PUBLIC HEALTH COUNCIL

A regular meeting of the Massachusetts Department of Public Health's Pub lic Health Council was held on Wednesday, June 13, 2007, 10:00 a.m., at the Department of Public Health, 250 Washington St., Boston, Massachusetts in the Henry I . Bowditch Public Health Council Room. Members present were: Chair John Auerbach, Commissioner, Department of Public Health, Ms. Helen R. Caulton-Harris, Mr. Harold Cox, Dr. Michèle David, Dr. Muriel R. Gillick, Mr. Paul J. Lanzikos, Ms. Lucilia Prates Ra mos, Mr. José Rafael Rivera, Mr. Albert Sherman, Dr. Michael Wong, Dr. Alan C. Woodward, and Dr. Barry S. Zuckerman. Absent was Council Member Philip C. Nasca, PhD. Also in attendance was Attorney Donna Levin, General Counsel, Department of Public Health.

Chairperson Auerbach announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance . The Commissioner also welcomed everyone and asked the Members of the Public Health Council to introduce themselves to the audience.

RECORD OF THE PUBLIC HEALTH COUNCIL MEETING OF APRIL 25, 2007:

A record of the Public Health Council Meeting of April 25, 2007 was presented to the Council for approval. Copies of the minutes were distributed to the Council Members prior to the meeting for review. After consideration, upon motion made and duly seconded, it was voted (unanimously) to approve the Record of the Public Health Council Meeting of April 25, 2007 as presented.

PRESENTATIONS:

"Healthcare Reform: Where We are Today", by Jon Kingsdale, Executive Director, Commonwealth Connector:

Jon Kingsdale, Executive Director, Commonwealth Connector made a presentation before the Council. He said in part, "…I thought I would summarize for you where we are with Health Reform in Massachusetts." Some of the statistics from his presentation are:

Uninsured in Massachusetts (Based on August 2006 Health Care Finance and Policy Statewide Survey):

- Total Commonwealth Population: 6,200,000
- Insured (94%) 5,830,000

Uninsured (6%) for summer of 2006 370,000

<100% Federal Poverty Level (FPL) Medicaid Eligible but unenrolled 70,000

0-300% FPL	Commonwealth Care	140,000
>300 FPL	Affordable Private Insurance	160,000

Mr. Kingsdale said in regards to the above chart, "We have divided it up for you into three different populations by sort of eligibility and income because pieces of the uninsured are targeted through sub-populations through expansion of Mass. Health, Medicaid, and through the creation of a new program that is subsidized health insurance for those under 300% of federal poverty, that we run out of the connector, called Commonwealth Care, and then through greater ease and affordability and requirements, frankly, to purchase private, unsubsidized health insurance. I would describe the reform as built on five pillars and those are as follows:

MA Landmark Health Care Reform Law

1. Subsidize insurance for low-income uninsured
2. Require individuals age 18 and older to have health insurance by July 1, 2007
3. Require employers with 11+ Full-Time Employees to provide some contribution & a pre-tax, payroll deduction plan
4. Reform the small- & non-group market
5. Increase MassHealth reimbursement levels (P4P)"

Mr. Kingsdale continued, "This is really about shared responsibility to fill-in the gaps in our existing financing system. We spend around fifty or sixty billion dollars in Massachusetts on health care. The object of this is not to replace half of that, that is private financing, but to fill in the hole. Everybody is going to have some responsibility, which means everybody is going to have some pain. Our element clearly is an element of social solidarity. We are going to subsidize insurance for low-income uninsured, who do not currently have access to employer or government-sponsored insurance, and that is primarily through the Mass. Health and Commonwealth Care programs. We are also asking adults in Massachusetts to have health insurance."

In regards to the requirement for insurance by July 1, 2007 for those 18 years of age and older, Mr. Kingsdale said, "…The Legislature, in its wisdom, is phasing that requirement in, in terms of penalizing folks for not having it, so there are no penalties unless you do not have insurance as of the end of this year; and, even then, it is a relatively modest financial penalty. The more significant financial penalties kick-in, in 2008, and there is also an affordability schedule that we have just developed, actually, to indicate prospectively to people, based on their income, and the price of insurance available to them, that meets minimum standards, whether they are deemed to be able to afford insurance. If they are not able to afford insurance, and then it is graduated by income, they are not required to have it."

"The third element", further said Mr. Kingsdale, "is employers are supposed to provide some contribution, a fair share contribution towards to their health insurance for their full-time employees, and to make a pre-tax payroll deduction financing mechanism available to most of their employees for their own contribution. The net impact is actually tax subsidies in the state average of (48 cents) of premium. A dollar moved from wages to premium contribution saves the employee 48 cents and the employer 7.65 cents for a total of 48 cents in federal withholding taxes. So there is more government subsidized health insurance… The fourth element is a reform of the market….There is good evidence that providers do a good job, hospitals particularly, at getting the private sector to make-up for what they perceive to be a shortfall in public sector payment. So, as part of the financial formula and probably the political formula, there is also a commitment to increase Mass Health reimbursement to hospitals and doctors, based on pay for performance."

Dr. Barry Zuckerman, Public Health Council Member asked, "What is the economic impact on both low income people paying their own premium and the employers, who get subsidized? What was the final political and economic formula? What principle was that derived from?"

Mr. Kingsdale replied in part, "This is not a mandate on employers to provide health insurance. Rather, the formula is that, for employers of 11+ full-time equivalent employees, so that exempts the vast majority of employers in this Commonwealth who are small employers but most workers work for larger employers. For those employers, there was a computed cost; sort of an average burden on other rate payers…and that was calculated at about $295.00 per person. There is a contribution expected of employers, if they do not make a fair and reasonable contribution towards health insurance for their employees, that they at least pick-up the burden of that free care. That is the choice they face…I suspect the largest impact on employers financially will be more employees taken their offer of insurance…"

Dr. Michèle David, Public Health Council Member inquired, "You mentioned fair and reasonable share for employers. Is there a definition of those terms?" Dr. David further asked, "What are the harsh penalties expected in 2008? And what is the penalty collection process?"

