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

MEET NAHCA – THE ELEVATED CARE FORCE

I am so excited and grateful to co-author this month's article with Lori Porter, one of the founders of the National Association of Health Care Assistants (NAHCA) www.nahcacna.org. The mission of NAHCA is to elevate the professional standing and performance of caregivers through recognition, advocacy, education and empowerment while building a strong alliance with health care providers to maximize success and quality patient care. NAHCA offers needed support that is welcome more now than ever.

In the many years and on the many levels I've been involved in long-term care, one of the most frequent topics of discussions is "staffing". In fact, several presentations were focused on staffing issues at the ARI ALF/Nursing Home Seminar just last week. Most recently I reported on the regulatory and operational reform hearings held before the Senate Finance Committee in March and July. Between Five-Star staffing measures, Payroll-Based Journal and the Final Rule related to staff education, the standing and performance of caregivers is receiving greater attention and change.

For example, the Final Rule took steps to improve staffing by requiring staff to have "appropriate competencies and skill sets" to care for the residents living in the facility; (2) required training around issues such as abuse prevention and dementia care; and (3) required an annual Facility Assessment which mandated nursing homes to assess necessary staffing needs for their facility by taking into consideration the number, acuity, and diagnoses of its resident population.

Meet NAHCA – the voice of Certified Nursing Assistants (CNAs), the "Care Force" and provider of educational resources for CNAs. CNAs provide over 90% of the direct patient care and make up the largest group of employees working in health care facilities today.

Lori's here to share with us how NAHCA can help support your Care Force community.

It has been a great honor to serve CNAs for the past 25 years; working with them to build a strong professional community. NAHCA also works directly with senior housing providers on CNA professional development, career lattices and resources to support their efforts in building a strong stable CNA team.

Very few understand what motivates a CNA, what drives them to achieve excellence. They do not have jobs, they have passion. When passion turns to burnout without any relief, we lose great people who must be transformed not terminated. The relationship between CNAs and residents/patients is one that can only be felt not understood.

Senior housing does not have a recruitment problem but rather a retention problem. Passion in action takes a great deal of support not present in most health care workspaces today. NAHCA not only speaks of it but has developed a host of proven solutions for both employers and their CNAs.

We look forward to collaborating with the Adelman Law Firm in developing and delivering new and innovative education on managing expectations with families and residents, incident reporting and investigation, communication and documentation.

Lori and I will be offering a webinar this Fall on CNA education so please reach out to us if you're interested in a complimentary registration.

The following is a list of educational resources that NHACA has developed to meet the diverse needs of its members and to provide the best possible learning experience:

The NAHCA Virtual Campus of Care (NVCC):

NVCC is a distance learning platform that allows members to drive their own learning experience. It enables them to learn at their convenience, anywhere, anytime and on any device. NVCC content is organized into five major categories: Clinical, General, Required, Exclusive and Elective Education.

The purpose of Clinical Education is to build on the fundamentals that each CNA received from their initial certification or licensure. The content within the category of General Education is intended to help in the development of skills such as communication, team building and problem solving. Required Education is NAHCA's effort to help our members better understand the Federal Regulations that impact their scope of practice, as well as the requirements for education that help them stay in good standing for their recertification. Exclusive Education houses some of our most prestigious course content. Members who have demonstrated genuine commitment to their growth are assigned these courses. The Elective Education category is available for members who wish to take an active role in course selection. NAHCA's leadership carefully considered

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NAHCA's members as they developed each course and current feedback says NAHCA has succeeded in creating relevant and meaningful education.

Professional Development Coaching:

This is a unique feature of membership. Some members of the NAHCA team serve as Professional Development Coaches (PDCs). They are selected based upon their depth of experience within the long term care system and service as CNAs. As PDCs, they work to guide our members toward desired outcomes like helping to decrease turnover. They also coach individual members on matters of personal and professional growth.

