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July 30, 2010

Ms. Paula Quirin, Project Analyst
Mr. Craig Smith, Section Chief
Certificate of Need Section
Division of Health Services Regulation
NC Department of Health and Human Services
701 Barbour Drive
Raleigh, North Carolina 27626

Re: Comments on Competing Johnston County Nursing Facility Beds CON Proposals –
Liberty Healthcare Properties of West Johnston County, LLC and Liberty Commons Nursing and Rehabilitation Center of West Johnston County, **J-8538-10**
Britthaven, Inc. d/b/a Britthaven of Johnston/Cleveland, **J-8539-10**
Britthaven d/b/a Britthaven of Johnston/Clayton, **J-8540-10**

Dear Ms. Quirin and Mr. Smith:

On behalf of UniHealth Post-Acute Care-Clayton (UniHealth), Project ID **J-8541-10**, thank you for the opportunity to comment on the above referenced applications for development of nursing facility beds in Johnston County. During your review of the projects, I trust that you will consider the comments presented herein.

We recognize that the State's Certificate of Need (CON) award for the proposed nursing facility beds will be based upon the State's CON health planning objectives, as outlined in G.S. 131E-183. Specifically, we request that the CON Section give careful consideration to the extent to which each applicant:

1. Demonstrates the positive aspects of competition and increased consumer choice;
2. Demonstrates the need its service area population has for nursing facility services;
3. Demonstrates the needs of populations currently being served will adequately be met;
4. Demonstrates immediate and long-term financial feasibility;
5. Demonstrates the availability of adequate staff to provide all proposed services;
6. Demonstrates the ability to provide all necessary ancillary and support services;
7. Demonstrates a cost effective alternative;
8. Offers service accessibility to all service area residents;
9. Provides evidence that quality care has been provided in the past; and
10. Effectively adheres to Policy GEN-3 –Basic Principals.

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The application from UniHealth, Project ID J-8541-10, best meets all of the above-referenced planning objectives.

Johnston County will benefit tremendously from UniHealth. UniHealth meets all statutory review criteria and is comparably the most effective applicant. UniHealth will:

- Bring the positive aspects of competition and increased consumer choice;
- Offer a smaller facility that promotes the highest quality of resident life possible;
- Offer the most access to much needed short-term rehabilitation services; and
- Promote the *2010 State Medical Facility Plan (SMFP)* Basic Principals.

Competition

Competition in Johnston County will only be enhanced with the addition of an alternative nursing care provider, one that does not currently offer nursing care in Johnston County. Britthaven and Liberty, or their related entities, have facilities in Johnston County. Adequate competition creates an environment that supports tendencies toward expanded access, service variety, innovation, higher salaries, higher quality, competitive charges, and value-based, cost-effective service.

Furthermore, the State Health Coordinating Council (SHCC) recognizes the advantages of competition and encourages new providers. On page 193 of the *2010 SMFP*, the basic assumptions of the nursing facility methodology state that "any advantages to patients that may arise from competition will be fostered by policies which lead to the establishment of new provider institutions."

A comparison of North Carolina Counties, with populations similar to Johnston County, shows that Johnston County residents lack sufficient choice.

Table 1- Competition Comparison

County	FY 2010 Population[1]	Number of Different Nursing Home Providers[2]
Johnston	**173,669**	**4**
Alamance	150,377	7
Cabarrus	179,236	7
Davidson	161,870	9
Iredell	154,615	6
Pitt	161,893	6

[1] demog.state.nc.us
[2] *2010 SMFP*, Table 10A

UniHealth is the only applicant that is a new provider; thus, is the best applicant to improve both access and quality. This is especially important in Johnston County because area long-term care advocates have recently questioned the quality of care provided by Britthaven and Liberty.

Small Facility

The "culture change" movement represents a fundamental shift in thinking about nursing homes. Facilities are viewed, not as health care institutions, but as person-centered homes offering long-term care services. Culture change principles and practices have been shaped by shared concerns among consumers, policy makers, and providers regarding the value and quality of care offered in traditional nursing homes.[3]

North Carolina nursing facilities are leading the charge in culture change. Their efforts are reinforced by the CON process, SMFP Policy NH-8, and laws passed by the CMS and the North Carolina General Assembly. Owners are investing in facility renovations, installing new fire-protection systems, and initiating programs that promote staff and resident quality of life.

Recent research is showing that smaller nursing facilities are better for promoting culture change. A study published by the Journal of the American Geriatrics Society suggests that residents of small nursing homes appear better satisfied and report a better quality of life than do residents of traditional large nursing homes. Often times, smaller facilities have a less-institutional approach, which provides residents a more enjoyable overall experience. Most noteworthy were the higher quality of life measurements such as meaningful activity and relationships comfort, and a sense of security, dignity, individuality, privacy, and the enjoyment of food. According to the study, in addition to higher quality of life measurement, residents of smaller nursing homes have lower incidence of later decline in activities of daily living when compared with selected residents in traditional nursing homes.[4]

UniHealth's proposed facility is the smallest of all the applicants and, in this respect, is best situated to improve Johnston County nursing home residents' quality of life.

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[3] http://www.commonwealthfund.org/Content/Publications/In-the-Literature/2010/Jan/Person-Centered-Care-for-Nursing-Home-Residents.aspx

[4] UniHealth application Section III.1.(a), page 96.

Short-Term Rehabilitation Services

During the process of preparing UniHealth's application, UHS-Pruitt representatives interviewed more than 130 local healthcare providers and long-term care advocates. As documented in the UniHealth application, these representatives were consistent in their assessment that Johnston County desperately needs a nursing home that provides short-term rehabilitation services. Ms. Nancy Murphy, Regional Ombudsman for Triangle J Council of Governments, specifically cited short-term rehabilitation as the number one unmet nursing facility need in Johnston County. Thus, in a competitive situation, it is important that the Agency select a new provider that will fill service gaps.

UniHealth is the best applicant to fill Johnston County's biggest service need. A comparison of cost (investment) shows UniHealth will provide far more rehabilitation services. Table 2 compares Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST) ancillary costs reported on Form C.

Table 2- Rehabilitation Cost Comparison

Facility Name	Project Year 2 PT, OT, ST Costs[5]
UniHealth Post-Acute Care -Clayton	**$681,543**
Britthaven of Johnston - Clayton	$442,000
Britthaven of Johnston - Cleveland	$442,000
Liberty	$263,843

It should also be noted that Liberty's application provides no description of a program associated with the proposed rehabilitation costs.

[5] Form C, "Ancillary Services"

Quality, Access, Value

Overview

The following summarizes the ways in which UniHealth meets the *2010 SMFP* basic principles: Quality, Access and Value.

Quality

Among the applicants, UniHealth shows the most evidence of investment in staffing in areas that have a significant impact on resident quality of life and quality of care. Though some differences among the applicants are small, cumulatively, they separate the excellent package proposed by UniHealth from the good to adequate proposals by others.

UniHealth proposes the highest percentage of salary in payroll benefit for staff.

Table 3- Benefits Comparison

Facility Name	Benefits as a Percent of Salary
UniHealth Post-Acute Care -Clayton	**22.1%**
Britthaven of Johnston - Clayton	22.0%
Britthaven of Johnston - Cleveland	22.0%
Liberty	20.0%

Source: Attachment E

Among the applicants, UniHealth will have the highest likelihood of attracting top caliber staff. UniHealth proposes the highest salaries for Director of Nursing (DON), Registered Nurse, and Certified Nursing Assistant (CNA). Recruiting top caliber nursing staff is essential to reducing errors and increasing quality care.

Table 4- Total Salary (Salary x Benefits) Comparison- Nursing Positions

Facility Name	DON	RN	CNA
UniHealth Post-Acute Care -Clayton	**$ 102,023**	**$ 67,535**	**$ 32,324**
Britthaven of Johnston - Clayton	$ 101,260	$ 65,978	$ 29,143
Britthaven of Johnston - Cleveland	$ 101,260	$ 65,978	$ 29,143
Liberty	$ 99,590	$ 62,400	$ 27,565

Source: Attachment E.

Because the proposed facilities differ in size, non-nursing care staff positions vary. Of the staff that all applicants have in common, UniHealth proposes the highest paid Food Service Supervisor, Cooks, Dietary Aides, Social Service Director, Activity Director, and Maintenance Supervisor. Higher salaries will decrease turn-over, increase staff productivity, and will allow UniHealth to recruit quality employees in each position.

Table 5- Total Salary (Salary x Benefits) Comparison- Non-Nursing Positions

Facility Name	Food Supervisor	Cooks	Dietary Aides	Social Services Director	Activity Director	Maintenance Supervisor
UniHealth Post-Acute Care - Clayton	**$51,691**	**$31,421**	**$23,395**	**$46,612**	**$35,613**	**$46,586**
Britthaven of Johnston - Clayton	$40,870	$22,204	$21,443	$39,040	$34,160	$40,260
Britthaven of Johnston - Cleveland	$40,870	$22,204	$21,443	$39,040	$34,160	$40,260
Liberty	$39,936	$18,720	$18,720	$44,928	$29,952	$44,928

Source: Attachment E.

UniHealth provides the most RN/LPNs per CNA. This will help reduce service errors and improve care. CNAs most often are the principal caregivers in a nursing home. With a greater RN/LPN to CNA ratio licensed and certified nurses will be able to provide more training to CNAs and have more time for monitoring service protocols.

Table 7- RN/LPNs per CNA

Facility Name	Ratio
UniHealth Post-Acute Care -Clayton	**0.58**
Britthaven of Johnston - Clayton	0.54
Britthaven of Johnston - Cleveland	0.54
Liberty	0.40

Source: Attachment E.

As stated above, UniHealth is the applicant offering the smallest facility. Studies show that smaller facilities have higher staff, resident and family satisfaction, staff turnover is less, and resident outcomes are improved.

Access

UniHealth offers the most access to Medicare, Medicaid, and Hospice recipients.

Table 8- Payor Comparison

Facility Name	Percent Medicare /Medicaid /Hospice
UniHealth Post-Acute Care –Clayton	**97%**
Britthaven of Johnston – Clayton	92%
Britthaven of Johnston – Cleveland	92%
Liberty	88%

Source: Section VI.3.

It is important to note that UniHealth is the only provider offering hospice services. Numerous published studies have revealed that nursing home residents who receive hospice care have superior pain management and fewer hospitalizations. Moreover, family satisfaction with care at the end of life is positively affected. Please see Attachment B.

As stated above, UniHealth is the applicant that proposes the most access to rehabilitation services. According to Johnston County area healthcare providers and long-term care advocates, this is the most needed nursing home service.

