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

Dementia Care: Positive Initiatives

This month, Human Rights Watch published its 157 page report *"'They want docile:' How Nursing Homes in the United States Overmedicate People with Dementia*" documenting, per HRW, nursing facilities' inappropriate use of antipsychotic drugs in older people as well as the administration of the drugs without informed consent, claiming that both of which arise primarily from inadequate enforcement of existing laws and regulations. The report is based on visits by HRW researchers to 109 nursing facilities, mostly with above-average rates of antipsychotic medication use, between October 2016 and March 2017 in California, Florida, Illinois, Kansas, New York, and Texas; 323 interviews with people living in nursing facilities, their families, nursing facility staff, long-term care and disability experts, officials, advocacy organizations, long-term care ombudsmen, and others; analysis of publicly available data; and a review of regulatory standards, government reports, and academic studies.

As is well known, the United States is aging rapidly. Most of the people in the nursing facilities HRW visited are over the age of 65. Older people now account for one in seven Americans, almost 50 million people. The number of older Americans is expected to double by 2060. The number of Americans with Alzheimer's disease, the most common form of dementia, is expected to increase from 5 million today to 15 million in 2050. HRW does not, however, reference the over 16,000 nursing facilities providing long-term care services and support to meet their needs and respect their rights and underreports the many initiatives at the local, state and federal levels increasing awareness and providing education and tools for enhanced dementia care.

For the past decade, our industry has been contending with the nursing facilities administering antipsychotic drugs to people who do not have diagnoses for which the drugs are approved. The drugs are often given without free and informed consent, which requires a decision based on a discussion of the purpose, risks, benefits, and alternatives to the medical intervention as well as the absence of pressure or coercion in making the decision. Most of these individuals have Alzheimer's disease or another form of dementia. While these symptoms can be distressing for the people who experience them, their families, and nursing facility staff, evidence from clinical trials of the benefits of treating these symptoms with antipsychotic drugs is weak. The US Food and Drug Administration (FDA) never approved them for this use and has warned against its use for these symptoms. Studies find that on average, antipsychotic drugs almost double the risk of death in older people with dementia. When the drugs are administered without informed consent, people are not making the choice to take such a risk. The HRW report highlights these issues and also points out that the drugs' sedative effect, rather than any anticipated medical benefit, too often drives the high prevalence of use in people with dementia.

Antipsychotic drugs alter consciousness and can adversely affect an individual's ability to interact with others. They can also make it easier for understaffed facilities, with direct care workers inadequately trained in dementia care, to manage the people who live there. In many facilities, inadequate staff numbers and training make it nearly impossible to take an individualized, comprehensive approach to care. Per the HRW report, many nursing facilities have staffing levels well below what experts consider the minimum needed to provide appropriate care.

The report iterates that the United States has domestic and international legal obligations to protect people who live in nursing facilities from the inappropriate use of antipsychotic drugs, among other violations of their rights. These obligations are particularly important as people in nursing facilities are often at heightened risk of neglect and abuse. Many individuals in nursing facilities are physically frail, have cognitive disabilities, and are isolated from their communities

The report points the finger at Centers for Medicare & Medicaid Services (CMS) stating that it is "failing in their duty to protect some of the nation's most at-risk older people. On paper, nursing home residents have strong legal protections of their rights, but in practice, enforcement is often lacking. Although the federal government has initiated programs to reduce nursing homes' use of antipsychotic medications and the prevalence of antipsychotic drug use has decreased in recent years, the ongoing forced and medically inappropriate use of antipsychotic drugs continues to violate the rights of vast numbers of residents of nursing facilities." The report encourages penalizing noncompliance to a degree sufficient to act as an effective deterrent, to end this practice. While a complete assessment of the report and data upon which it

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Pathway to Rehabilitation Excellence

By Lisa Chadwick, RN, MS
Director of
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Patient Safety: Always in the Forefront

Post-Acute Care is obliged to deliver care that provides better outcomes, in a shorter period of time, all the while ensuring that patient safety is in the forefront. We are responsible for increasing efficiencies without sacrificing safety.

