

DELAWARE NURSING HOME RESIDENTS QUALITY ASSURANCE
COMMISSION

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

FINAL

Meeting of May 13, 2008
MINUTES

Commission Members Present: Brian L. Posey; Patricia C. Engelhardt; Karen E. Gallagher; Representative Pamela S. Maier; Dr. McKinley Wardlaw; Senator Robert I. Marshall; Yrene Waldron; Thomas P. McGonigle, Esq. (Chairman).

Commission Member(s) Absent: Representative Joseph G. DiPinto; Wayne A. Smith; Vicki L. Givens and M/Sgt. Walter Ferris.

Others Present: Margaret Bailey; Tom Murray, Deputy Director of DLTCRP; Debbie Allen, Aid to Ms. Gallagher; Michael Duva, Delaware Health Care Association; Sean Finnegan, Legislative Hall; Amanda Lewis, Quality Insights of Delaware; Carol Lovett, Consumer; Mary Peterson, OHFLC Director (DPH); Harry Hill, Director of DMMA; Lisa Zimmerman, DMMA; Marie Nonnemaker, DMMA; Paul Smiley, Administrator at Gilpin Hall; Paul Omrod, Consultant; Renata Henry, Director of DSAMH and Dan Miller, Director of MFCU.

1. Call to Order:

The meeting was called to order at 9:06 AM by Chairman McGonigle.

2. Approval of Minutes of the meeting of:

Due to lack of quorum, the March 11, 2008 meeting minutes will be submitted for vote at the July 8, 2008 DNHRQAC Meeting.

Discussion of:

The meeting agenda was modified to accommodate guest speakers and lack of quorum at the beginning of the meeting.

A) Senate Bill 175

SB 175 was introduced July 2007 to amend Title 16 of the Delaware Code relating to “Eagle’s Law” as it pertains to nursing homes and similar facilities. DAG Miller, who assisted in drafting the bill, was present to discuss SB 175 that is currently pending in the Senate. The bill was sponsored by Senator Marshall, Representative Maier, Senator Blevins and Senator Henry.

DAG Miller, Director of Medicaid Control Fraud Unit, stated that MFCU is the entity in the Department of Justice that reviews, investigates and prosecutes neglect, abuse, and financial exploitation in Delaware nursing homes and other health care facilities. The Medicaid Fraud Unit receives grant funding to carry out their tasks. Various State entities send MFCU referrals- Arms of DHSS, State Police, Residents, Families and Facilities.

Green Valley Pavilion was investigated several years ago by the Department of Justice. As a result of that investigation and other cases, DAG Miller mentioned that DOJ was able to get a closer look at Eagle's Law and its impact in Delaware nursing homes. After further review, he offered that a host of written recommendations were prepared to develop Senate Bill 175. DAG Miller furthered that the intention of the bill is to aid in the quality of care for individuals in nursing homes.

SB 175 was drafted at the request of Senator Marshall and blessed by the Department of Justice. DAG Miller stated he met with other individuals from the Medicaid Fraud Unit and discussed which provisions needed further enhancement. He further prefaced that SB 175 is not in its final form and welcomed Commission members to ask questions about the recommendations to modify Eagle's Law. Since SB 175 entered Legislation, several items have been brought to DAG Miller's attention; including fiscal and grant related budget issues and work force shortage concerns. DAG Miller reiterated that the main consideration for drafting SB 175 was to ensure residential quality care.

During an open discussion, DAG Miller offered that SB 175 is recommending acuity level review for each resident on a quarterly basis for purposes of determining the acuity classification per resident. The Medicaid Reimbursement Team will gather the patient acuity information and forward the results to its appropriate facility and DLTCRP.

Subsection "f" of proposed SB 175 requires the Department (DHSS- specifically DLTCRP) to determine a patient's acuity level for Medicaid and Non-Medicaid a-like residents. Eagle's Law provides a minimum staffing level requirement for nursing homes. Any staffing below the minimum requirements would be a violation of the law. DLTCRP would be responsible for enforcing violations of the law.

Subsection "g" of proposed SB 175 ties into Medicaid reimbursement. Level 1 equals a low acuity level, whereas level 8, the resident needs the greatest amount of care. At present, Medicaid reimburses facilities based on the amount of care provided to each individual resident.

SB 175 proposes that the Attorney General's Office may open an investigation to determine whether civil or criminal prosecution is warranted should a facility not meet the proposed staffing levels. Ms. Waldron stated that DLTCRP is responsible for imposing enforcement of the law and civil penalties. DAG Miller stated he wasn't aware of specifics as to how DLTCRP currently imposes enforcement of the law.

