

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 September 6, 2011 9:30 - 11:30 a.m. CDPHE Campus, Building A Sabin-Cleere Room

Call to Order: Interim Deputy Director Jennifer McCants welcomed attendees and called the meeting to order at 9:32 a.m.

I. CDPHE Updates

Staff Changes: Jennifer McCants announced some staffing changes within the division. She introduced Nancy McDonald as the new division director for the Health Facilities and Emergency Medical Services division. Ms. McDonald described that the division's general direction is to do more partnering with providers around everything from helping them to be more efficient, to surveys, quality, training, and licensure. She announced that Jennifer McCants has been promoted to one of the division's new interim deputy division directors; the other new interim deputy director is Randy Kuykendall, who most recently was section chief over Emergency Medical and Trauma Services program. Ms. McDonald said that the division's leadership team for long-term care issues will do the best they can to work with providers. If a provider wants to visit with the long-term care leadership team in a private meeting, they will be available to you, for whatever your issues are. Consider it an open door,

The interim long term care program manager is Kristy Flodquist, who has been the complaints manager. She will be your main contact. You can also contact D'Alva Messina, Kim McClain, or Jane Garramone.

S&C Letter: 11-30 Reporting Reasonable Suspicion of a Crime in A Long-Term Care Facility: CMS instituted this policy; however, there are no new regulations in regards to enforcement at this time. The division still has processes in place for occurrence reporting and for complaints. As issues meet the criteria for occurrences, you will still submit them to HFEMSD. However, if there is serious bodily injury involved, you need to call them in within 2 hours instead of 24 hours. Anything else that meets the crime reporting criteria, call it into the state agency through the complaints line to Becky Davis. It may or may not be something that the department staff can investigate. We don't have a regulation that says you have to report these crimes or the department will sanction you. It talks about the fines; however, the department is not the enforcement agency at this time.

Regarding the crime piece, providers need to work with local law enforcement agencies to determine what meets the criteria for a crime, and work with them to make sure to call in things that are appropriate.

A brief summary of the Section 1150B of the Social Security Act and the Patient Protection and Affordable Care Act of 2010 requires specific individuals in LTC facilities to report any reasonable suspicion of crime against a resident in a facility. It only applies if you receive \$10,000 or more of Medicare and Medicaid money. It applies specifically to nursing homes, nursing facilities, SNFs, hospices in long term care, and ICFMRs. It directs facilities to develop policies and procedures to address this. There's a piece about educating staff and posting info so they know about reporting. There's a component dictating no retaliation against staff that report.

What we're going to do is send a message out on the web portal, so all facilities will receive further guidance. We're thinking about a one-page training document that we'll put together as well. This is effective immediately.

The whole S&C letter is available at this meeting. When they talk about the “covered individuals,” that means the owner, consultant, employee, anyone that works in the facility. It’s possible that if different employees know about an incident, multiple people could be calling us about an incident. We’d handle it as one complaint. People who have knowledge of a suspected crime are to call it into the state and law enforcement as well. There’s a piece about the fine: up to \$200,000 if the reporting isn’t done; however, we aren’t the enforcement agency.

a Q&A.

Q: Do we send this into complaints or occurrences?

A: If it already meets the criteria for occurrences, send it there. Otherwise send it to complaints.

A provider said that his facility staff struggles to get the local police department to accept their occurrences; they typically don’t consider it a crime and they’re not going to bother. Then the department looks at it and asks why didn’t you report it to law enforcement? Jennifer stated she would follow up with the AG’s office and HCPF.

Q: The original Elder Justice Act includes a mandatory notification of all vendors to a facility. The new Obama health care plan states you’re not only obligated to tell your employees of their responsibility to report within 2 hours to federal agency, but every single vendor as well, on an annual basis, must be reported within 2 hours. It implies that \$200-300,000 can be imposed upon vendors as well. I didn’t see it in the current letter; is that a part of the Act that’s being enforced?

A: Jennifer said it’s not in the S & C letter from CMS but she will look into it. The penalties can be imposed on the vendors as well.

Complaints: Kristy Flodquist, acting program manager for the LTC Program reported that due to the QIS training, the complaints program has had to get down to bare bones with 4-5 persons doing complaints. Beginning in October, another 4-5 staff will be added to complaints, POCs and revisits so complaints will get done in a more timely fashion. They’ve been meeting their complaint start requirements and their goal is to finish them quicker, so they’re not open so long. This will also help providers which will help you out.

Surveyors are becoming more efficient on the QIS surveys, and surveyors are hoping to be closer to 4-5 days on site, instead of 7 or 8 days on site.

