

**North Dakota Department of Health
LTC Collaborative Workgroup Meeting
April 9, 2015 – 10 am to 3 pm
State Capital, Judicial Wing, AV Rooms 210 & 212**

Welcome and Purpose of Meeting:

Darleen Bartz called the meeting to order at 10:05 am and welcomed everyone. She reviewed the information that will be reviewed and discussed in today's meeting.

The purpose of the workgroup is to identify key issues/concerns related to the survey and compliance of Long Term Care Facilities and prioritize those issues and concerns; and to discuss ways we can collaboratively work together on the identified priority issues/concerns. The focus of today's meeting is to discuss subjectivity in interpretation/decision making and G-level citations identified as priority issues/concerns.

Darleen reviewed the agenda for today's meeting.

Introductions:

Each member of the group introduced themselves and identified who they were representing.

Present:

- Darleen Bartz, Chief, Health Resources Section, NDDoH
- Bruce Pritschet, Director, Division of Health Facilities, NDDoH
- Lucille Rostad, Manager, Division of Health Facilities, NDDoH
- Rocksanne Peterson, Recorder, Division of Health Facilities, NDDoH
- Shelly Peterson, Executive Director, North Dakota Long Term Care Association
- Bruce Hetland, MD, North Dakota Medical Directors
- Char Christianson, Director of Nursing, Golden Acres Manor
- Gail Grondahl, Director of Nursing, St. Aloisius Medical Center
- Steve Przybilla, Administrator, St. Gabriel's Community
- Karla Backman, State Long Term Care Ombudsman, Division of Aging Services
- Pam Tyler, Quality Improvement Director, Sanford Health Continuing Care Center
- Renee Muhonen, Elim Care Inc.
- Janessa Vogel, Administrator, Elm Crest Manor
- Cathy Anhalt, North Dakota Long Term Care Association
- Michelle Lauckner, Quality Health Associates
- Guy Tangedahl, MD, Medical Director, UND Family Practice Center
- Joan Ehrhardt, former State Long Term Care Ombudsman, Consumer Representative
- Jerry Jurena, President, North Dakota Hospital Association
- Nancy Farnham, Administrator, Maryhill Manor
- Dr. Terry Dwelle, Health Officer, NDDoH
- Arvy Smith, Deputy Health Officer, NDDoH

Also Present:

- Joan Coleman, RAI and Training Coordinator, Division of Health Facilities, NDDoH

Absent:

- Jerry Jurena, President, North Dakota Hospital Association
- Barbara Groutt, Chief Executive Office, Quality Health Associates

Ground Rules – Darleen reviewed the ground rules of the meeting.

- It's your meeting (all participants).
- Everyone's comments will be considered equally (it is important for everyone to participate as we need to look at the whole picture)
- Respect each other when talking so that we have one conversation going at a time. You will have a chance to speak.
- Respect the time frames identified.
- No relevant topic is excluded.
- Respect each other's opinions (people think differently).
- Refrain from attribution (no placing blame).
- Silence is considered an agreement (so if you do not agree you need to voice your opinion).
- Work together toward common goals (finding a solution takes balance)

Review and Approval of the March 5, 2015 Meeting Minutes. Shelly Peterson motioned to approve the minutes of the March 5, 2015 meeting with the addition of Nancy Farnham as present, Renee Muhonen 2nd the motion; motion carried.

Recap of the March 5, 2015

- Darleen Bartz gave a recap of the March 5, 2015 meeting. The group discussed issues and concerns regarding the survey process, experience and citations. The group also prioritized their issues and concerns. The top five issues were:
 - 1) G-level citations;
 - 2) The IDR process;
 - 3) Subjectivity in interpretation and application of the regulations/decision making;
 - 4) The increased potential for deficiencies with medically and behaviorally difficult residents; and
 - 5) Sufficient time to discuss findings during the survey and at the exit conference of the survey.
- One participant stated she also works with facilities in Minnesota and she stated that surveyors there will give them a copy of the deficiency statement during the exit conference. There are differences in how things are carried out or done from state to state. It may also be that they are a state that has implemented QIS survey process.
- One participant stated she is concerned with the inconsistencies and the number of "G" tags being cited.
- Dr. Dwelle talked about getting to the root cause of the "G" level deficiencies and felt that it should be an unbiased assessment.
- There was discussion as to how we could objectively evaluate the assessment of facilities in a consistent manner among states. One participant felt it is not consistent among the

