

STATE OF COLORADO

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Dedicated to protecting and improving the health and environment of the people of Colorado

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Colorado Department
of Public Health
and Environment

Long Term Care Advisory Meeting
January 4, 2011
9:30 - 11:30 a.m.
CDPHE Campus, Building A
Sabin-Cleere Room

Call to Order: Acting Long Term Care Program Manager Kim McClain the meeting to order at 9:32 a.m.

I. Presentation on Medical Marijuana Q&A: Bob O'Doherty from the Department's Center for Health and Environmental Information held an open forum for providers to ask questions about medical marijuana. Prior to opening up the floor for questions, Mr. O'Doherty shared a brief background and statistics. The program was passed as a constitutional amendment in 2000. In the program's first year of operation there were 500 names on the registry and there was one person working on it. By year end 2008 there were 2,000 names on the registry. Today there are 120,000 on the registry. The real growth began when the new federal administration said they wouldn't prosecute anyone obeying state law in this arena. The registry went from 4,000 to 120,000 names in 12 months after that. There are about 1,200 physicians in the program. Most physicians have recommended fewer than 5 patients, and there are 15 doctors that have recommended most of the patients on the registry.

The state law does not transcend federal law. The state law allows the state to issue a card that allows a person to possess two ounces of marijuana and six marijuana plants. It does say that you may not use marijuana in plain view or in a place open to the general public. You may not use it in any way that it would endanger someone else (e.g., driving or operating heavy machinery).

When long-term care providers pose the question, "What does this mean in a long-term care facility," the real answer is 'We don't know.' The law doesn't speak to this. If you're in a federally funded facility, I can tell you anecdotally – from the phone calls we've received -- that other federal programs won't allow the use of marijuana. For example, that's why you don't see marijuana in veteran's hospitals or federally subsidized housing. All federal programs say that they operate under federal law and using marijuana is illegal under federal law. By state law, you may possess it.

Q: How does the rule, which allows individual patients to possess two ounces or six plants, allow these patients to walk into these shops and buy marijuana indiscriminately?

In the beginning, a patient could have a caregiver who could keep marijuana or plants for the patient. Two years ago, CDPHE tried to limit the number of patients a caregiver could have to five patients in rule, but the Board of Health denied the request, so caregivers could have an unlimited number of patients @ 6 plants each and patients could obtain marijuana from them. The dispensary model grew out of the lack of limits on patients to be served, and ultimately was codified in House Bill 1284, which just passed this last July 1. HB 1284 says that a medical dispensary or medical marijuana center may grow and hold your marijuana for you. All of this is available on our web site.

Q: How are the surveyors looking at it in nursing homes?

A: (Answered by LTC manager): Our surveyors survey using the federal regulations. Our latest direction from CMS is that it's not legal~~ly~~ federally so surveyors are not to look at medical marijuana as a treatment. Right now, surveyors aren't looking at it until more direction is provided from CMS.

Q: The ombudsman's office gets a lot of questions about facilities that refuse to admit someone who is using medical marijuana. My understanding is that that's fine and it's within their purview to say "no."

A: The facility has the option to choose not admit someone. There is no regulation that says providers have to have even a justifiable reason for not admitting them. That's a provider's opportunity to say that the resident's needs can't be met due to the medical marijuana considerations.

Q: I thought surveyors were looking at the clerical issues ... how is it stored and dispensed?

A (Response from survey team manager): Surveyors did have a few citations, sometime back, and those citations were deleted by CMS. In one instance the tag was deleted by CMS a year later. It's an area that surveyors don't have clear direction on.

Q: How's the backlog?

A (Response from Bob O'Doherty): The program has caught up. But we're not caught up with changes. For every person who applies for a card there is at least one change. So the registry program receives about 150,000 applications a year and about 120,000 are successful. Every year, the program gets about that same number of changes, e.g., "I'm changing from this medical center to that medical center;" so staff are behind by about 45,000 on those changes and anticipate being caught up by the end of March, 2011.

Q: Are there any pending requests for adding diagnoses?

A: There are none pending at the moment. There were several earlier this fiscal year, all of which were turned down.

II. Agency Reports

a. Department of Health Care Policy and Financing: Kim McCLain introduced Rose Marie Nelson, who came to the meeting as a representative of the agency; she is NOT the individual replacing Janice Brenner. Ms. Nelson reported that Janice Brenner's former position has not been filled yet. Ms. Nelson informed the audience that if anyone had questions, she would take those questions will bring them back to the agency and get back to attendees with the answers.

