

SKILLED NURSING FACILITY QUALITY WORKGROUP MEETING SUMMARY

Wednesday, December 17, 2008

10:15 A.M. – 3:15 P.M.

University of Southern California State Capitol Center
1800 I Street, Sacramento, CA 95814

Attending Stakeholder Workgroup Members:

Geneva Carroll, Sacramento Ombudsman
Mike Connors, California Association of Nursing Home Reform (CANHR)
Lori Costa, Aging Services of California
Deborah Doctor, Disability Rights Association
Robert Harris for Corinne Eldridge, Service Employees International Union (SEIU)
David Farrell, SNF Management
Jim Gomez, California Association of Health Facilities (CAHF)
Nancy Hall, Disability Services and Legal Center
Dionne Jimenez, Service Employees International Union (SEIU)
Jocelyn Montgomery, California Association of Health Facilities (CAHF)
Mary Mundy, Service Employees International Union (SEIU)
Darryl Nixon, California Association of Health Facilities (CAHF)
Betty Perry, Older Women's League
Tamara Rasberry, Service Employees International Union (SEIU)
Deb Roth, Service Employees International Union (SEIU)
Richard Thomason, Service Employees International Union (SEIU)
Michael Torgan, Country Villa Health Services
Nina Weiler-Harwell, American Association of Retired Persons (AARP)

State Representatives and Facilitator:

Toby Douglas, Department of Health Care Services (DHCS)
Ty Christensen, Office of Statewide Planning and Development (OSHPD)
Joe Rodrigues, Office of the State Long-Term Care Ombudsman
Pam Dickfoss, California Department of Public Health (CDPH)
Gina Henning, California Department of Public Health (CDPH)
Monique, Parrish, Facilitator

I. Welcome/Review Agenda

The fifth AB 1629 workgroup meeting opened with member and public introductions followed by a review of the agenda (see attached). The focus of the meeting was information presentations on a wide range of issues and elements addressing and/or impacting quality of care for residents in California's nursing homes. A revised order of presentations was suggested to accommodate several presenters' time constraints. The following order was approved by the workgroup:

Information Presentations Order

1. Megan Juring, Assistant Secretary, California Health and Human Services Agency
Addressing California efforts to support transitioning residents from nursing facilities to community living.
2. David Farrell, SnF Management
Addressing nursing home resident, family, and staff satisfaction – critical data to assess quality.
3. DHCS, Grant Gassman, Jim Matthews
Responding to workgroup data and information requests from DHCS.
4. Dr. Andrew Kramer, Professor of Medicine
Head, Division of Health Care Policy and Research, University of Colorado Denver
Addressing payroll based nursing home staffing measures for quality in the CMS 2008 Action Plan for Nursing Home Quality Report.
5. CDPH, Pam Dickfoss, Gina Henning
Responding to workgroup data and information requests from CDPH.
6. OSHPD, Ty Christiansen
Responding to workgroup data and information requests from OSHPD.

Workgroup members were reminded that prior to the conclusion of the meeting, a portion of the meeting time would be set aside to discuss the process for making recommendations (Workgroup Objective #2 – Define a process for reviewing information and making recommendations), in light of just two remaining workgroup meetings scheduled for January 2009.

II. Review Summary of 12/01/08 Meeting

No edits were offered for the summary report of the AB 1629 workgroup 12/1/08 meeting.

III. Status of Outstanding Issues/Requests

The facilitator encouraged workgroup members to:

- Maintain respectful conversations.
- Help monitor the internal workgroup processes, e.g., identify when discussions are off point or when consensus has been reached.
- Avoid Internet discussions – group discussions need to be conducted during the workgroup meetings (Bagley-Keene).

The facilitator also announced that all 20 Information gathering interviews with workgroup members were completed, and a redacted summary of the interviews would be available by the group's next meeting, scheduled for 1/12/09. She noted that at this

time a significant common theme was member perception that changes to the AB 1629 legislation *would* improve the quality of resident care in nursing homes.

