

Nurse Aide Registry FY19 3rd Qtr. Report
Long Term Care Facility Advisory Board Meeting
July 10, 2019



CURRENT CERTIFICATIONS

TYPES OF CERTIFICATIONS	FY2017	FY2018	FY19-Q1	FY19-Q2	FY19-Q3
Adult Day Care (ADC)	28	24	24	39	39
Long Term Care (LTC)	37,855	37,942	38,685	38,147	34,460
Certified Medication Aide (CMA)	6,068	6,074	6,221	6,116	6,432
Advanced CMA Gastrology (CMA/G)	2,821	3,061	3,154	3,165	3,327
Advanced CMA Glucose Monitoring (CMA/GM)	1,191	1,293	1,367	1,377	1,463
Advanced CMA Insulin Administration (CMA/IA)	862	951	1,006	1,002	1,066
Advanced CMA Respiratory (CMA/R)	2,907	3,134	3,212	3,222	3,385
Feeding Assistant (FA)	603	576	526	483	496
Home Health Aide (HHA)	13,839	13,707	13,827	13,482	14,023
Developmentally Disabled Direct Care Aides (DDCA)	1,268	1,248	1,228	1,187	1,186
Residential Care Aide (RCA)	69	57	57	55	54
TOTALS	67,511	68,067	69,307	68,275	65,931

WALK-INS FOR RENEWAL	FY2017	FY2018	FY19-Q1	FY19-Q2	FY19-Q3
First Floor - NAR Walk-Ins	5,026	6,647	1,730	1,110	1,300

NEW CERTIFICATIONS/REGISTRATIONS	FY2017	FY2018	FY19-Q1	FY19-Q2	FY19-Q3
INBOUND RECIPROCITY CERTIFICATIONS					
LTC	1,001	1,369	439	387	347
HHA	6	1	0	5	2
NEW CERTIFICATIONS FROM TRAINING					
LTC	5,568	5,291	1,286	1,144	1067
HHA	2,791	2,851	525	732	610
DDCA	209	240	70	43	45
RCA	0	19	0	0	0
ADCA	0	1	0	0	0
CMA	1,102	1,229	325	306	188
FA	230	198	28	15	6
TOTALS	9,900	9,829	2,234	2,240	1916
NEW ADVANCED CMA					
CMA-R	1024	1322	149	176	115
CMA-G	992	1315	147	150	111
CMA-GM	399	538	81	71	64
CMA-IA	304	399	54	50	37
TOTALS	2719	3574	431	447	327
RETEST					
Retest - CMA	148	61	19	16	12
Retest - LTC	400	250	61	58	43
Retest - HHA	128	76	18	18	9
Retest - DDCA	1	0	0	0	0
TOTALS	677	387	98	92	61

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OUTBOUND RECIPROCITY	FY2017	FY2018	FY19-Q1	FY19-Q2	FY19-Q3
Reciprocity - LTC	417	401	96	86	347

APPROVED TRAINING PROGRAMS	FY2017	FY2018	FY19-Q1	FY19-Q2	FY19-Q3
LTCA	134	131	132	127	127
HHA	0	0	0	0	0
DDDCA	10	10	9	9	10
RCA	1	1	1	1	1
ADC	0	0	0	0	0
CMA	46	50	50	49	49
CMA/Continuing Education Units(CEUs)	36	38	39	38	39
CMA/IA	21	23	24	25	25
CMA/GM	4	4	4	4	4
CMA/R	2	2	2	2	2
CMA/RG	26	29	28	29	30
CMA/G	4	1	1	1	1
TOTALS	281	289	290	285	288

ONSITE SURVEYS PERFORMED	FY2017	FY2018	FY19-Q1	FY19-Q2	FY19-Q3
LTCA	35	104	5	3	1
HHA	0	0	0	0	0
DDDCA	2	9	0	0	0
RCA	0	1	0	0	0
ADCA	0	0	0	0	0
CMA	16	7	5	11	2
CMA / CEU	14	6	4	10	0
CMA/IA	5	3	2	5	0
CMA/GM	2	0	1	1	0
CMA/R	1	0	0	0	0
CMA/RG	6	5	3	7	0
TOTALS	81	135	20	37	3

REVOCATIONS OF CERTIFICATIONS DUE TO CRIMINAL BARRIERS	FY2017	FY2018	FY19-Q1	FY19-Q2	FY19-Q3
	6	20	0	4	24

Abuse/Neglect/Misappropriation (ANM) Findings

Findings	SFY18-Q3 1/1 to 3/31		SFY18-Q4 4/1 to 6/30		SFY18		SFY19-Q1 7/01 to 9/30		SFY19-Q2 10/01 to 12/31		SFY19-Q3 1/1 to 3/31	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
Findings	14		7		53		31		8		11	
Default Judgement Service to Address on File	7	50%	4	57%	32	60%	12	39%	4	50%	5	45%
Event to Final Administrative Order Less then 9 months	8	57%	1	14%	18	34%	28	90%	2	25%	4	36%
Pending Notations												
Notations Posted	33		25		149		28		18		15	
Average Days to Posting	9.0		12.0		9.7		7.5		8.8		12.2	
Years: Certification to Finding												
Average	10		7		7		11		16		12	
Minimum	1		1		1		0		2		3	
Maximum	22		16		22		28		42		27	
Age at Finding												
Average	33		28		32		36		41		37	
Minimum	20		0		0		21		24		22	
Maximum	62		48		62		59		69		60	
Type Certification	14	100%	7	100%	53	100%	31	100%	8	100%	11	100%
LTC/HHA	13	93%	4	57%	39	74%	21	68%	7	88%	8	73%
CMA	0	0%	0	0%	1	2%	10	32%	0	0%	2	18%
DDCA	0	0%	1	14%	6	11%	0	0%	0	0%	0	0%
NTSW	1	7%	2	29%	7	13%	0	0%	1	13%	1	9%
Finding Type	14	100%	6	100%	52	100%	31	100%	8	100%	11	100%
Misappropriation												
Misappropriation/Meds	3	21%	0	0%	6	12%	11	35%	0	0%	2	18%
Misappropriation/Cash	3	21%	1	17%	7	13%	3	10%	1	13%	5	45%
Misappropriation/Property	4	29%	2	33%	12	23%	2	6%	2	25%	0	0%
Neglect												
Services	2	14%	2	33%	10	19%	1	3%	0	0%	0	0%
Transfer	2	14%	0	0%	7	13%	11	35%	3	38%	3	27%
Abuse												
Physical	0	0%	1	17%	8	15%	3	10%	2	25%	1	9%
Sexual	0	0%	0	0%	1	2%	0	0%	0	0%	0	0%
Verbal	0	0%	0	0%	1	2%	0	0%	0	0%	0	0%
Mistreatment	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Facility Type	14	100%	7	100%	53	100%	31	100%	8	100%	11	100%
Nursing	11	79%	4	57%	42	79%	19	61%	6	75%	8	73%
Assisted Living	3	21%	0	0%	3	6%	11	35%	2	25%	2	18%
Home Care	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Hospice	0	0%	1	14%	1	2%	0	0%	0	0%	1	9%
ICF/IID	0	0%	2	29%	7	13%	1	3%	0	0%	0	0%
Private	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Training Source	14	100%	7	100%	53	100%	31	100%	8	100%	11	100%
Career Tech	6	43%	1	14%	19	36%	11	35%	0	0%	1	9%
Provider Based	2	14%	2	29%	13	25%	2	6%	0	0%	0	0%
Private	0	0%	0	0%	2	4%	0	0%	0	0%	2	18%
Unknown	5	36%	2	29%	12	23%	18	58%	8	100%	7	64%
Reciprocity	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
OSU	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
NA: Non-technical	1	7%	2	29%	7	13%	0	0%	0	0%	1	9%
Hearings	14	100%	7	100%	53	100%	31	100%	8	100%	11	100%
Appeared	8	57%	2	29%	21	40%	16	52%	1	13%	3	27%
No Appearance	6	43%	5	71%	32	60%	15	48%	7	88%	8	73%
Agreed Order	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%

OKSCREEN and Abuse, Neglect, and Misappropriation (ANM) Findings

	SFY18-Q3 01/01 to 03/31		SFY18-Q4 04/01 to 06/30		SFY18		SFY19-Q1 07/01 to 09/30		SFY19-Q2 10/01 to 12/31		SFY19-Q3 01/01 to 03/31	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
Findings & OK-SCREEN Applicant Reviews												
Persons with ANM findings	13	100%	7	100%	52	100%	31	100%	8	100%	11	100%
ANM Applicant's with Status in OKS	13	100%	7	100%	49	94%	29	94%	7	88%	10	91%
No applicant record in OKS	0	0%	0	0%	3	6%	2	6%	1	13%	1	9%
ANM Applicant's with Status in OKS												
ANM Applicants with Status in OKS	0	100%	7	100%	49	100%	29	100%	7	100%	10	100%
Had eligible determination in OKS prior to finding	0	62%	7	100%	47	96%	28	97%	6	86%	10	100%
Had pending determination with provisional employment	0	31%	0	0%	0	0%	0	0%	0	0%	0	0%
Had incomplete or withdrawn application(s) or pending not eligible determination	0	8%	0	0%	2	4%	1	3%	1	14%	0	0%
Not eligible in OKS	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Prior Criminal History for ANM Cases w/ prior Eligible Determination in OKS												
ANM Cases with prior eligible determination in OKS	12	100%	7	100%	47	100%	28	100%	6	100%	10	100%
Had prior eligible criminal history	4	31%	2	29%	16	33%	7	24%	1	14%	0	0%
Had no prior criminal history	8	69%	5	71%	31	67%	21	76%	5	86%	10	100%
OKS Employment History for ANM Cases w/ prior Eligible Determination in OKS												
ANM Cases with prior eligible determination in OKS	12	100%	7	100%	47	100%	28	100%	6	100%	10	100%
Discharged @ Allegation	2	15%	5	60%	18	35%	2	8%	1	14%	7	70%
Terminated in OKS prior to ANM Finding	8	69%	0	0%	19	43%	13	50%	4	57%	2	20%
Terminated in OKS at or after ANM Finding	2	15%	1	20%	7	15%	4	8%	1	14%	1	10%
Termination date pending	0	0%	1	20%	3	7%	8	31%	0	0%	0	0%
Never employed	0	0%	0	0%	0	0%	1	4%	0	14%	0	0%
Employed with Pending Allegation Prior to ANM Finding	3		2		18		12		3		3	

Composite Scorecard for Oklahoma Nursing Homes

Select Long-stay metrics for the period ending December 31, 2018



This scorecard provides an overview of Oklahoma nursing home performance with comparative data from the region and nation. The data comes from the Minimum Data Set National Repository, which is referred to as MDS 3.0. The data for this scorecard edition was retrieved on February 26, 2019, for the period ending December 31, 2018. It includes a five-quarter review of performance on key quality measures. These 13 metrics comprise the composite score as designated by the Centers for Medicare and Medicaid Services. The composite score is a snapshot of overall quality in nursing homes and is featured as table 14 on the bottom right of the scorecard. Whether the change from previous to current year for Oklahoma is statistically significant or not is indicated by the traffic light indicator where 'Red' indicates change for worse, 'Yellow' indicates no significant change and 'Green' indicates change for better.