II Agency Reports

a. **Culture Change Accountability Board:** There’s a total of \$55,000 available to be awarded in the coming year. There have been a few changes in the process, one of which is that the deliverables will have to be specified upfront, as well as what you’re going to accomplish, and what your deadlines are. Previously they got that after the grants were awarded. Also as part of the new process, grantees will get reimbursed on a quarterly basis after you’ve completed your work for the quarter and submitted your expenses for reimbursement. The grant applications will be due on October 14, and once awarded, grants will have to be completed by June 30, 2012. This gives grantees approximately eight months to complete your work. Grant applications can be downloaded from the Culture Change web site at www.coculturechange.org

State Ombudsman Shelly Hitt added that HCPF dictated the changes to the reimbursement since they control the funds. The disbursement process has been interesting the past two years. HCPF was unwilling to make the check out directly to the grantees and needed an intermediary. With the change in the administration and leadership at HCPF and more focus on accountability. They’ve taken another look at the NF Accountability Board and the grant of CMP funds. Several people met with Sue Birch a few weeks ago; she’s supportive of culture change. She wasn’t opposed to the effort in any way, but there are folks there that are trying to understand it better. So for this year we have an abbreviated timeline. Hopefully some of you that are thinking about applying are thinking about projects. The first year they had 36 applications and the second year they had seven applicants. It was a smaller pot of money. The application is not complicated (6 pages). Call Shelley, Jennifer or anyone else on the Board if you have questions.

Ms. Hitt also reported that the Board is looking for two board members that are employees of a nursing facility after two representatives from the nursing home industry resigned. You do not have to be an administrator – you may have someone else on your staff you think are appropriate. The application is on the web site under Governors’ Office of Boards and Commissions. She met with the governor’s staff, who were also is also

supportive of the project. If you're going to apply, complete application and submit a current resume. We also have a vacancy for someone from the business community (which isn't defined) and a representative that has a disability that lives in a NF or a family member of a resident that has a disability that lives in a nursing facility.

The Board hasn't funded capital improvement projects because the total funding available is small, and one capital improvement alone could eat up all the money. In the legislation and S&C letter from CMS, the directive is that funded projects should be replicable, have broad impact on residents of LTC, and provide education. It's a combination of a small pot of money, replicable, ability to impact a lot of residents, The projects that have been funded so far have done an amazing job of sharing information with other facilities, stakeholders. Board members can see the ripple effect and they are very confident that we'll see more of that.

Q: In previous years, the former grantees were excluded as current applicants. Is this still the case?

A: Yes, grantees are excluded from applying for one year, so last year's grantees are excluded from applying this year. But those that applied the prior year *can* apply again. The intent is that as many different recipients as possible have the opportunity to get funds.

b. Culture Change Coalition: Penny Cook introduced herself as the new executive director of the Colorado Culture Change Coalition. The group has changed its educational programming from monthly to quarterly. Their hope is to have a national speaker twice a year and the other two times a more local interactive session. The next educational session is going to be on September 23 from 9-11AM at Garden Plaza at Aurora, with a speaker from the Greenhouse Project, who is going to talk about the role of nurses in a transforming organization. This is a great way to honor your nurses and it is free.

On November 18, the Coalition will host a pay-for-performance fair. The coalition is getting a group together that have done really well on the quality of life portion of their pay for performance application and they're going to share with you how they've done that, the techniques they've used, the programs they're using, how to complete the application, and how those deliverables for the application to maximize the points. That will be held on November 18 at Wheat Ridge Recreational Center from 9-11 AM.

On January 27, 2012, the speaker will be Kay Van Norman from Montana, a nationally known author and senior wellness consultant. This four-hour program is open to the whole senior community to talk about the unseen barriers to culture change. She'll talk about all our different perceptions of aging and how that impacts how we deal with older adults. There will be a charge for that session.

Ms. Cook also reported that the coalition was awarded a two-year grant for consumer education, so they've developed a speaker's bureau to educate consumers about culture change (they've got twenty speakers already). They will provide a one-hour presentation to any organization. If you are interested in volunteering for the Speaker's Bureau, the coalition has a presentation ready for you so you can do it yourself. They're excited to launch this. For more information, visit www.coculturechange.org.

c. State Ombudsman Report: State Ombudsman Shelley Hitt said she's had her radar up regarding the delay in processing Medicaid applications. Many providers have reported and provided feedback on how long it's taking for those applications once they're complete to be processed by the counties. She heard from other ombudsman that there is as much as a 6-9 month delay. Because you are less able to have Medicaid pending residents, she brought this to the attention of the department at least 18 months ago. It's troubling and it's hard to get any movement and it seems to be affecting residents.

A provider commented that Denver County has tried a new solution which has decreased the number of days from the time they apply to the time they're approved. They went back to designated technicians per facility and they're willing to meet with the facility. At the last LTC Advisory committee meeting w/ HCPF, they said they're taking this statewide and providing some education. The ombudsman recommended that, based on the problems they are aware of, El Paso County and Colorado Springs should go first.

Ms. Hitt put out some information about a program called *The Ombudsman for Medicaid Managed Care*. The Medicare Managed Care ombudsman is an underfunded program. One of their responsibilities is to advocate for anyone who gets their mental health services through Medicaid (all the BHOs). The other responsibility is for

people who are getting their Medicaid through managed care, which is a small percentage of our folks. But almost all of our folks get their mental health through a BHO. Getting those mental health services timely and high quality, etc. has been an issue for as long as she's been in long-term care. She hopes that Barbara Harrison will come to speak at one of these meetings and talk about what her responsibilities are.

