

STATE HEALTH COUNCIL

November 10, 2015

A meeting of the State Health Council was called to order by Chairman Wade Peterson at 9:00 a.m. on Tuesday, November 10, 2015 in AV Room 212 of the Judicial Wing, State Capitol, Bismarck, ND.

Members present:

Wade Peterson, Mandan, Chairman
Genny Dienstmann, Bismarck, Vice Chairman
Leona Koch, Raleigh, Secretary
Greg Allen, Jamestown (*phone*)
Howard Anderson, Turtle Lake
Jerry Jurena, Bismarck
Gordon Myerchin, Grand Forks
Duane Pool, Bismarck (*phone*)
Jennifer Schaeffer, Medora
Dennis Wolf, MD, Dickinson

Members absent:

Mike Jones, Bismarck

Staff members present:

Terry Dwelle, MD, State Health Officer
Arvy Smith, Deputy State Health Officer
Darleen Bartz, Health Resources Section
Kelly Nagel, Public Health Liaison
Karol Riedman, Internal Auditor
Londa Rodahl, Recording Secretary
Brenda Weisz, Division of Accounting

Others present: See ATTACHMENT A

Minutes

HOWARD ANDERSON MOVED APPROVAL OF THE AUGUST 11, 2015 MINUTES AS DISTRIBUTED. SECOND BY DENNIS WOLF AND CARRIED.

NDAC 33-17, Public Water Supply Systems

Greg Wavra presented the amendments to Article 33-17, Public Water Supply Systems, based on a new total coliform rule in the Safe Drinking Water Act. The revised total coliform rule was finalized April 13, 2013 and implementation of the rule begins April 1, 2016. The original rule was implemented in the late 1980s. The major differences are that some of the smaller systems that conducted bacteriological monitoring once per quarter will begin monthly monitoring. Some of the other systems will have to submit sample site plans or update them. There will be less repeat monitoring for some of the smaller systems. Another new part is that the Department will conduct assessments if the water supply systems do experience problems. He requested the Council's adoption of these amendments, contingent upon approval of the Attorney General.

DENNIS WOLF MOVED THE ADOPTION OF AMENDMENTS TO NDAC 33-17, PUBLIC WATER SUPPLY SYSTEMS, CONTINGENT UPON APPROVAL OF THE ATTORNEY GENERAL. SECOND BY JERRY JURENA.

The Chair requested a roll call vote and the MOTION CARRIED. Anderson, Dienstmann, Jurena, Koch, Myerchin, Peterson, Pool, Schaeffer, and Wolf voted 'aye'. There were no 'nay' votes. Allen and Jones—absent.

NDAC 33-06-16, Newborn Screening Program

Joyal Meyer noted that newborn screening is considered one of the greatest public health issues of the 21st century. Newborn screening is a blood test for various genetic and metabolic disorders. North Dakota law requires that all babies be screened; however, the parents or guardians must give their consent. Newborn screening began in North Dakota in 1964 with the metabolic screening disorder called phenylketonuria (PKU). Testing has evolved throughout the years to identify many more severe conditions. Infants with an inherited disorder often appear healthy at birth and this is why early identification is so important. Confirmatory testing and treatment can begin before a baby gets sick and may prevent any severe health or developmental delays or even death.

During the 2015 legislative session, SB 2334 passed to reflect current practices in newborn screening. Authority was given to the State Health Council to adopt rules relating to storage, maintenance, and disposal of blood spots or other newborn specimens. In addition, the Council was given authority to specify a list of panel disorders that must be performed. Screening panels must include disorders and diseases selected by the state health officer with input from the advisory committee. This authority was given to the Health Council to assure accountability and transparency to the public. These proposed amendments are reflective of SB 2334. A public hearing was held on September 3, 2015 and no one attended or provided any comment. The newborn screening team was very proactive during the drafting of the amendments and the Department feels that is why no public comments were received.

Some of the language was removed from the administrative rules and added to the law. The majority of the newborn screening process is in the Century Code and it was not necessary to duplicate it in the administrative rules. The law states what the program is responsible for and the administrative rule specifies how those responsibilities are to be carried out. She requested the Council's adoption of these amendments.

JERRY JURENA MOVED THE ADOPTION OF AMENDMENTS TO NDAC 33-06-16, NEWBORN SCREENING PROGRAM. SECOND BY DENNIS WOLF.

The Chair requested a roll call vote and the MOTION CARRIED. Anderson, Dienstmann, Jurena, Koch, Myerchin, Peterson, Pool, Schaeffer, and Wolf voted 'aye'. There were no 'nay' votes. Allen and Jones—absent.

Newborn Screening Advisory Committee Member List
and
List of Panel Disorders

Joyal Meyer stated the newborn screening advisory committee consists of 40 members and represents the interests of North Dakotans and assists in developing programs to ensure availability and access to quality genetic health care services. The committee advises the

Department regarding newborn screening and makes recommendations about the design and implementation of the program. The committee consists of representatives from professional groups, agencies, pediatricians, family practice physicians, consumers and individuals with an interest in newborn screening services. She requested the Council's approval of the committee list.

Ms. Meyer stated that the conditions for which newborns are screened vary in each state. A national committee provides recommendations to help guide and support states in developing their programs. Then the secretary of the U.S. Department of HHS reviews the committee's recommendations and makes the final decision of whether or not to include a condition on the list. Currently ND screens for 49 conditions that can be identified during the newborn screening process. The Department requests the addition of Severe Combined Immune Deficiency (SCID) or also known as bubble boy syndrome. She requested the Council's approval of the current list of disorders and the addition of SCID.

