Nursing & Assisted Living Facility *Professional*

"NEWS AND VIEWS YOU CAN REALLY USE"

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

THE HAT ADVANTAGE by Rebecca Adelman

Leadership – Transforming Long Term Care

I feel so inspired and encouraged! Last week I joined in the 2nd annual networking and leadership forum for Women Leaders in Insurance Defense, Claims and Compliance in New York City. The conference promotes diversity and prominence of women in the insurance community through substantive legal discussion, professional development and networking. I was honored to lead the half-day workshop "*PROFESSIONAL DEVELOPMENT AND COACHING FOR WOMEN LEADERS: IMPLEMENTING CRITICAL NEGOTIATION, LEADERSHIP, AND PRESENTATION SKILLS TO ACCOMPLISH YOUR GOALS*" with two distinguished career coaches. With General Counsels, Chief Litigation Officers, Chief Compliance Officers, Senior Counsel, and many more we engaged in practical and tangible professional development skills and identified the leadership needs and opportunities in the insurance industry. It is with this momentum that I'm writing this month's article about effective leadership in long term care.

For many years, this column and the conversation in the long term care industry has focused on changes: cultural, organizational, regulatory, work force, perception, care delivery systems, legal, risk and litigation. We've been experiencing changing times in healthcare and the more extensive the change, the more important leadership becomes. Effective leaders can make the difference between success and failure in our organizations.

As our industry has been transforming with quality and culture-change initiatives and "person centeredness", existing managers and leaders and the talented people interested and emerging as leaders in health and aging services administration have a multitude of resources available to them to redefine themselves and develop stronger and more effective leadership roles. The American College of Health Care Administrators Position Paper – *Effective Leadership in Long Term Care* and Implementing Change in Long-Term Care - *A practical guide to transformation* are two such resources. Education and mentoring programs for long term care managers and staff to develop and implement core leadership skills are worth exploring and will help increase leadership effectiveness (and inspire creativity, innovation and motivation!)

The Evolution of Long Term Care and Leadership

The ACHCA timelines the evolution of long term care and the rapidly changing healthcare marketplace. In the 60s, the industry was growing and regulations were minimal. The traditional nursing home operation was essentially faith based and there were no significant demands placed on leaders. In the 70s and 80s, there was a need for an efficient and organized approach to leadership in light of complex regulatory and financials systems. Publicly traded facility groups grew; however, there was still an absence of standards with the focus being on business and management. The 90s saw the greatest changes along with the need for a new approach to leadership. Changes in consumer preferences, resident acuity, growing quality expectations, human resource limitations, stressed finances, and competitive marketplaces have "raised the bar for the profession of health and aging services administration." With the increased regulatory scrutiny, expected changes in regulations, oversight from multiple federal organizations, and governing board and ownership liability and compliance, organizations face the need to improve quality of care and transform the long term care experience and improve organizational performance. Further, with varying types of aging services, there are expanded opportunities and greater available impact for leaders in long term care.

Leadership Traits and Concepts

These **traits and concepts** play a key role for effective leaders in our industry as they guide their organizations through the many changes ahead.

Engaging in strategic planning and systems thinking

Constant assessment of the environment, both internal and external

Surrounding yourself with the right people for the job

Building trust among staff and management

Making communication a priority

Engaging staff, families, and residents in key decision–making

Empowering staff

Providing tangible support to staff when needed

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Pathway to Rehabilitation Excellence

By Lisa Chadwick
Director of Risk Management

Risk Management: Getting To The Root Of The Problem And Action Planning For Successful Change

Uh oh — so you've had an adverse risk event occur--A resident injury, an employee event, or some other unexpected outcome. And what's worse, it's not the first time. Ugh, you just addressed this, didn't you? What went wrong?

How to Figure Out What Went Wrong

Often times we don't take the time to dig down to the root of a problem and correct the *root cause*, which will help prevent recurrence. Addressing root causes is different than addressing the symptom of a problem. When dealing with a recurring problem, you need to examine whether or not you've actually addressed the *true cause* of the issue. If the same issue is recurring, in all likelihood you've missed the mark and haven't identified the root of the issue. Time to dig deep! To find the actual cause, ask *why* until you're satisfied that you've identified where the breakdown initially stemmed from. Ideally, this will reveal where the issues is stemming from on a root level, and you'll be able to uncover a process breakdown and develop strategies to address. We'll dive more into that later — first, let's look at this commonly used example:

Problem: A mouse ate your cheese.
WHY: There's a mouse in the house.
WHY: The screen door is open.
WHY: The spring latch is broken on the screen door.

