

DELAWARE NURSING HOME RESIDENTS QUALITY ASSURANCE COMMISSION

ANNUAL REPORT FY 2011

(July 1, 2010- June 30, 2011)

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DELAWARE NURSING HOME RESIDENTS QUALITY ASSURANCE COMMISSION

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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 2011 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 Department of Justice, 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 Developmental Disabilities Services

Dr. Warren Ellis, Director for the Division of Developmental Disabilities Services (DDDS) Community Services Unit, presented an overview to commission members July 2010.

The Division's mission is to provide services to help people it serves achieve the quality of life they desire.

There are three Community Services locations: Fox Run, Thomas Collins and Sussex. Stockley Center is also part of DDDS.

There are more than 3,000 individuals in Delaware that DDDS provides some level of service: 144 individuals in foster placement (shared living) , 550 individuals in neighborhood homes, 160 individuals in apartments and 2,100 individuals living at home.

As of April 2010, 132 individuals receive respite care. Respite care hours are based on available funding.

The Division has health and safety training requirements for all direct care providers. Continuing education opportunities are contingent upon funding.

In addition to respite services, the Division offers family support (case managers).

The amount of time spent to develop or meet with families can vary depending on the individual and/or family needs.

Case managers are currently averaging 90 cases each. In Sussex, the case load per case manager averages 120. In NCC, the average case load per case manager is approximately 75-80.

Dr. Ellis shared that the optimal case load varies- younger clients need assistance in becoming enrolled for DDDS services and therefore primarily meet with case worker on a yearly basis. The younger clients do not require a lot of assistance and in that instance, a case worker may assist with some respite care or summer camp.

On the other end of the spectrum, Dr. Ellis added that DDDS also serves individuals living independently but require a greater amount of support. In those instances, the interaction and assistance with the case worker is much greater.

Residential Services (group homes, apartments, foster/shared living) is the primary support system for individuals living in the community. Many of the residential locations are staffed 24/7 and residents attend a structured day program (habilitation through community employment).

CMS now requires DDDS to develop client care plans. In the past, agencies were responsible for developing the care plans.

DDDS has a Home and Community Based Waiver which is used to fund most of the Division's Residential Services. In the future, there will be some changes made to the waiver. Currently, a small percentage of individuals in the Residential Services program are eligible for the waiver due to exceeding income limits. Those individuals' services are funded by the State. Yearly, the Division requests funds for individuals who are aging out of high school (special education) and will need to potentially attend adult day programs.

The Division has a system in place which sets up an individual budget. A certain amount of money is attached to a person based on an adaptive behavior scale called Inventory for Client and Agency Planning (ICAP).

The ICAP is forwarded to the state government, who in return, determines how many hours of support an individual will need. As a result, the hours are translated into dollars.

If a client has a medical change, the Division can ask for an exception so they may send the new supportive costs to the agency providing services. The Division in return would conduct a new client assessment to capture any changes.

Dr. Ellis mentioned that legal involvement might also require a client to receive a greater level of supervision. Behavioral issues may also require more client support.

DDDS has been charged in FY 11 with becoming more involved with the Department of Education (DOE) regarding students aging out (leaving school or graduating). The Division has Transitional Specialists in each region who attend Individual Educational Plan (IEP) meetings to create a seamless transition.

Dr. Ellis stated that the largest funding source for the Division comes from individuals who have aged out of school. Historically the Division has always been funded for individuals who have been identified as leaving special education. Every budget cycle, DDDS submits funding requests specific as to the number of special education school graduates. A day program has a huge impact on families.

Presently, there are 340 clients with autism and over 800 individuals with autism in the Delaware school system.

FY 10, there were 77 special education graduates and 24 additional students that transitioned out of school at the completion of 2009-10 school year.

The 24 additional students (totaled \$300,000) were not expected to be transitioning out of school (at that time) and therefore were not included in the totals provided to DDDS by DOE. The assumption is that a student will transition at age 18 or 21, however, some students transition out between 18-21 therefore funds were not anticipated nor projected in the Joint Finance Committee (JFC) hearings.

DDDS has a Quality Management Unit that performs licensing reviews. They review standards and make sure that agencies that provide services are reviewed for compliance. DLTCRP also performs annual site reviews specific to environmental

and physical plant regulatory compliance.

To file a general complaint a person can contact the Division, DHSS Secretary Office, Legislator or Governor's Office. The Division's constituent person, Chris Long, receives the complaint which is then forwarded to Dr. Ellis for a complete investigation. A follow-up is provided to the person filing the complaint as well as the State office who contacted the Division.

The Division has coordinators in each region to investigate PM 46's (allegation of abuse or neglect) and determine whether it will be substantiated. The

coordinators weigh the information

and make a determination whether there is enough merit to opening up an investigation. Dr. Ellis shared that a surprising number of staff files false complaints against one another. The case is assigned to an investigator usually within the agency involved. A report is then sent to DDDS and on to DLTCRP who determines whether it will be substantiated. DLTCRP will also decide if the individual will be placed on the Adult Abuse Registry or prosecuted.