Q: What is the status of the hospital backup program?

A: I can't discuss the hospital backup program. The new policy direction was a surprise to me as it was to the division. So we are still reacting to it. We have been contacted by the providers and they are concerned. I know the department is certainly invested in ensuring that the patient's needs are met. The question appears to be the setting in which those patients are being served. Preliminary discussions on the issue suggest that we will be having a cooperative process where the providers and other stakeholders can address this in a comprehensive manner. We don't really know what's going to happen, but by the end of this week we will be meeting with the providers and will start the process. I don't know what will come out of it.

Provider Comment: Jill Hanaberry doesn't see a use for the program. We sat around for two years. We had a meeting in September cancelled and a meeting in February cancelled. Obviously the position has been made and patients are clearly better off out-of-state; the state can save money when the truth of the matter is the client

leaves the state of Colorado to another state and its all by Medicaid. It bothers physicians. Jill Hanaberry believes that being stuck in a hospital for 29 days average is not impacting the clients in long-term care facilities. Her philosophy sets the tone.

Provider Comment: (As a question) The recommendation is that Colorado will no longer have a hospital backup program?

Provider Comment: It's frustrating that we've gone through this process for two years. It's kind of like being blown off and it's scary for the residents, because the facility can't operate if the population declines or there are no new admissions.

A: We didn't know about this policy until it was announced at the JBC (Joint Budget Committee) hearing. However, Mrs. Hanaberry has indicated to me in the past that she understands the responsibility that the state has in order to meet the needs of those very fragile patients. I'm not certain that the hospital backup will be going away. Structurally we may have some changes. It's premature to jump to conclusions. It's being discussed internally and we want to have a mutually agreeable program. We had this conversation a couple of years ago. This should be part of the process as we are moving/engineering the hospital backup so to speak. The ombudsman will be part of the discussion. It's going to be a cooperative process; that's what I'm recommending.

Q: How many residents are in the program?

A: For the entire state it's about 22. We have had a few admissions in recent months.

Q: What will the timeframe at which you'll be able to communicate with the community?

A: We're concerned about the anxiety that this uncertainty can cause for patients and their families. We are waiting for the administration to define the policy decisions so that we can communicate them to the community. Maybe they're waiting to meet with the providers before they make a decision set in stone. I'm not prepared to talk about this; I don't know enough to do so.

b. Culture Change Accountability Board: State Ombudsman Shelley Hitt reported that the Board has received seven applications, and will meet in two weeks to review them and make recommendations on funding to HCPF and CDPHE. Ms. Hitt said the Board hasn't determined the extent of the submissions, the total amount of the requests, or if they follow the guidelines. She will report on this at a future meeting.

c. Colorado Culture Change Coalition: Sherry Clark announced that the CCCC January education program will be a panel discussion about the revisions to the pay-for-performance application. This program will be held at the Aurora Summit from 9-11 am. Call for presentations have gone out for the Colorado Accord, which will be held in Colorado on April 18-19. The conference will feature presentations, speakers, and a consumer track. Current speakers include Dr. Bill Thomas, Dr. Al Power, and Dr. Bonnie Cantor from the Pioneer Network. Dotty Lamm is the Accord's keynote speaker. Dr. Al Power was here a few months ago talking about dementia beyond drugs, and his will be an excellent presentation to attend. The Coalition is still looking for presentations in different areas and is accepting applications through January 10. Attending the Accord will give attendees an opportunity to come and learn about different areas of expertise. Contact Sherry with any questions. In addition, the coalition has received a three-year grant from the Colorado Health Foundation to extend education and reach.

III. Presentation: Oral Health Care Needs of Vulnerable Adults and Persons with Disabilities:

Michelle Vacha, RDH, BS, is the founder of Senior Mobile Dental, a **non-profit organization** based in Colorado Springs, and has been a dental hygienist for more than 22 years. During these years, she found that the few elderly that were able to come into the dental office had (1) difficulty getting transportation to the office and (2) exhibited a lot of tooth decay and tooth neglect. She determined that it would be easier for her to take her skills to the elderly in need of dental care, rather than having them try to get to the dental office. Since Colorado was the first state in the nation that allows a dental hygienist to practice completely independently from the dentist, she was able to create this non-profit program to address oral health care needs of the elderly

During her presentation, Ms. Vacha focused on (1) the growth and oral health care needs of the vulnerable adult population, including statistics; (2) medical considerations and barriers to access to care and (3) solutions for implementing an oral health care program in long-term care communities. (Please see the attached presentation.)

