



LONG-TERM CARE FACILITY ADVISORY BOARD

Regular Meeting

October 9, 2013 at 1:30 in Room 1102

Oklahoma State Department of Health, 1000 NE 10th Street, Oklahoma City, OK 73117-1299

MINUTES

October 9, 2013

1) Call to Order

Kay Parsons, Chair, called the meeting to order at 1:32 pm.

2) Roll Call

Natalie Smith called roll with the following LTCFAB members present: Kay Parsons, Chair; Dewey Sherbon, Vice Chair; Theo Crawley; Luke Tallant; Alan Mason; Wendell Short; Dustin Cox; Ivoria Holt; Linda Brannon; Donna Bowers; Diana Sturdevant; and Willie Burkhart.

The following LTCFAB members were absent: Esther Houser; Jane Carlson; Sharon Housh; Margaret Wallace; Tammy Vaughn; and Renee Hoback.

The following guest were present: Mary Brinkley, Leading Age OK; Marilyn Kipps; Jim Kipps; Mary Womack, OSDH; Susan Daniels, LTC ONBCP; Gina Stafford, OK Board of Nursing; Oralene Sherbon, general public; Dr. Hank Hartsell, OSDH; Mike Cook, OSDH; Michael Jordan, OSDH; Walter Jacques, HDRS; Vicki Kirtley, NAR OSDH; Joyce Clark, Achievis; Marietta Lynch, OAHCP; Wes Bledsoe, A Perfect Cause; Bill Whited, Ombudsman; Karen Gray, OSDH; Lisa McAlister, OSDH; Paula Terrel, OSDH; Pam Hall, OSDH; Greg Frogge, McAfee Taft; Trish Ewing, State Council on Aging; Mark Stratton, OUSWPC; Keith Swanson, guest; Gara Wilsie, guest; and James Joslin, HRDS.

Currently, there are 9 vacancies on the LTCFAB which consist of 27 members.

A quorum was not met with 12 members present.

3) Review and Action to Approve/Amend January 09, 2013/ April 10, 2013/ July 10, 2013 Regular Meeting Minutes:

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<http://www.health.ok.gov/calendar/mtngs/index.html>

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No Quorum.

4) Proposed Rule Changes regarding Nonprescription Drugs in Nursing Facilities:

Mike Cook talked about the proposed rule changes regarding nonprescription drugs in nursing facilities noting the proposed rule amendment deletes the requirement which limits bulk nonprescription drugs at nursing facilities. The current requirement provides that only oral analgesics, antacids, and laxatives may be dispensed from bulk supply. This proposal will strike number (8) from 310:675-9-9.1. **Allowed nonprescription drugs.** Facilities may have only oral analgesics, antacids, and laxatives for bulk dispensing. No other categories of medication may be maintained as bulk medications. There has been other alternative language proposed and there are also other concerns and considerations.

LTC Concerns For Consideration for Rule development on Bulk Medications:

1. Pharmacist will not have individual pre-dispensing analysis and oversight readily available to determine potential side effects, interactions and contraindications.
2. Cough syrup – can be inviting unintended serious consequences – “Cough medication ingredients mixed with antihypertensive medications can be very harmful. Many cough and cold remedies contain alcohol or other sedating ingredients that mixed with psychotropic medications, antidepressants, or anti-anxiety medications can cause loss of consciousness or decreased vital signs. Cold remedies containing stimulants may cause hypertensive crises.”
 - a. Generic cold and cough remedies contain too many miscellaneous ingredients to be able to monitor all possible interactions for any/all residents who may receive occasional or frequent doses during the course of symptomatic illnesses.
 - b. Decongestants, antihistamines and cough medicine have many ingredients and should be customized to each situation – no size fits all
3. Medications being readily available may encourage staff and physicians to prescribe and administer what is available and before adequate medication review is conducted.
4. Topical medications – infection control between residents – what is the benefit to having a topical medication in bulk
5. Definition of “bulk meds” – what is that? Minimum quantity? Can this be a 16 oz or less?

Alternate language:

(8) Allowed nonprescription drugs.