Dr. Ellis responded that criminal background checks are required for all staff that provides direct care contact with clients. Contracts also state that all agency personnel (including day program employees) must have criminal background checks as well as drug screening.

DDDS has limited their incoming client placements to emergency situations only.

Due to the economic stresses on families, there has been an increase in their client base, particularly from behavioral health units like Rockford, MeadowWood or Dover Behavioral Health. In FY 10 there was funding for 40 emergency placements and the Division exceeded their projection by 15 clients.

Dr. Ellis stated that funding for 50 emergency placements has been set aside in

a contingent capacity under Office of Management and Budget (OMB). The Division is unclear at this point how they will be able to access the funds if needed for an emergency placement. The Division has monies set aside to cover 5-6 emergency placements in FY 11's budget. Dr. Ellis assured commission members that despite the Division's \$2.9 M base budget reduction (which was to cover dental and doctor treatment, medication monitoring, etc), they will find a way to cover the services. Dr. Ellis further added that most Delaware Psychiatrists do not accept Medicaid (or at least those that the Division contracts with will not accept Medicaid). As a result, the Division is paying straight State dollars for the service.

The DDDS family Support Unit provides some assistance in helping with aging parents but does not work on estate planning. The Division previously funded a training program delivered by the ARC. As funds got tight, the training program was placed on hold. In the future, the Division is planning on offering services to cover guardianship and estate planning.

Barriers for DDDS include: lack of qualified service providers depending on an Individual's support needs, lack of available funding for the Division, and lack of specialized medical services in Delaware.

DDDS is currently trying to figure out how to utilize Stockley's "new" Medical Center. A proposal was to invite specialists from surrounding States to set up clinics at Stockley. The facility is the home for 70 residents.

Regional Extension Center

Les DePizzo, Quality Insights of Delaware, spoke to the Commission in July 2010 regarding the Health Information Technology Regional Extension Center (REC). Delaware will receive slightly over \$4 million during a four year period. REC is a relatively free service to primary care physicians to help them implement electronic health records (EHR). REC is part of the stimulus bill to promote more

jobs and enable nationwide health information exchange. QI of DE will employ 20 new staff members—was an office of 9 staff members before REC.

REC's will each serve defined geographic areas and offer technical assistance, guidance and information on best practices to support and accelerate health care providers' efforts to become meaningful users of EHRs

The contract with the Office of the National Coordinator for Health Information Technology (ONC) was established to help implement 1,000 primary care physicians in DE and get them to meaningful use. DE currently has 1,200 primary care physicians and 250 have EHR's installed.

Mr. DeIPizzo stated that the majority of the program is located in southern Delaware. He further added that Christiana Care is starting a program with affiliated practices to purchase health information technology medical records. In addition, Mr. DeIPizzo shared that QI of DE is project managing the process for Christiana Care and helping the physicians with implementation. This effort is in addition to any stimulus funds a practice would be eligible to receive.

QI of DE receives payment based on signing practices up, bringing the practice to "go live" under electronic medical records and bringing the practice to meaningful use. QI of DE is targeting only primary care physicians with 10 providers or less.

Meaningful Use Regulations, final version, was announced July 13, 2010. It requires physicians to implement the use of electronic records and utilize electronic records to improve quality of care.

Meaningful Use involves the collection of specific data and includes functions, such as e-prescribing. An adequate support system must be established and alerts put in place to identify what tests/procedures should be performed. It will assist with the patient's historical and new condition.

There has to be some capacity to share information with other health care providers and in Delaware, the Delaware Health Information Network (DHIN) is really critical.

Finally, a physicians practice must be able to send quality indicator data out of their electronic health records to a data warehouse (CMS database) to report how they are performing. Each physicians practice is able to choose which quality indicators they will use.

CMS, in return, can publish the data or send information back to the practice so they are aware of their performance measures as they relate to others. QI of DE plans to provide feedback services to any practice they implement. This would be similar to what hospitals are using under the PQRI program where information is being provided voluntarily and physicians are receiving incentive payments if certain standards are met.

As an example of quality indicators, Mr. DeIPizzo shared that for individuals with diabetes it might be lipid levels, where as for prevention services, it might prompt the physician to check and see whether the patient has been screened for cancer or received a pneumonia/flu shot. Most of the indicators are accredited by the National Quality Forum- they are standard and have been validated.

Mr. DeIPizzo stated that a major benefit for a practice having an EHR and meeting meaningful use is they become eligible for substantial subsidy payments from the Federal Government. That means that the practice could receive up to \$44,000 for treating Medicare patients.

Mr. DeIPizzo stated that the impact on nursing homes will be light, yet profound.

Many of the primary care physicians QI of DE will implement serve as medical directors for Delaware nursing homes and also have a separate practice. ERH templates can be developed specific to each part of their business.

