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

Emergency Preparedness–Survey Guidance for LTC and Communication Plan

As our country and others recover from devastating natural and unnatural occurrences, it's helpful to focus on what we can do to help others and ourselves and community members before, and after crisis events. Last month, we discussed Phase II implementation of the Final Rule's emergency preparedness requirements that establish a comprehensive, consistent, flexible, and dynamic regulatory approach to emergency preparedness. This month, we'll review the interpretive guidelines and survey procedures in Appendix Z developed to support the adoption of a standard all-hazards emergency preparedness program for all certified providers and suppliers while similarly including appropriate adjustments to address the unique differences of the other providers and suppliers and their patients. Successful adoption of these requirements will enable all providers and suppliers wherever they are located to better anticipate and plan for needs, rapidly respond as a facility, as well as integrate with local public health and emergency management agencies and healthcare coalitions' response activities and rapidly recover following the disaster.

E-0006 – The Interpretive Guidelines and Survey Procedure for LTC Facilities in Appendix Z provides:

(a) **Emergency Plan**. The facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:

(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. §483.73(a)(1)
(2) Include strategies for addressing emergency events identified by the risk assessment.

Per the guidelines, facilities are expected to develop an emergency preparedness plan that is based on the facility-based and community-based risk assessment using an "all-hazards" approach. **An all-hazards approach is an integrated approach to emergency preparedness that focuses on identifying hazards and developing emergency preparedness capacities and capabilities that can address those as well as a wide spectrum of emergencies or disasters. This approach includes preparedness for natural, man-made, and or facility emergencies that may include but is 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.**

Facilities must document both risk assessments. An example consideration may include, but is not limited to, natural disasters prevalent in a facility's geographic region such as wildfires, tornados, flooding, etc. 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. This approach is specific to the location of the facility considering the types of hazards most likely to occur in the area. Thus, all-hazards planning does not specifically address every possible threat or risk but ensures the facility will have the capacity to address a broad range of related emergencies. Facilities are encouraged to utilize the concepts outlined in the National Preparedness System, published by the United States Department of Homeland Security's Federal Emergency Management Agency (FEMA), as well as guidance provided by the Agency for Healthcare Research and Quality (AHRQ).

"Community" is not defined in order to afford facilities the flexibility in deciding which healthcare facilities and agencies it considers to be part of its community for emergency planning purposes. However, the term could mean entities within a state or multi-state region. **The goal of the provision is to ensure that healthcare providers collaborate with other entities within a given community to promote an integrated response.** Conducting integrated planning with state and local entities could identify potential gaps in state and local capabilities that can then be addressed in advance of an emergency.

Facilities may rely on a community-based risk assessment developed by other entities, such as public health agencies, emergency management agencies, and regional health care coalitions or in conjunction with conducting its own facility-based assessment. If this approach is used, facilities are expected to have a copy of the community-based risk assessment and to work with the entity that developed it to ensure that the facility's emergency plan is in alignment.

When developing an emergency preparedness plan, facilities are expected to consider, among other things, the following:

- Identification of all business functions essential to the facility's operations that should be continued during an emergency;
- Identification of all risks or emergencies that the facility may reasonably expect to confront;
- Identification of all contingencies for which the facility should plan;
- Consideration of the facility's location;
- Assessment of the extent to which natural or man-made emergencies may cause the facility to cease or limit operations; and,

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Pathway to Rehabilitation Excellence

By Lisa Chadwick, RN, MS
Director of Risk Management

Partnerships in Care: How to Be Part of the Solution

By partnering with both upstream and downstream providers, Skilled Nursing Facilities are uniquely positioned to take the lead across the continuum of healthcare to ensure a seamless transition from one level of care to the next. As we see expectations of shorter lengths of stay and patients with higher acuity, coordinated changes will need to be implemented to ensure successful outcomes. One of your goals should be NO surprises at the time of transition.

Hospitals are looking for partners to assist with good outcomes for patients. They need solutions to the problems they are facing as healthcare shifts away from care being provided in silos to more of a continuum of care looking at each episode in its entirety. Hospitals are looking for partners who will help them decrease their readmission rates. Is this something that you are tracking in your facilities, is your therapy department actively working as part of that solution as well? You must be able to provide this information to your hospital referral sources.

