# 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

## Senate Finance Committee Hearing on Nursing Home Abuse: Only One Side of the Coin

On March 6, 2019, the Senate Finance Committee, chaired by Senator Charles Grassley (R-Iowa), held a hearing titled *Not Forgotten: Protecting Americans From Abuse and Neglect in Nursing Homes*. The committee heard testimony on reported instances of abuse and neglect in nursing homes and on the federal-state oversight system's enforcement of laws and regulations designed to prevent these situations from developing.

This article will provide an overview of witness testimony before the Committee addressing the persistent concerns of Sen. Grassley. Notably, the day before the hearing, on March 5, 2019, CMS made a pre-emptive strike to show that it's addressing nursing home safety concerns. Seema Verma, the Administrator at CMS, in her blog post *Protecting the Health and Safety of all Americans,* she states stresses the "alarming stories" of abuse and neglect in the healthcare system "despite stringent safeguards" and then the STRIKE! She says that "CMS is issuing new guidance that takes a key step towards making across-the-board improvements in healthcare safety and quality." The guidance relates to the Immediate Jeopardy "situations" . She explains "this new guidance clarifies what information is needed to identify immediate jeopardy cases across all healthcare provider types, which we believe will result in quickly identifying and ultimately preventing these situations. This new guidance can be found in Appendix Q of the State Operations Manual that federal and state inspectors use." I'll review the new guidance next month. For now, be rest assured that we'll hear plenty more about increased oversight and new guidance from CMS as the light is shined on it by the Senate Finance Committee.

Senator Grassley opened the hearings with familiar remarks about "horrible abuses" in nursing homes and his on-going efforts as the champion of the fight of the elders. While we can all agree that elder abuse (or any abuse of people or animals) is unacceptable. What Sen. Grassley fails to spotlight, however, is that the extremely high expectations he expresses cannot be achieved in light of financial constraints placed on skilled nursing facilities by the government. More oversight and sanctioning are not the answers.

Before the committee were Patricia Olthoff-Blank and Maya Fischer who shared stories about neglect and an assault on their loved ones in nursing homes. Testimony was then received by David C. Grabowski, PhD, Professor, Department of Health Care Policy at Harvard Medical School. He "took on" two issues: 1) nursing home quality; and 2) the reasons for the focus on quality for fifty years. Dr. Grabowski addressed staffing, poor care practices, poor outcomes

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and adverse events, safety, low quality of life and concluding that "care is often directed by the facility rather than the resident" and as a solution offers that "A more participatory management structure that engages CNAs in the decision-making process would help with staff turnover and performance." Why is nursing home quality "such a persistent problem"? According to Dr. Grabowski, "we get what we pay for." Highlighting lack of funds, inconsistent oversight, Certificates of Need, and lack of quality transparency, Dr. Grabowski summarizes that "These problems are related to system level issues in how we pay for care, how we regulate providers, and the inability of residents and their advocates to monitor and oversee care." No real solutions are proposed.

Dr. Kate Goodrich, Chief Medical Officer for CMS essentially testified about the new Federal Regulations and the increased oversight and partnerships to improve quality of care. She expressed that CMS is "deeply concerned" with labor and staffing issues and believes the Payroll-Based Journal (PBJ) data will provide better information to address quality of care issues. As we've reported over the past month, the PBJ is being used now by Plaintiff's attorneys to support claims of understaffing and poor quality outcomes as the data is easily manipulated.

Annette Bacon, Associate Deputy Attorney General from the same-named office in the Department of Justice (DOJ), testified about the far-reaching work that the DOJ has done combatting elder abuse and fraud in civil and criminal actions. She was joined by Keesha Mitchell, Director of the Medicaid Fraud Control Unit in Ohio Attorney General's Office. Director Mitchell testified about the role of the state Medicaid Fraud Control Units ("MFCUs") in investigating and prosecuting patient abuse and neglect in nursing homes. She cited several examples of investigations and stressed "We must also require nursing homes to properly report and detail incidents of patient abuse, neglect and misappropriation or face meaningful penalties."