Mr. DeIPizzo added that QI of DE will be speaking with DE nursing homes to encourage DHIN participation. DHIN is currently piloting a Continuing Care Record (CCR) that will resolve transition issues for individuals who are admitted/discharged from the hospital or nursing home/community. Standardizing and sharing of record systems with a broader community will provide a better communication of information. The CCR pilot will be a benefit to nursing homes. Several Delaware nursing homes have begun purchasing electronic records that do not communicate well with other software packages. Mr. DeIPizzo stated that QI of DE is available to speak with facilities about some things to avoid. Since 2005, QI of DE has been engaged with 2-3 nursing homes around this same discussion.

Mr. DeIPizzo reported that turning papered health information records into an electronic format can be achieved by scanning previous data or looking at structured data beginning at a specific point in time. This is one of the biggest barriers faced when switching to electronic health records.

Mr. DeIPizzo stated that there is synergy created between EHRs, DHIN and personal record keeping. DHIN is like a mini application. It can be used without EHRs. DHIN is set up to feed from EHRs to identify quality care outcomes specific to that patient.

Personal record keeping is more difficult because there aren't any standards yet established.

It was reported that until the Federal Government grants permission, controlled substances (such as pain meds) will not be able to be e-prescribed.

Best Buddies of Delaware

Mallory Karl, Program Manager for Best Buddies of Delaware, spoke about the international organization, whose mission is to promote global volunteer movement

that creates opportunities for one-to-one friendships, integrated employment and leadership development for individuals with intellectual and developmental disabilities (IDD). The program is located in all 50 States and 46 countries.

The program works to end social isolation for individuals with IDD by establishing meaningful and lasting friendships as well as life skills.

Individuals are matched based on: gender, age, common interests and proximity to home or work. All participants are asked to commit to a one-year friendship; maintain weekly contact by phone, mail or e-mail and see each other twice a month. The organization hosts six activities throughout the year for members and is offered free or for a nominal fee.

Best Buddies of Delaware is funded through individual gifts, foundation grants, Government grants and special events.

Best Buddies works with and supports many organizations: DFRC, Down Syndrome Association of DE, Special Olympics Delaware and Autism Delaware. There are also host sites (residential homes or schools specifically for individuals with IDD): Mary Campbell Center, Chimes, Easter Seals, and Meadow Wood School.

There are three programs offered through Best Buddies of Delaware.

School Program- 21 schools within all three counties participate in this program for students (10+ through college years) that operates as student run clubs at the schools. This was the first program offered through Best Buddies of Delaware when it opened in 2008.

Citizens Program- Adult community program (18+) where IDD individuals are paired with a non-disabled peer in the civic or corporate community (Bank of America).

Currently the Citizens Program has 45 matches and 10 individuals on the waiting

list. The Citizens Program began September 2009. Individuals with a disability need someone to sponsor them (family member, caregiver, etc) to speak on their behalf and act as a liaison.

E-Buddies is a national Best Buddies on-line pen pal program that pairs individuals with IDD with a non-disabled peer who lives in another state through e-mail. The server used blocks out phone numbers and e-mail addresses.

Disability awareness and leadership training is required for school based programs. For adults, all participants without disabilities are given a brief overview of disabilities during the interview. In addition, two training sessions are offered yearly for individuals without disabilities to learn about disabilities, participate in an open forum with program peers and an opportunity to hear from presenters regarding a specific topic.

IDD program participants are provided with a friendship and an annual Buddies United Leadership Development (BUILD) training session. Friendship training offers participants with life skills such as phone etiquette, etc. During the annual BUILD training, speakers are brought in to discuss how an individual may become a leader, self-advocate or influential community member. Participants learn how to prepare and present a speech.

Background checks are performed for every Citizens Program applicant. There is a telephone screening performed by Best Buddies of DE staff to see if the candidate's idea of the program is correct. A background check and in-person interview is also conducted.

School Program applicants are discussed first with staff members who serve as advisers as to whether an individual that signed up for the club should be in the club. Each of the 21 school's that participate in the program has 20-30 student matches. Background checks are also performed for e-buddy candidates. The program

currently serves 18 Delawareans.

Ms. Karl mentioned they are not currently involved with DDDS.

Ms. Karl stated that volunteer recruitment and volunteer management are the two most difficult barriers for the program. She further added that pairing younger adults with disabilities to non-disabled individuals also is a challenge.

Office of the Public Guardian

Lexie McFassel, OPG Director, provided commission members with an update since OPG's last DNHRQAC presentation.

The Office of the Public Guardian is a non-judicial agency for the Administrative Office of the Courts that makes medical decisions, health care decisions and maintains finances for individuals (both person and property) found to be incapacitated by the Court of Chancery. OPG can also assign Medicaid or Social Security benefits to facilities.

OPG involvement requires that an individual have an incapacity that renders them unable to make decisions for themselves. There cannot be another person able to serve as their guardian. The individual must be at some level of risk such as financial exploitation or a health risk, OPG often works with

Adult Protective Services (APS) for individuals that are at physical risk or in danger with their situation.

