DELAWARE NURSING HOME RESIDENTS QUALITY ASSURANCE COMMISSION
Herman M. Holloway, Sr. Campus – Room 301
1901 N. DuPont Highway, New Castle, DE

Meeting of March 14, 2006

MINUTES

Commission Members Present: Patricia C. Engelhardt; Vicki L. Givens; Joseph M. Letnaunchyn; Sen. Robert I. Marshall; Rep. Pamela S. Maier; Thomas P. McGonigle, Esq. (Chairman); Brian L. Posey; Yrene E. Waldron

Commission Members Absent: Walter E. Ferris; Karen E. Gallagher

Others Present: Steve Autman (Consumer); Carol Lovett (Consumer); Victor Orija, Senior Social Services Administrator (Division of Services for Aging and Adults with Physical Disabilities DHSS); Mary Rodger, Project Coordinator for Nursing Homes (Quality Insights of Delaware); Pamela Tyranski, Deputy Director (Division of Medicaid & Medical Assistance DHSS); Lisa Zimmerman (Consumer); Tom Murray, Deputy Director; Mitzi Murphy and Joan Reynolds, Support Staff (Division of Long Term Care Residents Protection DHSS).

1. Call to Order.
The meeting was called to order at 10:00 AM.

2. Approval of the Minutes.
The Minutes of December 13, 2005 were approved as written.

3. Discussion

- Administrative Staff Hiring for DNHRQA Commission

Chairman McGonigle announced that interviews were held. The position was offered to the first and second candidates of choice. Each candidate had issues that prevented her from accepting the job, i.e. salary, city tax, city parking, and commuting. Discussion followed about reclassifying the job to reflect expectations for a paraprofessional position with a commensurate salary for a flexible 30-hour week. Mr. Murray suggested the commission speak with the Office of Management and Budget (formerly the State Personnel Office) about getting the position reclassified and what kind of flexibility the Commission has in terms of casual-seasonal options; repackaging the job description; and the office location. Members were asked to refer to Chairman McGonigle anyone who might be interested in this position.

- Agency Review – Tom McGonigle

Based on articles currently appearing in THE NEWS JOURNAL of alleged activities in a nursing home; the Sunset Committee's current review of the Division of Long Term Care Residents protection; and indictments filed by the Office of Attorney General, Chairman McGonigle asked members if the Commission has a role in the interim to look at these issues from a systemic perspective to see if there are areas in which the Commission or the Division should be or not be involved. He then opened up the floor for discussion.

Ms. Waldron said her personal opinion concerning the indictments that have been filed by the AG's office, is that the Commission should wait until due process has occurred then the Commission may want to get involved in some way. She said there is a need to remember that these are allegations by the AG's office, they have yet to be proven. With regard to the Joint Sunset Committee's current review of DLTCRP it should be a review of the agency not a review of nursing homes. They have been dragged into it by the testimony that has been given. She said that with all due respect given to Senator Marshall, to the Joint Sunset Committee members, to Dianne Roberts and to the families involved, there are different agencies in place in the State that oversee the continuum of oversight. This Commission needs to be careful how and when it becomes involved because until folks are proven guilty they are innocent.

Chairman McGonigle agreed with Ms. Waldron in terms of being careful and he assumes what he has read in the newspaper is reasonably accurate. However, he has some concerns about what that case means in terms of the larger picture and what is being done with monitoring staffing levels. The Attorney General's office will take that case through the process but Chairman McGonigle asked if there are things that the case reveals, that are indicative of larger problems

in terms of how we monitor Eagle's Law, staffing, things like that. He said he was just asking the question and doesn't know the answer.

Ms. Waldron asked how we will know the answer until the case is over. Chairman McGonigle said he thinks that case is about very specific criminal charges involving the nursing home and those individuals. The question he is posing is do we as the Commission, have a roll in seeing whether given those issues which have been raised whether there are larger issues with respect as to how we monitor staffing levels in the State.

Mr. Letnaunchyn said the Division has oversight and the Commission receives reports from the Division on a fairly routine basis about staffing levels and whether they were met or not and where the problem facilities were if there were any. Then the Commission would react from that. For the Commission to conduct a review is not appropriate from the Division's prospective.