Lastly, Shelley's colleague (a state ombudsman) in Minnesota ended up going from the hospital to a rehab facility and did not have a good experience while she was there. Her story made the papers in Minnesota, and while she was only there for 25 hours she felt she lost part of her dignity. Part of her didn't want to go to sleep at night because she didn't know who was coming into her room and she didn't want any more checks. It was very dehumanizing. She has received a lot of comments and letters from people who've experienced similar things. Ms. Hitt said this serves as a reminder about the things we take for granted and how overwhelming it can be in a nursing home, especially during the first 24-48 hours.

d. Long-Term Care Ombudsman Report: Shannon Gimbel reported that Tamra Moore is now the Nursing Home Team supervisor, which was previously Ayo Labode. HCPF is looking at combining work groups for the CTS program with the money follows the person programs in order to ease the process for residents who desire to transition out of a nursing home into the community. HCPF would like to have a resident as part of this workgroup as a stakeholder. If providers have a resident they feel would be interested/able to participate, please call Ms Gimbel at 303-480-5621 or contact your local ombudsman. These meetings are currently being held at Atlantis Community in Denver.

October is Residents Rights Month. DRCOG is promoting this with the National Consumer Board and has packets available for providers. The packet contains an information page, government proclamation, lists of why you should be involved. Maybe you can get together with your residents and staff and have a meaningful event regarding residents' rights. Ms. Gimbel shared that in most of her homes, residents don't know what their rights are. Reach out next month. They have ideas, plans, events, etc. on their site. It doesn't have to be big or expensive, start brainstorming some ideas. The resident's rights BINGO Game that Ginny Frasier developed in the 1980's is being revised and is in production. It should be done by the end of September. They also have 5,000 copies being made which is a bookmark for residents. Call the DRCOG office and they'll get you some.

CDPHE Online Licensure: Kris Kiburz, Information Services Manager for the Governor's Office of Information Technology told us the Division is working on an online licensing application. It will start in November of this year for applications expiring in March of 2012. The main benefit for the online application is that it saves time for staff filling it in. Once you complete this the first time online, it will be easier next year. (It will be populated from this year's application plus the changes you've called in from the last time.) To process the hard copy application takes two hours; to process the online application takes about 20 minutes.

There are tips for getting assistance with the online application on the bottom of the page on the web portal. You can contact us online, in person (give us the application I.D.; right under "contact us," and see a list of people to call, based on the question they have. They can reference the application contact ID.

The same people who administer your facility's web portal can access this online or an additional account can be created for the individual that handles your licensing renewals. (Every facility has ONE portal application administrator at each facility, however, that administrator can create additional accounts for other staff, e.g., the person who submits your census online quarterly, the person who completes your online license application, etc..

Q: Is this initial license and renewals or is it changing your beds and address?

A: Right now it's only initials and renewals. Once we get all facilities up and running on this, we'll go back and make changes.

Q: Do you need a written signature to send in?

A: That's addressed on the "required attachments page." We get that written signature on an attestation page and that's one of the attachments you're required to submit. You can scan that and upload it as a PDF document or send it in with your check.

The other thing: safeguards for security purposes. If you get into this application and you don't click a button for 30 minutes, it'll time out and forget who you are. This has been built in because we know you get interrupted a lot, and if you sit down to work on this and you walk away, you don't want anybody to get in and enter fake information. You'll know that because it'll pop up a message on the screen that says "this session has ended." All you need to do is close your web browser, log back in and then get back into your application.

Q: When will the LTC application be online?

A: We're rolling this online licensure program out as part of a generic residential care online license application, so when we roll it out for long term care, we'll roll it out for DD homes as well. Then in December, we'll roll it out for ICFMRs and ATUs. In Jan 2012, we'll roll it out for ALRS and that will be for licenses expiring in May of 2012.

e. University of Colorado Denver, QIS National Data: Sayuri Kelly from the Division of Health Care Policy and Research at the University of Denver talked about the various aspects of the QIS process: (Please refer to the PowerPoint handout with contact info and updated QIS brochure.) One of their CMS contracts is the development, refinement and analysis of the Quality Indicators Survey, which replaced the traditional survey process. Colorado started QIS in July 2010.

One advantage of the new QIS process is that it is automated. Surveyors input their findings in a computer as they conduct your annual survey. Since the survey process has changed, there had to be a change/update/revision to all the other components of the survey, including federal oversight.

National Implementation: Five pilot states that began implementing QIS in 2005. In 2009 CMS formed six "bands" and the states that hadn't started QIS at that time were assigned to one of these six bands. There were two caveats: (1) the speed to which a state or band implements QIS depends on CMS funding and (2) states could request to start implementation sooner, but not later. All states and territories know what band they fall under; Colorado falls under band three. CMS is projecting that band 6 (the last band) should start QIS in the latter part of 2015. (For the entire implementation plan, see S&C Letter 0950).

Prior to beginning QIS implementation, each state develops its own implementation plan. Once the process begins, CMS requires each state to be fully implemented within three years. CMS tells each state how many trainers it's going to have in their state, the number of surveyors that have to be training and the availability of equipment and hardware. The first four-week surveyor training is conducted by a contractor named *Providigm*. When they're done, the state assumes the training responsibility and continues this four-week training cycle until all their surveyors become registered QIS surveyors. Once registered as a QIS surveyor, that surveyor will not conduct any more traditional surveys.

Currently 25 states have some form of QIS going on. Eleven of those are fully implemented and eight states are at least half way implemented. There are other groups at earlier stages of implementation of their state.