Robin Brunner, former OPG Director, presented a wish list to DNHRQAC members when she spoke about two years ago. The wish list included: funding for a Nurse Case Manager; developing a Data Management System; assisting with statute support enhancements, protocols and standards and providing legislative review.

The Data Management System was achieved through a personal contribution to OPG.

The non-judicial agency improved their on-call system. In the past, OPG staff was contacted on their cell phones and pagers if they were on-call. Presently, on-call notifications are sent to staff Blackberries eliminating pagers and duplication.

The National Guardianship Association recommends the public guardian be an attorney and Ms. McFassel is the first attorney ever hired as Public Guardian. The benefits of having an attorney as the public guardian: it is a legally intensive process when one is seeking guardianship and does the person seeking guardianship meet the legal definition of a person needing a guardian.

There currently are 600 pleadings being followed by OPG that were followed previously by the Department of Justice (DOJ).

The office was established in 1984 by a statute that enabled the agency to collect administrative fees and delegate guardianship services.

OPG is working on legislative initiatives:

Clarify that the public guardian has to be an attorney

Expand guardianship role to include advocacy or protective services

Modify existing statute to be able to collect guardianship fees

The non-judicial agency is anticipating that guardianship fees will off-set operational costs and enhance services for the wards. The guardianship fees could help to fund a nurse case manager position, something that has not been approved in previous budget requests.

The guardianship fees would come from a percentage of a ward's estate for administrative fees in handling their case and providing services. Ms. McFassel shared that it is a common practice among public guardian's offices to collect guardianship fees. The agency has investigated how to equitably collect fees from individuals who do not have much money.

OPG would also like to retain attorneys if necessary to aid in a court hearing should

a ward face criminal or other actions and assist in recouping assets in situations like financial exploitation.

Office of the Public Guardian currently serves 230 individuals and handles approximately \$1 million per year (social security checks included). The agency would like to expand the number of clients being served. Presently there are 60 case referrals that the office has not been able to take for one reason or another. Most of OPG's clients reside in long term care facilities but DDDS clients are also served by OPG.

Ms. McFassel shared that most case referrals come from other State agencies, hospitals or LTC facilities.

OPG case workers average between 50-70 open cases. The National Guardianship Association recommends 20-25 cases per case worker.

OPG plans on restructuring the agency so it may increase volunteer legal services possibly sub-contract out services if needed and continue being as efficient as possible within the agency's budget (which has not changed in five years).

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 were held at each Commission meeting and included information updates on a variety of issues:

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.

Information on DLTCRP investigated 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 2010.

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. The Division is in the process of having software developed which will track the hours of training and electronically link it to the CNA certification registry.

DLTCRP is also currently working with an independent contractor to develop and monitor a project that will make electronic connections, through a "Dashboard," so that an employer can efficiently determine whether a prospective employee is suitable to work in a long term care setting. This is not just about Criminal Background, it will include a variety of registries. The Division's target is to have a portion of the "dashboard" on-line by January 2012 with complete implementation in Septembers 2012.

Resident Council Meetings

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

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

The Resident Council must send out invitations to staff or others if the residents want them to attend a meeting. The staff provides record keeping of the meetings and are told by the council what they would like to have appear on the agenda. During an annual LTC facility inspection, surveyors check to see whether Resident Council meetings occurred and request a copy of the last six months of meeting minutes.

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

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

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

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

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

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

Organizations who want to present to the Resident Council, may contact Laura Hendrick or the EPB Social Services Department at (302)995-8400.

Ms. Hendrick shared that the population of residents at Bissell is a lot younger (majority between 40-55 years of age), a lot more alert, confident and oriented as to where they live. There is longevity in the residents at EPB-therefore they know the other residents and staff so they can share their concerns more freely than perhaps other facilities.

Ms. Hendrick mentioned that the staff reminds the residents that they are able to speak at meetings about concerns without staff present should they choose to do so.

Mr. Victor Orija from the Ombudsman's Office added that the Ombudsman have facility assignments and can only attend the Resident Council meetings if invited by residents.

Ms. Hendricks shared that staff attends the meetings monthly, unless told not to come.

Medicaid Fraud Control Unit

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

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

MFCU investigates and prosecutes cases involving patient abuse, neglect and financial exploitation for individuals that reside in licensed nursing homes, assisted living facilities, and group homes. The unit also performs

Medicaid fraud investigations. Since March 2010, Ms. Showalter screened 80-90 referrals from DLTCRP's investigation unit. If the referral is egregious in nature, the referral will be sent immediately. Otherwise, DLTCRP will conclude its investigation before a referral is made to MFCU.

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

The MFCU has jurisdiction for and investigate and prosecute Medicaid fraud involving any provider that accepts and is reimbursed by Medicaid. That includes, all doctors, hospitals, pharmacies, therapists, dentists, nursing homes, etc.

Medicaid fraud has been gradually increasing over the last decade all over the U.S. and reached such rates that the federal government and states were compelled to address it with coordinated efforts and increased resources. The MFCU works in collaboration with health care providers and provides educational training in licensed facilities.

