BERNARD: Good morning, my name is Bernard and I will be your conference operator today. At this time I would like to welcome everyone to the Nursing Home Statewide Telephone Call. All lines have been placed on me to prevent any background noise. After the speaker's remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press * then the #1 on your telephone keypad. If you would like to withdraw your question, press the # key. Thank you. Mary Absolon, you may begin your conference.

MARY: Thank you very much, Bernard, and we welcome everyone to our rescheduled statewide call. For those of you who called in yesterday, we apologize for those technical difficulties. We were able to use another IT system and been informed that we were going to be able to record this call and place it on the Department's website and so we will be hopefully able to do that within the next week is what we've been told, so that would be just great.

I wanted to mention to you that one of our speaker. Kristi Wergin has kindly rescheduled and she does have a meeting at noon sharp, so as we're going through our agenda and content if there are some questions related to the content area that she has, we'd like to prioritize those at the end during the Q&A that we'll be having.

So with that we're going to go right into our agenda

and proceed with our statewide call. We would like to thank you once again for all of your hard work and for working with the State Health Department. We appreciate everything that everyone is doing.

The first thing we wanted to provide an update for you on has to do with our Federal Integration update. As a reminder the Minnesota Department of Health is integrating responsibility for completing our Federal Nursing Home Complaint and Survey into a one program and that program is the Licensing and Certification Program at the Minnesota Department of Health that was effective 12/3/2018, and so as a reminder the Licensing and Certification Program have staff that are regionally located statewide and we are now integrating that into the workload there and we're conducting complaint investigations with surveys, as stand-alone surveys in conjunction with follow-up visits. It's been a learning experience for us and we are now fully operational with doing our triage, which is in real time every day and we are also looking at conducting the complaint investigation consistent with federal priorities. We wanted to mention that. There are under CMS guidelines, and we have a link for you here. You can go into what's called Chapter 5, which is the complaint procedures and that is the system that we are implementing. Many of the complaints are being investigated statewide.

As we do with our statewide calls, we really want to use this as an opportunity to give you tips or information that's most up to date and relevant to help with the work that we both do -- that you do -- and one of the tips that we have learned here with our complaints it that you really need to know where you are in enforcement cycle, if there are any violations that are outstanding, and to ensure that the facility is in compliance to be able to avoid any remedies and to maintain certification. A lot of the complaints that we're doing we need to do within a very short period of time and so more and more of those we're doing and so that timeliness is being pulled in and being reviewed by the Minnesota Department of Health in that process.

As I said before, effective December 3, 2018, all of the facility-reported incidents that we received as well as complaints, are being triaged and they're being triaged by surveyors at the Minnesota Department of Health who are federally trained with knowledge of the federal regulation so and we are doing this for all of the different federal provider types including nursing homes, but that would also include hospitals, CLIA labs, home health agencies, etc.

Through the triage process we have identified that some of the facility reports that we've received are very brief and what we're required to do under that Chapter 5 is

that we triage based on the information that is submitted in the report. Generally in most cases MDH is just to use information on that written report and some of these are very brief. An example of one that we received, it kind of illustrates this, is that the initial report was that it a subdural hematoma. That information, it was triaged as an immediate jeopardy and during the onsite investigation we learned that that situation related to the hematoma had occurred related to a fall prior to the admission to the nursing home. So that additional information would have made a difference regarding the level of priority and so that's one of the tips that we have for you. Whatever information that you have at that time of that initial submission.

The triage staff, we are contacting facilities directly at this time when we're finding that they're not meeting the federal regulations for reporting. As a reminder, during our statewide joint training session over the last two years we have spent time going through what's reportable, what's not reportable and providing additional guidance and will continue to do this, and our expert triage team is doing some individual outreach to assist facilities in that process.

One of the tips that we have from our team is that in terms of what's reportable is to please review -- and this

is under the F tag 600, the definition of Abuse, Neglect, Injury of Unknown Origin, Residential Resident Misappropriation of Property for What's Reportable, and that that would help a facility to determine if it actually has to be reported.