One interesting point: CMS has changed their definition of implementation. Prior to this last quarter, CMS was tracking a state's progress by the number of QIS registered surveyors there were within a state. Now they're trying to implement the guidance that you shouldn't go back and revert to traditional and are now tracking it by the number of QIS surveys that are conducted in a state. Those fully implemented should be 100% QIS occurring in their state.

Desk Audit Report –All of the information entered in the computer during a survey is now generating data for each QIS survey that is conducted. There are three reports:

(1) **Desk audit report for the state agency (or DARSA)** – currently CU is generating these data reports, analyzing them and discussing them with state agency. During these series of calls, the state becomes familiar with what the 32 data items are and the type of comments being generated; then the University trains the state to analyze its own reports. If a state is an "outlier" on a data item (on the high side or the low side of the national average), researchers will try to figure out why; if they find a concern (training) they have to address it with training or whatever it might be.

(2) **Desk audit report for the regional office/federal surveyors (or DARRO)** – goes to the regional office on a quarterly basis and provides data on all surveys conducted in a state in a calendar year. It provides a nice visual of the outliers across all the states in their region.

(3) **State specific DARRO** – goes to the state agency and regional office, and contains the exact same information as the DARRO, excluding other states within that region. Colorado, for example, can compare its data to the region and to the nation. If the state has districts, the district office level is also included in that report. The state-specific DARRO is used for a new federal oversight activity for QIS called *Quality Improvement Calls*. After the state office receives these reports, the Regional Office evaluator (RO) is supposed to call the state agency and discuss all the outliers in the report – The goal of this is to foster communication between both organizations, so that they can have problem solving discussions. If it's something states identified as a concern, the RO will ask about follow-up actions that have been taken, if there's been monitoring and whether there is any progress. The information gleaned during these QI calls and outliers on the State-Specific DAR are going to direct the additional federal oversight activities.

Federal Oversight: The regional office has to conduct two federal oversight activities: (1) FOSS (the name used for traditional surveys) is when the federal surveyors would join the state agency team during a survey and evaluate their performance as they conduct your annual survey). The other federal oversight is (2) the Comparative Process, when – after state surveyors exit – federal surveyors come into the same building and do a separate survey and compare results.

One of the University's tasks was to develop these two federal oversight activities for QIS.

FOQIS (Federal Oversight of Quality Indicator Survey) will replace the FOSS, where the federal surveyor goes onsite with the survey agency and evaluates their performance. If you've had experience in FOSS and you get a FOQIS, here are the highlights of the differences between the two processes (some are philosophical changes):

FOQIS is targeted and data driven by desk audit reports. From these reports are determined team selection and what they're doing on site. If you have a federal surveyor in your building along with the state, it isn't facility related. It's really based on these desk audit reports, which are state related. One goal in developing this FOQIS process was to make it more structured and objective, make it consistent for all regional office folks using this process across the country. A few procedural changes were implemented: (1) a parallel investigation: the federal surveyor will really be with the state agency surveyor to observe everything they're observing and whomever they are interviewing. The only thing they'll do separately from them is record reviews. For them to evaluate someone effectively they should be conducting joint activities, whenever possible, for the areas they're looking at. (2)

Another big change: the RO is expected to have ongoing dialogue with the state surveyors throughout the survey process, so the RO knows in a timely manner if there are concerns with the state investigation. The federal surveyor can now provide guidance and education to the state throughout the process. The goal is to be sure the state agency surveyor is conducting a comprehensive investigation. (With the FOSS, there wasn't a lot of communication between the federal and state surveyors until the end of the survey when federal surveyor told them if they were doing a good, bad or indifferent job.

Scoring has also changed: Two significant changes: (1) to make it more objective and structured, there were guidance and probes developed for each of the tasks that the federal surveyor has to do. Every RO or federal person who is evaluating a state agency team is looking at the exact same probes that are leading them to a final score for that agency team (2) the concept of scoring has changed; it's more comparable to how you are rated, based on the scope and severity grid concept.

The FOQIS was tested in several states and been finalized. In September, staff began training all the registered QIS federal surveyors across the country on the process which will be used, and it will be implemented beginning October 1. For Region VIII, your federal folks will potentially be able to come into your facility and do a FOQIS as of 10/1/11.

The other federal oversight activity is the *Comparative*, when ROs conduct their own survey following the state. For a QIS comparative, ROs will use as much matched sampling as possible from the state. There are two stages in QIS. Stage 1 is the preliminary investigation for the team and Stage 2 is the in-depth investigation.

In Stage 1, there are two different types of samples: *admissions samples* for newly admitted folks (they could still be in your building or discharged); the *census sample* is current residents in your building and the care that is going on right now. For the comparative the RO will have a 100% matched admissions sample. For the census sample, the folks currently in your building, the RO will be looking at the exact same sample excluding any resident that may have been discharged from the state's exit to the federal surveyor's entrance.

In Stage 2, if there are identical areas of concern (e.g., both state and region identify dignity or pressure ulcers as a concern that needed to be investigated) then the RO and state samples will match. In this case, be aware and let your staff, residents and family members know that there is going to be a lot of repetition on questions, since the ROs will have a lot of the same residents in their sample.