Dr. Stephen McDonough presented ATTACHMENT B.

HOWARD ANDERSON MOVED THE APPROVAL OF THE NEWBORN SCREENING ADVISORY COMMITTEE MEMBERSHIP LIST AND THE LIST OF PANEL DISORDERS, INCLUDING SEVERE COMBINED IMMUNE DEFICIENCY (SCID). SECOND BY JENNIFER SCHAEFFER AND CARRIED.

Loan Repayment Programs Manual

Mary Amundson stated that she worked with Arvy Smith, Brenda Weisz, and her colleagues Terri Lang and Michelle Montgomery, in drafting the loan repayment manual, which reflects the current law and the practice that the Health Council has been following. The manual was being presented to the Council for its consideration and approval. Mary noted the Council may wish to clarify the shaded areas in the document.

It was questioned if the manual had been reviewed by hospital administrators or clinic managers for further input and it had not. The Council was also requested to get input back to Mary before the next meeting.

JERRY JURENA MOVED THAT A COMMITTEE BE FORMED TO WORK WITH MARY AMUNDSON ON THIS PROCEDURE MANUAL BEFORE MOVING FORWARD. SECOND BY GENNY DIENSTMANN AND CARRIED.

(Following the meeting, Mary noted that she failed to mention that the manual was reviewed by the ND Dental Association, the Health Department's oral health director, and two state veterinarians at the Board of Animal Health.)

2014 Risk Assessment Report

Karol Riedman presented the 2014 Risk Assessment Report for the State Health Department and requested the Council's adoption of this report.

GORDON MYERCHIN MOVED THE ADOPTION OF THE 2014 RISK ASSESSMENT REPORT OF THE NORTH DAKOTA DEPARTMENT OF HEALTH. SECOND BY HOWARD ANDERSON AND CARRIED.

Audit Committee Charter and Internal Audit Charter

Wade Peterson reviewed the Audit Committee Charter and requested the Council's approval of it along with approval of adding Dawn Sackman, a certified internal auditor for MDU Resources, as an ad hoc member. Mr. Peterson also reviewed the Internal Audit Charter and asked for approval of this charter.

HOWARD ANDERSON MOVED TO APPROVE THE AUDIT COMMITTEE CHARTER, ADDING DAWN SACKMAN TO THE COMMITTEE, AND APPROVAL OF THE INTERNAL AUDIT CHARTER. SECOND BY LEONA KOCH AND CARRIED.

Open Meeting Letter

Arvy Smith stated that following the August 11, 2015 meeting there was a request made to the Attorney General's office to have a review of our open meetings practices. She noted that since the request was addressed to the Health Council, the Department asked Wade Peterson to sign the letter submitting our responses. The Department is awaiting the Attorney General's response.

J-1 Visa Waivers

Mary Amundson noted that the state has been implementing what is known as the Conrad J-1 Visa Waiver Program since 1994. The state has never had a request for family medicine physicians for visa waivers under what are called flex positions. However, there were now two requests—from Bismarck and Minot—to use two of the ten flex positions for family practice physicians. In visiting with Dr. Dwelle, Arvy and Brenda Weisz on these recent requests, it was thought that this was an issue the State Health Council members could give guidance.

Mary provided background information on the J-1 program stating that foreign medical graduates (FMGs) are students that come into this country to further their education and they enter on a J-1 visa. This permits them to study for seven years in this country. Once their education is completed, the student is required to return to their home country. Understanding the need for physicians to serve in rural and underserved areas across the state, several individuals worked with our North Dakota Congressional delegation to raise their awareness about this unmet need. As a result of those discussions, Senator Kent Conrad introduced legislation in 1994 to allow states to recruit these FMGs to practice in health professional shortage areas (HPSAs) and medically-underserved areas (MUAs). This legislation was known as the Conrad 20 J-1 Visa Waiver Program and it has permitted these physicians to practice in those HPSAs and MUAs in exchange for a waiver of their 2-year requirement to return to their home country.

Under this legislation, participating states could recommend 20 waivers per year. In 2004, the program then allocated five of those slots to be used as flex, to recruit physicians who were not physically located in a HPSA or a MUA, but would serve the patients from those underserved areas. In 2008, that number was increased to 10 so it's now the Conrad 30 Program. Therefore, 10 of the 30 slots can now be used for flex slots to assist the state's urban areas or non-designated areas in their recruitment efforts. Unfortunately, as the program gained in popularity and now has programs in all 50 states, North Dakota has received fewer and fewer applications for the vacancies in HPSAs and MUAs. Some physicians will come and then leave but some will stay.

Originally, the policy was developed to use the flex slots to assist urban areas in specialty recruitment and now we have a request for family medicine. Since 1994, North Dakota has recruited 193 J-1 physicians. Between 2004 and 2015, when the flex slots were available, 121 physicians were recruited. Of those, 21% were recruited to HPSAs and MUAs, which is what the program was intended to do, while 79% were recruited for flex. Since we implemented flex, with the exception of one year, all ten slots have been filled. In that one year, a physician reneged on his contract leaving the slot unfilled as it was too late to recruit another physician. It's interesting to note that the Health Resources & Services Administration in their Division of Policy and Shortage, the ratio of greater than or equal to 2000:1 indicates an overutilization of primary care physicians. Looking at family medicine physicians—in Minot and Bismarck—the ratio in Minot is 915:1, which shows no overutilization, especially for family medicine, and for primary care the ratio is 828:1. Using the same methodology for Bismarck, the ratio of family medicine physicians in the Bismarck-Mandan area is 1300:1 and for primary care in Bismarck is 741:1. Again, indicating no overutilization.