Of the nine measures showing statistically significant improvement this quarter (green lights), three of them have shown such improvement over ten consecutive quarters: Table 2 (Residents with Catheter Inserted or Left in Bladder), Table 10 (Influenza Vaccination), and Table 14 (Oklahoma's Composite Score).

For the last year, from December 2018 to December 2019, the number of residents with a catheter (Table 2) decreased 22.8% while residents with depressive symptoms (Table 11) decreased 17.4%. For this same period, we also observed a 10.6% decrease in residents with one or more falls with major injury (Table 7). The number of residents physically restrained (Table 5) has equaled the regional average for the last two quarters and remains below the national average. Oklahoma remains more than 11 points below the regional and national average in numbers of low risk residents who lose control of their bowel or bladder (Table 4) and have held near this level of separation for each of the last four quarters.

Our combined composite score of 8.0% (Table 14) continues to reflect statistically significant improvement over last year and has done so over ten consecutive quarters. Since September of 2016, Oklahoma has improved our combined composite score by 16.6%!

Statistically Significant Change: Previous to Current Year - Oklahoma	
Improved Performance Measures:	Worsened Performance
Catheter in Bladder (Table 2)	None
High Risk Residents with Pressure Ulcers (Table 3)	
Residents Physically Restrained (Table 5)	
Residents Who Loose Too Much Weight (Table 6)	
Residents With One or More Falls with Major Injury (Table 7)	
Influenza Vaccination (Table 10)	
Residents with Depressive Symptoms (Table 11)	
Pneumococcal Vaccination (Table 12)	
Composite Score for Oklahoma (Table 14)	

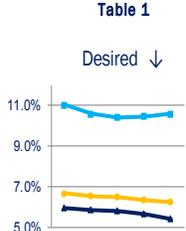
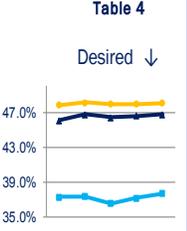
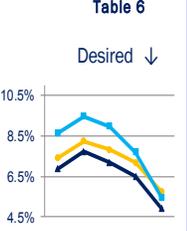
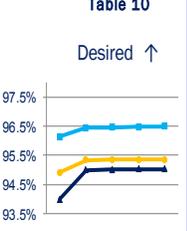
Note: Statistical significance was determined based on the 95% confidence interval.
 Email QIEShelpdesk@health.ok.gov for more information.

Composite Scorecard for Oklahoma Nursing Homes

Long-stay metrics for the period ending December 31, 2018

Source: Minimum Data Set (MDS) National Repository

Run Date: 02/26/2019

	<p>Residents Who Self-Report Moderate to Severe Pain (N=13,174)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Dec 2017</th> <th>Mar 2018</th> <th>Jun 2018</th> <th>Sep 2018</th> <th>Dec 2018</th> </tr> </thead> <tbody> <tr> <td>Nation</td> <td>6.7%</td> <td>6.5%</td> <td>6.5%</td> <td>6.4%</td> <td>6.2%</td> </tr> <tr> <td>Region 6</td> <td>5.9%</td> <td>5.9%</td> <td>5.8%</td> <td>5.7%</td> <td>5.4%</td> </tr> <tr> <td>Oklahoma</td> <td>11.0%</td> <td>10.6%</td> <td>10.4%</td> <td>10.5%</td> <td>10.6%</td> </tr> </tbody> </table>		Dec 2017	Mar 2018	Jun 2018	Sep 2018	Dec 2018	Nation	6.7%	6.5%	6.5%	6.4%	6.2%	Region 6	5.9%	5.9%	5.8%	5.7%	5.4%	Oklahoma	11.0%	10.6%	10.4%	10.5%	10.6%	<p>Table 1</p> <p>Desired ↓</p> 		<p>Residents With Catheter Inserted or Left in Bladder (N=16,149)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Dec 2017</th> <th>Mar 2018</th> <th>Jun 2018</th> <th>Sep 2018</th> <th>Dec 2018</th> </tr> </thead> <tbody> <tr> <td>Nation</td> <td>2.6%</td> <td>2.5%</td> <td>2.5%</td> <td>2.4%</td> <td>2.4%</td> </tr> <tr> <td>Region 6</td> <td>2.9%</td> <td>2.8%</td> <td>2.6%</td> <td>2.6%</td> <td>2.5%</td> </tr> <tr> <td>Oklahoma</td> <td>3.5%</td> <td>3.5%</td> <td>2.9%</td> <td>2.8%</td> <td>2.7%</td> </tr> </tbody> </table>		Dec 2017	Mar 2018	Jun 2018	Sep 2018	Dec 2018	Nation	2.6%	2.5%	2.5%	2.4%	2.4%	Region 6	2.9%	2.8%	2.6%	2.6%	2.5%	Oklahoma	3.5%	3.5%	2.9%	2.8%	2.7%	<p>Table 2</p> <p>Desired ↓</p> 
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	<p>Residents Physically Restrained (N=17,260)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Dec 2017</th> <th>Mar 2018</th> <th>Jun 2018</th> <th>Sep 2018</th> <th>Dec 2018</th> </tr> </thead> <tbody> <tr> <td>Nation</td> <td>0.39%</td> <td>0.35%</td> <td>0.32%</td> <td>0.29%</td> <td>0.27%</td> </tr> <tr> <td>Region 6</td> <td>0.24%</td> <td>0.23%</td> <td>0.22%</td> <td>0.20%</td> <td>0.18%</td> </tr> <tr> <td>Oklahoma</td> <td>0.31%</td> <td>0.30%</td> <td>0.27%</td> <td>0.20%</td> <td>0.18%</td> </tr> </tbody> </table>		Dec 2017	Mar 2018	Jun 2018	Sep 2018	Dec 2018	Nation	0.39%	0.35%	0.32%	0.29%	0.27%	Region 6	0.24%	0.23%	0.22%	0.20%	0.18%	Oklahoma	0.31%	0.30%	0.27%	0.20%	0.18%	<p>Table 5</p> <p>Desired ↓</p> 		<p>Residents Who Lose Too Much Weight (N=17,080)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Dec 2017</th> <th>Mar 2018</th> <th>Jun 2018</th> <th>Sep 2018</th> <th>Dec 2018</th> </tr> </thead> <tbody> <tr> <td>Nation</td> <td>7.4%</td> <td>8.2%</td> <td>7.8%</td> <td>7.2%</td> <td>5.7%</td> </tr> <tr> <td>Region 6</td> <td>6.9%</td> <td>7.7%</td> <td>7.2%</td> <td>6.5%</td> <td>4.9%</td> </tr> <tr> <td>Oklahoma</td> <td>8.6%</td> <td>9.5%</td> <td>9.0%</td> <td>7.7%</td> <td>5.4%</td> </tr> </tbody> </table>		Dec 2017	Mar 2018	Jun 2018	Sep 2018	Dec 2018	Nation	7.4%	8.2%	7.8%	7.2%	5.7%	Region 6	6.9%	7.7%	7.2%	6.5%	4.9%	Oklahoma	8.6%	9.5%	9.0%	7.7%	5.4%	<p>Table 6</p> <p>Desired ↓</p> 
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Region 6	0.24%	0.23%	0.22%	0.20%	0.18%																																																
Oklahoma	0.31%	0.30%	0.27%	0.20%	0.18%																																																
	Dec 2017	Mar 2018	Jun 2018	Sep 2018	Dec 2018																																																
Nation	7.4%	8.2%	7.8%	7.2%	5.7%																																																
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Legend N = OK Denominator for current period

 Nation

 Region

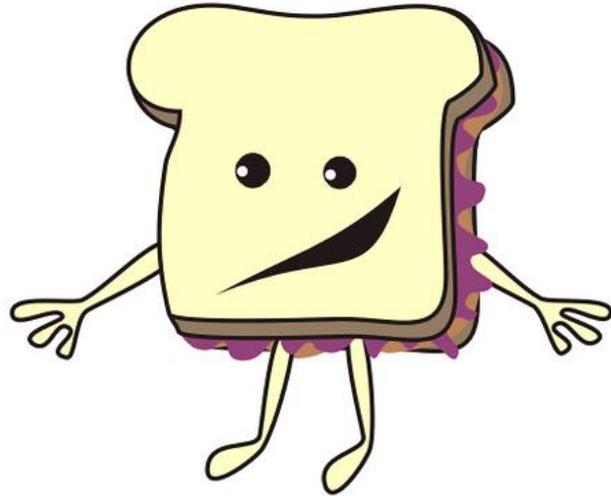
 Oklahoma

 Statistically significant change for worse from the first to the last period shown

