

**Nursing Home Bed Workgroup  
Meeting Notes  
August 17, 2016**

I. Call to Order and Introductions

a. Attendees of the meeting were:

- John Weir, Long Term Care Ombudsman's Office
- Deb Saur-MacKenzie, McLaren
- Marianne Conner, Advantage Living
- Pat Anderson, HCAM
- David Walker, Spectrum Health
- Sarah Slocum, Long Term Care Ombudsman's Office
- Brenda Rogers, MDHHS
- David Stobb, Ciena
- Susan Yontz, Leading Age Michigan
- Chad Tuttle, Spectrum Health
- Roger Mali, Mission Point Management
- Lisa Rosenthal, HCR Manor Care
- Umbrin Ateequi, BCBSM
- Melissa Cupp, RWC Advocacy
- Sean Gehle, Ascension Michigan
- Nancy List, McLaren
- Ryan Tisdale, MDHHS
- Walt Wheeler, Wheeler & Associates
- Matt Crowe, Warner Norcross
- Amber Myers, MDHHS
- Beth Nagel, MDHHS
- Joette Laseur, MDHHS
- Tulika Bhattacharya, MDHHS
- Arlene Elliott, Arbor Advisors

II. Charge 2 - Lease Renewals as Non-Substantive Review

a. The group continued discussing options for the Department to reasonably review all facility space lease renewals which would remove the current incentive to enter into short-term leases in order to keep the cost below the capital expenditure threshold thereby exempting them from CON review under the current Department policy. The following points were made:

- Tulika explained the current process for lease renewals and indicated that regardless of the project costs, a lease renewal is always non-substantive.
- The Department's concern continues to be with the incentive this creates for facilities to enter into short-term lease agreements even if those agreements are with related entities. Therefore they are suggesting that they review all lease renewals regardless of whether it exceeds capital expenditure threshold.
- The facility representatives and consultants pointed out that it is not the CON application that they are trying to avoid, but rather the application fees which can

be excessive for long-term leases because the application fee is based on the total lease renewal cost.

- Providers questioned the value of reviewing lease renewals at all since the location and building are not changing. The service provided is not changing. Often times the rent isn't even changing.
  - The Department indicated that they see value in the CON review because facilities must establish that they do not have any outstanding code deficiencies during that CON review and must agree to abide by the most current project delivery requirements.
  - Facilities pointed out that the plan of correction for the code deficiencies is something that has to be submitted to LARA within very strict timeframes anyway.
  - Ombudsman's office expressed concern with lease arrangements because the responsibility and liability gets split between 2 entities. Department will not dictate business practices, but there is concern so reviewing all lease renewals is an important opportunity to look at the quality element.
  - According to Ciena, HUD requires the split of the real estate entity from the operating entity. Most private lenders require the same.
  - A suggestion was made to look at the average annual rent instead of the total over the term of the lease in determining if CON review is necessary or perhaps in determining the project costs for purposes of calculating the application fee. Or in the alternative, not including the lease renewal cost at all in determining the application fee. If the CON application is solely for a lease renewal, then the project cost would be \$0, which would result in the lowest fee, currently \$3,000.
- b. Pat Anderson and David Stobb will work to draft up a suggested policy change that would allow for the application fee to be calculated based on the annual lease cost instead of the full term. This will likely need to go to the Attorney General's office for review because of the statutory definition of the fees and of capital expenditure. Need to be mindful of the potential impact of this on other sets of standards.

### III. Charges 3 and 4 - Special Population and High Occupancy Subcommittee Update

- a. The subcommittee did not get a chance to meet yet. However, Pat Anderson did pass out some information provided by Bill Hurtung on Michigan special population group utilization (see attached). The group discussed both charges and made the following points:
- If removed special populations from the standards, facilities could still take their own general beds and use them to create specialized units.
  - Issue with TBI/SCI is that there is no special reimbursement from Medicaid and many of the residents are Medicaid.
  - The question that needs to be answered for each pool is whether or not there is still a need for the group and if there are any new groups that need better access.
  - HCR Manor Care suggested getting rid of the special pool but then identifying groups that need more access and giving extra consideration (points in the comparative review, presumably) to applications proposing to care for those populations.
  - John Wier expressed an interest in keeping the pools to help encourage better access in hopes that facilities will utilize them and keep patients closer to home. He also suggested looking at adding bariatric patients as a special population as they see those patients being sent out of state currently.

