

# **DELAWARE NURSING HOME RESIDENTS QUALITY ASSURANCE COMMISSION**

## **ANNUAL REPORT FY 2010**

**(July 1, 2009- June 30, 2010)**

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# **DELAWARE NURSING HOME RESIDENTS QUALITY ASSURANCE COMMISSION**

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# DELAWARE NURSING HOME RESIDENTS QUALITY ASSURANCE COMMISSION

## ANNUAL REPORT 2010

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## I. BACKGROUND INFORMATION

### The Commission

The Delaware Nursing Home Residents Quality Assurance Commission (the Commission) was established in 1999. 29 Del. C. § 7907. The Commission's principal charge is to monitor Delaware's quality assurance system for nursing home residents in both privately and State operated facilities with the goal that agencies responsible for the oversight of facilities are coordinating efforts to achieve optimum quality outcomes.

As part of its monitoring effort, the Commission reviews state agencies responsible for investigating complaints of abuse, neglect, mistreatment and financial exploitation, as well as other agencies that have input on the quality of care in Delaware's nursing homes. The Commission reviews reports of serious citations of quality of care issues and staffing patterns prepared and presented on quarterly basis by the Division of Long term Care Residents Protection as directed by the Joint Sunset Committee in 2006.

The Commission is also charged by the General Assembly and the Governor with conducting specified studies relating to long term care and reporting its findings to the General Assembly and the Governor. Finally, the Commission is required to prepare and submit an annual report to the Governor, the Secretary of the Delaware Department of Health and Social Services (DHSS), and members of the General Assembly. This is the Commission's 2010 annual report.

## **Appointment of Commission Members**

- The Commission is composed of a total of 12 members, eight of whom are appointed by the Governor.
- One of the members appointed by the Governor is to be a representative of the developmental disabilities community protection and advocacy system established by the United States Code.
- The remaining members are to include representatives of the following: consumers of nursing home services, nursing home providers, health care professionals, law enforcement personnel, and advocates for the elderly.
- Of the remaining four members, two members are appointed by the Speaker of the House, and two members are appointed by the President Pro-Tempore of the Senate. These four members serve at the pleasure of their appointing authorities.

## **Frequency of Meetings**

While the Commission is only required by statute to meet at least quarterly, the Commission usually meets on a bi-monthly basis.

## **II. AGENCY REVIEWS**

### **Introduction**

Pursuant to 29 Del.C. § 7907(g) (1), the Commission is required to review and evaluate the effectiveness of the quality assurance system for nursing home residents. To do so, the Commission requests information and takes testimony (a snapshot in time) from representatives of state agencies. These include the Division of Long Term Care Residents Protection (DLTCRP), the Ombudsman's Office, Division of Medicaid and Medical Assistance, the Delaware Department of Justice, The Division of Aging and Adults with Physical Disabilities, Guardianship Monitoring Program, law enforcement agencies, other state agencies, health care professionals and nursing home providers.

To that end, the Commission invited representatives from state agencies and other presenters to appear and testify before the Commission. The following is a summary of these agency reviews:

Division of Services for Aging and Adults with Physical Disabilities, Long Term Care Ombudsman Program

Victor Orija, Senior Social Services Administrator of the Division of Services for Aging and Adults with Physical Disabilities(DSAAPD), often provides information and testimony to the Commission about the Ombudsman Program. The Ombudsman's role is one of impartial fact-finder to ensure that residents in long term care facilities receive fair treatment.

Ombudsman responsibilities include actions to:

- mediate disputes;
- investigate complaints regarding quality care and residents' rights violations;
- advocate for residents;
- recruit, train, and retain volunteers. The goal is at least one volunteer per facility.

The Ombudsman's Office generally handles non-criminal complaints and refers violations of the law to the DLTCRP and the Attorney General's office as applicable. The Ombudsman Program is not an enforcement agency and does not have law enforcement powers but tracks cases and complaints as required by the Federal Administration on Aging. In addition, the Ombudsman participated in the following Delaware events to promote resident's rights through efforts including:

- Residents Rights Rally in Dover, DE
- Director of Nursing Workshop.
- Consultation with residents, families, and facility staff.
- Outreach and education about residents' rights.
- Witness the execution of Advanced HealthCare Directives.

Division of Medicaid & Medical Assistance (DMMA)

Lisa Zimmerman, Chief of Operations for the Division of Medicaid and Medical Assistance, presented an update (March 2010) to the Commission regarding the Field Operation Unit. The Field Operations Unit, managed by Ms. Zimmerman, there are 95 staff positions. Six positions were permanently eliminated in fiscal year 2009.

Presently the unit has a 15% vacancy rate. Seven senior social worker/case manager positions have been filled which are responsible in determining financial eligibility for LTC Medicaid programs that includes SSI related and food stamp benefits for the community Medicaid clients. Two supervisor positions (Smyrna State Service Center and NCC registered nurse) also were filled.

DMMA has 90 days to determine eligibility for LTC Medicaid. Currently the Division is averaging 51 days state-wide. Last year with more staff, the Division averaged 49 days state-wide to determine eligibility.

In FY 2009, the number of applications received for LTC Medicaid averaged 174 per month. In FY 10, the number of applications received for LTC Medicaid is averaging 170 per month.

Ms. Zimmerman explained that the Division does not find placement for clients.

The Field Operation Unit's role to is determine medical and financial eligibility.

There are several instances that impact the applications received by the Division. Some of the applications received by the Division could be for residents currently in a LTC facility, individuals in the hospital trying to get into a nursing home or individuals in the community trying to enter a nursing home. Finally, the Division also does Spousal Impoverishment calculations. These rules apply when one spouse is a nursing home resident and the other lives in the community. The Division helps to divide their financial resources.

Ms. Zimmerman stated that DMMA and Christiana Hospital have a working relationship where LTC Medicaid applications can be expedited. Christiana Hospital also writes letters of guarantor that assists clients needing nursing home placement. Ms. Zimmerman stated that other hospitals used to have the same expedited application process, however due to staffing shortages within the Division the project was pulled. The Division has more staff in NCC than the lower two counties.