This process has been developed by Alpine Technology Group for a projected release for the summer of 2012. During the interim, CMS has told the federal surveyors they can do a comparative on the QIS. If they are coming into your building between now and the release, they'll be doing an independent QIS survey. The sample is randomized, so there may be some overlap in residents, there may not be.

Other items to be developed for QIS were the revisit and the standalone complaint. The revisit has been developed and the specifications have gone to the software developers. The process will be tested and it's projected to be included in the summer 2012 release. (Once finalized, this will be the process surveyors will use when conducting revisits for citations of "G" or above.) For standalone complaints, surveyors are using the same process providers are used to while the University works on researching and developing a new process. Once the requirements are developed, the specifications will go to the software folks and they can start putting it into the system.

Other research underway: (1) The Research Triangle Institute in North Carolina received a three-year award from CMS to analyze the QIS implementation. Their staff has provided CMS with their initial analysis and recommendations (2) The Government Accountability Office (GAO) is evaluating QIS in two parts: (1) an evaluation of QIS itself, which will go to Congress and (2) an evaluation of QIS implementation, which will go to CMS. GAO reports their tentative exit conference with CMS should be in the fall, followed up with a draft report. Once CMS has commented and the report is finalized, it will be made publicly available.

The University of One of our future tasks will be to develop a Desk Audit Report for the Central Office in Baltimore or *DARCO*. With this report, CMS can look at nationwide consistency, and the application of the survey process and the regulations. Based on their findings, they may refine the process or provide additional training.

Help us test our models: As the University refines or develops new models, they are always looking for volunteer facilities to test the product. It's like a mock survey with a free consultation – if the staff find concerns, they let you know. It also gives your staff, residents and their families a flavor of the QIS process. Two upcoming processes to be tested are the comparative survey and the revisit. Ideally, University staff would like to visit a facility that's had a recent QIS, to make it as real life as possible. If you're interested it at all, contact Julie Slater, Julie.Slater@ucdenver.edu. If you're not interested in the revisit or comparative, we'll put you on our list and contact you with other research.

Finally, all of the Stage 1 forms and Stage 2 protocols are available to print. This makes them aware of what folks are using, use them in their building to address any concerns that might arise from the forms. Also, your staff is aware. There's a really structured interview that occurs with your nursing folks in Stage 1; this makes them more aware; it's quicker for them and state folks to get that information.

Q: Does the number/percentage of FOQIS and Comparatives surveys stay the same?

A: It's the same

Q: Do we know how many Region VIII surveyors are trained in QIS right now?

A: Three out of five or six. What they've been doing are groups of federal training to get them registered. Because there isn't a full complement of a team in Region VIII, they've been using the Consortia to bring in other folks from other regions. Potentially if there are a group of folks coming in, it might be from different regional office

Q: How many typically go out onsite?

A: For the FOQIS, it's developed to be a 1(federal)-4 ratio; for the Comparative, it will be four. If it's less than 40 beds, the team size may shrink.

Q: How many surveyors have been trained in QIS in Colorado?

A: 50% are trained. We've had some turnover; we have 3 people that were trained that no longer work for us. This includes supervisors and managers, people currently doing complaints and revisits. As far as FTEs, we are about halfway. We have a new group starting at the end of September.

Q: If you've received a QIS, can you receive a traditional survey?

A: It's possible, but we're doing more QIS surveys than traditional. We have a new workload planned for Oct but we'll probably be doing one traditional survey a week.

Q: Do you have a perspective on some of the national data. We're concerned in CO because QIS ramped up the number of tags by 50% or so. Is this happening nationally. Does it change over time? What are you hearing from the state surveyors, after a year or two of implementation. Certainly the start up is challenging.

A: What we've heard in states that have implemented QIS is that there's a minimum six month training curve for them to get comfortable and to get back to the length of time they're spending for the investigations. We've also heard that surveyors really like the process; they'd rather do QIS than traditional (anecdotally we've heard this). There's been nothing published for national trends, however, pretty globally, there isn't a huge difference seen yet between the traditional and QIS process. Some of these new evaluations that are going on may glean a little information. Recitations, now that we've expanded to 25 states, that information hasn't been compared, that's available to the public. Hopefully, the GAO report will have some good information.

Q: Do you have any Colorado numbers for citations, so far?

A: Melanie and I prepared a presentation for the CHCA conference that I'll be giving next week. We did look at the data for QIS and we have seen the tags go up, but they're starting to come down, as are the hours. We're starting to see those numbers come down. The average number for QIS was 14; the last time we reviewed the data, it was 17, so we're starting to see a decrease. We definitely didn't meet the six-month time frame as far as getting back to the time and deficiencies, but we do have a trend heading in that direction. We're gaining some efficiency and we're starting to see some surveys finished in four-five days. Beginning in October, our goal is to finish our surveys in four days.

Q: Has Colorado had any Comparative surveys yet?

A: We've had our first CMS comparative survey about a month ago; they did cite about twice as many deficiencies as we did. That's the only one and it's not a lot to go on. Since it's a randomized sample that should be generalizable to your entire population, the results should be comparable.

f. Panel Discussion on Younger Residents in Nursing Homes: State Ombudsman Shelley Hitt, Acting Long-Term Care Acting Program Manager Kristy Flodquist, Administrator Maxine Roby (Rowan Communities); and Dr. Karen Leible, (president of the American Medical Director's Association) participated.