Highlights of her presentation include:

- In the last five years other states have begun to change their regulations for hygienists, but still no state is completely independent.
- It's often difficult and traumatic for seniors to come into the office; oftentimes they would be dropped off one hour before the appointment and then they'd have to wait for a few hours to be picked up after they were finished. As uncomfortable as they were in their physical state, this wasn't good for them.
- In November, Ms. Vacha attended the American Dental Association's first ever National Coalition Conference for the Disabled and Vulnerable Adult Population, which addressed the oral health care needs for this population. The association reported that – nationally – there isn't much care available for this population, specifically oral health clinics or programs for professional oral care.
The buzzword she picked up regarding the growth of the elderly population was “tsunami,” with January being the first month baby boomers reach this population. A well-conducted study out of California showed that the growth rate of the elderly population is faster than the growth of the population itself.
- It was thought that once someone hit his/her 80's, people didn't have their teeth anymore, but this isn't the case. Most persons between ages 65-84 have more than half their teeth.
- Ms. Vacha's main observation during her journey in this field is that elderly persons have taken care of their teeth their whole lives; just because they've lost the dexterity to brush their teeth and/or can't transport themselves to the dentist, their standard of care shouldn't change.
- Based on her experience, Ms. Vacha has found that the mouth of the a methamphetamine addict, also known as “meth mouth” and the senior mouth are very similar, because both are on a high quantity of drugs and both have poor oral hygiene. The difference is that meth addicts are slowly killing themselves, while seniors are trying hard to stay alive.
- The consequences of dental infections include extreme tooth pain, sinusitis, and bacteremia (when the infection has gone into the blood stream and affected person's physical health). Extreme tooth pain can change a senior's disposition. A facility staff member will say, “She's a sweet lady and now she is so aggressive and noncompliant that you can't bath her, and she won't cooperate with anything.” Then the exam finds that the resident is suffering from a dental abscess or something causing pain in her mouth;

once this problem is addressed and corrected, her whole disposition changes and she becomes herself again.

- Untreated dental infections can cause brain abscesses, facial cellulitis, and airway compromise.
- Besides decay and gum disease, oral cancer needs to be address.
- Oral cancer is one of the least discussed cancers, but if it's detected early there's an 80 percent chance of survival, but if detected late, there's only a 22 percent chance of survival.
- When untreated uncontrolled such as oral disease, e.g. oral decay or gum disease, it affects tooth loss. And tooth loss affects chewing problems, which results in malnutrition of the older adult population. A high percentage of institutionalized adults are malnourished in some way. The consequences of being malnourished are three times longer hospitalization, higher risks of infection, and cognitive impairment, which creates more dependence on help for activities of daily living.
- Besides the functionality of teeth, they are important to your smile, which has a huge emotional impact, and affects how you feel about yourself
- A report from the Surgeon General on oral health in May 2000 says oral health affects systemic health. It's been a silent problem affecting physical health. This is documented in type 2 diabetes, cardiovascular disease, respiratory disease (pneumonia) and cognitive impairment. The risk is especially high if someone with respiratory problems or pneumonia is having crisis; then they're intubated and their mouth is full of bacteria and disease. That tube is going through their mouth and into their lungs, which introduces those bacteria into the lungs.
- Early treatment for gum disease or decay could substantially lower medical costs for these systemic diseases. There were 8,000 hospitalizations due to **periapical abscesses** (a typical access in which a patient would get a root canal or have the tooth pulled), which resulted in 3-day hospitalizations or \$14,000 hospital bills. The amount of money that's saved for prevention of oral disease is a higher cost savings of the aids screening or the flu shot. The cost savings for prevention alone is coming to the attention of the federal government, which is beginning to realize the cost savings that would be realized
- There are two barriers to access to oral hygiene care: (1) transportation to dentist or (2) financial access/person lost their dental insurance; Medicaid doesn't cover preventive care; only PETI covers a little in nursing homes
- Four main areas how long term care facilities can institute oral health care programs:
 - **oral health education** – providing educational information at admissions; a lot of families already value oral health care, so if they know you have an oral health care program or clinic at your facility, this is going to boost your forward thinking and good for marketing
 - **prevention and daily care planning** –providing in-services for CNAs and caregivers, so prevention is the main thing. If residents can't brush their teeth and it's the CNAs job to do it, they have to know how to do it. There's very little education in CNA training re oral health care, and when it is discussed, it's about whether someone needs to be pre-medicated for a dental appointment
 - **assessment and needs** – identifying residents with disease
 - **create an oral health care program or clinic**