The Geriatric Care Specialist (GCS) Course:

This ten-module course of study is dynamic and enhances the clinical knowledge and competency of those who complete it. The GCS course starts with an in-depth look at Anatomy and Physiology and concludes with the Survey and Regulatory Process. The comprehensive exam at the end of the course reinforces how well the member understood the content and that they attained a level of mastery.

The Certified Preceptor Course:

One of the most challenging issues in long term care is the high rate of turnover. The majority of turnover occurs in the first 90 days of employment. CNAs have a great potential to help decrease turnover by serving as a teacher, mentor and coach for the newest members of our profession. This eight-module course is designed to equip our members with the tools necessary to serve as a bridge to help get the new staff through that critical phase of initial employment.

NAHCA's Annual Conference:

Each year, the Association hosts the nation's premiere gathering of CNAs, STLNAs, PCAs and other caregivers with similar scopes of practice. The Annual Conference provides 12 to 16 hours of education for all attendees, fantastic networking opportunities that allow folks to share best practices and culminates with the prestigious Key to Quality Awards Banquet where members are recognized for the noble and humanitarian service they render to those they care for on a daily basis.

The CNA Code of Ethics and Federal Regulations Handbook:

This handbook was created to educate our members related to NAHCA's strongly-held belief in a code of ethics that drives conduct and performance. A section on regulations was added because NAHCA members were being held responsible for complying with regulations that they had not necessarily been educated on during their certification course. This section is accompanied by examples of how the F-Tag might be observed.

The Edge E-Newsletter:

News you can use that comes right into your email inbox. This monthly periodical covers both the immediate and emerging issue with in the profession. NAHCA's Steering Commission, staff and guest contributors strive to provide the news you need to be your very best. The Edge also highlights caregivers who are doing exceptional work.

"Ask Lori Anything":

Lori presents 10 to 20 minute video segments based upon questions she receives from members. These videos are intended to educate and entertain the viewer. Lori is one of the most sought after speakers in long term care. Watch one segment and see why. You are definitely going to want to watch each new segment. "Ask Lori Anything" is released every month.

Please explore how the NAHCA can partner with your organization and provide education and training to your CNA staff for best practice and quality of care learning and professional development.

PLEASE SAVE THE DATES OF April 21-22, 2020 for the 8th annual National Long-Term Defense Summit! 2019 was amazing and look forward to education, networking and fun in New York City in 2020! You'll love The Parker Hotel and the penthouse Estrela conference room with 360 degree views of the city and Central Park! Please plan to join us!!!! For more information, please contact me at rebecca@adelmanfirm.com.

Rebecca Adelman is an entrepreneur, influencer, thought leader and founder of Adelman Law Firm, a Women's Business Enterprise National Council (WBENC) certified Women Business Enterprise (WBE) 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.

Contact Rebecca at rebecca@adelmanfirm.com and visit www.adelmanfirm.com and www.rebeccaadelman.com.

Lori Porter started her career in long-term care more than 35 years ago. She began as a dietary aide, moved on to be a CNA for 7 years, a nursing home administrator for nearly 7 years and operations director of 10 skilled facilities in the Midwest. In 1995 she followed a dream and created the National Association of Health Care Assistants to honor and recognize CNAs and other frontline care providers who serve our nations frail, elderly and disabled as well as elevate the profession of nursing assistant through professional development, advocacy and empowerment.

She and her staff have grown NAHCA to a membership of more than 30,000 members nationwide and a partnership with more than 800 nursing facilities across the country.

Lori is a nationally sought-after speaker and author of her book Everything I Learned in Life I Learned in Long Term Care. lporter@nahcacna.org

Getting on the Same Page by Paige Hector, LMSW

Want Sustainable Outcomes? Choose the Correct Improvement Strategy

Last month's topic addressed how to use the control chart, the graphical display that shows how a process changes over time. Those changes are represented by the upper and lower control limits that demonstrate what a process is perfectly designed to achieve (despite any goals set by leadership). Continuing with our falls scenario, the control chart tells us exactly (based on the data and statistical theory) the *range of falls* the facility can predict it will have in any given month. Just to recap, the facility in this example can expect between 0-22 falls in any given month. These are not random numbers; they are calculated from the data using proper statistical theory.