Chairman McGonigle agreed that the Commission discussed those reports and how that information is gathered. He said that he hasn't gone back and looked at those reports to see how they match up with what has now resulted in this investigation. He asked what was the report that we saw for that nursing home in terms of staffing levels. Mr. Letnaunchyn said he thinks that's going to be done by the AG office. They are going to compare those reports with what they found. Chairman McGonigle asked if he meant the reports that the Commission got. Mr. Letnaunchyn said he thinks that they are the same reports the AG office will look at. Mr. Posey asked if it is known that the AG office got any different reports. Mr. Letnaunchyn said the Commission is an oversight/advisory board and we got the data from the Division that showed staffing by facilities listed by some identification without knowing which facility. He said that the Commission's job is not to do audits of what the Division staff gave us and then say, "ah, we think you're fabricating the numbers," but it sounds like that's where we are going.

Chairman McGonigle said that he did not suggest that it is where we are going. Mr. Letnaunchyn stated that's a job for the Joint Sunset Committee to review i.e. what the agency is doing. It is the process they are in the middle of now or supposed to be but it's turning into facility reviews. The Chairman said for example, hypothetically, that for whatever reason the reports that were given to the Commission from the agency about this particular home showed that staffing levels were above and beyond what they needed to be and then we find out as a result of this criminal case that in fact that wasn't the case. I'm not saying the Division was falsifying reports but because they don't have the checks and balances maybe that they should have to insure that it doesn't happen. Isn't that our roll to make sure that this quality assurance system that we have here is doing what is should be doing?

Rep. Maier said that she feels it is beyond the numbers, it's the care of the nursing home residents and that's what the Commission should be looking at. She asked if it was not a matter of ratios but a matter of the care, i.e. bedsores, etc.

Ms. Waldron said she didn't think everybody has all the facts. All the facts won't be known until this case is heard and tried. From reading the articles in the newspaper, Ms. Waldron believes the AG is alleging that there is a lot of documentation that is to be done when care is given. Often the care is provided and the documentation is then completed. Ms. Waldron said she hopes there is no facility that is filling in holes that care was given but wasn't provided. If a record was not filled in when the care was given, it should not, after the fact, be filled in but a note should be made that this care was provided but the CNA or nurse did not document it. That's what Ms. Waldron believes this whole case is about from what she reads. She said that what they are trying to do is say if these records were filled in after the fact; they are assuming that care wasn't given. She doesn't think it has been proven whether the care was given or not they might have testimony from some of these nurses. She said it's unknown if they went back and filled some of these holes and if the care was actually given or not. For the Commission to start addressing this before the case is done is ludicrous. Using a palm pilot was suggested and Ms. Waldron said that is being worked upon at National level and LTC needs to get with the program with hospitals. There is care given many times in the hospital setting, outpatient setting, and LTC that is not documented because people have so much to do they forget.

Ms. Givens said that in acute care most documentation is done by exception vs. what is actually done. It is assumed in acute care that unless it is documented, it has been done.

Ms. Waldron said our reporting for LTC is totally opposite from acute care and that CMS is looking to change it. This is a great disconnect. Each nurse or CNA who provides care must document. The system has evolved over time and is very broken. The system that's in place for documentation for LTC is not just used for giving an overview of care provided, it is used for reimbursement. If OBRA '87 had been followed there would be time to do more hands on care. Nurses and staff need to be freed up from all this documentation and go to documentation by exception as it is done in assisted living and acute care. Ms. Waldron again stated that it would be unfair and premature to try to determine what the Commission should do until this case is heard.

