Nursing & Assisted Living Facility *Professional*

"NEWS AND VIEWS YOU CAN REALLY USE"

JULY 2016
ISSUE 7, VOLUME 6

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

THE HAT ADVANTAGE

by Rebecca Adelman

Long Term Care and Considerations of the Aging LGBT Adult

Over the past year, I've been increasingly advising and solution seeking with senior housing and aging services providers regarding the special aging needs of older lesbian, gay, bisexual, and transgender (LGBT) adults. I've been assisting long term care and assisted living organizations with developing policies and protocols and establishing training and education as the landscape in long term care continues to change. With the enactment of the Affordable Care Act, recent decisions from the United States Supreme Court allowing gay couples the right to marry and access to certain federal benefits including Medicare as well as federal regulatory guidance and proposed rules, long term care providers need to increase legal and policy understanding, awareness and education in their organizations. OBRA '87 (the federal Nursing Home Reform Act) and the resident's bill of rights protect LGBT residents from discrimination and harassment, regardless of their sexual orientation or gender identity or expression and long term care providers are encouraged to examine policies and practices to ensure that discrimination is clearly prohibited, that recommendations for equitable and inclusive care are being followed, and that staff are trained to provide knowledgeable, sensitive care.

On May 13, 2016, the Department of Health and Human Services issued *The Nondiscrimination in Health Programs and Activities* which is the final rule implementing Section 1557 of the ACA. This final rule seeks to advance health equity and reduce health care disparities. Under the rule, individuals are protected from discrimination in health care on the basis of race, color, national origin, age, disability and sex, including discrimination based on pregnancy, gender identity and sex stereotyping.

The final rule prohibits sex discrimination in health care by:

Prohibiting denial of health care or health coverage based on an individual's sex, including discrimination based on pregnancy, gender identity, and sex stereotyping.

Current estimates state that 9 million Americans identify as LGBT. One study found that 27% of LGBT baby boomers had significant concerns about discrimination as they age and there are reports that LGBT older adults encounter violations of their rights when seeking long term care services and support. Incidents of abuse are often unreported or unidentified; however, a majority of individuals responding to a recent survey (578 of the 649 respondents or 89%) felt that staff would discriminate against an LGBT elder. Additionally, negative treatment, including verbal and physical harassment, by other residents was the most commonly reported problem by respondents in this study.

The healthcare community is providing more attention to the special aging needs of the LGBT population. A recently-published, groundbreaking report—*LGBT Older Adults in Long-Term Care Facilities: Stories from the Field*—highlights the treatment that some LGBT elders may encounter and the reasons why LGBT older adults are less likely to access health and social services.

Review Residents Rights and Consider Best Practices

While we are familiar with the residents' bill of rights, understanding the particular importance to LGBT individuals living in a nursing home or assisted living as well as knowing the applicable state nursing home regulations and various anti-discrimination laws may help LGBT older adults feel more included and provide additional protections for your organizations.

Right to be free from abuse - All residents have the right to be free from abuse (by any individual - including other residents) and facilities must develop and implement policies and procedures that prohibit mistreatment of residents and investigate and report allegations of abuse. Resident mistreatment includes all types of abuse; such as verbal, sexual, mental and physical abuse, neglect and financial exploitation. For example, facility staff cannot refuse to provide care due to a resident's sexual orientation nor can staff harass a resident due to his/her gender identity.

Right to privacy - Residents have the right to private and unrestricted communication with anyone they choose (e.g. during in-person visits and through letters, telephone and electronic communication) and privacy regarding their medical,

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Pathway to Rehabilitation Excellence

By Melissa Ward
Director of Clinical Services

Therapy Program Development

Therapy Program development is something that is discussed frequently because as therapists we are often looking for ways to better address the needs of the patients we serve and communities we work in are looking for innovative programs to improve the lives of their residents. However, while intentions are pure, without proper planning, training, and ongoing coaching it can be difficult to get a new program off the ground and sustain it once developed. By understanding this inherent challenge, we can utilize a more a systematic approach to ensure longevity of the programs we work so hard in developing and implementing.

If we break program development into 4 stages, we can better understand the process and how to ensure success.

