1010DELAWARE NURSING HOME RESIDENTS QUALITY ASSURANCE COMMISSION
Emily P. Bissell Hospital
2nd floor conference room
3000 Newport Gap Pike
Wilmington, DE 19808
FINAL
Meeting September 14, 2010
Minutes

Commission Member(s) Present: Brian L. Posey, Chairman; Yrene E. Waldron; Karen E. Gallagher; Joe G. DiPinto; Lisa A. Furber; Patricia C. Engelhardt; Vicki L. Givens and M/Sgt. Walter Ferris.

Commission Member(s) Absent: Kyle Hodges; Wayne A. Smith; Senator Bethany Hall-Long and Representative Valerie J. Longhurst. In addition, DAG Pete FeliceAngeli was not able to attend.

Others Present: Margaret Bailey; Hattie Kirton, Aid to Ms. Gallagher; Ruth Cornelison, Consumer; Lisa Schieffert, DE Health Care Association; Mary Rodger, Quality Insights; Laura Hendrick, Emily Bissell Hospital; Tina Showalter, Medicaid Fraud Control Unit; Marsha White, Senior Protection Initiative; Mark Coffey, Catholic Charities; Chris Manning, Delaware Health Information Network; Frank DeMarinis, Emeritis Senior Living; Carol Lovett, Consumer; Dr. Karen Tanner; DPC; Andrea Wozny, DSAAPD; Victor Orija, DSAAPD; Pam Williams, Adult Protective Services and Kimberly Wolfe, Governor Bacon Health Center.

1. Call to order

The meeting was called to order at 9:43AM by Brian Posey, DNHRQAC Chairman.

2. Approval of the Minutes of the meeting of:

July 13, 2010 minutes were approved without changes.

3. Old Business/New Business:

DNHRQAC FY 10 Annual Report

The FY 10 Annual Report draft was reviewed by Chairman Posey and distributed to Commission members. Members voted during the meeting and approved without changes. The report will be copied and distributed to Governor, DHSS Cabinet Secretary and Legislators as stated in statue.

DNHRQAC FY 12 Budget

Administrative Office of the Courts has requested a preliminary FY 12 budget to be submitted to Office of Management and Budget. Ms. Bailey submitted the same budget as FY 10 (FY 11 there was a 2.5% salary decrease which was reinstated in July 2010- back into the equation).

Commission Business/Scope Discussion

Ms. Waldron mentioned that DNHRQAC also works with individuals with disabilities, home and community-based services, etc. Her suggestion is to take the focus off nursing

homes and to have the Commission be changed to Long Term Care Continuum Quality Assurance Commission.

Mr. DiPinto added that whether or not health care reform is passed it is contingent on community-based services being available and oversight is needed. He suggested that the Delaware Code be reviewed to make sure community-based services are being addressed and also suggested that hospice services be reviewed or used as benchmark since they have provided services in the community for quite some time.

Mr. DiPinto furthered that should the Commission want to explore the above, he suggested that a sub-committee be formed to figure out what the path would be best in moving in to that direction. Both Mr. DiPinto and Ms. Waldron stated they would be willing to serve on such a sub-committee.

Ms. Gallagher shared her experience with being transitioned into the community from a LTC facility and a recent incident that occurred in her home.

Chairman Posey mentioned over the years that increased demographics that point to an explosion, particularly in Delaware, is a focal point in which services need to be addressed to maintain daily living and provide assistance for individuals to remain as independent as possible.

Mr. Posey added that in Delaware there is recognition that options be available for independence as well as how to cope with increasing numbers and budget pressures (private pay versus Medicaid/Medicare).

Mr. Posey suggested that the Governors Commission for Community-Based Alternatives be invited to speak at the November 2010 DNHRQAC meeting.

4. Discussion of:

<u>Resident Council Meetings</u>

Laura Hendrick, Social Services Administrator at Emily P. Bissell Hospital spoke to the Commission regarding monthly Resident Council meetings held at the LTC facility. Ms. Hendrick mentioned that 13-20 residents usually attend the Resident Council monthly meetings.

Resident Council is one of the resident's rights that appear in the Delaware Code. EBH has a president and secretary who facilitate the monthly meetings. The two appointments are voted upon yearly by their peers.

The Resident Council must send out invitations to staff or others if the residents want them to attend a meeting. The staff provides record keeping of the meetings and are told by the council what they would like to have appear on the agenda.

During an annual LTC facility inspection, surveyors check to see whether Resident Council meetings occurred and request a copy of the last six months of meeting minutes.

Old meeting business is tracked to make sure that identified issues have been followed-up. Issues and concerns addressed at the Resident Council meetings are also discussed at the facilities Quality Improvement meetings.