There are a lot of tools available for use to help guide efficiencies. We've previously discussed and reviewed how communication across the continuum of care is an important factor for patient safety. As length of stay shortens it becomes vitally important to ensure accuracy of information that is passed on to the next care setting and provider. While accountability across the transitions to ensure a successful partnership is vital, it is equally important to look at patient safety events which contribute to patient injury.

Let's examine the patient safety goals that The Joint Commission has identified for 2018 in the post-acute setting.

- **Identify resident correctly**: The gold standard for patient identification is name and date of birth. However, you may be in a facility that does not have residents wearing identification arm bands. There is also the possibility that residents may be cognitively impaired and unable to accurately answer those simple questions. If you approach a resident and ask, "Are you Mrs. Smith?" A cognitively impaired individual may nod, smile, and be agreeable, when in fact you've just made a patient ID error. Each facility is challenged with ensuring that all care providers are able to easily identify all residents receiving medications and other treatments.

- **Use medications safely**: Recognize that residents who take anticoagulants are at greater risk for injury and ensure this is communicated to all care providers who would need to know. Accurate reconciliation of medications could not be more important. Many patients may use more than one pharmacy which means they could easily duplicate medicines if not reconciled prior to discharge.

- **Prevent infection**: Good hand hygiene prevents spread of infection. It would be easy to set up surveillance of staff to observe their compliance with hand hygiene practices, and good information to share with them. Ensure that you are following proven guidelines to prevent infections from MDROs, indwelling Foley catheters, and blood infections from central lines.

- **Prevent residents from falling**: Identify the residents that are at higher risk for falling and implement protocols that are proven to help decrease falls. Again, pay close attention to any resident who is at higher risk for injury from a fall, such as someone taking anticoagulants.

- **Prevent bed sores**: Identify those residents that are at higher risk for developing decubitus. Implement protocols or programs designed to decrease the incidence of bed sores. Establish a routine recheck process to examine those residents at risk.

The easiest way to determine if you've made progress is to track and trend events. Use the information to make systemwide changes and address processes. It's known that any safety error could delay discharge or transition to next level of care. Safety errors could require a hospital readmission. It's important to your residents, their families, and your staff to address safety concerns and be able to show sustained improvement.

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:

Survey Implications Part V

By Paige Hector and Steven Greenwald

Your heart skips a beat, surveyors just arrived at your facility. Whether it's for the annual survey, a follow-up survey, a complaint survey, or a combination, the atmosphere is stressful for everyone. Ensuring that staff is prepared and confident when interacting with a surveyor is imperative. Facilitating that level of training is the responsibility of the administrator and director of nursing.

Staff need to be able to respond confidently to surveyors when asked any number of questions regarding facility processes related to justice involved individuals. Train staff to think like a surveyor. What will a surveyor expect in terms of the assessment and management of a person with a history of criminal behavior? As a surveyor, would you not be concerned, first and foremost, for the safety of the entire resident population?

Consider this scenario – members of the surveyor team express concerns about the management of a person with a history of sex offenses. Staff must be prepared to discuss, and provide a copy, of facility policies addressing pre-admission screening, behavior management, care planning and discharge planning. Surveyors will ask questions to determine if the facility acted reasonably given the situation in question and whether appropriate action was taken when necessary. If there was an adverse outcome, they will investigate whether it could have been prevented. Surveyors often ask the following questions:

1. What type of screening or pre-admission evaluation was conducted?
2. Before accepting the individual did the facility use "due diligence" in checking available on-line data bases (e.g., state and federal websites identifying persons involved in the justice system)?
3. Did the facility complete an "onsite" screening of the resident in the previous environment (e.g., hospital, nursing home, other community setting)?
4. What was the rationale for determining that the prospective resident's needs could be met in this facility?
5. What type of training has been provided to prepare staff to meet the needs of justice involved individuals, and in this situation, for individuals with sex offender histories?
6. What type of assessments have been performed to adequately evaluate the resident's cognitive and behavioral needs (*beyond the MDS item set*)?
7. Do the assessments clearly define the type of management and supervision needs for this individual?
8. What type of care planning has occurred to address the resident's history, behavioral expression(s) and potential risk to other residents and staff?
9. What provisions are in place to keep everyone safe?
10. If the resident has been involved in behavioral incidents, has the care plan been appropriately revised with corresponding communication and staff training?