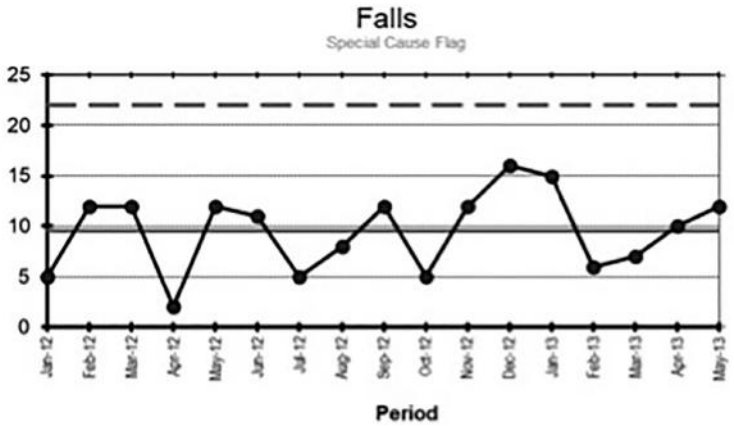
The bigger question becomes, "Can we improve, that is, reduce, the number of falls in our facility?" Since the facility leadership is committed to applying statistical theory, they will not make the common mistake of simply picking an arbitrary number and announcing the new goal, e.g. fewer than 12 falls each month. Instead, they've learned that in order to improve the outcome, they must focus on the PROCESS. I'll be blunt. The process doesn't care what you want, it is what it is. If you want a different number, improve the process.

Since we've already determined the type of variation as common cause (no trend and no clump of 8 from the run chart and no outliers on the control chart), I'm going to focus on the improvement strategies specifically indicated for common cause variation. Most of the variation in your facility will be common cause which is why learning those improvement strategies is so important. Here they are in order: 1) Exhaust in-house data, 2) Stratification, 3) Disaggregation, 4) Formally designed experimentation (e.g. Plan-Do-Study-Act "PDSA" cycle).

Leaders, please stop jumping to the most aggressive strategy or making the mistake of believing that a new policy, a new procedure or a new form is "the answer" to improvement. These actions simply add more complexity and chaos to a system that thrives on predictability and structure. Let's look at the correct improvement strategies, *in order*.

First, exhaust the data you've got. This simply means to plot the data points that you already have available. No doubt you have lots of data! Remember that plotting the dots means creating run charts and if no special cause variation is present, transitioning to the control chart. Continuing with our falls example, here's the control chart from last month.

This control chart clearly demonstrates common cause variation so it's time to move on to the second improvement strategy, stratification. In order to stratify (arrange or classify) something, you must first aggregate it (simply combine the data). Think of



it this way. Instead of focusing on just one fall or one month's worth of falls, aggregate many months of data and utilize improvement statistics to "see" the process and ultimately reduce variation. Process improvement means reducing variation! The variation for the process in our example ranges between 0-22 falls per month (the dotted line at the top of the graph and 0 at the bottom). Let's see if we can narrow those control limits, in other words, reduce the variation.

Let me introduce you to your new best friend, the Pareto Principle. Simply put, the Pareto Principle means we identify the 20% of an issue that is causing 80% of the problem. Think of the Pareto Principle as a "sweat index" – what are the 20% of the issues in your facility causing 80% of the "sweat?" Or, what wakes you up at night? Most likely that whatever wakes you up or makes you sweat is Pareto in action. We're looking for those hidden opportunities in the data that will allow us to reduce the variation which in turn results in improvement. Focusing your improvement efforts on that 20% is what yields the biggest bang for your buck. And, it's simply good management when we focus on those issues that are causing the most problems and we do it in a way that maximizes all our facility resources like staff time and money.