Finally, the facilitator acknowledged and thanked workgroup members and State Department staff for their efforts in locating and submitting for distribution relevant citations, articles, and links addressing the issue of quality in nursing homes. All submitted information is now posted on the AB 1629 Web page:

(<http://www.dhcs.ca.gov/services/medi-cal/Pages/SNFQualityWorkgroup.aspx>)

Public Comment

None

IV. Information Requests Presentations:

Megan Juring, Assistant Secretary of CA Health and Human Services Agency – Olmstead Activities

Ms. Juring introduced herself and her colleagues, Betsy Howard and Paula Acosta, and their presentation – California’s Community Transition and Community Choices Initiatives and Changes to the Minimum Data Set (MDS). The presentation addressed California’s efforts to improve consumer choice and access to community-based services. Presentation documents, previously e-mailed to members and the public, were distributed as handouts.

Betsy Howard, DHCS, Long Term Care Division: California Community Transitions

Ms. Howard provided an overview of the California Community Transitions Initiative, a five-year, rebalancing demonstration project administered by DHCS, in partnership with stakeholders. She provided the following project highlights:

- i. Under the project, federal funding is available to provide home and community-based services (HCBS) to eligible Medi-Cal beneficiaries who have lived in a facility for 6 months. This includes freestanding skilled nursing facilities (SNFs) and Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs).
- ii. CMS took a long time to give the project the go-ahead.
- iii. Services are directly delivered at the local level. Currently, the project is working with several home health care agencies and independent living centers.
- iv. Approximately 28 people in various stages of transition are involved in the program (DHCS is actively working on identifying organizations to work with the Department on behalf of this initiative); the goal is to transition more than 500 people by next year and 2,000 people by September 30, 2011.

Paula Acosta, California Community Choices, California Health and Human Services Agency:

Ms. Acosta provided an overview of both the Community Choices Project as well as changes to the MDS with Item Q, which addresses Resident Participation in Assessment and Goal Setting. She noted that the California Aging and Disability Resource Centers (ADRCs) – a partnership between Area Agencies on Aging and Independent Living Centers – under the Community Choices Project, provide a single point of entry for individuals seeking long-term support information and assistance. The two ADRCs associated with this initiative, Riverside and Orange County, went live with services on 12/1/08. Core services include Long Term Care Options Counseling – which provides consumers with decision support as they learn about services; Short Term Service Coordination – may involve referrals to In-Home support services (IHSS); and, other HCBS. She also highlighted the latest iteration of CalCareNet – California’s Web-based aging and long-term support information system dedicated to assisting consumers with information about long-term care. Pilots of the revised information system will be available in Riverside and Orange County, administered by the two ADRCs. The State intends to expand CalCareNet statewide, resources permitting.

Ms. Acosta also addressed changes to the MDS. Ms. Acosta represented DHCS on a multi-state workgroup with the Centers for Medicare and Medicaid to address the issue of transitioning residents from nursing facilities to community living. She noted the workgroup’s first outcome was a discharge-planning checklist (publication #11376 available at www.medicare.gov/publications). She also highlighted the progress of the MDS Version 3.0 of MDS and Item Q, question (2.2), (www.cms.hhs.gov/NursingHomeQualityInits/downloads/MDS30DraftItemSet.pdf) which directly asks the nursing home resident: *In the nursing facility, would you like to talk to someone about transitioning back to community living?* This revised question is required quarterly as well as each time there is a change in condition. Efforts are underway to develop a list of community organizations that can be contacted if the resident says “yes.” Discussions regarding resident instruction protocols are also in process.