UniHealth's proposed sites increase access by being easily accessible and located in the middle of the areas most in need of nursing facility beds. As stated in Section III.1.(b), application pages 101 and 102, of UniHealth's application, the northwestern townships of Pleasant Grove, Cleveland, Clayton, Wilders, and O'Neals have the greatest need for additional nursing beds in Johnston County. The Clayton Township is centrally located between Pleasant Grove, Cleveland, Wilders, and O'Neals. The Clayton Township can be easily reached from Wilders and O'Neals via NC Highways 42 and 96. The Clayton Township can be easily reached from Pleasant Grove and Cleveland via NC Highways 42, 50, and 210. Wake County also has a significant need for additional nursing beds. Of the Wake County townships that border Johnston County, Saint Mary's has the greatest need for additional nursing beds. Saint Mary's is located directly across the Johnston County border from the Clayton Township. Finally, the Clayton Township has access to major highways and interstates, public utilities, and is close to support and ancillary services such as the new Johnston Medical Center Clayton. The Clayton Township is the only township that offers all these things; thus, should be where Johnston County's next nursing home is located.

Value

UniHealth offers superior resident value compared to Liberty and Britthaven. A comparison of applicants should consider the fact that the amounts of Medicaid's daily nursing home payments are capped. Therefore, all applications should be reviewed for how much they invest in resident care for this set price. A nursing home with lower costs can realize higher profits. Thus, there is an incentive to decrease services to residents. UniHealth has the highest direct cost per resident day. This means that UniHealth proposes the greatest investment in resident care.

Table 9- Direct Cost (Less Ancillaries) Comparison

Facility Name	Cost Per Patient Day
UniHealth Post-Acute Care -Clayton	**$114.75**
Liberty	$114.08
Britthaven of Johnston - Clayton	$112.34
Britthaven of Johnston - Cleveland	$112.34

Source: Attachment E

To keep the comparison consistent, Table 9 compares only costs associated with nursing care, from Column B of Form C in Project Year 2.

Conclusion

Although all applicants are surely interested in providing quality service, it is our opinion that among the projects under review, competing applications offer less desirable alternatives, fall short of meeting the State of North Carolina's objectives for the provision of quality health care in most effective manner, and fall short of being conforming to all the CON Section's Review Criteria.

The application from UniHealth proposes a needed service and is competitively superior. It:

- Brings the positive aspects of competition and increased consumer choice;
- Offers a smaller facility that promotes the highest quality of resident life possible;
- Offers the most access to short-term rehabilitation services;
- Offers a site location easily accessible to the Johnston County residents most in need;
- Offers the most access to the medically underserved;
- Offers the most RN/LPNs per CNA;
- Offers the highest salaries; and
- Offers the highest investment in resident care.

Attached is an analysis of each competing application. Each application is discussed within the framework of the State's CON Review Criteria and applicable nursing facility services rules (10A NCAC 14C .1100). In each analysis, we have addressed only those criteria for which we believe the information provided is non-conforming. Because both Britthaven applications are almost identical, the applications are discussed together. Please feel free to call me if you have any questions.

Sincerely,

Sarah Haislip /pp

Sarah Haislip, Health Planner
UHS-Pruitt Corporation

Attachments:
Noncompliance with CON Review Criteria and applicable Rules: 10A NCAC 14C .1100
Hospice articles
Conversation log with Becky Wertz
UHS-Pruitt historical nursing home Medicaid accounts receivable
Table Calculations

Attachment A

COMPETITIVE REVIEW OF –
Liberty Healthcare Properties of West Johnston County, LLC and Liberty Commons Nursing and Rehabilitation Center of West Johnston County, J-8538-10 (Liberty)

CON REVIEW CRITERIA

1. ***The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, ambulatory surgery operating rooms, or home health offices that may be approved.***

Overview

The proposed application is not consistent with applicable policies in the *State Medical Facilities Plan (SMFP)*. The application does not demonstrate how the project will promote safety and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value. Therefore, Liberty fails to be consistent with Policy GEN-3: BASIC PRINCIPLES; thus, non-conforming to Criterion (1).

Additionally, the proposed project is not consistent with all the special rules for nursing facilities, in 10A NCAC Section 14C .1100 – Criteria and Standards for Nursing Facility Services, in Section II.1, thus, is not conforming to Criterion (1).

The discussion below outlines how the applicant is inconsistent with Policy GEN-3.

Safety and Quality

Safety and quality can not be assumed because the applicant fails to adequately demonstrate the availability of health manpower. Please see discussion in Criterion (7).

Access

Liberty's application provides no discussion of programs for short-term rehabilitation or memory support programming. As stated in Section III.1.(a), pages 92 through 94, of UniHealth's application, there is a tremendous need in Johnston County for short-term rehabilitation services and memory support programs. Thus, to ensure access to the services most needed by Johnston County residents, applicants must demonstrate an ability to care for nursing facility residents in need of Alzheimer's/dementia and short-term rehabilitation services. The Liberty application falls short on these measures.

Value

It is not possible to determine that Liberty's proposed project will maximize healthcare value, because the applicant does not adequately demonstrate the population to be served and the need of the population for the proposed nursing home service. Please see discussion in Criterion (3).

For the reasons stated above, Liberty failed to demonstrate that the application is consistent with the need determination and applicable policies.

3. ***The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.***

Population to be Served

Liberty did not adequately identify the population to be served for the following reason:

- Liberty application page 64, Section III.9.(a), states, without explanation, that one percent of projected resident origin is unknown. Thus, Liberty does not identify all of the population to be served by the proposed project. The agency has found this methodology non-conforming in the past. Please see Agency findings for Project ID# O-7945-07.

- Liberty's patient origin assumptions are unsupported. On Liberty application page 64, Section III.9.(b), the applicants state, that it is reasonable to serve Cumberland County because northern Cumberland County is underserved. However, the applicants provide no data to defend this statement. Please also see discussion below, in "Need for the Proposed Project".

Need for the Proposed Project

Liberty does not adequately demonstrate the need of the population to be served for the following reasons:

- Liberty identifies the population to be served as Johnston, Harnett, Wake and Cumberland Counties, in its presentation of patient origin, in response to Section III.9.(a). However, Liberty fails to show any need for nursing facility or adult care home services in Harnett, Wake and Cumberland Counties.

- Liberty's independent assessment of Johnston County's need for nursing facility and adult care home beds is incomplete. Liberty application page 51, Section III.1.(a), projects Johnston County nursing facility bed need in 2014, Project Year 2. However, the applicants do not project the Johnston County nursing facility bed need in Project Years 1 or 3. In Exhibit 11, the applicants project Johnston County adult care home bed need in 2014, Project Year 2. However, the applicants do not project the Johnston County adult care home bed need in Project Years 1 or 3.

- On Liberty application page 51, Section III.1.(a), the applicants state that relocating six nursing facility beds and 24 adult care home beds, from Liberty Commons Nursing and Rehabilitation Center of Johnston County to its proposed facility, is necessary to increase operational efficiencies at Liberty Commons Nursing and Rehabilitation Center of Johnston County. However, the applicants provide no explanation of what is currently inefficient at Liberty Commons Nursing and Rehabilitation Center of Johnston County or what specifically will be improved by the proposed relocation.

- Liberty application page 49, Section III.1.(a), states that this project will meet the unmet need for additional Medicaid beds and private rooms. However, the applicants provide no discussion of the need for more Medicaid beds or private rooms in Johnston County.

Liberty does not adequately demonstrate the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed because, as stated in Criterion (1), the applicants do not offer programs sufficient to care for persons in need of Alzheimer's/dementia and short-term rehabilitation services.

In conclusion, the applicants do not adequately identify the population to be served, do not adequately demonstrate the need that population has for the services proposed, and do not adequately demonstrate that all persons will have access to its proposed services. Therefore, the application is non-conforming to Review Criterion (3).

4. ***Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.***

The application is not conforming to other applicable statutory and regulatory Review Criteria. Therefore, Liberty did not demonstrate the least costly or most effective alternative has been proposed. As a result, the application is not conforming to this Review Criterion. See discussion in Review Criterion (1), (3), (5), (6), (7), (12), (13c), and (18a).

5. ***Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.***

Operational Projections

Liberty's operational projections are unsupported and unreliable for the following reasons:

- On Liberty application page 129, Section XII, Liberty projects licensure and certification on the same day. This is not possible. Please see Attachment C for a log of a conversation with Becky Wertz of the North Carolina Nursing Home Licensure and Certification Section.

- Liberty is proposing to relocate 24 adult care beds. This part of the application should be evaluated on its own merits as well. On Liberty application page 67, Liberty states that over 80 percent of its adult care population will be State-County Basic Assistance residents. Next, Liberty states that this population [State-County Basic Assistance residents] is typically underserved and is typically the most difficult to payor source to place in an adult care home. However, Liberty provides no quantitative or qualitative facts to substantiate its claims or validate the proposed payor mix.

- Liberty provides no assumptions for its proposed nursing facility bed payor mix.

Financial Projections

Liberty's financial projections are unsupported and unreliable for the following reasons:

- Liberty's projections for utilization are unsupported and unreliable. See discussion above. Consequently, costs and revenues that are based on the applicants' utilization projections are unreliable.

- Liberty provides no assumptions to substantiate its proposed charges, provided in response to application question X.4.

- Liberty provides no assumptions to substantiate the proforma worksheets provided on Liberty application pages 140-159.

- Application question X.8.(c) states that all applicants must complete Form B and C. The Liberty application provides proformas for only one of the two applicants. UniHealth assumes the proformas are for the operating company. Without proformas for the property owner, it is not possible to determine if the applicant will have adequate cash flows from rental income.

- Liberty provides estimates of start-up costs, initial operating expense, and total working capital needs for only one applicant. Furthermore, it is impossible to determine which applicant is responsible for the costs.

- The applicant failed to budget adequate expenses for appropriate levels of health manpower. See discussion in Criterion (7).

- Liberty's provider Medicaid Assessment Fee expense is too low. The current Provider Fee Assessment, for a facility with less than 48,000 bed days, is $12.75. A provider pays $12.75 for every bed day, less Medicare bed days. Thus, in year two the applicant should have budgeted $238,259. Liberty budgeted $95,294, a shortfall of $142,965.

a	b	c	d	e
Project Year 2 Total Bed Days (Less Medicare)	Provider Assessment Fee	Total Expense	Project Year 2 Budgeted Expense	Budget Shortfall
18,687	$12.75	$238,259	$95,294	$142,965

Source:

a) Liberty Application Page 74, Table IV.3

b) http://www.dhhs.state.nc.us/dma/cost/nfassessment.htm

*c) a*b*

d) Liberty Application Page 139, Form C

e) c-d

Availability of Funds

The applicants provide insufficient data to demonstrate availability of funds necessary to operate the proposed project for the following reasons:

- Liberty's bank letter does not indicate willingness to consider financing for $6,374,060 for the project. The letter simply states that that "Our client has informed the bank (BB&T), that a credit in the amount of $6,374,060 may be needed to finance the land purchase and construction of this new facility" and that "the McNeill's and Liberty Healthcare have a material banking relationship with BB&T." The letter does not "indicate a willingness to consider financing the proposed project", as instructed in Section VIII.3.

