DELAWARE NURSING HOME RESIDENTS QUALITY ASSURANCE COMMISSION
Herman Holloway Senior Campus
Main Bldg, Room 198
1901 N. DuPont Highway
New Castle, Delaware 19720
FINAL
Meeting of January 13, 2009
Minutes

Commission Members Present: Brian L. Posey, Chairman; Yrene E. Waldron; Karen E. Gallagher; Patricia C. Engelhardt; Holly Rolt; M/Sgt Walter Ferris; Lisa Furber; Vicki L. Givens; Joe DiPinto and Wayne A. Smith.

Commission Member Absent: Senator Robert I. Marshall.

Others present: Margaret Bailey; Tom Murray, Deputy Director DLTCRP; Candace Brothers, Aid to Ms. Gallagher; Lisa Zimmerman, Chief of Operations DMMA; Rosanne Mahaney, Deputy Director of DMMA; Jay Lynch, Communications Director for DHSS; Victor Orija, State Ombudsman; Pete Feliceangeli, DOJ; Carol Lovett, Advocate; Sherri Harmer, Court of Chancery; Dan Miller, Director Medicaid Fraud Control Unit; Mary Rodger, Quality Insights of Delaware; Geraldine Neil-Stewart, DHCI; Dr. Cheryl Bolinger, DHCI Medical Director; and Libby Zurkow, Consumer.

1. Call to order

The meeting was called to order at 9:34 AM by Brian Posey, DNHRQAC Chairman. Mr. Posey welcomed Lisa Furber as the newest DNHRQAC member. Ms. Furber is a Paralegal with Community Legal Aid Society, Inc. She works closely with monitoring LTC abuse and neglect at Dover Behavioral Health System.

Approval of the Minutes of the meeting of:

September 9, 2008 and November 18, 2008 were voted upon and approved without changes to the draft.

2. Discussion of:

Medicaid Fraud Control Unit- Dan Miller, Director

It was decided that Mr. Miller would provide an overview of the Medicaid Fraud Unit to the Commission. The unit polices the Medicaid budget for fraudulent activity. The unit: receives referrals, investigates and prosecutes the cases. The policing includes any health care facility in Delaware that receives Medicaid money. MFCU investigates and criminally prosecutes instances that arise in nursing homes, assisted living facilities, hospital's, and group homes.

Referral's to MFCU come from several entities: DLTCRP, facilities, and other agencies. The MFCU Chief Investigator receives referrals and makes recommendations to MFCU Director based on solvability and resources. The MFCU Director then makes the final determination based on the number of active cases, current workload and merit or lack thereof with the referral.

DLTCRP performs administrative review; and if abuse, neglect or financial exploitation is substantiated, the referral is then forwarded to MFCU to determine whether the case merits criminal investigation.

The Medicaid Fraud Control Unit has 4 prosecutors (Deputy Attorney General's), 8 investigators, a paralegal and 2 support staff.

Mr. Miller stated that often the victim of the crime cannot speak to the alleged abuse or neglect. He furthered that MFCU does not marshal statistics as a measure of how great things are but would rather make sure that the unit has an adequate referral network.

Medicaid Fraud Control Unit is federally funded. They prepare an annual report to their federal oversight agency which includes calendar year statistics.

Mr. Miller summarized his opinion for calendar year 2008- there were more referral's than ever submitted in the past. The level of allegations for 2008 was lesser than in the past.

Referrals are tracked per facility. They look to see if a facility is performing poorly in the survey process and number of referrals received will spark the unit to be more apt to open an investigation even if the solvability factors are less.

The Department of Justice will be rolling out their 2008 calendar year annual report in early February 2009. The information will be available on the DOJ website.

MFCA has a duel demand- prosecute criminal neglect, abuse and financial exploitation in nursing homes and to make sure Medicaid dollars are spent wisely.

Ms. Waldron asked what criteria(s) are used to determine criminal conduct versus human error. Mr. Miller stated that if an individual made a mistake, they will not be prosecuted. He furthered that if someone is radically departing from the standard of care and consistently making major mistakes by acting recklessly that could cause serious injury, Medicaid Fraud Control Unit will investigate.

Ms. Waldron asked about billing errors. Mr. Miller offered that the threshold is different in the civil context. Providers have signed agreements that state they will not request reimbursement unless they provide a service. The agreement certifies they are providing the service when they sign the bill.

In billing, there are civil (preponderance of evidence) and criminal (beyond reasonable doubt) conducts that could be investigated.

Ms. Bailey asked whether MFCU would investigate other State agencies. Mr. Miller shared that in contractual situations, the unit would not pursue a civil case against an agency because the contract is between the agency and the facility. Should MFCU see criminal conduct, they would prosecute the agency.