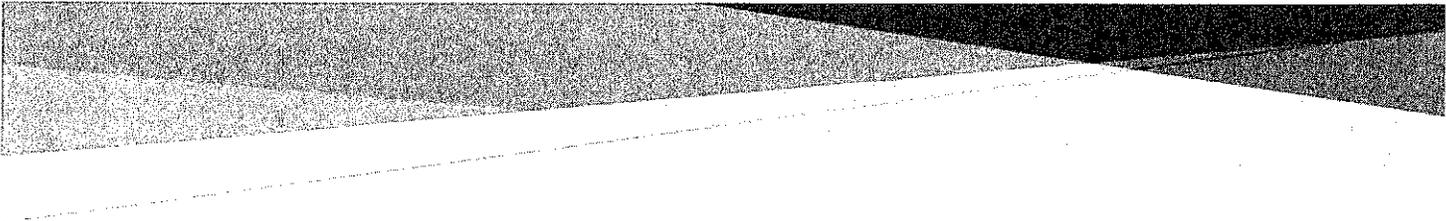
- Spectrum believes that special pools are very important but only if they are paired with a dependable funding source. Behavioral, TBI, and Ventilator should be retained but the people in this group should be working on the funding side as well. The 20/40 bed limit on some of these pools is also challenging. In order to make the care for these more complex patients more economical, having more patients is important.
- b. The subcommittee will meet before the next meeting.

#### IV. Charge 6 - Quality Metrics and National NH-HLTU Trends Update

- a. Bill Hartung sent a handout which summarizes the nursing facility quality measures (see attached) but was not available to attend today's meeting. Will discuss more at a future meeting. In the meantime, the group did discuss Charge 6 and wants to consider if any of the CMS quality measures should be added to the standards.
- b. The Department pointed out that Section 9(1)(f) requires an applicant that has a problem with one or more of the quality measures but still gets approved to acquire an existing facility to "participate in a quality improvement program....". Department is asking if there is a list of quality improvement programs that they could use in implementing this requirement. During a discussion of this issue, the following points were made:
  - A few years ago there was legislation passed to allow use of CMP funds for quality improvement programs. But it was the group's understanding that there aren't any specific criteria or parameters that could be used. Ryan from DHHS will look into this further for future discussion.
  - If leave language as is, without a list, then it would be up to the applicant to present a plan and for the Department to decide if they are sufficient. Department has not had an application submitted that fell under this language.
  - Language in standards doesn't need to change, but the Department will look at including a stipulation(s) in approvals and directing applicants to the Quality Improvement Organizations utilized by CMS for Special Focus Facilities.
- c. As the group discusses the quality measures further, need to keep in mind that the only place where quality measures will be monitored on an ongoing, annual basis, would be by adding them to the project delivery requirements.

#### V. Next Steps/Assignments

- a. Department will have information from the AG's office on replacements at the next meeting.
- b. Department will have information from Paul Delamater on the methodology at the next meeting.
- c. The Subcommittee will have a report at the next meeting.
- d. Lease renewal proposal will be distributed before the next meeting.
- e. Canceling September meeting due to conflict with HCAM annual conference. Next meeting will be October 13, 2016.



# NURSING FACILITY QUALITY MEASURES

Public Information Used For Relative Quality  
Measurement

## Abstract

Quality measures are posted on Nursing Home Compare, and are used in the calculation of Five-Star ratings. These quality measures can be used for relative performance in areas such as pain, skin care, infections, falls, activities of daily living, and return to acute settings.

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A set of quality measures (QMs) has been developed from Minimum Data Set (MDS) and Medicare claims data to describe the quality of care provided in nursing homes. These measures address a broad range of function and health status indicators. The facility rating for the QM domain is based on its performance on a subset of 13 (out of 24) of the MDS-based QMs and three MDS- and Medicare claims-based measures currently posted on Nursing Home Compare. The measures were selected based on their validity and reliability, the extent to which facility practice may affect the measure, statistical performance, and importance. Five additional measures (indicated below) were added to the Five-Star rating system in July 2016.

