www.qualitycouncilnh.org
nhdsqc@gmail.com

New Hampshire
NHDDQC
Developmental Services Quality Council

August 15, 2024

Erica Ross-Skianes
Program Planner III
Office of Client and Legal Services
New Hampshire Department of Health and Human Services
105 Pleasant Street
Concord, NH 03301

Re: He-M 1201 HEALTHCARE COORDINATION AND ADMINISTRATION OF MEDICATIONS

Dear Erica,

Thank you for the opportunity to provide input on the He-M 1201 rule prior to the start of the informal comment period. This feedback to you was approved by the Quality Council on XXXX.

Overview

As shared in previous comments, the Quality Council wants to encourage BDS to provide additional support to people with disabilities and families to understand the regulations and regulatory process. Simple changes like adding the title/topic when a rule references another rule would help with ease of understanding.

We also encourage BDS to develop or support the development of a guide to the regulatory process in plain language to be shared widely with people with disabilities and their families. We are pleased that BDS is developing a develop a plain language version of the He-M 310s and hope this expands to other rules.

Finally, the Council recommends the use of gender neutral language rather than his or her throughout this document.

He-M 1201.02 Definitions

(a) "Family residence" means a residence that is:
(1) Operated by an person or family residing therein; and
(2) Under contract with a provider agency.

The Council recommends that this definition is assessed to ensure that this also applies to a person with disabilities living in their own residence.

(m) "Frail health" means an acute or chronic medical condition that results in the inability of the individual to perform activities of daily living or daily

routines which the individual previously had the ability to perform, and which has been identified by a nurse trainer to require ongoing monitoring to guard against deterioration.

The Council would like more information about how this term is used in the rule and whether this is the best term to use as it appears this term is used to describe people in declining health. Perhaps life threatening, acute or complex is better. The Council recommends that this term is revised and better defined in the revision.

(o) "Licensed person" means one of the following persons, who are licensed or registered in the state of New Hampshire:

(1) A registered nurse;
(2) A licensed practical nurse;
(3) An advanced practice registered nurse;
(4) A physician;
(5) A pharmacist;
(6) A physician assistant;
(7) An optometrist
(8) A podiatrist;
(9) A dentist.

The Council is confused about this list of licensed persons and encourages the Department to assess whether other licensed persons like psychologists or psychiatrists should be included.

x) "Prescribing practitioner" means a licensed professional with prescriptive authority, including the following:

(1) Physician;
(2) Advanced practice registered nurse (A.P.R.N.);
(3) Dentist;
(4) Physician's assistant;
(5) Optometrist; and
(6) Podiatrist.

The Council recommends adding psychiatrist and psychologist to this list.

He-M 1201.03 Healthcare Coordination.

(a) A nurse trainer shall meet with each individual residing in a residence certified pursuant to He-M 1001 and his or her provider within 30 days of the individual's residency, and annually thereafter, to review the level of support provided.

(b) A review pursuant to (a) above shall include:

(1) For each individual;
a. Health history information;
b. Health Risk Screening Tool (HRST) monthly data tracker information;
c. Supports provided to maintain physical, mental, and social well-being as reflected in the service agreement pursuant to He-M 503.02 (t)(1)-(3); and
(2) The identification of individuals in frail health.

As noted above, the Council would like additional information regarding "individuals in frail health". How are these individuals tracked differently? What is done with this information? Is it reviewed by the medication committee or other committees?

The Council has a number of suggestions to improve the language of the section below section which is relevant when someone with a disability is accompanied to a medical appointment by someone else.

(d) Providers accompanying an individual receiving services pursuant to He-M 1001, He-M 507, He- M 518, He-M 521, He-M 524, or He-M 525, as applicable, to a non-emergent medical appointment shall have, at a minimum, the following information:

(1) The reason(s) or purpose for seeking non-emergent care;

It is important that the provide is able to provide data include trends, changes, things that indicate need for medical assessment to the medical professional. It is important that the person seeking care or person accompanying them is able to communicate important health information to the provide.

It is also important that the rule makes it clear that there must be time in the medical appointment for the person with disabilities to share information.

(2)(3) A list of the individual's current medications, allergies, and any recent diagnostic or laboratory testing, as applicable; and

(4) Relevant information reflected within the Health Risk Screening Tool (HRST) monthly data tracker.

The Council encourages BDS to assess whether the HRST is necessary when seeking services. It appears that it might dissuade someone from sharing.