The DMMA Reimbursement team participates in inter-rater reliability which was developed 2 ½-3 years ago. One of the nursing units that report to Ms. Zimmerman determine the actual reimbursement rate for clients in nursing homes. The goal is to provide a consistence review method state-wide during chart review. Quarterly charts are reviewed by the Division. In January 2010, the Division scored 100% on the inter-rater reliability. Ms. Zimmerman stated that the nurses determine the reimbursement for each individual client based on their needs but does not set the reimbursement rate. The rate is set by the Division's fiscal department.

#### Division of Long Term Care Residents Protection (DLTCRP)

Tom Murray, Deputy Director DLTCRP and Robert Smith, Licensing Administrator DLTCRP provided Commission members with assurance review, staffing and other matters related to long term care. Discussions included:



DLTCRP's Quarterly Assurance Review Team provided the Commission with reports showing, after team review, whether any "G" level deficiencies recommended by surveyor's would be upgraded or downgraded.

DLTCRP provided quarterly Staffing Reports to the Commission as a result of Eagle's Law enacted in 140th General Assembly Senate Bill - 115.

DLTCRP investigates complaints in nursing homes and assisted living facilities.

DLTCRP sponsors a Director of Nursing mandatory four day workshop for all new DONs. The Workshop was held in October 2009.

DLTCRP began implementing the new CMS survey methodology for certified nursing homes. Division staff was trained on the CMS Quality Indicator Survey (QIS) process which is a computer-assisted process designed to achieve more comprehensive and consistent surveys for nursing homes. Although the survey process is revised under the QIS, the federal regulations and interpretative guidance remain unchanged. Every state is required to move to this process eventually. To date, a few states have already begun the process of transferring from traditional surveys to QIS paperless surveys.

By October 2009 all surveyors were trained and certified using the QIS process.

CMS has provided Delaware with \$42,000 to purchase computers and training on the new system.

DLTCRP's future plans include providing more education for caregivers with a special focus on Certified Nursing Assistants who provide the majority of hands-on care to the residents.

DLTCRP set up a web-based Adult Abuse Registry September 2009. The Adult Abuse Registry (HB165) was passed on 6/25/09 which permits online access to the names and nature of the conduct committed by those persons who are actively listed on the Adult Abuse Registry as a result of substantiated findings of abuse, neglect or financial exploitation.

### Hospice Collaboration

Sheila Grant, RN, BSN, CHPN, is Vice President of the Hospice and Palliative Care Network of Delaware and works as a hospice nurse-educator. She spoke to the Commission (July 2009) about how hospices can collaborate with long term care facilities to improve care for residents.

Hospices support LTC staff by assisting with personal care, offering grief support, and providing coverage for medically necessary equipment and hospice-related medications. Hospice care includes four levels of care, including Respite and General Inpatient care, which are often provided in long-term-care facilities.

Hospice staff includes: physicians, nurses, CNA's, bereavement counselors, chaplains, social workers, and volunteers, who are able to supplement staff in LTC facilities. A hospice medical director is also available to consult with LTC staff.

A Duke University study, published in the October 2007 issue of the Journal of Social Science and Medicine, was distributed to Commission members. The research showed hospice care saves the Medicare program an average of \$2,309 per hospice beneficiary.

The most common diagnoses found in hospice patients are: cancer, heart disease, debility, and dementia.

In 2002, The Robert Wood Johnson Foundation funded a study on end-of-life care. States were compared in a report-card format. Delaware received a "D" (24.4%) for number of people older than 65 years of age using hospice services in the last year of life. Currently, the number is about 34%. Experts estimate a

theoretical maximum percentage of people who could benefit from hospice at about 70%.

Ms. Grant stressed that some individuals are unaware, misinformed or afraid to learn about hospice services. Health care professionals and the public need to be more informed about hospice services which can assist in enhancing care and supporting families during end of life.

Ms. Grant's employer, Compassionate Care Hospice, compiles quarterly survey data. The most common survey response from families after using hospice services is "we wish we had started hospice sooner". Presently there are 6 physicians in Delaware that are certified in hospice and palliative medicine.

Hospice trends include: employers encouraging hospice clinicians to obtain specialty certification, a push toward evidence-based practice, and a new focus on professional collegiality among local hospice providers. There are two new hospice organizations in Delaware: *The Hospice & Palliative Care Network of DE*, which made Delaware the 48<sup>th</sup> State to form its own statewide hospice organization, and the Greater Delaware Valley Chapter of Hospice and Palliative Nurses Association, which meets bi-monthly to provide continuing education for nurses. Ms. Grant added that the National Board of Hospice and Palliative Nurses offers Board Certification in the specialty. Prior to taking the exam, nurses must have two years experience in the hospice and palliative care field.

Ms. Grant stated that there are several hospices licensed in the State, and that patients are able to choose the one that best meets their needs. Compassionate Care Hospice differentiates itself by using no agency staff, keeping caseloads low, providing one-on-one "crisis care" for symptom control, offering in-services (with continuing education credits for nurses), and employing a full-time, hospice and palliative care-certified physician as its medical director. They also have a massage therapist and a dietician on staff. Compassionate Care will open an in-patient facility within St. Francis Hospital this coming year, for patients whose symptoms cannot be managed at home.

Ms. Grant shared that she once cared for a hospice patient with a physical and

cognitive disability. She added that there is a new body of knowledge developing in end-of-life care regarding the needs of people with disabilities at end-of-life and the ethical and legal issues surrounding their care. Continuing education on these issues for hospice and palliative care professionals will be important in years to come.