We also wanted to mention that CMS is revising and looking at clarifying what is reportable federally and so stay tuned for that regarding forthcoming clarification. We do not know any specific timeframe related to that.

And then we just have a link for you with Chapter 5.

The next item on the agenda has to do with deficiency trends and I'm very happy to be able to introduce Elizabeth Selke. Liz has been a trainer and a surveyor with our program for a number of years. She has just accepted a position as a supervisor with our training CLIA and our nursing assistant registry program unit. So with that, Liz, I'll turn this over to you to provide us up-to-date information related to the federal deficiencies that have been found by MDH during complaint and surveys.

ELIZABETH: Thank you, Mary. Good morning, everyone. Attached to the agenda you'll see multiple surveying complaint, Deficiency and Frequency Report. I just wanted to just briefly update you. We included reports for fiscal year 2017 and 2018. They weighted to the top 25 tags, as well as the fiscal year 2018 top 25 emergency preparedness

tags.

What I'd really like to focus on is our G-level tags, our harm tags and immediate jeopardies, and those reports are also attached. So last fiscal year 2018, we cited for complaint and survey 98 citations at our level G and from January 1 to February 14 we've cited 24 G's. We wanted to bring that to your attention. Most of the citations are in the -- if you look back at the top 25 cited deficiencies for fiscal year 2018, most of them are in the same areas.

So some of those areas just real briefly include F686, pressure ulcers; 689, free of accident hazards; 690, bowel and bladder incontinence; 692, nutrition, hydration status; and then 745, provision of medically related social services.

So we just wanted to bring that to your attention as well as in relation to the immediate jeopardies. So we had a total of 31 immediate jeopardies that were cited for fiscal year 2018, and this was both for complaints and surveys. We wanted to bring to your attention so far this year to date, so from January 1 to February 14, we've had 12 immediate jeopardies and actually last week we cited two more so we have a total of 14 immediate jeopardies, so we wanted to bring that to your attention. We also wanted to walk through some of the areas that we're citing our immediate jeopardies.

Just to go back on the agenda, I just want to let you know that all of these reports are public information and we've included the link here for you to the Q source cite where you can go and monitor the citations as well.

I'm just going to walk through, as I said, some of the areas -- regulatory groupings that we've had deficiencies in.

First of all, freedom of abuse and neglect. What we found for some examples are suspicious bruising on our residents' loin, breasts and neck area, which was not identified, reported or investigated. Less handling by staff, physical abuse, inappropriate physical touch and yelling at residents, sexual and verbal abuse. And in the area of accident hazards, some examples include transfer with mechanical lift, with the straps not properly connected and/or the bling too large, failure to supervise residents at risk for falls, a resident at risk for falls and who also had dementia and impulsive behavior, anxiety and agitation and this resident had repeated self-transfers resulting in a self-transfer with multiple fractures, smoking while using oxygen.

In relation to infection control, an example, residents displaying symptoms of influenza and no action to protect other residents in the facility from influenza.

The area of pressure ulcers, an example, did not

provide treatment for prevention of stage 3 to stage 4 pressure ulcers. And then in the area of quality of care, an example is the physical was not notified in regards to a resident who was having bloody stools and on coumadin, which resulted then in the resident being hospitalized with a low hemoglobin and required blood product transfusion.

So we just wanted to share that information with you. thank you.

MARY: Thank you, Liz. So the next person that we would like to have on the agenda is Brenda Fisher. Brenda is a new assistant program manager in the licensing and certification program and for a number of years was a unit supervisor in our team in St. Cloud, and Brenda is going to be going over a new CMS memo related to emergency preparedness. Because one of those areas that's new in this content relates to emerging infectious diseases, we also just wanted to know that staff -- we worked very closely interconnectively with staff at the State Health Department and one of those key people are people in our infectious disease area and so we have ICAR staff, Jean Rainbow, on here listening to our questions as we are going to be working in this area and implementation of this regulation. So, thank you, Brenda.

BRENDA: Okay, good morning, and thank you, Mary.