Senior Mobile Dental:

- Goes into the facility once a month and it's a good rotation. If someone breaks a tooth or needs something looked at – pain or an infection or a broken tooth – it gets done in a timely manner. The hygienist can also see if this affecting a resident's intake or nutritional status. Having these assessments will help with the state regulations.
- Has mobile equipment that is brought right into the facility, rather than a resident having to go into a van in the front of the building; this is very comfortable for the residents, especially those with advanced dementia. They can set up wherever it's convenient for you, whether it's in an open room or a beauty shop (somewhere where they can get a little privacy). When they're seen in familiar settings, these residents are more compliant. A lot of dental professionals don't want to work on this population because it's difficult and they're frail.
- Is a non-profit organization. Ms. Vacha doesn't want financial constraints to be a barrier for them to get the care that they need. Being independent, they can give unbiased opinions and assessments, not based on money. They are applying for a grant that is for assisting vulnerable adults in Denver, and they are expanding across the state, and around the nation. She has a denture dentist that is mobile and comes in the facilities; she has dentists that will accept seeing patients and if a resident has a dentist of record, she will report to the family, facility, physician, and dentist.
- Assists with treatment plans that are always **age and health appropriate**. Families appreciate different ideas on taking care of their family's teeth, not just one plan that requires thousands of dollars worth of treatment. Everything is individualized so it can go from taking care of the problem and the decay down to no treatment and a call and monitoring for pain and infection.
- Follows the Medicaid PETI fee schedule. For cleaning and exam, plus putting a protective varnish on the teeth and the house call, the total is \$110.37. For those that are not PETI-eligible, the non-profit can bill EVERCARE, or it can be private pay. This is a non-profit organization; she reported that most funding for oral health care goes to children's programs, but she's trying to educate funders, so that they will include the older adult population.

Q: What kind of training have you done for facility staff?

A: We provide in-service training because CNA's seem to be the ones providing the daily brushing and they haven't received the training on how to approach someone. We did an in-service at an Alzheimer's facility and brought someone up to see how to brush a resident's mouth. It's all in the approach. The big thing that CNAs say is that the resident has the right to refuse care, so they assume that if a resident purses his/her lips this is a refusal of care. But it's not; it's just *instinct*. Seniors with teeth have taken care of their teeth every day; they brushed their teeth every day. So if you can get past that initial resistance, and the person feels the toothbrush in there, they remember that sensation and they allow that person to brush their teeth. Even with the noise of the suction and the tooth polisher, the person remembers that they're getting their teeth cleaned and they allow it to happen.

Q: What about family education?

I found that I haven't needed to do family presentations, but we do report all findings and our procedures to the POA.

Q: If someone needs to have teeth extracted, do they pull them all out at once?

A: It depends on the dentist, the patient's health and stamina, the patient's longevity, which tooth or teeth are causing the pain. It's an individualized assessment. The majority of the people we see – and most are in skilled nursing– the families and staff choose for the hygienist to monitor rather than going through the trauma of the care.

