Oversight Committee on Quality of Care In Nursing Homes and Assisted Living Facilities

January 15, 2015

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
State House H-107
Annapolis, Maryland 21401

The Honorable Michael E. Busch
Speaker of the House of Delegates
State House H-101
Annapolis, Maryland 21401

Dear Gentlemen:

Subject to §2-1246 of the State Government Article and to comply with Health General Article 19-1409 (Chapter 400 of the Laws of Maryland 2005), the following is the required annual report of the Oversight Committee on Quality of Care in Nursing Homes and Assisted Living Facilities (the "Oversight Committee") for activity from December 2013 through November 2014. The committee met three times during this period. Agendas and minutes of the meeting are attached.

The charge of the Oversight Committee is to evaluate the progress in improving nursing home quality and assisted living facility quality statewide, including consideration of nine specific areas:

1. Quality of care standards for nursing homes and assisted living facilities;
2. Standards for the identification of the onset of dementia and Alzheimer's Disease;
3. Standards for the identification of conditions appropriate for hospice services;
4. Staffing patterns and staffing standards;
5. Policies and procedures for inspecting nursing homes and assisted living facilities, and responding to quality of care complaints;
6. A comparison of Maryland standards, policies and procedures to those of other states;
7. The labor pool available to fill nursing and nursing aide jobs;
8. State funding mechanisms for nursing homes and assisted living facilities, including the Medicaid Nursing Home Reimbursement System, and regulation of nursing homes; and
9. The provision and quality of mental and behavioral health care services to meet the needs of nursing home and assisted living facility residents.

The Oversight Committee focused on (1) the proposed nursing home and assisted living regulations from the Office of Health Care Quality ("OHCQ"), (2) staffing, (3) mental and behavioral health issues, (4) Culture Change and (5) the State's Ombudsman program.

The Oversight Committee did this utilizing a four-fold approach:

1. Expanding its knowledge base by soliciting input from outside experts in the field of long-term care. For example, it sponsored a presentation by Judah Ronch, PhD, Professor of Practice and Dean of the Erickson School at the University of Maryland, Baltimore County, an expert on culture change in long term care, who discussed:

"Making the Case for Culture Change—A Look at Replicable Practices" at the December 2013 meeting.

2. Soliciting input and recommendations from its own stakeholder members. For example, Kim Burton of the Mental Health Association of Marylandpresented on "Nursing-facility-based Behavioral Healthcare Challenges and Opportunities" at the November 2014 meeting.
3. Obtaining periodic reports from its members and staff with program management and oversight responsibilities. For example, Tricia Nay, MD, Director of the Office of Health Care Quality (OHCQ) of the Maryland Department of Health and Mental Hygiene provided a report on the implementation of OHCQ's statutory and regulatory long-term care mandates at the June 2014 meeting. Alice Hedt, State Ombudsman, Maryland Department of Aging provided the MD Long-Term Care Ombudsman Program Annual Update at the November 2014 meeting.
4. Monitoring the status of significant program initiatives. For example, Dr. Nay briefed the Oversight Committee on the specific provisions in the proposed nursing home and assisted living regulations at the June 2014 meeting. Chrissy Vogeley, Chief of Staff, OHCQ reported on the three public stakeholder meetings held to secure input on the nursing home regulations at the November 2014 meeting.

The Oversight Committee will continue to review and obtain recommendations on what measures can be implemented given the budget challenges faced by government and providers to insure quality of care for persons residing in nursing homes and assisted living facilities. When appropriate, the Oversight Committee will make recommendations to the Governor and General Assembly to help insure quality of care for Maryland's long term care population.

Should you require additional information, please do not hesitate to contact Marty Roach, Oversight Committee staff, at 410-767-1067 or martha.roach@maryland.gov.

Sincerely,

Gloria Lawlah
Chairman

Attachments: Oversight Committee Meeting Minutes with Attachments
Oversight Committee Membership 2014

cc: Jodie Chilson, Department of Legislative Services
Martha C. Roach, Maryland Department of Aging
Alice H. Hedt, Maryland Department of Aging
Rosanne B. Hanratty, Maryland Department of Aging

Oversight Committee on Quality of Care
in Nursing Homes & Assisted Living Facilities
Woodmore House Assisted Living Facility, Upper Marlboro, MD
December 12, 2013
Minutes

Members Present:
Susan Eddy, Voices for Quality Care
Sister Irene Dunn, Assisted Living Provider, 10 or more residents
Virginia G. Crespo, United Seniors of Maryland
Margie Heald, Department of Health and Mental Hygiene (DHMH), Office of Health Care Quality (OHCQ)
Valarie Colmore, Maryland Department of Human Resources (DHR), Office of Adult Services, Social Services Administration
Karen Sylvester, Acting Division Manager, Prince George's County Department of Family Services, Aging Services Division
Odile Brunetto, Director, Montgomery County Area Agency on Aging (AAA)
Kim Burton, Mental Health Association of Maryland
Charlotte Harris Branch, Assisted Living Provider, 5—9 residents
Ilene Rosenthal, Alzheimer's Association

Members Not Present:
Honorable Gloria G. Lawlah, Secretary Maryland Department of Aging (MDoA), Chair
Harriet L. Johnson, Consumer Representative
Brian Hepburn, M.D., Mental Hygiene Administration (MHA)
Honorable Shirley Nathan-Pulliam, Health and Government Operations Committee
Bill Holman, LifeSpan
Regina Bodnar, RN, Hospice NetOffice
Antoinette Turner, SEIU

Other:
Clare Whitebeck, Voices for Quality Care
Stephanie Numer, Prince George's County Ombudsman
Susan Panek, DHMH, Medicaid
Chrissy Vogeley, DHMH, OHCQ

Alissa John, RN, Director, CM/DN
Several Residents of Woodmore House Assisted Living

Staff:
Stephanie Hull, Deputy Secretary MDoA
Donna DeLeno Neuworth, Alice Hedt, Marty Roach, MDoA
Rosanne Hanratty, ReServe Program, MDoA

Jodie Chilson, Senior Policy Analyst, Department of Legislative Services

Minutes:

After a brief facility tour, Stephanie Hull welcomed attendees and expressed her thanks to the Woodmore House Assisted Living Facility and their staff for hosting the meeting.

The Minutes from October 2, 2013 were approved with one change—correcting the meeting date on the minutes' document. Donna DeLeno Neuworth summarized the initial work and structure of the Alzheimer's Council.

Presentation:

Judah L. Ronch, Ph.D. Professor of Practice and Dean of the Erickson School at the University of Maryland, Baltimore County, an expert on culture change in long-term care, made a presentation on: "Making the Case for Culture Change—A Look at Replicable Practices."

Dr. Ronch stated that a model of medical acute care has historically been adopted in long-term care but is unsuited to it. He said that an acute care model promotes "excess disability" because it emphasizes elders' functional deficits instead of promoting functional enhancement and individuation. While there was some movement away from functional deficit model in the 1980s, he noted, the "culture change" movement began in earnest with Thomas Kittwood's model of "person-centered" care which views elders not as passive recipients of care but as proactive shapers of their own lives. The quality of life and the quality of care must be together. Dr. Ronch stated culture change occurs at three levels of organizational culture. These are artifacts—what is seen; norms—how work is organized; and values—what matters to the organization. Artifacts, such as a facility's physical features, are the easiest to modify but have the least impact. Normative changes, such as rewritten procedures, may not adequately address foundational values. Actual value change encourages a paradigm of person-centered care that values those who provide and receive care; treats those who provide and receive care as individuals; looks at the world from the perspective of those providing and receiving care; and creates a positive social environment in which those within it experience well-being.