Sen. Marshall said the Commission's role regarding the review of the Joint Sunset Committee would be for the Chairman or a Commission member to attend the Public Hearing on April 12, and comment in support of the mission of the Division and the role of the Commission but not enter into any specific detail. He stated it would be an appropriate public posture for the Commission to take because the issues are complex, wide and deep. He said that on the issue of staffing and the investigation, the AG and the Feds should conduct the appropriate investigation. The Sunset Committee will conduct the review of the accountability of the system. He said that the big issues were identified in 1998-1999 about no accountability, no supervision of CNA's, just a weak system of documentation. He said that we tried to write that with supervisors within the facilities on the floor there would be accountable for services. It was learned there was a patient who walked off the site, left the building, was lost for 5 days and the CNA simply checked off the care plan for the week for those individuals she had under her care. That was an abomination. Sen. Marshall said the level of commitment differs in each facility. Some are outstanding, others have weak leadership management. He said that maybe 15% to 20% of the nurses don't care and 80% are outstanding individuals who are dedicated. There's a critical mass of too many who possibly take the attitude of "let's get the paperwork completed on time" and they are not evaluating bedside care and the reality that it's being provided. Sen. Marshall thinks that the more public discussion, the more valuable it is to improve the system. He thinks the Joint Sunset Committee is attempting to do that and hopefully will have recommendations for the legislature.

Ms. Givens, as a facility administrator said that unfortunately negative publicity makes it impossible to do a good job. It makes some staff members not want to stay in an industry that is constantly being criticized for the few. It makes the rest of staff look bad regardless of whether the motive is good or not, it affects every facility even if it has a good reputation

Sen. Marshall asked if all the self protection and defensive mechanisms are peeled away shouldn't the outlook be positive? When horrific situations are uncovered and made public don't we all benefit long term? When incidents of neglect, abuse and financial exploitation are cleaned up isn't this a positive?

Ms. Waldron said it's all in the approach. She said that as a representative of her profession she believes not all providers are created equal; there are many who need to work on quality issues. If there is any one in the profession who is violating any standards they need to be held accountable by all the agencies that are in place. The agency is only one part of the continuum of agencies that are supervising the care. Ms. Waldron said that she is offended by the approach that Sen. Marshall has taken since 1997. It has been punitive and jugular and it needs to stop because it is driving the best people away from the nursing home profession.

Chairman McGonigle asked Commission members what is their role with respect to some of these larger issues that have been raised. Not necessarily a particular patient and a particular allegation of fraud but there's a criminal indictment and those things get investigated pretty thoroughly before there's an indictment. There's something there that's going to be looked at through the criminal process and the question is should it be looked at by the Commission?

Mr. Letnaunchyn said if the AG finds that there was some problem with the reporting isn't it the Division's job to go back to those reports that show there was adequate staffing and care provided. If those reports were incorrectly filed and the finding by the AG is that, I'm not sure what the Commission's role is. It's the job of the Division to ask if they need to strengthen their procedures to do some other type of review to ensure to the best of their ability that they get information that can't be falsified. The Commission is supposed to be looking at quality and outcome. That's our mission we're not the investigative agency. Mr. Letnaunchyn said he was getting a sense that the Commission is saying that if the AG determines that their findings are substantiated in the reports then we should do something about it.

Sen. Marshall said to Mr. Letnaunchyn that he brought out a very new issue and it relates to the Chairman's concern about the public place that quality assurance commission plays. I'm going back to 2003 when Ms. Ellis in a public meeting indicated that due to a variety of reasons the Division would not support staffing by shift and enforce Eagle's Law. If it somehow plays a role and there's a linkage of the dots and it goes back to the problems regarding understaffing, I don't know, I'm just raising the question, and then the Commission may have a role in speaking publicly, but not now.

Mr. Letnaunchyn said the Commission should not get into the nitty-gritty detail operations. The Commission is supposed to be looking at quality, outcome and oversight of those types of issues. The Sunset Committee is supposed to be looking at the process of the Division. However, Mr. Letnaunchyn said it is straying from what it is supposed to do. They are looking at the role of the Division and the Commission can do that too. If there is a deficiency somewhere between the reports that they get and the reports that they rely on and the AG finds that the reports they relied on were not correct, were falsified, whatever their finding is, then they would probably look at their procedures to ensure how they could get more accurate information and not have any loopholes for false reporting it.