1. **Program identification**. It is critical to consider several factors when selecting a new program. You have to take into consideration actual need. This can include the needs of the residents in the community to which you work (ALF, SNF, Life Plan Community), needs of the referral sources, staff, and care providers.
   During the program identification stage, you will need to assess readiness. Thing to consider:
   - How well does program fit actual need?
   - How well does the program fit the current initiatives, priorities, and community values?
   - What is the availability of resources – do you have the staffing, supplies, and equipment to implement and sustain the program?
   - What are the expected outcomes if implemented?
2. **Installation phase.** By this time, you have identified an appropriate program and this phase is where you acquire or repurpose the resources needed to do the work ahead. This phase can include selecting staff, identifying resources, providing initial training, and assuring access to the needed supplies and equipment.
3. **Initial implementation.** This when the innovation or program is being used for the first time. Clinicians and staff are attempting to use newly acquired skills or innovative products. Initial implementation is the most fragile phase because this is when team members are trying new things but the urge to do 'business as usual' is tempting to them. In order to sustain change into daily integration, staff will require external support. This could be from a manager or a program champion. Someone to inspire and help them stay focused!
4. **Final implementation.** When 50% or more of the intended team members are using an innovation or program accurately with good outcomes, you can consider the program to be in this phase. But beware! Once established, programs are difficult sustain without continue support due to the potential for changes in staff, management, or system changes.

Program develop and growth is a very important part of our jobs as therapists and by looking at it in a systematic way can help ensure elite results for our patients. I encourage everyone reading this to consider what programs does your team offer and what can be added to enhance your current clinic offerings?

Getting on the Same Page by Paige Hector, LMSW

Everything We Do Is A Process. So What?

From the moment you get up in the morning until the moment your head hits the pillow at night, everything you do is a process - getting ready in the morning and out the door, making it through your workday, driving home, making dinner, etc. For me, splashing water on my face and brushing my teeth are paramount before I can enjoy that first cup of coffee. Talk about the Law of Initial Beginnings!

Do you think you and your staff engage in processes at work? Of course! Let's take a look. A nurse reports for his shift. There is a sequence of events to accomplish in order to be prepared to care for the residents – read the shift report, get report from the previous nurse, see what orders need to be noted, check the appointment log, determine what labs are due, etc.

The activity director has a process for creating the monthly calendar, the business office manager has a process for sending out accounts receivables, the maintenance director has a process for prioritizing work requests, nurses' aides for assisting a resident with bathing and so on.

While all this sounds mundane and you might be thinking "what's the point?" I encourage you to consider how significant the process-oriented context of thinking really is.

One of my favorite images to use when I teach this concept is called the Universal Process Flow Chart. Envision the most convoluted flow chart you can image and you, the leader, at the top telling your staff how you want things to work and by golly "Just do it!" Well, at the bottom of this crazy flow chart is the frontline staff and the reality of their daily work may be filled with confusion, conflict, complexity and chaos (hopefully not all of the time). The front line knows how things really work (despite what the policy and procedure says). This gap between how things *should* work and how they *actually* work is called VARIATION. I'll talk more about variation in my next column but for right now let's stick with processes.

Consider these process-oriented questions: 1) Do you ever waste time waiting when you should not have to? 2) Do you ever redo your work because something failed the first time? 3) Do the procedures you use waste steps, duplicate efforts, or frustrate you through their unpredictability? 4) Is information that you need ever lost? 5) Does communication ever fail?*

If you answered "no" to all these questions or even half of them, I want to work in your organization! I dare you – ask your frontline staff these questions and give them permission to be absolutely honest. What you will uncover are the problems lurking in your facility that drain staff energy, waste time and money and likely result in errors or near misses. Look for the work-arounds that staff has implemented (sometimes unknowingly) just to make it through their day. Talk about ideas for great Performance Improvement Projects!

Principle 1 of a process-oriented context is that your processes are perfectly designed to get the results they are already getting, and will continue to get. Stop here and read that again. It's a tougher concept than you might think at first blush. I'm telling you that the things happening in your facility from infections, readmissions, falls, pressure sores, and any other metric that you measure are happening the way they are perfectly designed to happen, even when they are undesirable or unintended.

