Nursing & Assisted Living Facility Professional

"NEWS AND VIEWS YOU CAN REALLY USE"

2014
ISSUES 1-12, VOLUME 4

SENT EACH MONTH TO YOU AS A MEMBER OF THE HEALTHCARE HEROES

THE HAT ADVANTAGE

by Rebecca Adelman

Resolutions for a New Year in Nursing and Assisted Living - Issue 1, Volume 4

The Year Ahead – 2014; Aging Services and Senior Housing – Issue 2, Volume 4

Person Centered Care – Quality of Care – Issue 3, Volume 4

All Eyes on Adverse Events in LTC and ALF Including Plaintiffs' Attorneys *Risk Reduction and Litigation Reduction* – Issue 4, Volume 4

On the Horizon for Long Term Care and Assisted Living – Issue 5, Volume 4

The LTC Medical Director – Survey Implications and Support – Issue 6, Volume 4

The Assisted Living Physician and Nurse Practitioner – The Health Care Leaders – Issue 7, Volume 4 Nursing Home Emergency Preparedness: Filling in the Gaps – Issue 8, Volume 4

Achieving a Focused Work-Life Balance – Issue 9, Volume 4

Unavoidable Pressure Ulcers – They Do Occur! – Issue 10, Volume 4

Pressure Ulcer Prevention and Treatment – Issue 11, Volume 4

Resolutions for a New Year in Nursing and Assisted Living – Issue 12, Volume 4

Nursing & Assisted Living Facility *Professional*

"NEWS AND VIEWS YOU CAN REALLY USE"

JANUARY 2014
ISSUE 1, VOLUME 4

SENT EACH MONTH TO YOU AS A MEMBER OF THE HEALTHCARE HEROES

THE HAT ADVANTAGE by Rebecca Adelman

RESOLUTIONS FOR A NEW YEAR IN NURSING AND ASSISTED LIVING

"We will open the book. Its pages are blank. We are going to put words on them ourselves. The book is called Opportunity and its first chapter is New Year's Day." – Edith Lovejoy Pierce

Welcome to the New Year 2014! The third year of the newsletter introduced a new name and style and expanded offerings including new contributors, the *Education Arena*, and the NAL Professional Hot Button. Stay tuned in 2014 for more exciting new features. Last year presented various challenges to the healthcare industry; however, there were also things worth celebrating (see December 2012 newsletter story). In the spirit of learning from the past to enhance the future, I have compiled "Resolution List 2014" in hopes of setting goals for those committed to the nursing and assisted living industry. The list highlights newsletter articles from the past year.

QAPI – Continuing Quality Improvement – Organizations have been changing and creating new infrastructures and policies and procedures for implementing QAPI. Expanded leadership and operations and comprehensive training is also necessary. In 2013, CMS rolled out QAPI Tools as a resource for nursing homes. A few tool highlights include: the *QAPI Self-Assessment Tool* used to begin work on QAPI and subsequently for annual or semiannual evaluation of the organization's progress; *Guide for Developing Purpose, Guiding Principles, and Scope of QAPI* used to establish the purpose, guiding principles and scope for QAPI within the organization; *Guide for Developing a QAPI Plan* used as a guide for the organization's performance improvement efforts; and *Goal Setting Worksheet* which is important for any measurement related to performance improvement. Resources have also been identified by CMS. Continue to develop best practices for risk reduction and quality of case at all levels will promote the most effective QAPI.

Understand Assisted Living Provider and Resident Care Litigation Risks - By understanding the litigation risks facing the healthcare industry, we can develop more comprehensive defense strategies. Being knowledgeable about legal duties imposed on nursing and assisted living will serve as a foundation of that understanding. Legal duties are governed by the following: 1) *State Health Care and Malpractice Act* – Most states have legislation that governs medical malpractice or healthcare liability and establish the elements that a Plaintiff must prove in order to support a claim including the burden of proof and standard of care presented by qualified experts; 2) *Statutes and Regulations* – Statutes and Regulations governing the rights of residents, Assisted Living operations and protection of vulnerable adults are used by Plaintiff's attorneys to establish liability for violation of specific statutes particularly related to admissions,

Continued on page 3

IN THIS ISSUE:

PAGE TWO:

- **Pathway to Rehabilitation Excellence**
- **The Scrabble Game Grand Prize Winner - Plus This Month's New Contest**

PAGE FOUR:

- **Dart Chart Systems**
- **Update Your Contact Information**

KESSLER'S CORNER

by Chip Kessler

"My Daughter's Speeding Ticket"

Funny how you might believe that once your children become adults they may not rely on their parents as much. Think back to those times your mother or father said something that made you feel like a child, and yet you were well over the age of 21. And so it was the other night when my 22 year old daughter Brooke called me in tears because she got stopped doing 40 in a 20 miles per hour zone. Her excuse: *I thought the speed limit was 40!"* So now she'll get to experience going to traffic court, and maybe what's called "driver's school" to get the speeding ticket taken off her driving record, if the judge says she can do this. Plus there's the matter of the ticket and its price tag of $102.50 which I've already informed her she'll have to pay

Continued on page 3

Pathway to Rehabilitation Excellence

By Cherie Rowell, COTA

Director of Clinical Services

DISCHARGE PLANNING: PREVENTING RE-HOSPITALIZATION

Is your patient ready to go home?

Comprehensive discharge planning has become a key component of care planning in long term care settings as increased scrutiny and pending financial sanctions loom for both hospital and nursing home health care providers. How do we ensure that the patients we serve are ready to return home safely and at their highest level of independence?

The Pathway for a Safe Return Home

Functional Pathways has developed a comprehensive interdisciplinary discharge-planning tool to ensure each patient has achieved the functional capacity and skills necessary for a safe discharge. Whether the patient will remain in long term care or be discharged to a lesser level of care, the discharge planning process is crucial in preventing re-hospitalization and missed opportunities to assist the patient in reaching maximum functional independence.

An Interdisciplinary Approach

Effective discharge planning requires an interdisciplinary team approach. All members of the care plan team must be involved in setting goals for potential discharge of the patient on the day of admission.

- What are the patient's goals?
- Where do they want to live?
- What is the realistic potential for return to home?
- What was the prior level of function?
- Is the patient's immediate family/caregivers part of the goal setting process?

Therapy Services

Communication with the care plan team is crucial in developing and a safe and effective discharge plan. Skilled therapy services can improve a patient's ability to return to prior functional levels and promote a safe discharge home. When establishing discharge readiness from therapy services we must consider the following.

- What is the discharge setting? (home, ALF, SNF)
- Has the potential discharge environment been assessed by therapy? (home evaluation)
- Have all long and short term therapy goals been met? (goals revised, if needed)
- Has the patient stopped making functional gains?
- Has caregiver and patient training been completed?
- Has the interdisciplinary team discussed the patient's status and come to an agreement regarding the discharge plan?

OUR **PEOPLE.** OUR **VALUES.**

PASSION
COMMITMENT
INNOVATION
RESPONSIBILITY
RELATIONSHIPS
SELF-IMPROVEMENT

EXCELLENCE IN REHABILITATION

fp Functional Pathways™
Excellence in Rehabilitation

www.functionalpathways.com | 888.531.2204

Preventing Re-Hospitalization

Premature discharge as a result of poor discharge planning can lead to significant incidences of re-hospitalization for patients in the long term care setting. As the industry sees more and more acute admissions, patients will have an expectation of shorter stays and in returning home.

It is vital to assist them in maximizing functional performance in everyday living skills, mobility and safety prior to returning home to decrease the potential of falls and recurring medical problems that could have been reduced with comprehensive care and interdisciplinary discharge planning. Often, ongoing communication and education is required to involve our patients in the recovery process and helping them to establish realistic goals and realistic time frames for safe

For more information, please contact Cherie Rowell, Director of Clinical Services Functional Pathways at crowell@fprehab.com. *You can also discover more at www.functionalpathways.com*

CONGRATULATIONS TO PERMELIA CLARK AT THE LEGACY@PARK VIEW, ULYSSES, KS

Winner of a $100 Wal-Mart Gift Card Grand Prize in our November 2013 Scrabble Game

(Several other correct entries will get a $25 Gift Card)

THIS MONTH FOR A $100 WAL-MART GIFT CARD:

"What TV Show Features the Character of Dr. Sheldon Cooper?

E-mail your answer to Chip@ecpnews.net

(One correct answer will be chosen for the prize)

The HAT Advantage continued from page 1

on-going assessments, and transfers; 3) *Contracts* – Admission Agreements and other admission contracts as well as Resident Handbooks and marketing materials are used as the basis for liability related to levels of care and representations by the operator that have been allegedly breached; 4) *Policies and Procedures* – Failure of the community to comply with its Policies and Procedures also forms the basis of liability. Policies and Procedures are used by Plaintiff's attorneys to establish standards of care for the community. If the policies are unrealistic or set unreasonably high guidelines, Plaintiff's attorneys can support claims that the facility breached the standard of care by violating its own policies.

Continue Implementing Proactive Approaches to Litigation Risk Management - Considerations for your community to include in proactive risk management and quality improvement plans are: *Formal Expectations Management Programs* - Setting realistic expectations with residents and families through formal programs at admission and continuing expectations management through the residency will significantly reduce the chances and opportunities of a resident or family member filing a formal lawsuit against the community; *Consistent and Complete Documentation* – In addition, to timely and accurately documenting care and services, it is important to document discussions with staff, physicians, residents and families. Record audits should be regularly conducted for compliance with state regulations and policies and procedures; *Continuing Assessments to Evaluate Suitability for Placement and/or Increased Need for Services for Aging in Place* - Liability risks are compounded when residents remain in an assisted living facility that cannot provide the appropriate care. Admission criteria should be consistently applied, with resident needs reassessed regularly and documented prominently in the record and recommendations for home care, physical therapy and other ancillary services noted. Involuntary transfer of a resident to a skilled nursing facility may otherwise result in unnecessary operational, legal and risk management problems; *Assess and Address Changing Staffing Needs* –Employing staff in sufficient number, with ability and training to provide the basic resident care, assistance, and supervision required, based on the assessment of the acuity levels and residents needs is the best defense to these claims. Monitor the adequacy of staffing ratios based on residents' needs at regular intervals. *Analyze Marketing Materials Including Internet Advertising* – Analyze marketing materials to determine if they are consistent with the level of services provided. Be certain that information on the Internet is current, accurate and that organizations are properly identified. A legal review should be completed on all marketing materials including services or statements that could present exposure; *Review Admissions Agreements, House Rules and Resident Handbooks* - Review resident contracts for consistency of terms. Focus on areas such as discharge and retention policies. Expectations management programs should be included in the Admissions Agreements as well as House Rules; *Review and Revise Policies and Procedures as Necessary* - Draft policies and procedures that address operational, business and clinical issues to promote consistency in actual practices by the staff and compliance with state regulations and "best practices". Monitor the staff for compliance of established policies and include outcomes in annual competency and performance evaluations; *Assessment of Residents' Rights* - Ongoing assessment of a facility's compliance with residents' rights should be an integral part of the risk management program. Best practices must include documentation of the monitoring and evaluation of a resident rights compliance program which will also create a strong defense should litigation transpire.

***Implement an Arbitration Agreement and Training Program* –** An arbitration agreement is a contract that requires all disputes between a resident and an assisted living facility to be resolved through binding arbitration before a neutral arbitrator as opposed to a judicial forum. Properly executed by the resident or legal representative the agreement is enforceable and significantly reduces the cost and expense of a lawsuit and the reward to a Plaintiff. Arbitration agreements are not desirable for a Plaintiff's attorney as history shows that recovery in arbitration is nearly 30%-35% less. A formal training program and materials will direct the admissions process and identify the steps necessary to obtain the legal authority that will provide the best chance for success of an enforceable agreement. Proper training and program materials will direct the admissions process and identify the steps necessary to obtain the legal authority which will provide the best chance for success for an enforceable agreement. The health care industry is benefitting from the enforcement of arbitration agreements after many years of anti-arbitration opinions and legislation. The objective being to reduce the costs and expenses associated with jury trials and the uncertainty of a jury and potential runaway verdict.

Confirm HIPAA/HITECH Compliance - HIPAA-covered entities (CE) are required to meet essentially all aspects of the new HIPAA rules that were recently updated to implement the Health Information Technology for Economic and Clinical Health (HITECH) Act. Assure that your organization has updated compliance programs by drafting new policies, privacy notices, and Business Associate Agreements. Focus on the important components of compliance including training, implementation of individual privacy rights, breach reporting, security measures, and business associate contracting.

Evaluate Abuse Prevention Risk Prevention, Planning and Strategies - CMS continues to implement the Affordable Care Act's provisions for quality improvement, dementia care, and prevention of abuse as its current, high priority initiatives. The law mandates the inclusion of training for nurse aides working in nursing homes on abuse prevention and care of persons with dementia. State regulations for assisted living also include abuse prevention reporting and training mandates. By including a comprehensive abuse prevention program with on-going assessment and training as part of your organization's Quality Assurance/Performance Improvement, incidences of abuse can be reduced and quality of care improved.

Celebrating Assisted Living and Nursing Homes 2014 - Identify individuals, organizations, and industry members that provide inspiration, support, and opportunities for well-being and enhanced quality of life to our seniors. Please send along heart-warming and inspirational stories for next year's Top 10 List!
May the New Year 2014 bring limitless opportunities for personal and professional growth and development for your organizations that have delivered such valuable services to our communities around the country.

Rebecca Adelman, Esq. – Ms. Adelman is a Shareholder of Hagwood Adelman Tipton, PC and practices in the Memphis, Tennessee office. She is a member of the Board of Directors and serves as the firm's President. For over 20 years, Rebecca has concentrated her practice in healthcare law, long-term care assisted living and medical malpractice defense litigation. Her expertise and her scope of practice involve all insurance defense litigation areas including premises and product liability as well as employment law. Please feel free to contact her at radelman@hatlawfirm.com.

Kessler's Corner continued from page 1

(Brooke's a nursing student in college and still lives at home). Yes, she works some part time jobs, house sitting and teaching dance so it's going to sting having to use some of her $$$ to pay the piper. Oh yes, despite her having to pay the ticket and getting a lecture from both her mother and me, when it comes time for her court date, I'll be right by her side. As I said earlier, I wouldn't let her go through this alone because your children always remain your children.

Chip Kessler has created over 20 staff training and development programs for use in our nation's nursing and assisted living facilities. He's also the author of two books on marketing. Chip serves as General Manager of Extended Care Products, Inc. Discover more at www.extendedcareproducts.com

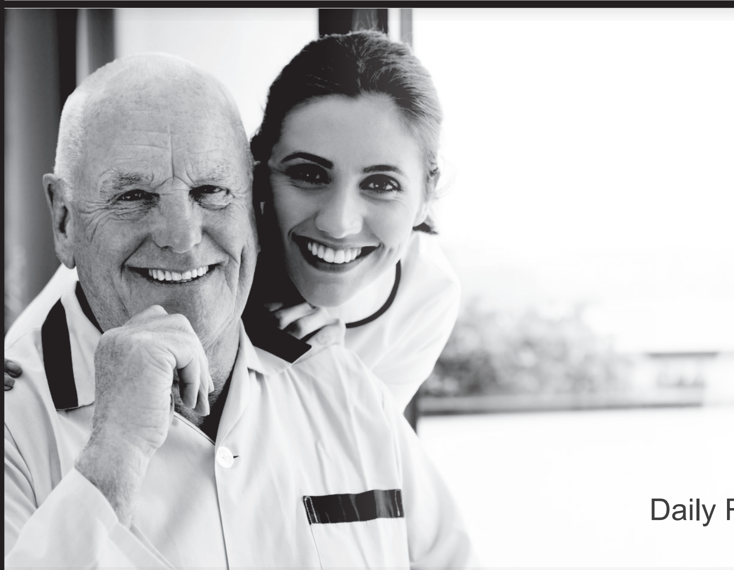
NAL Professional Not Coming Addressed to You Personally?

We want to make sure you are personally getting this newsletter each month, not just have it forwarded to you because you're now holding down the position of a predecessor! Let us know you now are on the job. E-mail your name, facility/company name and address to chip@ecpnews.net & we'll update our records. Just put NAL Professional on the e-mail subject line and we'll take care of the rest.

NAL PROFESSIONAL
P.O. Box 4852
Johnson City, TN 37604

PRSRT STD
US POSTAGE
PAID
MWI

Documentation, Analytics & Reimbursement Optimization To Ensure Quality Care



Quality Care

Automated Instant Risk Alerts

Real-Time CNA to Nurse Instant Messages

Prevents Unnecessary Hospital Readmissions

Improves Patient Outcomes

Reimbursement

ADL Rule of Three Analytics

Daily RUG Score Combines CNA, Therapy & Nursing Data

1.888.210.3200
www.DARTChart.com

We Believe You Deserve Credit For All The Care You Provide

Nursing & Assisted Living Facility *Professional*

"NEWS AND VIEWS YOU CAN REALLY USE"

FEBRUARY 2014
ISSUE 2, VOLUME 4

SENT EACH MONTH TO YOU AS A MEMBER OF THE HEALTHCARE HEROES

THE HAT ADVANTAGE by Rebecca Adelman

The Year Ahead - 2014
Aging Services and Senior Housing

As 2014 unfolds, we'll be considering the trends in aging services and senior housing while identifying litigation and risk management opportunities. Next month we will evaluate the AHCA/NCAL 2013 Quality Report and in April we will review The 2013Long Term Care General Liability and Professional Liability Actuarial Analysis all with an eye toward using the various benchmarks to assess where we've been, where we're going and the best methods for managing the complexities of the industry. Leading industry reports (see *Senior Housing News*) focus on the unknown impact the Affordable Care Act will have on the senior housing and aging services industry as well as the real probability that the main assets of retirees, home equity and investment portfolios, will not be the anchor of decision making that they were during the past five years. According to *SHN*, "the new anchor will be the realistic, responsible lifestyle choices retirees make to ensure how and where they spend this time in their lives and the ability to live within their means on their current and future resources."

Below are the trends that have been identified for 2014 and considerations for organizational risk management support.

Extended Professional Lives – More time is being added to the professional lives of those 65 and over. According to a poll released in October by the AP-NORC Center for Public Affairs Research at the University of Chicago, more than 80 percent of 50-plus workers say that it is "somewhat likely" they will work to earn money in retirement and that they expect to retire at least two years later than their expectation was at 40. Thus, as we've reported, providers deliver higher levels of care for more complex acuities in the aging services industry. The 85-plus population is projected to triple from 5.7 million in 2011 to 14.1 million in 2040.

Consider – Evaluate admission criteria, staffing and policies to prepare for increased servicing to the aging population and implement new risk prevention and management strategies related to the high-risk areas (elopements, falls, wounds, medications).

The American Retirement Dream – Financial benchmarks indicate that asset values for baby boomers are increasing;

Continued on page 3

In This Issue:

PAGE TWO:
- Pathway to Rehabilitation Excellence

PAGE THREE:
- Save the Date

PAGE FIVE:
- Slippery Times for The RAI

PAGE SIX:
- Dart Chart Systems
- Update Your Contact Information

KESSLER'S CORNER

by Chip Kessler

"Meet Functional Pathways"

I my role as a consultant for nursing and assisted living facilities nationwide, I have the pleasure of associating with many outstanding companies that provide products and services to the healthcare sector. One of these companies is Functional Pathways. Recently I had the opportunity to speak with Sheila G. Capitosti, RN-BC, NHA, MHSA, Vice President Clinical and Compliance Services to learn more about what this cutting-edge organization offers in its field of rehabilitation therapy services. As well, Sheila's the featured columnist is this month's "Pathway to Rehabilitation Excellence" … make sure you don't miss it.

Continued on page 4

Pathway to Rehabilitation Excellence

By Sheila G. Capitosti, RN-BC, NHA, MHSA

VP Clinical and Compliance Services

Happy New Year—A Budget Agreement Has Been Met!

A budget agreement has been met which cuts the deficit by about $300 million from FY 2014 – 2023, through a reduction of other healthcare spending. Approximately $28 billion of the savings would come from a two year extension of a 2 percent cut to Medicare providers included in the sequester.

Key provisions of this agreement include:

1. A three month extension of current physician rates and bills permanently repealing the SGR ready for final action before the extension runs out
2. An increased in the therapy 2014 caps amount to $1,920 PT/ST and $1,920 OT
3. Extension of the therapy cap exceptions process through March 31, 2014. (Current law regarding therapy Part B exceptions process is in effect through 3/31/14)- 3 month extension
    a. KX modifier at $1,920 PT/ST, and at $1,920 for OT
    b. Submission of manual medical review requests at $3,700 threshold for PT/ST, and at $3,700 for OT

After return from holiday recess January 6, 2014, Congress will need to compromise their reforms into one bill with a deadline of 3/31/14.

While this is good news for the long-term care industry and physicians, it does not come without danger. To eliminate the SGR, lawmakers will need to find ways to offset the cost, and the nursing home industry is bracing for potential attack.

The three-month extension will give lawmakers time to hash out a permanent doc fix and permanent lifting of the therapy caps leaving our charge for the next several weeks to continue to make the case that random, arbitrary cuts to skilled nursing to pay for SGR reform is unwise.

Legislation approved by the Senate Finance Committee would require the Centers for Medicare & Medicaid Services (CMS) to replace the therapy caps by 2015 with a system of prior authorization medical review (PAMR), designed around such factors as setting, services, provider practices and dollar thresholds. The legislation makes no changes to the current Manual Medical Review (MMR) process for 2014, but repeals it at the end of 2014 so the new PAMR process can begin.