Dietary concerns tend to be brought up by residents and discussed during each Resident Council meeting. A dietary assistant meets often with residents to discuss the quality of food and issues to improve service. As a result, EPB has seen a reduction in dietary complaints.

Staffing concerns are also frequently brought up during the meetings. As a result, the staff often provides hiring updates to residents during the meetings.

All residents that attend the Resident Council meetings are asked individually if they would like to comment about an issue or concern. In addition, the Council's president asks each facility department head if they have facility updates or items to discuss such as projects- i.e.…elevator repairs, painting, etc. The council also invites presenters-like MFP or DART, to name a few.

The meetings are listed on the facilities activities calendar so all residents are aware of when the meetings occur.

The Resident Council is involved with developing social programs, bringing in outside visitors, supplying requests for entertainment, etc.

Should a group or organization want to present to the Resident Council, please contact Laura Hendrick or the EPB Social Services Department at (302)995-8400.

Ms. Gallagher asked how staff helps to ease residents so they can discuss their concerns without thoughts of potential retaliation. Ms. Hendrick shared that the population of residents at Bissell is a lot younger (majority between 40-55 years of age), a lot more alert, confident and oriented as to where they live. There is longevity in the residents at EPB-therefore they know the other residents and staff so they can share their concerns more freely.

Chairman Posey asked whether the residents are aware they can discuss issues and concerns during a Resident Council meeting without staff present. Ms. Hendrick mentioned that although not all residents are aware, the staff reminds the residents that they are able to speak at meetings about concerns without staff present should they choose to do so.

Chairman Posey asked whether the Ombudsman's Office has a database of the Resident Council presidents to contact and share information. Mr. Orija added that the Ombudsman have facility assignments and can only attend the Resident Council meetings if invited.

Ms. Engelhardt asked if the staff is invited to the Resident Council meetings each month or is it expected that they attend the meetings. Ms. Hendricks shared that staff attends the

meetings monthly, unless told not to come. Ms. Waldron added that offering the residents a chance to speak alone or with staff present to address issues or concerns is a good blend.

Ms. Gallagher suggested that facilities offer a one-on-one opportunity to have residents address concerns if they need to speak in a smaller setting. Chairman Posey agreed and suggested that perhaps the Ombudsman's Office help to facilitate awareness to the council presidents that not all residents want to speak in a group setting and therefore other arrangements could be made to help that person feel more comfortable in a smaller group.

Medicaid Fraud Control Unit

Tina Showalter, Esquire, Director MFCU, presented to DNHRQAC members. Ms. Showalter was appointed Director of the Medicaid Fraud in March 2010. Prior, Ms. Showalter spent 20 years as a criminal prosecutor and was unit director for domestic violence, family court, and felony trial. She was also appointed as chief prosecutor in Kent County for three years.

Due to the aging population, and the fact there are many vulnerable individuals in Delaware, Ms. Showalter is honored to continue as an advocate.

Ms. Showalter shared that it's important to figure out how the health care reform bill can be utilized to enhance services for individuals needing medical care as well as keeping in mind quality of life as they age.

MFCU investigates and prosecutes cases that meet criminal culpability involving patient abuse, neglect and financial exploitation for individuals that reside in licensed nursing homes, assisted living facilities, and group homes. The unit also performs Medicaid fraud investigations. Since March 2010, Ms. White screened 80-90 referrals from DLTCRP's investigation unit. If the referral is egregious in nature, the referral will be sent immediately. If not, it might be a few weeks or months before MFCU receives the referral from DLTCRP.

There is a Memorandum of Understanding between DLTCRP, law enforcement and MFCU whereby MFCU is to receive a referral immediately in certain circumstances-death (not due to degenerative disease or natural causes), sexual allegations, or hospitalization as a result of an incident.

MFCU is seeing an exponential increase regarding Medicaid fraud because of an increase in individuals entering home health care services or facilities. MFCU provides educational training in licensed facilities.

Ms. Waldron mentioned that Delaware Health Care Facilities Association (DHCFA) shares MFCU's training information to members via their newsletter. A concern Ms. Waldron shared with Ms. Showalter is that as the state moves into home and community based services, how are we as a society (in DE) going to be able to ensure that those folks are not exploited financially, abused or neglected.

Ms. Pam Williams added that perhaps there should be a year follow-up provided for individuals transitioned back into the community from nursing homes. Ms. Waldron suggested that some of the funds received for Money Follows the Person (MFP) or the Adults with Disabilities Resource Center (ADRC) be used to follow-up on individuals transitioned back into the community. Ms. Waldron also suggested an incident referral system be put in place for individuals who receive services in the community.