### Guardianship Monitoring Program

Sherri Harmer, Executive Director, spoke to commission members (July 2009) regarding the program created in November 2008. A guardian is able to be appointed to become a fiduciary in order to make medical and/or financial decisions for someone with a disability or that has become incompetent due to medical condition or age. The monitoring program has 5,100 active guardianship cases- 55% are disabled adults (2,807) and 2,500 reside in LTC/AL facilities in Delaware or community. 224 guardianship cases fall under the Office of the Public Guardian. 2,200 cases involve guardianship of minor's property (assets).

Ms. Harmer's position is three-fold: creating regulations and rules for fee-for-service guardianship agencies (Senior Partner, Life Solutions, Icor and Supportive Care); direct court liaison between the community or facility and Court of Chancery; and creator/coordinator of a volunteer program with members of the community as well as student interns at Wilmington University, Delaware Technical and Community College and Wesley College to assist in the Guardianship Monitoring Program. The volunteers make home and facility visits of wards subject to guardianship and provide reports to the Director who reviews them individually and determines if further investigation is required. To date, the volunteers have visited approximately 60 wards state-wide, and notified the Court of approximately 12 deaths and 5 unreported moves.

The Court of Chancery has oversight of guardians and therefore the guardians must provide yearly status reports for their wards. Financial fiduciaries must provide the Court of Chancery yearly with a complete inventory of all assets owned by the ward within 30 days of their appointment as guardian and must file an accounting yearly- if

the guardian is spending the person's money. Any accounting discrepancy is investigated and sometimes the court can appoint attorney fact finders to assist in financial investigations. Moreover, any case can be investigated by the Director per request of a judge. Guardianship can be removed with evidence from other agencies such as the Department of Justice regarding financial or physical abuse of a disabled person is demonstrated.

Ms. Harmer shared that guardians are required to provide the court with yearly accounting records and that a power of attorney does not report what is spent. The accountings are audited by the court accounting clerk and then subsequently reviewed and approved by a judge.

Ms. Harmer stated that if a person was granted guardianship in another state and moves to Delaware, their order is easily accepted and the person is to abide by Delaware guardianship rules. The person would not need to file a brand new case as if they were applying to become a new guardian.

Delaware is involved in the Uniform Adult Guardianship and Protective Proceedings Jurisdiction Act (Chapter 39A).

If a disabled person or one deemed incompetent contacts Court of Chancery stating they would like to regain control over their medical or financial decision making, Ms. Harmer is responsible to investigate. An attorney will be assigned to the person who will submit a report to the Court of Chancery to terminate the guardianship due to recovery. A medical affidavit must specifically address the ailments suffered by the ward that originally initiated the guardianship.

It takes about 30 days after filing guardianship papers with the Court of Chancery to have the case be heard in court. If a case is contested, it is assigned to a judge and a hearing will be set according to the schedule of the presiding judge.

The Guardianship Monitoring Program would like to create a tracking program in Delaware Criminal Justice Information Systems (DELJIS) to run guardians/disabled

person's names and should they become arrested, the Guardianship Monitoring Program would receive a notice. The cost for the tracking system is \$3,000.

### Money Follows the Person Program

Eddi Ashby, MFP Program Administrator, presented to Commission members (March 2010) on the Money Follows Person Program that is administered by DMMA.

The Program received a three year grant which is being used to transition 100 Delaware LTC residents into a community setting.

To be eligible for MFP: an individual must be 6 month resident in LTC facility; must be Medicaid eligible at least 30 days prior to discharge; have healthcare needs that can be met safely in the community; voluntarily consent to participate; and be eligible for a state waiver .

MFP also provides services that include: transition services; counseling, education and training workshops; assistive technology; personal assistant services; set up and moving expenses (security deposits, furniture, etc);home accessibility modifications; and respite care.

In addition, MFP provides clients with access to a transition coordinator who will assist in developing safe discharge plans and follow the individual through 365 days. A post discharge follow-up meeting also will occur to ensure that the move was satisfactory and that the individual's needs are being met in the community.

To date, 24 individuals have been transitioned into the community through MFP.

Chairman Posey asked meeting participants to note the need to acknowledge that housing has been a huge barrier for some of the state run programs.

Ms. Ashby stated that the MFP program works with the individual to help develop a support system in the community utilizing family, friends and community resources (church, synagogue, community centers, etc.).

### Journey's Program

Andi Wozny, Nursing Home Transition Administrator, shared that the Division of Services for Aging and Adults with Physical Disabilities offers two programs for

individuals interested in transitioning into the community-MFP and Journey's (March 2010) . Both programs work together. If an individual does not qualify for one program, the application is forwarded to the other program for eligibility review.

To be eligible for the Journey's Program, the following applies: minimum 6 month LTC stay; must be Medicaid eligible for 30 days prior to discharge; and utilize one of the 5 separate state waivers. The Journey's Program provides more opportunity to a larger population of individuals that are requesting services.

In calendar year 2009, 16 individuals were transitioned using the Journey's Program.

None of the individual's transitioned through the program has returned back to LTC facilities.

Ms. Wozny stated that lack of housing issues effect placement of individuals that are approved in the Journey's Program.

#### State Office of Volunteerism

Carrie Hart presented to the Commission (March 2010) regarding the State Office of Volunteerism.

A Volunteer Toolkit was also distributed to DNHRQAC members present.

The State Office of Volunteerism is broken down into four main areas: Retired and Senior Volunteer Program (RSVP), Americorps, Foster Grandparents and Volunteer Resource Center.

The RSVP Program was designed to match skills and talents of adults 55+ so that they can provide assistance throughout Delaware. RSVP volunteers receive insurance while traveling to/from and during their volunteer experience. Currently, Delaware Emergency Management Agency (DEMA) and Division of Aging and Adults with Physical Disabilities (DSAAPD) utilize RSVP volunteers. RSVP's webpage is: <http://dhss.delaware.gov/dhss/dssc/sov/rsvp.html>.

Ms. Hart is a Volunteer Services Administrator in the Volunteer Resource Center.

The resource center assists with the following: offers volunteer opportunities and referrals State-wide; provides direct contact to agencies seeking volunteers;

develops outreach contacts; locates technical assistance for agencies; and provides training sessions for volunteer coordinators.

