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 ADELMAN ADVANTAGE

by Rebecca Adelman

Emergency Preparedness – Stay Proactive *The Critical Elements and Proactivity*

In just a little more than six weeks, five hurricanes have undergone rapid intensification in the Atlantic and eastern Pacific Oceans and research suggests this could become more common as the world warms from climate change. Not only have our senior housing community members been impacted, displaced and suffered trauma, our employees and their families have experienced great losses. Hurricane relief is far from ending. Please consider how you can help. The aftermath of these catastrophes and the rebuilding of battered lives will take years. Thank you to Robert Young, International Goodwill Ambassador for Blue Team Restoration, for his co-authorship and insight into proactivity in disaster planning.

Notably, it has been nearly two years since the CMS *Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers* regulation went into effect. Health care providers and suppliers affected were to comply and implement all regulations one year after the effective date, on November 15, 2017. On September 17, 2018, CMS issued a proposed rule impacting a wide range of Medicare providers that includes revisions to the new emergency preparedness regulations. According to a CMS press release, the proposed rule is part of the agency's efforts to "relieve burden on healthcare providers by removing unnecessary, obsolete or excessively burdensome Medicare compliance requirements for healthcare facilities." The emergency preparedness requirements are targeted for rollback even though they were implemented less than a year ago.

The current emergency preparedness provisions represent years of study and review by federal agencies, nursing home providers, emergency preparedness experts, advocates, and others following the horrendous impact of Hurricane Katrina on vulnerable and frail nursing home residents. In the preamble to the current regulations, CMS states that the regulations are based on lessons learned from the past and today's proven best practices Now, however, CMS is proposing to change the rules based solely on its intent to reduce provider burden. Despite these rollbacks, senior housing communities cannot ease up on being fully ready when disaster strikes.

As reported by LiveProcess, only 3% of long-term care facilities said they were not ready to meet the requirements of the CMS emergency preparedness rule. The vast majority, 78%, described their facilities as somewhat ready, while 19% described their facilities as completely prepared. This month, Mr. Young and I will be reviewing the core elements of emergency preparedness and unique ways to be proactive.

The CMS regulations identify **Four Core Elements of Emergency Preparedness** listed below. Note that the * reflects that there are proposed changes/rollback regulations proposed by CMS in September 2018.

- **Risk Assessment and Emergency Planning (Included but not limited to):**
  - Hazards likely in geographic area
  - Care-related emergencies
  - Equipment and power failures
  - Interruption in communications, including cyber attacks
  - Loss of all/portion of facility
  - Loss of all/portion of supplies
  - Plan is to be reviewed and updated at least annually *

***Proposed Rollback of Emergency plan**: A facility would only be required to review and update its emergency plan **every two years rather than annually**. The plan is designed to address the hazards identified through a risk assessment. These risks do not remain static and can change quickly. Waiting for two years to update a plan means it is likely to not reflect important changes in both the facility and its environment. Because the plan guides and directs the facility's response to an emergency or disaster, a flawed, inadequate plan can have catastrophic results for the safety and welfare of residents. In addition, CMS is proposing to eliminate the requirement that the emergency plan include documentation of efforts to contact local, tribal, regional, state and federal emergency preparedness officials and a facility's participation in collaborative and cooperative planning efforts. These efforts are critical for the emergency plan to succeed, but there is no way to determine if the facility has actually contacted

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and collaborated with emergency preparedness officials without documentation.

- **Communication Plan**
  - Complies with federal and state laws
  - System to contact staff, including patients' physicians, other necessary persons
  - Well-coordinated within the facility, across health care providers, and with state and local public health departments and emergency management agencies. *

* **Proposed Rollback of Communication Plan**: Nursing homes would be mandated to reexamine their communication plan and bring it up-to-date **every two years and not annually** as currently required. This communication plan ensures that the facility has a system to contact appropriate staff; attending physicians; other long-term care facilities; federal, state, tribal, regional or local emergency preparedness staff; and others to ensure continuation of resident care. Because the individuals and entities included in such a plan can change frequently, failure to update the plan every year could result in faulty and inaccurate information and the inability to reach the people/agencies needed to protect resident health and safety in the event of a disaster.