You are also seeing a trend for patients who previously have utilized PAC to be discharged directly home from hospitals. One crisis facing Acute Care Hospitals is finding a facility that will accept patients with increased medical needs, they may need to hold on to a patient for several days before adequate placement is found. This roughly translates into a need for Skilled Nursing Facilities admitting more acutely ill patients. If efforts are increased to ensure adequate training of all licensed staff in PAC facilities are focused on increased acuity, this will also place your SNF in a position to be part of the solution.

The time is ripe for therapy and nursing departments to develop niche programming based on specific resident needs. Expanding your model of care delivery and taking the opportunity to integrate multidisciplinary care at the bedside is innovative. Showing good outcomes, decreased LOS, increased patient satisfaction, while reducing readmissions are outcomes that should be highlighted.

Just as hospitals will look to Skilled Nursing Facilities to report their progress and outcomes, the SNFs should be looking downstream at the Home Care Providers and expect the same. Coordinated care across the healthcare continuum is the right thing to do for the patient, be a part of the solution.

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

Getting on the Same Page by Paige Hector, LMSW

Assessing and Managing Sex Offenders in the LTC Setting

Part I

By Paige Hector and Steven Greenwald

On a daily basis, skilled nursing facilities across America are faced with screening, making admission decisions, evaluating and caring for persons now referred to by CMS as "Justice Involved Individuals." According to the CMS, justice involved individuals include inmates of a public institution, individuals under the care of law enforcement, and individuals under community supervision (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-16-21.pdf). This may include a person from prison, an individual on probation or parole or someone convicted of a crime but is allowed to remain in the community, usually with the stipulation of receiving rehabilitative services and making restitution to the victim(s) of their crime(s). For any number of reasons, these individuals may be referred to a facility for post-acute rehab or in some cases, long term care.

Between states and within states, there are differences in how facilities address the myriad of issues related to justice involved individuals. This article is part one of a series that will discuss the issues related to working with justice involved individuals, specifically sexual offenders, and offer discussion points for the interdisciplinary team as well as guidance for success.

While over 10 years old, the United States Government Accountability Office issued a report that provides relevant guidance and points for discussion regarding sex offenders residing in long-term care facilities (http://www.gao.gov/new.items/d06326.pdf). Given the variability of correctional systems across states, facility leadership is advised to investigate the requirements *for their state* and identify nuances that impact the admission, care and discharge of justice involved individuals. Let's look at a couple of state examples, one quit rigorous, one less so.

Illinois has specific rules and criteria regarding justice involved individuals including performing three admission screens to determine the person's background (a State Police Background Check, review of the Sex Offender website and review of the Department of Corrections website). If a crime is identified (generally a felony) the person must also be fingerprinted in order to remain in the facility setting. http://www.ilga.gov/commission/jcar/admincode/077/077003000C06250R.html

In Wisconsin, while there are no laws that stipulate specific screens, prudent facilities check a court-related website upon receiving the referral for admission (https://wcca.wicourts.gov/index.xsl).

Pre-admission Screening and Critical Thinking

When considering any prospective patient for admission it is wise to gather as much information as possible to make an informed decision. Generally speaking, for every referral the facility requests a history and physical, nurse and physician progress notes, specialist reports, medication list, case manager and therapy notes, labs and films to name a few items. The facility should also request social work notes which may provide valuable information regarding the patient's biopsychosocial status, anticipated discharge plan and possible barriers, *including criminal history information*.

As with any aspect of care in the facility, incorporating a consistent process is critical. For the admission process, that includes checking appropriate (state and national) sex offender websites, *before an admission decision is made*. There is just no excuse for not taking this most simple precaution. When the admission team is reviewing the patient's records, it should be the norm to ask about the results from these screens. This is a crucial part of the strategy to help facilities make informed decisions. But, the process must be followed for every – yes, every - referral. When the facility gets lax and doesn't take the time to do this most basic screen, the likelihood of admitting a patient with a sex offender history (or any criminal history) is increased. While a criminal history does not automatically preclude admission, it does necessitate a discussion to determine if the individual is a good fit in the facility setting.