(5) Contact information for other affiliated medical professionals

The Council believes that #5 above should be added. It is important that medical professionals know if other medical professionals are involved in the person's care.

He-M 1201.04 Medication Administration.

(h) Medication orders and protocols shall be valid for no more than one year unless otherwise specified by the prescribing practitioner.

The Council believes that this should be changed to 13 months to allow for any unexpected delays in scheduling or having a yearly check up. This could include snow storms, provider shortages or many other reasons.

(1) PRN protocols that shall include:

a. The specific condition(s) for which the medication is ordered;

b. A maximum daily dosage;

c. The interval between doses;

d. Any special instructions approved by a nurse trainer or prescribing practitioner, and

e. Review by a nurse trainer in accordance with the orders of the prescribing practitioner, but no less frequently than 2 years from the date of the protocol.

The Council recommends adding a provision that PRN protocols comply with the requirements for behavioral intervention plans as outlined in He-M 310 when the PRN is related to behavioral issues and respect the rights of people with disabilities as outlined more broadly in He-M 310.

(l) In the event of discovery of a medication error, or of a medication refusal, an authorized provider shall:
(1) Consult immediately with a nurse trainer or licensed designee or the individual's prescribing practitioner or licensed designee concerning any actions to be taken;
The Council wants to make sure that some organization is tracking whether "action to be taken" as referenced above actually occurs. Who tracks this now? It is important that the service coordinator, area agency and BDS are aware of errors.
It is also important that someone is tracking any potential repercussions of the medication error, assessing whether it is part of a larger pattern of errors and how this error can be prevented in the future.
(2) Document each medication error or individual's refusal pursuant to He-M 1201.07 (k) immediately upon discovery of the medication error or the individual's refusal; and
(3) Forward the documentation to the nurse trainer within 24 hours.

He-M 1201.05 Self-Administration of Medication
The Council is concerned about this section of the rule, particularly that the expectations outlined exclude some people with disabilities from the independence of self-administering medication unnecessarily, restricting their independence. As one example, the Council understands, about 10 years ago, people who self administer medications lost the ability to use pill planners to assist with self administering. People with disabilities should be able to use many types of assistance with to retain this ability. In addition, there are a number of virtual/electronic technologies to assist with self administration that are not captured below. Also, people with disabilities should be able to request a reasonable accommodation in this process that is not captured here. Finally, the Council urges the Department to consider the supported medication model as part of the spectrum of self administration.
The Council urges BDS to consider whether the inability to administer one type of medication like eye drops would restrict the individual from self administering any medication. This seems unreasonable. Many people, with and without disabilities, have trouble administering some medications without supports. In addition, many of these medications are only administered for a short period of time and should not limit the ability of the person to self administer medications for the long term. We also urge BDS to consider whether someone who is not authorized could help with medication administration in some circumstances. Ultimately, it should be the decision of the person with disabilities with some oversight.
Related, the Council urges BDS to consider whether self administration of medication could be appropriate in some emergency situations in some cases like a snow storm.
Overall, the Council believes that BDS should look closely at this section to try to expand the ability of people with disabilities to self administer medications and retain their independence.
(a) An individual shall be presumed to be capable to self-administer medications unless the individual:
(1) Has been appointed a guardian, pursuant to RSA 464-A, with the authority to consent to or approve of medical treatment or care; or
(2) Has been assessed pursuant to (b) and (c) below and does not demonstrate the ability to self- administer medications.

(b) An individual who wishes to self-administer medication(s), with the approval of his or her guardian, if applicable, shall be assessed by a nurse trainer and determined to be capable of self-administering medications if the individual demonstrates the ability to do the following:
The Council suggests clarifying that a request for support does automatically indicate that someone is not capable of self administering medication.
(1) Identify each medication;
(2) Indicate the purpose of each medication;
(3) Indicate the dosage, frequency, time, and route of administration for each medication;
(4) Understand the potential consequences of not taking the medication or of not taking the medication properly;
(5) Indicate circumstances for which assistance should be sought from licensed persons; and
(6) Seek assistance, if needed, from authorized persons.
The Council suggests a further look at whether authorized person is the best word to use to describe the person who is able to help.