 No Statistically significant change from the first to the last period shown

 Statistically significant change for better from the first to the last period shown

**Payroll Based Journal (PBJ)
Staffing Hours
Oklahoma State Department of Health**



**Adapted from PBJ 101: The Basics
Centers for Medicare and Medicaid Services**

Quality Care

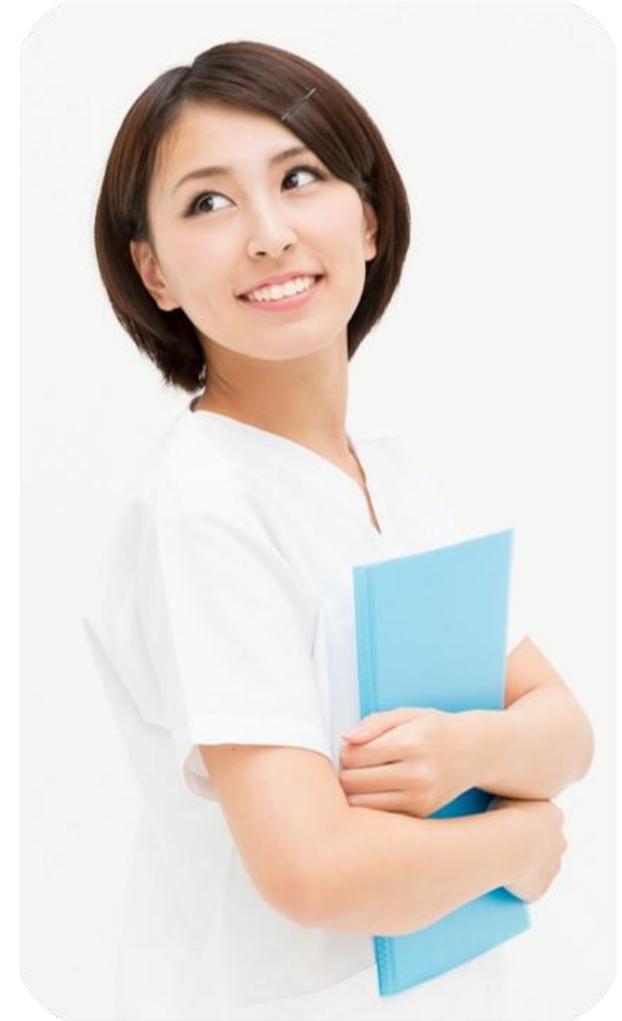
Why is staffing important?

- A top concern among residents, families
- Coordination of care to meet resident needs
- Direct correlation to quality of care
- Putting loved ones in someone else's hands
- RN Staffing Requirement
 - 8 consecutive hours a day, 7 days a week.
 - 1819(b)(4)(C) and 1919(b)(4)(C) of the Act, and 42 CFR §483.35(b))



Looking Back

- 1998: CMS started Nursing Home Compare
- Originally based on health inspection data
- 2003: Quality measures added
- 2008: Five-Star Rating added
- CMS continually seeking to improve its value



Five Stars, Many Uses

What exactly is the Five-Star Rating system used for?

- A tool for consumers
- Adopted by other programs
 - Medicare/Medicaid
 - Medicare Advantage plans
 - Hospital discharge planners
- One source of information about nursing homes



Electronic submission of Payroll-Based Staffing Information

- Section 6106 of the Affordable Care Act
- Funding provided by the IMPACT Act of 2014
- Report staffing levels, turnover, and tenure
- Auditable back to payroll data
- Collected more frequently than 671/672 forms
- Finalized through FY16 SNF PPS Rule as 42 CFR 483.75(u)

<https://www.federalregister.gov/articles/2015/08/04/2015-18950/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities>)



Evolution of Staffing Information

From 671 to PBJ...

- **CMS 671 form**

- Covers 2-week periods
 - Submitted approximately annually
- but...
- Does not capture changes, is not auditable

- **Payroll-Based Journal**

- Voluntary at first
- Then became mandatory
- Public use files (PUFs)

	Tag Number	A			B		C		D
		Services Provided			Full-Time Staff (hours)		Part-Time Staff (hours)		Contract (hours)
		1	2	3					
Administration									
Physician Services									
Medical Services									
Other Physician									
Physician Extender	F33								
Nursing Services	F34								
RN Director of Nurses	F35								
Nurses with Admin. Duties	F36								
Registered Nurses	F37								
Licensed Practical/Vocational Nurses	F38								
Certified Nurse Aides	F39								
Nurse Aides in Training	F40								
Medication Aides/Technicians	F41								
Dietary Services	F42								
Food Service Workers	F43								
Therapeutic Services	F44								
Occupational Therapists	F45								
Occupational Therapy Assistants	F46								
Physical Therapists	F47								
Physical Therapists Assistants	F48								
Speech/Language Pathologist	F49								
Therapeutic Recreation Specialist	F50								
Qualified Activities Professional	F51								
Other Activities Staff	F52								
Qualified Social Workers	F53								
Other Social Services	F54								
Dentists	F55								
Podiatrists	F56								
Mental Health Services	F57								
Vocational Services	F58								
Clinical Laboratory Services	F59								
Diagnostic X-ray Services	F60								
Administration & Storage of Blood	F61								
Housekeeping Services	F62								
Other	F63								
Name of Person Completing Form	F64								
Signature	F65								
	F66								
	F67								
	F68								
	F69								
	F70								
	F71								

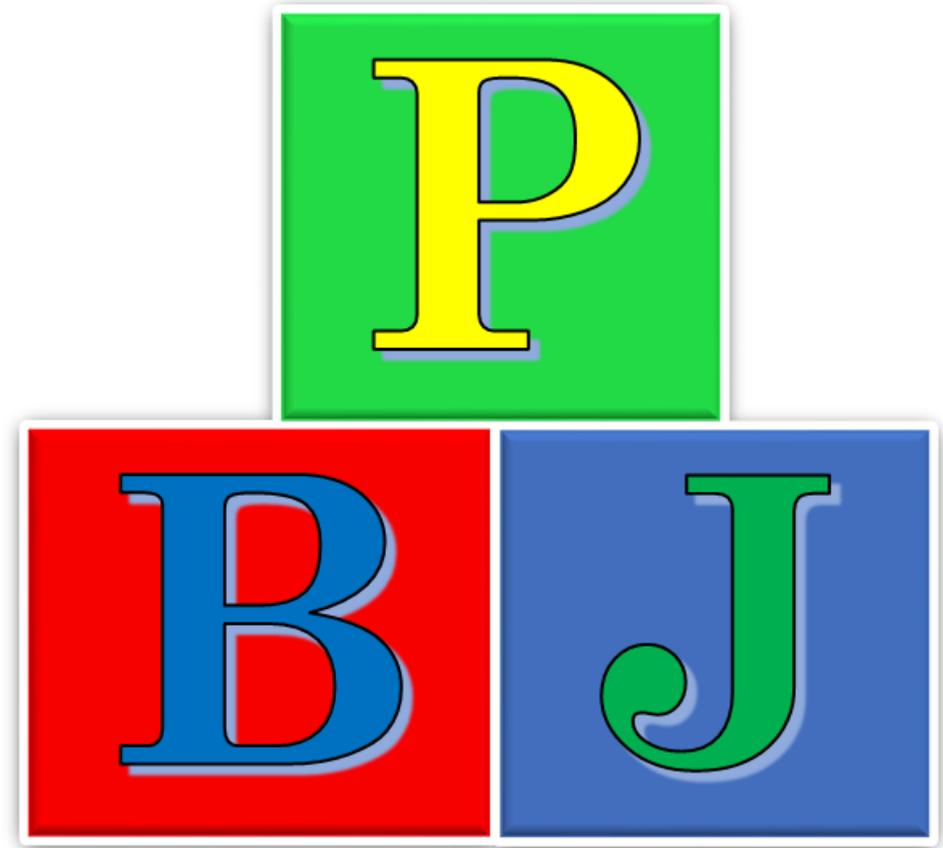
Form CMS-671 (1202)

Time _____
Date _____

PBJ Basics

A quick refresher course...

- Reports staff paid hours
- Submitted quarterly
- Auditable and verifiable
- Data submitted at the employee level
- Accounts for changes
- Deep insights
- Feedback to facilities



Submission Deadlines

- Direct care staffing and census data will be collected for each fiscal quarter. Staffing data includes the number of hours each staff member is paid for working each day within a quarter. Census data includes the facility's census on the last day of each of the three
- Submissions must be received by the end of the 45th calendar day (11:59 PM Eastern Standard Time) after the last day in each fiscal quarter in order to be considered timely. The PBJ system will accept submissions after the deadline. However, these submissions will not be considered timely and will not be used to calculate a facility's staffing measures.

FISCAL QUARTER	REPORTING PERIOD	DUE DATE
1	October 1 – December 31	February 14
2	January 1 – March 31	May 15
3	April 1 – June 30	August 14
4	July 1 – September 30	November 14

Latest PBJ changes

- PBJ now source of Five-Star staffing hours rating
- 671 staffing hour section obsolete
- PBJ ID linking
- New ratings criteria:
 - RN staffing requirements
 - Exclusion criteria
- Census from MDS, not PBJ
- CMS is now posting hours for non-nursing staff



Five-Star Staffing Calculation

Who is Included?

RN

- 5 - Registered Nurse Director of Nursing
- 6 - Registered Nurse with Administrative Duties
- 7 - Registered Nurse

LPN

- 8 - Licensed Practical/Vocational Nurse with Administrative Duties
- 9 - Licensed Practical/Vocational Nurse

Nurse Aid

- 10 - Certified Nurse Aide
- 11 - Nurse Aide in Training
- 12 - Medication Aide/Technician

Five-Star Staffing Calculation

How is Adjusted HRD calculated?