Dr. Ronch identified regulatory strategies states have used to implement culture change. He discussed methods that can be utilized to measure culture change success, noting these often are qualitative instead of quantitative. He noted there are a few good controlled studies that do indicate cost-neutrality for culture change initiatives. Nevertheless, he acknowledged that competing models of change are often not methodologically comparable and that the longer-term effects of culture change are rarely studied. He believes the baby boomers will demand

culture change or person centered care for their parents and the workers entering the workforce now will demand it.

Discussion and Identification of Future Efforts of the Oversight Committee:

In the discussion that followed the presentation, attendees raised several issues about culture change including how the resources for culture change can be secured and how to obtain buy-in from stakeholders; the necessity for development of best practices and peer coaching; and the need to develop strategies to ensure that values, not merely artifacts and norms, are actually addressed.

The discussion of future efforts of the Oversight Committee was conceptually divided between those efforts dealing specifically with promoting culture change and those dealing with additional key issues.

With regard to culture change, suggestions for Oversight Committee efforts included:

- convening stakeholders (including long-term care residents, families, staff and providers) to identify goals and best practices designed to facilitate person-centered care;
- identifying the resource demands and regulatory and program design constraints on culture change initiatives;
- discussing strategies that facilities can use to promote culture change in the face of limited resources; and
- compiling documentation that can be used to make the case for culture change to legislators and regulators.

With regard to other areas for Oversight Committee efforts, suggestions included:

- examining the impact of, and strategies to develop, a long-term care workforce that is increasingly multi-cultural and multi–lingual;
- studying staff stress and its relationship to abuse and neglect;
- exploring strategies for quality improvement of underperforming facilities;
- assessing facility compliance with quality-of-life regulatory standards;
- examining issues of resident behavioral health needs and substance abuse treatment; and
- identifying best practices for transitions from facilities and reintegration into the community generally, and specifically for residents with behavioral health issues.

Additionally, the need to ensure that all slots on the Committee are filled was raised as a concern.

The meeting adjourned at 3 PM.

Oversight Committee on Quality of Care
in Nursing Homes & Assisted Living Facilities
House Government Operations Committee Hearing Room
Annapolis, MD
June 6, 2014
Minutes

Members Present:
Secretary Gloria Lawlah, Chair, Secretary of Maryland Department of Aging (MDoA)
Odile Brunetto, Director, Montgomery County Area Agency on Aging
Kim Burton, Mental Health Association of Maryland
Valerie Colmore, Maryland Department of Human Resources, Office of Adult Services
Sister Irene Dunn, Assisted Living Provider, 10 or more residents
Susan Eddy, Voices for Quality Care
Tricia Nay, MD, Maryland Department of Health and Mental Hygiene (DHMH), Director Office of Health Care Quality (OHCQ)
Ilene Rosenthal, Alzheimer's Association

Members Not Present:
Regina Bodnar, RN, Hospice NetOffice
Charlotte Harris Branch, Assisted Living Provider, 5—9 residents
Virginia Crespo, United Seniors of Maryland
Brian Hepburn, Maryland Mental Health Administration
Bill Holman, Lifespan
Harriet L. Johnson, Consumer Representative
Honorable Shirley Nathan-Pulliam, Health and Government Operations Committee
Ofelia Ross, Ombudsman
Karen Sylvester, Prince George's County Dept. of Family Services, Area Agency on Aging

Other:
Ashlie Bagwell, HJM
Clare Whitbeck, Voices for Quality Care

Staff:
Jodie Chilson, Department of Legislative Services
Rosanne B. Hanratty, MDoA
Margie Heald, DHMH, OHCQ
Alice H. Hedt, MDoA
Marty Roach, MDoA
Chrissy Vogeley, DHMH, OHCQ
Gwen Winston, DHMH, OHCQ

Welcome:
Secretary Lawlah welcomed committee members and noted that a presentation and discussion on the proposed nursing home and assisted living regulations were the main items to be covered at this meeting.

Approval of December 12, 2013 Minutes
The December 12, 2013 minutes were approved without change.

Presentation by Tricia Nay, MD, DHMH OHCQ
Dr. Nay opened her presentation with a summary of the status of OHCQ's mandate, i.e., oversight of 14,452 community-based providers utilizing a budget of $19.3 million and a staff of 187. She noted that OHCQ has achieved new efficiencies in performing its work, thus allowing an increase in the number of surveys completed under its statutory mandate. Such efficiencies include a fully electronic survey instrument. She also noted OHCQ has recently filled eight vacancies including several specialized facility surveyors. A Quality Initiative Unit was formed at OHCQ that includes a director, health policy analyst, surveyors, IT analyst, and coordinator. Dr. Nay also commented that over 51% of OHCQ staff will be eligible for retirement within the next 5 years.

She stated that the nursing home and assisted living regulations have been in the regulatory revision process for seven years and that OHCQ's target for issuance of draft regulations is CY 2014. She said that she believes consensus has been reached on substantive issues and that future regulatory revisions will take place on a four-year cycle. She also noted that over 1,000 comments, of which several hundred are substantive, have been received in response to the 45-day informal review posting of the draft regulations on the DHMH website.

Proposed Nursing Home Regulations:
Discussing the nursing home regulations, Dr. Nay and other staff addressed three topics:

- new construction and approval of drawings,
- staffing and hours of bedside care, and
- care of residents with dementia and serious emotional disorders.

With regard to new construction, Dr. Nay noted that in the past the State had an in-house architect who approved pre-construction drawings but that the position of State architect does not currently exist. Therefore facilities have had the responsibility to ensure that any new construction is in compliance with building codes and State and Federal requirements. The proposed regulations do not contain a requirement for pre-construction approval by the State.

With regard to staffing and hours of bedside care, Alice Hedt noted that the current regulatory requirement is 2.0 hours and the proposed regulation requires 3.0 hours; however, a study by the Centers for Medicare and Medicaid Services (CMS) indicated that 4.1 hours of bedside care are needed to ensure that residents' status does not decline. She said that the CMS study showed that unnecessary hospitalizations are reduced as well as costly medical conditions (i.e., pressure sores) when a higher staffing level is maintained.

Dr. Nay stated that quality of care does not necessarily correlate with number of hours of bedside care and that the proposed 3.0 hours is a minimum requirement that might be exceeded to ensure quality. Margie Heald explained that the 3.0 hour requirement was suggested by a 2007 workgroup. Moreover, Maryland's regulations will not require certain ratios of staff to residents so that the 3.0 hour minimum may be exceeded on certain shifts when the resident needs can be expected to be greater. She also explained that both State and Federal surveyors have the authority to access facility payroll data to independently calculate hours of bedside care.

Alice Hedt noted that staffing data reported by nursing homes and used on the CMS website Nursing Home Compare is not audited and that the Federal regulations do not contain a standard for the number of hours of bedside care but rather require that staffing to ensure that the needs of the resident are being me. She also said that in addition to ensuring that facilities comply with the requirement for a minimum number of hours of bedside care, facility management should be supportive of staff as indicated through staff training, benefits and compensation to promote stable staffing and reduced staff turnover.

With regard to care for residents with dementia or serious emotional disorders, Margie Heald stated that eight hours of specialized dementia care training is required for geriatric nursing assistants who deliver such care and that the requirement can be found in the proposed regulations' section on special care units. She also said that in general secured dementia care units would be covered under the regulations for "special care units."