Chairman McGonigle agreed that it is their role. This Commission was structured so that we would also play a role in making sure that gets done in a timely way. This Commission was created to have this oversight responsibility to make sure it would get done. We've been given reports on staffing levels on a fairly regular basis. We've been told staffing levels are very good, exceeding standards with a few exceptions. If it turns out that in reality that was not the case at one facility that we know of, it seems incumbent upon the Commission, not in an accusatory way, to engage the Division to figure out ways to get reliable reports. The Chairman said a criminal case takes 2 years; does the Commission have to wait 2 years to find out if there is a systemic problem in the way results are measured?

Mr. Letnaunchyn said he believes the facilities are reporting on what the legislation and regulations say and that the Division is monitoring compliance based on what the legislation and regulations say. If there is a disconnect there then that issue ought to be looked at but we can't say that if one facility falsified reporting that we have to make the assumption of let's change the system to make sure that nobody else is doing that because then we are accusing others of doing something that we have no right to do and it's not our role.

Chairman McGonigle said he was suggesting if there is a loophole here that exists in the system isn't it the Commission's role to work with the Division to close that hole? Do we have to wait until the end of this investigation to do it? Ms. Waldron asked if this investigation is about staffing or is it about documentation of care that was provided and then later filled in. She said that what she read in the newspaper was very different from what is being said.

Sen. Marshall asked if the Division is enforcing the requirement by shift as described in Eagle's Law. Ms. Waldron said a facility meets the 3.28 as a minimum then follows either phase 1 or phase2 for the ratio. That's what they checked on and documented and that's what the law says. Sen. Marshall said the issue is the Division enforcing staffing ratios by shift?

When the question was asked what is the role of the Commission, Mr. Letnaunchyn said if the findings aren't substantiated at one facility he does not want the Commission to start looking at data and calculations because there may be some other facilities doing incorrect recording. That's the Division's role to look at their process and ask if there is a problem the way data is accepted or the data that is coming into the Division, then they can respond to the Commission. It is premature to try to change a problem or make a problem that doesn't exist. Ms. Waldron said the Commission does not have enough information from the AG office to know what the issues are.

Sen. Marshall said issues like the incident or the charges of indictments only happened because of former employees who were determined to come forward and that triggered the investigation. I don't know that the Division is that aggressive in its survey and review process, annual or complaint survey to seek out and identify issues like those alleged to have occurred. Usually what we're reading about is generated by others; let it come from the nursing home. It doesn't come from the Division, it doesn't even come thru the AG office, it happens through former employees. In a better world the Division and its employees would monitor and enforce. Ms. Waldron asked Mr. Murray how many civil money penalties the Division collected during 2004 and 2005. Mr. Murray answered 26 - 27 different facilities were cited. Ms. Waldron said this shows the Division is doing its job.

Mr. Posey said he would like to review the role of the Commission and what it is chartered to do. Mr. Posey suggested if the Commission is going to review closed cases that we begin doing that now for closed cases that began 2 years ago. He said he feels it is appropriate for the Commission to be having the present dialogue. Ms. Waldron would like to continue having reports from all the entities that have oversight of the facilities. She said once this case is done she would like the Commission to invite Dan Miller, Deputy Attorney General to speak and describe how the case happened, what the AG office thought it had in proof, how things evolved and their recommendations. She said that we cannot lose sight of the fact that there is a process for justice to be meted out.

Chairman McGonigle said his question is does the Commission have some role in the interim to look at this issue from a systemic perspective to see if there are things that we should be doing that we are not doing or the Division should be doing. Why does the Commission have to wait until all that process is over? For example, maybe the members should look at the probable cause warrants that got filed when they did the indictments and see what's in there, see if it helps the members to decide what this case is about. It doesn't have to be an investigation about this particular nursing home. Chairman McGonigle reminded the Commission we had the Division here and we discussed the fact that, in large part, the system is based on self-reporting. It sounds like, for some reason, what was reported did not turn out to be correct.