Unfortunately, people do not take the time to really understand the process-oriented concepts and the result is arbitrary goals that get imposed on staff. Imagine you're in a monthly performance improvement meeting. Someone in leadership announces that there are just "too many falls" this month and to "fix it." Remember that universal process flow chart with the leader at the top telling staff to *make it so* and the staff on the front line stuck in the chaos, confusion and muck (there might be some requisite eye-rolling too)? Simply telling staff to reduce falls *will not work*.

The variation between what the *process* is perfectly designed to achieve (number of falls) and what leadership thinks it should be (usually fewer) is the VARIATION. In order to improve performance in any area, you must first understand what the process is perfectly designed to produce. Skip that step, and you must accept the result of enormous time wasted in meetings with staff trying to justify why this month's number is more or less than last month (quarter, year, etc.) when they have done *absolutely nothing different with the process*. You will further complicate the situation, frustrate staff and waste precious resources.

Stay tuned for next month's topic on variation.

Hint: If you want a head start get a copy of Davis Balestracci's book *Data Sanity 2nd Edition*!

Donald Berwick editorial "Continuous Improvement as an Ideal in Healthcare" in the New England Journal of Medicine, December 1989. http://cds.web.unc.edu/files/2014/09/Berwick-1989.pdf

OLYMPICS FUN FACTS

The early Olympic Games were celebrated as a religious festival from 776 B.C. until 393 A.D., when the games were banned for being a pagan festival (the Olympics celebrated the Greek god Zeus). In 1894, a French educator Baron Pierre de Coubertin, proposed a revival of the ancient tradition, and thus the modern-day Olympic Summer Games were born. Host Greece won the most medals (47) at the first Olympic Summer Games in 1896. The first Winter Olympic Games were held in Chamonix, France in 1924.

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personal and financial affairs. Residents also have the right to privacy regarding their bodies, and all care must be given in a manner that maximizes that privacy.

Right to receive visitors - Residents have the right to receive visitors of their choosing. According to the federal government, "residents must be notified of their rights to have visitors on a 24-hour basis, who could include, but are not limited to, spouses (including same-sex spouses), domestic partners (including same-sex domestic partners), other family members, or friends."

Right to participate in activities - Residents have the right to participate in (or choose not to participate in) social, religious, and community activities both inside and outside of the facility. For example, LGBT individuals have the right to participate in and promote an event, training or resource regarding LGBT equality without fear of discrimination or abuse.

Right to be treated with respect - All residents have the right to be treated with dignity, respect and consideration and have the right to exercise their choice and self-determination. For example, all residents have the right to be addressed how they want to be addressed (e.g. using a resident's preferred pronoun) and the right to be clothed and groomed consistent with their gender identity.

Right to participate in care - Residents have the right to be informed about care and treatment, participate in their own assessment and care planning and make decisions regarding their treatment, including health care choices related to gender transition. Residents also have the right to designate a legal surrogate (or, decision-maker) to act on their behalf. State laws, such as health care power of attorney and guardianship laws, govern how someone (including same-sex partners or spouses or other family of choice) can make decisions on their behalf.

Right to be fully informed - Facilities must inform residents of any changes in services, changes in care or treatment, what is covered by Medicare and Medicaid or other health care insurance and of a change in roommate or room. Facilities must provide notice before a change in roommate and be as "accommodating as possible" by considering each resident's preferences. In regards to benefits, the federal government states that Medicare Advantage enrollees are entitled to equal access to services in the same skilled nursing facility their spouse resides in, regardless of sexual orientation. Specifically stating that, "this guarantee of coverage applies equally to couples who are in a legally recognized same-sex marriage, regardless of where they live."

Right to choice - Residents have the right to make their own choices, including what to wear, how to express themselves and their daily routine. Residents also have the right to retain and use personal items (e.g. some furnishings, pictures). Additionally, residents have the right to room with a person of their choice, including same-sex spouses or partners, if they live in the same facility and both consent to the arrangement.

Right to remain in the home - A facility cannot transfer or discharge a resident unless one (or more) of the permissible reasons for transfer or discharge apply. Residents cannot be transferred or discharged due to their sexual orientation or gender identity.

In-service and education and training in residents' right and best practices and setting new benchmarks in your organization will enhance the quality assurance and risk management programs and the quality of care delivered in the communities.