Additionally, CMS would be required to develop a new standardized data element collection process, presumably to replace the current claims-based functional limitations data collection (g-codes) process, which would sunset when the new system begins. Beginning January 1, 2015, each claim would need to indicate if a therapy assistant provided the therapy service. CMS also would need to design a new outpatient therapy system.

The House Ways & Means Committee's bill, which was approved by the House Energy & Commerce Committee, does not contain therapy provisions. So early in 2014, those issues will need to be resolved by Congress when it reaches its final decisions on ending the SGR and, perhaps, the Medicare therapy caps as well.

Be ready to continue working to educate lawmakers so they have a solid understanding of the issues at stake when all of this comes before them.

For more information, please contact Sheila Capitosti, VP Clinical and Compliance Services, Functional Pathways at scapitosti@fprehab.com or call 888-531-2204. You can also discover more at www.functionalpathways.com

ELITE people who give ELITE care and produce ELITE results

OUR PARTNERSHIP PROMISE IS EXCELLENCE IN REHABILITATION

Functional Pathways™
Excellence in Rehabilitation

www.functionalpathways.com | 888.531.2204

The HAT Advantage continued from page 1

however, finding retirement with the many unknowns ahead will be a challenge. The cost of care is increasing for home health, assisted living and skilled services. Coupled with longer life expectancies, managing retirement resources will be the focus of our aging population as they evaluate their choices of care models. We can expect to see continued and greater pressure on government programs.

Consider – Evaluate Revenue Cycle Management in the organization and identify revenue cycle solutions to respond to healthcare consumerism, accelerating cash collection and improving payor performance.

To Profit or Not to Profit - As *SHN* notes, one of the growing divides in senior housing lies in the discussion about the roles and responsibility of for-profit and not for profit senior housing. It is important to appreciate that both models must consider fiscally responsible operations that serve the same consumer and the delivery of quality care is the driver.

Consider – Join in conversations regarding non-profit and for-profit aging services to better understand the issues and opportunities in both models.

Information Technology – HIPAA, HITECH, ACA and the growth of ACOs have highlighted the importance, legally and operationally, of creating the most enhanced and impenetrable information technology processing systems.

Consider – Evaluate budgets for upgrading or replacing systems and develop an IT plan that can integrate billing, customer relationship management, operations management, and monitoring and risk management.

Hug a Lawyer Today – Your attorney contributor disclaims this trend as reported in *SHN* (smile) although it is certain that senior care can sometimes be a lesson in risk management on a day-to-day basis. Developing a strong relationship with your counsel could be one of the most important parts of any organization's risk management strategy. The litigation risk management information we've shared in these pages for the past years include operational risk, employment, regulatory, safety, and state and federal regulations all of which impact the overall risk prevention and management programs.

Consider – An increase in your legal budget and a hug for a lawyer today.

The Continuing Impact of Media – We've reported on many senior living stories presented in the media and we can expect that, with the focus on regulations state and nationally, this trend will continue and high levels of media scrutiny will be seen in 2014.

Consider – Evaluate and update crisis communication plans consistent with the organization's missions and visions and management and other PR related changes. Take advantage of state and national opportunities to promote the positive aspects of the aging services industry. The best defense is our offense and also hug a lawyer today.

Staffing/Labor Issues - Increased need for staffing consistent with the changing mission of the senior care industry and the higher acuity levels of the residents continues to be a significant focus for the industry. Risk issues present in employment law as well as healthcare litigation that translate into liabilities with under-staffing models as a tool for Plaintiff's attorneys. More skilled staff and advanced training will be necessary to meet the care needs of the aging population.

Consider – Evaluate staffing needs relative to increased resident acuity and make necessary adjustments in training and staffing levels. Provide education incentives for long-term investment in staff and financial incentives for quality performances and benchmarks.

Your Brand Matters – Experienced providers with brand recognition as well as new companies entering the industry, must recognize the importance of their brand and direct marketing efforts to a changing aging population. Consumers are more sophisticated with greater asset value and being prepared with a meaningful brand should be a priority for service providers.

Consider – Audit your company's position in the community and evaluate the current marketing and branding strategies. Evaluate the needs of the residents and future expectations of the aging population in and around your communities and design enhanced brands and products to respond to those needs and expectations.

It will be important for all industry sectors to be looking back on industry performance to develop positive responses in corporate structure, management, risk management, quality improvement and overall market positioning into the years ahead. The trends identified for 2014 and the quality indicators we will be reviewing over the next months will provide a strong foundation for your organization to plan and prepare for industry success in these uncertain times of healthcare.

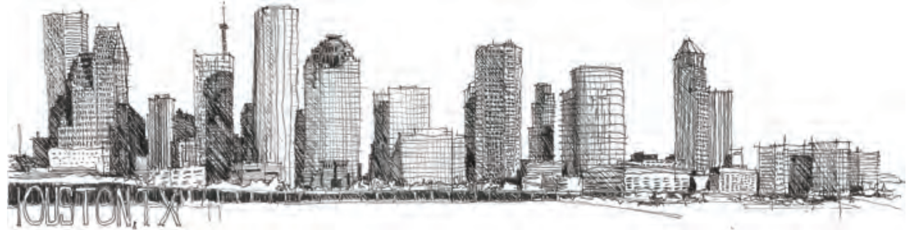
Rebecca Adelman, Esq. – Ms. Adelman is a Shareholder of Hagwood Adelman Tipton, PC and practices in the Memphis, Tennessee office. She is a member of the Board of Directors and serves as the firm's President. For over 20 years, Rebecca has concentrated her practice in healthcare law, long-term care assisted living and medical malpractice defense litigation. Her expertise and her scope of practice involve all insurance defense litigation areas including premises and product liability as well as employment law. Please feel free to contact her at radelman@hatlawfirm.com.

SAVE THE DATE

LITIGATION RISK AND DEFENSE STRATEGIES FOR LONG TERM CARE & ASSISTED LIVING PROVIDERS, INSURERS AND BROKERS

MAY 2, 2014 • HOUSTON, TEXAS
ROYAL SONESTA HOTEL • 2222 WEST LOOP SOUTH, 77027

HOSTED BY: COWAN & LEMMON, LLP • EBANKS HORNE ROTA MOOS, LLP • HAGWOOD ADELMAN TIPTON, PC • KAUFMAN BORGEEST & RYAN, LLP



Kessler's Corner continued from page 1

Chip: To begin with, please provide our readers with some detail regarding the specific services Functional Pathways provides to both nursing and assisted living facilities.

Sheila: We're a national therapy provider. We're based in Knoxville, TN and are owned and operated by therapists who have extensive clinical experience. Since our establishment in 1995, we've consistently provided excellence in rehabilitation to a wide spectrum of healthcare facilities, including skilled nursing facilities, CCRCs, assisted living, hospitals and post-acute care units. Functional Pathways has created and we've utilized an elite therapy model that's based on our values, our innovation, and our partnership promise. We feel that these three unique aspects provide our clients with clinically appropriate programs that will result in appropriate patient care, clinical and financial outcomes that result in a lower risk for audits and Medicare take backs, and increase communication and outcome reporting with hospitals, doctors and families. We have several innovative products, including our recently introduced *Clinical Mapping Tools* which are actual clear pathways for patient care that are based on evidence-based clinical programs. We also have clinical program champions and these folks are in each one of our client facilities. These individuals serve as an active participant in the professional development of the therapy team inside in the facility, plus they also help to promote growth and implementation of clinical programs to promote excellence in care. We also have what we're calling our *Care Program* and here "Care" stands for: Client Acute-Care Readmission Education. This program includes an inter-active certified instructor who just happens to be me, and a transitional care coordinator who is a rehab technician that works for Functional Pathways in the facility to help work with care transitions that the client is experiencing. We also have CEU accredited presentations that we offer for clients' referral sources, case managers, case workers and nurses on hospital readmissions. Functional Pathways also has RightTrack™ which is a proprietary program that was developed by us. It tracks functional outcomes based on base diagnosis and it also communicates resident's progress to physicians, hospitals, administrators and family members. We also have census development support. We have a director of marketing David Higdon who offers brochures and collateral materials to clients. He offers marketing training and market analysis, and also strategic planning for Accountable Care Organizations. And finally we have our *Elite Living Programs* which is our wellness program. These programs are designed to improve overall health and they embody the full scope of health and wellness.

Chip: Do you find that it's more cost effective and thus more popular these days for nursing and assisted living facilities to use contract rehab and therapy management services such as Functional Pathways' provides versus buildings doing this task on their own?

Sheila: I do, particularly in today's environment of heightened scrutiny on therapy services. Contract rehab and therapy management services offer expertise to support not only the therapy operations and the clinical services themselves, but also compliance initiatives for our clients.

Chip: Do you find that while a great many nursing facilities offer rehabilitation therapy services that these days, more and more assisted living communities are also providing rehab therapy too?

Sheila: They are. I think that assisted living communities are experiencing a higher population surge because I believe often times they're seen as less institutional than a skilled nursing facility, and along with this higher population surge comes increased acuity levels. So, I do believe that more and more assisted living communities are looking at being able to provide out-patient therapy service and wellness programs to the residents of their region. In addition, I think that assisted living facilities are also exploring what role they're going to play in the formation of Accountable Care Organizations because I believe they will have a role just as the skilled nursing facilities do. As well, what role will assisted living facilities play in managed care? Here, in order to be competitive they're going to need to be able to demonstrate positive outcomes related not only to the cost of care and services but also the decrease in hospital readmission rates. For that reason, I think you're looking more and more to contract therapy services.

Chip: From a census building standpoint, how does having a strong rehab therapy department help in the marketing of a nursing facility or assisted living community to key referral partners, and the region's population in general?

Sheila: I believe the ability to provide therapy services allows for a building to offer a more well-rounded product to the consumer. Plus it also allows for the ability to obtain services such as therapy and wellness in one location- one-stop shopping if you will. And as we've already discussed, therapy and wellness can position a nursing or assisted living facility to be competitive when they're dealing with Accountable Care Organizations and Managed Care Services.

Chip: Let's talk about Functional Pathways University and the role it plays in making and keeping your company as one of the leaders in its field.

Sheila: We're very proud of Functional Pathways University. We created our own on-line CEU University which is available for all full time therapists with our company at no charge, and also to a shared cost to our part time therapists. We cover over 100 accredited courses for physical therapists, physical therapy assistants, occupation therapy, certified occupational therapy assistants, and speech language pathologists with over 1,000 credit hours available. Our university is a unique benefit for our employees and they're taking full advantage of this convenient on-line tool for learning. We've also created our own training module as part of this university. These include mandatory orientation for new employees on such subjects as HR Compliance Policy, our Functional Pathways Values, Abuse and Neglect, HIPPA, Medicare Reimbursement, and Documentation and Coding. We also host an annual CEU symposium and here during the course of the semester staff members are able to earn CEU credits presented by world-class speakers. We hold this symposium in a centralized location, and it's open to any of our therapists that want to come. We also offer a comprehensive two and a half day training that's conducted by our executive Management Team. This training begins with Dan Knorr, our President, and it's held at our corporate offices here in Knoxville for every new clinical manager that's hired. We also have a mentor program that's available to pair new clinical managers with a seasoned mentor clinical manager in the field. This program provides ongoing advice and support on a monthly or on an as-needed basis.

Chip: Does Functional Pathways keep its client facilities aware of changes taking place in your fields of expertise, and then work with your facilities to implement these changes?

Sheila: We do. Again here, this is something we're very proud of as well because we don't just look at ourselves as being a contract rehab provider for our clients. Rather we look at our relationship as a partnership, so we do a lot of direct communication from our operations and compliance departments to key personnel in the facilities like the administrator, corporate office staff, directors of nursing, and MDS coordinators. We also send out e-mail alerts; we do a monthly newsletter; we have blogs that are done by key management staff from Functional Pathways. Plus we also do educational presentations and webinars, many of these are CEU accredited as well. We have the ability to offer CEUs to nursing home administrators, to case managers, to nurses, and to social workers.

Continued on page 5

Winter is Here Bringing Slippery Times for the RAI

by Joel VanEaton, BSN, RN, RAC-CT, CPRA

If you have been following the changes to the RAI manual this fall and winter, you have been in for a ride. The MDS 3.0 RAI User's Manual was revised in October and sections G and O once and appendix B twice since then. The key revisions to the Manual are to be found in the following areas; Title page, Table of Contents, Chapter 1, Chapter 2, Chapter 3 sections G, H, K, M, O, Q, Z, Chapter 5, Chapter 6, Appendix A, B and F.

The most notable revisions were made in Chapter 3 Section G to the rule of 3 instructions, Section K related to the way that fluid intake is recorded, and to section O regarding the recording of distinct calendar days. Even if you were thoroughly versed in these revisions, not many could have anticipated some of the conversation surrounding the RAI that has occurred on the SNF Long Term Care Open Door Forum in the last few months.

First, as I hope most of you are aware, beginning in July 2014, all MA plans will require a HIPPS code on the UB-04 for billing, regardless if the plan bills by levels and does not required RUG scores to bill. This is an informational gathering process by the MA plans and CMS. Bottom line is that PPS MDS assessments will have to be completed for all MA beneficiaries that will have payment days in July in order for the bills to process and not be rejected. Currently there is only a warning message if the HIPPS code is not included.

There has been much discussion related to this impending requirement by yours truly and others on the Open Door Forums. In the January 16th forum, CMS indicated they may Invite folks from the Managed Care side of CMS to participate in the next call. Our chief concern is the additional work load that will be created by having to complete PPS assessments simply to generate a HIPPS code, not for billing purposes but simply for information gathering, poses an undue burden on already stressed providers. It remains to be seen if CMS will grant any reprieve in this regard.

Also, if you have been listening in on the Open Door Forums, you recognize that CMS dropped a bombshell in December when they announced that the rules governing the COT, esp. as noted on page 2-51 of the Revised RAI Manual, really indicate that if on day 7 of the COT observation period a Rehab RUG is not generated because there were not 5 distinct calendar days of therapy provided in the last 7, the COT cycle essentially stops and the next opportunity to generate a rehab RUG would be the next required assessment that affects payment. In some scenarios, this could be a lengthy period of time where rehab services would be provided a t a significantly reduced non-rehab RUG rate.

Again, yours truly and other made our strong opinions known regarding this issue indicating that we believe that it is not the intent of the guidelines to restrict us in this way. First, the only criterion currently for stopping the COT cycle is when all therapy stops, see Chapter 6 page 6-13. And, CMS publication 100-2, chapter 8 indicates that the daily requirement for therapy services, "should not be applied so strictly that it would not be met merely because there is an isolated break of a day or two during which no skilled rehabilitation services are furnished and discharge from the facility would not be practical."

CMS seems to have taken these arguments into consideration. They have also recognized that the rules on page 2-51, cited by CMS in the December ODF, were originally intended to apply to cases where the COT cannot be the first assessment to get a resident into a rehab RUG. CMS has indicated that they will review this matter further as well the implications it will have on providers. This is welcome news and we anticipate to more on this topic in future ODFs and or manual revisions.

As always, Extended Care Products has a full range of MDS 3.0 products to help you stay current with all of these changes, from our exclusive Downloadable RAI Manual to the recently updated OMRA Handbook. Stop by www.mycaring.com today and check out what's available.

Kessler's Corner continued from page 4

We also host a customer advisory board that meets on an average of every four-six months at a centralized location for our clients and these meetings cover all regulatory and industry updates, trends, and facility challenges. As well, in addition to our monthly column in *Nursing & Assisted Living Professional,* we've also have published articles in industry journals, and we also offer training for our clients on various topics such as wellness, fall risk, nutrition, hospital readmissions, and effects of various medical conditions. We recently did a training session for a client on stroke management. My department, the compliance department, offers educational sessions on MDS 3.0, coding of section G, functional status, and right now I have a lot of clients who are very interested on nursing and therapy documentation together, to avoid claim denials. This is a new presentation that we're putting together.

Chip: Is there anything you'd like to touch on that I haven't asked you about?

Sheila: I think the only thing that I'd like to add is, I spoke about how we have a lot of innovative products but I also want to focus on the fact that Functional Pathways believes we're also unique because of our values. We believe that we live our values everyday, and those values include: commitment, relationships, responsibility, innovation, self-improvement and passion. We start every partnership with this promise- "Excellence in Rehabilitation." We employ elite people who provide elite care and elite results.

Chip Kessler is General Manager of Extended Care Products, Inc. He has created over 20 programs concentrating on marketing/census building, customer services, crisis communications/risk management, media training for nursing and assisted living facilities, plus he provides personal consulting services for nursing and assisted living facilities nationwide. Discover more at www.extendedcareproducts.com and assisted living communities may also visit www.AssistedAdvantage.com

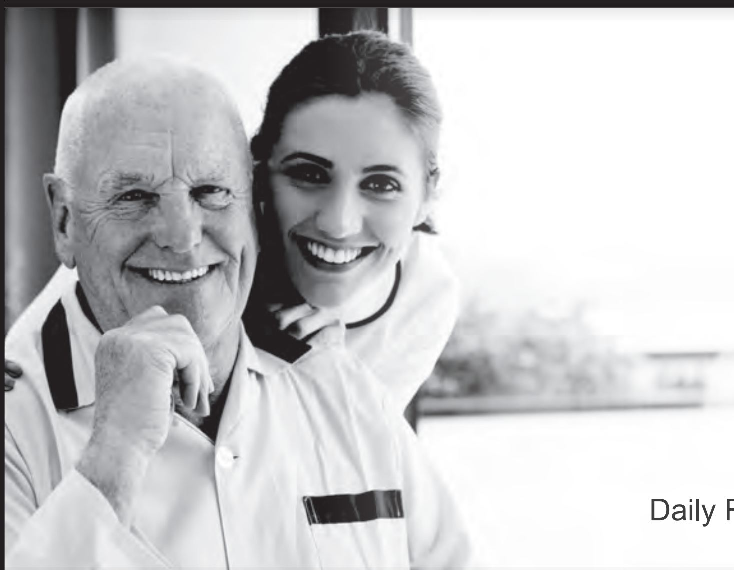
NAL Professional Not Coming Addressed to You Personally?

We want to make sure you are personally getting this newsletter each month, not just have it forwarded to you because you're now holding down the position of a predecessor! Let us know you now are on the job. E-mail your name, facility/company name and address to chip@ecpnews.net & we'll update our records. Just put NAL Professional on the e-mail subject line and we'll take care of the rest.

NAL PROFESSIONAL
P.O. Box 4852
Johnson City, TN 37604

PRSRT STD
US POSTAGE
PAID
MWI

Documentation, Analytics & Reimbursement Optimization To Ensure Quality Care



Quality Care

Automated Instant Risk Alerts

Real-Time CNA to Nurse Instant Messages

Prevents Unnecessary Hospital Readmissions

Improves Patient Outcomes

Reimbursement

ADL Rule of Three Analytics

Daily RUG Score Combines CNA, Therapy & Nursing Data

1.888.210.3200
www.DARTChart.com

We Believe You Deserve Credit For All The Care You Provide

Nursing & Assisted Living Facility *Professional*

"NEWS AND VIEWS YOU CAN REALLY USE"

MARCH 2014
ISSUE 3, VOLUME 4

SENT EACH MONTH TO YOU AS A MEMBER OF THE HEALTHCARE HEROES

THE HAT ADVANTAGE by Rebecca Adelman

Person Centered Care – Quality of Care

In this article and our next, we will be highlighting person-centered care and its essential aspect of delivering quality of care to the LTC resident and trending more to ALF resident, as well. In the last decade, the culture change movement has started to transform the culture of aging in America and bring person-centered care to the senior care industry. This movement is creating a less institutionalized and more humane environment that supports the elder's life, dignity, rights and freedom. Many CMS regulations govern the person-centered model including *F 172 Access and Visitation; F 175 Married Couples; F 241 Dignity; F 242 Self-Determination and Participation; F 246 Accommodation of Needs; F 247 Notice Before Room or Roommate Change; F 252 Safe, Clean, Comfortable, Homelike Environment; F 255 Private Closet Space; F 256 Adequate and Comfortable Lighting; F 371 Sanitary Conditions; F 461 Resident Rooms; F 463 Resident Call System; and Changes to Life Safety Code.*

CMS states its "vision for long-term care is that the system will be person-centered; that is, the system will be organized around the needs of the individual rather than around the settings where care is delivered." Person-centered care refers to the practice of basing key long term care decisions– in areas ranging from how meals are served and how bathing is offered to how work is structured in an organization – on individual resident needs, preferences, and expectations.

In 2012, the American Health Care Association launched its Quality Initiative and the resulting 2013 Quality Report provides valuable information and quality trends that will assist the industry to enhance the delivery of quality of care. On a national level, quality is improving. http://www.ahcancal.org/qualityreport/Pages/default.aspx/default.aspx. There has been an increase in the percentage of care centers receiving five stars on the CMS Five-Star rating scale. There have also been improvements in almost all the industry quality measures including hospital readmissions, staff stability, customer satisfaction and the off-label use of antipsychotic medications.

Safety Related Deficiencies - In the six-year time period reported, the frequency of medication error citations has decreased/improved, however, infection control citations have increased from 20 percent to 40 percent. The average number of citations appears to be decreasing along with the citations for scope and severity greater than G. The percent of skilled nursing care centers that have citation-free standard and complaint surveys has increased. These trends direct the industry to focus on infection control policies and procedures and best practices and highlights the impact quality initiatives have had on improved quality of care overall.