While the testimony of these witnesses is important to the continued conversation in this country about aging and elder care and abuse and neglect prevention, what is glaringly absent is testimony of the multitude of instances of high quality and innovative services the nursing homes provide. I, alone, am aware of many nursing home organizations that collaborate with CMS and policymakers in establishing best practices. Consider the nursing homes that have eliminated of restraints and the reduced the inappropriate use of antipsychotic drugs, reduced hospital transfers, increased resident choice and patient-centered care initiatives and have had great success in improving the quality of care in nursing homes,

Those who commit illegal acts must be punished and improper care cannot be tolerated. There are already extensive regulatory systems addressing unacceptable situations and delivering appropriate remedies. How can more regulation really help the industry?

Let's include in our conversations and committee testimonies how collaborative work might reduce incidents that we heard about through the witnesses.

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*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

# Risk Management and Forms: Policy Considerations

Last month I introduced the topic of forms and the importance of critically evaluating the forms in your facility. This month, I'll expand the topic and address the relationship between forms and facility policy.

Policies and procedures (P&P's) are not very exciting and may be considered a hassle to write and update, but great policies are part of the backbone of a strong facility. Often when a facility is cited for deficient practice, the citation includes "failure to follow facility policy." I find it interesting that while facilities continue to be cited with regularity for not following their own P&P's, the prevalence of outdated and inaccurate documents is significant. What will it take to move P&P's out of the realm of "paper compliance" to useful documents that guide resident care, support staff and improve quality? Let's use a real life example of a smoking policy, and assessment tool, to demonstrate key points.

This facility was cited at immediate jeopardy for failure to assess residents for safe smoking abilities. I'm sure it comes as no surprise that the policy and assessment form contributed to the problem. Before we go any further, I want to stress that old adage about hindsight being 20/20, and while it's hard to imagine being in the position of this particular facility (because we're looking back on the situation), don't fool yourself that a similar situation couldn't happen in your facility.

There were several instances in which the smoking policy differed from the assessment form, e.g. the consequences if the resident didn't follow the policy were different on both documents. The policy did not state what assessment tool would be used, there was no date on the policy (and clearly had not been reviewed in a long time given the disbelief of leadership and corporate when they investigated), and, the definitions of an independent smoker and a supervised smoker were different between the two documents.

The assessment form had additional problems: there was no date when it was reviewed, poorly worded questions such as "short term memory okay?" and "decision-making skills reasonable?", and there was no line for the evaluator to sign and date the form. Consider the subjectivity of the question "decision-making skills reasonable." What does "reasonable" mean and how does the evaluator assess that? Are there specific decision-making skills that are more relevant to safe smoking than say, decision-making skills of what to eat for lunch or what activities to attend? Here's another way to think about these types of questions. How would you or a staff member respond to a jury of your peers if asked those questions? And, did you demonstrate good critical thinking skills that resulted in good clinical judgment?

A couple of more points regarding forms, and this smoking evaluation, in particular. The text font size is 9, all the text is single-spaced, bolded and squished in the middle of the paper (literally, the margins are huge), the columns don't line up and the grammar would cause heart palpitations for any English teacher. Take this sentence, "Residents with no answers of No may manage and maintain own smoking materials while following smoking rules." Not only is the syntax awful, the spelling errors ("Resindents'" and "llimits") certainly don't help.

Let's look at sections of the policy and procedure. This smoking policy states that the resident "will be assessed for their ability to smoke safely upon first availability for staff supervision." A smoking assessment should be done upon admission, before the resident ever lights up for the first time. The procedure goes on to state, "staff will review the status of a resident's smoking privileges periodically" yet the assessment form states "re-evaluated quarterly and PRN." The procedure states, "Upon completion of the assessment, the interdisciplinary team will evaluate the resident's ability to safely smoke" yet there is no place on the assessment tool to indicate that the IDT completed such an evaluation or the resultant decision. The policy further states, "the designated area shall be under periodic observation of facility personnel or responsible designee." Imagine trying to defend "periodic observation" to a surveyor, an attorney, or your state's version of a board of nursing home administrators.