Alice Hedt noted that the Virginia I. Jones Alzheimer's Disease and Related Disorders Council is examining the issue of care for residents with dementia and that the impact of increasing numbers of residents with dementia has especially been experienced by assisted living facilities. Marty Roach added that in continuing care retirement communities there is an ongoing issue of residents who have received care in the "memory care units" of assisted living communities and who exhaust payment resources for assisted living but when transferred to nursing homes under Medicaid payment, they may not receive the care that they require—for example in a secured unit with the dementia programs.

Kim Burton expressed concern over training for facility staff not only in dementia care but also in addressing care of those with behavioral health problems and with the needs of residents with both dementia and behavioral health issues. Kim asked if there would be parallel systems or what for behavioral needs vs dementia. Both need personalized behavioral care. Dr. Nay stated that the increased need to address care of residents with dementia and with behavioral health needs reflects the overall increase in medical complexity of residents being admitted to long-term care facilities.

Proposed Assisted Living Regulations:
Discussing the assisted living regulations, Dr. Nay and other staff addressed:

- proposals to delete levels of care from the regulations,
- the assisted living resident assessment tool, and
- dementia care and care for residents with serious emotional disorders.

OHCQ is working primarily with three groups: HFAM, LifeSpan and LeadingAge Maryland. These are the trade associations representing the providers. Alice Hedt asked that resident groups be included since the groups and individuals that are impacted should always be included.

With regard to levels of care, Gwen Winston, the coordinator for quality initiatives at OHCQ, said that levels of care are presently used for two reasons: to determine the resident's medical level of acuity and in billing. She stated that even if the levels of care are deleted from the new regulations, completion of an updated Resident Assessment Tool (RAT) would be required in order to determine the level of services the resident requires.

Sister Dunn, Level II Provider, said the levels of care help because if the person needs Level III care and wouldn't have to move but we can't keep because we don't have the staff.

Marty Roach explained that she gets many complaints because of the move from Level I to Level II or III and the increased cost. It helps to be able to explain that the person's needs have increased and they are now a Level II or III with additional costs.

Clare Whitbeck said that the current division into three levels of care was well-understood and expressed concern that removing the designation of resident level of care might prove difficult for family members to understand, especially when a resident's condition changes. Clare further explained that people understand Levels I, II and III. Level I is good, Level II is worse and Level III the person is in trouble.

Dr. Nay said that a pilot project indicated that the change was acceptable to family members, stakeholders and providers and that even with the deletion of levels of care from the regulations, the present requirements for establishing a care plan and its periodic updating would remain.

Kim Burton expressed concern that changes in the Medicaid programs for home and community services and the assessment required for these services would be duplicative of the current RAT and that Medicaid waiver providers will object to completing two assessment forms. Dr. Nay stated the proposed OHCQ regulatory changes had been acceptable to Medicaid staff in DHMH but that she was aware of the issue of duplication.

Alice Hedt expressed concern about possible unintended consequences of the deletion of levels of care, especially on smaller providers who deliver lower cost services and do not have the capacity to generate the more sophisticated assessment tools and processes that larger

providers can generate. She suggested that more discussions take place with a variety of affected stakeholders, including those knowledgeable of the issues encountered by people with disabilities of every age. She also noted that assisted living providers need additional training on how to care appropriately for residents with dementia.

With regard to dementia care and care for persons with serious emotional disorders, Dr. Nay stated that she recognizes the challenges faced by smaller providers of care to this resident population. Kim Burton stated that providers, including nursing home providers, need comprehensive information at resident admission about total care needs of the person. She also noted the special difficulties faced by residents of assisted living facilities who are discharged at the facility's discretion without the protections and appeal rights of nursing home residents facing such discharges. Sr. Irene Dunn asked about the rationale for the requirement of a ratio of one direct care staff person for every eight residents with dementia, noting the ratio could appropriately vary by shift and needs of the residents. Dr. Nay committed to research this.

Other issues:

Dr. Nay stated that any position on possible legislation on background check requirements would be at the DHMH level, not at OHCQ's. Alice Hedt said that the Ombudsman Program appreciates OHCQ's increased use of substantial financial sanctions and facility closures to address problems at facilities that have consistently provided low quality care. Dr. Nay said that such increased sanctions have come at the behest of CMS and represent a new policy that fines be uniform across all CMS regions. CMS has used its high-cost regions as the benchmark for determining the level of fines. She stated that the increased amount of, and short term for payment of, fines is of significant concern to the nursing home industry. She also noted that both Federal- and State-imposed fines are returned as grants to nursing homes for studies and other efforts to improve the quality of care delivered to residents.

Alice Hedt updated the committee on culture change, which had been its primary focus in 2013. The e Maryland Culture Change Coalition is now operational, officers were elected in January and the Coalition will be applying for grants to study the methods for delivering person-centered care within existing budgetary constraints. Margie Heald stated that three webinars on culture change were presented for OHCQ surveyors and that Alice Hedt had been a presenter.

The meeting adjourned by Secretary Lawlah at 3:35 PM.

Oversight Committee on Quality of Care in
Nursing Homes and Assisted Living Facilities
Health and Government Operations Committee Room (HGO)
Annapolis, MD
November 13, 2014

Members Present:
Secretary Gloria Lawlah, Chair, Secretary of Maryland Department of Aging (MDoA)
Odile Brunetto, Director, Montgomery County Area Agency on Aging (AAA)
Kim Burton, Mental Health Association of Maryland
Virginia Crespo, United Seniors of Maryland
Danna Kauffman, (designee for Bill Holman), LifeSpan
Sister Irene Dunn, Assisted Living Provider, 10 or more residents
Karen Sylvester, Prince George's County Dept. of Family Services, Area Agency on Aging
Chrissy Vogeley (designee for Tricia Nay, MD), Department of Health and Mental Hygiene (DHMH), Office of Health Care Quality (OHCQ)
Clare Whitbeck (designee for Susan Eddy), Voices for Quality Care

Members Not Present:
Regina Bodnar, RN, HospiceNet Office
Charlotte Harris Branch, Assisted Living Provider, 5—9 residents
Valerie Colmore, Department of Human Resources
Brian Hepburn, DHMH, Mental Health Administration
Bill Holman, Lifespan
Harriet L. Johnson, Consumer Representative
Honorable Shirley Nathan-Pulliam, Health and Government Operations Committee
Ilene Rosenthal, Alzheimer's Association

Other:
Sharlene Liberton, Ombudsman Program Director, Department of Aging and Disabilities, Anne Arundel County
Kerry Watson, Alexander and Cleaver, HFAM
Vicky Woodruff, Mental Health Association of Maryland

Staff:
Jodie Chilson, Department of Legislative Services
Rosanne B. Hanratty, MDoA
Alice H. Hedt, MDoA
Mark Leeds, DHMH/Medicaid
Marty Roach, MDoA

Welcome:
Secretary Lawlah welcomed committee members and guests, asked that all attendees introduce themselves and noted the items on the agenda for discussion.

Approval of June 6, 2014 Minutes:
The June 6, 2014 minutes were approved without change.

Presentation by Alice H. Hedt, State Ombudsman, MDoA:
Ms. Hedt presented the Fiscal Year (FY) 2013 MD Long-Term Care Ombudsman Program Annual Update (appended).

She noted that the Ombudsman Program serves over 47,000 people in 233 nursing homes and assisted living facilities in the state through the MDoA Office of the State Long Term Care Ombudsman with a State Ombudsman and Ombudsman Specialist; 19 local programs (36 FTEs) located in AAAs; and 146 volunteers contributing $623,747 worth of time. She said that in FFY 2013 the Long-Term Care Ombudsman Program made over 11,000 facility visits, addressed 2873 complaints of which 36% were from residents, 36 % were from families or friends, 12% were anonymous, and 5% were from the facility or its staff. In addition, there were a number of other complaints from sources such as clergy, public officials, banks, and other agencies. There was a 23% increase in complaints, a 34% increase in survey participation and a 15% increase in community education sessions.