Now the request has come for two family medicine physicians to use flex slots in Bismarck and Minot. The question for the Council is whether or not to use two of the 10 flex slots for these two family medicine applicants. The State's policy since 2004 has been to use the flex slots for specialty physicians or for other areas that are not designated as HPSAs or MUAs.

Randy Pederson, Chief Executive Officer at Tioga Medical Center, stated he offered six contracts to J-1 physicians in 2015 and they came for a site visit, they were impressed with the community, the city, the hospital, the newly built clinic—and for some reason or another, it's not the money that's turning them away. It's something else and whether it's their spouse saying 'we're too small' or whatever, he was very concerned that giving flex slots to urban areas will set a precedent and that it will be very tough for rural America—rural North Dakota—to compete with the urban areas if they are allowed to fill family practice physicians with J-1 physicians. He feels that his recruiting power will be diminished greatly. In the ten years he's been the CEO, he's been able to recruit two J-1 physicians through the program to Tioga.

Also, to counter the high cost of housing, the medical center bought two houses in Tioga to be able to offer to physicians at a very reasonable price rather than the Bakken rates in western ND. They want to assure that the physician's family will have a very nice place to live and be comfortable in the community and not have to worry about the currently exorbitant housing prices. He feels they have done just about everything they can think of and yet they still have trouble trying to get somebody to sign on the dotted line. It's always some other circumstance that they don't sign and he has no control over why they go somewhere else.

Al Hurley, the Chief Operating Officer for Sanford-Bismarck and responsible for the west region, said each state handles the program differently and this process is not simple but a very complex situation in a changing environment. He noted that Luverne, MN (a HPSA) created an incentive for physicians to come to their city by purchasing city blocks for them since they were only 15 miles from Sioux Falls, SD. He stated there aren't as many family medicine or primary care physicians as there are subspecialists.

The J-1 process requires the physician to stay within their zip code and cannot do outreach. He suggested that we don't lose candidates this year that wish to stay in the state, especially those in our residency programs. He recommended a committee be formed to figure out how to change the process in order to get primary care into rural areas.

JERRY JURENA MOVED THAT WE MAINTAIN THE STATUS QUO AS FAR AS HOW THE PROCESS HAS BEEN WORKING AND THAT WE FORM A COMMITTEE OF CRITICAL ACCESS HOSPITALS, PROSPECTIVE PAYMENT SYSTEM HOSPITALS, AND MARY AMUNDSON, TO WORK OUT THE LOGISTICS IN THIS AND FIGURE OUT HOW TO IMPROVE THE SYSTEM AND NOT LOSE THOSE SLOTS SO IT'S TO EVERYONE'S BENEFIT. SECOND BY DUANE POOL AND CARRIED.

DUANE POOL MOVED TO APPROVE THE TWO CANDIDATES THAT HAVE BEEN PROPOSED FOR THE TWO FLEX SLOTS. SECOND BY JERRY JURENA.

The Chair requested a roll call vote and the MOTION CARRIED. Allen, Anderson, Dienstmann, Jurena, Koch, Myerchin, Pool, Schaeffer, and Wolf voted 'aye'. Peterson abstained. There were no 'nay' votes. Jones—absent.

F-Tags in Nursing Facility Inspections

Darleen Bartz explained that the Division of Health Facilities is responsible for completing the federal Medicare and Medicaid surveys of long term care facilities under a contract with the Centers for Medicare & Medicaid Services (CMS). The survey is a prescribed quality assurance process that takes a point-in-time look at the quality of care and services provided to the recipients to ensure that the facility is meeting the minimum standards set forth in the federal requirements. Each federal requirement is assigned a data tag, or F-tag in the case of long term care, for reference purposes.

The Department survey teams have been giving preliminary F-tags to providers while onsite at the exit conference as long as CMS allowed and if it wouldn't negatively impact the State's agreement with CMS. However, yesterday the department received ATTACHMENT C, which states the Department is to no longer furnish the facility with preliminary F-tags. She understands the providers' wishes to have the practice of receiving the preliminary F-tags given at the exit meeting. She suggested the industry work through the ND Long Term Care Association, the state's Congressional delegation in Washington, or both, to change this in the survey process.

Shelly Peterson, President of the ND Long Term Care Association, presented ATTACHMENT D, which also requested the Council's assistance in working with them to ask North Dakota's Congressional delegation for help in getting this changed.

JERRY JURENA MOVED THAT THE STATE HEALTH COUNCIL SEND A LETTER TO NORTH DAKOTA'S CONGRESSIONAL DELEGATION INDICATING THE COUNCIL'S SUPPORT OF WHATEVER LEGISLATION/ACTION THE ND LONG TERM CARE ASSOCIATION MEMBERS PROPOSE REGARDING SHARING F-TAGS WITH A FACILITY AT THE EXIT CONFERENCE. SECOND BY GORDON MYERCHIN.

