

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
May 3, 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 9:30 a.m.

I. Agency Reports

a. Ombudsman Program: State Ombudsman Shelley Hitt reported that:

- The annual report for The Legal Center for People with Disabilities and Older People is completed. It includes statistics, as well as an insert with some ombudsman stories from around the state in the past year.
- The Legal Center has also created a new poster for the ombudsman program, which will be distributed to facilities. If your community does not receive one, please ask about them.
- New MDS brochures for residents, which explain the process, can be obtained from the Centers for Medicare and Medicaid (CMS).
- A number of transfer and discharge letters that providers send are often addressed to the wrong people; for example, letters for Ms. Hitt are addressed to former state ombudsman Pat Tunnel – who has been gone for three years. Ms. Hitt reminded providers that when she began as state ombudsman, she sent out an information packet with sample letter, regulatory guidance about transfer and discharge with all facilities. If you ever need any help or want to see sample letters, or to talk through transfer or discharge notices, please contact Ms. Hitt or any of the other ombudsmen.
- Ms. Hitt is aware that providers are struggling with applications to Medicaid for residents that are Medicaid-pending. A lot of individuals have been working with HCPF on this problem, which started at least a year ago. Members of the Long Term Care Advisory Committee at HCPF and the Nursing Facility Advisory Council have been providing data and a lot of information showing that some applications take six months or more to process. Ms. Hitt, who sits on both of these committees, and Janet Snipes, are both asking very seriously for HCPF to address this. John Berry didn't seem to be aware of the problems or the tools he has at his disposal when working with CMS, i.e., the regulations specifying how fast Medicaid applications are supposed to be processed.

The problem impacts ombudsmen when providers do not accept residents that are Medicaid-pending or when they try to discharge residents that are Medicaid pending. Her message is: **Residents who have their applications complete to Medicaid and are waiting for an answer on that application cannot be discharged.** Tag 177 in the guidance says: “A resident cannot be transferred for nonpayment if he or she has submitted to a third party payer all the paperwork necessary for the bill to be paid.” Nonpayment would occur if a third party payer – including Medicare or Medicaid – denies the claim and the resident refuses to pay for their stay.

Q: What about when you have a transfer coming and there is a delay in that?

A: Let me know if there are counties worse than others. We really have had a lot of conversations with HCPF about this 9-12 months ago and brought in a lot of information showing where it was falling apart at the county level – facilities sending the required information over and over again and still being asked to send it over! There are no easy solutions, but it's a high priority on my radar, and I'm not letting up until we can craft some solutions. This is on the agenda for both HCPF's Long Term Care Advisory Committee and the Nursing Facility Advisory Council. (Both groups met monthly, and there is a lot of overlap between the issues they cover, but this is being sorted out; both meet monthly.

b. Board of Nursing: Kenetha Julian introduced herself as the program director for the State Board of Nursing. She reminded everyone about the medication aide authority that was statutorily updated last year. Anyone interested in being a medication aide or any facilities interested in creating programs to educate medication aides, can find information and applications available on the Board of Nursing web site, www.dora.state/nursing, under CNAs. Ms Julian encouraged everyone to participate.

Ms. Julian also encouraged providers to look at their web site for updated forms and information. (They still get forms with the name Nancy Smith, who was at the Board of Nursing ten years ago.) If you need assistance with anything, contact Kenetha directly at 303-894-2819. If she can't help with your specific request, she'll get you to the person who can.

Q: Are you getting applications?

A: Not yet. We've had several calls from facilities that are interested, but they haven't followed through with getting the application; maybe they're in the preparation stage. Should the Board find that CNAs truly have no interest in this career ladder, it won't be an ongoing path. Since the nurse practitioner and advance practice nurse was expanding, the legislature and other stakeholders wanted to expand the career ladder at this end of spectrum to allow CNAs to become medication aides – and to be more educated and more skilled, than some of the QMAPs that we have. (There has been ongoing concerns and issues with the QMAPS.) It's more than someone just taking a class and taking on that role. The rules are rigid: CNAs have to be sponsored, have a letter of recommendation saying that they have the characteristics providers would like your medication aide to have.

