North Dakota Department of Health
Division of Health Facilities

LONG TERM CARE ADVISORY
COMMITTEE MEETING MINUTES
December 17, 2010

Committee Members Present:
Darleen Bartz, Chief, Health Resources Section, ND Department of Health
Bruce Pritschet, Division of Health Facilities, ND Department of Health
Shelly Peterson, Executive Director, North Dakota Long Term Care Association
Beverly Herman, North Dakota Long Term Care Association
Rosanne Schmidt, Vice President, St. Alexius Medical Center
Randal Albrecht, Rep. Board of Examiners for Nursing Home Administrators
Joan Ehrhardt, State LTC Ombudsman, ND Department of Human Services
Karen Tescher, Assistant director, LTC Continuum
Barb Groutt, Chief Executive Officer, North Dakota Health Care Review, Inc.
Dave Remillard, Public Member, Minot
Arvy Smith, Deputy State Health Officer, ND Department of Health

Committee Members Absent:
Carole Watrel, AARP
Dr. Jonathan Berg, Nursing Home Medical Directors Association
Representative Gary Kreidt, ND House of Representatives (New Salem)
Betty Keegan – Rolette County Social Service Board

Other individuals Present:
Cindy Kupfer, Recorder, Division of Health Facilities, ND Department of Health
Lucille Torpen, Division of Health Facilities, ND Department of Health
Monte Engel, Division of Life Safety & Construction, ND Department of Health
Mark Seibold, Northland Program of All-inclusive Care for the Elderly (PACE)
Tami Anderson, Northland Program of All-inclusive Care for the Elderly (PACE)

Welcome
A meeting of the Long Term Care Advisory Committee was called to order at 10:07 a.m. on December 17, 2010. Darleen Bartz welcomed the committee members to the meeting. There were no visitors and no public comments.

There was an addition to the agenda, Arvy Smith, Deputy State Health Officer, NDDoH, presented an overview of the department's budget. This will be added under new business, and she will present

when she is able to join the meeting. Monte Engel, Life Safety & Construction, will here around 11:30a.m. to give his report for the Division of Life Safety and Construction.

Approval of Minutes

The following changes were made to the minutes:

- Page 2, #1 – instead of "nursing home", this was changed to "health care setting".
- Page 3, Upper Payment Limits- This paragraph will be rewritten by Shelly Peterson, Long Term Care Association.
- Page 13, Other, Dr. Bruce Hetland and Dr. Tangedal's name should have been added.
- Page 5, Report from the North Dakota Health Care Review, paragraph 2 and 4 will be deleted.

Barb Groutt made the motion to approve the September 17th minutes; seconded by Bruce Pritschet with the changes mentioned above.

Standing Reports

Representative Gary Kreidt was not available to provide a legislative update.

Report from the North Dakota Long Term Care Association

Shelly Peterson discussed the legislation issues the NDLTCA will be following. There are nine priorities that were voted on this week as a board. A 3% annual increase for everyone is top priority; this is in the Governor's budget. A Bed Layaway Program has been proposed, which would allow ND to layaway beds for 48 months, yet not loose beds. There are currently 30 facilities under 90% occupancy. With this Program, they can be brought back into service. Darleen Bartz mentioned that facilities cannot take the beds out, and put them back in again in the same year. Shelly indicated that the committee will be sending out information to the members, and will keep the conversation going with Health Facilities on this issue.

The NDLTCA is looking at a $30,000, four- year student loan scholarship.

The NDLTCA is looking at guardians for the disabled population. This would fall under the Elder Justice Act. Darleen Bartz mentioned that CMS indicated that it has still not been decided which federal agency will be responsible for the Elder Justice Act; it is not funded nor mandated, and not implemented.

A high priority for the NDLTCA is to encourage the legislature increase the budget for the Long Term Care Facilities.

Another area being looked at is related to personal spending funds for individuals on Medicaid. The NDLTCA would like to see the amount increased, as it has not been increased for many years.

Shelly reported that the Legislature Council does not have the bill numbers assigned yet, but would keep us posted when the bill numbers are assigned.

Darleen stated that she will contact Fred Larson again to see what the status is on the contract for him to work on the Guide to Nursing Home Charges book.

