

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 THE DOL WHD. OMG!



The healthcare industry continues to be a main target of Department of Labor (DOL) Wage and Hour Division (WHD) claims asserting violations of unpaid overtime and missed meal periods. These claims often result in millions of dollars being paid out to settle lawsuits and government investigations.

Recent settlements resulting from

DOL investigations include a \$4 million settlement on behalf of over 4,500 nurses and hospital technicians who claimed they were not paid the proper overtime. Similarly there have been large settlements in state and federal class action litigation across the country. Notably, healthcare employers have recently had some significant successes in healthcare wage and hour class and collective actions, obtaining dismissals, defeating plaintiffs' motions for conditional certification in an FLSA collective action, and obtaining decertification. The increase of wage and hour actions against healthcare employers is due because it is one segment of the economy is growing and expanding its workforce, especially now with the enactment of health reform.

Besides increased government enforcement, the healthcare industry has become an attractive target for private wage and hour litigants. Plaintiffs' attorneys are becoming much more aggressive in their efforts to target vulnerable employers. No longer waiting for a disgruntled employee to make a complaint, plaintiffs' attorneys are using the ease of the internet to identify potential class members and highlight their investigations against susceptible healthcare providers.

As our industry is significantly trying to control costs, improve efficiencies, respond and adjust to healthcare reform legislation, and retain employees, healthcare employers must stay alert and know that they are increasingly the focus for a government investigation or a class action lawsuit.

In 2000, A second investigation-based compliance survey of the nation's nursing home industry by the DOL WHD (the first was in 1997) found only 40 percent of nursing homes in compliance with the Fair Labor Standards Act (FLSA). This is a sharp drop from the 70 percent compliance level reported by the department in 1997.

This month we'll look at the main areas of DOL WHD investigations in healthcare and suggestions for preventative measures.

Overtime Practices Investigations and Lawsuits

“Off-The-Clock” – Investigations and lawsuits often focus on and include allegations that hourly paid nurses and other employees are not compensated for work performed “off-the-clock”. These claims include “automatic” meal break deductions and rest breaks and failure to pay for work over 40 hours per week.

“Before and After Shifts” and “Mandatory Training” – Claims are

similarly made by employees not compensated for work performed before and after shifts and for mandatory training.

“Misclassification” - The FLSA requires that covered employees be paid minimum wage for all hours worked and overtime at least time and one-half the regular rate for all hours worked over 40 hours in a workweek. Exempt from the FLSA minimum wage and overtime requirements are individuals that meet certain executive, administrative or professional exemptions under the Act. The exemptions are narrowly construed against the employer and the employer must establish exempt status. In July 2015, the DOL proposed substantial amendments to the white collar exemption regulations. The DOL proposed raising the minimum salary threshold from \$23,660 to \$50,440 and to automatically increase the salary threshold annually basis based on inflation or other factors.

Family and Medical Leave Act

FMLA Compliance – The DOL is focused on failure to provide employees requesting FMLA leave a timely notice of their eligibility for leave; failure to notify employees of their rights and responsibilities under FMLA; failure to notify employees on a timely basis whether or not their leave was designated as FMLA; and failure to keep accurate records as required under the act. These notification and designation violations may create situations where employees, per the DOL, were unlawfully denied FMLA protected leave, or leave taken was not properly designated as FMLA, which can impact employee' personnel records and can put workers at risk for suspension, termination of employment, and other adverse employment actions.

Self-Audit and Prevention

We counsel our clients on the measures that employers can take to minimize liability and exposure for WHD issues.

Developing and implementing a comprehensive W&H program would include:

- Verification of independent contract, subcontract and agency agreements
- Evaluate job descriptions
- Assess time-keeping systems
- Confirm records retention and record-keeping policies
- Develop a formal program for reporting and resolving employee wage concerns
- Establish a Workplace Practices Committee

Conduct internal and external W&H audits and comply with recommendations.