Mr. Kingsdale answered, "The definition is set forth in regulations done by the Division of Healthcare Finance and Policy and it is a contribution. There are sort of two tests. One is either the employer contributes 33% of the cost of the premium for a single, not family but single coverage, for full-time employees, or 25% of the FTE work force participates in the employer-sponsored health insurance. Those are the two tests – an employer has to pass one of them. The law calls for the penalty to be assessed for each month that the individual who is required to have health insurance goes without health insurance, although there is an exception for between jobs kind of thing, and that penalty is supposed to be 50% of the premium of the lowest cost available health insurance plan, that meets minimum federal coverage standards. That is a complicated formula and we are working to see if we can get that down to less than ten thousand different premium calculations." Mr. Kingsdale noted that penalty collection is through individual tax filing.

Mr. Kingsdale continued his presentation. "We have made good progress. We opened one of our two programs in November and expanded eligibility as of February. There is the subsidized

Commonwealth Care program for the uninsured below 300% of the federal poverty level who do not have access to subsidized government or employer subsid ized insurance." Mr. Kingsdale noted that they have exceeded their original enrollment target of 67,500 with 140,000 enrollments in Commonwealth Care. And further that 30% of the uninsured enrolled between July 2006 and June 2007. He noted that their non-group insurance plans offer twice the value at half the price. It was noted that the Commonwealth C hoice offers various health plans to young adults (19 to 26 years of age), non-group individual plans (buying out of own pockets), and small businesses (up to 50 full time employees) and allows for Voluntary plans (payroll deduction, pre-tax, sub-tax subsidized financing – employee pays for own insurance but with pre-tax payroll deduction dollars). Participating providers are Blue Cross Blue Shield, Harvar d Pilgrim, Tufts, Fallon, Neighborhood Health Plan and Health New England. The Commonwealth Choice Plans offers benefit level plans in Gold, Silver and Bronze. See the chart below:

EXAMPLE* OPTIONS UNDER COMMONWEALTH CHOICE (37-year old)

Benefit Level	**Carrier A**	**Carrier B**	**Carrier C**	**Carrier D**
Gold	$400	$460	**$285**	$370
Silver	$300	$340	$235	$230
Bronze	$240	$280	**$184**	$202

In reference to the Commonwealth Choice Chart above, Mr. Kingsdale noted that the $184.00 plan is half the $335.00 premium this sam e individual would pay now and that the $335.00 premium plan currently available buys less (i.e., no Rx coverage and has a $5,000 deductible). The $184.00 plan above covers Rx and office visits and emergency room visits immediately, plus 80% of other costs after a $2,000 deductible. Mr. Kingsdale noted further that "bronze is the minimum credible coverage with substantial cost sharing, gold is that old fashioned HMO plan that we used to love to hate…It is actually ten dollars per office visit, and you can compare premiums on line. There are trade-offs to be made between a narrow network product with a heavier sort of managed care element to it, that might be offered by Carrier C and D, and a broader network product that might be offered at a significantly higher price for Carrier A and B.

*Chart above does not have exact numbers. People may go to www.mahealthconnector.org, and plug in their zip code and age and one or two other facts and then up will p op a variety of benefit packages available with various premiums.

Discussion continued between Mr. Kingsdale and the Council Members (please see verbatim transcript of the meeting for full discussion). One topic discussed was the cost of premiums and Dr. Alan Woodward asked in part, "W here is the money going?" It was noted that the money goes to pharmaceuticals, doctors, hospitals, and for administrative and advertising. Mr. Kingsdale said that about 88% of premiums are being paid out to providers.

During discussion, it was also noted by Mr. Kingsdale that because health insurance contracts are typically for a twelve-month period, one would have to start coverage in February of 2008 in order to have it in place by January 1, 2009. Several Council Members inquired about the Commonwealth Connector's outreach campaign. Mr. Kingsdale noted some of their outreach activities as follows:

- Send a letter to the 93,000 employers in the Commonwealth explaining in two pages what Commonwealth Choice is all about.

- Connector staff are doing seminars across the state

- Distributing color brochures

- Maintaining a Web-site with all the information

- Fostering partnerships with business associations, major employers, Greater Boston Interfaith Organization, community outreach workers in emergency rooms and community health centers and out in the communities. They have partnerships with the Boston Red Sox, Bank of America, CVS and Shaws' Supermarkets and Comcast and others

- Paid advertising in non-English Language Newspapers.

Council Member Lucilia Prates Ramos noted, "I would like to commend you on all the work the Connector has done to date. However, I am in the business of making sure that limited English proficient populations have information. While I have obtained some of the posters and multi-sized postcards from "Health Care for All" in English, Spanish, and Portuguese, people have to go to the web site to get this information. Typically, these populations are not on the web. They are not surfing the web, and I haven't seen anything on television, or in ethnic newspapers, and I frequently read the Portuguese one, but I haven't seen anything in other languages…" Mr. Kingsdale said they started with Spanish and were working on other languages but that it would take some time.

In conclusion, Mr. Kingsdale stated, "Many people have asked, 'Will Health Reform work?' and he answered, "I think it is working so far, in the sense that we have probably newly enrolled about 30% of the folks that we thought represented the population of the uninsured. We have made Non-Group insurance much more easy and affordable to buy, and I am very pleased that we have been able to conserve the goodwill and broad support that Health Care Reform enjoyed as a result of taking three years to carefully consider all points of view before enacting it. My board which is pretty diverse in its political views and interest it represents, has been able to reach unanimity on a bunch of very controversial issues. I think it is working, in part, because we took that three years, and the Legislature took a very considerate and sort of everybody-in-the tent approach to try and do something. It is pretty radical. It is pretty fundamental when you think about refinancing one-sixth of our entire state's economy….And, obviously, not only did they come up with a consensus, but that has been maintained, and they came up with a comprehensive intelligent plan."