- **Policies and Procedures**
  - Complies with federal and state laws*

* **Proposed Rollback of Policies and Procedures**: The review and update of policies and procedures would be mandated **every two years instead of every year**. The facility's policies and procedures support the successful execution of its emergency plan. Many factors can cause policies and procedures to become outdated or ineffective, thereby jeopardizing the facility's ability to carry out its plan. A biennial rather than an annual review could easily fail to identify the need for revisions in a timely manner, including changes necessary based on the facility experiencing an emergency or problems during a drill or exercise.

- **Training and Testing ***
  - Complies with federal and state laws
  - Maintain and at a minimum update annually

***Proposed Rollback Training and Testing Program**: Similar to the changes noted above, the training and testing program would have to be reviewed and **updated every two years and not yearly**. In order to be effective, this program must be modified when gaps, problems or areas for improvement are identified. Delaying necessary changes for two years leaves the facility ill-equipped and improperly prepared for an emergency that can arise at any time. In addition, significant turnover rates among both staff and administration in nursing homes raise concerns about staff readiness if emergency preparedness training is extended to every two years.

My recommendation is to continue annual reviews, testing and training. Timely planning provides the foundation for effective emergency management.

Robert Young and Blue Team Restoration understand that the response to an emergency can impact an entire community and can involve numerous medical and public health entities, including health care provider systems, public health departments, emergency medical services, medical laboratories, individual health practitioners, and medical support services. A coordinated response is essential.

Mr. Young offered me many insights into comprehensive emergency management which includes the following phases:

Hazard Identification: Health care providers should make every effort to include any potential hazards that could affect the facility directly and indirectly for the particular area it is located. Indirect hazards could affect the community but not the provider, and as a result interrupt necessary utilities, supplies or staffing.

Hazard Mitigation: Hazard mitigation is activities taken to eliminate or reduce the probability of the event, or reduce its severity or consequences, either prior to or following a disaster or emergency.

The emergency plan should include mitigation processes for both residents and staff. Mitigation details should address care for the facility residents, and how the facility will educate staff in protecting themselves in the likelihood of an emergency. Comprehensive hazard mitigation efforts, including staff education, will aid in reducing staffs' vulnerability to potential hazards. These activities precede any imminent or post-impact time frame, and are considered part of the response.

Preparedness: Preparedness includes developing a plan to address how the provider will meet the needs of patients and residents if essential services breakdown as a result of a disaster. It will be the product of a review of the basic facility information, the hazard analysis, and an analysis of the provider's ability to continue providing care and services during an emergency. It also includes training staff on their role in the emergency plan, testing the plan, and revising the plan as needed.

Response: Activities immediately before (for an impending threat), during and after a hazard impact to address the immediate and short-term effects of the emergency. Mr. Young offers his insight from twenty-four years in the disaster recovery industry. From an emergency preparedness perspective, you can never be prepared enough for mother nature or man-made disasters. Technology and foresight for business continuity are the key factors. Learning the idiosyncrasies of each and every property within every portfolio is mission critical to the mitigation and business interruption. It is all a part of a proactive risk management approach. Blue Team Priority Response includes a Pre- Loss Assessment conducted for the community properties. The information is then loaded into database that overlays those properties and with proprietary weather tracking systems, ownership and property facilities and management are forewarned of impending threats. Whether it be from hurricane, flooding, wind, hail, wildfires, tornadoes, or any other natural disaster to allow time for communities to be best prepared in these type of events. For example, if a community is performing work on the exterior of the building and a storm has developed in the Gulf of Mexico or the Atlantic or Pacific Oceans, and the storm can be tracked to find the cone of certainty and where and when it will come into contact properties. Information will automatically populate into the database and will be distributed directly to those properties. The communities and staff and their residents and families can then prepare for the storm. Blue Team can also

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Getting on the Same Page by Paige Hector, LMSW

Uncovered Territory of Person-Centered Pain Assessment

Following an excellent conference that I attended this August presented by Dr. Robert Rosenbaum on behavioral treatment of pain, I began writing a series of articles. The first two articles focused on a person-centered approach to pain assessment and management within a biopsychosocial context. This month's article delves into a different topic, a mindfulness approach to person-centered assessment.

