

Note: We asked the group if they preferred the term 'Long-Term Care Facility' or 'Nursing Home.' While a few of the participants said they liked the term 'nursing home' because it was more familiar to the public and had a 'nurturing' connotation, most said they preferred long-term care facility, so that's what we'll use in this paper.

KEY ISSUES

Regulatory Issues

- The State survey process came up time and time again. While participants agreed for the need to provide high quality care to their patients, many thought the survey process excessive and punitive at times. The participants requested that the surveyors provide more information and technical assistance to help facilities strengthen and improve their care, rather than simply writing up deficiencies and levying fines.
- There was discussion about the great variation between oversight of LTC facilities compared to hospitals and assisted living facilities. (See the attached chart.)
- There was agreement that the regulations too often seem to focus on documentation and paperwork, rather than patient care.
- The focus on paperwork means the nurses have less time to spend with patients, resulting in poorer quality of care and nurses leaving the profession.
- There was agreement that the Medicare regulations for LTC facilities are outdated, poorly organized, and almost-impossible to search. One participant challenged the group to try to find the regulation covering the temperature of milk.
- There was concern and agreement that the new Medicaid web portal system will not work efficiently in rural facilities that don't have access to high speed Internet.
- The lack of resources in many rural areas makes it impossible to comply with some regulatory regulations and requirements such as ancillary services and staffing. One facility provided the example that only 'qualified' personnel are allowed to push a patient in a wheelchair.

Reimbursement and Funding

- The cap on administrative costs is difficult, if not impossible for smaller, low-volume facilities. The group agreed that rural facility costs almost always exceed the cap.
- There was general concern about the Medicaid budget. Rural facilities rely much more heavily on Medicaid financing than their urban counterparts.
- One facility provided the example that they lose almost \$40/day/resident for a total of \$2,200/day due to the low Medicaid reimbursement. This is causing them to consider limiting the number of Medicaid patients they will accept, which many facilities have had to do.
- Smaller, rural facilities can have grave difficulty with cash flow. When adjustments are made by Medicaid - for example the delay of payment last year to move costs to the next fiscal year - caused serious problems for some facilities.
- The general lack of funding and financing for capital improvement is a serious challenge.

Transportation

- Many communities lacked public transportation. If it was available, it was often not flexible or frequent enough to meet all the seniors' needs. Patients often need transportation to see specialists or therapists. Transportation to social events or 'meet and eats' was also a concern. Rural seniors are much more isolated than their urban counterparts, which can have a dramatic impact on their overall health and well-being.
- The participants noted they have seen a dramatic decrease in the number of visiting specialists from urban-based facilities. This can mean much longer trips to the cities for care, and these costs are not covered by insurance, including Medicare or other insurance.

Lack of Trained Staff

- While healthcare workforce shortages have had an impact on all healthcare facilities, rural areas historically suffer greater challenges in recruiting providers. This is due to many factors including professional isolation, few providers and their spouses appreciating a rural lifestyle, training programs being urban-biased, lower salaries (in some rural communities), and limited staffing resulting in longer hours and multiple duties.
- In rural communities, there is a lack of access to mental health and dental health; lack of access to therapists - Physical Therapy, Occupational Therapy, Speech Therapy; and lack of access to vision and hearing care. It is very difficult to serve patients with special needs due to lack of these basic resources.
- Limited staff can make it impossible to provide weekend admissions. An admission can take up to 4 hours of staff time and requires a team of nursing, social workers, and billing staff. Hospitals need to discharge patients within a certain timeframe, which often ends up being a weekend. Smaller, low volume facilities can't afford to maintain full staffing on weekends. This creates problems for both facilities, and certainly the patients and their families.

Additional Issues Discussed

- Other necessary community health services being discontinued due to lack of funding - home health for example.
- Physicians and other providers feeling 'disconnected' from peers, professional isolation, makes it challenging to recruit and retain providers to rural areas.
- 'Pool nurse' mentality - nursing hired temporarily through placement firms aren't 'connected' to the community, the facility, or the patients.
- Lack of anonymity - in a small rural community; everyone knows everybody else's business. This can make HIPAA compliance particularly challenging in a community where patients names, status, and even visitors and meals were previously found in the local paper.
- Physicians can be slow to make decisions because they know the family.
- General economic and population decline in several northeastern Colorado communities; young people leaving for employment.
- Higher insurance costs and lack of availability of insurance products - this included not only healthcare insurance for staff and residents, but also malpractice insurance for providers, and even D&O insurance for board members and administrators.
- Medicaid eligibility related to land ownership can be a more common issue in rural communities.
- Preadmission Screening and Resident Review for Mental Health (PASRR) process and paperwork can be particularly overwhelming for low volume, facilities with limited staffing.
- 'City folk' setting the rules, conducting the surveys, and interpreting guidelines, but not understanding rural environments.
- And while they had listed 'access to capital' as a general challenge shared by all LTC facilities, the group added 'access to capitol' - as in our 'State Capitol', as an added rural challenge.