In his closing remarks, Mr. Kingsdale further said, "Is it sustainable?" "He said it will take years to implement; it will not insure everybody, if we can get the uninsured rate down to about 1 or 2% that would be progress but it will not be sustainable unless we can find ways to bend the inflationary trend in the cost of medical care (the next major challenge for Health Reform)."

Mr. Kingsdale noted that a lot of other states in the country have dealt with soaring costs of health care by kicking people out of insurance and employers dropping insurance… "In a way we have made a bold statement, we say, we are going to try to insure virtually everybody. Either we bend the trend or share the cost. We are going to be doing both. Health care is not this year what it was last year. It is never going to cost less. Hopefully, it will be single digit, not double digit increases in premiums."

Discussion continued. Dr. Alan Woodward noted, "Three comments, first of all, thank you for what you listed as intelligent leadership, Jon. It is incredible, and the consensus process that you have cultivated so far, this is really revolutionary, and I think everybody in this room realizes what it took to get to this point, and the fact that we already have roughly a third of the uninsured insured in less than a year is incredibly impressive. I do think that the biggest challenge is going to be sustainability and is going to be cost control, and I would encourage you to go forward, working with the insurers to look at the issue of defensive health care costs. It is estimated, minimum, to be three billion dollars a year in Massachusetts, roughly five hundred dollars per person. HHS has estimated it at twelve percent of the overall health care cost, and I think it is something that we need to address going forward. It doesn't cost anything to fix this problem, and I think there are some mechanisms to achieve a radical change, and I think it is going to be very difficult to get providers to follow evidence-based clinical guidelines when their concern is about whether those are the standards of care, and the repercussions of the current liability system. I hope that we could have a dialogue and move on this huge cost of health care, which does nothing to help the quality of care; in fact, thwarts it."

Chair Auerbach asked Dr. Woodward to explain what he meant by 'defensive health care costs'. Dr. Woodward said, "Defensive health care costs are health care costs that are driven by the current liability system; meaning that providers do tests, even procedures, out of fear of liability repercussions…It isn't just the high premiums for providers, which are driving many of our high risk providers out of state, out of practice, into premature retirement or to modify their practice. Nearly half of our providers are modifying their practice, avoiding high risk procedures, or high risk patients, as a result of the liability system, but it is the defensive health care costs that are driven by this dysfunctional health liability system, which account for national, in the most recent study, well over a hundred and twenty-four billion dollars a year; in this state, well over three billion dollars a year, and if you go by the HHS estimate, it would be closer to six billion dollars in Massachusetts."

Dr. Woodward said further, "I think there are mechanisms to improve quality of care and control the costs, other than just trying to ratchet reimbursement, which, in many sectors, is going to cause other providers to go out of business. I think there is an opportunity to work cooperatively between the state and the insurers, and others, to address some of the dysfunction of this current system."

Mr. Kingsdale said, "I just want to agree with you and point out two things. Those are tough issues and we are going to have to confront tough issues like that, and one of the things that I hope Health Reform will do, will help create a new dialogue in Massachusetts, about, if access and quality relate to cost, how do we control the cost? They are not separate discussions. They

need to be brought together, and hopefully the Public Health Council can help lead that dialogue."

Chair Auerbach added in part, "…We look forward to continuing this discussion in a variety of different manners, including the issues of cost and quality. Hopefully, we will have many opportunities to talk and invite you back, as well."

No vote/Information Only

"2007 Nursing Home Satisfaction Survey", by Paul Dreyer, Director, MDPH Bureau of Quality Assurance and Control, Brian Robertson, Principal Investigator Market Decisions, Richard Bane, President, Massachusetts Extended Care Federation:

Dr. Paul Dreyer, Director, Bureau of Quality Assurance and Control, addressed the Council. He said in part, "The Bureau of Quality Assurance and Control is responsible for a majority of the regulatory activities in the Department, particularly with respect to licensure and certification of health facilities of all kinds, hospitals, nursing homes, clinical laboratories, rest homes, clinics, and the list goes on. What I wanted to do today is talk about how we regulate nursing homes…I am going to talk about nursing home oversight activities, in terms of workload and what it takes to do what we do, and then I am going to talk a bit about how the federal survey process works…"

Dr. Dreyer said, "Nursing home regulation is dictated, in large part, by rules from Certified Medicaid and Medicare Operations (CMS). CMS is responsible for the regulations that nursing homes must follow if they are to receive either Medicare or Medicaid payment around 70% of nursing home reimbursement is in Medicaid dollars. The industry is largely dependent on Medicaid as a payer, and the Medicare and Medicaid regulations are the same."

In response to Dr. Woodward asking, Dr. Dreyer noted the number of nursing homes and patients in Massachusetts. He said, "Massachusetts has about 450 nursing homes with about 42,000 patients. Ten years ago the figure was about 560 nursing homes and 60,000 patients."

Dr. Dreyer continued, "We do several things to oversee the quality in nursing homes. The oversight agency is the Division of Health Care Quality. It has a contract with Medicare to be the designated 'Single State Agency' to do the Medicare certification work for Massachusetts. Our oversight activities include annual inspections at every nursing home. Those inspections are to occur in a nine to fifteen month window. They are unannounced and they are random. Random means you cannot predict the date of your next survey from knowing when your previous survey occurred. The next survey date is chosen from a random number…The second thing we do is complaint investigations. We respond to consumer complaints, to facility reported incidents, with on-site investigations. And the third group of activities has to do with the following up on deficiencies that we have cited, to see if they are corrected, and we do that with respect to both annual surveys and complaint investigations."

Dr. Dreyer said further, "Who does the work? We have a staff of 56 inspectors, who conduct annual surveys in the 435 Medicare certified facilities (not the 450 I mentioned earlier). Most

are Medicare or Medicaid certified but there are a small number of facilities that are not certified and are treated slightly differently. Fifty-six surveyors are responsible for the annual surveys. Each survey requires, on average, a 150 person hours and that includes post-survey documentation. The process is about two-thirds of that 150 hours is on-site work, and the other 1/3 is writing up the results of the survey. That will vary dramatically, depending on the findings. If there are no deficiencies found, then the post-survey write-up is very minimal. About half of the surveys result in follow-up visits, and those consume about 35 hours per visit."