Continuing with the falls example, even though the variation is correctly identified as common cause, there could be *hidden*

Stratification of Falls Data (Pareto matrix)
Strategy #2

Event Type	Unit A	Unit B	Unit C	Total
Walking	24	2	8	34
Wheelchair	6	2	25	33
Toileting	5	6	2	13
Found on Floor	0	8	11	19
Rolled from Bed	4	0	8	12
Transferring	18	15	18	51
Totals	57	33	72	162

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special cause variation in the data. How do we find those nuggets of opportunity? We operationalize the Pareto Principle and create a Pareto Matrix, the actual tool that allows us to quickly identify those opportunities. Here's what a Pareto Matrix looks like.

A Pareto Matrix is a method to stratify data and identify hidden improvement opportunities. The data is stratified into categories, in this example falls are stratified by type. Most likely, you are already doing some variation of this with each incident report or perhaps with a monthly falls report. However, rather than focusing on just one resident or one month, the second improvement strategy *aggregates multiple months* of data from a stable process (again, stable process means common cause variation) and then *stratifies the data* to see the bigger picture of the process over time.

Disaggregation of Falls Data *(FOCUS on the 20%)*
Strategy #3

Event Type	Unit			Total
	A	B	C	
Walking	24	2	8	34
Wheelchair	6	2	25	33
Toileting	5	6	2	13
Found on Floor	0	8	11	19
Rolled from Bed	4	0	8	12
Transferring	18	15	18	51
Totals	57	33	72	162

Now we're ready to move on to the third strategy for improvement, disaggregation. This is where the Pareto Matrix shines as it allows us to quickly identify those areas to focus on. Disaggregation simply means to dissect the process. Take a look at the next iteration of the Pareto Matrix with the colors. Obviously, your eyes are immediately drawn to the highlighted sections. It's Pareto in action! Those colored sections represent the 20% of all the falls (162 total falls over 17 months) and are where leadership needs to investigate further.

Based on the matrix, we can identify four potential areas that need to be further investigated to see what is happening with the process (notice that I'm not just jumping to the conclusion that training is the answer). Unit A has a high number of falls while walking, but the other two units do not have this issue. That likely means that the inputs (resident/patient diagnoses, physical environment, equipment, etc.) on Unit A are different. If you guessed that Unit A is a rehab unit, you are correct. Would it then make sense to institute a facility-wide training on falls while walking? A training may not even be appropriate for Unit A, *not until we learn more about the process that is contributing to the falls*. We might incorrectly assume that the problem is staff competency but what if it has nothing to do with staff? What if there is a process problem, an equipment problem, or a staffing problem? If we incorrectly assume that the problem is with staff and mandate training, we're once again wasting time and money and increasing staff cynicism.

Let me deviate for just a moment to clarify an important point. In her book *Competency Assessment Field Guide: A Real World Guide to Implementation and Application*, Donna Wright says, "Educational strategies should address education deficits, period." She uses the term "spray and pray" as what typically happens in healthcare in the event of an incident, a near miss, a mistake or sentinel event. "We spray education on everyone and pray that it improves outcomes." Why do we do this? I think it's because we've never learned what else to do, specifically, how to use process-oriented thinking and improvement statistics.

Take another look at the matrix in its disaggregated format (the one with the colored sections). Notice that falls during transfers is an issue for all three units. Interesting. That's all we know right now. The next step is to investigate, be curious and ask questions. Hopefully, you see how we're focusing on the 20% of the processes that are causing 80% of the problems. What other opportunities to "dig deeper" on the processes do you see based on this matrix? Unit C has a higher number of falls overall but where are they concentrated?

And, all of this process-oriented thinking, discussion and investigation happens well in advance of the fourth strategy, formally designed experimentation. Only choose this strategy if no other improvement opportunities can be identified with the other strategies first. Introducing an experiment (PDSA cycle) into the workplace can be disruptive and frustrating for staff, people whose time is already consumed 100% and now they are being asked to engage in an experiment, which if not presented carefully, will be perceived as just "extra work."