Ms. Waldron stated that as a representative of facilities, she is informed when a facility is cited for violating Eagle's Law and whether it was self reported or during an annual

survey. She furthered that the Civil Fine Penalty Fund grew greatly due to CMP's enforced by the Division and as a result, \$80,000 was transferred out of fund and into the State's General Fund. Ms. Waldron mentioned that civil penalties have been imposed upon facilities due to not meeting a minimum ppd level or patient staff ratios, but for the most part, facilities are staffing well above 3.28 minimum ppd while trying not to bring in agency assistance.

Chairman McGonigle intervened by stating the DNHRQAC receives quarterly compliance reports. He questioned whether the Commission should take a closer look into enforcement of the law as it pertains to Eagle's Law.

Senator Marshall asked DAG Miller why SB 175 was introduced in June 2007, yet DOJ was not permitted to discuss until today's DNHRQAC meeting. DAG Miller explained that a part of the Green Valley Pavilion Whistle Blower suit remained active until after the last DNHRQAC meeting in March 2008. DOJ did not feel comfortable talking about the lawsuit that was under Federal Court seal. DOJ feared that the Green Valley Pavilion case would be discussed at a commission meeting before it was able to be discussed.

Senator Marshall asked if Delaware nursing home residents have been short changed in the quality of care. Ms. Waldron stated that facilities strive to provide great quality of care to their residents. She further mentioned that if any provider is committing fraud, she supports DOJ to take action.

Ms. Waldron expressed concern about SB 175 and added that the right parties should be involved in drafting a bill for residential improvements. She further questioned why this bill was drafted, especially after DOJ's successful prosecution of the Green Valley Pavilion and a dozen other cases. Furthermore, Ms. Waldron offered that there is a current system in place to go after individuals or facilities that do not follow the law.

DAG Miller mentioned that a significant issue the drafter of the bill listed as troublesome is shift ratios. He further stated that in some instances, a CNA is not able to complete all they are expected to complete during their designated shift, especially if a resident requires additional assistance time. As a result, the bill recommends that the ratios be lowered. He cautioned that this recommendation does not keep in mind the financial impacts which should be explored if the bill moves forward.

DAG Miller explained that section "i" of the bill is intending to incorporate, by reference, Federal Regulations into Delaware Law. He furthered that this section would need some work. Ms. Waldron offered to be part of the group that would work on appropriate language for section "i" of the bill if and when the bill moves forward.

Under the current process, providers submit staffing documentation to DLTCRP as it pertains to Eagles Law. Subsection "j" of the proposed bill is designed to make it more difficult for a facility to provide inaccurate information. As a result, the Division would provide an unannounced audit twice a year. DAG Miller stated that the current survey process and SB's twice a year audit would be separate review of information. He

reiterated that this bill deals with enforcement and tightening up Eagles Law whereas the survey process deals with the quality of care. A written summary of the audit would be required. In return, it would be sent to the Medicaid Fraud Unit for review. DLTCRP would forward supporting documentation to AG's Office and be responsible for notifying them of suspected Eagles Law staffing or self reported violations.

DAG Miller stated that SB 175, sub-section "k", lists the logical progression the Attorney General's Office would follow after review and in return, determine whether a civil or criminal investigation is warranted. A list of penalties is outlined in SB 175 based on the facilities knowledge of the offense and how it was reported.

Ms. Waldron stated it appears DAG Miller was unaware of current systems and processes in place at DLTCRP that ascertains whether staffing and ratio levels are met. She furthered that DLTCRP is currently enforcing facilities to comply with the law or be fined a civil monetary penalty.

DAG Miller mentioned that another key piece of SB 175 discusses criminalization of a low level felony would be enforced upon any facility employee who knowingly makes a false statement in connection with an investigation being conducted by AG or DLRCRP. Ms. Waldron suggested that this section of the bill be re-worded to differentiate how to address human error versus knowingly made false reporting.

Ms. Waldron mentioned she thought that that SCR 24 was attached to SB 175 initially and that a group of individuals met to prepare recommendations. Senator Marshall stated SCR 24 was blocked by the Majority Party in the House and that there was a concurrent resolution. Senator Marshall asked Representative Maier if she could provide leadership and pry the bill out of committee between now and June 30, 2008.

Ms. Waldron stated that if a task force is formed to review SB 175 and its financial and prosecutorial impacts, she recommends that knowledgeable individuals be a part of the task force. Ms. Waldron will forward a list of recommended task force members to Representative Maier.