- Liberty's bank letter does not refer to Liberty Healthcare Properties of West Johnston County, LLC, the entity that will borrow the funds. The bank letter simply refers to "the McNeill's" and "Liberty Healthcare."

- The funding letter in Liberty Exhibit 33 does not specify which applicant will be given $333,211 for working capital needs and $2,874,144 for capital cost needs.

If the CON Section determines the applicants did provided sufficient funding documentation for the capital costs proposed in the application, the applicants still do not provide sufficient data to demonstrate the availability of funds necessary to operate the proposed project for the following reasons:

- The applicants' working capital needs are underestimated and unverifiable for the following reasons:

    - Liberty fails to apply a lag to Medicare and Medicaid/County Assistance receipts. Per a conversation with Becky Wertz of the North Carolina Nursing Home Licensure and Certification Section, UniHealth believes it is unreasonable to collect Medicare or Medicaid/County Assistance revenue until the second quarter of operations. Please see Attachment C. By underestimating the cash flow lag, Liberty understated its initial operating expenses. A longer lag in cash flow would call for access to more initial operating capital. If Liberty's quarter one Medicare and Medicaid receipts were removed from the cash flow projections, Liberty would need an extra $627,693 to fund operations. This is important because, on Liberty application page 104 and 405, Section IX.5 and Liberty application Exhibit 33, Liberty allocates $333,211 for working capital needs. Thus, Liberty does not provide evidence of funds sufficient to cover any increase.

    - UniHealth believes Liberty's revenue collection assumptions, provided on Liberty application page 100, Section IX.2.(d), are very aggressive. The applicant states that it will receive Medicaid reimbursement within five days of billing and the applicant plans to bill once a week. Thus, the maximum wait will be 12 days. UHS-Pruitt's history in North Carolina is 31 days. By underestimating the cash flow lag, Liberty understated its initial operating expenses. A longer lag in cash flow would call for access to more initial operating capital. As discussed above, Liberty does not provide evidence of funds sufficient to cover any increase. Please see Attachment D.

    - As discussed above, the applicants provide estimates of start-up costs, initial operating expense, and total working capital needs for only one applicant. Thus, it is impossible to determine if sufficient working capital funds have been allocated.

- Liberty understated its capital costs. On Liberty application page 45, the applicants state the proposed facility will have a van. However, the applicants do not budget for a van in the capital cost estimates provided on Liberty application page 95, Table VIII.1. This is important because on Liberty application page 96 and 405, Section VIII.2 and Liberty application Exhibit 33, Liberty allocates $9,248,204 for capital costs needs. Thus, the applicants do not provide evidence of funds sufficient to cover any increase in capital costs.

- Liberty understated its capital costs because it did not include renovation cost estimates for its existing Johnston County facility. Please see Criterion (12). As stated above, the applicant does not provide evidence of funds sufficient to cover any increase in capital costs.

In conclusion, the applicants did not adequately demonstrate the availability of sufficient funds for capital and operating needs and the applicants' utilization and financial projections are unreliable. Thus, the application is non-conforming to Criterion (5).

6. ***The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.***

The application failed to adequately demonstrate the need for the proposed nursing home and adult care home facility. The application's need methodology is incomplete.

The applicants provide no discussion of the need for more Medicaid beds or private rooms. The applicants provide no discussion on the need for nursing home or adult care home beds in their secondary service area counties. The applicants do not forecast nursing home or adult care home bed need in Project Year 1 or 3. Therefore, the applicants failed to demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities and are non-conforming with this Review Criterion.

7. ***The applicant shall show evidence of the availability of resources, including health manpower and management personnel, for the provision of the services proposed to be provided.***

Liberty does not show evidence of the availability of resources including health manpower and management personnel, for the provision of the services proposed. In Section VII of its application, Liberty underestimated direct care staffing requirements. The applicants proposed staffing by shift in Table VII.2 and converted these to FTEs in Table VII.3. However, the applicants did not add FTEs to cover staff positions when employees utilize paid time off (PTO) or provide evidence that its benefit percentages include funds necessary to replace staff on PTO.

12. ***Applications involving construction shall demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative, and that the construction project will not unduly increase the costs of providing health services by the person proposing the construction project or the costs and charges to the public of providing health services by other persons, and that applicable energy saving features have been incorporated into the construction plans.***

Liberty did not demonstrate that construction shall demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative for the following reasons:

- The applicants provide no discussion of the acceptability of the site for building, as requested in application question XI.2.(j). Thus, it is impossible to determine if the proposed site is buildable.

- The applicants provide no estimate of the costs associated with converting a portion of Liberty's existing Johnston County nursing home semi-private rooms to private rooms. Thus, it is impossible to determine if the renovations costs are reasonable.

13. ***The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:***

(c) ***That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services; and***

The application is non-conforming to this Criterion. As stated in Criterion (1), the applicants do not offer programs sufficient to care for residents in need of Alzheimer's/dementia and short-term rehabilitation services. Please see discussion in Criterion (1).

18a. ***The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for the service for which competition will not have a favorable impact.***

This is not a proposal to enhance competition. Liberty, an existing nursing facility in Johnston County, failed to demonstrate that relocating and increasing its bed count in the county will enhance competition or have a positive impact upon Johnston County residents' access to adult care or nursing facility services; therefore, the application is nonconforming to this criterion. Furthermore, Liberty is non-conforming with Criterion (1), (3), (4), (5), (6), (7), (12) and (13c). As a result, it is impossible to determine if the facility will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; thus, the application is non-conforming with this criterion. Please see discussions in Criterion (1), (3), (4), (5), (6), (7), (12) and (13c).

20. ***An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past.***

Liberty's ability to provide quality care should be closely examined in this review. During a review of Liberty Commons Nursing and Rehabilitation Center of Johnston County's licensure file, UniHealth discovered that in May, 2010, Judy Markanich, North Carolina DMA, contacted the North Carolina Complaint Intake Unit, about poor care being provided at Liberty's existing Johnston County facility. Renee Filippucci-Kotz, MSW, of the North Carolina Complaint Intake Unit, confirmed receipt of this complaint in a letter to Judy Markanich dated May 6, 2010. No details of the complaint are currently provided in the Liberty Commons Nursing and Rehabilitation Center of Johnston County licensure file. However, UniHealth believes deeper investigation by the Agency is warranted. The Nursing Home Licensure Section would not release a copy of the letter but it is available in the Liberty Commons Nursing and Rehabilitation Center of Johnston County licensure file.

SECTION .1100 – CRITERIA AND STANDARDS FOR NURSING FACILITY OR ADULT CARE HOME SERVICES

10A NCAC 14C .1101 INFORMATION REQUIRED OF APPLICANT

(a) ***An applicant proposing to establish new nursing facility or adult care home beds shall project an occupancy level for the entire facility for each of the first eight calendar quarters following the completion of the proposed project. All assumptions, including the specific methodologies by which occupancies are projected, shall be stated.***

The applicants' projections for utilization are unsupported and unreliable. See discussion in Criterion (5).

(b) ***An applicant proposing to establish new nursing facility or adult care home beds shall project patient origin by percentage by county of residence. All assumptions, including the specific methodology by which patient origin is projected, shall be stated.***

The application is non-conforming to this Review Criterion. On application page 64, Section III.9.(a), Liberty states that one percent of its resident origin is unknown. Thus, Liberty does not project resident origin by percentage by county of residents. Furthermore, the applicants' resident origin is based on undocumented assumptions. Please see discussion in Review Criterion (3).

(e) ***An applicant proposing to establish a new nursing facility or adult care home shall document that the proposed site and alternate sites are suitable for development of the facility with regard to water, sewage disposal, site development and zoning including the required procedures for obtaining zoning changes and a special use permit after a certificate of need is obtained.***

The application is non-conforming to this criterion. Liberty does not provide evidence that its proposed site is appropriate for building. Please see Criterion (12).

10A NCAC 14C .1102 PERFORMANCE STANDARDS

(b) ***An applicant proposing to establish a new nursing facility or add nursing facility beds to an existing facility, except an applicant proposing to transfer existing certified nursing facility beds from a State Psychiatric Hospital to a community facility, shall not be approved unless occupancy is projected to be at least 90 percent for the total number of nursing facility beds proposed to be operated, no later than two years following the completion of the proposed project. All assumptions, including the specific methodologies by which occupancies are projected, shall be clearly stated.***

Liberty's projections for utilization are unsupported and unreliable. See discussion in Criterion (5).

(d) ***An applicant proposing to establish a new adult care home facility or add adult care home beds to an existing facility shall not be approved unless occupancy is projected to be at least 85 percent for the total number of adult care home beds proposed to be operated, no later than two years following the completion of the proposed project. All assumptions, including the specific methodologies by which occupancies are projected, shall be stated.***

Liberty's projections for utilization are unsupported and unreliable. See discussion in Criterion (5).

COMPETITIVE REVIEW OF –
Britthaven, Inc. d/b/a Britthaven of Johnston/Cleveland, J-8539-10
Britthaven, Inc. d/b/a Britthaven of Johnston/Clayton, J-8540-10
(Britthaven)

CON REVIEW CRITERIA

Britthaven, Inc.'s two applications are identical except for information related to the site. No comments below relate to either of Britthaven's sites; thus, all comments below apply to both applications.

1. ***The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, ambulatory surgery operating rooms, or home health offices that may be approved.***

Overview

The proposed application is not consistent with applicable policies in the *State Medical Facilities Plan (SMFP)*. The application does not demonstrate how the project will promote safety and quality in the delivery of health care services or maximize healthcare value. As a result, Britthaven fails to be consistent with Policy GEN-3: BASIC PRINCIPLES; therefore, non-conforming to Criterion (1).

Additionally, the proposed project is not consistent with all the special rules for nursing facilities, in 10A NCAC Section 14C .1100 – Criteria and Standards for Nursing Facility Services, in II.1, thus, is not conforming to Criterion (1).

The discussion below outlines how the applicant is inconsistent with Policy GEN-3.

Safety and Quality

Safety and quality can not be assumed because the applicant fails to adequately demonstrate the availability of health manpower and ancillary services. Please see discussion in Criterion (7) and (8).