This panel is based on some research. Trending in the last eight years, residents ages 31-64 have entered nursing homes at a higher rate than the elderly. The number of younger patients than over age 65 has increased 22 percent in the last eight years and has climbed up to 14.9 percent in the nursing home population overall. Some facilities take younger residents than other facilities. Even in traditional homes, we're seeing a big increase in younger residents. We were interested in reaching out to find out some guidance and develop some materials.

Karen Leible: AMDA sent out a survey looking at what are some of the hot topics we want to address in the next year and dealing with younger patients is part of that. Today, we're doing an update on our health maintenance on long term care and to quote: "one of the issues is the number of residents less than 65; its gone from 9.8-12% in 2004. It's become one of our focus to talk about those issues. From a physician/clinician's perspective, we broke it down into 3 areas:

- (1) Health maintenance: when we think about our seniors/frail elders living in our communities, the quotas of the severity of number of co-morbid conditions for the number of disease processes they have, plus a functional impairment, will help to predict end of life issues for older persons. How many functional disabilities plus how many disease processes they have? What does that say for our younger populations? Does that hold true? We don't have this information and we need to move forward with.
- (2) When we look at the approach to health maintenance in LTC setting, it's dotted by functional status, probable life expectancy, or the elder's resident preferences, goals of care, values and wishes, and not just age. You can see we have some issues when we start dealing with younger resident populations. Is it just for functional status, what's their life expectancy, and how much more do we focus in on their wishes of the residents?
- (3) When we think about prevention, so many of our older people have gone past that cold concept of "primary prevention." Primary prevention is when doctors give patients an aspirin to prevent your risk of coronary artery disease. We're already looking at secondary prevention, which are asymptomatic conditions. Someone with osteoporosis that we've picked up on a screening test. Or someone newly presenting for breast cancer picked up on mammography or colon cancer picked up on colonoscopy. That would be the secondary aspects of it. Tertiary prevention is chronic symptomatic disease, to decrease further complications or loss of function. Many of the younger people with multiple sclerosis, Huntington's chorea; we're already running into tertiary? There are a lot of questions to be answered into where we're at. How much do we spend on primary prevention with these young individuals, how much are we spending on secondary and where do we go with that tertiary? Just to share you some of the things we've seen: looking at screening for diabetes. For many seniors we don't. We're working with the Pioneer network with dining standards.

Do we use medicalized diets, like no added salt? When we're dealing with a frail elder, this seems kind of clear. We're looking at the whole issue. We've gone past primary prevention and looking at secondary and tertiary. With our younger populations, where are we with that? Is it reasonable to look at the diet and provide education on this? A new concept that came up last year was a pregnancy in one of our facilities. How long can that individual stay in that facility? Having been a newborn intensive care nurse, I had an idea what the age of viability was, in terms of letting that live in the community which had been her before we needed to move the person into another facility that could accommodate the pregnancy. The whole issue of cancer screening in those individuals; we don't routinely send our elders out for mammograms or colonoscopies; same thing for osteoporosis. What about prostate exams? The whole issues of medications, those individuals that are on steroids that can promote osteoporosis.

The whole issue of vitamin deficiency: do we think about this for our elders in our communities? There are a lot of issues around disease processes that we have down for frail population. Where are we moving now with our

younger populations? The AMDA is going to review these. There's also the whole issue of psycho-social, we have a lot of issues with depression, isolation and withdrawal that we see then with our elders but we can also see them with our younger residents. Then there are issues of physical dependence, such as alcohol dependence, drug dependence, the use of pain medication becomes a little more complicated dealing with a 30-year-old that has a history of drug and alcohol dependence and prescribing pain medications than it does with an 85-year-old. Is that my own bias or is it looking at that person's life expectancy and functional capacity?

Sexuality: Educating about sexually transmitted diseases (although this can occur at *any* age; I've diagnosed a 65 year old as HIV positive). We think about it in our younger residents. The issue of pregnancy and their capacity...we assume younger individuals may lack capacity but still have the basic human desire... dealing with families and their families on that psycho-social plane. Many of these individuals have young children or their children are in their 20's (and they have children) and have to deal with mom or dad in our facilities...or dealing with their parents. ...we had an issue with a younger resident. We kept talking to the dad, who has total capacity and can totally speak for himself. It gets highlighted with these younger residents. They can speak for themselves. These are some of the issues AMDA are going to tackle in the next year.

Shelley Hitt: The AMDA announcement in late June solidified for me what I've been hearing from local ombudsman for years. The demand for their information, intervention and assistance was being more and more driven by the needs of the younger residents. There is a lack of resources. The problems that we're presented with include everything from substances abuse, chronic mental illness, the lack of mental health support, the psychiatric crises, the folks that get transferred to hospital so no one will take them back *(lots of transfer/discharge issues). If you have a mixed population, this is the kind of problems that's creating. In large measure, my desire to start this conversation was to start talking about solutions, options, resources. I'm not telling you anything you don't already know. We talked about isolation. I haven't felt very able to help the local ombudsman in terms of good solutions and good resources and good support with this very complicated situation present themselves.