Delaware Health Information Network (DHIN)

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

Delaware Health Information Network was created by statute in 1997. The program went live in 2007 with Christiana Care, Beebe Medical and Bay Health along with Lab Corp. DHIN then added the capability of searching historical data through clinical information for patients. In addition to being an electronic post office, the system also provided the ability to search for a patient of their clinical history.

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

DHIN is a secure system for delivering patient information from hospitals, labs and radiology facilities directly to the doctor's office. The network provides doctors with a fast, efficient delivery system to receive information securely as soon as it is available and in a standard format. DHIN is available at no cost to medical practices. There are LTC providers (less than five) that are senders or receivers of information under DHIN. It helps residents who are being admitted to a nursing home or assisted living facility by allowing electronic medical records to follow the person. This could improve the quality of care by allowing additional access that was not available beforehand.

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

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

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

Mr. Manning shared that when a provider signs up to receive information, they only receive information addressed to them. If using the patient search function, the first level of information that can be accessed is information regarding their patients for

which they have been copied on only. Should a provider want additional information from another provider, one must “break glass” by identifying their relationship to the patient –access which is then tracked and audited.

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

There was a statutory change recently and as a result, in January 2011, DHIN will be an independent public-private not-for-profit organization.

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

Catholic Charities Counseling Services

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

CC offers counseling services to individuals with mental health issues such as depression and anxiety, as well as work on substance abuse and behavioral issues. Catholic Charities provides counseling services to anyone regardless of their ability to pay, but does accept most third party insurances, as well as Medicare and Medicaid. If there isn't any insurance, a sliding fee scale is used to make counseling affordable. 1/3 of the counseling service clients do not have insurance so they are charged a very nominal fee.

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

Presently there are two LTC facilities downstate (Methodist Manor and Seaford House) which Catholic Charities provides counseling services on-site weekly. Catholic Charities is hoping to expand counseling services in New Castle County. Dr. Coffey shared that Catholic Charities has the ability to enter in to a contracted in-house counseling service agreement with LTC facilities. Catholic Charities Counseling Services: (302)655-9624

Division of Services for Aging and Adults with Physical Disabilities

Bill Love, DSAAPD Director, provided an overview of the Division. He discussed issues, priorities and challenges affecting DSAAPD which included:

FY11-2012 Priorities:

Implementation of the Aging and Disability Resource Center (ADRC), Medicaid Waiver Consolidation, State LTC facility transition, managing the economic downturn and coalition building.

Approximately half the Division's funding is from the Federal Government (Administration of Aging). Most of the services in the community are provided by partnerships the Division has with non-profit community.

Mr. Love emphasized the need to rebalance long-term care services in Delaware as 87% of expenditures are spent on facility-based services while over 80% of Delawareans want services to support them in their own homes as they grow older. It is also much more cost effective as an average of 3 individuals could be supported in the community for the cost of one person living in a long-term care facility.

DSAAPD Services include: Case Management, Respite Care, Adult Protective Services, Adult Foster Care, Attendant Services, Adult Day Services, Alzheimer Day Treatment, Assistive Devices and Cognitive Services.

Delaware's population explosion of older Delawareans is impacting the need for

services at a rapid growth rate. The Division is focused on preparing for the growing number of Delawareans who will need services as well as building access to community-based long-term care services. Housing is a barrier to services and the Department of Health and Social Services has several initiatives to provide more opportunities for housing including a partnership with the Delaware State Housing Authority to provide more vouchers to subsidize the cost of housing for low income individuals.

The Division hired a Community Ombudsman in Fall 2010 who will work with individuals that live in the community.

Currently there are three Medicaid Waivers (Acquired Brain Injury, Assisted Living and Elderly/Disabled) that the Division made significant changes in order to consolidate them into one waiver called the Elderly& Disabled Waiver. The consolidated waiver will be effective 12/1/10 and will expedite administration and facilitate access to more services. Self-directed services are a key component of the consolidated waiver.

ADRC began implementation in October 2010. The Delaware model includes a 1-800 call center, website and core support services (case management, options counseling and transition services). The ADRC and will open more doors for DSAAPD to apply for additional federal grant opportunities. The ADRC will provide access to more information and services over time- a one stop center of information.

Transition of 3 State Facilities (Bissell, Bacon and DHCI) to DSAAPD will occur in the next several months. The goal is to transition staff and residents smoothly and to complete a comprehensive assessment of each resident to identify support needs and interest in community-based placement.

Long Term Care Ombudsman Program and Adult Protective Services will be transferred out of DSAAPD and into the Office of the Secretary to enhance visibility of the programs, provide more impact across the department, and avoid perception of potential conflict with the three LTC facilities moving into DSAAPD.

The Division is continuously looking at Federal grant opportunities to offset funding obstacles and still be able to provide and improve services.

The Division continues to work with stakeholders (agencies, non-profit organizations, advocacy groups and consumers).