Senator Marshall submitted a motion to have DNHRQAC endorse SCR 24 be acted upon and enacted before the end of the legislative session with consideration for changes in membership. The motion was approved and seconded by the Commission.

Mr. Posey asked DAG Miller if SB 175 had been passed years ago, how it would have helped with the Green Valley Pavilion case. DAG Miller responded that from a prosecutorial stand point there would have more options to go after certain people that made false statements in the Eagle's Law process.

Mr. Posey asked if the audit in sub-section "j" would have assisted in providing documentation that would have triggered the investigation. DAG Miller did not want to speculate about how Green Valley management would have responded, knowing it was

the law. He did state that it would have been far more difficult for Green Valley to do what the evidence showed that they did.

Ms. Waldron stated that Paul Amrod, a financial consultant for a private firm, created a report outlining the fiscal impact of SB 175. The report findings showed that it would cost \$5.7-\$6.3 million dollars to change staffing ratios outlined in SB 175. Chairman McGonigle asked if the figure presented was for the Medicaid portion exclusively and covered both Federal/State share. Ms. Waldron offered that the figure quoted is the States Medicaid portion only.

Mr. Paul Smiley, Administrator of Gilpin Hall, clarified that the Licensing Section of DLTCRP reviews payroll, staffing sheets, pay roll register and agency invoices multiple times a year.

Chairman McGonigle mentioned that it appears further review of SB 175 recommendations are needed if the bill moves forward.

B) Community Discharge Process- Renata Henry, Director DSAMH, presented the community discharge process to the Commission. Ms. Henry apologized for not being able to present at the March 2008 DNHRQAC meeting.

Ms. Henry stated that DSAMH receives funding for 17 group homes; totaling 137 beds. 24 hour supervision, support and rehabilitative services are offered on site. All of the group homes are licensed by DLTCRP.

Ms. Henry furthered that the target population for a group home is an individual that is unable to live independently due to his/her psychiatric disability at a given time. The individual needs to demonstrate a willingness to develop skills needed for independent living and that he/she would benefit group living as an alternative to his/her existing living situation.

Ms. Henry added group home eligibility requirements: at least 18 years of age; diagnosis of a serious mental illness with significant disability (cognitive, physical or emotional) that has been impaired by the psychiatric condition; assessed not likely to be dangerous; no current illegal drug use and have a willingness to live in a group home setting.

In addition to group homes, there are supervised apartments which are designed for two individuals and offer 24 hour on site supervision. DSAMH strives to cluster apartments in one location. Target population for supervised apartments: individual with serious mental illness able to live semi-independently but needs significant case management support to maintain his/her tenure in the community.

Ms. Henry mentioned that there are 4 stages DPC reviews in the community discharge process: planning, transition, discharge and follow up.

Ms. Waldron expressed concern about DOC sex offenders being released into the community and asked who would register and monitor the individuals. Ms. Henry replied that for the most part group homes do not have registered sex offenders, however agrees that it is a tough group to place in the community.

Ms. Waldron asked what safeguards are there to avoid or protect residents from abuse, neglect or exploitation in group homes or supervised apartments. Ms. Henry replied that All group homes are licensed by DLTCRP who partners with DSAMH for facility and staffing concerns. DSAMH reviews the quality of care issues for group home residents.

Ms. Henry mentioned that licensing reviews group homes yearly and certification for Medicaid reimbursement is reviewed.

Mr. Murray mentioned that group home incidents are not reported on the QART Report provided to DNHRQAC since they are not nursing homes.

Mr. Posey asked for the average length of stay in a group home and what alternatives are there besides a group home. Ms. Henry answered that the average stay in a group home is a year and half to a life time. She mentioned that the progression desired is group homes to supervised apartments to scattered sight housing and then hopefully back to home before issues.

Chairman McGonigle asked whether most of the group home residents are on Medicaid. Ms. Henry offered that 60 % of group home residents are receiving Medicaid. Part of the group home living fees are covered under Medicaid specifically the rehabilitation option. The remaining 40% have limited or no resources and therefore the Division's General Fund cover their fees. There are individuals that may not be eligible for Medicaid. Group homes do have a sliding scale to collect some fees from individuals who are not covered by Medicaid or any other insurance source.

Chairman McGonigle asked the difference between group homes versus hospital per diem. Ms. Henry replied that a group home averages between \$150k-160k per resident per year versus \$227k per individual at a State Hospital.

Ms. Bailey asked if there is an Ombudsman currently available for group home resident's and asked about the current complaint process. Ms. Henry mentioned that there is a consumer affairs department in the Division that can be contacted should someone be dissatisfied.