I spoke with the Colorado Commission on Aging on trends and asked all local ombudsman to talk about what they were seeing. The influx of younger residents has presented an increase in issues such as drug and alcohol use, lack of psych services, especially in emergencies due to insurance coverage. An issue that comes up every week in meetings is better behavioral support for facilities, the challenges of the younger populations. It isn't just younger mentally ill, younger MS residents, head injuries, those with CP, and those of our veterans. The landscape in LTC is changing dramatically; also we see an increase in HCBS. Everybody wants to stay home with increases in HCBS services and money follows the person. What's that population going to look like in the next five years? Are we going to be able to meet their needs? What are we doing in Colorado?

Maxine Roby: I have quite a few younger folks at our facility. From an administrator's point of view, I'd echo what you've already heard...sex, drugs and rock 'n roll. The mere fact that people of all ages, especially younger people are very active sexually is going to have a lot of implications on how you manage your overall facility. We've had cohabitating couples, we even had a domestic violence incident and had to call police because of a cohabitating couple where there was abuse going on. Peeling back the layers of the onion, it gets deeper and deeper the more you get involved with it.

People can easily access drugs outside the facility. One of the things we need to work on as a group of professionals is the medical marijuana piece because it interrelates with the kinds of conditions that the younger people are presenting to us upon admission – like MS, for example (it can be very helpful to some of the symptoms they experience). So our residents have figured out that they can access their own drugs if we're not going to provide them. It hasn't really been too much of a problem because we have this rule... as long as you're not doing it on the grounds. We had a resident that was accessing marijuana and went into a stupor, and the police were called. You're police get more involved in your lives when you have younger people. I've been pretty impressed with how well trained they are. You can have issues with just behavioral things, where they're more likely to strike out at others, especially crowding --- that's one thing I'd make note of. A lot of young people have powered wheelchairs and they're sort of dangerous. They can knock over people that are trying to walk. Some go down Colorado Boulevard because that's "where the action is." They'll be down at some restaurant or shopping

center and say that they're powered wheelchair broke down (like we're AAA). They are heavy and difficult to move when they've lost power. This is real life stuff.

About the rock 'n roll piece: part of it is noise. A traditional nursing home with elders tends to be quieter. When you come into a facility with younger people, everyone is up and out of bed. They eat their meals in the dining room unless they have an acute episode temporarily and they have to eat in their rooms. It's more social that way. Our resident rooms are very small; it's always a difficult thing. When they see our rooms, they're semi private and kind of small. But we can get by with it because people use it to sleep or for sex. They're not in their rooms and beds all day. You have to look at food differently. Younger residents want Philly cheese steaks, burritos, pizza. They don't want the traditional nursing home fare, which also lends itself to challenges when it comes to swallowing. Some that want those things have difficulties with swallowing or issues around that.

Damage to the building is a constant issue, especially because of the powered wheelchairs – but even with regular wheelchairs – they're ramming into the furniture, ramming into the walls. Part of that is that they don't have feelings in their lower extremities. They do it without intention. We even have some special dining tables created that are 72 inches around, which is really huge compared to most nursing home dining tables, but that was because we have some many people with leg extensions on their chairs – we want them to be able to hide them so they can roll up to the table and sit like the rest of us when we're eating, and not tilted to the side, or they have to sit at separate tables.

You'll find that there are a lot of males: 40 percent of our population is males. As you get older, that group gets less and less. When I looked at it, we also have 40 percent of employees are males. It's important when you have that many males as residents, that you have plenty of male interactions. Keep that in mind. Training-wise, there's a lot of specialized training, whether it's a disease process or behavioral issue, but CPI is very important. We primarily use it more for avoiding behaviors than we do after it happens. We find if your staff is really good at this stuff, it doesn't get to the point where you have to do more extreme measures.

Younger residents are also very verbal. They'll tell you what they need or what they want. It's nice, but it can be a challenge when it comes to surveyors, because they'll tell surveyors anything. They love the attention. They know if they say things that sound bad, they get even more time with the surveyors. They love the audience, so it's different for that. Reimbursement is different because they're younger people; they might have Medicaid or be Medicaid eligible. Many of our residents have private insurance because it wasn't that long ago that they were working, so they may have COBRA. Some companies (with younger workers) have been understanding of the nature of the illness and offered them as part of their severance to have insurance. The other side of that is they may not have Medicare yet. You have to wait a period of time with disability before you can claim that. We think it's our responsibility to help people apply for and access whatever benefits that they're eligible for. Those are just some generalized things I thought of that you might want to think about.

It's difficult to have a geriatric facility and just admit a few young people. That's where I see the bigger problem. They have such unique and specialized needs that are different. It's difficult to offer them a life that is "quality" to them, because they want to be out and about. It's bad enough to go to a nursing home, but they certainly don't want to be put away. They want to go to college, they want to go swimming, skiing, horseback riding, shopping. They're still a part of life. You need a community program, their social services needs are different, the noise level, the need for privacy for certain activities. Keep that in mind if you're admitting young people. You need to **at least** be able to support them with the kinds of services they need; they need their clinical and medical needs but the quality of life piece.