Responding to Surveyor Questions

What to Avoid and What to Say

We've identified many of the questions that the survey team is likely to present when a facility admits justice involved individuals. In this section we will review problematic statements that are commonly shared by LTC staff and offer ideas for focused comments that directly address surveyor questions. Remember, when answering surveyor questions, it is wise to be succinct and to the point. Refrain from volunteering extraneous details or too much information. Wait for the next question after the initial question is answered. The responses below are only suggestions and must be modified to fit the unique qualities of your facility. The use of role playing is strongly urged as an integral part of your training program to provide staff the experience of what to say, and not say, to a surveyor. Simply "training" staff is insufficient, they need to have experience using the statements and to develop confidence.

1. What type of screening or pre-admission evaluation was conducted?
    - **Avoid** – "I'm not sure." Or, "That's not my department."
    - **Respond** – "Yes, each person is screened carefully prior to admission." *If the surveyor specifically asks what type of screening is conducted, confidently answer,* "We check multiple websites/data bases to learn about the person's history. We interview referral sources and if the person was in a previous facility we request information from that facility."
2. Before accepting the individual did the facility use "due diligence" in checking available on-line data bases (e.g., state and federal websites identifying persons involved in the justice system)?
    - **Avoid** – "I don't know, that's the admission department's job."
    - **Respond** – "We check state and federal sex offender data bases, court websites and inmate locaters (*note*, some states require state police background checks and fingerprinting so adjust this response accordingly).
3. Did the facility complete an "onsite" screening of the resident in the previous environment (e.g., hospital, nursing home, other community setting)?
    - **Avoid** – "We are too busy to go the hospital to

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relied as well as the misunderstandings and limited views presented in the report are beyond this article, it can be said that much valuable information about nursing home operations, management, initiatives and efforts to reduce the use of antipsychotics for dementia care has been unreported.

In 2012, CMS created the National Partnership to Improve Dementia Care in Nursing Homes, in recognition of the unacceptably high prevalence of antipsychotic drug use. The initiative contributed to the reduction of the use of antipsychotic medications over the last six years. The HRW report fails to recognize the significance of the initiative's efforts stating that "it cannot substitute for the effective regulation of nursing homes, including by ensuring that facilities face meaningful sanctions for noncompliance with mandatory standards. " According to the HRW report, its research found that CMS is not using its full authority to address this issue and then cites out of context that "Recently, CMS is in fact moving in the opposite direction, limiting the severity of financial penalties and the regulatory standards with which facilities must comply."

Human Rights Watch identified several key areas of concern to support the allegations that "CMS and the state agencies with which it contracts to enforce federal regulations are not meeting their obligation to protect people from the nonconsensual, inappropriate use of antipsychotic drugs."

CMS has long identified staffing as one of the vital components of a nursing home's ability to provide quality care. Over time, CMS has utilized staffing data for a myriad of purposes in an effort to more accurately and effectively gauge its impact on quality of care in nursing homes. CMS posts staffing information on the CMS Nursing Home Compare website, and it is used in the Nursing Home Five Star Quality Rating System to help consumers understand the level and differences of staffing in nursing homes. Despite CMS's efforts and the positive directions taken by nursing facilities to hire, train and retain staff, HRW cites lack of minimum staffing regulations as the primary reason for overmedication.

The HRW report cites weak enforcement of federal regulations specifically banning chemical restraints and unnecessary drugs further stating that "federal and state enforcement of these regulations is so weak that the drugs are routinely misused without significant penalty."