So as Liz identified as well, in your agenda, there is

a link to the new memo for emergency preparedness. It's under the key list O-1906, which is our old S&C memos, if you're familiar with those.

So what this is, it basically identifies a couple of areas that have changed in this past year and this is effective immediately is what the memo identifies. When you look at the definition, it talks about an all hazards approach and in that all hazards approach it talks about planning for using an all hazards approach to include emerging diseases, the EID threats. So examples of those would include influenza, Ebola, Zika virus and others.

So when you go through this memo, this specifically is identified underneath the tag E4. So E4 talks about the plan -- your overall emergency plan -- regarding the facility and the population and the surrounding areas is considered, so this is the area that you will get for national disasters, man-made disasters and facility disasters and in this area it's identified for the EID, for the emerging infectious diseases, and the specific area it wants you to look at as part of your policy is the facility has developed protocols to protect health and safety of the patients, as well as isolation and PPE equipment measures when they are looking at that as part of their plan.

The next area under the emergency preparedness we'd like to bring your attention to is the change is under E15.

E15 talks about the alternative sources of emergency you need to make at a ____ , have a provision of subsistence needs for your patients and your staff that are in the facility.

And underneath E15 it also talks about the heating and cooling and that it's actually not required to evenly heat the entire building, but you must ensure that there's safe temperature to protect the patient and others in the facility and then for your provisions of storage of your goods as well during an emergency.

So through your facility assessment, some providers have determined that maybe their current generator or something is not working and they're going to be needing to use an additional portable to mobile generator that's going to meet their needs better than what they currently have. So they can be doing that. So what this kind of clarifies is that they are deciding that a portable or mobile generator is needed that they do not actually have to follow the lifesaving provision regarding the testing and the loading and stuff that you would do in a permile(?) effects(?) generator, but this is not needed, but you still do have to follow the national code for electrical, the NSPA70.

This is also identified under E41, the emergency and standalone power as well.

We'd like to let you know that so we're implementing all and enforcing all regulations for emergency preparedness and we expect everyone to be complying with these areas in any updates that we've provided. Thank you.

MARY: Thank you very much, Brenda, and we also just want to give shout-out to everyone. It was a little bit over a year ago that we started to enforce this national standard across a lot of our providers -- all of our providers federally -- and that people have done, just we've found a lot of work in terms of getting this and it's gotten a lot better. We're not citing as many deficiencies as we originally were and so, thank you much for all of your work. You can really tell people have done a lot of work in that area and I believe that there is a conference even related to this so we'll continue to do that as well as emergency is obviously an area we're vigilant in. Thank you very much.

So with that I'm now happy to go through some tidbits of information that we wanted to bring to your attention and I'll turn the program back to Liz Selke.

ELIZABETH: All right, thank you, Mary.

All right, I'm going to provide you a little bit of an update on the most oversight survey the resource and support survey.(?) So we recently have had CMS federal surveyors join our MDH survey team to implement this

process and the resources support survey is a new federal oversight survey process and it includes no rating or scores for the survey team, but it focuses on ongoing dialogue with the federal surveyor, investigation and survey protocols. The intent is for surveyors to be able to share concerns and seek clarification and guidance from the federal surveyor.

The federal surveyor also has specific focus areas and I'll share with you what those areas are. Nationally, it's abuse and sufficient staffing and regionally the focus area is on necessary medications. And an area specific to Minnesota that the federal surveyors focus on is activities.

So after the survey is complete the federal surveyor sends a report and that report includes lessons learned and a summary, but clarifying areas -- or identifying clarifications that were provided on survey and also includes a review of concern areas, citations and how to improve documentation on the 2567.

Then during the second half of the year the resource and support surveys will focus concerns to these. That again will be conducted by federal surveyors and they'll be conducted 30 to 60 days of the state survey and they'll focus on areas that were identified in the resource support survey and they want to be able to determine if an area is

investigated and deficiency determination was appropriate. Also attached to the agenda is a little bit more extensive summary of this process.

Then we'll just move on to Agenda item #5. We just wanted to share with you that external CMS contracted surveyors will be conducting focus dementia surveys for providers. We don't have much more information than that to share, so just for your information.