The Volunteer Resource Center also is involved with the Delaware Volunteer Credit Program that permits students grades 9-12 to earn 1 elective credit towards graduation upon completing 90 hours of community service. The Volunteer Resource Center's website is: <http://dhss.delaware.gov/dhss/dssc/sov/volresctr.html>.

Delaware was the first State to initiate the volunteer credit program.

Americorps is similar to a domestic Peace Corps, which provides individuals an opportunity to apply skills in an effort to aid others in the community. The Americorps member recruits and manages an average of twelve community volunteers. They can help coordinate a project of any size. There is a small fee to utilize Americorps service which supplements the Federal grant the group receives.

Volunteer In Service To America (VISTA) is a new volunteer subsidized program for senior citizens who would like an opportunity to work. The company pays the senior citizen minimum wage training.

Ms. Hart mentioned that there is not a lot offered for disabled individuals wanting to provide volunteer services.

#### Delaware ADRC Project

Chris Oakes from the Division of Services for Aging & Adults with Physical Disabilities (DSAAPD) provided an overview to Commission members (March 2010) about Delaware's Aging and Disability Resource Center (ADRC).

In February 2010, DSAAPD installed a call center to prepare for the launch of the statewide ADRC later this year. Establishing the call center was a major benchmark for the ADRC project, funded by the Administration on Aging (AOA) under a three-year federal grant. The budget was certified for the first year (\$228,854) only with second (\$249,978) and third (\$249,978) year(s) funding is dependent on availability.

Year one (October 2009-September 2010) of the ADRC Project has been



designated as a planning and development phase. Infrastructure development, cross-training and outreach efforts are currently underway and will complete the projects slated for the first year activities. Year two activities include: planning for sustainability and long-term expansion and support for person-centered discharge planning. Year three will be dedicated to statewide implementation of a fully-functioning ADRC.

In February 2010, the statewide ADRC call center was installed. The call center staff consists of 8 DSAAPD employees who are available to serve older adults, caregivers and adults (18 years +) with physical disabilities. This call center system will enable staff to assist callers by making “warm transfers” and connecting them with outside resources when needed. The call system has a number of other features, such as data tracking that will assist DSAAPD staff in the operation of the ADRC project. The call center’s toll free number is: (800)223-9074.

The Delaware ADRC is scheduled to begin full operation in Fall 2010. Planning is underway for other major operational components, including an online searchable database of services and a web portal for making referrals to the ADRC. For more information about the National ADRC initiative and/or State profiles, visit the national website at: [www.adrc-tae.org](http://www.adrc-tae.org) . DSAAPD’s website includes information about Delaware’s ADRC project and can be accessed at: <http://www.dhss.delaware.gov.dsaapd/> .

As a result of the ADRC Project, DSAAPD is partnering with several state and private agencies including: other DSAAPD programs (e.g. Adult Protective Services, Care Delaware, Ombudsman Program, etc.), DHSS agencies, Delaware Helpline/ 211 System, LTC support and service providers, critical pathway providers (e.g. hospitals, healthcare providers), DMMA, ElderInfo, Independent Resource Center and Freedom Center, to name a few.

The concept of an ADRC is to provide a single point of entry for information and assistance about LTC options, including home and community-based

services, and to streamline access to these services. In addition, the project will work to identify available LTC services and the gaps that exist to better achieve the projects long-term goals and objectives.

Per the Delaware ADRC model, an individual would contact the ADRC call center and, through a series of queries, the situation assessed immediately.

ADRC staff could be on the phone simultaneously with providers to facilitate a resolution to the immediate issue. An extended “option counseling” session would be available to the public should someone need additional time to discuss services with ADRC staff. An individual would contact the ADRC to learn more about this service and/or schedule an appointment.

Ms. Oakes noted that the Division is working with Christiana Care Health System on developing a hospital discharge planning model that may be adapted and used at other hospitals or LTC settings.

Ms. Oakes shared that ADRC services will be available to caregivers. She added that the Administration on Aging (AOA) already helps to fund the caregiver program in Delaware (Title III).

Cross-training between DSAAPD and partnering organizations is underway now and will continue as the ADRC develops.

HB 351- SA 1 signed into law to create the Delaware Aging and Disability Resource Center within the Division of Services for Aging and Adults with Physical Disabilities of the Department of Health and Social Services, replacing the current Elder Care Information and Support System for Delaware Families legislation.

The Aging and Disability Resource Center will provide support for the elderly and adults with physical disabilities by combining existing Alzheimer’s specific information into the program and supporting future Federal grant applications for ADRC projects.

#### Practice Without Pressure

Jane Miller, Outreach Director, presented to the Commission (May 2010) regarding

the Practice Without Pressure Program. PWP offers on-site medical, dental and personal care services for individuals who fear or avoid routine care. Specialists use a step-by-step process that promotes trust and learning.

In the past, individuals might have been restrained or sedated to receive routine dental cleaning, x-rays, exams, and other services. PWP is staffed by dedicated professionals to recognize, address and support individuals needs in a relaxed and comfortable environment.

PWP is a fee-for-service provider that accepts Medicaid, Medicare and most major medical insurance plans.

Practice session fees, when not covered by insurance or state contracts, will vary based on individual needs and determined at the initial evaluation.

Ms. Miller suggested that if anyone is interested in PWP services, they should call: (302)832-2800.

#### Mobile Dentistry Unit

Dr. Greg McClure, DPH Dental Director, spoke (September 2009) regarding the Division of Public Health's dental services which focus in 2 areas:

1. Provide direct clinical services to Medicaid eligible children under the age of 21 years of age. The service has been in place for approximately 40 years due to federal mandate that any state that receives Medicaid dollars must provide dental care for children under 21.

Until 1999, this was the only way Medicaid eligible children received dental services. Since then, private dentists and community clinics have been added into the Medicaid program.