Continued on page 3

In This Issue:

PAGE TWO:

- **Pathway to Rehabilitation Excellence**

PAGE THREE:

- **Special Webinar Opportunity**

PAGE FOUR:

- **Dart Chart Systems**
- **Update Your Contact Information**

KESSLER'S CORNER

by Chip Kessler

"The One-Eyed Proofreader"

A few weeks ago I needed to have surgery for a hole in the retina in my left eye. After a few days off for recuperation I was back in the office trying to conduct business as usual, though without any kind of vision in the eye. At the time I'm writing this in mid-February I still don't have anything but blurry vision in the eye (and will for a few more weeks). I won't know if the surgery was successful until around mid-spring.

Now, I don't mean to compare what I'm experiencing to people who have lost vision completely in both of their eyes or the ability to hear or smell for example- where wisdom is that the loss of one of our

Continued on page 3

Pathway to Rehabilitation Excellence

By Sheila G. Capitosti, RN-BC, NHA, MHSA

VP Clinical and Compliance Services

Jimmo vs. Sebelius Settlement

CMS Issues Manual Updates for SNF, IRF, HH, and OPT

It is official! As part of its court-directed educational campaign, on December 6, 2013, the Centers for Medicare & Medicaid Services (“CMS”) published revisions to several portions of the Medicare Benefit Policy Manual pursuant to the settlement agreement in the case of Jimmo et al. v. Sebelius, which requires the agency to clarify key components of the Medicare coverage requirements for Skilled Nursing Facilities (“SNFs”), Inpatient Rehabilitation Facilities (“IRFs”), Home Health (“HH”), and Outpatient Therapy (“OPT”) related to skilled nursing and rehabilitation care. Although the provisions have an implementation date of January 7, 2014, CMS has reiterated that the changes have no true “effective date” from a practical standpoint, as they reflect long-standing agency policy and nothing in the Jimmo settlement agreement has modified, contracted, or expanded the existing Medicare eligibility requirements for skilled care. The publication of the Manual changes was followed by an educational call for Medicare contractors on December 16, 2013 and a CMS National Provider Call on December 19, 2013.
My blog entry today summarizes certain important Manual changes, in addition to key highlights from the CMS National Provider Call as they pertain to provision of skilled therapy services.

1. Clarifications on “Improvement Standard” and New Focus on “Skilled Care”

The Manual changes include extensive language, as well as several examples, to highlight that an “Improvement Standard” may not be applied as a basis for denial of maintenance claims for which skilled care is required in the SNF, HH, and OPT settings. The primary addition to the Manual provides that coverage for skilled care does not turn on the presence or absence of an individual patient’s potential for improvement, but rather on the patient’s need for skilled care to improve or maintain the patient’s current condition, or to prevent or slow further deterioration.
As a result, CMS appears to refocus medical review efforts on the presence or absence of skilled care. Manual provisions further highlight that the skilled care criterion is met when an assessment of the individual patient’s clinical conditions supports the need for the specialized judgment, knowledge and skills of a qualified therapist. In addition, to be considered a skilled service, the services provided must be a level of complexity such that they can only be safely and effectively performed by, or under the supervision of, such skilled staff. However, CMS re-emphasizes that a service that typically may be considered unskilled may be classified as a skilled service based on an individual patient’s special medical complications that necessitate the skills of a therapist be provided.

2. Setting-Specific Limitations on the Use of Therapy Assistants

Consistent with the agency’s previous practice of limiting the use of therapy assistants in the home health and outpatient settings, the Manual revisions for HH explicitly provide that any maintenance program billed as skilled care must be performed by a qualified therapist, not an assistant. Similarly, the Manual provisions regarding OPT services states that physical therapy assistants may not “develop, manage, or furnished skilled maintenance program services” or take responsibility for such services. In contrast, the agency appears to allow for skilled maintenance therapy rendered in the SNF setting to be performed either by a qualified therapy or a therapy assistant under the direct supervision of a qualified therapist (i.e., onsite at the facility).

3. Differentiating Rehabilitative/Restorative Therapy and Maintenance Therapy

In clarifying the coverage standards for skilled rehabilitation, the agency distinguishes patients requiring rehabilitative/restorative therapy from those patients requiring maintenance therapy, and notes that an expectation of improvement would be an appropriate consideration for those patients receiving rehabilitative/restorative therapy in the SNF, HH, and OPT. Rehabilitative/restorative therapy is defined as those services provided with a goal of reversing, in whole or in part, a patient’s loss of function. In contrast, maintenance therapy is appropriate where the patient’s special medical complications or the complexity of the therapy procedures is such that skilled care is required to ensure the safe and effective performance of a maintenance program.

4. Additional Guidance on Appropriate Documentation

Although the Jimmo settlement itself did not address medical record documentation, CMS included additional guidance related to documentation in the revised Manual provisions. While CMS notes that the presence (or absence) of such documentation is not an element of the definition for “skilled” services, the agency states that appropriate documentation is a critical part of supporting the need for the skilled services upon medical review by a Medicare contractor. By adding specific guidance on “best practices” for documentation to several portions of the Manual, CMS appears to suggest that the absence or lack of such documentation may serve as the basis for a medical necessity denial.

Continued on page 3

INNOVATIVE REHAB OUTCOMES

RightTrack™
Innovative Rehab Outcomes
Patient's Name – Full Report
Overall Progress to Goal

EXCELLENCE IN REHABILITATION

Functional Pathways™
Excellence in Rehabilitation

www.functionalpathways.com | 888.531.2204

Kessler's Corner continued from page 1

senses is compensated for with a greater degree of usefulness of our other abilities. No, my point here is that I've discovered that the loss of one-half of my vision at the moment has caused me to become much more mentally focused.

I've titled this column "The One-Eyed Proofreader" and with good reason- even with a pair of working eyes, I'm a rotten proofreader. My challenge was and is- how to perform this task on various written items such as this column so that I don't miss a spelling mistake or a typo. Fact is we all have challenges to face, no matter if we have a pair of functioning eyes, or just one like me at the moment. Fact #2: there is no greater group of folks who deal with challenges on a daily basis than those of you who work in a nursing or assisted living facility. You don't need me to spell out these challenges for you, so I won't. Suffice to say your responsibilities are many, and many times the praise isn't forthcoming from families and residents, though the thanks and gratitude you do receive hopefully more than makes up for times the compliments are lacking.

As I mentioned earlier, the loss or at least the reduction in one of our senses can sharpen our overall skills. We naturally compensate. In my example, my loss of usable vision has caused me to study each word much closer on the page to make sure I'm not missing anything. How wonderful it would be if we don't have to make up for any shortcomings, and have this kind of focus everyday on the job.

That's my goal, and something that's my wish for you as well. It can't help but make all of us more productive and valuable in whatever it is we do. And that's a couple of characteristics that can't be beat, especially when it comes to taking care of others who can no longer fully take care of themselves!

Chip Kessler is General Manager of Extended Care Products, Inc. He has created over 20 programs concentrating on marketing/census building, customer services, crisis communications/risk management, media training for nursing and assisted living facilities, plus he provides personal consulting services for nursing and assisted living facilities nationwide. Discover more at www.extendedcareproducts.com and assisted living communities may also visit www.AssistedAdvantage.com

Pathway to Rehabilitation Excellence continued from page 2

For example, under the SNF portion of the Manual, CMS notes that the patient's medical record must document:

· The history and physical exam pertinent to the patient's care, (including the response or changes in behavior to previously administered skilled services);
- · The skilled services provided;
- · The patient's response to the skilled services provided during the current visit;
- · The plan for future care based on the rationale of prior results;
- · A detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences;
- · The complexity of the service to be performed;
- · Any other pertinent characteristics of the patient.

In addition, the Manual provisions provide that "vague or subjective" descriptions of the patient's care will not be adequate to support skilled services. Examples of such terminology are provided and include notes such as "Patient tolerated treatment well," "Continue with Plan of Care," and "Patient remains stable."

The argument can be made that the Manual revisions go beyond what the actual Jimmo settlement. The intent of the Jimmo settlement, and the goal of revising the Manual, was to clarify CMS policy regarding the "Improvement Standard" and preclude improper denials by Medicare contractors for appropriate skilled care. However, instead of clarifying only those sections related to the improper "Improvement Standard," CMS has made significant changes to the Manual to add guidance on the documentation required to support the patient's need for and the provider's provision of skilled care. Even though the agency reiterated that its intent was not to create any new obligations related to documentation the CMS National Provider Call, it is likely that these provisions related to documentation will serve as de facto coverage requirements for skilled care in future medical reviews.

For more information, please contact Sheila Capitosti, VP Clinical and Compliance Services, Functional Pathways at scapitosti@fprehab.com or call 888-531-2204. You can also discover more at www.functionalpathways.com

Presenting The Webinar "Say Hello to Your Old Friend: OMARA"

Hosted by Nationally Known MDS-RAI Expert Joel VanEaton, RN, BSN, CPRA

Thursday, March 13th (two times to choose from) 60-minuteWebinar Followed by a 30-minute Q & A Session

Comes with Two Free Bonus Gifts Open to the First 125 Registrants Per Session

Discover more at www.WebinarLTC.com or at 1-800-807-4553

The HAT Advantage continued from page 1

Five-Star Rating System - From 2009 to 2013, the number of skilled nursing care centers receiving five stars has increased by about 8 percent. The proportion of skilled nursing care centers receiving one star has decreased from 22.5 percent to 13.5 percent.

Customer Satisfaction – The report reflects that customers have reported an overall satisfaction and willingness to recommend the center to a friend are reported as high. Long-stay residents and their families seem to have higher rates of satisfaction and willingness to recommend the center to a friend than those discharged following a short stay. The report seems to suggest inconsistencies in the area of customer satisfaction identifying the need for a standard questionnaire to measure overall satisfaction and willingness to recommend a center to a friend. Comprehensive expectations management programs are also recommended as risk prevention tools and collaborative efforts at greater understanding about challenging clinical issues.

There have been measurable quality improvements in a number of areas signaling the industry positively responding to the changing role of providers along the continuum of care in the aging population. Continuing to improve the quality of care and identify trends as the needs of the growing aging population become greater and more varied is vital to providers successful navigation through the complexities of the health care environment. CMS offers a Change Package which is a menu of strategies, change concepts and specific actionable items that any care facility can choose from to begin testing for purposes of improving quality of care. The Change Package is focused on the successful practices of high performing nursing centers.

Rebecca Adelman, Esq. – Ms. Adelman is a Shareholder of Hagwood Adelman Tipton, PC and practices in the Memphis, Tennessee office. She is a member of the Board of Directors and serves as the firm's President. For over 20 years, Rebecca has concentrated her practice in healthcare law, long-term care assisted living and medical malpractice defense litigation. Her expertise and her scope of practice involve all insurance defense litigation areas including premises and product liability as well as employment law. Please feel free to contact her at radelman@hatlawfirm.com.

NAL Professional Not Coming Addressed to You Personally?

We want to make sure you are personally getting this newsletter each month, not just have it forwarded to you because you're now holding down the position of a predecessor! Let us know you now are on the job. E-mail your name, facility/company name and address to chip@ecpnews.net & we'll update our records. Just put NAL Professional on the e-mail subject line and we'll take care of the rest.

NAL PROFESSIONAL
P.O. Box 4852
Johnson City, TN 37604

PRSRT STD
US POSTAGE
PAID
MWI

Documentation, Analytics & Reimbursement Optimization To Ensure Quality Care

Quality Care

Automated Instant Risk Alerts

Real-Time CNA to Nurse Instant Messages

Prevents Unnecessary Hospital Readmissions

Improves Patient Outcomes

Reimbursement

ADL Rule of Three Analytics

Daily RUG Score Combines CNA, Therapy & Nursing Data

1.888.210.3200
www.DARTChart.com

We Believe You Deserve Credit For All The Care You Provide

Nursing & Assisted Living Facility Professional

"NEWS AND VIEWS YOU CAN REALLY USE"

APRIL 2014
ISSUE 4, VOLUME 4

SENT EACH MONTH TO YOU AS A MEMBER OF THE HEALTHCARE HEROES

THE HAT ADVANTAGE by Rebecca Adelman

All Eyes on Adverse Events in LTC and ALF Including Plaintiffs' Attorneys *Risk Reduction and Litigation Prevention*

The March 3, 2014 U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG) report, *Adverse Events in Skilled Nursing Facilities*, reads somewhat like a Plaintiffs' Complaint against an LTC or ALF operator. Evaluating the sample selection and profile and methodology of the study extends beyond the scope of this report (essentially a simple random sample of 655 Medicare beneficiaries out of the 100,771 beneficiaries who had skilled nursing stays that met 3 sample criteria). The study evaluates adverse events in skilled nursing facilities with the OIG concluding that a little over 1 in 5 (22%) short stay residents experienced an adverse event and another 11% experienced a temporary harm event. Roughly two-thirds (59%) were determined to be clearly or likely preventable. They attributed much of the preventable harm to substandard treatment, inadequate resident monitoring, and failure or delay of necessary care. These are the same types of claims alleged in the lawsuits we defend for the SNF and ALF providers, and Plaintiffs' attorneys will no doubt be looking to this OIG report as supportive data for their crusades. Setting aside the litigation perspective in reviewing the OIG report, it sets the stage for increased levels of scrutiny by CMS, additional evaluation tools and also opportunities for providers to evaluate resident safety and implement quality improvement protocols.

In the report, the OIG recommended that the Agency for Healthcare Research and Quality (AHRQ) and CMS raise awareness of nursing home safety and seek to reduce resident harm through methods used to promote hospital safety efforts. CMS and OIG currently are condensing a list of 261 specific instances of nursing home resident harm in order to help nursing home operators and government inspectors quickly identify health issues that may be related to substandard treatment. In addition, CMS plans to adopt OIG's "trigger tool," which OIG developed to help identify potential harm. CMS should also instruct State agency surveyors to review nursing home practices for identifying and reducing adverse events. Per CMS, State survey agencies will be instructed to include an assessment of adverse event identification and reduction in their evaluations of QAPI and QAA compliance and link related deficiencies specifically to resident safety practices. CMS notes that this link would provide an incentive to nursing homes to develop strategies to reduce adverse events. (See the February and March 2013 NAL *Professional* articles related to QAPI).

Regarding the report finding, below is the list of adverse events 22% of SNF residents experienced per the OIG report:

Types of Adverse Events

Events Related to Medication
Excessive bleeding due to medication;
Fall or other trauma with injury secondary to effects of medication;
Constipation, obstipation, and ileus related to medication.

Events Related to Resident Care
Fall or other trauma with injury related to resident care;
Exacerbations of preexisting conditions resulting from an omission of care;
Acute kidney injury or insufficiency secondary to fluid maintenance;
Fluid and other electrolyte disorders (e.g., inadequate management of fluid);
Venous thromboembolism, deep vein thrombosis (DVT), or pulmonary embolism (PE) related to resident monitoring.

Events Related to Infections
Aspiration pneumonia and other respiratory infections;
Surgical site infection (SSI) associated with wound care;
Urinary tract infection associated with catheter (CAUTI);
Clostridium difficile infection.

Per the report, an estimated 1.5 % of Medicare SNF residents experienced events that contributed to their deaths. A review of a standard lawsuit against a SNF or AL reflects that there are claims included for medication errors, substandard resident care and development of infections. While focused on the Medicare SNF populations, the level of awareness in ALF's must also be raised and resident care and safety protocols evaluated and modified as necessary to reduce the incidences of adverse events.

Although no single type of event was prominent within the sample as contributing to death, residents who died as a result of events shared commonalities. *Most had multiple, complex co-morbidities that physician reviewers determined made their care more challenging, weakened their conditions, or both*. Complex medical and psychological conditions are relied upon for clinical defenses in claims against SNFs and ALFs and the OIG report provides additional information to consider. For example, one resident who died from a PE had a range of other chronic and acute conditions,

Continued on page 3

Pathway to Rehabilitation Excellence

By Cherie Rowell, COTA, Director of Clinical Services

POSITIONING TO IMPROVE FUNCTION

Therapists and nurses working in the long term care (LTC) environment often note poor posture and inadequate seating with their residents. This comes with the territory, unfortunately, as many LTC residents have disease processes and injuries that have weakened their muscles, decreased functional endurance and impacted the ability to maintain adequate balance during daily tasks. Regardless of whether positioning deficits are noted with a wheelchair, bed, recliner or other seating mechanism, it is up to daily caregivers and clinical staff to ensure safety, comfort and promote highest level of function.

OTs and PTs are uniquely qualified to address seating and positioning problems, but it takes a village, i.e. care plan team, to ensure follow-through and brain storm solutions with challenging resident situations. Often, therapists and caregivers find themselves limited by reimbursement and available funds, so creative clinical problem solving is a must! Recently, FP sent out a reference tool for common seating & positioning problems with possible interventions. This was provided to rehab managers to enhance decision making and problem solving. It is crucial to understanding that poor posture and positioning can be the cause of numerous problems for the resident including:

- Falls, increased use of restraint devices
- Pain
- Swallowing deficits (dysphagia)
- Impaired respiration/breathing
- Reduced circulation
- Loss of skin integrity, skin tears, pressure ulcers
- Muscle atrophy and contractures
- Reduced endurance and fatigue
- Decreased social interaction and poor daily task performance

It is paramount in providing elite care that therapists and daily caregiving staff understand the importance of good seating and positioning to enhance quality of life and promote independent function.

For more information, please contact Cherie Rowell, Director of Clinical Services Functional Pathways at crowell@fprehab.com. *You can also discover more at www.functionalpathways.com*

OUR **PEOPLE.** OUR **VALUES.**

INNOVATION
COMMITMENT
PASSION
SELF-IMPROVEMENT
RELATIONSHIPS
RESPONSIBILITY

EXCELLENCE IN REHABILITATION

Functional Pathways™
Excellence in Rehabilitation

www.functionalpathways.com | 888.531.2204

KESSLER'S CORNER

by Chip Kessler

"Showing What You Got"

Among the many programs and services my company Extended Care Products provides to nursing and assisted living facilities nationwide is mystery shopping services. I want to share something interesting I've read time and time again in the mystery shopper reports that come across my desk before being sent to our clients utilizing this valuable service. It occurs after the mystery shopper appears at the facility and requests a tour. The staff member (usually the building's marketing/admissions director) shows the person around, pointing out various aspects of the care and services provided, and answering any questions. However there's another facet to the tour that our mystery shoppers (and I'm sure anyone who visits and is shown around your facility) notice: "how well does staff relate to your current residents." Without fail, the mystery shoppers always point out when the staff person speaks to residents as the tour's being given. In other words, people (i.e prospective new family members touring your building) like to see this staff/resident positive, loving, caring interaction. It may just be a hello to a resident, or if the resident needs assistance then helping him or her deal with the situation at-hand. Yes you want sparkling clean floors to show off, and a spacious dining room to present, however, if staff folks (whether it's the person giving the tour or other employees going about their jobs) come across as aloof and uncaring, then your nursing or assisted living facility isn't "showing all that you got!"

One of the best investments you can make is bringing a sound mystery shopping program into your facility. You'll discover things about your building that you may have not realized before, just like my proceeding example. I invite you to visit our website www.extendedcareproducts.com to find out more about the benefits of mystery shopping or call me at 1-800-807-4553 for us to speak personally.

The HAT Advantage continued from page 1

including a serious infection, chronic heart and kidney diseases, a history of blood clots, and dementia. Other residents who died had previously experienced multiple instances of the types of events that ultimately contributed to their deaths. For example, one resident who died of aspiration had suffered multiple prior strokes that likely hampered swallowing ability.

In litigation, we often refer to the "cascade" adverse event where multiple, related events occurred in succession. Plaintiffs' attorneys customarily identify substandard care as the precipitating event. The report seems to suggest this as an estimated 4 % of Medicare SNF residents experienced at least one "cascade" adverse event and cascade events counted as single events. Within the sample, medication often played a secondary role in the cascading harm. For example, in one sample cascade event, a resident with multiple comorbidities, including neurological disorders and chronic kidney insufficiency developed significant gastrointestinal bleeding from excessive anticoagulation. Also within the sample, a number of cascade events began with inadequate resident hydration. *In at least one sample case, a resident experienced significant dehydration followed by an electrolyte imbalance and damage to the kidneys because SNF staff did not actively monitor and manage the fluid intake.*

An additional 11 percent of Medicare SNF residents experienced events during their SNFs stays that resulted in temporary harm. Included in the *Events Related to Resident Care* are Pressure Ulcers (19%), Fall or Other Trauma (8%) and Skin tears, abrasion and other breakdown (7%). These same events form the allegations in most legal complaints against SNFs and ALFs and Plaintiffs' attorney will find more support to target our industry.

Notably, physician reviewers determined that 59 percent of adverse events and temporary harm events were *clearly or likely preventable*. In making preventability determinations for specific cases, physicians factored in both the residents' condition and the adequacy of SNF monitoring and interventions. *For example, all cases of hypotension in the sample were considered preventable because all the residents developed the condition because of insufficient monitoring. Similarly, all allergic reactions identified in the sample were considered not preventable because the residents' medical records lacked historical information about allergies.* The impression left from this report creates an even more negative perception of skilled care despite valiant efforts and positive results from the industry to improve quality of care over the past decade.