Ms. Waldron is concerned about the nurses who are involved in the indictment being judged guilty as charged until due process has been completed. Ms. Givens said every one of her employees was affected when the article appeared in the newspaper and on television. She met and reviewed with them all the policies in terms of documentation and she advised them if they ever chose to document falsely that they would lose their jobs. Mr. Posey said it's important to have this conversation and in his opinion, punish the bad facilities, don't defend them if they are found to be guilty, but recognize in some fashion the good work that 75% - 80% of the facilities are giving. He said that amongst all the things that the Commission can do is not only punish the people who have done bad things but we need to protect the nursing home residents who could be affected by bad morale. Sen. Marshall asked to comment on Mr. Posey's thoughts. He said one issue that came up beginning in '98 was that it was learned the CNAs were almost running the floors because of the way the system is set up. They were being required to do all the documentation and paper work. We recommended a change that would create a senior CNA within the system that would allow one CNA on a floor to be elevated, paid more, trained, and provide accountability. Structurally, Sen. Marshall does not think that it was accepted and implemented by the industry. That career ladder never happened. Sen. Marshall stated if this system was implemented there might not be so many problems on the floor with that small percentage who tend to get into mischief. Mr. Letnaunchyn said there will always be a faction in any profession who are slackers. No education, no opportunities will change some people. Mr. Letnaunchyn said that we are trying to find the 2% who are bad and we're trying to extrapolate that and say the industry is bad.

Chairman McGonigle said that is not what this conversation is about. He said the Commission has a responsibility to be overseeing the quality assurance system. Part of that system includes the staffing laws, the ratios, all that gets measured, and making sure there is compliance. His question is, does the Commission have a role now to look and see whether there's a problem along those lines and to work with the Division. We have a continuing role to do that and that requires us to take a look at what some of these allegations are and see whether or not it speaks of larger problems.

Mr. Letnaunchyn said he thinks that is where the disconnect is, he thinks the Commission ought to say it has a continuing ongoing role to monitor the staffing issue and that means it needs to have continuing ongoing dialogue with the Division and their responsibilities to determine how the documentation they are getting and the system being used, can be improved.

Chairman McGonigle said the Commission got reports on a monthly basis that indicated things were going well, staffing levels were being met. There's some suggestion that in this one facility in these news articles that there's a problem. And all I am asking is whether the Commission has an obligation to take a look and make sure that it is not systemic. Is there a problem in the way these things are reviewed? Ms. Waldron said the Commission doesn't know what the problem is. Mr. Letnaunchyn said if the Commission has an ongoing role and responsibility to look at the process, we ought to do that regardless of these accusations. We're tying to fix a problem and we don't know what it is.

Chairman McGonigle said he thinks the Commission ought to look at what ever public documents are on file and take a look at the process by which the Division confirms that staffing levels are being met with an eye toward the allegations whether they are true or not. See if there are holes in the system, something we missed last time we had the conversation. He asked what is the bigger picture, does it work are there problems? Mr. Letnaunchyn said he thinks it is a problem because we are going to take whatever public documents and we're going to say let's look at those allegations and see if there's a problem in the system. What we need to do is look at the reporting system whether by ratio, by week, by day, by shift. Look at that and determine if we have a problem there. He said he hates to look at accusations or allegations, and say let's see if they exist in other facilities, we don't know if they are true or not, they are alleged. Chairman McGonigle said let's assume that there are accusations suggesting that there are holes in the system. The Commission is all ready having a conversation now, not waiting until the end of this investigation. Mr. Letnaunchyn said he doesn't think any of the accusations are the holes in the system. He said if we want to do a systemic review we ought to do it and not because there is an ongoing review by the AG office. Let's determine that we want to do a review of the system, the reporting process, let's do it top down or bottom up but let's forget what the AG is accusing somebody of doing. Chairman McGonigle asked how do we know that there isn't some thing that the Division could be doing to avoid letting the individual do that. That's my point. There is a question that has been raised in a very public way about whether this system that is set up is working as it should. He said he thinks the Commission has a role in looking into that question. He said that it doesn't matter whether we do it in the context of the criminal investigation. I think we need to go back and take another look and make sure that what we thought we had, we had. This Commission got reports that said things were good, staffing levels were being met, people were hitting the ratios, and with very few exceptions, they were all very good reports and maybe that's all true but there is at least a question now as to whether or not it was and maybe it deserves another look by this Commission, that's what I'm suggesting.

