.m.

Go to MHHA.com and click on Events, then The New Quality Indicators Survey Process to register, <http://www.mhha.com/inc/data/850700.pdf>.

This initial program will help staff from skilled nursing facilities develop a solid understanding of the purpose and goals of this new survey that utilizes interactive technology to prompt surveyors through the process. It will also provide the most up-to-date information on the timetable for its rollout in Minnesota.

Further comprehensive training is being offered by MHHA in 2008 on Jan. 9 in Bloomington and Feb. 5 in St. Paul with the experts from Nursing Home Quality LLC - the same group that will be training Minnesota's surveyors.

For further information, contact Heidi Simpson at hsimpson@mhha.com.

Elsewhere

Nursing Home Residents Go Home After California Fires

A Los Angeles Times article last week told of the homecoming of residents of a Rancho Bernardo nursing home who had been evacuated due to the southern California wildfires. Reporter Charles Ornstein wrote that when 52 residents of Remington Club Health Care Center were told that encroaching wildfires would force them to leave and in most cases be moved to other nursing homes, the anxiety was palpable, the chaos upsetting. It was a difference scene when the residents returned from their three-day evacuation.

Valerie Grimsinger and the 51 other residents were greeted with smiley-face balloons and large signs that said, "Welcome Back." "It was really a jubilant thing to come back here," said Grimsinger, 73, who is recovering from hip replacement surgery.

The article praised the care center for having an evacuation plan that worked. Staffers called in ambulances and other transportation, handing residents their medications and copies of their medical records before they departed.

Fourteen nursing homes in San Diego County evacuated nearly 1,200 residents, according to the latest estimates from the state Department of Public Health. Two acute-care hospitals and a psychiatric hospital in the county temporarily shut down.

Eighty-five assisted-living facilities, which housed as many as 2,189 seniors, also were emptied, as were an untold number of independent-living centers.

Shortly after 4:30 a.m. Monday, a charge nurse called Remington Club's nursing home administrator at home to report that residents were receiving automated calls ordering them to evacuate. After driving to the facility, administrator Scott Tarde arranged for the transfers by 8 a.m.

Forty-seven residents were evacuated within 100 minutes to three other facilities, Tarde said. Five residents went home with their families.

Some asked him more than once what was going on "because they would forget where they were going," Tarde said. "We just kind of did a lot of validation. 'We're going to another building. We want to make sure that everybody is safe.'"

UCLA Study Blasts Healthcare for Vulnerable Older Adults

UCLA researchers, using quality-of-care measurements developed by the Assessing Care of Vulnerable Elders (ACOVE) project, found that vulnerable elderly patients received only 65 percent of the tests and other diagnostic evaluations and treatments recommended for a variety of illnesses and conditions, including diabetes and heart disease. The study findings appear in the October issue of the peer-reviewed journal *Medical Care*.

"Thirty-five percent of the medical care interventions that they should have received were not provided, indicating significant room for improvement," said lead author Dr. David S. Zingmond, assistant professor of general internal medicine and health services research at the David Geffen School of Medicine at UCLA. "We'd much rather have everything higher--say, at least 90

percent."

The researchers gathered data from 100,258 community-dwelling geriatric patients in 19 California counties between 1999 and 2000. All the patients were enrolled in both Medicare and Medicaid. The mean age of participants was 81, 70 percent were women, 45 percent were non-Hispanic whites, 26 percent were Asian, 9 percent were African American, 13 percent were Hispanic and 7 percent were of unknown race or ethnicity. "Vulnerable elders" are defined as geriatric patients who are at increased risk of death or functional decline.

Using linked Medicare and Medicaid data from the California Center for Long Term Care Integration--a collaborative effort between the UCLA Division of Geriatrics and the University of Southern California School of Gerontology--researchers examined quality for 43 specific types of care (for example, receiving a new medication or having a diagnostic test) for common conditions such as depression, diabetes, hypertension and heart failure.

They found that in too many instances, elderly patients were not given the full range of treatments and services for their conditions. For example, only 42 percent of patients with diabetes were tested to gauge their blood sugar control or received an eye examination during the one-year study period. Likewise, many patients who were newly diagnosed with heart failure did not receive recommended diagnostic evaluations or medications known to be effective.

In the absence of electronic medical records, the use of administrative data such as those on which the researchers based their work can be a gauge of the quality of some important aspects of care for elderly patients, Zingmond said.

MHHA thanks business partner [Dorsey & Whitney LLP](#) and our other business partners for their support.

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