2. Provide population based services to:
  - Ensure there are services provided
  - Keep track of disease and resources
  - Help formulate/establish policies to address the issues
  - Maintain prevention programs

Dr. McClure shared that dental disease is relatively easy to prevent, however the prevention must begin at an early stage in life. There are grants being used to assist in the prevention of dental disease- including increasing awareness and changing behaviors.

Dr McClure, a staff of one, also provides Medicaid consultation services.

Presently, the Division of Public Health's dental services focus primarily on children.

An Oral Health Coalition was established a few years ago under Public Health. The focus is to have the coalition become an independent non-profit organization and provide advocacy for increased care.

There are individuals with special healthcare needs that face additional barriers or need additional accommodations to meet their needs.

There are dental services provided beyond the Division of Public Health. Locations include: Stockley, DDDS and other LTC State facilities.

Medicaid has a narrow definition when it comes to paying for residential care. A person could have an abscess on their leg and the treatment would be covered under Medicare. The same person could have an abscess in their mouth and the cost for treatment would not be covered because it is not considered medically necessary.

The Institute of Medicine and American Dental Association has submitted their recommendations to change what is considered medically necessary.

Medicaid in Delaware does not have adult Medicaid dental benefit coverage.

although some states offer limited Medicaid dental benefit coverage for adults.

Currently, when a resident is admitted to a nursing home, an initial dental assessment is performed with periodic assessments made regarding the resident and their medical condition.

Under the current regulations, a facility must ensure that a resident can access dental

care- but not necessary pay for it. Therefore, a dentist may be contracted or hired part-time and be available to provide dental services for that nursing home.

Dr. McClure stated that dental and oral health status for nursing home residents throughout the country is a problem. The Minimum Data Set (MDS) can provide Delaware with a general idea; however it does not address the whole picture.

The Pennsylvania Dental Hygienists Association prepared a report a few years ago regarding PA nursing home residents. The potential solutions from their findings were to allow dental hygienists ability to perform more services to residents in nursing homes. The recommendation would impact licensing and scope of practice issues.

Collaborative Practice Law could be addressed to alter the ability to permit hygienists to enter a nursing home without the supervision of a dentist and therefore provide more services to residents.

Medications and mental/physical conditions also contribute to dental and oral health issues. It's important to educate care givers regarding oral hygiene.

In the past, a Dover area dentist provided mobile dentistry. He has since retired. The State of Delaware looked at the van he used but decided to build one instead.

Ms. Zimmerman, DMMA, shared that if a client is on LTC Medicaid and has a source of income (SS, SSI Disability) there is a mechanism for DMMA to protect that income and allow the resident to pay for dental services as long as it is medically necessary.

The process is called protection of income.

She furthered stated that every month; clients, who have an income, pay that income (patient pay amount) directly to the nursing home. Should the resident require something not paid out right by Medicaid, like dental services, the resident may use that income source to pay for that service/item for as many months as it would take to pay it off. An example used: If a resident's income is \$200/month and a dental procedure costs \$600, Medicaid would allow the resident for the next 3 months to take their patient pay and apply it to their dental bill. Medicaid would then

pay the difference to the facility so they are still receiving the residents patient pay amount and would not forgo the money.

Ms. Waldron mentioned that a group of stakeholders met approximately a decade ago to address dental needs, but it appeared that the dental association did not want to relax any of the barriers regarding hygienists coming to provide services in LTC facilities.

She further suggested that this might offer a great career ladder opportunity. Dr. McClure shared that Minnesota recently started a program called a Dental Therapist.

Ms. Waldron asked Dr. McClure if he could provide the Commission with other States laws regarding dental service care for individuals who live in nursing homes. Dr. McClure shared that a great resource is the American Dental Hygienists Association. He encourages commission members to visit the University of Minnesota Dental School website which addresses federal and state laws regarding dental care for nursing home residents: <http://www.dentistry.umn.edu>.

Chairman Posey asked what could be done regarding adult preventative dental services for residents of LTC facilities. Dr. McClure shared that a bill was introduced last year in Delaware to include Medicaid dental services for adults, however the bill was not passed.

Dr. McClure stated that NCC is in pretty good shape in regards to dentists versus population ratio. Sussex County has the highest growth rate and fewer dentists available per population. Kent County also has a professional shortage of dentists and has the greatest demand of all the counties in Delaware.

Henrietta Johnson, West End Neighborhood House and LA Red Health Center offer sliding fee scale services for more mobile individuals regarding dental services. LA Red also leases office space at Stockley Center.

DPH is having a mobile dental van being built. The construction should be completed the end of September 2009. There will be 2 fully equipped dental suites-

one on the back and one in the front. The middle of the van will be used for intake and sterilization center.

Dr. McClure stated that the original funding request was for the mobile van, and that a separate grant was submitted requesting funding for a part-time funding for a dentist position.

The mobile dental van will be available state-wide to provide services at schools. DPH would like to loan the van out to community organizations and nursing homes. DPH is not able to provide dentists to staff the van- it would be the responsibility of the facility to hire staff.

Dr. McClure mentioned that DPH is still working out specific details as to restocking supplies, costs associated with using the van and other administrative procedures.

Dr. McClure stated that the mobile dental van will have adult lift chairs to accommodate individuals with a disability. He further encourages DPH to review those amenities prior to the completion of the van project in Fall 2009.

#### Psychiatric Admissions Process- Sam Abdallah

Mr. Sam Abdallah, DPC Director, presented to the Commission (January 2010) regarding the psychiatric admissions process. Chairman Posey mentioned that over the years the issue of psychiatric conditions for nursing home residents has often come up for discussion. He asked if the state meets the psychiatric needs for residents and how can the state provide psychiatric service without necessarily relying on the limited space available in the LTC Carvel Unit at the Delaware Psychiatric Center. Two common misconceptions noted by Mr. Abdallah:

“There seems to be a belief that if a referral is made for a DPC admission, the individual has to be accepted.”

