



Regulation Review for 10.07.02 (Sections .13-.21)

Subject: LTC Stakeholders Meeting (Session 2)

Hosts:

Patricia Tomsko Nay, M.D., Executive Director, OHCQ
Amanda Thomas, Regulatory Affairs Analyst, OHCQ
Chrissy Vogeley, Chief of Staff, OHCQ
Margie Heald, Deputy Director of Federal Programs, OHCQ
Gwen Winston, Quality Initiatives Coordinator, OHCQ
Jasmin Watson-EI, Executive Associate, OHCQ

Date: October 23, 2014

Place: Office of Health Care Quality (Administrative Conference Room)

Agenda:

- I. Welcome & Introductions
 - a. Welcome from Dr. Nay, Executive Director, OHCQ
 - b. Introductions by all stakeholders (Phone and in person)
 - c. Review ground rules
 - i. 2 minute time limit for each speaker.
 - II. Review regulation 10.07.02 (sections .13-.21)
 - III. Next Steps
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I. Welcome & Introductions

- a. Dr. Nay welcomes everyone to the session and thanks you all for coming.
- b. The floor is open for stakeholder introductions

- i. Attendees include:
 - 1. Adriene Borts
 - 2. Barbara Brocato
 - 3. David Burke
 - 4. Carol Christmyer
 - 5. Philip Cronin
 - 6. Donna DeLeno Neuworth
 - 7. Phyllis Fatzinger McShane
 - 8. Isabella Firth
 - 9. Jennifer Goldberg
 - 10. Alice Hedt
 - 11. Theresa Hershey
 - 12. Meredith Hauf
 - 13. Beth Hill
 - 14. Barbara Hoffstein
 - 15. Vanessa Hughes
 - 16. Anne Hurley
 - 17. Tracy Immel
 - 18. David Jones
 - 19. Arlene Kleinman
 - 20. Terry Lawrence Nelson
 - 21. Ruth Anne McCormick
 - 22. Margaret Muth
 - 23. Kristen Neville
 - 24. Susan Panek
 - 25. Sonal Patel
 - 26. Brenda Roup
 - 27. Marie Savage
 - 28. Lisa Toland
 - 29. Stanley Weinstein
 - 30. Clare Whitbeck
 - 31. Gail Wowk
 - i. VOICES
 - ii. Carroll Lutheran Village
 - iii. MD Legal AID
 - iv. Board of Pharmacy
 - v. St. Elizabeth's
 - vi. Broadmead
 - vii. Margaret and Associates
 - viii. DHMH
 - ix. MD Medicaid
 - x. OHCC
 - xi. MD Dieticians and Health Care
 - xii. MD Board of Social Work Examiners
 - xiii. Lynn Meadows Retirement Community
 - xiv. HMR Maryland
 - xv. MD Health Care Commission
 - xvi. Manor Care
 - xvii. Health Facilities of MD
 - xviii. Genesis Health Care
 - xix. Alzheimer's Assoc.

- xx. LifeSpan
- xxi. Health Occupations Board
- xxii. Dept. of Aging Ombudsman program
- xxiii. MD Health Care Commission

- ii. VOICES requests a copy of the attendance sheet with names and organizations.
- c. Ground Rules: Please limit comments to 2 minutes. Amanda has a timer and will let you know when time is up.
 - i. We will take comments from the room first and then open the floor to those who have dialed in.
 - ii. When you stand to speak, please come to the front of the room. Everyone in the room and on the phone should say their name and the organizations they represent.
 - iii. Please complete the survey that is sent following the session. If you do not have a comment, leave the section blank.
 - iv. OHCQ is here to listen. We want to provide enough time and the opportunity to hear our feedback. After getting all the feedback, we can do our internal review of everything from surveys and the in-person sessions before we put together one new document to have you all review.
 - v. Question: Will everyone here receive the new document after you are done review?
 - 1. Answer: Yes, we will send to everyone on the email list.
 - vi. Question: Is there a deadline for feedback?
 - 1. Answer: Yes, Monday, October 27th by 5 p.m.
 - vii. Question: Will we be able to comment about something from previous session?
 - 1. ANSWER: Yes, please note which section you have comment on. However, we have to limit feedback and shut down the session comments because we are meeting for few hours to talk about feedback and hope not to keep revisiting.
 - viii. Question: Can we comment after the last document is sent out?
 - 1. Answer: The next session your last chance to make changes to any surveys from the past. We have to close the comments period so that we may move the regulations forward.

