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

SNF QRP OMG

May this Thanksgiving be filled with love and friendship and hope. I am grateful to each of you for your continued support of Extended Care Products and this monthly publication. Chip Kessler has been an inspiration since we embarked on this collaborative journey to provide quality education, risk management and other relevant resources to the healthcare community. Thank you for the opportunity, Chip!

On October 24, 2018, in accordance with Section 1899B(g)(1) of the Social Security Act, which requires CMS to provide for the public reporting of SNF provider performance on the quality measures, CMS announced the inaugural release of the Skilled Nursing Facility Quality Reporting Program (SNF QRP) quality data on Nursing Home (NH) Compare.

Specifically, the following five SNF QRP measures are now being displayed on the NH Compare site:

Assessment-based measures:

Percent of Residents or Patients with Pressure Ulcers that are New or Worsened

Application of Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

Application of Percent of Residents Experiencing One or More Falls with Major Injury

Claims-based measures:

Medicare Spending Per Beneficiary

Discharge to Community

CMS has decided not to publish a 6th quality measure, Potentially Preventable 30-Day Post-Discharge Readmissions, at this time. Per CMS, "Additional time would allow for more testing to determine if there are modifications that may be needed both to the measure and to the method for displaying the measure. This additional testing will ensure that the future publicly reported measure is thoroughly evaluated so that Compare users can depend upon an accurate picture of provider quality. While we conduct this additional testing, CMS will not post reportable data for this measure, including each SNF's performance, as well as the national rate."

On November 1, 2018, SNF Provider Preview Reports were updated and are now available. Providers have until November 30, 2018 to review their performance data on quality measures based on Quarter 2 -2017 to Quarter 1 - 2018 data, prior to the January 2019 Nursing Home Compare site refresh, during which this data will be publicly displayed. Corrections to the underlying data will not be permitted during this time. However, providers can request a CMS review during the preview period if they believe their data scores displayed are inaccurate.

The SNF QRP is a critical component to the Patient-Driven Payment Model (PDPM) taking effect on October 1, 2019. I addressed the keys to the PDPM in he August 2018 edition of this publication. In order to enable assessment of the functional outcome measures, CMS added new Section GG items to the MDS on October 1, 2018. Below are observations and researched recommendations on what the new measures mean to you.

Initially, the only financial penalty associated with these new measures will be a 2% withhold of Med A payments based on failure to report at an 80% threshold of Med A stays. Beginning in FY 2020 (October 1, 2019), facilities will be measured on their actual performance, with outcome incentives and penalties applied based on facility performance against established benchmarks for performance. The data collected between 10/1/18 and 12/31/18 will be used to inform payment bonus/ penalty starting 10/1/19 (FY20). The data collection period will then move to a calendar year and the data from 1/1/19 to 12/31/19 will be used to inform payment starting 10/1/20 (FY21), and so on.

What the new measures mean to you.

Increase in measures focusing on Section GG of the MDS version effective 10/1/18 reflects additional questions in Section GG . There are added questions regarding ability to

Continued on page 2

The Adelman Advantage continued from page 1

self care prior to admission to the SNF as well as an additional question regarding the resident's cognition and the affect on self care prior to admission to the SNF. QRP Measures are also beginning to compare function recorded on the 5 day PPS assessment to the SNF Part A PPS discharge assessment. Did your resident improve or decline in function over the course of the stay? Did the resident reach the goals set with them during the stay?

All MDS measures are based on the 5 day PPS assessment and the SNF Part A PPS discharge assessment and impact traditional Medicare A only. The measures are calculated based on the data from MDS assessments submitted to the QIES-ASAP system. **If items are dashed the calculation is not accurate**. If errors are present on the items completed the data is not accurate. If assessments are completed late or submitted late the data is not accurate. These considerations present risk issues for facilities for litigation and how the data is used by Plaintiff's attorneys.

QRP and the MDS Section GG.