A word of caution, do not hold the misconception that only younger adults are at risk of a criminal background. Preadmission screening should occur for EVERY referral, no matter the age, level of debility (or cognition) or gender.

Each state has access to a national sex offender registry website operated by the Department of Justice, https://www.nsopw.gov/?AspxAutoDetectCookieSupport=1. Another helpful website is the federal "inmate locator" site run by the Bureau of Prisons that may identify justice involved individuals and their terms of probation or parole (in addition to persons currently incarcerated), https://www.bop.gov/inmateloc/. Also consider checking www.mugshots.com to identify if an individual is involved with the criminal system.

And, here's even more impetus to be diligent and make informed admission decisions. With the revision to the Requirements of Participation (F tags), facilitating a transfer for an individual exhibiting behavioral challenges will be more difficult than ever (effective 11/28/2017). The rules now mandate that the facility document what patient needs cannot be met (in the current facility), attempts by the facility to meet those needs and what services will be available at the receiving facility that will meet those needs. Finding an alternate facility willing and capable of

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- Determination of what arrangements may be necessary with other health care facilities, or other entities that might be needed to ensure that essential services could be provided during an emergency.

In situations where the facility does not own the structure(s) where care is provided, it is the facility's responsibility to discuss emergency preparedness concerns with the landlord to ensure continuation of care if the structure of the building and its utilities are impacted.

For LTC facilities, written plans and the procedures are required to also include missing residents within their emergency plans.

Facilities must develop strategies for addressing emergency events that were identified during the development of the facility- and community-based risk assessments. **Examples of these strategies may include, but are not limited to, developing a staffing strategy if staff shortages were identified during the risk assessment or developing a surge capacity strategy if the facility has identified it would likely be requested to accept additional patients during an emergency**. Facilities will also want to consider evacuation plans. For example, a facility in a large metropolitan city may plan to utilize the support of other large community facilities as alternate care sites for its patients if the facility needs to be evacuated. The facility is also expected to have a backup evacuation plan for instances in which nearby facilities are also affected by the emergency and are unable to receive patients.

Survey Procedures for E-0006 include:

- Surveyors ask to see the written documentation of the facility's risk assessments and associated strategies.
- Surveyors interview the facility leadership and ask which hazards (e.g. natural, man-made, facility, geographic) were included in the facility's risk assessment, why they were included and how the risk assessment was conducted.
- Surveyors verify the risk-assessment is based on an all-hazards approach specific to the geographic location of the facility and encompasses potential hazards.

E-0007- The Interpretive Guidelines and Survey Procedure for LTC Facilities in Appendix Z provides:

(a) **Emergency Plan**. The facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:

Address patient/client population, including, but not limited to, persons at-risk; the type of services the facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.

The emergency plan must specify the population served within the facility, such as inpatients and/or outpatients, and their unique vulnerabilities in the event of an emergency or disaster. A facility's emergency plan must also address persons at-risk that may have additional needs in one or more of the following functional areas: maintaining independence, communication, transportation, supervision, and medical care.

Also "at-risk populations" are individuals who may need additional response assistance including those who have disabilities, live in institutionalized settings, are from diverse cultures and racial and ethnic backgrounds, have limited English proficiency or are non-English speaking, lack transportation, have chronic medical disorders, or have pharmacological dependency. At-risk populations would also include, but are not limited to, the elderly, persons in hospitals and nursing homes, people with physical and mental disabilities as well as others with access and functional needs, and infants and children.

Mobility is an important part in effective and timely evacuations, and therefore facilities are expected to properly plan to identify patients who would require additional assistance, ensure that means for transport are accessible and available and that those involved in transport, as well as the patients and residents are made aware of the procedures to evacuate.