Value

It is not possible to determine that Britthaven's proposed project will maximize healthcare value, because the applicant does not adequately demonstrate the population to be served and the need of the population for the proposed nursing home service. Please see discussion in Criterion (3).

For the reasons stated above, Britthaven failed to demonstrate that the application is consistent with the need determination and applicable policies.

3. ***The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.***

Need for the Proposed Project

Britthaven does not adequately demonstrate the need of the population to be served for the following reasons:

- Britthaven identifies the population to be served as Johnston, Wake, Wayne, Wilson, Nash, and Harnett Counties in its presentation of patient origin in response to Section III.9.(a). However, Britthaven fails to show any need for nursing facility services in Wake, Wayne, Wilson, Nash, and Harnett Counties.

- Britthaven's independent assessment of Johnston County's need for nursing facility beds is incomplete. On Britthaven application pages 109-114, Section III.2.(a), the applicant projects Johnston County nursing facility bed need in 2014, Project Year 2. However, the applicant does not project the Johnston County nursing facility bed need in Project Year 1 or 3.

- On application page 60, Britthaven proposes to group younger residents in the same neighborhood. However, there is no discussion of the need for nursing facility beds for younger residents.

- Britthaven does not adequately document the need for its proposed Alzheimer's special care unit. On page 98, the applicant states,

  > "considering the projected number of individuals with Alzheimer's disease in the near future (2,153), 38 beds simply are insufficient to meet growing needs."

  However, the application provides no statistical projection of how Johnston County's projected Alzheimer's need translates to the need for Alzheimer's beds in a nursing home, in Johnston County. Furthermore, the applicant does not adequately document that its proposed facility needs a locked Alzheimer's Special Care Unit. On page 98, Britthaven states that Alice Watkins, Executive Director of the North Carolina Alzheimer's Association, believes that even at the skilled level of care, patients with Alzheimer's disease are best cared for in a secure unit. However, the applicant provides no evidence that a secure unit must be a locked unit.

  It has been UHS-Pruitt's experience that with comprehensive Alzheimer's programming, a neighborhood design, sufficient staffing, and technology, such as wanderguard, nursing facility Alzheimer's/dementia residents are very safe. People with advanced stages of Alzheimer's disease, who need nursing home care, require programming that addresses their unique disabilities. However, these people are generally past the mobile, wanderer stage and are in need of special care, but not necessarily locked, designated special care units.

3a. ***In the case of a reduction or elimination of a service, including the relocation of a facility or a service, the applicant shall demonstrate that the needs of the population presently served will be met adequately by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly to obtain needed health care.***

Britthaven does not demonstrate that the needs of the population presently served will be adequately met by the proposed relocation or by alternative measures. In response to application question III.7.(a), Britthaven states that it will relocate 40 beds from Britthaven of Smithfield to its proposed facility. On application page 134, Britthaven states that, since FY 2009, Britthaven of Smithfield is operating with 22 to 27 empty beds. Yet, to execute the proposed project, on the day its proposed facility is licensed, Britthaven of Smithfield will be required to de-license 40 nursing facility beds.[6] Britthaven of Smithfield does not have 40 empty nursing beds. On application page 141, Britthaven states that its proposed facility will fill at a rate of four residents per week. Thus, the day that the proposed facility is licensed, if Britthaven of Smithfield is operating with 22 to 27 empty beds, 13 to 18 residents will need a place go. Based on the utilization assumptions provided in Britthaven application Section IV.2, the proposed facility will not accommodate these residents. The applicant provides no plan for these displaced residents.

4. ***Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.***

The application is not conforming to other applicable statutory and regulatory Review Criteria. Therefore, Britthaven did not demonstrate the least costly or most effective alternative has been proposed. As a result, the application is not conforming to this Review Criterion. See discussion in Review Criterion (1), (3), (3a), (5), (6), (7), (8), (12), and (18a).

[6] *Please see Attachment C for a conversation log with Becky Wertz of the North Carolina Nursing Home Licensure and Certification Section.*

5. ***Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.***

Operational Projections

The applicant's operational projections are unsupported and unreliable for the following reasons:

- Britthaven's patient day projections by payor are unreliable. Britthaven application pages 54 and 60, states that it will serve hospice and VA recipients. However, Britthaven's Table IV.3, Table VI.3, and Form B show no VA or hospice utilization.

- In Britthaven application Section XII, the applicant projects licensure and certification on the same day. This is not possible. Please see Attachment C for a conversation log with Becky Wertz of the North Carolina Nursing Home Licensure and Certification Section.

- Application Question IV.2 and IV.3 asks applicants to provide Table IV.2 and IV.3 for the first three full fiscal years of operation. Britthaven only provides Table IV.2 and IV.3 for the first two full fiscal years of operation.

Financial Projections

The applicant's financial projections are unsupported and unreliable for the following reasons:

- The applicant's projections for utilization are unsupported and unreliable. See discussion above. Consequently, costs and revenues that are based on the applicant's utilization projections are unreliable.

- The applicant failed to budget adequate expenses for appropriate levels of health manpower. See discussion in Criterion (7).

- Britthaven's loan payments are based on an unverifiable interest rate. In Britthaven application Exhibit P, the applicant provides documentation of commercial financing at a rate of Libor +1.5% (Libor currently 0.32%). However, the applicant does not provide documentation of which Libor rate will be applied. There are fourteen Libor Rates.[7] Currently rates vary from 0.28 to 1.16.

[7] http://www.liborated.com/current_libor_rates.asp

Availability of Funds

The applicant provides insufficient data to demonstrate availability of funds necessary to operate the proposed project for the following reasons:

- The applicant fails to apply a lag to Medicare and Medicaid receipts. Per a conversation with Becky Wertz of the North Carolina Nursing Home Licensure and Certification Section, UniHealth believes it is unreasonable to collect Medicare or Medicaid/County Assistance revenue until the second quarter of operations. Please see Attachment C. By underestimating the cash flow lag, the applicant understated its initial operating expenses. A longer lag in cash flow would call for access to more initial operating capital. If Britthaven's quarter one Medicare and Medicaid receipts were removed from the cash flow projections, Britthaven would need an extra $268,797 to fund operations. This is important because Britthaven provides evidence of funds sufficient to cover only the initial operating expenses provided in Britthaven application Section IX.5. Please see Britthaven application Exhibit P. Thus, the applicant does not provide evidence of funds sufficient to cover any increase.

- Britthaven application page 191 states that start-up will take one month and its start-up costs are $170,508. On application page 222, Britthaven states that it will execute its loan on January 1, 2011. Thus, the applicant will make loan payments for 22 months prior to opening. The applicant provides no indication that start-up costs include money necessary to make principal payments on the loan during the start-up period. As a result, the applicant underestimated its start-up expense. As discussed above, the applicant does not provide evidence of funds sufficient to cover any increase.

- On Britthaven application page 71, the applicant states the proposed facility will provide transportation services. However, the applicant does not budget for a van in the capital cost estimates provided in Table VIII.1. This is important because Britthaven provides evidence of funds sufficient to cover only the capital cost estimates provided in Britthaven application Section VIII.2. Please see Britthaven application Exhibit P. Thus, the applicant does not provide evidence of funds sufficient to cover any increase.

- In Britthaven application Exhibit V, the applicant projects that renovation costs at Britthaven of Smithfield will total $325,000. However, the applicant did not include this estimate in Table VIII.1. As stated above, the applicant does not provide evidence of funds sufficient to cover any increase in capital costs.

In conclusion, the applicant did not adequately demonstrate the availability of sufficient funds for capital and operating needs and the applicant's utilization and financial projections are unreliable. Thus, the application is non-conforming to Criterion (5).

6. ***The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.***

The application failed to adequately demonstrate the need for the proposed nursing home facility. The application's need methodology is incomplete. The applicant provides no discussion on the need for nursing home beds in its secondary service area counties and does not forecast nursing home bed need in Project Year 1 or 3. Therefore, the applicant failed to demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities and is non-conforming with this Review Criterion.

7. ***The applicant shall show evidence of the availability of resources, including health manpower and management personnel, for the provision of the services proposed to be provided.***

The applicant does not demonstrate that it will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services for the following reasons:

- The applicant did not budget appropriate funds for dietician services. On page 569, the applicant provides a letter stating that its proposed dietician will have an hourly rate of $50-60 per hour. However, Britthaven budgets only $32 per hour for dietician services. Please see Britthaven application Table VII.3.

- In Britthaven application Section II.4.(a), the applicant states that it will contract for a Medical Records and Wound Care Consultants. However, the applicant's proformas do not allocate funds for such services.

- Britthaven application page 56 states that the proposed facility's staff will have access to an IV nurse consultant. However, the applicant's proformas do not allocate funds for such services.

8. ***The applicant shall demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. The applicant shall also demonstrate that the proposed service will be coordinated with the existing health care system.***

The applicant does not demonstrate that it will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services for the following reasons:

- In Britthaven application Section II.4.(a), the applicant states that Respiratory Therapy will be provided by *PeopleFirst.* However, the letter from PeopleFirst, provided in Britthaven application Exhibit I, does not state that such services will be provided.

- Table VII.3 indicates that Britthaven will contract for a pharmacy consultant. However, the applicant provides no documentation of a pharmacist willing to provide such services.

- In Britthaven application Section II.4.(a), the applicant states that it will contract for a Medical Records and Wound Care Consultants. However, the applicant provides no documentation of consultants willing to provide such services.

- Britthaven application page 56 states that the proposed facility's staff will have access to an IV nurse consultant. However, the applicant provides no correspondence from a provider willing to provide such services.

- Britthaven provides sample agreements from Britthaven of Smithfield for Beauty and Barber and Mental Health services in Britthaven application Exhibit H. However, Britthaven provides no correspondences from these providers stating that they would be willing to work with Britthaven's proposed facility.

- Britthaven application Table II.4 indicates that Britthaven will contract for dialysis services. However, the applicant provides no documentation of an entity willing to provide such services. The application is also unclear on what services would actually be provided to Britthaven by contract.

12. ***Applications involving construction shall demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative, and that the construction project will not unduly increase the costs of providing health services by the person proposing the construction project or the costs and charges to the public of providing health services by other persons, and that applicable energy saving features have been incorporated into the construction plans.***

The applicant did not demonstrate that construction shall demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative for the following reason. As discussed in Criterion (3), the applicant did not demonstrate that a locked Alzheimer's/dementia special care unit was needed.

