Rule Advisory Committee Meeting
January 14, 2019

Attending:
Lynn Beaton, Policy Analyst, DHS/APD/SOQ - Facilitator
Gwen Dayton, General Counsel, OHCA
Phil Bently, OHCA
Mike McCormick, Deputy Dirctor DHS/APD
Robert Gust, AFH Policy Analyst DHS/SOQ
Debbie Concidine, CBC Policy Analyst, DHS/SOQ
Jeanne Bristol, Survey Manager, DHS/SOQ
Warren Bird, CBC Policy Analyst, DHS/SOQ
Jan Karlen, Policy Analyst DHS/SOQ
? Oregon Medical Board
Lia Knauss – AFH Licensor, iNorthwest Seniors and Disabilities
Heidi Rowell, Alzheimer's Association of Oregon and SW Washington
Kimberly Colkitt- Hallman, Rules Coordinator, DHS?APD
Barb Hansen, Oregon Hospice and Palliative Care Association, Check
Ruth Gulyas, CEO LeadingAge Oregon
Maureen Nash, MD, Providence ElderPlace
Petronella Donovan, AFH provider,
Kendall Mason, SEIU
Bob Weir, Policy Analyst, APD
Fred Steele, JD, LTC Ombudsman's Office

Mike McCormick provided an explanation for the draft rules.

- During the HB 3262 meetings issues were identified discussed, and recognition of opportunities for improvement.
- Report was completed in December of 2017 on how bill could be improved and was widely distributed and appreciated by the Oregon Legislature. It has been decided not to pursue any further legislation, however rules needed to be implemented.
- Consulted with DOJ on what we could or could not do, they gave us more authority than we thought we had, for example impose prescribing authority for physicians, but the department decided not to pursue that.
- Our approach to adopting HB 3262:
    - Consistent definition for psychotropic medications across all settings, using the definition from nursing facilities;

    - Consistent definition for primary care provider across all settings
    - Require facilities to contact the primary care provider when another licensed healthcare provider has prescribed a psychotropic medication.
    - Through the evaluation and service planning process facilities must demonstrate they have attempted non-pharmacological interventions.
- These same concepts and rule language will be incorporated into the AFH rules.
- The RAC was set up intentionaly to ensure that AFH providers understand that this same rule language/concepts will be incorporated into the AFH rules.

Discussion:

- Comment from OHCA - overarching concerns HB 3262 some of the draft rules are outside the scope of the statute. Statute requires different reporting than what is stated in the rules. Has the department considered these issues?
  DHS response – DHS is exercising broad regulatory authority to develop rules based on the legislation, and the language that allows us to adopt other rules to carry out the law. It was noted there may be areas that are lacking, however the department is using its broad authority to implement the rules that meet the intent of HB 3262.
- OHCA 3262 are codified – draft rules are different in that these rules require facilities to report vs. licensed healthcare providers to report to primary care providers. HB 3262 require physicians to report, cannot swap out, has to implement the law as written. Bill also directs other things such as prescriptions for 7 days. Also violating the law if you don't follow a legal prescription.
- DHS Response - DHS is not adopting rules around all the provisions in 3262. Only implementing the provisions that we feel that are within our normal regulatory authority as faithfully as possible.
- What other agencies are taking action on this legislation?
  DHS response , we not aware of any other agencies

Review of draft rules:

Definitions:

Primary Care Provider - "Primary Care Provider" (PCP) means the health care provider primarily responsible for the on-going diagnosis and treatment of the resident where they currently reside.

Discussion –

- Definition is stated exactly as in the final report that was sent to the Legislature in December 2017.
- Question as to who designates the PCP, would it be a medical director if an ALF or RCF has one.
  Response – Typically there is a PCP that is on record when a resident moves into the facility. The resident would also have a say as who their PCP should be. However, if a resident doesn't have a PCP or their PCP doesn't want to follow the resident at the RCF/ALF or AFH, then the facility may be able to designate the PCP while they are residing at the facility.
- Mental health providers – mental health prescriber is the one who will sign the prescription for mental health concerns, and the PCP doesn't always know about the prescription.
- AFH Providers - Other providers such as mental health providers or neurologists will write orders that are not clear. It is very difficult to get the PCP to write clarifying orders when another provider has written them. Many times the contract RN will have to contact a provider to ensure an order is clear. Does the medical board
- AFH rules do not require the home to inform the physician when a new medication has been ordered by another provider, however it should not be considered a burden to notify that physician. Would be a good idea, because there could be several side effects of those medications.
- The issue of a community physician not communicating with a medical director or PCP is a concern system wide, not just with AFHs or RCFs and ALFS. Is it reasonable for all facility types to notify the physician when there are medication changes?
  - Response from OHCA– the bill doesn't direct that, it is considered illegal and imposes an obligation on facilities where they may not know who all the providers are.
  - May be two separate issues as to who is the PCP and who should be informing the PCP.
- More discussion on what has been drafted into these rules is in conflict with HB 3262 in that OHCA believe that the language is clear that the

licensed healthcare provider who orders a psychotropic medication is the one responsible for notifying the residents PCP.
DHS Response – DHS is implementing the intent of HB 3262 with their overarching regulatory authority to ensure as much as possible that psychotropic medications are prescribed appropriately and that a resident's PCP is informed of psychotropic medication prescriptions when another licensed health care provider orders that medication. There will be an opportunity at the hearing for more comments.