Ms. Hedt highlighted the accomplishments in 2014 including the certification of employed (42) and volunteer (94) ombudsmen who were certified for the first time in the program's 30+ year history in Maryland. The certification process included training sessions conducted by the State Ombudsman on ombudsman basics as well special training sessions on ombudsman communication skills with residents. Each volunteer and employed ombudsman had to take a certification exam as well as sign documents about confidentiality and conflict of interest. Now that it has been implemented, the certification process is required for all new ombudsmen. This will ensure a baseline of knowledge and skills throughout the program.

Ms.Hedt also highlighted that a majority of complaints are from residents, relatives and friends – a shift from the sources of complaint years ago. This indicates that ombudsmen are visiting the facilities and focusing on the residents whom they are required under the Older Americans Act to serve. Other changes include more nursing home closures and bankruptcies in assisted living and nursing homes that include a long term care ombudsman serving as the Patient Ombudsman. This work is extremely important but very time consuming.

Ms. Hedt emphasized that the ombudsman program is increasingly focused on assisted living facilities, particularly those with on-going problems. Unfortunately, ombudsmen are only able to visit 22% of assisted living facilities regularly compared to 100% of nursing homes because there are over 1350 assisted living facilities. Ms. Hedt explained that the Ombudsman Program is working more closely with both OHCQ and the Medicaid Waiver Program to work on strategies to address facilities with serious problems.

Ms. Hedt stated that the most frequent complaints in nursing homes dealt with discharge and eviction, care plans and resident assessments, resident dignity and respect for example as reflected in staff attitudes, failure to respond to requests for assistance such as call bells and medications and personal hygiene. For the first time in the history of the program, discharge problems became the most common complaint in assisted living to the ombudsman program. (The complete list of complaints in nursing homes and assisted living facilities is included in the appended report)

Ms. Whitbeck explained that her organization, Voices for Quality Care, is seeing an increase in problems with rehabilitation. Ms. Hedt explained that in the ombudsman program, complaints about rehabilitation increased by 45% between FY12 and FY13.

She noted that the overall goals for the State ombudsman program are: (1) providing the resources to ensure that the program is operated in consistence with applicable Older Americans Act provisions and consistently among local ombudsman programs; (2) advocating with and on behalf of MD residents who live in long-term care facilities; and (3) promoting quality of care and life for residents including those with dementia through training, consultations, highlighting successful practices and through public policies that support resident-centered care.

Presentation by Chrissy Vogeley, Chief of Staff, OHCQ:
Ms. Vogeley said that OHCQ has completed three public stakeholder meetings with a total attendance of about fifty persons on the proposed nursing home regulations. She stated that the regulations are on track to be published in the first Register of February of 2015. She noted that OHCQ has formed a Behavioral Health Workgroup that will consider the issues of dementia care and behavioral health issues in both assisted living and nursing home facilities. Behavioral Health will not be included in the February regulations but hopefully will be ready to be included in the summer of 2015. In response to questions from committee members she clarified that the Behavioral Health Workgroup does not have behavioral health issues in group homes under its purview, that it will address a definition of behavioral health, and that the group includes, among others, DHMH and MDoA staff, as well as representatives of MHA and Voices of Quality Care and invited Sr. Irene Dunn to join the group, if desired, as an assisted living provider representative.

Ms. Vogeley also updated the Committee on personnel changes at OHCQ, including the hiring of John Parrish, Ph.D. as the Director of Quality Initiatives.

Presentation by Kim Burton, Mental Health Association of MD:
Ms. Burton gave a presentation on Nursing-facility-based Behavioral Healthcare Challenges and Opportunities. (appended)

She stated that there has been a sizable increase in the behavioral health needs of nursing facility residents that is beyond the scope and intensity of behavioral health needs that have been evidenced in the past. For example, among the growing population of people with dementia, fully 80% will have manifestations of psychiatric/behavioral health disorders. In addition, adults with chronic mental disorders are living longer, some percentage of older adults will have late-onset mental health issues and there is a rise in older adults with substance use disorders including addiction to alcohol and narcotic-based medications. She noted that the increased needs seen in nursing facilities are also "trickling down" to assisted living facilities. In addition, the resident populations of facilities are increasingly culturally diverse.

She said that better preparation; education; and accessibility to assessment, treatment and recovery are necessary to adequately meeting residents' increased needs. She made several recommendations, to include:

- enhancing the training and education of health and human service professionals, caregivers, families and older adults regarding later life behavioral health -- for example by using the Mental Health First USA curriculum now in development;
- establishing enhanced staff education and training requirements in regulation;
- ensuring access to behavioral health specialty services by including expectations for such services in regulation;
- providing prevention program in facilities; and
- utilizing staff and volunteers to implement such approaches as person-centered activities, transitional support, and community engagement.

She also stated that there is both a lack of, and uneven coverage of, behavioral health services and providers. While noting that there are new provider services in development, she made the following recommendations:

- providing the opportunity for provider groups to learn of billing and reimbursement options for facility-based services especially with regard to substance use disorders;
- incentivizing community providers to expand services; and
- utilizing tele-health options for behavioral health services in nursing facilities.

She concluded by recommending that a stakeholder workgroup be established to address substance use disorder treatment services for older adults, including identifying barriers to providing such services and determining solutions to meet the increased need for substance abuse treatment among older adults. She also recommended that pilot programs be established to test models for addressing residents' behavioral health needs.

Other Issues and Discussion: Ms. Burton said that there has been some lack of support by nursing homes in addressing resident behavioral health issues but that she believes that some culture change initiatives may serve to create a facility milieu more supportive of addressing residents' behavioral health needs. Ms. Burton stated that staffing ratios are insufficient to meet such needs. Ms. Hedt said that she agrees with this assessment and recommended that staff ratios be increased from the current 2.0 to 4.1 in order to meet both the physical and mental health needs of residents rather than the 3.0 proposed in the draft nursing home regulations. Ms. Whitbeck stated that she does not believe present staffing ratios are adequately enforced and that staff resources, when added, are provided unevenly -- with the greatest percentage going to private- and Medicare-paid residents as opposed to Medicaid-paid residents, although difference in services based on source of payment are prohibited.

She also expressed support for use of psychiatric nurse practitioners as providers of services especially in view of the shortage of psychiatrist services in long-term care facilities. Ms.Crespo said that clinical social workers are another source of providers for mental health services.

Secretary Lawlah reiterated the importance of addressing behavioral health issues and of increasing the visibility of such issues before state legislators.

Ms. Whitbeck informed attendees about two recent studies: one that found inflation of staff ratios in nursing home self-reports to the Centers for Medicare and Medicaid Services and the second that found that hundreds of nursing homes with low Federal quality ratings were granted

HUD mortgages that cumulatively amounted to billions of dollars. She stated that information on the latter report may be found on the website for the Center for Public Integrity.

Ms. Hedt explained that the White House Conference on Aging has started its events, many of which will be held on line due to budget constraints. However, she was able to attend an event that included residents and consumers that was held in November in Washington DC by the National Consumer Voice for Quality Long Term Care. The Oversight Committee members were encouraged to put comments on the WHCOA webpage and to look at it for more information. http://www.whitehouseconferenceonaging.gov/

Ms. Hedt also pointed out that the Culture Change Coalition of Maryland has been functioning for one year and will be offering more training opportunities in 2015. This is a concept that the Oversight Committee had studied and supported in its 2013 activities. Contact her to be on the Culture Change mailing list.