The emergency plan must also address the types of services that the facility would be able to provide in an emergency. The emergency plan must identify which staff would assume specific roles in another's absence through succession planning and delegations of authority. Succession planning is a process for identifying and developing internal people with the potential to fill key business leadership positions in the company. Succession planning increases the availability of experienced and capable employees that are prepared to assume these roles as they become available. During times of emergency, facilities must have employees who are capable of assuming various critical roles in the event that current staff and leadership are not available. At a minimum, there should be a qualified person who "is authorized in writing to act in the absence of the administrator or person legally responsible for the operations of the facility."

In addition to the facility- and community-based risk assessment, continuity of operations planning generally considers elements such as: essential personnel, essential functions, critical resources, vital records and IT data protection, alternate facility identification and location, and financial resources. Facilities are encouraged to refer to and utilize resources from various agencies such as FEMA and Assistant Secretary for Preparedness and Response (ASPR) when developing strategies for ensuring continuity of operations. Facilities are encouraged to refer to and utilize resources from various agencies such as FEMA and ASPR when developing strategies for ensuring continuity of operations.

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managing the behavioral challenges that may be exhibited by an individual with a sexual offender status may be very difficult.

Stay tuned for Part II in October where we'll address facility policy aspects of this important issue.

STEVEN C. GREENWALD is a graduate of the University of Illinois School of Social Work (Urbana-Champaign). He earned a Master's degree, as well as a Bachelor's degree in Social Work from UIUC. He is the founder and president of SocialWork Consultation Group. Mr. Greenwald's experience includes work with geriatric, psychiatric, substance dependent and generally underserved populations in residential, in-patient and outpatient settings. Mr. Greenwald and SocialWork Consultation Group provide educational services to many long-term care facilities in several states including Illinois, Wisconsin, Indiana, Michigan and Florida. Mr. Greenwald is a popular instructor at seminars and workshops designed to enhance the delivery of social work and mental health services in long-term care and hospital settings. He is recognized as an authority in the field of long-term care and has provided testimony as an expert witness. Mr. Greenwald became a member of the Academy of Certified Social Workers (ACSW) early in his career and is a Licensed Clinical Social Worker (LCSW). He has received national recognition for his long-term care resource books and newsletter publication.

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Survey Procedures for E-0007 include:

Surveyors interview leadership and ask them to describe the following:
- The facility's patient populations that would be at risk during an emergency event;
- Strategies the facility has put in place to address the needs of at-risk or vulnerable patient populations;
- Services the facility would be able to provide during an emergency;
- How the facility plans to continue operations during an emergency;
- Delegations of authority and succession plans.

Surveyors verify that all of the above are included in the written emergency plan.

Maintaining access to healthcare services during emergencies requires safeguarding human resources, maintaining business continuity and protecting physical resources. We've discussed the **Risk Assessment and Emergency Planning** and provided an overview last month **of Policies and Procedures** and **Training and Testing**.

Communications Plans are another element of the comprehensive Emergency Preparedness plan and design and implementation can be challenging. Following are best practices considerations for transparent and accurate communications with stakeholders, especially the media, during *and after.* A well-developed Communications Plan contributes to a successful resolution of the problem, including a positive evaluation by stakeholders and the public. AHCA/NCAL offer a six-point outline to guide the process and these points can be incorporated into existing risk management and crisis communication plans.

1. Form a Team

An early step in emergency preparedness is to designate an Emergency Communications Team (ECT), or person, as part of a broader Incident Management Team. Typically the ECT will consist of the organization's leadership; with the Administrator or Executive Director, or CEO in the lead and designated "Commander." But any staff can fill any position on the ECT.

The first goal of the ECT is to evaluate the scope and severity of the event, gather accurate information about it, and report back to the Commander and other ECT members. In an emergency there may be limited or conflicting information about the event or its impact. "Facts" matter and may change several times as new information is available. Thus, the ECT team needs training and practice in evaluating and communicating accurate details about the emergency.

Planning and practicing for typical scenarios and a variety of magnitudes of events is a keystone to a successful outcome in an actual emergency. When an emergency strikes, the organization's staff responders and spokesperson should know instinctively what to do and how to report "up the chain of command."

