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

EMERGENCIES – ARE YOU PREPARED?

CMS Emergency Preparedness Rule – Final Rule

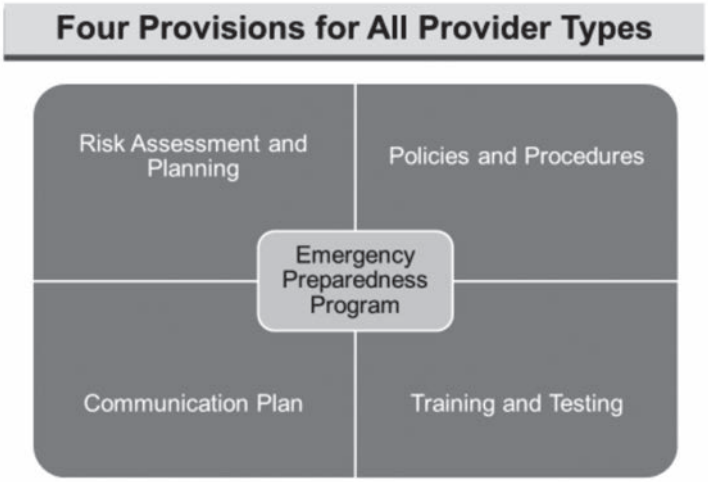
As I'm writing, all communities in the Southeast and Texas are braving through the recovery from the devastation of hurricanes Harvey and Irma. The full impact of these events is truly unknown except that we know for millions across the country, life will never be the same. There is a particularly devastating impact on many older adults in long-term care facilities in preparing for and dealing with hurricanes and other disasters. In Florida and beyond, the country is experiencing the outcome of the challenges long-term acre and assisted living providers face in emergencies. Our industry continues to promote many approaches to planning, response, and recovery from all sorts of emergencies. The first priority of healthcare providers and suppliers is to protect the health and safety of their residents and patients.

We need only look back over time to identify a multitude of natural and man-made disasters. As a result of the September 11, 2001 terrorist attacks, anthrax attacks, hurricanes, flooding in the Midwest, pandemics and other threats and catastrophes, our nation's health security and readiness for emergencies have been on the national agenda.

As we know Phase II implementation of the Final Rule set November 16, 2017, includes emergency preparedness requirements that establish a comprehensive, consistent, flexible, and dynamic regulatory approach to emergency preparedness and response that incorporates the lessons learned from the past, combined with the proven best practices of the present. As CMS states, "…central to this approach is to develop and guide emergency preparedness and response within the framework of our national healthcare system. To this end, these requirements also encourage providers and suppliers to coordinate their preparedness."

On September 16, 2016, CMS publish the final rule Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers. The new Emergency Management regulations are set to go into effect on November 16, 2017.

Following is an overview, training resources and focus on emergency communication. The four provisions for 17 provider and supplier types are:



1. Risk Assessment and Planning:

Per CMS, for this provision:

Develop an emergency plan based on a risk assessment.

Perform risk assessment using an "all-hazards" approach, focusing on capacities and capabilities.

Update emergency plan at least annually.

An all-hazards approach is an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters, including internal emergencies and a man-made emergency (or both) or natural disaster. This approach is specific to the location of the provider or supplier and considers the particular type of hazards most likely to occur in their areas. These may include, but are not limited to, care-related emergencies, equipment and power failures, interruptions in communications, including cyber-attacks, loss of a portion or all of a facility, and interruptions in the normal supply of essentials such as water and food.