Stressing increased government enforcement, HRW states that federal and state governments need to do more to ensure that the rights of residents are adequately protected.

The "Key Recommendations" from the HRW are noteworthy yet are nothing new from what providers and the regulatory enforcement organizations already know and that have served as the foundation for objectives and initiatives, namely:

•End the inappropriate use of antipsychotic drugs in older people with dementia in nursing facilities, including many instances where they are administered without free and informed consent; used as chemical restraints; or where their use qualifies as an "unnecessary drug."

•Require nursing facilities and residents' physicians to seek free and informed consent prior to the administration of antipsychotic medications to nursing facility residents.

•Ensure nurse staffing numbers and training levels are adequate.

•Strengthen enforcement on particular subjects linked to the inappropriate use of antipsychotic drugs, including care planning requirements and transfer and discharge rights.

The HRW report does not fully address that AHCA launched its metric-based Quality Initiative in 2012 and later joined CMS' National Partnership to Improve Dementia Care in Nursing Homes to raise awareness about safe alternatives to antipsychotic medications for residents and patients with dementia through a systems-based and person-centered approach to care. In 2014, AHCA and CMS set goals to further decrease the use of antipsychotics in skilled nursing centers by a total of 30 percent by December 2016.

On October 2, the National Partnership to Improve Dementia Care announced that it met its goal of reducing the national prevalence of antipsychotic use in long-stay nursing home residents by 30 percent by the end of 2016. It also announced a new goal of a 15 percent reduction by the end of 2019 for long-stay residents in those homes with currently limited reduction rates. Nursing homes with low rates of antipsychotic medication use are encouraged to continue their efforts and maintain their success.

Between the end of 2011 and the end of quarter one of 2017, the national prevalence of antipsychotic use in long-stay nursing home residents was reduced by 34.1 percent, decreasing from 23.9 percent to 15.7 percent nationwide. All 50 states and every CMS region showed improvement. Some states showed much more improvement than others. The states that have reduced their rate by the highest percentage include the District of Columbia (47.8 percent), Tennessee (43.5 percent), California (43 percent), and Arkansas (41.6 percent). The December 2017 date update on the initiative shows that regarding the goal to safely reduce the off-label use of antipsychotics in long-stay nursing center residents by a total of 30% by December 2016, 56.8% of AHCA members achieved the goal of a 30% reduction.

Also, the California Coalition for Person-Centered Care (CCPCC) recognized the issues present in the HRW report and worked collaboratively with many senior care organizations and specialist to develop a "toolkit" to address that exact concern. CCRCC has long been an active participant-leader in California's successful efforts to reduce the unnecessary use of antipsychotics in skilled nursing facilities and other senior living environments. CCPCC, is a non-profit coalition of consumers, providers, labor and senior care organizations all with the focus of enhancing the care and services to seniors and their caregivers wherever they may reside or work. Using grant monies from the California Department of Public Health and the federal Centers for Medicare and Medicaid Services, CCPCC developed materials to reduce the use of antipsychotics.

Focused on improving the quality of care and quality of life for residents with a dementia diagnosis, these materials provide clear, practical guides for senior living providers and health care professionals to assess, reduce and prevent the unnecessary use of antipsychotics. Residents, family members and resident advocates are provided materials to ask the right questions and guide decision-making.

This and other helpful information is available free-of-charge and can be found at the following site: https://www.calculturechange.org/. CCPCC encourages seniors, their families and care providers, and others interested reducing the use of antipsychotics to access these materials

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Also, unmentioned by the HRW report, CMS's final rule revised the training required for staff for dementia management. The entire training section §483.95 will be implemented in Phase 3 (November 28, 2019) with the exception of training on Abuse/ Neglect/Exploitation, Dementia Management, and the Feeding Assistant requirement. These 3 components were required by the Phase 1 implementation date of November 28, 2016. Abuse training is currently required but facilities will have to educate staff as to understanding of the new term "exploitation". Dementia management training will need to be expanded beyond nurse aides to other direct staff. CMS indicates that training currently part of the nurse aide training program or existing materials such as "Hand-in-Hand" can be utilized. Staff not currently the recipients of the required training will need to be brought up to compliance with the new requirement.