Choosing, or creating, an assessment tool is important. As I cautioned in Part I, do not assume that just because you purchase a form, that it automatically passes muster for your facility. I'm looking at a smoking evaluation from a reputable forms company. On one side is a series of "Yes/No" questions and, based on those answers, the evaluator then proceeds to a summary section in which there is a series of options (like outcomes) to consider. The check boxes include independent smoking or with set up, unsupervised smoking in designated area, and supervised smoking by staff, volunteer or family member. Regarding a family member assuming responsibility for safe smoking – is it possible that some family members are unsafe smokers themselves or even incapable of handling an emergency should one occur (e.g. ash falling on a resident and igniting clothing)? Yet, the assessment form includes that verbiage - so if the facility chooses to use it, they need to address it.

I'm not so much taking issue with the form itself as I am with the lack of critical thinking skills; leadership needs to incorporate relevant components from the form into the facility policy and procedure. If the assessment form defines safe smoking or supervised smoking, the policy needs to match. And, the procedure must be something that staff can accomplish, consistently and successfully. If interventions like cigarette holders and smoking aprons are included on the evaluation form, they must be addressed in the policy as well. And, the items must be always be available, and in good working order, for staff and residents.

Staff in nursing homes are good people, coming to work at very tough jobs and trying to do the best they can. They are inundated with tasks, demands and paperwork. While not good, it's understandable how things like policies and forms may not take a front seat of importance. Folks, it's time to change that. Support staff with policies and procedures that are relevant, updated, consistent and easy to implement. Protect your patients, residents, staff, and your facility too!

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# 5-Star is Changing, Will You be Ready

By: Joel VanEaton, BSN, RN, RAC-CT MT VP of Compliance and Regulatory Affairs

DPM this month to address a late breaking development. On March 5th , with barely a months' notice, CMS announced (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO19-02-NH.pdf) that they will be overhauling Nursing Home Compare and the 5-Star rating system in April. And what an overhaul it will be. From the memo entitled, "*April 2019 Improvements to Nursing Home Compare and the Five Star Rating System*", here is a breakdown of the primary changes you can expect.

**Health Inspection Domain** – CMS will be "unfreezing" the survey data affecting this domain. This means that CMS will end the freeze and begin including inspections of facilities conducted on or after November, 28, 2017 into a facility's overall star rating calculation. Ratings will again be based on three cycles of inspections (the three most recent standard inspections and any complaint inspections occurring within the past three years). Also, suppressing the star ratings for Special Focus Facilities.

**Quality Measure Domain** – The April 2019 update includes the following improvements to the QM rating domain.

- **Short-stay and long-stay ratings**: To help consumers better understand the level of quality each nursing home provides to these two groups, CMS is creating separate short-stay and long-stay QM ratings. Each facility will continue to have an overall QM rating, which will be used to calculate the overall nursing home star rating.
- **New QM rating thresholds**: CMS will be adjusting ratings' thresholds to raise the expectations for quality and incentivize continuous quality improvement.
- **Implement a process for continual improvement of QM thresholds**: Every six months, QM thresholds will be increased by 50% of the average rate of improvement in QM scores. This action aims to incentivize continuous quality improvement and it will reduce the need to have larger adjustments to the thresholds in the future.
- **QM weightings and scoring**: Two different weighting levels are being established: high and medium. CMS is employing this to better reflect the clinical significance and room for improvement in each measure.
- **Other QM updates: 1.** CMS will add the measure of long-stay hospitalizations to the rating system in April 2019, **2.** CMS will also add a new measure of long-stay emergency department transfers to the Nursing Home Compare website and the rating system, **3.** Additionally, CMS will replace two short-stay QMs, pressure ulcers and successful discharge to community, with two similar measures from the Skilled Nursing Facility Quality Reporting Program, **4.** Furthermore, the QM of long-stay residents who were physically restrained will no longer be included in the rating system. However, CMS will continue to report the QM on the Nursing Home Compare website, **5.** Lastly, there are small technical updates to specifications for a few QMs.

**Staffing Domain:** The April 2019 update includes the following improvements to the staffing rating domain.

• **Set new staffing rating thresholds**: To incentivize improved nursing home staffing levels, CMS will be establishing new thresholds for staffing ratings. CMS will also be adjusting the staffing rating's grid to increase the weight registered nurse staffing has on the staffing rating.