18a. ***The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for the service for which competition will not have a favorable impact.***

This is not a proposal to enhance competition. Britthaven, an existing nursing facility in Johnston County, failed to demonstrate that relocating and increasing its bed count in the county will enhance competition or have a positive impact upon Johnston County residents' access to nursing facility services; therefore, the application is nonconforming to this criterion. Furthermore, Britthaven is non-conforming with Criterion (1), (3), (3a), (4), (5), (6), (7), (8), and (12). As a result, it is impossible to determine if the facility will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; thus, the application is non-conforming with this criterion. Please see discussions in Criterion (1), (3), (3a), (4), (5), (6), (7), (8), and (12).

20. ***An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past.***

Britthaven's ability to provide quality care should be closely examined in this review. While completing its application, UniHealth interviewed local long-term care advocates regarding existing Johnston County nursing home care. One of the providers UniHealth representatives spoke with was Nancy Murphy, Regional Ombudsmen for Area on Aging- Triangle J Council of Governments. Ms. Murphy stated that Britthaven of Smithfield probably had the most quality issues of any existing provider. Please see UniHealth application Exhibit 30. Additionally, in February 2010, a resident of Britthaven of Chapel Hill, a Britthaven of Smithfield sister facility, died because of Medication errors.

SECTION .1100 – CRITERIA AND STANDARDS FOR NURSING FACILITY OR ADULT CARE HOME SERVICES

10A NCAC 14C .1101 INFORMATION REQUIRED OF APPLICANT

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The applicant's projections are unreliable. Please see discussion in Criterion (5).

(b) ***An applicant proposing to establish new nursing facility or adult care home beds shall project patient origin by percentage by county of residence. All assumptions, including the specific methodology by which patient origin is projected, shall be stated.***

The applicant's projections are based on undocumented need. Please see discussion in Criterion (3).

10A NCAC 14C .1102 PERFORMANCE STANDARDS

(b) ***An applicant proposing to establish a new nursing facility or add nursing facility beds to an existing facility, except an applicant proposing to transfer existing certified nursing facility beds from a State Psychiatric Hospital to a community facility, shall not be approved unless occupancy is projected to be at least 90 percent for the total number of nursing facility beds proposed to be operated, no later than two years following the completion of the proposed project. All assumptions, including the specific methodologies by which occupancies are projected, shall be clearly stated.***

The applicant's projections are unreliable. Please see discussion in Criterion (5).

Attachment B

1: J Am Geriatr Soc. 2002 Mar;50(3):507-15.

Does receipt of hospice care in nursing homes improve the management of pain at the end of life?

Miller SC, Mor V, Wu N, Gozalo P, Lapane K.

Department of Community Health, Center for Gerontology and Health Care Research, Brown University, Box GH-3, Providence, RI 029191. susan_miller@brown.edu

OBJECTIVES: To compare analgesic management of daily pain for dying nursing home residents enrolled and not enrolled in Medicare hospice. DESIGN: Retrospective, comparative cohort study. SETTING: Over 800 nursing homes in Kansas, Maine, Mississippi, New York, and South Dakota. PARTICIPANTS: A subset of residents with daily pain near the end of life taken from a matched cohort of hospice (2,644) and nonhospice (7,929) nursing home residents who had at least two resident assessments (Minimum Data Sets (MDSs)) completed, their last between 1992 and 1996, and who died before April 1997. The daily pain subset consisted of 709 hospice and 1,326 nonhospice residents. MEASUREMENTS: Detailed drug use data contained on the last MDS before death were used to examine analgesic management of daily pain. Guidelines from the American Medical Directors Association (AMDA) were used to identify analgesics not recommended for use in managing chronic pain in long-term care settings. The study outcome, regular treatment of daily pain, examined whether patients received any analgesic, other than those not recommended by AMDA, at least twice a day for each day of documented daily pain (i.e., 7 days before date of last MDS). RESULTS: Fifteen percent of hospice residents and 23% of nonhospice residents in daily pain received no analgesics (odds ratio (OR) = 0.57, 95% confidence interval (CI) = 0.45-0.74). A lower proportion of hospice residents (21%) than of nonhospice residents (29%) received analgesics not recommended by AMDA (OR = 0.65, 95% CI =0.52-0.80). Overall, acetaminophen (not in combination with other drugs) was used most frequently for nonhospice residents (25% of 1,673 prescriptions), whereas morphine derivatives were used most frequently for hospice residents (30% of 1,058 prescriptions). Fifty-one percent of hospice residents and 33% of nonhospice residents received regular treatment for daily pain. Controlling for clinical confounders, hospice residents were twice as likely as nonhospice residents to receive regular treatment for daily pain (adjusted odds ratio = 2.08, 95% CI = 1.68-2.56). CONCLUSION: Findings suggest that analgesic management of daily pain is better for nursing home residents enrolled in hospice than for those not enrolled in hospice.The prescribing practices portrayed by this study reveal that many dying nursing home residents in daily pain are receiving no analgesic treatment or are receiving analgesic treatment inconsistent with AMDA and other pain management guidelines. Improving the analgesic management of pain in nursing homes is essential if high-quality end-of-life care in nursing homes is to be achieved.

Publication Types:
- Comparative Study
- Research Support, Non-U.S. Gov't
- Research Support, U.S. Gov't, P.H.S.

PMID: 11943048 [PubMed - indexed for MEDLINE]

1: J Am Geriatr Soc. 2000 Aug;48(8):879-82.

Comment in:
- J Am Geriatr Soc. 2000 Aug;48(8):1017-8.
- J Am Geriatr Soc. 2001 Apr;49(4):492.

Families' perception of the added value of hospice in the nursing home.

Baer WM, **Hanson LC**.

Division of General Medicine, School of Medicine, University of North Carolina, Chapel Hill 27599-7110, USA.

OBJECTIVE: To determine if family members perceive that hospice improves the care of dying nursing home residents during the last 3 months of life. DESIGN: Mailed survey. PARTICIPANTS: Family members for all nursing home hospice enrollees in North Carolina during a 6-month period. MEASUREMENTS: After residents' deaths, family members answered questions about the quality of care for symptoms before and after hospice, the added value of hospice, the effect of hospice on hospitalization, and special services provided by nursing home staff or by hospice staff. RESULTS: A total of 292 (73%) of 398 eligible family members completed surveys. The average age of the nursing home residents who had received hospice was 79.5 years; 50% had cancer and 76% were dependent for self-care. In their last 3 months, 70% of decedents had severe or moderate pain, 56% had severe or moderate dyspnea, and 61% had other symptoms. Quality of care for physical symptoms was rated good or excellent by 64% of family before hospice and 93% after hospice (P<.001). Dying residents' emotional needs included care for moderate or severe depression (47%), anxiety (50%), and loneliness (35%). Quality of care for emotional needs was rated good or excellent by 64% of family before hospice and 90% after hospice (P<.001). Fifty-three percent of respondents believed hospice prevented hospitalizations. Family estimated the median added value of hospice to be $75 per day and described distinct special services provided by hospice and by nursing home staff. CONCLUSIONS: Family members believe that nursing home hospice improves quality of care for symptoms, reduces hospitalizations, and adds value and services for dying nursing home residents.

Publication Types:
- Research Support, Non-U.S. Gov't
- Research Support, U.S. Gov't, P.H.S.

PMID: 10968290 [PubMed - indexed for MEDLINE]

1: J Pain Symptom Manage. 2003 Nov;26(5):998-1009.

The problem of assessment bias when measuring the hospice effect on nursing home residents' pain.

Wu N, Miller SC, Lapane K, Gozalo P.

Department of Community Health, Brown University School of Medicine, Providence, Rhode Island 02912, USA.

This study examined the observed differential documentation of pain on nursing home (NH) resident assessments (minimum data sets [MDS]) when dying residents were and were not enrolled in hospice. We studied 9,613 NH residents who died in 6 states in 1999 and 2000. Documented pain was compared among three groups of residents who were categorized by their hospice exposure. At the time of their last MDS completion, residents in hospice were more likely to receive opioids for their moderate to severe pain than were non-hospice residents and residents enrolled in hospice after the last MDS assessments. However, hospice residents were twice as likely as non-hospice residents and 1.3 times as likely as residents who eventually enrolled in hospice to have pain documented. These counterintuitive findings suggest that there is differential documentation of pain on the MDS when hospice is involved in care, perhaps because of superior pain assessment by hospice.

Publication Types:
- Research Support, U.S. Gov't, P.H.S.

PMID: 14585551 [PubMed - indexed for MEDLINE]

Collaborative Care: Improving the Hospice-Nursing Home Relationship

California HealthCare Foundation

Introduction

As the nation's population ages, care received by patients at the end of life is becoming more extensive, and choice among options more important. Much media attention has been paid to the importance of end-of-life care choices, but there has been little focus on nursing homes as a site where people receive end-of-life care. Nursing homes have become a significant provider of care delivery at the end of life, particularly for frail Medicare beneficiaries. For these patients, hospice care can significantly improve their quality of life. Consequently, a relationship between a hospice and a nursing home that facilitates access to hospice care delivery is a crucial element of high quality end-of-life care.

Although California hospices are widely known as pioneers in the development of hospice care in the United States, California has been slower in moving hospice care into nursing homes compared to the country as a whole. In 2006, for example, approximately 17 percent of all hospice admissions and 18 percent of all hospice deaths in California occurred in nursing homes, compared to 22 and 23 percent, respectively, in the United States.[1] Although the reasons for this disparity have not been thoroughly analyzed, the greater number of for-profit and larger nonprofit hospice providers in other states may influence patterns of nursing home use by hospices there. Additionally, some other states may have more flexible reimbursement or regulatory policies that encourage hospices to collaborate closely with nursing homes. In Rhode Island, for example, state law requires that on admission to a nursing home, each patient not only receive the Patient's Bill of Rights but also have the right to hospice care specifically noted and explained.[2]

The potential benefits of hospices bringing their services into nursing homes are significant. Nursing homes receive the hospices' expertise in pain and symptom management, access to enhanced patient benefits such as pharmaceuticals and bereavement support, and access to training resources. Hospices gain access to alternative bed arrangements for inpatient care, round-the-clock support and supervision, and dietary services. Perhaps most importantly, hospices and nursing homes working well together create a synergy that is better able to meet the end-of-life care needs of nursing home residents than either could provide on its own.

How beneficial the relationship is in any particular facility, however, depends heavily on how well the hospice and the nursing home are able to cooperate. Despite the significant benefits that might accrue to all parties involved, creating a strong relationship between a hospice and a nursing home is not always easy.

To better understand how hospices and nursing homes work together, the California HealthCare Foundation commissioned The Corridor Group, Inc. (TCG) to conduct research on these relationships in California: benefits and risks for each entity; types of collaboration; perceived quality of care by each provider type; and opportunities for improvement in care delivery, resource allocation, and cooperation.