Another area of priority is the Nurse Aide registry bill which will create one nurse aide registry for North Dakota with the Department of Health. Barb Groutt asked for explanation of one long term care registry. Shelly indicated this would add portions of the Unlicensed Assisted Persons (UAP) registry currently with the Board of Nursing (BON) to the Department of Health's Certified Nurse Aide registry, and have just one registry. This would include the Medication Assistants I and II, Home Health Aides, and Nurse Aides. This registry would indicate which area they are qualified to work in. The Health Department currently has staff to investigate CNA complaints in Skilled Nursing Facilities. One of the positive aspects of the one registry is that there would be only one place to check instead of two for nurse aides. Shelly said the Board of Nursing is supporting this. Hopefully this will go through the legislature. The Board of Nursing and other stake holders were involved with the decision.

Shelly reported that there have not been any changes from the Labor Department regarding the use of the Lift by high school aged employees. The NDLTCA met with the federal legislators in Washington in this issue and they did seem to listen. Senator Conrad is taking a lead on urging the Labor Department to change their decision due to the impact this will have on staffing in facilities and use of these employees.

Shelly reported that Dunseith and McVille have reached the Upper Payment limit.

Report from Education and Training

Beverly Herman reported she had 34 facilities on web seminars on the MDS 3.0. Hopefully questions on the 3.0 will settle down. Bev had not heard from Joan Coleman, ND Department of Health, regarding state training on the MDS 3.0. Darleen Bartz stated that the Department is required to do training a couple times of year. Bev Herman will be notified when this happens. Bev indicated that there will be a two day MDS 3.0 training, Tuesday and Wednesday, March 8, and 9. Also, a new Quality Care Series will be planned soon.

Report from the North Dakota Health Care Review, Inc.

Barb Groutt

Quality improvement data for NH has been limited since October 1st due to the implementation of the MDS 3.0. Physical Restraints have been 7.3% to 1% average; the pressure sore rate average went from 20.1% to 11%. Nursing Homes have seen positive results.

Since the implementation of the MDS 3.0, Barb reported that they were trying to access raw data to use to provide feedback.

NDHRI is waiting to hear about a grant coming out of HRQ, REACH, that will be for clinics and hospital. While they envisioned this getting done quickly, dates have been pushed back from six months to one year. This is a Health reform grant is for funding health information, support technical break through projects, needed support for technical projects, care transitions and working with long term care.

A presentation which concentrates on transition can be sent in electronic version to the group.
We have a standard format.

There is a group in North Dakota trying to talk about the issue involving the cost when a person is moved from one health care setting to another health care setting. This contract will be an area of focus. Nothing will be heard until March, but the patient is the main focus; the money should not matter.

Transition in Care workgroup in our state was initiated through CMS. A summary of the meeting was put together. A quick analysis of showed that 394 individuals were discharged from a Hospital to Nursing Home; and 459 were discharged from the Nursing Home in one year, including deaths. There are a lot of vulnerable people going between places.

There is a mini course available, the Kaiser experience. It discusses the value of pre-discharge coaching and teaching, clear communication with meds, and follow-up, standardize, follow-up phone calls, with the first few weeks if discharge. We want to reduce readmissions to hospitals is possible. We are doing a better job of what people need during end of life.

A question arose about planning for discharge; do they start to plan for discharge upon admission? Making a home visit before the person is discharged was recommended. A question came up about grants, what will the money be used for? It would be used for a toolkit on Urinary Tract Infections that could be easily implemented by any nursing home.

<u>North Dakota Department of Health budget Request Overview</u>

Arvy Smith, Deputy State Health Officer, discussed the budget for Health Department. The Community Health Trust Fund- (handout) the Tobacco Share of the fund is used to fund public Health issues but there is not enough funding to cover everything. The tobacco source was to be a one-time contingency fund, which will do nothing for next year. There was $4,388,119, expenditures, but we had to cut 2 million. This was ruled as a one- time funding, and we lost key priority grants. The Health Department is mostly federally funded.
The second page of the budget showed the base budget; all the things that the Governor approved has been added to the base budget. Most of the items were restored; however one that was not funded was the Dental Gap. This was funded as a one- time grant. Part of the process was to put up a 3% reduction, however, sections were asked for 5%, one item for $59,000 for basic car. We have limited

options, with $21 million of base budget, $21.8 million is general funding, all others funding is federal. General funding is very specific. If we pull from the general budget, it affects the federal budget.