The 5 day PPS assessment requires Section GG Admission Performance and Discharge Goal (at least 1) be completed. Discharge goals are not required if the stay is incomplete meaning less than 3 days or unplanned discharge or death. The end of the Medicare PPS stay discharge assessment requires the discharge performance to be completed. For the MDS Coordinator, the codes used in Section GG are different than those used in Section G. Also, Determining usual function is not typical for how items on the MDS are coded.

Consider how to prepare for the new measures and changes.

All but 3 of the measures are based on MDS data so discuss with your MDS coordinator/RNAC how is this data gathered?

What sources are utilized?

Is there communication and collaboration with the therapy department? •

How and where is this information documented?

If there is a change in self care/mobility what steps are taken especially if there is a decline to attempt improvement? AND who is aware there is a change during the stay and not just on discharge?

Are your MDS assessments accurate and completed per regulation?

Are your MDS assessments submitted per regulation?

If not is there a plan in place to correct those issues?

Are the review and correct reports accessed routinely and if needed are corrections being done within the time frame specified?

If there are issues noted with the QRP MDS based measures is this a part of your QAPI?

The new measures, increased reporting and increased risks of public information used in litigation, the SNF QRP measures present many questions and concerns. It is difficult to comprehend how consumers can understand what a specific measure means and the impact on a resident. The information can be helpful yet tells only a fraction of a community's story and quality of care. Likewise, for the communities, the quality measures focus only on a portion of what a community can offer a resident and families.

Above all else, know your data and be prepared to explain the information to prospective residents and their families.

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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Getting on the Same Page by Paige Hector, LMSW

Help, We Need QAPI Ideas!

Process (different from performance) improvement is part of everyday life in post-acute and long-term care settings. With the most recent revision to the requirements of participation, CMS emphasizes the facility QAPI process (F867). Included in Phase 3 of the revisions is the requirement that facilities will carry out improvement activities on high-risk, high-volume or problem-prone areas.

We tend to collect a lot of data in nursing homes. In your facility, maybe you've tackled projects on infection control, antibiotic stewardship, antipsychotic medications or lost laundry. Besides these "big ticket" topics, what are other areas for improvement that might be a little different, that involve staff and residents more, and address issues that significantly impact facility culture? Just recently on a national listserv, new improvement ideas were the topic of discussion. I decided to turn my response into this month's article.

When I think of improvement, I ALWAYS think process first; hence, the note in parentheses in the beginning. In my humble opinion, the "PI" in QAPI should stand for *Process* Improvement, not Performance. If improvement is desired in ANY area, start with the process. Check out these questions that go after process breakdowns and can help identify areas for improvement (Donald Berwick):

- Do you ever waste time waiting?
- Do you ever redo your work?
- Do the procedures you use waste steps, duplicate efforts, or frustrate you through their unpredictability?
- Is information that you need ever lost?
- Does communication ever fail?

Imagine asking the nurse aides about what frustrates them on the job! What parts of their job do they dread? Why? The answers to the above questions can identify fantastic improvement ideas that will make a difference to staff and their ability to do wonderful work. Envision simplifying steps in a process, streamlining systems, minimizing repetitive work, increasing efficiency and ultimately making work more enjoyable for everyone. And, most likely better outcomes for residents too.

If you feel stuck-in-a rut, or that creativity seems in short supply when it comes to generating new, dare I say exciting or fun, improvement ideas in your facility, check out these suggestions to kickstart a new project:

- Simply ask staff what they would like to see improve. (This is NOT a satisfaction survey suggestion!) No matter how grandiose the idea, allow, encourage and give staff permission to think BIG. If the idea in its entirety can't be accomplished, perhaps there's a smaller piece that can. Gather all the ideas and prioritize them.
- Ask people if they had a magic wand what they would do to improve the home.
- What are things they *wish* could happen in the nursing home but just can't imagine how? Be outlandish! Let creativity run free.
- Imagine your favorite hotel, resort, spa, salon, recreation area, store – what's special about that place? What makes going there an *experience*? Can any part of that be re-created in your nursing home?
- What complaints and grievances do you get in the facility? This could be a very rich and wonderful area to explore. If you're not getting complaints, that in itself is a problem and worth exploring. Complaints are gold. Complaints mean that people are comfortable in your facility and trust that they can speak up. Yep, sometimes, they're not much fun either.
- One of my all-time favorite books is *If Disney Ran Your Hospital, 9 ½ Things You Would Do Differently* by Fred Lee. He makes so many brilliant points in this book, one of which is the difference between courtesy and efficiency. This difference has profound implications in process improvement work and overall happiness for staff. All sorts of ideas in his book!
- Consider the mandatory inservices and staff training. Are there ways to improve those experiences? Make them more informative? Incorporate adult learning principles? Make them more fun? Here's a link to an article I wrote in April this year about the difference between training and education with some ideas for improvement projects - https://extendedcareproducts.com/displaypdf.php?r=48.
- This may sound crazy but pick one regulation and READ it! Look at it critically and imagine creating an improvement project. Invite each department to pick one aspect of a regulation most pertinent to their department and explore improvement ideas. There are so many ideas to be had and they're all in the regulations!
- Consider developing a program in which staff members take turns providing education. Let them pick a topic of interest and develop a 5-10 minute inservice. Empower staff to be leaders and help them be successful. Partner with local agencies and if possible, other facilities to compile basic public speaking tools and tips. Two of my favorite resources are *Presentation Zen* by Garr Reynolds and *Confessions of a Public Speaker* by

Continued on page 4

Cyber Security Now!

With Rick Smith

Each month 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: *many nursing and assisted living facilities have an IT person on staff or access to one, is this enough to prevent cyber-crime from happening?*

Ricky Smith: Often times this leads to a false sense of security because, if you think about it, you're talking about only one person or a very small department. Yes you may have someone on staff with this title, but are they totally focused on preventing cyber criminals from getting into your system, or does the IT person have other responsibilities? More than likely it's the latter so they have many distractions. If your IT staff is doing other things besides being totally focused on your security, you are at risk. Plus, cyber criminals are very savvy; they're constantly coming up with new ways of making your life miserable. Is your IT staff up-to-date on the latest occurrences? The bottom line is, there are going to be holes in your cyber security- that's just the nature of things. Just because you have an IT staff doesn't mean you aren't vulnerable- every system is vulnerable. You just have to figure there are gaps. That's why as part of your overall risk management process you have to be willing to invest in outside help to bridge these gaps.

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.

Getting on the Same Page continued from page 3

Scott Berkun. Both these authors' websites are worth checking out too. (Just to be clear, I don't have any financial relationship with either writer.)

- Consider improvement ideas that involve the public. From a public relations perspective, think of ideas that offer continual education, discussion groups, or ways for the nursing home to become a hub where people feel welcome to stop by and to become involved. What are some of the interests of the residents? How can you partner with community agencies and members?
- This summer I attended a phenomenal workshop on the behavioral treatment of pain by Dr. Robert Rosenbaum. I believe we can be doing so much more in this area. This article series (August, September and October) could stimulate great improvement ideas. Here's a link to the NAL website with all the articles - https://extendedcareproducts.com/newsletters.php

You spend more of your waking hours at work, with colleagues, patients, residents and their families than with your own family. So, no matter what direction you take improvement, try to incorporate elements of fun. Having fun is essential to our well-being and certainly makes for a more pleasurable work environment. Wishing you happy improvement projects!