Similar to the defenses advanced in litigation, the OIG report does find that in other cases, similar events had different preventability determinations, often because of variation in the health of SNF residents involved. In support of Plaintiff's theories, reviewers described pressure ulcers as preventable when the resident was generally healthy and able to comply with pressure ulcer precautions (e.g., frequent rotation of the resident) *but received inadequate evidence-based pressure ulcer precautions*. *They described pressure ulcers as not preventable when they found evidence that the resident received evidence-based preventative pressure ulcer care but developed the ulcers because of comorbidities that greatly increased their risk of developing pressure ulcers. Physician reviewers reported that these comorbidities made it difficult for SNF staff to provide the type of care typically used to prevent such ulcers.*

A list of rationale that we similarly face in litigation from the Plaintiffs is identified by the OIG as *Adverse and Temporary Harm Preventability Rationale* of preventable events and includes:

Appropriate treatment was provided in a substandard way;
The resident's progress was not adequately monitored;
Necessary treatment was not provided;
Error was related to medical judgment, skill, or resident management;
Resident care plan was inadequate;
Care plan was incomplete or not sufficient in describing resident's condition;
The resident's health status was not adequately assessed.

The rationale list of *Not Preventable Events* includes the clinical defenses we rely on in litigation:
Resident was highly susceptible to event because of health status;
Event occurred despite proper assessment and procedures followed;
Resident's diagnosis was unusual or complex, making care difficult;
Care provider could not have anticipated event given information available.

The industry needs to be prepared for what's on the horizon in response to the OIG report. The AHRQ and CMS have already concurred in the recommendations of the OIG and stated:

AHRQ and CMS should raise awareness of adverse events in post-acute care and seek to reduce harm to nursing home residents through methods used to promote hospital safety;

AHRQ and CMS should collaborate to create and promote a list of potential nursing home events;

CMS should include potential events and information about resident harm in its quality guidance to nursing homes (expect changes to the survey as noted above related to QAPI links);

AHRQ and CMS should encourage nursing homes to report adverse events to Patient SafetyOrganizations (PSOs); and

CMS should instruct nursing home surveyors to review facility practices for identifying and reducing adverse events.

While the mission and vision of the OIG report and its findings are designed to identify adverse events and improve resident safety (and reduce costs), the report is framed as an indictment against SNFs that serves to perpetuate the negative perceptions in the aging services industry and undermines the efforts that have been made industry-wide to improve the quality of resident care. Many recent surveys have established that resident and families are becoming more satisfied with the care at SNFs due in large part to examination of the culture of quality and safety over the past many years. While the OIG report provides data creating opportunities for continued improvements and compliance with the QAPI principles and best-practices, it also sends the clear message that higher levels of scrutiny by state and federal agencies can be expected adding more regulatory matters to consider.

Rebecca Adelman, Esq. – Ms. Adelman is a Shareholder of Hagwood Adelman Tipton, PC and practices in the Memphis, Tennessee office. She is a member of the Board of Directors and serves as the firm's President. For over 20 years, Rebecca has concentrated her practice in healthcare law, long-term care assisted living and medical malpractice defense litigation. Her expertise and her scope of practice involve all insurance defense litigation areas including premises and product liability as well as employment law. Please feel free to contact her at radelman@hatlawfirm.com.

NAL Professional Not Coming Addressed to You Personally?

We want to make sure you are personally getting this newsletter each month, not just have it forwarded to you because you're now holding down the position of a predecessor! Let us know you now are on the job. E-mail your name, facility/company name and address to chip@ecpnews.net & we'll update our records. Just put NAL Professional on the e-mail subject line and we'll take care of the rest.

NAL PROFESSIONAL
P.O. Box 4852
Johnson City, TN 37604

PRSRT STD
US POSTAGE
PAID
MWI

Documentation, Analytics & Reimbursement Optimization To Ensure Quality Care

Quality Care

Automated Instant Risk Alerts

Real-Time CNA to Nurse Instant Messages

Prevents Unnecessary Hospital Readmissions

Improves Patient Outcomes

Reimbursement

ADL Rule of Three Analytics

Daily RUG Score Combines CNA, Therapy & Nursing Data

1.888.210.3200
www.DARTChart.com

We Believe You Deserve Credit For All The Care You Provide

Nursing & Assisted Living Facility Professional

"NEWS AND VIEWS YOU CAN REALLY USE"

MAY 2014
ISSUE 5, VOLUME 4

SENT EACH MONTH TO YOU AS A MEMBER OF THE HEALTHCARE HEROES

THE HAT ADVANTAGE by Rebecca Adelman

On the Horizon for Long Term Care and Assisted Living

In anticipation of the *second annual Litigation Risk and Defense Strategies for Long Term Care and Assisted Living Providers, Insurers and Brokers* conference, I prepared a presentation focusing on what is on the horizon for the long term care and assisted living industries from both litigation and risk prevention views. This article will summarize that presentation as we look ahead in 2014 and beyond.

On the Horizon for Long Term Care – The Facts

Long-term care is experiencing increased scrutiny, increased claims, increased tactics, and increased liabilities. The **OIG Strategic Plan 2014-2018** established its goals as 1) Fight Fraud, Waste and Abuse; 2) Promote Quality, Safety and Values; 3) Secure the Future; and 4) Advance Excellence in Innovation. The **OIG Work Plan 2014** and the February 2014 **OIG Adverse Events Skilled Nursing Facilities** certainly emphasize OIG's goal to "Fight Fraud, Waste and Abuse" promise.

While the OIG 2014 Work Plan is shorter than the 2013 Work Plan, scrutiny will be no less for nursing homes and other providers.. A brief overview of the OIG 2014 Work Plan as it relates to skill nursing facilities includes the following directions: 1) policies and practices describing SNF billing practices in selected years and describing variations in billing among SNF's in those years. We can expect the Work Plan to focus on Medicare Part B Billing by SNF's; 2) focus on questionable billing patterns for Part B Services during nursing home stays not paid under Part A. Expect the OIG to be monitoring Part B billing for abuse during non-Part A stays; 3) quality of care and safety issues including state agency verifications of deficiency corrections identified during surveys in accordance with the federal requirements. Expect increased on-site reviews and requests for other evidence of correction; 4) continued development of a program for national background checks for long-term-care employees and determination of the outcomes of the state programs to determine whether the programs led to any unintended consequences; 5) determination of the extent to which Medicare beneficiaries residing in nursing homes are hospitalized as a result of conditions thought to be manageable or preventable in the nursing home setting. The context for this Work Plan item is the OIG 2013 review finding that 25% of Medicare beneficiaries were hospitalized for any reason in 2011. Finally, the OIG 2014 Work Plan will include anew area of the extent to which hospices serve Medicare beneficiaries who reside in assisted living facilities.

Long term care has also been and will likely continue to experience increased claims. The **2013 Long Term Care Report** key findings show that loss rates are increasing by 5% annually and that frequency is increasing by 2% annually. In addition, long term care severity is increasing by 3% annually on an overall basis. The forecasted 2014 accident year long term care GL/PL severity is $213,000 per claim limited to $1,000,000 per occurrence. As reflected in the **New England Journal of Medicine – *Relationship Between Quality of Care and Negligence Litigation Nursing Homes,*** the best performing nursing homes are sued only marginally less than the worse performing ones.

Included on the horizon are increased tactics by media and plaintiff's attorneys that highlight sensational aspects of the industry and enhance the scrutiny while driving claims. Plaintiff's attorneys are developing litigation theories such as "The Reptile Theory" and "Rules of the Road" along with target advertising, increased social media and nursing home abuse blogs and dramatic and emotional headlines for nursing home and assisted living occurrences. All of these initiatives serve to increase the focus and activity in LTC and ALF litigation.

Continued on page 3

KESSLER'S CORNER

by Chip Kessler

Getting to Know You

In my role as a marketing and customer service consultant for nursing and assisted living facilities nationwide, along with being someone who creates and develops census building staff training and development programs for buildings, I find there's an important question that often goes unanswered. **Do you know how people are finding your facility?** You may or may not be surprised to discover that there are many well-meaning, intelligent assisted living and nursing home administrators, executive directors, and marketing directors who can't specifically answer this question when I ask them it. So I'm asking you as well: *"how are those folks who are placing someone in your care coming to know about and find your facility?"* Here are some possibilities:

Continued on page 3

Pathway to Rehabilitation Excellence

By Sheila G. Capitosti, RN-BC, NHA, MHSA

VP Clinical and Compliance Services

President Obama Signs the Protecting Access to Medicare Act of 2014

On April 1, 2014, President Obama signed into law the ***Protecting Access to Medicare Act of 2014***. This new law prevents a 24% cut in reimbursements for physicians treating Medicare patients on April 1, 2014 and replaces it with a 0.5% update (through December 31, 2014) and a 0% update from January 1 until April 1, 2015.

A summary of provisions of interest to long-term care providers includes:

1. Extends through March 31, 2015, the therapy cap exception process for beneficiary annual limits set at $1,920 a year for occupational therapy (OT), or for a combination of physical therapy (PT) and speech language pathology (SLP). Also, extends the existing manual medical review process for all patients that exceed the $3,700 threshold for either OT or for both PT and SLP services
2. Extends the Medicare Geographic Practice Cost Index (GPCI) floor through March 31, 2015 at 1.0. The three GPCI's (work, malpractice, and practice expense) are used to adjust payments for resource costs that vary geographically. In 2003, Congress set in place a floor that suspends the GPCI at 1.0 for those localities with resource costs that are below the national average. Absent legislation, this floor is set to expire on April 1, 2014
3. Extends the CMS "probe and educate" program for auditing hospital discharges around CMS' two-midnight policy for 6 months. Secretary shall not conduct patient status reviews (as described in such notice) on a post-payment review basis through RACs for inpatient claims with dates of admission October 1, 2013, through March 31, 2015, unless there is evidence of systematic gaming, fraud, abuse, or delays in the provision of care by a provider of services
4. Makes technical corrections to the Long Term Care Hospitals (LTCH) site neutral payment policy to: 1) clarify that only Medicare fee-for-service discharges will be used to calculate the numerator and denominator of the LTCH discharge payment percentage; and 2) establish an exception to the building moratorium for LTCHs
5. Repeals Section 1302(c)(2) of the *Affordable Care Act* and eliminates deductible limitations on small group health plans
6. Delays the transition to ICD-10 under the Medicare program for 1 year, to October 1, 2015
7. Establishes a skilled nursing facility (SNF) value-based purchasing (VBP) program by October 1, 2019. The SNF VBP program will be based off of individual SNF performance on a hospital readmission measure. No later than June 2021, MedPAC shall submit to Congress a progress report
8. Reforms the current Medicare lab fee schedule by adopting market-based private sector payment rates under the Medicare program for lab services. Increases a "sample collection fee" by $2 from an individual in a SNF or by a laboratory on behalf of a home health agency. Mandates a GAO study and report on the implementation of new payment rates for clinical diagnostic laboratory tests no later than October 1, 2018
9. Uses funds set aside in *H.J. Res. 59, the Bipartisan Budget Act of 2013,* which set aside $2.3 billion for patching the SGR. This provision would use these funds to help offset the cost of this legislation
10. Realigns the Medicare sequester in 2024 without increasing the overall effect on Medicare providers
11. Allows the Secretary of HHS to use information received from medical providers and other sources to adjust code pricing to address misvalued codes used under the Medicare Physician Fee Schedule. In addition, this provision would address GPCI payment locality irregularities in the state of California and disclose the data used to establish the radiology multiple procedure payment reduction published in the *Federal Register* in 2012

For more information, please contact Sheila Capitosti, VP Clinical and Compliance Services, Functional Pathways at scapitosti@fprehab.com or call 888-531-2204. You can also discover more at www.functionalpathways.com

The HAT Advantage continued from page 1

We are also seeing increased liability for other defendants including medical directors, non-physician practitioners, administrators, and corporate entities based on corporate liability. The nursing home transparency provisions in the Patient Protection and Affordable Care Act along with recent court holdings on corporate liability and expanded roles of non-physician providers have resulted in broader liability for these various categories of defendants.

Overall, the industry should continue preparing for increased scrutiny and litigation while also implementing all quality measures and CMS compliance programs as part of overall risk prevention and risk reduction strategies

On the Horizon for Assisted Living – The Facts

We are seeing an expansion of the reach of home and community-based service programs across the country. Assisted living is a primary choice for those wishing to age in place along with the other supportive service programs and models for newer and expanding programs in the community. As part of the focus on the "aging in place" models, ALFs are seeing increased state regulations and higher levels of scrutiny by the government and plaintiff's attorneys. The **Assisted Living State Regulatory Review 2013** evidences that eighteen states reported making regulatory, statutory or policy changes affecting assisted living/residential care communities through January 2013. At least nine of these states made major changes including developing new models for surveys, expanding disclosure and reporting requirements, addressing life safety, and infection control, and allowing increased delegation of medication administration to non-nurse staff. These changes in regulations are, in some states, responsive to the reform packages movement toward residential care facility. In California, there is a strong movement toward reform in residential care. In Florida, the senate passed a bill increasing licensing for homes that handle mentally impaired residents and requires a rating system be in place for assisted living facilities by March 2015. The public can also read anonymously posted reviews and complaints of assisted living facilities and owners of these facilities would face higher fines for repeated serious violations. The increased scrutiny in the *Bayless/Glenwood Gardens* and *Boice/Emeritus* incidences as well as the Frontline and other media reporting on assisted living, have created an environment for plaintiff's attorneys to bolster advertising and social media toward increased litigation in assisted living. As in LTC, liability models for defendants, such as medical directors, individual nurses and administrators and ancillary service providers, are being developed.

On the Horizon – Recommendations for Risk Prevention Strategies

Now and looking ahead, LTC and ALF must continue to implement quality measures consistent with state and federal regulations and also develop plans for responding to crisis through proactive communications. For LTC, the OIG has identified multiple recommendations that have been accepted by AHRQ and CMS, which provide a road made for facilities in developing more enhanced QAPI program. In February 2014, CMS published its **Process Tool to the QAPI Five Elements** that can also serve as a guide for advanced quality assessment performance improvement programs. In both LTC and ALF, evaluating QA/QIC committees and protocols for investigating nursing home LTC and ALF events should be part of the overall increased risk management strategies. Evaluating and modifying abuse prevention policies and training along with policy and procedures handbooks for your facilities will continue to serve as risk prevention strategies. In assisted living, we are increasing the use of negotiated risk agreements as residents are choosing to age in place and we continue to recommend arbitration agreements and comprehensive training programs in both LTC and ALF. A proactive crisis communication plan and positive community profiles through marketing efforts are the tools necessary for presenting positive images for our industries. There are a multitude of recommendations for preparing and addressing the future of risk in LTC and ALF. I invite you to send me an email and would be pleased to send a list of resources and the presentation material from the conference.

With continued awareness of what is on the horizon, we are ready for current and emerging risks as well as enhancing the delivery of quality care.

Rebecca Adelman, Esq. – Ms. Adelman is a Shareholder of Hagwood Adelman Tipton, PC and practices in the Memphis, Tennessee office. She is a member of the Board of Directors and serves as the firm's President. For over 20 years, Rebecca has concentrated her practice in healthcare law, long-term care assisted living and medical malpractice defense litigation. Her expertise and her scope of practice involve all insurance defense litigation areas including premises and product liability as well as employment law. Please feel free to contact her at radelman@hatlawfirm.com.

Kessler's Corner continued from page 1

- They just happen to know about your facility (more about this later)
- Direct referral from a local hospital, or a local physician
- Media advertising on local radio, newspapers or television
- On-Line Presence such as your web site and/or Facebook
- Some Other Advertising/Marketing Initiative

These are just some of the avenues that folks come to know about your building and then take the next step regarding admission. However no matter how you are getting new residents, the bottom line is that YOU MUST KNOW specifically where they're coming from. There are a couple of reasons why: 1) whatever's bringing you new residents is working so you want to do more of this and 2) when you know what's working well, you also discover what isn't going so great and you need to either refine this or stop doing it entirely.

Now I've touched on knowing how people discover your facility, and you may be wondering how do I find out? Let me give you a few suggestions: 1) make it a point to ask anyone who calls your facility inquiring about your care and services, comes to your facility to take a tour, and/or admits a new resident how he or she first heard about you? As well here, you want to get as specific information as possible. Remember my earlier *"Just Happen to Know About Your Facility"* response listed among the potential choices: here you may get this response, and it's too vague. Yes the person *"knows about you"* but how? Perhaps they've always lived in the town or city you're located, yet something spurred them into selecting your facility … what was it?

I'd like to help you to find out. A while back I developed a special Extended Care Products Marketing and Advertising Tracking Form© that I'll send you as a special free gift for being a reader of *Nursing & Assisted Living Facility Professional.* This short form eliminates the need for you asking folks a bunch of questions and tells you what's working or not working well, so you can make intelligent and educated marketing/advertising decisions in the future. Just e-mail me at chip@extendedcareproducts.com and in the subject line put: "Tracking Form" and you'll receive this with my compliments. The bottom line here is that you want to be able to trace from this point forward every new admission and every new inquiry about your facility.

Chip Kessler, General Manager of Extended Care Products, is a member of the Census Building Academy, a group of nursing and assisted living facility professionals dedicated to helping you get more new residents. Discover more at www.CensusBuildingAcademy.com

NAL Professional Not Coming Addressed to You Personally?

We want to make sure you are personally getting this newsletter each month, not just have it forwarded to you because you're now holding down the position of a predecessor! Let us know you now are on the job. E-mail your name, facility/company name and address to chip@ecpnews.net & we'll update our records. Just put NAL Professional on the e-mail subject line and we'll take care of the rest.

NAL PROFESSIONAL
P.O. Box 4852
Johnson City, TN 37604

PRSRT STD
US POSTAGE
PAID
MWI

WEBINAR: "Get to Know Your PEPPERs" Discover More at www.WebinarLTC.com

Documentation, Analytics & Reimbursement Optimization To Ensure Quality Care

Quality Care

Automated Instant Risk Alerts

Real-Time CNA to Nurse Instant Messages

Prevents Unnecessary Hospital Readmissions

Improves Patient Outcomes

Reimbursement

ADL Rule of Three Analytics

Daily RUG Score Combines CNA, Therapy & Nursing Data

1.888.210.3200
www.DARTChart.com

We Believe You Deserve Credit For All The Care You Provide

Nursing & Assisted Living Facility
Professional

"NEWS AND VIEWS YOU CAN REALLY USE"

JUNE 2014
ISSUE 6, VOLUME 4

SENT EACH MONTH TO YOU AS A MEMBER OF THE HEALTHCARE HEROES

THE HAT ADVANTAGE by Rebecca Adelman

The LTC Medical Director - Survey Implications and Support

Over the last decade, the responsibilities of the LTC medical director have expanded significantly along with related survey implications. Facilities must ensure compliance with F501 governing medical director and should look to the medical director to have an enhanced role in the survey process. In addition to F501 – medical director, other F-tags directly pertain to the required responsibilities of medical directors per the State Operations Manual (SOM). As CMS and OIG scrutiny of the survey process increases, facilities are encouraged to place greater focus on the Medical Director's role. The Medical Director's involvement in and understanding of the survey provides the facility necessary support through the process.

F501 – Medical Director

The Federal Regulations state:
§483.75(i) Medical Director
(1) The facility must designate a physician to serve as Medical Director.
(2) The Medical Director is responsible for –
(i) Implementation of resident care policies; and
(ii) The coordination of medical care in the facility.

Per CMS, the Medical Director has an important leadership role in actively helping LTC facilities provide quality care. The two roles identified by the regulation provide the basis for the functions and tasks discussed in the survey guidance. The physician serving as medical director must be knowledgeable of current standards of practice and be able to coordinate and oversee care of LTC residents. The Medical Director's clinical leadership and input promote the attainment of optimal resident outcomes. The Medical Director is in a position to provide input to surveyors on physician issues, individual resident's clinical issues, and the facility's practices. The original Guidance to Surveyors pertaining to F501 included broad and vague language. In addition, there were no investigative protocols for surveyors to follow and no formal method to tie the medical director and physician staff to deficiencies in other areas of care.

Under the revised F501, expectations for the Medical Director are outlined and involvement is tied into quality of care. Organizations and respective medical directors should consider the following:

- Collaborate with the facility as it develops policies and protocols that guide clinical decision-making by practitioners
- Assist the facility as it incorporates current standards of practice into residents care policies and procedures/ guidelines
- Provide input into development, review, and approval of resident care policies
- Guide, approve and help oversee implementation of resident care policies such as admission policies and care practices that address residents' needs; availability, qualifications and clinical functions of staff necessary to meet residents' care needs; and provision of physician services.

Coordination of medical care is a key role and responsibility of the Medical Director and should include:

- Helping the facility obtain and maintain timely and appropriate medical care
- Assuring medical care that supports residents' health care needs is consistent with current standards of practice and helps the facility meet regulatory requirements
- Reviewing and evaluating aspects of physician care and practitioners services
- Helping the facility identify, evaluate, and address health care issues related to the quality of care and quality of life

Additionally, F520 - Quality Assurance, notes a Medical Director may be the physician designated by the facility to serve on the quality assurance committee. Many clinically based Interpretative Guidelines associated with various F-tags imply the Medical Director's oversight and responsibility roles to quality assurance. These include F329-unnecessary drugs, F327-hydration, F325-nutrition, F321-22-naso-gastric tubes, F315-urinary incontinence, F314-pressure sores, and F221-26-restraints.