ISSUE BRIEF

September 2008

In undertaking the project, TCG conducted telephone or online surveys with 138 industry stakeholders and representatives of hospices and nursing homes throughout California. (Although the goal was to obtain a cross-section of information and opinions from each of these sectors, it should be noted that far more survey responses were obtained from hospices than from nursing homes or other industry stakeholders.) This issue brief explores the survey findings, and recommends a call to action in response to certain challenges observed in the relationship between hospices and nursing homes, with the goal of improving end-of-life care delivery and access in California nursing homes.

Background

Since 1983, Medicare has provided coverage of hospice services at four levels of care.[3] Most care under the Medicare Hospice Benefit is provided in the patient's place of residence. Typically, this is in the patient's private home, but in recent years hospice care delivery has increased in nursing homes as patients' nursing home stays have lengthened, with the nursing home becoming their primary residence. The two levels of care provided in the primary residence are referred to as routine home care and continuous care.

Hospice providers are also required by Medicare to provide short-term inpatient care, when appropriate, in Medicare- or Medicaid-certified facilities. These facilities are typically acute care hospitals and skilled nursing facilities (nursing homes). This short-term inpatient care may be provided at either of two levels: inpatient care for symptom and pain management (referred to as general inpatient care), and inpatient care for the purpose of providing caregiver respite (known as inpatient respite care).

There are separate delivery and reimbursement guidelines for each of these four levels of care. There are additional reimbursement implications to hospices and nursing homes when care is delivered to patients in a nursing home. (See Appendix: California Hospice Payment and Benefit Structures.)

Whenever hospice care is provided in a nursing home—whether to a long term resident or to a patient the hospice moves to a nursing home for short term care—the hospice and nursing home must enter into a contractual agreement that reflects standards established by 42 C.F.R. 418 (§§418.108, 418.110, 418.112). These standards set out the roles and responsibilities of the hospice and the nursing home with regard to staffing, physical environment, safety management, eligibility, and professional management.

With the increased use of nursing homes by hospice patients, significant interest has been generated concerning the quality of end-of-life care in nursing homes, the level of pain and symptom management provided there, the types of relationships that exist between hospices and nursing homes, and models of collaboration to enhance these relationships—subjects that this issue brief addresses.

Key Findings

The relationship between a hospice and a nursing home works best where:

- There is good and open communication between them;
- The nursing home leadership and staff alike understand the value of hospice;
- The leadership of both the hospice and the nursing home are committed to making the relationship work;
- Both the hospice and nursing home make a significant effort to work collaboratively, especially in care planning; and
- The hospice consistently sends the same personnel to a particular nursing home.

The relationship between a hospice and a nursing home often flounders, however, where the nursing home staff does not understand the overall value of hospice or what its role is, including what specific services it provides and how and why it uses certain drugs. The relationship also may not work well if the hospice staff does not understand how to function in a nursing home, in particular showing a lack of responsiveness, a lack of staffing consistency, or poor communication with the nursing home staff. Not surprisingly, hospice does not do well in a nursing home if neither side shows a commitment to building a relationship. All of these problems are compounded when there is high turnover of nursing home clinical staff.

Significant Benefits

The survey respondents indicated many benefits to both hospices and nursing homes when a good relationship develops. The stronger the relationship is, the greater the benefits to hospice, nursing home, residents, and families.

Benefits to the Nursing Home and Its Residents

The most common benefits accruing to the nursing home from a good relationship with a hospice include:

Nursing homes get expertise in pain and symptom management. Many patients require intensive pain management during the end stages of life. Hospice staff are trained in the nuances of pain management and often are better able than nursing home staff to titrate medications (under the direction of the patient's physician or the hospice medical director) for maximum patient comfort.

Residents can receive great value from the hospice interdisciplinary team. Most nursing home residents are eligible for the Medicare or Medi-Cal (Medicaid) hospice benefit. Residents who elect this hospice coverage are eligible for extra nursing, hospice aide, social work, and pharmaceutical benefits, in addition to services already provided by the nursing home.

Residents, families, and nursing home staff can receive grief support. After a resident on hospice dies, hospice continues to serve the family through its bereavement program for up to a year after the death. Hospice also can provide grief support, as well as bereavement education and training, to the nursing home staff.

Nursing homes get the added services of certified hospice aides (nursing assistants). Hospice aides complement services already provided by the nursing home and may offer a level of personal care assistance not often available throughout the nursing home.

Non-hospice residents receive secondary benefits. Research has found that non-hospice residents residing in those nursing homes that have a greater proportion of residents enrolled in hospice are less frequently hospitalized at the end of life and more frequently have pain assessment performed.[4,5] Also, hospice bereavement counselors may be available to provide additional grief counseling to residents not in the hospice program. Some hospices have community bereavement programs that are offered as a community service and may be arranged through the nursing home.

Hospice staff are expert resources for the nursing home. Hospice staff are experts in end-of-life care and are available to answer questions and provide guidance, particularly in those relationships where the leadership of both hospice and nursing home understands the overall benefits of hospice care and encourages collaboration.

Benefits to the Hospice and Its Patients

The benefits to the hospice provider of a good relationship with a nursing home include:

Hospices are able to meet the end-of-life care needs of more patients. Hospices hope to serve as many patients as possible who are at the end stage of life. Since this includes many nursing home residents, hospices that work regularly with nursing homes have the opportunity to serve more patients.

Hospice patients in nursing homes receive access to additional facility-based services. Hospice patients often need care when regular hospice visiting staff is not working. The nursing home setting offers round-the-clock care and supervision to patients, as well as dietary services. This can reduce the need for the hospice staff to visit outside routine business hours.

Hospices may obtain alternative bed arrangements for their patients. While most people would prefer to be at home at the end of life, for many this is not possible due to family circumstances, financial resources, or cultural mores. Additionally, hospice patients may need inpatient care for acute or respite stays. Nursing homes offer a good venue for short term stays of hospice patients who are not nursing home residents.

Hospices may realize a more efficient environment and better flow of patients. Hospices may serve multiple residents in the same nursing home, allowing for one team of hospice staff to concentrate on one facility. This is not only cost-effective but also provides an opportunity for stronger nursing home relationships, since the same hospice staff visit frequently and the two staffs thus become more familiar with each other.

Significant Challenges

The survey identified six significant challenges to a good relationship between a hospice and a nursing home.

Lack of Understanding

Frequently, a lack of understanding exists on the part of each staff regarding what is expected from the other: what role each has; what services hospice can and should provide; how hospice should operate in a nursing home setting; and how narcotics and other medications are to be used.

This lack of understanding is due partly to the Hospice Medicare Conditions of Participation, which place the responsibility of professional management on the hospice, though the nursing home remains legally responsible for the patient. For example, the hospice must develop a plan of care that guides delivery to the hospice patient of all medical care related to the terminal illness, and the hospice is responsible for all decisions related to such care. But the nursing home, too, must develop a plan of care that guides its delivery of care and services. When nursing home staff members do not fully understand these rules, there may be confusion about who is responsible for the plan of care, as well as about individual care decisions.

Education and training for both staffs about the role of the hospice care plan can help alleviate this confusion.

Hospice as Substitute for Nursing Home Care

A distinct undercurrent was detected from surveyed hospice providers that some hospices (labeled frequently as the "for-profits") are providing more services to nursing homes then federal law allows. At the same time, some nursing homes may feel they are not receiving a full range of hospice interdisciplinary services, including volunteers and spiritual care counselors. These attitudes can lead to confusion by both hospice and nursing home when entering into contractual agreements or care coordination activities. They may also result in a strain on the relationship when some hospice services are requested but not provided.

Clear delineation of these responsibilities in a written contract is essential to avoid conflict or confusion about the care that is to be delivered by each entity, pursuant to the following categories of responsibility:

- The hospice is responsible for providing medical direction and patient management, nursing, counseling, social work, medical supplies, durable medical equipment, and pharmaceuticals related to the patient's terminal illness. The hospice may use the nursing home staff to assist with the administration of prescribed therapies.

- The nursing home is responsible for providing 24-hour room and board care, and for meeting the personal care and nursing needs that would have been provided by the primary caregiver at home.

Leadership Cooperation Between Hospice and Nursing Home

Coordination of the plan of care between nursing home and hospice can be difficult in even the best of relationships between the two staffs. In a poor relationship, nursing home staff can present real barriers to some hospice interventions. A clear, coordinated written plan of care developed together by the nursing home and the hospice can obviate some of these problems. But when the leadership of either entity is not invested in the relationship, there may be insufficient incentive for the nursing home care delivery staff to collaborate on the patient's care plan, to suggest improvements in the plan of care, or to contact the hospice staff when the patient's condition changes, requiring care plan modifications.

In stronger relationships, the leadership of both hospice and nursing home create a culture of collaboration that allows for and encourages care plan coordination. In this regard, some hospices even develop special teams that circulate to various nursing homes to assure that patient care delivery is well coordinated with each facility.

Nursing Home Staff Turnover

The staff turnover rate in California nursing homes is 67 percent. To the extent high staff turnover exists in any particular nursing home, building a strong, durable relationship with hospice providers is extremely difficult. (Turnover rates of hospice staff are not available, but anecdotally are perceived to be relatively low.) Since there are no "standard" plan of care requirements, medication regimens, or other elements of clinical care delivery, the hospice must provide frequent education to new staff—a difficult task when both hospice and nursing home staffing resources are limited.

The high nursing home staff turnover also impacts the ability of hospice and nursing facility staffs to develop long term relationships and loyalty to a particular end-of-life care delivery approach, which may produce subjective and idiosyncratic approaches to care that are not always in patients' best interests.

Lack of Surveyor Understanding

Nursing homes are visited each year by a team of surveyors from the state, to ensure compliance with state and federal regulations. A number of hospice providers interviewed for this study reported that some surveyors do not fully understand hospice regulations. Specific surveyor misunderstandings relate to control of the plan of care, medication management, and resident eligibility for hospice. These misunderstandings tend to trigger various negative outcomes: surveyors misinterpreting the scope of work that the regulations permit hospice aides to perform in a nursing home; a greater number of deficiencies issuing from any given survey; and nursing home reluctance to enter into a hospice relationship because of fear of surveyor citations. The newly revised (June 5, 2008) Medicare Hospice Conditions of Participation (CoPs) may improve surveyor understanding and interpretation of hospices in nursing homes; in this regard, however, careful training and attention to the new CoPs will be important.

Lack of Hospice Access to Nursing Homes

Not all nursing homes have a relationship with a hospice. Some nursing homes feel they do not need hospice because they believe their staff can provide good end-of-life care without it. Other nursing homes have had such negative experiences with individual hospices that they do not see the value of hospice as worth the significant effort that would be needed to make the relationship work.