As members of the interdisciplinary team, each clinician contributes to a comprehensive pain assessment. My deliberate use of the term *clinician* encompasses professionals including nurses, social workers, and therapists. Pain assessment and management is much broader than the relationship with the medical provider, especially in the nursing home.

Let's set the scene. Today you are meeting a patient (or resident), perhaps for the first time, or in a follow-up visit to address pain. You'll certainly ask about the quality of the pain, location, severity, past treatments, etc. Hopefully, your assessment will include questions to learn about the person's biopsychosocial pain experience like *What has been the most difficult adjustment?* and *If you could change one thing, what would it be?* (For more assessment questions, refer to the August and September NAL articles).

When you consider a biopsychosocial approach to pain assessment, do you think, "I don't have time for that!"? That's an understandable point. Incorporating a person-centered approach requires more time. Hold that thought.

Allow me to offer a different perspective about the ubiquitous challenge of time. There's no denying that time is a resource and that we make decisions of how to spend it. Do we choose to spend our time in a wasteful cycle, attempting less effective interventions based on incomplete assessments and not achieving the desired outcome? Or, do we spend more time at the outset building therapeutic relationships based on comprehensive assessments, engaging in a person-centered approach? I know which one I choose.

Dr. Rosenbaum approaches person-centered care with a mindfulness lens. One definition of mindfulness is "paying attention in a particular way, on purpose, in the present moment, nonjudgmentally." (Jon Kabat-Zinn) Another wonderful definition is, "The ability to fully experience a situation without being bound by our expectations, our conditioned reactions and perceptions." This mindset is especially important in the realm of pain treatment.

Embracing a mindfulness lens to person-centered care can be therapeutic for the patient, and the clinician. Dr. Rosenbaum says, "To the extent that the patient feels the meeting with you is a "re-run," there will be little increase in hope or motivation." As a clinician, how can we apply a mindfulness approach to patient care and *hear the story new*?

Re-read that last part - *hear the story new*. How can we do that?

Dr. Rosenbaum recommends eliciting a fresh perspective which includes asking about "uncovered" territories. The questions below may elicit discomfort to the newest, and the most seasoned clinicians. The purpose with these questions is to discover unexplored areas. With a mindfulness approach to pain assessment, the clinician engages with the individual (not *case*) with curiosity and genuine wonder at the possibility of a new idea or a fresh perspective.

Consider asking:

- What does the patient think the doctors are missing?
- When the patient wakes in the middle of the night with pain, what does he/she patient fear?
- How does the patient bear it?

As you explore this uncovered territory, utilize these Assessment Guidelines to help embrace a biopsychosocial assessment model.*

Validate – *"You are in pain. You hurt."*
Validation is critical. If the individual doesn't feel heard, there can be no productive work.

Educate – *dispel fears based on myths, trauma*
Much of what we do as healthcare professionals is educate. People harbor many fears when it comes to pain, some of which include: fear they have a fatal disease, that doctors are missing something or not telling them everything, that doctors are withholding treatment to save money, that they will be blamed for their pain, or that others will think they're faking pain, seeking drugs, are 'crazy' or, worse, hopeless.

Separate – *you are not your pain*
In the midst of pain, a person may feel lost, that their life has been subsumed by the pain. Gentle reminders with examples of how a person's being is not solely defined by their pain can help build resiliency and a trusting relationship.

Investigate – *open-minded inquiry into the triggers and ameliorators of pain*
This includes the traditional questions to determine the type, location, intensity, quality, duration, etc. of the pain, asked with deeper listening and curiosity.

Celebrate – *encourage coping abilities*
The individual may share they don't know how they are bearing the pain. You might say, "That's interesting. You are bearing it, but you don't know how. Let's explore that." So often, people have, and are using, strengths that they are not aware of.