MFCU has jurisdiction to investigate and prosecute any entity that submits a request for reimbursement to Medicaid. The also have jurisdiction for any health care facility that cares for anyone that is on Medicaid.

MS. Engelhardt asked whether OIG (Office of the Inspector General) would prosecute home health care agencies. Mr. Miller mentioned that MFCU would more than likely investigate because OIG doesn't have the support staff.

Mr. Smith asked what level coordination is there between various state and federal agencies in the investigations. Mr. Miller stated that many federal entities are paid to review claims and therefore there could be some overlap.

MFCU does not have as much oversight for a managed care entity as they would for a fee for service entity. The fee for service entities submit a request for reimbursement to the Medicaid program, where a managed care environment it often layered.

MFCU takes referral's straight out of the newspaper, too, but often have already received a referral before it appears in the newspaper.

If Medicaid monies are recovered by MFCU, 50% of it is returned to the Medicaid Program in a form of a check. Ms. Waldron mentioned that she believes the percentage is now 53%. The remaining monies go to the General Fund also in a form of a check. The only instance that monies do not go to the Medicaid Program or General Fund is when there might be investigative costs (example- paying a vendor to copy or create an image for a large volume of documents).

Mr. DiPinto clarified that the Medicaid Program involves state contributions that are allocated through the General Fund. There isn't a recovery fund.

Bariatric Residents- Dr. Cheryl Bolinger, DHCI

Dr. Bolinger has been the medical director for the State LTC centers for the past year. The facilities include: Delaware Hospital for the Chronically Ill, Emily Bissell and Governor Bacon.

Dr. Bollinger came to speak in particular regarding bariatric patients, which aren't something new. DHCI had a bariatric resident for 20 years whose weight ranged 350-500 lbs.

There are three rooms at DHCI that have double-door entrances which permit movement of large beds, lift systems, whirlpool bath tubs and other equipment.

Dr. Bolinger is very thankful that DHCI has an adaptive equipment unit which works to locate equipment to meet the needs of the residents.

Dr. Bolinger informed members of the Commission that the facility is no longer able to order electric wheel chairs for LTC residents. Rosanne Mahaney, Deputy Director for DMMA, will check further as to the above directive.

February 2008, DHCI admitted a 51 year old resident who weighed 474 lbs. The resident was able to stand and pivot into a wheel chair. The resident developed rapid weight gain which the cause was not able to be identified thus far. The resident currently weighs 653 lbs.

The resident uses C-Pap for breathing and is confined to bed. Her goal upon admission was to go home. She has skin folds and the skin is splitting open.

DHCI has reached out to many other LTC providers without success and is not sure where to go at this point. It requires 4-7 staff members to provide this resident her daily care.

Bathing care has seized for this resident because there isn't a bath tub to accommodate her. The resident is no longer able to be placed in a wheel chair. DHCI spent $13,000 on a bed to hold up to 1,000 lbs. A custom wheel chair was purchased for $5,000-one that she has outgrown. Additional bariatric bed pans, commodes, lift pads, an over the bed lift ($5,000), and shuttle chair ($3,000) were also purchased.

Care issues: patient is a wake, alert and sensitive to her condition, transportation is almost impossible, outreach has net zero results, and CPR is not an option in bed. The facility is working with the Smyrna Fire Department and EMS squad to make arrangements to move the resident.

The resident has been in Christiana Care and Bay Health. Testing is limited plus inconclusive due to body mass and hospital surgical suites cannot accommodate her.

DHCI has reached outside Delaware to see if another State may be able to assist this Medicaid resident.

Chairman Posey asked whether DHCI has contacted Delaware's Medicaid Office to see what help they could provide or facilitate regarding other states. Dr. Bolinger stated that DHCI is completing the paperwork for Cleveland Clinic and a facility in Rock Island, Illinois and then will submit the paper work to Delaware's Medicaid Office.

The facility is concerned about transporting the resident to another facility far away. Dr. Bolinger shared that there are facilities in NY that work with bariatric issues, but do not accept Medicaid, only private insurance.

Ms. Engelhardt asked if the resident has a caring and supportive family. Dr. Bolinger stated that depression regarding the resident's family members also creates a barrier for her. The resident is oriented and competent of making her own medical decisions.

Master Sergeant Ferris asked whether DHCI has contacted St. Francis Hospital in Wilmington noting that they had a patient that weighed 700 lbs. Dr. Bolinger stated that they have not contacted St. Francis. Mr. Smith offered that St. Francis Hospital was the first center in bariatric excellence in Delaware. It was recommended that DHCI contact St. Francis Hospital before exploring out of state facilities.

Ms. Waldron mentioned that there are many bariatric issues throughout the State of Delaware and across the country. She asked whether this resident has been evaluated by a Psychiatrist noting that individuals tend to sooth themselves sometimes with food. Ms. Waldron suggested that a wing be set aside in a facility for bariatric care to handle gastric by-pass surgery and psychiatric healing.