- Sum hours and daily census for the quarter
- Calculate Reported Hours Per Resident Per Day (HRD = hours/census,
- Calculate Expected HRD using data from the CMS Staff Time Resource Intensity Verification (STRIVE) Study
- Calculate Adjusted HRD using the formula below:
Hours Adjusted = (Hours Reported/Hours Expected * Hours Nat'l Avg.)



Five-Star Staffing Calculation

How is a Star Rating Assigned?



- RN and total nurse staffing ratings are calculated individually
- The overall staffing rating is based on the combination of the two individual ratings

Table 4

Staffing and Rating (updated April 2019)

RN rating and hours		Total nurse staffing rating and hours (RN, LPN and nurse aide)				
		1	2	3	4	5
		< 3.107	3.107 – 3.573	3.574 - 4.037	4.038 – 4.403	≥4.404
1	< 0.316	★	★	★★	★★	★★★
2	0.316 - 0.500	★★	★★	★★	★★★	★★★
3	0.501 – 0.723	★★	★★★	★★★	★★★	★★★★
4	0.724 – 1.041	★★★	★★★	★★★★	★★★★	★★★★
5	≥1.042	★★★	★★★★	★★★★	★★★★★	★★★★★

Note: Adjusted staffing values are rounded to three decimal places before the cut points are applied.

Suppression Rules

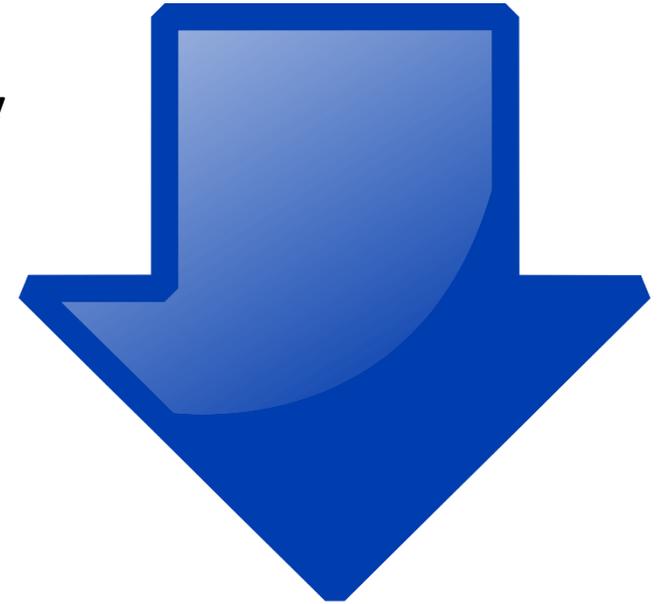
Staffing data are suppressed (i.e. displayed as “Data Not Available”) if any of the following are true:

- No MDS census data available for all days in the quarter.
- Total nurse staffing (job codes 5-12), aggregated over all days in the quarter with both nurses and residents is excessively low (<1.5 HRD)
- Total nurse staffing (job codes 5-12), aggregated over all days in the quarter with both nurses and residents is excessively high (>12 HRD)
- Nurse aide staffing (job codes 10-12) aggregated over all days in the quarter with both nurses and residents is excessively high (>5.25 HRD)



Downgrade Rules: One-Star Overall and RN Rating

- Nursing homes that fail to submit any staffing data by the deadline for the quarter.
- Nursing homes that report four or more days in the quarter with no RN staffing on which there were one or more residents in the facility.
- Nursing homes that fail to respond to PBJ audits, or for which the audits identify significant discrepancies



		OKLAHOMA AVERAGE	NATIONAL AVERAGE
Staffing rating	 Much Below Average		
Average number of residents per day	49.1	62.8	86.0
Total number of licensed nurse staff hours per resident per day	1 hour	1 hour and 16 minutes	1 hour and 33 minutes
RN hours per resident per day	13 minutes	19 minutes	40 minutes
LPN/LVN hours per resident per day	48 minutes	57 minutes	53 minutes
Nurse aide hours per resident per day ⓘ	2 hours and 25 minutes	2 hours and 23 minutes	2 hours and 20 minutes
Physical therapist staff hours per resident per day ⓘ	2 minutes	3 minutes	7 minutes

Registered Nurse (RN) staffing only

Registered nurses (RNs) are licensed healthcare professionals who provide direct care to residents. Some nursing home residents who are severely disabled may be better able to meet the needs of those residents.

This facility either didn't submit staffing data, has reported a high number of days without a registered nurse onsite, or submitted data that couldn't be verified through an audit.

Registered Nurse (RN) staffing rating	 Much Below Average		
Average number of residents per day	49.1	62.8	86.0
RN hours per resident per day	13 minutes	19 minutes	40 minutes

Staffing Concerns

Registered Nurse (RN) Staffing

Nursing homes are required to have an RN onsite at least 8 consecutive hours a day, 7 days a week. There is also a strong relationship between RN staffing and quality.

- Some nursing homes don't report any RN hours for some days, particularly on weekends.

Significantly low weekend staffing

Most facilities report lower staffing on weekends. However, we are concerned about some facilities showing significantly low staffing.



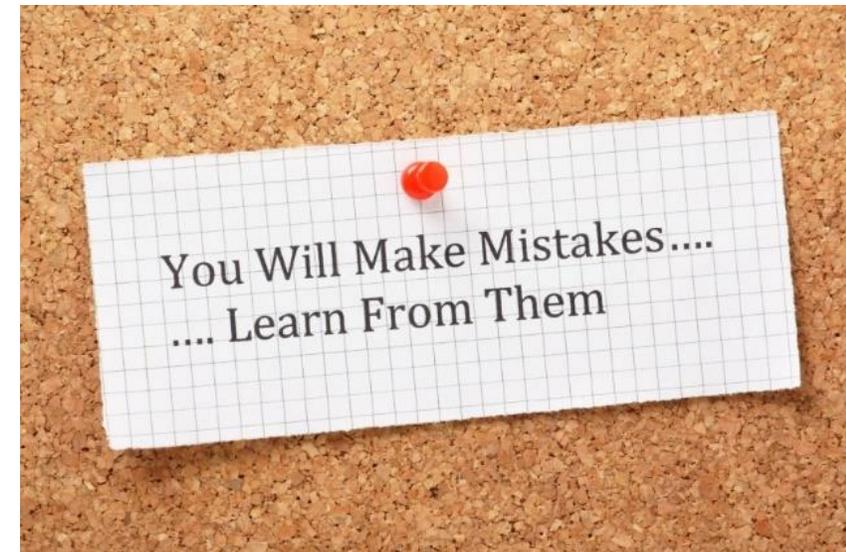
Payroll Based Journal Audit



- Facilities are selected for audits based on data analysis.
- There are two types of audits:
 - Targeted audits looking at a specific issue which may indicate inaccurate reporting and;
 - General audits looking at overall PBJ reporting
- Facilities receive a letter from Myers and Stauffer, the audit firm contracted by CMS.
- Facilities have 5 business days to submit the requested data to a secure FTP site.
- If the facility does not comply with the request, they will receive a 1 star rating in the 5-star Quality Rating System, which will reduce the facility's overall (composite) rating by one star for three months.

Lessons Learned –Common Errors

- Not excluding time for meal breaks
- Failure to assign unique IDs
- MDS assessments not completed for all residents
- Including hours for staff providing care to individuals in non-certified areas
- Submitting corporate staff hours for non-direct facility care
- Days with no RN hours reported
- Days with no CNA hours reported