(XX) Drugs listed in a facility formulary developed or approved by the consultant pharmacist, medical director and director of nurses.

(XX) Non formulary over the counter medications may be prescribed if the resident has drug failure to the formulary over the counter medication or a drug allergy to facility formulary over the counter medication. Decongestants, antihistamines and cough medicine will be excluded from this list of allowable nonprescription medications.

Theo Crawley questioned the origin of the proposal, and who was recommending there would be bulk meds without pharmacist involvement. Dorya Huser noted this was submitted to the health department several years ago and when rule development was stopped it did not go forward, origin is unclear at this time. Wendell Short noted this would not be without pharmacist involvement, the formulary would be developed with the pharmacist, medical director, and the director of nursing, and there would still be doctors orders required in order to use this; it’s simply the manner in which the medication can be maintained within the facility. You can have a bulk bottle rather than an

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individual bottle. Alan Mason stated in the healthcare dynamics we are seeing more people using OTCs, if you notice the FDA is taking more drugs off of prescription and moving them to OTC. Not only does it give a greater option for the patient, but it also decreases cost for the facility, the patient, and the insurance company. Mr. Kipps asked the board who would be responsible to check if the amounts coincide with what should be left in bulk, in the facilities. Alan noted that he could see where it would be brought up but does not see where it would be a big concern. Anything brought into the facility has to follow an ordering procedure and a receiving procedure, Alan also noted that the consulting pharmacist is responsible for everything within the facility even the policy, which means if this change occurs all the policies and procedures in all the nursing facilities in the state will have to be updated. Gara Wilsie noted that a pharmacist will always order the medication; a resident will not receive medication that is not ordered for them. The intent for the alternate language is to focus on the products that are appropriate for the elderly. Dustin Cox questions if the push for this change is financial or convenience and is the prescription going to be filled in the facility as opposed to being filled in the pharmacy. Alan stated it has a financial benefit to all three the insurance, the facility and the resident; they will also be able to get the medication much faster since it will already be there. The facilities will also have a requirement of a formulary, which is a list of what is available along with dosage strengths and this is the same process that hospitals use.

Alan Mason stated all the prescribers are not in the building anytime they need an order they call them, most orders are received by telephone; which means right now when they are prescribing oxycodone or morphine or anything else they are using the same process they are proposing for Tylenol. You can't be afraid of more of what is happening with the Tylenol than with the morphine, because it is working, the prescribers are very consciences. There can always be a drug error, that's why we look at things so closely, this really does not change the process, and it just changes the availability.

5) Update and Proposed Rule Changes to Implement the Fingerprint Based National Background Check:

James Joslin discussed Chapter 2 procedures of the State Department of Health, noting 675 and Chapter 2 have been published as a notice of rulemaking and the public comment period for the rules has begun and this will run thru November 1, 2013. On November 1, 2013 there will be a public hearing as an additional opportunity for public comment to be received on these rules. After the public hearing the department will develop a response that is submitted to our senior leadership to indicate these are the comments that were received, and the actions that are proposed to take in response to the comments. At that time a final determination will be made on the rules being moved forward to the board of health. These rules are tentatively scheduled to go to the board of health on December 10th's meeting of the board. At that time if the board sees fit to adopt those rules, they will then be submitted to our legislature for the legislation to act.

The Oklahoma National Background check program is now getting very close to the rule making. The requirements for a fingerprint base were adopted in statue in 2012 in HB 2582. The law authorized staggered effective dates for rule making. The law also identified the employers which will be affected and whom the law applies too. The law specifies who this is applicable too stating "An employer shall not employ independently contract or grant clinical privileges to an individual who has direct patient access". Direct patient access is access to the patient, property, medical or

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financial information; if the individual has access to this information then they are subject to the requirements of the background check program. Willie Burkhart questions if nursing is the only one doing the background checks. James noted that he believes that nursing is the only one at this time using this; he also noted that he does not believe that pharmacists are not using it at this time. Gina Stafford from the board of nursing stated that she believes they are the only ones doing it right now, they have been doing this for over a year and currently they check new applicants and endorsements for advanced practice nurses; but a nurse that has had a license for years has not had fingerprints.