2. Plan Ahead

With the ECT in place, the incident Commander and spokesperson should quickly begin to develop communications, like a press statement or interview notes, that accurately address anticipated (or specific) questions from stakeholder groups, including the news media. In planning for emergencies, an important role for the ECT is to develop templates of materials to make outreach more efficient in the early stages of a crisis.
In an actual emergency, the ECT should have pre-existing template materials, modified to suit the situation at hand and tailored to various stakeholders (groups *and* individuals). The ECT needs to coordinate distribution of consistent messages across all stakeholder groups. This works well when a specific person is the designated the official spokesperson. He or she will work with the Commander to finalize internal and external comments related to the emergency to ensure accuracy and consistency of all messages.

To kick start the ECT in working on the Communications plan, here are a few initial projects members can do:

- Check records of resident relocation and staff contacts for accuracy
- Prepare a memo to update staff on the emergency preparedness plan
- Practice how to handle media inquiries, including social media
- Practice how to handle inquiries from families (who may be in a panic)
- Brainstorm possible scenarios/responses

3. Know the Stakeholders

As tempting as it may be, management should not rely exclusively on one way to communicate (e.g. telephone) statements and messages. There should always be options in a plan for using alternate communications channels -- like text, wired telephone, cell phone, Internet, etc.
A key task of the ECT is to develop a priority list of stakeholders to contact in various scenarios, depending on the severity or scope of the event (e.g. elopement, hurricane).

-First responders (911, EMS, fire, police)
-Utility companies (power, water, gas)
-Residents and families
-Employees, volunteers, and families
-News media (print, broadcast, internet)
-Regulators (local/state/federal), elected officials, etc.
-Corporate management (up the chain of command)
-Neighbors living near the facility
-State health care associations and others

4. Know How to Contact Stakeholders

Have the ECT compile contact information for each stakeholder group and individuals; try to acquire multiple ways to contact them. The ECT should establish a policy schedule to update all lists. Other factors include:

-Keep duplicates in digital and hard copy form
-Copies of lists should be available at *alternate* evacuation sites along with other emergency resources
-Secure lists to protect confidential information and make it available only to authorized users

5. Communication Channels
One person should have final approval of all official statements. Ideally, that person is the Commander, working with the spokesperson. Following are typical channels to disseminate a statement or other communications to stakeholders:

- Press conference with press statement
- Interview with the media
- Telephone
  - Emergency hotline
  - Phone chain
- Live Interview
- Email
- In-facility briefing
- Social media (Facebook/Twitter/YouTube)
- Web site

6. Honor Confidentiality

Brief the ECT on HIPAA compliance and employment law to ensure confidentiality of covered information. Remind staff not to speculate or discuss an event, especially with media.

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The Media Plan

The key ingredient for dealing effectively with an emergency is through preparing, or updating, a Media Plan as part of a Communications Plan. It is critical to respond quickly and deal with the situation transparently and provide information and answers in a coherent, consistent way. As a rule of thumb, an organization's leadership should release a statement in an hour or so of being contacted by the media about an emergency.

Developing the Media Plan

A media plan should include policies on how, when and who is designated to talk with the media, the surrounding community, residents, families, and the staff. Everyone on staff should be aware of who the authorized spokesperson is and how and when to contact him or her. Disseminate the overall communications plan to all employees.

To develop a media plan, start with these basic steps:

1. To prepare, an organization needs to pre-draft emergency statements that incorporate relevant language or concepts from the organization's mission statement (i.e. "importance of resident safety"); identify who to quote as part of this process. Just leave space to fill in specific details related to the emergency. Use these statements for any type or level of emergency or activity that generates media interest.
2. Make a comprehensive list of the radio, television, newspapers, senior publications and websites covering the profession in the area. Add the names and titles of key contacts and include web addresses, intranet sites, or other mass notification systems such as group e-mail lists, text messages, and social media as a way to distribute statements and updates.
3. Prepare several media "*kits.*" The kit should be in a folder containing a brief history of the organization and general information about the company.

Identify Spokesperson

The organization should identify at least two staff members to be a primary and substitute spokesperson. Ideally, spokespersons should be staff members who are, or can become, familiar with the organization's operations, policies, procedures, and history.