Measures for Long-Stay residents (residents in the facility for greater than 100 days) that are derived from MDS assessments:

- Percentage of residents whose need for help with activities of daily living has increased
- Percentage of residents whose ability to move independently worsened\*
- Percentage of high risk residents with pressure ulcers (sores)
- Percentage of residents who have/had a catheter inserted and left in their bladder
- Percentage of residents who were physically restrained
- Percentage of residents with a urinary tract infection
- Percentage of residents who self-report moderate to severe pain
- Percentage of residents experiencing one or more falls with major injury
- Percentage of residents who received an antipsychotic medication

Measures for Short-Stay residents that are derived from MDS assessments:

- Percentage of residents whose physical function improves from admission to discharge\*
- Percentage of residents with pressure ulcers (sores) that are new or worsened
- Percentage of residents who self-report moderate to severe pain
- Percentage of residents who newly received an antipsychotic medication

Measures for Short-Stay residents that are derived from claims data and MDS assessments:

- Percentage of residents who were re-hospitalized after a nursing home admission)\*
- Percentage of residents who have had an outpatient emergency department visit\*
- Percentage of residents who were successfully discharged to the community\*

\*Added July, 2016

The quality measures using MDS assessment data are updated on a quarterly basis and are posted on [www.medicare.gov](http://www.medicare.gov). There is information posted at the individual facility level for a four-quarter period for each measure. The time period ends on the last day of the second quarter prior to the effective date. Quality measures using MDS assessment data only that were posted in July, 2016 covered the period of April, 2015 through March, 2016.

Claims-based quality measures will be based on data from a twelve-month period, and will be updated on a semi-annual basis. Quality measures using claims data that were posted in July, 2016 covered the period of July, 2014 through June, 2015.

A weighting system is available to generate a score that allows for the determination of a relative measure of quality.

**Table 6 Quality Measures Used in the Five-Star Quality Measure Rating Calculation**

Measure	Comments
<b>MDS Long-Stay Measures</b>	
<b>Percentage of residents whose ability to move independently worsened</b>	This measure is a change measure that reports the percent of long-stay residents who have demonstrated a decline in independence of locomotion when comparing the target assessment to a prior assessment. Residents who lose mobility may also lose the ability to perform other activities of daily living, like eating, dressing, or getting to the bathroom.
<b>Percentage of residents whose need for help with activities of daily living has increased<sup>1</sup></b>	This measure reports the percentage of long-stay residents whose need for help with late-loss Activities of Daily Living (ADLs) has increased when compared to the prior assessment. This is a change measure that reflects worsening performance on at least two late loss ADLs by one functional level or on one late loss ADL by more than one functional level compared to the prior assessment. The late loss ADLs are bed mobility, transfer, eating, and toileting. Maintenance of ADLs is related to an environment in which the resident is up and out of bed and engaged in activities. The CMS Staffing Study found that higher staffing levels were associated with lower rates of increasing dependence in ADLs.
<b>Percentage of high-risk residents with pressure ulcers</b>	This measure captures the percentage of long-stay, high-risk residents with Stage II-IV pressure ulcers. Residents at high risk for pressure ulcers are those who are impaired in bed mobility or transfer, who are comatose, or who suffer from malnutrition.
<b>Percentage of residents who have/had a catheter inserted and left in their bladder</b>	This measure reports the percentage of residents who have had an indwelling catheter in the last seven days. Indwelling catheter use may result in complications, like urinary tract or blood infections, physical injury, skin problems, bladder stones, or blood in the urine.
<b>Percentage of residents who were physically restrained</b>	This measure reports the percentage of long-stay residents who are physically restrained on a daily basis. A resident who is restrained daily can become weak, lose his or her ability to go to the bathroom without help, and develop pressure ulcers or other medical complications.
<b>Percentage of residents with a urinary tract infection</b>	This measure reports the percentage of long-stay residents who have had a urinary tract infection within the past 30 days. Urinary tract infections can often be prevented through hygiene and drinking enough fluid. Urinary tract infections are relatively minor but can lead to more serious problems and cause complications like delirium if not treated.
<b>Percentage of residents who self-report moderate to severe pain</b>	This measure captures the percentage of long-stay residents who report either (1) almost constant or frequent moderate to severe pain in the last five days or (2) any very severe/horrible pain in the last 5 days.
<b>Percentage of residents experiencing one or more falls with major injury</b>	This measure reports the percentage of long-stay residents who have experienced one or more falls with major injury reported in the target period or look-back period (one full calendar year).
<b>Percentage of residents who received an antipsychotic medication</b>	This measure reports the percentage of long-stay residents who are receiving antipsychotic drugs in the target period. Reducing the rate of antipsychotic medication use has been the focus of several CMS initiatives.
<b>MDS Short-Stay Measures</b>	
<b>Percentage of residents whose physical function improves from admission to discharge</b>	The short-stay improvements in function measure assesses the percentage of short-stay residents whose independence in three mobility functions (i.e., transfer, locomotion, and walking) increases over the course of the nursing home care episode.
<b>Percentage of residents with pressure ulcers that are new or worsened</b>	This measure captures the percentage of short-stay residents with new or worsening Stage II-IV pressure ulcers.
<b>Percentage of residents who self-report moderate to severe pain</b>	This measure captures the percentage of short-stay residents, with at least one episode of moderate/severe pain or horrible/excruciating pain of any frequency, in the last 5 days.