Ombudsman Program

Victor Orija, State Ombudsman, spoke to the Commission about the Long Term Care Ombudsman program which was established to provide advocates on behalf of LTC residents to ensure they have a strong voice in their own treatment and care.

There are four LTC Ombudsman (dedicated facility coverage) that work with Mr. Orija. In August 2010, a Home and Community-Based Services Ombudsman was hired. The Ombudsman Program also has volunteers who assist in Delaware's 50 NH's and 33 AL facilities.

The Ombudsmen investigate and resolve complaints; offer friendly visits; monitor federal and state regulations; provide outreach and education; witness Advance Directives and advocate for legislative changes.

The Ombudsmen work with many state agencies as well as all licensed nursing homes and assisted living facilities to ensure residents rights.

The Ombudsmen are not able to attend the Resident Council meetings unless they are invited.

There is a web based report produced at the end of January each year which is used for funding purposes (National Ombudsman's Report).

Mr. Orija shared that they survey residents regarding satisfaction

but only receive a 20% response rate of return.

Many facilities develop and implement their own satisfaction surveys for residents and staff while other facilities hire companies to do the surveys. The Delaware Health Care Facilities Association initially funded two years of satisfaction surveys for providers however, DHCFA no longer funds these.

Hospice Collaboration

Sheila Grant, VP of Hospice & Palliative Care Network of Delaware, provided an update to Commission members in November 2010. The network began 1 ½ years ago and the 48th state to participate in the national network of providers.

The network's mission is to improve the quality and accessibility of hospice and palliative care in the state. There were several hospice providers (also Hospice & Palliative Care Network of DE members) in attendance at the meeting.

40% of hospice patients nationwide are nursing home residents. Ms. Grant added that LTC's focus is primarily comprised of rehabilitation and restorative care.

Ms. Grant shared that the American Geriatrics Society warns that 45-80% of nursing home residents have substantial pain that is under treated. She further added that the society states that many (40%) cancer and (25%) non-cancer patients do not receive pain medication although they experience pain daily.

Nursing home residents enrolled in hospice are less likely to be hospitalized in final 30 days of life; have physical restraints; receive IV/parenteral feeding; receive meds by IV or inter-muscular injections or have tube feedings in place.

Ms. Grant also provided the Commission with a meta-analysis from the Journal of Pain and Symptom Management September 2009 edition. The study shows that nursing home residents with hospice services are more likely to be assessed for pain, and 2 times more likely be treated daily for pain and receive pain management

in accordance to clinical guidelines.

Hospice focuses on quality of life and the priority is comfort. Hospice services include: medication, continuous care, psycho-social support, extra CNA care, and bereavement counseling for family/caregiver.

6% of nursing home residents nationally elect hospice services.

Ms. Grant reported common feedback from nursing homes include : “We don’t use hospice here”, “We do our own hospice” and “We do our own comfort care/palliative care”.

Ms. Grant reported the following common barriers to hospice in LTC:

-Hospice providers must have a contract with nursing homes in order to care for residents.

-Nursing homes may choose to contract with hospice (or not).

-Regulations

-Reimbursements cut payments

Nursing homes bill individuals based on their level of care. Skilled facilities receive the following daily reimbursements from Medicare: \$549.45 Rehabilitation, \$261.89 Extensive Services, \$325.67-\$225.34 Special Care (hospice) and \$241.84-\$179.99 Clinically Complex.

Ms. Wozny (DSAAPD) shared that the Journey’s Program has had great success in working with hospice providers when transitioning individuals back out into the community.

Quality Indicator Survey Update and Survey Process

Rob Smith, DLTCRP Administrator, provided oversight to Commission members about the Quality Indicator Survey (QIS) annual survey process by CMS for Delaware nursing homes. DLTCRP implemented the QIS survey process over a year ago in Delaware for annual surveys. The regulations have not changed,

just the process. Complaint surveys are still performed in the traditional fashion.

Delaware is currently ranked #2 for the number of deficiencies cited in the U.S (was ranked #1 in the traditional process). The number of deficiencies and level of severity remains the same for QIS versus the traditional survey process.

QIS is a computer assisted long-term care survey process used by State Survey Agencies and Centers for Medicare & Medicaid Services (CMS) to determine if Medicare and Medicaid certified nursing homes meet Federal requirements.

During a QIS survey (which is a Federal survey process), the team leader connects their computer up to the MDS server (which every facility is responsible for inputting data for every resident). The computer selects the sample (40 active records and 30 discharge records). In the traditional survey process, the surveyors would randomly choose samples based on a facilities census.

There are two stages to the QIS annual survey process:

-Stage 1: the computer triggers which areas should be reviewed based on interviews of: residents, family members and Resident Council.

-Stage 2: Records are reviewed, interview staff and 50 med passes (dose, times and given according to doctors order).

*Any deficiencies discovered are then conveyed to the facility (in writing and during the exit interview). The facility must provide a written plan of correction within 10 days to DLTCRP.