Discussion from workgroup:

1. *Clarification:* Question (1.a), in the current MDS, asks about community living preferences; however, the revised question (2.2) phrases it more directly.
2. *Question:* Is the number of residents that would be interested in returning (size of population) known? *Response:* That will be addressed in CDPH’s report due to the Legislature on January 1, 2009.
3. *Statement:* About 22% of the population already answers yes to the MDS question (1.a). Texas has moved 16,000 residents out of nursing homes.
4. *Statement:* Dr. Schnell’s report shows 1-2% of nursing home residents are interested in returning to community living. I don’t believe the State of Texas is relevant; Texas is well known for not having a HCBS program. By contrast, CA has fewer nursing home beds than other large states. CAHF is supportive of the

Money Follows the Person [California Community Transitions] Project, but there is a concern about whether there are sufficient services available in the community to respond to the needs of residents returning to community living. We now have a more robust question and the new preference interview tool is now mandated, but what is the process for what happens next? *Response:* A screening tool developed by a CMS funded grant and tested in nursing facilities is available. Money Follows the Person is using it to identify eligible residents, who are interviewed twice. It is not however a mandatory tool statewide but is acknowledged to be useful. Health and Safety (H&S) Code states that residents should be asked quarterly.

5. *Question:* Is there going to be documentation of compliance? *Response:* The preference interview tool fulfills the mandate of the statute. Lead organizations are instructed to ask the resident if they can share that information with the nursing home.
6. *Question:* How would they [State] envision a performance measure? *Response:* We defer to discussions of the workgroup because there are multiple issues to consider, e.g., length of stay, expression of desire to transition, etc.
7. *Question:* Where can the preference interview document be found? *Response:* CA Community Transitions website:
<http://www.dhcs.ca.gov/services/ltc/Pages/CCT.aspx>

David Farrell, SnF Management

Mr. Farrell provided an overview of the key issues associated with nursing home resident, family, and staff satisfaction and the relationship between these measures and the quality of resident care in nursing homes. A hardcopy of his PowerPoint presentation addressing this topic was distributed to workgroup members (an electronic copy was also sent out via e-mail). Mr. Farrell reviewed his 18 years of experience working in nursing homes and with national pilots addressing workforce retention. He noted these experiences led him to accept a position as an administrator at a poorly performing nursing home in Oakland, where he was interested in applying some of the improvement approaches he had analyzed and evaluated. Mr. Farrell indicated that once he began to use satisfaction data from staff, family, and residents, he witnessed improved resident care, as well as facility and staff performance. In closing, Mr. Farrell emphasized the importance of measuring compassion and giving voice to people on the front line using satisfaction and other outcome measures to improve the quality of resident care. He also cited four reasons for collecting and publicly reporting satisfaction data: the humanistic reason, the efficiency reason, the marketing reason, and the economic reason. Together, all four address the different forces necessary to deliver care with empathy and preserve quality of life for all stakeholders.

Discussion from workgroup:

1. *Statement [to group]:* The concept of how you treat people and the importance of better leadership, etc. are part of the Omnibus Budget Reconciliation Act (OBRA), which has been around for 20 years. *Question:* Why is the issue of satisfaction an important issue now when it wasn't mentioned during AB 1629?

Response: One issue is the state of the art [the focus on satisfaction has been gaining ground in the health and social service arena]. *Response [other group member]:* In crafting AB 1629 we didn't use the term satisfaction, but we recognized that working on increasing pay to workers would surely improve satisfaction, and improvement to facilities would also improve satisfaction. They may not be in the terms we are discussing today, but the intent of the legislation was to make improvements that would create satisfaction. *Response [from a fellow workgroup member]:* I disagree. I think satisfaction was key in the discussions for AB 1629. Increased staffing relates to employee satisfaction. Turnover was critically important. When we look at wages and benefits, both are part of employee satisfaction. In addition, some of the new attention to this issue can be correlated with the contemporary literature, which now addresses the importance of respect, empowerment, etc. The [AB 1629] rate structure tried to address these issues, but recent research is showing more clearly the need for satisfaction. Recent research equally demonstrates that it is not the employees that are the problem. It is the leadership, the management, and the environment that are the problems, not the employees.