Ms. Roach stated that Mark Leeds, OHCQ will give a presentation on the FY 2015 Medicaid budget at the next meeting and drew attention to Mr. Leeds FY 2014 budget report that was distributed as a handout. In addition she requested that committee members review the list of proposed meeting dates for 2015 on the Agenda and to let her or Rosanne Hanratty know if there were any issues with the dates. The proposed meeting dates for 2015 are: Monday, January 26; Thursday, April 30; Thursday, July 30; Thursday November 19.

The meeting was adjourned by Secretary Lawlah at 3:40 PM

Martin J. O'Malley
Governor

Anthony G. Brown
Lt. Governor

MARYLAND
DEPARTMENT OF AGING

Gloria Lawlah
Secretary

Long-Term Care Ombudsman Program
FACT SHEET June 2014

Authority: Annotated Code of Maryland, *Title 10 – Human Services – Sections 212-214* Older Americans Act, including the requirements of 42 U.S.C. § 3058G

Protecting the rights and promoting the well-being of residents of long-term care facilities

The Ombudsman Program serves 47,000+ people in 233 Nursing Homes and 1389 Assisted Living Facilities through:

- The Office of the State Long-Term Care Ombudsman at the Maryland Department of Aging with a State Ombudsman and Ombudsman Specialist
- 19 Local Programs (36 FTEs) located in Area Agencies on Aging
- 146 volunteers contributing $623,747 worth of time (94 certified)

In FY13, the Long-Term Care Ombudsman Program provided:

- 11000+ Facility visits
- 10580 Consultations to individuals
- 323 Community Ed. Sessions
- 544 Meetings with resident councils
- 2873 Complaints addressed
- 5517 Consultations to facilities
- 159 Meetings with family councils
- 267 Participation in long-term care facility surveys

Sources of complaints:

- Residents – 36%
- Relative/Friend – 36%
- Other – Non relative guardian, bankers, clergy, public officials, other agencies
- Anonymous – 12%
- Facility /Staff – 5%

Most frequent complaints handled in Nursing Homes:

1. Discharge/eviction – planning, notice, procedures, abandonment
2. Care Plan/resident assessment – inadequate, failure to follow plan or physician's orders
3. Dignity, respect- staff attitudes
4. Failure to respond to requests for assistance – call bells, etc.
5. Medications- administration, organization
6. Personal Hygiene - includes nail care and oral hygiene, dressing and grooming
7. Accident or injury of unknown origin – falls, improper handling, etc.
8. Symptoms unattended, including pain
9. Exercise preference/choice and/ or civil/religious rights, individual right to smoke
10. Therapies – physical, occupational, speech

Most frequent complaints handled in Assisted Living Facilities:

1. Discharge/ Eviction Discharge/eviction – planning, notice, procedures, abandonment
2. Medications- administration, organization
3. Food service – quantity, quality, variation, choice, condiments, utensils, menu
4. Physical Abuse
5. Billing/charges-notice, approval, questionable accounting wrong or denied
6. Dignity, respect – staff attitudes
7. Exercise preference/choice and or/ civil/religious rights, individual rights to smoke
8. Equipment/building – disrepair, hazard, poor lighting, fire safety, not secure
9. Accident or injury of unknown origin
10. Shortage of staff

Program Improvements:

MDoA retained independent, national experts to thoroughly examine the Ombudsman Program and offer recommendations for improvement. Since the completion of their report in 2009, MDoA has undertaken a significant retooling of the Long-Term Care Ombudsman Program. While more work remains to be done, there has been measurable progress toward improving and enhancing this program. Accomplishments include:

- The passage of legislation submitted by the Department to align the Federal and State Ombudsman statutes in 2010,
- Hiring of a State Ombudsman and Ombudsman Specialist (a new professional position in the Office of the State Long-Term Care Ombudsman),
- Establishment of a Stakeholder's Group in 2011 to provide input on barriers and strategies and a Coordination Team to provide ground level guidance,
- Certification requirements established and completed by all employed and volunteer Ombudsmen including special training sessions, exams, and on-line national curriculum in 2013/2014,
- State and Local Ombudsman involvement in statewide groups addressing long-term care issues,
- Implementation of a workload-based funding formula to allocate local ombudsman funds based on number of nursing homes, number of facility beds, and geographic size of the local program, and
- Expansion of the volunteer component from 98 to 146 volunteers.

State Ombudsman Goals:

1) Provide the resources needed to ensure that the Maryland Long-Term Care Ombudsman Program is operated consistently with Older American's Act provisions and operating consistently within and between the local ombudsman programs.
2) Advocate with and on behalf of Maryland residents who live in long-term care facilities.
3) Promote quality of care and quality of life for residents including those with dementia through training, consultations, highlighting successful practices, and public policies that support resident-centered care.

This Fact Sheet summarizes the FY13 data submitted to the Administration for Community Living.
For more information contact Alice H. Hedt, State Long-Term Care Ombudsman,
alice.hedt@maryland.gov, 1-800-243-3425 (toll free in Maryland) or 410-767-1100

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NF Based Behavioral Healthcare Challenges and Opportunities:

(Kim Burton, 11/13/14, contact: kburton@mhamd.org)

Rise in behavioral health needs of residents:

This rise exists in all settings and is beyond the scope and intensity of issues we've seen in the past. We all need better preparation and education as well as access to assessment, treatment and recovery services.

Recommendations: Enhance education and training offerings to health and human service professionals, caregivers, family and older adults regarding late life behavioral health. (There is a Mental Health First Aid USA curriculum on aging issues in the pipeline.)

Recommendation: Establish enhanced staff education and training requirements in new regulations.

Recommendation: Ensure access to behavioral health specialty services as needed by the resident – make expectations obvious in regulatory language.

Recommendation: Provide resident and family with information on behavioral health issues and options for support / treatment.

Recommendation: Provide prevention programming in facilities.

Recommendation: Employ staff or utilize volunteers to implement such things as person-centered activities, transitional support, and community engagement.

Lack of behavioral health providers / uneven coverage:

This reality is a great burden to facilities and contributes to push-back on enhanced behavioral health expectations within facilities. However, there are new providers on the horizon.

Recommendation: Provide opportunity for provider groups to learn of all billing and reimbursement options for facility based services – especially with regard to substance use disorders.

Recommendation: Incentivize community providers to expand services to facilities.

Recommendation: Utilize tele-health options for behavioral health in NFs.

Lack of substance use disorder treatment for older adults:

Recommendation: Engage stakeholders in a workgroup to explore the barriers and determine solutions.

Lack of standards for facility based care:

A few meetings of providers have already been held – and more are to come with appropriate stakeholders - to establish standards for behavioral health care in nursing homes (assisted living to follow.) Standards will cover such things as credentials of providers, treatment modalities, and components for contractual agreements.

Recommendation: Convene stakeholders to quickly establish standards.

Settings unable to support behavioral health prevention / early intervention needs:

With low staff to resident ratio and limited social service and recreational therapy staff, the time and attention necessary to address emerging / existing behavioral health problems does not exist. Non-pharmacological behavioral interventions require human engagement. If we can't dedicate more staff time to these issues, perhaps we can better utilize family and friends for this role.

Recommendation: Support any and all culture change initiatives.

Recommendation: Establish higher staff to resident ratio through the regulatory process.