Ms. Wozny, Nursing Home Transition Administrator with the Division of Aging, shared that technical coordinators are assigned to each individual. The technical coordinators are contracted from Jewish Family Services or United Cerebral Palsy who in turn follow the individuals for a year as they enter the community. The interaction with the coordinators is a face-to-face two visits a week interaction for a period of a year. In addition, after the MFP transition closes, under the Medicaid waiver, a Medicaid RN and Medicaid case manager follow the client forever.

Per Chairman Posey: the cost for a years worth of waiver services is $16,000 versus $81,000 for Medicaid.

Ms. Wozny added that initially technical coordinators form a relationship with individuals considering a transition out to the community. An assessment is completed by a Medicaid RN and circle of friends is set up for the individual in the community as a resource (both family members and friends).

Senior Protection Initiative/Elder Abuse Unit

Marsha White, Esquire, DOJ, spoke regarding her role with the Senior Protection Initiative. In addition to prosecuting criminal cases in the family division for victims of domestic violence, Ms. White also prosecutes those who perpetrate crimes against the elderly and vulnerable and is an advocate.

The Attorney General's Office began an initiative in 2008 to combat elder abuse and created a specialized unit of investigators-it is headed by Ms. White and called the Senior Protection Initiative.

If Medicaid funds are involved for neglect, abuse or financial exploitation, the prosecution of those cases would be carried out by MFCU. If Medicaid is not a factor in a situation regarding abuse, neglect or financial exploitation, the case for an elderly or disable person would be investigated and prosecuted by the criminal division of the Attorney General's Office; particularly in the family unit.

In addition, the Senior Protection Initiative was created and includes: law enforcement, social workers, nurse gerontologists, APS, DLTCRP, National Center for Elder Abuse, Criminal Justice Council and other state agencies, to name a few members.

The Senior Protection Initiative's goal is to be proactive about issues in the community regarding abuse, neglect and financial exploitation. Awareness is the primary key issue.

In the past two years the group has accomplished: two law enforcement trainings (for first time responders); MOU between APS, DOJ and all law enforcement agencies; World Elder Abuse Awareness (yearly on June 15th); Vulnerable Adult Statue; public awareness; 24-hour APS hotline (began July 2010); and discussions surrounding a senior shelter, to name a few.

The Elder Justice Act has set aside funds to work on promoting and combating elder abuse, neglect and financial exploitation.

Ms. White (NCC) has enlisted the help of a prosecutor in Kent and Sussex counties to review specifically and prosecute cases regarding abuse, neglect or financial exploitation. In addition, there are two DOJ investigators who assist law enforcement with subpoenas and investigate neglect and abuse cases. Ms. White has been informed recently that a grant will fund a full-time social worker position and filled within the next month.

The more difficult cases Ms. White has prosecuted involves financial exploitation- paper trails, subpoenas, etc. Cases involving abuse are pretty straight forward-bruising or broken bones. Neglect cases where individuals are left to lie in their own excrement or bed sores, is slightly difficult to prosecute.

This past year, Judge DelPesco and Ms. White worked together to create a new statue for Delaware called "Crimes Against a Vulnerable Adult". In Title 31 (APS) there are violations against someone who creates a crime to an infirmed person but did not include crimes against a vulnerable adult. The Governor signed the bill July 17, 2010 at the MOT Senior Center.

Ms. Waldron suggested that DOJ and other state agencies work with phone companies to identify vulnerable and infirmed adults and provide them with useful service phone messages. Ms. Gallagher added that DOJ may want to consider adaptive devices as a means of providing assistance, too.

Chairman Posy asked what the difference is regarding self-reported verses against family members or others. Ms. White stated that the majority of the time the report comes from a family member. She added that there are multiple reasons why a person does not self-report: fear, embarrassment, doesn't know, etc.

Delaware Health Information Network (DHIN)

Chris Manning, Director of External Affairs for DHIN, spoke to Commission members about the benefits of being part of the network. Delaware is the first state to have an operational state-wide health information system.

Delaware Health Information Network was created by statute in 1997. The program went live in 2007 with Christiana Care, Beebe Medical and Bay Health along with Lab Corp. DHIN then added the capability of searching historical data through clinical information for patients. In addition to being an electronic post office, the system also provided the ability to search for a patient of theirs clinical history. 2009 Quest Diagnostic and Doctors Pathology Services were added as data senders. St. Francis Hospital will be "live" the end of September 2010.