Regarding complaint investigations, Dr. Dreyer stated, "We receive about 1100 complaints from consumers. We also receive reports from facilities of incidents that have occurred: self-reporting. We have 20 complaint staff. In 2006, 20 staff conducted 708 on-site investigations of consumer complaints. Complaints average around 23 hours per investigation, and again that includes both on-site activity and write-up. The complaints are much more focused than the annual survey; and so they are much less labor intensive on a unit basis."

Dr. Dreyer noted that for all re-certification, licensure and complaint surveys a "Statement of Deficiency" is generated if regulations are found not in compliance. The facility then has to submit a "Plan of Correction" and if the deficiencies are not corrected the results would be a termination for the Medicare program or a license revocation. Dr. Dreyer said, "There are three or four of those a year."

Dr. Woodward asked for clarification on the revocations and Dr. Dreyer explained, "There are permanent revocations. Terminations from the Medicare program do not have to be permanent. They can be time limited, but it is usually the case, when we get to that point, that we institute a companion licensure action, and that typically results in permanent closure of the facility."

Dr. Dreyer cited the first federal regulation, 42 CFR §483.25, Quality of Care regulations which states, "Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care."

Dr. Dreyer explained "The Deming Cycle" for total quality improvement which is "Plan", "Do", "Check" and "Act". Dr. Dreyer said further, "Nursing Home Regulations are essentially an embodiment of the Deming Cycle. The Deming plan says to establish the objectives and processes necessary to deliver results and according with the specifications in the nursing home world. That essentially means you have to access residents and develop a care plan. The "Do" part of the Deming Cycle says you have to implement the processes – that is implementation of the care plan. "Checking" is to monitor and evaluate the processes and results against objectives ands specifications, and report the outcome. In the nursing home world, you have to continue to assess the resident, to see if the care plan is achieving its goals. "Act" means to apply actions to the outcome for necessary improvement. This means reviewing all steps, Plan, Do, Check, Act and modifying the processes to improve it before its next implementation. In the nursing home world, that means you revise the care plan as necessary, based on the results of ongoing assessment."

In sum, Dr. Dreyer said in part, "…So what happens in nursing homes is – there is an expectation that facilities will assess residents, and there is a whole set of regulations that govern assessment upon admission. You develop a care plan based on the assessment. You reassess to see if the care plan is achieving its desired goals. If not, revise the care plan and go through the cycle again…This gives us the ability not only to look at individual outcomes but to follow the whole process of care through its cycle, and verify that the faci lity has control over its entire process of care delivery, which I think is a very powerful tool to enable us to get a good handle on what is happening in facilities."

Dr. Dreyer noted briefly the items that are looked at during a nursing home survey and cited the document that is used by the surveyors' which can be reviewed on -line: State Operations Manual for the survey process: http://www.cms.hhs.gov/Manuals/IOM/list.asp .

What happens on a survey? See list below and the State Operations Manual.

- A – General Observation of the Facility
- B _ Kitchen/Food Service Observation
- C _ Resident Review
- D _ Quality of Life Assessment
- E _ Medication Pass
- F _ Quality Assessment/Assurance Review
- G _ Abuse Prohibition Review

No Vote/Information Only

Discussion followed by the Council. Council Member Woodward asked who pays for surveys. Dr. Dreyer replied that the funding comes from CMS (on duly certified nursing homes). The Department can claim 90% of the survey costs; however, the Department only receives half of the 90% back. The other 45% goes to the Medicaid program and from there to the general fund. The state of Massachusetts makes up the rest of the 45% to the Department. The nursing homes do not have to pay a fee. It was noted that this survey program costs about Thirteen million dollars. Council Member Caulton-Harris inquired about communication vehicles with the local boards of health and city health agencies in regards to the nursing home surveys. She said some things appear to overlap, that the local governments license, for instance, the kitchen facilities. And further, are the surveys shared with the local public health officials in the cities and towns where the nursing homes are? Dr. Dreyer noted that complaints often come from the local agencies regarding sanitation issues and building conditions. Results of the complaint investigations are shared with the complainant, the surveys results are posted in the facility and also are available on the DPH website.

Council Member Gillick brought up the issue of the Green House Model. She said, "In this month's Journal of the American Geriatric Society, there was an article studying the effectiveness of the Green House Model….These fa cilities are more home-like, where the focus is on trying to provide resident-centered care and maximize the autonomy of the nursing home resident, and they do this by trying a less institutionally flavored environment, and by breaking down some of the rigid barriers between the providers, and what this study found was that these

models did as well as conventional nursing homes on conventional quality indicators, and did a lot better on what others may call enhanced quality indicators. I have two questions. Recognizing that CMS is calling the shots here and that you only have a small degree of wiggle room, I still wonder was any consideration of modifying the survey process so it wasn't just looking at remediation deficiencies; but rather, giving incentives to Massachusetts nursing homes to pursue this type of model? And secondly, whether there was interest in enriching the quality of life indicators that you used, not just the ones currently mandated by CMS?"

Dr. Dreyer responded, "What I can say is that we are very strong supporters of the Green House Model. One of the things that we do to foster the model, is to try to allay a lot of myths about an apparent disconnect between the Federal survey process and the Green House Model. There is no conflict at all between the Federal survey process and the federal regulations and the Green House Model….From the highest levels of CMS on down, everyone supports the attempt to make nursing facilities less institutional and more home-like….I think we are enhancing our quality of life indicators and I think the quality of life indicators now are certainly not inconsistent with the Green House model. They probably could be improved to foster even more, but I think the best thing we can do right now is convince people that we and the regulatory system are in no way barriers to the model."

Dr. Gillick added, "That is certainly important, but I think there is also the question of whether there are actual incentives to pursue a different strategy, rather than merely to be able to say that you are a deficiency-free institution, to be able to say proudly that you are an institution that does x, y and z, as opposed to just that you don't violate various regulations. The question is also whether there are incentives."