Recommendation: Establish a pilot program to develop family / friends / volunteers as "life enhancement partners" who are educated in behavioral health issues / prevention as well as person-centered activities. The goal would be to reduce rate of depression / anxiety, reduce incidents of behavioral problems and increase resident quality of life.

Medicaid Nursing Home Reimbursement

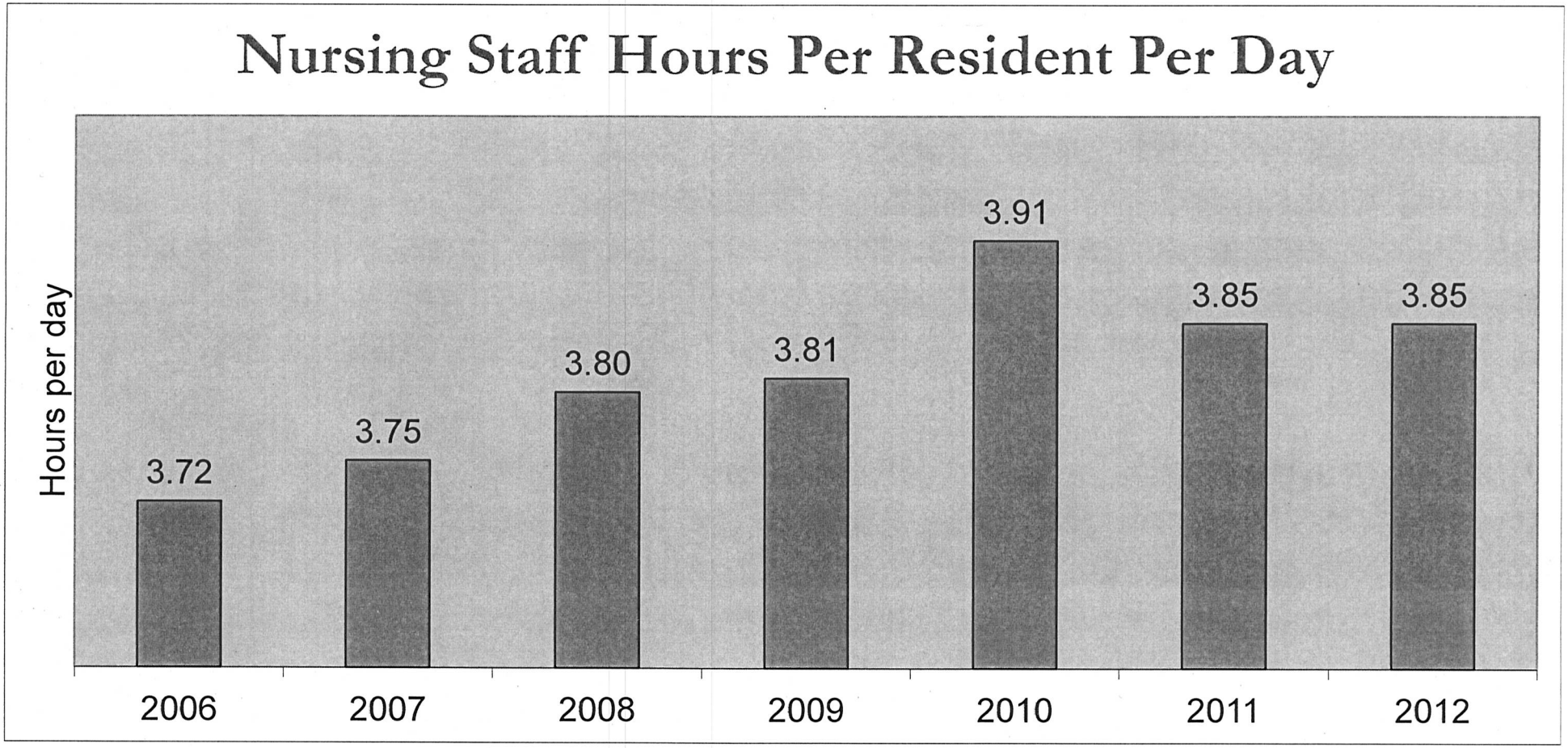
Mark A. Leeds, Director
Long Term Services and Supports Administration
Maryland Department of Health and Mental Hygiene

Oversight Committee on Quality of Care in Nursing Homes and Assisted Living Facilities
Fiscal Year 2014

Nursing Home Reimbursement – FY14 Summary

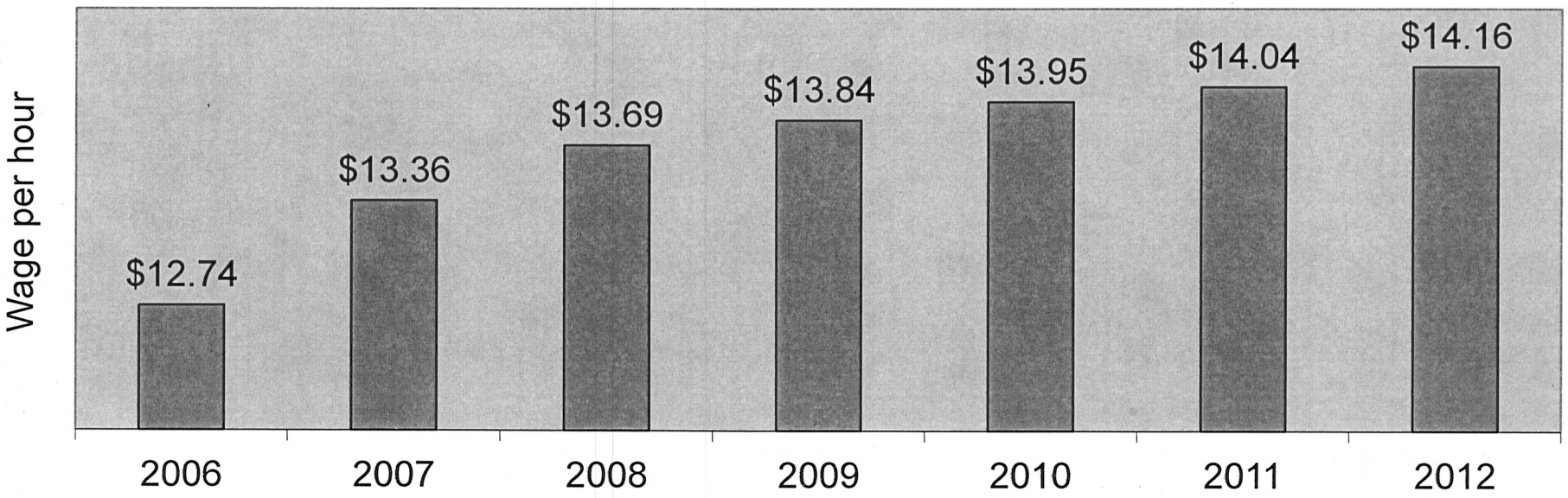
The FY 2014 budget request allowed for a 1.5 percent rate increase in Nursing Facility rates. An additional $3 million in funding was approved in a supplemental appropriation to compensate providers for reductions by Medicare.

The resulting 1.725 percent rate increase was implemented by increasing the payments in the Administrative /Routine, Other Patient Care and Capital cost centers by 3.2%.