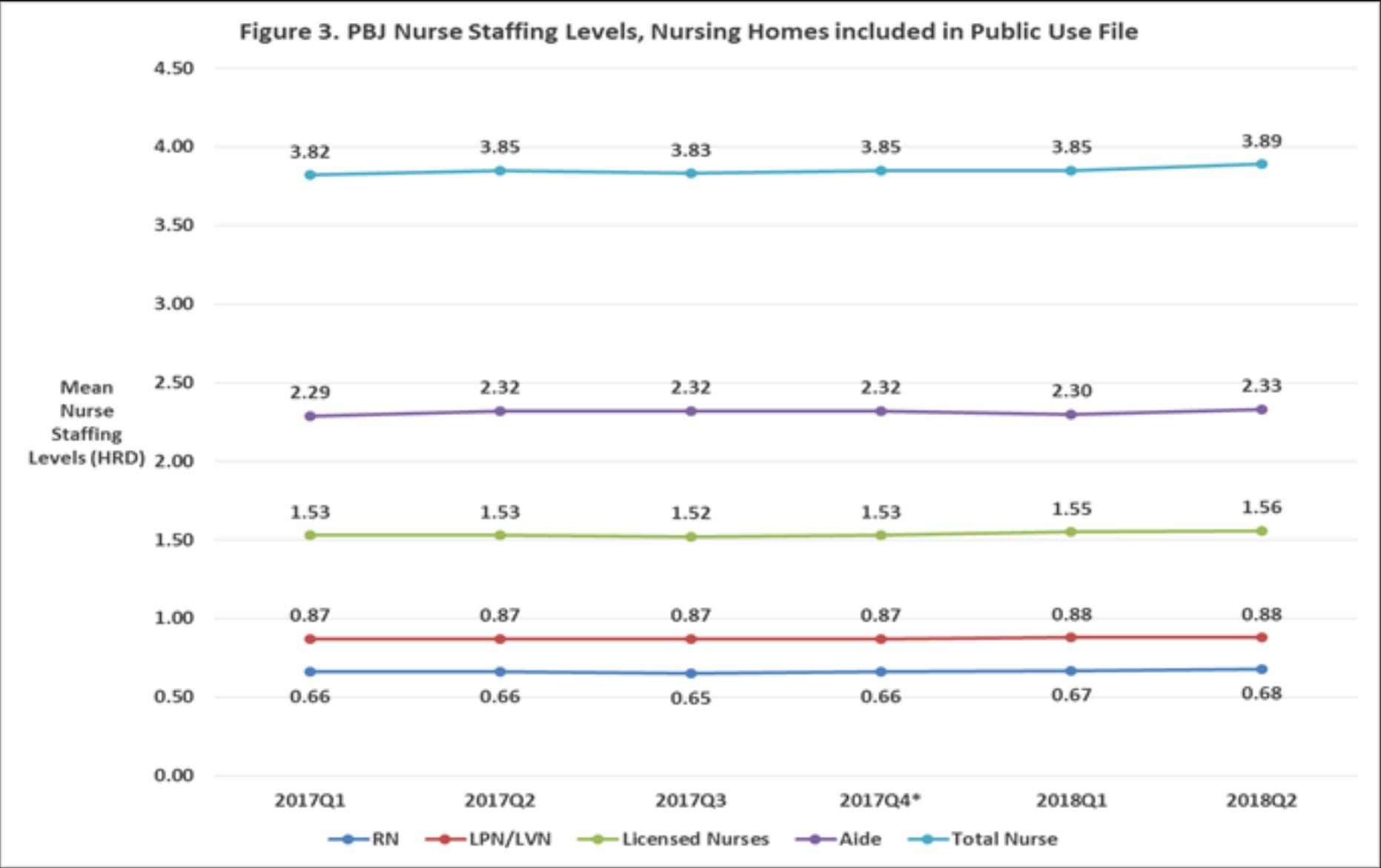


Completeness and Quality of PBJ Data

- Most nursing homes are submitting data through the PBJ system.
 - Overall, 97.2% of nursing homes submitted some nursing data for 2018 Q2.
 - Number of nursing homes submitting data has increased though it has been stable for the past two quarters.
- The completeness and quality of the submitted data have increased as well.



Average Reported Staffing Levels Have Increased Slightly





The PBJ System and CASPER Reports

- PBJ Data
- Who is submitting data and when?
- How are they submitting?
- How can Data be verified? (CASPER Reports)

Three Types of PBJ Data for Submission

Employee Data

- ❖ Employee ID



Staffing Hours

- ❖ Hours per Day per Job Title Code
- ❖ Exempt, Non-exempt, Contract



Employee Linking (optional)

- ❖ Old Employee ID
- ❖ New Employee Id



= Same Employee System ID

Figure 1: Sample Employee Entry Screen

CMS Payroll Based Journal Welcome, [blurred name] Sign Out

Home File Upload Manual Data Entry Help

Add New Employee [← Back to Previous Page](#)
* indicates required field(s)

Facility:
[Dropdown menu]

Employee ID: *
[ENTER EMPLOYEE ID]

Hire Date:
[MM/DD/YYYY] [Calendar icon]

Termination Date:
[MM/DD/YYYY] [Calendar icon]

[SAVE NEW EMPLOYEE] | CANCEL

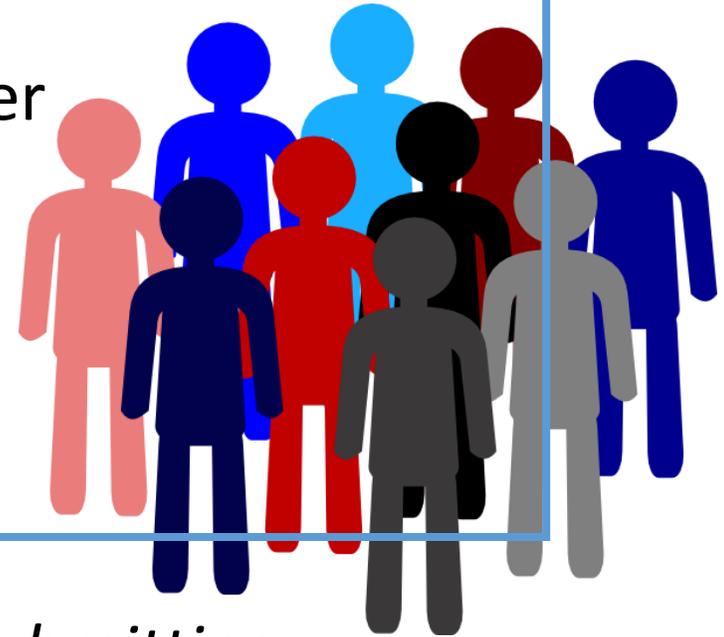
Table 1: Labor and Job Codes and Descriptions

Labor Category Code	Job Title Code	Labor Description	Job Description	Description of Services
1	1	Administration Services	Administrator	Administrative staff responsible for facility management as required under 483.70(d) such as the administrator and the assistant administrator.
2	2	Physician Services	Medical Director	A physician designated as responsible for implementation of resident care policies and coordination of medical care in the facility in accordance with 483.70(h).
2	3	Physician Services	Other Physician	A salaried physician, other than the medical director, who supervises the care of residents when the attending physician is unavailable, and/or a physician(s) available to provide emergency services 24 hours a day.
2	4	Physician Services	Physician Assistant	A graduate of an accredited educational program for physician assistants who provides healthcare services typically performed by a physician, under the supervision of a physician.
3	5	Nursing Services	Registered Nurse Director of Nursing	Professional registered nurse(s) administratively responsible for managing and supervising nursing services within the facility. Do not additionally reflect these hours in any other category.
3	6	Nursing Services	Registered Nurse with Administrative Duties	Nurses (RN) who, as either a facility employee or contractor, perform the Resident Assessment Instrument function in the facility and do not perform direct care functions. Also include other RNs whose principal duties are spent conducting administrative functions. For example, the Assistant Director of Nursing is conducting educational/in-service. Facilities with an RN waiver who do not have an RN as DON report all administrative nursing hours in this category.
3	7	Nursing Services	Registered Nurse	Those persons licensed to practice as registered nurses in the State where the facility is located. Includes geriatric nurse practitioners and clinical nurse specialists who primarily perform nursing, not physician-delegated tasks. Do not include Registered Nurses' hours reported elsewhere.

PBJ User Base

- User Base

- ❖ Total Facilities: 15,741 with a PBJ associated user
- ❖ 7569 Individual Users
- ❖ 975 Corporate Users
- ❖ 90 Third Party User



PBJ Users range from Individual Facilities submitting their own data to Corporations and Vendors submitting on behalf of the facility.

PBJ Deadline Processing



❖ PBJ Cut-off Dates (at 11:59 PM ET)

- ✓ Feb 14
- ✓ May 15
- ✓ Aug 14
- ✓ Nov 14

❖ August Cutoff

- Aug 7: 49 million Staffing Records Submitted in Total
- Aug 14: (at cut-off) 87 million Staffing Records Submitted in Total
- **44% of Staffing Records were submitted in the final week**

CMS reminds Facilities to submit data before the deadline and not to wait until the last two weeks to submit and encourages them to submit monthly, if possible.

PBJ CASPER REPORTS for Providers



- ✓ Verify data submitted to PBJ
- ✓ Cross-check with Payroll Data
- ✓ Verify data prior to deadline
- ✓ All PBJ data can be viewed via CASPER Reports

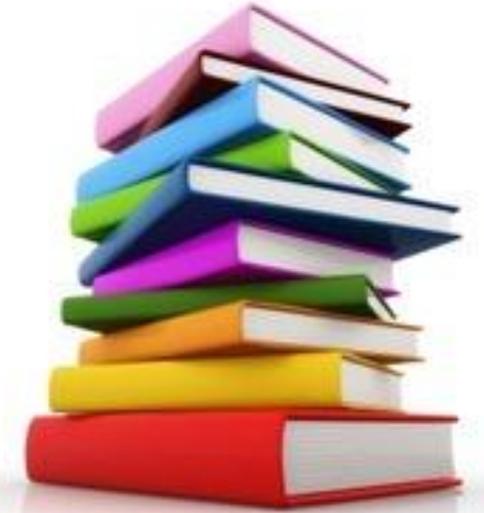
- **1700D EMPLOYEE REPORT** – lists total Staffing Hours per Employee ID for a User-specified time period.
- **1702D INDIVIDUAL DAILY STAFFING REPORT** – lists daily Staffing Hours per Employee ID for a User-specified time period.
- **1702S STAFFING SUMMARY REPORT** – summarizes total Staffing Hours by Job Title for a User-defined time period. Breaks down the hours by Exempt, Non-Exempt, and Contractor.
- **1703D JOB TITLE REPORT** – lists per day the Staffing Hours per Job Title for a User-specified time period. Breaks down the hours by Exempt, Non-Exempt, and Contractor. [Job Title Report](#)
- **1704S Daily MDS Census Summary Report** – lists total daily census, based on MDS assessments submitted to QIES, for a User-defined time period. [Census Reports](#)
- **1704D Daily MDS Census Detail Report** – lists Internal Resident ID's per day which make up the total daily census.

CFR Nurse Staffing Waiver Criteria [42 CFR 483.35(e) and CMS SOM 7014.1.1]

- (1) Demonstrates diligent efforts w/ wages at prevailing rate
- (2) State determines will not endanger health or safety
- (3) Must have registered nurse or physician obligated to respond immediately to telephone calls from the facility;
- (4) Subject to annual State review;
- (5) May be required by State to use other qualified, licensed personnel;
- (6) State must provide notice of waiver to the Long-Term Care Ombudsman and APS; and
- (7) The facility must notify residents of the facility and their representatives.

PBJ-related resources

- **CMS PBJ Policy Manual:**
<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/PBJ-Policy-Manual-Final-V24.pdf>
- **CMS PBJ Policy Manual FAQ:**
<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/PBJ-Policy-Manual-FAQ-09-26-17>
- **CMS Staffing Data Submission PBJ:**
<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ.html>
- **CMS Five-Star Quality Rating System Technical Users Guide:**
<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/usersguide.pdf>
- **CMS memo: Transition to PBJ Staffing Measures for Five-Star Quality Rating System:**
<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO18-17-NH.pdf>
- **CMS Employee ID Linking Methodology:**
<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/PBJ-Linking-Methodology.pdf>



Who Should Providers Contact?