He-M 1201.06 Training and Authorization of Providers.
(a) Providers who request training to be authorized to administer medications shall complete a training program that:
(1) Includes of a minimum of 8 hours of classroom training, exclusive of testing or nurse trainer evaluation of whether or not the provider is competent;
(2) Is conducted by a nurse trainer and utilizes the New Hampshire state-approved written curriculum and test distributed by the bureau of developmental services; and
The Council encourages BDS to consider whether some of this training could be provided virtually.
(3) Covers the following topics:
a. Effective health care coordination;
b. The role, responsibilities, and performance of the authorized provider in the medication administration process;
c. The rights of the individual regarding accepting or refusing medications;
d. Principles of infection control as they relate to medication administration;
e. Anatomy and physiology as they relate to medication administration;
f. Common reactions to medications;
g. Categories of medications and their effects;
The Council encourages the addition of “Side effects and related symptoms” to this list. It is important that these individuals understand and monitor for potential long and short term side effects of medication. It is also important that administrators of medication stay current on emerging issues and newly identified/understood side effects of medication.
h. Effective management of poisoning or medication overdose;
The Council encourages BDS to consider whether Narcan could be considered allowable for an overdose like an EpiPen is now.
i. Storage and disposal of medications;
j. Communication with individuals or guardian, if applicable, about the individual’s medications;

k. The 6 principles of medication administration, including:
1. The correct medication;
2. The correct dosage of the medication;
3. The medication to the correct individual;
4. The medication at the correct time;
5. The medication to the individual by the correct method; and
6. The accurate documentation;
l. Methods of administration including:
1. Oral;
2. Topical;
3. Inhalant;
4. Sublingual;
5. Transdermal;
6. Nasal;
7. Ocular;
8. Auricular;
9. Vaginal;
10. Rectal; and
11. When indicated by the needs of the individual:
(i) Subcutaneous;
(ii) Enteral; and
(iii) Intramuscular only for epinephrine from a labeled and pre-set or pre-drawn delivery system; and
m. Methods of documenting:
1. The administration of medications;
2. The use of controlled substances; and
3. Medication errors or refusals.

The Council encourages BDS to consider adding this documentation to the monthly data capture and to consider whether this should be included in He-M 506.

The Council encourages BDS to add training on communicating with medical providers and how to support the individual to do communicate with medical providers to this list.

He-M 1201.07 Documentation.

(a) Documentation of medication administration shall be performed and maintained by authorized providers or licensed persons only.

(b) Authorized providers and licensed persons shall document medication administration only for those medications that they administered themselves.

(c) For each individual for whom medications are administered, an authorized provider shall maintain documentation of medication administration that includes:

(1) The name of the individual;
(2) If applicable, the guardian's name and contact information;

(3) Allergies, if applicable; and
(4) For each medication prescribed:
a. The name;
b. The dosage;
c. The frequency of administration;
d. The route of administration;
e. The date and time of administration;
f. The name of the prescribing practitioner;
g. The order date; and
h. Special considerations in administering the medication, if applicable, as directed by the prescribing practitioner or the pharmacist.
The Council recommends adding "Supplemental instructions on the process to administer the medication (yogurt, crushed, etc)".

(d) The authorized provider or licensed person shall document all medication administration on the individual's medication log as soon as possible following administration including, at a minimum, elements specified in Nur 404.
The Council recommends adding "and within 24 hours" after as soon as possible. This will make the requirement clearer to ensure medication administration documentation happens quickly.

(h) When a controlled drug is prescribed for an individual, authorized providers or licensed persons shall maintain an inventory that includes:
(1) The name of the drug and strength;
(2) The amount used;
(3) The amount remaining;
(4) The signature of the authorized provider or licensed person who administers the controlled medication;
(5) Documentation of a daily count; and
(6) If applicable, documentation of disposal in the presence of 2 people, at least one of whom is a licensed person.
The Council recommends that NARCAN be added to the inventory when applicable. It is easily available and critical in an overdose.

(k) Upon discovery of each medication error, and each time an individual refuses medications, except as noted in He-M 1201.04 (m), the authorized provider or licensed person shall document, at a minimum, the following:
(1) The individual's name;
(2) The date and time of medication error or individual's refusal;
(3) The drug name, dosage, frequency, and route of administration;
(4) A description of the medication error or individual's refusal;
(5) Date and time of consultation of a licensed person, pursuant to He-M 1201.04 (l);
(6) Actions recommended by the licensed person;
(7) Actions taken by the authorized provider; and

(8) Date and time of notification of a nurse trainer.
(l) The nurse trainer shall submit a written report to the area agency, and subcontract agency within 5 business days regarding any authorized provider or licensed person who demonstrates a pattern of noncompliance with He-M 1201 as determined by Nur 404, and include documentation from (k) above.