The Chair requested a roll call vote and the MOTION CARRIED. Allen, Jurena, Koch, Myerchin, Peterson, Schaeffer, and Wolf voted 'aye'. There were no 'nay' votes. Anderson, Dientsmann, Jones and Pool—absent.

Study of Loan Repayment Programs

Arvy Smith reviewed House Bill 1036, which provides for a study of health professional assistance programs and for the Health Department to periodically report back to the Health

Care Reform Review Committee during the 2015-16 interim. The Department was not provided a budget for this study and is suggesting that the Department's internal auditor conduct it for the Department. However, internal audit is separate from the Health Department, which is why the Health Council's Audit Committee was formed, and that committee would have to ask Karol Riedman to do this study.

GORDON MYERCHIN MOVED TO ASSIGN KAROL RIEDMAN TO CONDUCT THE STUDY REQUIRED BY HOUSE BILL 1036 REGARDING HEALTH PROFESSIONAL ASSISTANCE PROGRAMS. SECOND BY WADE PETERSON AND CARRIED.

Overview of Health Council's Powers & Duties

Edward Erickson, assistant attorney general, distributed and reviewed ATTACHMENT E.

Other Business

Kelly Nagel presented the finalized content for the long term care informational brochure on behalf of the Council's subcommittee. The subcommittee was appointed as a result of the Council's strategic planning process and the State Health Council Data Committee's responsibility to inform the public so it can make better healthcare decisions. The next step is for it to be designed and uploaded on the State Health Council's website. There was no budget for having it printed.

JERRY JURENA MOVED THAT A DISCLAIMER BE ADDED TO THIS INFORMATIONAL MATERIAL AND THAT IT BE APPROVED. SECOND BY DENNIS WOLF AND CARRIED.

The meeting adjourned at 1:15 p.m.

Submitted,



Leona Koch, Secretary

**Testimony to the State Health Council of the North Dakota Department
of Health on Proposed Rule to add Severe Combined
Immunodeficiency (SCID) to North Dakota Newborn Screening**

Stephen McDonough MD

November 10, 2015

Good morning Mr. Chairman and members of the State Health Council. My name is Stephen McDonough and I am here in **support of the proposed rule to add severe combined immunodeficiency (SCID) to the newborn screening panel.** I would like to share a little about my background. I retired earlier this year after working 35 years in North Dakota as a pediatrician. From 1985 to 2000, I worked at the North Dakota Department of Health and oversaw the newborn screening program and served as the medical director. During that time, Governor George Sinner and State Health Officer Robert Wentz asked me if we could participate in regional screening when the Governor signed legislation adding galactosemia to North Dakota's newborn screening. I led the effort which resulted in Iowa performing our testing.

In 2011, I was appointed by the United States Secretary of Health and Human Services to the Advisory Committee on Heritable Disorders in Newborns and Children for a four-year-term which was to end this year. This committee makes recommendations to all states as to which conditions should be screened at birth. With reauthorization, I have been asked to stay on the committee until 2017. Several months ago, the North Dakota Health Department appointed me to the SCID task force. **I wish to make it clear that I come before you today speaking only for myself and not representing any committee or organization.**

SCID is a group of fatal conditions that result in death at an average age of 1 year. Fortunately, stem cell transplantation can result in a cure if the child is identified before becoming seriously ill. Unfortunately, physicians are often unable to make the diagnosis in time resulting in what is called a diagnostic odyssey (which parents refer to as a nightmare) during the time that the child is frequently ill and deteriorating without the right diagnosis and treatment.

A highly reliable newborn screening test is available with low false positives and negatives.

In 2010, the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children recommended that SCID be added to the Recommended Uniform Screening Panel.

SCID occurs in North Dakota. Several years ago, a mom brought to me her 4-month-old child who had been born at another facility with several congenital anomalies. At 1 month of age her child developed a severe rash and was referred to the University of Minnesota and Mayo Clinic where the diagnosis was congenital anomalies and psoriasis. Her child had seen a pediatric immunologist who is a specialist in the immune system. I began treating her child and did additional testing. I diagnosed her child with immunodeficiency and arranged a multi-specialty evaluation at Mayo Clinic. The week before her child was to be seen at Mayo Clinic, I received a letter from North Dakota Medicaid denying the referral, informing me that the child did not have immunodeficiency. I sent Medicaid a tersely written letter reaffirming my diagnosis of immunodeficiency and told mom to take her child to Mayo.

Mayo clinic diagnosed the infant with SCID and recommended transfer to the Cincinnati Children's Hospital for stem cell transplantation. Mayo was amazed that the infant was in such good shape because at 8 months of age, children with SCID are often dying. Although I did not know if at the time, I was treating the infant's frequent skin infections with an antibiotic that prevented more serious opportunistic infections. The infant received a stem cell transplant and is alive today.

If North Dakota was doing SCID screening at the time of this infant's birth, the diagnosis would have been established in the first weeks of life.