Dr. Dreyer said it is something that the Department can look into. Chair Auerbach added, "I would suspect that we can look at that both from the perspective of the Nursing Home Survey, and from the perspective of the DoN applications because there is nothing, I think, to prevent us from including that as a component of the discussion process. I don't know if we can create a positive incentive but perhaps we can. Maybe that is something we will talk about later."

Dr. Dreyer responded, "It would be possible to consider Green House like issues when we look at nursing home replacement DoNs. For example, we could say, I am not suggesting we do this, but the most radical thing to do is say, we won't consider a nursing home application unless it follows the Green House Model. I don't think we should do that, but we could come-up with some ways in that direction."

Chair Auerbach said, "Let's make a commitment to have a report back on this particular question."

Dr. Dreyer made introductory remarks about the 2007 Nursing Home Satisfaction Survey. He said in part, "…In 2003, there was legislation that mandated that we conduct a survey of nursing home family member satisfaction. You might ask why family members rather than residents, and the answer is that resident interviews are prohibitively expensive because, the only way to do it is to do a face-to-face interview with each resident, and because you want to make judgments about each individual facility, you need a very large sample size. That would be 20,000

individual interviews a year. So, we decided to go with a survey of family members which is not prohibitively costly."

Mr. Brian Robertson, Principal Investigator, Market Decisions explained the survey to the Council. He said, "…We responded to a RFP put out by the Department with our research partners Rutgers University. We worked with the Department of Public Health and developed a satisfaction survey, getting feedback from family members themselves, as the tool for developing the instrument. We conducted a pre-test back in 2003 just to test and validate the survey. The first full scale data question was done in 2005 with the delivery of a final report towards the end of that year. The next administration was in the beginning of this year in January and preliminary results I will show you this month. Just to give you a brief idea of the survey methodology, all nursing homes in Massachusetts were included in the sample. This included some transitional care units, but generally included all nursing facilities."

Mr. Robertson continued, "In January we contacted each of the nursing homes in the State, and we asked them to provide a list of responsible parties. The initial contact came from the Department of Public Health in letter form. Then our company got involved and we actually contacted each facility by phone, requested the information; and, in essence, kept calling them until they provided the information. The nursing homes provided a list of responsible parties, which were in large part the son or daughter, or spouse, of the resident, and that person was actually asked to participate in the survey. The data collection actually took place from February until April of 2007. We mailed out a total of roughly 35,000 surveys to responsible parties. We used a fairly rigorous methodology to ensure that we got a fairly decent response. An initial survey packet was mailed out in February to each responsible party that was eligible for the survey. One week later, a reminder postcard was sent to each participating respondent. Two weeks after that, a second copy of the survey was mailed to those who did not respond to the initial survey; and, finally, we did make initial telephone calls to increase response rates in certain facilities."

Mr. Robertson stated further, "The overall survey response rate in 2007, which was the first year in which this was mandatory; we had 439 nursing homes participate. So, every eligible nursing home in the State participated in the survey process. This compares to 2005 when it wasn't mandatory; but, even in 2005, we had two-thirds of the facilities participate. There were 297 out of 449 nursing homes."

Mr. Robertson noted the following information:

- For 2005, we mailed out approximately 26,000 surveys, and received 16,000 back, a response rate of 64%

- Among the facilities that participated in 2005 and in 2007, we sent out roughly 25,000 surveys, got 15,000 back for a response rate of 61%

- For those that only participated in 2007, approximately 10,000 surveys were sent out, 5800 were returned, for a response rate of 59%

- The three measures of overall satisfaction in the survey were:

    1) Overall, how satisfied are you with this nursing home?
    2) Overall, how satisfied are you that residents' needs are met?
    3) Would you recommend this nursing home to a friend or family member? (This question asked only in 2007)

Note: These measures were done on a five point scale (1 = very dissatisfied and 5 = very satisfied).

Preliminary Survey Results by Question:

Question 1: Overall, how satisfied are you with this nursing home?

	2005	**2007**
Facilities that participated in 2005 and 2007	4.25	4.23
Facilities that participated only in 2007	N/A	4.09

Question 2: Overall, how satisfied are you that all of the resident's needs are met?

	2005	**2007**
Facilities that participated in 2005 and 2007	4.10	4.09
Facilities that participated only in 2007	N/A	3.97

Question 3: Would you recommend this nursing home to a friend or family member?

	90%	**10%**
Facilities that participated in 2007	Yes	No

In addition to the overall satisfaction measures, the survey uses about 53 individual questions which encompass into six domain scores. The domains are: Administrative and Personal Care Staff, the Physical Environment, Activities, Personal Care Services, Food and Meals, and the Resident's Personal Rights.

Domain Scores:

	Facilities that Participate in 2005 and 2007	**Facilities that Participate in 2005 and 2007**	**Facilities that Participated in 2007 Only**
	2005	**2007**	**2007**
Administrative and Personal Care Staff	**4.18**	**4.19**	**4.11**
Physical Environment	**4.15**	**4.13**	**3.96**
Activities	**3.84**	**3.86**	**3.75**
Personal Care Services	**4.08**	**4.10**	**3.99**

Food and Meals	**3.94**	**3.94**	**3.86**
Residents' Personal Rights	**4.09**	**4.11**	**4.01**

	Facilities that Participated in 2005 and 2007		**Facilities that Participated Only in 2007**
	2005	**2007**	**2007**
Region			
Metro	4.22	4.21	3.90
North	4.25	4.22	4.11
South	4.31	4.30	4.15
West	4.21	4.18	4.16
Bed Size			
60 or fewer beds	4.36	4.42	4.19
61-80 beds	4.28	4.26	4.10
81-100 beds	4.29	4.31	4.09
101-140 beds	4.22	4.19	4.07
141+ beds	4.22	4.19	3.99

A brief discussion followed by the Council. Dr. Woodward asked, "Did you feel you got a statistically significant sample on each facility? (Woodward said about 20,000 responses from about 400 facilities average to about 50 responses per facility.) Mr. Robertson replied that there were about 18 facilities that they felt they didn't get a sufficient response from. Council Member Caulton-Harris asked, "Were you able to assign any significance to the facilit ies that only participated in 2007, as to why the data was a bit lower? Mr. Robertson replied in part, "…The differences between those two groups appear to be just differences in their satisfaction scores."