II. Review Regulation 10.07.02 (Sections .13-.21)

a. 13 - Dietetic Services

- i. Technical change: registered licensed dietician is not a proper term. Please change the definition.
 - 1. Chrissy- we did change that definition and will fix throughout
- ii. Agree with removal of term "or other qualified person" from sections.

- iii. It was difficult to find certified dietetic managers. More people will be able to take the CDM or DTR going forward.
- iv. 13 D(3) - Culture change results in universal workers. They cook and make it seem like there is just cooking at home. Visit the Greenhouse in Baltimore as a good example. In a culture change facility, people can go get an apple easily. Regs need to provide a more user friendly way to deliver food.
- v. Eating is important for quality of care and quality of life. It's great that residents can participate in meal planning.
- vi. Section G: Add "Efforts should be made to accommodate religious and cultural preferences of the residents". It can be healthier than prescribed meals.
- vii. LifeSPan supports culture change and this should be a part of the regs.
- viii. Totally against mandated weekly hours with registered dietician. This is fiscally straining. State should remedy for facilities struggling in dietary services
- ix. Concern for required minimum of dietician hours. Facilities that are over this will think it is ok to reduce dietician hours. For facilities that have trouble meeting the hours, it is a fiduciary problem. There should not be a mandated formula. Dieticians are being pigeon holed into a formula.
- x. With the CDM and qualified dietary supervisor: please don't leave out those who are not certified. There are qualified people with degrees who are capable of providing good services.
- xi. Dieticians are very hands on.
- xii. The GRID: The prescriptive nature of number of hours is problematic. Prescribing hours isn't a good measure of accountability in meeting resident needs.
- xiii. VOICES: Agree with religious food preferences. Food is coming up at wrong temps. OHCQ can say they are going to enforce but OHCQ doesn't have the staff. It needs to be clear cut and in the regs.

b. .14 - Specialized Rehabilitative Services - Occupational

- i. .14 (b) - make sure health care practitioners have appreciation for cultural differences among residents.
- ii. ADD chiropractors in with OTs and PTs
- iii. ADD licensed in with OTs PTs, etc.
- iv. Speech pathologists and audiologists are 2 separate credentials. People may be confused if they are grouped together.
- v. Have a stand-by ventilator in room with each person on a standard vent.
- vi. Recommend 1 patient ventilator for every 10 patients.
- vii. If you are using the term Dementia Unit, there should be special accommodations for those if not, do not use term.
- viii. Please have adequate staff to answer call bells on dementia unit. Please lower staff ratios. Some people need one-on-one attention so lower ratios are needed.
- ix. Calling it a dementia unit doesn't mean anything if specialized services aren't offered for those on the unit.
 - 1. Additional dementia-specific training requested for the specialized dementia care unit. Focus on understanding the disease, reduce pain, reduce behavioral issues.

