

Memorandum

To: Members of the Policy Work Group
From: Karyl Lee Hall
Date: March 22, 2004
Re: Notes from Meeting of March 10 at CAHCF

Participants: Rick Brown, Teresa Cusano, Maggie Ewald, Marilyn Denny, Jan Van Tassel, Waldo Klein, Gene Hickey, Julie Robison, Cindy Gruman, Karyl Lee Hall. Mag Morelli sent information, unable to attend.

1. The meeting began with an informal discussion of current issues including:

1. The Windsor Hall closing. Teresa gave details.
2. Proposed legislation.

Discussion concerned the work group proposed by H.B. 5004, possible duplication of effort and whether to attempt to unify the proposed study group with our policy work group. ** Maggie will discuss options with Edith Prague.

2. Jan Van Tassel reported on the Colorado Home and Community-based waiver program. The program has a very narrow target population – only those individuals with severe mental illness. Depression is screened out. There is no definition of specialized services. ** Jan will continue to seek information concerning this waiver and its applicability to a Connecticut setting. ** Jennifer Glick will contact some of her sources concerning the definition of specialized services.

3. Enforcement Issues.

- a. Tennessee is regulating Alzheimer's's units and secured units. ** Karyl Lee will provide. Tennessee is also requiring description of services to be provided in such units, as a consumer protection. Statute provided.

Waldo Klein reminded us that we should be focusing on behavior, not diagnosis.

b. The group discussed the defects in the present system of incident reporting, regulatory enforcement of deficiencies and plans of correction. Issues: How to deal with the Attorney General's office. Department of Public Health not at table.

The group agreed that one step toward addressing the above issues is to submit some questions to Valerie Bryan.

** Group must define these questions.

c. Training for CMS.

d. Group agreed we should get something in writing (from the attorney general, DPH, CMS) about how the enforcement process (including incident reporting) works. Likewise, there was agreement that we must strategize a way to encourage the Attorney General's office to work with us before making formal contact. We agreed to ask Paul Miller for some advice on outreach to the agencies.

e. The group discussed the survey process. Last meeting, Rick raised concern with overregulation and penalties and suggested looking at Massachusetts's IDR (Informal Dispute Resolution). However, as negotiations in Ct have a 50% success ratio, he suggests not tampering with same. Marilyn questioned survey process is flawed.

4. ** Rick promised to set up a web page for the Work Group with sections for the three committees, with links to the source material.

5. Care Planning. ** Mag Morelli will be providing some material on Best Practices addressing the W-10. Question: Does the nursing facility receive an accurate picture of resident needs upon admission? Do individual care plans reflect resident needs or progress? Recommendation: Somehow get enforcement systems to include the documentation and monitoring of care planning. But: will this result in another layer of federal survey?

Marilyn: Toby Edelman reports 1. Quality indicators are being used to assess the practices of nursing facilities based, not on OBRA, but on comparative practice of other facilities. 2. Quality indicators measure bad outcomes but not the absence of good outcomes.

Rick: OIG found that staff did not know how to fill out the MDS. A problem with multiple choice. On the other hand, Marilyn found that, in her experience, the MDS reflected the patient pretty well and were pretty accurate over time except that stereotyping has a tendency to generate note observations.

Gene introduced introduced new members of workgroup, Cindy and Julie, who were both involved with Braceland Center study. The study was longitudinal as opposed to a snap shot in time. Julie gave a summary. The study followed individuals discharged from hospitals and admitted to inpatient psychiatric units where they were stabilized. Ninety-

five percent of these were subsequently discharged to nursing facilities. Five percent to community settings. The study focused on nursing facility compliance with the discharge plan. Findings: Indications of association between close care planning and certain symptoms. Gene raised concern of patients being shunted around. Moves ranged from 0 to as many as 19. Report was passed out to members of the Policy Work Group. Recommendations: improved communications with family, control intervention design, intensive training of staff. Permanent assignment of staff to unit and to individual patient results in better outcomes. Braceland is presently doing a study on staff retention which will be relevant to this last point.

** Rick offered to scan the CT DPH manual comparing federal and state standards for posting on our web page..

6. Summary of Issues for the Next Meeting:

- a. Look at the proposed legislation and figure possible strategies to deal with the proposed work group and ways to keep these important issues from becoming politicized.
- b. We will ask Valerie Bryan for information concerning incident reports and changes in condition so as to try to ascertain what particular behaviors are problems for Connecticut facilities. This information might help us to develop model for Connecticut.
- c. Waldo and Julie will look for data on violence in nursing homes, generally, in order to begin forming a theoretical profile.
- d. We will ask Valerie Bryan and Paul Miller about enforcement. Is the process not working, or is the surveying flawed? Reference the IDR.

Next Meeting: April 7, 2004 at CAHCF. 9 - 11:30.