Guidance on Policies and Procedures

Nondiscrimination policies that prohibit LGBT discrimination are a first and necessary step toward ensuring resindets have equal access to respectful, knowledgeable treatment and long term care. Recommendations and guidance on your organization's policies include:

Gender Identity and Gender Expression Nondiscrimination Policies

Residents' Bill of Rights

Protocols for Interactions with Transgender Patients

Room Assignments

Access to Restrooms

Access to Personal Items that Assist Gender Presentation

Admitting/Registration Records—Collection of Gender Identity Data

Compliance with Privacy Laws

Insurance Issues

(See: Lambda Legal)

Reviewing and revising policies and practices for greater inclusiveness is consistent with federal and state regulatory compliance. Compliance will support risk prevention with regulatory complaints and reduce litigation. Moreover, commitment to diversity in the changing world of healthcare and especially eldercare highlights your organization's best care policies and practices and improves quality of care for all elders.

Education, Training, Public Relations and Programming

The question to be posed in the senior healthcare industry is: *How is aging as an older LGBT adult different than aging as a heterosexual and/or non-transgender adult, and how might we reflect and honor these differences in our communities?*

There are an abundance of resources available to educate and train our organizations. I've included a list of those we are relying on with our advisory and legal services. To begin with:

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DO presume your organization has LGBT residents;
DO NOT assume you can identify LGBT individuals by appearances, experiences,
or external characteristics;
DO remember that a resident's sexual orientation and gender identity are only two aspects of a person's overall identity and life experience;
DO ask your residents about their sexual orientations and gender identities in a safe
and confidential manner;
DO NOT assume that treating everyone the same, regardless of sexual orientation
or gender identity, is effective or will make LGBT older adults feel safe or welcomed.

Education and training and modifications to protocols in the following areas are recommended:

Admission and Interview and Social Work Forms - Use inclusive terms, phrases, and language that do not presume a sexual orientation, gender identity, or relationship status.

Confidentiality – Detail how resident information is kept confidential and private and shows residnets that they are respected and that they do not need to fear intrusion or harassment.

Cultural Competency Training – Train all staff on how to identify and address the needs of LGBT older adults is key to making a community inclusive.

Public Relations – Create inclusive marketing materials that reflect a commitment to diverse aging populations.

Programming – If possible, offer LGBT-specific programming demonstrating to other providers and agencies in your community that your community is welcoming of broader diversity principles.

Here are some of the central resources: The National Resource Center on LGBT Aging is the country's first and only technical assistance resource center aimed at improving the quality of services and supports offered to LGBT older adults. Established in 2010 through a federal grant from the U.S. Department of Health and Human Services, the National Resource Center on LGBT Aging provides training, technical assistance and educational resources to aging providers, LGBT organizations and LGBT older adults. The center is lead by Services & Advocacy for GLBT Elders (SAGE) in partnership with 14 leading organizations from around the country.

With the increased level of oversight in long term care including compliance with nondiscrimination regulations policies, your organization will need to review and revise policies and practices through increased understanding in the area of LGBT elder care. Through these efforts, risk and litigation and compliance complaints can be reduced and quality of care increased to all elders we serve. I look forward to this continued conversation and services to our clients in this aree of legal and regulatory compliance and care delivery.

Rebecca Adelman, PLLC, Esq. - Ms. Adelman is a founding shareholder of Hagwood Adelman Tipton, PC and practices in the firm's Memphis, TN office. She is the chair of the firm's Strategic Planning Committee and Women's Rainmaker Mentoring Program. For over 25 years, Rebecca has concentrated her practice in insurance defense litigation representing national insurance carriers and self-insureds with a concentration in healthcare law. Please feel free to contact her at radelman@hatlawfirm.com.

Ms. Adelman will be attending the 2016 American Conference Institute's second Annual Networking & Leadership Forum for Women Leaders in Insurance Defense, Claims, and Compliance held July 20-21 in New York City. She will present on the conference panel titled, "Professional Development and Coaching for Women Leaders: Implementing Critical Negotiation, Leadership, and Presentation Skills to Accomplish Your Goals". The second annual event focuses on promoting diversity and increasing the prominence of women in the insurance community through substantive legal discussion and professional development.

NAL Professional Not Coming Addressed to You Personally?

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P.O. Box 4852
Johnson City, TN 37604

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