RECOMMENDATIONS

The group did offer a few requests and recommendations. They also unanimously agreed to work cooperatively with State and Federal stakeholders willing to address these concerns and challenges:

- The Medicare LTC regulations could be better organized and 'searchable' by topic.
- State surveyors could be educated and sensitive to rural settings. (Several volunteered to help develop a 'rural-sensitivity' training program for new and existing surveyors.)
- Consider an adjustment of the administrative cap for rural and/or low-volume facilities. It was noted that hospitals and primary care facilities both have programs that provide enhanced Medicaid and Medicare reimbursement in some areas. Why is this not available for LTC facilities?
- Improve the process and format of notification of regulatory changes. (more readable; not as lengthy; less 'bureaucratize')

- Clarify the role of 'feeding assistants' so that facilities can take advantage of this program in better serving their residents. Rural facilities, with a smaller labor pool, rely on non-certified staff to assist with feeding residents. While the federal government has approved this program, states were to develop their own requirements and Colorado has not yet done so.
- Explore the feasibility of developing a 'rural-experienced' pool of nurses - identification of nurses and other temporary staff who are experienced with rural settings.
- Could private insurance companies be required/expected to help pay for transportation costs to necessary specialty care?
- Rural Workforce Council offices could devote more resources toward healthcare workforce needs.
- Clarify and provide flexibility on use of volunteers - an integral part of rural LTC staffing.
- Change the rule or process, which currently takes four months from date of hire to licensure for Certified Nurse Aids (CNAs)
- Assess the potential for 'unintended' consequences in rural areas as new regulations and processes are developed. For example, monitor the impact of the new Provider Web Portal, which will be used to submit claims and request authorizations, to make sure it is feasible in rural communities that might have limited access to equipment and the Internet.

Again, all the participants offered to work with regulators and stakeholders at the State and Federal level and other partners in seeking solutions to these issues.

WRAP UP

We didn't want to end the meeting focused on problems and challenges, so we asked the participants what kept them in the LTC field despite the environment. One participant summed up their comments when she said: *"I wanted to give something back to my community. When I returned to my hometown, I realized that by working here, I'd not just be taking care of 'residents', but of my family, neighbors, teachers, and friends who had taken care of me when I was younger. It's a way of giving back to people who built this town and gave me such a good start."*

Appendices

- 1 - Graph showing number of beds and ownership (government, not-for-profit, private)
- 2 - Chart comparing regulation of hospitals, LTC facilities, and assisted living centers.
- 3 - Map of Rural LTC Facilities

Special thanks to....

Lancaster Pollard generously provided lunch for the group.

Herman Schreivogel, the administrator of the Lincoln Community Hospital and Nursing Home in Hugo hosted the meeting in Hugo's lovely Lincoln County Courthouse.