Currently, 80-90% of all hospital encounters are sent through DHIN which includes: lab results, pathology reports, radiology findings, hospital information (admissions, discharges and transfers) and transcribed reports (data type). DHIN eliminates faxes, couriers, snail mail and other traditional means of clinical information delivery. It also standardizes the format so each provider does not have to try and decipher another's format of information.

DHIN is a secure system for delivering patient information from hospitals, labs and radiology facilities directly to the doctor's office. The network provides doctors with a fast, efficient delivery system to receive information securely as soon as it is available and in a standard format. DHIN is available at no cost to medical practices.

There are LTC providers (less than five) that are senders or receivers of information under DHIN. It helps residents who are being admitted to a nursing home or assisted living facility by allowing electronic medical records to follow the person. This could improve the quality of care by allowing additional access that was not available beforehand.

DHIN's contact information: email- Info@DHIN.org, web-www.DHIN.org or call-(302)678-0220.

DHIN has a clinical and consumer advisory group as well as a continuum of care work group.

The group is most excited about a new feature of being able to generate and share continuity of care documents- to summarize information about an individual in one document. The information captured includes: hospital encounter history, problems, medications, allergies, and physician providers.

Ms. Engelhardt asked how DHIN addresses HIPAA. Mr. Manning shared that when a provider signs up to receive information, they only receive information addressed to them. If using the patient search function, the first level of information that can be accessed is information regarding their patients for which they have been copied on only. Should a provider want additional information from another provider, one must "break glass" by identifying their relationship to the patient which is then tracked and audited.

DHIN's funding is comprised of: 1/3 state (bond bill), 1/3 Federal (recently health information exchange cooperative agreements) and 1/3 stakeholders (hospitals and labs).

DHIN moved in FY 12 under Delaware Health and Social Services (previously under another state agency). There was also a statutory change recently and as a result, in January 2011, DHIN will be an independent non-profit public private corporation.

Ms. Showalter asked whether DHIN has been approached about the prescription monitoring program, Mr. Manning stated that DHIN has been approached and piloted a medication history function in Spring 2010 that permitted users to click on a link and pull down 12 months of filled prescription history on an individual. The capacity is available there to be able to provide prescription information but the conversations have not matured to any point further.

Catholic Charities Counseling Services

Mark Coffey, M .Ed, CADC, LCDP, presented to DNHRQAC members regarding Catholic Charities (CC) Counseling Services.

CC offers counseling services to individuals with mental health issues such as depression and anxiety, as well as work on substance abuse and behavioral issues.

Catholic Charities provides counseling services to anyone regardless of their ability to pay, however does accept most third party insurances, as well as Medicare and Medicaid. If there isn't any insurance, a sliding fee scale is used to make counseling affordable. 1/3 of the counseling service clients do not have insurance so they are charged a very nominal fee.

Currently there are nine full-time therapists (paid and licensed) throughout Delaware that provide counseling services.

Presently there are two LTC facilities downstate (Methodist Manor and Seaford House) which Catholic Charities provides counseling services on-site weekly.

Catholic Charities is hoping to expand counseling services in New Castle County.

Chairman Posey asked whether CC would consider contracting with LTC facilities to come in and provide on-site counseling services. Dr. Coffey shared that Catholic Charities does have the ability to enter in to a contracted in-house counseling service agreement.

As a follow-up, Chairman Posey asked whether there is a certain level of acuity that best served by Catholic Charities staff versus that of a Delaware Psychiatric Center (DPC) therapist. Dr. Coffey mentioned that an individual's acuity level can change and therefore assessment is important to determine the more suitable treatment plan needed for an individual.

Catholic Charities Counseling Services: (302)655-9624

5. Public Comment

Residents Rights Rally

Victor Orija, State Ombudsman, shared that the Residents Rights Rally will be held October 5, 2010 from 1-3 p.m. at the Dover Sheraton. All facilities were notified about the event and encouraged to attend the yearly event. Residents Rights week is also recognized yearly during the second week of October. This year's Residents Rights week is October 3-10th. The number of residents that attend each year is 150-200. The Attorney General will be speaking at the event. All Commission members were invited to attend. Flyers were also distributed to all the facilities so they may participate.

6. Next meeting will be **Tuesday, November 9, 2010** at 9:30 AM. The location:

   Emily P. Bissell Hospital
   3000 Newport Gap Pike
   2nd floor conference room
   Wilmington, DE 19808

7. Adjournment

The meeting was adjourned at 12:16 PM by Chairman Posey.

Attachments: Meeting agenda
July 13, 2010 DNHRQC meeting minutes draft
Residents Rights Rally brochure
Dept of Justice- Elder Abuse, Neglect and Financial Exploitation brochure
DHIN brochure
Catholic Charities- Counseling Services brochure