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Integrate – *motivate by exploring client meanings, values, activities*
Use their interests, hobbies, and anything that has meaning in their life to make analogies to their pain, to help them see it from a perspective that makes sense to them.

For example, of the retired construction foreman, ask, "When you were almost done with a complicated building project and there's still one more floor to complete, how did you do it?" Or to the octogenarian painter, "When you feel stuck with what direction to take your painting, what do you do?" Then, correlate their pain experience with their meaningful activities. Identify examples of strength and resiliency and how they can apply the same principles to their experience of pain.

There is no magic wand or a one-size-fits-all approach to pain treatment but working within a person-centered care framework is always the right choice. As competent clinicians, we continue to fill our "toolboxes" with a variety of techniques to, hopefully, hear stories anew. To all the clinicians who work so hard every day to ease others' suffering, physically, emotionally, mentally and spiritually, I thank you.

*Printed with Dr. Rosenberg's permission

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allocate the necessary resources to the regions of the country to ensure client coverage on every property. This type of innovative proactivity should be explored for your communities.

Recovery: Activities and programs implemented during and after response that are designed to return the facility to its usual state or a "new normal."

It is essential to be prepared for emergencies and mitigate as much risk as possible proactively. Lay down the best plans possible for your organization and engage staff in training. There are many lessons to be learned from these recent catastrophes so let's make sure we respond to these lessons and be prepared. Let me know how we can assist with plan compliance.

SAVE THE DATE!!!! The annual complimentary long term care conference I host along with Horne Rota and Kaufman Borgeest & Ryan is in its 7th year and not to be missed! Please save the dates April 3-4, 2019 for The National Long-Term Care Defense Summit (love our new conference name!) in Memphis! Education, networking, blues and BBQ! Please contact me for more information and stay tuned for details.

Rebecca Adelman is an entrepreneur, influencer, thought leader and founder of Adelman Law Firm, established in 2001. For nearly 30 years, Rebecca has concentrated her practice in insurance defense and business litigation. The firm's practice extends through the Tri-States of Arkansas, Mississippi and Tennessee. Rebecca's insurance defense practice includes representation of insurance companies and long-term care providers and their insurers, both regionally and nationally. She also provides consulting services and educational programming to healthcare professionals and business associates. She has active practices in the areas of general liability, professional liability, premises, and employment law. She is a listed mediator serving all areas of business and healthcare litigation.

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Robert Young is the National Account Executive and International Ambassador for Blue Team Restoration. Blue Team provides progressive solutions on a national basis for remediation, restoration and reconstruction of commercial properties. The core business is providing emergency response, resulting from day-to-day natural events. Blue Team also provides construction services to return the facility back to pre-loss condition. Blue Team takes on capital improvement projects as expansion plans often accompany the rebuilding effort. It also has established a specialized roofing division. Blue Team creates distinct advantages by offering a complete turn-key service with the infrastructure to handle multiple emergencies at catastrophic scale nationwide. Blue Team serves property owners and operators in the hospitality, senior and health care, commercial office, municipal, and institutional markets. www.blueteamrestoration.com

KESSLER'S CORNER

by Chip Kessler

"The Great Disappearing Act"

If you ever seen a magician perform (and basically who hasn't in her or his lifetime) then you've no doubt watched the point in the act where he or she goes into a box or behind a curtain. The assistant is then seen shortly thereafter pulling back the curtain and the magician has vanished. Likewise if the magician went into a box- the door's opened and no one is there. Amazing!

And yet, I'm here to report that I've seen a similar occurrence take place several times during my course of running operations at Extended Care Products over the past 16 years. First, let me set the scene for you, and then I'll use it to make my point appropriate to your nursing or assisted living facility.

Over the years, I have gotten a telephone call or it may be an e-mail from a person who's interested in developing a program or a service, and then have us take it on as something we would market and sell to the assisted living and/or nursing facility profession. No problem here because I'm always willing to listen to their idea, and then take a look at what they're wishing to do. Said person is always very enthusiastic about their "thing" at this point, and is full of reasons why the program or service is just what is needed in the nursing and/or assisted living facility environment.