As a CMS initiative, dementia care is a major focus. The earlier dementia focused surveys identified deficits in training and CMS has continued the selective use of the dementia-focused survey. Materials produced from those surveys have been made available by CMS in S&C 16-04. Facilities should become familiar with these documents and use them to assess their current needs.

There are many evidence-based resources for improving dementi care in nursing homes and assisted living. The Alzheimer's Association's *Dementia Care Practice Recommendations for Assisted Living Residences and Nursing Homes* focuses on a different set of care recommendations that can make a significant difference in an individual's quality of life. Phase 1 focuses on the basics of good dementia care and three care areas: food and fluid consumption, pain management and social engagement. Phase 2 covers three additional care areas — wandering, falls and physical restraints. In the next few years, AA will add recommendations in new care areas, such as end-of-life care, and update recommendations as new evidence on effective care interventions becomes available. Download the program at: https://www.alz.org/national/documents/brochure_dcprphases1n2.pdf

Also, experts from Rutgers Institute for Health, Health Care Policy and Aging Research and Duke University School of Nursing presented research findings on what is being done to improve the safety of care for nursing home residents with dementia at the 21st World Congress of Gerontology and Geriatrics. https://www.geron.org/meetings-events/iagg-2017-world-congress-of-gerontology-and-geriatrics

Implementing best practices and continuing to collaborate on initiative to improve dementia care in nursing homes and assisted living is our continued mission and despite the HRW report, these efforts have seen results that have enhanced the lives of many of our aging community. For more information, please contact me for discussion and resources and assistance with developing and implementing best practices and compliance with state and federal regulations.

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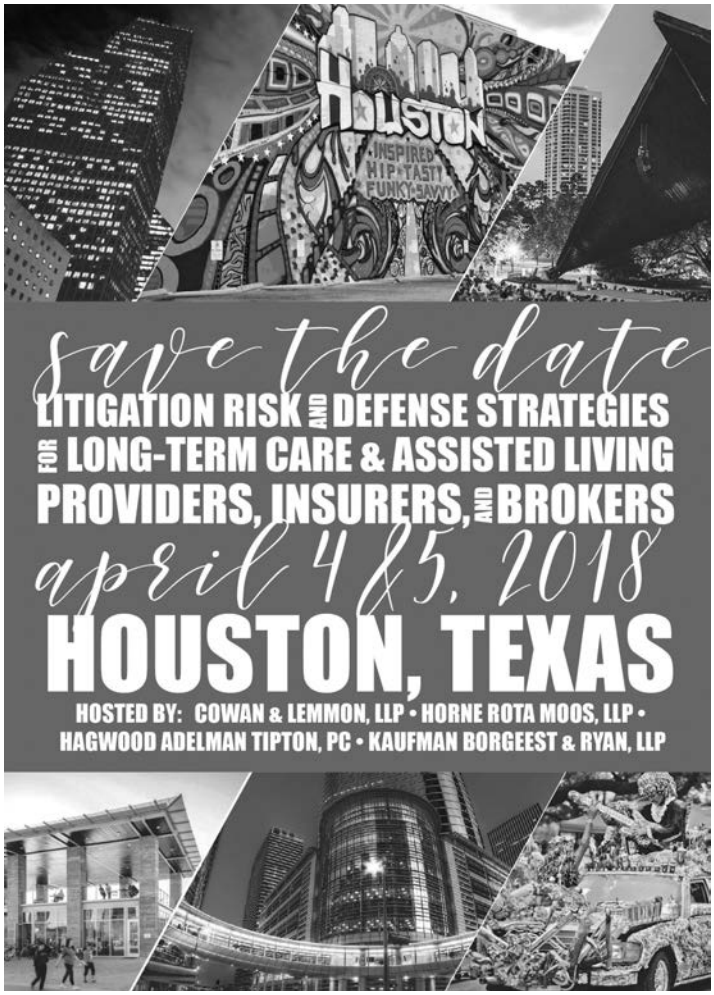

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do that" or "We have marketers/liaisons for that, but I don't know how they decide who to visit." (*note*, keep in mind that marketers are generally non-clinical personnel, and having them conduct an onsite visit for a complex psychosocial or clinical issue may be of concern.)