There are no new FTE's, also there are no cuts. This budget will go to the House first. The Legislation submitted five bills, but they are not related to Long Term Care. There is no fiscal limit.
Life Safety and Construction positions were added, we should be safe, not cut out of the 3%. We are not generating enough for the one third, nothing to the legislature, but maybe there will be an increase in the amounts that are charged. There are no new fees and taxes in the budget address. We were able shuffle some funds around, despite the budget. These were collected before the biennium, and help with our shortfall.

HIPAA person was funded with General Funds. However, we shifted the funding to Indirect as this is a cross cutting programs. The General Funds that became available were used to fund the Division of Food and Lodging. W e do not want to decrease the Basic care surveys. They should be surveyed every two years.

The cost share issue related to the survey process has surfaced again. CMS is completing a national study – looking at state and federal rules. This could possibly impact our funding and staffing for survey.

<u>Comments from the ND Department of Health, Division of Life Safety & Construction</u>
Monte Engel discussed the "Citation Frequency Report". The first three pages of the handout all related to one another. This is the data from the fiscal year 2010, which ended in September. On the first line, "other" is miscellaneous site where there is not an established tag for. K-tags are established, but some are not written as, definite as others, or other than LSC, not direct reference to electric code, standard health code, services two purposes

When you compare the National level and Regional level have electrical wiring and equipment issues (K0147) number one. Sprinkler System Maintenance (K0062) is listed second, it being common between the State, Region and National level. There were 85 surveys completed on this report. Common Wall (K0011) is on the list for the state report. We are not sure if this is a deficiency in other states, but we do see this in Nursing Homes and Basic Care Facilities.

Monte discussed page four of the handout "Average Number of Deficiencies Report," comparing all of the states relating to the average number of life safety code deficiencies per survey by scope and severity during the fiscal year. In comparing North Dakota statistics with the other states in Region Viii, the following is the breakdown: North Dakota averaged 1.87 in 85 surveys; Colorado averaged 6.64 deficiencies in 211 surveys; Montana averaged 7.94 deficiencies in 87 surveys; South Dakota averaged 2.96 deficiencies in 112 surveys; Utah averaged 5.86 deficiencies in 101 surveys; and Wyoming averaged 4.76 deficiencies in 38 surveys.

Shelly Peterson mentioned that three or four facilities were to put in the nurse call system, was that issue resolved Monte said a resolution was not reached, and not cited for it, since this is not a Life Safety issue.

The average time to review plans was three months, but this has improved.

Comments from the Ombudsman Program, ND Department of Human Services

Joan Ehrhardt said that a full-time ombudsman did not make it to the Governor's budget. Brian has two areas, Fargo is one. Visits have to be short, with three to four a day plus travel. Another person making quarterly visits would have time to visit with family and residents.

Aging Services did not make the budget, except for a small annual payments to the guardians. The numbers are up for the guardian program.

The top issues are: is financial exploitation, dignity and respect, and discharge eviction notice. The ombudsman gets calls on preference of choice: smoking or non smoking? As ombudsman, their stance is the residents who entered a facility smoking have the right to smoke, but if facility has the policy not to smoke at the time of admission, they can support this. People are coming in that are life time smokers they have to quit smoking, History shows that as vets they were given free cigarettes for war efforts, then some quit, but one of their pleasures, hard to take away..

PACE Program Update

Mark Seibol, Executive Director, and Tami Anderson, Bismarck site Manager, presented information on the Northland Program of All-Inclusive Care for the Elderly (PACE).

National History – The PACE model of care originates in the early 70s. The Chinatown-North Beach Community of San Francisco saw the growing long term care service needs for families whose elders had immigrated from Italy, China and the Philippines. Community leaders formed a nonprofit organization, On Lok Senior Health Services, to create a community-based system of care. On Lok is Cantonese for "peaceful, Happy Abode".

PACE is an outreach of Northland HealthCare Alliance. NHCA, a Bismarck-based not-for-profit organization, was established in 1996 by a group of Catholic acute and long-term care facilities to help serve the medical needs of people in western and central ND. This is accomplished through collaborative efforts that expand services and efficiencies of members beyond their individual capabilities.

2008 had their first admission. It is located here on the corner of 24th and Broadway in Bismarck; and partnered very heavily with St. Benedicts Health Services, Dickinson

PACE Philosophy - Program of All-inclusive Care for the Elderly, model is centered around the belief that is better for the well-being of seniors with chronic care needs and their families to be served in their own homes, whenever possible.