Ms. Waldron asked why the resident did not have the bariatric surgery when she was at 400 lbs. Dr. Bolinger offered that this DHCI resident had gone to be evaluated however was not compliant and did not complete all the pre-operative requirements.

Ms. Bailey provided a January 7, 2009 CMS Report that lists US Bariatric Facilities. The report does not explain what factors were used to compile the list of facilities. Ms. Bailey will forward the report to Dr. Bolinger.

Ms. Waldron asked whether psychiatric medications as well as active counseling are occurring for this resident. Dr. Bolinger stated that psychiatric medications have been modified recently and that a geriatric psyche team meets with the resident.

Mr. Orija, State Ombudsman, offered that patient's rights come into play with concerns such as bariatric issues.

Dr. Hundle from the Endocrine Unit at Christiana Care came this morning to see the patient at DHCI.

DMMA- Rosanne Mahaney, DMMA Deputy Director

Ms. Mahaney mentioned that there are "newly implemented" Medicaid Programs and one that the Division was able to roll out in FY 09 despite the current fiscal environment.

A. Money Follows the Person Program- 5.3 million dollar federal grant from CMS designed to help transition individuals from Delaware institutions to the community. This is a State matched program with 75% State matched for services; therefore the State puts in the remaining 25% for services received. The grant is for 5 years and the program received federal approval June 2008. To date, three individuals in NCC facilities have transitioned to the community. This is not a Medicaid qualifying program. This is a wrap around program for the first year while the individual transitions into the community. Once the individual leaves the facility, they will be entered into one of the Medicaid Home and Community Based Waiver Programs. The three NCC individual's went into

the Elderly and Disabled Home and Community Based Waiver Program which is operated by the Division of Aging and Adults with Physical Disabilities. Under this waiver program, there is a budget neutrality factor, where in the aggregate, it must cost less for all of the individuals under the waiver program to live in the community than it would be to serve those individuals in a facility.

Mr. Smith asked if the 5 year grant is not renewed, will the individual's have to be re-institutionalized. Ms. Mahaney shared that the program was designed to rebalance the Medicaid Program so the services for Money Follows the Person recipients will remain on an ongoing basis. The expectation is to serve 100 individuals in the program over 5 years.

Ms. Waldron mentioned that a 1/5/09 article was published that discussed that States may not have the infrastructure to support a potential increase in home and community-based services, according to the Congressional Budget Office. The agency released a report highlighting the projected costs and ramifications of more than 100 healthcare policies, including many proposed for LTC. Ms. Waldron will forward the article to Ms. Bailey to share with other commission members.

B. Medicaid Buy-In Program- A Medicaid qualifying program offering Medical Assistance for disabled workers. The intent is to assist individuals that work and make too much money to receive Medicaid services. It allows individuals to buy in to Medicaid by paying a monthly premium so they can continue to receive medical services and work, too. This program is funded through the General Fund and is federally matched. It is anticipated to service 100-150 individuals.

C. Medical Assistance during transition to Medicare (MAAP)-existing Medicaid Program that was expanded FY 09. This program was originally designed to assist Supplemental Security Income (SSI) recipients who loose their eligibility for SSI because they begin receiving SSI Disability. SSI recipients automatically qualify for Medicaid. The MAAP Program bridges the gap to provide individuals Medicaid until Medicare begins. The program was originally just for SSI recipients but the program was expanded in FY 09 to serve anyone who receives Medicaid under any Medicaid qualifying program.

Ms. Zimmerman shared that the Division set up a State-wide (intake) Pre-Admission's Screening Unit: (800) 940-8963. The unit can be reached Monday-Friday 8:00 AM-4:30 PM for Long Term Care Medicaid help.

5 Star Nursing Home Report-Mary Rodger, Quality Insights of Delaware

Ms. Rodger presented to the Commission the new 5-Star Nursing Home Report that appears on the CMS website. The report was designed to assist residents and families in making distinctions between high and low nursing homes. The second goal was to stimulate nursing homes to improve quality.

The report is based on the best, most available data. The system has an overall 5 star rating system (5 being the best possible). The annual state survey which includes health inspection for the past three years and last 36 months of substantiated complaint survey's

is used to compile data in the report. The state survey is weighed- most recent survey accounts for half, the previous 1/3 and the 3rd year back is factored at 1/6th.

Number scoring is used regarding health inspection surveys related to scope and severity. Points are added as the scope and severity increases. There are additional points accumulated if a scope/severity "F" tag appears as a result of sub-standard care in the quality of life section. Penalty points are assigned for this instance.

Finally, if any repeat visits are required to clear a deficiency for an "F" tag or above, the regulations require the service agency return. Penalty points are assigned in this instance, too.