And then agenda item #6, so the phase 3 long-term care requirements, they will be implemented on November 28 of this year and some of the changes include new regulations related to infection control, quality assurance and program improvement qualities(?) in trauma and _____ care.

CMS has indicated that new interpretive guidelines are to be released, but at this time the data that's released is not known and then we just wanted to also let you know we'll be doing will be part of joint training and the state, too, for upcoming dates.

And also attached to the agenda is a State Operations Manual. So I just wanted to bring that to your attention. Thank you.

MARY: Thank you, Liz. And, now I'm happy to be able to include our professional support from our quality improvement organization, Kristi Wergin with Stratis. As a FYI we did some data analysis and so far in our surveys in

fiscal year ’19, the top most frequently cited deficiency relates to infection control F-880. We’ve issued that 36 times and that data obviously is changing from week to week so we wanted to bring that to your attention as we’re working together in this area this year.

So, Kristi, please provide some updated information in terms of the tools that Stratis has for us and thank you for your ongoing help in everything you do.

KRISTI WERGIN: Thank you, Mary, I appreciate it. I’m Kristi Wergin and I am a program manager at Stratis Health, but this morning I am representing the Collaborative Health Care Associated Infection Network or CHAIN. So for those of you who haven’t heard about CHAIN, it’s a statewide team approach to coordinating the use of health care-associated infection in antimicrobial resistance prevention funds and we coordinate across the continuing of health care delivery to support patients, individuals and their families to prevent harm from infection acquired in the process of care and also to combat antibiotic resistance.

So CHAIN began in 2011 and it’s a partnership between the Minnesota Chapter of the Association of Professionals and Infection Control or APIC Minnesota, the Minnesota Department of Health, the Minnesota Hospital Association and Stratis Health. And then in early 2017, CHAIN expanded membership to include organizations representing providers

across care settings. So that includes long-term care. There's currently a long-term work group and on that work group is the Minnesota Department of Health, Care Providers of Minnesota, Leading Age Minnesota, the Minnesota Alliance of Geriatrics Inspired Practitioners or MAGIC and Stratis Health.

So our goals for this year through the end of this year are to coordinate, promote and support implementation and enhancement of the core elements of antibiotic stewardship across a continuum of care, promote and support coordination and communication across transition of care related to treating and preventing infections, increase awareness and share best practices for the prevention, control and containment of multi-drug resistance organisms or MDROs and recognize high performers and spread best practice. We do have an annual CHAIN conference that I suppose many of you have been to so keep your eye out and that's really where we celebrate those high performers with awards and that sort of thing.

If you're more interested in CHAIN we do have a website that you could just Google CHAIN Minnesota, or it is at www.mnreducinghai.org. So today though I'd like to highlight a resource that was developed by the Minnesota Department of Health and as I'm sure you're all aware, nursing homes are required to have a system of surveillance

in place designed to identify possible communicable diseases or infections before they can spread to others in the facility. And you're also required to have an antibiotic stewardship program in place that includes a system to monitor antibiotic use.

So CHAIN identified a need for an infection and antibiotic use tool that serves as an infection surveillance tool as well as an antibiotic use tracking tool. So MDH took that on and developed it.

So included in the agenda for this meeting there is a link to the tracking tool as well as a link to the instructions on how to use it. This tracking tool is in Excel format that you will automatically calculate infection rates for you and upon completion of the tool each month, you also have the ability to access data reports and charts that include days of antibiotic therapy rates, infection rates per 1,000 resident days, antibiotic prescription origin, for example, was it prescribed in the ED, the clinic, the hospital, long-term care center, the percent of infections meeting criteria and antimicrobial class utilization so you could see what classes of antibiotics you're using. So it's really a neat tool and you put your data in and it kind of figures all this stuff out for you. So if you're not currently -- well, you all have to be doing some kind of surveillance, but if you

really want to do more in-depth surveillance, this tool is really great.