2. *Comment:* The tenant of a union is employee satisfaction. SEIU is different because the union also gets involved in the policies that affect their employees. Improving the policies that drive the workplace leads to employee satisfaction.
3. *Comment:* AARP wasn't part of the group that wrote the law, but we appreciate that the issue of *the need for good management* is being brought up.
4. *Clarification:* In AB 1183 the law asks that we look at employee satisfaction. The literature search addressing this issue (referenced the 11-page literature review document addressing resident, family, and workforce satisfaction electronically distributed to workgroup members and the public) demonstrates the connection between resident satisfaction and employee satisfaction, and how they relate to one another.
5. *Question:* How does poor satisfaction and poor management relate to the rate system?
6. *Question:* If we do provide higher rates for increased satisfaction, where is the money going to come from?

Jim Matthews, Grant Gassman, John McCraw, DHCS

DHCS presented additional department information (handouts were distributed) in response to workgroup questions regarding DHCS data and information. The following is an abbreviated summary of the presentation highlights (DHCS's information is posted on the AB 1629 webpage <http://www.dhcs.ca.gov/services/med-cal/Pages/SNFQualityWorkgroup.aspx>)

- AB 1629 Freestanding Adult Subacute (six charts)
 - *Question:* What are the total days?
 - *Question:* What was the number of new subacute contracts started, and the number of discharges?

- Quality Assurance Fee (QAF): the QAF is collected by DHCS (sends letters, etc.). It is important to evaluate the data in terms of the time lag. DHCS works diligently with providers to get fees in on time, but it doesn't happen 'overnight'. *Question:* Does DHCS withhold [if QAF is not submitted]? *Response:* Yes, withholds are occurring; we work closely with CDPH. There is a process however to ensure that the collection doesn't negatively impact the patients.
- The workgroup was asked to reference the document entitled "AB 1629 Workgroup Questions 12-01-08." *Comment:* Regarding the way the current cost report is designed; it is difficult to pull out the data required. *Response:* Some room exists for fine-tuning, but we are always able to release the rates on time and accurately.
- DHCS Exhibit 1. Indirect care going up, patient days going down.
- DHCS Exhibit 2. Yellow bar charts – 2008 rates but 2006 costs. Direct labor is keeping pace with total expenditures.
 - *Question:* how far away are we from hitting the cap on this issue? *Response:* It varies by peer group. Within labor, not all facilities are below cap, but the overall cap, in aggregate, went way over the cap. If labor had gone up even more, it would have pushed the expenditures up as well. *Question:* Is it true that not every facility is hitting the cap? Looking at disparities, a number of facilities could have spent more, and didn't. *Answer:* The overall 5.5% percent cap would have hit these facilities.
 - DHCS can show with a chart the number of facilities that came close to the cap, etc.
- DHCS Exhibit 4 Caregiver training. Not a lot being spent – downward trend. *Comment:* The workgroup recognizes the importance of training. While the chart shows the spending isn't happening, "on the floor" training would show up in labor costs, not training. How do we help the Department determine how those costs should be reported? *Question:* Does training include in-service? *Response:* We capture the formal training program only.
- DHCS Exhibit 3: Liability insurance isn't costing as much. *Question:* why? *Response:* It is costing less – there are many more insurers in the market place and there is a decrease in the cost of insurance.
- DHCS Exhibit 5: Consumer Price Index.

Dr. Andrew Kramer Head, Division of Health Care Policy and Research, University of Colorado Denver (via phone on the conference call-in line)

Dr. Kramer, lead researcher on the CMS contract to develop specifications for collecting nursing home payroll data, presented findings from the four-year research pilot addressing payroll specifications and quality measures in nursing homes. The following highlights are from Dr. Kramer's presentation and the ensuing discussion:

Dr. Kramer opened his presentation by acknowledging California's positive efforts to address the nursing home staffing issue and overall quality of care in nursing homes. He then summarized the pilot project:

We implemented a multiyear project in which we collected, analyzed, and produced findings regarding nursing home payroll data for staffing. Our focus was to develop specifications and related staffing measures. We collected payroll data from eight large corporations willing to submit payroll information. We then used a broad specification without constraints on the file structure – we wanted to make it a minimal cost to organizations. Much of the data however was submitted in different file structures. Some of the data was limited; some of the data was not easily reportable. We then developed a specification so the payroll could all come in with the same format from the different organizations.