Seriously consider that the executive director/administrator may not always be the best primary spokesperson. A top leader needs to manage a difficult environment and may not be available to properly handle the media or arrange interviews.
If a staff person is already involved with the media (e.g. community events),
If a staff person is already involved with the media (e.g. community events), he, or she, may be best suited to fill the spokesperson's role.

After identifying and training spokespeople, post their contact information, such as office and cell phone numbers and e-mail addresses, in a place where staff can easily access it.
Task the spokesperson with gathering information about an emergency and to answer basic questions from the media and others regarding what is going on. To do this properly, and expeditiously, the spokesperson should:

- Have access to senior management to understand the situation and its ramifications
- Know basic statistics about the organization, and larger parent company, such as the number of residents, census data (number of beds, units, etc.), the number of employees, and a general outline of the company and its mission statement.
- Release information or clarifying points of fact; arrange for the release of a statement, or arrange interviews or tapings by the media.

If the organization fails to cooperate, such as stating "no comment" to questions about the emergency, assume that reporters will attempt to interview anyone, even residents, who may be willing to talk about of the situation without regard to accuracy.

Your work in healthcare and specifically in assisted living and extended care industries places you in the most difficult times in the lives of residents and their families. A crisis event can arise as a result of many different circumstances but whatever the specifics of the event may be, a crisis in a healthcare organization always means the physical, emotional or privacy dimensions of someone's life have been adversely affected.

At some time, all organizations will be faced with a crisis situation. Being proactive and prepared with a team and a well-designed plan to deliver information to employees, to families and to the public as well as other stakeholders, will prevent a challenging situation from escalating into a major crisis with far-reaching negative impact.

The healthcare industry and particularly extended care providers are highly scrutinized by the public which can result in a negative financial, political, legal and government impact. The reputation of a long-term care provider can be judged by one event at one location. Many times, the public judges an organization's reaction to a crisis more than the actual crisis itself. Diffusing a crisis and controlling the release of information through managing the expectations of news will result in reduced risk of the event. Sound crisis communications can make a significant difference in restoring and even perhaps advancing an organization's status in the community.

A crisis communications plan should be a key component of an organization's overall risk management and disaster response plan. A risk management plan including crisis communications reflects an organization's commitment to quality and will influence the way the public develops opinions about an event. There may be quality assurance protections and attorney-client privileges that protect the crisis communications plan; however, these legal issues are beyond the scope of this program and guide.

A crisis may be unpredictable but it should not be unexpected.

SAVE THE DATE FOR 6TH ANNUAL LITIGATION RISK AND DEFENSE STRATEGIES 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 for 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.

Meet
Rosemary Angsten

By Chip Kessler

DART Chart Systems Chief Operating Officer Focused on Meeting Clients' Needs

For any company to move forward and serve its customers, innovative ways of getting things accomplished are a must. Often this is achieved when new leadership joins an already accomplished team. So it is with our nation's front-runner in post-acute reimbursement, DART Chart Systems, which earlier this year named Rosemary Angsten as Chief Operating Officer. She joins DART Chart President Linda Kunz and CEO Bernard Hoffmann to help guide the company's mission to help maximize Medicare and Managed Care revenue for over 600 providers.

"I knew DART Chart very well because I was a client utilizing their Map and Track system," states Ms. Angsten, who'd spent the last 15 years working in varied positions within the nursing facility environment, and is a licensed administrator herself. "I transitioned from this and started a healthcare consulting firm". DART Chart partnered with Angsten to bring the industry expertise of skilled nursing reimbursement to their providers.

Because she was a DART Chart client, it wasn't hard to spot these benefits from an administrator's perspective. In March 2017, Rosemary was appointed the company's COO.

"My main responsibility is to insure that we are mapping all of our client's contracts effectively and accurately, and getting each new client up and running as soon as possible with as little impact to their current workflow as possible" she explains. "I also make sure we bridge the gap between operations and technology, and that we're continuing to enhance the technology such as adding increase integrations and improved analytics."