2. There have been cases of patients on locked units but do not have dementia, are mentally ill. Mental illness is not the same as dementia. Having no additional services for dementia care patients is misleading to
 - x. MD consumers. Having a consumer disclosure may be good
 - xi. State should say "what makes dementia care a specialized unit"
 - xii. Care-planning for dementia care should also include activities, which will be different for these residents. They can have quality of life with focused activities that help.
 - xiii. Thanks for revising the language that allows hiring or contract with board certified pulmonologist.
 - xiv. Dementia care change term locked unit to secured unit for dignity reasons.
 - xv. 14B - services being done within 36 hours. There are 3 or 4 services prescribed and only 1 being done.
 - xvi. Can policies and procedure be provided to resident and family councils?
 - xvii. Restorative care of nursing services: Please require how staff provides those services be calculated in

c. **.15 Pharmaceutical**

- i. Add statement that responsible pharmacist advise within first 72 hours to review patient history and make recommendations
- ii. What are provisions for emergency drug delivery?
- iii. 15 A (ii an iii) Change to licensed registered dietician, take out the "and" or just say registered dietician
- iv. A 1 - typo "biologicals"
- v. A 1 - language without abridging the person right to choosing pharmacy" be added to end
- vi. Have family council
- vii. How can a person get mail delivered drugs if families are not allowed to take meds into the building? Regs need to handle this problem.
- viii. A 3B: Can quarterly mtgs be held at same time as quality assurance mtgs?
- ix. Only medications should be held in chosen refrigerators. People are storing food and other items in with medications.
- x. Entire section needs its own meeting. Family and sponsors should be allowed to bring medications into the facility. Local pharmacists can take a long period of time to fill prescriptions.
- xi. Culture change should not need a waiver. Meds should be stored individually in the resident's room.

d. **.16 - Laboratory an Radiologic Services**

- i. NO COMMENT

e. **.17 - Dental Services**

- i. Need a definition of emergency dental services
- ii. Dental services are very difficult to obtain in nursing homes
- iii. Should have a director of quality of life for facilities
- iv. Prevent dental problems by having enough staff
- v. Add language for residents who cannot do their own dental care to have nursing staff do this once per day at least.

- vi. Spell out what dental care is (brushing, cleaning, etc.)
- vii. There is pain that comes from not assessing oral hygiene at least once per day
- viii. Add something that indicates that nursing staff or aids are also responsible for caring for dentures. They have been tossed in trash and out with dishes on food tray.

f. **.18 Social Work Services**

- i. 18 b - Should read LCSW LCSWC, LSW or LBSW (Spell out)
- ii. What is a social work consultant? May consider taking that out and say if no social worker on staff, contract out
 - 1. Chrissy- we fixed that already
- iii. Social work associate is LBSW
 - 1. Chrissy - we fixed already
- iv. Licensed Social worker should be in each building and include quality of life responsibilities

g. **.19 resident activities**

- i. Think about certification program for activities directors. Residents need more than just BINGO. Univ. of Delaware has a program. UMD should too.
- ii. Give residents a voice in what activities are planned for them

h. **.20 Clinical records**

- i. Discharge summary should be current for transition of care record AT THE TIME OF DISCHARGE
- ii. Thank you for the mention of electronic records

i. **.21 - Infection Prevention and Control Program**

- i. Please include something that includes uniformity for facilities about infection prevention. Facilities have different policies, protocols
- ii. Add in CDC recommended protocols
- iii. Masking mentions are overly prescriptive. REMOVE ENTIRELY: not in MD statute.
- iv. Who's responsible for the one dose boost for pertussis vaccine? Does employer cover costs, co-pays?
 - 1. Short answer is no, employee is responsible.
- v. misspelling "Access" should be assess
- vi. Prescribed ratio for 1 FTE: What's being accomplished with this ratio? Current regulations are adequate.
- vii. Is there going to be some backing to mandate the flu vaccine for LTC facilities?
- viii. Staffing ratio is needed because the person needs time to do their job, wearing 10 hats.
- ix. Do not look for a statute that requires flu vaccine. Hospital statute was done by the private sector.

III. Next Steps

- a. Please complete the survey, providing feedback about the regulations and the stakeholders meetings. We greatly value the information and feedback as we mold these to fit our various units.

IV. Meeting adjourned at 11:57 a .m.