Ms. Waldron said the Commission may need to take a full day retreat with the Division, the AG office, the Ombudsman office, the Medicaid office, all the agencies that supervise facilities, that come and review them, that audit them and let's have a little round table as to how they are communicating with each other and are there any loopholes there. Maybe there are loopholes there that need to be fixed. We have everybody coming in our buildings and looking down our charts, looking at everything we do and we welcome it because we have nothing to hide. We are not perfect. Let's get all the entities in Delaware that give us oversight together in one room, give us an overview of what they do and how they communicate with each other. There's an MOU between the Division and the AG office, how is that working? Do we need to fix that a little bit? What is their connection between the Division and the Medicaid office, how is that working? Is there something we've missed? That's something I think is our role. I think it's something that would be very helpful Ms. Waldron concluded.

Sen. Marshall said that same discussion occurred back in 1998 at a public hearing when there were three at a table, an AG representative, an ombudsman, a survey representative, and I raised the question, how often do you meet to communicate on issues relating to nursing home issues and they all looked at each other dumbfounded, never. Then that led to the MOU and hopefully it's opened up a line of communication. Actually it's probably a role that it would take a full year for the Joint Sunset Committee to review.

Ms. Engelhardt suggested that the Commission plan to have a meeting in a nursing home. She said that is what we need to do more than anything else. She said that the Commission has had all those people come to our meetings and nothing came out of it. We need to have a meeting in a nursing home. Mr. Posey asked what was meant by "nothing came out of it". Ms. Engelhardt does not feel that having all the agencies meet together would be as helpful as having individually one group at a time. The Commission could get more information. Ms. Waldron said it would be more helpful to her to hear how all the agencies are talking to each other. It was agreed that the Commission would have a meeting in a nursing home. Suggestions for the meeting included taking a tour after the meeting or a meeting that would include a workshop.

Chairman McGonigle asked members if they were in agreement to take a look at the staffing issue from a global perspective at our next meeting. Mr. Letnaunchyn said he was comfortable with that but he does not want the accusations against the facility as a starting point. He said he thinks it should be done from an overall review of the process.

Previous Minutes that included the reports given by Rob Smith, Licensing and Certification Administrator, DLTCRP, were requested to be e-mailed to members. Chairman McGonigle requested that members track any of the

public documents that are available to see what they say, but not as a basis for the investigation by the Commission but rather to help us conduct a review of this issue from a global perspective. Ms. Waldron said it is important for members to review again what is the process required of the Division by CMS, and State law. What is their process when they go into a facility to do a survey and they check staff? Sen. Marshall suggested redacting the name of a facility for a working model for the discussion of policy and practices. Chairman McGonigle said he cares about all facilities not just the one facility being investigated. He asked if there are lessons to be learned. We are talking about policy and practices not individual cases and facts. That is our role that we need to engage in and be disciplined in our conversations at our next meeting to keep it at that.

Mr. Letnaunchyn suggested the name of the facility be redacted but not include the facility that is being investigated as reported in THE NEWS JOURNAL. If there are 45 facilities to pick from why would the Commission pick the one that is being already being reviewed by the AG office? Sen. Marshall suggested the Commission pick three, redact the names, but have among the three the one. Just to give a balance to see how the Division is doing its work. Ms. Waldron said she did not think the AG office would be happy that this is happening in a public forum.

Ms. Engelhardt requested that if Rob Smith comes to the meeting she would like to see a handout that is Commission Member friendly not a sheet of numbers where some of the things at the top don't even apply to the bottom. Last time we had one sheet of numbers. She would like to see a report that will tell the members something without trying to figure it out.

As an appropriate public posture, Sen. Marshall asked for representation from this Commission at the public hearing on March 15th to make comment in support of the mission of the Division and the role of the DNHRQA Commission.