Continued on page 3

Pathway to Rehabilitation Excellence

By Cherie Rowell, COTA, Director of Clinical Services

MEDICATION AND THERAPY TREATMENT

Prescription drugs are important in the treatment and management of chronic diseases and pain in the senior population. The right medication can greatly contribute to improvement in quality of life, decreased pain and chronic symptomology, as well as increasing life span. Polypharmacy, including many over the counter remedies, is common with this population, often resulting in physical and cognitive deficits that impact recovery and achievement of positive therapy outcomes.

Seniors at highest risk include those with chronic disease processes, high level of fragility, existing cognitive deficits (dementia), and depression. Polypharmacy can result in increased hospitalizations (due to adverse drug events), increased falls with injury, decreased cognition and safety awareness. It is vitally important that the interdisciplinary team pay close attention to and monitor physical and psychological/ cognitive changes for the resident that requires multiple medications. Even so, any single medication can produce subtle side effects that can impact optimal participation and positive outcomes while receiving PT, OT or ST.

On an initial therapy evaluation, the evaluating therapist should note the medications currently being prescribed, any over the counter remedies being used and document changes to the medication regime on an ongoing basis during the course of care. Therapists should be knowledgeable about specific medication, possible side effects and be able to recognize and report those side effects if interfere with the resident's overall recovery and progress in therapy. Side effects that may affect therapy treatment include but are not limited to:

- Decreased balance, shuffling gait
- Decreased safety awareness
- Change in cognition
- Increased agitation
- Nausea/vomiting
- Weakness/decreased endurance
- Muscle tone changes/rigidity
- Increased sleepiness/lethargy

It is crucial that the long term care community's interdisciplinary care team work together in recognizing and monitoring side effects to ensure the resident every opportunity to achieve the highest level of quality of life and functional independence possible.

For more information, please contact Cherie Rowell, Director of Clinical Services Functional Pathways at crowell@fprehab.com. *You can also discover more at www.functionalpathways.com*

INNOVATIVE REHAB OUTCOMES

EXCELLENCE IN REHABILITATION

Functional Pathways™
Excellence in Rehabilitation

www.functionalpathways.com | 888.531.2204

Extended Care Products Inc.

Presents The 60-Minute Webinar/Teleconference

"Survey F-tags and the MDS - What You Need to Know"

Tuesday, June 17th (Two Times to Choose From)

Do you know what the State Operations Manual (SOM) says about the MDS? Did you know that CMS is currently developing a focused survey processes in order to inform future activities to enhance MDS 3.0 accuracy and care planning in nursing homes, including potentially more widespread survey activities?

Join Noted MDS expert Joel VanEaton for an in depth look at the survey tags that directly affect the MDS. In the webinar Survey F-tags and the MDS - What You Need to Know, Joel will explore the F-tags that most directly impact the MDS and what you can do to be sure that your facility is compliant and ready for what is sure to become increased survey scrutiny of the MDS. Don't miss out, space is limited.

Please visit www.WebinarLTC.com for more information and to register, or you may call 1-800-807-4553.
All registrants receive two free bonus gifts!

The HAT Advantage continued from page 1

Some states may also have specific regulations on the role of the medical director and compliance on the sometime expanded regulations must be focused. For example, in Tennessee:

(d) The Medical Director shall be responsible for the medical care in the nursing home.

The Medical Director shall:
1. Delineate the responsibilities of and communicate with attending physicians to ensure that each resident receives medical care;
2. Ensure the delivery of emergency and medical care when the resident's attending physician or his/her designated alternate is unavailable;
3. Review reports of all accidents or unusual incidents occurring on the premises, identifying hazards to health and safety and recommending corrective action to the administrator;
4. Make periodic visits to the nursing home to evaluate the existing conditions and make recommendations for improvements;
5. Review and take appropriate action on reports from the Director of Nursing regarding significant clinical developments;
6. Monitor the health status of nursing home personnel to ensure that no health conditions exist which would adversely affect residents; and,
7. Advise and provide consultation on matters regarding medical care, standards of care, surveillance, and infection control.

The American Medical Directors Association offers the following tips for facilities that want to ensure compliance with the revised F501 tag:

1. Select a physician medical director based on availability, interest, identification of responsibilities required by law, regulations, and recommendations by professional associations.
2. Develop a job description by the administrator and the medical director working together based on the facility's needs and the desired or required medical director functions.
3. Establish a plan to guide the medical director's activities that involves clarifications of relationships between the facility and its medical director and physicians, identification of how the medical director will define physician responsibilities, and determination of the medical director's quality assurance activities.

An examination of the facility's existing contractual relationship with the medical director is also recommended. Are performance requirements and specific activities included? Are there expectations for involvement in the survey process to include plans of correction? As medical directors have greater responsibility and more visibility, they are often being named as defendants in lawsuits associated with failing to perform one's duties. Understanding all aspects of the role and your organization's relationship with the Medical Director is critical to risk and liability reduction.

The Medical Director and the Survey Process

Consistent with the American Medical Directors Association, medical directors should be involved in the survey process by both understanding the survey itself and the elements of care that influence survey results. They should be aware of survey problems as they arise, attend the exit conference, and be knowledgeable of potential deficiencies and their merits. They should be significantly involved in dispute resolutions and plans of correction, and providing needed clinical expertise often lacking. These steps would help promote the medical director's role in defining, establishing, and monitoring care processes and policies.

AMDA also promotes medical directors "functioning as key sources of education, information, and guidance for state survey agencies, providing clinical information, and medical interpretations for issues within nursing facilities. Medical directors can help reduce the number and severity of deficiencies by overseeing and evaluating specific care practices, and by educating physicians and staff in the importance of appropriate, documented care, that meets regulatory needs. Medical directors can play an integral role throughout the survey process; and should be notified by the facility when the survey starts. They should ask to be contacted regarding clinical care or medical concerns of any resident in the facility. Administrators or directors of nursing should notify medical directors of all quality of care and medical issues noted during the survey. Medical directors should contact attending physicians of residents whose care is questioned by surveyors. If appropriate, medical directors may wish to help clarify issues directly with surveyors before consulting with attending physicians. Medical directors also can help explain, as appropriate, the judgment of other facility professionals."

The AMDA also recommends that medical directors must have an understanding of "deficiencies involving resident care and help in determining which should be challenged and which should be addressed as legitimate problems. Whether disputed or not, plans of corrections must involve the input of medical directors. This is especially true of issues on quality of care, physician services, drug usage, and clinical issues such as pressure sores and infection control. Medical directors should assist in drafting, and not just reviewing, plans of corrections in these areas. They should ensure that these plans of correction are meaningful, thorough and will address care process problems and not superficial issues." A valuable white paper by the AMDA on the Medical Director as leader and manager is worthy of review. http://amda.com/governance/whitepapers/A11.cfm

Consider your medical directors and their roles and responsibilities as defined by CMS and the standards governing medical services in the delivery of quality of care. Fewer deficiencies and less litigation can be the positive results of a greater focus on the medical director's role in the facility and during the survey.

Rebecca Adelman, Esq. – Ms. Adelman is a Shareholder of Hagwood Adelman Tipton, PC and practices in the Memphis, Tennessee office. She is a member of the Board of Directors and serves as the firm's President. For over 20 years, Rebecca has concentrated her practice in healthcare law, long-term care assisted living and medical malpractice defense litigation. Her expertise and her scope of practice involve all insurance defense litigation areas including premises and product liability as well as employment law. Please feel free to contact her at radelman@hatlawfirm.com.

Do You Want Your Facility to Be Ready in an Emergency?

Discover Why "The Crisis Cure Action Plan" is the Answer!

Visit www.ExtendedCareProducts.com to Find Out More

NAL Professional Not Coming Addressed to You Personally?

We want to make sure you are personally getting this newsletter each month, not just have it forwarded to you because you're now holding down the position of a predecessor! Let us know you now are on the job. E-mail your name, facility/company name and address to chip@ecpnews.net & we'll update our records. Just put NAL Professional on the e-mail subject line and we'll take care of the rest.

NAL PROFESSIONAL
P.O. Box 4852
Johnson City, TN 37604

PRSRT STD
US POSTAGE
PAID
MWI

Documentation, Analytics & Reimbursement Optimization To Ensure Quality Care

Quality Care

Automated Instant Risk Alerts

Real-Time CNA to Nurse Instant Messages

Prevents Unnecessary Hospital Readmissions

Improves Patient Outcomes

Reimbursement

ADL Rule of Three Analytics

Daily RUG Score Combines CNA, Therapy & Nursing Data

1.888.210.3200
www.DARTChart.com

We Believe You Deserve Credit For All The Care You Provide

Nursing & Assisted Living Facility *Professional*

"NEWS AND VIEWS YOU CAN REALLY USE"

JULY 2014
ISSUE 7, VOLUME 4

SENT EACH MONTH TO YOU AS A MEMBER OF THE HEALTHCARE HEROES

THE HAT ADVANTAGE by Rebecca Adelman

The Assisted Living Physician and Nurse Practitioner – The Health Care Leaders

While there is debate about best models for assisted living, there is consensus the nursing facility population has changed, and shifts of care sites have expanded the care delivery systems for assisted living (AL). AL is meeting needs previously met by skilled nursing facilities. For many, AL is a site of choice. The autonomy of the social model delivers personal choice and a focus on wellness. AL is responsible for assisting families in addressing the emotional and end-of-life issues of aging residents. The clinical profile of an older AL resident as overall healthy, primarily ambulatory, and in need of moderate assistance has changed. I have reported on the statistics of the new AL resident with multiple co-morbid conditions, complex medication regimen, in need of extensive assistance and likely with cognitive deficits including dementia. Families have unrealistic expectations of the AL model and its responsiveness to their loved ones.

Liability issues in ALs reflect the increasing changes of the residents. State regulations are addressing the changing role of AL, and AL has seen heightened levels of scrutiny. AL providers can respond to these trends by adding health care team members, implementing staff training, and enhancing risk management programs. The physician and nurse practitioner as health care leaders are key resources in AL medical and social models. ALs must address complications of aging and medical conditions that affect the chronically ill. The appropriate management of medical issues may significantly affect quality of life including personal and social function. These issues present challenges and this article will focus on the roles of the physician and nurse practitioner in AL and offer recommendations for the facility and provider.

The Physician Care Challenge – *AMDA* conducted a series of interviews of residents, families, staff, and administration of various smaller ALs revealing four major physician-A concepts:

(1) magnification of physician authority

(2) (2) disagreements with physician care

(3) (3) physician communication

(4) (4) continuity/discontinuity of physician care

The first concept, magnification of physician authority, found that the primary care physician might write an order that is misinterpreted (magnified) by the staff. The second concept, disagreements (by the residents, families, or staff) with physician care, is common and may reflect the limited information provided to the physician from the AL or family forming the treatment plan decision. The third concept, physician communication, focuses on the need for the staff, family, and others to communicate with the physician, which is time consuming for a physician. The fourth concept, continuity/discontinuity of physician care, is prevalent in most ALs because of geographic separation and the involvement of hospital physicians during hospital admissions and of specialists managing specific diagnoses.

Recommendations for the AL

Setting Expectations* with *Disclosures before Admission – Clearly identify medication policies, clinical capabilities, and service and care limitations to potential residents and their families.

Disclosures After Admission - Provide detailed information about clinical capabilities and limitations to off-site pharmacies and resident's physician.

Clearly Defined Lines of Communication in the Facility- Know who to contact when there are medication or clinical issues such as continuing indications for treatment or suspected adverse consequences.

Continued on page 3

KESSLER'S CORNER

by Chip Kessler

How to Join the Top 5% Percent

I've touched on this subject before with my nursing and assisted living consulting clients in the past, and am going to offer it up here for your consideration. Question: How to be in the top 5% of folks in the workplace environment? Answer: Follow through.

Continued on page 2

Pathway to Rehabilitation Excellence

by David Higdon

Opportunity Is Knocking — Value-Based Purchasing

by David Higdon

With the multitude of value-based purchasing changes emerging from the Affordable Care Act it is easy to miss some. Most of you know that in October new conditions will added to the hospital re-admissions penalty program. What you may have missed in all of this is that the Centers for Medicare and Medicaid Services (CMS) are going to initiate financial penalties on hospitals with high episodic spending, and here is the interesting part, it could involve thirty days of post-acute care.

You may be asking yourself, what does this mean to me? It means there is opportunity looking you squarely in the eye.

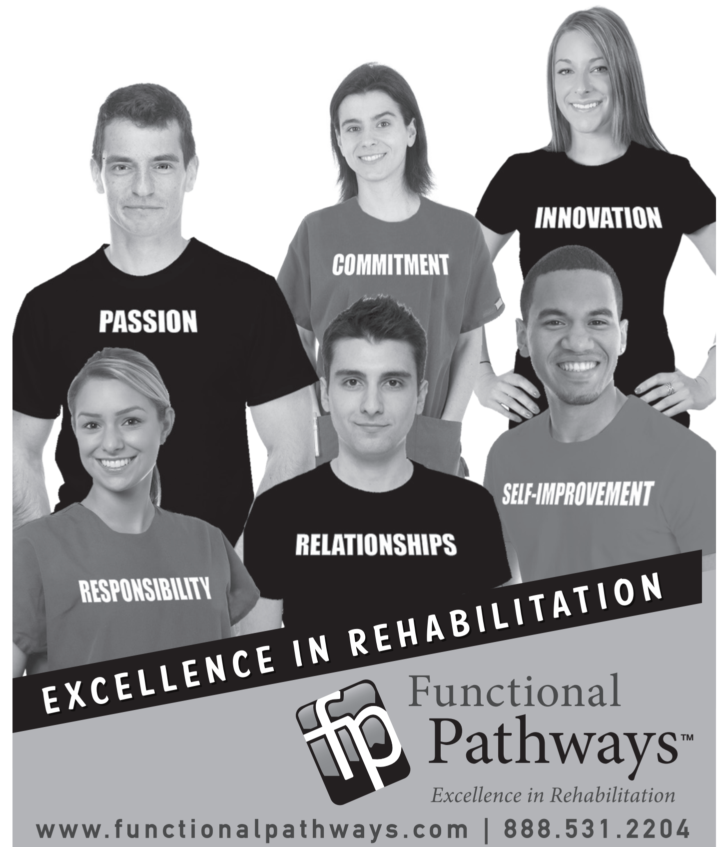
In their on-going effort to shift providers' efforts to value from volume CMS is implementing the Medicare Spending per Beneficiary (MSPB) as part of the Value-Based Purchasing Program (VBP). This will increase hospitals' responsibility for care after discharge. Because CMS is looking at spending across an episode of care, hospitals and post-acute providers now have reason to work together. Since spending is being tracked during the thirty days after a hospital discharge, post-acute providers will have an impact on the MSPB scores either positively or negatively.

Now that you see the opportunity it is time to chart a course on how to approach a hospital about working together. Hospitals are under more intense scrutiny every day and you need to demonstrate your understanding of this.

First you should know the hospitals' MSPB score which you can obtain from the CMS website. This is extremely important for you to know as it shows you are paying attention to the hospital as well as yourself. Secondly you need to know that that re-hospitalizations, length of stay of a SNF and cost associated with all post-acute providers. Lastly you must be able to articulate your outcomes and how they can be helpful to that hospital.

I have talking for a long time now about metrics and how you must be aware of your own. This is a perfect opportunity to use those and become a true partner with a hospital. You help them and they reward you with referrals. That my friend is answering the door when opportunity knocks.

David Higdon is Director of Marketing for Functional Pathways, the leader in contract rehabilitation and therapy services throughout the United States. For more information please call 865-474-8418 or visit www.functionalpathways.com



Kessler's Corner continued from page 1

Two words ("follow through") however two very powerful words indeed. This may sound like a gripe session, though I write about it to prove my point. I can't begin to count how many times over the course of doing business that I'm disappointed in the manner people act and react. Case-in-point: you call and leave a message, making sure to speak clearly and slowly so that the recipient gets your name, telephone number and the reason for your call, only to not hear back from them. Perhaps you're even calling and wish to do business with their company or organization (i.e. spend money) and zilch. Indeed when someone gets in touch with me (phone call or e-mail) regarding a program product or service we have at Extended Care Products; you better believe I'm responding. If someone has gotten in touch with your nursing facility or assisted living community to find out more about your care and services, will their phone call or e-mail receive a response? However every day such calls and/or e-mails go ignored, no matter what business you're looking at, healthcare related or not.

Let's take the "follow through" mantra one step further and add another word into the mix: "dependability." Do you believe it's a good character trait to become that person your fellow co-workers, clients, residents, family members, etc. can depend on? Would it help your nursing or assisted living facility to posses this kind of reputation in your region? Would it help your census?

Anymore, I pay close attention to how people react to my inquiries, questions and requests. Families scouting out caregiving options are doing the same. In the nursing and assisted living facility environment there are choices. You need to give people reasons to select your building. Is it that you and your fellow staff members, perhaps without realizing it, are giving folks reasons why they shouldn't do business with you?

Chip Kessler's latest customer service program is now on display at www.YearofCustomerService.com with an exciting new twist.

The HAT Advantage continued from page 1

Clearly Defined Lines of Communication with the Physician - Inform the physician when the patient is admitted and notify appropriate clinical office, nursing supervisor, or administrator providing the physician's phone number and procedures regarding who to contact to communicate new/changed orders or status of resident.

Notification of Transfers - Develop policies that include notification of the physician of hospital transfers so that issues such as medication reconciliation and medication management can be reviewed and updated as needed.

Recommendations for the Physician

Understand the AL - Understand the facility's medication policies and clinical capabilities and limitations. Meet and communicate with the administrator, operator, and clinical staff.

Support the patient – Help and encourage the facility to accommodate the patient wishes and preferences, to the extent possible.

Clear Communication Lines - Find out who to contact to provide medical orders and other clinical instructions, e.g., monitoring BP, weight, labs, etc. and identify who at the facility will notify about problems with his/her patients.

Set Clear Expectations – Discuss and describe the likely trajectory of the resident's illness/condition(s) and expected outcomes with resident/family and key staff, and understand the resident/family expectations.

Know About Negotiated Risk Agreements – Be familiar with the AL policy regarding negotiated risk agreement (NRA). Be aware of the resident contemplating an NRA to allow for making a determination if the medical plan of care might be in jeopardy and the physician possibly is at risk of malpractice.

The Role of the Nurse Practitioner

The demand for primary care services in the United States is expected to increase over the next few years, particularly with the aging and growth of the population and passing of the Affordable Care Act (ACA). Research suggests that NPs trained to deliver many primary care services already do, and therefore may be able to help increase access to primary care, particularly in underserved areas. In the AL setting, NPs demonstrate a convergence of social and medical models and are ideal candidates for the role of health services director/health care leader in AL settings. Particularly NPs with gerontologic education, AL's can benefit from experiences in geriatric concerns such as polypharmacy, falls and fall prevention, incontinence and cognitive issues.

Potential NP Roles (*see GAPNA*)

Primary care management
Specialty practice in incontinence
Mental health care including behavior management
Wound management
Medication therapy management services
Staff, resident, and family education
Risk management (e.g., designing fall risk reduction programs)
Administration

The goal is optimal care to AL residents, consistent with applicable standards of practice. The role of the physician and NP should expand to meet the more extensive social and medical needs of the AL resident. They will need ample detailed information about their patients to make appropriate clinical decisions. As part of overall risk management and quality of care operations, ALs must have clear policies about the extent of the capabilities, which they provide to physicians and NPs, caring for their residents. Informing medical providers (as well as residents, families, and staff) about limitations affecting the physician or NP's ability to promote treatment approaches is central to relationship between the AL and the physician/NP. Collaboration with the physician and NP will create a social and medical model for the AL as we continue to self-evaluate and grow in AL and meet the challenges and rewards ahead.

For additional information and resources, visit *AMDA – The Society for Post-Acute and Long-Term Care Medicine* and *The Gerontological Advanced Practice Nurses Association (GAPNA).*

Rebecca Adelman, Esq. – Ms. Adelman is a Shareholder of Hagwood Adelman Tipton, PC and practices in the Memphis, Tennessee office. She is a member of the Board of Directors and serves as the firm's President. For over 20 years, Rebecca has concentrated her practice in healthcare law, long-term care assisted living and medical malpractice defense litigation. Her expertise and her scope of practice involve all insurance defense litigation areas including premises and product liability as well as employment law. Please feel free to contact her at radelman@hatlawfirm.com.

Extended Care Products Inc.

As Part of Our "Tuesday Talks" Summer Series
Presents The 60-Minute Webinar/Teleconference:

The 5-Star Quality Measure - Do You Measure Up?

Tuesday, July 22nd (Two Times to Choose From)

Recently *McKnight's Long Term Care News* reported that, "staff understanding of MDS Quality Measures is mediocre at best", and that there is a consensus opinion that all staff should, "…be involved in using QIs to inform care."

While administrators and DON's understand the Staffing and Health inspection stars. The confusion is often surrounding the QM piece of the 5-star rating especially which QM's affect it, how those QMs are calculated, how the Quality star rating is calculated based on those measures, and then how to apply individual facility data to care processes.

It is imperative that nursing home staff have a firm grasp on this information so that it can be used to address facility level quality areas represented in the 5-star rating. Join nationally recognized MDS expert Joel VanEaton for this webinar that will be sure to leave you equipped to understand and apply your 5-star quality rating.

Please visit www.WebinarLTC.com for more information and to register, or you may call 1-800-807-4553.