James noted that this law authorizes an appeal process for anyone who is disqualified but believes that the circumstances present and the time have gone by, merits a waiver. The rule at this point in the proposal identifies criteria to be applied to the waiver request. The applicant will be notified if they are ineligible of a right to appeal, they will then have 30 days to file to appeal request or a waiver, the types of appeals are specified (i.e. accuracy and completeness of the criminal history record). Lastly they can request a waiver based on a demonstration that they should be allowed to work because they do not pose a risk to patients, facilities, or their property. It has been proposed if they request the waiver the following criteria be applied: time of laps, insinuating circumstances, rehabilitation, work history since the offence, letters of endorsement, treatment records, the relevancy of the event to the job they will be doing and other rehabilitation references. James then discussed RAP/Back and criminal history monitoring, noting this is a provision in the law not in the rule. This provision is established thru law; it states that if someone has an arrest, it's not a disqualification, the office would notify the employee that they are aware of the arrest and under this law, it requires them to notify the employer of the arrest. The employee would then receive notice that upon conviction would be disqualified. This office would then monitor that arrest thru dismissal or conviction. Once the screening is complete the employer will receive a print out for the files and they will also receive the eligibility determination form. In the initial rule it was proposed to have a January 1, 2014 effective date, this will be for the emergency rule making, the permanent rule will be possibly in July. The January date will possible be pushed back due to the reviewing process.

Kay Parsons questioned if there will be employees of the health department at the live scan sites. Live scan is a term used to indicate that they are scanning live human beings with a picture of their finger prints. These sights are maintained by a contract company that the Board of Nursing is also using called Saffran. The actual sites are run by a sub-company called Identogo. When the individual has their finger prints taken, the file is actually sent to OSBI. It has been discussed on piggy backing on a contract with the Department of Education for the live scan work they are doing, but ended up piggy backing with the Board of Nursing, since they had a better rate. The next step will be NAR along with the Department of Education and DHS all come together for one bigger contract to attempt to drive a better rate for all. James Kipps noted this was a major undertaking for Mr. Joslin and very time consuming and that Mr. Joslin and his staff have done a wonderful job handling this.

6) Renewal Certifications:

Vicki Kirtley gave the board an update on Nurse Aide Registry renewal certifications, noting the NAR receives on average 100 phone calls a day. A survey was completed on these phone calls and found out most of the phone calls were in regard to renewal applications. These calls inquired to

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whether the applications had gone thru the process, if they were certified yet, if their certification card had come in the mail, or they had received a problem letter due to an incomplete renewal application. The Nurse Aide Registry completes approximately 1,800 renewal applications a month with a staff of 3 individuals. Vicki's staff has begun to come up with ways to educate individuals on the renewal process and the forms need to complete the process, in hopes to better educate those needing this service. There are four main things that slow up the renewal process: 40% of the applications that come in that are not complete have Oklahoma tax holds; they don't show work proof, they have to show 8 hours of work in the last 2 years; the affidavit of lawful presence is required every renewal period; and lastly some just don't fill out their renewal form. Vicki's staff has done an incredible job and is taking approximately 7 days to process a renewal. Certification cards are mailed out every 2 weeks. The certification cards will tell you if they are certified but it will not tell you if they are in good standing. You can check to see if an individual is in good standing by checking the Nurse Aide Registry web site or by calling the Nurse Aide Registry.

7) Nominating Committee for New Officers:

Willie Burkhart presented the nominations for officers for 2014: Dewey Sherbon, Chair; Donna Bowers, Vice Chair; Rene Hoback, Secretary. Due to no quorum, the board was unable to vote on this. This item was tabled until the January 2014 meeting.

8) LTCFAB Size:

Kay Parsons began a discussion on the LTCFAB size noting we have a 27 member board set up by legislative statute under the Nursing Home Care Act at this time we have 1/3rd either unassigned or vacant. Dorya Huser explained she has been in constant communication with the governor's office working on appointments for this board. It would require a statute change to make changes to the composition of the board. It is believed that we will have appointments soon. Theo Crawley questioned if the quorum size was also set by the legislature. Dorya stated it was and the requirement is the majority of the total members of the board, so we always have to have at least 14. Willie Burkhart requested to propose that if there is a meeting and all members in attendance are valid members, that the majority has the right to make decisions regardless of the quorum. Mary Womack stated she will need to research the open meeting act to address this, statute can be changed but it is a long process.