Legislative and Trends – Yrene Waldron
HB 190 and HB 507
The statute that was passed and ready for regulations to be written had combined Home Health Agencies with Personal Care Service Agencies. There is a need to separate both so the Bills have been put back and regulations will be written that will be better for consumers with regard to Personal Care Agencies.
Nursing Home Board of Examiners – Pending
There has been communication with Chairman McGonigle who wanted to see some changes.
Joint Sunset Committee - Currently reviewing the Division of Long Term Care Residents Protection

Outreach - Pat Engelhardt – Outreach paper is for the Annual Report

- DNHRQA Commission - Subcommittee Reports
  Agency Review Subcommittee - Chair - Tom McGonigle
  Legislative/Regulatory Subcommittee - Chair, Sen. Marshall
  Quality Initiatives Subcommittee - Chairs, Pat Engelhardt, Brian Posey
    Culture Change Position Paper
    Some facilities have in-house satisfaction surveys that would be helpful to see. The Culture Change coalition created a PowerPoint and sent it to CMS where it was well received.
    Friday, April 7, 2006, at 11 PM, ALMOST HOME, a documentary about quality initiatives and person directed care will be shown on PBS. Ms. Waldron volunteered to bring in the DVD of ALMOST HOME to a meeting.

5. Public Comment

Mr. Autman stated many reasons why less documentation in facilities is not a wise idea. If there is no trail of what has occurred with an individual, it could put into further jeopardy the ability of families to pursue correction of mistakes that are not documented or traceable.

All E-mails, requests for information, or questions about DLTCRP that are directed personally to a Commission member, should be referred promptly to that agency for reply. The E-mail address to use is: ircuser@state.de.us.

(complaint & and incident reporting 24 hrs. - 7 days a week). Mr. Murray was asked to have this E-mail address printed on the agency business cards.

Mary Rodger, Project Coordinator for Nursing Homes for Quality Insights (QI) of Delaware, the State Medicare/Medicaid quality improvement organization, requested time to comment on a few of the statements made today. QI has a contract with CMS to bring quality improvement programs to every health care provider in Delaware. Quality of care in nursing homes is a multifaceted issue. Adequate staffing levels are essential but are not the only factor involved in quality of care. Work force retention is an issue. Documentation that is burdensome at the medical record level, the surveyor level, and at the nursing administrator level reduces quality of care. This is an area that should be reviewed. Ms. Rodger said that this particular commission spends the bulk of its time discussing monitoring and investigation. Very few members chose to attend the meeting celebrating nursing home providers who are nationally recognized for their quality improvement work through the CMS initiative. Invitations were issued to every Commission member to attend meetings presenting the CMS corollary, Culture Change. Less than half of the Commission Members attended. Ms. Rodger said that the Commission is reactive by putting emphasis on investigation when it could be powerfully proactive. High quality education, not more investigation will reduce abuse. There are Delaware skilled nursing homes that have volunteered to work for three years on quality improvement through this national program. Data collected from participating homes show a reduction of absenteeism and better retention of the workforce. The 10 pioneering facilities are: Brackenville; Kentmere; Cokesbury Village; Gilpin Hall; Life Care at Lofland Park; Lewes Convalescent Center; Harbor Health Care Center; Delaware Hospital for the Chronically Ill; Green Valley Terrace and Parkview Nursing & Rehab Center. CMS provides national speakers for QI meetings. The Power Point presentation from Gilpin Hall is being used in national training. The Division of Long Term Care Residents Protection has sent multiple representatives to each and every one of QI meetings and appears to be extremely supportive of resident directed care and culture change within skilled nursing facilities in Delaware.

Chairman McGonigle in response to Ms. Rodger's comments said that he does not disagree that the Commission's balance should be a bit different than it has been. However, the Commission was created to ensure those systems are in place and that nothing falls through the cracks. Specifically oversee agencies that have an enforcement role in quality assurance. By definition that is to make sure that there is a certain bottom level of care as opposed to the top level of care. The Commission has been charged by law to make sure those systems are in place and that nothing falls through the cracks.

6. The Next Meeting

Tuesday, April 11, 2006, at 10:00 A.M. DHSS Campus, Main Building, Room 301.

7. Adjournment

The meeting was adjourned at 11:50 AM.

FINAL MINUTES – The March 14, 2006 Minutes were approved as written