All registrants receive use of a toll-free telephone line plus a copy of Joel's webinar slides as free bonus gifts!

NAL Professional Not Coming Addressed to You Personally?

We want to make sure you are personally getting this newsletter each month, not just have it forwarded to you because you're now holding down the position of a predecessor! Let us know you now are on the job. E-mail your name, facility/company name and address to chip@ecpnews.net & we'll update our records. Just put NAL Professional on the e-mail subject line and we'll take care of the rest.

NAL PROFESSIONAL
P.O. Box 4852
Johnson City, TN 37604

PRSRT STD
US POSTAGE
PAID
MWI

Documentation, Analytics & Reimbursement Optimization To Ensure Quality Care

Quality Care

Automated Instant Risk Alerts

Real-Time CNA to Nurse Instant Messages

Prevents Unnecessary Hospital Readmissions

Improves Patient Outcomes

Reimbursement

ADL Rule of Three Analytics

Daily RUG Score Combines CNA, Therapy & Nursing Data

1.888.210.3200
www.DARTChart.com

We Believe You Deserve Credit For All The Care You Provide

Nursing & Assisted Living Facility *Professional*

"NEWS AND VIEWS YOU CAN REALLY USE"

AUGUST 2014
ISSUE 8, VOLUME 4

SENT EACH MONTH TO YOU AS A MEMBER OF THE HEALTHCARE HEROES

THE HAT ADVANTAGE by Rebecca Adelman

NURSING HOME EMERGENCY PREPAREDNESS: FILLING IN THE GAPS

Thank you to co-authors Stan Szpytek and Steve Wilder for their editorial support and contribution on Nursing Home Emergency Preparedness: Filling the Gaps. Pursuant to Federal Register Volume 78, Issue 249 (December 27, 2013) (Dec. 27, 2013), 17 different providers and suppliers, including nursing homes, must meet new emergency preparedness requirements to participate in the Medicare and Medicaid programs. The regulation "Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers," https://www.federalregister.gov/articles/2013/12/27/2013-30724/medicare-and-medicaid-programs-emergency-preparedness-requirements-for-medicare-and-medicaid.

The regulations and revised CMS emergency preparedness checklist found at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-14-12.pdf, were designed after a 2012 Office of Inspector General (OIG) report reviewed state survey data for emergency preparedness in nursing homes and found that although most long-term care facilities had emergency plans, the majority of the plans were wholly inadequate. Half of the sampled plans contained only 50 percent of the CMS-recommended checklist items, according to the OIG's "Gaps Continue to Exist in Nursing Home Emergency Preparedness and Response During Disasters: 2007-2010." The report surveys were conducted following natural and man-made disasters such as 9/11, Hurricane Katrina, and other threats and perils requiring comprehensive emergency preparedness protocols and disaster planning initiatives. Events like earthquake, fire, flood, power failure, terror-related incidents, severe weather, and other adverse occurrences require robust preparedness and action planning to help safeguard communities and have been the focus of federal agencies.

While many facilities have historically developed disaster or emergency plans focused on common hazards or those geographically specific (i.e. Midwest- severe weather, Coastal regions- hurricanes, Seismic zones- earthquakes), the new rule will require providers to develop plans utilizing an "All Hazards" approach to emergency preparedness.

Summary of the Emergency Preparedness Regulation

Key areas of the proposed rule that providers should be familiar with:

- Emergency Operations Plan (EOP) must be developed in accordance with a risk analysis of the types of emergencies that can potentially impact the facility. This will require the completion of a Hazard Vulnerability Assessment (HVA) or similar process identifying all potential threats and perils based on natural and man-made factors.

- Written policies and procedures must be developed in accordance with the facility's risk analysis and the specific information contained in the EOP, and reviewed and updated annually.

- The EOP must identify specific amounts of subsistence (food, water, supplies, etc.) for both patients and staff during an emergency or disaster.

- The facility must have an emergency preparedness communications plan that complies with state and federal law.

Continued on page 2

KESSLER'S CORNER

by Chip Kessler

"To Serve and Protect"

The title of my column this month can apply to many special people in a few chosen professions. I've heard it used with those folks who are members of a local police department who are out and about serving and protecting our lives and liberties.

Continued on page 3

Pathway to Rehabilitation Excellence

By Sheila G. Capitosti, RN-BC, NHA, MHSA

VP Clinical and Compliance Services

Length of Stay---Longer Is Not Necessarily Better

Health care facilities have been tracking and measuring their success for many years related to clinical outcomes and while the cost of care to produce successful clinical outcomes has always been a key factor in overall analysis of results, it is becoming more and more crucial that in order to compete in today's market, one must produce not only good quality clinical outcomes but also demonstrate the least financial cost for the beneficiary, third party payer and local referral sources.

Length of stay is becoming a key indicator that providers must learn to manage in order to effectively partner with local referral sources as well as to negotiate and maintain managed care contracts, participate in a bundling arrangement or secure a seat at the ACO table.

Post-acute care efficiency is related to three things: hospital readmissions, skilled nursing facility length of stay, and use of high-cost PAC settings (for example, long-term acute care hospitals and inpatient rehabilitation facilities instead of SNFs, or SNFs instead of home health).

The winners in this changing health care market will be able to demonstrate their efficiency by presenting both their efficiency and quality story. Length of stay must be critically analyzed---are there opportunities to provide the same clinical outcome with a lesser length of stay? Can you partner with home health agencies to include this avenue in your discharge plan and decrease your length of stay along with maintaining excellent clinical outcomes and increasing patient satisfaction by returning them to their home environment as soon as feasible? Even if you have a higher length of stay, be prepared to explain how your care can prevent hospital readmissions or how the patient needed managed in the SNF setting because of multiple comorbidities and how the cost of care in your setting is less than in a LTAC or IRF. Be ready to explain how your clinical and financial management of patient risk can be part of the post-acute strategy going forward—demonstrate your leadership in becoming part of the team that works together for the end result of excellent patient care.

For more information, please contact Sheila Capitosti, VP Clinical and Compliance Services, Functional Pathways at scapitosti@fprehab.com or call 888-531-2204. You can also discover more at www.functionalpathways.com

The HAT Advantage continued from page 1

- The facility must have a well-organized, effective emergency preparedness training and testing program.
- The facility must participate in community-wide mock disaster drills.
- The facilities must conduct table-top exercises.
- The facility must have emergency generators compliant with the National Fire Protection Association in addition to other strict requirements for testing, recording and fuel storage.

There will be an expectation for a nursing home to develop and maintain an Emergency Preparedness "**program**" based on factual information that is frequently reviewed and updated to help ensure an appropriate response to a crisis or disaster. This will require comprehensive risk analysis, continuous training, drills, exercises and collaboration with other healthcare and emergency response stakeholders in the whole community.

Revised CMS Emergency Preparedness Checklist

Some key items in the revised CMS checklist include:

• *Collaborate with local emergency management agency*: Work with local emergency management agencies to ensure the development of an effective emergency management plan.

• *Analyze each hazard*: Analyze specific vulnerabilities of the facility and determine actions for each identified hazard.

Continued on page 3

The HAT Advantage continued from page 2

• *Decision criteria for executing plan*: Include factors to consider when deciding whether to evacuate and shelter in place. Determine decision-maker and chain of command

• *Develop shelter-in-place plan*: Provide for various emergency measures, such as assessing whether the facility can withstand the threat, measures to secure the building, at least seven days' worth of resources such as food and power, and security plan

• *Develop evacuation plan*: Consider factors such as pre-determined evacuation locations, evacuation routes, and adequate food supply and logistical support.

• *Communication infrastructure contingency*: Develop communication plan in the event of telephone failures, such as walkie-talkies and ham radios.

In litigation, we are commonly defending claims for violations of state and federal regulations as well organizational policies and procedures. In those case involving damages arising from events experienced in the last decade, we can expect that EOPs will be a focal point for Plaintiff's attorney as they will be for surveyors. Non-compliance with EOPs is another arrow in the quiver of Plaintiff's attorney. There is no time to lose in evaluating your current emergency preparedness plan and filling in gaps as prescribed by federal regulations, state rules, and the revised CMS checklist as no facility enjoys immunity from the possibility of an emergency. New regulations are nearly sure to follow and by developing and maintaining a compliant and effective plan, your organization will not only be prepared to provide high levels of safety for residents and staff, but will also be prepared for the future changes in regulation. Stan, Steve and I have been working closely with clients to evaluate and design individualized compliant plans and welcome any questions on this current issue.

Stan Szpytek is the president of Fire and Life Safety, Inc. (FLS) and is the Life Safety/Disaster Planning Consultant for the Arizona Health Care Association and California Association of Health Facilities (CAHF). Szpytek is a former deputy fire chief and fire marshal with more than 35 years of experience in life safety compliance and emergency preparedness. FLS provides life safety and disaster planning consultative services to healthcare and senior living providers around the nation. For more information, visit www.EMAllianceusa.com or e-mail Szpytek at Firemarshal10@aol.com.

Steve Wilder, BA, CHSP, STS is President and CEO of Sorensen, Wilder & Associates (SWA), a healthcare safety and security consulting group based in Bourbonnais, IL. A board certified Healthcare Safety Professional, he is the co-author of the book The Essentials of Aggression Management in Healthcare: From Talkdown to Takedown. He has spent the past 30 years in healthcare risk management, and works with hospitals and long-term care providers across the nation. Steve can be reached at 800-568-2931or at swilder@swa4safety.com

Rebecca Adelman, Esq. – Ms. Adelman is a Shareholder of Hagwood Adelman Tipton, PC and practices in the Memphis, Tennessee office. She is a member of the Board of Directors and serves as the firm's President. For over 20 years, Rebecca has concentrated her practice in healthcare law, long-term care assisted living and medical malpractice defense litigation. Her expertise and her scope of practice involve all insurance defense litigation areas including premises and product liability as well as employment law. Please feel free to contact her at radelman@hatlawfirm.com.

Kessler's Corner continued from page 1

I've also heard the "serve and protect" statement applied to individuals who make up our local fire departments as they are charged with putting out blazes, and protecting our lives and property. It can also most certainly be used when thinking about the men and women who are members of our nation's armed forces, whether they're serving and protecting our shores or stationed overseas.

Let me give you another group that I also believe has earned the right to proudly wear the "serve and protect" mantra as well: the dedicated people who work in our nation's nursing homes and assisted living facilities. Think about it, these men and women report to their healthcare building every workday charged with the responsibility of caring for, serving, and protecting citizens who may not be able to completely do this on their own anymore. In my book, these healthcare employees are every bit the heroes the aforementioned military, police and fire professionals are, and with good reason: they are doing a job that many of us neither have the training or the desire to do.

I've said it countless times over the years- not everyone has the wherewithal and the strength to work in an assisted living or nursing facility. This not only includes the front line staff of caregivers; it includes everyone who's employed in the building. You see for some, they may not wish to be around elderly people, sad as this is to say. Why? Because it may serve as a reminder to them that we all face the aging process sooner or later. And yet, for those working in a nursing home or assisted living community I hear story after story of the great joy the building's residents provide them. So in reality for nursing and assisted living facility staff, "the reminder" comes in the form of older Americans demonstrating how to live life to the fullest, despite any obstacles or challenges.

Accordingly, it's those who have never visited, let alone never worked in an assisted living or nursing facility, that are missing out! So if you are one of the select few who can cut the mustard and say you are an nursing or assisted living facility administrator, executive director, director of nursing, or you work in nursing, social services, admissions, marketing, housekeeping, dietary, janitorial, the office, human resources … or if you are one of those employed in a healthcare management company, you are to be commended and appreciated for what you do to help make the lives brighter for your residents.

No you don't get the accolades of the athletes, or receive the attention sometimes given to our military, police and fire department personnel however, you're doing a job that has to be done, and from my vantage point doing it well!

Chip Kessler is General Manager of Extended Care Products, Inc. He has created over 20 programs concentrating on marketing/ census building, customer services, crisis communications/risk management/media training for nursing and assisted living facilities, plus he provides personal consulting services for nursing and assisted living facilities nationwide. Nursing facilities may discover more at www.extendedcareproducts.com and assisted living communities can visit www.AssistedAdvantage.com

Discover "Done For You" Web Site Design Services at www.ExtendedCareProducts.com

NAL Professional Not Coming Addressed to You Personally?

We want to make sure you are personally getting this newsletter each month, not just have it forwarded to you because you're now holding down the position of a predecessor! Let us know you now are on the job. E-mail your name, facility/company name and address to chip@ecpnews.net & we'll update our records. Just put NAL Professional on the e-mail subject line and we'll take care of the rest.

NAL PROFESSIONAL
P.O. Box 4852
Johnson City, TN 37604

PRSRT STD
US POSTAGE
PAID
MWI

DART Chart's HMO MAP & TRACK℠

Easy Implementation

- Digitized mapped contracts
- Interface existing data
- Ready for use

Actively Manage Costs

- Cost of care is tracked
- Overages are displayed
- Co-pays during stay
- HIPPS Code reports

Maximize Revenue

- Less time managing contracts
- Cost containment
- Mitigate claim denials
- Higher revenue

Proactive MCO Management

Effective MCO Contract Management doesn't have to be complex

888-210-3200

www.DARTChart.com

Nursing & Assisted Living Facility *Professional*

"NEWS AND VIEWS YOU CAN REALLY USE"

SEPTEMBER 2014
ISSUE 9, VOLUME 4

SENT EACH MONTH TO YOU AS A MEMBER OF THE HEALTHCARE HEROES

THE HAT ADVANTAGE by Rebecca Adelman

ACHIEVING A FOCUSED WORK-LIFE BALANCE

Every year after Labor Day, you can feel the change in the pace as this holiday marks for most the last vestiges of summertime and the start of a new life rhythm. The increased pace of back-to-school for parents and children/students and related activities; catching up from Summertime vacations and managing emails, calls, paperwork; the feeling that the holidays will arrive soon; the sense that the year after year is passing by so fast; the rhythm changes, as if over one long weekend, from a waltz to a boogie-woogie. This month, instead of focusing on the industry, I'd like to focus on us and the people in the industry who experience high levels of stress and anxieties especially during this annual transition. How can we stay focused on what's important; How can we reduce stresses and encourage caregivers, managers and our other teams to find some time to slow the pace, even slightly, and flow more easily through this time of the year. By promoting wellness for ourselves and others, the elders we care for will also feel a positive impact in the quality of care and their overall well-being.

Last year, I wrote a blog and coined the phrase "Work-Life Being" to describe how I try to find my wellness center. I'd like to reprint it this month for you as one way to consider how to transition through stressful and overwhelming times. I also include some ideas that may help us all have a more content, smoother and joyous and fun time.

Last night, near the end of his nighttime routine, my young son asked me to sit on his bed. "Mom, I'm the happiest kid I know. I have a super-long hug for you." Time stood still as he embraced me with pure love.

After lingering for some time with the emotions of his words and expressions, I unpacked my "work-box" (having abandoned the briefcase years ago for lack of functionality) and began my nighttime routine. It generally consists of completing outstanding projects from the day, responding to emails, and planning for the coming days.

I'm often asked about my take on managing a life as a woman business owner and lawyer, sole parent, and communitarian with many interests and inspirations and drive. Having ruminated about these issues personal to me and in a broader social, economic and spiritual framework, I'd like to coin a new phrase for discussion around the personal and professional satisfaction. For me, the notion of "Having it All" has never been the measurement of success. The idea of "Work-Life Balance" is an illusion and can't serve as the standard for happiness. Consider instead "Work-Life Being," my personal mantra, as a path to identifying the choices and meeting the challenges of professional achievement, committed parenting, and self-care in a political and social climate that still needs changes for women.

I am not a loud voice in advocating for universal daycare, better schools, a higher minimum wage, and other equalities. I hope I am, however, serving a role in helping other women envision the possibility that ambition and achievement and a satisfying personal and family life (and fashion and beauty, of course) all can co-exist.

The idea of "Work-Life Being" is to reject the stress, guilt, and anxiety of the expectations (your own and others) and cultivate the ability to be present at work, at home, on the soccer field, packing lunch, paying bills … so that whatever your choices are, you are increasing your chances of feeling fulfilled, happy, and content because you are alive in the moment and not distracted by the past or future.

I have two business partners who motivate me with their intelligence, expertise, professionalism, and ethical approach to the changing norms for women in the workplace. One of my partners challenged the social and political norms of Southern women as she pursued degrees and positions of influence and leadership paving the professional path for other women in the law and beyond. The other partner has experienced the evolution of women in law and generally in the workplace through the last decades. He has adapted, promoted, and invested in women in the workplace. I am proud that our partnership places the needs of working mothers high on our priority list offering benefits and schedules that allow security and flexibility.

Women are not alone in having to evaluate if and when to advance their careers, to have children, and define themselves as a professional and a parent. Men also want to be more active parents and move away from a one-dimensional work life. They understand that more hours aren't necessarily more value either at your job or with your children. We all want to have not only integrated lives but satisfying ones.

Perhaps when considering how to achieve work success and prosperity and a meaningful family life, the direction to go isn't upward but inward. Being on the top shouldn't be the goal; rather,

Continued on page 2

Pathway to Rehabilitation Excellence

By David Higdon

DOING A MARKETING PLAN? DO YOUR HOMEWORK FIRST

Everyone does marketing plans, some are done annually and some are done quarterly. The plan is what will drive your marketing efforts that hopefully keep your beds full. The problem is the plan is no good unless you have strong programming to market. Strong programming is only as good as the clinicians performing it and only used if there is a need in the medical community for it. To equate this to sales, people buy for their reasons not yours. You can have the best clinicians delivering the best programs but if the referral sources don't need it then it will not be successful. That is why doing your homework before doing your marketing plan is essential.

You must get out and talk to the folks that send you patients and ask them, are the programs you are presently providing still needed? How can we make them better? Are there any programs that are not currently being offered that need to be offered? If they give you a program idea you could consider asking them, what are their thoughts on how it should look. The more you can involve them, the closer they will feel to it and support it. You already know who your sources are, Case managers, Social workers, Nurses, Physicians and yes payers due to the proliferation of managed care. Get out there and engage them. If you do end up using one of their suggestions, that simply presents another opportunity for you to go back and share that with them. It says to them you are listening. Then you ask them to refer you some business. Sales analogy #2, ask for the order.

Another component of a good marketing plan is to know what your competition is doing. If you have built strong relationships within your referral network they will tell you who does what well and who does not. You simply have to ask. This is very helpful in devising your programming.

Having knowledge as to the type and number of discharges that the acute care hospitals in your area are putting out is another big component when gathering information for your plan. There are websites that can provide this type of information for you or again, if your relationships in the medical community are strong enough, you can get it directly from the hospitals themselves.

Knowledge is king and relationships are the key that opens the door to that knowledge. Without either of these, your marketing plan will just like my chemistry quizzes in college, an uneducated guess.

David Higdon is Director of Marketing for Functional Pathways, the leader in contract rehabilitation and therapy services throughout the United States. For more information please call 865-474-8418 or visit www.functionalpathways.com

INNOVATIVE REHAB OUTCOMES

EXCELLENCE IN REHABILITATION

Functional Pathways™
Excellence in Rehabilitation

www.functionalpathways.com | 888.531.2204

The HAT Advantage continued from page 1

being in the center is the right place. By moving inward, we can discover what we really want and need and can identify the obstacles to contentment. There are times when work needs all my attention and intention. Other times, my son and I need me more than any client. There's no chance for balance. It's in the "off-balance" where the real lessons can be found and where we experience the truth of our character and the values we hold closest.

When I'm with my son doing homework or cheering at a game, "Work-Life Being" reminds me to put the iPhone away, forget about what I need to do when I get home, and to just be a parent and engage in the energy of my son. As I'm boarding a plane for business travel, preparing for a presentation, or up all night with a project, "Work-Life Being" is my way to let go of any guilt or worry for missing a play, serving take-out, or rescheduling time with a friend and to focus on service excellence.

Needless to add, there are people who face great daily challenges and are struggling to hold on to what they have. The inequalities in their daily lives need attention and solutions. Perhaps living the life you want and helping others live the lives they want, will make a difference that can be felt everywhere. Don't strive for "balance." Celebrate "being." May we all share my son's feeling and "be the happiest kid I know".

Some practical ideas for "Work-Life Being" that I've found helpful and serve as foundations for *FOCUS: The Hidden Driver of Excellence* by author Daniel Goleman as well as wellness teachers.

1) Manage your settings instead of letting them manage your attention. Turn off those pop-ups that tell you you've just gotten an email and ringtones. Those calls and messages may seem urgent, but they are not important enough to break your focus -- get to them later. Give yourself protected time to sustain your focus on the task at hand so you can stay present to your child, spouse, employee and yourself.

Continued on page 3

Extended Care Products Inc.

Presents The 60-Minute Webinar/Teleconference

Passing Your "Final"- The 2015 PPS Final Rule is Here!

Tuesday, September 16 at 10 a.m. (eastern); 9 a.m. (central); 8 a.m. (mountain) and 7 p.m. (pacific)
Or
Tuesday, September 16 at 2 p.m. (eastern); 1 p.m. (central), 12 noon (mountain) and 11 a.m. (pacific)

One of the most important CMS announcements for your nursing facility's financial future is here! The FY 2015 PPS Final Rule has been published and CMS has announced that the Revised RAI Manual will be posted in early September. Several changes are on the horizon for FY 2015. **Reimbursement margins are tight.** Because of this, it's vital that your nursing facility is at its very best in understanding these important modifications. **Failing to do so will cost your building money.**

Join nationally recognized Reimbursement and MDS 3.0 expert Joel VanEaton, RN, BSN, RAC-CT for an in depth analysis of the Final Rule and the RAI Manual revisions …and what they mean for your facility. Missing out on this important information could affect your bottom line in the coming year.