- **Respond** – "We send a clinical person to meet and evaluate the person prior to admission. This might be a nursing supervisor or social worker. We complete a pre-screening evaluation and then the team reviews the prospective admission."

4. What was the rationale for determining that the prospective resident's needs could be met in this facility?

    - **Avoid** – "We never know for sure. We just base it on census. If we are low they make us take everyone."

    - **Respond** – "We look at several factors. First is history of course. We look at their stability and appropriate interaction with others. We review their medical, mental health, cognitive status and related needs to decide if our facility is a good fit."

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5. What type of training has been provided to prepare staff to meet the needs of justice involved individuals, and in this situation, for individuals with sex offender histories?
    - **Avoid** – "Training? We have yearly abuse and neglect inservices."
    - **Respond** – "We have on-going training sessions with knowledgeable professionals (clinical educators, etc.) and we make use of on-line resources."
6. What type of assessments have been performed to adequately evaluate the resident's cognitive and behavioral needs (*beyond the MDS item set*)?
    - **Avoid** – "Well, we really think the MDS is sufficient."
    - **Respond** – "We complete an 'Identified Offender Risk Assessment' and in some cases, we complete an aggression or violence risk screening. We want to be confident that we have thoroughly assessed this person."
7. Do the assessments clearly define the type of management and supervision needs for this individual?
    - **Avoid** – "We assess the person, but I don't know what happens after that."
    - **Respond** – "We review each admission as a team when we complete the Baseline Care Plan. The assessments help us determine the level of supervision the person requires. For example, if the person is ambulatory the supervision needs are different from a person with limited mobility."
8. What type of care planning has occurred to address the resident's history, behavioral expression(s) and potential level of risk to other residents and to staff?
    - **Avoid** – "We haven't gotten around to that yet. We will soon though" or "I don't attend the care plan meeting."
    - **Respond** – "We review our assessments and encourage the team to share their impressions and insights. If we feel the person needs more supervision we place the individual in a room closer to the nurse's station and we have a rounds/room check system in place to observe the person (*note*, include appropriate interventions in this response that fit the specific situation)."
9. What provisions are in place to keep everyone safe?
    - **Avoid** – "We just observe the person and take care of problems when they come up."
    - **Respond** – "We have a monitoring and rounds system in place to provide the necessary attention. The person is in a room closer to the nurse's station. We check the communication reports carefully and follow up if there is a behavioral expression."
10. If the resident has been involved in behavioral incidents, has the care plan been appropriately revised with corresponding communication and staff training?
    - **Avoid** – "I think so" or "Updating the care plan is [*fill in*] job."
    - **Respond** – "Yes, we view the care plan as a working, fluid document. If there is a behavioral expression we modify the care plan and we continually seek appropriate interventions."

Surveyors will review the resident's clinical record in detail to verify all critical elements of care are in place from assessment to the revision and provision of the care plan. They may have reviewed the record prior to speaking to staff. Teach staff that if they are unsure how to answer a question that it is okay to say, "I don't know the answer to your question but let's go talk with my supervisor who can help us." What staff shouldn't do it guess at an answer.

Surveyors will also look for evidence that the medical provider is an integral part of the interdisciplinary team. It is expected that the facility collaborates with the provider in discussions and issues related to the resident's status as a sexual offender. It is important that the medical provider support the plan of care and behavior contract (if one is in place) in his/her documentation and interactions with the resident. If the medical provider is not the medical director, it may also be apropos to keep the director informed as to the status of the resident, especially with any concerns that arise.