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Pathway to Rehabilitation Excellence

By Gina Tomcsik
Director of Compliance
Privacy Officer

Medicare Part B Therapy Caps

I remember about ten years ago when my dad had his first hip replacement and was excited when he finally "graduated" from home health Physical Therapy (PT), which allowed him to go to Outpatient Physical Therapy. He was elated. He went to his Outpatient PT evaluation and was ordered PT three times a week for Outpatient PT. When he and I discussed his Outpatient PT plan of treatment, I asked him about his benefit coverage and if the Outpatient Physical Therapist explained his coverage under Medicare Part B. He told me that the receptionist did talk to him about it and "*everything is covered! I have Medicare Part B and AARP so even my co-pay is covered*". I showed my excitement for him but then I gently said, "*So you are good with the Medicare Part B cap as well*?" He looked at me funny and then said that he didn't know what I was talking about. When I explained it to him, he was furious! He said he didn't have a clue that there was a cap on the amount of therapy he can get and Congress "*needs to get their act together*". He called his State Representative and Senator and voiced his opinion. He and my mom began to advocate for repealing the caps through the link that I provided to them from *National Association for the Support of Long Term Care (NASL).* My dad's PT rehab was favorable and he eventually could walk without his cane but doing so came long after his Medicare Part B cap amount and threshold was exhausted. See, the Medicare Part B cap and threshold didn't consider the debilitating state that my father's joint was in, the club foot he has been suffering with all his life, and the comorbidity impact of his spinal stenosis. The dollars were met, he was discharged from PT, and no more therapy for that year!

What are the Therapy Caps and Threshold? Let's review:

- Physical Therapy and Speech Therapy (ST) share a bucket of Medicare Part B dollars per calendar year and Occupational Therapy (OT) has their own bucket of dollars.
- In the PT/ST "bucket" is $1,980 for 2017 and in the OT "bucket", there is $1,980 for 2017.
- Once the dollars are spent in each bucket, and before reaching the $3,700 threshold, that space between the cap ($1,980) and the threshold ($3,700) is where the exceptions process comes into play.
- If the skills of a therapist are vital to treat the patient's condition and the services are medically necessary, with the addition of a KX modifier on the claim, therapy can continue to provide the services.

Times haven't changed much since my dad's first hip replacement. And yes, we are still dealing with Medicare Part B Therapy Caps… for **20 Years Now**! We should be grateful as providers, that Congress stopped the "hard cap" on services, which at one time we were dealing with. But when the "hard cap" went away, we were burdened with multiple, temporary alternatives, and the "exceptions processes". The "exceptions process" has provided relief to providers and allowed the medically necessary care to beneficiaries over the cap. But at times, the process has been a pain in the neck.

A few years back, as providers, we had to obtain prior authorization through the Medicare Administrative Contractor (MAC) to continue therapy past the cap amount. This pre-approval process left patients not receiving the medically necessary care they required while the provider was waiting on the MAC's decision. At times providers would receive no authorization to continue, would receive approval for a limited number of visits that would not meet the needs of the beneficiary, and providers even received an approval letter one day followed by another letter denying approval for the same beneficiary the very next day, and the list of issues goes on and on.

NASL has informed providers, "*Congressional leadership has shown real interest lately in fixing the therapy cap once and for all, and a successful Energy and Commerce Health Subcommittee hearing was recently held in the House. Now is the time to make sure there is great demonstration of Congressional support for a permanent fix!"*

We can't do it alone, though. We need your help. Please join Functional Pathways and NASL in urging Congress to revisit this critical issue before the exceptions process expires at the end of 2017. It only takes a minute by clicking on the appropriate link below.

Please TAKE ACTION:

Part B for Patients: http://cqrcengage.com/nasl/app/write-a-letter?3&engagementId=355113

Part B Link for Family Members: http://cqrcengage.com/nasl/app/write-a-letter?7&engagementId=355073

Part B Link for Providers: http://cqrcengage.com/nasl/app/write-a-letter?10&engagementId=353573

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

Getting on the Same Page by Paige Hector, LMSW

Making Rounds, Changing Culture

As a health care leader, what actions do you take each day that positively impact staff performance? Stop for a moment and really think about that question. Whether you're the administrator or a department manager, what do you do each day that lets staff know they are supported, they are heard and their input is important?