“Some folks seem to think that if someone is admitted to DPC, the treatment will be free.”

Mr. Abdallah shared that there are several steps that must be followed to determine

whether an individual will be admitted to DPC.

A Pre-Admission Screening Annual Resident Review (PASRR level) is determined by the Division of Medicaid and Medical Assistance (DMMA). In addition, psychiatric evaluations are performed and used to determine the best possible treatment.

The Enrollment Eligibility Unit (EEU) falls under the Division of Substance Abuse and Mental Health (DSAMH). The Unit reviews referrals being made to DPC to ensure individuals meet admissions criteria and functions as the “gatekeeper” for DSAMH’s long term care system.

The Delaware Psychiatric Center has 7 units (Carvel; Sussex I, II, III; Kent I, II; and Mitchell) and 198 bed capacity. DPC is licensed as hospital and facility license is held by the Office of Health Facilities and Certification (OHFLC).

Carvel is a 35 bed unit within DPC and licensed as an Intermediate Care Facility/Institute for Mental Disease (ICF/ICFM). DLTCRP performs the federal certification (Medicare/Medicaid) and OHFLC performs the state certification. All the beds are currently occupied.

DPC is working to educate other Delaware LTC facilities that DPC is not a residential facility- it is an intermediate care facility to treat and stabilize individuals and then discharge the individual back to their home.

Chairman Posey asked whether DPC has referred residents to be discharged to other states. Mr. Abdallah confirmed that it has occurred, however the criteria guidelines used when discharging to another state and the process is quite extensive (weeks, months or year).

Last year, there were discussions with Delaware Division of Public Health, state-owned nursing homes in particular, to form a partnership regarding psychiatric care. In this scenario DPC enters a state facility, reviews a case and then makes recommendations on whether to admit a resident to DPC.

DPC requires a full medical evaluation to determine whether an individual is



medically stable.

DPC meets Eagles Law staffing level of 3.28. The facility would only staff at a higher rate than 3.28 if an adjustment is needed due to a resident's acuity level. Currently, the Carvel Unit has four residents that require a 1 to1 level of care due to: fall precautions, an individual who keeps removing his peg tube and another that keeps removing his feeding tube. The individuals are not displaying psychiatric issues.

They do have signs of dementia and/or delirium and therefore need around the clock observation. Ms. Waldron shared that private facilities cannot afford 1 to1 resident care. Mr. Abdallah added that DPC's overtime budget is greatly affected by 1 to 1 care.

Often DPC is contacted by Delaware LTC facilities regarding individuals who do not have a history of psychiatric needs. The resident might be acting out and therefore the nursing home feels they are not able to manage the behavior. Mr. Abdallah suggested that perhaps a facility believes a resident has a psychiatric issue and therefore that individual requires care at DPC. Mr. Abdallah

shared that DPC and state nursing home staff and psychologists will be working on behavior plans to model, mentor and train on what DPC does to treat residents.

Chairman Posey surmised that the ability to admit individuals into the skilled Carvel Unit is dependent upon having a bed available. He further asked that if a resident in a Delaware licensed nursing home requires a higher level of psychiatric care than the facility can provide, what is the individual's fate. Mr. Abdallah stated that the individual would most likely wait in a general hospital –some individual's wait up to 100 days. There are presently 4 individuals on DPC's wait list for admission.

Chairman Posey asked Mr. Abdallah if he would expand more about why hospitals are the default location where individuals stay until a bed becomes available. He further added that it quite expensive to the stay is in the hospital longer than necessary and wanted to know if there was something that could be done to decrease the hospital stay time and high fees associated with being in the hospital

for an extended time.

Mr. Abdallah responded that often individuals go to a hospital emergency room for treatment. The individual is admitted at the hospital because, at times, a nursing home states they don't know what else they can do to help them. In some cases, a nursing home refuses to take the individual back and therefore the individual remains in the hospital until another placement is secured. Ms. Waldron added her perception that individuals also living in the community often goes to an emergency room for psychiatric or behavior situations.

Not long ago, a group of individuals gathered to form a mobile nursing home response team. DPC's Medical Director, Dr. Gerard Galluci and other mobile nursing home crisis response members assess an individual that resides in a state facility. The mobile team then provides the facility with recommendations (as they do not have practice privileges at those facilities) as to how to stabilize the resident. If the recommendations are not effective, the team would then begin working on admitting the individual to DPC.

Mr. Abdallah stated that the mobile unit is new and is being piloted only with DHSS Facilities: Emily P. Bissell Hospital, Delaware Hospital for the Chronically Ill and Governor Bacon Center.

Mr. Abdallah shared that often both private and state facilities have a hard time accepting a resident back once they are discharged from DPC because of prior care experience or the facility's inability to manage someone that might have behavioral issues. There are currently 10 individuals that have been evaluated and are ready for discharge; however DPC cannot locate a nursing home bed. Mr. Abdallah also added that when DPC attempts to discharge individuals for home and community-based care that there is often resistance by family members.

Mr. Abdallah shared that the length of stay for individuals at DPC ranges from 3 months to 20 years. He reminded Commission members that DPC is an

intermediate care facility and the length of stay should be for a few months- a year, in order to stabilize the individual.

There are quarterly town hall meetings offered for residents and the community. Mr. Abdallah will forward a schedule of the 2010 meetings to the Commission.

#### Anti Psychotic Medications- Dr. Troy Thompson

Dr. Troy Thompson, a Psychiatrist at DPC for 4 years, spoke to the Commission (January 2010) regarding anti psychotic medications. Before working at DPC, Dr. Thompson was Chair of the Psychiatry Department at Jefferson Medical College in Philadelphia. He also held a faculty position at the University of Colorado. While at Jefferson Medical College, Dr. Thompson created a geriatric psychiatry unit in Wills Eye Hospital.

Dr. Thompson praised the Dementia Cares Training Program which educates individuals on how to manage dementia symptoms other than by medication.