- Questions regarding PBJ Policy issues should be directed to NHStaffing@cms.hhs.gov
- Questions regarding the PBJ Data Specifications or PBJ Technical Issues should be directed to NursingHomePBJTechIssues@cms.hhs.gov. (Software developers or vendors that provide services such as automated payroll or time and attendance systems that will support electronic submissions should use this address.)
- Providers requesting access or needing to register to submit PBJ data should contact the QTSO helpdesk at 1-888-477-7876.



Q&A

You have

Questions

We have

Answers



Office of Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 12-13-NH

DATE: December 16, 2011

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Use of Federally Imposed Civil Money Penalty (CMP) Funds by States - **Update**
Supersedes S&C: 11-42-NH

Memorandum Summary

Centers for Medicare & Medicaid Services (CMS) Approval: Beginning January 1, 2012, States must obtain prior approval from CMS for the use of federally imposed CMP funds, as follows:

- Effective January 1, 2012 CMS approval is required for any new project, new grantee, or new use of federally imposed CMP funds, as well as for any previously State-approved use or project that is planned or approved for a period that will endure more than 36 months from December 31, 2011.
- Current State-approved CMP projects or uses that a State has in effect prior to January 1, 2012 do not require retrospective CMS approval so long as the project, grantee, use or purpose is not planned to endure for a period of more than 36 months from December 31, 2011. If the period of performance is planned or approved for a period of more than 36 months, then the project must receive CMS approval.
- This memorandum replaces a previous version of S&C: 11-42-NH dated September 30, 2011. Please disregard the September 30, 2011 version.

State Options to Enlist Many Entities: States may direct collected CMP funds to a variety of capable organizations as long as funds are used in accordance with statutory intent, the use is consistent with Federal law and policy, and the use is approved by the CMS.

A. Background

Sections 1819(h)(2)(B)(ii)(IV)(ff) and 1919(h)(3)(C)(ii)(IV)(ff) of the Social Security Act (the Act) incorporate specific provisions of the Patient Protection and Affordable Care Act, (the Affordable Care Act) (Pub. L. 111-148) pertaining to the collection and uses of CMPs imposed by CMS when nursing homes do not meet requirements for Long Term Care Facilities.

The Act provides that collected CMP funds may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).

The specific use of CMP funds collected from Long Term Care Facilities as a result of federally imposed CMPs must be approved by CMS on behalf of the Secretary. CMPs levied for deficiencies that are not Federal, and instead are imposed exclusively under State licensure authority, are not subject to the statutory requirements or procedures in this memorandum.

The information provided in this memorandum supersedes earlier guidance¹ to States for directing CMP funds toward efforts that will benefit nursing home residents except for the guidance in S&C-11-12-NH.

B. CMS Approval Process

Effective January 1, 2012, CMS approval is required for any new project, new grantee, or new use of federally imposed CMP funds, as well as any previously State-approved use or project that is planned or in effect for a period that will endure more than 36 months after December 31, 2011. States must obtain prior approval from CMS except for temporary use in the case of sudden nursing home relocations, natural disasters, or similar emergencies. In such emergency cases, the State must seek CMS approval within 10 working days of the emergency use.

Current CMP projects or uses that a State has in effect prior to January 1, 2012 do not require retrospective CMS approval as long as the project, grantee, use or purpose is not planned for a period of more than 36 months from December 31, 2011. If the period of performance is planned or is State-approved for a period of more than 36 months, then the project must receive CMS approval.²

¹ Memoranda S&C-02-42, S&C-09-44 and the September 30, 2011 version of S&C-11-42

² We further indicated in the final rule (p. 15123) that “we do not plan to approve uses that lock in civil monetary penalty funding to very long term programs that would create the reality or the appearance of an on-going revenue demand so strong that it could affect the judgment of the State or CMS in imposing civil monetary penalties, or to fund programs for which Congress has provided another on-going funding source.” In the notice of proposed rule-making we also indicated that our sense of “long term” was 36 months. While it is not likely that we will approve projects of longer duration, we reserve the right to make exceptions to this general policy based on very unusual or emergency circumstances or causes if we also find that the project does not raise the prospect of conflict of interest.

Requests for approval must be sent to the appropriate CMS Regional Office (RO) for review and final approval. CMS will respond no later than 45 calendar days after receiving a request with either:

1. Approval;
2. Denial, with explanation; or
3. Request for more information. If CMS requests more information within the 45-day period, then the period needed for project approval will be extended and will depend on the nature of the information needed and the response turnaround time by the State. If CMS requests additional information from the State, CMS will undertake further review and a final decision will be provided to the State by the CMS Regional Office within 30 calendar days of the date CMS receives the additional information.

If none of the above three actions occurs within 45 days of confirmed CMS receipt of a complete project description and request for approval package (see item C below), the State should contact both the Regional Office and QualityAssurance@cms.hhs.gov for priority processing.

In our final administrative rule, we expressed an intent to develop categories of pre-approved uses that would not require prior CMS approval, and a previous version of this Memorandum (issued on September 30, 2011) described a number of such uses. However, we received so many questions about the categories of proposed pre-approved uses that we have removed that provision from our procedures at this time. As a general guide to States and others, we have included in Appendix One examples of uses that generally conform to the criteria we will use for review, but wish to be clear that all projects requiring approval will now need to be submitted to the appropriate CMS Regional Office. If this change causes any immediate timing problems for new projects that a State has planned to implement in early CY2012, please consult with your Regional Office as soon as possible and we will make appropriate accommodations.

C. Content of Requests for Approval

States must submit to CMS (and a copy to the email box QualityAssurance@cms.hhs.gov) a description of the proposed use/project that includes:

1. ***Purpose and Summary:*** Project title, purpose, and project summary;
2. ***Expected Outcomes:*** Short description of the intended outcomes, deliverables, and sustainability;
3. ***Results Measurement:*** A description of the methods by which the project results will be assessed (including specific measures);
4. ***Benefits to NH Residents:*** A brief description of the manner in which the project will benefit nursing home residents;
5. ***Non-Supplanting:*** A description of the manner in which the project will not supplant existing responsibilities of the nursing home to meet existing Medicare/Medicaid requirements or other statutory and regulatory requirements;

6. **Consumer and other Stakeholder Involvement:** A brief description of how the nursing home community (including resident and/or family councils and direct care staff) will be involved in the development and implementation of the project;
7. **Funding:** The specific amount of CMP funds to be used for this project, the time period of such use, and an estimate of any non-CMP funds that the State or other entity expects to be contributed to the project;
8. **Involved Organizations:** List all organizations that will receive funds through this project (to the extent known), and organizations that the State expects to carry out and be responsible for the project;
9. **Contacts:** Name of the State contact person responsible for the project and contact information.

States must provide information and obtain prior approval from its CMS regional office for any project for which the State wishes to use CMP funds, and CMS reserves the right to disapprove such projects (with prior notice and reconsideration opportunity for the State should CMS disapprove the requested project or use).

D. Many Qualified Entities May Receive CMP Funds to Improve Quality of Care

States may contract with, or grant funds to, any entity permitted under State law provided that the funds are used for CMS approved projects to protect or improve nursing home services for nursing home residents, and provided that the responsible receiving entity is:

- Qualified and capable of carrying out the intended project(s) or use(s);
- Not in any conflict of interest relationship with the entity(ies) who will benefit from the intended project(s) or use(s);
- Not a recipient of a contract or grant or other payment from Federal or State sources for the same project(s) or use(s);
- Not paid by a State or Federal source to perform the same function as the CMP project(s) or use(s). CMP funds may not be used to enlarge or enhance an existing appropriation or statutory purpose that is substantially the same as the intended project(s) or use(s).

States may target CMP resources for projects or programs available through various organizations that are knowledgeable, skilled, and capable of meeting the project's purpose in its area of expertise as long as the above criteria are met and the use is consistent with Federal law and policy. Examples of organizations that could qualify include, but are not limited to, consumer advocacy organizations, resident or family councils, professional or State nursing home associations, State Long-term Care Ombudsman programs, quality improvement organizations, private contractors, etc.

E. Annual Reports

We are finalizing the requirements and specifications for an annual transparency report which will be due no later than January 1st of each year, beginning in 2013. More information will be

provided after further dialogue with States and others. We are providing this information now only to provide advance notice and to aid State plans for record-keeping.

Effective Date: This clarification is effective January 1, 2012. Please ensure that all appropriate staff is fully informed within 30 days of the date of this memorandum.

Questions or Comments: Questions regarding specific proposals or applications for approval of the use of CMPs should be directed to the appropriate CMS regional office, Division of Survey & Certification, Quality Improvement, and State Operations. Questions or comments regarding CMS policy for CMP use may be directed to Lori Chapman at lorelei.chapman@cms.hhs.gov.

/s/
Thomas E. Hamilton

Attachments – Appendix One and Two

cc: Survey and Certification Regional Office Management

Appendix One: Examples of Previous CMP Uses by States³:

- 1. Culture Change:** "Culture change" is the common name given to the national movement for the transformation of older adult services, based on person-directed values and practices where the voices of elders and those working with them are considered and respected. Core person-directed values are choice, dignity, respect, self-determination and purposeful living. CMP funds may be used to promote culture change in projects that involve multiple nursing homes. Examples:

Louisiana - CMPs funded a workforce and culture change project focusing on achieving staffing stability in nursing homes, and a culture change conference in the State.

Illinois - enabled the Long-Term Care Ombudsman Program (LTCOP) to promote the Pioneer Movement.

New York - funded projects that facilitated nursing homes' implementation of culture change.

Georgia - used CMP funds for "Culture Change in Nursing Homes Symposia" to educate providers and develop public policy recommendations; for scholarships on behalf of long-term care ombudsman to attend Culture Change summit of Georgia; and for development of web-based training modules for ombudsman staff and volunteers focused on culture change principles and practices.