The Council recommends that reports of medication errors are submitted to the area agency, provider agency and service coordinator.

The Council requests additional information regarding what happens after a medication error or refusal to take medications is reported. What are these organizations supposed to do with the report? Is this addressed in HeM 504? If not, it is important to clarify the next step here. The Council also requests information about what happens when the error involves a licensed nurse.

He-M 1201.09 Quality Review.
(a) A nurse trainer or licensed designee shall review the following for all individuals whose medications are administered by authorized providers:
(1) Documentation that the provider administering the medication(s) holds a current authorization;
(2) Medication orders and PRN protocols;
(3) Medication labels and medications listed on the medication log to ensure that they match the prescribing practitioner's orders;
(4) Medication logs to ensure that documentation indicates:
a. That medication was administered as prescribed;
b. Refusal by the individual to take medication, if applicable;
c. Any medication occurrences; and
(5) Medication storage to ensure compliance with He-M 1201.08; and
(6) Controlled drug inventory pursuant to He-M 1201.07(h).
(b) Reviews pursuant to (a) above shall occur according to the following timeframes:
(1) At least once every 6 calendar months, for:
a. Family residences with 3 or fewer individuals certified pursuant to He-M 1001; and
Does this apply only to enhanced family care residences or other residences? It is important to use consistent terms throughout all rules whenever possible.
b. Individuals receiving medication administration in accordance with these rules and services pursuant to He-M 521, He-M 524, or He-M 525;
(2) At least monthly for the first 3 months for newly eligible individuals beginning services or for individuals receiving services in a new setting, with the initial review occurring at least 30 days after the individual begins service or moves into a new setting;
(3) At least once every 6 calendar months, for authorized providers who:
a. Administer medications but do not reside in the family with 3 or fewer individuals
Again, is this consistent with other rules? Does this apply to other residences?
b. Administer medications in programs certified under both He-M 507 and He-M 1001; and

(4) At least monthly, for all other settings in which authorized providers administer medications.
(c) Any deficiencies discovered and documented by the nurse trainer pursuant to the required review in
(a) above shall not result in deficiencies cited during a certification review pursuant to He-M 1001.

The Council is concerned about reporting and tracking of deficiencies. Where do the documented deficiencies get reported? Then, how are these corrected if they don't get cited during the review? The Council recommend adding language related to the "quality review" process and expectation for correction within a reasonable time frame (especially for egregious errors or consistent patterns of errors).

(d) The nurse trainer shall submit information regarding patterns of non-compliance, as demonstrated by reports in He-M 1201.07 (Documentation) (l) above, to the medication committee pursuant to He-M 1201.11

Again, the Council recommends additional detail regarding these pattens. At minimum, patterns of noncompliance must be reported via the 6 month Medication report.
(e) The provider agency shall retain the documentation of reviews for at least 6 years, with the most current year kept in the individual's record.

He-M 1201.11 Medication Committee.
(a) The bureau administrator shall appoint a medication committee to review information summarized and submitted on forms required by (g) below.
(b) The committee shall be composed of at least the following:
(1) The medical director of the bureau or physician designee who shall serve as chairperson of the committee;
(2) Two registered nurses from provider agencies;
(3) Two non-nurse representatives from provider agencies; and
(4) A representative of the bureau.
(c) Each provider agency shall complete and submit to the area agency Form 1201-A "Six Month Nurse Trainer Report to NH Bureau of Developmental Services Medication Committee – For Programs with Reportable Errors" (May 2020), or Form 1201-A Short "Programs Without Reportable Errors - Six Month Nurse Trainer Report to NH Bureau of Developmental Services Medication Committee" (May 2020) and Form 1201-B "Six Month Provider Agency Report to NH Bureau of Developmental Services Medication Committee" (May 2020) according to Table 12.1.1 for each service in which authorized providers administer medications.
(d) Using Form 1201-C "Six Month Area Agency Report to NH Bureau of Developmental Services Medication Committee" (May 2020), an area agency shall report on each provider agency's performance regarding medication administration based on the information submitted through Form 1201-A and Form 1201-B.

(e) Area agencies shall submit reports prepared on Forms 1201-A, 1201-B, and 1201-C to the bureau.
(f) Area agencies and provider agencies shall submit reports in accordance with Table 12.1.1 below:
The Council recommends adding a requirement that the area agencies send reminders to the provider agencies about due dates for these to the provider agency's nurse trainer so that this is communicated consistently. Perhaps it could go into HRST.