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Pathway to Rehabilitation Excellence

By Lisa Chadwick, RN, MS
Director of Risk Management

Workplace Violence in the News

Violent actions in the workplace are ever present in the news these days. It is becoming more and more common to hear of violent actions performed against healthcare workers in all the various healthcare environments. Due to the nature of our jobs, we tend to be placed at greater risk than many other professions.

In the recent news: *Hospital patient attacks nurses injuring one who has fallen in the hallway; Angry patient on shooting spree fatally injures hospital employee; Patient kicks staff member which results in a fall and pelvic fracture.* As a nurse myself, I've been kicked, pinched, spit at, yelled at and threatened by angry patients and or families. This is not an isolated occurrence. Understandably, according to OSHA, healthcare workers face a significant risk of violence in the workplace.

Data from the Bureau of Labor Statistics state healthcare workers report the most nonfatal workplace violence with up to 50% of all reported assaults in workplace attributed to the healthcare environment. We must be attuned to the risk factors and be able to readily identify the hazards when present. We should also be providing safety training and education for staff on how to avoid situations that could lead to potential violence and be able to redirect and de-escalate when faced with a potentially violent and/or threatening patient or family member.

According to OSHA "Guides for Preventing Workplace Violence for Healthcare and Social Service Workers" best practice is to identify the risk factors and develop proactive plans. Many facilities have already taken measures to secure certain areas of their buildings during night time hours, added security video, panic alarms, and staffed with security guards. The risk of violence not only comes from patients, disgruntled families, and residents but from public knowledge that healthcare institutions also house Pharmaceuticals. Violence prevention programs in healthcare institutions are becoming the norm. They require a cooperative agreement between management and active participation of all employees to ensure success. All staff must work together to identify areas and situations of concern. Quick response teams can redirect a potentially violent situation before it gets out of control.

A good program will **train**.

Be able to rapidly **identify** a potentially dangerous situation.

Have a mechanism in place to alert and **respond** quickly.

Address the situation in a manner to **prevent** injury.

Be able to **minimize** the effect on all parties.

Evaluate and learn to improve.

Take the time to review the information that will provide the education and training your staff needs to react in a serious and potentially violent situation. A quick search of the web will provide several resources. Attached below is the link to OSHA guidelines. www.osha.gov Guidelines for Preventing Workplace Violence for Healthcare and Social Services.

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

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New 5-Star Quality Measures, Will You Measure Up

By Joel VanEaton, BSN, RN, RAC-CT

Did you know? In April, CMS will begin posting data for six new quality measures on Nursing Home Compare, five of which will begin affecting your 5-star rating in July. These six new MEASURES are:

1. Percent of short-stay residents who were successfully discharged to the community (**Claims-based**),
2. Percent of short-stay residents who have had an outpatient emergency department visit (**Claims-based**),
3. Percent of short-stay residents who were re-hospitalized after a nursing home admission (**Claims-based**),
4. Percent of short-stay residents who made improvements in function (**MDS-based**),
5. Percent of long-stay residents whose ability to move independently worsened (**MDS-based**),
6. Percent of long-stay residents who received an antianxiety or hypnotic medication (**MDS-based**)

Measures 1-5 will be factored into the Nursing Home Compare 5-star rating system via a phase-in process beginning July, 2016, 25% in July, 50% in October and full weight January 2016. CMS has not issued a user's manual yet, however, a PDF with preliminary details may be found at the following web address: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/Improvements-NHC-April-2016.pdf>

Extended Care Products will offer a comprehensive training opportunity via webinar later this spring after CMS releases an updated 5-star user's guide.

CODE STATUS DISCUSSION - WHO AND WHEN?



Admissions to the post-acute care center, skilled nursing facility or nursing home are time-intensive. From reviewing the transfer paperwork (oftentimes lacking which necessitates staff time to call the hospital to obtain the missing information) to the dozens of questions on numerous assessments, to a full body skin check, ordering and reconciling medications, situating and orienting the new person and their family to the room and the facility, and signing form after form, a new admission can take hours. What about determining code status?