The first visit, no points are assigned- 50 points assigned for 2nd visit, 75 pints for 3rd, and 100 points for the 4th. The CMS rational is simply put-NH's that cannot clear deficiencies within 1 visit appear to have problems with quality of care being provided to their residents

The base calculation has to do with the last 3 years of health surveys, weighted heavily on the last year.

Step 2, stars can be added or subtracted based upon facilities staffing numbers. The staffing calculation is very complex. The staffing measure uses 2 calculations- RN hours per resident day and total nursing (RN, LPN and CNA) staff hours, but heavily weighed towards RN's. The RN plus total staffing measure are equal and combined to form the staffing numbers. The numbers are derived from OSCAR data, which is directly inputted by facilities to the State survey agencies. Its case mixed and adjusted based on the RUGS category (Residents Utilization Groups) related to morbidity, acuity, other complex factors with rehab and a potential for improvement. The staffing measure can only have 2 stars added or one star removed from the base survey measure.

Ms. Waldron mentioned that the case mix adjustment has to do with Medicare acuity and that high level of Medicare acuity will not necessary be captured by the case adjustment.

Ms. Rogers offered that there is a risk adjustment for Medicaid under the third domain-quality measures. There have been concerns that facilities which admit residents with higher morbidities may be disadvantaged by this system. There is an attempt to offset this by weighing the ADL decline measures heavily for chronic care residents. For quality measures, a star can only be added if you have 5 stars already and only one star added if it is a 1 star facility. A facility would need to have a big decline in ADL's or have quality measures in the negative zone to not receive a good score in this area.

Ms. Rolt commented that the average person who accesses this new rating system they might not be able to comprehend the technical aspects that were used to develop it. Ms. Waldron shared that DE Health Care Facilities Associate and Quality Insights of Delaware are putting together a program for providers in February 2009 that will walk through the technical manual.

Ms. Waldron published an article recently in the Delaware State News about the 5 star rating system.

Ms. Rodger shared that the CMS website is updated monthly. A state survey being performed at another facility could affect another facilities rating. The results are based on quintiles where the top 10% of Delaware nursing homes can start with 5 stars in their health survey at a given time. Stars can be added by staffing and quality measures to make a facility 5 stars overall.

Ms. Waldron voiced concern for facilities that received one star due because they accepted higher acuity leveled residents. Resident's that no other facility would accept. She furthered that she would not be surprised if those providers revamped their admissions policy and looked closer at resident's acuities beforehand.

Mr. Posey added that CMS's website provides the 5 star rating system but also encourages families to visit facilities, ask around, etc before making a decision as to a particular facility.

QART Report- Tom Murray, DLTCRP Deputy Director

Mr. Murray presented the Quality Assurance Review Team's fourth quarter 2008 results to the Commission. There were twenty-four surveys; six "G" level citations reviewed during this time frame and one "G" level was downgraded by the QART Team to a "D" level.

Ms. Bailey also distributed a cumulative 2008 calendar year report that reflected "G" level citations reviewed by QART. In 2008, there were 34 "G" level citations and of those, 7 "G" level deficiencies were downgraded.

3. Old Business/New Business:

DNHRQAC Personnel Sub-Committee

Chairman Posey stated that he will be in touch with DNHRQAC Personnel sub-committee members to schedule another meeting. There was a conference call with the Personnel Sub-Committee two months ago that was fruitful. Updates will be provided to the Commission at the March 2009 meeting.

Ms. Gallagher attended a Community Based Alternatives for Persons with Disabilities meeting December 2008 to address DART Para Transit concerns. Information was presented at that meeting regarding Ms. Gallagher's personal experience with Para Transit. After the December 2008 Community Based Alternatives for Person's with Disabilities meeting, Ms. Gallagher was given use of a van to provide her transportation.

DART will be attending the DNHRQAC March 2009 meeting. Commission members and the public were asked to submit questions they want DART to address at the meeting to Ms. Bailey.

Ms. Gallagher will continue to advocate for DART Para Transit riders.

5. Public Comment

Libby Zurkow, consumer, mentioned to the commission that she is involved with the Academy of Life-Long Learning at the University Delaware. There will be a program offered spring 2009 to discuss independent verses skilled living, advanced directives, and more. The program will include speakers from hospice, visiting nurses, social services and others to share with participant's useful information during a transitional phase in life.

Ms. Zurkow distributed her business card and invited commission members to contact her if they are interested in participating or have topics that should be explored.

6. Next meeting will be **Tuesday, March 10, 2009** at 9:30 AM. The location:

   Emily P. Bissell Hospital
   3000 Newport Gap Pike
   2nd floor conference room
   Wilmington, DE 19808
   Switchboard: (302)995-8400

7. Adjournment

The meeting was adjourned at 12:00 PM by Chairman, Brian Posey.