Massachusetts - used CMP funds for a State-wide culture change coalition conference, a culture change newsletter and a 2-year project with several nursing homes on Quality Improvement and consistent staff assignments.

- 2. Resident or Family Councils:** CMP funds may be used for projects by not-for-profit resident advocacy organizations that:
 - Assist in the development of new independent family councils;
 - Assist resident and family councils in effective advocacy on their family members' behalf;
 - Develop materials and training sessions for resident and family councils on state implementation of new federal or state legislation;

For example, CMP funds could be used to support facilitators, involvement of knowledgeable experts in council meetings, or other initiatives to engage residents and families in the development and implementation of quality improvement programs.

Examples:

Maryland - provided a multi-year grant to the National Citizens' Coalition for Nursing Home Reform (NCCNHR, now "Consumer Voice") to support the development of family councils in the State, including resources and information such as a DVD on family councils and an informational booklet.

³ These are only intended as previous examples of how States have used CMP funds in the past. Beginning January 1, 2012, States must provide information and obtain prior approval from CMS for any project or use that the State considers for use of CMP funds, regardless of whether the use was conducted in the past.

Appendix One: Examples of Previous CMP Uses by States⁴:

Minnesota - used CMP funds to host a conference for family members that highlighted quality improvement success stories in MN nursing homes for consumers.

Connecticut - used CMP funds to support their VOICES program which brings together presidents of resident councils to share their thoughts and to bring the concerns and ideas of residents to the attention of public officials who can assist in addressing problems.

- 3. Direct Improvements to Quality of Care:** CMP funds may be used for projects designed to directly improve care processes for nursing home residents of multiple nursing homes. Examples:

New York - has used CMP funds to promote:

- *Hiring of independent consultants to train nursing home staff on four “life enrichment modules:” Therapeutic Small Group Activities, Soft Sensory Programming (to relate to dementia residents through aromatherapy, music and gentle touch), Roving Cart Activities (provide individualized activities to residents) and a Dignity and Sensitivity Boot Camp (exposes staff to life as their residents experience it).*
- *A project to improve resident balance and mobility and decrease falls using innovative exercise and balance programs that include Tai Chi and Yoga.*
- *Several projects to enable facilities to substantially improve their residents’ dining experiences. One project funded a fine dining project. The facility committed its own funds for renovations, while the project funds paid for training of all staff in fine dining procedures, steam tables, music systems for the dining rooms, elegant linens, etc. The project incorporated staff, resident, and family satisfaction.*

Resource on improving cultural competence: HHS Office of Minority Health, a discussion of cultural competency <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=11>.

- 4. Consumer Information:** CMP funds may be used to develop and disseminate information that is directly useful to nursing home residents and their families in becoming knowledgeable about their rights, nursing home care processes, and other information useful to a resident. Examples:

- *Use CMP funds to develop and distribute printed and Web-based toolkits for residents, families and caregivers on how to identify mental health issues, such as depression and anxiety, and treatment options so that individuals can overcome stigma, understand their options and take control of their mental health care.*
- *Ohio - funded start-up of Ohio’s consumer guide Web site <http://www.ltcoho.org/consumer/index.asp>.*

⁴ These are only intended as previous examples of how States have used CMP funds in the past. Beginning January 1, 2012, States must provide information and obtain prior approval from CMS for any project or use that the State considers for use of CMP funds, regardless of whether the use was conducted in the past.

Appendix One: Examples of Previous CMP Uses by States⁵:

- 5. Resident Transition due to Facility Closure or Downsizing:** CMP funds may be considered for use for the temporary support and/or protection of residents of a facility that closes or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), or to transition residents to alternate settings for a facility downsizing that requires a reduction in facility census. Example:

Michigan - funded a CMP project to pull together a workgroup (1½ years) to figure out the underlying factors of facility closure and come up with creative ideas to address closure issues and their impact on residents.

- 6. Transition Preparation:** CMP funds may be considered for use to fund an initial home visit for a nursing home resident to help him or her evaluate the appropriateness of a potential transition to another living arrangement or home or community based setting. See S&C Memorandum 11-12-NH for more details.
- 7. Training:** CMP funds may be considered for training in facility improvement initiatives that are open to multiple nursing homes, including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, training for resident and/or family councils, LTC ombudsman or advocacy organizations and other activities approved by CMS. For example, this effort might include a statewide pressure ulcer or fall prevention collaborative that includes joint training of surveyors and facility staff from multiple nursing homes that are committed to implementing effective fall prevention programs.

⁵ These are only intended as previous examples of how States have used CMP funds in the past. Beginning January 1, 2012, States must provide information and obtain prior approval from CMS for any project or use that the State considers for use of CMP funds, regardless of whether the use was conducted in the past.

Appendix Two: Examples of Prohibited Uses of CMP Funds

- 1. Conflict of Interest Prohibitions:** CMS will not approve projects for which a conflict of interest exists or the appearance of a conflict of interest. Similarly, we will generally not approve uses that commit CMP funding to very long term projects (greater than 3 years). By obliging the State to fund a long and large multi-year expense, we consider such projects to raise the appearance of a conflict of interest where the levy of future CMPs could be construed to be done for the purpose of raising revenue rather than for the statutory purpose of deterring or sanctioning poor quality. We will, however, consider each project in light of the specifics of each individual case. Large projects may avoid the appearance of conflict, for example, to the extent that the State is able to demonstrate a plan for sustaining the project on a long term basis without CMP funds.
- 2. Duplication:** States may not use CMP funds to pay entities to perform functions for which they are already paid by State or Federal sources. CMP funds, for example, may not be used to enlarge an existing appropriation or statutory purpose that is substantially the same as the CMP project. Also, CMP funds may not be used to fund State legislative directives for which no or inadequate state funds have been appropriated.
- 3. Capital Improvements:** CMP funds may not be used to pay for capital improvements to a nursing home, or to build a nursing home, as the value of such capital improvement accrues to a private party (the owner). Federal and State payments also already acknowledge the expense of capital costs, so the use of CMP funds for such a purpose would duplicate an existing responsibility of the nursing home. Examples of prohibited uses:
 - *Building or Capital Redesign: CMP funds may not be used to build or redesign a nursing home, including conversion to a Green House.*
 - *Capital Expense: Replacing an aging boiler.*
- 3. Nursing Home Services or Supplies:** CMP funds may not be used to pay for nursing home services or supplies that are already the responsibility of the nursing home, such as laundry, linen, food, heat, staffing costs, etc. This prohibition, however, does not prevent the temporary payment of salary for an individual who will work in the nursing home as part of an evaluated demonstration of a new service, skill set, or other innovation that the nursing home has not previously had in place and which the nursing home may sustain after the demonstration if resources permit. Examples might include new use of a wound specialist and adoption of new skin care techniques, new uses of advance practice nurses, new methods of retention and training for certified nurse assistants, etc.
- 4. Temporary Manager Salaries:** CMP funds may not be used to pay the salaries of temporary managers who are actively managing a nursing home, as this is the responsibility of the involved nursing home in accordance with 42 CFR §488.415(c).
- 5. Supplementary Funding of Federally Required Services:** For example, CMP funds may not be used to recruit or provide Long-Term Care Ombudsman certification training for staff or volunteers or investigate and work to resolve complaints as these are among the responsibilities of Long-Term Care Ombudsman programs under the federal Older Americans Act (OAA), regardless of whether funding is adequate to the purpose. On the other hand, there is no prohibition to an Ombudsman program receiving CMP funds to

Appendix Two: Examples of Prohibited Uses of CMP Funds

conduct or participate in approved projects, or to carry out other quality improvement projects that are not within the Ombudsman program's existing set of responsibilities under the OAA. Nor is there any prohibition to Ombudsman program staff or volunteers to participate in training that is paid by CMP funds but open to a broad audience, such as nursing home staff, surveyors, consumers, or others.

PRESENTATION: LTCFAB – JULY 10, 2019

I. Brief history of my experience as a Nurses' Aide and continued education to my Master's Degree from The University of Oklahoma and attaining Advanced Practice Nursing, Certification in Gerontology from ANCC.

II. Senate Bill 280

A. Passage with only "one no vote"

B. Excerpts from the T.W. Article:

"In exchange for the money, nursing homes agree to more oversight, including more long-term care ombudsmen and an advisory group to help determine how pay-for-performance incentives will be directed. The legislation targets improvements in long-term, high-risk patients who develop pressure sores, lose too much weight, develop urinary tract infections or receive antipsychotic drugs.

The nursing homes also agree to require clinical employees to receive at least four hours of Alzheimer's or dementia training.

III. What is the most important item to secure while a member of any work force and especially one that cares for the Older Adult?

A. CONTINUING EDUCATION

B. Why do we need to address this item?

Need Statement: The Eldercare Workforce Alliance, 2015, EWA – Why do we need to seriously consider Continuing Education Programs in all of our Nursing Homes?

1. "the breadth and depth of geriatric education and training for health care professions remain inadequate...and despite some improvements, geriatric principles are still too often insufficiently continued in health care training curricula

and clinical experiences focused on gerontology are not robust”.

2. “Direct care workers like CNAs have low confidence and are inadequately trained to meet needs of residents while they provide 70-8-% of the “hands on” care in LTC”.

IV. The following represent Proposed additions to Senate Bill 280 allowing our Nursing Homes a pathway to improve: (1) EDUCATION and (2) QUALITY PATIENT-CENTERED CARE:

A. Gerontological Certification for the:

- 1. Nurse Aides and Medication Aide**
- 2. Licensed Practical Nurse**
- 3. Registered Nurse**

B. Establishment of Monthly Continuing Education Programs for the Nursing Home Staff:

Skilled Units (SKU)

Assisted Living Center (ALC)

Long Term Car (LTC)

C. Nursing Staff being taught at the ALC or LTC

Having the course at the LTC and or ALC allows for clinical rounding following classes.