Just because a person has a criminal history or is a sexual offender, it does not automatically mean they cannot integrate successfully into facility life. With great critical thinking skills that drive every decision from pre-admission and throughout the person's stay, a nursing home can offer a viable living arrangement for a justice involved individual.

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RCS-1 is Coming! Will You Be Ready?

By Joel VanEaton
BSN, RN, RAC-CT

The Resident Classification System version 1 or RCS-1 train has left the station. Consider the following quotes by CMS out of the Notice of Proposed Rule Making published last summer.

- "…the current RUG–IV case-mix classification system reduces the varied needs and characteristics of a resident into a single RUG–IV group that is used for payment. As of FY 2016, of the 66 possible RUG classifications, over 90 percent of covered SNF PPS days are billed using one of the 23 Rehabilitation RUGs, with over 60 percent of covered SNF PPS days billed using one of the three Ultra-High Rehabilitation RUGs."
- "The implication of this pattern is that more than half of the days billed under the SNF PPS effectively utilize only a resident's therapy minutes and Activities of Daily Living (ADL) score to determine the appropriate payment for all aspects of a resident's care. Both of these metrics, more notably a resident's therapy minutes, may derive not so much from the resident's own characteristics, but rather, from the type and amount of care the SNF decides to provide to the resident."
- "Even assuming that the facility takes the resident's needs and unique characteristics into account in making these service decisions, the focus of payment remains centered, to a potentially great extent, on the facility's own decision making and not on the resident's needs."
- "While the RUG–IV model utilizes a host of service-based metrics (type and amount of care the SNF decides to provide) to classify the resident into a single RUG–IV group, the RCS–I model under consideration would separately identify and adjust for the varied needs and characteristics of a resident's care and then combine them together."
- "We believe that the RCS–I classification model could improve the SNF PPS by basing payments predominantly on clinical characteristics rather than service provision, thereby enhancing payment accuracy and strengthening incentives for appropriate care."
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To better ensure that resident care decisions appropriately reflect each resident's actual care needs, we believe it is important to remove, to the extent possible, service-based metrics from the SNF PPS and derive payment from objective resident characteristics that are resident, and not facility, centered. To that end, RCS–I was developed to be a payment model which derives almost exclusively from verifiable resident characteristics. CMS states the following as the goals of RCS-1;

1. To create a model that compensates SNFs accurately based on the complexity of the particular beneficiaries they serve and the resources necessary in caring for those beneficiaries;
2. To address our concerns, along with those of OIG and Med PAC, about current incentives for SNFs to deliver therapy to beneficiaries based on financial considerations, rather than the most effective course of treatment for beneficiaries;
3. To maintain simplicity by, to the extent possible, limiting the number and type of elements we use to determine case-mix, as well as limiting the number of assessments necessary under the payment system.

MEDPAC and the OIG have also indicated that the current RUG based system inappropriately incentivizes facilities to take certain types of patients to the exclusion of others and to provide care based primarily on financial considerations not on the resident's unique needs. As noted above, CMS has answered these critiques with RCS-1. It is important to begin now to understand the type of system that CMS is proposing to implement so that you and u=your organization will not be caught off guard.

Here's something else to keep in mind: while CMS had initially targeted January 2019 to implement RCS-1; however talks now beginning to surface that it may actually happen later this year. Because of this, the time is now to get more familiar with and be ready for RCS-1 because it is coming!

Join nationally recognized reimbursement and RAI expert Joel VanEaton, BSN, RN, RACT-MT for an informative and necessary conversation on all things RCS-1. His new 60-minute webinar "RCS-1: What You Need to Know to Prepare" is on Tuesday, March 13th. There are two presentations to choose from. This webinar has been approved for CEU credit hours from the NAB and NCERS. Discover more and register at WebinarLTC.com or call 800-807-4553. Space is limited so act now.

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