Paula, from the Colorado Health Care Association said that the association is pleased that the Board of Nursing will participate (for the first time) in their CNA leadership conference this year on June 17.

II. Presentations:

a. The Particulars of Parkinson's Disease: Jennifer McCants introduced Cheryl Siefert, executive director of the Parkinson's Association of the Rockies. Ms Siefert shared that prior to the Parkinson's Association, she has been the executive director of the Life Quality institute (palliative care education), the executive director of the Life Source Institute (end-of-life education), and also spent many years working for the Alzheimer's Association. (Please see the PowerPoint presentation, which is located with this meeting summary.) Ms. Siefert provided this overview of Parkinson's disease:

- Parkinson's is a progressive neurodegenerative disease where we begin to break down dopamine receptors. Parkinson's is the second most common neurodegenerative disorder to Alzheimer's. It affects approximately 1.5 million Americans; 17,000 people in Colorado have Parkinson's.
- Unlike Alzheimer's disease, Parkinson's is not fatal. It is a degeneration of dopamine neurons; dopamine ensures that we have smooth muscle movement; it enables us to walk smoothly without suddenly freezing. It enables us to do fine motor things, like holding a cup of coffee without our hands shaking.
- By the time people begin to see any symptoms of Parkinson's they have already lost 70 percent of their dopamine.
- The onset of Parkinson's occurs between the ages of 40 and 70 years old; the most common age is within the 60's; 5-10 percent of all patients are under the age of 40. There is a slightly higher incidence of Parkinson's in men. Parkinson's is found in all ethnic groups and races. There is a gene that may be linked within the Jewish population (not all proven at this point).

- There's no known cause of Parkinson's disease. Interestingly, there are a few things that may increase the risk: environmental toxins and individuals that live in rural areas seem to have a higher incidence of Parkinson's due to the pesticides being sprayed on the fields and the residual in their drinking water. Rural living may actually increase risk of developing Parkinson's.
- Once diagnosed, people live on average for 20 years, unless they have a Parkinson's related dementia. The most common dementia associated with Parkinson's disease is Lewy Bodies disease.
- Parkinson's reduces people's life expectancy because people with Parkinson's can have pulmonary infections or pulmonary embolisms, urinary tract infections, aspiration, or complications from falls and fractures (which is more common). If people take their medications, they can help persons live longer than 20 years; the most common medications are L-dopa, Levodopa and Carbidopa.
- The onset of Parkinson's can be subtle and only affect one side (called resting tremors.) You'll also get lots of arm swing. Individuals also get slower in their movement. When symptoms expand, individuals notice changes in the hands, the feet, the legs, rigidity in posture/not relaxed/slightly stooped. There's a Parkinson's posture. Clinical signs that the patient might not be aware of are cog wheeling rigidity/jerky movement, a pill rolling tremor. This is usually confirmed by the therapeutic attempts.
- Secondary signs that can accompany Parkinson's are dementia, depression, anxiety, less frequent blinking, speech impairment, swallowing problems. Sleep attacks (suddenly falling asleep), sleep apnea, and depression/anxiety are other disorders. There can be a loss of smell and constipation, induced by Parkinson's medications. As the disease progresses, people with Parkinson's speak very quietly.
- The first treatment for Parkinson's should be Parkinson's medications combined with exercise, specifically yoga. Yoga increases the core strength of persons with Parkinson's; it's also great for relaxation and meditation; it's almost euphoric in how positively it affects their attitude. Dance is another great exercise for persons with Parkinson's.
- Parkinson's is a medication intensive disease, in terms of its treatment; some people take 10-15 drugs a day, and it's a complicated regimen that isn't easy on the body. To reduce the symptoms of Parkinson's as long as possible, use the drugs Levodopa and Carbidopa. The dopamine agonists stimulate the dopamine receptors. It's possible the medications can cause more of the jerky movements. Actor Michael J Fox's twisty/jerky body movements, also known as dyskinesia, are induced by the medications he's taking. While these involuntary movements are difficult to control, if he wasn't taking the medication, he could be frozen and not moving at all. Medications can also quit working for some people