Years ago I read Quint Studer's quintessential book *Hardwiring Excellence* and I'm going to highlight what I think is one of the most important, brilliant, actually, single action that a leader can do every day that makes a significant difference in the culture of the facility. This action is salient today, if not more so given the intense pressure to do more, achieve more, do it faster and with less. If there was one thing you could do each day that would have such an impact, would you do it?

Here it is, three words. Rounding for outcomes.

Rounding for outcomes is the number one action to increase employee satisfaction. In fact, Studer calls it a "Must Have."

Rounding for outcomes does not mean doing a "fly by" and asking staff "How are you?" (as you continue walking) when it's understood that all you want to hear is "fine" because you don't have time to stop and listen. If you're not ready to slow down, stop reading now, just continue driving 75 mph down the interstate with four flat tires thinking you don't have time to stop and change them. This article is not for you.

The uniqueness of rounding for outcomes has to do with the relationships that a leader develops with staff, the gap between "them" and "us" being reduced and eventually eliminated. Rounding for outcomes focuses first on employees, then patients. If employees are satisfied, if they are loyal and want to be working in your organization, that lays the foundation for patient satisfaction.

Start your day out on the floor, not in your office. Go to each unit, each department and engage with staff. This mean all shifts on all days, not just M-F morning rounds. Go see staff in their element and ask what they need. Don't ask how they are doing as you'll likely receive an answer of "fine." Really, what are they supposed to say to that question?

Studer advises saying this instead, "I work for you. What do you need today?"

You might be thinking 'What?!' Tell my staff that I work for them?!

Yes, tell staff you work for them (don't worry if they take a step back and have an odd expression on their face) and then ask what they need to be successful in their job. They may be hesitant at first to say what they need but if you are genuine, if you are consistent, and if you truly listen and take action on what they say, they will come to trust you. They will tell you what they need and chances are it won't be too onerous.

Studer gives us more ideas of questions to ask staff: What makes your job hard? What's getting in your way? How can I help make your job easier? Are there any individuals whom I should be recognizing? Is there anything we can do better? Do you have the tools and equipment to do your job?

A nurse aid might say, "We keep running out of washrags for morning baths. Can we get more?" Or, "The Hoyer lift is acting up and needs to be fixed." Or, "Mr. Evans is upset about…"

A housekeeper might say, "I just put away Mrs. Piper's clothes and noticed ants in her closet." Or, "The vacuum isn't working right."

A nurse might say, "I am so frustrated with the EMR. I've tried logging in three times but keep getting an error. I have so much documentation to do."

A dietary aid might say, "The residents really loved the dessert last night. I hope we can get it on the menu again soon."

The receptionist might say, "Yesterday the coffee ran out in the lobby and it took quite a while to get it refilled – I think the kitchen was really swamped."

Administrators, think back to a time when you were a manager or worked in some capacity "on the floor," even if it wasn't in health care. What would it have been like to have your supervisor come find you, tell you he/she works for you and ask what he/she could do to make your job easier and then wait patiently while you composed an answer?

Every one of the situations above has a simple solution and it would make the employee's job so much better! Many of them would also positively impact residents and families. And the wonderful part is that you get to be part of the solution *in real time*.

These questions go after the process issues that frustrate staff and result in workarounds that ultimately frustrate administrators and managers. These simple questions are so powerful, but the leader must act on the answers staff provide.

Studer gives us another very powerful question to ask staff, "Tell me what is working well today." Especially in health care, we are trained to focus on what is wrong, what needs to be fixed. We need to make a conscious choice, a consistent and conscious choice, to look at and acknowledge what is going right. Look around your facility and you'll notice acts of kindness, compassion, clinical expertise, unwavering dedication, and extraordinary patience.

Does rounding for outcomes take time? Sure it does. But, so does dealing with the process problems and complaints when issues are not addressed, or not addressed in a timely manner. Rounding for outcomes requires upfront time for the administrator *and* it's time well spent. Engage with and delight your staff; they'll do the same with the patients and residents. Happy Rounding!