D. Nursing Educators who are Certified in Gerontological Nursing, Teaching... (Work toward this as a goal)

V. The passage of Senate Bill 280 is definitely a step in the right direction. Continuing Education for staff who care for our Geriatric patients and residents in our hospitals, SKU, ALC, & LTC will be a valuable asset for our staff and patients/residents.

VI. I ask that we, schedule a meeting(s) during non-session and discuss the Research/Data, include Certified Gerontological Nurses, both RNs and APRNs, the ONA and ANA Representatives and additional leaders involved in the study of the **Growth of**

Aging that we all need to be prepared for now and in the very near future - such as Representatives from The Eldercare Workforce Alliance (EWA), Coalition of Gerontological Nurses, Collaboration of Gerontological Nursing Organizations (CGNO), and AARP, here in Oklahoma. Also, and most importantly, the Director of OSDH and the Nurse Aide Curriculum and their CNA Certification Curriculum.

An excerpt from **Gerontological Nursing, Competencies For Care**, Kristen L. Mauk, PhD, DNP, RN, CRRN, GCNS-BC, FAAN.

Chapter 6- Comprehensive Assessment of the Older Adult
“The basis of an individualized plan of care for an older adult is a comprehensive assessment. Enhanced skills in comprehensive geriatric assessment can improve health outcomes, increase nursing assessment confidence, and provide a role model for health care teams (Stolee et al., 2003). Assessment has been described as the cornerstone of gerontological nursing, and the goal is to conduct a systematic and integrated assessment (Olenek, Skowronski, & Schmaltz, 2003). The health and healthcare needs of older adults are complex, deriving from a combination of age-related changes, age-associated and other diseases, heredity, and lifestyle. Assessment requires knowledge and an understanding of these complex factors, and a comprehensive baseline assessment is necessary in order to recognize changes that occur in relation to these complex factors. In assessing and providing care to older adults, nurses are members of a healthcare team that includes physicians, therapists, social workers, spiritual care workers, pharmacists, nutritionists, and others. Each member of the team has a contribution to make, and nurses should draw upon the knowledge of other team members to enhance the assessment process.”

Joanne L. Alderman, MS-N, APRN-GCNS, RN-BC, FNGNA

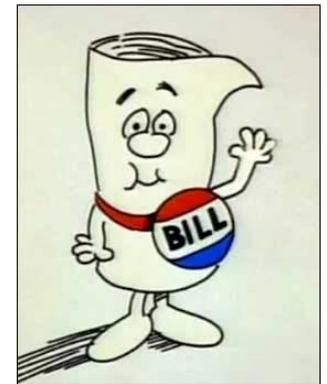
Bills

SB 142 – no long-term care resident shall be prescribed or administered an antipsychotic drug that was not already prescribed to the resident prior to admission to the facility unless certain conditions have been satisfied

SB 201 – Personal degradation" means a willful act by a caretaker intended to shame, degrade, humiliate or otherwise harm the personal dignity of a vulnerable adult

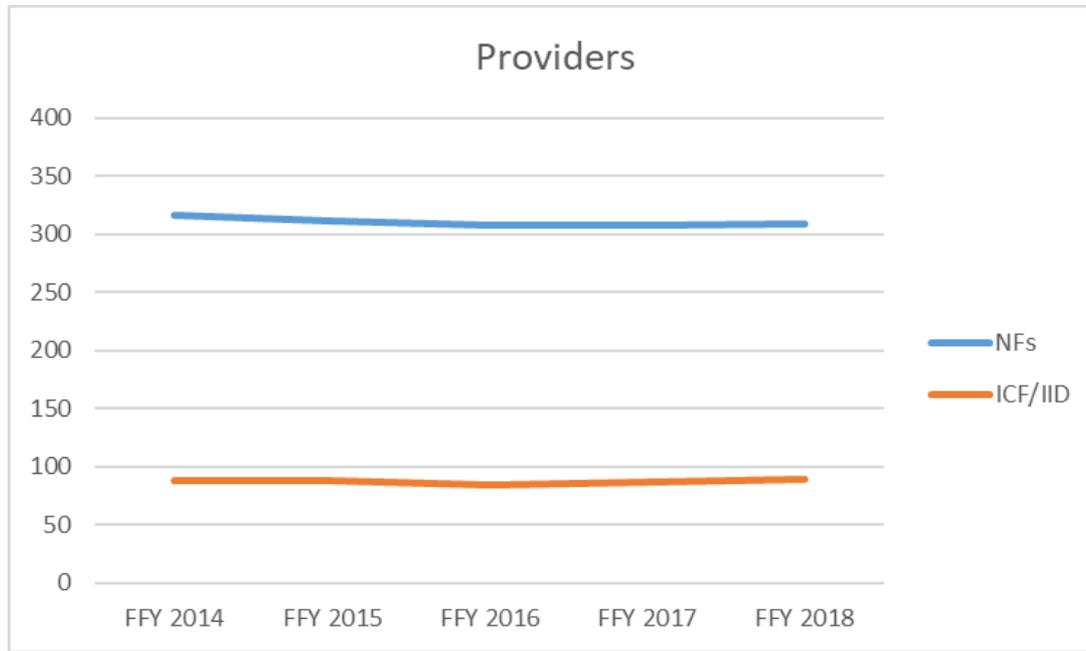
SB 280 – An Act relating to long-term care which relates to nursing facility incentive reimbursement rate plan

SB 888 – Persons who are fifty-five (55) years of age or older, or their legal guardians or lay caregivers, shall receive options counseling for long-term care prior to admission to a long-term care facility

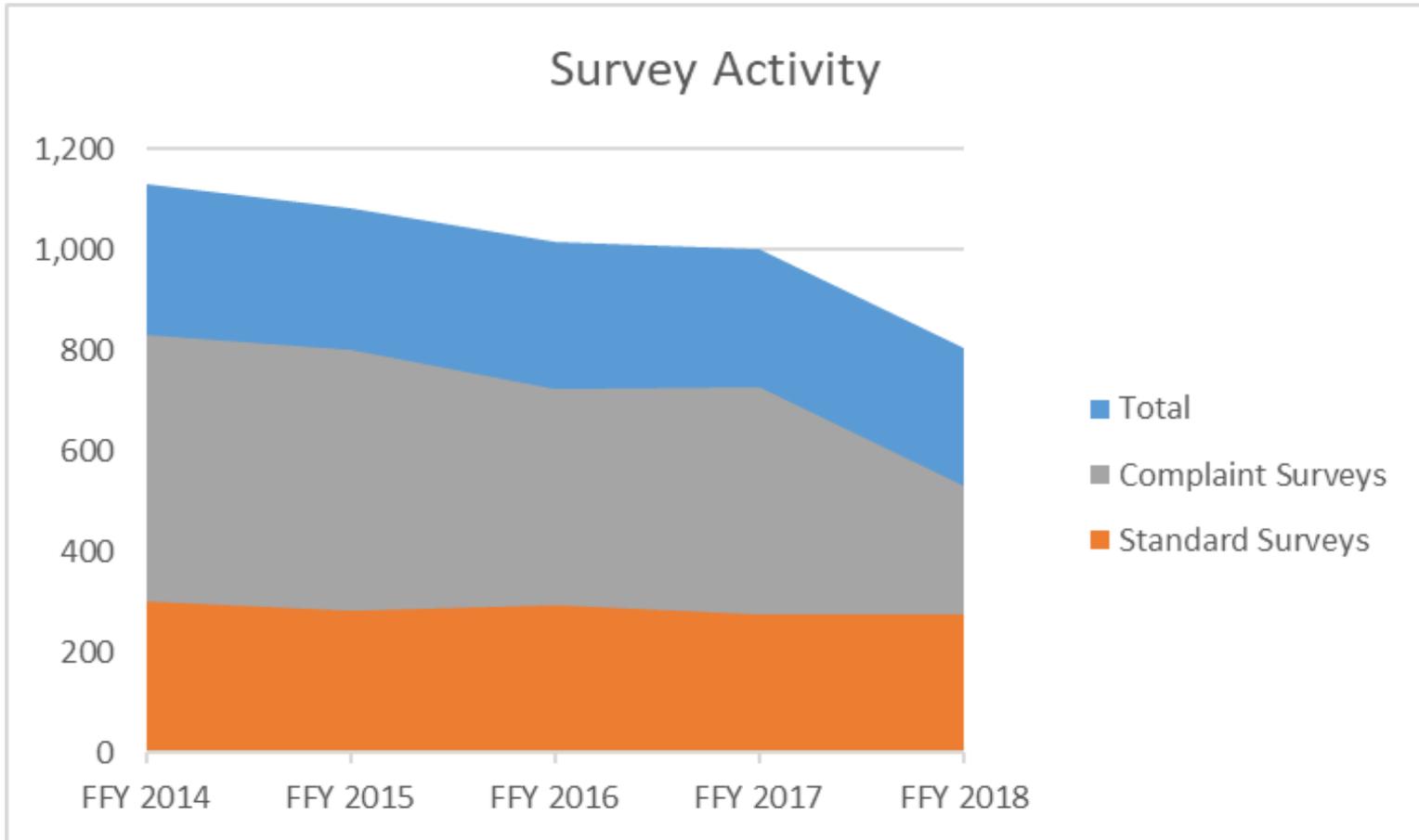


Providers

	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018
NFs	316	311	307	308	309
ICF/IID	88	88	85	87	89



Surveys



NFs	OTC	AH	IJ	Total
FFY 2014	3569	138	77	3784
FFY 2015	3314	104	103	3521
FFY 2016	2652	85	47	2784
FFY 2017	2593	133	77	2803
FFY 2018	2419	94	37	2550



NFs	OTC	AH	IJ	Total
FFY 2014	94.3%	3.6%	2.0%	100.0%
FFY 2015	94.1%	3.0%	2.9%	100.0%
FFY 2016	95.3%	3.1%	1.7%	100.0%
FFY 2017	92.5%	4.7%	2.7%	100.0%
FFY 2018	94.9%	3.7%	1.5%	100.0%