Another medication common to persons with Parkinson's is Mirapex. Mirapex increases obsessive behaviors, i.e., gambling or increased desire for sexual activity. (If a resident is being too touchy-feely or too forward about wanting sex, he or she may not be able to control this impulsive behavior. Talk with the resident's doctor about these medications.)
- Make sure your documenting how your residents are responding to medications on a regular basis.
- When a point is reached when a person's medications stop working, some people are eligible for deep brain stimulation (DBS) or "neuromodulation." What happens is this: there are two places in the brain that are affected by Parkinson's, and doctors insert electrodes into the two areas of the brain. There's a program meter implanted so that it delivers stimulation to the brain. And it affects the dopamine receptors. It's only been an approved treatment for Parkinson's for 5 years; they don't know how long it will last (it doesn't stop the disease). It's very invasive surgery and doctors can evaluate which patients they think it will be more effective on.
- One of the times Parkinson's medications don't work is when individuals have instead Multiple Systems Atrophy (MHA) which presents as Parkinson's. It will run its course in 5-7 years.
- Exercise is important and the type of exercise makes a difference: balance, the core strength, neck movement, and a lot of stretching makes a difference. The Parkinson's Association of the Rockies is

conducting a training to prepare fitness instructors to deliver programs specifically geared to persons with Parkinson's disease. The Parkinson's Association has excellent exercise videos that they lend out.

- Complimentary therapy for speech uses the Lee Silverman Voice Treatment therapy, which is very beneficial with people with Parkinson's. It gets individuals with Parkinson's standing up, breathing better, using better enunciation and increased volume.
- Attitude plays a huge role in fighting Parkinson's; even as the disease is progressing, keep up that aggressive fight.
- Parkinson's will probably be cured before Alzheimer's because it only affects two areas of the brain, while Alzheimer's affects the whole brain.
- The Parkinson's Association of the Rockies has launched an I-phone application called *PD Life*, to help persons manage their medication regimen throughout the day. (A person using the application gets a reminder on their phone to take their medications. When he/she answers "Yes," (took their meds)," a screen pops up and asks "How do you feel?" It asks, "Are you "on" or "off?" (People with Parkinson's use the terminology, "ON/OFF:" They say they're "on" when their medications are lessening the symptoms of Parkinson's. They'll say they're "off," when the medications begin to wear off and they see the loss of the benefit. There can be abrupt and unpredictable changes in how they move). Then it asks, "Are you having side effects?" hallucinations, leg cramps, constipation, and additional dyskinesia. The person can time how often he/she wants to record how he/she is feeling. The person can then give the information to the doctor, who can look at medications and make any necessary adjustments. This is just one of the tools for individuals for Parkinson's and their families. It helps them to monitor the effects of what's happening with their medications.
- The Parkinson's Association of the Rockies conducts in-home assessments, in which a licensed social worker will observe an individual in the home and provide information on how to get help. The association has free equipment loan programs in which people can try out equipment for up to six months. They have support groups, weekly exercise classes; information and referral help line, newsletters, educational seminars and a lending library. The association has 35 different support groups, including three in Wyoming, most in Colorado, including GJ, Montrose, Durango, Greeley, Fort Collins, and two in Western Nebraska. They have free Saturday education programs at St. Joseph's Hospital. All of these services are free. The association has an annual walk on Father's Day, June 19, called *Shake Rattle and Stroll*. Registration is at 8 AM and the walk starts at 9 AM.

Q: You said not everyone that has Parkinson's experiences dementia. Wouldn't slow speech be observed as dementia?