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Broad River Rehab, "*A **knowledgeable** and **compassionate** Partner*"

Editor's Note: ***Nursing & Assisted Living Facility Professional*** **is pleased to welcome Broad River Rehab to our group of monthly contributors! We invite you to enjoy their monthly columns, in addition to the informative message they'll be including in each issue. Up first from Broad River Rehab is a column from a long-time friend to this publication, and our nation's leading clinical reimbursement specialist, Joel VanEaton.**

Understanding the Value of The MDS Nurse under the Patient Driven Payment Model (PDPM)

By Joel VanEaton, BSN, RN, RAC-MT,
VP of Compliance and Regulatory Affairs at Broad River Rehab

As the SNF world draws its collective breath and begins to consider the Patient Driven Payment Model (PDPM), the new reimbursement system that will drive payment for Medicare Part A for SNFs starting October 1, 2019, there are many questions and misunderstandings. Because of the major changes to the payment system, compared to RUG IV / 66, particularly with regard to the reduced assessment requirement, a question I hear often is, "What will happen to the MDS Nurse?" "Will they still be important?"

My short answer is an emphatic, YES! Recently I responded to that question in another blog post with the following; "Never in the history of MDS and PPS has there been a time where the MDS nurse can truly be a nurse and do the things they were trained to do. The PDPM will require that the MDS nurse be accomplished and capable resident condition assessors. It is a challenging yet rewarding time to be an MDS professional and it is my opinion that accomplished and capable MDS professionals will be one of the most highly sought-after individuals in LTC." I stand by that statement.

The reasons that I know this will be true have to do with what PDPM will require for facilities to be successful under this payment system. First, none of the skills for which these nurses are currently seen as valuable will disappear. In fact, revised conditions of participation requirements, PBJ, 5-Star, QRP, MDS assessment completion, CAAs, Care Planning, and really the whole RAI process, are here to stay and are all driven by accurate and timely MDS completion.

In addition to these, PDPM is a payment system that is driven by resident characteristics, not service metrics like RUG 66 is currently. Facilities will need MDS nurses who are competent ICD-10 coders. All payment categories under PDPM, PT, OT, SLP, Nursing and Non-Therapy Ancillary or NTA, are defined to one degree or another by appropriate ICD-10 coding. MDS nurses will need to be capable and proficient at this skill and understand how ICD-10 will intersect with PDPM so that the initial reimbursement gets off to the appropriate start.

Also, because PDPM is resident characteristic driven, understanding the entire reason the resident will be receiving care at your SNF will be critically important. Currently, much of the reimbursement that flows to SNFs is driven by therapy services. Not so under PDPM. The amount of therapy provided to a resident will have no impact on the amount that Medicare will reimburse a facility. When PDPM arrives, each resident will need to be individually and intricately assessed since each of the payment categories will be uniquely constructed by the resident's individual clinical characteristics. Getting this process right will be the only way providers can be sure they are being appropriately reimbursed by Medicare.

Finally, the only Medicare required assessments under PDPM will be the 5-Day and Part A PPS Discharge assessments. The 5-Day assessment will set payment amounts for the resident's entire Part A stay, so getting this one assessment right will be paramount. As of the publication of the FY 2019 SNF PPS final rule, CMS will allow what is called an Interim Payment Assessment or IPA. This assessment will be voluntary, completed at the provider's discretion, when any of the payment categories payment amount changes and the provider wishes to capture the new rate. CMS has yet to publish more specific rules governing this assessment type. However, as of the current rule it will be to the providers benefit to complete this. Successful completion of an IPA will require that someone has their eye on the broad range of elements that contribute to PDPM payment as well as which of those elements are attributable to a given resident throughout his or her stay. Not paying attention at this level of detail will cost providers no small chunk of change. The MDS nurse will be an integral asset that will allow providers to navigate these processes successfully.

So, I repeat, under PDPM the MDS nurse will not lessen in his or her importance despite what some may be saying. As I stated earlier when PDPM arrives, "…it is my opinion that accomplished and capable MDS professionals will be one of the most highly sought-after individuals in LTC." I stand by that statement. Providers who fail to understand the MDS nurse's importance then, as now, are simply shortsighted.

Visit the Broad River Rehab Website to ask an Expert about anything related to MDS or PDPM, www.broadriverrehab.com

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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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