Learning something new is tough. Unlearning what we were doing incorrectly and then learning a new way is even tougher. I hope this summer series piqued your interest enough to learn more about improvement statistics and commit to sustainable process improvement in your facility.

Years ago, I was introduced to the world of improvement statistics and subsequently met Davis Balestracci, author of *Data Sanity*, at a conference. Words cannot express my gratitude for his wonderful mentorship. His work changed my world and how I will forever teach improvement. Thank you, Davis. Paige

Balestracci Davis. *Data Sanity 2nd Edition*. Englewood, CO: Medical Group Management Association; 2015.

Contact Paige at 520-955-3387 or at paige@paigeahead.com
Discover more about her at www.paigeahead.com

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

PDPM is Finally Here – Yay?

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

Well, it's finally here. The proof will be in the pudding. Will the months of learning and preparation pay off? That remains to be seen. As it stands now, the Transition IPA will reset the Variable Per Diem Adjustment to day 1. This means the starting on October 1, facilities will be paid at 3x's the NTA rate for the first three days of October regardless of the ARD (Oct. 1-7). This is good news, right?

Yes and no. It is good news for facilities who understand the value of NTAs under PDPM, bad news for those who don't. Here is a list of the NTA's and the associated point values and the NTA payment table.

Condition/Extensive Service	Source	Points
SNF Claims		
HIV/AIDS	SNF Claim ICD-10 B20	8
Section H		
Bladder and Bowel Appliances: Intermittent catheterization	H0100D	1
Bladder and Bowel Appliances: Ostomy	H0100C	1
Section I - Gastrointestinal		
Inflammatory Bowel Disease	I1300	1
Section I - Infections		
Wound Infection Code	I2500	2
Active Diagnoses: Multi-Drug Resistant Organism (MDRO) Code	I1700	1
Section I - Metabolic		
Active Diagnoses: Diabetes Mellitus (DM) Code	I2900	2
Section I - Neurologic		
Active Diagnoses: Multiple Sclerosis Code	I5200	2
Section I - Nutritional		
Active Diagnoses: Malnutrition Code	I5600	1
Section I - Pulmonary		
Active Diagnoses: Asthma COPD Chronic Lung Disease Code	I6200	2
Section I - Other Additional Active Diagnoses I8000		
Lung Transplant Status	I8000	3
Major Organ Transplant Status, Except Lung	I8000	2
Opportunistic Infections	I8000	2
Bone/Joint/Musde Infections/Necrosis - Except: Aseptic Necrosis of Bone	I8000	2
Chronic Myeloid Leukemia	I8000	2
Endocarditis	I8000	1
Immune Disorders	I8000	1
Disorders of Immunity - Except: RxCC97: Immune Disorders	I8000	1
End-Stage Liver Disease	I8000	1
Narcolepsy and Cataplexy	I8000	1
Cystic Fibrosis	I8000	1
Specified Hereditary Metabolic/Immune Disorders	I8000	1
Morbid Obesity	I8000	1
Psoriatic Arthropathy and Systemic Sclerosis	I8000	1
Chronic Pancreatitis	I8000	1
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	I8000	1
Diabetic Retinopathy - Except : Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	I8000	1
Complications of Specified Implanted Device or Graft	I8000	1
Aseptic Necrosis of Bone	I8000	1
Cardio-Respiratory Failure and Shock	I8000	1
Myelodysplastic Syndromes and Myelofibrosis	I8000	1
Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	I8000	1
Severe Skin Burn or Condition	I8000	1
Intractable Epilepsy	I8000	1
Cirrhosis of Liver	I8000	1
Respiratory Arrest	I8000	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	I8000	1
Section K		
Parenteral IV Feeding: Level High	K0510A2 K0710A2	7
Parenteral IV feeding: Level Low	K0510A2 K0710A2 K0710B2	3
Nutritional Approaches While a Resident: Feeding Tube	K0510B2	1
Section M		
Other Foot Skin Problems: Diabetic Foot Ulcer Code	M1040B	1
Other Foot Skin Problems: Foot Infection Code, Other Open Lesion on Foot Code, Except Diabetic Foot Ulcer Code	M1040A, M1040C	1
Stage 4 Unhealed Pressure Ulcer Currently Present	M0300D1	1
Section O		
Special Treatments/Programs: Intravenous Medication Post-admit Code	O0100H2	5
Special Treatments/Programs: Ventilator or RespiratorPost-admit Code	O0100F2	4
Special Treatments/Programs: Transfusion Post-admit Code	O0100I2	2
Special Treatments/Programs: Tracheostomy Post-admit Code	O0100E2	1
Special Treatments/Programs: Suctioning Post-admit Code	O0100D2	1
Special Treatments/Programs: Isolation Post-admit Code	O0100M2	1
Special Treatments/Programs: Radiation Post-admit Code	O0100B2	1