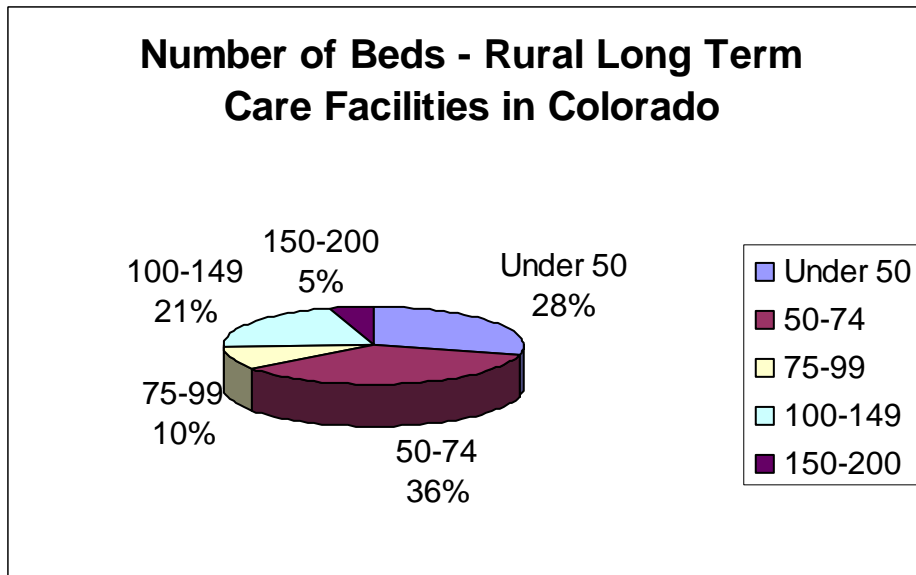
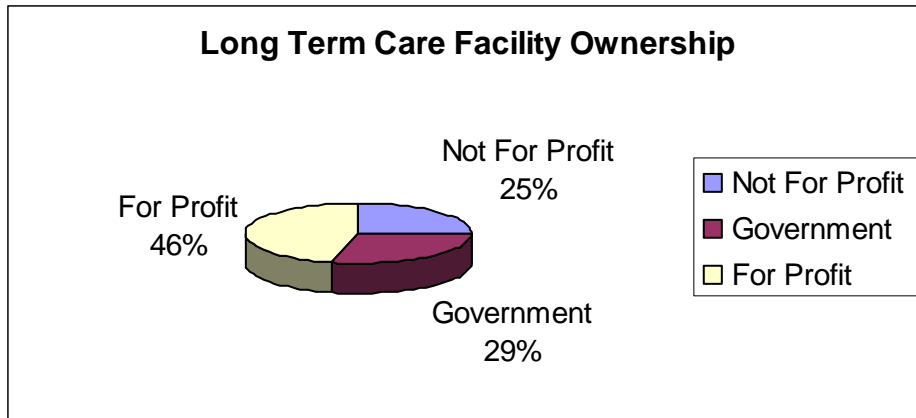
Becky VanVorst of the High Plains Research Network assisted with the meeting and compiled the statewide data for us.

All the participants who gave us a few hours of their time and taught us so much.

This report was prepared by the Colorado Rural Health Council. The Council served as the advocacy arm of the Colorado Rural Health Center from 2001 to 2005. Members of the Council identified, discussed, and prioritized emerging rural health issues. They then developed strategies for educating others about these issues and addressing them. The Council was composed of representatives from public and private organizations

Long Term Care Facilities in Rural Colorado Ownership Types

Ownership Type Totals	
Not For Profit	16
Government	18
For Profit	29
Total	63



Source: This information was taken from the Colorado Department of Public Health and Environment Facilities website and shows the number of beds occupied as reported on 9/3/03

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Colorado Facilities Survey and Regulation Procedures