surveyors. This participant felt that the periodic surveys conducted by the feds whet a ways in responding to this. Another participant stated it was important to have conversations with both the providers and the surveyors regarding new CMS directives. Another participant asked if there could be communication between the facilities and Health Facilities regarding the new CMS directives so she would work of fixing things before it becomes a problem. Darleen stated that the S & C letters are disseminated at the Long Term Care Advisory Committee meeting. Shelly Peterson asked if Health Facilities could send out the S & C's that pertain to LTC every Friday. Darleen indicated that the Division should be able to send the ones that are pertinent to long term care. The group felt the Division should send the information to Shelly and then she would email the S & Cs to the long term care facilities.

- One participant brought up the subject of the air gap deficiencies. Bruce Pritschet stated the issues regarding air gaps resulted from a presentation given by the plumbing board. The plumbing board asked our surveyors to evaluate the plumbing of the prep sinks because they are not out there enough to evaluate it themselves, thus resulting in the air gap deficiencies.
- Dr. Dwelle stated that we are trying to protect the residents of the state. He was also wondering if there was any data from CMS identifying facility staff turnover, behavioral problems, and so forth, from other states that could be compared with North Dakota. Bruce stated that CMS is not comparing those issues from state to state. One participant stated that the type of patients have changed a great deal in the last five years. Our state population is very unique and facilities have to take residents that are more difficult. Another participant asked about the definition of actual harm, questioning, "Are we doing it right and everyone else is doing wrong or vice versa?" Arvy Smith asked if we have different levels of care or needs than other states. Lucille stated that we are limited with facilities able to take care of transitional patients. North Dakota only has one transitional care unit. Darleen also spoke about the number of specialized facilities such as the gero.psych units in North Dakota, and that this continued to be an area of need.
- More discussion took place related to root cause analysis and what information should be looked at. One participant indentified the ND has double the aged people over age 85 compared to other states. Other information suggested to look at was turnover of staff and demographics. The question was raised on how to collect data when we cannot collect data from other states. The changing population or residents in facilities, more difficult and acute residents, needs to be considered. ND is unique in some ways and we have different referral patters.

Presentations and Group Discussion

- ***Deficiency Categorization and Levels of Severity – Joan Coleman***
 - Joan Coleman gave a presentation regarding deficiency categorization and the four levels of severity. As well as determining the degree of harm, three levels of scope, general score procedures and psychosocial outcomes. One participant indicated that she felt the word "potential" left it is open to an individual's interpretation.
 - Another participant asked about the definition of "reasonable person." Joan stated that the team discusses what has occurred and how a reasonable person would feed in that situation and how to handle the situation.