Now, last Friday, on February 15, Cody Shardin, the developer of the tool, and Tammy Hale, the nurse specialist who leads the infection control assessment and response or ICAR team provided a webinar that introduced this tool. They used a screen share function. They walked through the basics of how to enter data into the monthly tracking sheets while following the accompanying instruction sheet. And they also addressed several questions they've had regarding the tool and walked through a summary sheet on how a facility can utilize the information obtained by completing the spreadsheet.

Now, that webinar if you happened to miss it, it was really excellent and if you happen to miss it, it was recorded. It's not yet available, but it will be available on the MDH website.

So that's all I've got, but I just wanted you all to make sure you were aware of this tracking tool that was developed. It's actually been updated a couple of times already based on feedback from users. That's all I've got. Thanks, Mary.

MARY: Thanks so much, Kristi. And I know that we wanted to connect with you and we'll see how our Q&A goes, but would folks just call -- what would be the best way to get

a hold of you, email you and what's your email?

KRISTI: Yes, probably email me. k w e r g as in George I N as in Nancy @stratishealth.org.

MARY: Great! Thank you so very, very much. We really appreciate your help.

KRISTI: You're welcome thanks for the opportunity.

MARY: Okay, so it's about 11:30 here and Bernard, I think we're going to key this up and move into our Q&A and we'd appreciate your help and if folks could -- if we have specific questions for Kristi, it would be great to prioritize those. Obviously, we have about a half hour here so we'll work that timeframe and, Bernard.

BERNARD: Yes, Ms. Absolon. At this time I would like to remind everyone, in order to ask a question, please press * and then the #1 on your telephone keypad. Again, *1 on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

MARY: Thank you very much.

BERNARD: You're welcome. Again, if you'd like to ask a question, please press * and then the number 1 on your telephone keypad. We have a question from 1 from Doug Beardsley from -- from Heath, your line is open.

DOUG: Hi, this is Doug Bear. Hey, Mary, and all, this is Doug Bearsley from Care _____ Minnesota. I guess I want to go back to the immediate jeopardy citations. I know we've

had some discussions about this. I looked at it using Q Core from calendar year 2018 for year to date 2019, and it looks like in 2018 there were 28 IJ issued at 21 facilities in calendar year 2018 by the Minnesota Department of Health and there's already been 14 issues in the first 45 days of 2019. That looks like it will be about a 245 percent increase year to year if it extrapolates out through the year. I don't see the same change occurring in either Region 5 that we're in or in the nation. So I'm wondering what's going on in Minnesota. Are we using a different survey protocol than the rest of the nation or is this part of the integration of complaints or can you -- any ideas about why we are almost tripling the number of IJ's recently?

MARY: I would just -- thank you very much that's one of the reasons why we are bringing this to people's attention. We wanted to identify the kind of areas that we have found. We have started -- when we integrated the federal complaints, we're following those same regulations and process that other states are. CMS is very closely watching what we're doing to assure that when we're appropriately going out in terms of citing things, that kind of thing as well as triaging the findings that we have are we would say that those are valid findings. One of the things that is maybe different is in our timeliness under

the federal guidelines there are certain areas, incidents that have to be investigated within two days depending on if they're a potential for an immediate jeopardy and then there are ones that are less severe and with our proximity of our team statewide and CMS prioritizes those at a higher level we are investigating all of those and the timeliness of that in connection with the reports that we're getting are quite close to each other. That may relate to that. At this point in time we are fairly new and we are open collectively to try and figure out why some of these things are happening in our state or and some of the underlying reasons for that and so I think at this point we're calling it as we're seeing it in that investigative process that we've been following.

DOUG: Okay, I think your observation is correct in that the minority of IJ's cited in 2018 were cited as a result of complaint surveys, but it appears the majority in 2019 are being cited as a result of complaint surveys so I think the one change that's obvious is the way complaint surveys are being handle and that seems to be resulting in more IJ's.