The QIS objectives:

Improve consistency and accuracy of quality of care and life;

Provide timely and effective feedback;

Objective investigation; and

Target quality concerns specific to the facility.

Currently, Exceptional Care for Children and Mary Campbell Center do not use QIS.

National Center on Elder Abuse

Sharon Merriman-Nai, NCEA Co-Manager, presented to Commission

members about the National Center on Elder Abuse (NCEA). NCEA

is directed by the U.S. Administration on Aging (AOA) which is committed to helping

national, state and local partners to ensure older Americans will live with dignity, integrity, independence-without abuse, neglect and exploitation.

NCEA is a resource center for elder rights advocates, health care professionals, law enforcement and legal professionals and others who work with or on behalf of older individuals. NCEA has a publications database which provides access to numerous publications on many topics, including LTC issues.

NCEA's website at www.ncea.aoa.gov provides many resources for the public as well as for professionals. One of the services NCEA provides is a professional Listserve, which features a weekday email newsfeeds to subscribers regarding topics of elder mistreatment and related issues.

NCEA often provides training for professionals regarding Adult Protective Services or other elder abuse topics of interest.

In addition, the Clearinghouse on Abuse and Neglect of the Elderly (CANE) is the nation's largest database of annotated references on elder abuse literature (www.cane.udel.edu) and is located at the University of Delaware (Center for Community Research and Service) in Newark.

NCEA is engaged in raising public awareness on a national scale (World Elder Abuse Awareness Day is June 15th); promoting the development of multidisciplinary approaches to address mistreatment; and strengthening professional training and education.

Medical Interpreter Training

Division of Public Health (DPH) Office of Minority Health Program Manager, Ronniere Robinson spoke to DNHRQAC members regarding DPH's Medical Interpreter Corps Program.

The purpose of the program is to increase the pool of trained medical interpreters available during emergency situations in the state. In addition the program provides training to bilingual medical personnel working in all aspects of the healthcare setting. Mr. Robinson explained that by eliminating the language barrier between provider and patient it decreases the chances of missed diagnosis; avoid inappropriate or incorrect treatment and eliminate poor patient follow up which increase costs associated with diagnostic tests or even death.

The Federal civil rights law mandates that healthcare providers provide access to interpreter services upon delivery of medical treatment. DPH offers medical interpreting training (Bridging the Gap) to bilingual medical interpreters who promote access to quality health care by:

- Enhancing the therapeutic relationship between patient and provider;
- Facilitating communication during the health care encounter for meaning and understanding; and
- Incorporating awareness of and respect for cultural perspectives.

After Bridging the Gap training, trainees will be able to:

- Adhere to the Standards of Practice and Code of Ethics of the National Council on Interpreting in Health Care (NCIHC);
- Apply each of four main roles of the medical interpreter (conduit, message clarifier, cultural broker, patient advocate);
- Acquire and use essential medical terminology;
- Function effectively in the triadic encounter across many settings; and

- Function effectively as an integral member of the health care team.

New Horizon Adult Day Program

Evelyn Wells, Division of Aging Director for New Horizon Adult Day Care, provided a program overview. The New Horizon Adult Day Care is located at Delaware Hospital for the Chronologically Ill (DHCI) in Smyrna and hours of operation: 7:00 am-4:00 pm.

New Horizon is the only state operated adult day program in Delaware. New Horizon participates in the Medicaid Waiver program and also offers a sliding fee scale based on a families ability to pay. Services will not be denied to anyone regardless of income.

The day program offers a safe environment and is designed to encourage independence for seniors and adults with disabilities while enriching the individual's quality of life. There are currently 17 clients in the day program which has the capacity to serve 46 individuals.

The staff receives on-going training to assist client needs. Clients are able to receive some skilled nursing services: care plan management, medication, incontinence care, activities, physical therapy, etc.

Transportation and lack of marketing efforts are the biggest barriers for this program.

New Horizon Adult Day Care contact information: Evelyn Wells @ (302)223-1033 or evelyn.wells@state.de.us.

End-of-Life Coalition- Murt Foos

Murt Foos, trainer for the education committee, presented to Commission members about the Delaware End-of-Life Coalition (DEOLC). DEOLC is a voluntary organization established 10 years ago to strengthen collaboration between

public and professional communities regarding all end-of-life issues. To visit

DEOLC's website: <http://deolc.org>.

DEOLC's mission:

- Share resources
- Promote public and professional education
- Foster innovations
- Address public policy
- Increase cooperation among end-of-life service providers

DEOLC sponsors a variety of programs annually to support its mission:

- Excellence awards for Hospice & Palliative Care Professionals (Oct and Nov)
- National Survivors of Suicide Loss Program (Nov)
- National Healthcare Decisions Day (April)
- National Bereavement Teleconference (TBD)
- Festival of Hope for Bereaved (Nov)

End-of-Life issues impact the practice of all healthcare providers, counselors, clergy, hospice staff, social workers and many others.