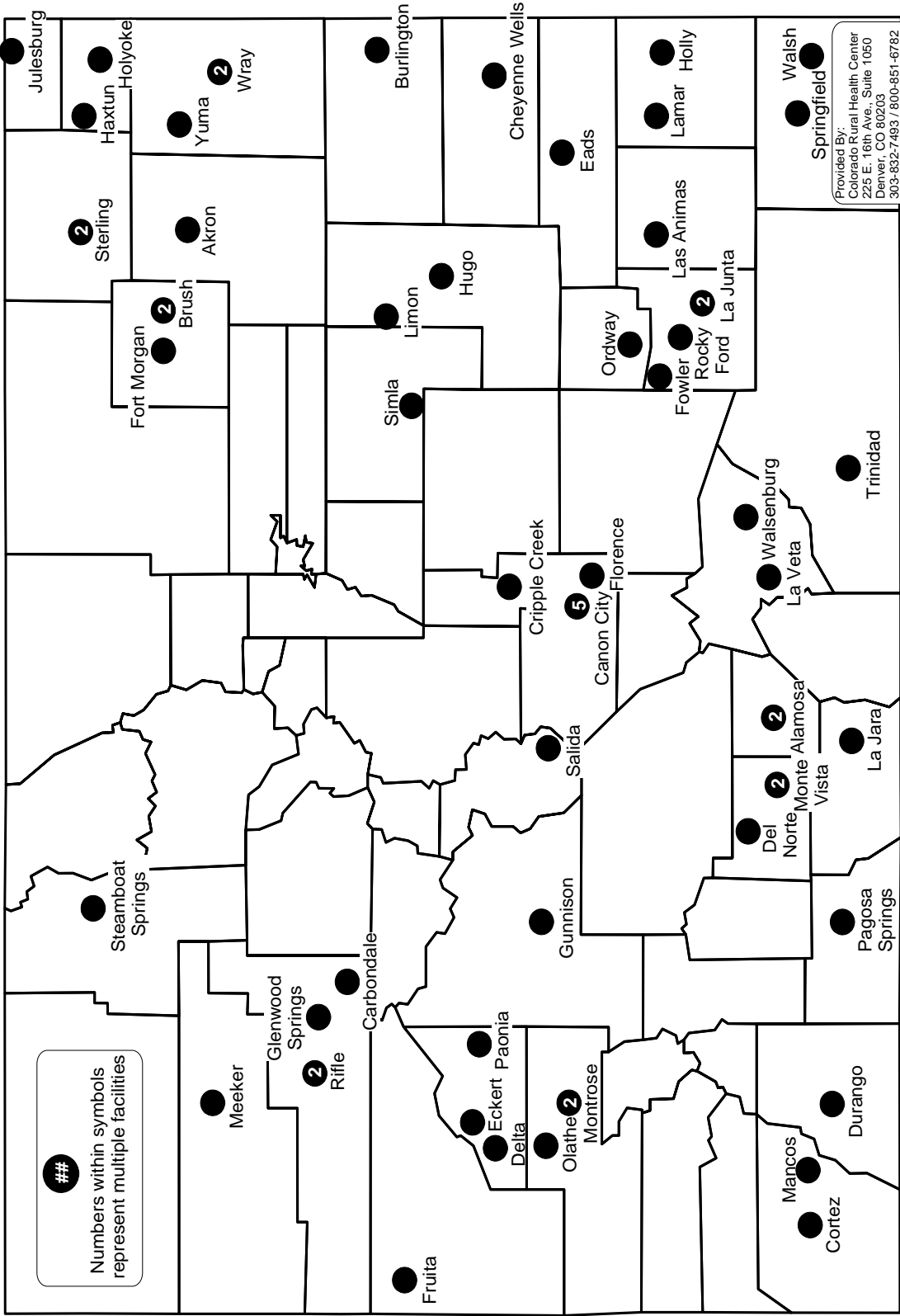
	Hospitals	Nursing Homes	Assisted Living Centers
Survey	<p>Accredited hospitals – under review by JCAHO (Joint Committee on Accreditation of Healthcare Organizations) approx. every 3 years (takes place of state survey). No set schedule for review. Hospitals pay for this service.</p> <p>Non-accredited (usually smaller and rural hospitals). 33% are surveyed every year (budget permitting; may be less if money not available)</p>	<p>Annually – every 9 – 15 months (average: 12 months) for facilities under Medicaid and Medicare guidelines.</p> <p>Private facilities – initially licensed by state but no follow-up survey conducted.</p> <p>Surveyors are funded by the OBRA regulation federal department and surveys use the federal OBRA regulations along with state regs (although not as much emphasis is placed on the state regs)</p>	<p>Medicaid facilities (about 265 in state) are surveyed annually (between 9-14 months).</p> <p>Private pay: annually beginning 7/1/03 (when general funds were made available). Prior to 7/03, private pay facilities were not inspected because of funding issues</p>
Prior notice	Announced for non-accredited hospitals by a few days to allow staff to be present	Unannounced – strictly enforced	Unannounced
Complaints	Facilities investigate all complaints for accredited and non-accredited hospitals.	Whenever a formal complaint is received for all facilities an abbreviated survey is performed that highlights the complaint areas.	Whenever a formal complaint is received
Deficiencies	Facilities make recommendations to CMS. CMS reviews and determines whether hospital should be sent written letter regarding deficiency and determines follow-up procedure.	<p>Following survey, facilities has 10 days to issue form 2567 (deficiency list). Facility had another 10 day written period to respond with a plan of correction (POC). Revisit Process occurs 60-90 days later and may include an on-site follow-up survey</p> <p>CMS reviews all deficiency recommendations by facilities and determines whether the penalties will be monetary or not.</p>	<p>10 day written response period: facilities will review and either approve or send back for revisions. Revisit if necessary (usually depends on whether it was an isolated or systematic issue)</p> <p>Monetary fines are imposed only for severe deficiencies (less often than nursing homes)</p>
Source:	Sharon Haney (CDPHE)	Debbie Burton (CDPHE)/ CDPHE website*	Dee Reda (CDPHE)

*<http://www.cdphe.state.co.us/hf/broch/pcf1.htm>

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Colorado Rural Long Term Care Facilities

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KK/Maps/Special Maps/Project Maps D2/Long Term Care Facilities Map