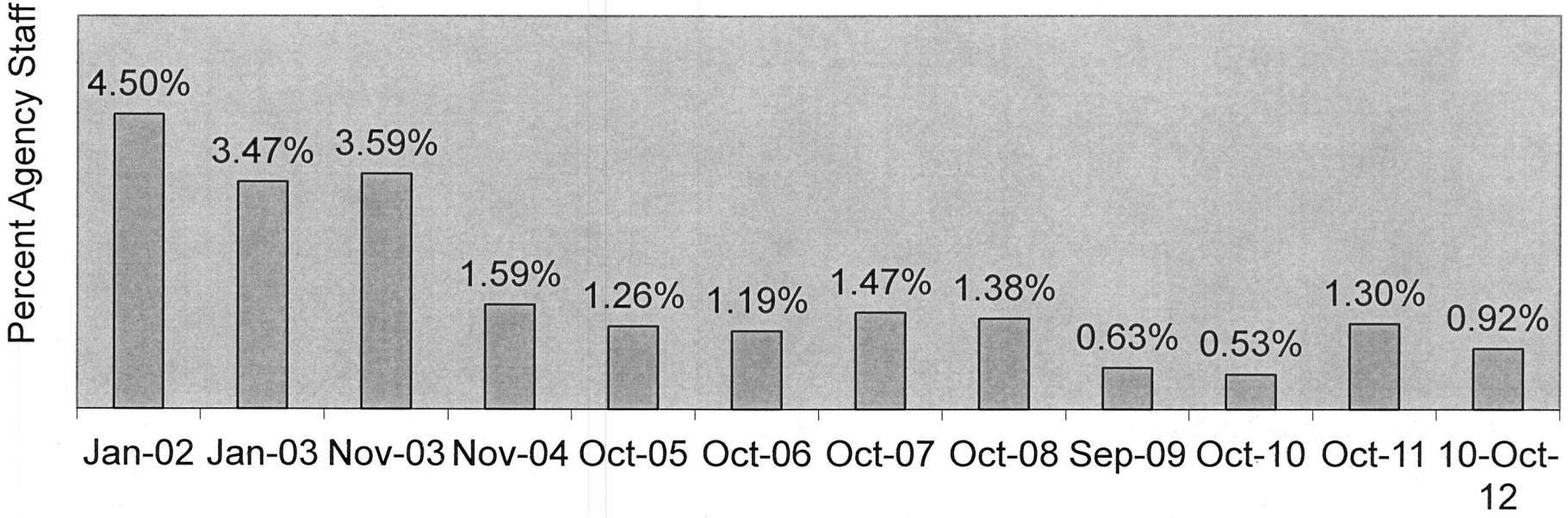
Nursing staff hours per resident remained as 3.85 in October 2012.

Average Raw Wages for Nurse Aides and Certified Medication Aides in the Baltimore Nursing Region



Nurse aide average wages in the Baltimore region have increased modestly the past two years.

Percentage of Total Hours of Care Performed by Agency Staff

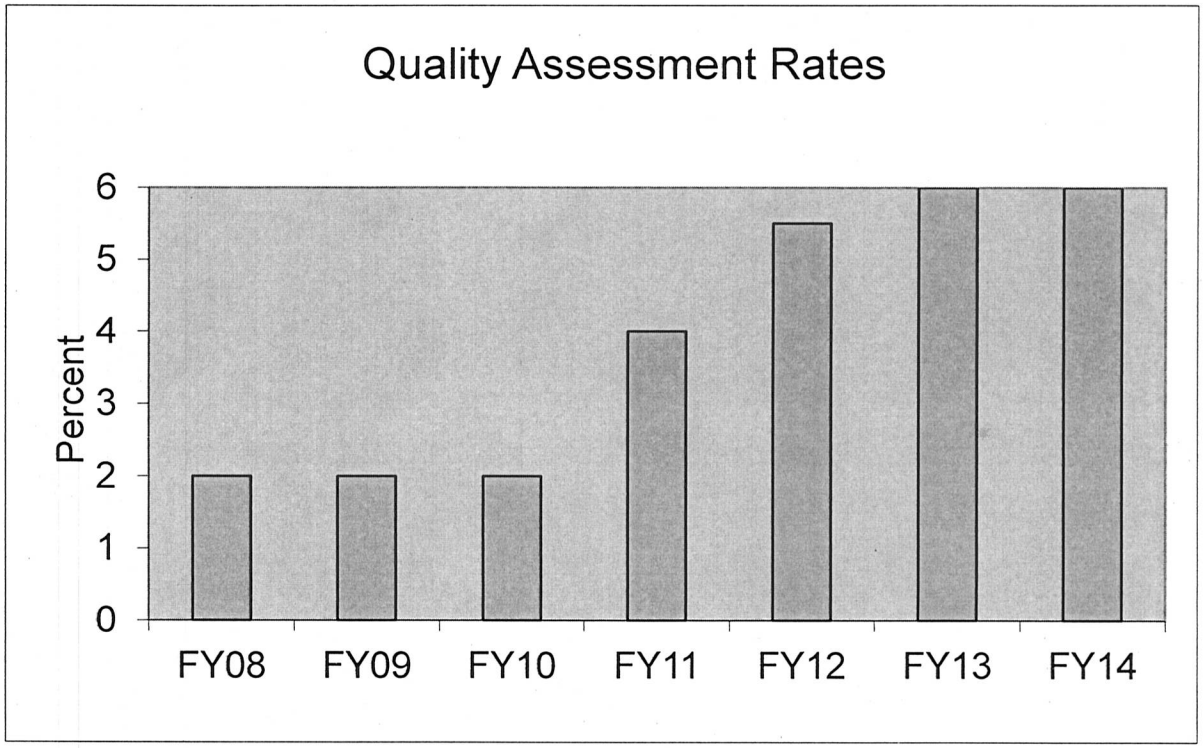


Agency staff usage decreased in 2012.

Nursing Home Quality Assessment

- In order to restore prior cost containment reductions, the General Assembly adopted legislation (SB 101, 2007) to initiate an assessment on nursing facilities in Maryland based on non-Medicare patient days. CCRCs and facilities with fewer than 45 beds are not subject to the assessment.

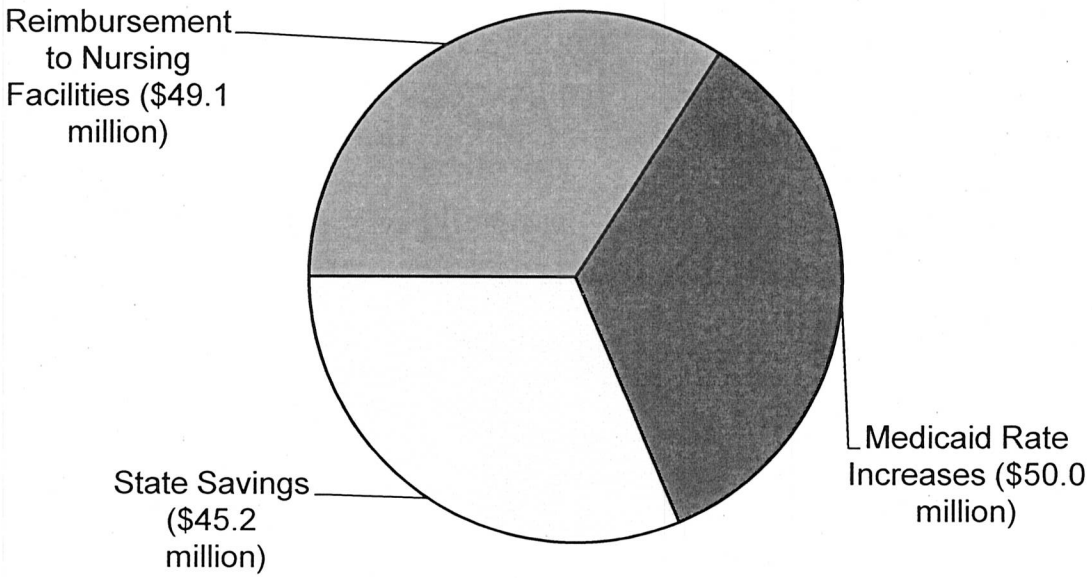
  - Certain nursing homes are negatively affected from this assessment and are not retrieving sufficient additional funding through increased reimbursement to offset their assessment costs.
  - 6.0 percent is the maximum allowable under federal law.