Mr. Richard Bane, Chairman, Massachusett s Extended Care Federation testified before the Council. He said in part, "We represent nearly 500 nursing homes and assisted living residences in Massachusetts. We provide care to over 100,000 people annually, and that juxtaposes the number that Paul gave you before, when he indicated that there are 42,000 residents in Massachusetts nursing homes. That's at any one time. During the course of a year, we will take care of a 100,000 individuals, as many of those individuals come for short -term, post acute rehabilitative stays that last anywhere from seven to thirty or forty days, and then they go home…Those residents are cared for by Medicare. Many of the long term care chronic residents are paid for under the Medicaid program. However, the survey proces s that Paul spoke of, addresses all of the residents in the facility, whether they are cared for under Medicare, Medicaid, or any other individual payer sources. As the provider community, I have to tell you that we are very excited about the release of t hese 2007 survey results since they are an affirmation of what we think we already kno w. That is when people experience our service they are more than satisfied…When you think about your own interactions in the places that you

purchase services, goods and services, a nine out of ten satisfaction rate and recommendation rate is extraordinarily high and that is something that we are very proud…"

Mr. Bane noted further, "…Probably the group that really deserves the most credit, that we are most proud of, is our employees, who provide the passionate, high care quality to the frail elderly and disabled residents each and every day. Caring for people with multiple medical diagnosis and cognitive impairment such as dementia and Alzheimer's disease is no easy tas k, and the work force that interacts with our residents every day, they are supremely qualified and we are just incredibly proud of them."

Mr. Bane noted other initiatives that MECF endorse that approve quality care: a national campaign called Advancing Excellence in America's Nursing Homes, spearheaded by a coalition of Congressional Advisors, CMS, the American Health Care Association and other provider groups, which is a two-year campaign, aimed at improving the quality of life for nursing home residents; and the state-funded Extended Care Career Ladder Initiative (ECCLI) that provides training and increased wages for o ver 7500 workers. This program promotes opportunities for Certified Nursing Assistants to become LPNs, and for LPNs to become registered nurses.

Mr. Bane commented, "Certainly, Falls are an issue, and many of our residents that live in our facilities suffer from these chronic dementia-related diseases, so the tension that Paul talked about before, between the restraint-free environments and protecting residents from accidents is a real tension, something that we will continue to work on , on a regular basis."

For the record, Discussion on the Nursing Home Satisfaction Survey results ha d to be postponed until after the Determination of Need docket items were heard. Discussion continues on page 19 of this document.

No Vote/Information Only

DETERMINATION OF NEED PROGRAM:

PREVIOUSLY APPROVED DoN PROJECT NO. 4-4916 OF CARITAS PET IMAGING, LLC: Request for a significant change to add Holyok e Medical Center, Noble Hospital and Cooley Dickinson Hospital as host sites to the previously approved mobile Positron Emission Tomography/Computerized Tomography (PET/CT) Service:

Ms. Joan Gorga, Director, Determination of Need Program, presented the Ca ritas Pet Imaging request to the Council. Ms. Gorga spoke briefly, stating in part, "Caritas PET Imaging has requested a significant change to DoN Project No. 4-4916, a mobile Positron Emission Tomography (PET)/Computerized Axial Tomography (CT) service. The significant change involves the addition of Holyoke Medical Center, Noble-Hospital and Cooley Dickinson Hospital as new locations to its exiting two units, mobile PET/CT service. The request will not increase the number of days of service approved un der the original DoN in April of 2006. The service presently operates the first unit seven days per week, and will operate similar service for the second unit when it is placed in service in the near future."

Staff's memorandum, dated June 13, 2007 to the Council stated, "The Department, within the 20-day filing period of the significant change, received no comments objecting to the proposed amendment to DoN Project No. 4-4916. The request qualifies as a significant change since the addition of a service location doe not qualify as either an immaterial or a minor change. Therefore, consistent with DoN Regulations 105 CMR 100.753(A), Public Health Council action is necessary…The holder states that there will be no substantial capital expenditures as a result of the addition of the three locations. Each of the three host sites has a mobile tech dock capable of accommodating the mobile PET/CT. The fair market value of the use of the facilities averages less than $70,000 per site or $210,000 for the three sites and therefore does not exceed the DoN capital expenditure threshold for clinics. The operating expenses for the three days of service will be about $300,000 which is below the DoN operational expense for clinics. Staff recommends that the proposed significant change be approved."

In staff's analysis, presented in the Council memorandum dated June 13, 2007, it states in part, "The holder states that the reason for filing the significant change is to provide residents of Western Massachusetts with access to PET/CT services in their community through the addition of mobile PET/CT host sites in Holyoke, Westfield and Northampton. Noble Hospital in Westfield and Cooley Dickinson in Northampton do not presently receive PET/CT services and the provider at Holyoke Hospital in Holyoke has discontinued services at the hospital due to certain business arrangements with another hospital in the area. Prior to filing the request, each of the hospitals consulted with the holder to determine if mobile PET/CT services could be provided on the hospital's campus to meet the needs of the hospital's patients who must now travel to receive PET/CT services…"

A brief discussion was held. Council Member Sherman made the motion for approval of the amendment. After consideration, upon motion made and duly seconded, it was voted unanimously to approve the request by **Previously Approved DoN Project No. 4-4916 of Caritas Pet Imaging, LLC** for a significant change to add Holyoke Medical Center, Noble Hospital and Cooley Dickinson Hospital as Host sites to the Previously Approved Mobile Positron Emission Tomography/Computerized Tomography (PET/CT) Service. This amendment is subject to the following condition:

1. All conditions attached to the original and amended approval of Project No. 4-4916 shall remain in effect.

PROJECT APPLICATION NO. 4-1489 OF ARC BELMONT, LLC: for new construction of a 58-bed Level II Skilled Nursing Facility as part of a 343 residential-unit Continuing Care Retirement Community called Freedom Commons at Belmont Hill to be located at 100 Olmsted Drive, Belmont, MA.:

Mr. Jere Page, Senior Analyst, Determination of Need Program, presented the ARC Belmont application to the Council. He noted, partly in his presentation and partly in his staff summary, "…Freedom Commons at Belmont Hill is proposing to establish a 58-bed Level II skilled nursing facility (SNF) within a new Continuing Care Retirement Community (CCRC) to be called Freedom Commons at Belmont Hill and located at 100 Olmsted Drive in Belmont, MA. Freedom Commons will be a full-service CCRC located along the southern edge of the McLean

Hospital campus in Belmont. The 12-acre complex will be anchored by a three-story Commons building and will also include five residential buildings of five to six stories housing 292 units. In addition, there will be a five-story healthcare building housing 30 assisted living units, 21 memory enhancement units, as well as the proposed 58 skilled nursing beds. The entire project is expected to be completed by June 2009. CCRCs are residential complexes that feature health care and support services for the residents. The great majority of CCRCs have a nursing home within the complex and many have physician offices and home health services. The resident has a contract with the CCRC sponsor that specifies the sponsor's obligations, which include medical and support services….Freedom Commons reports that entrance fees for the residential units will range from $495,000 to $995,000 depending on the size of the unit, and monthly fees for single occupancy will range from $2,740 to $4,995."

Staff further noted, "…Type A CCRC nursing home beds are exempt from the nursing home bed need projections in the Determination of Need Long Term Care Bed Guidelines. The rationale for exempting Type A facilities from the nursing home bed need projections is that these facilities are offering true 'life care', with a guarantee that the residents will be cared for without the use of public assistance (e.g., Medicaid funds). In addition to the DoN Guidelines for Continuing Care Retirement Communities the Nursing Facility Replacement and Renovation Guidelines were used in the review of this project. "

Mr. Page stated, "The recommended MCE, maximum capital expenditure, is 21.5 million dollars (in January 2007 dollars). This will be funded in two ways; one, with a forty percent equity contribution of 8.6 million dollars from available funds the Freedom Common currently has, and the remaining MCE of 12.9 million will be funded through a short-term loan from a yet to be determined lender. The anticipated term of that is five to seven years, with a 7.5 percent interest rate…"

A brief discussion was held. Council Member Sherman made the motion for approval. After consideration upon motion made and duly seconded, it was voted unanimously to approve **Project Application No. 4-1489 of ARC Belmont, LLC,** with a maximum capital expenditure of $21,500,000 (January 2007 dollars) and first year incremental operating costs of $5,721,485 (January 2007 dollars). A staff summary is attached and made a part of this record as **Exhibit No. 14, 884**. This approval provides for new construction of a 58-bed Level II skilled nursing facility as part of a 343-unit Continuing Care Retirement Community called Freedom Commons at Belmont Hill to be located at 100 Olmsted Drive, Belmont, MA. This Determination is subject to the following conditions:

1. Freedom Commons shall not admit Medicaid patients or seek Medicaid funds for residents of the CCRC. Freedom Commons at Belmont Hill, as a Type "A" CCRC long term care facility granted Unique Application status, is precluded from accepting Medicaid patients.

2. Freedom Commons shall accept the maximum capital expenditure of $21,500,000 (January 2007 dollars) as the final cost figure except for those increases allowed pursuant to 105 CMR 100.751 and 105 CMR 100.752.

3. Freedom Commons shall contribute 40% in equity ($8,600,000 in January 2007 dollars) to the final approved MCE.

4. Freedom Commons shall not commence construction of its 58 s killed nursing home beds until 146 of the 292 residential care units have been presold.

5. Freedom Commons shall comply with the residency agreement/contract submitted to the Determination of Need Office on January 30, 2007, and amended on April 30, 2007, which meets the contractual requirement criteria to qualify as a "Type A" CCRC facility.

6. Freedom Commons shall, prior to construction, sign formal affiliation agreements with at least one local acute care hospital and one local home care corporation that i nclude provisions for respite care services.

7. The total approved gross square feet (GSF) for this project shall be 48,354 GSF of new construction for the 58 Level II beds, which Freedom Commons may construct at its own risk.

8. Freedom Commons shall obtain M edicare certification for its Level II beds.

9. Prior to commencing construction of the proposed CCRC, Freedom Commons shall submit documentation of maintenance of restricted reserve funds to cover refunds and facility operations, as well as documentation that a Massachusetts escrow agent has been selected for entrance fees and deposits.

10. Freedom Commons shall adhere to the terms of 105 CMR 100.552 (B) by filing a progress report regarding compliance with the above conditions with the DoN Program once within two years after implementation of this project. The report shall be filed annually thereafter.

Staff's recommendation was based on the following findings:

1. ARC Belmont, LLC d/b/a Freedom Commons at Belmont Hill, is proposing to build a Continuing Care Retirement Community (CCRC) at 100 Olmsted Drive in Belmont, consisting of 343 units together with a 58 -bed Level II nursing home or SNF, which will serve only the residents of the CCRC.

2. The application was filed as an unique application pursuant to 105 C MR 100.302 (B) of the Determination of Need regulations because as a Type A CCRC Level II bed nursing home, it will only be open to residents of the CCRC, and will be supported entirely by private funds.

3. The health planning process for this project was sa tisfactory.

4. The proposed Freedom Commons project qualifies as a Type A facility under the Continuing Care Retirement Community Guidelines. Therefore, the 58 Level II beds associated with this facility are exempt from the nursing home bed need projection s, which show a surplus of existing beds through the year 2010, resulting in a moratorium on the construction of new nursing home beds until 2010, voted by the Public Health Council at its meeting on January 26, 2006, as discussed under the health care requirements of the staff summary.

5. The project, with adherence to certain conditions, meets the operational objectives of the Nursing Facility Guidelines.

6. The project, with adherence to a certain condition, meets the standard compliance factor of the Nursing Facility Guidelines.