After approximately two years of collecting and organizing the data, we took another two years to analyze and render it efficient. We developed staffing measures that examined staff turnover (position change over one year) and tenure (months, years). We combined the various positions – Registered Nurse (RN), Licensed Vocational Nurse (LVN), and Certified Nurse Assistant (CNA). Our focus was on the relationship between the staffing measures and quality measures. Next, we determined there should be a composite of staffing levels where one is licensed staff together and the other CNA. We also determined that the Registered Nurse (RN) and Director of Nursing (DON) should be a composite. Turnover of all staff was related to quality. RN turnover however was most heavily weighted with quality. With tenure, our focus was on the licensed categories – RN, DON, and LVN.

Discussion from workgroup:

A list of questions was submitted to Dr. Kramer in advance of the presentation. Dr. Kramer noted that many of the questions addressed current CMS efforts related to the payroll issue, but that he was not up-to-date on CMS's most recent work. He did however respond to the following workgroup questions:

1. *Question:* The workgroup is looking at quality measures as well as rate structure change. Are the findings from this CMS work constructed so they could be adapted by a state to avoid redundancy? *Response:* Fields are built so that payment variables could be added. The payroll specification deals with hours for individual staff – there was no intent to report personnel cost information.
2. *Question:* From start to finish, how long did the process take? *Response:* Four years. The first two years were consumed with trying to render the data comparable across organizations. Once we had the format, the analytical work took the remainder of the time.
3. *Question:* Which specific quality measures were most sensitive to the staffing measures? *Response:* We found that quality measures in general were most sensitive to staffing but also strongly associated with short-and long-term stays, rates of rehabilitation, and rates of discharge. Post-acute measures were inversely related to staffing, driven in part by self-selection (these may also have been more related to case-mix, e.g., residents with greater disability). Additionally we found longer tenure for CNAs was correlated with decreased quality, while longer tenure for RNs, DONs, and LVNs was associated with increased quality. The CMS report which summarizes these

findings is posted on their website; this information will be used in pay-for-performance (P4P).

4. *Question:* Regarding tenure for licensed staff, but not CNAs - why does licensed staff tenure tell us more? *Response:* When looking at tenure for CNA and quality – once tenure was close to 10 years, the relationship of tenure and improvement of quality dropped. We are not sure why – double shifts might be one reason.

5. *Comment:* Castle and Engberg's study seems to say otherwise with respect to lengthy CNA tenure. *Response:* There is so much variability among the different studies we did not want to compare findings. There is also some ambiguity in the results from the study we did. That said, our findings indicated that longer RN and DON tenure were strongly associated with quality, while the same was not true for CNAs.

Public Comment:

Question: Regarding Olmstead, what happens if there isn't an assessment tool that gets passed through the Legislature? How can the Legislature ensure quality? *Comment:* IHSS needs to be brought into the process.

BREAK FOR LUNCH

Continued: Information Requests Presentations

Prior to beginning the afternoon part of the meeting, the facilitator reminded workgroup members to stay on track and respect each other.

Mike Harrold and Emilee Hogg, DHCS Audits and Investigation (A&I)

Ms. Hogg provided an overview of the audit process. Handouts of the A&I presentation were provided to workgroup members and the public. Ms. Hogg noted that OSHPD data, downloaded once monthly, are utilized on an annualized basis for the audits. Cost reports without Medi-Cal days are excluded, as are change of ownership and closed facilities data. Additionally, facilities with less than six months of data are also excluded. One third of all audits are field audits, two thirds are desk audits and the number of audits varies per year. For 2005-2006, 332 audits were done. In 2007, 751 were done and in 2008, 997 were completed. Ms. Hogg and Mr. Harrold highlighted the following:

- The audit division is fully staffed.
- 100 percent of the cost reports for which a rate is needed are now audited.
- Field audits are done more frequently for some facilities, given the specific circumstances. Note: cookie-cutter audits are not done; however, for some facilities, certain audit steps are not done if they are not necessary.
- This year, more field audits will be done.
- Additional audit data is also available on the A&I website:
(<http://www.dhcs.ca.gov>)
- Lawsuit and home office cost data is not available, with respect to audit disallowances (percentages).