Historically, DART Chart has offered several different products to the skilled nursing sector. For the past 20 years it's has had a Point-to-Care system that focused on capturing the best Medicare revenues. Always monitoring the clinical reimbursement landscape, as managed care came more into the forefront some five years back, DART Chart expertly developed a system to be able to map contracts in order to help skilled nursing facilities best capture their managed care revenue.

Says Rosemary Angsten: "we've also taken that same Medicare algorithm that we've used for determining appropriate reimbursement and have essentially switched that into a reverse algorithm to be able to identify the appropriate payer for dual eligible participants. We work directly through the state Medicaid departments and TPL's and directly with the Insurance Companies to be able to insure that patients are not switching over to Medicaid prematurely while they still qualify for nursing RUGS. We work with several states today with our Medicaid recovery program. Plus with the managed care services, we have more and more customers that are asking for additional support with managed care. As a result, we developed a case management department where we do full case management for providers that don't have the resources within their facilities to do it effectively, or who want additional support to ensure they are getting the reimbursement they are entitled to. Here we do everything from benefit verifications to authorizations to concurrent reviews and the Appeals. So we provide the full gamut of case management services, and this has been a growing division within the DART Chart family. We manage their patients and any changes, which can affect their length of stay, affect getting authorizations at the right level and billing appropriately at the end of the month for ancillaries.

The ability to recognize the needs of clients has been in the forefront of the company's success over the years. "The biggest thing that DART Chart does to be a leader within the ever-changing healthcare environment, is that first and foremost we listen to our customers;" states Rosemary. "We want as much input from them as possible regarding potential enhancements and what could be developed from a software standpoint to make their job easier, whether that's increased integration or whether it's an additional product or service or an additional reporting-type function. We're constantly soliciting feedback from our customers to improve the system to make it effective in their day-to-day use. Additionally, we stay ahead of changing regulations and changing needs. We stay highly involved in understanding regulatory and legislative changes so that once those changes are determined, we have a solid grasp and understanding of what we need to do to modify for our customers, so that those transitions are as easy as possible for them."

As you can tell, DART Chart prides itself on adapting to the needs of its customers, as exemplified by its move into providing dedicated case management services, thus taking this burden off of facilities. What other new offerings may be on the horizon?

"We have some pretty exciting projects that we're working on in terms of our Medicare reimbursement, "offers Rosemary Angsten. "Accordingly we're evolving our initial Point-to-Care system to be able to help support and provide better integration to continue to help providers who use other systems to be able to enhance their revenue cycle to be able to capture the best reimbursement they're entitled to as well on the Medicare side. We'll have more to come on this, to assist both our present and future customers."

Anything else we need to know?

"One thing we're keeping a very close eye on is the regulatory proposals on how reimbursement will change in skilled nursing facilities in 2018 regarding the RUG reimbursement. DART Chart, as it has historically done as things have changed in MDS and RUGS reimbursement, is staying ahead of those changes and watching them very closely and adjusting our technology. We're already putting enhancements in to be able to help our customers if this particular change is approved."

Ever on the lookout, don't be surprised if the folks at DART Chart debut some other new programs and services in the future. "The exciting thing is that we're in an extreme growth phase," Angsten mentions. "We thoroughly enjoy working with our customers and helping them to capture the best revenue, and to give them an edge in a very competitive and very lean and narrow market."

Please visit dartchart.com to discover more about what DART Chart Systems can do for you, or call 888-210-3200.

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If you attend only one more webinar is 2017- this is it!

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DART CHART **Upcoming Events:**

PointClickCare SUMMIT

November 6 - 9, 2017 | Orlando, FL | Gaylord Palms Resort & Convention Center

Nov. 6-9

DART CHART

Booth #407
Gaylord Palms Resort
Orlando, FL

PointClickCare will be hosting its SUMMIT convention this November. Learn how our contract automation and case management services can improve your bottom line.

In Attendance:
Bernard Hoffman, CEO
Linda Kunz, President
Rosemary Angsten, COO
Tracy Hall, National Account Executive

For info, Call Tracy Hall at (414) 331-7282

www.dartchart.com | Tracy Hall: 414-331-7282 | thall@dartchart.com