Kristy Flodquist: From the survey perspective, here's what we're seeing when we survey the younger population. With activities, they don't want to do the arts and crafts with macaroni or play bingo. They want to go to Blackhawk. Socially they have different needs. They want to be on the computer. We've heard complaints about not having computer time and other communication devices. Their music is different and don't want to hear the same music as geriatric folks are listening to. They have different heroes, and different values. They're a different generation. They want to be heard. They demand a higher standard of care. When our surveyors talk to the younger people, it takes twice as long to interview them as it does the older people. They want a sense of purpose. They want to know they're contributing to society. A lot of times there's a lack of family support: they

have guardians rather than family that take care of their needs. We need training to the staff about STDs and the symptoms because sexuality is higher in that population.

Q: How do you handle people with traumatic brain injuries? We're seeing more of that with the veterans that are coming back from Iraq and Afghanistan. That's a whole different animal.

A: (Maxine) We have a lot of those. Community says a lot of those. We don't have wings of people with MS, people with psychiatric issues. We have all people mixed together, like an apartment complex. Even though we've have a couple of people that would fit into that category.. One thing we have to be careful about with people with traumatic brain injury, we have a lot of boys and it can be very upsetting. We generally have people that have traumatic brain injuries that have had them for weeks and years, as opposed to months."

Kristy Flodquist: we've recently been to facilities with people with behavior problems. Remember the regulations still apply and even though there's a psych diagnosis, you can't be doing takedowns and forcing people to be held.

Shelley Hitt: As ombudsman, we get concerned about lack of placement options, and how many calls we get when someone is transferred to the hospital and the facility refuses to take them back because they don't meet their needs. The person could have aggressive behavior, be a bully, a registered sex offender, someone with sexually transmitted disease that is sexually active in the building. There's no alternative; nothing comes to mind.

We had a resident that spent several weeks in the hospital. She never really got admitted to the psych unit but just spent some time in the emergency room and they finally gave her a bed because they didn't have a place for her to go. Hospital staff was calling us and the local ombudsmen daily. Finally, a week or so before Christmas, the hospital put her in a taxi and took her to the Department of Social Services (because DSS was her guardian), and left her in the lobby. The person decompensated quickly and wound up at Denver General. It was not a good outcome but at least they were willing to take her. Everyone in the situation felt really desperate. There's a story or perspective from each of these folks -- the discharging facility, the hospital, the client or resident, the guardians. And maybe the intensity of the problem and the scope of the problem is getting bigger.

Maxine: If we have younger people admitted to a facility that is generally for elders, the staff doesn't know how to work with them. Not only are they not therapeutic in the way they work with those individuals, but they're also doing things that are causing the negative behaviors, when we in turn ship them out and say we're not taking them back.

Shelley Hitt: It happens once a day, once a week. Are they getting deficiencies for this? Yes, they'll take it. They've been advised by legal, etc. that it's better in the long run to take the deficiency.

Maxine Roby: They have a sitter and they do well because the hospital isn't set to deal with it. I think it scares admitting facilities, because they think I can't provide a one-to-one sitter or if the person is sexually acting out. Sometimes it sounds horrible, but if you have a purposeful activity program I think it's a different story. The problem is when they admit a young person and don't know what to do once they get them.

Provider: Technology and outlets, they're charging their cell phone and their I POD. I certainly agree that the need for social activities, social service staff to adapt fully.

ShelleyHitt: Do you feel you get the kind of support in mental health?

Gloria Devonshire: One of the biggest issues in the rural issues, we don't mind taking the people, but we don't have the support. We don't have the medical staff or mental health support. So you're just out there dealing.

Shelley Hitt: In rural areas, we see residents don't have many other options. Your residence might not be the best fit. The closest facility that's appropriate may be 50 miles away.

Dr. Jacobs: As facilities try to gear up to meet these needs, we need some consideration from state. That's what makes providers say, "I'd rather get a tag than get an IJ for what they create in our facility." So, a little bit of consideration from state – until they are capable of dealing with it – would be nice. Until there are other facilities ready to deal with this, it's mandatory. This is where the partnership should begin...with some consideration for

the facilities that have a unique niche... a unique population. It's better to have them in the facility than to have them in the street or under the viaduct until they get sick and then back in the hospital.

Shelley Hitt: These regulations are made to deal with geriatric population.

Jennifer McCants: The situations you're talking about is with younger, more physically active residents. They can be aggressive or assaultive to other residents. These are issues that we have to investigate. It's a good point to take into consideration that these are difficult folks. When the ante's up, we have to make sure that the vulnerable are protected.

Dr. Jacobs: That's the contention of the facility that won't take them. We can't protect our elderly population. Frequently when in the hospital they don't accomplish what they said they did. So when we go and evaluate them, they're no better off – sometimes patients are even worse than they were on admission, but we have to take those back. And we've done all we can do and they're not going to be any improvement.

Shelley Hitt: I'm interested in working on this further. If someone would like to join a task force, please let us know.

Maxine Roby: Good consideration should be given to culture change as it relates to this population: the Eden Alternative and culture change as it. A pharmacological response is not the best response when you're having issues. There are so many other things that can be done that have a better outcome and are less expensive. And, as of October 1, Rowan is going to have four more beds.

f. The next Advisory Committee meeting will be November 1 2011.