• **Reduce the number of days without an RN for a one-star staffing assignment:** Beginning in April 2019, the threshold for the number of days without an RN onsite that triggers an automatic downgrade to one-star will be reduced from seven days to four days.

CMS indicated that when these changes take place many nursing homes will see a decline in their rating in these areas until they make further improvements. Because the QM and Staffing ratings are also used as part of the Overall rating, some nursing homes will experience a decline in their Overall Five Star.

Providers need to be aware of how these changes will affect their facility and how the resulting changes will affect their relationship with other outside entities like Hospital preferred provider networks, ACOs, participation in a bundled payment initiatives as well as contracting with managed care organizations.

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# KESSLER'S CORNER

**by Chip Kessler**

As human beings we have one fatal flaw in our make-up. Call it a selfish characteristic if-you-will but because we all have this trait I don't believe it is such a bad thing. We basically make decisions in our own self-interests, or in other words: "what's in it for me?" This is a very important fact to keep in mind as you're setting up a marketing and/or advertising program or initiative.

In the case of selecting a nursing facility or assisted living community, or some other caregiving option out there, the person or persons making the choice are going to do so for strictly self-serving purposes … and hopefully in the best interests of the person receiving care if they are acting or behalf of a family member.

Accordingly, you must answer the question the decision maker is asking him or herself: *why should I go with you?* If the person is acting for a loved one, where you're located (whether it's near home or work) could be a definite factor, presuming you measure up in other important categories. However this isn't something you can use in your marketing/advertising since you are going to be conveniently situated near some folks and not so much for others. As a result, you need to focus on the following in your messages:

- Peace-of-Mind (is your care and services such that the family/resident going to feel that you and your fellow staff members are meeting the needs-at-hand on a consistent basis)

- Attention-to-Detail (your marketing/advertising must convey a message of strength, i.e.- your facility is home to the healthcare experts who have the knowledge to handle whatever comes up)

- Personal Satisfaction (here your message needs to resonate to the public-at-large and in particular strike a responsive cord to those who happen to be looking for caregiving help. Right here, I'm going to give you a vitally important tip: how adept you are at using testimonials within your advertising and marketing will make the difference between census success and failure. I could once again do an entire newsletter column on how to effectively use testimonials and probably will at some point because it's that important! The quickie course here is that having satisfied families (and residents if you can call on them) to sign your facility's and staffs' praises is much more effective than you doing it yourselves. And when you get a personal testimonial to use, let's say in a newspaper or an on-line advertisement, make sure you use the person's full name and the town or city he or she is from. No, you shouldn't print his or her street address however you also shouldn't use Paula T. either. People see an initial and think the testimonial is made-up. Make sure if Paula's willing to provide you with a positive comment about your facility that she also agrees to let you use her full name.

You must give people reasons why your building should be their #1 option. And don't be bashful about responding to this internal question on their minds. Moreover, don't be shy about appealing to peoples' emotions. For most selecting an assisted living community or a nursing home whether for themselves or especially for a loved one is a very emotional decision. You already know this. If I may be so bold here, you must take advantage of this fact and shape your marketing and advertising campaigns to provide just the right touch.

Naturally, you must be careful not to overpromise. You can't project an image of being Shangri-la. All this will potentially do is make residents and families upset because you've served to pump up their expectations. Yes, there's somewhat of a fine line to walk though: it is easily accomplish when you use sound judgment. Your goal is to tell your story to the audience out there waiting to read and here what you have to say.

Letting them know that you can provide some very reasonable answers to their caregiving challenges gives you a definite leg-up on your competition. That's the beauty of the healthcare business you're in- it gives you a ready platform to position you, your fellow staff members, and your facility as the best choice available to provide a service and offer up an answer to a very important need. Don't take this responsibility lightly as you make your case to get much needed new residents.

*Chip Kessler provides consultation services for nursing and assisted living facilities nationwide. Discover more at ExtendedCareProducts.com or at 800-807-4553.*

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