A coordinated Care Model- Northland PACE employ a group of professionals called a **care team** that coordinates all aspects of healthcare for PACE participants. This 11 team of specialist includes a physician, registered nurse, social worker, rehabilitation and recreation therapists, health aides and others who will assist in healthcare management and provision.

We meet to decide if we need to change or add a team.
Participant care services includes: the participant, family and Northland PACE combined. One requirement is that they live independently in the community. Shelly Peterson said if they need care outside their home and if they decline, and have a contract with facilities, maybe Basic Care, PACE pays for that if placed in Nursing Home.

Services

- Comprehensive Primary Medical Care Provided by PACE Physician
- Meals & Nutritional Counseling
- Medical Specialists
- All Necessary Prescription Drugs
- Hospital & Emergency Services
- Nursing Home Care when necessary
- Home Health Care & Personal Care
- Social Services
- Transportation
- Therapies

There is a contract in place with the local bus to transport people. Those on Medicare are eligible and private pay. If you qualify for Medicare/Medicaid the rate is $4,900 per month. Not straight private pay, $4,900 with Medicare. Medicare services flow thru PACE not Medicare D, we can go above Medicare/Medicaid to help with medical. This will keep them in their homes longer.

Exclusive Care – As long as a participant is enrolled, all medical care and services received will be through the Northland PACE program. The PACE Care Team must approve all services, (except for emergency services). This is known as the "lock-in" provision. If you have a Primary Care MD, then switch into your program, what happens? Some have refused The Primary Care MD was allowed for specific issues, but a person would still need the PACE's physician. If they are going to a specialist, they need to contact PACE.

Eligibility - To be eligible to enroll in the Northland PACE Program you mush:

- Be at least 55 years old

- Live within an area served by Northland PACE
- Meet nursing home level of care
- Be able to life safely in your own home.

We treat them like an employee of ours, but in our network. Providers have to adhere to standards that CMS have set up. Training and qualified staff, we need to manage the documentation, to make sure they are qualified.

Funding Sources – PACE is a capitated managed care program that accepts a variety of payment sources:

- Medicaid
- Medicare
- Self funding
- "Money Follows the Person"

The money we get is not enough to pay for Nursing Home care. PACE pays for all of the medical needs, medicines, walker, etc, and $700 for their home needs.

Enrollment Process-

- Intake
- Assessment
- Plan of Care
- Enrollment

This Involves the parent and the child, with an assessment, visit with a social worker who gathers the medical records to see if eligible for a Nursing Home. Then it goes to the team to decide; then the team decides their care. A person can only enroll on the first day of the month. This is a nation-wide policy. Long Term Care Insurance will pay for PACE buy no guarantees. PACE can have a total of 35 participants in Dickinson and 125 in Bismarck. When these numbers are reached then we will reconsider our options. At this time there are 31 in Dickinson and 36 in Bismarck. Keeping a person safe is the most important issue to PACE, if you look at any barriers.

Why PACE? –

- PACE provides a full range of preventive, primary, acute and long term care services that enable seniors to live in their own homes a long as possible.
- PACE combines adult centers, home care, care team and transportation. Providers can respond to the unique needs to each individual served.
- PACE promotes a level of care and independence for seniors unmatched my any other current long-term care option.

The PACE Mission – Northland PACE Senior Care Services promotes independence for older adults through coordination of all health services, allowing participants to continue living safely and with dignity at home.
A Day Center has been established partnership with St. Alexius Medical Center for food. Register Nurses and Physicians come in once a week. They can have the services at home, if they cannot make it to the center, for therapy for example.

A grant for the establishment of a rural PACE is still being developed. PACE is currently leasing the site, however, we would like have a permanent site.

The team determines as a group, what is necessary for that person, and make sure the needs are met, never just based on financial. Some things can be planned in advance, with the family. PACE has in their plan of care sometimes more than the NH provides, not only financial, but the needs of the resident.

Protection for the catastrophic! We have insurance, transplant, heart, etc. The question came up
If you have an agreement with a family, can they be dis-enrolled if the family cannot take care of them?.
No, the team looks at the qualification/needs first before enrollment.

Jamestown would like to be included, however social workers are hard to find that meet the qualifications from CMS. We work closely with the partnership with Benedictine Health system, Dickinson. It is a young program, but we are still learning. CMS thought we were doing good.