Dewey Sherbon noted he has done quite a bit of contacting and discussing the difficulties to not making the meetings. Most are valid reasons but if they are coming up frequently, then it has to be asked if you keep having reasons you cannot be here should you really be on the board. The absences are thru all position types, they are not centered in position type. Dorya noted that right now it is a challenge due to so many vacant positions. Theo Crawley asked since the governor's office has the appointment power, how many have been appointed. Dorya stated there are only 5 positions that are not appointed by the governor; those 5 positions are representatives from specific offices. Theo Crawley asked if there are supposed to be 27 members on the board, how many positions have not been filled. There are currently 10 vacant positions on this board. Mary Womack asked if the agencies that have representatives serving can designate someone to come if the representative cannot make it. The open meeting act prevents agency representatives to have a proxy when they cannot attend.

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9) Comparing the Differences:

Speaker unavailable at this time item tabled until next meeting.

10) Long Term Care Update:

Dr. Hank Hartsell spoke to the board on the civil money penalties fund, noting the civil money penalties are penalties paid by Medicare and Medicaid certified facilities as a result of deficiencies found on survey. These monies are governed by the federal government on how they can be spent. In the affordable care act there were additional restrictions that went in to place in 2012, now there must be approval from the centers of Medicare and Medicaid services prior to expending any funds from the civil money penalties. The civil money penalties are to be used for the benefit of residents of nursing facilities. The money is not to be used for projects or activities that CMS is already paying for. They cannot be used for survey and certification activities. Per guidance from CMS preference is given to agencies outside of the surveying agency especially those that are working in partnership to develop projects for the benefit of residents of nursing facilities and skilled nursing facilities. There is a strong preference from CMS for short term projects of less than 3 years duration. The parameters include: federal and state limitations, state bidding process, proposals/ suggestions. Willie Burkhardt stated that a few years ago it was proposed that the monies were going into a special fund and that some of the homes that had paid those fines were being allowed to set up a plan of correction and being allowed to pull some of those funds. Hank noted this money cannot be paid to a facility to come into compliance; this money is used for training, career ladder program and quality improvement projects. Mr. Jim Kipps questioned if a University could help with a project and still qualify for the money. Dorya Huser stated it is possible this was done with the CAN career ladder.

Dorya Huser talked on the assisted living enforcement project stating much was learned and very informational and came out with a new plan of correction tool and it is optional, it is on the OSDH website. In assisted living there is no enforcement cycle, so you can end up with multiple revisits and if you do don't have a good plan of correction you can receive fines for long periods of time. This tool can help benefit and educate the industry and help facilities to come into compliance. Presentations can be heard at Provider training on the 15th and Leading Age on the 18th of October. Letters have been sent out for assisted living IDR panels and for nursing home IDR panels. Training for IDR panels the 24th of October from 1pm to 4pm. Assisted living IDR is set to launch in November provided the slots can be filled. On the Camera forms it was decided to put the location of the individual and also add a line at the bottom for a signature of a representative of the facility and the facility name. These forms will be added to the website once we obtain a form number. Becky Moore asked what the resident themselves do not agree to have the camera in the room. Dorya noted the portion of the bill that states the law. Mr. Whitehead stated the resident has the right to override what the representative wants, the only way the resident cannot override the decision of the representative is if they have been appointed by the court to make decisions for the resident.

11) New Business:

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Kay Parsons read the letter to the board that will be sent out to Mich Magness' wife, Mary Ann Magness, on his passing. Kay Parsons appointed Dewey Sherbon to conduct the next LTCFAB meeting on January 8, 2014 at 1:30pm.

12) Public Comment

Public Comment was made throughout the meeting.

13) Adjournment

The meeting adjourned at 4:08 p.m.

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