Over 30 states are screening their newborns for SCID. North Dakota needs to join these states. Iowa is currently testing newborns for SCID. **Please support this request to add SCID to North Dakota newborn screening.**

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Denver Regional Office
1961 Stout Street, Room 08-148
Denver, Colorado 80294



Western Division of Survey & Certification

Refer to: WDSC-RO8-JRC

November 9, 2015

Department of Health
Health Resources Section
Attn: Darleen Bartz, PhD., Chief
600 East Boulevard Avenue
Dept. 301 Bismarck, ND 58505-0200

Dear Dr. Bartz,

This is to clarify the referencing of F-Tags during the exit for Long-Term Care (LTC) Certification surveys. The Centers for Medicare and Medicaid Services (CMS) has provided guidance to surveyors that F-Tags should not be provided in reference to issues determined to be out of compliance at the exit conference.

The State Operations Manual (SOM) provides a process and protocol to which surveys are conducted. The exit conference is both a courtesy to the provider as well as a way to expedite the provider's planning ahead of the formal CMS-2567 report. The CMS-2567 is, in fact, the official notification by CMS to the provider of deficiencies cited, with supporting evidence.

Appendix P of the SOM, under the instructions for Task 7, "Exit Conference states that the exit conference is to *"inform the facility of the survey team's observations and preliminary findings"*. These preliminary findings are subject to the standard review processes and the final assignment of F-Tags, by federal protocol, when the CMS-2567 report is finalized by the agency.

The SOM guidance states, *"During the exit conference, provide the facility with the opportunity to discuss and supply additional information that they believe is pertinent to the identified findings. Because of the ongoing dialogue between surveyors and facility staff during the survey, there should be few instances where the facility is not aware of surveyor concerns or has not had an opportunity to present additional information prior to the exit conference."* Additionally, the guidance states, *"Provide information in a manner that is understandable to those present, e.g., say the deficiency "relates to development of pressure sores," not "Tag F314"*.

The 1864 Agreement provides CMS with the authority to designate the content of the survey process to be followed by the States. The 1864 Agreement is the agreement between CMS and the State survey agency to carry out the provisions of Sections 1864, 1874, and related provisions of the Social Security Act. Article II of the 1864 Agreement specifies the functions to be performed by the State. Article II, A.1. (c), reads that the State is “*responsible for surveying for the purpose of certifying to the Secretary the compliance or non-compliance of providers and suppliers of services and resurveying such entities, at such times and manner as the Secretary may direct.*”

As we discussed, CMS is requiring that the State of North Dakota State Survey Agency follow the directed policy and guidance and not provide F-tags when presenting preliminary survey findings to providers during the exit conferences of Long-Term Care Surveys.

Sincerely,

A handwritten signature in black ink, appearing to read "Robt Chickering" with a stylized flourish at the end.

Steven D. Chickering,
Associate Regional Administrator
Western Division of Survey and Certification

Copies via e-mail to:

Thomas E. Hamilton, Director, Survey and Certification Group
Karen Tritz, SCG, CCSQ
David Wright, Deputy Regional Administrator, CQISCO

**Presentation with State Health Council
Survey Process of Nursing Facilities
November 10, 2015**

Thank you for the opportunity to visit about an issue regarding the surveying of Nursing Facilities in North Dakota. My name is Shelly Peterson, President of the North Dakota Long Term Care Association. We are a non-profit trade association representing long term care facilities in North Dakota. All nursing facilities and basic care facilities are members of our Association. As well, we represent assisted living facilities.

For the past 9 months the Health Department, long term care providers and others have been meeting to identify key concerns related to the survey process of nursing facilities. Nursing Facilities are committed to providing the highest of quality to every resident they serve. In looking at ND and other states, we were concerned about the number of deficiencies and the high scoring on the ranking of the scope and survey of the deficiencies.

We are still in the information gathering, sharing and analyzing, with much work yet to be accomplished. We appreciate the leadership and support of the Health Department in this important endeavor. We have hit a stumbling block and we are working cooperatively and jointly with the Health Department to resolve the issue. The issue is with CMS, who has been participating in our collaborative.

Background:

Approximately every 12 months, every licensed Nursing Facility receives an unannounced survey by the State Health Dept., who is under contract with CMS. The survey reviews compliances with federal regulations. The survey is composed of seven tasks, and the process is directed by the state operations manual (SOM). The seven tasks include:

- Task 1 – Offsite Survey Preparation
- Task 2 – Entrance Conference and Onsite Preparatory Activities
- Task 3 – Initial Tour
- Task 4 – Sample Selection
- Task 5 – Information Gathering
- Task 6 – Information Analysis for Deficiency
- Task 7 – Exit Conference

Issue: Task 7 – Exit Conferences

The general objective of the exit conference is to inform the facility of the survey team's observations and preliminary findings. During this time the facility is given an opportunity to provide additional information that they believe is pertinent to the identified findings.

CMS encourages a dialogue between surveyors and facility staff during this time and indicate in the SOM that there should be few instances where the facility is not aware of surveyor concerns or has not had an opportunity to present additional information prior to the exit.

Nursing Facilities view the exit conference as very valuable. They want to be aware of any areas of non-compliance so they can begin working on a solution immediately. As well as the exit conference is a great time to assure surveyors have all the information related to an issue, because all parties want a fair determination based on the facts.

During the exit, preliminary findings are identified. The survey team identifies what they believe the F-tag citations will be. "F-tag" is a designation that CMS uses for the purpose of identifying a specific portion of each requirement of participation. There are 372 F-tags. They do not share the scope and survey scoring of the citation, as that is never determined until a supervisory meeting occurs back at the central office in Bismarck. They also state that the specific F-tags are preliminary and that F-tags can be added or deleted after the final survey review in Bismarck.