The number of nursing homes without a hospice relationship is a serious challenge because nursing homes provide end-of-life care to so many patients, particularly frail Medicare beneficiaries.

Issues for Consideration

This project's key findings identify a need to develop, provide, and fund enhanced education to support the hospice-nursing home relationship. The project's survey identified a number of opportunities to improve the relationships between hospices and nursing homes, thus enhancing care delivery at the end of life for residents of nursing homes and for hospice patients who are moved to nursing homes to receive care. There is also an opportunity to improve understanding by federal and state nursing home surveyors regarding hospice. Also, acting on these opportunities may more broadly impact the care that is provided to non-hospice residents of nursing homes.

Individual hospices and nursing homes have a responsibility to collaborate to improve care at the end of life. A strong step in that direction would be for them to participate, and to the extent possible take a leadership role, in the programs of education described below.

But this important task should not be left to individual providers. State and national trade associations can also take a significant role in educating their provider and consumer membership, as well as influencing policy makers to support and fund education of clinical care delivery staff and related consumer awareness campaigns. As the need for hospice services continues to expand and the terminally ill population shifts increasingly to nursing homes, trade associations will be in a unique position to inform on, and provide professional and paraprofessional training in, the benefits of hospice care delivery in nursing homes.

Finally, philanthropic organizations also have a role, to support and fund critical training areas to ensure improvements in quality and care delivery.

Critical Education Opportunities

Training for Nursing Home Leadership and Staff

Education programs should be made available for administrators and directors of nursing homes to help them more fully understand:

- What, when, and how hospice services can be provided;
- What specific laws and regulations (particularly pertaining to inducement, fraud, and abuse) govern hospice care in nursing homes; and
- What the role is of hospice and nursing home staff, under their respective Medicare Conditions of Participation, in caring for a terminally ill nursing home patient.

These programs should go beyond the minimum education efforts from hospices to nursing homes mandated by regulations of the Medicare Hospice Benefit. Nursing homes can collaborate with hospices in this education, and trade associations can help standardize training by developing outlines to guide such programs. The National Hospice and Palliative Care Organization (NHPCO) has already taken a significant lead in such training and could serve as a model for these efforts. NHPCO training resources can be found at www.nhpco.org (public use may require authorization from NHPCO).

Training for Hospice Leadership and Staff

Education programs should be made available for hospice leadership and staff to help them better understand nursing homes and more effectively communicate and collaborate with nursing home staff. This could include efforts to help hospice staff become more familiar with nursing home structures and procedures, facilitate two-way communication, successfully introduce themselves into a new nursing home setting, and address the needs of a nursing home and its staff. Part of such an education program could incorporate reflection

by hospice leadership about the role hospice agencies themselves play in creating strains on the relationship between hospices and nursing homes.

One way to introduce such education would be to make existing certification programs for hospices and nursing homes, currently provided by private organizations and state trade associations, a requirement to obtain state and federal funding. For example, California regulations already specify that certain credentials are required to be an administrator or director of patient care services. These could be strengthened by requiring staff training in certain fundamentals of hospice care in nursing homes.

Training for Consumers

Education programs should be provided to consumers to help them better understand hospice and its value in a nursing home, as well as how to effectively request such care. Educational materials need to be developed, to be provided to potential hospice patients and their families in a nursing home. Trade associations can play a major role in developing and producing such programs and materials.

Coordinated Action Among CMS, Surveyors, Hospices and Nursing Homes

Facilitated Meetings

Meetings between the Centers for Medicare & Medicaid Services (CMS), state surveyors, hospices and nursing homes would help all parties better understand hospice care in nursing homes. Such meetings should address issues including: how and why different medications and treatments are used by hospice; how to reduce the level of required documentation by a nursing home for hospice patients; and how to develop a single collaborative care plan that can meet both hospice and nursing home regulations for care plan documentation.

Expert Attention to Staff Turnover

Factors influencing staff turnover in nursing homes have been addressed in a variety of forums, and the relationship between nursing home staff turnover and quality of care is known. Turnover also has a profound effect on end-of-life care delivery, and on the often poor relationship between hospice and nursing homes. As hospice care delivery in nursing homes continues to increase, nursing home staff turnover will become an even greater barrier to hospice patient care delivery. Implementing practices to reduce turnover should be a high priority for payers, providers, and consumers.

Clarification of Surveyor Guidelines

In collaboration with key state hospice and nursing home leaders, state surveyor guidelines should be updated to clarify: who is an appropriate patient for hospice services in a nursing home; what are the appropriate roles for hospice and the nursing home in caring for the terminally ill (especially the role of facility nursing assistants and hospice aides); and what are the expectations for and by hospice in a nursing home. State trade associations can and should serve as a driver of such efforts to improve the understanding of surveyors about the specific nature of care delivery by hospices in nursing homes.

Appendix: California Hospice Payment and Benefit Structures

Overview

For a hospice patient in a nursing home, the hospice is responsible for providing all core hospice services (nursing, physician care, social work, and counseling), plus medications, supplies, and durable medical equipment. The nursing home provides room and board, and care unrelated to the terminal illness.

Approximately 86 percent of all hospice patients in California nursing homes are under the Medicare Hospice Benefit, with 6 percent more receiving hospice care under Medi-Cal.[1] Medicare pays the hospice directly, based on which of four levels of care the patient is receiving. Three levels of care are paid on a per diem basis; the fourth, continuous care, is paid at an hourly rate. If the patient is dually eligible for both Medicare and Medi-Cal, then the state also pays the hospice provider directly for the patient's room and board, and the hospice in turn pays the nursing home based on their contractual arrangement.

From its Medicare payment, the hospice pays the nursing home for the drugs, supplies, and durable medical equipment provided by the nursing home and related to the terminal illness. The hospice and the nursing home negotiate the rates the hospice will pay the nursing home for the services, drugs, and supplies provided. From the remaining funds, the hospice covers its expenses related to patient care.

Medicare and Medi-Cal Hospice Benefits

Medicare and Medi-Cal follow the same reimbursement guidelines, with Medicare rates serving as the basis.

There are four levels of care under the Medicare Hospice Benefit. For each level, the hospice is paid a per diem for each resident day (or an hourly amount for continuous care). Actual amounts vary depending on the patient's geographic location within the state.

Routine Home Care

Routine Home Care enables hospices to visit patients in their home, whether a private residence, a nursing home, or an assisted living facility. At this care level, the hospice's interdisciplinary team provides intermittent service. In 2006, an estimated 97 percent of all patient care days were routine home care.[1] The per diem base payment rate for routine home care in 2008 is $135.11.[6]

Room and board can be paid by the resident with private pay, private insurance, or Medi-Cal (Medicaid). If the patient is dually eligible for both Medicare and Medi-Cal, the hospice bills the state for 95 percent of the normal Medi-Cal skilled nursing facility room and board rate. The hospice then pays the nursing home for room and board, the actual amount negotiated between the hospice and the nursing home. Following written guidance and oversight by the DHHS Office of Inspector General, the hospice is not to pay the nursing home at more than the normal room and board rate. Because hospice is in a highly competitive market, most hospices pay the entire room and board payment they receive directly to the nursing home.

A small number of nursing home residents on hospice have Medi-Cal coverage but not Medicare. In those cases, the hospice provider receives payment from Medi-Cal at rates set for each level of care, and also receives 95 percent of the nursing home's Medi-Cal room and board rate, out of which it pays the nursing home.

General Inpatient Care

General Inpatient Care (GIP) is provided to a hospice patient who meets hospice acute care criteria, whether in a hospital or nursing home. At this more intensive level of hospice involvement, the patient is visited frequently by hospice staff. GIP involves short-term pain control or acute symptom management when care cannot be provided in another setting. In 2006, an estimated 2 percent of all patient days were GIP.[1] The base payment rate for GIP in 2008 is $601.02.[6]

Inpatient Respite Care

Inpatient Respite Care is provided when the family needs short term relief to prevent caregiver burnout. It is offered at infrequent intervals of no more than five consecutive days. Because nursing home regulations require significant paperwork for such a short stay, many nursing homes are reluctant to admit hospice patients for respite care. The base payment rate for inpatient respite care in 2008 is $139.76.

Continuous Home Care

Continuous Home Care is provided during brief periods of patient crisis. It is comprised predominantly of nursing care for at least eight hours during a 24-hour period. Because of its intensity, many smaller hospices do not have the capacity to provide this level of care. For those hospices that are able to provide it, continuous care can be a significant competitive advantage. The base payment rate for continuous home care in 2008 is $788.55 (billed hourly).

About the Research Partner

The Corridor Group, Inc. (TCG) of San Francisco, CA and Overland Park, KS, provides consulting, executive search, and educational resources to the home care industry. TCG staff and associates involved in this report were Jeannee Parker Martin, R.N., M.P.H. (president and co-owner of The Corridor Group, Inc.); David English, D.B.A; and Cheryl Musial, R.N., B.S.N. More information on TCG is available at www.corridorgroup.com.

About the Foundation

The California HealthCare Foundation is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, our goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information on CHCF, visit us online at www.chcf.org.

Endnotes

1. National Hospice and Palliative Care Organization. December 2007. *NHPCO 2006 National Summary of Hospice Care, SUPPLEMENT: State Comparison Report.*

2. *R.I. Gen. Laws,* Section 23-17.16-1 *et seq.*

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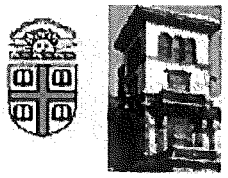
Nursing Home End-of-Life Care:
The Nursing Home / Hospice Partnership

A Project Funded by the Robert Wood Johnson Foundation



I. Executive Summary

With the growth in the aging population in the United States, nursing homes have become a common site of death. In 1989, 19% of Americans died in a nursing home. A short eight years later, one in four Americans died in a nursing home.[1] This rate varies across the United States, with some states have more than one in three persons die in a nursing home. This striking change in demography requires rethinking on how we provide nursing home services for dying persons and their families. This rethinking is especially needed since research supports the notion that pain and symptom management in nursing homes is less than optimal,[2-5] and thus, raises a concern that the quality of care at the end-of-life in nursing homes may need improvement.