Future DSAMH plans: continued community placement for DPC patients and DOC residents discharged with a mental illness.

C) Hospice Care Services- Mary Peterson, Director Office of Health Facilities Licensing and Certification, presented to the Commission regarding Hospice Care Services. OHFLC survey and regulate all the health care facilities in the State which the DLTCRP does not regulate which includes acute care and outpatient health care providers. That

includes: hospitals, psychiatric hospitals, home health agencies, hospice programs, and adult daycare.

Ms. Peterson shared that hospice is an agency that provides care to people who are terminally ill. Further she offered that terminally ill is defined as people who have a life expectancy of less than six months if the illness runs its normal course. The focus of hospice care is not curing, just caring for the individual.

For Medicare purposes, Ms. Peterson mentioned that there are benefit or payment periods. There are (2) ninety day benefit periods which are renewable. After the 90 day renewable periods, there are indefinite numbers of 60 day renewable periods.

She mentioned that the National average of life expectancy on average is two weeks. The vast majorities of hospice care in Delaware and nationally is through Medicare. Medicare pays for about 77% of all hospice care in the nation.

Ms. Peterson stated the process for using hospice is different from other Medicare health benefits. The beneficiary has to choose to go into a hospice program therefore waiving all rights to curative care.

Ms. Peterson offered 1998 data that reflected that the top five of hospice diagnoses were cancer related. As of 2005, that changed and that only three of the top 10 hospice diagnoses were cancer related. The fastest growing diagnoses in hospice care are Alzheimer's, debility not otherwise specified, adult failure to thrive and Senile Dementia.

Ms. Peterson shared that in Delaware, there are eight outpatient hospice providers. Two of them now have inpatient facilities (Milford and Pike Creek). The most common place for hospice services is in the individual's own home. Hospice can also be provided in the hospital, long term care or independent living setting.

She furthered that the core services a hospice care provider must offer their clients include: medical nursing, medical social work, counseling and volunteer services.

Ms. Peterson stated that an inter-disciplinary team is created to specialize in pain and symptom management, and help the patient with the emotional, psychosocial and spiritual aspects of dying. They also coach family members on caring for the dying individual. Bereavement care and counseling is also performed for surviving family and friends for thirteen months after the individual.

Ms. Peterson furthered that there is no legal requirement for a nursing home to enter into a contract with hospice provider. Medicare beneficiaries that reside in a nursing home can only receive the hospice benefit only if the nursing home chooses to contract with a hospice provider. Medicare, Medicaid and most private insurer's will pay for hospice care.

Ms. Peterson mentioned that once there is a contract with a hospice provider and the resident elects the hospice benefit, hospice takes full responsibility for managing the residents care plan. The nursing home is no longer in control of that residents care plan. Hospice then becomes the payee and negotiates with the nursing home what types of care the nursing home will continue to give to the hospice resident and what fee the nursing home will receive from the hospice service.

Ms. Peterson stated that the quality of a resident's end of life care can be further enhanced by a hospice and nursing home partnership, therefore integrating two models of care (palliative versus restorative).

Ms. Peterson stated that there are barriers to hospice care in a nursing home. The reasons for the barriers include: different programs with different goals and perceived conflicting regulations. A senate task force was created a few years ago to review hospice barriers. Educational issues and Medicare financial reimbursement were two noted barriers. The task force recommended an end of life coalition so money could be allocated for hospice education. The task force did not explore further.

D) QART Report- Tom Murray, Deputy Director of DLTCRP, presented to the Commission results from Dec 16, 2007-March 15, 2008.

Nineteen surveys were conducted during the first quarter 2008 and surveyors recommended eleven "G" level deficiencies. The Quarterly Assurance Review Team reviewed and determined to downgrade five of the eleven "G" level deficiencies.

Mr. Murray walked the Commission through each of the five "G" level deficiencies that were downgraded by QART.

Chairman McGonigle asked if the Commission could receive cumulative "G" level deficiencies results per facility. Mr. Murray offered to work with Ms. Bailey on the request.

4. Old/New Business:

State Website Recommendations- The Commission decided to address this at the July 8, 2008 meeting.

5. Public Comment:

There was not public comment made during the meeting.

6. Next meeting will be held at Herman Holloway Senior Campus on Tuesday, July 8, 2008 at 9 AM.

8. Adjournment:

The meeting was adjourned at 12:02 PM by Chairman McGonigle.

Draft Minutes – March 11, 2008

Senate Bill 175

Community Discharge Presentation- Renata Henry

QART Report- Tom Murray

Hospice Care Services (2) - Mary Peterson