Facilities feel the sharing of the specific F-tag is critical to their understanding the deficient practice as they begin immediately to review their practice and correct any deficient practice.

Facilities feel without this information, it will be far more difficult to begin the important work of correcting the perceived problem. The formal report, listing the final F-tag violations is usually not received by the facility for 2 weeks, sometimes much longer, after the exit conference. Facilities are required to develop a written plan of correction within 10 calendar days of receiving the formal report (2567).

If they don't begin immediately to address the deficient practice, it is very difficult to submit a complete report, which has many required elements within that time period. More importantly is the safety and well-being of each resident. The nursing facility needs to begin their work and review of the issue immediately upon exit of the team. They need to know and understand the specific details so they can put their resources in the right area. The identification of the preliminary F-tag allows that to happen.

CMS verbally informed all members of the collaborative on November 2, 2015 that the State must stop providing the identification of the preliminary F-tags at the exit survey. On November 9th, they sent a written directive.

What is going on in other States in our region and the US:

The one thing that is consistent is that CMS is inconsistent. States in our region and in the US are receiving the preliminary F-tags at exit. Some states are not receiving the F-tags. The guidance from CMS can be found at these two sources:

What exits in Regulations:

Task 7 – Exit Conference (See Appendix A)

Do not discuss survey results in a manner that reveals the identity of an individual resident. Provide information in a manner that is understandable to those present; e.g. say the deficiency “relates to development of pressure sores, “not” Tag F314”.

SOM-Chapter 2 – §2724 Exit Conference (See Appendix B)

2724C – Presentation of findings

In presenting findings, avoid reading your findings or referring to them by their data tag number.

2724D – Closure

Inform the provider that you will send a formal statement of deficiencies, unless your procedures call for Form CMS-2567 to be left with the provider following the exit conference. See Appendix B

What does CMS do when they survey:

When the federal surveyors are in ND and they survey, they give the facility a preliminary list of the F-tags.

Neither CMS nor the State Health Department can recall any adverse event when sharing the F-tags with nursing facilities.

We believe it promotes better communication and identification of problem areas, thus facilities can begin to fix the problem at the exit conference.

We ask for your help in seeking Congressional Action to allow this practice. North Dakota has been providing this information for as long as anyone can remember.

We believe it is good practice and one that has been identified through the collaborative as an excellent means of communicating key information.

Thank you for your consideration of this request.

Shelly Peterson, President
North Dakota Long Term Care Association
1900 North 11th Street
Bismarck, ND 58503
(701)-222-0660

Appendix P

Task 7 - Exit Conference

A. General Objective

The general objective of the exit conference is to inform the facility of the survey team's observations and preliminary findings.

B. Conduct of Exit Conference

Conduct the exit conference with facility personnel. Invite the ombudsman and an officer of the organized residents group, if one exists, to the exit conference. Also, invite one or two residents to attend. The team may provide an abbreviated exit conference specifically for residents after completion of the normal facility exit conference. If two exit conferences are held, notify the ombudsman and invite the ombudsman to attend either or both conferences.

Do not discuss survey results in a manner that reveals the identity of an individual resident. Provide information in a manner that is understandable to those present, e.g., say the deficiency "relates to development of pressure sores," not "Tag F314."

Describe the team's preliminary deficiency findings to the facility and let them know they will receive a report of the survey which will contain any deficiencies that have been cited (Form CMS-2567). If requested, provide the facility with a list of residents included in the standard survey sample. Do not give the team's Roster/Sample Matrixes to the facility, because they contain confidential information.

If an extended survey is required and the survey team cannot complete all or part of the extended survey prior to the exit conference, inform the Administrator that the deficiencies, as discussed in the conference, may be amended upon completion of the extended survey. (See §2724 for additional information concerning exit conferences.)

During the exit conference, provide the facility with the opportunity to discuss and supply additional information that they believe is pertinent to the identified findings. Because of the ongoing dialogue between surveyors and facility staff during the survey, there should be few instances where the facility is not aware of surveyor concerns or has not had an opportunity to present additional information prior to the exit conference.

2724A - Introductory Remarks

(Rev. 1, 05-21-04)

Introduce yourself to those present. Restate why the survey was conducted. Express the team's appreciation for anything the provider has done to facilitate the survey. Explain that the exit conference is an informal meeting to discuss preliminary survey findings and thereby assist the provider or supplier in developing an acceptable PoC, if appropriate and required. Indicate that official findings are presented in writing on Form CMS-2567 and will be forwarded to the provider within 10 working days. Indicate that the provider will, in turn, have 10 calendar days to submit a PoC. (See §2728.)

2724B - Ground Rules

(Rev. 1, 05-21-04)

Explain how you will conduct the exit conference and how the team's findings will be presented; for example, each surveyor may present a portion of the total findings. Inform the provider that where there are disagreements between the team and the provider about the findings that cannot be resolved during the conference or before the team leaves the facility, the provider will have the opportunity to submit additional evidence to the team, the State, and/or the RO after the conference. (See §2728.B. concerning provider attempts to refute survey findings on the Form CMS-2567.)

2724C - Presentation of Findings

(Rev. 1, 05-21-04)

In presenting findings, avoid reading your findings or referring to them by their data tag number. Explain why the findings are a violation of Medicare requirements. If the provider asks for the regulatory basis, provide it. Under no circumstances should you make general statements such as, "Overall the facility is very good." Stick to the facts. Do not rank requirements. Treat requirements as equally as possible. Cite problems that clearly violate regulatory requirements. Avoid statements such as, "The condition was not met," or "The standard was not met."