If you only addressed the symptom by placing a mousetrap, you may succeed in eliminating the problem temporarily. However, without addressing the broken door latch, you leave the door open (so to speak) for the problem to reoccur. In this example, fixing the broken door latch is addressing the root of the problem. While clinical risk management is more complex and can involve many more levels of digging, minimizing risk is vital for both employee safety and resident recovery.

How to Minimize Risk Going Forward

Using Root Cause Analysis (RCA) is a common tool used in health care settings in a patient safety and quality improvement program.

A thorough RCA includes three essential elements:
1) **What happened:** A clear understanding of what actually occurred, and an exhaustive analysis of event with focused attention to detail.
2) **Why it happened:** Dig deep and get to the root of the problem. Leave no stone unturned.
3) **Action Planning:** What are you going to do about it? Corrective action plans to address the root cause.

We covered how to determine the **Root Cause** of a problem. If you've identified the problem, next you need to develop and execute a strong plan of action. The action planning process is key to solving a problem at its root. Strong action plans address **process issues**.

Why the Action Planning Process is the Root of Successful Change
Often times in the healthcare setting, the root of a problem lies in a broken, out dated, or unclearly communicated process. The plan of attack that provides a strategy to eliminate the possibility of future error recurring is best. We should aim to greatly reduce the rate of recurrence, and a great way to accomplish that is to refine the process at fault.
While it may seem intimidating or feel daunting to think about trying to effect change to a process already in place — especially if a particular individual is connected to the process in question — action planning for process changes doesn't always need to include personnel issues. Those may be handled through a separate channel, such as via your Human Resources department.

6 Qualities of a Strong Action Plan

A strong action plan will:

1) Address the root cause; the issue that has a clear cause and effect relationship.
2) Be outlined in a step by step approach.
3) Be achievable and reasonable.
4) Identify responsible person to ensure needed steps are completed. (This person should be someone who can have a direct impact on the required action — they need to be in a position to be able to make it happen.)

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Getting on the Same Page by Paige Hector, LMSW

What's the Difference between Common and Special Cause Variation and Why Should You Care?

Last month's article was about the process-oriented context, the importance of understanding that your processes are perfectly designed to get the results they are already getting and will continue to get. Let's take the next step and talk about variation.

Consider this non-healthcare related example. Most of you likely drive to work. You probably drive on the same route every day with the same number of stop signs, stop lights, and school crossing zones. Sometimes you get "lucky" and nail all the green lights and make it to work in 20 minutes. Other days you're cursing the "red light Gods" as you hit the brakes yet again - time to work, 28 minutes.

Did you "make" either scenario happen? Of course not. How absurd! It just happened, *nothing special*. It just IS. There is a "dead band" of drive time (between 20-28 minutes) and each day your commute will land somewhere in that band. That dead band has another name and it's called *common cause variation*. The drive-to-work time may vary from day-to-day but the process (the route) is the same every day and it will take you between 20-28 minutes. Now, let's modify this scenario. You decide to change your work hours and leave for work at 3AM (as if!). The roads are blissfully clear and you zip to work in 12 minutes. Did you change the process? *Yes*! You introduced something different which is called *special cause variation*.

Just one more example to drive home (no pun intended) the difference between common and special cause variation. Forget leaving your house at 3AM. Instead, the government paved a new road and only YOU can drive on it – no stop lights, no speed limit. Yahoo! You fly to work in 7 minutes. Different process? You bet. That means it's special cause.

Switch to healthcare and an example that happens every month in facilities across the country. Imagine your last QA meeting (or whatever your facility calls it). Every month, department managers compile data sets of the numbers of falls, infections, readmissions, pressure ulcers, grievances, safe work days and likely a variety of other metrics. *[*Check out the side note below regarding wasted time.*]

And, each month staff regurgitates the requisite information, often comparing the number this month to the number last month or perhaps quarter to quarter, or to this time last year. No matter the time frame, there is nothing efficaciously actionable when you compare two numbers. Yet, this is what happens again and again. Leadership looks at a report and circles numbers they are either happy or unhappy about. "Falls are too high. What is staff doing wrong?" "Too many readmissions, I'm disappointed." "Fewer pressure ulcers this month! Great job!" Then, staff gets reprimanded for "unhappy" numbers and directed to do better next month. Or, staff gets rewarded with a pizza party to celebrate "happy" numbers. Either way, the right question was never asked and leadership is already taking the wrong action. Although don't get me wrong, I love pizza and it's awesome when staff gets something fun at work! The professional term for this phenomena of circling numbers (typically on a bar graph) and proclaiming meaning is "WAG" (Wild a** guess). What's the right question you ask? Here it is.