(a) The medication committee shall evaluate reports submitted pursuant to (f) above.
(b) Upon evaluation of reports submitted pursuant to (f) above, the medication committee shall:
(1) Recommend that the bureau administrator accept the report if, as demonstrated by the reports, the area agency or provider agency has complied with the provisions of He-M 1201;
(2) Request that additional information be submitted by the area agency; and
(3) Identify areas of non-compliance, as demonstrated by the reports, for those area agencies or provider agencies that failed to comply with the provisions of He-M 1201, and make recommendations:
a. To the area agency regarding plans for monitoring, oversight, and quality improvement; and
b. To the bureau administrator for corrective actions to be taken by those area agencies or provider agencies identified.

The Council recommends that there is additional detail here including timelines for a and b above.
(a) The bureau administrator shall:
(1) Review all recommendations for corrective action made pursuant to (j)(3) above;
(2) Require the area agency or provider agency to take corrective action if he or she determines that the action is necessary for the area agency or provider agency to be in compliance with the provisions of He-M 1201; and
(3) Send written notification of the required corrective actions in (2) above to the area agency or provider agency.
(b) Within 30 days of the date of the written notification in (h)(3) above, the area agency or provider agency shall forward the corrective action plan to the medication committee and fully implement the plan.

The Council recommends that the rule includes a process to assess whether the corrective action plan has been fully implemented and specifics about who is responsible for this.

He-M 1201.12 Revocation.
(a) The bureau administrator shall revoke the designations of those nurse trainers and authorizations to administer medications of those providers in programs where corrective action has been required, under the following circumstances:

The Council recommends additional details about whether a revocation of this designation means that all the people who are authorized to administer medications under that nurse's designation also lose this authorization and would have to be retrained/assessed to continue to administrate meds. This language is not clear.

He-M 1201.14 Waivers.

(a) An area agency, provider agency or individual may request a waiver of specific procedures outlined in this chapter, in writing, from the department.

(b) The entity requesting a waiver shall:

(1) Complete the form entitled "NH Bureau of Developmental Services Request for Waiver to He-M 1201" (May 2020 edition) certifying that policies and procedures are in place for:

a. Nurse trainer oversight of authorized staff; and

b. Communication protocols between day and residential services; and

(2) Include a signature from the individual(s) or legal guardian(s) indicating agreement with the request and the area agency's executive director or designee recommending approval of the waiver.

(c) All information entered on the forms described in (b) above shall be typewritten or otherwise legibly written.

The Council is not sure this is necessary. It should be consistent with other rules.

(d) No provision or procedure prescribed by statute shall be waived.

(e) The request for waiver shall be granted by the commissioner of the department or his or her designee within 30 days if the alternative proposed by the requesting entity meets the objective or intent of the rule and it:

(1) Does not negatively impact the health or safety of the individual(s); and

(2) Does not affect the quality of services to the individual(s).

(f) The determination on the request for a waiver shall be made within 30 days of the receipt of the request.

(g) Upon receipt of approval of a waiver request, the area agency's, individual's, or provider agency's subsequent compliance with the alternative provisions or procedures approved in the waiver shall be considered compliance with the rule for which waiver was sought.

(h) Waivers shall be granted in writing for the minimum period necessary to accomplish the waiver request's purpose, with the specific duration not to exceed 5 years.

(i) All waivers related to certified settings shall end with the termination of certification.

(j) An area agency, provider agency or individual may request a renewal of a waiver from the department. Such request shall be made at least 90 days prior to the expiration of a current waiver.

(k) A request for renewal of a waiver shall be approved in accordance with the criteria specified in (e)
above.

As noted in previous comments, the Council believes that people with disabilities and families could benefit from additional information regarding waivers, including what is and is not in statute and therefore eligible for a waiver. The Council suggests a one-page document with this information.

As noted in previous rules comments, the Council recommends that information about any current waivers be available on the provider's website. This could include all waivers received, trended data on specific rules waivers and information about efforts to come into compliance with the waivered rule. The rules should also set specific timelines for the Bureau to respond to waiver requests, ideally within 72 hours.

Thank you for the opportunity to provide these comments.
Sincerely,

Stephanie Patrick, Council Chair
Isadora Rodriguez-Legendre, Council Vice-Chair