During this 60-Minute Webinar
(Followed by a question and answer session)
Joel Van Eaton will:

- Thoroughly explain The FY 2015 Final Rule Breakdown
- Detail the RAI Manual Revision for FY 2015
- Get you confident and comfortable to handle this critical new material
- Review MDS 3.0 v1.12.0 item set changes
- Provide additional review and discussion on this material

"Our nursing facility has come to rely on Joel VanEaton's knowledge and expertise. His understanding of MDS issues is fabulous, and best of all he's able to explain things in such a way that you're able to successfully grasp what he's saying to you."
Mary Seay, LPN, MDS Coordinator, Christian Care Center of Cheatham County, Ashland City, TN

Your investment is $129.00 for unlimited facility participation which includes use of a toll-free telephone line, **plus as an additional free bonus gift**, you'll receive a copy of the actual power-point slides that Mr. VanEaton will be using during the webinar to follow along with and refer back to as often as you wish!

To register please visit www.WebinarLTC.com or you may call 1-800-807-4553.

The HAT Advantage continued from page 2

2) Focus on one thing at a time – Reduce multi-tasking. Think about your day as sleep time, exercise time, family time, work time, play time, meditation time and so on. From there, dedicate yourself to only one task at once. Feelings of stress surface when you think of everything you need to do. This is disruptive and distracting.

3). S.T.O.P. - Take time to STOP. S: stop what you are doing, T: take a few deep breaths, O: observe your body and smile, P: proceed with kindness and compassion.

4) Take 20 minutes for yourself - Sit quietly, without an agenda, for 15 or 20 minutes each day.

5) Focus tanks when we are sleepy -- and there's an epidemic of sleep deprivation. No matter how many hours sleep you manage to get, the real measure of whether you are sleeping enough is whether you feel like dozing off during the day. A short mid-day nap (if you can get away with it) reboots your brain.

6) Eat high protein, low carb meals at breakfast and lunch - Carbs convert to sugar quickly, giving you a burst of energy and then a crash. Proteins become the brain's fuel more slowly, giving you a steady energy level that helps sustain focus.

7) Sip your caffeine slowly - A steady low dose helps your focus go on and on. Too much at once gives you a high (or nervousness) that ends in a focus crash.

For our organizations, we can offer support to employees and co-workers.

In many organizations, managers are overworked, stressed out, and frustrated by competing demands and pressures. Consider encouraging others to enjoy "Work-Life Being" by changing a few physical and mental habits. Also consider:

1) Giving Rewards – Encourage team building by developing a rewards system. Award each other for an achievement and a job well done. Exhibiting and expressing your organization's vision and mission and qualities are great opportunities for a little "somethin' somethin'" as my grandmother would say.

2) Promote Culture – Incorporate your organization's vision and mission and organization's culture into training sessions, meetings and activities. Lighten up the job environment with fun training materials and opportunities for people to share stories.

3) Support a Healthy Lifestyle – Invest in wellness programs in the local community and in-house. Providing support for nutrition, exercise (yoga, for example), group training and other activities can create a friendlier and lower stress environment.

4) Encourage Staff to Have Fun and Play – Coordinate parties and activities in the environment and support a spirited staff with social events, competitions and community fund-raisers.

As the pace of this season increases, find ways for you and your organization to stay focused, relax, have fun and stay well and the transition will be smooth sailing!

Rebecca Adelman, Esq. – Ms. Adelman is a Shareholder of Hagwood Adelman Tipton, PC and practices in the Memphis, Tennessee office. She is a member of the Board of Directors and serves as the firm's President. For over 20 years, Rebecca has concentrated her practice in healthcare law, long-term care assisted living and medical malpractice defense litigation. Her expertise and her scope of practice involve all insurance defense litigation areas including premises and product liability as well as employment law. Please feel free to contact her at radelman@hatlawfirm.com.

NAL Professional Not Coming Addressed to You Personally?

We want to make sure you are personally getting this newsletter each month, not just have it forwarded to you because you're now holding down the position of a predecessor! Let us know you now are on the job. E-mail your name, facility/company name and address to chip@ecpnews.net & we'll update our records. Just put NAL Professional on the e-mail subject line and we'll take care of the rest.

NAL PROFESSIONAL
P.O. Box 4852
Johnson City, TN 37604

PRSRT STD
US POSTAGE
PAID
MWI

DART Chart's HMO MAP & TRACK℠

Easy Implementation

- Digitized mapped contracts
- Interface existing data
- Ready for use

Actively Manage Costs

- Cost of care is tracked
- Overages are displayed
- Co-pays during stay
- HIPPS Code reports

Maximize Revenue

- Less time managing contracts
- Cost containment
- Mitigate claim denials
- Higher revenue

Proactive MCO Management

Effective MCO Contract Management doesn't have to be complex

888-210-3200

www.DARTChart.com

Nursing & Assisted Living Facility
Professional

"NEWS AND VIEWS YOU CAN REALLY USE"

OCTOBER 2014
ISSUE 10, VOLUME 4

SENT EACH MONTH TO YOU AS A MEMBER OF THE HEALTHCARE HEROES

THE HAT ADVANTAGE by Rebecca Adelman

UNAVOIDABLE PRESSURE ULCERS - THEY DO OCCUR!

Litigation Patterns and Risk Management

Wrongful death claims are the most litigated in long-term care and assisted living lawsuits. The runner up is pressure ulcer litigation. In defense of claims that a pressure sore is avoidable and the provider was negligent, defense counsel develops evidence relying, in part, on 42 CFR § 483.25(c) - Pressure Sores and F314. Through clinical records, lay witness and expert witness depositions, we try to find support that the resident developed the pressure ulcer even though the facility had evaluated the residents clinical condition and pressure ulcer risk factors; defined and implemented interventions that are consistent with resident needs, goals and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate. This is the definition of "unavoidable" by set forth in F314.

The defense focuses on risk factors such as impaired/decreased mobility and decreased functional ability; co-morbid conditions (end-stage renal disease, thyroid disease or diabetes mellitus); medications that may affect wound healing (steroids); impaired diffuse or localized blood flow; generalized atherosclerosis or lower extremity arterial insufficiency; resident refusal of some aspects of care and treatment; cognitive impairment; exposure of skin to urinary and fecal incontinence; and under nutrition, malnutrition, and hydration deficits.

Stating the obvious, plaintiff's attorneys allege that the pressure ulcer was "avoidable" supporting the claim by evidence that the provider failed to evaluate the residents clinical conditions and pressure ulcer factors and further failed to establish evidence that the pressure ulcer was "unavoidable." This is accomplished through the provider's own Policies and Procedures as well as incomplete, inconsistent or inadequate records. Plaintiff's attorneys have been successful in pressure ulcer litigation and we are now seeing increased frequency of this litigation across the continuum of care. This month, my article will present a brief overview of the consensus reached by the National Pressure Ulcer Advisory Panel (NPUAP) this past Summer that unavoidable pressure ulcers do occur. Of note, the new 2014 International Pressure Ulcer Guidelines are now available (go to npuap.org). *The Guideline* was developed to appraise available research and make evidence-based recommendations for prevention and treatment.

The NPUAP consensus outcomes are presented at length in *Unavoidable Pressure Injury-State of the Science and Consensus Outcomes*. (J Wound Ostomy Continence Nurs. 2014: 41(4): 313-334). This consensus, along with federal and state regulations regarding clinical unavoidability, will be a central tool to risk management and litigation defense.

Consistent with the outcomes, we know that pressure ulcers are unavoidable when the magnitude and severity of risk are high or preventative measures are either contraindicated or inadequate. The article identifies intrinsic factors and extrinsic and other risk factors for pressure ulcer development which increase the likelihood where an unavoidable pressure ulcer can develop. Providers, risk managers and defense counsel all benefit from the consensus outcomes.

Intrinsic Factors

Impaired tissue oxygenation/cardiopulmonary dysfunction: Identified in this intrinsic factor group are vasopressor drugs; hypotension; hypoxemia; anemia; hypoventilation; and congestive heart failure.

Hypovolemia: Hypovolemia is defined as an inadequate volume of blood in the circulatory system. Intrinsic risk factors for the development of unavoidable pressure ulcers include infection, sepsis and hypoalbuminemia; and systemic inflammatory response syndrome (SIRS).

Body edema/anasarca: Massive body edema secondary to fluid resuscitation is a non-modifiable pressure ulcer risk factor. The consensus found that other conditions leading to massive body edema and or anasarca include severe CHF, severe hypoalbuminemia and renal disease, and severe liver disease.

Peripheral vascular disease: Intrinsic factors in this category include chronic kidney disease, hepatic dysfunction, sensory impairment/altered level of consciousness, multiple sclerosis, stroke, coma, spinal cord injury, anesthetist/operating room time, age, issues related to end of life (end-stage dementia and skin failure), MODS, critically ill/critically injured status, and burns.

Body habitus: Per the consensus outcomes, while studies suggest that obesity does not increase the risk for pressure ulcer development, it is known that obesity negatively affects all body systems and the bariatric individual has increased difficulty moving independently or with assistance. Indirect evidence suggests that obesity may increase the risk for suspected deep tissue injury.

Continued on page 2

Pathway to Rehabilitation Excellence

By David Higdon

WELLNESS – THE WINDOW TO YOUR COMMUNITY

People are always looking for ways to get the biggest bang for their buck. Communities are always looking for a low cost means to market their services. If I told you there such an animal exited, you would be interested, right? There is and it is called Wellness. If done correctly, Wellness will fill many needs.

If you have Independent and Assisted Living residents on your campus, it is a wonderful way to keep them active and healthy, while doing so right where they live. It is also a great opportunity with senior adults who do not live on your campus, but may in the near future, to get to know your campus, get comfortable with the surroundings and develop a relationship with you. You are providing something positive for them before they need you, all the while building goodwill.

Let's first look at the fact that you are offering something good for the area in which you live. You are filling the many needs that seniors have. The six dimensions of Wellness address the physical, vocational, intellectual, social, spiritual and emotional aspects of one's life. You can choose to offer all dimensions or just one.

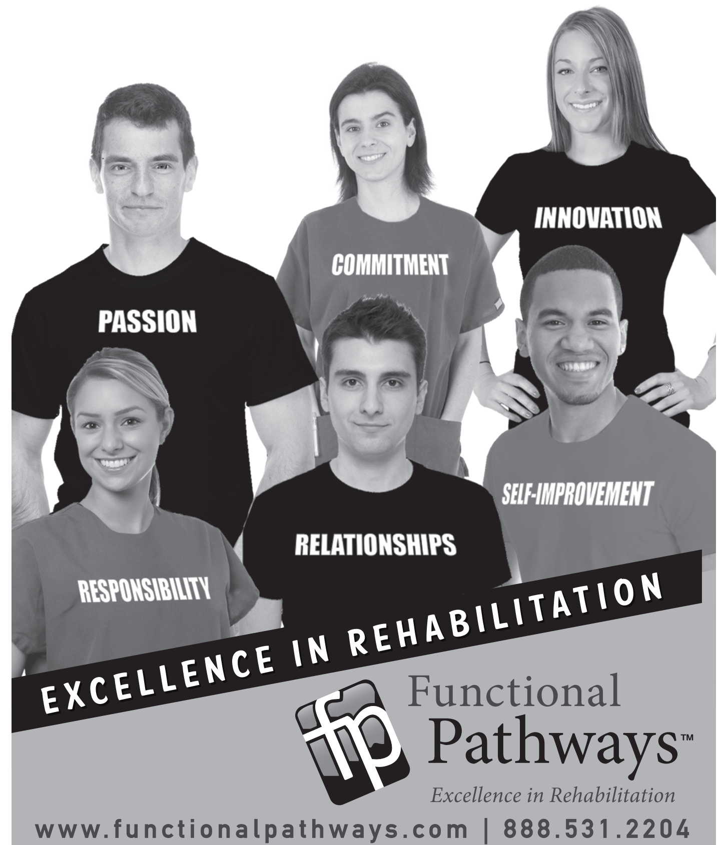
Now, let's consider the marketing side of wellness. Primary care, Orthopedic and Rheumatology physicians are three specialties which you may choose to market to. These doctors know the benefits of exercise for patients, and are looking for ways to make that available to them. You would also have the opportunity to let those physicians know of all the other services that your community provides.

Senior organizations such as the Arthritis Foundation and the Office of Aging, in your area, are constantly providing information to seniors about locally provided services. Churches also have large senior membership that could potentially provide participants. All of these organizations have large numbers of seniors, but you have to get out and make them aware of what you have.

You may be thinking to yourself that this is going to cost you a bundle but the truth is, it does not. We are talking for the most part about a deconditioned population. You don't have to purchase treadmills, bicycles and stair climbers to have a program. Folding chairs and light resistance bands are enough to get you started.

I strongly encourage you to consider adding Wellness to what you offer. I believe you will find it a great way to put your best foot forward to large group of potential residents and referral sources.

David Higdon is Director of Marketing for Functional Pathways, the leader in contract rehabilitation and therapy services throughout the United States. For more information please call 865-474-8418 or visit www.functionalpathways.com



The HAT Advantage continued from page 1

Extrinsic and other risk factors

1. Head-of-bed elevation (HOB)
2. Hip fracture
3. Prone positioning
4. Nutrition
5. Hospital length of stay
6. Smoking
7. Medical devices
8. Behavioral Risk Factors: Nonadherence

The final statement of the consensus group finalizes the experience of everyone in attendance, "*unavoidable pressure ulcers do occur*." With more important literature, research and resources on the issue of unavoidable pressure ulcers, we will continue to see improved patient outcomes in pressure ulcer prevention and treatment as well as stronger defense theories in pressure ulcer litigation.

Next month, we will discuss risk and litigation management tools related to the care and treatment of pressure ulcers including training, assessments, documentation, policies and procedures (guidelines) and other points. With increased attention on pressure ulcers in the regulatory and litigation fronts, comprehensive risk management and an interdepartmental approach to prevention and treatment requires increased focus.

Rebecca Adelman, Esq. – Ms. Adelman is a Shareholder of Hagwood Adelman Tipton, PC and practices in the Memphis, Tennessee office. She is a member of the Board of Directors and serves as the firm's President. For over 20 years, Rebecca has concentrated her practice in healthcare law, long-term care assisted living and medical malpractice defense litigation. Her expertise and her scope of practice involve all insurance defense litigation areas including premises and product liability as well as employment law. Please feel free to contact her at radelman@hatlawfirm.com.

CMS Makes Key Changes to the FY 2015 RAI User's Manual and Data Set

by Joel VanEaton, BSN, RN, RAC-CT

Hello!

With October we come to expect the changing leaves on the trees and changes to the MDS 3.0 RAI User's Manual. This October we not only have a revised manual v1.12 but we also have a revised MS 3.0 Data set v1.12.0. Keeping up with these changes is important not only to a facility's financial future, but also to the way each facility is viewed from the Care Plan to Nursing Home Compare. Facility staff members working closely with MDS 3.0 need to be aware of these revisions that took effect on October 1st in order to be compliant with the RAI process as CMS has instructed.

I wanted to take a few moments and outline, some of the important revisions that have taken effect:

MDS 3.0 RAI User's Manual v1.12 Summery of Changes (Total of 334 pages inc. Change Tables and Replacement pages):

- Chapter 1
- Chapter 2
- Chapter 3 sections A, C, E, G, H, J, K, M, N, O, X, Z
- Chapter 5
- Chapter 6
- Appendix F
- Appendix H

Also, please note specifically the following changes to the COT guidelines, effective Oct. 1 2014, found on page 2-56 of recently released v1.12 of the MDS 3.0 RAI User's Manual:

Generally, a COT OMRA may only be completed when a resident is currently classified into a RUG-IV therapy group (regardless of whether or not the resident is classified into this group for payment), based on the resident's most recent assessment used for payment. The COT OMRA may be completed when a resident is not currently classified into a RUG-IV therapy group, but only if *both of the following conditions are met:*

1. *Resident has been classified into a RUG-IV therapy group on a prior assessment during the resident's current Medicare Part A stay, and*
2. *2. No discontinuation of therapy services (planned or unplanned) occurred between Day 1 of the COT observation period for the COT OMRA that classified the resident into his/her current non-therapy RUG-IV group and the ARD of the COT OMRA that reclassified the resident into a RUG-IV therapy group.*

For example: Mr. T classified into the RUG group RUA on his 30-day assessment with an ARD set for Day 30 of his stay. On Day 37, the facility checked the amount therapy provided to Mr. T. and found that while he did receive the requisite number of therapy minutes to qualify for this RUG category, he only received therapy on 4 distinct calendar days, which would make it impossible for him to qualify for an Ultra-High Rehabilitation RUG group. Moreover, due to lack of 5 distinct calendar days of therapy and a lack of restorative nursing services, Mr. T. did not qualified for a therapy RUG group. Mr. T.'s rehabilitation regimen has continued throughout this time period. The facility may complete a COT OMRA with an ARD of Day 44 to reclassify Mr. T. back into RUA.

Transition guidelines as well as further clarification regarding the appropriate interpretation of these revised guidelines may be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Spotlight.html

It's my hope that you and your nursing facility stay ahead of the curve in both understanding and implementing these important revisions.

FYI: I recently conducted a 60-minute webinar on these CMS revisions. It's available for you to watch as often as you wish and comes complete with the power-point slides I used during the presentation. Discover more at www.WebinarLTC.com

Do you have your FY 2015 Revised RAI Manual Yet? If you were a subscriber to Extended Care Products' downloadable RAI Manual you would! Subscribe today and get the very latest up to date material. Our guarantee to you as an ECP Downloadable RAI Manual subscriber is that you will never have to wait more than 7 days following a manual revision or update to receive your copy. Discover more at www.myMDSresource.com or at 1-800-807-4553.

Discover Why Nursing & Assisted Living Facilities Have Invested in The Setting Realistic Expectations Program

• Keeps Families From Getting in Your Face Over Caregiving Issues
• Promotes Open & Honest Communication • Prevents Potential Litigation

Learn more at:
www.ExtendedCareProducts.com

NAL Professional Not Coming Addressed to You Personally?

We want to make sure you are personally getting this newsletter each month, not just have it forwarded to you because you're now holding down the position of a predecessor! Let us know you now are on the job. E-mail your name, facility/company name and address to chip@ecpnews.net & we'll update our records. Just put NAL Professional on the e-mail subject line and we'll take care of the rest.

NAL PROFESSIONAL
P.O. Box 4852
Johnson City, TN 37604

PRSRT STD
US POSTAGE
PAID
MWI

DART Chart's HMO MAP & TRACK℠

Easy Implementation
- Digitized mapped contracts
- Interface existing data
- Ready for use

Actively Manage Costs
- Cost of care is tracked
- Overages are displayed
- Co-pays during stay
- HIPPS Code reports

Maximize Revenue
- Less time managing contracts
- Cost containment
- Mitigate claim denials
- Higher revenue

Proactive MCO Management

Effective MCO Contract Management doesn't have to be complex

888-210-3200

www.DARTChart.com

Nursing & Assisted Living Facility
Professional

"NEWS AND VIEWS YOU CAN REALLY USE"

NOVEMBER 2014
ISSUE 11, VOLUME 4

SENT EACH MONTH TO YOU AS A MEMBER OF THE HEALTHCARE HEROES

THE HAT ADVANTAGE by Rebecca Adelman

PRESSURE ULCER PREVENTION AND TREATMENT

Clinical Practice Guidelines

Last month, The HAT Advantage presented an overview of the consensus reached by the National Pressure Ulcer Advisory Panel (NPUAP) that unavoidable pressure ulcers do occur. This month we will discuss risk prevention and litigation management related to the care and treatment of pressure ulcers including continued education on applicable regulations and evaluation of Plaintiff's "evidence".

483.25 (c) Pressure Sores – F314.

In medical malpractice litigation, the standard of care is determined by expert opinions; and requirements differ from state-to-state. Often, Plaintiffs will present experts who testify about non-compliance with Federal Regulations; however, the regulations do not establish the standard of care. The defense will establish that the provider did comply with F314 and a pressure ulcer was clinically unavoidable and that the resident is receiving necessary treatment. The pressure ulcer requirement has two aspects and the understanding of the interpretation of F314 is necesary. The first aspect requires the facility to prevent the development of pressure ulcer(s) in a resident who is admitted without pressure ulcer(s), unless the development is clinically unavoidable. The second aspect requires the facility to provide necessary treatment and services to promote healing, prevent infection, and prevent new ulcers from developing. Some central guidance found in the regulation follows.

Assessments, Care Plans, and Orders

- Confirm assessments, care plans, and orders identify facility interventions and guide observations. For a newly admitted resident either at risk or with a pressure ulcer, the staff is expected to assess and provide appropriate care *from the day of admission*.
- Identify interventions, notes, and/or follow up on deviations from the care plan as well as potential negative outcomes. Implement the care plan over time and across various shifts.
- Assess pain related to the ulcer and monitor interventions for effectiveness. Take preemptive measures for pain associated to dressing changes or other treatments, such as debridement/irrigations.