A: When we're observing for dementia we have to observe very different things other than the pace of their speech. The important thing is looking at their recall, the cognitive aspect, not if the words are slowing down. Think: Are they finding the right words?

b. HFEMSD Medical Director's Association presentation: Program Manager Jennifer McCants presented the PowerPoint presentation that Howard Roitman gave at the Medical Director's Conference in April 2011. (Please see attached presentation.) Most of this is statistical information:

- The top five tags haven't changed between from FFY 2009 to FFY 2010. They are: F 323, accidents; F 281, standards of practice; F 309, quality of care; F 279, care plans; and F371, kitchen sanitation.
- Most cited under F 323, accidents are issues related to falls are: not assessing for causes of falls, not using safety devices that are care planned, not checking alarms to make sure they're working properly, unsafe smoking, resident-to-resident abuse
- Most cited under F 281, standards of practice, are issue with medication administration, including issues with MARs, not verifying orders, not transcribing orders properly, poor practices during medication pass.

- Most cited under F309, quality of care are issues are similar to past years: pain that's not addressed, low and high blood sugar issues, diabetic care with insulin administration, and lack of ulcer care.
- Care plans, F279 are the same year to year. Care plans are more generic in nature and don't cover specific individual issues
- F 371, kitchen sanitation is known for hand hygiene when preparing food, dishwashing, and in the dining room feeding residents; food holding temperatures, and temperatures of food in refrigerators and freezers, lack of regular cleaning, food delivery, and sanitation during the meal service.
- The total number of deficiencies in Colorado for FFY 2010 are slightly higher – 2481 – than the 2202 in FFY 2009.
- There has been a slight decrease over the last two years in deficiency free surveys.
- If you look at deficiency data for the nation, region, and Colorado for the annual surveys, the numbers are fairly similar for the “nation” and “region” and the number is increasing in Colorado. QIS weighs in here as part of the trend for FFY 2010.
- The average number of deficiencies for the first half of FFY 2011 is: for the nation, 5.9; for the region, 7.0 and for Colorado, the average number is 12.0.
- The number of complaint surveys is in a downward trend 2004-2005. That's a little bit of good news.
- Immediate jeopardies in long-term care was eight in FFY 2010: two had to do with smoking with oxygen, two for hot beverage temperatures that were too hot, three were cited for gaps between side rails and bars; and one was for a hypoglycemic residents. The program staff cited fewer diabetic issues.
- For immediate jeopardizes for the first half of FFY 2011, there's one citation of smoking with oxygen, another hypoglycemic resident and one resident-to-resident abuse.
- IDR data is from 2003-2011; 82 percent of tags taken to IDR are sustained; this has remained consistent over time.
- QIS data for the first half of FFY 2011 (the first 6 months): surveyors have completed 26 QIS surveys. The QIS survey is very thorough and takes more time. the average number of days spent on survey is 6.8 (a big increase in onsite time) 17.4 is the average number of tags per QIS surveys (which explains the increase in tags per survey). There are also more surveyors on each survey.
- The QIS doesn't necessary result in higher scope and severity. 3.8 percent of QIS result in IJ and 3.6 in tags G or above. That's not showing an increase in the higher level tags, but an increase in the total number of tags
- Problems with QIS:
 - LTC program is finding it difficult to meet the workload – some of your communities are getting close to your 15.9 month window – we're going to be late on a certain percentage of our surveys.
 - There's increased surveyor turnover and negative ergonomic implications (surveyors have to carry around computers, extra computers, printers, and extra batteries; holding all of these items for over 10 hours a day have led to a few workman's comp claims.)
 - The training period is longer: for traditional surveys, surveyors could be trained in 4-5 months; the training period for QIS takes longer – around 7 months.
 - Dependence on technology – if the computer crashes or printer goes down: we're stuck until the technology is up and running again—we're completely dependent on technology.
- The first group of 9 surveyors trained in QIS occurred last July; four of those surveyors are now trainers (having completed the train-the-trainer program) and only 6 ½ are still working here. Of the second group of 8 trained in January, only 7 remain on staff, for a total of 13 ½ surveyors trained right now.