- Many adjustments are made for reasons other than cost inaccuracies. Note: once a determination is made by A&I, it cannot be changed without an appeal.
- Fringe benefit and agency costs findings are often significant – their classifications (costs) often differ from how the providers classify costs.
- Reviews of management fees and costs are done (not separately) as part of the review of administrative costs; however, most large providers are over the 50% administrative costs cap.

Discussion from workgroup:

1. *Comment:* You mentioned that you might conduct home office audits as a possibility for audits. *Response:* Yes, that would be desirable. Allocations to the individual facilities provide the most challenge for auditors. Also, costs over the 50% cap are not scrutinized, since these costs are not reimbursed.
2. *Question:* Shouldn't the public have more exposure to quantified audit results? *Response:* A&I has been working with OSHPD to report changes that would provide for a better comparison with audit reports. Regarding the amount of lawsuit litigation costs, A&I requires a specific request from facilities for the data.

Pam Dickfoss and Gina Henning, CDPH

Ms. Dickfoss announced that the Governors Office recently (12/16/08) approved release of the draft report (Annual Report to the Legislature – assessing various indicators of the quality of patient care in freestanding skilled nursing facilities) scheduled for formal release on 1/1/09. A hardcopy of the draft report was provided to workgroup members and the public. Ms. Dickfoss briefly reviewed the focus of previous reports before addressing the following 2009 report highlights:

- Nursing Care Hours Per Patient Day (NHPPD) has been increasing incrementally. The percentage of compliant facilities has been gradually increasing.
- The number of facilities with serious findings is addressed in the report.
- Average wages and benefits have increased, in some years [see report].
- The number of residents requesting to return to the community and home has increased; however, increased community support is needed to address their needs.

Discussion from workgroup:

1. *Question:* What was the sample size? *Response:* Approximately 250 facilities for 24 consecutive payroll days for each of the two years. A sample had to be utilized because of resource constraints. The increase in survey staff likely increased the number of citations.
2. *Question:* Were average salaries and wages compared to OSHPD data? *Response:* Yes. The sample only was utilized for compliance with the 3.2 requirement.

3. *Comment:* Salaries have been adjusted for the Consumer Price Index (CPI) – I would like to request this data in real terms (note: OSHPD data addresses this).

Ms. Henning distributed handouts with responses to previous workgroup questions for CDPH. She informed the workgroup that the data is for citations where staff issues/complaints were involved and noted that a response for question 4 was not available.

Discussion from workgroup:

1. *Comment:* The data needs to specify whether major or minor issues are involved, and the duration of the deficiency. *Response:* CDPH did not look at patient days due to resource constraints.
2. *Comment:* CANHR summarizes all citation information on their website (www.canhr.org). *Clarification:* A “B” citation refers to a “threat to the health, safety, and security of the resident.”
3. *Request:* Would CDPH provide the specifics of the sample for the citation data? *Response:* Yes [CDPH].
4. *Clarification [CDPH]:* Deficiencies are always greater in number than citations. *Comment:* One day of non-compliance must be considered in the context of the greater picture of increasing compliance levels. *Comment:* Sometimes limited non-compliance is due to circumstances beyond the facility’s control.
5. *Question:* Are facility-reported incidents investigated? *Response:* CDPH will provide data regarding such investigations.
6. *Request:* Would CDPH provide a breakdown of the total spending under the AB 1629 methodology to date by General Fund, Quality Assurance Fee, and Federal Financial Participation? *Response:* DHCS will provide the breakdown.