**Table 6 Quality Measures Used in the Five-Star Quality Measure Rating Calculation**

Measure	Comments
Percentage of residents who newly received an antipsychotic medication	This measure reports the percentage of short-stay residents who are receiving an antipsychotic medication during the target period but not on their initial assessment.
<b>Claims-Based Short-Stay Measures</b>	
Percentage of residents who were re-hospitalized after a nursing home admission	This measure reports the percentage of all new admissions or readmissions to a nursing home from a hospital where the resident was re-admitted to a hospital for an inpatient or observation stay within 30 days of entry or reentry.
Percentage of short-stay residents who have had an outpatient emergency department (ED) visit	This measure reports the percentage of all new admissions or readmissions to a nursing home from a hospital where the resident had an outpatient ED visit (i.e., an ED visit not resulting in an inpatient hospital admission) within 30 days of entry or reentry.
Percentage of short-stay residents who were successfully discharged to the community	This measure reports the percentage of all new admissions to a nursing home from a hospital where the resident was discharged to the community within 100 calendar days of entry and for 30 subsequent days, did not die, was not admitted to a hospital for an unplanned inpatient stay, and was not readmitted to a nursing home.

<sup>1</sup>Indicates ADL QM as referenced in scoring rules

Sources: Based on information from the AHRQ Measures Clearinghouse and the NHVBP Draft Design Report and the MDS 3.0 Quality Measures User's Manual.

### Michigan – Special Population Groups

Special Population Group	Pool	MDS Question	Active Residents
Alzheimer's Disease	0	I4200, Active Diagnoses, Alzheimer's Disease	5,774
Hospice	130	O0100K1, Hospice Care – While Not A Resident	268
		O0100K2, Hospice Care – While A Resident	1,768
Behavioral	400	E0100A, Hallucinations	618
		E0100B, Delusions	1,652
		E0200A, Physical Behavioral Symptoms Directed Toward Others	1,609
		E0200B, Verbal Behavioral Symptoms Directed Toward Others	2,669
		E0200C, Other Behavioral Symptoms Not Directed Toward Others	1,558
		E0500A, Symptoms put the resident at significant risk for physical illness or injury	403
		E0500B, Symptoms significantly interfere with the resident's care	841
		E0500C, Symptoms significantly interfere with the resident's participation in activities or social interactions	620
		E0600A, Symptoms put others at significant risk for physical injury	433
		E0600B, Symptoms significantly intrude on the privacy or activity of others	439
		E0600C, Symptoms significantly disrupt care or living environment	813
		E0800, Resident rejected evaluation or care that is necessary to achieve the resident's goal for health and well-being	2,961
		E0900, Wandering – Presence And Frequency	1,693
		E1000A, Wandering placed the resident at significant risk of getting to a potentially dangerous place	375
		E1000B, Wandering significantly intrudes on the privacy or activities of others	344
		Traumatic Brain Injury	400
Ventilator Dependent	179	O0100F1, Ventilator Or Respirator – While Not A Resident	142
		O0100F2, Ventilator Or Respirator – While A Resident	191

*Beds In Use*  
384  
 70  
 142

132  
 40

Source: cms.gov, MDS 3.0 Frequency Report, Second Quarter 2016.