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PDPM continued from page 5

NTA Score Range	NTA Case Mix Group Group	NTA Case Mix Index	Urban Rate	Rural Rate
12+	NA	3.24	$ 258.91	$ 247.34
9-11	NB	2.53	$ 202.17	$ 193.14
6-8	NC	1.84	$ 147.03	$ 140.47
3-5	ND	1.33	$ 106.28	$ 101.53
1-2	NE	0.96	$ 76.71	$ 73.29
0	NF	0.72	$ 57.54	$ 54.96

Facilities who have done the legwork to prepare for this transition understand the value of one NTA point. In the rate table above, you have noticed already that the average reimbursement difference between each point range is around $40.00/day. That's significant. Facilities who pay attention to the resident detail here will benefit, those who do not will lag behind. This applies to the transitional IPA as much as it does to any 5-Day that will be completed after October 1.

The beauty of the PDPM is that it allows facilities to actually be paid for the resident's unique characteristics. That was not true under RUG IV. However, it is up to facilities to vigilant to the resident's unique characteristics, not only on initial PDPM assessments like the Transitional IPA, and 5-Day Assessments, but on the regular IPA's as well. This means that evaluating the resident in light of all of the moving parts that account for reimbursement under PDPM does not stop with an initial assessment. Rather, this type of analysis should be happening daily.

At Broad River Rehab, we have developed tools that can help you make quick decisions on initial assessments related to NTAs as well as ongoing IPA assessment decisions. Our Document Navigator will help pick the NTA "needles" out of the documentation "haystack:". The PDPM Navigator ® will help make on the fly IPA decisions.

We would love to Chat. Visit us at www.broadriverrehab.com or call us at 800.596.7234. Do you have a tough PDPM related question?

Ask an expert at https://www.broadriverrehab.com/expert/

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Pumpkin Facts & Trivia

In 1584, after French explorer Jacques Cartier explored the St. Lawrence region of North America, he reported finding “gros melons.” The name was translated into English as “pompions,” which has since evolved into the modern “pumpkin.”

Pumpkin are low in calories, fat, and sodium and high in fiber. They are good sources of Vitamin A, Vitamin B, potassium, protein, and iron.

The Connecticut field variety is the traditional American pumpkin.

Pumpkin is 90 percent water.

The largest pumpkin ever grown was 1,689 pounds. It was grown by Joe Jutras of North Scituate, Rhode Island.

Pumpkin seeds should be planted between the last week of May and the middle of June. They take between 90 and 120 days to grow and are picked in October when they are bright orange in color. Their seeds can be saved to grow new pumpkins the next year.

Pumpkin are fruits. A pumpkin is a type of squash and is a member of the gourd family (Cucurbitacae), which also includes squash, cucumbers, gherkins, and melons.

Colonists sliced off pumpkin tops; removed seeds and filled the insides with milk, spices and honey. This was baked in hot ashes and is the origin of pumpkin pie.

Pumpkins were once recommended for removing freckles and curing snake bites.

The largest pumpkin pie ever baked was in 2005 and weighed 2,020 pounds.

Pumpkins have been grown in North America for five thousand years. They are indigenous to the western hemisphere.

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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