Old Business

Comments from the ND Department of Health, Division of Health Facilities
Bruce Pritschet provided a handout entitled the "Average Number of Deficiencies Report."
We do not have any information for 2011; the system that contains the reports does have the data for FY 2011. This report ends Oct. 2010. There is a little difference between Sept and this one.

In comparing North Dakota to the other states in Region VIII, the statistics break down as follows: North Dakota averages 3.98 deficiencies per survey in 112 surveys; Colorado averages 6.66 deficiencies per survey in 450 surveys; Montana averages 3.83 deficiencies per survey in 136 surveys; South Dakota averages 3.63 deficiencies per survey in 115 surveys; Utah averages 2.20 deficiencies per survey in 186 surveys; and Wyoming averages 6.29 deficiencies per survey in 63 surveys. The national average is 2.02 citations per survey.

Total number of surveys we started behind, we had more than 85. We did not have any facility close as of the last meeting.

We had one facility with a Double G, which will have a ban of admissions, and if they had a Nurse Aide Training Program, they would lose that.

On a state level, the top five citations are as follows:
1. F323 (Facility is Free of Accident Hazards) was cited 49 times in 43.75 % of surveys;
2. F441 (Facility Establishes Infection Control Program) was cited 45 times in 40.18% of surveys;
3. F371 (Store/prepare/distribute food under sanitary conditions) was cited 32 times in 28.57% of surveys;
4. F309 (Provide Necessary Care for Highest Practical Well Being) was cited 24 times in 22.43% of surveys; and
5. F329 (Drug Regimen is Free From Unnecessary Drugs) was cited 17 times in 15.18% of surveys. On the

Region level, the top five citations are as follows:
1. F323 (Facility is Free of Accident Hazards) was cited 361 times in 33.99 of surveys;
2. F441 (Facility Establishes Infection control Program) was cited 280 times in 26.37% of surveys;
3. F281 (Services Provided Meet Professional Standards) were cited 273 times in 25.71 of surveys;
4. F371 (Store/prepare/distribute food under sanitary conditions) was cited 264 times in 24.86% of surveys; and
5. F309 (Provide Necessary Care for Highest Practical Well Being) was cited 250 times in 23.54% of surveys.

On the National level, the top five citations are as follows:
1. F323 (Facility is Free of Accident Hazards) was cited 7,438 times in 12.5% of surveys;
2. F441 (Facility Establishes Infection Control Program) was cited 5,998 times in 10.12% of surveys;
3. F309 (Provide Necessary Care for Highest Practical Well Being) was cited 5,680 times in 9.6% of surveys;
4. F371 (Store/prepare/distribute food under sanitary conditions) was cited 5,528 times in 9.3% of surveys; and
5. F281 (Services Provided Meet Professional Standards) was cited 5,243 times in 8.85 of surveys.

Affordable Care Act

We were directed by CMS to post on the web site the deficiency statements and plans of correction for Skilled Nursing Facilities. The Health Department is working with ITD and may have that working by 2011.

The process of Independent Informal Dispute Resolutions (IIDR) was discussed. The person that does the IIDR needs to have knowledge of the survey process, yet not have a conflict of interest. The committee was wondering if there is an outside person/company that we could use, if they have the correct credentials. NDHCRI may be a possibility unless their Quality Improvement work is viewed as a conflict. Currently, Darleen sees the IDRs first, then either completes them herself or gives it to a person that is not part of the survey process. Maybe they should be totally outside the entity. There is a need for the Department to explore options on this.

Shelly indicated the question on how Basic Care Facilities could charge for services was raised. Should they be charged for separately or all-together? More research needs to be conducted on this.

Also, there is a question related to the providing CPR in Basic Care. If a resident has an advanced directive indicating CPR is wanted, can they change their mind so that they can reside if a facility that does not provide it? Then the facility rules not to provide CPR would apply. This is big issue in the rural areas with little or no emergency volunteer help, and it is hard to train staff on CPR.

Comment [b1]: Advanced directive or durable power of attorney or ????

Next Meeting Date:

- March 14th, is the next Long Term Care Advisory Committee Meeting. This will be held in the AV Room 212, Judicial Wing.

Other:

- Transitions in care meeting: February 10, AV room.1-3:30.

The meeting adjourned at 2:55