- The next group that will be trained starting in the middle of May (for 6 week training program) so we'll probably have 2 more full groups. Seven new surveyors were hired in the last 6 month period, and three more were hired yesterday. All new hires immediately start with QIS. We're doing very few traditional surveys now because we don't have many people back that are trained in traditional surveys.
- In FRY 2012, we should have everyone trained by the end of the fiscal year 2012. Some of the QIS teams are a little larger. One section starting in May and another in September

c. QIS survey, Updates and Q & A Session: Ann Schuck presented this update on the QIS process: She reported that it takes a little longer to get started on the QIS survey if the survey team doesn't get the information they request when they are on site. Coming in, surveyors ask for different information than they traditionally did. During stage one, the first day to day and half, surveyors are gathering information. The second stage is where surveyors would start a traditional survey (when we were using the quality indicators). This is the actual investigation when surveyors talk to staff.

1. The first thing surveyors ask for when they arrive at a community is an alphabetical list of residents with their room numbers. It's helpful if the information is fairly accurate.
2. Surveyors also request a new admission information form for residents admitted after a particular date; anyone admitted after that date should be listed on that form. Surveyors need this information it for their "reconciliation," which means that they need to verify that all the residents listed on the pool are still in the building (the list the MDS provides to the survey team via their computers). For new admissions, if they don't have an MDS submitted yet, they won't be on the list. (Surveyors use it to supplement their list if residents selected for the first stage of the survey aren't there.)
3. There is no longer a general "meet the staff" meeting; it's not part of the QIS process.
4. When surveyors arrive, surveyors will still inspect the kitchen with one or two people.
5. When surveyors take a tour, they don't go into every room and talk to every resident; surveyors will introduce themselves, meet residents, meet staff, and try to meet and talk with families, if they are there. Surveyors **don't** meet everyone; they get general impressions now in stage one, not specific (this is because the specifics are in the computer in the MDSs).
6. Surveyors talk with administration and present them with a list of things they need, including a new admission list and alphabetical list.
7. Surveyors ask for other information: they verify which residents are in the building, which will affect the survey sample. Surveyors look at two sets of sample residents: one is the admission sample of up to 30 residents, and surveyors review medical record only (they look at the areas designated by the form and by the computer). The second sample is the census residents and there are 40 residents in the sample, regardless of the size of the facility. If a facility has 44 residents, 40 will be in the census sample. Surveyors review five areas: (1) is resident interviewable? Surveyors make that determination; if yes, with their permission and if they're available (2) observation of resident (3) talk to nursing staff that provide care (either medications or treatment) to those people (4) medical record review (selected areas come from computer) (5) if resident isn't interviewable, surveyors will look to see if family/responsible party is interviewable. Surveyors are required to do 3 per survey.
8. In both resident samples (of seventy residents total), surveyors review resident weights. Make sure that this is someplace surveyors can get it.
9. A form is completed that lists residents with any of the following: level 2 PASSR, on a ventilator, receives dialysis or end of lives services, including hospice. These individuals aren't selected until the stage two, the investigative survey.

Q: How is occurrence information used in the survey, and how is the information from the ombudsman and the community ombudsman integrated into the process?

A: The occurrence information— as it was previously – is available for review to look at prior to initiating the survey. It wouldn't be evaluated or put into place until stage two.

Q: If abuse is on an occurrence, you'd address that in stage two?

A: There are 46 care areas, and if they're triggered, surveyors have to do an investigation. Some of them are very directed, like guidelines in regulations. But, surveyors don't do the assessment portion until stage two; that's when any concerns raised would be investigated. The only time surveyors would investigate in stage one would be if there was a potentially serious outcome or immediate jeopardy. Then, surveyors would stop and address it on the spot. In all other circumstances, the investigation happens at stage two. This is true for information from the ombudsman as well as complaints. Surveyors look at any and all information they've been given, and if there's a recommendation that a resident is having a lot of problems or a complaint involving a resident, the person would be added to a sample in the second stage, if they weren't already triggered.