Studer, Q. *Hardwiring Excellence*. Gulf Breeze, FL: Fire Starter Publishing; 2003.

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.

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The HAT Advantage continued from page 1

2. Policies and Procedures:

An overview of this provision includes:

Develop and implement policies and procedures based on the emergency plan and risk assessment.

Policies and procedures must address a range of issues including subsistence needs, evacuation plans, procedures for sheltering in place, tracking patients and staff during an emergency.

Review and update policies and procedures at least annually.

3. Communication Plan

The Communication Plan will be discussed in more detail in this article space in October. CMS identifies the keys to this provision as:

Develop a communication plan that complies with both Federal and State laws.

Coordinate patient care within the facility, across health care providers, and with state and local public health departments and emergency management systems.

Review and update plan annually.

4. Training and Testing:

An overview of the training and testing program is:

Develop and maintain training and testing programs, including initial training in policies and procedures.

Demonstrate knowledge of emergency procedures and provide training at least annually.

Conduct drills and exercises to test the emergency plan.

- Facilities are expected to meet all Training and Testing Requirements by the implementation date of November 15, 2017.
    - **Participation in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based exercise.**
- Conduct an additional exercise that may include, but is not limited to the following:
    - **A second full-scale exercise that is individual, facility-based.**
    - **A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.**

Facility-Based: When discussing the terms "all-hazards approach" and facility-based risk assessments, CMS considers the term "facility-based" to mean that the emergency preparedness program is specific to the facility. Facility-based includes, but is not limited to, hazards specific to a facility based on the geographic location; Patient/Resident/Client population; facility type and potential surrounding community assets (i.e. rural area versus a large metropolitan area).

Full-Scale Exercise: A full scale exercise is a multi-agency, multijurisdictional, multi-discipline exercise involving functional (for example, joint field office, emergency operation centers, etc.) and ''boots on the ground'' response (for example, firefighters decontaminating mock victims).

Table-top Exercise (TTX): A table-top exercise is a group discussion led by a facilitator, using narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. It involves key personnel discussing simulated scenarios, including computer-simulated exercises, in an informal setting. TTXs can be used to assess plans, policies, and procedures.

On June 2, 2017, CMS released an advanced copy of the interpretive guidelines and survey procedures that will be incorporated into the SOM under Appendix Z and applies to all 17 provider and supplier types. Since the Conditions of Participation (CoPs), Conditions for Coverage (CfCs) and requirements apply across providers and suppliers and only vary slightly, CMS has compiled the requirements under one appendix. Check it out at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/Advanced-Copy-SOM-Appendix-Z-EP-IGs.pdf.
In October, this article will also address tag E-0006 and E-0007 applying to long-term care facilities.

CMS has also recently issued information on training and testing requirements for Emergency Preparedness. Check out https://surveyortraining.cms.hhs.gov.

Now that the interpretive guidelines have been released, it's time to complete the training and testing exercises and a comprehensive plan. Next month, we'll discuss the specifics set forth in the interpretative guidelines as well as a communications plan. Please feel free to contact me for guidance as your emergency prepared programs advance to completion. We can expect "Tag E" to be a focus for CMS on November 17, 2017 and forward.

SAVE THE DATE FOR 6TH ANNUAL LITIGATION RISK AND DEFENSE STARTEGIES FOR LONG-TERM CARE & ASSISTED LIVING PROVIDERS, INSURERES AND BROKERS.

Join me and my firm and co-hosts Cowan & Lemon, LLP, Horne Rota Moos, LP and Kaufman Borgheest & Ryan, LP for our annual conference held in Houston April 4-5, 2018. Stay tuned for more information on our program! Email me at radelman@hatlawfirm.com updates.

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 or visit her website: www.rebeccaadelman.com.

save the date

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