DEOLC is offering Thanatology certification in partnership with the University of Delaware. Thanatology addresses many aspects of grief, loss and bereavement. For additional information or to register: www.udel.edu/dsp/thanatology or call: (302)831-8370.

Ms. Foos mentioned that there are challenges and barriers for the Delaware End-of-Life Coalition. Funding continues to impact many organizations interested in providing public awareness events. In addition, cooperation instead of competition could be viewed as a potential barrier or challenge-there are many venues available for end-of-life care.

Medical Orders for Life Sustaining Treatment (MOLST) is a document that states persons wishes should they need urgent medical care and/or transportation services.

Ms. Foos mentioned that MOLST appears in Delaware's May edition of the Register of Regulations in tandem with proposed regulatory changes to the Personal

Advanced Care Directives (PACD).

Senior Protection Initiative/Elder Abuse Unit

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

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

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

In addition, the Senior Protection Initiative was created and includes: law enforcement, social workers, nurse gerontologists, Adult Protective Services, DLTCRP, National Center for Elder Abuse, Criminal Justice Council and other state Agencies.

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

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

A statewide event was celebrated on June 15th, 2011, to mark the 6th Annual World

Elder Abuse Awareness Day (WEAAD), sponsored by the Delaware Senior Protection Initiative with the Delaware Aging Network. A purple balloon release was launched in all three counties signifying the recognition of the worldwide problem of elder abuse.

Individual events were held at the Newark Senior Center, Modern Maturity Center, and CHEER Community Center. In Dover, the cupola at Legislative Hall was lit in purple during the evening of June 15th to also mark the special day. Margaret Bailey, Commission staff, serves as a member of the World Elder Abuse Awareness Day planning committee, formed to plan activities commemorating the day.

The Senior Protection Initiative also sponsored an outreach effort in Spring 2011 where Delaware High School students were invited to make a short YouTube video about elder abuse as part of the *Connecting Generations: Compassion in Action* video contest to help get the word out about elder abuse. The winner of the 2011 contest was Bernard Dennis, a sophomore at Cape Henlopen High School. The video may be viewed at: www.delaware.gov/connectinggenerations.

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

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

This past year, Judge DePescio (DLTCRP) and Ms. White worked together to create a new statute for Delaware called "Crimes Against a Vulnerable Adult". In Title 31 (APS)

there are violations against someone who creates a crime to an infirmed person but did not include crimes against a vulnerable adult. The Governor signed the bill July 17, 2010 at the Middletown (MOT) Senior Center.

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 15th 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:

SB 24 w/SA2- AN ACT TO AMEND TITLE 12 OF THE DELAWARE CODE RELATING TO THE OFFICE OF THE PUBLIC GUARDIAN AND TO ESTABLISH THE DELAWARE GUARDIANSHIP COMMISSION. This bill was signed 6/8/11.

SB 59- AN ACT TO AMEND TITLE 24 OF THE DELAWARE CODE RELATING TO WAIVER OF CRIMES AND ESTABLISHMENT OF CRIMINAL BACKGROUND REQUIREMENTS RELATED TO PROFESSIONS AND OCCUPATIONS. This bill was signed 6/8/11.

SB 102- Long Term Care Ombudsman was passed in House 7/1/11.

SCR 11- IN RECOGNITION OF THE 2011 ALL STAR AWARD RECIPIENTS OF THE DELAWARE HEALTH CARE FACILITIES ASSOCIATION DURING NATIONAL NURSING HOME WEEK. The bill was passed in House 5/5/11.

SCR 15 –A Resolution to commemorate CNA Day was passed in House 6/8/11.

HB 63- AN ACT TO AMEND TITLE 16 OF THE DELAWARE CODE RELATING TO SEXUAL ABUSE OF PATIENTS IN FACILITIES. This bill was passed 5/19/11.

HB 51- AN ACT TO AMEND TITLE 11 OF THE DELAWARE CODE RELATING TO THE GOLD ALERT PROGRAM FOR CERTAIN MISSING PERSONS. This bill was signed 5/4/11.

HB 45 HA1- AN ACT TO AMEND TITLE 24 OF THE DELAWARE CODE RELATING TO NURSING. This bill was signed 5/31/11.

HB 214 w/HA1+SA1- To act amend several title of the Delaware Code relating to the removal of insensitive and offensive language was signed 6/30/11.

HB 91- AN ACT TO AMEND TITLE 29 OF THE DELAWARE CODE RELATING TO THE USE OF RESPECTFUL LANGUAGE WHEN REFERRING TO PERSONS WITH DISABILITIES. This bill was signed 8/17/11.

HCR 18 –A Resolution to commemorate World Elder Abuse Awareness Day was passed in Senate 6/14/11.

HCR 21- A Resolution to commemorate Residents Rights Rally 2011 was passed in Senate on 6/30/11.

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 67 nursing homes and assisted living facilities in the period between July 1, 2010 and June 30, 2011. There were also 5 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 employee recruitment and retention challenges to aid in the quality of care for residents.

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