7. The recommended maximum capital expenditure (MCE) of $21,500,000 (January 2007 dollars) is reasonable, assuming no Medicaid reimbursement.

8. The estimated operating costs of $5,721,485 (January 2007 dollars) for the project's first full year of operation (FY 2010) are reasonable, assuming no Medicaid reimbursement.

9. The project is financially feasible and within the financial capability of the applicant.

10. The project meets the relative merit requirements of the Nursing Facility Guidel ines.

11. The project is exempt from the community health initiatives of the DoN regulations.

12. The Division of Health Care Finance and Policy did not submit comments on the proposed project regarding MassHealth reimbursement for capital costs, as no Medicaid reimbursement will be sought for the project's nursing home patients.

13. The Executive Office of Elder Affairs (EOEA) submitted no comments on the proposed project.

14. The Division of Medical Assistance submitted no comments on the proposed project.

Discussion on the Nursing Home Satisfaction Survey continued after the DoN items had been heard as follows:

Council Member Harold Cox asked two questions (1) if the survey data was presented only in aggregate form or is the information shared with the individual nursing homes; and (2) Does random survey inspections help with fuller compliance in nursing homes? Dr. Dreyer responded that each nursing home will receive the data on their own particular facility and further that the data will be available to consumer s on the DPH website www.mass.gov/dph as the "Nursing Home Report Card" (click on this icon on the front page, left column). Regarding the random survey inspections, Dr. Dreyer replied that he hasn't looked at form ally at the question but "from being around these data for a long-time, is that there is not that great a difference."

As a result of a question by Council Member Paul Lanzikos, Mr. Robertson clarified that the satisfaction survey only surveyed long term stay patients (residents surveyed had to be there at least four weeks) due to the fact that short term stay and long term stay patients would require separate surveys, one couldn't use the same survey estimate to measure satisfaction.

Dr. Muriel Gillick, Council Member stated, "With respect to the satisfaction survey, and I appreciate your comment that it would be impractical to try to systematically survey residents throughout the State. On the other hand, what you did was to survey family members, and there is some powerful work that has been done, suggesting that what non-residents think is important and what residents think is important may diverge rather substantially. So, is there any interest in following up with a small sample of nursing home residents who are cognitively able to participate in a survey process, with their insights to be represented?"

Dr. Dreyer responded, "We would love to do it. It is a matter of funding. We need the funding to support the effort. I think, to get a representative sample, we would probably need maybe two thousand surveys (not facility specific). Mr. Robertson added, "I think the very minimum that you have to do is 35 surveys per facility – multiply that by 400+ facilities…"

Dr. Gillick replied, "Like, I said, it wouldn't be to get facility-specific data. It would be to get more general data that could be, in turn, applied to specific facilities." Mr. Robertson said, "Well, if you want something meaningful, at the state level, you are probably still looking at two thousand surveys in sixty to eighty facilities."

Chair Auerbach added, "I hear the observation though and I would suggest that what Dr. Gillick is suggesting is that we attempt to prioritize that; and so, in addition to our coming back with the discussion that we talked about earlier, about the Green House Model, let's also come back and maybe do an assessment of what is the least amount of cost that would be associated with having a meaningful survey, even if it was just statewide, and what is the feasibility of our doing that in the near future." Dr. Dreyer replied, "Yes, we can do that. I am sure Brian could probably give us an estimate from his point of view pretty quickly, as to what it might cost."

Discussion continued, Dr. Woodward inquired about the funding source for the nursing home satisfaction survey? Dr. Dreyer noted that the legislature initially provided $300,000 but no more was appropriated. Now the funds were taken from the Resident Empowerment Program, which has about 2 million dollars in it from fines paid by nursing homes. The program is primarily to fund small grants to nursing home facilities for innovative programs that improve quality of life for the residents. Dr. Dreyer spoke about some of the programs.

Chair Auerbach clarified Ms. Caulton-Harris' suggestion about sharing the surveys with local health departments for the nursing homes in their jurisdiction. He asked staff if there would be a way to do that electronically. Dr. Dreyer said, "Yes, it's mostly a question of logistics." Chair Auerbach said, "We will look into that and try to report back on that." Mr. Lanzikos added, "Right, now, the surveyor does reply to the local nursing home ombudsman. So, I imagine you

could have a similar procedure for the local health officer." Dr. Dreyer said, "We could do that."

Council Members Lanzikos and Prates Ramos inquired about the survey reaching the non-English speaking populations. Dr. Dreyer responded, "I will make a promise that the next time we do the survey, we will do it right in that regard."

Discussion continued by the Council Members about how to get the results of the Nursing Home Satisfaction Survey out to residents, residents' Councils, families and the local ombudsman, other than by just posting it on the DPH web page. Asking facilities to post the results at their facilities was suggested without a regulation requirement.

In closing, Chairman Auerbach, stated, "It is encouraging both to know that the quality of the staff that are doing the monitoring, the satisfaction survey does have very positive results, and it is clear that the industry is working in collaboration with the Department of Public Health, and with its residents and families. We are pleased to hear that. This is a new Council with a lot of thoughts and expertise and recommendations. We are feeling our way, but I think this may be a good test case. When we talk about a particular issue and Council Members come forward with ideas and suggestions, we want to be responsive to those and determine a way of maybe getting feedback about the outcome over time and, Paul, you will be our test case, and we will appreciate it." Dr. Dreyer said, "Glad to be". Chair Auerbach responded, "We appreciate that because we really do want to take advantage of the richness of the experience and expertise of the Council, and I think that will have a positive impact; but clearly good work is being done, and we are very grateful for that. Thank you all."

Richard Bane, Chairman of the Massachusetts Extended Care Federation noted that he would like to get input on the culture piece as it is developing from the Council and would be happy to meet at any time. Chair Auerbach said, "I suspect that that will be a topic of a future Council Meeting, that may have to do with a full discussion of what it will take to make a significant culture change in long term care facilities."

The meeting adjourned at approximately 12:15 p.m.

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John Auerbach, Chairperson

LMH/lmh