Nursing Home Quality Assessment

- 2012 legislation increased the assessment from 5.5 percent to 6 percent of revenue. Per diem payments increased in FY 2014 from $22.94 to $23.59 for most providers.
- During FY 2014, all but 17 of 182 facilities subject to the tax received a net benefit because:
  - Nursing facilities are reimbursed for the cost of the provider tax for their days of care to residents paid for by Medicaid;
  - Medicaid rates are funded in part with revenue from the assessments.

FY14 Assessment Collected ($144.3 million)

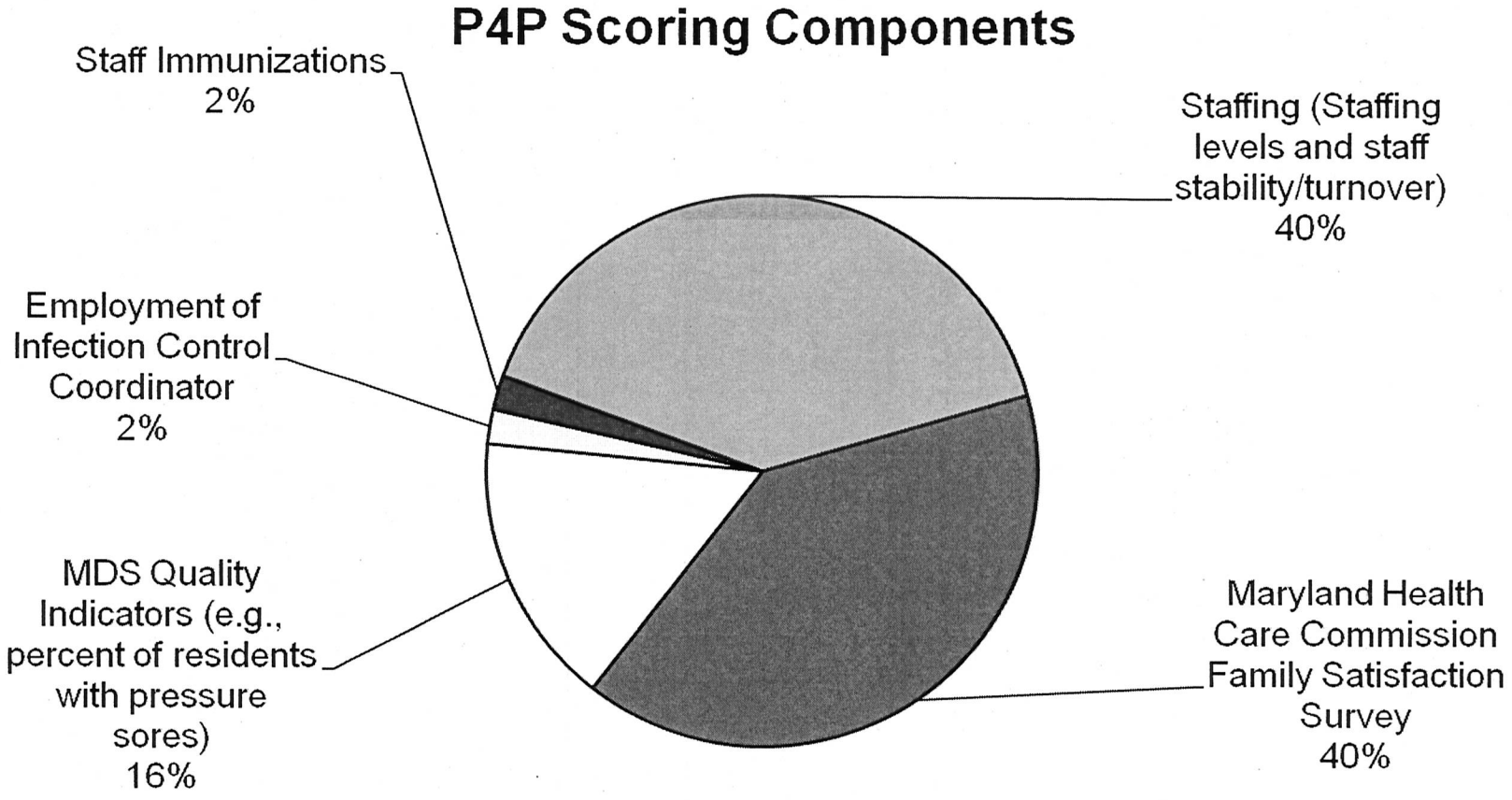


Reinvestment of the assessment is subject to a federal match, doubling our commitment:

- State's reimbursement to Nursing facilities for the assessment = $98.2 million
- Medicaid Rate Increase = $100.1 million

Nursing Facility Pay for Performance (P4P)

Pay for Performance (P4P) program was established pursuant to SB 101 (2007). In FY 2014, over $5.8 million was paid to providers who qualified under P4P criteria. A portion of this funding was awarded to facilities based upon improvement from the previous fiscal year's P4P evaluation.



Rate Reform Workgroup

- The Department developed a Rate Reform Workgroup in 2011 that will continue meeting through 2014.
- The workgroup has been tasked with implementing a RUGs-based Case Mix Index system, and paying nursing facilities prospectively.
- On January 1, 2015, the Department will:
  - Move to a Case Mix Index system for paying nursing costs,
  - Adjust payment methodology for other cost centers, and
  - Begin prospective payment of nursing facilities.

FY 2015 Budget

- The FY 2015 budget includes a rate increase of 1.725 percent beginning on January 1, 2015.

OVERSIGHT COMMITTEE ON QUALITY OF CARE IN NURSING HOMES AND ASSISTED LIVING FACILITIES MEMBERS
CALENDAR YEAR 2014

Committee Member Name	Slot
Vacant	Senator, Finance Committee
Vacant	Senator, Education, Health & Environmental Affairs Committee
Shirley Nathan-Pulliam*	Delegate, Health & Gov. Operations Committee (1)
Vacant	Delegate, Health & Gov. Operations Committee (2)
Gloria Lawlah, Chair (or Secretary's designee)	Secretary, Dept. of Aging
Patricia Nay, MD (Secretary's designee)	Secretary, DHMH or Secretary's designee
Brian Hepburn, MD	DHMH, Mental Hygiene Administration
Valarie Colmore (Secretary's designee)	Secretary, DHR or Secretary's designee
Odile Brunetto	Area Agency on Aging (1)
Karen Sylvester	Area Agency on Aging (2)
Vacant	Area Agency on Aging (3), from Ombudsman Program
Bill Holman or designee	Mid-Atlantic LifeSpan
Regina Bodnar	Hospice Network of Maryland
Virginia Crespo	United Seniors of Maryland
Susan Eddy or designee	Voices for Quality Care
Kimberly Burton	Mental Health Association of Maryland
Ilene Rosenthal or designee	Alzheimer's Association, Greater Maryland Chapter
Vacant	Assisted Living (1-4 residents)
Charlotte Harris Branch	Assisted Living (5-9 residents)
Sister Irene Dunn	Assisted Living (10 + residents)
Vacant	Consumer (1)
Vacant	Consumer (2)
Harriet Johnson	Consumer (3)-- resident in an assisted living facility