MARY: And we'll report on that data as we see it. It's only six weeks. I know one of the really wonderful things we have going on in Minnesota is we do have these statewide phone calls. We're able to get the word out and that's why

we prioritized even rescheduling this from yesterday because we did want to get this word out to all of our facilities and to bring this to folks' attention and as we worked together. That being said, it's interesting that from a national perspective that one of the focal areas that they're looking at is related to freedom of abuse and neglect and that's one of our areas that we have found and so we'll need to continue to monitor that and be vigilant with that. If you have any questions, we would encourage facilities to reach out to our supervisors in terms of information, that kind of thing and when there are those incidents of things that happen to be on top of it as soon as possible that really -- it makes a difference so and we thank you for all your work so.

DOUG: Thank you.

MARY: Bernard.

BERNARD: Yes, again, if you'd like to ask a question please press * and then the number 1 in your telephone keypad.

We have a question from one of our participants. Please state your first and last name and the name of your facility. Your line is open.

VERONICA: My name is Veronica Polinsky from Presbyterian Homes and I have a question about the antibiotic tracking tool. We have started using this at our sites and one of

the things that we found is that it is a challenge to try and print all of the information on the antibiotic tracking tool because there is columns. I'm wondering if there is a good recommendation as to how that can be printed because those are things that surveyors have been expecting us to provide to them when they come in for annual surveys.

KRISTI: Hi, Veronica, yeah, this is Kristi. Thanks for that question. Did you happen to -- were you on the call on Friday about the tool, did you happen to listen to that call?

VERONICA: I was not able to be on that call, no.

KRISTI: Well, Cody did discuss this and he gave some suggestions on how to print using screen and that kind of thing so I would recommend that you listen to the recording. The other option would be to contact -- I'm trying to see if I have his. I know Tammy's on -- to contact --

VERONICA: Is that Tammy Hale with MDH, Kristi?

KRISTI: Yes. I wonder if she has Cody's contact information because he's the developer. He could answer those questions way better than Cody Charden. Do you guys have --

VERONICA: Yeah, and I've spoken to him about it and he said to take screen shots, which is just a picture and then it usually comes out pretty blurry so that's a challenge

that we're going to face for being able to provide this to surveyors when they come out to the site.

MARY: Yeah, the tracking system, right, Veronica?

VERONICA: Correct.

MARY: So we need to work on that.

KRISTI: Okay, I can let Cody know about the concern that we heard, too.

MARY: Okay, thank you. Let's do that.

VERONICA: Great.

MARY: Thank you very much. Sometimes it's the logistics of just getting our work done and if we can make things easier we can work together on that and try to get some outreach with that. I'm glad that Jean is listening to that so she can piece that together with her staff also.

KRISTI: Yeah, and I know that they've done updates regularly based on these kind of questions so I'll make sure that he's aware of that because I don't believe he's on the call.

MARY: Thank you, Kristi. Okay, Bernard, next question.

BERNARD: Again, if you'd like to ask a question and then the number 1 on your telephone keypad. We have another question. Participants, please state your first and last name and the name of your facility. Your line is open.

PAULA: Paula Starling, Chapelview.

MARY: Hi, Paula, how are you.

PAULA: Hi. Thanks for the call today. Could you talk a little bit more about the -- with the complaint investigations and being aware of our federal survey cycle?

MARY: Yes, I'll be happy to talk about that. So when a provider is -- with the combination of the recertification survey and if there are complaint investigations that we're doing and we triage the facility-reported complaints just as they come in and there may be an unannounced inspection with that or not, sometimes what can happen is that there can be multiple visits the Department is making and potentially in those situations if we would issue a violation and if they're close together it means that your "survey cycle" and I'll explain that in a second is open and once a facility is identified as not being in substantial compliance, there's a six month time period that needs to occur where you need to get back into compliance and a lot of these situations happen very quickly where they're cited and you get back into compliance. Others because of the timeliness of the high priority complaint investigation, we're getting out there sooner and they may occur close to each other through -- based on the federal timeframe. And what's happening is some facilities may have a couple of these and then you get closer to that five or six months, so what the comment from the Department is, is to work on being in compliance to

avoid that and then if you are found out of compliance work at being in compliance, getting the plan of correction back to the Department approved and then closing that survey cycle.