- ***Decision Making – Darleen Bartz***

- What is your severity score? Darleen completed an interactive scoring exercise for participants regarding severity scores. The fifteen scenarios came from the CMS procedure manual. Each person was to identify the severity level of each scenario using clickers. Participant responses varied on each of the example, and discussion as to why it received the score given by CMS took place. There were two Scenarios which the rationale for the level of CMS citation was not understood. Scenario #9 and Scenario #12. Darleen will ask CMS for an explanation related to the CMS scoring on these two examples.
- Dr. Dwelle asked if tools like this would help develop consistency with the survey. Darleen stated that a similar exercise had been completed with surveyors when they were in for training.
- Two participants indicated they can tell what deficiencies will be cited by who is on the team. Dr. Dwelle indicated this was a good point, and one that is struggled with during the Public Health Accreditation process. The two participants asked if it was possible to identify internally who is consistently writing certain tags. Bruce indicated that this information is in the ASPEN database for each facility; however, there is not a report available to generate the number of times a specific tag was cited by each surveyor.
- One participant indicated that certain combinations of team members can impact the outcome of a survey. Lucille indicated that the Division changes the team members on the survey teams to help improve consistency between teams. She also indicated that additional training is provided to surveyors if we have identified an issue with their understanding and completion of the survey process. A surveyor's area of expertise varies dependent upon their professional background and work experience, and this is expected and why we have a variety of professionals on every team. A surveyor that has a work background in long term care will draw upon that experience when surveying facilities. Their job as surveyor is to make sure facilities are compliant with the federal rules and regulations and to protect the residents who reside in the facilities. Deficiencies are based on facts gathered through the survey process.
- Discussion took place related to the IDR process as an opportunity for additional information not presented at the time of the survey to be submitted. Some participants felt that some surveyors are more supportive than others when the facility is collecting documentation for a deficiency to give them. Two participants shared some examples from surveys/investigations which took place at their facilities. Dr. Dwelle stated charts can be an issue, if documentation is not there, need to find out what is happening.
- One participant asked if we get many of the survey evaluations forms back from facilities following a survey. Lucille indicated, no, we don't get very many back. Lucille stated that we value the information from the ones we do get back. In fact we encourage facilities to send them back. If a facility has an issue or concern the evaluation form would be a good place to voice those concerns because we do need specific information so that we can work with surveyors on concerns identified.
- More discussion took place related to G-level citations and collection of data for a root causes analysis. One participant stated that data can be explained away. Dr. Dwelle

indicated we should consider who could complete a root cause analysis to identify what the root cause is. Discussion took place related to what information should be collected to complete a root cause analysis. There was discussion related to looking at citations by surveyor. The information is there, but it is not in a usable form. Darleen indicated that the information is on the CMS database and may not be releasable and we would need to check with CMS on this. Arvy questioned if there would even be enough data for the analysis to be statistically sound. It was identified that it would be hard to get information from other states and to compare data from other states because many states use the QIS survey process rather than the traditional process, so we would not be measuring apples to apples. Darleen indicated that the discussion had focused on the survey process; however, we also need look at what is occurring from the facility perspective resulting in the surveyors identifying situations which resulted in harm of harm to residents being identified through the survey process. She indicated there is work that needs to be done in the survey agency and the facilities. Dr. Dwelle agreed we need to look at what is occurring with facilities also, and that there is a need to identify someone who can take an un-bias look at the data.

- As a result of the discussion, the conclusion was reached that it would be beneficial to look at the whole picture and find what the root cause is for the high number of G-level citations.
- ***G-Level Citations – Darleen Bartz***
 - Due to time constraints, the G-level citation information will be reviewed and discussed at the May 11, 2015 meeting.
- ***Other Discussions/Issues***
 - The group discussed whether other states look at or have gero-psych facilities. Arvy asked about looking at the case mix in North Dakota and in other states. Steve said we may have to look more at the diagnosis versus the skill level. Renee felt we could possibly benefit from some of the information. We may need to get some of the information from Human Services.
 - Dr. Dwelle suggested that someone from the Long Term Care group and Health Facilities visit to identify variables to look at for a root cause analysis. It may also be necessary to contact CMS to see if we can access and use the CMS survey data.
 - There was also a discussion regarding issues that Darleen could bring forth to the regional office: During a look behind surveys, why do they add deficiencies, and not take any away? Why is our region higher in citations? Do other states struggle as much with gero-psych? What is the basis of the CMS scoring of Scenario #9 and #12? What CMS information can be released to the workgroup?

Meeting Dates: **April 9, 2015 (this meeting)**
 May 11, 2015
 June 12, 2015 (Tentative, however not looking good for many
 workgroup members, need to look for other possible dates)

Meeting Adjourned: 3:10 pm.