Joe Rodrigues, CA Department of Aging. State Ombudsman:

Mr. Rodrigues provided an overview of the chart handout (previously distributed electronically to the workgroup and public) *Nursing Home Complaints by National Ombudsman Reporting System Categories*. The chart addresses complaints received; the determination of whether complaints were resolved was based on the response (satisfaction) from the party filing the complaint. Mr. Rodrigues noted complaints are received over the phone, through the mail, from members of the legislature, and from Ombudsman staff visiting the facilities. He noted some complaints go directly to Licensing and Certification (L&C). Verification of complaints through the Ombudsman usually takes place through interviews with concerned parties and involves a lower level of proof relative to what L&C requires for their investigations. No trends in the number of complaints have been detected. Improvement in care is not uniform throughout the state.

Discussion from workgroup:

1. *Comment:* I am very concerned about the future of the Ombudsman program, given the fiscal climate. *Response:* The General Fund (GF) allocation was lost this year and, as a result, the Ombudsman program was drastically cut. Local

programs have terminated paid staff and the number of volunteers has also declined. Nevertheless, all complaints will continue to be investigated, just not as quickly as before.

2. *Comment:* I am an Ombudsman that has been laid off, but I am continuing to work as a volunteer. I have seen an increase in the caseload (complaints) and complaint referrals from bus and ambulance drivers, as well as hospitals. I have also seen more cases of abuse since the implementation of AB 1629.
3. *Comment:* A more serious ongoing “watchdog” function is needed.
4. *Comment:* I have also seen that a competent administrator can quickly turn around a poor facility.
5. *Comment:* The Quality Improvement Organizations (QIOs) take complaints from Medicare beneficiaries only.

Public Comment

1. *Question:* Has nursing home quality increased? *Response:* I cannot determine that but can say that the number of complaints has increased. In addition, our program assists residents with transitioning to a lower level of care or returning home.
2. *Question:* Are complaints broken down by category, detailing the source of the complaint? *Response:* Our department will provide those figures. It is also important to take into consideration that the increase in complaints could be related to changing patient case-types.

BREAK

V. Continue Discussion and Refinement of Objectives 1,2,&3

Prior to the OSHPD presentation, the facilitator asked if the group might spend some time addressing the process for making AB 1629 workgroup recommendations. Highlights from this discussion and the agreed upon format for the next meeting are identified below. The OSHPD presentation was rescheduled for the beginning portion of the January 12, 2009 workgroup meeting.

Process Recommendations and Next Steps:

1. *Recommendation:* Workgroup members should consider developing recommendations with their respective stakeholder groups, or individually, and present those recommendations at the 1/12/09 meeting. *Comment:* It would be better if the development of recommendations were done with the entire workgroup. Additionally, each recommendation should have an accompanied analysis (e.g., pros and cons).
2. *Recommendation:* The workgroup would be bettered served if we could develop some criteria for making our recommendations (an issue previously introduced but not addressed). I agree with the accompanying analyses and would add that a consideration of costs also be included in the analyses.

3. *Comment:* There are different kinds of recommendations, and we should be able to include those as well. For example, there are some areas that really need more consideration and evaluation and merit a recommendation.
4. *Comment:* Regarding recommendations, it would be beneficial if we include criteria for measuring the outcomes of the recommendations.
5. *Request:* Can the workgroup have the cost estimates for the higher staff to patient ratios by the next 1/12/09 meeting?
6. *Recommendation:* The facilitator and Toby Douglas, DHCS, might consider developing a template for the group with regard to developing recommendations.
7. *Question:* Toby Douglas was asked about DHCS's role in reviewing the workgroup recommendations and the department's report to the Legislature. Mr. Douglas responded that the report was the work of the workgroup and, as such, input from all workgroup members would be included. He further noted that it would not be possible, because of time constraints, to have the workgroup review and comment on the final report but underscored that it would be representative of the workgroup's efforts, process, and recommendations.
8. *Recommendation:* Based on past experiences in which one of the stakeholder group's responses was considered "frivolous" it is important that all recommendations be considered and there be no limit on recommendations.
9. *Recommendation:* Because the group has received so much data, it is important that the workgroup thoughtfully address what the data means and what conclusions/agreements can be drawn from the data. *Response:* It is also important to be cognizant of our time constraints for making recommendations.