Take a moment and think about who is responsible for discussing and obtaining code status in your facility. Is it the social worker? Or, a social services staff member? Is it the admissions coordinator? Or, is it a nurse? And, you wonder, why does it matter?

Coupled with the intense pressure on the facility to maintain census is yet another source of pressure, to not send patients back to the hospital. Sometimes this is a really tough balance to achieve. Research studies continue to show that two important factors that contribute to hospital readmissions are the family (or patient) insistence on returning to acute care and the lack of advance care planning. These two factors are actually closely related in many situations.

Advance care planning (ACP) is not a single event but rather a continuous process of meeting with the patient and/or family to discuss diagnoses, prognosis, treatment options, values, resources, challenges and strengths, hopes and fears. Sometimes advance directive documents are completed. Engaging people in this type of conversation takes skill and training - and time.

One scenario I see often is that obtaining code status is assigned to the social worker or social services department. Typically, this person does not see the patient until several hours or even days after admission. So what happens in the meantime if the patient codes? What is your facility policy?

If the patient was admitted with a code status designation

from the hospital, that's a good start but the nursing home *still needs to verify the status with the patient or surrogate decision-maker*. Code status is an aspect of patient care that changes, sometimes several times. A person may start out with a full code status but then a decision is made to change it to DNR, or, vice versa.

It is simply not acceptable to wait on obtaining an accurate code status designation. The responsibility for that discussion belongs to the *admitting nurse* and should be determined at the same time as the admission assessment is done. Allowing this important information to be obtained days after admission may result in chaos, confusion and ultimately treatments being administered or withheld from a patient erroneously.

The social worker certainly has a very important role related to code status and the overall advance care planning process. While completing the biopsychosocial assessment, the social worker should verify the code status along with determining what other directives are completed or need to be completed, e.g. a living will or power of attorney. This is a good check-and-balance system - making sure the code status accurately reflects the person's wishes and then also ensuring that all the components of the facility's policy and procedure are in place, e.g. a colored sticker designation in the facility that still has physical charts, the requisite paperwork completed, the care plan up-to-date, etc.

Upon admission and throughout the stay, nurses and social workers alike must be comfortable discussing code status and be knowledgeable about this medical treatment. In fact, group of treatments.

Now, if only all nurses and social workers received adequate training on *how* to discuss code status...to be continued in next month's column.

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

The HAT Advantage continued from page 1

Train staff and educate managers about W&R regulations/laws.
Education would include:

- Understanding overtime and recordkeeping
- Educating about DOL WHD inspection procedures
- Educate employees with policies and procedures to protect their wage rights
- Educate employees with the DOL's inspection rights

Establish a Response Team and Inspections Protocols.

- FMLA Compliance. Self-auditing would include: Thorough reviews of your FMLA policies
- Compliance with employer posting requirements
- Legally compliant FMLA forms
- Legally compliant FMLA correspondence
- Update recordkeeping
- Train employees on FMLA policies and administration of the FMLA

The DOL WHD Request for Information/Records/Subpoena and Investigation - The DOL WHD inspection procedure complies with a set format with customary requests for information/records/subpoena before the on-site visit and interviews. For more information about the process and with assistance in preparing for a DOL WHD investigation, please contact our offices. These issues are beyond this article.

Mistakes We See By Employers

The most common mistakes we encounter with our healthcare employer clients and DOL issues are 1) failing to appropriately classify and/or maintain employee exemption status; 2) failure to calculate overtime rates for non-discretionary bonuses; 3) automatic deductions for meal periods; 4) joint employment; 5) management's failure to monitor off-the-clock work; 6) pushing and pulling hours (crossing over workdays/workweeks); 7) compensation issues regarding meetings/seminars/workshops/education/training; 8) compensation issues regarding travel time; 9)improper classification of non-employees; and 10) state law violations.

Recognizing that the DOL WHD continues its scrutiny of healthcare employment practices allows our organizations to take proactive measures to minimize the risks described in this article. Healthcare employers must establish comprehensive compliance programs and evaluate compliance with state and federal wage and hour requirements with in-house and/or outside counsel.

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