Resident/Staff Involvement

- Evaluate resident/family involvement and preferences in care plan, choices, goals, and interventions
- Assess awareness of approaches, such as pressure redistribution devices or equipment, turning/repositioning, and weight shifting to prevent or address pressure ulcer(s)
- Determine whether counseling on alternatives, consequences, and/or other interventions was offered if treatment is refused

Staff Training

- Evaluate staff knowledge of prevention and treatment of ulcers, including facility guidelines/protocols and specific interventions for the resident
- Educate nursing assistants on changes in skin conditions and what, when and to whom to report
- Monitor the implementation of the care plan, changes in skin condition, development of pressure ulcers, and frequency of review and evaluation of an ulcer

Record Review/Documentation

Assessment

Review the Resident Assessment Instrument (RAI) and other documents such as physician orders, progress notes, nurses' notes, pharmacy, and dietary notes regarding resident's overall condition, risk factors, and presence of a pressure ulcer(s). Determine if the facility identified the resident at risk and evaluated the factors placing the resident at risk.

Consider the appropriateness of the facility's response to the presence, progression, or deterioration of a pressure ulcer. Take into account the resident's condition, complications, and time needed to determine the effectiveness of treatment and the facility's efforts to remove, modify, or stabilize the risk factors and underlying causal factors.

Care Plan

For the resident at risk for developing or who has a pressure ulcer, determine if the facility developed an individualized care plan

Continued on page 2

Pathway to Rehabilitation Excellence

By Jill Fiala
Director of Elite Living

FALL BACK INTO GOOD HABITS

It is that time of year again when time flies. Football is in full swing, children activities are keeping you busy, and the weather is beautiful. Drive thru, take out, tailgating, and don't forget the holidays are on the way. I encourage you to be proactive with your own health by taking the extra steps daily to keep the extra winter pounds away. Here are some tips:

- Plan your week
- What nights can I cook?
- Where can I incorporate a brisk walk for 30 minutes?
- How can I use my time more wisely?
- Take the healthier route
- For your next tailgate, how can I cut corners to make myfood a little healthier?
- Do I really need two hot dogs, or am I satisfied with one?
- Holiday parties?
- Eat before you go, and only snack while you are there
- Bring a healthier dish, encourage others to do the samE
- Play active games
- Exercise
- Warm up for the cold months with a workout
- 20-30 minutes daily or even 15 minutes twice a day has benefits

There are a variety of ways to cut corners throughout your everyday routine. Everyone is unique and different. Hence, you have to figure out what works for you. By paying attention and cutting corners all of the time, you are able to develop better habits. Better lifestyle habits leads to an overall healthier, happier, life. How will you start cutting corners? Share your comments and maybe your ideas can make a difference in someone else's life.

Jill Fiala is Director of Elite Living for Functional Pathways, the leader in contract rehabilitation and therapy services throughout the United States. For more information on what Jill has shared with you this month, please e-mail her at: JFiala@fprehab.com

The HAT Advantage continued from page 1

that addresses prevention, care, and treatment of existing pressure ulcers including specific interventions, measurable objectives, and approximate time frames.

If the facility's care of a resident refers to a treatment protocol with details of the treatment regimen, the care plan should refer to that protocol. The resident care plan should clarify any deviations or revisions to that protocol.

A specific care plan intervention for risk of pressure ulcers is not needed if other components of the care plan address related risks adequately. For example, the risk of skin breakdown posed by fecal/urinary incontinence addressed in the care plan that deals with incontinence management.

If the resident refuses or resists staff interventions to reduce risk or treatment of existing pressure ulcers, determine if the care plan reflects alternatives efforts to address the needs identified in the assessment.

Revision of the Care Plan

Determine if staff has been monitoring the resident's response to interventions for prevention and/or treatment and revising the care plan based on resident's response, outcomes, and needs.

Compliance Criteria

Defense strategies are enhanced when compliance criteria are present.

Resident who developed a pressure ulcer after admission, the facility is in compliance with F314 if staff:

- Recognized and assessed factors placing the resident at risk for developing a pressure ulcer, including

Continued on page 3

The HAT Advantage continued from page 2

specific conditions, causes and/or problems, needs and behaviors

- Defined and implemented interventions for pressure ulcer prevention in accordance with resident needs and goals and recognized standards of practice
- Monitored and evaluated the resident's response to preventive efforts
- Revised the approaches as appropriate

Resident who was admitted with a pressure ulcer, who has a pressure ulcer that is not healing, or who is at risk of developing subsequent pressure ulcers, the facility is in compliance with F314 if staff:

- Recognized and assessed factors placing the resident at risk of developing a new pressure ulcer or experiencing non-healing or delayed healing of a current pressure ulcer, including specific conditions, causes and/or problems, needs and behaviors
- Defined and implemented interventions for pressure ulcer prevention and treatment in accordance with resident needs and goals and recognized standards of practice
- Addressed the potential for infection
- Monitored and evaluated the resident's response to preventive efforts and treatment interventions
- Revised the approaches as appropriate

Plaintiff's attorneys and their experts also look to other related regulations in establishing deviations from the standard of care and violation of regulations, and understanding the interrelatedness is essential.

See also: **F157**- Notification of Changes; **F272**-Comprehensive Assessments; **F279**-Comprehensive Care Plans; **F280**-Comprehensive Care Plan Revision; **F281**-Services Provided Meet Professional Standards; **F309**-Quality of Care; **F353**-Sufficient Staff; **F385**-Physician Supervision; and **F501**-Medical Director.

Sources of Evidence in Pressure Ulcer Lawsuits

During pressure ulcer litigation, Plaintiff's attorneys will request volumes of varied types of records to establish deviations from the standard of care. Included are a few thoughts on each source from a litigation risk perspective:

Clinical records – All documentation must be timely, accurate, complete, and relevant to the skin condition

- Admission Assessments
- Electronic Medical Records
- Physician/Nurse Practitioner Notes
  - Document turning and repositioning
  - Document interventions

Accident and Incident Reports - may be privileged

- Conduct complete investigations and follow-up
- Report findings to the resident/family

Facility Policies, Procedures, and Guidelines

- Review all policies/guidelines so they are consistent with facility practices
- Avoid specifics in policies and guidelines
- Avoid terms like "every, always, never"
- Demonstrate staff education and competencies related to pressure ulcer prevention and management
- Conduct regular in-service training on policies

Staffing Sheets

- Evaluate proper staffing levels based on acuity

Employee Personnel Records and Time Cards

- Document all performance related actions
- Conduct exit interviews, if possible

Pressure Ulcer/Infection Tracking Reports - may be privileged

- Document measures addressed in the tracking reports
- Note communication with medical director

Management Agreements

- Review facility's management agreement to understand the duties and responsibilities of the parties
- Modify to reflect consistent with actual working relationship

Pressure ulcer prevention is at the forefront of clinical education in long-term care. Pressure ulcer development and progression is at the forefront of Plaintiff's attorneys theories forming the basis for lawsuits. Self-surveying using F314 and other related regulations pursuant to Quality Assessment and Assurance programs, will benefit the quality of care of the resident and the defense team strategies. If improvements are indicated and made, everyone gains. Greater risk prevention is established, and barriers are created to Plaintiffs ability to develop evidence. Spend time with your teams to review facility wound care protocols, regulations, and related tools before the end of the year and start the New Year with a greater sense of quality care.

Please note The National Pressure Ulcer Advisory Panel (NPUAP) is proud to announce that World Wide Pressure Ulcer Prevention Day is to be celebrated on November 20, 2014. The objective of World Wide Pressure Ulcer Prevention Day is to increase national awareness for pressure ulcer prevention and to educate the public on this topic. NPUAP has developed an extensive media materials package appropriate for all healthcare settings and organizations. To download this free material visit: http://www.npuap.org/resources/educational-and-clinical-resources/2014-world-wide-pressure-ulcer-prevention-day/

Rebecca Adelman, Esq. – Ms. Adelman is a Shareholder of Hagwood Adelman Tipton, PC and practices in the Memphis, Tennessee office. She is a member of the Board of Directors and serves as the firm's President. For over 20 years, Rebecca has concentrated her practice in healthcare law, long-term care assisted living and medical malpractice defense litigation. Her expertise and her scope of practice involve all insurance defense litigation areas including premises and product liability as well as employment law. Please feel free to contact her at radelman@hatlawfirm.com.

ANNOUNCING THE EBOLA ALERT AWARENESS PROGRAM

What You Need to Know and Explain to Residents & Families

Discover More at www.ExtendedCareProducts.com

NAL Professional Not Coming Addressed to You Personally?

We want to make sure you are personally getting this newsletter each month, not just have it forwarded to you because you're now holding down the position of a predecessor! Let us know you now are on the job. E-mail your name, facility/company name and address to chip@ecpnews.net & we'll update our records. Just put NAL Professional on the e-mail subject line and we'll take care of the rest.

NAL PROFESSIONAL
P.O. Box 4852
Johnson City, TN 37604

PRSRT STD
US POSTAGE
PAID
MWI

DART Chart's HMO MAP & TRACK℠

Easy Implementation

- Digitized mapped contracts
- Interface existing data
- Ready for use

Actively Manage Costs

- Cost of care is tracked
- Overages are displayed
- Co-pays during stay
- HIPPS Code reports

Maximize Revenue

- Less time managing contracts
- Cost containment
- Mitigate claim denials
- Higher revenue

Proactive MCO Management

Effective MCO Contract Management doesn't have to be complex

888-210-3200

www.DARTChart.com

Nursing & Assisted Living Facility *Professional*

HAPPY HOLIDAYS!

DECEMBER 2014

ISSUE 12, VOLUME 4

"NEWS AND VIEWS YOU CAN REALLY USE"

SENT EACH MONTH TO YOU AS A MEMBER OF THE HEALTHCARE HEROES

THE HAT ADVANTAGE by Rebecca Adelman

RESOLUTIONS FOR A NEW YEAR IN NURSING AND ASSISTED LIVING

"Every time you tear a leaf off a calendar, you present a new place or ideas and progress." -Charles Kettering

As 2014 draws to a close, we reflect on our professional and personal successes and challenges and set intentions for positive change. I want to express my gratitude to the people and organizations that have shared the past four years as our newsletter has evolved. We look forward to delivering quality information in 2015. Stay tuned for a quarterly webinar series as well. Finally, mark your calendar for April 30 - May 1, 2015. The third annual Litigation Risk and Defense Strategies for Long Term Care & Assisted Living Providers, Insurers and Brokers conference will be held in Memphis, Tennessee. Conference hosts, Cowan & Lemmon; Ebanks Horne Rota Moos; Hagwood Adelman Tipton; and Kaufman Borgeest Ryan invite you to enjoy the education and be entertained at the Beale Street Music Festival.

In looking back in 2014, I compiled a "Nursing and Assisted Living: Resolutions 2015" to support goal setting for all of us committed to the nursing and assisted living industries. The list highlights some of the articles from this year's HAT Advantage.

<u>**Trends in Aging Services and Senior Housing and Identification of Litigation and Risk Management Opportunities**</u>

- Evaluate admission criteria, staffing and policies to prepare for increased servicing to the aging population and implement new risk prevention management strategies related to high-risk areas (elopements, falls, wounds, medications)

- Evaluate Revenue Cycle Management and identify revenue cycle solutions to respond to healthcare consumerism, accelerating cash collection and improving payor performance

- Join in conversations regarding non-profit and for-profit aging services to better understand the issues and opportunities in both models

- Consider an increase in your legal budget and a hug for a lawyer this year

- Evaluate and update crisis communication plans consistent with the organization's missions and visions and management and other PR related changes. Take advantage of state and national opportunities to promote the positive aspects of the aging services industry. The best defense is our offense

- Evaluate staffing needs relative to increased resident acuity and make necessary adjustments in training and staffing levels. Provide education incentives for long-term investment and staff financial incentives for quality performances and benchmarks

- Audit your company's position in the community and evaluate the current marketing and branding strategies. Evaluate the needs of the residents and future expectations of the aging population in and around your communities and design enhanced brands and products to respond to those needs and expectations

<u>**Person Centered Care and Essential Aspects of Delivering Quality of Care**</u>

- Positively respond to the changing role of providers along the continuum of care. Continue to improve the quality of care and identify trends as the needs of the growing population become greater and more varied. Utilize the CMS Change Package focused on the successful practices of high performing nursing centers.

<u>**The OIG Strategic Plan 2014 – 2018 and OIG Work Plan FY2015 (released on October 31, 2014)**</u>

- Many issues with the OIG Work Plan FY2015 are continuations of issues identified in prior years (see Nursing & Assisted Living Facility Professional, May 2014)

- Continue to implement quality measures consistent with state and federal regulations and develop plans for responding to crisis through proactive communication

- Enhance the QAPI program referencing the Process Tool to the QAPI Five Elements published by CMS

- Evaluate QA/QIC committees and protocols for investigating nursing home events

- Evaluate and modify abuse prevention policies and training along with policy and procedure handbooks (next month the newsletter will review the August 2014 OIG report Nursing Facilities' Compliance With Federal Regulations for Reporting Allegations of Abuse or Neglect)

Continued on page 2

Pathway to Rehabilitation Excellence

By Gina Tomcsik,
Director of Compliance
Privacy Officer

And......Take Two!

We have another “go live” date for ICD-10----**<u>OCTOBER 1, 2015</u>**! Are you ready? Of course you are! We were all ready to go for the October 1, 2014 date, weren’t we?

We will be transitioning from utilizing 14,000 codes (ICD-9) to utilizing 69,000 codes in ICD-10.

ICD-10 offers more specificity because of the expansion of codes. Making sure that the most specific code is reported will maximize ICD-10’s ability to provide meaningful patient care data and demonstrate the severity of the patient’s condition.

Documentation plays a very important role in the ICD-10 coding world. Improvement in specific documentation practices is a must. If physicians are not specific enough in their documentation, this can affect the accuracy of the coding. Because ICD-9 limitations exist, ICD-10 is a significant improvement over the current ICD-9 system and medical terminology and classification of diseases have been updated to be more consistent with current healthcare practices. These current healthcare practices need a classification system that will reflect clinical detail to capture technological improvements in the services we provide.

As the healthcare industry continues with breakthrough clinical pathways, ICD-10 will be able to expand to reflect these improvements.

<u>There are five questions you need to ask when thinking about ICD-10 implementation:</u>

1. Will your vendors be ready?
2. Will your payers be ready?
3. How will you train and ensure retention of knowledge?
4. How will the coder’s efficiency be affected?

So….are you *really* ready?

For information on ICD-10 preparedness, please visit AHIMA Website .

For more information, please contact Gina Tomcsik, Director Compliance Functional Pathways at gtomcsik@fprehab.com or call 865-531-2204. You may also discover more at www.functionalpathways.com

INNOVATIVE REHAB OUTCOMES

EXCELLENCE IN REHABILITATION

Functional Pathways™
Excellence in Rehabilitation

www.functionalpathways.com | 888.531.2204

The HAT Advantage continued from page 1

- Consider negotiated risk agreements in assisted living
- Be proactive with crisis communication plans and positive community profiles through marketing efforts

<u>The Medical Director’s Involvement</u>

- Review medical director’s roles and responsibilities as defined by CMS (F501-Medical Director) and the standards governing medical services in the delivery of quality of care

<u>Assisted Living Physician and Nurse Practitioner-Healthcare Leaders</u>

- Recommendations for the assisted living facility (facility or NP)
  - o Set expectations with disclosures before admission identifying medication policies, clinical capabilities and service and care limitations
  - o Continue disclosures after admission by providing detailed information about clinical capabilities limitations to off-site pharmacies and residents physician
  - o Clearly define lines of communication within the facility
  - o Clearly define lines of communication with the physician
  - o Develop policies that include notification of the physician of hospital transfers
- Recommendations for the physician
  - o Understand the facilities’ medication policies and clinical capabilities and limitations

Continued on page 3

The HAT Advantage continued from page 2

o Help and encourage the facility to accommodate the patient's wishes and preference

o Create clear communication lines and identify contacts to provide medical orders and other clinical instruction

o Discuss and describe the likely trajectory of resident's illness and expected outcome setting clear expectations with the resident's family and key staff

o Be familiar with the assisted living policy regarding negotiated risk agreements

Emergency Operations Plan and Regulations

• Collaborate with local emergency management agencies

• Analyze specific vulnerabilities and determine actions for each identified hazard

• Identify decision criteria for executing the plan

• Develop shelter-in-place plans

• Develop an evacuation plan

• Develop communication plans in the event of telephone failures or other infrastructure contingencies

Achieve "Work-Life Being"

• Manage settings instead of letting your settings manage your intention

• Focus on one thing at a time

• S.T.O.P. (S-stop what you are doing, T-take a few breaths, O-observe your body and smile, P-proceed with kindness and compassion)

• Take 20 minutes for yourself

• Get plenty of rest

• Eat high protein-low carb meals at breakfast and lunch

• Sip your caffeine slowly

Pressure Ulcer Management

• Self-survey using F314 and other related regulations pursuant to Quality Assessment and Assurance programs

• Spend time with your teams to review facility wound care protocols, regulations and related tools

Let's make 2015 the best year yet, both personally and professionally. Commit to Nursing and Assisted Living: Resolutions 2015 that will elevate the quality of care and improve our organizations. Our own well-being and the health of our companies deserve all we can do!

Rebecca Adelman, Esq. – Ms. Adelman is a Shareholder of Hagwood Adelman Tipton, PC and practices in the Memphis, Tennessee office. She is a member of the Board of Directors and serves as the firm's President. For over 20 years, Rebecca has concentrated her practice in healthcare law, long-term care assisted living and medical malpractice defense litigation. Her expertise and her scope of practice involve all insurance defense litigation areas including premises and product liability as well as employment law. Please feel free to contact her at radelman@hatlawfirm.com.

KESSLER'S CORNER

by Chip Kessler

"A Look Back … A Look Ahead"

As we come to the close of 2014, I like most of you, like to reflect back on the past months of the year. As this newsletter completes its fourth year of existence, its popularity continues to climb with request after request to be added to our mailing list. To you who receive *Nursing & Assisted Living Facility Professional*, whether it's been for all or part of the past four years, I want to thank you for your kind comments and wonderful support!

I'd also like to extend my thanks and best wishes to those whose columns each month are the staple of what this publication is- first to Rebecca Adelman who has been with me from the very start, I say you are the best of the best! Your insights and contributions are a true mainstay of these pages, and I know that I speak for our readers in saying thanks for all that you do. The same appreciation goes to the outstanding group of contributors from Functional Pathways headed by Sheila Capitosti. To Sheila, David Higdon, Cherrie Rowell, Gina Tomcsik, and their newest contributor in 2014 Jill Fiala, I appreciate all you have done and continue to do to make this newsletter so successful. To Linda Kunz and the great folks At DART Chart Systems, I send my sincere thanks and gratitude for your support over the years. I can speak from personal experience that facilities using DART Chart's services are the more successful for it, and give this outstanding company my highest personal recommendation. I can also echo the same sentiments for Functional Pathways' services as well!

To Joel VanEaton for his columns over the past few years, I say thanks as well, and last but certainly not least, I offer my gratitude and appreciation to the unsung hero in this monthly endeavor, my fabulous graphics designer Lori Wilhoit who puts all of this together into one neat package for you to enjoy. Indeed this is a true team effort and I'm blessed to have a great group of dedicated folks around to make this all happen.

Now let me look ahead to 2015. First let me jump back quickly to 2014 with the comment that for a great many assisted living and nursing facilities nationwide it was (and continues to be here in December 2014) the most challenging year ever. Nowhere is this more evident than in your marketing and census building efforts, and as we move forward things promise to be just as testing. The continued emergence of in-home health services is a major factor, as well as increased competition on all flanks. Accordingly, let me give you some predictions to ponder: 1) facilities who place too much of their census success on only getting new residents via referrals from hospital discharge planners and/or physicians are going to run the real risk of total failure 2) facility leaders (not just the marketing folks) are going to have to plunge head-first into their building's marketing efforts, and those who don't are going to have to live with the consequences and 3) facilities are going to have to come up with new and innovative ways to attract families/residents through their doors, and failing to adhere to this will put these buildings in jeopardy. The good news is that buildings that accept these challenges are going to see steady growth in the months ahead, because your competitors aren't as well versed in the tremendous opportunity that's out there- if you act on it! Will you be one of those who'll make this commitment?

Chip Kessler is General Manager of Extended Care Products. He's developed several discovery programs on marketing and has also written two books on the subject. He provides personal consulting services for nursing and assisted living facilities nationwide. Discover more at www.extendedcareproducts.com.

NAL Professional Not Coming Addressed to You Personally?

We want to make sure you are personally getting this newsletter each month, not just have it forwarded to you because you're now holding down the position of a predecessor! Let us know you now are on the job. E-mail your name, facility/company name and address to chip@ecpnews.net & we'll update our records. Just put NAL Professional on the e-mail subject line and we'll take care of the rest.

NAL PROFESSIONAL
P.O. Box 4852
Johnson City, TN 37604

PRSRT STD
US POSTAGE
PAID
MWI

DART Chart's HMO MAP & TRACK℠

Easy Implementation

- Digitized mapped contracts
- Interface existing data
- Ready for use

Actively Manage Costs

- Cost of care is tracked
- Overages are displayed
- Co-pays during stay
- HIPPS Code reports

Maximize Revenue

- Less time managing contracts
- Cost containment
- Mitigate claim denials
- Higher revenue

Proactive MCO Management

Effective MCO Contract Management doesn't have to be complex

888-210-3200

www.DARTChart.com