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Denver Regional Office
1961 Stout Street, Room 08-148
Denver, Colorado 80294



Western Division of Survey & Certification

Refer to: WDSC-RO8-JRC

November 9, 2015

Department of Health
Health Resources Section
Attn: Darleen Bartz, PhD., Chief
600 East Boulevard Avenue
Dept. 301 Bismarck, ND 58505-0200

Dear Dr. Bartz,

This is to clarify the referencing of F-Tags during the exit for Long-Term Care (LTC) Certification surveys. The Centers for Medicare and Medicaid Services (CMS) has provided guidance to surveyors that F-Tags should not be provided in reference to issues determined to be out of compliance at the exit conference.

The State Operations Manual (SOM) provides a process and protocol to which surveys are conducted. The exit conference is both a courtesy to the provider as well as a way to expedite the provider's planning ahead of the formal CMS-2567 report. The CMS-2567 is, in fact, the official notification by CMS to the provider of deficiencies cited, with supporting evidence.

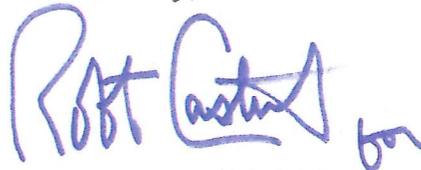
Appendix P of the SOM, under the instructions for Task 7, "Exit Conference states that the exit conference is to *"inform the facility of the survey team's observations and preliminary findings"*. These preliminary findings are subject to the standard review processes and the final assignment of F-Tags, by federal protocol, when the CMS-2567 report is finalized by the agency.

The SOM guidance states, *"During the exit conference, provide the facility with the opportunity to discuss and supply additional information that they believe is pertinent to the identified findings. Because of the ongoing dialogue between surveyors and facility staff during the survey, there should be few instances where the facility is not aware of surveyor concerns or has not had an opportunity to present additional information prior to the exit conference."* Additionally, the guidance states, *"Provide information in a manner that is understandable to those present, e.g., say the deficiency "relates to development of pressure sores," not "Tag F314"*.

The 1864 Agreement provides CMS with the authority to designate the content of the survey process to be followed by the States. The 1864 Agreement is the agreement between CMS and the State survey agency to carry out the provisions of Sections 1864, 1874, and related provisions of the Social Security Act. Article II of the 1864 Agreement specifies the functions to be performed by the State. Article II, A.1. (c), reads that the State is "*responsible for surveying for the purpose of certifying to the Secretary the compliance or non-compliance of providers and suppliers of services and resurveying such entities, at such times and manner as the Secretary may direct.*"

As we discussed, CMS is requiring that the State of North Dakota State Survey Agency follow the directed policy and guidance and not provide F-tags when presenting preliminary survey findings to providers during the exit conferences of Long-Term Care Surveys.

Sincerely,



Steven D. Chickering,
Associate Regional Administrator
Western Division of Survey and Certification

Copies via e-mail to:

Thomas E. Hamilton, Director, Survey and Certification Group
Karen Tritz, SCG, CCSQ
David Wright, Deputy Regional Administrator, CQISCO

**Open Meetings &
Records 2015**
Health Council

Who is subject to Open Record and Meeting Laws?

“Public Entities” – N.D.C.C. § 44-04-17.1(13):
Public or governmental bodies, boards, bureaus, commissions, or agencies of the state or any political subdivision, including any entity:

- created or recognized by Constitution, state statute, resolution, ordinance, rule, by law, order of the governor, etc.
- supported by or expending public funds
- acting as an agent or agency of a public entity performing a governmental function on behalf of the public entity

Basics of Open Meetings

Quorum of
Governing body
Of a public entity
• Discussing public business
Is a meeting

*N.D.C.C. § 44-04-17.1(9) definition of
“meeting”*

“Public Business”

“all matters that relate or may foreseeably relate in any way to ...the performance of the public entity’s governmental functions, including any matter over which the public entity has supervision, control, jurisdiction, or advisory power; or...the public entity’s use of public funds.”

N.D.C.C. § 44-04-17.1(12)

Exceptions:

Meetings of national, regional, or state associations.
Chance or social gatherings.
Delegation to one person - one person is not a committee.

N.D.C.C. § 44-04-17.1(9)(b)

There are no exceptions for:

Committees: two or more people acting collectively pursuant to authority delegated to that group by the governing body.
Did the governing body delegate any sort of authority?
Is the committee doing something the governing body could do itself?

It doesn't matter.....

- If the committee doesn't have final authority;
- If the committee is just "brainstorming" or "factfinding;"
- If the committee is only going to recommend something to the governing body.

A meeting can happen...

- By conference call;
- At a restaurant;
- On very short notice;
- Over video conference;
- By e-mail.

Precautions

- Do not hit "reply all."
- Do not conduct telephone straw polling.
- Do not hold serial meetings – less than a quorum is not ok if the smaller gatherings collectively constitute a quorum and if the members hold the gatherings for the purpose of avoiding the open meetings law. N.D.C.C. § 44-04-17.1(9)(a)(2).

Notice: What should it say?