Dr. Thompson provided the Commission with statistics regarding baby boomers: 5% of individuals over the age of 65 years have dementia, and 20% of individuals over 80 years old have clinically significant dementia. He further added that it will be quite challenging to care for the 20% with dementia.

In addition, Dr. Thompson shared that 1-2% of the population has severe and persistent mental illness. These individuals are at increased risk for dementia as well as other medical conditions as they age. Further, report information was shared stating 50% or more nursing home residents have dementia and 40% have major depressive disorder that is untreated. Dr. Thompson shared that nursing homes have the highest undiagnosed and untreated psychiatric illness of any type of facility in the world.

Dementia is a loss of mental ability that an individual previous had. In mental retardation, the person has not ever developed the abilities. 60% of dementia is Alzheimer's disease which affects the cortex of the outer level of the brain. 20%

have vascular hardening of the arteries so blood is not able to flow to the cortex adequately.

Dr. Thompson added that delirium tends to be a larger problem than dementia. An acute loss of mental function with moments of confusion can fluctuate at different times of the day for residents with delirium. Residents with delirium can hurt themselves and others and they can also tend to get aggressive. In this situation, treatment needs to occur. Most often, a simple solution would be to have a familiar staff member interact with the resident or to increase lighting to help ease the situation.

Antipsychotic medication is often misused and if given to dementia residents on an ongoing daily basis, it will dampen down the function of the brain powerfully. If used properly, anti psychotic medications have enabled mental hospitals to help many people recover and therefore live in the community.

Residents, family members, mental health professions and nursing home staff need to be educated on the differences between dementia and delirium. Medication is often more successful if taken in low doses when symptoms first occur. People often wait on giving medication for delirium agitation or confusion. By then, more medication is needed and only works half as well. The best intervention for someone who has delirium, agitation or confusion is to have the individual talk with a family member or friend, even if it has to be by telephone. Nursing homes should have consistent resident care assignment to allow staff caregivers to connect with residents more fully, and to build the resident/staff relationship.

Psychosocial human interactions are also important and lacking in education. Dr. Thompson stated that the Dementia Cares Program (Carol Lovett, Instructor) does a great job in educating about the psychosocial human interaction piece.

Dr. Thompson added that nursing home staff should be taught, in regards to dementia, about what were the resident's passions, hobbies, etc so staff can engage and connect with the individual.

Psychosocial interactions should also be a part of education criteria for nursing home staff.

Short term solution appears to be a psychosocial human interaction approach to improve an individual's health and wondered how it dovetails with Governor Markell's interest in volunteerism.

### **III. JOINT SUNSET COMMITTEE**

The Commission oversees that the Joint Sunset Committee's recommendations made for the Division of Long Term Care Residents' Protection are reviewed as follows:

- ✓ The Division of Long Term Care Residents' Protection established a Quality Assurance Review Team (QAR Team) that reviews deficiency reports quarterly. The QAR Team provides a written quarterly report to the Commission regarding any upgrades to "G" level or above and downgrades to "G" level or below by the QAR Team, setting forth the number of such downgrades and upgrades at each facility and the reason for each. Quarterly reports are submitted to the Commission on the 15<sup>th</sup> of every September, December, March and June.
- ✓ A Medical Director was added to the QAR Team who reviews medical records, advises the Division on medical issues, testifies on the Division's behalf at Informal Dispute Resolution hearings, and participates in the QAR Team.

The Division of Long Term Care Residents' Protection submits a written quarterly report to the Delaware Nursing Home Residents Quality Assurance Commission identifying a nursing home's noncompliance with staffing ratios by shift under Eagle's Law (16 Del. C. §1162).

### **IV. LEGISLATION AND REGULATION REVIEW**

The Commission reviewed regulations and legislation effecting long-term care residents in the State of Delaware, including:

House Bill #36- This Bill clarifies the role of the Community Legal Aid Society, Inc. (CLASI), designated for the past 30 years as Delaware's Protection and Advocacy Agency pursuant to federal law, in protecting patients and residents in nursing and

similar facilities. As a complement to the existing protective system operated by the Department of Health and Social Services, CLASI is authorized to solicit and investigate reports of abuse, neglect, mistreatment and financial exploitation in covered facilities. Finally, the Bill deters interference and retaliation against persons cooperating with such investigations.

\* HB # 36 was signed 8/24/09.

House Bill #38- This Bill requires mental hospitals and residential centers covered by the Mental Health Patients' Bill of Rights Act to report deaths and critical incidents to the State Protection & Advocacy Agency which is authorized by federal law to investigate such occurrences.

\* HB # 38 was signed 8/24/09.

House Bill #39- Currently statutory anti-retaliation and protective provisions for patients and others only apply to licensed long-term care (LTC) facilities. Only part of the Delaware Psychiatric Center (DPC) is a licensed LTC facility. This Bill, to protect all patients and employees at DPC, applies such protections to all the DPC facilities.

\*HB #39 was signed 8/24/09.

Senate Bill # 72- This Bill provides an exemption from activities considered within the scope of nursing for assisting HIV/AIDS patients residing in residential group homes with self administration of medication, provided the person has successfully completed a Board-approved medication training program. This Bill would enable CNA's to perform this needed function.

\*SB # 72 was signed 2/1/10.

Senate Bill# 182- This Bill prohibits the use of the title nurse unless such person is a registered nurse or a licensed practical nurse. It also includes limits, titles and abbreviations for advanced practice nurses as well. This Bill will provide needed protection for the public.

\*SB # 182 was signed 3/31/10.

House Bill # 302- This bill is intended to encourage the reporting of suspected financial exploitation of the elderly and infirm adults by providing immunity from

criminal and civil liability for making such reports. Under the bill, anyone who makes a good faith report to law enforcement authorities of such suspected activity is immune from criminal and civil liability for making that report. In addition, any person that adopts a formal written program for reporting suspected financial fraud is immune from civil or criminal liability for any report, act, or omission under that program.