Psychotropic Medications - Psychotropic Medications" means any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to drugs in the following categories:

(a) Anti-psychotic.
(b) Anti-depressant.
(c) Anti-anxiety.
(d) Hypnotic

Definition already is being used in nursing facility regulations and has been adopted in the AFH rules and now being adopted into the RCF and ALF rules. This definition would be consistent across all settings.

Discussion –

- Want to make sure the definition is used consistently.
- Is there a formulary list – the definition includes the four categories that are the most prescribed psychotropic medications. There should be a list. The AFH industry would need a list of the medications and different classes of medications. There is a top 20 list that needs to be available to all AFHs. Question as how would the list be updated. We can check on the nursing facility regulations for more medications and classes of medications.
- Would this also cover over the counter as well as prescription and would supplements be included? Over the counter medications in all settings have to be prescribed.
- What about medical marijuana or CBD oil. Marijuana, is not prescribed, but would it fall under this definition?

Resident Evaluation - "Resident Evaluation" means an evaluation that uses the information obtained when addressing the elements required in OAR 411-054-0034 (5). The evaluation identifies the resident's preferences, strengths,

relationships and activities that are meaningful to them as well as their physical health status and environmental factors that help them function at their optimal level. The resident evaluation provides the foundation of the resident's service plan.

Discussion:

- Suggest that the definition ends at the first sentence, because it is already described in the body of the rule. Delete the reference to sub paragraph 5. Use the language that is currently in the definition when referring to it in OAR 411-054-0034.

OAR 411-054-0034 – Resident Move-in and Evaluation

Review of changes to Resident Evaluation. Seems reasonable, but will review in terms of HB 3262 and person centered assessment. Resident evaluation is used more broadly than just in terms of psychotropic medications.

OAR 411-054-0055 (6) (b)Psychotropic medications:

Discussion:

- What if someone moves in with prescription of a psychotropic medication, what does the facility do?
- Evaluation drives the service planning process but doesn't make the determination about what non-pharmacological interventions need to be used, that is the function of the service planning process. So, this needs to be revised.
- In the adult foster home there is the screening and care planning process, is the screening the same as the evaluation process and care plan the same as service plan? Yes
- Also, the timing of doing the evaluation, evaluations are required at time of move-in and quarterly, as well as change of condition. Would a facility be required to do the evaluation within a couple or few weeks before the next evaluation us due? Possibly if there is a change of condition.

Suggested wording:

Prior to requesting a psychotropic medication, the facility must evaluate the resident and develop a service plan that demonstrates non-pharmacological interventions have been attempted. Concern that this is adding a requirement that may not be required.

- Need to look at language
- If there is something that is going to be added, there is a section on the care plan for psychotropic medications.

OAR 411-054-0055 (6) (d) Requirement to notify primary care provider:
Discussion:

- It is unlawful because it is outside the statute, nor any of the law, because and should be struck. And suggest that these be struck
- Concern that providers often don't know when the order is given or who gives the order. Should be re-worded to "when a facility is notified".
- Medical providers (prescribers) don't know or understand the different long-term care settings.
- Comment regarding HB 3262 requiring the licensed health care provider (other than the primary care provider) to notify the Primary care provider and the report on page 12 where it says "Provide the OMB and OSBN with the explicit authority to adopt rules necessary to carry out the provisions of this bill…. The expectation would be for OMB and OSBN to write rules regarding notification. To DHS's knowledge that has not happened. However, DOJ has said that DHS does have the authority to do so.
- Need to address notifying mental health providers. Need definition for mental health provider. Look at other rules or statutes. Previous discussion with the recommendation of HB 3262 workgroup was to put into the same definition as PCP.

Suggested language -
When a psychotropic medication is ordered by a health care practitioner other than the resident's primary care provider, or mental health provider, the facility is responsible for notifying the resident's primary care provider of that medication order within 72 hours of **when the facility is notified of the order**. This includes weekends and holidays. Notification may be either by telephone or electronic submission and should be documented by the facility.

Ending comments:
Concepts will be discussed in the AFH RAC tomorrow (January 15, 2019.