Michelle can be contacted at 719-338-2195 or Michelle@SeniorMobileDental.com

IV. HFEMSD

- **MDS Update:** Kristen Gurney reported that providers should go to the MDS web site to view updates on MDS assessment, section A and information with links to training. The web site is http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp#TopOfPage
- **QIS Update and Q&A:** Kristen Gurney discussed some of the statistical differences between the QIS vs. traditional survey process. (Please see attached document.) Her data analysis was only based on 13 surveys with one group of eight surveyors included in the analysis, so while Kristen said it was too early to count the data as a true “statistical analysis,” the data does provide an overview of the differences between QIS and the traditional survey. All the data she presented was based on surveys with exit dates between 7/15/10 and 12/15/10.
 - The average number of deficiencies: has gone up: Traditional surveys: 44; QIS Surveys: 13. This is consistent with all the other states as well
 - The most prevalent citations are pretty similar between QIS and the traditional survey. The *big difference* is F279, the care plan tag. In traditional surveys, things like care plans, MDS', assessments, used to be cited in the care tag itself. However, CMS had always wanted surveyors to separate them out and do the care plan separately from the care tag. So now, with the QIS process and with CMS and the University looking over the survey process, *and* with the computer in a sense dictating the different paperwork and care deficiencies, surveyors have had more of these citations.
 - Regarding IDR results: 23 percent were deleted in the traditional surveys and 37 percent were deleted in the QIS surveys. Program staff is looking into why this is happening to determine if surveyors are providing enough evidence with their QIS investigations. The QIS surveys have been taking much longer and sometimes surveyors have found that they don't have the time to investigate all the care areas that are triggered.

Ms. Gurney also provided information on an interim policy on the QIS revisit process; this is only an interim policy because this is what surveyors are doing *until* the QIS revisit software is developed. (Please see attached document.) The QIS revisit is done using the CE critical element pathways. It can be done on the computer or it can be printed out and done manually (it depends on surveyor preference.)

The biggest differences are that the QIS revisit tends to be: (1) Instead of taking a sample of 60 percent of the original sample from the survey, surveyors have to take three residents under each care area, so the sample will tend to be bigger; and (2) Using the CE pathways requires more documentation, observation and record review than the traditional revisit, so facilities can expect revisits to be a little longer as well. Documentation revisits are conducted in the office.

The second group of eight surveyors have been trained and are now going through their second survey of record. After this survey, the program will have four teams of four QIS surveyors. Before long the surveys will be all

QIS surveys. The process is speeding up because there are 11 vacancies so all of the new positions will be trained in QIS.

Q: ARE they doing any FOSS surveys in QIS?

A: Not now, but we will be and the FOSS process will be different and we don't know what it will be like yet. We haven't received any guidance yet from CMS on this; the regional office staff hasn't been trained in the QIS process so until that happens, we won't do them.

Janet Snipes of Holly Heights Nursing Home, who has gone through the QIS process at her facility, shared that she was amazed at the process and that it was interesting to see it work. She noted that, just because of the software, it is a ton of the work for the surveyors. Several times pathways were triggered and it really extended the survey. She also found it interesting how the survey almost exactly followed the training she had received. When surveyors were in Stage 2 of the survey, she could see what pathways they were following by the questions surveyors were asking.

Kristen Gurney explained that the environmental path can be triggered so easily and that the CE pathway has to be completed, no matter what triggers it. The CE pathways directs everything. She encouraged providers to view them on line and get an idea of how surveys are conducted, and reminded providers that the surveys are replicable, and that every part of the process is transparent.

V. Other Updates:

- Acting Program Manager Kim McCLain reported that Betty Keen, the program's MDS coordinator is leaving the department and the program staff are in the process of replacing her. Danielle Branum will be with the program until the end of January; she is an available contact for MDS questions and can be reached at 303-692-2913. Providers can also refer to the web site cite earlier by Kristen Gurney, which is http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp#TopOfPage
- At the end of January, Carmen Bowman will be talking with the long-term care staff about culture change, as part of the grant that her organization was awarded through the Culture Change Accountability Board. She will also come again in April, 2011
- Shelley Hitt had a request for Maureen Paris, the ombudsman for medical managed care, to talk about mental health benefits, however she has since resigned her position and staff hopes to invite her replacement to come to the next meeting to discuss this topic. When asked for suggestions about other future meeting topics, it was suggested that staff could share the intricacies of J&K deficiencies cited in the last six months. Ms. McCLain agreed that this could be a future topic.
- Jeanne King, who works with Medicare review services with beneficiary protection at the Colorado Foundation for Medical Care, told providers with Medicare health plans or Medicare managed care beneficiaries, there are new notices now that have been posted to the CMS web site. She provided a handout of the CMS web site MA ED notices, also a contact for CFMC staff members for questions. She said that when an appeal is received, they will recognize the old notices until the end of February. She encouraged providers to go on line, get the new notices and get rid of the old ones for the MA plan; the notices have been changed a lot.

VI. Next Meeting: The next meeting will be held on March 1.