Did the process that produced this number differ from the process that produced that number? I'll bet you a hundred pizzas that the process is the same. When the process is the same (which invariably it is in long-term care) that is called common cause variation. And, when you have common cause variation, you cannot take action on any one number because essentially all the numbers in that dead band are exactly the same. If the dead band for falls each month goes from 12-21 (which are actually called the upper and lower control limits and are calculated statistically), a data point of 13 falls is exactly the same number as a data point of 21 falls. The. Same. Why? Because the process didn't change.

Now to demonstrate an example of special cause variation which means that something happened to the system, the process was different. Your facility hired a new pharmacy. You're excited about the better service but of course there are hiccups as the new system and processes get implemented, including a different electronic ordering system. In the performance meeting this month, you notice that the number of medication errors is unusually high, that the number is outside the common cause band of variation in which all the data points of medication errors are essentially the same. And, before you opt for a crisis-driven, knee-jerk reaction, you instead choose to have a conversation with staff about what processes still need work. Excellent!

What you have done is remove the human variation, the WAG component, by letting the data speak for itself and engaging in a productive process-oriented conversation.

I would like to express my eternal gratitude to Davis Balestracci, for his mentorship and his book (Data Sanity 2nd Edition) that forever changed the way I perceive and understand data and human behavior.

*Side Note: Do you ever wonder how much time you and your staff spend on tasks related to data and meetings with data? Honestly, do you feel like that time is wasted? I see you nodding your heads! Mark Graham Brown (www.markgrahambrown.com/index.html) published findings that senior management meeting time with data is 50% waste. Middle managers waste 1 hour a day reviewing unimportant performance data which results in pounds of wasted reports (of which 60% is waste) which results in 80% waste in corporate financial reports. What a mess. Let me know when you're ready to stop the insanity.

Paige Hector is a clinical educator, who gives workshops and seminars across the country on diverse topics including clinical operations for the inter-professional team, meaningful use of data, advance care planning, refusal of care, documentation and care plans. She is skilled at inspiring staff to critically evaluate their own organizations and then gives them the resources and guidance to make necessary changes. Contact Paige at 520-955-3387 or at paigehector@gmail.com plus you more discover more about her at www.paigeahead.com

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Creating an organizational culture that portrays a sense of caring

Personally modeling a compassionate perspective for the needs of others

The core **qualities of effective leaders** based on research (and our own self-assessments) include:

Providing Direction

Leading courageously

Taking a stand for your values

Confronting issues and concerns promptly

Challenging others to make tough choices

Influencing others

Fostering teamwork

Championing change

Coaching and developing others (mentors and sponsors)

Motivating and inspiring others

Building relationships

Leadership in senior services may be affected by leadership history, established organizational culture and customer differences and each of these areas should be assessed by exiting leadership as changes are made. As the ACHCA points out, the other factors to consider that impact leadership approaches in long term care include:

The high touch, labor intensive nature of providing long term care and services

The highly "regulatory-driven" and reactive environment

The predominately non-professional labor force with high employee turnover rates

The fairly "flat" organizational structure that makes it desired and beneficial for management to build relationships with as many staff as possible

The frequent changes in administrator, director of nursing services, and other key position

The governing boards, owners, and corporate level managers often lack an understanding or sensitivity to the complexity of daily operations and the changing environment

What Can We Do As Leaders?

As we implement changes in our industry and respond to the needs of our residents and organizations and the demands of government, here are a few suggestions for **what we can do**:

Be clear about why a change is being implemented

Understand what your staff is experiencing by actively participating in the change

What you do is more important than what you say

Anticipate and address staff responses

Decide how you will determine whether you have been successful

Look at whether your daily activities are consistent with the changes you are implementing

Respond to challenges that occur during change implementation by helping staff clarify the problem

Peer Mentoring

With the need for nursing and assistant staffing in long term care, leadership and strong workforce competencies and loyalty can be fostered with mentoring programs that extend past orientation or preceptorships. At our conference, we shared about the importance of mentoring on both the mentor and the mentee. Mentoring is a partnership between the mentor as a teacher and the mentee as a learner. As adult learners, mentees are responsible for their own learning and behaviors. As teachers, mentors act as guides or facilitators of learning. Part of mentoring is developing leadership skills and also transferring the information to another. Benefits include:

Increased self-confidence

Enhanced leadership skills

Accelerated acclimation to the culture of the unit/facility

Advancement opportunities

Enhanced communication skills, especially with the interdisciplinary team

Reduced stress

Improved networking ability

Political savvy

Legal and ethical insight

Peer mentoring has been shown to significantly improve retention among direct-care staff. Addressing the need to be prepared for the realities of caregiving work, mentors can smooth the transition from the orientation/training environment to the work environment. Imagine the benefit of new care-provider being assisted by a more experienced staff with problem solving, clinical skills, and handling the emotional impact of the work. The mentors are also exhibit their value to the organization through the sharing of skills and leadership development. There are several peer mentor training programs to choose form that would be suited for your organization.

As leaders in your organization it makes business sense and improves outcomes to offer support early and often and to shift resources away from filling vacancies to supporting valued employees to build the workforce.

Leadership Resources for Long Term Care

The American Health Care Association (AHCA) and the American Association of Homes and Services for the Aged (AAHSA) have each developed leadership programs for their members. The American

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Medical Directors Association (AMDA), the National Association of Directors of Nursing Administration/Long Term Care (NADONA), the Assisted Living Federation of America (ALFA), and the National Center for Assisted Living (NCAL) have also initiated various levels of leadership programs for their members. The American College of Healthcare Executives (ACHE) provides leadership programs and certifications that are more traditionally focused on acute care facility executives.

Strong leadership at all levels in our organizations is essential for driving positive change. Inspired, passionate and visionary leaders create the sustainable leadership legacy that the changes in our industry will need now and in the future. I've been assisting executives and staff with leadership initiatives and training, would welcome the opportunity to assist each of you and welcome feedback on leadership programs and initiatives that are helping your organizations continue to succeed.

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5) Have specific due dates. (Due dates need to be reasonable, but a deadline to solve the issue is crucial for success.)
6) Be measurable. (Simplifying a process by removing unnecessary steps is a measurable strategy. Reducing variability by standardizing a process is a measurable strategy as well.)

The above qualities serve well as your action items of an action plan. As always, if required, prior to implementing changes, resource allocation must be approved.

Celebrate your successes. Share your stories. You know that there is someone else in your organization that has the same issue, and by working together, positive change is possible. Don't forget to learn from each other.

Lisa Chadwick, RN, MS is Director of Risk Management for Functional Pathways. For more information please contact her at lchadwick@fprehab.com or call 888-531-2204. You can also discover more at www.FunctionalPathways.com

Are You Ready for FY 2017?

By Joel VanEaton, BSN, RN, RAC-CT

The RAI Manual has been revised related to the upcoming IMPACT Act requirements that will take effect this fall. Requirements for both the new section GG as well as requirements for the new Part A PPS discharge data set have been issued. Other revisions have also been made to the manual including revisions to section C items for coding delirium and to the Delirium CAA and the Confusion Assessment Method (CAM), changes to section A, clarifications to the instructions for coding falls with major injury and pressure ulcer present on admission. It is critical that providers begin to get a handle on these revisions so that they will have a smooth transition on October 1. Access the DRAFT RAI Manual at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursinghomeQualityInits/MDS30RAIManual.html

CMS has also revised the 5-star rating system. The technical user's guide has been published and, according to CMS on the July Open Door Forum, starting with the July posting of the quality measures on Nursing home compare on July 27, the 5-star ratings will reflect these changes. Preview reports were available on CASPER July 23. Five new quality measures have been added to the mix, the scoring methodology has been revised resulting in new cut points. The impact of these changes will be phased in, 50% with July reporting and 100% with January 2017 reporting. Once again this July and next January, provider star ratings may change overnight, regardless of the quality of care they are currently providing. With more and more weight being placed on the star rating with regard to bundled payments etc. providers need to know how and why their start ratings appear as they do and be prepared to discuss this with prospective referral sources. Technical specifications and the technical user's guide may be found at https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/fsqrs.html

Joel VanEaton serves as MDS/RAI/PPS Education Coordinator for Extended Care Products. Besides developing various MDS 3.0 related programs for your investment, he also presents webinars and seminars on important nursing facility reimbursement issues. His latest webinar offering "Hang on Tight, It's Time for FY 2017" covering what he's written about here (and more) will be presented on Tuesday, August 9. For more information and to register please visit www.WebinarLTC.com or call 1-800-807-4553.

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