Ms. McCants reported that the long term care staff will try to have ongoing discussions about QIS at every LTC Advisory Committee meeting.

c. Culture Change Accountability Board Information: Jennifer McCants reported that the Board didn't get a lot of applications this year and they're hoping to get more applications for the coming year. The deadline for applications is September 30, 2011. The application is being finalized and you will soon be able to go to the web site on the sheet and download the grant application.

The Board is currently looking for some more board members: (1) They need an individual from the business community (it goes through the Governor's board); (2) a long-term care resident with developmental disabilities or a family member of a resident with these disabilities; and, (3) An administrator. Being a Board member is somewhat time consuming, but very rewarding. Ms. McCants said that it's a great group of people and exciting to be part of. Ms. McCants reported that there's an info sheet on the grants that were awarded the first year. The kinds of things that were funding were facility based or organizations.

d. Rhythm Circles: Marcia Brenowitz received a grant from the Culture Change Accountability Board during the first year that grants were awarded. If you receive funds the first year you cannot receive funds the second year, but can apply again in the third year. She urged providers to utilize this grant; the application is only five-pages. Keep in mind the philosophy of "pay it forward." She cautioned that the Board does not award funds for capital improvements. Even though remodeling a bathroom or kitchen would improve the quality of life for residents, the legislation and direction from CMS does not allow it.

Ms. Brenowitz selected rhythm circles, which have been done for centuries, because of the quality of life and relationship opportunities it provided for those who lived in their communities. She requested funds for equipment, but also for a health rhythms facilitator training, during which she spent five days studying with people. Have them sit in a circle. Not everyone can drum but some can chant. She would have bought the health rhythms set, which is for health facilities. Drum for self esteem. End it with meditation to chimes.

These are well documented reasons to have a rhythm circle and a drum circle, both of which are known to reduce stress and pain and depression (they have been shown to increase T cells). Alzheimer's disease has shown an improvement, Parkinson's has seen improvement. So very much drumming and rhythm are part of the wellness movement. Their greatest impact, however, is the sense of connectedness and relationship building that occurs, and this is why Ms. Brenowitz chose this program. It provides opportunities for self expression, for leadership (to be the one that's directing and encouraging people, and for range of motion (popular with restorative staff). It's something everyone can do; it's inclusive, and it allows self expression, communication. It's very social too.

Her community, Northstar, is home to people living with chronic mental illness or progressive Multiple Sclerosis; they have many young residents who never thought they'd be living their life in a NH.

Her grant proposal said they'd look at stress reduction based on self reporting by residents and their care partners, pain reduction based on PRM med use, and connectedness based on observed increases in public areas with others or at scripted social events. Interestingly, Ms. Brenowitz didn't include lower blood pressure about one of her

community (which is a document effect of these circles). For the six weeks she tracked blood pressures, she never had a blood pressure go down 8 – 10 points.

Everyone can do the rhythm circles regardless of physical limitations. If only one hand works due to stroke or injury, you put the drums on one side of the wheelchairs (they're called "not so loud" drums). When working with hospice residents, you can get something that softens the sound of the drums.

When she told her residents (ages 24-83) she was making a presentation today, and asked what they wanted to share about their experiences with these circles, they, said It's a great way to promote interaction with each other; it's awesome fun; it gets everyone involved; it's a fun way to play.

Ms. Brenowitz has done rhythm circles with young boys at St. Vincent's Home, with the Colorado Activity Professional's Association, students in the activity professional course at a community college, the Culture Change Coalition, and with families and staff at the Alzheimer's Annual Association. She lends the equipment to other communities: Brookshire was the first place to use it and they loved it. Staff said they had participation from residents that never came to anything.

She encourages providers to review the catalogs she brought, and to look for the drums that are empty on the bottom because you can store equipment in the empty space. The equipment is washable, synthetic. She demonstrated a frame drum, a buffalo drum and ocean drums. If providers are only thinking of drums, she said everyone loves the ocean drums. Go to thrift stores, it's a great way for staff and family members to join in.

e. Jennifer introduced Phyllis Brighton as the new MDS coordinator. She can be reached 303-692-2894 or Phyllis.Brighton@state.co.us.