\*HB #302 to House Judiciary Committee 1/7/10.

House Bill # 351- This Act creates the Delaware Aging and Disability Resource Center within the Division of Services for Aging and Adults with Physical Disabilities of the Department of Health and Social Services, replacing the current Elder Care Information and Support System for Delaware Families. The Aging and Disability Resource Center will provide support for the elderly and adults with physical disabilities by combining existing Alzheimer's specific information into the program and supporting future Federal grant applications for Aging and Disability Resource Center projects.

\*HB # 351 was signed 5/14/10.

Senate Bill # 122- This Act requires that all Delaware Psychiatric Center employees providing direct care to patients be subject to criminal background checks and drug testing. The drug testing provides for both pre-employment testing and testing where reasonable suspicion that an individual is impaired by an illegal drug exists.

\*SB # 122 was signed on 6/15/10.

Senate Bill # 254 w/SA 1- This Bill will create a State Civil Penalty Trust Fund. Currently, all sanctions which are imposed as a result of the surveys and complaint investigations of the Division of LTC Residents Protection are placed in the Long Term Care Residents Trust Fund which is governed by very restrictive federal regulations. It is not compulsory to put the revenue derived from State sanctions into the Long Term Care Trust Fund—but that has been our practice. By splitting the money, and creating a fund which receives civil penalties imposed pursuant to state statutes and regulations, the Division will be better able to support community based residential efforts while, at the same time, taking care of long term care needs with the Long Term Care Trust Fund.

\*SB #254 w/SA 1 was signed on 6/28/10.

House Concurrent Resolution # 60- Recognizing the week of October 3<sup>rd</sup>, 2010 as "Delaware Long-term Care Residents Rights Week" and praising the Delaware

chapter of the National Consumer Voice for Quality Long-Term Care on its 9<sup>th</sup> Residents' Rights Rally.

\*HCR # 60 was passed in the Senate on 6/30/10.

Senate Bill # 303- This Act will further the purpose of Chapter 30A of Title 16 by clarifying the authority of the Division of Long Term Care Residents Protection to regulate nursing assistant training programs.

\*SB # 303 was signed 7/12/10.

House Substitution for House Bill # 348 w/HA 3- This purpose of this Act is to provide greater protections for Delaware's vulnerable adults, individuals the General Assembly considers to be particularly at risk of physical, emotional and/or financial exploitation. The Act creates a new criminal offense, Crime Against a Vulnerable Adult, which imposes enhanced penalties in more than 50 criminal offenses if the victim is a vulnerable adult.

\*HS1 for HB #348 w/HA 3 was signed 7/16/10.

House Concurrent Resolution # 53-This House Concurrent Resolution recognizes June 15, 2010, as Delaware Elder Abuse Awareness Day.

\*HCR # 53 was passed in Senate on 6/16/10.

Senate Bill # 291 w/SA 1- This Bill makes changes which require the Division of Long Term Care Residents Protection to post online the results of its surveys of nursing facilities.

\*SB # 291 w/SA 1 was signed 7/15/10.

House Bill # 455- An Act to Amend Title 12 of the Delaware Code relating to Durable Powers of Attorney and adding a chapter 49A thereto relating to Durable personal powers of Attorneys.

\*HB # 455 was signed 8/19/10.



House Concurrent Resolution # 45- This Resolution recognizes the 2010 All Star Award Recipients of the Delaware Health Care Facilities Association during National Nursing Home Week.

\*HCR # 45 was passed in the Senate 5/12/10.

House Concurrent Resolution # 40- This concurrent resolution designates May 2010 as "Older Americans Month" and urges us to honor older adults and the professionals, family members, and citizens who care for them, and to improve the lives of Delawareans older adults.

\*HCR # 40 was passed in the Senate 5/6/10.

## **V. COMMISSION STAFFING**

The Delaware Nursing Home Residents Quality Assurance Commission members hired a full-time Administrative staff person as of January 31, 2007. The Administrative Office of the Courts funds the salary and budget of this position. The staff reports to the Commission and works closely with State Agencies to aid in the quality of care for residents in licensed Delaware State and Private Nursing Homes and Assisted Living Facilities.

## **VI. NURSING HOME AND ASSISTED LIVING FACILITY VISITS**

Members of Delaware Nursing Home Residents Quality Assurance Commission and staff visited 64 nursing homes and assisted living facilities. There were also 4 visits to Hospice providers. The purpose of the visits was to promote an atmosphere of information sharing so that the Commissioners would be able to fulfill their responsibility to monitor the effectiveness of the quality assurance system in the State of Delaware. Commissioners interacted with facility administrators, staff, residents and families.

## **VII. COMMISSION GOALS**

The Commission has set the following goals for its work in the coming months:

- Continue to review agency performance and coordination.
- Continue to review and comment on regulations proposed concerning long term care.
- Focus on assisted living by reviewing what other states are doing to ensure quality of care and provide recommendations to the Governor and Members of the General Assembly.
- Encourage collaborative initiatives that will reduce high turnover of nursing home staff and help recruit qualified nurses to long term care.
- Foster and promote abuse/fraud investigation training for law enforcement agencies statewide.
- Monitor and if needed recommend enhanced enforcement of Eagle's Law so as to ensure minimum staffing level compliance.
- Enhance outreach to consumers of long-term care to increase Commission profile so as to ensure the Commission is called upon to review problems and deficiencies in long term care.
- Address quality of life issues for nursing home residents including end-of-life and hospice care services.
- Identify "Gaps" in services available for aiding in the care for the elderly and disabled.
- Provide access to National Crime Information Center (NCIC) database to DLTCRP investigators.
- Monitor "length of stays" for nursing facility residents in hospitals.
- Monitor results and request updates from the Quality Improvement Initiative Study.
- Review educational programs such as Certified Nursing Assistants (CNA) and make educational recommendations to enhance the programs.
- Focus on State employee recruitment and retention challenges to aid in the quality of care for residents.