While many nursing homes provide compassionate, competent, and coordinated care, chronic staff shortages, high staff turnover and inadequate reimbursement often adversely affect the quality of care. In these challenging times, hospice represents a means by which to bring existing resources and expertise into nursing homes. Previous work on hospice care in nursing homes attests to hospice's positive impact on the care of nursing home residents enrolled in hospice.[6-9] This work also suggests that when hospice is present in the nursing home there is a "spill over" or diffusion of hospice philosophy and practices to the care of those dying without formal hospice services. Furthermore, it appears that the effects of this diffusion increase as the presence of hospice care in nursing homes increases.[6]

As a means to improving end-of-life care in nursing homes, the provision of hospice care acknowledges the limitations of such improvement using the resources of nursing homes alone. Nursing home staff and attending physicians possess varying knowledge regarding palliative care and end-of-life symptom management. Education is one means to remedy this uneven expertise, but such education in nursing homes must be continuous so to accommodate the large turnover of aides and nurses at many nursing homes, and is hindered by staff shortages. In fact, one research study has shown that staff education alone does not result in improved quality of end-of-life care in nursing homes.[10]

While research has found hospice care in nursing homes benefits dying residents, it has also identified barriers to achieving greater improvements, and it has identified barriers to more widespread implementation of hospice care in nursing homes.[7] These barriers arise because of the differing care expertise of nursing home and hospice staff, the conflicting regulatory guidance and oversight, and the administrative challenges that often accompany such a collaborative effort. There is the administrative challenge of coordinating billing, staffing, and other operations; the challenge of integrating clinical care practices across program and staff lines; and the challenge of ensuring consistent and coherent communication at the administrative, clinical and staff supervisory level. The goal of this study is to identify, synthesize and disseminate "best practices" for nursing home end-of-life care. The availability of "best practices" (both through the project Internet site and through the project product "Best Practices for Nursing Home End-of-Life Care") will allow nursing homes and hospices to coordinate care of dying residents more easily and thus to maximize the potential synergy of their relationship sooner than is currently observed.

Nationally, approximately 22% of nursing home residents who died in the Year 2000 elected Medicare hospice; 31% of residents with Medicare HMO coverage and 20% with Medicare fee for service coverage elected hospice. But, approximately 66 percent of persons dying in nursing homes in 1996 (N=367,570) could have elected hospice (based on residents' payment sources and the restriction that Medicare Part A SNF residents cannot currently access Medicare hospice).[11] There exists an opportunity to greatly expand the hospice / palliative care influence in nursing homes so to improve nursing home end-of-life care. This is the right time to promote this expansion--nursing home and hospice provider associations are collaborating and the Center for Medicare and Medicaid Services (CMS) is vested in improving nursing home quality, and appears supportive of the provision of hospice care in nursing homes. This grant proposal is based on the premise that there are "best practices" out there, and if these are disseminated and integrated into practice, more success will result--leading to higher quality of nursing home end-of-life care.

The over arching goal of the proposed project is to improve the quality of care for dying nursing home residents by increasing the proportion of nursing homes who collaboration with hospice, and the proportion of residents in nursing homes who receive care from hospice / palliative care professions and who are referred to and elect hospice. Additionally, the project publication on "best practices" can be used to begin to address similar needs in relation to the provision of hospice care in assisted living facilities, and thus, the proposed project has the potential to also positively influence the quality of care for assisted living residents. The specific aims of this project are to:

1. Synthesize existing research, guidelines and resources relevant to nursing home end-of-life care, particularly in relation to hospice care;
2. Establish a project Internet site (as an extension of the RWJ-funded Community-State Partnership WWW site--www.BESTPRACTICENH.com);
3. Identify "best practice" sites and disseminate "best practice" case study information through state and national presentations on "how it's done;"
4. Identify "best practice" policies and procedures to address administrative practices (billing/payment, staffing, etc.), care practices (mode/frequency of communication, care plan documentation, etc.), and other processes (education provided, other) and make these available on the project's Internet site; and
5. Write and widely disseminate "Best Practices for Nursing Home End-of-Life Care" which will contain a synthesis of existing research, guidelines and resources and "best practice" case study information.

II. References

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This web site is published by the Center for Gerontology and Health Care Research at the Brown Medical School. For further information, contact the webmaster via e-mail at NH_Hospice@Brown.edu. Last edited 12/01/2005 15:50:48. Last edited March 26, 2005.

Attachment C

PDA

C O N V E R S A T I O N L O G

DATE: 6/30/10 **TIME:** 3:00 p.m. **PDA Job #:** (66-5010-10)

CLIENT: UHS-Pruitt **PROJECT:** Johnston County Nursing Home Beds

SUBJECT: Licensure Process **INITIATED BY:** Trey Adams
WITH: Becky Wertz **COMPANY:** Nursing Home Licensure Section

PHONE #: (919) 855-4580 **In Person / Telephone:** Telephone

Agenda

- Mr. Adams asked Ms. Wertz to discuss the process for building a new nursing home; utilizing CON approved beds and existing county beds.

Notes

- Ms. Wertz stated that the new facility will need a new license and provider number.
- Ms. Wertz stated that the process would function as follows:
    - CON approval for new beds and relocation of existing beds
    - Construction Section approval
    - Licensure approval
        - The existing beds will be delicensed at the existing facility the day the new facility is licensed
        - Changing the license can be done quickly by submitting a form to Ms. Wertz
    - Get Certification approval
- Ms. Wertz stated that since all beds will be under the new facility license, no Medicaid revenue is possible until the new facility is certified.
- Ms. Wertz stated that the certification process can take a few months.

Attachment D

UHS-Pruitt Corporation

DSO Report for the period ended May 31, 2010

		Medicaid Gross DSO
SN323	*UniHealth Post-Acute Care - Carolina Point*	-
SN307	*UniHealth Post-Acute Care of Durham*	50
SN036	*Heritage Healthcare of Elkin*	25
SN039	*Heritage Healthcare of Farmville*	26
SN3C8	*Heritge Healthcare of High Point*	30
SN327	*The Oaks at Mayview*	40
SN054	*The Oaks at Brevard*	19
SN4D2	*The Oaks of Carolina*	34
SN091	*The Oaks at Town Center*	36
SN099	*Two Rivers Healthcare - Neuse Campus*	32
SN041	*Two Rivers Healthcare - Trent Campus*	39
SN328	*The Oaks at Whitaker Glen*	-
	Total Coastal North	**31**

Attachment E

Benefits as a Percent of Salary -Project Year 2

	a	b	c
Facility Name	**Total Salaries**	**Total Benefits**	**Benefit as a Percentage of Salaries**
Liberty	$2,075,029	$415,005	20.0%
Britthaven of Johnston - Clayton	$2,744,208	$603,727	22.0%
Britthaven of Johnston - Cleavland	$2,744,208	$603,727	22.0%
UniHealth Post-Acute Care -Clayton	$2,058,170	$454,913	22.1%

Source:
a) Form C; only basic skilled nursing
b) Form C; only basic skilled nursing
c) b/a

Calculation of Nursing Salaries Including Benefits- Project Year 2

Step 1- Determine Salaries Less Benefits

Facility Name	DON	RN	CNA
Liberty	$82,992	$52,000	$22,971
Britthaven of Johnston - Clayton	$83,000	$54,080	$23,888
Britthaven of Johnston - Cleavland	$83,000	$54,080	$23,888
UniHealth Post-Acute Care -Clayton	$83,555	$55,310	$26,473

Source:
Table VII.3

Step 2- Determine Benefits Percentage

Facility Name	Benefit as a Percentage of Salaries
Liberty	20.0%
Britthaven of Johnston - Clayton	22.0%
Britthaven of Johnston - Cleavland	22.0%
UniHealth Post-Acute Care -Clayton	22.1%

Source:
Form C

Step 3- Multiply Salaries Less Benefits by Benefits Percentage

Facility Name	DON	RN	CNA
Liberty	$99,590	$62,400	$27,565
Britthaven of Johnston - Clayton	$101,260	$65,978	$29,143
Britthaven of Johnston - Cleavland	$101,260	$65,978	$29,143
UniHealth Post-Acute Care -Clayton	$102,023	$67,535	$32,324

Calculation of Non-Nursing Salaries Including Benefits- Project Year 2

Step 1- Determine Salaries Less Benefits

Facility Name	Food Supervisor	Cooks	Dietary Aides	Social Services Director	Activity Director	Maintenance Supervisor
Liberty	$33,280	$15,600	$15,600	$37,440	$24,960	$37,440
Britthaven of Johnston - Clayton	$33,500	$18,200	$17,576	$32,000	$28,000	$33,000
Britthaven of Johnston - Cleavland	$33,500	$18,200	$17,576	$32,000	$28,000	$33,000
UniHealth Post-Acute Care -Clayton	$42,334	$25,733	$19,160	$38,174	$29,166	$38,153

Source:
Table VII.3

Step 2- Determine Benefits Percentage

Facility Name	Benefit as a Percentage of Salaries
Liberty	20.0%
Britthaven of Johnston - Clayton	22.0%
Britthaven of Johnston - Cleavland	22.0%
UniHealth Post-Acute Care -Clayton	22.1%

Source:
Form C

Step 3- Multiply Salaries Less Benefits by Benefits Percentage

Facility Name	Food Supervisor	Cooks	Dietary Aides	Social Services Director	Activity Director	Maintenance Supervisor
Liberty	$39,936	$18,720	$18,720	$44,928	$29,952	$44,928
Britthaven of Johnston - Clayton	$40,870	$22,204	$21,443	$39,040	$34,160	$40,260
Britthaven of Johnston - Cleavland	$40,870	$22,204	$21,443	$39,040	$34,160	$40,260
UniHealth Post-Acute Care -Clayton	$51,691	$31,421	$23,395	$46,612	$35,613	$46,586

RN/LPNs per CNA- Project Year 2

	a	b	c	d
Facility Name	**RNs**	**LPNs**	**CNAs**	**Ratio**
Liberty	7.0	7.0	35.0	0.40
Britthaven of Johnston - Clayton	7.0	12.6	36.5	0.54
Britthaven of Johnston - Cleavland	7.0	12.6	36.5	0.54
UniHealth Post-Acute Care -Clayton	5.6	7.4	22.4	0.58

Source:
a) Table VII.3; only basic skilled nursing
b) Table VII.3; only basic skilled nursing
c) Table VII.3; only basic skilled nursing
d) (a+b)/c

Direct Cost (Less Ancillaries) - Project Year 2

	a	b	c
Facility Name	**Total Direct Costs (Less Ancillaries)**	**Patient Days**	**Direct Cost per Patient Day**
Liberty	$2,664,965	23,360	$114.08
Britthaven of Johnston - Clayton	$3,311,143	29,474	$112.34
Britthaven of Johnston - Cleavland	$3,311,143	29,474	$112.34
UniHealth Post-Acute Care -Clayton	$2,429,180	21,170	$114.75

Source:
a) Form C; only basic skilled nursing
b) Table IV.2; only basic skilled nursing
c) a/b