Several members endorsed the template suggestion and prioritizing recommendations. Others indicated they would not support this format but did support providing an analysis for each recommendation, with justification for the recommendation. The facilitator (with group support) subsequently asked workgroup members to develop recommendations with the criteria listed below, in mind. Members were also encouraged to organize their recommendations into short- and long-term goals and e-mail them to the facilitator by **Thursday, January 8, 2009**, so they can be distributed to the group in advance of 1/12/09 meeting. The group agreed to address the specific process for sharing recommendations at the next meeting following OSHPD's brief information presentation.

1. Consonant with AB 1629 Workgroup Purpose (see below):

The AB 1629 workgroup, representing diverse stakeholders, has the responsibility of developing AB 1629/ratesetting methodology recommendations for the Department of Health Care Services (DHCS), pursuant to W&I Code Section 14126.02(a), and may take into consideration all factors deemed relevant to ensure the quality of resident care.

- 2. Analysis and Justification** -- include an analysis (pros and cons) of and justification for the recommendation, the latter referencing the specific problem, lack of information, etc., that the recommendation is addressing.

3. **Measure Impact** – how would you measure the impact of the recommendation?
4. **Costs** – consider any and all costs associated with the recommendation -- as well as California's current economic situation.
5. **Feasibility of Implementation** - consider how feasible it will be to implement the recommendation.
6. **Different Kinds of Recommendations** – recommendations that are broad, for example requesting more research or analyses, are legitimate and acceptable recommendations.

Public Comment

Request: A member of the public requested that the workgroup make recommendations primarily with the consumer in mind.

VI. Develop Meeting Agenda for January 12, 2009

Because the meeting agenda for the 1/12/09 meeting was developed at the 12/1/08 meeting, the workgroup addressed agenda setting for the 1/22/09 meeting – the last scheduled AB 1629 workgroup meeting. In addition to the standard agenda items, consensus was the 1//22/09 agenda should address these items:

- Continued development of AB 1629 workgroup recommendations
- Discussion of Workgroup Summary Report
- Final closing remarks and summary meeting process evaluation

Public Comment

None

VII. Closing Remarks and Meeting Evaluation

The facilitator summarized the focus of the meeting's information presentations and the next steps for making recommendations.

Public Comment

None

VIII. Adjournment

SKILLED NURSING FACILITY QUALITY WORKGROUP AGENDA

Wednesday, December 17, 2008

10:15 a.m. to 3:15 p.m.

University of Southern California State Capitol Center
1800 I Street Sacramento, CA 95814

Welcome	Monique Parrish (MP), Facilitator
Review agenda	MP
Review summary of 12/01/08 meeting	MP
Status of outstanding issues/requests	MP
Public comment	MP
Information Requests Presentations	MP
Public comment	MP
Continue discussion and Refinement of Objectives 1 & 2 & 3:	MP
Objective 1: Identify information needed to make recommendations to the Department of Health Care Services for the Legislative Report	
Objective 2: Define a process for reviewing information and making recommendations	
Objective 3: Establish a process for reviewing the final set of recommendations for the workgroup summary report, with public input	
Public comment	MP
Develop meeting agenda for January 12, 2009 meeting	MP
Public comment	MP
Closing remarks and meeting evaluation	MP
Public comment	MP
Adjournment	

Notes:

Morning and afternoon breaks will be included as part of this agenda.

A working lunch will occur - lunch is provided for the Workgroup only.

NEXT MEETING: January 12, 2009 10:15 A.M. – 3:15 P.M.