Fair enough. We usually end the conversation (if it's an initial contact via e-mail then I will follow up and arrange a time to speak) with the person's promise to keep me updated on the progress they're making in order to eventually send it to me to review, or if they already got a finished version to then send it my way to see if it's worth a joint venture partnership here.

Here's the rub, in EVERY CASE the person disappears at one point or another during this process, and is never heard from again. Usually it's during the development stage. There's only one case where I've been sent something to take a look at, and that turned out to be a disaster (a story in itself for another time). It's certainly not because I've discouraged these people from moving forward, so the question is why do they basically turn into magicians and "disappear" from the world? It's a question I don't have a definite answer to, though there could be several factors ranging from their wavering confidence in the respective program or service to their inability to follow through on the project.

Now, let's bring it back to your particular facility and your team members, and how The Great Disappearing Act can affect the care and services you provide to residents and their family members. It has to do with the second potential reason that prospective program/service developers "disappear" from me- the inability to follow through to the very end.

It's important for what you look to do for your residents- the art of following through. For your purposes, it's staffs' ability to be front and center when duty calls. How would you gauge this kind of personal interaction between those healthcare professionals in your facility and your residents? Do you have any (disappearing) "magicians" on the payroll? Hopefully not.

As I mentioned in the past, my company offers mystery shopping services to facility clients, and also has a family follow-up personal contact program "Family Relationships 101" (details at ExtendedCareProducts.com). As an offshoot of this, a running occasional theme of the family follow-up contact reports from the Family Relationships program I read is that the facility is perceived to be understaffed and not as attentive to residents' needs (i.e. call lights go unanswered for a long period of time, etc.).

You and I both know that you are not understaffed per-say, that staffing is budgeted and is based on the number of residents in your building. However the "understaffed feeling" may very well be there by families and residents, so you have to do your best to combat it. Because of this, you don't need any Houdini's lurking around, and not giving their all to the job-at-hand.

Indeed it can be a challenge to get good quality employees who are dedicated to doing the very best they can, and meeting the responsibilities that come with working in an assisted living or nursing facility. And yet these people are out there ready to do what's needed! You just have to find them. As important is knowing when a team member isn't cutting the mustard (and shows no inclination to improve), and removing them from your facility.

In other words, let's save the professional disappearing acts to the magicians on stage!

Visit ExtendedCareProducts.com to discover more about the staff training/development programs and services provided to the nursing and assisted living facility profession.

NAL Professional Not Coming Addressed to You Personally?

We want to make sure you are personally getting this newsletter each month, not just have it forwarded to you because you're now holding down the position of a predecessor! Let us know you now are on the job. E-mail your name, facility/company name and address to chip@ecpnews.net & we'll update our records. Just put NAL Professional on the e-mail subject line and we'll take care of the rest.

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Cyber Security Now!

With Rick Smith

Editor's note: Each month in the pages of Nursing & Assisted Living Facility Professional, Ricky Smith, President of Innovative Business Technologies (IBT), our nation's leading supplier of specialized IT systems and cyber security to the healthcare industry, answers a key question. Discover more about IBT at IBusinessTech.com

This month's question: *what is the biggest misconception out there regarding on-line security issues at our nation's nursing and assisted living facilities?*

Ricky Smith: I think there are two things. One, like many events in life, people don't think it can happen to them. Because of this, cyber security is not a problem until something happens, and then they realize how big of an issue it is. Second, people don't think their building is vulnerable, believing they have everything in place. Unfortunately, you can never get complacent with this stuff! It's always changing and advancing. You just have to take the attitude that you're always vulnerable to on-line hackers, and keep cyber security in the forefront of your mind. If you don't, you're asking for trouble.

Extended Care Products is pleased to partner with Ricky Smith to present the new DVD video series "Cyber Attack." Discover more at ExtendedCareProducts.com or call 800-807-4553 for more information. This video series is available for a risk-free 30-day review.