PAULA: That's what that was about.

MARY: And it might get -- and if there's some specific questions at a survey or a complaint please ask our staff those questions. We, too, are saying to our staff, be aware of where a facility is. We're also doing that in relationship to onsite follow-up visits that we need to do and then assuring that when there is a plan of correction that that's actually followed through on and it's covered so that when we do go onsite that the correction is there so that's just more efficient and smooth for everyone. Thank you very much, Paula for raising that.

BERNARD: Our next question from Pam Cyler, your line is open.

MARY: Hi, Pam.

DEEDEE: Actually it's Deedee Weiland from Mount Olive Careview Home.

MARY: Okay. Hi, Deedee.

DEEDEE: And I just have a question regarding when you submit the initial OHFC report that you're saying to have more information in there. My understanding was you're supposed to report right away and then investigate.

MARY: We'll talk a little bit more in detail about that. That's the NHIR and I'm going to ask Pam Kursin to please comment on that.

PAM: Okay, thank you, Mary, I'd be glad to do that.

Per the regulations you do have timeframes and we understand that if it's regarding abuse or there's been a significant injury you've got your two hours in there, then, too, but now that Ellen See is doing triages we do see that many of the NHIR's have very brief information and what you have to understand is we triage that initial report based on what we get and so the example that Mary gave earlier that if it says something a resident or _____ sustained a subdural hematoma, of course, we all know in health care profession that that's a significant concern. So sometimes the more information that you can share I think would be beneficial. It doesn't mean that we don't -- sometimes we will triage something on face value, but depending what the incident is, but our triage staff are also at times contacting a facility before your five-day report is due. We realize you've got five days, but sometimes we need additional information to make sure -- to determine is this an IJ, do we need to get out there in two days, is it a non-IJ high or we need to give it the appropriate triage prioritization so. I guess the most -- a sentence doesn't really tell us a whole lot so if you can

give a little bit more information on that initial report and just be aware that sometimes you may be contacted by MDH triage specialist just to get some additional information. And then we also do review your five-day report when it comes in because sometimes that will make a difference on how we triage that.

MARY: And, Pam, this is information that the facility would have based on that initial incident and so it's based on just the nature of that and just a little bit more information. Some of them, what we've identified in some cases is that it's just extremely brief, it's just maybe a word or two or a very brief sentence and that there really is a little bit more information that there's even on that initial report and so we are working through that process and so that's the outreach that we're doing now to bring this to your attention.

PAM: Yes, exactly because sometimes initially within the two hours you haven't done your entire investigation and you have to -- you can include what you do know and that might be limited to you because you haven't conducted your investigation yet, but more than a sentence would be helpful.

MARY: And the piece about this, this is where this ties into the onsite visit is that under the federal guidelines MDH is required to triage based on that initial report and

so we're not waiting for the five-day, it's triaged based on that initial report and it's based on information that we have as face value. We are required then to make an onsite visit based on the level of priority and the example that we gave before was one with just the additional information, it would have certainly been relevant the fact that the person had fallen or had the hematoma prior to even being admitted in the nursing home. Okay, thank you very much, Pam.

DEEDEE: Thank you.

PAM: Welcome.

MARY: Bernard, take it away.

BERNARD: Yes, again, if you'd like to ask a question please press * then the number 1 on your telephone keypad. There are no questions at this time. Please continue, presenters.

MARY: Okay, thank you very much, Bernard, for your help and I'd like to thank Kristi and Pam and Brenda and Liz for all your work in pulling this together and once again we appreciate everyone's participation on this rescheduled call and hope that you all are safe if you happen to be in the snow part of Minnesota like some of us are and we look forward to our next call which will be -- let's see here, I know it's on our agenda -- Monday, May 13th from 11:00 to 12:00. Stay tuned to any new updates. We'll posting that

on the Health Department website and we wish you a wonderful February and March. Take care.

BERNARD: Ladies and gentlemen, this concludes this conference call. You may now disconnect. Presenters, please stand by. (THE END)

BOS:bsg
99999 - 02/28/2019 05:04:08