Time, date, and location of the meeting;
Topics to be discussed;
Notice of any executive session.

The public should be able to read the notice and understand what the governing body is planning to discuss. Don't be vague.

N.D.C.C. § 44-04-20

Where do you put it?

At the main office;
Appropriate central location: city auditor, county auditor, secretary of state OR put on public entity's website;
Location of the meeting;
Give to anyone who has requested it.

Myth: publishing of notice

Two kinds of meetings

- | | |
|---|--|
| ◊ Regular | ◊ Special |
| ◊ Agenda should contain all topics known at the time of drafting the notice | ◊ Can only discuss the items on the notice |
| ◊ May discuss items not on the agenda at the meeting | ◊ Provide notice to the official newspaper |

Executive sessions

N.D.C.C. § 44-04-19.2

- To discuss confidential information – no motion necessary.
- To discuss exempt information – need motion.
- Most common: Attorney consultation and negotiation. (N.D.C.C. § 44-04-19.1)
- Most common violation: closing meeting to discuss personnel matters!

Executive session procedure:

- Convene in open meeting;
- Announce in open meeting the topics to be discussed and legal authority;
- Record the session (keep for 6 months);
Note time of executive session and who attended in minutes;
- Only discuss topics in announcement;
- Final action in open meeting.

N.D.C.C. § 44-04-19.2(2)

Minutes of Meetings

- Must contain:
 - Names of members attending
 - Date and time meeting was called to order and adjourned
 - List of topics discussed
 - Description of each motion made and whether seconded
 - Results of every vote taken
 - Vote of each member on every recorded roll call vote (required for all nonprocedural votes)

N.D.C.C. § 44-04-21(2)

Open records

All records
Possession of public entity
Regarding public business
OPEN

Definition of "RECORD"

Recorded information of any kind, regardless of the physical form or characteristic by which the information is stored, recorded, or reproduced.

N.D.C.C. 44-04-17.1(16)

Unless specifically provided by law...

There has to be a law that specifically says the record is protected.

The law will say the record is "not subject to Article XI of the ND Constitution," "not an open record," "exempt," or "confidential."

Exempt vs. Confidential

- Exempt records may be released.
- Discretion is with the public entity.
- May be called a "closed" record.
- Not against the law to release an exempt record.

- Confidential records cannot be released.
- No discretion.
- Can only release pursuant to the statute.
- Class C felony to knowingly release. §12.1-13-01

N.D.C.C. § 44-04-17.1(2) ("closed record") (2) ("exempt record")

N.D.C.C. § 12.1-13-01

Examples

- Exempt
- § 44-04-18.1
- Home address
- Home phone number
- Photograph
- Payroll deduction info
- § 44-04-26 security system plans

- Confidential
- Social security numbers
- Employee medical records
- Computer passwords
- Employee use of EAP records

Generally Open:

- Personnel file
 - Job performance
 - Evaluations
- Business related records
- E-mails that are business related
- Computer records
- Contracts with a public entity - prices, costs

The basic rules:

Every person has the right to inspect or make a request for a public record.
The request DOES NOT have to be in writing.
The requester DOES NOT have to give their name or reason for the request.
You must provide records – not opinions or explanations.
Do not have to create new records
You only have to provide one copy of the record, once.

The basics continued...

You only have to provide records you have in your possession.
Requests should reasonably identify the record – you can ask for clarification, but cannot intimidate.
Give a legal reason for any denial of records.
Review and redact for confidential information. (N.D.C.C. § 44-04-18.10)
Communicate with requester – give estimate of time, costs, etc.
Provide records within a reasonable time.

“Reasonable Time”

Provide records within a “reasonable time.”
Several factors used to determine appropriate length of any delay, including:
need to consult with attorney if reasonable doubt exists on whether the record is open
excising confidential information
bulk of request and volume of documents reviewed
accessibility of documents
office staff and availability, workload, balancing of other responsibilities

Basics of charging:

25 ¢ per copy for 8x11 or 8x14 page.
Locating records, even electronic records – first hour free, thereafter \$25/hour.
Redacting confidential information – first hour free, thereafter \$25/hour. Electronic records are included in this, but have a special case for copy charges.
Actual cost of postage, maps, color photos.
Can ask for money up front.
Access is free!!!

N.D.C.C. § 44-04-18

Electronic records

Must provide reasonable access to electronically maintained records.
Can't impair ability to access records by contracting with a third party.
No charge for electronic copy unless it takes IT longer than one hour to produce.
If longer than 1 hour – charge actual cost of IT resources.

Health-Specific Exceptions

Protected Health Information—HIPAA and "Little HIPAA"—research studies
Hospital licensing information—N.D.C.C. § 23-16-09
Some environmental information, for example, trade secrets are confidential under the Air Pollution Control chapter
Numerous individual provisions throughout the Century Code

Violations

Violations may be subject of civil action under N.D.C.C. § 44-04-21.2.
Action must be commenced within 60 days of the date the person knew or should have known of the violation or 30 days from issuance of AG opinion.
Court may award \$1,000 or actual damages for intentional or knowing violations.

Violations

AG can refer a public servant to the state's attorney for multiple violations.
A public servant who knowingly violates the law is guilty of a class A misdemeanor.

N.D.C.C. § 44-04-21.3
N.D.C.C. § 12.1-11-06

More information

www.ag.nd.gov
Manuals
Opinions
Fact Sheets
